Massachusetts Health Reform

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November 17, 2009

Congressional Research Service
7-....
www.crs.gov
R40931

Summary

As Congress debates the justification for comprehensive health reform and considers various proposals, some states have taken the initiative by enacting reforms to address concerns about health insurance coverage and health care costs, among other issues. Massachusetts is one such state. While Massachusetts has a legislative history full of reforms to its health care system, its most ambitious effort to date was enactment and implementation of a comprehensive health reform law that sought to provide universal health insurance coverage and reduce health care costs at the same time.

In 2006, Massachusetts enacted a comprehensive health reform law that included provisions to expand eligibility for certain public coverage programs, provide premium subsidies for certain low-income individuals, require the purchase of insurance by adult residents who can afford it, and require employers to make contributions toward health coverage. To make private health insurance plans more accessible, it modified state insurance laws and created a quasi-public entity called the Health Insurance Connector Authority whose duties include facilitating the purchase of insurance primarily by individuals who are not offered subsidized insurance by a large employer and are not eligible for public coverage.

Health reform's impact on health insurance coverage, health care costs and spending, and access to care have produced both promising results and troubling trends. Massachusetts has achieved near-universal coverage. The state had the lowest uninsured rate among all states in 2008, and by 2009, state survey data showed the insured rate was 97.3%. Along with the increase in health coverage, state residents have paradoxically reported increases in obtaining medical care and problems accessing health services. In addition, state costs associated with gains in coverage have exceeded initial projections, and consumers have experienced both increases and reductions in affordability of obtaining health care during the initial implementation phase of health reform.

Statements on the success or failure of Massachusetts health reform are far from final. The impact of the state's ambitious health reform plan may not be fully quantified and analyzed until the plan has been implemented and in operation for some time. However, the initial impact on coverage and costs simultaneously deserves attention and raises concerns. The drop in uninsurance is impressive by any measure, but long-term sustainability is seen as an open question, especially with respect to costs.

This report provides background information on the main components of the state's reform law and the law's initial impact on coverage, costs, access to care, employers, and uncompensated care. The report will be updated as circumstances warrant.

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As Congress debates the justification for comprehensive health reform and considers various proposals, some states have taken the initiative by enacting reforms to address concerns about health insurance coverage and health care costs, among other issues. Massachusetts is one such state. While Massachusetts has a legislative history full of reforms to its health care system, its most ambitious effort to date was enactment and implementation of a comprehensive health reform law[1] that sought to provide universal health insurance coverage and reduce health care costs at the same time.

This report provides background information on the main components of the state's reform law and the law's initial impact on coverage, costs, access to care, employers, and uncompensated care.

Massachusetts Health Reform Law and Implementation

In 2006, Massachusetts enacted a comprehensive health reform law that included provisions to expand eligibility for Medicaid and the State Children's Health Insurance Program (CHIP), provide premium subsidies for certain individuals with income below 300% of the federal poverty level (FPL),[2] require the purchase of insurance by adult residents who can afford it ("individual mandate"), and require employers to make contributions towards health coverage ("employer mandate"). To comply with the individual mandate, individuals must enroll in insurance that meets "minimum creditable coverage" (MCC) standards. Firms with at least 11 full-time equivalent employees must (1) establish Section 125 plans[3] which allow workers to buy health insurance on a pre-tax basis, and (2) pay an assessment ("fair share contribution" of up to $295 annually per employee) if they do not make "fair and reasonable" contributions to employee health benefits ("pay or play" provision). Employers may be subject to a "free rider surcharge" if they do not establish Section 125 plans but are required to, or if any one of their employees receives free care three or more times in a year or if a firm has five or more instances of employees receiving free care in a year.

To make private health insurance plans more accessible, the state modified its insurance laws (e.g., merging the state's non-group and small group markets) and created a quasi-public entity called the Health Insurance Connector Authority ("Connector") whose duties include facilitating the purchase of insurance primarily by individuals who are not offered subsidized insurance by a large employer and are not eligible for public coverage (e.g., Medicaid). The Connector, governed by a board of directors, serves as an intermediary to assist individuals and small groups in

[1] Massachusetts 2006 Session Law, Chapter 58 of the Acts of 2006, "An Act Providing Access to Affordable, Quality, Accountable Health Care."

[2] In 2009, the poverty guideline in the 48 contiguous states and the District of Columbia is $10,830 for an individual, and $22,050 for a family of four. "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4199, January 23, 2009.

[3] Section 125 of the Internal Revenue Code allows taxpayers to choose among taxable benefits (e.g., wages) and nontaxable benefits (e.g., health benefits) offered by an employer without paying taxes if they select the latter. As a rule under tax law, when taxpayers are offered a choice between taxable and normally nontaxable income they will be taxed on whichever they choose. Section 125 makes an exception to this rule for benefits such as health insurance that meet the section's requirements.

acquiring health insurance through private insurance carriers. In this role, the Connector manages two programs:

- Commonwealth Care ("CommCare"), which offers public subsidies to individuals up to 300% FPL who are not otherwise eligible for traditional Medicaid or other coverage (e.g., Medicare, job-based coverage) for the purchase of Connector-approved plans (Plan Types 1, 2, and 3 based on income) offered by several health insurers; and
- Commonwealth Choice ("CommChoice"), which offers an unsubsidized selection of four benefit tiers (Gold, Silver, Bronze, and Young Adult), from a handful of insurers, to individuals and small groups.

Before reform, Massachusetts administered the Uncompensated Care Pool (UCP). UCP paid for medical services provided by community health centers (CHCs) and acute care hospitals to eligible individuals with income up to 400% FPL.[4] Under the reform law, UCP was renamed the Health Safety Net (HSN) and redesigned to finance services obtained by individuals with income up to 400% FPL who are not eligible for comprehensive coverage under MassHealth (the state's combined Medicaid program and State Children's Health Insurance Program), or Commonwealth Care.[5]

To partially pay for the reforms the state relied on a federally approved waiver of statutory Medicaid restrictions. The state redirected some existing Medicaid funding that was used to reimburse health care providers (primarily hospitals) for treating uninsured and other patients who generated uncompensated care costs. It obtained additional federal Medicaid and CHIP dollars, collected assessments from insurers and hospitals, used state general funds, and collected fair share contributions from employers.

Initial Impact of Health Reforms

Limitations of Analysis

The stated goals of the reform plan as articulated by then-Governor Mitt Romney are so "every uninsured citizen in Massachusetts [would have] affordable health insurance and the costs of health care [would be] reduced."[6] A typical approach to assess the impact of reform is to use a before-after framework, comparing data on coverage, cost and access prior to enactment with similar data after enactment. Some state-level data exists that has allowed researchers to do such comparisons. However, it would be erroneous to attribute data changes solely to the impact of the health reform law. For example, economic conditions tend to greatly impact the labor market,

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[4] Persons eligible for UCP-financed services included not only uninsured individuals but also those who were "underinsured." (Underinsured refers to insured individuals whose coverage is not adequate to cover high health care expenses.) In those cases where the individual had coverage, UCP was the secondary payer. Moreover, UCP made payments to hospitals to cover the costs for emergency care provided to uninsured persons for which payments could not be collected ("emergency bad debt charges").

[5] Certain CommCare enrollees may be eligible for HSN secondary payments for dental services not covered by their CommCare plan.

[6] Governor Mitt Romney, "Health Care for Everyone? We Found a Way," *The Wall Street Journal*, April 11, 2006, p. A16.

which, in turn, impacts the availability and cost of employer-sponsored health benefits. Access to providers is, in part, a function of the supply and mix of providers in the state, which is affected by non-reform factors such as the standard of living in a given area. Given the difficulty in attributing changes to coverage, cost, and access to the health reform law, apart from other factors, any analytical findings should be considered with caution.

Moreover, implementation of the law's various components and rules has occurred in stages since enactment and still continues to some degree, which makes definitive statements about overall progress difficult to make. For example, while the two programs administered by the Connector each have been in operation for a full two years, the MCC standards developed by the Connector became effective in January 2009. In addition, the current penalty for violating the individual mandate is more substantial than the original penalty.[7] To the extent that outcomes and impact of the reform law may be observed and quantified, reliable data may become available only after provisions have been implemented for some time so that the full effects may be captured.

Initial Impact on Coverage

Notwithstanding the limitations of analysis, some research has been conducted to assess the initial impact of reform on health insurance coverage. According to the latest health coverage data, Massachusetts had an uninsurance rate of 2.7% in 2009.[8] This compares with an uninsurance rate of 6.4% in 2006, the year of enactment.[9]

Since enactment, the number of newly insured persons has increased by approximately 430,000. Of this group, 34% were newly enrolled in private, employer-sponsored coverage, 9% had private, non-group coverage (through the traditional non-group market or CommChoice program), 18% had public coverage through MassHealth, and 38% had fully or partially subsidized coverage through Commonwealth Care.[10]

Certain subpopulations experienced statistically significant increases in coverage as compared to other groups. Given the focus of many components of health reform on lower-income adults, such individuals reported greater gains in coverage than higher-income individuals. In 2006, the uninsurance rate for nonelderly adults with income below 300% FPL was 19.5%; by 2009 that rate dropped to 6.2%. In contrast, for nonelderly adults with income at or above 300% FPL, the change in uninsurance rate went from 8.6% in 2006 to 2.0% in 2009.[11]

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[7] The individual mandate became effective July 1, 2007. Residents to whom the mandate applied who did not show proof of health insurance coverage on their 2007 tax returns were subject to the loss of their personal exemption ($219 per individual). After that tax year, higher penalties were assessed, based on a formula that takes into account the individual's income and age. See 2008 and 2009 Health Care Reform Information, Massachusetts Department of Revenue, Personal Income Tax webpage, at http://www.mass.gov/?pageID=dortopic&L=3&L0=Home&L1=Individuals+and+Families&L2=Personal+Income+Tax&sid=Ador.

[8] In other words, approximately 97 % of Massachusetts residents surveyed during the spring and summer of 2009 reported having health coverage at that time S. Long and L. Phadera, "Estimates of Health Insurance Coverage in Massachusetts from the 2009 Massachusetts Health Insurance Survey," October 2009.

[9] Massachusetts Division of Health Care Finance and Policy, "Massachusetts Household Survey on Health Insurance Status, 2007."

[10] Shares do not add up to 100% due to rounding. Kaiser Family Foundation, "Massachusetts Health Care Reform: Three Years Later," Sept. 2009, available at http://www.kff.org/uninsured/upload/7777-02.pdf.

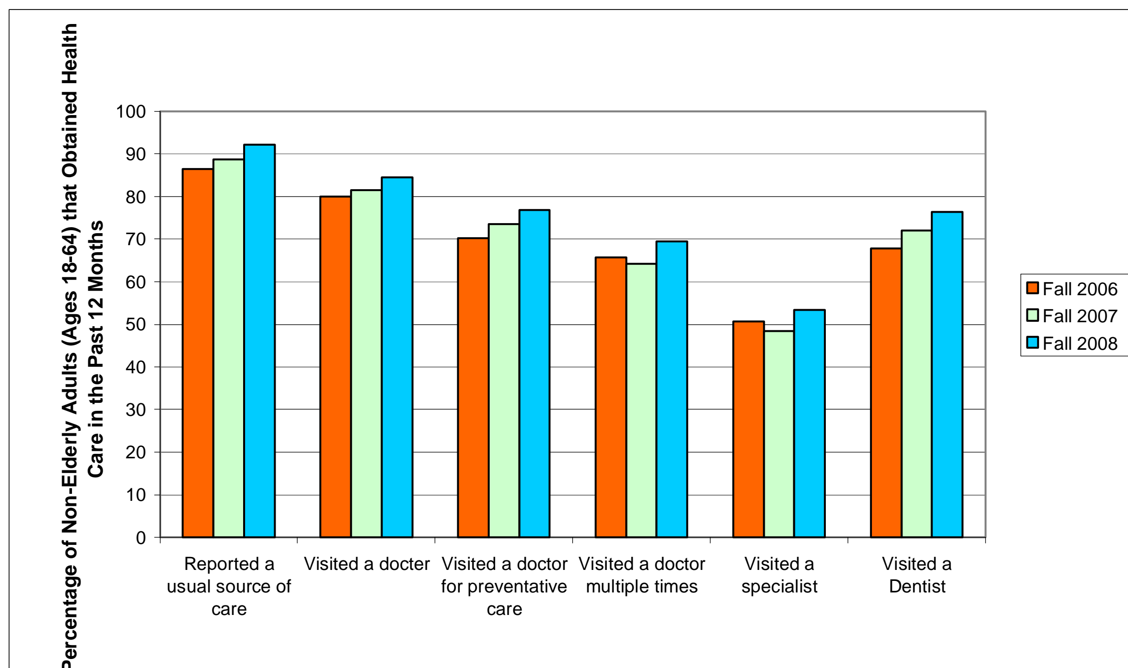
[11] S. Long, "Who Gained the Most under Health Reform in Massachusetts?," Policy Brief, Massachusetts Health Reform Survey, October 15, 2008, available at http://www.urban.org/publications/411770.html, and Op. cit.

Another group that experienced significant gains in coverage during the initial implementation phase was young adults. The uninsurance rate for adults ages 18 to 34 was about 18% in 2006. A year later that rate had dropped to around 7%.[12] This decrease in uninsurance may be attributed in large part to the availability of low-cost "Young Adult" plans offered through CommChoice, and the requirement that insurers allow dependents to remain on their parent's insurance policy up to age 25 or two years past the loss of their dependent status, whichever comes first.

Initial Impact on Access to Providers and Services

A likely correlation with the increase in coverage was an overall increase in health care use. From 2006 to 2008 there was a 4.5% increase in doctor visits and 6.6% increase for preventive care doctor visits for nonelderly adults (see **Figure 1**). There also has been a steady increase in visits to dentists, and more people have reported having a "usual source of care" (excluding the emergency department). [13]

Figure 1. Reported Health Care Use by Type of Care, 2006-2008



Source: Sharon K. Long and Paul B. Masi, "Access And Affordability: An Update On Health Reform In Massachusetts, Fall 2008," Web Exclusive, *Health Affairs*, May 28, 2009.

Similar to their experience in coverage gains, lower-income (less than 300% FLP) adults had somewhat greater gains in access to care than higher-income adults.[14]

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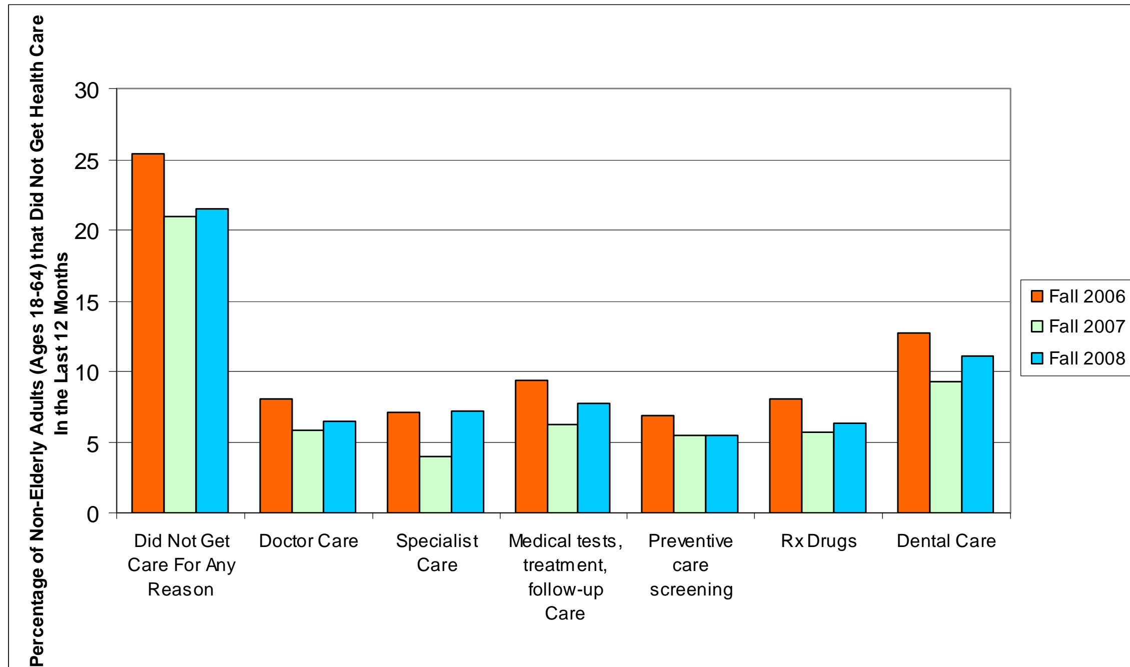
[12] Ibid.

[13] S. Long and P. Masi, "Access And Affordability: An Update On Health Reform In Massachusetts, Fall 2008," Web Exclusive, *Health Affairs*, May 28, 2009. (Hereafter cited as "Access and Affordability.")

[14] Ibid.

At the same time as the increase in health care use, there has been an overall mixed trend regarding reports of unmet medical need. As seen in **Figure 2**, from 2006 to 2007, a smaller share of nonelderly adults reported problems accessing health care, but from 2007 to 2008, that share grew for all but one type of care reported. While these increases were generally slight, they were statistically significant for a couple of types of care (specialist care and medical tests, treatment, or follow-up care).

Figure 2. Reported Unmet Need by Type of Care, 2006-2008



Source: Sharon K. Long and Paul B. Masi, "Access And Affordability: An Update On Health Reform In Massachusetts, Fall 2008," Web Exclusive, *Health Affairs*, May 28, 2009.

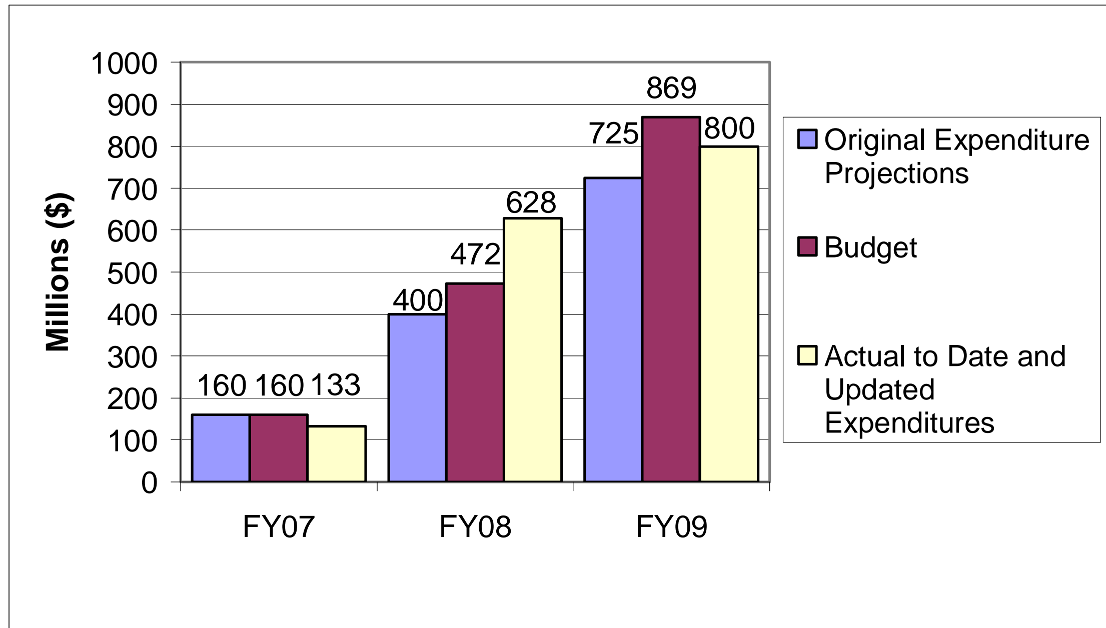
Initial Impact on Costs

State Spending under Commonwealth Care

Along with the rapid increase in health insurance coverage, the state has experienced higher than expected costs. Concerns about costs have focused primarily on the Commonwealth Care program. As seen in **Figure 3**, original expenditure projections for the CommCare program in FY2007, FY2008, and FY2009 were $160 million, $400 million, and $725 million, respectively.[15] While actual spending for FY2007 was less than originally projected, expenditures for FY2008 and FY2009 were greater than original projection amounts.

[15] J. Holahan and L. Blumberg, "Massachusetts Health Reform: Solving the Long-Run Cost Problem," Urban Institute, January 2009, available at http://www.urban.org/publications/411820.html. (Hereafter cited as "Cost Problem.")

Figure 3. Commonwealth Care Expenditures



Source: Massachusetts Health Insurance Connector Authority, "Health Connector Facts and Figures," Nov. 2009, and J. Holahan and L. Blumberg, "Massachusetts Health Reform: Solving the Long-Run Cost Problem," Urban Institute, January 2009.

The difference between projected and actual spending is due, in part, to greater than anticipated enrollment in the CommCare program, at least during initial implementation. One of the reasons is that the state originally underestimated the size of the uninsured population. According to 2006 state survey data, there were 395,000 individuals without coverage.[16] This underestimated the number of uninsured persons in the state, especially in light of the previously mentioned coverage statistic that 430,000 individuals became newly insured since enactment.[17] The 2006 uninsured estimate also understated the number of uninsured persons with income below 300% FPL—individuals who potentially could access subsidized coverage under CommCare. These factors, along with a successful outreach campaign, led to greater enrollment in the Commonwealth Care program than previously anticipated.

Besides size of enrollee population, costs under CommCare were larger than expected because the subsidies provided under the program are more generous than originally specified. The law stated that full premium subsidies would go to enrollees with income up to 100% FPL. However, full premium subsidies have been provided to individuals with income up to 150% FPL since July 2007.[18] Moreover, the program initially experienced some adverse selection.[19] Enrollment began

[16] Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," January 2008.

[17] Even taking into account projected state population growth from 2006 to 2009 and the estimated share of uninsured persons represented in that population, the difference in uninsured estimates cannot be fully explained.

[18] Massachusetts Health Insurance Connector Authority, "Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008," October 2, 2008. (Hereafter cited as "Legislature Report.")

[19] Adverse selection in health insurance refers to the circumstance when a disproportionate share of unhealthy people comprise a risk pool, leading to higher than average costs.

in October 2006 (FY2007) and grew steadily until November and December 2007 (FY2008) when it spiked due to increased public outreach and the advent of tax penalties for non-compliance with the individual mandate. The individuals who enrolled during the first year were less healthy than the uninsured population overall, and disproportionately enrolled in full-subsidy plans rather than across both fully and partially subsidized coverage.[20] These factors taken together led to the large initial increase in spending under Commonwealth Care.

However, it appears that enrollment and costs in the program have stabilized to some degree. According to the most recent data available, Commonwealth Care enrollment was 165,000 participants in March of this year, down from the peak of 176,000 enrollees in June 2008.[21] Although still large, the increase in payments to insurers participating in CommCare was lower between FY2008 and FY2009. In FY2008 government payments increased by 15.4%, but for FY2009 the payment increase dropped by six percentage points to 9.4%.[22]

Nonetheless, the state has underlying cost problems that may end up undermining gains in coverage in the long run. For instance, Massachusetts has greater-than-average health care spending. Per capita health spending in the state is 26% higher than in the nation as a whole. In addition, health insurance premiums in Massachusetts grew nearly 9% per year from 2001 to 2007, slightly faster than the national average growth rate of 7.7%. Some researchers have suggested that Massachusetts's health care system is more expensive than the nation as a whole, in part, because either the state's use of medical services is increasing at a faster rate, technological innovations are adopted more quickly, or provider payments are growing faster.[23]

Notably, the state's health insurance market is characterized by dominant players in both the provider and insurance carrier markets. Some in the provider market enjoy marquee status as premier medical institutions, making negotiations with insurers on payments and network inclusion somewhat one-sided. This is particularly the case in the greater-Boston area. In past contract negotiations (prior to health reform) with carriers, "[provider] organizations with strong reputations and strong physician-hospital relationships [were] well positioned to prevail,"[24] ultimately leading to more expensive insurance products. For example, Partners HealthCare System, Boston's prestigious hospital system, had heated negotiations with local plans in 2000. In the end, Partners came away with "large payment increases that forced the plans to raise premiums significantly."[25] While contract negotiations no longer are so contentious, providers still retain and wield tremendous market power. In addition, there is little competition over costs between the dominant providers and other provider systems in local markets, also contributing to the cost growth trend in the state. On the carrier side, the state, and to a great degree the whole of the Northeast, is dominated by Blue Cross Blue Shield both in terms of size and brand name appeal.[26] Some observers have noted the difficulty that other insurers have competing with such a

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[20] See "Cost Problem."

[21] Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," August 2009.

[22] See "Legislature Report."

[23] See "Cost Problem."

[24] B. Strunk, et al., "Health Plan-Provider Showdowns on the Rise," Center for Studying Health System Change, Issue Brief No. 40, June 2001, p. 4, available at http://hschange.org/CONTENT/326/?words=.

[25] J. White, et al., "Getting Along or Going Along? Health Plan-Provider Contract Showdowns Subside," Center for Studying Health System Change, Issue Brief No. 74, January 2004, p. 2.

[26] For data regarding health insurance markets, see American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets 2007 Update," 2007, and CRS Report, CRS Report R40834, *The Market* (continued...)

dominant player, coupled with the lack of incentive for the Blues to constrain premiums in order to gain market share, further exacerbate the state's long-term cost problem.

From a broader economic perspective, typically as unemployment rises more people lose access to employer-sponsored health insurance. To the extent that such persons still have to comply with the individual mandate, this may increase the demand for subsidized health coverage, placing further demands on limited state resources.

Out-of-Pocket Spending under Health Reform

Massachusetts residents initially experienced gains in affordability during the first year after reform enactment. However, during the second year of reform, the percent of residents "reporting problems paying medical bills and problems with medical debt they were paying off over time moved back toward the fall 2006 levels for all adults."[27] In addition, the share of family income spent to cover out-of-pocket health care costs has increased from the past year (see **Table 1**). Not surprisingly, a greater proportion of low-income adults (those with income below 300% of FPL) experienced these financial problems.

Table 1. Percentages of Non-Eldery Adults in Massachusetts Experiencing Financial Burden Related to Health Care, 2006-2008

All Adults	Fall 2006	Fall 2007	Fall 2008
Out-of-pocket health care costs over past 12 months			
5% or more of family income for those <500% of poverty	21.8%	17.0%	17.7%
10% or more of family income for those <500% of poverty	8.9	5.3	6.6
Had problems paying medical bills in the past 12 months	20.4	16.5	17.9
Have medical bills that they are paying off over time	20.8	18.1	19.8
Adults with family income below 300% of FPL			
Out-of-pocket health care costs over past 12 months			
5% or more of family income for those <500% of poverty	25.9	18.5	19.6
10% or more of family income for those <500% of poverty	12.7	7.2	9.0
Had problems paying medical bills in the past 12 months	32.1	23.8	28.5
Have medical bills that they are paying off over time	26.8	22.7	25.9

Source: S. Long and P. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," Web Exclusive, *Health Affairs*, May 28, 2009.

This increase in financial burden likely had contributed to the aforementioned increase in unmet medical need from 2007 to 2008. One study concluded that there were "some increases in unmet need for care because of costs over that period."[28]

(...continued)

Structure of the Health Insurance Industry, by (name redacted) and (name redacted).

[27] See "Access and Affordability."

[28] Ibid, p. w583.

Consumer Costs under Commonwealth Care

Commonwealth Care enrollees face different premium and cost-sharing structures depending on their income. By statute, persons with the lowest income receive full premium subsidies and face very few cost-sharing requirements. Individuals with higher income face a progressive scale of increased cost-sharing for copayments and premium contributions (see **Table 2**).

Table 2. Commonwealth Care Premiums and Co-payments for Selected Services by Type of Plan, 2009

	Plan Type 1	Plan Type 2		Plan Type 3
Enrollee Income	0%-100% FPL	100.1%-150% FPL	150.1%- 200% FPL	200.1%-300% FPL
Lowest Available Monthly Premium	$0	$0	$39	$77
Copayments				
Office Visit (PCP/Specialist)	$0	$10/$18		$15/$22
Prescription Drugs (Generic/Preferred/Not Preferred)	$1/$3/$3	$10/$20/$40		$12.5/$25/$50
Hospital Inpatient Stay	$0	$50[a]		$250[a]
Emergency Room Visit	$0	$50		$100 (no co-pay if admitted)
Outpatient Surgery	$0	$50		$125
Our of Pocket Maximum for Prescription Drugs	$200[b]	$500[b]		$800[b]
Out of Pocket Max for All Services Excl Drugs	$0	$750[b]		$1500[b]

Source: Massachusetts Health Insurance Connector Authority, Commonwealth Care Overview, Health Connector website at http://www.mahealthconnector.org/portal/site/connector/.

a. Co-pay waived if transferred from another inpatient unit.

b. The benefit is from July 1, 2008-June 30, 2009.

Initial Impact on Employers

According to the latest research on employer-provided health benefits in Massachusetts, it appears that reform has not led to a substitution of public coverage for job-based insurance (“crowd out“), at least during the initial implementation phase. A survey of Massachusetts employers in 2008 found that 79% offered health benefits, a slight increase from 73% in 2007. The increase in offer rate of health insurance was found across all firm size categories, including the smallest firms surveyed (firms with 3-10 workers and 11-50 workers).[29] Moreover, 3% of Massachusetts firms surveyed in 2008 were “somewhat likely” to drop coverage next year; no

[29] J. Gabel, et al. “After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage,” Web Exclusive, *Health Affairs*, October 28, 2008. (Hereafter cited as “Massachusetts Employers.”)

firms indicated that they were "very likely" to do so. In contrast, 6% of firms across the nation indicated that they were either somewhat or very likely to drop coverage.[30]

A survey of individuals in the state found similar results regarding availability and enrollment in employer-provided health coverage.[31] The share of workers in firms that provide health benefits to any worker have incrementally increased from 89.7% in 2006 to 91.3% in 2008 (see **Table 3**). Similarly, both the share of workers who qualify for coverage offered by their employer, and the share with employer-sponsored health insurance also increased over that time period.

Table 3. Access to and Enrollment in Employer-Sponsored Health Insurance in Massachusetts, 2006-2008

	2006	2007	2008
Share of workers in firms that provide health benefits to any worker	89.7%	90.8%	91.3%
Share of workers who qualify for coverage offered by their employer	79.9	80.2	83.2
Share of workers with employer-sponsored health insurance	80.3	82.7	84.3

Source: S. Long and K. Stockley , "Massachusetts Health Reform: Employer Coverage From Employees' Perspective," Web Exclusive, *Health Affairs*, Oct. 1, 2009.

Overall, these findings reflect a general commitment by the business community to provide health benefits. According to a 2008 survey of Massachusetts employers, including those that did and did not offer coverage, 77% agreed with the sentiment that all firms bear some responsibility for offering health coverage to their employees.[32] And to the extent that employers did offer coverage, the state made deliberate efforts under health reform to discourage workers from dropping employer-sponsored health benefits. For example, in order to be eligible for subsidized coverage under CommCare an individual must have low income and not have access to employer-sponsored insurance.

Nonetheless, given the underlying cost pressures that are especially acute in Massachusetts's health care system, employer support of health reform may weaken over time. As health insurance premiums and health care costs continue to grow, more and more employers may find it difficult to continue to offer health benefits. Moreover, the offer dilemma may be further exacerbated if unemployment continues to remain high and health care costs continue to grow rapidly. To underscore such cost concerns, a coalition of business organizations and health plans submitted a letter to state legislative leadership in July 2008 in opposition to proposed employer assessments to further fund health reform. In the letter, the coalition argues that employer spending has increased by $500 million so far in response to direct and indirect requirements under health reform. Further, it questions the merit of new employer assessments in the midst of the downturn in the economy.[33]

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[30] See "Massachusetts Employers."

[31] S. Long and K. Stockley , "Massachusetts Health Reform: Employer Coverage From Employees' Perspective," Web Exclusive, *Health Affairs*, Oct. 1, 2009. (Hereafter cited as "Employees' Perspective.")

[32] Op. cit.

[33] "Letter from 23 Business Groups to House Speaker DiMasi and Senate President Murray," July 23, 2008.

At the same time, Massachusetts employers are facing greater benefit responsibilities under health reform. As previously mentioned, the Connector-defined minimum creditable coverage (MCC) standards for individuals became effective on January 1, 2009. To the extent that job-based coverage did not meet these standards prior to that date, those employers must now decide whether to expand their benefit offerings so that workers will be in compliance with the MCC requirements. The expectation is that employers will be pressured to offer coverage that meets these requirements. In doing so, firms would protect their employees from having either to obtain additional coverage or pay the tax penalty for non-compliance. Employer compliance with MCC standards may be expensive. For example, according to one estimate approximately 163,000 Massachusetts residents with health insurance did not have prescription drug coverage, one of the required benefits under the MCC standards. Of those residents, over 80% have employer-sponsored health insurance. One estimate of the cost to employers to meet the requirement to provide prescription drug coverage is $24 million.[34] Financially vulnerable firms, especially small ones, "may decide that the requirements associated with offering their employees coverage are onerous or costly ... and may opt instead to forgo providing coverage" altogether.[35] Or employers may pass along the cost of providing richer benefits to their workers in the form of lower wages, higher premiums, or greater cost-sharing.

Employees of Small Businesses under Health Reform

While employers generally are supportive of health reform, there is some evidence that workers in small firms are facing greater increases in premiums and cost-sharing relative to workers overall. In 2006, 13.3% of all workers had premium contributions that were at least twice the average employee contribution for health insurance, compared to 16.0% of workers in small firms (50 or fewer workers). By 2008, the share of workers with premium contributions that were twice the average were 15.7% for all workers and 24.6% for workers in small firms.[36] A similar pattern emerges with respect to high out-of-pocket spending. In 2006, the share of workers[37] reporting high out-of-pocket spending was 7.2% for all workers, and 4.7% for workers in small firms. By 2008, those shares had increased for all workers and workers in small firms to 10.3% and 14.6%, respectively.

Initial Impact on Uncompensated Care Providers and Costs

As previously mentioned, Massachusetts's health reform law established the Health Safety Net (HSN) program to provide access to medical care to low-income individuals ineligible for publicly subsidized health insurance coverage. For uninsured individuals with income up to 200% FPL who are eligible for HSN assistance, the program serves as their only payer. For eligible uninsured individuals with income between 200% and 400% FPL, HSN provides partial payments to cover costs associated with receiving medical care. HSN also is a secondary payer for eligible individuals with coverage, and provides payments towards emergency bad debt charges.

[34] "Get ready to spend more on your company's health insurance" *Cape Business*, January/February 2009, available at http://www.capebusiness.net/article/1430.

[35] D. Draper, et al., "Massachusetts Health Reform: High Costs and Expanding Expectations may Weaken Employer Support," Issue Brief No. 124, Center for Studying Health System Change, October 2008, p. 6.

[36] See "Employees' Perspective."

[37] The workers surveyed had family income less than 500% of the federal poverty level.

Since enactment, HSN-financed hospital and community health center (CHC) visits have dropped. In the first six months of FY2008, there were 496,000 Health Safety Net-financed visits, a 36% drop from the same period in FY2007 when there were 777,000 Uncompensated Care Pool (UCP) visits (see **Table 4**). Likewise, program costs have also dropped. Comparing the same time periods, HSN payments to hospitals decreased from $620 million to $373 million (38%), and payments to CHCs decreased from $41 million to $37 million (10%).[38] Since health insurance provides a broader range of care, including visits to private doctors and specialists, than the episodic visits paid through the pool, reductions in free-care spending will not cover the total cost of subsidies.[39]

Table 4. Uncompensated Care Pool/Health Safety Net-Funded Total Service Volume

(thousands of visits)

	Partial FY06[a]	Partial FY07[a]	Partial FY08[a]
Hospitals	624	590	369
CHCs	228	187	127
Total	852	777	496

Source: Massachusetts Division of Health Care Finance and Policy, "2008 Annual Report: Health Safety Net," December 8, 2008.

a. This period refers to October through March of each fiscal year.

From October 2006 to September 2008, more than 90,000 individuals who were formerly eligible for UCP assistance were determined to be eligible for subsidized coverage through the CommCare program. Nonetheless, HSN-financed medical facilities continue to provide a significant service to low-income people. In particular, CHCs "play a critical role in caring for newly insured patients while simultaneously serving as the primary care safety net for uninsured residents."[40] For example, CHCs continue to serve a disproportionate share of uninsured individuals, even after reform enactment. One study found that CHCs served one-third of uninsured persons in 2007.[41]

Other Health Reform Issues

Statements on the success or failure of Massachusetts health reform are far from final. The impact of the state's ambitious health reform plan may not be fully quantified and analyzed until the plan has been implemented and in operation for some time. However, the initial impact on coverage and costs simultaneously deserves attention and raises concerns. The drop in uninsurance is impressive by any measure, but long-term sustainability is seen as an open question especially with respect to costs. Massachusetts's experience also raises other relevant

[38] Massachusetts Division of Health Care Finance and Policy, "2008 Annual Report: Health Safety Net," December 8, 2008.

[39] Massachusetts Health Insurance Connector Authority, "Health Reform Facts and Figures, October 2009," available at http://www.mahealthconnector.org/portal/site/connector/.

[40] Op. cit., p. 1.

[41] L. Ku, et al., "How Is the Primary Care Safety Net Faring in Massachusetts?," Apr. 2009, available at http://www.kff.org/healthreform/upload/7878.pdf.

health system issues. In particular, what changes to the health delivery system may be necessary to fully support coverage expansions?

For example, about 20% of nonelderly adults in the state reported problems obtaining care because the physician's office or clinic either were not accepting new patients or did not accept their type of insurance. This problem was much more common for lower-income adults and adults with public coverage, compared to adults with higher-income or private coverage.[42] Consistent with these reported problems finding a health care provider or the previously mentioned difficulties regarding unmet need, there was "no change from pre-reform levels in emergency department (ED) use for nonemergency conditions.[43] However, some of the reasons behind these findings may pre-date health reform. For instance, according to the Massachusetts Medical Society, there were severe to critical shortages in primary care providers (family medicine and internal medicine) in 2006.[44] Nonetheless, these findings point to the limitations of comprehensive coverage reforms without equivalent changes to the health care delivery system.

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Acknowledgments

Jerry Stenquist made contributions to this report.

[42] See "Access and Affordability."

[43] Ibid, p. w583.

[44] Massachusetts Medical Society, Physician Workforce Study, 2008.

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