kaiser commission on medicaid and the uninsured

KEY FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

June 2007

Massachusetts Health Care Reform Plan: An Update

On April 12, 2006, Massachusetts enacted legislation that would provide nearly universal health care coverage to state residents. The bipartisan legislation combines the concept of individual responsibility through an individual mandate on the purchase of health insurance with government subsidies to ensure affordability. Implementation of the plan began at the end of 2006. By May 2007, over 100,000 previously uninsured people had gained coverage.

COMPONENTS OF THE PLAN

Individual Mandate

The Massachusetts Health Care Reform Plan requires all adults in the state to purchase health insurance by July 1, 2007, and would impose financial penalties of up to 50 percent of the cost of a health insurance plan on those who do not via income tax filings.

Employer Requirements

By July 1, 2007, employers with 11 or more employees are required to provide health insurance coverage or pay a "Fair Share" contribution of up to $295 annually per employee. In addition, these employers are required to offer a Section 125 "cafeteria plan" that permits workers to purchase health care with pre-tax dollars or face a "free-rider surcharge" if employees make excessive use of uncompensated care.

Commonwealth Health Insurance Connector

The plan creates the Commonwealth Health Insurance Connector to "connect" individuals to insurance by offering affordable, quality insurance products. Small businesses and individuals can purchase insurance through the Connector. The Connector Board approved plans offered by seven of the state's health insurers that provide a range of coverage options, including a specially designed, lower-cost product for 19-26 year-olds. These Commonwealth Choice plans became available May 1, 2007.

Commonwealth Care Health Insurance Program

A central piece of the plan is the provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance. The Commonwealth Care Health Insurance Program provides sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level (or $30,630 for an individual) for the purchase of health insurance. Individuals with incomes less than 150 percent of the federal poverty level ($15,315 for an individual) are not required to pay any premiums. Plans offered through Commonwealth Care do not have deductibles, and are offered by the managed care organizations that participate in the Medicaid program. As of June 1, 2007, nearly 80,000 low-income adults had enrolled in Commonwealth Care plans.

MassHealth Expansion

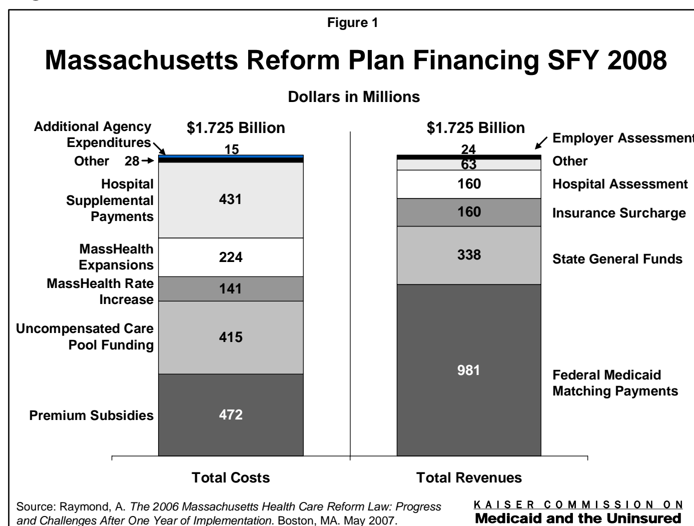
The plan includes an expansion of Medicaid to children up to 300 percent of the federal poverty level. Enrollment caps on existing Medicaid programs for adults have also been raised. By March 2007, MassHealth enrollment had increased by 53,000.

Insurance Market Reforms

Insurance market reforms are also an important component of the plan. In particular, the plan will merge the individual and small-group insurance markets by July 2007. A recent study, mandated by the legislation, to assess the impact of merging these two insurance markets concluded that the cost of health insurance premiums for small employers would increase by about 1.5 percent, while premiums for individuals would fall 15 percent.

Preservation of the Safety Net

The existing Uncompensated Care Pool, which reimburses providers for uncompensated care, will be converted into a new Health Safety Net Trust Fund that will combine these funds with other Medicaid funds, including Medicaid Disproportionate Share Hospital funds. A new fee schedule will be developed to standardize provider reimbursement. As more uninsured gain coverage and uncompensated care drops, funds will be shifted into the health insurance subsidy program.



Financing

For the upcoming state fiscal year, Governor Deval Patrick (D) has requested $1.725 billion to fund the program (Figure 1). The complex financing relies on redistribution of existing funding, including federal Medicaid payments previously paid to safety net providers and funds from the Uncompensated Care Pool. New funding will come from the employer contributions and General Fund revenues.

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IMPLEMENTATION ISSUES

Many of the more difficult issues raised by the reform plan, such as determining what level of coverage would be required to meet the individual mandate and what constitutes affordable coverage, were not addressed in the legislation. Instead, the reform law charged the Board of the Commonwealth Connector with setting the minimum coverage and affordability standards.

Minimum Coverage Standards

Balancing the need for adequate coverage against the potentially high cost of comprehensive plans proved challenging for the Connector Board. In June 2007, the Board approved minimum creditable coverage as including "preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services and prescription drug coverage." The coverage standards also cap deductibles at $2,000 for individuals and $4,000 for families and limits out-of-pocket spending to $5,000 for individuals and $10,000 for families. Although advocates applauded the inclusion of prescription drug coverage, some raised concerns that some employers and individuals may need to switch plans to comply with the coverage standards. To address this concern, the Board delayed enforcement of the new coverage requirements until January 2009.

Affordability Standards

In setting the affordability standards for health insurance in the state, the Board was charged with determining the subsidy levels for the Commonwealth Care program and the premium amounts that would be considered affordable for individuals and families with incomes above 300 percent of the federal poverty level. The Board announced preliminary premium contribution requirements in September 2006. In March 2007, the Board revisited the premium structure, eliminating premiums for individuals with incomes up to 150 percent of the federal poverty level, and reducing premiums for those with incomes between 151 and 200 percent of the federal poverty level from $40 to $35 per month.

The Board also approved draft affordability standards for those with incomes above 300 percent of the federal poverty level. However, due to an error in the draft regulations, the monthly premium amounts that the Board has determined to be affordable for individuals and families at different income levels are not available. The Board is expected to release the final affordability standards before the individual mandate goes into effect on July 1st. Based on the approved draft standards, the Board has estimated that up to two percent of the state's population, mainly those with incomes only slightly above 300 percent of the federal poverty level, will not be able to find health insurance that is deemed affordable and will, thus, be exempt from the mandate to purchase insurance.

IMPLICATIONS FOR OTHER REFORM EFFORTS

The Massachusetts plan has generated a great deal of interest among national and state policymakers and has sparked a broader debate over the merits and feasibility of comprehensive health care reform. Initially considered a unique model with limited replication potential, many states are now including components of the plan in reform proposals of their own. At the same time, the challenges currently facing the plan, though not unexpected, reveal how difficult implementing a plan of this magnitude and complexity can be. Still, there are a number of important lessons to be learned from this effort.

Medicaid provides an important foundation for expanding health care coverage. The Massachusetts plan builds on a broad base of public coverage for the poor and near poor, and relies very heavily on federal Medicaid funds to finance the plan. Other states, however, may not have access to such funding.

Massachusetts has achieved early success in enrolling low-income individuals into subsidized coverage. The enrollment of nearly 80,000 adults in Commonwealth Care demonstrates that adequate premium subsidies and benefits building on the Medicaid infrastructure can be an effective approach for providing coverage to low-income individuals. It also indicates the importance of creating early opportunities for success.

Ensuring that affordable health plans offering comprehensive coverage are available to everyone in the state will be a challenge. The individual mandate included in the Massachusetts plan offers a new approach to achieving near universal coverage, one that is being considered in a number of other states. Adequate subsidies, along with rules to promote comprehensive health insurance plans to ensure individuals and families are able to obtain affordable and meaningful coverage, are essential to an effective individual mandate.

Health care reform can mean combining different strategies from across the political spectrum to win support from key stakeholders. As proposals are advanced in other states and, perhaps, at the national level, understanding the factors that contributed to the Massachusetts plan's passage will be important, but also evaluating the success and difficulties encountered during implementation will shape how the Massachusetts plan influences future policy.

Additional copies of this publication (#7494-02) are available on the Kaiser Family Foundation's website at www.kff.org.

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