POINT-COUNTERPOINT: “CONNECTOR” IS KEY TO NEW MASSACHUSETTS LAW

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On April 4, the Massachusetts Legislature did the undoable: it passed an individual mandate that requires all adults to buy health insurance by July 2007 or face a fine. Backers predict that the law will expand coverage to 95 percent of the state’s uninsured over the next three years by mandating coverage and by:

- Providing subsidies for those whose income is below 300 percent of the federal poverty level ($60,000 for a family of four, $29,400 for an individual);
- Rewriting the state’s insurance laws to merge the individual and small-group markets (pooling these risks could reduce premiums by 25 percent);
- Requiring businesses to provide insurance to their employees or pay a maximum assessment of $295 per employee per year; and
- Creating an insurance “Connector” that will help small businesses and uninsured individuals obtain health insurance coverage on a pretax basis, and take their policies with them when they change jobs. The Connector also will certify plans as being of good value.

Below is an interview with Sen. Richard T. Moore, one of the prime movers behind the new law, as well as excerpts (edited for length and clarity) from recent presentations given by other experts on the law.

Sen. Richard T. Moore:

Q: Massachusetts has enacted a unique approach to universal health insurance coverage. Did you have a strategy for getting the bill passed? What were the major obstacles?

A: The strategy was simply that both the Governor and the House and Senate leadership were interested in getting something passed. And the goal was to get the best bill put together that we could.

Administratively, we (the House and the Senate) had some similar plans, but there were several obstacles. First, the House bill would have imposed a broad-based employer tax as well as a cigarette tax, although [the cigarette tax] was later dropped. The Senate bill planned to use existing reserves and growth in revenue.

Both the House and Senate wanted to insure as many people as possible. The difference lay in how quickly each proposed to cover people. The Senate plan proposed covering half of the uninsured, reassessing our position in about two years and then going forward. But the House version attempted to do it all within the bill they were considering.
The other key differences were that the House bill wanted to merge the non-group and small-group insurance markets, and the Senate wanted to study that, because that’s something that hasn’t been done anywhere else. These were the big hurdles and decisions that had to be made by the conferees as well as the leadership, mostly because they had major budgetary implications.

The House bill also included an individual mandate to have insurance, and the Senate preferred to have it as a study, as it was also new territory. As a compromise we did include the individual mandate, but the penalties are phased in over a couple of years. We also provided a mechanism whereby individuals who are unable to find affordable insurance can apply for a waiver. We left to our health insurance “Connector” the responsibility of defining whether somebody could afford insurance or not.

We both agreed to use our existing uncompensated care funding for subsidy of the insurance program, rather than impose any new tax. We still have a small uncompensated care fund (for hospitals) to deal with, we hope, a shrinking number of people. We expect that in the first year or so, the market might not be sufficiently developed enough for everybody to find affordable health insurance. If they apply for and receive the waiver, those folks would still show up at the emergency room for uncompensated care, and we didn’t want the hospitals to have to eat that whole expense.

Plus, individuals are not required to have health insurance unless they’ve been in the state for 63 days. So you might have some people that just moved into the state, who have a health need but have not obtained insurance—they would still be eligible for uncompensated care. And, of course, we have undocumented aliens who, under federal law, must be cared for in the emergency room.

Q: Is the plan adequately financed? What will happen in the future if the state economy dips?

A: We have analyzed the program three years out and we believe the program is affordable at least for that time period.

We are studying the new requirements of the individual mandate and the “fair share” assessment that we’re putting on smaller non-insuring businesses—do they make small groups have to pay more for health insurance premiums? If they do, we will need to look at reinsurance at some level to get them a zero increase in their premiums. The results of this study are due in January, and the merger (between the individual and the small group markets) takes place next July so there will be an opportunity to make adjustments.

We are also looking at other ways to fund the program, but a lot of it depends on the degree to which the provisions we have implemented are effective in controlling costs. To encourage provider participation, we’re increasing Medicaid reimbursement rates to get them as close to comparable as possible to Medicare reimbursement. Right now, we estimate that Medicaid reimburses doctors and hospitals at around 70 percent of cost versus Medicare, which reimburses at around 93 percent of cost.

In the second year of the program, we’re implementing a pay-for-performance system in Medicaid. To the degree that pay-for-performance imposes some cost-effective controls, and we are able to some degree to manage the growth of costs, that may help us to continue to keep the program affordable.
As far as the economy and the rate of federal participation go, these are unknowns. But they certainly would affect the program. If we have to cut back on support for the program, that would probably force premiums up and result in people becoming uninsured again or at least poorly insured. So it does depend on continuing on having a reasonably strong economy and, hopefully, some continued level of support from the federal government, particularly in Medicaid and Medicare funding.

*James Mongan, president and CEO of Boston-based health system Partners HealthCare, speaking at a briefing held by the non-partisan Alliance for Health Reform:*

The strength of the anti-tax movement has essentially blocked expansions of coverage nationally, sweeping both tax increases and employer mandates off the table as financial resources. Massachusetts had it easier than many other states because our problem was only two-thirds as large as it is in other states: only 10 percent of people in Massachusetts are uninsured compared to the national average of 15 percent.

Secondly, we had a tax-funded uncompensated care pool to cover hospital costs for the uninsured. That pool includes a $160 million surcharge on insurance payments, a $160 million assessment for hospitals and $220 million from general revenues. The law will rechannel these funds, so that instead of supporting uncompensated care delivered by institutions, they will be used to help pay for individual insurance policies. The state also will get $180 million of new federal matching funds, $125 million of state surplus funds (which were allocated to health care rather than tax cuts), and $50 million from the assessment on employers who do not pay for coverage.

If the subsidies remain adequate and adequate lower cost policies (with deductibles, benefit limitations and limits on the choice of provider) are available, the individual mandate likely will be sustainable. If not, the mandate likely will be repealed.

The governor’s willingness to reframe the individual mandate—with the support of the Washington, D.C.-based Heritage Foundation—as personal responsibility rather than as a tax increase was a critical conceptual breakthrough in achieving success.

*Edmund Haislmaier, research fellow, Center for Health Policy Studies, The Heritage Foundation, speaking at NCSL’s recent Health Chairs meeting, sponsored by the Henry J. Kaiser Family Foundation (click here for a videocast and transcripts):*

There are really, from a policy perspective, two key elements in this. One is the reform of the insurance markets—the merging of the individual and small-group markets, and the creation of the insurance Connector. The Connector is all about creating a safe world in which employers—particularly small employers—can be relieved of having to run an insurance plan while still contributing to it and being assured that their employees will have quality coverage to pick from. Everything in there is state-regulated insurance. But at the same time, people get what they want, which is portability of insurance.

The other piece is the fundamental shift from subsidizing institutions to subsidizing people. In Massachusetts, they went from spending about $1 billion dollars in three checks to three large hospital systems, to spending that money on income-related policies for the 150,000 people who are uninsured. If you go from three checks to 150,000, having one place—the Connector—to match people, plans and payments it makes it much simpler administratively. And all sorts of benefits pop out of the woodwork. Say, someone works for two employers, you can combine the contributions from the two employers in one place.
The Census Bureau found that 85 million people in this country were uninsured for some period during 1996 to 2000. Only 12 percent were uninsured for the full four years. What that suggests to me is that if you find a way to make health insurance go with the person and not the job, you would probably solve, depending on your state, between one-third and one-half the problem with no new money—right out of the box.

Make the system stable and portable before you go on and do anything else. That, I think, is the absolute key takeaway from this.