REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-09

Subject: Effects of the Massachusetts Reform Effort and the Individual Mandate

Presented by: David O. Barbe, MD, Chair

At the 2008 Interim Meeting, the House of Delegates adopted the recommendations of Resolution 808, which asked that the American Medical Association (AMA) study the effects of the Massachusetts individual health insurance mandate on individuals, taxpayers and physicians, including details on the number of uninsured remaining, public financing required, effect on private health insurance, primary care physician availability, physician reimbursement, and physician public reporting and compliance requirements. The Board of Trustees assigned Resolution 808 (I-08) to the Council on Medical Service for a report back to the House of Delegates at the 2009 Annual Meeting.

This report, which is provided for the information of the House of Delegates, provides background on Massachusetts health reform, outlines the results and impact of the Massachusetts reform effort, examines implementation issues, describes state and federal initiatives addressing individual mandates, and summarizes relevant AMA policy and activity.

BACKGROUND ON MASSACHUSETTS HEALTH REFORM

On April 12, 2006, Massachusetts enacted landmark health reform legislation, Chapter 58 of the Acts of 2006. The goal of the legislation was to provide near-universal health insurance coverage of the Massachusetts population, based on the tenet of shared responsibility. In 2006, as many as 650,000 individuals in Massachusetts were uninsured, compared to 167,300 as of summer 2008.

One of the most controversial aspects of the legislation was its inclusion of an individual mandate that requires most adults in Massachusetts to have minimum creditable health insurance coverage. If an individual remains uninsured despite having access to an affordable health insurance plan, a penalty is assessed when the individual files a state tax return. The penalty in 2007 for not complying with the individual mandate was the loss of one's personal income tax exemption, or $219. However, as of January 2008, the penalty for noncompliance is more severe and can reach up to 50% of the insurance premium for creditable coverage for every month the individual fails to comply with the mandate, up to a maximum of $912 annually. Penalties for noncompliance with the individual mandate vary based on income and age. Those exempt from the individual mandate include those deemed unable to afford health insurance and those who qualify for a religious exemption.

Another controversial aspect of the law is that it requires employers with 11 or more full-time equivalent (FTE) employees to make a fair and reasonable contribution toward coverage for full-time employees, or pay a "Fair Share Contribution" of up to $295 per employee. Additionally, employers with 11 or more FTEs are required to establish a Section 125 plan to enable full- and part-time employees to purchase health insurance on a pre-tax basis as a payroll deduction.

Chapter 58 also established the Commonwealth Health Insurance Connector, an independent state authority. The Connector assists residents in acquiring health coverage, thereby helping them avoid tax penalties associated with the individual mandate. Chapter 58 authorized the Connector to uniformly apply a surcharge to all health benefit plans to pay for its administrative and operational expenses. The Connector serves as manager of the Commonwealth Care (CommCare) and Commonwealth Choice (CommChoice) programs.

CommCare provides subsidized coverage for individuals with incomes up to 300% of the federal poverty level (FPL) who are not otherwise eligible for employer-sponsored health insurance (ESI) or other public programs (i.e., Medicare and Medicaid). To minimize crowd-out—individuals opting for public coverage who would otherwise be privately insured—the eligibility process for CommCare requires individuals to specify if they currently have ESI or had access to ESI in the last six months. If ESI is offered to the individual, and the employer covers at least 20% of the annual premium cost for a family insurance plan or at least 33% of the cost for an individual insurance plan, then the individual is not eligible for CommCare. Therefore, if ESI is deemed affordable, even with employers making only a relatively modest contribution, affected individuals receive no subsidy for coverage. Health insurance under CommCare is completely subsidized for qualified adults with incomes up to 150% FPL, with plans available with no monthly premiums. For those earning above 150% FPL and up to 300% FPL, premium subsidies are provided. In particular, for individuals earning above 150% FPL and up to 200% FPL, plans are available with minimum monthly premiums of $39. For those earning above 200% FPL and up to 250% FPL, monthly premiums of available plans are as low as $77. For children, the MassHealth (Medicaid) program was expanded to children of parents earning up to 300% FPL. In 2009, 300% FPL is $32,490 for an individual and $66,150 for a family of four.

CommChoice provides unsubsidized health insurance through the Connector. Implemented along with CommChoice was the merging of the small and non-group health insurance markets in the state. Six private health plans, which are selected by competitive bidding, are offered under CommChoice through the Connector to individuals, families and certain employers in the state. Each of these CommChoice plans offered through the Connector may also be purchased directly from the individual carriers. As of the fall of 2008, small employers with 50 or fewer workers are able to purchase health insurance directly through the Connector. The six plans currently offered in the Connector are Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. The Connector assists individuals and employers with their choice of plans by grouping the plans into three levels of benefits and cost-sharing: “gold,” “silver,” and “bronze.” The “gold” level is set to a generous health maintenance organization (HMO) benefit, the “silver” level is set to approximately 80% of the actuarial value of the “gold” level, and the “bronze” level is set to roughly 60% of the “gold” level. On each level, premium levels vary. In April 2009, bronze-level premiums for a 37-year-old Bostonian can range between $211 and $308. Silver-level premiums can range between $294 and $402, with gold-level premiums varying between $367 and $584.

The funding of the Massachusetts reform effort comes from both the state and federal governments. Outside of the state budget, one of the main funding streams is the state’s Medicaid 1115 waiver, which is the primary source of funding for subsidies provided in CommCare. The funds raised from employers who were required to make a “Fair Share Contribution” payment of up to $295 per year per employee are used to help offset the cost of the subsidized health insurance programs. Tax penalties associated with noncompliance with the individual mandate also generate additional revenue, which is deposited into the Commonwealth Care Trust Fund that supports CommCare, certain provider payment rates, and the Health Safety Net. In addition, starting in fiscal year 2009,

the state raised taxes on cigarettes by $1 per pack, the increased revenues from which are allocated to the Commonwealth Care Trust Fund.

RESULTS AND IMPACTS OF THE MASSACHUSETTS REFORM EFFORT

Based on data collected by the Massachusetts Division of Health Care Finance and Policy (DHCFP), more than 430,000 individuals in the state are newly insured. Of this number, 43% are enrolled in private insurance (34% enrolled in ESI and 9% in non-group coverage), and 57% are insured by CommCare or MassHealth (39% and 18% respectively). More than half of these new enrollees contribute significantly toward or pay their entire monthly premium. Overall, the non-group market has doubled in size between June 30, 2007 and March 31, 2008. Thus far, evidence indicates that crowd-out is not taking place.

According to the 2008 Massachusetts Health Insurance Survey (HIS) conducted by the Urban Institute during the summer of 2008, 2.6% of Massachusetts residents remain uninsured, a continued decrease from 2007 HIS findings, which estimated that approximately 5% of Massachusetts residents were uninsured in 2007. This figure paralleled data from the Massachusetts Department of Revenue, which found that 5% of the 3.3 million tax filers in 2007 reported being uninsured as of December 31, 2007. The decrease in the number of uninsured makes Massachusetts the state with the lowest rate of uninsured in the country.

Resulting from the decrease in the number of uninsured residents, there has been a decline in the use and cost of the Massachusetts Health Safety Net. Formerly known as the Uncompensated Care Pool, the Health Safety Net provides medical services for residents whose income is below 400% FPL and do not qualify for MassHealth and Commonwealth Care. According to DHCFP, Health Safety Net payments for hospitals and community health centers declined by 38% in the first two quarters of fiscal year 2008, compared to the same period in fiscal year 2007 of the Uncompensated Care Pool. Health Safety Net volume for hospitals and community health centers—the sum of inpatient discharges and outpatient visits—declined by 36% in the first two quarters of fiscal year 2008, compared to the same period in fiscal year 2007 of the Uncompensated Care Pool.

The implementation of tax penalties associated with the individual mandate also affected the taxpayers of the state, who had to be educated regarding changes to the tax filing system as well as the individual mandate and the availability of coverage through the Connector. A postcard was mailed in May 2007 to roughly 3 million Massachusetts taxpayers. According to the Massachusetts Department of Revenue, only 1.4% of individuals who filed taxes for 2007 did so incorrectly. Five percent of the 3.3 million tax filers in 2007 reported being uninsured as of December 31, 2007. Of these taxpayers, approximately 97,000 were deemed able to afford coverage and therefore self-assessed a penalty. Roughly 71,000 taxpayers were exempt from the mandate due to being deemed not able to afford health insurance or due to their religious beliefs. The number of individuals appealing the tax penalty has remained low, with estimates ranging between 4,000 and 6,000.

More than 3,300 employers responded to the law by creating Section 125 plans with the Connector in the first year of the program. Approximately three-quarters of Massachusetts employers offer health insurance to their employees, compared to roughly 60% nationally. The employer offer rate held steady in Massachusetts from 2001 to 2007. Most Massachusetts employers who offer health insurance coverage contribute at least 75% toward their employees' health insurance premiums. According to the Massachusetts Division of Unemployment Assistance, of the employers with 11 or more FTEs who filed Fair Share Contribution reports for 2006-2007, three percent owed a fair share assessment. The high rate at which Massachusetts employers are offering health insurance to

their employees has translated into lower than expected revenues from employer fair share assessments, which some argue only add to the existing concerns related to the long-term financial sustainability of Massachusetts' plan. According to Kaiser Commission on Medicaid and the Uninsured, as of May 2008, Massachusetts had raised about $6.7 million from approximately 750 employers that did not offer health insurance coverage to their employees. This $6.7 million from fiscal year 2008 is much less than was estimated when Chapter 58 was enacted into law.

The law also has had an impact on physicians, both as practitioners and employers. The increase in the number of insured patients through CommCare and CommChoice has increased demand for physician services. The law included a provision to increase Medicaid payment to physicians by an additional $81 million over a three-year period. In addition, a MassHealth Payment Policy Advisory Board was established to "review and evaluate rates and payment systems." The Massachusetts Medical Society is represented on the board. A concern for physicians is that the use of select or tiered networks to control costs is a preferred plan-design feature for health insurance products to be awarded the Connector Seal of Approval. As of April 2009, four carriers offer select network designs through the Connector. Physicians have had to review existing payer contracts and agreements to determine whether they are required to participate in the new programs.

Physicians have also been impacted as employers if their practice has 11 or more FTEs, in which case they would be required to make a fair and reasonable contribution toward the health insurance coverage of FTEs or make a "Fair Share Contribution." Therefore, physicians may have had to make changes to and contribute more toward the health insurance coverage of their employees. These practices also would be required to establish a Section 125 plan to enable full- and part-time employees to purchase health insurance on a pre-tax basis as a payroll deduction.

IMPLEMENTATION ISSUES

A major concern with the Massachusetts health reform effort is its escalating cost. Due to higher than expected enrollment, the implementation of a generous subsidy schedule and other issues, the reform effort has exceeded budget projections. As a result, the state may have to seek new and sustainable funding sources for the program, or in the long-term, may have to make cuts in coverage, which may entail making more people exempt from the individual mandate. In particular, the Special Commission on the Health Care Payment System, created since Chapter 58's enactment, is evaluating alternative payment methods, including medical homes, global budgeting, and capitation, in an effort to contain health care costs.

For fiscal year 2008, spending on CommCare was $628 million, exceeding initial budget projections by more than $150 million. The fiscal year 2009 budget is $869 million, which exceeds initial budget projections of $725 million. Projections as of March 2009 indicate the FY2009 cost of the program will be $820 million or less. The fiscal year 2010 budget put forth by Massachusetts Governor Deval Patrick is $880 million. Future budgetary pressures will depend on the state's Medicaid waiver being continuously renewed at an appropriate level, enrollment growth in programs that are partially or fully funded by the public sector, in addition to premium increases and other factors. One other such factor is the procurement process for Medicaid managed care organizations, which provide coverage under CommCare.

There are also emerging coverage and access disparities in the state, including disparities based on income as well as racial and ethnic differences. According to the 2008 HIS, Hispanic residents were much more likely than other non-Hispanic groups to be uninsured. At the time of the survey, in summer of 2008, 7.2% of Hispanics were uninsured, versus 2.6% for the population at large, and

2.2% for non-Hispanic whites. This disparity is much more severe for Hispanic adults in Massachusetts, 13.1% of whom are uninsured—approximately three times higher than other, non-Hispanic groups. Hispanics were also more likely to experience lower access to care compared to white, non-Hispanics and other racial and ethnic groups. Income-related coverage and access disparities also exist; 8% of non-elderly adults with family incomes less than 300% FPL were uninsured, compared to roughly 4% of those with incomes between 300 and 500% FPL and less than 1% of those with higher incomes. Lower-income residents also had lower access to care across all measures of the survey compared to higher-income groups.

The increase in the number of insured residents has led to problems with health care access. Nearly one quarter of Massachusetts residents reported difficulty obtaining health care in 2008, and 21% did not get the care they needed due to cost in the 12 months prior to the 2008 HIS. According to the 2008 Physician Workforce Study conducted by the Massachusetts Medical Society, 35% of family medicine physicians were no longer accepting new patients. These results paralleled other survey results, which showed that 42% of internists and 35% of family medicine physicians were not accepting new patients in 2008. The study also showed that among family medicine/general practitioner (GP) physicians accepting new patients, the average wait time for an appointment is 36 days. For internal medicine, among the offices accepting new patients, the average wait time for an appointment is 50 days. Since Chapter 58's enactment, Massachusetts created the Healthcare Workforce Center and its Advisory Council to increase the number of primary care physicians in the state and address several factors that impact physician recruitment and retention.

The affordability of health insurance, including monthly premiums and other cost-sharing, will remain an issue as the Massachusetts health reform effort matures. This has been highlighted by health insurance premiums in the state increasing by 8.9% per year between 2001 and 2007—outpacing the average national growth in premiums of 7.7%. The Connector establishes and updates annually an affordability schedule that determines the applicability of the individual mandate on individuals and families. The schedule defines maximum monthly premiums that are deemed affordable for individuals and families to pay based on income. CommCare enrollees are already facing premium increases and higher cost-sharing for physician visits. Concerns have been raised that changes in the affordability schedule will outpace increases in workers' earnings.

Overall health care spending in Massachusetts per capita is also substantially higher than the national average and has been increasing at a faster rate. Health spending per capita in the state is 26% higher than in the nation as a whole. Even before Chapter 58 was enacted into law, per capita spending was increasing at an expeditious rate, from $3,249 per capita in 1991 to $6,683 per capita in 2004. Hospital spending in the state accounted for approximately half of the gap in per capita spending between Massachusetts and the country.

However, the replacement of the Uncompensated Care Pool with the Health Safety Net is presenting some financial difficulties for hospitals and community health centers who still care for large numbers of uninsured individuals, located mainly in urban areas. Whereas Uncompensated Care Pool payments were made using block grants based upon prior period hospital charges, the Health Safety Net pays hospitals based on adjudicated claims. Also, hospitals caring for low-income, newly-insured patients have noted the differences in payment levels between the Uncompensated Care Pool and CommCare.

INDIVIDUAL MANDATES ON THE STATE AND FEDERAL LEVEL

Other states in addition to Massachusetts are exploring the option of individual mandates, albeit with different design features. For example, beginning July 8, 2009, New Jersey will require all children in the state to obtain private or public health insurance. Vermont, another state that has recently implemented a comprehensive coverage expansion, will reevaluate the need for an individual mandate if 96% of state residents are not covered by 2010, as required by state law.

As the 111th Congress considers federal legislation related to health reform, individual mandates will likely be discussed, potentially as a requirement for parents to obtain health insurance coverage for their children, a provision supported by several members of Congress and President Obama. For example, Senator Kerry (D-MA) has introduced S. 142, the Kids Come First Act of 2009. If enacted into law, S. 142 would provide for expanded public coverage of children through Medicaid and the State Children's Health Insurance Program (SCHIP), and would amend the Internal Revenue Code to provide a refundable income tax credit for health insurance coverage of children, and forfeit the personal tax exemption for any child not covered by health insurance.

RELEVANT AMA POLICY AND ACTIVITY

Since its launch in 2007, the AMA "Voice for the Uninsured" campaign has raised awareness about the uninsured and the AMA proposal for covering the uninsured. The AMA proposal advocates providing individuals with refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits. These individual tax credits would allow patients to purchase coverage of their own choosing (Policies H-165.920[3] and H-165.865, AMA Policy Database).

To ensure patient choice, the AMA supports the development of new health insurance markets to enhance health insurance options through legislative and regulatory changes. Greater national uniformity of market regulation across health insurance markets is encouraged. State variation is permissible as long as the departures from national regulations do not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances, or create adverse selection. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements (Policy H-165.856[1,2,9]). AMA policy supports eliminating or capping the present exclusion from employees' taxable income of employer-sponsored health insurance as financing mechanisms for covering the uninsured (Policies H-165.920[11] and H-165.851[2]). In addition, the AMA supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured (Policy H-160.923[1]).

Council on Medical Service (CMS) Report 3-A-06 developed AMA policy concerning "individual responsibility" in the context of the AMA proposal for reform. Individuals and families earning greater than 500% of the federal poverty level should be required to obtain at least coverage for catastrophic health care and evidence-based preventive health care. For those earning less than 500% of the federal poverty level, the individual responsibility requirement is supported only upon implementation of a system of refundable tax credits or other subsidies to help obtain health insurance coverage (Policy H-165.848[1,2]). In 2009, 500% FPL is $54,150 for an individual and $110,250 for a family of four.

AMA policy also addresses state health reform initiatives and state experimentation to cover the uninsured. CMS Report 3-I-07 developed principles to guide the AMA in the evaluation of state health system reform proposals. The principles address portability of coverage, patient choice of

coverage option and physician, individual mandates, transparency, affordability and personal responsibility (Policy H-165.845). The AMA supports federal legislation as a means to authorize and fund state-based demonstration projects to expand health insurance coverage to the uninsured, including combining advance and refundable tax credits to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need (Policies D-165.959, D-165.968[1], D-165.966[1,2]). AMA policy also advocates for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds. (Policy D-165.966[1,2]). The AMA is committed to working with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons (Policy D-165.966[3]).

The AMA Advocacy Resource Center (ARC) monitors and reports on comprehensive state approaches to covering the uninsured on its Web site, www.ama-assn.org/go/arc. The ARC also regularly issues an "ARC Update," which includes highlights of state legislative activity addressing the uninsured.

CONCLUSION

Studies and data from this early stage of Chapter 58's implementation show that the Massachusetts reform effort has been largely successful in covering the uninsured in the state, with only 2.6% of Massachusetts residents remaining uninsured. The reform effort also has modified the market for health insurance in the state by requiring individuals to have health insurance and merging the small and non-group markets, which have resulted in the lower premiums of plans available through the Connector in comparison with pre-reform levels. Support for Chapter 58 among the public, including employers, remains high, which is essential for the initiative's success and ability to be sustainable in the long-term.

Ultimately, the success or failure of the Massachusetts reform effort is dependent on all of its elements, not just the individual mandate. Going forward, the Council believes that it will be imperative to continue to monitor the implementation of state coverage initiatives, including that of Massachusetts. In particular, the policy options the state chooses to address the long-term cost problem it faces will have to be reviewed, especially the recommendations of the Special Commission on the Health Care Payment System.

In the event that federal legislation to cover the uninsured is introduced that uses the Massachusetts reform effort as a model and includes an individual mandate, AMA advocacy will be guided by policy. Accordingly, the Council believes that examining and evaluating the impact of Massachusetts' reform law—the individual mandate, subsidies for low-income groups and the creation of a health insurance exchange—is integral because it has the potential to serve as a model for health reform in other states and on the federal level. The limitations of Massachusetts as a model include the state's relatively low rate of uninsurance initially, substantial regulations on premiums and other aspects of health insurance, the concentrated nature of the hospital and physician market in the state, and ample financing to initially implement the massive reform effort.

References are available from the AMA Division of Socioeconomic Policy Development.