

Key Components of Massachusetts Health Insurance Reform Legislation

- Expansion of MassHealth (Massachusetts' Medicaid program) to include children up to 300 percent of the federal poverty level; also restored services such as vision and dental for adults
- Creation of CommCare, which provides fully and partially subsidized coverage to low-income adults (up to 300 percent of the federal poverty level) who are ineligible for MassHealth
 - Only available to low-income residents without access to employee-sponsored coverage
- Creation of the CommChoice program, that provides individuals with access to non-subsidized plans from private insurers that meet state requirements
 - Only available to residents *without* access to employer-sponsored coverage
- Establishment of the Commonwealth Health Insurance Connector Authority, an independent state entity
 - Governed by a 10 member board
 - Responsible for administering the CommCare and CommChoice programs
 - Negotiates health plan prices and benefits
- Requirement that all adults over 18 must purchase health insurance, provided an affordable option is available
 - The Connector is responsible for defining what constitutes "affordable" coverage and what minimum levels of coverage must be provided
- Requirement that any employer with more than 11 employees make a "fair and reasonable" contribution to employees health care costs
- Requirement that employers establish Section 125 plans that allow employees to use pre-tax dollars to purchase health insurance
- Statewide merger of the non-group (66,000 members) and small-group (700,000 members) insurance markets²

Informing the National Debate

Background

In April 2006, Massachusetts enacted landmark healthcare legislation that was designed to ensure all residents in the state had health insurance. The law expanded public programs, increased access to private coverage options, established new responsibilities for employers and required all residents to obtain coverage. As of fall 2008, only 4 percent of state residents were without health insurance.¹

With healthcare reform being a top priority at a national level, components of the Massachusetts plan have been mentioned as potential models for a national effort. The purpose of this paper is to highlight key components of the Massachusetts legislation, review what has happened as a result of insurance reform and discuss any conclusions that can be drawn about a similar program nationally.

Overview of Massachusetts Health Insurance Reform Legislation

The goal of Massachusetts health insurance reform was to ensure everyone in the state had health insurance. By ensuring near-universal coverage, the law sought to reduce the amount of uncompensated care provided by hospitals in the state while improving access to routine and preventative care for low-income residents and those currently without insurance.

The individual and small group health insurance markets in Massachusetts were already fairly regulated prior to the 2006 legislation. The state had guarantee issue requirements mandating that insurers provide coverage to any eligible resident regardless of their current health condition. Community rating standards prevented insurers from varying premiums based on a health condition.

Under the 2006 health insurance reform legislation, public programs were expanded. Eligibility for children in MassHealth (Massachusetts' Medicaid program) was expanded and services such as vision and dental were restored for adults. The Commonwealth Care Health Insurance Program (CommCare) was created to provide partially and fully subsidized coverage to low-income adults (up to 300 percent of the federal poverty level) who were ineligible for MassHealth and without access to employer-sponsored coverage.

Higher-income residents who did not have the option of employer-sponsored insurance were given access to coverage through the Commonwealth Choice (CommChoice) program. CommChoice plans are non-subsidized and provided by private insurance carriers, but must meet specific standards established by the state around affordability and level of coverage. To pool risk and lower premiums on individual coverage plans, the non-group and small group markets were merged in July 2007.

The law created an independent state entity called the Commonwealth Health Insurance Connector Authority ("the Connector"), governed by a 10-member board. The Connector is responsible for overseeing and implementing the

CommCare and CommChoice programs and defining requirements for minimum levels of coverage. The Connector Web site also serves as a statewide health insurance exchange for CommChoice plans, providing residents without access to employer-sponsored coverage or employees of certain small employers in the state with comparisons between private coverage options.

All adults in the state are required to purchase health insurance provided an affordable option (as defined by the Connector’s board based on a resident’s annual income) is available. In order to meet this requirement in 2009, residents must enroll in a plan that meets the Connector board’s criteria for “minimum creditable coverage” (MCC). Residents who do not obtain adequate coverage in 2009 are subject to a penalty of as much as \$1,068 on their annual tax return, up from a maximum penalty of \$912 in 2008.³

What Happened — Or Didn’t Happen — in Massachusetts?

To better understand what happened — and what didn’t happen — as a result of health coverage reform in Massachusetts, we reviewed a number of studies looking at the impact of the legislation on coverage, access to care, public opinion and cost.

Impact on Coverage

The goal of the legislation was to achieve universal coverage in the state, and do so in a way that did not cause newly-expanded public options to replace employer-sponsored coverage (known as the “crowd-out” effect). In Massachusetts, crowd-out would occur if employers (particularly those with many low-income workers) drop health insurance because of the availability of more comprehensive individual options.

During the first two years of health insurance reform, Massachusetts was successful in reducing the number of uninsured residents in the state. In the fall of 2007, after the first year of the plan, the percentage of adults who lacked health insurance at some point in the year decreased four percentage points from 2006 to 14.5 percent. By the fall of 2008, 10 percent had lacked insurance at some point in the previous 12 months. Among low-income adults, 18 percent were uninsured at some point during 2008, a decrease of 17 percentage points from 2006. The number of adults considered underinsured, defined as insured residents with out of pocket healthcare costs greater than 10 percent of family income, dropped by an estimated 70,000 people between 2006 and 2007.^{4,5}

By the fall of 2008, only 4 percent of Massachusetts residents lacked health insurance.⁶ Of the newly insured, more than one-third enrolled in employer-sponsored coverage, while almost 10 percent enrolled in an individual option offered through the Connector or a private insurance company.⁷ About 57 percent enrolled in partially or fully state-subsidized plans, far exceeding original estimates. As a result, actual costs for CommCare during fiscal year 2008 exceeded the program’s budget by approximately \$153 million (over 30 percent).⁸

The Massachusetts Health Connector Web site (www.mahealthconnector.org) allows residents eligible for a CommChoice plan to compare multiple private insurance options (all of which meet the requirements for minimum level of coverage). Visitors are prompted for their age and zip code, and are then presented with available plans tiered by cost and level of coverage. The Web site provides comparisons between premium prices, deductible amounts, and co-pays for prescription drugs and ED visits. Eligible residents also have the option of enrolling in a plan online.

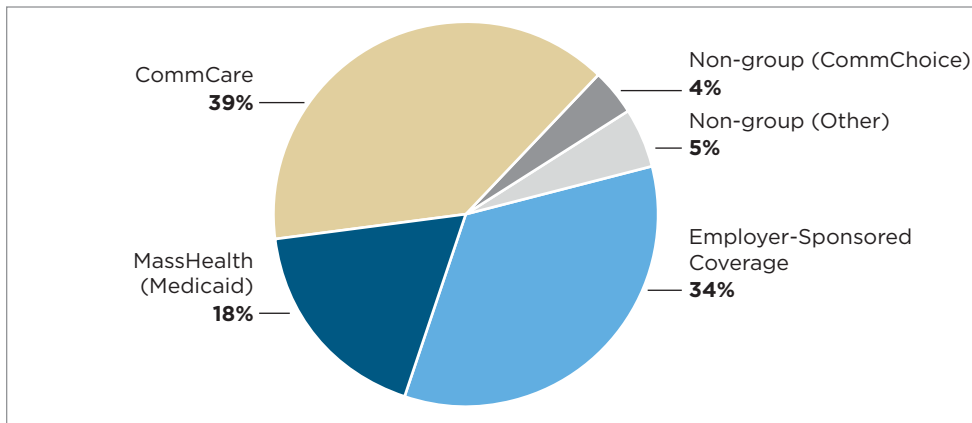


Figure 1: Newly Insured Residents in Massachusetts Since Health Reform Took Effect, September 2008⁹ (n=432,000)

Despite higher participation in public programs than expected, studies have found no evidence of crowd out of employer-sponsored coverage after the first two years of the program. In fact, between 2007 and 2008, the percentage of companies in the state offering coverage actually increased from 73 percent to 79 percent. In the fall of 2006, two thirds of Massachusetts adults had employer sponsored coverage; this rose to 69 percent in the fall of 2007 and to 71 percent in the fall of 2008.¹⁰ Among Massachusetts firms with 3 – 50 employees, no firms said they were “very likely” to drop coverage in 2009, and only 3 percent indicated they were at least “somewhat likely” to do so.

Between 2007 and 2008, a decreasing number of employers also felt Massachusetts health insurance reform was a financial burden. Among firms offering coverage, 36 percent characterized the legislation as a financial burden in 2007, compared with 29 percent in 2008. Among firms not offering coverage, the percent who believed reform was a financial burden dropped from 80 percent in 2007 to 47 percent in 2008.¹¹

However, pressures on employers are increasing. Premiums are expected to increase almost 10 percent in the state in the coming years.¹² In 2009, minimum creditable coverage (MCC) includes prescription drug coverage, deductible restrictions and other criteria. Employers are not required to provide the minimal level of coverage, but failing to do so will result in employees needing to purchase additional insurance to avoid the tax penalty.

Impact on Access to Care

By expanding coverage in the state, lawmakers hoped to improve access to care for lower income and previously uninsured residents. The goal was to increase routine and preventative office visits, reduce reliance on (ED) department for non-urgent issues and improve the health status of patients.

In the first full year of reform, data suggest that continuity of care (particularly for low-income residents) improved. By the fall of 2008, more than 87 percent of low-income adults in Massachusetts reported having a usual source for care other than the emergency room, an estimated increase of roughly 102,000 people from the fall of 2006. Approximately 98,000 more low-income residents had at least one preventative visit from the fall of 2006 to the fall of 2008.^{13 14}

Health reform initially appeared to reduce cost as a barrier to receiving care for many residents, but recent data suggests some of these gains may have leveled off. In the fall of 2008, 11 percent of Massachusetts adults reported not seeking needed care in the past year because of cost; down from 17 percent in the fall of 2006, but unchanged from the fall of 2007. The percent of low-income Massachusetts residents reporting problems paying medical bills dropped from 32 percent to 24 percent between 2006 and 2007, but increased to 27 percent in the fall of 2008.¹⁵

The sudden influx of many new patients has also resulted in a strain on providers, resulting in difficulty scheduling appointments. According to a 2008 study from the Mass Medical Society, the average waiting time for a routine or regular office visit with a PCP has increased since 2006 and a growing number of primary care physicians in the state are no longer accepting new patients (see table below).¹⁶ Among low-income residents surveyed in the fall of 2008, 29 percent reported difficulties obtaining care because providers were not accepting new patients.¹⁷

The increase in demand has caused some providers in the state to revisit approaches for delivering care. By the end of 2009, Harvard Vanguard plans to offer patients the option of a group visit, also known as a shared medical appointment, with at least 50 of the group’s physicians and nurse practitioners, which would make it the largest program in the country.¹⁹

	Open Panel		
Specialty	2008	2007	2006
Family Medicine	65%	68%	75%
Internal Medicine	52%	56%	69%

Percent of PCPs with Open Panels¹⁸

Perhaps as a result of higher demand for outpatient services, Massachusetts residents — particularly the newly insured — also continued to rely on EDs for non-emergency care in the two years following enactment of health reform. According to a November 2008 poll from the Boston Globe, 14 percent of state residents reported going to the ED in the past year for an issue “that they thought could have been treated by their doctors.”²⁰ Among CommCare enrollees, the rate of ED use for visits that did not result in hospital admission was 14 percent higher than the state average.

Impact on Public Opinion

Public opinion of health insurance reform in Massachusetts declined between the summer of 2008 and the fall of 2009 but overall remains favorable. Fifty-nine percent of residents who were aware of the legislation in September 2009 supported it, down from 69 percent who expressed support in June 2008.²¹ Sixty-four percent believe the law at been at least “somewhat successful” at reducing the number of uninsured people in the state; only 22 percent feel it has not.²²

Residents surveyed in September 2009 were spilt about the future though. Forty-three percent of adults familiar with the legislation feel the state “cannot afford to continue” with the law as it currently stands, compared with 40 percent who believe it can. However, although 57 percent of respondents felt the legislation should continue “with some changes,” only 11 percent thought the law should be repealed altogether.²³

Employer support thus far has been fairly positive. More than half of Massachusetts employers surveyed in June 2008 agreed with the statement “the health care reform plan has been good for Massachusetts,” while 33 percent disagreed.²⁴ Interestingly, researchers found that support did not change significantly between firms offering coverage and those that were not.

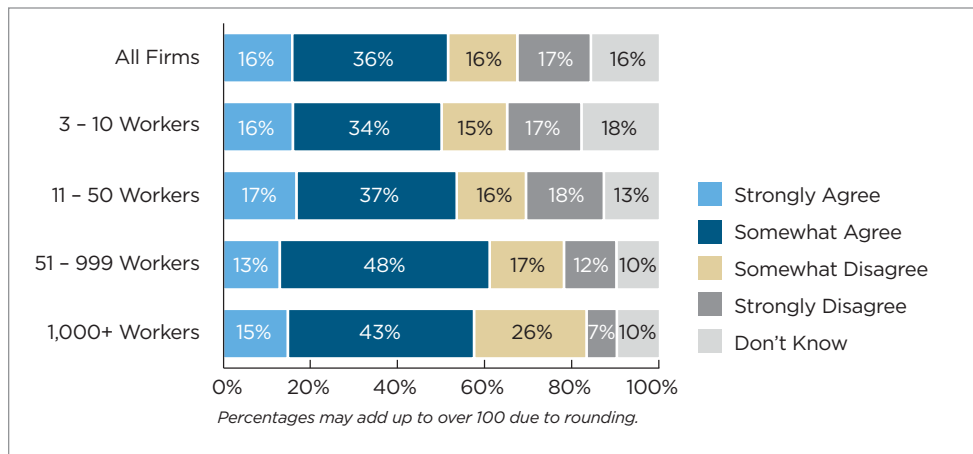


Figure 2: “Overall the Massachusetts Health Care Reform Plan Has Been Good for Massachusetts,” responses by firm size 2008²⁵

Impact on Healthcare Costs and Spending

The legislation changed the way healthcare was paid for in the state, resulting in reallocation of some healthcare costs. With fewer uninsured residents, uncompensated care provided by hospitals in the state decreased an average of 7.5 percent from 2006 to 2007. Research from the Massachusetts Hospital Association found that increases in CommCare and MassHealth enrollment were directly proportional to drops in uncompensated care.²⁶

Health reform had little impact on total healthcare spending in the first two years. Initial savings were expected through substitution of unnecessary ED visits for less expensive office appoints — but ED use was largely unchanged, probably due to higher overall demand. Longer term, increasing the percentage of residents who have preventative office visits could eventually lead to a healthier — and less costly — population to care for, but those savings will likely take time to materialize.

The Bottom Line: Potential Implications Nationwide

Several factors that contributed to health insurance reform were unique to Massachusetts. Prior to reform, the state was one of only a few in the country with guarantee issue and community rating laws. The percentage of uninsured — and underinsured — residents in Massachusetts in 2006 was also lower than the nation as a whole. The state was already spending a considerable amount to cover the costs of free care, and having a significant amount of money already in the system enabled legislators to implement reform without significant tax increases.

The experience in Massachusetts does have potential national implications however. The effect of near universal coverage on demand for care was evident. A national plan would likely exacerbate the severe provider shortages already facing hospitals and physician practices nationwide.

An individual mandate means that healthy people cannot opt out of obtaining health insurance. In a model where insurers are required to provide coverage regardless of health status, such as in Massachusetts, an individual mandate ensures the participation of healthy people, which pools risk and offsets the costs of those who need care. Most national proposals to date have called for an individual mandate or requirement that all residents need to obtain health insurance.

Many proposals for national health reform include a National Health Insurance Exchange that would allow individuals to compare and choose between a range of both public and private coverage options. Although the Connector portal provides residents who do not qualify for subsidized coverage only direct comparisons between private plans (per state rules to avoid crowd out), some aspects of the site serve as a possible proof-of-concept for a national health insurance exchange. Data shows that residents were able to access the site during the workweek, spending an average of more than 6 minutes per visit. Traffic to the Connector Web site during the first two months of 2009 was almost 30 percent higher than the same period the previous year, averaging more than 3,050 unique hits a day.

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