An Interim Report Card on Massachusetts Health Care Reform

Part 2: Equitable and Sustainable Financing

No. 51
February
2010

A Pioneer Institute White Paper

by Amy M. Lischko and Kristin Manzolillo

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

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An Interim Report Card on Massachusetts Health Care Reform

Part 2: Equitable and Sustainable Financing

Amy M. Lischko

Kristin Manzolillo

Contents

FOREWORD

In Massachusetts and across the country, the Commonwealth's health care reform has taken on an exaggerated "persona"; for some, it embodies all that is evil about government intrusion into health care markets; for others, it exhibits all the virtues of government action.

The simple fact is that the reform is an experiment. It is likely to succeed on some fronts and fail on others. Given the early stage of our 2006 reform, we are now only starting to gain access to data on outcomes, and the series of years covered is often inadequate to making judgments.

State-level experimentation is needed to test and ultimately to drive the national debate on health care reform. As occurred with welfare reform in the eighties and nineties, robust experimentation allowed federal officials to draw important lessons from the successes and failures of a number of states as they sought a thoughtful national welfare reform bill.

It is undeniably premature to enact a reasoned national-level solution based on Massachusetts' or other state experiments. They have yet to be evaluated. In a field as complicated as health care, where government involvement is already considerable and where states have historically played a defining role, we need a sensible debate based on facts.

That's where the *Interim Report Card* series of reports come in. Our Report Card series is the first attempt to provide a comprehensive assessment of the Massachusetts Health Care Reform Act. In January, we released an assessment of the reform's impact on access to care. This second chapter focuses on the sustainability and fairness of the financing model employed. It is worth noting that the cost and quality of care will be dealt with separately, in the fourth and final installment in this series.

Pioneer has not yet taken a position on the reform act. We seek first to understand and measure its performance empirically. Only after publication of the *Report Card* series will we begin suggesting fixes and formulating a comprehensive position.The tone and substance of current federal proposals does not remotely resemble the quality of dialogue we need.

James Stergios

INTRODUCTION

On April 12, 2006, Chapter 58 of the Acts of 2006, entitled "An Act Providing Access to Affordable, Quality, Accountable Health Care" was passed reforming the Massachusetts health care system. The goals of the legislation were to make health insurance affordable to most every resident and establish mechanisms to help control health care inflation.[1]

Key components of the reform included employer and individual requirements, a small Medicaid expansion, the creation of a state-subsidized insurance program and an insurance exchange, and the merging of the non-group and small group insurance markets. Although the Massachusetts reform has expanded insurance coverage to many of the state's uninsured, the success of other aspects of the reform has yet to be comprehensively evaluated. While much data has been collected on the reform's impact, not all information has been gathered and evaluated in such a manner to provide an inclusive review of the reform.

As an alternative to analyzing the reform's impact on isolated issues, in January 2009 the Pioneer Institute proposed a framework for evaluating the reform.[2] The framework focuses on an evaluation of four key areas:

- Reduction of barriers to access
- Equitable financing, based on ability to pay
- Administrative efficiency
- Efficacy, efficiency, and quality of care.

Specific metrics to evaluate each of the above areas were proposed in order to conduct a comprehensive review of Chapter 58. This quantitative outcomes approach can help highlight what has and has not worked well as a part of the Massachusetts reform, and can help guide policymakers on the latest reform efforts.

This report is the second in a series of four. The first report looked at access to health insurance and health care[3], while the focus of this report is on equitable and sustainable financing. The analysis will be organized by the six "Scorecard Metrics" presented in Figure 1.

No new data collection was performed to conduct this evaluation. Rather, a systematic approach was taken to evaluate available data. Unfortunately, good data are not readily available for all of the proposed scorecard metrics. When this situation occurred, several different pieces of data were synthesized to arrive at a conclusion. A grade was assigned to each of the scorecard metrics as follows:

A = Excellent performance, high level of certainty that the goal has been achieved.

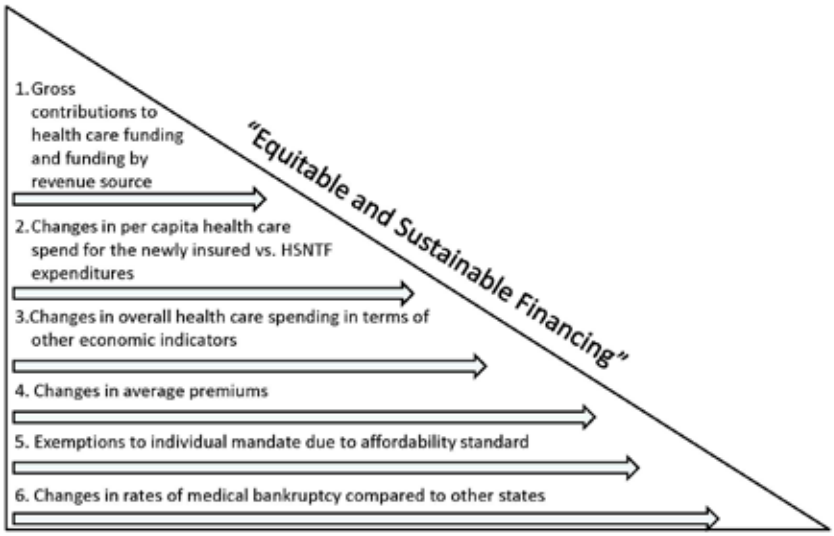
B = Good performance, moderate level of certainty that the goal has been achieved.

C = Mixed results, the available evidence is inconsistent, more research is needed.

D = Poor performance, a high level of certainty that the goal has not been achieved.

I = Current evidence is insufficient to assess whether the goal has been achieved.

Figure 1: Scorecard Metrics for Equitable and Sustainable Financing



BACKGROUND

Prior to the reform, Massachusetts health care costs exceeded national averages and were growing at faster rates than the nation overall. For example, Massachusetts' 2004 per capita health expenditure of $6,683 was 27% greater than the national average of $5,283.[4] In addition, health care spending from 2000 to 2004 grew by 7.4% in Massachusetts, compared with 6.9% nationally.[5]

Several components of Chapter 58 deal specifically with achieving equitable and sustainable health care financing as follows:

- Employer responsibility: Under the legislation, employers with more than 11 full-time equivalent employees must facilitate pre-tax availability of health insurance coverage to their employees. In addition, employers with 11 or more full time equivalent employees that do not make a "fair and reasonable" contribution toward employee health insurance premiums are charged an annual per employee fee of $295 (or $73.75 quarterly). An employer is considered offering a "fair and reasonable contribution" if 25% of his full-time employees are enrolled in the employer's group plan or he contributes at least 33% of the individual premium. Employers with 50 or more employees must fulfill both tests unless 75% of employees are enrolled, then the 33% contribution level does not apply.

- Merging of small group and non-group markets: The legislation required the merging of the small and non-group insurance markets to create one risk pool with one set of rate bands to facilitate lower costs for individuals and families purchasing insurance without employer subsidies.

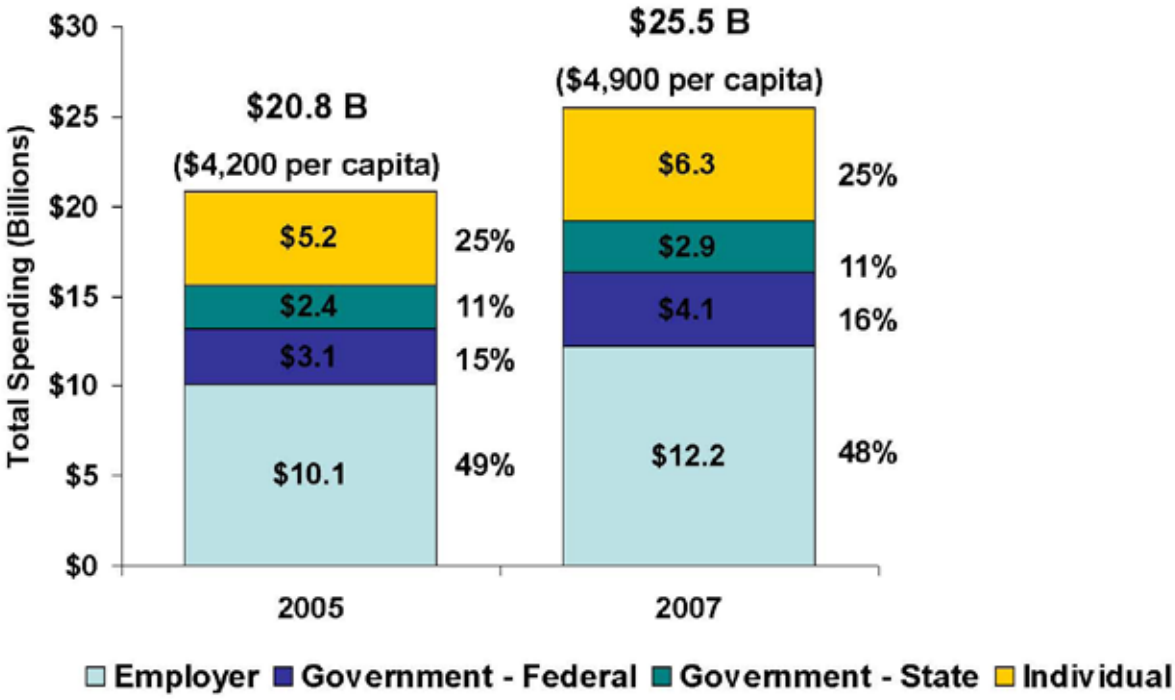
- Creation of Commonwealth Care and Health Safety Net Trust Fund: A new program called "Commonwealth Care Health Insurance Program," was established by the legislation. This program provides subsidies towards the purchase of health insurance for adults with incomes below 300% of the Federal Poverty Level (FPL). Full subsidies are available for those with incomes less than 150% of the FPL, with sliding scale subsidies available between 150 and 300% of the FPL. Additionally, the state replaced its Uncompensated Care Pool with the Health Safety Net Program (HSN), which reimburses hospitals and community health centers for services provided to low income uninsured and underinsured residents.

- Individual responsibility: The legislation embraced personal responsibility as a cornerstone of health care reform. Beginning January 1, 2008, all residents of the Commonwealth ages 18 and older were required to obtain and maintain a minimum level of health insurance. People who do not purchase health insurance face penalties if insurance coverage is deemed affordable for them.

SCORECARD METRIC 1: GROSS CONTRIBUTIONS TO HEALTH CARE FUNDING AND FUNDING BY REVENUE SOURCE

At the foundation of the Massachusetts health reform's financing is the concept of shared responsibility among individuals, employers and the government. Each entity is expected to contribute its 'fair share' to the cost of health care. Scorecard Metric 1 examines both the gross contributions and the percentage of total funding by each revenue source, including federal contributions, employer contributions and penalties, and private contributions (especially out-of-pocket). A report released in March 2009 found that each revenue source is contributing as expected. Figure 2 below shows that the allocation

Figure 2: Total Spending (in Billions) for Coverage by Revenue Source, 2005 vs. 2007



Note: Above figure does not include Medical Security Program (MSP)
Source: Seifert R, and Swoboda P. *Shared Responsibility: Government, Business, and Individuals: Who Pays What for Health Reform?* Blue Cross Blue Shield of Massachusetts Foundation, March 2009.

of contributions among revenue sources had not significantly changed from 2005 to 2007.[6]

However, the above figure also shows that government spending has increased more rapidly when compared to both individual and employer spending. Government spending (federal and state) grew 27% between 2005 and 2007, from $5.5 billion to $7.0 billion. Employer and individual spending increased by 21% and 22%, respectively, during this same time period. The more rapid increase in government spending is largely due to the introduction of the publically financed Commonwealth Care program, which accounts for 8% of the total increase in health care spend from 2005 to 2007.[7] On a per capita basis, total spending increased by 19% from 2005 to 2007.[8]

Certain data have been made available since Seifert and Swoboda's March 2009 study (referenced in Figure 2), and this updated information may have a material impact on the distribution of spending by revenue source. For example, the Massachusetts Division of Health Care Finance and Policy recently released data from the 2009 Employer Survey.

As noted in Figure 3 below, while employer contributions increased at rates of approximately 10% for single coverage and 14% for families from 2005 to 2007, the percentage employers contributed to their employees' plans decreased from 2007 to 2009, keeping the dollar value of their contributions virtually the same despite premium increases. This action by employers in the aggregate suggests that employers retreated somewhat in 2009 probably in response to a combination of poor economic conditions and increasing health care costs. Recent findings such as these could alter the distribution of spending presented in Figure 2. If employers continue to decrease their subsidies to employees' plans, individuals will be forced to contribute a greater amount to health care spending. The consistent

allocation between revenue sources from 2005 to 2007 could then be shifted moving forward.

However, employers have not backed away from offering coverage. The 2009 survey data shows that offer rates have remained steady or have increased across all sizes of firms (Figure 4). Employee take-up of health insurance from their employers also remains steady except for a small decrease found for small employers (11-50 employees), which went from 78% in 2007 to 75% in 2009 (not shown).

Evaluating individuals' monthly premium contributions, as well as out-of-pocket spending, provides further detail on what Massachusetts residents are spending on health care pre- and post- reform. Figure 5 displays trends in self-reported out-of-pocket spending. Although great strides were made early on in the reform (from 2006-2007) there is some slippage in affordability. In addition, Figure 6 shows that employee contributions to premiums have continued to increase for both single and family coverage.

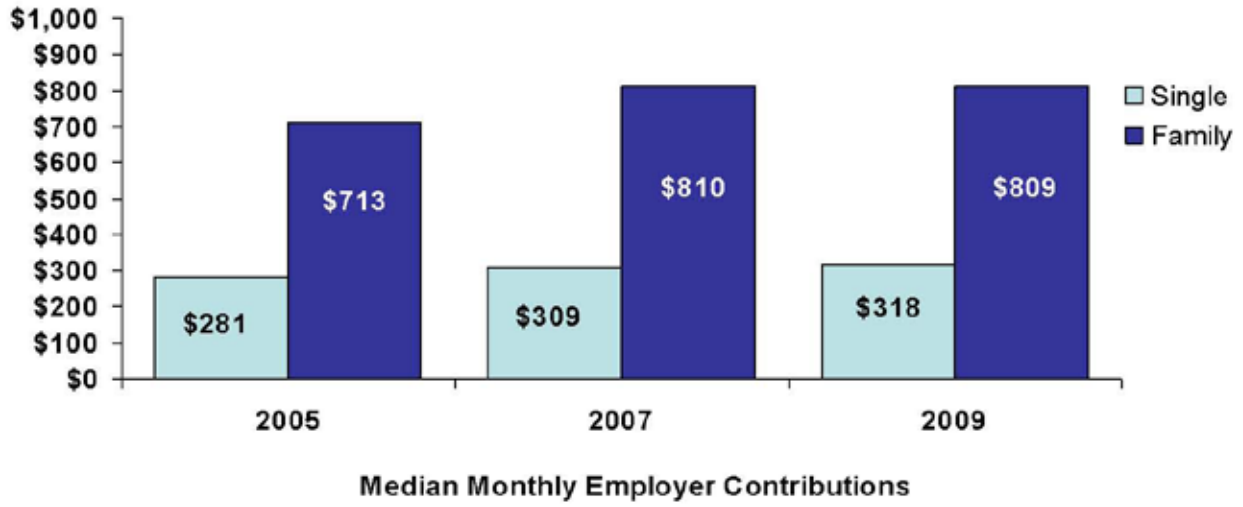
The rise in employee contributions from 2005 through 2009 could be attributed to both the overall instability of the economy in addition to the increasing pressures on employers. Interestingly, the increase in employee contributions from 2007 to 2009 (15-17%) was still less than the increase observed from 2005 to 2007 (25-26%), further illustrating the decrease in overall premium growth over this period.

As of 2007, the government, employers, and individuals are each contributing to health care spending as anticipated on a proportional basis. However, there is some indication that a shift in this balance may have occurred more recently. This analysis should be conducted on an annual basis to provide information to policymakers regarding the balance of financing. Rising health care costs could quickly threaten this equilibrium.

This is perhaps best illustrated by increasing employer premiums and employee contributions. If premiums continue to increase at high rates, employers will need to choose between absorbing these costs, passing them on to their employees, or dropping insurance altogether.

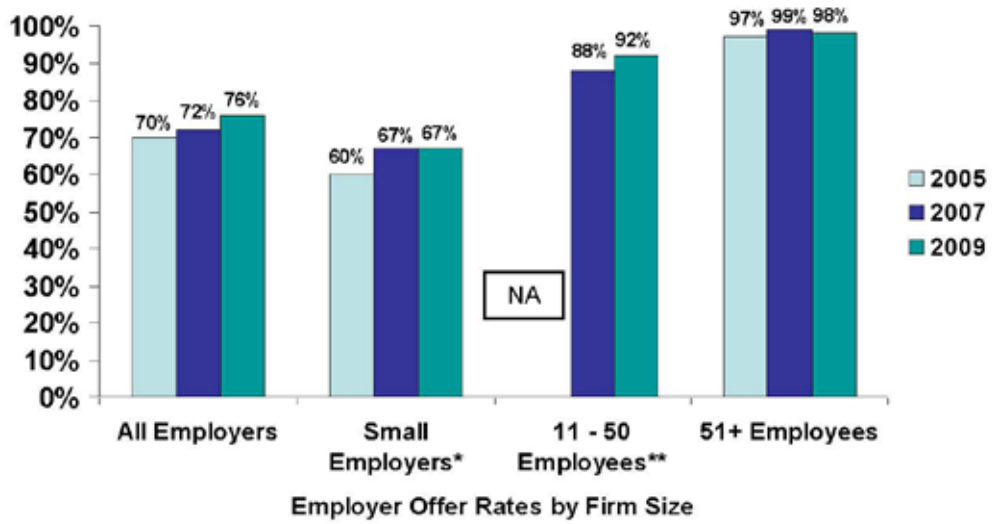
Health care costs will have to be closely monitored and likely contained to maintain a 'fair share' of spending across revenue sources. Available data

Figure 3: Median Monthly Massachusetts Employer Premium Contributions, 2005-2009



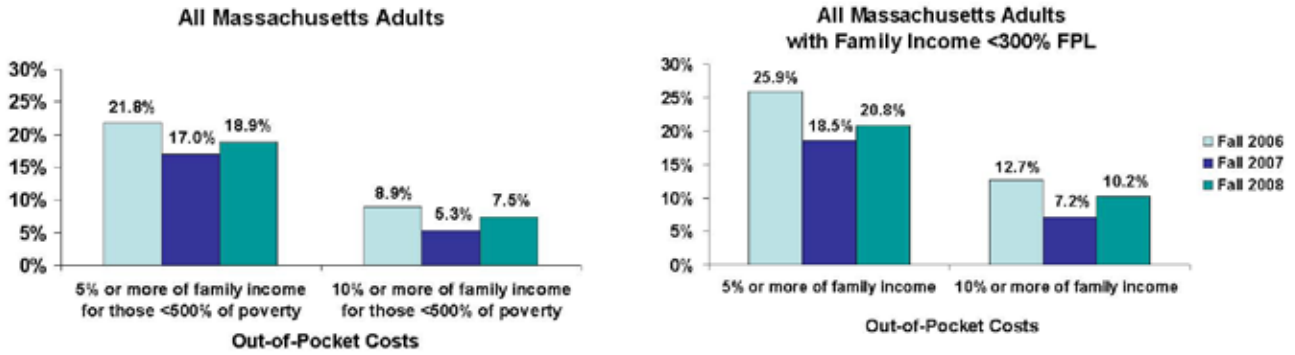
Source: DHCFP, Massachusetts Employer Survey 2009. Calculated based on median monthly premium and median monthly employer contribution percentage.

Figure 4: Massachusetts Employer Health Insurance Offer Rates by Firm Size, 2005 – 2009



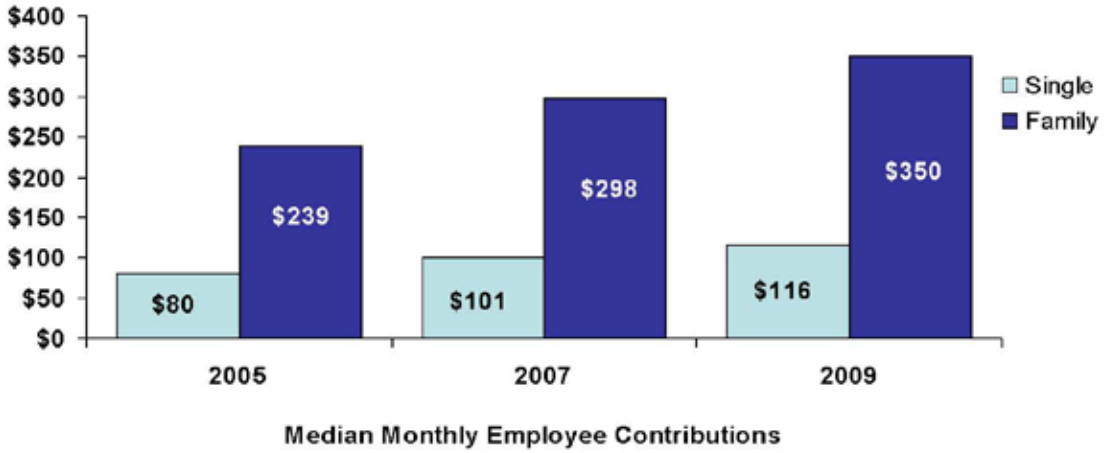
Notes: * "Small Employers" defined as 2 – 9 employees for 2005 and 2007, and 3 – 10 employees for 2009 ** Data for 11-50 employees is unavailable for 2005. In 2005, 88% of organizations with 11-24 employees offered insurance, while 95% of organizations with 25-50 employees offered insurance.
Souces: DHCFP, Massachusetts Employer Survey 2009. DHCFP, Massachusetts Employer Survey 2005.

Figure 5: Out-of-Pocket Spending for Massachusetts Adults Ages 18-64, 2006 - 2008



Source: Long, S.K., & Masi, P.B. *Access And Affordability: An Update On Health Reform In Massachusetts*, Fall 2008. Health Affairs. 28 May 2009: w578 – w587.

Figure 6: Median Monthly Massachusetts Employee Premium Contributions



Source: DHCFP, Massachusetts Employer Survey 2009

indicate good performance in this area in the early phases of reform; however, without more recent data available, there is only a moderate level of certainty that this has been sustained. Therefore, this Scorecard Metric earns a grade of B.

Overall grade for Scorecard Metric 1: B

SCORECARD METRIC 2: CHANGES IN PER CAPITA HEALTH CARE SPENDING FOR THE NEWLY INSURED VS. HSNTF EXPENDITURES

As a part of Chapter 58, Massachusetts Uncompensated Care Pool (UCP), which reimbursed hospitals and community health centers for services provided to the uninsured and underinsured in Massachusetts since the mid 1980's, was replaced with two new mechanisms: the Health Safety Net program (HSN) and Commonwealth Care. While the HSN operates in a manner similar to the UCP, Commonwealth Care is a government-subsidized insurance program for the low-income. Policymakers intended for the revenue requirements of the HSN to decrease significantly with the introduction of Commonwealth Care. Scorecard Metric 2 examines how per capita health care spending for the newly insured has changed through an evaluation of HSN and Commonwealth Care spending.

In order to make an 'apples to apples' comparison, it is necessary to look at how spending on the newly insured changed from FY 2005 (the last full year prior to reform) and FY 2008 (when the newly insured are enrolled in Commonwealth Care). However, while the reform aimed to cover virtually all residents with insurance, it is important to keep in mind that some individuals remain uninsured because of eligibility restrictions or immigration status. Therefore, the post-reform spending of the Health Safety Net Trust Fund (HSNTF), which collects and distributes funding for the Health Safety Net program, must also be taken into consideration. Figure 7 presents a pre- and post-reform comparison on spending for the uninsured and newly insured in Massachusetts.

When taking into account spending for both the UCP/HSNTF and Commonwealth Care, costs for the newly insured increased by 38% from FY 2005 to FY 2008. Although not a direct comparison, premiums for employer-based insurance for individuals in Massachusetts increased by 21% from 2005 through 2009.[9] There are at least two factors that contributed to this increase in spending for those enrolled in Commonwealth Care: 1) additional spending on health care services not previously sought by the uninsured, and 2) an overall increase in health

Figure 7: Spending on Uncompensated Care and Commonwealth Care, 2005 vs. 2008

	FY 2005	FY 2008	% Change
UCP / HSNTF[1]			
Number of Utilizers	451,000	309,000[3]	-31%
Total Costs	$739,400,000	$415,600,000	-44%
Per Capita Spend	$1,600	$1,300	-19%
Commonwealth Care[2]			
Number of Utilizers	NA	158,000[4]	NA
Total Costs	NA	$628,000,000	NA
Per Capita Spend	NA	$4,000	NA
Total			
Number of Utilizers	451,000	467,000	8%
Total Costs	$739,400,000	$1,043,600,000	41%
Per Capita Spend	$1,600	$2,200	38%

1. Fiscal year for UCP/ HSNTF runs from October 1 to September 30 of the following year
2. Fiscal year for Commonwealth Care runs from July 1 to June 30 of the following year
3. Annualized based on first 3 quarters of FY 2008
4. As reported in December 2007. Includes premium and non-premium members

Sources: Commonwealth Connector Authority, Health Reform Facts and Figures October 2009, October 2009.
DHCFP, 2009 Annual Report Health Safety Net, September 2009.
DHCFP, Health Care in Massachusetts: Key Indicators, August 2009.
DHCFP, Uncompensated Care Pool PFY05 Annual Report, May 2006.
Governor Deval Patrick's Budget Recommendation – House 1 Fiscal Year 2010, FY2010 House 1 Budget Recommendation: Policy Brief, retrieved November 20, 2009 from: http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm[10]

care costs.

Post-reform data (2008) indicate that per capita spending on Commonwealth Care is three times that of the per capita spending in the UCP/HSNTF. This suggests that sicker uninsured individuals may have been enrolled in Commonwealth Care. In addition, per capita costs for people using the safety net have decreased 19% from 2005 to 2008. Furthermore, the recently released Governor's budget for 2011 suggests that costs for Commonwealth Care members have been growing rapidly with a proposed line item of $839 million to fund an estimated 174,000 members. That's a cost of $4,822 per person, representing a 20% increase since 2008.

These differences are large enough to warrant further analysis. How do patterns of care differ for those who were enrolled in the safety net versus Commonwealth Care? Is there greater utilization of particular services that add to the quality of their health care or are they seeking care from more costly providers? These are important areas of inquiry that require further study.

While the number enrolled in Commonwealth Care was somewhat higher than expected, this program alone does not tell the entire story of government-subsidized care. While the HSNTF was reduced by 44% from 2005 to 2008, over $400 million was spent on providing care to more than 300,000 uninsured and underinsured in 2008 via the Health Safety Net. The reform's sustainability in part relies upon a continuing decrease in the use of the HSNTF as more individuals gain access to insurance. With funding going towards both the HSNTF and Commonwealth Care, along with increased per capita spending on the newly insured, it remains unclear if this model is sustainable. Because the outlook is uncertain, this Scorecard Metric earns a grade of C.

Overall grade for Scorecard Metric 2: C

SCORECARD METRIC 3: CHANGES IN OVERALL HEALTH CARE SPENDING IN TERMS OF OTHER ECONOMIC INDICATORS

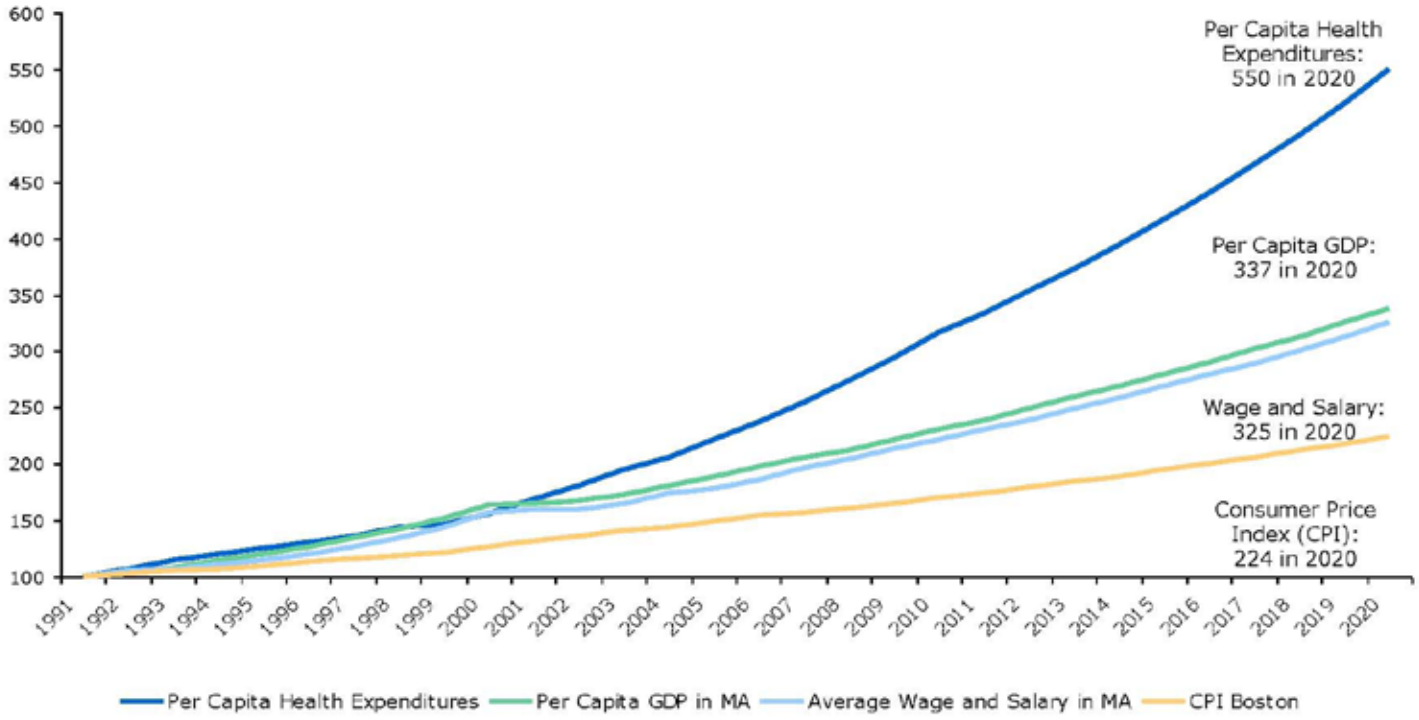
Rising health care costs have consistently made headlines throughout the past two decades. When compared to the rest of the nation, the problem of increased spending on health care is particularly acute in Massachusetts. To date, the cost of the Massachusetts reform has been somewhat higher than anticipated prior to the reform's implementation.[11] Scorecard Metric 3 analyzes how health care spend has changed due to reform by looking at spending in terms of other economic indicators.

The Massachusetts Division of Health Care Finance and Policy (DHCFP) tracks per capita health spending in relation to GDP, average wage and salary, and Boston CPI (Figure 8). Massachusetts per capita GDP outpaced health care expenditures until 2001, when the trend lines costs. The Division estimates that per capita health care expenditures will continue to grow rapidly and exceed the GDP by 63% in 2020.

Figure 9 presents a comparison of Massachusetts and national health care expenditures (defined by residence location and as personal health expenditures by CMS) as a percent of GDP for 2000 and 2007. On a per capita level, Massachusetts health care expenditures were 24% higher than the national average for 2000. The DHCFP estimated that in 2007 Massachusetts per capita expenditures were 30% greater than national expenditures and represented a larger share of the GDP.[12] Note that while per capita health care expenditures in Massachusetts increased by almost 65% from 2000 to 2007, Boston CPI increased by only 24%.[13]

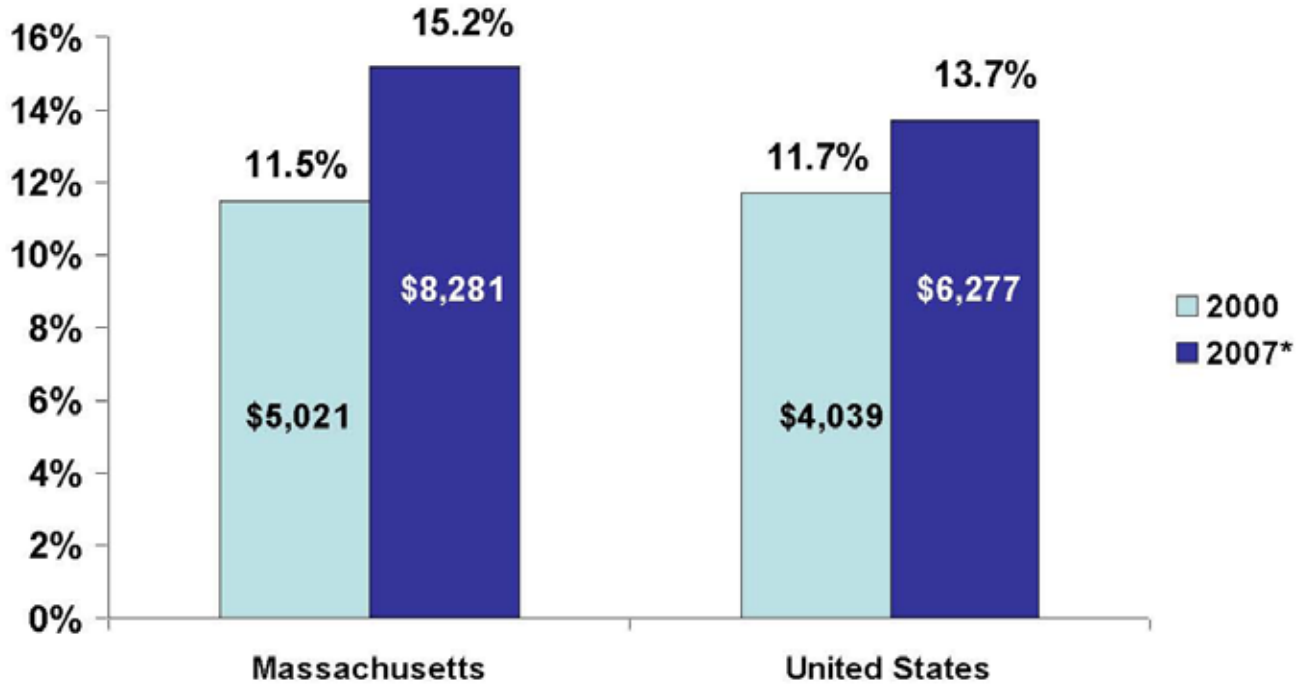
Historically, Massachusetts' health care spend has been higher than that of other states. The

Figure 8: Index of Per Capita Health Expenditures and Other Indicators in Massachusetts, 1991-2020



Source: DHFCP, Massachusetts Health Care Cost Trends Historical (1991 – 2004) and Projected (2004 – 2020), November 2009.

Figure 9: Health Care Expenditures as a Percent of GDP



Source: DHFCP, Massachusetts Health Care Cost Trends Historical (1991 – 2004) and Projected (2004 – 2020), November 2009.
*Massachusetts 2007 data projected based on average annual growth rate of 7.4% experienced in 2000-2004

Health Care Quality and Cost Council (HCQCC), established by Chapter 58, has proposed a "Roadmap to Cost Containment" to combat this problem; proposed solutions include payment reform.[14] However, the data available to date do not provide conclusive evidence to determine if the reform or the HCQCC is helping to reduce health care spend as a percent of state GDP or other economic indicators. The data used by the DHCFP for these analyses are only available from CMS every five years.

In projecting future health care spending, the DHCFP used two different annual growth rates. For years 2004-2010, the annual growth rate is based on the average annual growth rate of 7.4% experienced in 2000 – 2004; the state used an average annual growth rate of 5.7% for 2010 – 2020 projections. Although the health insurance landscape in Massachusetts prior to 2006 was different from that of today, the delivery of health care has not changed very much. There is no evidence to suggest that the reform has changed the general health care growth trend that was estimated based on 2004 data; however, it is inappropriate to rely on these older data for evaluation of this metric. Therefore, Scorecard Metric 3 is assigned an incomplete until additional data using actual spend figures are available from CMS early next year.

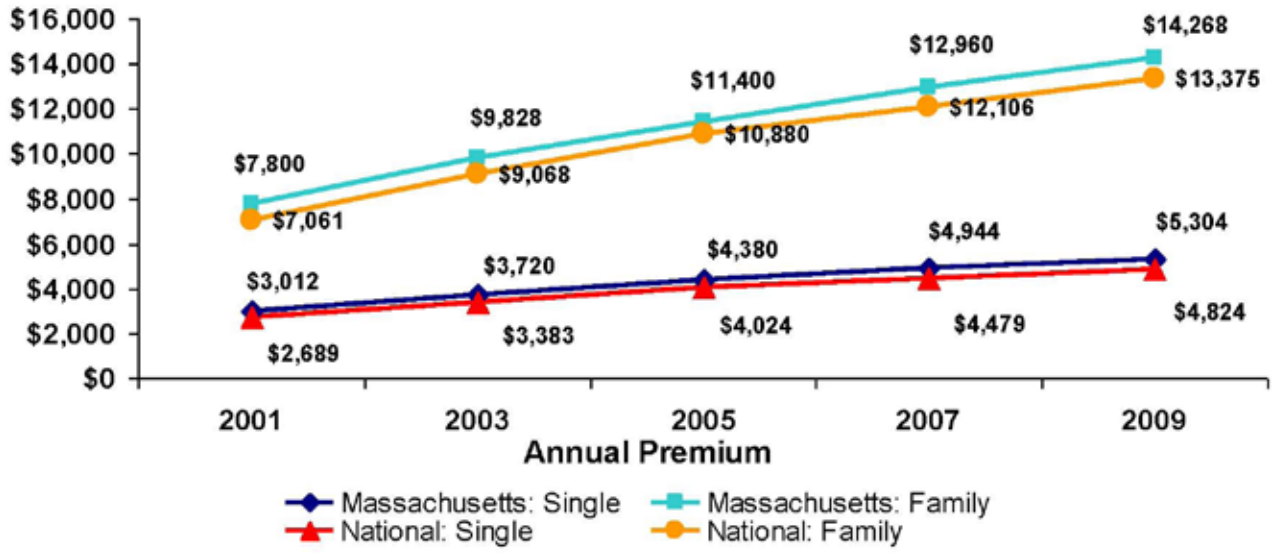
SCORECARD METRIC 4: CHANGES IN AVERAGE PREMIUMS

In addition to examining health care spending on a per capita level, evaluating health care costs in terms of the way they are experienced by health care consumers – including employers and individuals – is also essential. Health care costs are primarily experienced by employers and individuals via premium rates. Scorecard Metric 4 evaluates how average premiums have changed since reform.

Data from the Massachusetts Employer Survey suggests that annual premium rates for private employers in Massachusetts have continued to rise post-reform for both single and family coverage (Figure 10). These premiums exceed national average employer-based premiums collected in the Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

Despite the continuous rise of premiums in Massachusetts, annual trend increases have in fact decreased post-reform. For example, the Massachusetts Employer Health Insurance Survey data indicate that family premiums increased by 12% annually from 2001 to 2003, compared with 5% annually from 2007 to 2009. The same holds

Figure 10: Annual Premiums for Private Employers, Massachusetts vs. US



Sources: DHCFP, Massachusetts Employer Survey 2009. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999 – 2009.

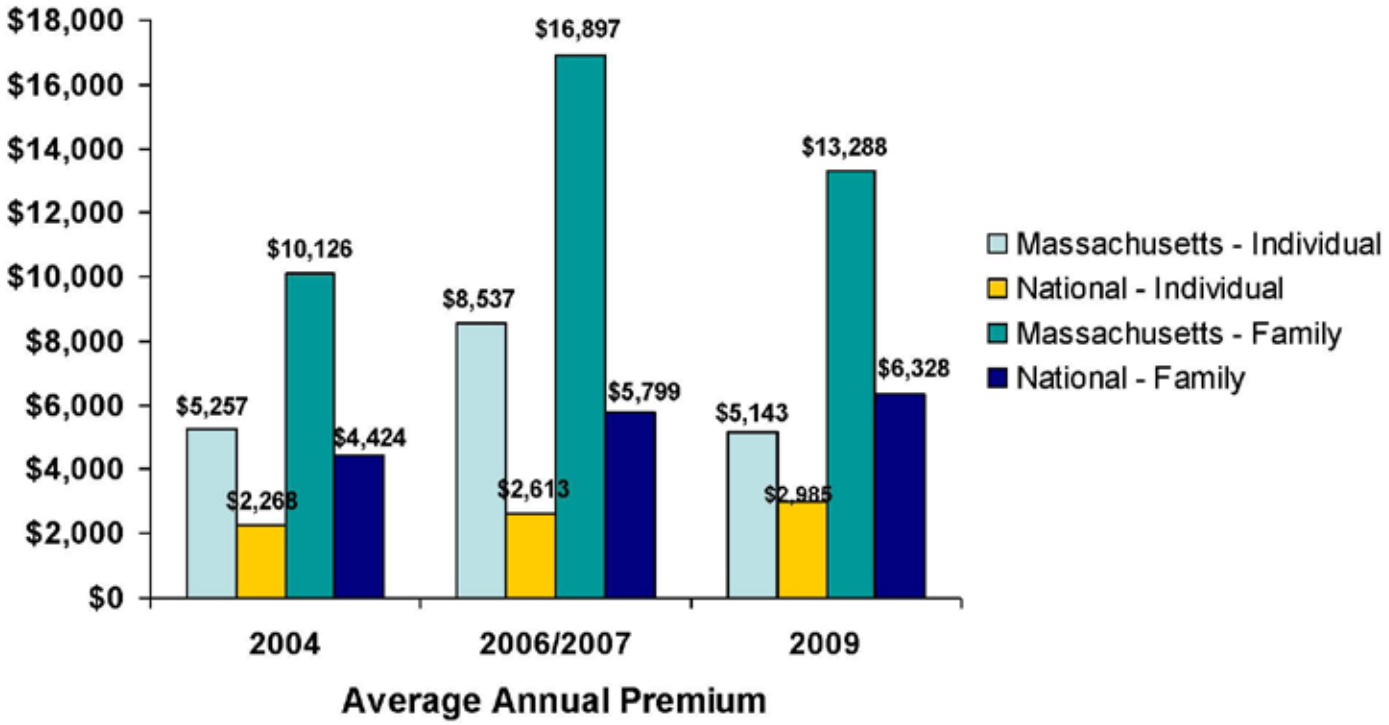
true for individual coverage premiums, with an 11% annual increase from 2001 to 2003, and a 4% annual increase from 2007 to 2009. These increases from 2007 through 2009 are comparable to the increase in CPI for Boston (about 5%) for this same time period.[15]

The trend patterns present in Massachusetts, however, are similar to the national trend rates illustrated in the Kaiser/HRET survey, where individual and family premiums also increased by 4-5% annually from 2007 to 2009. Because this indicates that the Commonwealth's experience with trend increases is in-line with the rest of the nation, it is difficult to attribute the slowing pace of premium increases observed in Massachusetts to health care reform. Additionally, it is important to note that the premiums collected in each of these surveys do not take into account changes in plan design. While costs might be increasing at a slower rate, this could be attributed to the fact that today's plan designs are less generous than those offered in the early 2000's.

Those Massachusetts residents who do not receive insurance from their employer or subsidized care from the state are left to purchase non-group insurance coverage. Figure 11 offers a comparison between non-group premiums in Massachusetts and the national average over time. While both Massachusetts and national premiums rose from 2005 to 2006/2007, there was an actual reduction in premium rates in Massachusetts from 2006/2007 to 2009, whereas national rates increased.

Chapter 58 merged the non-group and small group insurance risk pools, with the intent of decreasing premiums for individuals purchasing

Figure 11: Average Annual Premium for Non-Group Insurance Coverage, 2004-2009



Sources: America's Health Insurance Plans, Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits, August 2005. America's Health Insurance Plans, Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits, December 2007. America's Health Insurance Plans, Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits, October 2009.

in the non-group market.[16] The data presented in Figure 11 illustrate that this did occur, with close to a 40% decrease in individual premiums, and a 21% decrease in family rates for those purchasing insurance on their own, from 2006/2007 to 2009. However, Massachusetts premiums still exceed national averages.

In addition, recent data suggest that the dampening premium trend experienced from 2007-2009 may be accelerating once again with small groups experiencing larger premium increases for 2010. The Boston Globe reported that Massachusetts small businesses are facing significant increases for plan year 2010, threatening their participation.[17,18] The Massachusetts Division of Insurance held a series of hearings this fall to better understand the continuing unexpected large increases experienced by many small groups.[19] Further investigation is underway to determine what may be causing these significant premium increases.[20]

While the reform to date has succeeded at reducing individual premium rates, costs in Massachusetts still exceed national averages. Furthermore, the significant cost increases experienced by small groups need to be understood and quickly addressed to ensure sustainability of the reform moving forward. Given the inconsistent results in this area this Scorecard Metric receives a score of C.

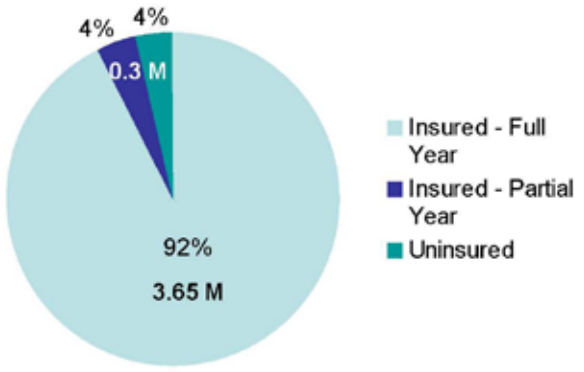
Overall grade for Scorecard Metric 4: C

SCORECARD METRIC 5: EXEMPTIONS TO THE INDVIDUAL MANDATE DUE TO THE AFFORDABILITY STANDARD

One of the major features of Chapter 58 is the individual mandate, which requires all adults to obtain health insurance coverage, should an affordable plan be available, or face tax penalties. The Connector oversees three interconnected policies that define affordability: the 'affordability standard,' 'minimal creditable coverage' (MCC), and the level of premium subsidy. Scorecard Metric 5 examines the affordability of health insurance coverage in Massachusetts by way of individual mandate exemption.

As shown in Figure 12, 92.5% (3.65 million) of Massachusetts tax filers reported being insured for all of tax year 2008 (based on 96% of expected tax returns for 2008). An additional 3.9% of filers reported being insured for parts of tax year 2008, and 3.6% of filers were uninsured for the entire year. Of these adult residents who reported being uninsured for either the partial or entire year, the Massachusetts Department of Revenue deemed that approximately 53,000 residents (or 1.3% of total tax filers) were able to afford such coverage.[21] After the appeals process, 44,935 residents were assessed a penalty for tax year 2008.

Figure 12: Uninsured and Insured Tax Payers for Tax Year 2008



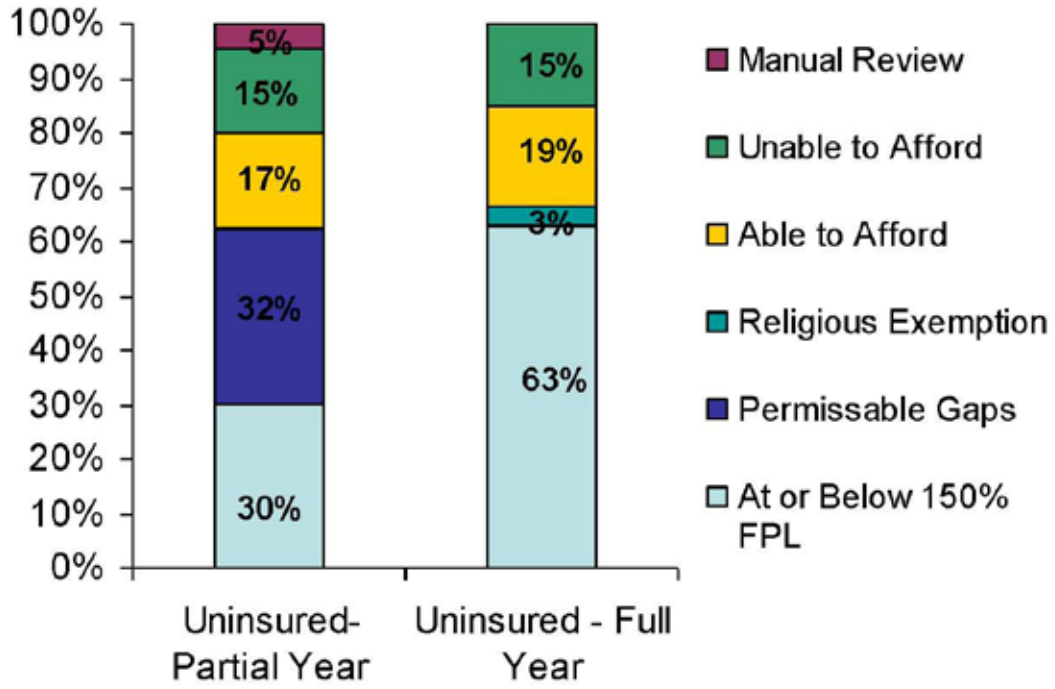
Source: Massachusetts Department of Revenue, Individual Mandate 2008 Preliminary Data Analysis. December 2009.

Comparatively, for tax year 2007, 118,000 residents (or 3% of total filers) were penalized by the Massachusetts Department of Revenue for not meeting the mandate's requirements. However, of these residents, 51,000 had sufficiently low incomes to qualify for No Tax Status or a Limited Income Credit. In many instances, this nullified or reduced the tax penalty. Furthermore, 6,000 residents filed an appeal for a review of their exemption status in 2007.[22]

Figure 13 provides additional detail on those filers that were uninsured for part or all of tax year 2008. 1.1% of Massachusetts tax filers (approximately 45,000 residents) who reported being uninsured for either all or part of 2008 were determined unable to afford coverage and exempt from the individual mandate. After accounting for additional exemptions (including those under 150% of FPL, religious exemptions, and those holding certificates of exemption), 4.7% of filers were exempt.[23] While only slightly more than 2% of filers were exempt in tax year 2007, it is important to note that in 2007 filers were only required to show proof of one day of coverage for the entire year. Conversely, in 2008, filers needed to show proof of continuous coverage throughout the year.[24]

The Commonwealth Connector Board may make changes to the affordability schedule each year based on new premium and subsidy information. For calendar year 2009, these changes included a flat increase in premium contributions for those up to 300% of the FPL, and a 3.5% increase in premium contributions for those individuals above 300% of the FPL.[25] Additionally, the affordability schedule was further revised in June 2009 due to adjusted FPL criteria from the Centers for Medicare and Medicaid Services (CMS). Upper income brackets at 150 – 300% of FPL were decreased by $12 or $24 for individuals and couples; changes were not made for below 150% or above 300%, or for families.[26] These changes will impact the overall affordability of health insurance plans at various income levels by impacting monthly premium contributions.

Figure 13: Detail on Uninsured Tax Payers for Tax Year 2008



Source: Massachusetts Department of Revenue, Individual Mandate 2008 Preliminary Data Analysis. December 2009.

For tax year 2010, maximum noncompliance penalties are expected to increase by 8% to $1,116, according to draft guidelines released by the Department of Revenue. Additionally, penalties for residents above 300% of the FPL will be based upon age, with those ages 18 to 26 subject to penalties half of the lowest priced Commonwealth Choice Young Adult Plan premium, and those ages 27 and above subject to penalties half of the lowest priced Commonwealth Choice Bronze premium. The Department of Revenue indicates that penalties will range from $234 to $1,116, annually.[27]

While the above data are useful in evaluating the affordability of health insurance coverage in Massachusetts, limitations to this information must be considered. The most recent data available on individual mandate exemptions are from tax year 2008. This represents a period early on in the reform, and all of the components of Chapter 58 were not in full effect. For example, full compliance for MCC was not phased in until January 2009.[28,29] The impact of yearly revisions to the affordability schedule on individual mandate exemptions should be closely monitored. Revisions to the affordability standards for calendar year 2010 were the subject of a recent Connector board meeting. Because of rising health insurance premiums and a stagnant economy, the tension between a robust mandate and affordability continues to be a thorny issue for policymakers and a key issue for long-term sustainability.

Based on the available data, the initial number of individuals deemed unable to afford coverage is minimal. However, the long-term stability of this indicator is questionable; therefore this Scorecard Metric earns a grade of B.

Overall grade for Scorecard Metric 5: B

SCORECARD METRIC 6: CHANGES IN THE RATES OF MEDICAL BANKRUPTCY, COMPARED TO OTHER STATES

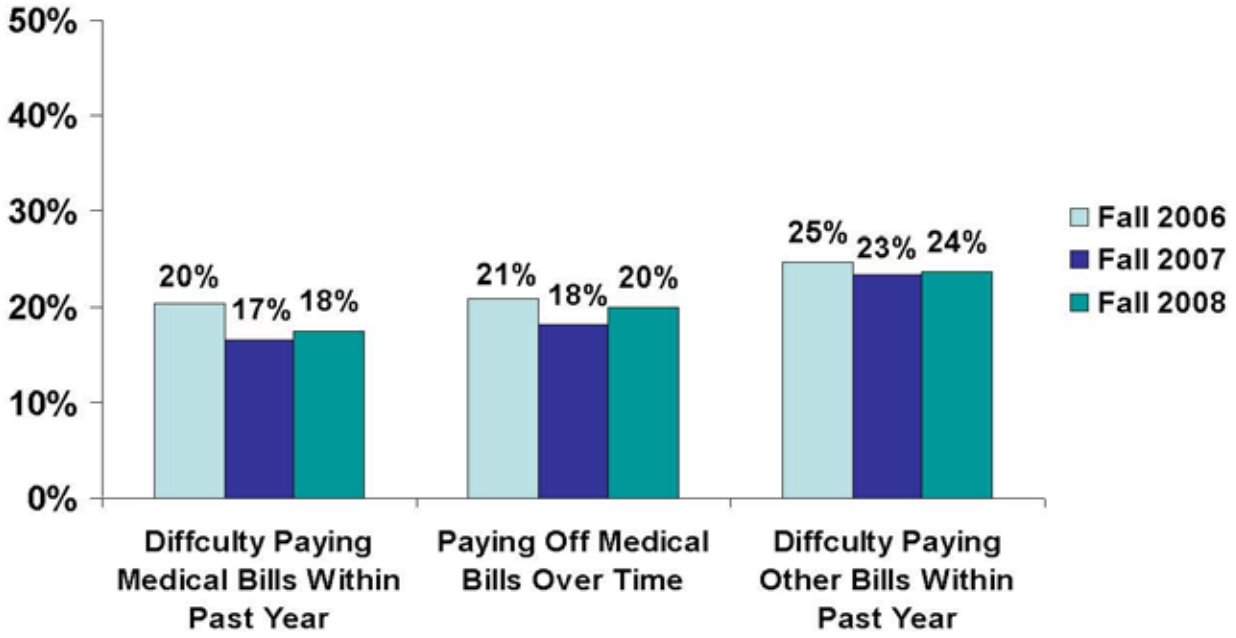
While having affordable insurance coverage is important, insurance alone does not preclude an individual from incurring medical debt. Massachusetts' residents typically have less medical debt than residents in other states due to a generous safety net. While the uninsured must sometimes contend with non-discounted medical services, expensive premiums or contributions and high out-of-pocket costs can also put a financial strain on the insured. Scorecard Metric 6 aims to examine any impact reform has had on medical bankruptcy and debt for Massachusetts adults.

While medical bankruptcy data are available at the national level no such analysis exists specifically for Massachusetts.[30] As a proxy for bankruptcy data, self-reported medical debt information for Massachusetts adults is used to assess this scorecard metric.

Figures 14 and 15 provide snapshots of the impact of the reform on medical bill payments in 2006 (slightly before the implementation of key reform components), 2007, and 2008. The data are presented for two groups: all Massachusetts adults, and those Massachusetts adults < 300% of poverty. For both populations, self-reported difficulty with paying medical and other bills decreased after the first year of the reform. However, from 2007 to 2008, payment difficulty increased, but remained under 2006 levels.

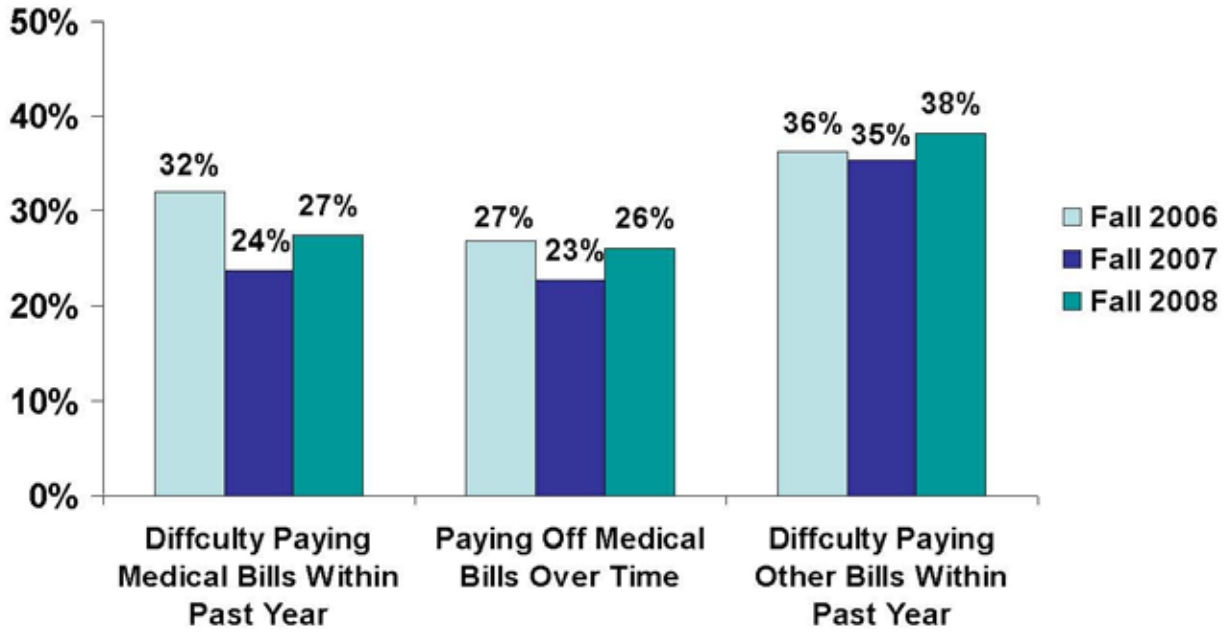
Similar self-reported national data collected by the Commonwealth Fund indicate that an increasing number of Americans are facing medical debt. In 2005, 23% of American adults aged 19 to 64 reported having difficulty paying bills within the past year; in 2007, this number jumped to 27%. Additionally, in 2005 21% of Americans surveyed were paying off medical bills over time, compared with 28% in 2007.[31]

Figure 14: Unadjusted Impact of Reform on Bill Payment – All Massachusetts Adults Ages 18 - 64



Source: Long, S.K., & Masi, P.B. *Access and Affordability: An Update on Health Reform in Massachusetts*, Fall 2008. Health Affairs. 28 May 2009: w578 – w587.

Figure 15: Unadjusted Impact of Reform on Bill Payment – Massachusetts Adults Ages 18 - 64 with Family Income <300% of Poverty



Source: Long, S.K., & Masi, P.B. *Access and Affordability: An Update on Health Reform in Massachusetts*, Fall 2008. Health Affairs. 28 May 2009: w578 – w587.

Although the Commonwealth Fund's metrics and study timing differ from that of the Massachusetts data, the two data sets are similar enough to draw preliminary conclusions about medical debt in Massachusetts compared to the rest of the United States. The prevalence of medical debt in the United States has been growing since 2005, with more Americans struggling to make medical payments. Conversely, in Massachusetts, medical bill payment difficulty appears to have lessened since the reform was enacted.

Though we can glean some insight into medical debt in Massachusetts and the nation from the available data, it is important to note that the above metrics are all self-reported. It is possible that those Massachusetts residents could have inaccurately reported their bill payment difficulty after reform implementation because they felt like the reform should have made payment easier. For example, while payment difficulty in Massachusetts decreased from 2006 to 2007, difficulty was again on the rise in 2008. Initially, residents could have hyperbolized the impact the reform would have on their medical spending, and after living with the reform for over a year, gained a better understanding of the reform's actual effects on medical debt.

Additionally, one must keep in mind the generous Uncompensated Care Pool that was in place in Massachusetts prior to the reform. This UCP provided medically necessary care to qualified residents at minimal cost.[32] Some residents who previously received "free" care through the UCP and who are now enrolled in an insurance plan might report medical debt simply because they are now incurring costs for the care they receive – something that had previously not occurred.

While Massachusetts residents reported a decrease in the difficulty of medical bill payment since 2006, 1 in 5 adults indicated that they were paying off medical bills over time in 2008. When looking at adults <300% FPL, over 1 in 4 are carrying medical debt.[33] The inconclusive data results in this Scorecard Metric receiving a grade of C. Further studies that make use of filed bankruptcy data at the state level will provide more empirical evidence regarding the impact of reform on medical debt.

Overall grade for Scorecard Metric 6: C

CONCLUSIONS

Overall, the framework and scorecard metrics proposed by the Pioneer Institute were useful in summarizing the effects of the Massachusetts Health Care Reform around equitable and sustainable financing.

First, although good evidence was found concluding that the reform had been successful early on in distributing the funding required for shared responsibility among individuals, employers and the government, the data used to assess this metric are dated and it is important that the state monitor this distribution closely moving forward. Small employers, in particular, seem to be at the receiving end of large increases in premiums and a better understanding of why this is occurring is paramount.

While increases in per capita spending for health care for the uninsured are observed, they are not out of line considering annual health care cost growth. It was interesting to note that the data suggest that the sicker uninsured may have been enrolled into Commonwealth Care. It is important for the state to monitor who is receiving services reimbursed by the Health Safety Net and to confirm that they are not eligible for Commonwealth Care or other insurance. While the HSNTF funding requirements have decreased over time, there remains a not insignificant amount of revenue flowing through this mechanism. Thus, sufficient oversight by the state is necessary to ensure that this remains a safety net and not a substitute "program" for uninsured people.

Health care costs continue to rise at faster rates than the GDP[34] and there is no evidence to suggest that health care reform has had a meaningful impact on constraining health care costs. However, it was frustrating that more current data were not available from CMS to accurately measure this trend. CMS should provide state-level data more frequently or the state should devise a method for producing these data from a state-based all-payer claims database. It seems essential to monitor this closely to better understand the impact various policy changes have on overall health care costs in a timely fashion.

Exemptions to the individual mandate are about what was expected. It will be especially important to monitor this over time. It is likely that as costs continue to rise, more people will be exempted from the mandate creating increased pressure on the state to develop strategies to constrain health care costs. The Health Care Quality and Cost Council has made recommendations in this regard and it will be interesting to see what policy changes will be made in upcoming years.

Finally, the dearth of data to measure medical bankruptcy in Massachusetts pre and post reform made this metric particularly challenging to assess. Massachusetts likely scored well on this indicator even before reform with its generous safety net. There are no good data to conclude anything about reform's impact on this metric.

Overall, the scorecard for equitable and sustainable financing earns a C. Although much of the evidence points in a positive direction, the data are too dated in many cases to provide a current picture of the reform's outcomes in this area and some of the recent data that are available point to some deterioration in regards to financing. While evaluating the impact Chapter 58 had on equitable and sustainable financing was useful, an additional examination of Chapter 305, "An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care," might shed further light on health care financing in post-reform in Massachusetts. Chapter 305 contained specific measures aimed at controlling costs, including the creation of a commission charged with reforming the current payment system.[35]

As was suggested in the Access Chapter, the Commonwealth may want to consider using its resources and data systems to devise new methods for measuring the outcomes of reform. For example, with the establishment of an all payer claims database one could more readily look at overall health care costs and provide annual reports that also identify specific cost drivers. The DHCFP has work under way in this regard.

The next issue in this series will evaluate the administration of health care reform and will answer the following questions: What has been the experience administering the Connector and Commonwealth Care? Have there been efficiencies realized by merging the small group and individual markets? Has a competitive market within the Connector been established and if so, has it helped to constrain premium rates? How do administrative costs of Commonwealth Care compare to other plan administrative costs?

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About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the "conventional wisdom" on Massachusetts public policy issues.

Endnotes

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