

# Promising Elements of the Massachusetts Approach: A Health Insurance Pool, Individual Mandates, and Federal Tax Subsidies

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*Massachusetts has garnered national attention recently for its bipartisan health care reform legislation. Other states, especially those with similar demographic and financial characteristics, could consider three promising elements of the Massachusetts plan. First, a health insurance exchange, or pool, allows uninsured individuals to purchase quality, affordable health insurance products and creates administrative efficiencies for employers. Second, because voluntary pools have little effect on health insurance costs or coverage rates, Massachusetts mandated that individuals have insurance. Mandating individual coverage assures that the exchange covers both healthy and unhealthy individuals, thereby avoiding the problem of attracting too many high-risk and high-cost individuals. Mandatory approaches also reduce cost shifting, minimize employer crowd out, and limit insurers cherry-picking the best risks. Third, by mandating that employers set up (but not necessarily contribute to) Section 125 cafeteria plans for all employees, workers will receive a significant federal tax subsidy at no cost to the state. Employers stand to benefit as well because FICA taxes are reduced.*

In the absence of federal legislation, several states, including Maryland, Maine, Illinois, and Massachusetts, have taken action to extend coverage to their uninsured. Perhaps the state that has received the most attention is Massachusetts, which passed its bipartisan health care reform plan in April 2006 with an implementation date of July 1, 2007. The aspect of this legislation that has been of particular interest to policymakers is its mandate that all individuals have coverage. The intent is to move Massachusetts close to universal coverage of its residents.

Key aspects of the Massachusetts approach may be used by Wisconsin and other states to cover the uninsured. Some states, like California and Montana, have vastly different demographics and economic constraints, which makes importing the Massachusetts model more difficult. Other states, like Minnesota and Wisconsin, have more similar characteristics, which may make it easier to adapt components of the Massachusetts approach to their state. This chapter describes the Massachusetts model and explains its most promising elements. The chapter concludes by explaining how states can adapt the Massachusetts model, illustrated with three alternative models recently developed and analyzed for California.

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## What are the Main Components of the Massachusetts Plan?

**Everyone must have health insurance.** Individuals are required to have health insurance. This mandate will be enforced through income tax penalties; however,

those individuals for whom insurance coverage is not “affordable” will not be penalized. Within three years, 95% of the uninsured are expected to be covered.

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**The Commonwealth Health Insurance Connector Authority will act as a health insurance exchange, or pool, to manage key aspects of the plan.** The Massachusetts legislation more generally merges the individual and small business insurance markets, which is expected to reduce premium costs for individuals by 24%.<sup>1</sup> Low-income individuals will have access to subsidized coverage through the Connector, which will also offer coverage to individuals and to employees of participating small businesses with 50 or fewer workers. It will “connect” them to private health insurance products that are certified as affordable and high quality.

Under this system of mandated insurance, the Connector can assure that workers not eligible for employer coverage can readily obtain a choice of affordable plans and tax shelter their premium payments through their employer, while minimizing the administrative burden on their employer. The Connector will (a) work with employers to enroll eligible workers, (b) collect workers’ health care payroll deductions (and any employer contributions) from employers, and (c) coordinate with private health plans to distribute enrollment information and premium payments.

**Most employers are required to play a role.** Employers with more than 10 full time equivalent (FTE) employees must establish a Section 125 plan (“cafeteria plan”) to allow workers to have their health insurance premiums deducted on a pre-tax basis. Employers who simply set up Section 125 plans but contribute nothing to their worker’s health premiums, or fail to contribute a “fair and reasonable” amount, must also pay a “Fair Share Contribution” of up to \$295 per worker per year.<sup>2</sup> If no employer plan is offered, the worker’s full premium payment can be made on a pre-tax basis. Employees who work part year or more than one job will be able to pool all of their own contributions, as well as any employer contributions, toward the purchase of insurance.

**Low-income people will receive premium subsidies.** The Connector manages a subsidized insurance program called the Commonwealth Care Health Insurance Program. People below 300% of the poverty line and who are ineligible for MassHealth (Medicaid) qualify for coverage in the Program. Premiums will be based on income and people below 100% of the poverty line will pay nothing toward premiums. The Program is open only to those individuals whose employer does not offer and contribute towards a health plan.

Low-income workers whose employer offers them coverage are not eligible for subsidies from the Connector, but the state does subsidize such workers’ premiums if they qualify for Medicaid/SCHIP or the expanded “Insurance Partnership” program (for small businesses under 50 employees). Such workers generally cannot bypass their employer plan and purchase insurance directly from the Connector. However, the statute provides the Connector Board with potential authority to waive the restriction, but only if the employer forwards its contribution to the Connector. It is unclear whether and how this waiver authority might be used to extend coverage to these low-income workers.

## Can Other States Adopt the Massachusetts Model?

Massachusetts enjoys some advantages over other states in developing this type of health insurance reform. It has a small low-income population, a high percentage of workers with employer coverage, a low percentage of those with employer coverage who have low incomes, and a relatively large uncompensated care pool they can use to fund the program. These demographic and financial factors translate into a plan that comes with an “almost free” price tag. Realistically, other states will probably not be able replicate the model without increasing overall spending. To determine if Wisconsin could adapt some of the elements of the Massachusetts model with relatively modest increases in spending, policymakers could ask the following questions:

- How many Wisconsin citizens are low-income uninsured and would therefore need insurance subsidies?
- What is the risk of employer “crowd out?”
  - o How many workers are low-income but still have employer-sponsored insurance?
  - o How many workers are employed in low-wage firms?

Massachusetts and Wisconsin have some similarities in these respects, especially compared to the U.S. average. Both have below the U.S. average of nonelderly who are low income (below 300% of the poverty line). While the U.S. average is 46.7%, Massachusetts has just 35.9% whereas Wisconsin has 42.0%.<sup>3</sup> This suggests that both Massachusetts and Wisconsin would experience lower subsidy costs to cover the low-income population than other states like California, where 48.9% residents are low income.

One concern other states may have with the Massachusetts approach is how employers will respond to subsidies, particularly if it causes “crowd out” of employer-sponsored coverage. Crowd out occurs when some employers elect to discontinue coverage for lower-wage workers who are likely to qualify for premium subsidies in the absence of an employer contribution. In Massachusetts, 43.5% of the low-income population (under 300% of the poverty line) has employer-sponsored insurance, which is lower than Wisconsin (49.9%) and higher than the U.S. average (42.6%). Because Wisconsin has more modest-income workers covered by employers, there is potentially more exposure to employer crowd out than in Massachusetts.

Another way to assess potential crowd out is to look at the number of workers who have employer-sponsored coverage and work for low-wage firms. In Massachusetts, 10.3% of workers are in this situation, compared to the U.S. average of 17.0% and the Wisconsin average of 12.2%.<sup>4</sup> Wisconsin and Massachusetts are similar in this respect, although Wisconsin has a slightly higher risk of crowd out using these criteria.

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## Which Elements of the Massachusetts Plan are Promising for Health Insurance Reform?

States eyeing the Massachusetts model for possible policy approaches will find three promising elements to consider: a health insurance exchange or choice pool offering subsidized coverage for low income individuals, mandatory participation in insurance coverage, and access to federal tax benefits. Individually, these three elements will not cover a substantial number of uninsured. Taken together, these three elements create an effective public policy that brings people into coverage in ways that are both accessible and affordable. Importantly, a plan with these three elements assigns shared responsibility for coverage to individuals, employers, and government. (It is assumed that that these elements operate in an environment in which low-income individuals and families receive premium subsidies.)

**Health Insurance Exchanges (Or Choice Pools).** Many states see the relative success of large employer groups and try to replicate this “natural” insurance group through voluntary health insurance purchasing pools for individuals and/or small employers. But the end result typically is adverse selection and ultimately ineffective pools. Without needed safeguards, individuals who participate in such pools are too often high cost and cannot get coverage elsewhere. Small employers, by definition, do not have a large population and are more likely to have a disproportionate share of low-risk or high-risk workers. If an employer or pool has a disproportionate share of unhealthy people, over time the pool’s rates increase due to its higher costs. Eventually, the healthy, low-risk people find cheaper rates elsewhere in the market and the pool “sinks.”

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Health insurance pools, or exchanges, are not a magic bullet. For an exchange to be effective, it must reproduce the efficiency and effectiveness of natural pools formed by large employer groups. To do this, individuals must have a compelling reason to join the pool; for example, the exchange could be the exclusive coverage venue for anyone without employer coverage, or subsidized coverage could be made available only through the pool. Research shows that voluntary, unsubsidized insurance pools have little or no effect on health insurance costs or coverage rates.<sup>5</sup> These are the very problems the pools are supposed to address.

**Individual Mandates.** A mandate that all individuals have insurance prevents systemic adverse selection by ensuring that both healthy and unhealthy individuals who do not have employer-sponsored coverage participate in the pool. These individuals include part-time or temporary workers, the self-employed, or workers at small businesses that do not offer insurance. In addition to avoiding adverse selection problems, mandatory approaches reduce cost shifting, prevent employer crowd out, and avoid insurers cherry-picking the best risks.

Voluntary insurance pools ultimately encourage cost shifts from private employers to state coffers. Research shows that subsidies need to be very high to induce the uninsured to voluntarily purchase coverage.<sup>6</sup> In fact, the premium that modest-income uninsured people are willing to pay is much lower than what many other people at the same income level are paying for employer-sponsored coverage. With such high subsidies available, low-income workers will, when possible, seek out

employers that will pay them higher wages instead of offer them health insurance. It's a win-win situation for them, as they can then obtain state-subsidized coverage, often at a lower cost than their previous employee contributions. Over time, however, the state picks up the tab for more and more individuals who might have otherwise obtained coverage under employer plans.

Mandatory approaches alone or in conjunction with a health insurance pool are not a panacea. This is particularly true if the approach provides premium subsidies in an either/or way to workers: (1) if the employer does not offer a health plan, workers receive subsidies, and (2) if the employer does offer a plan, workers do not receive subsidies, regardless of how much the employee has to pay for the premium. In Massachusetts, the only workers covered by employer plans who will still receive subsidies will be those eligible for the pre-existing Mass Health (Medicaid) programs, or those whose employers join the pre-existing Insurance Partnership.

Under these types of mandatory approaches, employers, being rational actors in a competitive market, will slowly shift to not offering coverage ("crowd out"). Employers can then offer higher wages to their employees knowing their workers have access to subsidized health insurance. Even employers who wish to continue coverage may be compelled to drop coverage to compete with other firms that do not offer insurance.

**Federal Tax Subsidies.** An important feature of the Massachusetts plan is that it links the purchasing pool to employers. Employers with more than 10 workers will be required to offer a Section 125 "cafeteria plan" that allows all its workers to purchase health care with pre-tax dollars. These plans must be set up *even if the employer chooses not to offer a health plan or does not contribute to the plan if one is offered*. Plans set up only to tax-shelter employer contributions are called Premium Only Plans.

These plans must also be set up for workers who do not qualify for the employer's health plan, such as temporary or part-time workers. If the employer does not offer a plan, the workers' contributions are forwarded to the health insurance pool. There, workers can use the pre-tax contribution to purchase insurance through the pool and subsidies can be easily applied to the premium due.

By mandating Section 125 plans for all workers, the state can ensure that people receive a significant federal tax subsidy at no cost to the state. Using Section 125 plans, workers are able to shelter some of their income from FICA (Social Security and Medicare) taxes and federal income taxes. Employers, too, benefit from these savings because their FICA taxes are reduced as well. As a result, workers get a boost in their income and the state pays that much less in subsidies.

Some argue that those with low incomes have a low federal tax rate and therefore would not see significant savings. This is true for parents under about 125% of the poverty line and childless adults under about 85% of poverty. But most states are considering reforms to cover the uninsured for those under 200%, 250%, or even 300% of poverty. At these income levels, workers will garner tax savings that are not insignificant.

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## What are Some Ways States Can Use the Massachusetts Model?

There are difficult issues that state policymakers need to address when considering the Massachusetts model. Three alternative variations were developed for California,<sup>7</sup> a state that has a much higher percent of low-wage workers, a higher lower-income population, and no funds to shuffle around to finance health care reform. Some of the differences between the three plans and the Massachusetts plan are presented below to illustrate possible policy options for Wisconsin.

	<b>Plan 1 Basic Individual Mandate</b>	<b>Plan 2 “Pay-or-Play Plus”</b>	<b>Plan 3 “All-Consumer Choice Exchange”</b>
<b>Employer contribution level required</b>	None, current contribution levels assumed.	5% of Social Security wages is required for part-time workers and at least that much must be spent for full-time workers.	Health insurance funded primarily by mandatory payroll-based fee paid by employers and workers. The percent of Social Security wages that is sufficient to fund a mainstream benefit plan to all full-time workers and their dependents will be determined. Employers would pay 80% of the fee and workers would pay 20%. Low-income workers pay on a sliding scale.
<b>Contribution of families with employer coverage</b>	Workers contribute to their employer plan, but low-income people will receive premium assistance to offset some or all of the costs.		Employers would pay 80% of the fee and workers would pay 20%. Low-income workers pay on a sliding scale.
<b>Benefits</b>	Medi-Cal and Healthy Families maintained. Others under 250% FPL will get comprehensive coverage through the Exchange or through employer coverage. Higher-income people must have \$5,000-deductible coverage, or better, to meet mandate.		Full-time workers and dependents get, at minimum, what average employer-plans currently offer (“mainstream benefits”). Others, see plans 1 and 2.

Unlike Massachusetts, the three alternative models analyzed for California assumed the following:

- The upper income limit for premium subsidies was set at 250% of the poverty level, instead of 300%. *Reason:* To align with California’s relatively lower income distribution, health insurance premiums, and state revenue base.
- All employers, not just those with more than 10 workers, would be required to set up Section 125 plans for their workers. Employers must also cooperate with the health insurance exchange/pool for enrollment of workers and transmittal of workers’ tax-sheltered contributions. *Reason:* To harness significant federal tax savings for *all* workers to reduce their net health care costs, while decreasing public subsidy costs and extending individual choice of health plans. Payroll deduction is the most efficient, reliable, and easy way to make and obtain worker health insurance contributions. Tax benefits should be available to all workers, no matter what size firm they work for.
- Low-income people with employer coverage would still be required to participate in that coverage, like Massachusetts. Premium assistance

***Under the three California proposals, all employers would be required to set up Section 125 plans for their workers.***

(subsidies) would be based solely on income, however, rather than whether the worker qualifies for Medicaid, SCHIP or an Insurance Partnership-like program. This would allow more workers to receive subsidies. *Benefit:* To create equity between workers whose employers offer coverage and those whose do not. It seems unfair that workers without employer coverage might be better off because they are always eligible to access subsidized health plans through the health insurance exchange, whereas other workers are bound to their employer plan. Without this provision, workers would have incentives to select employers who do not offer plans and some low-wage employers might have an incentive to drop their coverage. Such “crowd-out” could greatly increase state costs over time.

- The state pays the same proportion of the worker’s premium for employer coverage as it would pay for the premium coverage through the health insurance exchange. *Reason:* To encourage employers to continue contributing by assuring that their contributions benefit their own workers. The state also benefits because subsidy costs in this scenario would not increase as much as they would if all low-income workers were enrolled in public coverage through the pool.

Unlike Massachusetts, alternative plans 2 and 3 establish employer contribution requirements based on a percent of their wages. Plan 2 requires a modest minimum employer “pay-or-play” contribution for full-time workers and an employer fee for other workers. Plan 3 is funded by payroll fees on all employers and workers. The plan funding mechanism was designed to minimize any ERISA challenges. Plan 3 effectively replaces the employer-based coverage system and channels all coverage through the health insurance exchange.

## Conclusion

Covering the uninsured will require some new spending in most states. The existing system of hidden cross subsidies has obscured cost accountability, making it more difficult to contain costs. An increasing share of our economy is being diverted to health care, compromising our ability to compete in a global economy. Sustaining the current system will become more difficult. The Massachusetts model and the three alternative plans that were briefly discussed ensure that everyone has access to essential medical services when needed. These approaches assign individual, employer, and government responsibilities, unlike the current health insurance system.

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