

# Turning *DEBATE* into

**A**MONG THE FACTORS that came together to make meaningful reform in Massachusetts possible, perhaps the biggest was \$385 million in federal Medicaid waiver money. The state was informed by the Centers for Medicare and Medicaid Services (CMS) that it would lose this money unless it instituted reform that significantly decreased the number of uninsured without simply adding to the rolls of Medicaid.

Pressure from consumer groups further contributed to the sense of urgency. One consumer advocacy group offered a proposal to expand coverage by expanding Medicaid and levying a payroll tax on employers not providing coverage to employees. This proposal may become a ballot question posed to all Massachusetts voters.

In addition, there is another ballot initiative proposed by advocacy groups to make health care a right in Massachusetts. While the passage of either of these ballot questions would essentially require universal health care in Massachusetts, they would also provide state legislators and regulators much less flexibility and input in defining the law, not to mention determining how to pay for it. Under these combined pressures, Governor Mitt Romney and state legislators made health care reform a top priority.

Massachusetts also benefited from a funding mechanism that was already being applied within the health care system. For the fiscal year ending June 30, 2006, according to a report by the Massachusetts Division of Health Care Finance and Policy, the state will collect \$526 million to fund its uncompensated care pool. This is a pool that pays for care provided by Massachusetts hospitals and community health centers when the uninsured are unable to pay for services. The funding comes from a combination of general revenues, assessments on hospitals, and assessments on insurers. These funds were able

to be redirected to subsidize the upfront purchase of health insurance rather than funding free care for the uninsured.

While the problem of the uninsured is a significant one in every state in the nation, Massachusetts has a relatively low percentage of uninsured when compared to the nation as a whole. According to the Kaiser Commission on Medicaid and the Uninsured, the percentage of non-elderly uninsured in Massachusetts in 2003-2004 was 12.7 percent, compared to a national average of 17.8 percent. Closing the coverage gap won't be easy in Massachusetts, but it may not be as daunting as it might be in states where the uninsured represent 20 percent or more of the population.

## Medicaid Expansion

The federal money at stake required addressing the uninsured beyond just the expansion of MassHealth, the state's Medicaid program. But make no mistake, Medicaid expansion is a major part of the Massachusetts plan to reduce the uninsured population.

The Romney administration estimates that there are roughly 500,000 uninsured residents in Massachusetts. About 100,000 of them are currently eligible for MassHealth and haven't yet enrolled. There will be enhanced community-based outreach in an effort to reach more of these people who could already have coverage today.

Current regulations allow children from families with incomes up to 200 percent of the federal poverty level (FPL) to enroll in MassHealth. The legislation expands this limit to 300 percent FPL (\$49,800 for a family of three). This policy will have an impact in two ways: It will allow more children to attain health coverage through the state, but it will also reduce the cost of coverage for the adults because they require only individual or two-party policies rather than a more expensive family option. In addition, the law increases the enrollment caps on MassHealth for people with disabilities and the chronically unemployed.



# ACTION

## UNIVERSAL HEALTH CARE IN MASSACHUSETTS

On April 12, 2006,  
a landmark health care reform law  
created a framework for nearly  
universal health care coverage  
for the citizens of Massachusetts.  
Will the Commonwealth be  
the first state to solve the problem  
of the uninsured?

BY JON CAMIRE AND DIANNA WELCH

### Commonwealth Care

The Romney administration estimates that, in addition to those eligible for Medicaid, there are 200,000 additional uninsured citizens below 300 percent FPL. While the new law essentially imposes a health insurance mandate on all individuals, it will create a program called Commonwealth Care designed to facilitate affordable coverage for these citizens in lower income ranges.

With the ranks of the uninsured drastically reduced, the needs of the uncompensated care pool should be similarly diminished. Since there is no plan to reduce assessments on insurers and providers (currently \$160 million for each), the Commonwealth Care program is expected to be the beneficiary of much of the redirected spending.

For those with incomes below 300 percent FPL, premium subsidies will be made available on a sliding scale. For those with incomes below 100 percent FPL (\$9,800 for an individual), there will be fully subsidized premiums. In addition, Commonwealth Care will prescribe certain product designs, and no deductibles will be allowed. This program, like many other provisions of the new law, will be administered through a complex new state organization called the Commonwealth Health Insurance Connector Authority (the Connector).

### The Connector

The eventual success of Massachusetts health care reform may rest on the performance of the Connector. It's a complex structure with broad responsibilities intended to facilitate the sale and administration of health insurance, partnering with the state programs, health plans, small businesses, and individuals.

One of the Connector's most important responsibilities will be certifying products as "affordable." The law will require individuals over 300 percent FPL who don't have other coverage to purchase health insurance without subsidies if affordable and high-quality product options are available. Allowable cost-sharing and network design options will be expanded, and there will be even looser product restrictions on certain individuals in the 19-26 age group, but the Connector must decide what really constitutes affordable coverage for a family of three with gross income of \$49,800 or a family of four at \$60,000.

But the definition of "affordable" isn't clearly spelled out. If the certification is based purely on premiums, could these families be forced into policies with \$10,000 upfront family deductibles?

In addition to certifying products, the Connector will also function as a clearinghouse and a one-stop shopping experience. Carriers will submit products for consideration and those that are certified

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The health care reform law merges the small-group and individual markets into one market with one rating pool.

will be available directly for purchase through the Connector.

Employers may contribute to the Connector on behalf of their employees. This is particularly important for individuals with multiple part-time jobs. The part-time employers, if they wish, could contribute a portion of the cost of coverage to the Connector and the individual could take advantage of funds from all contributing employers. The additional employee premium contributions paid through the Connector will be tax deductible, similar to other employer-sponsored plans.

### Coverage Requirements and Penalties

As of July 1, 2007, all adult residents in Massachusetts will be required to have health insurance coverage if the Connector has determined that there are affordable options for them in the market. Those who don't buy coverage will be subject to penalties.

Massachusetts taxpayers will be required to report their health insurance coverage on their tax returns, and, initially, the penalty for no coverage will be a loss of the personal state tax exemption. Eventually, the penalty will rise to 50 percent of the premium cost of an affordable health insurance plan. When fully phased in, this will create an interesting dilemma for the borderline income families: Spend \$8,000 on a high-deductible health plan, or be subject to a \$4,000 penalty and have no coverage at all?

In addition to the individual mandate, the idea of employer responsibility was a major topic of the health-reform debate in the state legislature. The Massachusetts House of Representatives initially passed a bill that required a 5 percent to 7 percent payroll tax on employers who don't contribute significantly to employee health insurance. The Senate version, which was far less expansive, required neither employer coverage nor a payroll tax.

When the conference committee had nearly reconciled on all other issues, and with the deadline for the federal Medicaid money looming, the Senate and House leaders had stopped communicating and the issue of employer responsibility nearly killed the bill. Ultimately, with the support of business and community leaders, a compromise was reached.

The compromise bill requires businesses with more than 10 employees that don't contribute toward health insurance to be assessed a "fair share contribution" of up to \$295 per employee per year. In addition, the same employers may be subject to an additional "free rider surcharge" when their employees frequently use the uncompensated-care pool. This surcharge may be as much as 100 percent of the cost of care to the state.

While these penalties may not reach the level of the House-recommended payroll tax, there is a clear rationale for some level of employer responsibility. Since the health plans and providers in the state are assessed a combined \$320 million to fund the uncompensated care pool, these amounts are passed into the premiums that employer groups pay for coverage. Why should employers who provide coverage be subsidizing care for the employees of the businesses that don't provide coverage?

### Key Reform Measures

The reform law makes significant changes to the way in which insurers price the individual and small-group markets. To understand the impact of the changes, one must first appreciate the current regulations in Massachusetts.

The small-group market is defined as employers with under 51 employees, including self-employed individuals. Coverage is guaranteed issue and guaranteed renewable. Rating requirements of the small-group market include:

- Rates may vary based on age, industry, participation, and group size, provided that the highest rate charged to a group is no more than twice the lowest rate charged to any other group. This is referred to as the 2:1 rate band.
- Outside of the 2:1 rate band, rates may vary based on geographic region and benefit design.
- No adjustments are permitted for health status or gender.

The individual market, unlike most states, is also guaranteed issue and guaranteed renewable. Similar to the small-group market, no adjustments are permitted in rating for health status or gender. Age rating is subject to a 2:1 rate band. Due to these restrictions, there is significant adverse selection in the current individual market risk pool compared to the employer-sponsored, small-group pool.

The health care reform law merges the small-group and individual markets into one market with one rating pool. Because the current small-group market is several times larger than the individual market, this merger will result in significant reductions in premiums for individual plans. As an offset, there will need to be modest increases to the small-group rates—at least in the short-term.

The Senate reform proposal had provided for some state-funded reinsurance for high-cost claimants. Such reinsurance could have helped to minimize the adverse impact on the small employers of pooling them with individual plans, but the reinsurance provision wasn't included in the final law.

There are other inherent difficulties with rating an employed market with an individual market. For example, what will carriers

do with their industry, group size, and participation factors? These will continue to be valid rating characteristics, but actuaries will need to be meticulous in setting rating factors to avoid inequities or unintended disincentives for employers to continue offering health insurance to their employees.

The law also adds tobacco usage as a rating factor and expands the wellness rating factor. The intent was to create additional incentives for healthy behaviors; the factors were put inside the 2:1 rate band, however, which will mute their impact.

Ultimately, time will tell what impact reform will have on the combined individual and small-group markets. There are a number of healthy individuals who are currently going without coverage. The strength of the individual mandate could have a significant impact on the premiums in this market. If affordable products are available in the market, it's possible that inclusion of additional healthy individuals in the pool will at least partially offset the impact of the high-cost insureds who currently purchase coverage in the individual market.

However, if those individuals choose to pay the tax penalties rather than purchase insurance, or if the lack of affordable options weakens the individual coverage requirement, there will most certainly be a net increase in small-group premiums.

### Product Options

The enforceability of the individual coverage mandate relies on the availability of affordable products in the market, and it will be up to carriers to design those products. Carriers with at least 5,000 small-group members in Massachusetts must file a product for consideration by the Connector. Before approving the product, the Connector must determine that it's affordable and of high value to the consumer.

Unlike in many other states, the local Massachusetts market is heavily penetrated by HMO plans. These tend to be the most affordable products in the market for the benefits provided. While PPO plans are available, they're not as popular as HMO plans in Massachusetts. Yet HMO benefit designs are more restricted in the current regulatory environment, prohibiting certain lower cost HMO options from being offered.

Most of these restrictions aren't written specifically into Massachusetts regulations, but they're enforced by the Division of Insurance's interpretation of what constitutes comprehensive coverage and access to care. Coinsurance isn't allowed and designs with individual deductibles above \$2,000 haven't been approved.

The health care reform law requires the insurance commissioner to put these restrictions in writing. The law also grants



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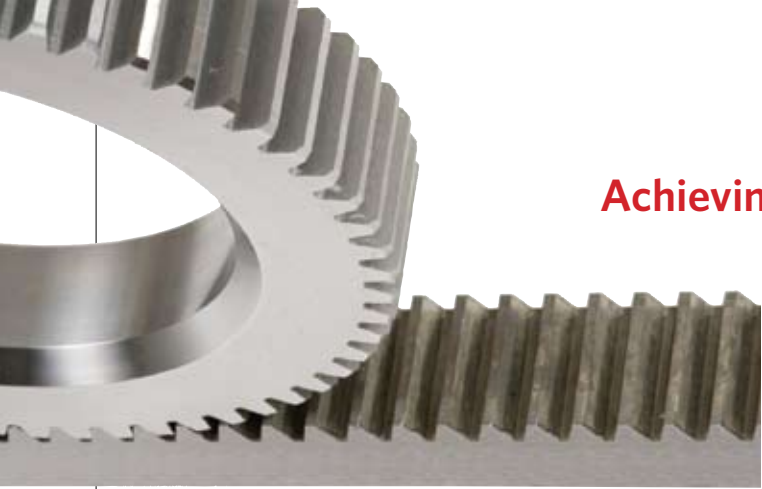
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## Achieving affordability in the long term requires

products designed only for 19-26 year-olds who don't have employer-sponsored coverage. The additional flexibility with this population is designed to entice more of the young and healthy uninsured to purchase coverage.

### Quality

While subsidies and product design are important levers for reducing premiums, they don't address the underlying cause of the affordability problem: The high cost of health care continues to increase faster than inflation.

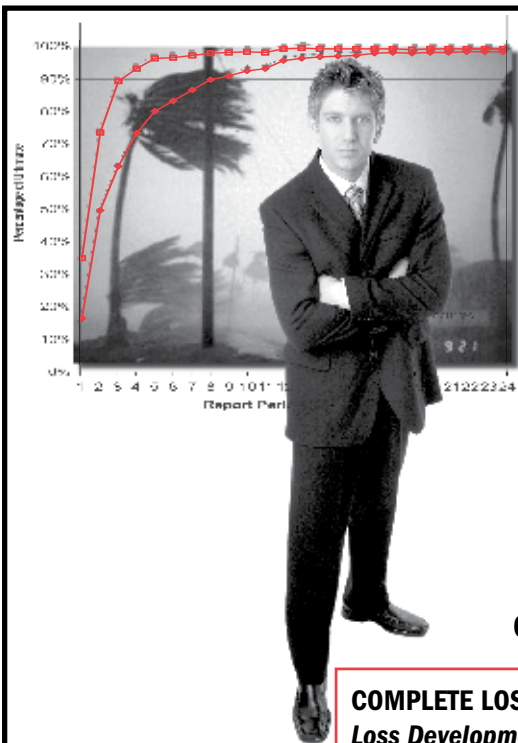
Achieving affordability in the long term requires reducing the inefficiencies in today's health care delivery system. There are several ways in which the reform law attempts to address this through health care quality.

One way is with the creation of a Health Care Quality and Cost Council. The council will develop goals to improve both affordability and quality of care. Although it's up to the council to set its goals, the law lays out a number of objectives.

For example, the council is to provide support to consumers in making health care decisions by establishing a transparency website. The website will provide general health information to consumers as well as cost and quality information that will allow consumers

the Connector authority to approve the benefit designs it sells directly. In addition, the law explicitly allows HMO plans to offer deductibles up to the maximum allowable 2006 health savings account contribution level as determined by the Internal Revenue Code: \$2,700 for single coverage or \$5,400 for family coverage. Products may also be offered with differing provider networks, opening the door for tiered or limited network products.

Massachusetts currently has some of the most costly mandated benefits in the nation, such as coverage for infertility treatments and more generous mental health coverage than federally required. While the idea of reducing mandates was debated, the health care reform law didn't remove any of the currently mandated benefits. Instead, it placed a moratorium on introducing new mandated benefits until Jan. 1, 2008. The only exception the law made to the benefit mandate requirements is for new



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## reducing the inefficiencies in today's health care delivery system.

to compare facilities and physicians. The hope, of course, is that this will drive members to use the state's better and more efficient providers, thus reducing overall costs and encouraging under-performing providers to improve their efficiency and outcomes.

Many health insurers across the country have made strides in providing more useful cost and quality information to their members. The difficulty in many cases has been in deciding which measures are appropriate to share. Insurers often struggle to find meaningful metrics that can be calculated from limited claims data rather than real outcome data, such as test results or complications.

At the same time, providers often resist dealing with multiple carriers that use different definitions of quality care. The Health Care Quality and Cost Council will have the opportunity to overcome some of these long-standing barriers. It can require both providers and insurers to submit data, and publish all payer measures based on both process and outcomes.

Improving health care quality will also be addressed through the Medicaid payment methodology. The law provides for increasing Medicaid payments to hospitals. While payment increases are guaranteed in the first year, subsequent increases must be earned through pay-for-performance programs that improve quality and reduce racial and ethnic disparities.

These programs should raise the bar on quality of care provided to all patients, not just those covered by Medicaid. In many cases, MassHealth currently pays providers below the cost of care, resulting in cost shifting to private payers. Increased payments may reduce this shifting as the public shortfall is lessened.

### Determinants of Success

The million-dollar question is whether Massachusetts will succeed in providing near universal coverage to its residents. How will we know if the reform has succeeded?

The first indicator of success will be retaining the \$385 million at risk through the federal Medicaid waiver. Another obvious measure of success will be the number of Massachusetts residents who remain uninsured after the reform is fully implemented. But what will determine if the uninsured purchase, and more importantly maintain, coverage over time?

The reform contains several carrots and sticks intended to expand coverage. By expanding government subsidies and encouraging more affordable products, it hopes to entice more to get coverage. The onus is on the Connector and health plans to ensure the right products are available. It's critical that individuals, employers, and the government all play their roles as the legislators intended. If the enticements aren't enough to persuade individuals and employers to purchase coverage, will the risk of penalties persuade them?

Funding is a key component of success. Initially, subsidies will be set to reach certain affordability goals for lower-income residents. The problem the entire market has faced in recent years has been double-digit increases in medical costs. Will the quality measures successfully moderate the trend? If not, will Massachusetts be able to afford to increase the subsidies significantly

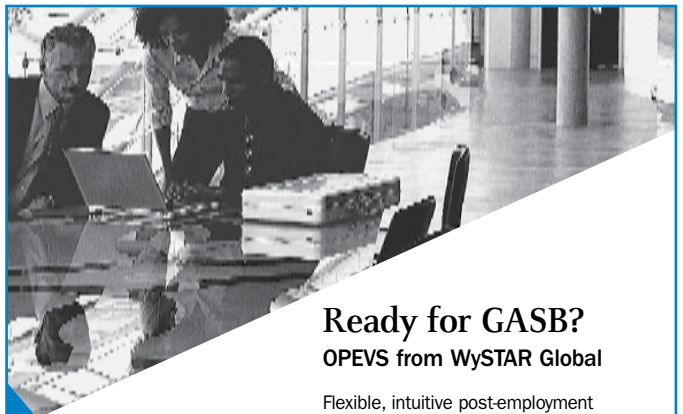
enough to maintain affordable options for the low income?

Can Massachusetts serve as a model for expanding coverage in other parts of the country? The regulatory, financial, and political situation in Massachusetts made it ripe for reform. Any state will have to tailor potential reform to its own market conditions and financial situation. There are certainly lessons that can be learned not only from the reform itself but also in showing how legislators and the business community can work together to make real reform a reality.

It will certainly take some time and perspective to determine how well health care reform in Massachusetts succeeds. While many of the details of the regulations have yet to be determined by the Division of Insurance, vocal critics have already emerged to identify flaws in the approach.

The eventual outcome will never satisfy all the naysayers, and certainly errors will be made while the rest of the country is watching. But it was clear that something had to be done for the uninsured, and Massachusetts has already achieved some level of success by accomplishing what few other states have: advancing the issue from debate to action.

JON CAMIRE and DIANNA WELCH are actuaries with Blue Cross Blue Shield of Massachusetts in Boston.



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