

Testimony of the Council for Affordable Health Insurance
Before
The Senate Banking and Insurance Committee

June 18, 2008

Good afternoon Chairman White and members and staff of the Senate Banking and Insurance Committee. I'm Kevin Wrege and I'm here today on behalf of the Council for Affordable Health Insurance, a national research and trade organization representing health insurers, agents, actuaries and small business owners.

I'm going to take a few minutes today to discuss the Massachusetts health care reforms, provide a general update on that initiative and to offer any thoughts that may be pertinent to reform efforts now being considered here in Harrisburg.

The Environment Prior to Reform

First, it is important to note the problems afflicting the health insurance market in Massachusetts prior to the enactment of the reform law in April 2006. Massachusetts has for many years been a high-cost healthcare regional, with high relative premium rates for both individual and small group coverages. These relatively expensive policies have been offered by a dwindling number of health insurance carriers, with dominant market positions maintained by a small number of domestic PPOs and HMOs.

Ten years before the new reform law was enacted, the legislature passed the Non-Group Health Insurance Reform Act, which severely restricted the underwriting, pricing and marketing of individual and small group plans by requiring the following:

- The state division of insurance defined a standard individual insurance policy, specifying deductibles, premiums and coverage mandates for one HMO, one PPO and one indemnity-style plan. Insurers serving the individual insurance market were permitted to offer only the standardized plan in each category;
- Rates could be modified from the state-established community rate only for age and geography. Rate variation for age was extremely limited, ensuring that the young (with lower average incomes) subsidize the older population (with higher average incomes). Rates for plans with enhanced benefits could be adjusted to account for the benefit differences, but not for health risks; and
- Insurance premiums were subject to review and pre-approval by the insurance commissioner. The process resulted in a tacit linkage of premium rates, meaning that a given insurer's rates were tied to its competitors' rates.

regardless of the experience of the carrier applying for the rate increase.

As these reforms took hold, the results were disappointing, but, in hindsight, not altogether surprising. Two years after the 1996 legislation was adopted, approximately 20 health insurers stopped marketing plans in Massachusetts. According to a report published in the March 26, 2004 issue of the *Boston Business Journal*, Blue Cross Blue Shield statistics, based on state reports, reveal that the number of uninsured persons in the state increased from 365,000 to 500,000 in 2000.

As for premium rates, the 2000 Medical Expenditure Survey, conducted by the Agency for Healthcare Research and Quality, found that by that year Massachusetts had the highest average annual premiums in the nation for family coverage through small group policies: \$8,468. Individual insurance rates in the state also rose and, as a result, the share of persons insured in the state's individual insurance market fell from 10.8 percent in 1994 to 8.3 percent in 2003. As of June 2005, monthly premiums in the state's non-group market ranged from \$384 for a 25-year-old individual (\$4,618 per year), to as high as \$4,291 for the two-adult plan (\$51,494 a year). Those rates were substantially higher than the national average annual premiums reported in the January/February 2004 issue of *Healthplan* magazine: \$2,070 for single coverage and \$4,009 for family coverage.

What the Reforms Did

The Massachusetts Health Care Reform Plan, enacted in April 2006 and implemented beginning in late 2006, requires all adults in the state to purchase health insurance by July 1, 2007, and imposes financial penalties of up to 50 percent of the cost of a health insurance plan on those who do not via income tax filings. Additionally, employers with 11 or more employees are required to provide health insurance coverage or pay a "Fair Share" contribution of up to \$295 annually per employee. These employers are also required to offer a Section 125 "cafeteria plan" that permits workers to purchase health care with pre-tax dollars or face a "free-rider surcharge" if employees make excessive use of uncompensated care.

The plan creates the Commonwealth Health Insurance Connector to "connect" individuals to insurance by offering approved major medical policies for purchase by small businesses and individuals. The Connector Board has approved plans offered by seven of the state's health insurers that provide a range of coverage options, including a specially designed, lower-cost product for 19-26 year-olds. These Commonwealth Choice plans became available May 1, 2007.

A central piece of the plan is the provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance. The Commonwealth Care Health Insurance Program provides sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level (or \$30,630 for an individual) for the purchase of health insurance. Individuals with incomes less than 150 percent of the federal poverty level (\$15,315 for an individual) are not required to pay any premiums. Plans offered through Commonwealth Care do not have deductibles, and are offered by

the managed care organizations that participate in the Medicaid program. As of June 1, 2007, approximately 80,000 low-income adults had enrolled in Commonwealth Care plan.

Insurance market reforms are also an important component of the plan. In particular, the plan merges the individual and small-group insurance markets, the first state in the country to do so. A legislative study projected that combining these markets would lead to a slight increase (1.5 percent) in the small group rates, while premiums for individuals would fall 15 percent.

Early Results of the Reform Law

The results of the reforms to date have been mixed. The goal of the plan was to cover nearly all adult residents of the state within three years of full plan implementation. While the plan has only been in effect for about a year, more residents are becoming insured. However, there are clouds on the horizon: the growing costs of covering individuals who qualify for subsidies is prompting concerns about the ongoing financial viability of the subsidized portion of the reform plan as its costs continue to rise faster than anticipated.

First, the good news. The state has seen a reduction in the number of uninsured residents. In fact, the Massachusetts Division of Health Care Finance and Policy reported in January 2008 that “[T]he number of people enrolled in private or subsidized health insurance products has increased by 256,000 people since health care reform began to be implemented.” That same report stated that the state’s overall uninsured rate dropped from 6.4 percent to 5.7 percent from 2006 to 2007, and the number of people without coverage fell from 395,000 to 355,000, a 10 percent decrease in the overall uninsured rate. A recent survey published in *Health Affairs* generated even more promising results. It reported that in the first year of reform, uninsurance among working-age adults dropped from 13 percent from the fall 2006 to 7 percent in fall 2007.

As for program costs, the news is less promising. Initially, the reform plan was projected to cost roughly \$400 million annually. In a nutshell, the budget called for redirecting about \$600 million from the state’s uncompensated care pool, obtaining \$385 million from the federal government as part of a comprehensive Medicaid waiver and adding \$300 million in general revenues, totaling approximately \$1.2 billion over three years. Currently, however, the costs for FY 2008 are about \$618 million, exceeding the initial annual projection by more than 50 percent. The budget estimate for FY 2009 stands at \$879 million. According to a Boston Globe report, this does not include a new \$153 million shortfall that will also need to be closed. By at least some projections, the plan could cost as much as \$1.35 billion *per year* by 2011.

The state is awaiting word on its Medicaid waiver renewal, which should be determined in the coming weeks.

Implications for Other States’ Reform Efforts

The Massachusetts plan has generated substantial interest from national and state policymakers and has triggered a broader debate over the merits and feasibility of comprehensive health care reform generally and individual and employer coverage mandates in particular. Several states are now including components of the plan in reform proposals of their own. At the same time, the challenges currently facing this multifaceted plan, though not unexpected, reveal how difficult implementing a program of this scope and complexity can be.

These are some considerations for policymakers in other jurisdictions to keep in mind as they consider their own reforms:

- The plan relies very heavily on substantial federal Medicaid funds for financing. Other states may not have access to such funding, or such funding may not be as robust. Also, Massachusetts is a relatively wealthy state and it was blessed with a relatively low uninsured rate prior to reform. States with fewer resources and/or higher rates of uninsureds will find that this plan won't work for them because they won't be able to afford it.
- Massachusetts policymakers were able to persuade hospitals to forego funding they had been receiving for uncompensated care, creating crucial additional funding by diverting some payments that had gone to institutions and redirecting those funds to subsidize coverage for lower-income enrollees. This may or may not be politically feasible in other states.
- The early public data show that enrollment in subsidized coverage has significantly out-paced those who have purchased unsubsidized connector coverage with their own funds. Moreover, three-quarters of those who have obtained subsidized coverage make no contributing premium payments. This puts the state on the hook for a large number of new policyholders who are getting free coverage.
- If policymakers make commitments to subsidize coverage based on income, and if they do so at generous levels, they must be prepared to undertake major long-term financial commitments, the size of which may be difficult to project. Given the fact that underlying medical trends are increasing faster than both general inflation and wage rates, the costs of providing coverage on a means-tested basis can easily balloon.
- There are limits to implementing insurance and access reforms that are not accompanied by efforts to constrain underlying medical costs.

I would be happy to try to answer any questions you have. Thank you.