



Leadership is our business

Associated Industries of Massachusetts

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Statement of Associated Industries of Massachusetts (AIM) before Chairman Edward M. Kennedy, Senator Michael B. Enzi and Members of the Health Education Labor and Pension Committee’s Roundtable Hearing entitled “Learning From the States: Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform.”

Good afternoon. For the record my name is Eileen McAnney, Senior Vice President and Associate General Counsel of Associated Industries of Massachusetts (AIM), the state's largest nonprofit, nonpartisan association of Massachusetts employers. AIM's mission is to promote the well-being of its 6,500 members and their 680,000 employees and the prosperity of the Commonwealth of Massachusetts by improving the economic climate, proactively advocating fair and equitable public policy, and providing relevant, reliable information and excellent services.

On behalf of our membership, I am honored to provide the employer perspective on Massachusetts health care reform. AIM has a very diverse membership, representing employers in all sectors of the economy, of all sized and from all regions of our state. A common denominator for them, however, is that they all offer health insurance to at least a portion of the workforce. This fact certainly shapes AIM’s point of view.

1. Key Lessons Learned

Chapter 58 of the Acts of 2006, the most recent attempt by Massachusetts to adopt and implement major health care reform, has been very successful to date for several reasons. Although Massachusetts health care reform is often touted as a “bold experiment” and “landmark legislation,” it was prompted by several far more mundane factors. The need to win federal approval of the Commonwealth’s Section 1115 Medicaid Waiver under which the state’s Medicaid program had operated for more than a decade to retain hundreds of millions of dollars in federal funds certainly served as an impetus. In 2005, the Center for Medicaid and Medicare Services (“CMS”) urged Massachusetts to devise a plan to provide health insurance coverage more efficiently to the uninsured. Rather than making payments to the disproportionate share providers, CMS wanted the money to go directly to individuals to pay for health insurance premiums.

In addition, there were two ballot initiatives pending that were problematic to the business community. The first would have made very comprehensive health care a right under the Massachusetts' Constitution. The second established a payroll tax on Massachusetts' employers that would be used to fund an expansion of public health care programs. Because both initiatives required the business community to pay significantly more for health care but did not change the delivery system in any way or give the employer community a say in how the money would be spent, neither ballot question was appealing. This served to motivate employers to engage in the dialogue among major stakeholders about how to cover the uninsured more efficiently in Massachusetts. Lastly, Speaker of the House Salvatore DiMasi, Senate President Robert Travaglini and Governor Mitt Romney all demonstrated unflagging leadership and commitment to ensuring that Massachusetts devised a way to cover the uninsured in way that would win CMS's approval, improve the lives of the uninsured and win the approval of employers.

Equally important was the participation in the dialogue of all major stakeholders – doctors, hospitals, consumers, insurers, employers and lawmakers – and the consensus among them that the status quo was not optimal. Their participation allowed for very thoughtful and well-informed dialogue, and perhaps more importantly, made them vested in the long-term success and sustainability of health care reform as we moved forward with implementation and encountered the inevitable “bumps in the road.”

Massachusetts took an incremental approach to its reform. We did not seek to fundamentally revamp the way people obtained coverage, to eliminate employer-sponsored coverage or conversely, to impose an employer mandate. Instead, we sought to adapt the existing sources of coverage and fill in the gaps. For example, Medicaid income-eligibility thresholds were expanded to cover children under 300% of the federal poverty level. All insurance policies sold in Massachusetts were required to expand the definition of “dependent” to include children: (1) until they reached 26 years of age or (2) for full-time students for two years after they lost their status as a dependent under the Internal Revenue Code, whichever came first. This change was designed to get more young adults covered in a cost effective manner. A young adult plan was also introduced into the marketplace that did not include all the mandated benefits as a way to make the insurance more affordable. This targeted approach, although not universally supported, allowed Massachusetts to move forward.

Massachusetts policy makers did not let the perfect get in the way of the good. At the time the legislature enacted Chapter 58, for example, future funding sources for some of the expansions remained uncertain, and several of the elements were met with a healthy dose of skepticism by various stakeholders. Public policy makers forged ahead to ensure approval of the Medicaid Waiver, but also because the goal of universal coverage was a worthy one and the challenges were not insurmountable.

2. Key Elements of Massachusetts Health Reform Critical in the Context of National Reform.

Massachusetts was well-suited relative to many other states to address the issue of the uninsured and to strive for universal coverage. Prior to enactment of Chapter 58, Massachusetts: had one of the lowest rates of uninsured in the nation (between 6-9%); spent over \$1 billion annually in

reimbursement to hospitals for coverage for the uninsured already through the Uncompensated Care Pool; had a higher rate of employers providing health insurance to employees than the nation as a whole and a higher percentage of employees taking that coverage. In many ways, this made Massachusetts uniquely situated to address the challenge of covering the uninsured.

Nevertheless, there are key elements included in the Massachusetts plan that are readily transferable and key to the success of a national model.

Massachusetts reform was premised on the concept of shared responsibility and central to that is the individual mandate requirement. In fact, much of Massachusetts' success in reducing the number of uninsured can be attributed to the individual mandate. Many of the 432,000 newly-insured had access to coverage prior to enactment of health care reform in 2006, but chose not to enroll. Of those, 160,000 people, who were offered employer-sponsored plans and refused them prior to imposition of the individual mandate, are today covered through their employer's plan. Similarly, of the 72,000 people newly signed up for MassHealth, many were eligible prior to health care reform but did not enroll. Thirty-two thousand individuals purchased coverage for themselves when they opted not to before. The balance of the newly-insured, about 175,000 covered lives, is covered by Commonwealth Care, the state's subsidized insurance product. While the compliance burden of the health care mandate falls on the individual, employers and the state largely shoulder the cost. From the employer perspective, it is critical that lawmakers recognize the increased cost implications of the individual mandate on the employer community.

In addition, the requirement that all residents of the Commonwealth have insurance begs the question about how much insurance is enough to satisfy this requirement. The debate about what is "minimum creditable coverage" in Massachusetts evoked strong reactions from employers. While individuals ultimately must comply or face tax consequences, employers wanted to make sure that the benefits they offered met the MCC standard. Otherwise, employers would be in the untenable position of providing health insurance coverage at great expense yet their employees would still be subject to fines. The challenge is defining MCC in a way that ensures adequate coverage while allowing employers to be flexible in the coverage that they provide.

Creation of the Commonwealth Health Insurance Connector was one of the more innovative provisions of the Massachusetts health care reform law. Its purpose was threefold. Its primary function was to facilitate the purchase of health insurance by individuals by serving as a clearing house for all products that provided good value to consumers. These products received the Commonwealth's seal of approval. In addition, the Connector administered the Commonwealth Care product (subsidized insurance on a sliding scale for those with income below 300% of the federal poverty level) and Commonwealth Choice, a product offered to all individuals without any income limitations. Lastly, the Connector was charged by the legislature with making some critical public policy decisions such as what is minimum creditable coverage and when is an individual excused from the health care mandate because insurance is unaffordable.

3. The Most Difficult Aspects of the Massachusetts Health Reform

The most difficult aspects of health care reform, from the employer perspective, were the provisions that were adopted as "workarounds" to federal law and are therefore not directly

relevant to the national discussion. For example, to provide all individuals with the federal tax benefits available to employer-based insurance, Massachusetts requires all businesses with 11 or more full time equivalents to establish and maintain a Section 125 plan. This enables employees who are ineligible for employer-sponsored insurance to pay for the entire health insurance premium in pre-tax dollars and those that are eligible for employer-sponsored insurance to pay for their portion of the premium in pre-tax dollars. Should Congress enact national health reform and want to provide a tax exemption for the cost of health insurance, the necessary changes could be made to the Internal Revenue Code.

The most contentious aspect of the health care reform debate in Massachusetts was whether or not to impose an employer mandate. Predictably, the consumer advocates wanted to impose an employer mandate and the employer community vehemently opposed it. The compromise requires certain employers that do not offer health insurance to a sufficient number of their employees or subsidize it adequately to make a monetary contribution to the state towards the cost of subsidized care. The “fair share contribution” provision has proven very difficult to understand and comply with. Since its initial implementation, the FSC requirements have been amended to impose more frequent reporting requirements and additional burdens on business, particularly those with part-time, seasonal or temporary help. This issue, along with the definition of minimum creditable coverage, threatened to undermine the consensus that Massachusetts had carefully built around health care reform.

In many ways, the most difficult aspect of health care reform in Massachusetts lays ahead. Massachusetts health care reform was intended to cover the uninsured. Although the employer community’s preference was to address the increasing cost of health care before we expanded coverage, and warned that the long-term viability of health care reform would be jeopardized if cost was not addressed, we did not stand in the way of the Commonwealth’s efforts to provide health insurance to the uninsured, and in fact, are committed to that goal.

The high cost of health insurance, which serves as a barrier to purchasing health insurance for many small businesses and individuals and acts as a competitive disadvantage for the businesses located here, must be addressed. The cost of health insurance in Massachusetts exceeds the national average by 30% and health care reform has done nothing to moderate premium trends to date. In fact, as a result of health care reform, some businesses now must pay a fair share contribution. Others are now providing coverage to more of their employee population or have increased their benefit offerings to comply with the minimum creditable coverage standard. Despite these additional costs, nearly three-quarters (72%) of Massachusetts employers offer health insurance to their employees and this offer rate has held steady, even as the employer offer rate nationally has declined from 68% to 60% between 2001 and 2007.

The economic challenges confronting Massachusetts employers, and their willingness and/or ability to offer coverage going forward, will be key a determinant in whether Massachusetts reform is sustainable absent significant progress on reducing health care costs.

On behalf of Associated Industries of Massachusetts and the employers we represent, I thank you for the opportunity to provide comments and look forward to working with members of the Committee as you explore national health reform.