An Analysis of the Essential Role of Employers in Massachusetts Health Care Reform

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Overview

The Massachusetts health care reform law, Chapter 58 of the Acts of 2006, has attracted national attention for its carefully balanced approach and for its early success in enrolling previously uninsured residents in health insurance plans. The beauty of the law's design is that it relies upon a partnership of government, employers and individuals, based on the principle of shared responsibility. State and federal programs will fund health insurance for low-income residents; private sector assessments and government funds that now pay for "uncompensated care" will shift, in part, to subsidizing private insurance coverage; employers will take on the additional costs of funding coverage for previously uninsured workers and, in some cases, will provide additional benefits to help their employees meet the state's "minimum creditable coverage" standard; and individuals will be required to obtain and maintain health insurance that is deemed by the state to be adequate and affordable based on their incomes.

Chapter 58 creates a new independent public agency, the Commonwealth Health Insurance Connector Authority ("the Connector"), to implement significant portions of the law and to administer Commonwealth Care, which offers subsidized insurance to people with annual incomes up to 300 percent of the Federal Poverty Level (FPL, see Appendix A), Commonwealth Choice, which provides commercial health products to uninsured individuals and small businesses, and Young Adult Plans, which offer low-cost coverage to residents 19-26 years of age who do not have access to employer coverage or MassHealth.

The drafters of Chapter 58 determined that without an obligation for individuals to purchase health insurance, a large number of relatively healthy people who could afford insurance, including many who are offered coverage by their employers, would continue to opt out of coverage. Without an adequate number of low-cost, low utilizers of medical services to balance the high-cost, high utilizers, the price tag for coverage would rise at an unsustainable rate and the law's goal of nearly universal coverage would be unachievable. So, Massachusetts chose an "all-in" approach to coverage that has not been attempted in any other state in the country.

The purpose of this report is to highlight and clarify the broad scope of employer participation that is critical to the success of health care reform. Prior to health care reform, employer-sponsored coverage provided nearly 80 percent of all health insurance for non-elderly residents of Massachusetts, and, with the exception of very small businesses, 90 percent or more of the state's employers offered health insurance plans to their employees. Total employer spending for health care in 2007 is estimated to be $11 billion, and if past cost trends continue, that amount will increase by some $800 million next year.

Implementation of Chapter 58 will result in an even greater amount of employer-based coverage by encouraging employees who had chosen not to accept employer coverage to do so. Specifically, the Foundation estimates that when family coverage is taken into account, 28,500 to 31,000 newly enrolled employees will mean 42,608 to 51,460 Massachusetts residents being newly insured through employer-sponsored health plans at an additional cost to their employers of up to $157 million.

Health care reform will also affect employer-sponsored coverage through the requirement, effective January 2009, that individuals must maintain "minimum creditable coverage" (MCC) as defined by

the Connector in order to be in compliance with the individual mandate. While it is not an employer requirement, per se, employers will be under pressure to offer their employees plans that meet the MCC standards, which, for some, will mean offering richer benefits than they do currently. For instance, the Foundation estimates that the additional cost to employers of meeting the MCC prescription drug benefit requirement will be $24 million.

The total estimated cost of current and future employer spending for providing coverage to Massachusetts residents is enumerated in Section VII of this report, along with a summary of caveats and factors that could drive that number higher or lower.

The complementary relationship between individual and employer obligations of Chapter 58 is key to achieving nearly universal coverage in Massachusetts. It is especially significant that the implementation of Chapter 58 will expand enrollment in employer-sponsored health insurance without trying to force employers to offer health insurance to their employees by taxing them for not doing so. Legislative leaders rejected "play or pay" employer mandates and payroll taxes during the final negotiations leading up to the law's enactment, believing that they would harm job creation and increase the overall costs of reform without expanding access to coverage, and they exempted the state's smallest employers from most provisions of the law. Rather than taking a punitive approach toward employers that do not offer employee health coverage, the law is designed to build on the state's already strong base of employer coverage and give more options to individuals and businesses that have not been able to afford coverage.

There are also specific employer provisions in the law encouraging pre-tax payment of employee health insurance premiums and equalizing the employer obligation for funding uncompensated care through the "fair share assessment," which this report examines in some detail.

Chapter 58 obligates every employer with 11 or more full-time-equivalent employees to set up and maintain an IRS Section 125 "cafeteria plan" that allows employees to make pre-tax payroll deduction payments for their health insurance, whether or not the employer pays any part of the health insurance premium. The Section 125 provision helps make substantial tax savings available to most employees – both those eligible for employer-sponsored insurance and those who have to buy it for themselves.

The "fair share assessment" is one of the most widely discussed and misunderstood employer-related provisions of Chapter 58. It has been characterized by some as both a mandate for employers to offer coverage and as a significant source of new funds to help finance reform. It is neither. Rather, as will be explained in this report, it is explicitly intended to equalize the employer burden of paying for uncompensated care, and is expected to be applied to a relatively small number of employers.

In summary, this report examines how, using the principle of shared responsibility rather than an employer tax or mandate, the Massachusetts health care reform law will expand employer participation to help fill the coverage gaps that government-subsidized insurance alone cannot reach.

I. Employer-sponsored insurance is the foundation for Massachusetts health care reform

A June 2006 household survey by the Massachusetts Division of Health Care Finance and Policy found that an estimated 395,000 Massachusetts residents were uninsured prior to health care reform, or about 6.4 percent of the state's total population of 6.2 million. Adults under the age of 65 accounted for about 309,000 of the uninsured, or 8.2 percent of a non-elderly population of 3.8 million.[1] Other surveys, using U.S. Census data and different survey methodologies, have estimated the number of uninsured adults at 500,000 or more.[2] The goal of Massachusetts health care reform is to achieve nearly universal coverage within several years by expanding access to both public and private insurance coverage. Without a continuing high level of employer sponsorship of health insurance, this goal would be unattainable.

Massachusetts employers have long recognized that offering health insurance to their workers keeps them competitive in the labor market. In addition, the Massachusetts economy is driven by sectors that traditionally have high rates of employer-sponsored insurance, including finance, high tech, education, health care and insurance. As a result, the state has one of the highest levels of employer-sponsored health insurance in the nation. Prior to the enactment of Chapter 58, employer-sponsored coverage provided nearly 80 percent of all health insurance for non-elderly residents of Massachusetts, and the percentage of the state's employers offering health coverage averaged close to 90 percent in every category except those with 2 to 9 employees. Today it is estimated that Massachusetts employers contribute more than $11 billion annually to their employees' health care coverage,[3] and, as Table 1 indicates, the rate of employer-sponsored insurance in Massachusetts is significantly higher than the national average. This is especially true among very small employers where the rate of health coverage in Massachusetts is 28 percent higher than the national average.

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[1] In August 2007, the Massachusetts Division of Health Care Finance and Policy revised its 2006 estimate of the total number of uninsured Massachusetts residents as reported in *Health Insurance of Massachusetts Residents, December 2006*, from 6.0 percent or 372,000, to 6.4 percent or 395,000, correcting for an underestimation of uninsured young adults.

[2] *Reform: Insurance Coverage and Access to and Use of Care in Massachusetts in Fall of 2006,* Sharon Long and Mindy Cohen of the Urban Institute for the Blue Cross Blue Shield Foundation of Massachusetts, August 2007.

[3] The Urban Institute's *Roadmap to Coverage: Synthesis of Findings* for the Blue Cross Blue Shield of Massachusetts Foundation estimated employer spending in 2005 at $9.64 billion. Using an estimated average premium increase of 8 percent annually, employer spending in 2007 would total $11.24 billion.

Table 1

Number of employees	Percent of MA employers offering health coverage[4]	Number of employees	Percent of US employers offering health coverage[5]
2-9	60%	3-9	47%
10-24	88%	10-24	72%
25-50	95%	25-49	87%
51-250	96%	50-199	93%
251+	99%	200+	98%

The same state and federal surveys found that, during the five-year period preceding the passage of Chapter 58, the percentage of employers offering health insurance coverage to their employees rose slightly in Massachusetts while the national rate fell by more than 11 percent.

Table 2

	2001	2003	2005
Massachusetts	69%	68%	70%
United States	68%	66%	60%

The state's high rate of employer-sponsored coverage was an important factor in lawmakers' rejection of proposals to impose a payroll tax on employers that do not provide employee health coverage. In December 2005, the Taxpayers Foundation issued an analysis of the leading reform proposals, including the payroll tax, in a report entitled, *Health Care Reform: Expanding Access Without Sacrificing Jobs*. The Foundation's analysis found that the payroll tax would have harmed job creation and increased the overall costs of reform while producing little net additional revenue to help subsidize coverage for low-income residents.

II. Health care reform will increase employee take-up of employer health insurance

In recent years, the percentage of eligible employees who participated in employer coverage (the take-up rate) has fallen slightly in Massachusetts and nationally, indicating that, as premiums continued to rise, more workers decided to opt out of coverage.

[4] Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Health Insurance Survey*, 2005.
[5] Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET), *Survey of Employer-Sponsored Health Benefits*, 1999-2006.

Table 3

Employee Take-up Rate	2001	2003	2005
Massachusetts	80%	85%	78%
United States	84%	82%	82%

Implementation of Chapter 58 will result in expanded employer-based coverage by encouraging employees who had chosen not to accept employer coverage to do so. The Foundation estimates that the total number of Massachusetts residents with employer-sponsored coverage will increase by approximately 42,608 to 51,460, at an additional cost to their employers of $145 million to $157 million.

Calculating the number of newly insured employees with employer coverage

M.I.T. economists Jonathan Gruber and Clara Lewis have estimated that there are approximately 69,000 uninsured adults in Massachusetts who are eligible for employer coverage but who are not taking the offer.[6]

Table 4

Income as % of federal poverty level (FPL)	Number of uninsured adults not accepting employer coverage
<100%	19,763
100-150	9,186
150-200	7,502
200-250	4,238
250-300	3,770
300-350	4,436
350-400	3,337
400-450	4,226
450-500	916
500% and greater	11,385
Total	**69,157**

Approximately 30,000 of these individuals earn less than 150 percent of the federal poverty level (FPL) and would be eligible for fully subsidized coverage under the state's new Commonwealth Care program if they were not offered employer-sponsored insurance. (Individuals eligible for MassHealth or employer coverage are currently not eligible for Commonwealth Care, based on

[6] Jonathan Gruber and Clara Lewis for the Massachusetts Health Insurance Connector Authority, April 2007.

policy guidelines developed by the Connector.) Under the affordability schedule established by the Connector, any amount they would have to pay for employer-sponsored health insurance is deemed unaffordable, so they are exempt from the individual mandate. It should be noted that some small percentage of these individuals may nevertheless accept employer coverage.

Approximately 23,000 of the remaining uninsured employees earn between 150 percent and 400 percent of the FPL. Some of them will be exempt from the individual mandate because their share of the premium for employer-sponsored insurance is deemed unaffordable at their income level. For example, an individual making between 300 percent and 350 percent of the federal poverty level in 2007 (a gross annual income of $30,631 to $35,000) is exempt from the individual mandate if his or her share of the health insurance premium is more than $150 per month.[7] We do not assume, however, that everyone who is exempt from the mandate will decline employer coverage.

The approximately 17,000 uninsured employees earning more than 400 percent of the FPL are very likely to be subject to the individual mandate because their share of the premium for employer-sponsored insurance will be deemed affordable.

The Foundation estimates that with the individual mandate in place:

- none of the 30,000 uninsured employees under 150 percent of the FPL will take the employer offer;
- 50 to 60 percent of the 23,000 uninsured employees between 150 and 400 percent of the FPL will accept the offer; and
- all of the 17,000 uninsured employees earning above 400 percent will take the offer.

These increases will result in approximately 28,500 to 31,000 newly insured employees under their employers' plans.

Adjusting for family size

Most of the uninsured in Massachusetts are single rather than married, so we estimate that two-thirds of these employees will take individual coverage and one-third will take family coverage. A covered family could comprise an adult couple, a couple with one or more children, or a single parent with one or more children. Children in families that earn less than 300 percent of poverty are eligible for fully subsidized coverage through MassHealth, so we assume a relatively small family size for the purpose of our calculations.

The tables below estimate the total number of newly insured by assuming that two-thirds of the newly insured employees will have individual coverage and that the average number of family members for the one-third that take family coverage will be 2.5 or 3.0. These calculations result in an estimate that the total number of newly insured Massachusetts residents under employer plans will range from 42,608 to 51,460.

[7] Commonwealth Health Insurance Connector Authority, *Affordability and Premium Schedule*, June 2007.

Table 5

28,500 Newly Insured Employees

1/3 Family contracts	Family size	Family members	2/3 Individual contracts	Total insured
9,405	2.5	23,513	19,095	42,608
9,405	3.0	28,215	19,095	47,310

Table 6

31,000 Newly Insured Employees

1/3 Family contracts	Family size	Family members	2/3 Individual contracts	Total insured
10,230	2.5	25,575	20,770	46,345
10,230	3.0	30,690	20,770	51,460

Calculating the additional cost to employers

To calculate the cost to employers of their newly insured employees, we start with an estimate of the median annual premium for individual coverage offered by employers in Massachusetts, which is $5,108, and the median annual premium for family coverage, which is $13,297.[8]

Prior to health care reform, the median employer contribution to employee health insurance premiums in Massachusetts was 75 to 77 percent.[9] Assuming that employers with lower contribution levels were more likely to have employees turn down coverage, we use a lower contribution level for the sake of our calculations – 65 percent. Based on an employer contribution of 65 percent, employers would contribute approximately $3,320 for individual coverage and $8,643 for family coverage. As the following tables show, this would result in an increase in employer spending for newly insured employees of approximately $145 million to $157 million.

[8] The Massachusetts Division of Health Care Finance and Policy's *Massachusetts Employer Health Insurance Survey*, conducted in 2005, estimated the median annual individual premium to be $4,380 and the family premium to be $11,400. Adjusting for an average annual premium increase of 8 percent, the median in 2007 is estimated to be $5,109 for individual coverage and $13,297 for family coverage.

[9] *Massachusetts Employer Health Insurance Survey*, 2005.

Table 7

28,500 Newly Insured Employees (Total insured: 42,608 - 47,310)

	Number of contracts	Employer contribution	Cost to employers
2/3 Individual contracts	19,095	$3,320	$63,395,400
1/3 Family contracts	9,405	$8,643	$81,287,415
			Total: $144,682,815

Table 8

31,000 Newly Insured Employees (Total insured: 46,345 - 51,460)

	Number of contracts	Employer contribution	Cost to employers
2/3 Individual contracts	20,770	$3,320	$68,956,400
1/3 Family contracts	10,230	$8,643	$88,417,890
			Total: $157,374,290

Will more employers offer health coverage?

It is likely that, in a competitive job market, health care reform will put pressure on employers that have not provided employee health coverage to begin doing so, especially those that are growing and hiring new employees. The employees of these non-offering companies will be required by the individual mandate to purchase insurance if they have access to coverage that is deemed affordable by the state. In addition, employers with 11 or more full-time employees (as defined by regulation) will be required to offer Section 125 cafeteria plans that allow employees to purchase health insurance through payroll deductions on a pre-tax basis. These provisions of the law will make employer-sponsored health insurance more attractive to some employers that had chosen not to offer it before reform.

On the other hand, the majority of the non-offering companies are very small businesses (Table 1) and it is likely that most of those will still not be able to afford coverage for their employees – a problem that will be exacerbated if the trend in health insurance rate increases does not moderate. In addition, small businesses account for a high percentage of low-wage uninsured workers who will be eligible for state-subsidized Commonwealth Care coverage through the Connector, so these employers will have less of an incentive to begin offering employee coverage.

Employers that have 11 or more employees and that do not meet either of the state's "fair and reasonable contribution" tests for employee coverage (see Section V, below), will pay an annual assessment of up to $295 per uninsured employee to help fund uncompensated care. Some predict that this will encourage more employers to offer coverage, while others believe it will encourage some employers to consider dropping coverage.

Taking all these factors into account, the Foundation believes that more employers are likely to offer coverage under health care reform. However, in order to be conservative in our calculations, this report does not include estimates of the additional employee coverage and employer spending that may result.

III. Employers will expand benefits to ensure minimum creditable coverage

Minimum creditable coverage (MCC), which is defined in regulation by the Connector, is used to determine if a person's coverage is adequate to comply with the individual mandate in Chapter 58. Individuals enrolled in plans that do not meet the MCC standards will be deemed uninsured as of January 1, 2009, and subject to the individual mandate tax penalty.

While employers are not required to offer MCC-compliant coverage, they are likely to do so in order to help their employees comply with the individual mandate. In an advisory to employers, a national employment and labor law firm recommended that: *Employers should determine whether their plans, including their self-funded plans and ERISA plans, meet this minimum standard because plan participants will not be able to satisfy the individual mandate if their employers' plans fall short of the required minimum coverage. To ensure that employees have the required minimum coverage by January 1, 2009, employers whose plans do not meet the minimum standard should consider revising their plans in time for open enrollment in 2008.*[10]

For employers currently offering plans that do not meet MCC requirements such as prescription drug coverage and certain limits on deductibles, buying MCC-compliant coverage will most likely mean higher health insurance costs.

It has been estimated that 163,000 insured individuals do not have prescription drug coverage through their plans,[11] 30,000 of whom have non-group coverage and the remaining 133,000 of whom have employer-sponsored coverage. If the employers of three-quarters of those with employer coverage add a drug benefit when it is required for minimum creditable coverage in 2009, at an average cost of $40 per employee per month (employer drug coverage currently averages $55 per member per month, but the Connector has proposed a "slimmed down" benefit to meet MCC requirements) and the employer pays half of the cost of coverage, the additional cost to employers will be $24 million (100,000 employees x 12 months x $20 per member per month).

[10] *Massachusetts Health Care Reform Law Update*, Martha M. Walz, Littler Mendelson, March 2007.

[11] *In Bind, Connector Seeks Prices on Health Plans that Don't Cover Drugs*, Patricia Yeon, State House News Service, February 8, 2007.

IV. More employers will offer Section 125 plans

Under Section 125 of the IRS code, employers can set up "cafeteria plans" that allow employees to receive certain benefits, including health insurance, on a pre-tax basis. The financial benefits of Section 125 plans are substantial. Participating employees can save from 28 percent to 48 percent of their premium contributions, depending on their federal tax bracket, and employers can save an additional 7.65% on their share of payroll taxes.

It is estimated that half of Massachusetts employers offered Section 125 plans prior to passage of health reform: 45 percent of employers with 2-50 employees and 80 percent of employers with 51 or more employees.[12]

Chapter 58 requires employers with 11 or more FTE employees to set up and maintain Section 125 plans for their employees. The right to participate in the plan must be extended to employees regardless of whether or not they are eligible for the employer's health plan (including part-time employees unless they work, on average, fewer than 64 hours per month).

Section 125 plans reduce insurance premium costs for people who are offered coverage by their employers, and also make coverage more affordable for employees who are required to comply with the state's individual mandate but who are not offered employer-sponsored coverage. Even if an employee is not offered coverage or is ineligible, he or she can use the employer's Section 125 payroll deduction to purchase Commonwealth Choice coverage, which is offered through the Connector or directly from health plans, with pre-tax dollars.

An employer that fails to comply with the Section 125 requirement may have to pay a "free-rider surcharge" if its employees or their dependents make "excessive" use of uncompensated care. If a non-complying company's employees or their dependents receive uncompensated care five or more times in a year, or if any employee or employee's dependent receives uncompensated care more than three times in a year, and if free care for its employees exceeds $50,000 in a year, then the employer will be required to pay a percentage of the total free care used by its employees or their dependents into the Commonwealth Care Trust Fund (see Appendix B).

While a non-complying company could be required to pay a substantial amount if its employees or their dependents use an "excessive" amount of free care, the free-rider surcharge was designed to be an enforcement mechanism for the Section 125 requirement, not a source of funding for health care reform.

Because of the tax savings Section 125 plans offer, a high level of compliance is expected. The Connector is making every effort to help companies set up new Section 125 payroll deduction plans, but the regulations governing the plans are complex, and even employers that already offer the plans may need to redesign them or extend them to certain employees that had previously been ineligible to participate. Small companies, in particular, may need to develop or purchase new legal, human resource and payroll services in order to comply.

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[12] Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Health Insurance Survey*, 2005.

It is important to note that the requirement excludes small businesses with fewer than 11 employees, which is where employees are significantly less likely to be offered or to accept coverage. Some employers in this segment may choose to set up Section 125 plans in order to help their employees reduce the cost of complying with the individual mandate, and the Foundation believes future consideration should be given to extending the requirement to employers with 2 to 10 employees if the absence of pre-tax payroll deductions puts employees of these very small businesses at a disadvantage.

V. The employer fair share assessment will equalize the burden of paying for free care

The employer "fair share" provisions of Chapter 58 are among the most discussed and debated aspects of health care reform, and they have been widely misinterpreted as setting a minimum standard of employer coverage. That is not the case. Rather, the fair share contribution is specifically tied to equalizing the obligation on employers to pay for free care.

Massachusetts employers that provide employee health insurance contribute approximately $320 million to the funding of uncompensated care. Specifically, the annual $160 million insurance payor surcharge for uncompensated care is passed on through insurance premiums, and the $160 million assessment on providers is passed on to health plans and, in turn, to employers that provide health coverage. (A small amount of the provider assessment is paid by patients who have non-group coverage or who pay providers directly for their care.) Employers that do not provide health coverage make no contribution. Legislative leaders and business representatives agreed during the drafting of Chapter 58 that the law should level the playing field by having "non-contributing employers" with 11 or more employees pay for the uncompensated care costs of their uninsured employees.

The legislative intent of the fair share assessment is clearly stated in the language of Chapter 58:

"For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee contribution..."

The law then specifies a detailed, ten-step formula for calculating the amount of the fair share assessment each year, based on the annual amount of free care and the number of employees of non-contributing employers (see Appendix C).

Chapter 58 charges the Division of Health Care Finance and Policy with setting a standard that will differentiate between employers that do contribute to uncompensated care and those that do not – the so-called "fair and reasonable" test. After a series of consultative sessions and public hearings, the Division adopted regulations establishing a two-part test for determining whether an employer is making a "fair and reasonable contribution" under this provision of the law.

The first test requires that a minimum of 25 percent of an employer's full-time, permanent employees participate in the health plan offered by the employer in order for the employer to be exempt from the assessment. Employers that provide coverage for full-time employees but not for part-time employees are not liable for the assessment so long as they meet the minimum

participation rate among their full-time employees.

Should an employer fail to meet the enrollment target, the second test stipulates that an employer will be exempt if the employer offers to contribute at least 33 percent of the premium. This provides protection for those employers that offer a health plan but whose employees have declined an offer of coverage.

In the Foundation's view, these standards fairly reflect the intent of the law's provisions. If too high a threshold were set to satisfy the "fair and reasonable" requirement, employers would lose the incentive to help their employees because they would have to pay once towards their employees' premiums and again for the fair share assessment.

Chapter 58 caps the annual fair share contribution at $295 based on an estimate of the per-employee cost of free care in 2005 for all employees working for employers that made no contribution toward their health care coverage. As more uninsured residents obtain coverage – many of them through their employers for the first time – the costs of free care are expected to decline, and the amount of the assessment, recalculated annually according to the formula in the law (Appendix C), will also decline. In any case, the fair share contribution was never expected to be a major funding source for health care reform. The Commonwealth's FY08 budget anticipates approximately $23 million in projected fair share assessments.

VI. Other provisions of Chapter 58 will create direct and indirect costs and obligations for employers

Non-discrimination rules

Employers must offer the same health benefits to all full-time employees who live in the Commonwealth, and, with certain exceptions, they cannot make a higher premium contribution toward the coverage of higher-paid employees than to lower-paid employees.

Dependent coverage

The law requires that carriers with insured health benefit plans that cover dependent children make coverage available to them for up to two years after they are no longer a dependent or until their 26th birthday, whichever comes first.

The small group/non-group merger

A special commission formed to estimate the impact of the merger prior to its implementation reported that the market merger was likely to result in an average *decrease* in current non-group rates by 15 percent and an average *increase* in current small group rates by 1.0 to 1.5 percent. The burden on small employers will be exacerbated if factors like the merger of the small-group and non-group markets drive up small-group rates more than anticipated.

The safety net fund

As noted above, employers will continue to make a major contribution to the private funding of uncompensated care and “safety net care” through the $160 million third-party payer surcharge plus another $160 million through the provider assessment. (A small amount of the provider assessment is paid by patients who have non-group coverage or who pay providers directly for their care.)

One of the fundamental goals of Massachusetts health care reform is to reduce the number of people who have been receiving uncompensated care, or "free care," from hospitals and community health centers, by moving them to insured care. The Uncompensated Care Pool (UCP) has provided a safety net for people who do not have insurance, but it has been an expensive and inefficient way to pay for medical care, often in an emergency room rather than in a primary care setting, and without the benefits of prevention, coordination, disease management and continuity of care.

On October 1, 2007, the UCP was replaced by the "Health Safety Net Trust Fund," with the expectation that free care will decline as more people are insured. The Fund will continue to be maintained by government payments, hospital assessments and surcharges on "third party payers," which include health insurers and self-insured employers. Payer surcharges are passed on to employers that offer coverage to their employees in the form of higher premiums, or, in the case of self-insured employers, directly.

VII. Adding up the cost of employer participation

Employer participation is just one of the three legs of Massachusetts health care reform, along with government-funded programs and the participation of individual residents, and like the other two, it is essential. The law's goal of nearly universal coverage would be unachievable without a strong and expanding foundation of employer-sponsored coverage as summarized here along with some of the factors that could make the real cost either higher or lower than the Foundation's estimates.

Table 9

Current cost to Massachusetts employers	
Estimated employer spending on health care coverage	$11 billion
Cost of uncompensated care for employers providing coverage	$320 million
Additional costs to employers (estimated)	
Previously uninsured employees taking the employer offer of coverage	$145-$157 million
Employers adding a prescription drug benefit for MCC	$24 million

Employer contribution to health care coverage, pre-reform

The estimate of $11 billion is based on a simulation model used by the Urban Institute for the Blue Cross Blue Shield Foundation's *Roadmap to Coverage*, which estimated employer spending in 2005 to be $9.6 billion. We have adjusted that estimate for an average 8 percent annual increase in health insurance premiums since that time. This is approximately what the Kaiser Family Foundation found the national average to be, but the Massachusetts average may be higher or lower.

Cost of uncompensated care for employers providing coverage

The estimate of $320 million assumes that the entire $160 million payor surcharge and $160 million provider assessment for uncompensated care have been passed through to employers in the form of higher insurance premiums, or, in the case of self-insured employers, as higher payments for claims. A small amount of the provider assessment is actually paid by patients who have non-group coverage or who pay providers directly for their care.

Previously uninsured employees taking the employer offer of coverage
The estimate of $145 million to $157 million is based on calculations of how many employees in each income category will take the employer offer of coverage because of the individual mandate, the mix of individual and family contracts, and the likely employer contribution to the premium.

Employers adding a prescription drug benefit for Minimum Creditable Coverage
The estimate of $24 million is based on rough calculations of how many employers will add drug coverage to their employee benefits, their average contribution to the premium, and the average per member per month cost of the drug benefit.

Factoring in future rate trends
The trend in health insurance premiums will be one of the most important variables influencing both employer and individual decisions and actions under health care reform. Rising premiums may force some employers to consider choosing lower-cost and more limited benefit plans or reducing the amount they contribute to their employees' premiums. At the same time, rising premiums and lower employer contributions may result in more employees becoming exempt from the individual mandate because coverage is deemed unaffordable for them. Perhaps most significantly, adequate federal and state funding for programs that subsidize private insurance for low-income residents who do not have employer-sponsored coverage will be in jeopardy unless rising health care costs can be tamed.

The delicate balance of shared responsibility among government, employers and individuals – and the broad consensus of support for health care reform in Massachusetts – assumes that health coverage will not become "unaffordable" for any of the parties, an assumption that will be constantly tested as more and more residents become insured through their employers, through government funded plans, and on their own.

Appendix A

The federal poverty level (FPL) is the earnings threshold below which Americans are considered to be living in poverty. It is published each year by the U.S. Department of Health and Human Services, adjusted for the number of people in a family. For the purpose of Chapter 58, the FPL is revised on April 1st of each year. On April 1, 2007, the federal poverty level was set as follows:

Number in Family	Annual income level for 100% of FPL
1	$10,210
2	$13,690
3	$17,170
4	$20,650
5	$24,130
Over 5, add $3,480 per family member	

Appendix B

Chapter 59 of the Acts of 2006 - Free Rider Surcharge

CHAPTER 151F
EMPLOYER-SPONSORED HEALTH INSURANCE ACCESS
Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:—
"Employee", any individual employed by any employer subject to this chapter and in employment subject thereto.
"Employer", an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association, corporation or other legal entity, employing employees subject to this chapter; provided, however, that the owner of a dwelling house having not more than 3 apartments and who resides therein, or the occupant of a dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or buildings appurtenant thereto shall not because of such employment be deemed to be an employer. The word "employer" shall not include nonprofit entities, as defined by the Internal Revenue Code, that are exclusively staffed by volunteers nor shall the word employer include sole proprietors.
"Connector", the commonwealth health insurance connector, established under chapter 176Q, acting through its board.
Section 2. Each employer with more than 10 employees in the commonwealth shall adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules and regulations promulgated by the connector. A copy of such cafeteria plan shall be filed with the connector.

SECTION 44. Said chapter 118G is hereby further amended by inserting after section 18A the following section:—
Section 18B.
(a) The division shall, upon verification of the provision of services and costs to a state-funded employee, assess a free rider surcharge on the non-providing employer under regulations promulgated by the division.
(b) The amount of the free rider surcharge on non-providing employers shall be determined by the division under regulations promulgated by the division, and assessed by the division not later than 3 months after the end of each hospital fiscal year, with payment by non-providing employers not later than 90 days after the assessment. The amount charged by the division shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state of the services provided to the state-funded employee, considering all payments received by the state from other financing sources for free care; provided that the "cost to the state" for services provided to any state-funded employee may be determined by the division as a percentage of the state's share of aggregate costs for health services. The free rider surcharge shall only be triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for any employer's employees, or dependents of such persons, in aggregate, regardless of how many state-funded employees are employed by that employer.
(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the division that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services from the uncompensated care pool, under chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees for whom the non-providing employer provides health insurance.
(d) If a state-funded employee is employed by more than one non-providing employer at the time he or she receives services, the division shall assess a free rider surcharge on each said employer consistent with the formula established by the division under this section.
(e) The division shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers. Said regulations shall include, but not be limited to, the following provisions:— (i) Appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and (ii) Penalties for nonpayment or late payment by the non-providing employer, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.
(f) All surcharge payments made under this Section shall be deposited into the Commonwealth Care Trust Fund, established by section 2000 of chapter 29.
(g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership be assumed by the successor in interest to the non-providing employer's.
(h) If a non-providing employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the division, the division shall provide written notice of the required information. If the employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(i) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.
(j) No employer shall discriminate against any employee on the basis of the employee's receipt of free care, the employee's reporting or disclosure of his employer's identity and other information about the employer, the employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of chapter 93A.
(k) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide any uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services, as provided in section 41 of chapter 268. The division shall promulgate a standard written notice form to be made available to health care providers in English and foreign languages. The form shall further include written notice of every employee's protection from employment discrimination under this section.

Appendix C

Chapter 59 of the Acts of 2006 - Fair Share Contribution

SECTION 47. Said chapter 149 is hereby further amended by inserting after section 187 the following section:—
Section 188.
(a) As used in this section, the following words, unless the context clearly requires otherwise, shall have the following meanings:—
"Commissioner", the commissioner of health care finance and policy.
"Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined in regulation by the division of health care finance and policy.
"Department", the department of labor, established by chapter 23.
"Director", the director of the department of labor.
"Division", the division of health care finance and policy, established by chapter 118G.
"Employer", an employing unit as defined in section 1 of chapter 151A.
"Employee", any individual employed by an employer subject to this chapter for at least 1 month, provided that for the purpose of this section self-employed individuals shall not be considered employees.
(b) For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of the department of labor, in this section called the fair share employer contribution. Said contribution shall be pro-rated by a fraction which shall not exceed one, the numerator of which is the number of hours worked in a year by all of the employer's employees who worked for the employer for at least 1 month and the denominator of which is the product of the number of employees employed by an employer during that year for at least 1 month multiplied by 2,000 hours.
(c) The director shall, in consultation with the division of health care finance and policy, annually determine the fair share employer contribution rate based on the best available data and under the

following provisions:—
(1) The per-user share of private sector liability shall be calculated annually by dividing the sum of hospital liability and third-party payor liability for uncompensated care, as defined by law, by the total number of individuals in the most recently completed fiscal year whose care was reimbursed in whole or in part by the uncompensated care pool, or any successor thereto.
(2) The total number of employees in the most recent fiscal year on whose behalf health care services were reimbursed in whole or in part by the uncompensated care pool, or any successor thereto, shall be calculated. In calculating this number, the division shall use all resources available to enable it to determine the employment status of individuals for whom reimbursements were made, including quarterly wage reports maintained by the department of revenue.
(3) The total number of employees as calculated in paragraph (2) shall be adjusted by multiplying that number by the percentage of employers in the commonwealth that are not contributing employers, as determined by the division.
(4) The total cost of liability associated with employees of non-contributing employers shall be determined by multiplying the number of employees, as calculated in paragraph (3) by the per-user share of private sector liability as calculated in paragraph (1).
(5) The fair share employer contribution shall be calculated by dividing the total cost of liability as calculated in paragraph (4) by the total number of employees of employers that are not contributing employers, as determined by the division.
(6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted annually to reflect medical inflation, using an appropriate index as determined by the division.
(7) The total dollar amount of health care services provided by physicians to non-elderly, uninsured residents of the commonwealth for which no reimbursement is made from the Health Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that the division determines is most accurate.
(8) The per-employee cost of uncompensated physician care shall be calculated by dividing the dollar amount of such services, as calculated in paragraph (7) by the total number of employees of contributing employers in the commonwealth, as estimated by the division using the most accurate data source available, as determined by the division.
(9) The annual fair share employer contribution shall be calculated by adding the fair share employer contribution as calculated in paragraph (6) and the per-employee cost of unreimbursed physician care, as calculated in paragraph (8).
(10) Notwithstanding this section, the total annual fair share employer contribution shall not exceed $295 per employee; and provided further, that the director shall allow employers to make the annual fair share employer contribution either annually, or in equal amounts semi-annually or quarterly, at the employer's sole discretion.
(d) The director of labor shall determine and collect the contribution under subsections (b) and (c), and shall implement penalties for employers that fail to make contributions as required by this section, provided that in order to reduce the administrative costs of collection of contributions the director shall, to the extent possible, use any existing procedures that have been implemented by the department to make similar collections. All amounts collected shall be deposited in the Commonwealth Care Trust Fund, established by section 2000 of chapter 29.
(e) In promulgating regulations defining the term "contribution" under this section, no proposed regulation by the division of health care finance and policy, except an emergency regulation, shall take effect until 60 days after the proposed regulations have been transmitted to the joint committees on health care financing and financial services.