Massachusetts
HRSA State Planning Grant

FINAL REPORT

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EXECUTIVE SUMMARY

Massachusetts HRSA State Planning Grant

The Commonwealth of Massachusetts is a leader among states in providing health care and health care coverage to uninsured populations. Through MassHealth (Medicaid) expansions, reforms to small-group and non-group markets, and a strong employer base, Massachusetts has consistently maintained lower rates of uninsurance than most other states. In addition, Massachusetts has a strong safety net of community health centers and hospitals that provide care to low-income uninsured and underinsured individuals who are not eligible for, or choose not to enroll in, public insurance programs.

Even with these strong attributes, Massachusetts policy makers continue to face challenges in extending and maintaining access to health care and health care coverage for all residents. For example, Massachusetts' uninsurance rate increased from 5.9% in 2000 to 7.4% in 2004, and health insurance premiums in the employer-sponsored health insurance market rose to $950/month in 2005 from $640/month in 2001 for a family plan. At the same time, however, Massachusetts continues to be a leader in maintaining and expanding access to health care services and insurance coverage, even in the face of rapid price increases. Evidence of our commitment is highlighted in this report, e.g., our employer health insurance offer rate has remained unchanged since 2001.

Over the past two years, Massachusetts has continued to research and foster new and practical solutions to this complex problem using supplemental funding from HRSA. In this second grant period, we undertook analyses that capitalized on the progress made in the initial HRSA grant; e.g., we built upon surveying efforts of earlier years in order to update our data and keep abreast of current conditions. In 2004 the statewide household insurance survey was administered once again, while earlier this year, the statewide employer health insurance survey was also administered. These data formed the foundation on which the Governor built his innovative proposal for health care reform in Massachusetts (see Section 4).

This report documents the results of work completed by DHCFP with supplemental funding from HRSA. Tasks completed centered around four activities:

- We extracted more useful data from the Uncompensated Care Pool (Pool) claims database and used these data to assess patterns of care among high-cost Pool users;

- We evaluated changes to public and private health insurance specifically to look for evidence of crowd-out;

- We gathered data from Massachusetts employers, including a re-survey of small employers that were included in the 2003 sample; and

- We improved the predictive capabilities of a Massachusetts-specific model for assessing the effects of changes in health programs.

Results of these analyses include the following outcomes, which informed our supplemental grant activities:

- One percent of Uncompensated Care Pool users are responsible for nearly half of all inpatient costs covered by the Pool, a proportion much more skewed than among patients in the insured population. Analysis of high-cost Pool users suggests that this subset of patients is likely to be male, with more than one chronic medical condition.

- Our crowd-out studies indicate that between 2000 and 2004, fewer households reported that they were covered only by private employer-sponsored insurance and more households reported public coverage. These and other results provide some indication that there is a link between trends in private employer-sponsored coverage and public coverage trends.

- Our employer survey results suggest that the employer health insurance offer rate has remained fairly stable. Large employers continue to be much more likely to offer health care coverage than small employers. Results of interviews conducted with a sample of small employers who do not offer health insurance revealed that employees often have coverage through other sources. Employers were knowledgeable about issues related to health insurance and understand they are taking a business risk when they do not offer health insurance.

- Finally, with economic consultation, Massachusetts was able to develop a predictive model for assessing the impact of various changes on the Commonwealth's health insurance market. This model was useful in further developing the Governor's proposal for enhancing health care coverage.

Recommendations by DHCFP staff (based on our research) were incorporated into the Governor's proposal for enhancing coverage. These recommendations include:

- Continue and improve efforts to attain full enrollment of all currently-eligible Massachusetts residents into existing public programs;

- Construct a mechanism that would allow tax deductions for the full cost of health insurance through an Insurance Exchange for the self-employed and those without access to employer-sponsored health insurance;

- Encourage commercial development of less rich, but still adequate, insurance plans combined with medical savings accounts;

- Develop an educational approach to inform consumers of all available health insurance coverage options.

With supplemental funding from HRSA, Massachusetts conducted more extensive analyses of the many factors that influence health care coverage trends. Although formal HRSA support ended, Massachusetts is committed to maintaining its record as a leader among states in providing health care and health care coverage to uninsured populations. Massachusetts will

continue to expand available data, updating important data elements as they become available, and continue to assess the best options for expanding access to affordable health insurance in the future.

SECTION 1

Summary of Findings: Uninsured Individuals and Families

Massachusetts data sources include the Division of Health Care Finance and Policy (DHCFP)'s Surveys of Health Insurance Status of Massachusetts Residents, the Urban Institute's National Survey of American Families (NSAF) findings for Massachusetts (1999), Massachusetts hospital discharge data from the Uniform Hospital Discharge Data Set (2004), eligibility data from individual applications to the Massachusetts Uncompensated Care Pool (2001), and data from outpatient claims of the Boston Medical Center (the Commonwealth's highest volume hospital provider to the uninsured). Although more heavily used in Section 2, Section 1 also draws upon the findings of DHCFP's Surveys of Massachusetts Employers Regarding Health Insurance and the Massachusetts findings from the Agency for Health Care Research and Quality's Medical Expenditure Panel Survey (IC: 1996-1999). Please see Appendix II for online access to the complete text of the employer and household surveys.

1.1 What is the overall rate of uninsurance in your state?

The Massachusetts uninsured rate for all ages, including the elderly, was 7.4% in 2004. This is a significant increase from 6.7% in 2002 and 5.9% in 2000.

At the time of the most recent survey, 460,000 Massachusetts residents of all ages were uninsured. A higher proportion (10.2%) of Massachusetts residents were either uninsured at the time of the survey or uninsured at some time during the past twelve months (630,000 people).

1.2 What are the characteristics of the uninsured?

Source of Insurance
The majority of Massachusetts residents (79%) continued to receive health insurance through an employer-sponsored plan while Medicaid remained the second largest source of insurance (15%) in 2004. The proportion of insured covered through Medicare, school and college plans, direct purchases from an insurance company/agent, or some other method remained relatively unchanged from previous years.

Income
Just over half (56%) of the uninsured lived in households earning more than 200% of the federal poverty level (FPL). In 2004 this was income of about $18,700 or more for an individual. However, residents living in lower-income households (earning 200% or less of the FPL) were nearly three times as likely to be uninsured as those living in moderate- or high-income households. And these lower-income households were also more likely to be uninsured in 2004 than in 2002.

Age (Non-Elderly)
Adults in Massachusetts were significantly more likely to be uninsured in 2004 than they were in 2002. Just over 38% of the uninsured were between ages 25 and 44. One-quarter of young adults age 19 to 24 were uninsured in 2004, a significant increase over 2002. Adults ages 45 to 64 were also significantly more likely to be uninsured in 2004 than in 2002 (7.9% versus 6.3%). However, the rate of uninsured children remained stable at around 3%.

Gender
In 2004, men were more likely to be uninsured than women, 56% compared to 44%. There is a trend of increasing uninsured rates among both men and women since 2000. Changes in uninsured rates by gender vary by age group. Although there were more uninsured men ages 19 to 24 in 2004 than in 2002, the proportion of uninsured men ages 45 to 64 steadily increased. For uninsured women, changes among age groups have remained consistent in 2004 from 2002.

Family Composition
Married uninsured adults experienced the largest proportional uninsured growth, increasing from 27% in 2002 to 34% in 2004. Uninsured adults in each marital status category (i.e., married, divorced, separated, widowed, never married) experienced higher uninsured rates.

Health Status, Access to Care
Nearly three-quarters of insured adults (74%) said they needed some kind of health care in 2004 compared to 61% of uninsured adults. Nearly all of the insured adults who needed care said they received it (94%) compared to 56% of the uninsured adults who needed care and said that they received it.

Employment Status
In Massachusetts nearly 80% of insured non-elderly residents obtain their coverage through employment. However, in 2004 there was a significant decrease in the percent of uninsured adults who reported working. Although 73% of the uninsured ages 19 to 64 were employed in 2002, this proportion dropped to 68% in 2004. During the same time period, the percent of working insured adults remained stable at 79%.

Self-employment continues to be fairly common among the working uninsured. In 2004, the working uninsured continued to be significantly more likely to be self-employed than the working insured.

There is also much variation in duration of employment by insurance status. More than two times as many uninsured workers as insured workers worked for the same employer for less than one year. However, in 2004 there was also some shifting. Fewer working uninsured worked for their employer for less than one year, decreasing to 33% from 42% in 2002. Therefore more uninsured workers worked for the same employer for more than one year in 2004 than in 2002. Still, the majority of working insured adults continued to work at the same place of employment for five or more years (54%), compared with working uninsured adults, just 27% of whom worked five or more years for their employer.

There is also significant variation in the number of hours worked by insurance status. In 2004, uninsured working adults were much more likely to work part-time (32%) than insured working adults (11%); this was also true in 2002.

Availability of Private Coverage

Employers (including the military, unions, and professional associations) provide insurance for the majority of non-elderly Massachusetts residents (79%) who have health insurance coverage. About half of working uninsured adults said that their employer did not offer health insurance coverage. Just over half (55%) of working uninsured adults who said their employer offers health insurance coverage, reported they could not be covered by that health insurance. Cost was the most common reason for opting not to take employer-offered coverage, with 82% reporting it was too expensive in 2004 compared to 57% in 2002. Respondents also felt that the benefits offered were not sufficient to convince them to buy the insurance. Thirty-nine percent gave this reason for not taking employer-offered coverage in 2004, compared to 28% in 2002.

According to data from the DHCFP's 2005 Survey of Massachusetts Employers, the percentage of employers who offer insurance to their employees varies by establishment size. Nearly all employers with more than 50 employees offer health insurance (97%), compared with 68% of employers with between 2 and 50 employees. Small establishments employ a large percentage of working uninsured; the proportion of such individuals remained stable at nearly 60% in 2004 compared to 2002. However, as there were significantly more uninsured adults in 2004 than in 2002, there were more uninsured adults employed at small firms. This is significant because small firms are less likely to offer health insurance, and even when it is offered, the cost to the employee is often higher than at a large firm because the small employer premium is generally higher then the larger employer premium.

Availability of Public Coverage

About 15% of Massachusetts residents receive health insurance coverage through the Commonwealth's Medicaid program, MassHealth. Between mid-1997 and late 2000 MassHealth enrollment increased by more than 230,000 residents. Currently Massachusetts Medicaid covers more than 992,000 people including the elderly. There are several different MassHealth coverage plans, each having a set of eligibility rules and benefits. Generally, due to expansions in eligibility criteria over the past several years, public coverage is available to pregnant women, disabled people, and children up to age 19 in households earning up to 200% of the FPL. Depending on employment and parental status, public coverage is also available to adults in households earning up to 133% of the FPL, and premium assistance is available to those with incomes up to 200% of the FPL who work for qualified employers.

Race/Ethnicity

Most Massachusetts uninsured are white, 68.5% in 2004, yet white residents were less likely to be uninsured than other racial/ethnic groups. Blacks, Hispanics, and other multiple racial/ethnic groups were more likely to be uninsured than white residents. For instance, Hispanic residents comprised 16% of the uninsured but just 7% of the insured population in 2004. Uninsured rates for many of the racial/ethnic groups increased in 2004. Uninsured residents of other or multiple race/ethnicities experienced the largest increase in uninsured rates (11.6% in 2004 versus 8.8% in 2002).

Immigration Status
According to the 1999 National Survey of America's Families (NSAF), 86.9% of Massachusetts residents are U.S.-born, 6.4% are foreign-born naturalized citizens and 6.7% are foreign-born non-citizens. Although the survey estimates for insurance status by citizenship for Massachusetts were too small for valid comparison, the NSAF survey does reveal a difference between the 1999 uninsured rates of U.S.-born adult Massachusetts residents (7.9%) and foreign-born adult residents (11.2%). However, Massachusetts' pattern in this regard is not nearly as dramatic as the national picture, in which 32% of all foreign-born adults are uninsured.

The 1999 NSAF data also revealed variation in income between U.S.-born and foreign-born Massachusetts residents. Of the foreign-born residents, 28% had family incomes below 200% of the FPL, compared to 16.3% of U.S.-born residents.

Another finding from the 1999 NSAF data was the distribution of Massachusetts Hispanic adults into subgroups: 33% of Massachusetts Hispanics are from Puerto Rico compared to only 12% nationally. Although survey estimates were too low to determine the insurance status of Massachusetts Puerto Ricans, national data reveal that the uninsured rate for Puerto Ricans is significantly lower (12%) than the rate for all other non-Puerto Rican Hispanics (37%). The large proportion of Puerto Ricans in Massachusetts coupled with the likelihood that their uninsured rate is comparatively lower than other Hispanic groups may explain the lower overall Hispanic uninsured rate in Massachusetts as compared to the national rate. However, Hispanics in Massachusetts still have the highest uninsured rate among non-elderly adults (23.3% compared to the overall statewide rate for non-elderly adults of 10.6%).

The 1999 NSAF also asked immigrant adults how long they had lived in the United States: fewer than three years, three to ten years or ten years or more. Sixty-nine percent of Massachusetts immigrant adults lived in the United States for ten or more years, another 22% were in the U.S. for three to ten years and only 8% lived in the U.S. for fewer than three years. The survey estimates were too small to determine the insurance status of Massachusetts immigrant adults based on length of time in the country, but it is possible to look at the same variable nationally

Geographic Location
The Massachusetts household surveys on health insurance status use a sampling methodology that stratifies the state into five regions: Metro Boston, Northeast, Southeast, West, and Worcester (or Central). In 2002, Massachusetts also did a separate survey that focused on five specific urban areas, one in each of the five regions. These five surveyed urban areas were: Boston, Fall River/New Bedford in the Southeast, Lawrence/Lowell in the Northeast, Springfield in the West, and Worcester in the central region of the state. Below are findings under each approach.

Regional Analysis
The geographic distribution of the uninsured changed significantly from 2002 to 2004. Although 40% of the uninsured lived in the Metro Boston region in 2002, that proportion dropped to 34% in 2004. Both the Northeast and the Southeast regions of the state saw significant increases in their uninsured rates. In the Northeast region the uninsured rate increased to 9.7% in 2004 from

6.4% in 2002, and in the Southeast region the uninsured rate increased to 8.9% from 6.8%. The uninsured rates in the West and Worcester regions remained stable (7.8% and 7% in 2004).

Adults: The largest proportion of uninsured adults resided in the Metro Boston (35.3%) and Northeast (22.3%) regions of Massachusetts. The Northeast also had the highest uninsured rate among adults in 2004 (12.1%).

Children: The largest proportion of uninsured children resided in the Northeast (27.9%) and Southeast (24.4%) regions of Massachusetts, with Metro Boston a close third (23.9%) in 2004. The Northeast also had the highest uninsured rate among children in 2004 (4.5%).

Urban Area Analysis

All of the five surveyed urban areas (Boston, Fall River/New Bedford, Lawrence/Lowell, Springfield, and Worcester) had higher uninsured rates than the statewide uninsured rate. The average uninsured rate for all five urban areas (all ages) was 10.4% compared to the statewide rate of 6.7% in 2002.

Massachusetts: Percent Uninsured by Age, 2002

	Five Urban Areas	Statewide
All Ages	10.4%	6.7%
Ages 0 to 64	11.3%	7.4%
Ages 19 to 64	14.0%	9.2%
Ages 0 to 18	5.2%	3.2%

Urban area residents were more likely to be uninsured than residents statewide. Compared to the other urban areas, Boston and Lawrence/Lowell had significantly higher rates of non-elderly uninsured (ages 0 to 64) and adults (ages 19 to 64). While still higher than statewide, Worcester had significantly lower rates of non-elderly uninsured and adults than the other urban areas.

Children under age 19 were the least likely to be uninsured and their uninsured rates varied by urban area. Children in Fall River/New Bedford and Worcester were less likely to be uninsured than were children statewide. In contrast, children in Boston and Lawrence/Lowell were significantly more likely to be uninsured than were children statewide.

In most urban areas, non-Hispanic minority racial or ethnic groups had a greater likelihood of being uninsured than their comparable statewide populations. Hispanics, however, had higher rates of uninsured statewide than in each of their comparable urban area populations, except Boston.

Statewide, the uninsured were twice as likely to live in low-income households than were the insured. Comparatively, urban area uninsured residents were not any more likely than insured residents to live in low-income households. For example, in Fall River/New Bedford and Lawrence/Lowell, the insured were just as likely as the uninsured to live in low-income

households, while the insured in Springfield were more likely than the uninsured to live in low-income households. The majority of insured urban area residents received health insurance coverage from their employer, with Medicaid being the second most common source of health care coverage. Insured urban area residents were more likely than insured residents statewide to have obtained health insurance coverage from Medicaid. Most urban area uninsured residents were employed, worked full-time hours and had worked for an employer for more than one year. Compared to the working insured, the urban area working uninsured were more likely to be self-employed. Urban area working uninsured were also less likely to work for the same employer for more than a year, and were more likely to work for a small firm. With the exception of Fall River/New Bedford, urban area working uninsured were also less likely to work full-time hours.

Duration of Uninsurance

In 2004, one-quarter of uninsured adults in Massachusetts reported never having had health insurance coverage (an estimated 100,000 adults). The majority of these never insured adults were working at the time of the survey (75%). Firms with fewer than fifty employees employed just over half of these working never insured adults.

Less than half of uninsured adults reported being without health insurance coverage for more than one year (46.4%, or 186,000 adults), 83% of whom were between ages 25 and 64. Another 42,000 uninsured adults reported no health insurance coverage for 7 to 12 months (36% were ages 19 through 24), and 72,000 uninsured adults reported no health insurance coverage for six months or less.

Other: Knowledge of Health Plans

There has been little change in uninsured adults' awareness of public health care programs since 2002. Both MassHealth and "free care" recognition increased slightly in 2004 (83.5% and 53.6% respectively). Free care refers to care paid for by the Massachusetts Uncompensated Care Pool, which reimburses hospitals and community health centers for medically necessary care they provide to low-income uninsured and underinsured people.

Other: Housing and Economic Hardship

The 1999 NSAF survey indicated significant differences between Massachusetts insured and uninsured adults with regard to economic hardship. Massachusetts uninsured adults were found to be twice as likely as their insured counterparts to worry about running out of food and were three times more likely to have been unable to pay their mortgage or rent within the last 12 months.

1.3 Summarizing the information provided above, what population groupings were particularly important in developing targeted coverage expansion options?

Most uninsured people in Massachusetts live in low- or moderate-income households and are employed. Of the working uninsured, a large majority was either not offered or was not eligible for employer-sponsored insurance, and the rest could not afford it. Targeting the working uninsured is one area of particular focus in Massachusetts.

Analysis of our free care application data indicated that the low-income applicants who appear to have been eligible for MassHealth based on income were "characteristically" or "categorically" ineligible for public insurance. That is, they were not pregnant, disabled, HIV positive, children, or did not belong to some other "category" that would have enabled them to qualify. This group presents an opportunity to examine what changes could be made to the eligibility requirements of public insurance programs to better cover our most financially needy. There may also be some outreach opportunities in this group, particularly targeted at minority populations.

DHCFP data revealed that minorities were disproportionately uninsured, and 1999 NSAF findings indicated that the state's immigrants were as well. This reinforces the need for any new or changed plans or programs to include an outreach component specifically targeted at minority and immigrant groups in the urban areas in which they most likely live.

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Data gathered in the Massachusetts 2004 household survey were examined to extract information regarding the willingness of the uninsured to pay for coverage. According to the Massachusetts survey, three-quarters of uninsured adults reported they were willing to pay some amount for health care coverage in both 2004 and 2002. Just over half of the uninsured adults in 2004 who reported being willing to pay would be willing to pay $100 or more a month for health care coverage.

When looking at those willing to pay by household income, the data illustrate a shift among uninsured adults. Uninsured adults residing in low-income households reported being willing to pay more for health care coverage, with 44% willing to pay $100 or more a month in 2004 compared to 36% in 2002. More than half (56%) of higher-income households reported being willing to pay $100 or more a month for health care coverage.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Uninsured individuals and families do not participate for a variety of reasons. Some are not aware they may be eligible for certain public programs. Many find the enrollment process confusing, and there are language and cultural barriers. Some potential public-program eligible residents are afraid to jeopardize pending immigration status.

1.6 Why do uninsured individuals and families disenroll from public programs?

Focus groups conducted by the Access Project identified a number of reasons that individuals and families do not access public program benefits for which they are eligible. The Access Project is a Robert Wood Johnson funded initiative seeking to improve access to health care and coverage for the uninsured. Most of the focus group participants, who were all Latinos, knew about MassHealth; fewer were aware of the Insurance Partnership Program. However, language

barriers prevented many from understanding program details. Participants reported difficulties as a result of the complexity, length, and redundancy of benefit forms, and therefore did not complete the application process. Pending immigration status made many participants fearful of accessing public assistance programs. In addition, they had difficulty understanding renewal and disenrollment notices.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

In 2004, about half of working uninsured adults said that their employer did not offer health insurance coverage. Just over half (55%) of working uninsured adults who said their employer offers health insurance coverage reported they could not be covered by it. Cost was the most common reason for opting not to take employer-offered coverage, with 82% reporting it was too expensive in 2004 compared to 57% in 2002. Respondents also felt that benefits offered were not sufficient to encourage them to enroll. Thirty-nine percent gave this reason for not taking employer-offered coverage in 2004 compared to 28% in 2002.

Policy literature overwhelmingly cites cost as the primary reason health care coverage is declined by eligible employees. However, there are other factors that influence an employee's decision to decline coverage including individual preferences, age, race, level of educational attainment, and family composition. According to information gathered in the Access Project focus groups, cost and pending immigration status, along with confusion over plan options and complexity of enrollment forms all were barriers to participation in employer-sponsored coverage. However, focus group members did find great value in having health insurance.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Qualitative data gathered in the Access Project focus groups did not provide information regarding workers' preferences around an employer's role in the provision of health insurance.

1.9 How likely are individuals to be influenced by availability of subsidies? Tax credits or other incentives?

An MIT economist, Jonathan Gruber, Ph.D., was hired in 2002 to develop a micro-simulation model to illustrate the impact of alternative expansions or contractions of existing Massachusetts public programs to increase insurance coverage of Massachusetts residents. This model included components to examine the impact of alternative tax policies. The model simulated a range of policy changes including new tax credits for non-group insurance purchases; new tax credits for employers and employees; and expansions and contractions of the public safety net. One answer the model provided is that without an "individual responsibility" mechanism, tax incentives had minor penetration, or very little effect. Based on these results, the Massachusetts health care reform proposal incorporates a "personal responsibility principle." Personal responsibility means

that all Massachusetts residents should be insured, or have the means to pay for their own health care needs. The administration's plan includes a component requiring residents to have a minimum level of health care insurance, or proof of financial means.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

A number of barriers that prevent the purchase of health insurance were revealed in the Massachusetts 2005 employer survey. Cost, offer rates, establishment size, and a firm's workforce characteristics (employee income and part-time status) are factors that impact whether employees purchase health insurance. Most Massachusetts establishments offer health insurance (69.7%). This proportion has remained stable since 2001. However, this means that a number of employees are not offered insurance at their place of employment.

Firm size is a major factor in determining whether insurance is offered. Smaller employers (2 to 50 employees) are less likely to offer insurance than larger employers (more than 50 employees), 68% versus 96.8%. In addition, firms comprised of a large number of low-wage workers (earning less than $40,000 annually) are less likely to offer health insurance to their employees. Part-time employees are frequently excluded from coverage programs. According to employers offering insurance, 76% report that insurance is offered only to full-time employees. In addition, when small employers do offer health insurance, the premium they are charged is higher than large employers; although they contribute to the total cost of premium often at the same or better rate as large employers, the higher premium results in a higher employee contribution required.

Waiting periods imposed by employers upon new employees also contribute to the existence of at least short term uninsurance. The 2005 DHCFP employer survey found more than half of employers (56.5%) require a waiting period.

The Access Project focus groups also identified a number of obstacles, other than cost, that prevent the purchase of health insurance: pending immigration status, complexity of plan options and enrollment forms, and language barriers.

Affordability remains the greatest barrier to the purchase of health insurance. This finding is supported by household surveys, employer surveys, literature reviews, and focus group discussions.

1.11 How are the uninsured getting their medical needs met?

Massachusetts Non-Elderly Adults

Nearly three-quarters of insured adults (74%) said they needed some kind of health care in 2004 compared to 61% of uninsured adults. Nearly all of the insured adults who needed care said they received it (94%) compared to 56% of the uninsured adults needing care who said that they received it.

Physician Office Visits: According to the 2004 Massachusetts household survey, there were significant variations by insurance status with respect to utilization of health care services. Uninsured adults were much less likely to have visited a physician office than insured adults. About 47% of uninsured adults did not visit a physician in 2004, compared to only 13% of insured adults. The percent of uninsured adults who reported between one and four visits to a physician in the last year increased to 42% in 2004 from 36% in 2002. In addition, more insured then uninsured adults reported making multiple visits to a physician's office. Nearly 19% of insured adults visited a physician's office five to ten times, compared to 7% of uninsured adults in 2004.

Emergency Room Visits: In 2004, the majority of both uninsured and insured adults continued to report no visits to an emergency room (ER). However, more uninsured adults visited an ER in 2004 than in 2002. The percent of uninsured adults reporting no visits to an ER declined to 69% in 2004 from 75%. In addition, a larger proportion of uninsured adults made more visits to an ER in 2004 than insured adults. Utilization of an ER by insured adults remained stable in 2004 compared to 2002.

Dental Visits: There is significant variation, by insurance status, in the percent of adults who made dental visits. Nearly 60% of uninsured adults reported no dental visits in 2004, compared to just 18% of insured adults. The insured adults were twice as likely as uninsured adults to have one or more dental visits in 2004.

Massachusetts Children

Physician Office Visits: The majority of uninsured children reported visiting a physician within the past year (62%). Uninsured children however, were less likely to have visited a physician than insured children, 62% compared to 91% respectively.

Emergency Room Visits: The majority of both uninsured and insured children did not visit an emergency room (ER) in the past year. Uninsured children were slightly less likely to have visited an ER than insured children; 77% of uninsured children made no visits to an ER compared to 71% of insured children. In 2004 insured children were more likely to have visited an ER one or more times than uninsured children.

Dental Visits: Similar to uninsured adults, uninsured children were significantly less likely to have visited a dentist than insured children. In 2004, 42% of uninsured children had no dental visits compared to 14% of insured children. The majority of insured children (86%) made one or more visits to the dentist in 2004.

1.12 What are the features of an adequate, barebones benefit package?

The Commonwealth of Massachusetts does not specifically define which benefits should be in an "adequate" benefit package; however, the state has a number of general laws requiring insurers operating in specified markets to cover certain health care benefits. The laws regulate services and supplies, providers, contracting arrangements, eligibility requirements, and prohibit discriminatory practices against providers and the insured. In addition, the non-group health

insurance market is regulated by the stipulations outlined in the Massachusetts non-group law of 1996, which requires that insurance carriers offering a non-group product cover a minimum set of standard benefits.

The Massachusetts health care reform proposal includes the prototype of a new product, called "Commonwealth Care" that is offered as an example to insurers and proposes to offer comprehensive coverage including primary care, hospitalization, mental health, and prescription drug coverage in a defined provider network with annual deductibles and copayments. Certain exclusions to mandated benefits might be approved.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Attempting to put a definition to the term "underinsured" is an extremely challenging task. Massachusetts quantitative and qualitative data do not capture information specifically targeted at understanding the underinsured. Literature reviews show a variety of ways of calling a population "underinsured." Massachusetts has not developed a specific "underinsured" definition.

SECTION 2

Summary of Findings: Employer-based Coverage

In a continuing effort to document and understand health insurance purchasing behavior among Massachusetts employers, the Division of Health Care Finance and Policy (DHCFP) conducted additional rounds of its employer survey in 2003 and 2005, following the general format of the original survey conducted in 2001. The state contracts with the Center for Survey Research (CSR) at the University of Massachusetts to conduct these surveys. The survey instrument used in the most recent rounds followed the same format of the earlier instrument. Some questions were changed, added or dropped based on data validity of earlier responses and policy needs. Please see Appendix II for online access to the complete text of the employer survey. Most questions remained the same to allow for longitudinal trend studies.

The sampling frame for the 2003 and 2005 surveys was purchased from employer listings maintained by Dun & Bradstreet. All Massachusetts employers were eligible for sample selection except individuals who were self-employed, and federal and state government employers. With these exceptions, employers from the Dun & Bradstreet list were randomly selected within strata for size of establishment. The 2003 strata included four groups of employers with: 2 to 9 employees, 10 to 49 employees, 50 to 249 employees and 250 or more employees. In order to obtain data specific to small employers, in 2005 the middle strata were changed to the following: 10 to 24 employees, 25 to 50 employees, and 51 to 249 employees. Note that the smallest employer size for either survey was two.

In addition to the statewide survey of employers of all sizes, a longitudinal re-survey of small employers was also completed. All employers with 50 or fewer employees who participated in the 2003 survey were re-surveyed in 2005. The 2003/2005 longitudinal sample was independent of the 2005 cross-sectional sample. Of the 564 employers in the 2003 sample, 531 were still in business and 423 (75%) responded to the re-survey. These data are intended to provide information on longitudinal trends in coverage among small employers, including trends in crowd-out.

Finally, in lieu of conducting a focus group of employers, in 2004 we interviewed a purposive sample of small employers who do not offer health care coverage. Employers were asked a series of questions from a semi-structured interview protocol about their experiences related to health care coverage and their decisions regarding whether to offer health insurance to employees (see Appendix III for a summary of the interviews).

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer Size

In both 2003 and 2005, just under 70% of the private-sector employers in the Commonwealth of Massachusetts offered health insurance coverage to their employees. Nearly all employers with more than 50 employees offer health care coverage. Smaller employers are less likely to offer

health insurance coverage. Only 66% and 68.1% of employers with 50 or fewer employees offered insurance in 2003 and 2005, whereas 99.9% and 96.8% of employers with more than 50 employees offered health care coverage (see chart below).

Offer Rate by Employer Size		
	2003	**2005**
All Employee sizes	67.8%	69.7%
2 to 49 Employees	66.0%	68.1%
50+ Employees	99.9%	96.8%

The two most common factors small employers (2 to 50 employees) cited as being very important in their decision not to offer health insurance were that premiums were too high (79.5% in 2003 and 72.3% in 2005), and that most employees were covered through other sources, such as Medicaid or through a spouse (64.7% in 2003 and 64.5% in 2004).

Reasons for not Offering Health Insurance, 2005 (Small Employers Who Do Not Offer Insurance)			
	Very Important	Somewhat Important	Not at all important
Premiums too high	72.3%	12.7%	15.0%
Employees covered through other sources	64.5%	23.7%	11.8%
Financial status	50.6%	21.2%	28.2%
Most employees part-time/ temp/ contracted	36.3%	19.2%	44.4%
Not needed to attract good employees	21.3%	29.5%	49.2%
Employees prefer higher pay	18.8%	21.5%	59.7%

Industry Sector

Rates of health care coverage tend to vary significantly by type of industry. In 2003, firms in agriculture, construction, retail trade, and services were least likely to offer health insurance, with about two-thirds or fewer firms in these industries offering coverage. In 2005, firms in construction, retail trade and services were least likely to offer health insurance, with about two-thirds of firms in these industries offering coverage.

Insurance Offer Rate by Industry Sectors		
	2003	**2005**
Agriculture, Forestry, and Fishing	*	*
Construction	68.7%	62.5%
Financial, Insurance, and Real Estate	73.7%	77.4%
Manufacturing	90.1%	79.6%
Retail Trade	63.1%	63.4%
Services	65.4%	66.6%
Transportation, Communications	72.3%	77.7%
Wholesale Trade	79.8%	86.6%

** sample size too small to report*

Employee Income Brackets

Of all employers who offer health insurance, the largest proportion employed workers with low to middle incomes (between $20,000 and $40,000) in both 2003 and 2005. Employers who are least likely to offer health insurance have lower wage employees. More detailed data gathered in 2005 indicate that among employers offering health insurance coverage, the largest share has employees earning middle-income wages ($30,000 up to $40,000).

Employee Income by Access to Employer-Offered Coverage, 2003			
Employee Income	**Employer Offers HI**	**Employer Does Not Offer HI**	**All Employers**
Less than $20,000	17.1%	33.6%	22.2%
$20,000 to $40,000	45.0%	43.6%	44.6%
More than $40,000	37.9%	22.8%	33.2%

Employee Income by Employer-Offered Coverage, 2005			
Employee Income	**Employer Offers HI**	**Employer Does Not Offer HI**	**All Employers**
Less than $20,000	10.3%	14.3%	11.4%
$20,000 to $40,000	45.2%	49.0%	46.3%
More than $40,000	44.9%	37.3%	42.9%

Part-time Workers

More than three-quarters of employers offered coverage only to full-time employees in both 2003 and 2005 (75.3% and 76.1%). For the one-quarter of employers offering health insurance to part-time workers, more than 43% in both 2003 and 2005 required that employees work more than half time in order to be eligible for health insurance.

For employers who offer to part-time workers, what is the minimum portion of each week an employee must work to be eligible? (2003)	
Fewer than 20 hours	8.2%
20 hours	42.5%
Greater than half time	48.7%

For employers who offer to part-time workers, what is the minimum portion of each week an employee must work to be eligible? (2005)	
No minimum	23.6%
Less than half time	9.6%
Half time	22.4%
Greater than half time	43.9%

Note: Due to survey question wording changes, the two charts above are not directly comparable with each other.

Geographic Location

The employer survey was not stratified by geographic location. Since the largest concentration of Massachusetts employers is in Boston, there are more employers in the sample from that region. However, there were some distinct shifts in where employers offering health insurance coverage were more likely to be located between 2003 and 2005. In 2003 employers in the Metropolitan Boston region were most likely to offer health insurance coverage to employees, while employers in the Northeast region were least likely to offer coverage. However in 2005, employers in both Metropolitan Boston and in the Western region of the state were most likely to offer coverage, while employers in the Southeast region were least likely to offer coverage.

Offer Rate by Geographic Location		
	2003	**2005**
Metro Boston	73.4%	74.3%
Northeast	59.8%	64.2%
Southeast	68.2%	62.5%
West	63.0%	74.2%
Central	68.0%	70.7%

Employee Age
There was very little variation in the distribution by the age of workers employed at firms that offered health insurance compared to firms that did not offer health insurance in 2003. However, employees at firms that do not offer coverage were slightly younger than employees at firms that do offer coverage. These data were not available in 2005.

Employee Age, 2003			
Age	**Employer Offers HI**	**Employer Does Not Offer HI**	**All Employers**
Under Age 25	12.6%	14.4%	13.2%
Ages 25 to 55	67.3%	67.3%	67.3%
Ages 56 to 64	16.3%	13.5%	15.4%
Ages 65+	4.0%	4.8%	4.2%

Policy Premiums
The following chart shows the monthly individual and family policy premiums by firm size according to data from the 2003 and 2005 employer surveys. Median monthly premiums have been increasing, with about a 17% jump in 2005 from 2003. The median monthly individual premium across all firms increased to $365 in 2005 from $312 in 2003. The median monthly family premium increased to $950 in 2005 from $810 in 2003. Median monthly premiums increased within each firm size in 2005.

Median Monthly Premium for Individual and Family Plans by Company Size				
	Median Monthly Individual Plan Premium		**Median Monthly Family Plan Premium**	
	2003	**2005**	**2003**	**2005**
2 to 50 employees	$314	$365	$810	$950
51+ employees	$294	$350	$829	$958

Contribution Levels
Employees are contributing more towards their health care premiums. Median monthly employee contributions to individual plans increased from $60 to $80 between 2003 and 2005, and from $217 to $239 for family plans. In addition, the proportion of monthly premiums that employees were asked to contribute toward both individual and family plans increased slightly between 2003 and 2005.

Employee Contribution to Medium Monthly Premiums by Firm Size				
	Individual Plans		Family Plans	
	2003	2005	2003	2005
2 to 50 employees	$60	$78	$226	$237
51+ employees	$61	$88	$195	$269

Smaller employees were more likely to cover 100% of premium costs than large employers, and employers were more likely to cover 100% of individual premium costs than family premium costs.

Employers that Cover 100% of the Costs of Health Insurance Benefits			
Individual Plans			
	2 to 50 employees	51+	All sizes
2003	33.7%	8.8%	31%
2005	32.5%	7.4%	30.4%
Family Plans			
	2 to 50 employees	51+	All sizes
2003	24.7%	7.4%	22.2%
2005	26.9%	4.4%	24.8%

Take Up Rates

While most employees eligible to enroll in their employer-sponsored health insurance coverage opted to take offered coverage in 2005, the proportion participating declined to 77.6% in 2005 from 85% in 2003. In both 2003 and 2005, less than a quarter of employers offering health insurance required employees to provide proof of coverage from another source before they were allowed to refuse employer coverage. Small employers were somewhat more likely than larger employers to require such proof of coverage.

Does the organization ask for proof of insurance coverage from another source if employee turns down employer-sponsored coverage?		
	2003	2005
All employee sizes	22.1%	22.6%
2 to 50 employees	22.4%	23.2%
51+ employees	19.1%	16.1%

Waiting Periods

More than half of all employers offering health insurance (61.2% in 2003 and 56.5% in 2005) required new employees to wait a specified period of time before enrolling in health care coverage. Nearly half (46.8%) of all companies with a waiting period require employees to wait less than three months. Smaller employers with waiting periods are much more likely than larger employers to require employees to wait six months or longer (13.3% compared to 3.3%).

Percent of Employers Requiring a Waiting Period Before Employees Can Be Covered by HI		
	2003	**2005**
All sizes	61.2%	56.5%
2 to 50 employees	61.0%	55.8%
51+ employees	62.5%	66.0%

Median Wait Among Companies Imposing a Waiting Period, 2005			
	Less than 3 Months	At Least 3 Months, but Less than 6 Months	6 Months or Longer
All sizes	46.8%	40.9%	12.3%
2 to 50 employees	44.8%	41.9%	13.3%
51+ employees	65.2%	31.5%	3.3%

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

In both 2003 and 2005 the two most common reasons employers gave for not offering health insurance was the high cost of premiums and that employees are covered through other sources (such as through a spouse, a union, or Medicaid). In 2005, 85% of employers chose the response that premiums are too high as a very or somewhat important reason for not offering health insurance (down from 93.5% in 2003). Eighty-eight percent chose the response that employees are covered through other sources as a very or somewhat important reason for not offering health insurance in 2005 (up from 85% in 2003).

Primary Reasons Employers Cited for Electing Not to Provide Coverage, 2005			
	Very Important	**Somewhat Important**	**Not at all Important**
Premiums are too high	72.4%	12.7%	14.8%
Employees covered through other sources	64.4%	23.8%	11.8%
Financial status of org. prohibits offering	50.5%	21.1%	28.3%
Most employees are part-time/temp/contracted	36.4%	19.2%	44.4%
Not needed to attract good employees	21.4%	29.3%	49.3%
Employers prefer higher pay	18.9%	21.5%	59.6%
Employee turnover	12.9%	25.9%	61.3%
Organization is too new	9.3%	7.2%	83.5%
Administrative Hassle	8.4%	21.2%	70.4%
Past negative claims experience	5.9%	0.3%	93.9%

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

Employers make decisions about whether and which health insurance to offer to their employees based on a number of factors, although, as described in subsections 2.2 and 2.5, both our survey and interview results suggest that benefit decisions are heavily influenced by the cost of coverage and employer financial position.

Results of our small employer re-survey in Massachusetts indicate that a large core of employers appear to be committed to offering benefits to employees, even though company financial status may require them to find ways to cut costs as premiums rise. For example, the offer rate among our re-surveyed small employers remained steady at about 75% in both 2003 and 2005, although there was some fluctuation around the specific employers offering coverage; perhaps these employers embrace their role as a benefit provider. Our re-survey data show that employers who offered health insurance were also likely to offer retirement (i.e. pension, not health care) benefits. In 2003, 67% of employers who offered health care coverage also offered retirement benefits. In 2005 this proportion was slightly less (64%). On the other hand, in both 2003 and 2005 only half of those employers who offered health insurance also offered dental insurance.

As described below, it appears that employers responded to increases in premium costs by making changes to health plan eligibility. For example, our small employer re-survey data indicated that in 2003, 87% of employers offered coverage to dependent children of employees.

This proportion decreased to 78% in 2005. In addition, employee contributions to health plan costs increased between the two years.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

In an economic downturn or with continued increases in costs, it is likely that employers will continue to look for plan changes that will help them manage the costs of offering health insurance coverage to their employees.

We asked employers what changes they made over the last year to their most popular health plan. The question wording changed in 2005. One of these changes was to see if those employers who had not made a change in the last health insurance renewal cycle were planning on making a change in the next renewal period. In both 2003 and 2005, employers were most likely to have changed or planned to change deductibles or copayments. In 2005, no employers reported a "pay for performance" plan, and only one or two are planning to add this in the next insurance cycle. This option is only open to self-insured employers because they can customize their health plans.

At the time of your last renewal, what changes were made to your health plans? (2003)	
	Changed in Last Renewal Cycle
Increase copayment	59.5%
Increase deductible	42.7%
Encourage generic drugs	40.2%
Reduce benefits	6.6%
Increase benefits	5.4%
Disease management program added	2.8%
Other	10.2%

What were or are going to be the changes made to health plans? (2005)			
	Changed in last year	Plan to change next year	No change made or planned
Change deductibles or copayments	38.7%	10.7%	50.6%
Institute a high deductible consumer driven health plan	4.1%	5.2%	90.7%
Eliminate specific benefits, such as pharmacy	3.25%	0.89%	95.9%
Institute disease management program	3.5%	1.5%	95.0%
Reduce network	2.4%	2.2%	95.5%
Offer plan with cheaper hospitals	0.7%	2.2%	97.2%
Pay-for-performance bonus plan	0%	0.8%	99.2%

2.5 What employer and employee groups are most susceptible to crowd-out?

Crowd-out occurs when those who are already covered, especially by private sources, drop their coverage in order to enroll in a public health care coverage program. Examples of ways that crowd-out can occur include:

- Individuals, usually employees, drop private coverage for public coverage
- A public program enrollee refuses an offer of private coverage
- An employer changes coverage offerings in response to expansion of a public program for which his employees are likely to qualify

Since our first employer survey in 2001, data have consistently shown that nearly all larger employers offer health care coverage, while about a third of small employers do not. Therefore, small employers and their employees may be more susceptible to crowd-out than larger employers.

We implemented our small employer re-survey as one means of gaining information about trends in crowd-out among small employers. Since individuals often cycle in and out of different types of public or private coverage over time, crowd-out is a problem that is best studied using longitudinal data.

Our re-survey data suggest that some crowd-out may be occurring, particularly around offer rates to dependent children. For example, in 2003 a minority of small employers (4.4%) in our sample indicated that the proportion of their employees declining coverage had increased. This proportion increased to 6.9% in 2005. In addition, in 2003, 87% of employers offered coverage to dependent children of employees. This proportion decreased to 78% in 2005. In 2003, 89% of employers offered coverage to spouses of employees, and about 11% offered coverage to same-sex or opposite-sex domestic partners. In 2005 81% of small employers offered coverage to opposite-sex spouses of employees, 18% to same-sex spouses (now legal in Massachusetts), 12% offered coverage to opposite-sex domestic partners, and 9% to same-sex domestic partners.

Among small employers in this longitudinal sample, median employee premium contributions increased between 2003 and 2005. Median individual plan employee contributions grew from $60 to $74, while family plan employee contributions increased from $224 to $280.

In 2005, 6% of small employers indicated that they assist employees who are ineligible for employer-sponsored health care coverage to apply for MassHealth (Massachusetts Medicaid program). Only 1% of the 2005 small employer sample that does not offer coverage reported that it is very likely they would offer health care coverage in the next two years.

In 2004, we conducted interviews with a purposive sample of small employers who do not offer health care coverage. Results indicated that employees of these small firms often have health care coverage through other sources. Employers are knowledgeable about issues related to health insurance and understand that they are taking a risk by not offering health insurance to their employees. In addition, employers reported that not offering health insurance does affect their business when, for example, a potential employee takes a job at another firm that offers

coverage. However, while they understand the impact of not offering employees health insurance, these small employers felt they couldn't afford it. An interesting result is that small employers have been creative in finding solutions to the problem of how to access health care coverage for employees. Strategies that employers have used to obtain coverage for their employees are as varied as their values, job sector, health and work status, and income. A complete report of the results of our small employer interviews is in Appendix III.

2.6 How likely are employers who do not offer coverage to be influenced by the following factors?

Insurance History

Only 19.1% of employers not offering coverage in 2003 and 12% of those not offering coverage in 2005 offered health insurance to employees at some point in the past. Only 3.2% in 2003 and 3.7% in 2005 of the employers not offering coverage responded that it was very likely that they would begin to offer coverage during the next two years. Most employers responded that it wasn't likely at all that they would begin to offer coverage in the next two years (78.3% in 2003 and 73.2% in 2005). Therefore, it is reasonable to assume that a significant change in the insurance market or the economy or the implementation of an individual health insurance mandate would be required before these employers would begin to offer coverage or feel more pressure from employees to do so.

How likely is organization to offer health insurance in the next two years?		
	2003	**2005**
Very likely	3.2%	3.7%
Somewhat likely	18.5%	23.1%
Not likely at all	78.3%	73.2%

Expansion/Development of Purchasing Alliances

Purchasing alliances appear unlikely in Massachusetts due to a number of non-group and small group market reforms that have been implemented over the last several years. Moreover, there are insurance intermediaries in Massachusetts that act as purchasers for member small employers. Therefore, we did not specifically ask employers about their preferences with regard to purchasing alliances. However, in 2005 we asked employers questions about whether they purchase health insurance as part of a larger group. Larger companies reported that they were more likely to be one of multiple sites affiliated with their organization. In addition, 41.4% of employers reported that they purchase health insurance through a larger group such as a parent company or a purchasing consortium. Smaller employers were slightly more likely than larger employers to report that they purchase health insurance in this way.

Does this organization exist only at this site, or are there other sites within the United States? (2005)		
	Only Site	**Other Sites**
All sizes	76.85%	23.15%
2 to 50 employees	78.5%	21.5%
51+ employees	47.8%	52.2%

Does this organization purchase health insurance through a larger group such as a parent company or a purchasing consortium? (2005)		
	Yes	**No**
All sizes	41.4%	58.65%
2 to 50 employees	41.7%	58.3%
51+ employees	36.9%	63.1%

Individual or Employer Subsidies

The Massachusetts Insurance Partnership (IP) program offers employers insurance subsidies to provide coverage to low-wage employees. Of the employers who were aware of the IP and who had 50 or fewer employees, 63.3% of employers in 2003 and 58.6% in 2005, responded that the low IP subsidies were very or somewhat important for not using the partnership. Many employers (63.3% in 2003 and 72.1% in 2005) responded that the low-income limits were very important or somewhat important in their reason for not using the partnership.

For employers who were aware of the IP, reasons for not using the partnership						
	Very important		Somewhat important		Not at all important	
	2003	**2005**	**2003**	**2005**	**2003**	**2005**
Subsidies too low	40.9%	34.2%	22.4%	24.4%	36.7%	41.3%
Administratively difficult	30.4%	14.2%	13.4%	28.5%	55.9%	57.4%
Negative stigma	7.0%	15.4%	0%	7.7%	93.0%	77.0%
Income limit too low	49.0%	57.1%	14.3%	15.0%	36.7%	27.9%

Additional Tax Incentives

In 2003, 81.7% of employers not offering coverage indicated that tax credits for offering coverage would be very or somewhat likely to motivate them to offer health care coverage. This proportion decreased to 73.8% in 2005.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

We asked employers a series of questions about other factors that might motivate them to offer coverage. Responses to these options are presented in the table below for 2003 and 2005. In

2003, requiring businesses to pay a fee if they did not offer insurance was the least likely to motivate employers to offer coverage, while a tax credit for offering insurance was the most likely to motivate employers to offer coverage. A plan with limited benefits and high copayments was the least likely to motivate employers to offer coverage while a tax credit for offering insurance continued to be most likely to motivate employers to offer coverage in 2005.

What would motivate employer to offer coverage? (2003)			
	Very Likely	Somewhat Likely	Not Likely at All
Lower premium rates by offering a plan w/ only basic hospital coverage	21.9%	32.5%	45.6%
Lower premium rates by offering a plan w/ fewer hospitals and doctors in the network	9.4%	38.2%	52.4%
Lower premium rates by offering a plan w/ service restrictions	11.5%	36.4%	52.1%
Eliminate minimum employee participation	32.2%	27.8%	40.0%
Government subsidy for low-income employees	36.6%	30.3%	33.1%
Tax credit for offering insurance	51.5%	30.2%	18.4%
Requiring business to pay fee if no insurance	16.4%	20.3%	63.3%

What would motivate employer to offer coverage? (2005)			
	Very Likely	Somewhat Likely	Not Likely at All
Plan w/ limited benefits and high copayments	19.5%	30.5%	50.0%
Eliminate minimum employee participation	31%	33.1%	35.9%
Government subsidy for low-income employees	29.7%	30.8%	39.5%
Tax credit for offering insurance	46.5%	27.3%	26.3%
Requiring business to pay fee if no insurance	8.8%	22.5%	68.7%
Legal mandate to insure all	23.9%	19.8%	56.3%

SECTION 3

Summary of Findings: Health Care Marketplace

The Massachusetts Uncompensated Care Pool Review of High-Cost Users: Demonstration Project

The Massachusetts Uncompensated Care Pool (UCP) pays for medically necessary services for low-income uninsured and underinsured residents at hospitals and community health centers (CHCs) in the Commonwealth. The UCP was created in 1985 as a safety net for providers who provide significant amounts of uncompensated care to individuals who do not qualify for other programs. To receive payments from the UCP, providers must first access all other sources of funding that may pay for all or part of a patient's care. Patients apply for the UCP at hospitals and CHCs, using the Medicaid application process, and are first screened for Medicaid eligibility. The UCP pays for care at hospitals and CHCs, but does not pay for services by private physicians, independent care groups, sub-acute care, or long-term care facilities. The UCP does not function as insurance, and serves primarily to help hospitals and CHCs receive payment for some of the costs of health care for the uninsured and underinsured.

Introduction

One of the activities of the Massachusetts HRSA Grant was to construct a more useful dataset for the UCP, and to use that data to create a more comprehensive picture of the uninsured Massachusetts residents whose medical services are paid for by the UCP. This activity involved both quantitative and qualitative analyses, which over the past year have resulted in the development of an innovative intervention project centered on the costliest users of the UCP.

Hospitals and CHCs began electronic submission of UCP claims in March 2001. During Pool Fiscal Year 2003 (PFY03), October 2002 through September 2003, the Massachusetts Division of Health Care Finance and Policy began withholding payments from hospitals with incomplete data. As a result, compliance with data submission requirements has improved dramatically. The availability of a complete and comprehensive dataset of UCP claims, beginning in PFY03, has allowed more sophisticated and detailed analyses of the UCP.

The UCP claims dataset already incorporated a metric similar to the episode of care construct that we proposed developing in the initial grant plan. This discharge/visit count combines many individual claims into one inpatient discharge or one outpatient visit, facilitating an easier, more useful analysis of claims.

Quantitative Analyses

The focus of this grant activity is to understand the characteristics of the high-cost Pool users. High-cost users are defined as those with the top 1% of aggregate costs during PFY04 (October 2003 through September 2004). In PFY04 high-cost users were comprised of 4,543 individuals generating over $171 million in costs to the UCP. Analyses focused on their demographic traits, utilization patterns, and costs to the Pool.

The high-cost Pool users differ from the general UCP population in certain significant ways. One variation found was in regards to age. High-cost users were older than other Pool users. Almost half (45%) of the high-cost users were between the ages of 45 and 64, compared to 21% of all other Pool users. Additionally, high-cost users were more likely to be male; 61% of this group was male, while only 49% of the other Pool users were male. This difference may be related to general hospital utilization patterns; male Pool users are more frequent users of inpatient services and therefore generate higher costs. No variation was detected in geographic location of high-cost Pool users compared to other Pool users.

The high-cost Pool users had very high inpatient and outpatient Pool utilization in PFY04. On average, high-cost users had nearly five times as many provider visits as other Pool users (19 visits versus 4 visits). The majority (70%) of the high-cost users used Pool services five times or more; among all other Pool users only 22% had five or more visits during the year. The high-cost Pool users had 7,586 hospital discharges, representing 17% of total discharges for all Pool users during PFY04. The high-cost Pool users had 78,279 outpatient hospital visits, representing 5% of total hospital outpatient Pool visits during that year.

Clinically, high-cost users often had either diagnoses or treatments for chronic, serious, long-term disorders. Commonly, these were cardiac conditions and cancer. High-cost users were more likely than other Pool users to receive procedures, surgeries, and treatments such as chemotherapy that were not only expensive, but were also indicative of chronic disease. This is a significant finding; one initial research question had been whether or not the high-cost users were "catastrophic" cases, e.g., uninsured individuals who had car accidents or other traumas, but were otherwise healthy. Our research clearly indicates that the high-cost users were not "catastrophic" cases, and used the UCP for regular, consistent medical care. Additionally, many of these users had more than one complex medical condition. Case studies of the high-cost users have confirmed these conclusions.

High-cost Pool patients generated significantly high costs to the UCP. In PFY04, these 4,543 users generated over $171 million in costs, or 25% of total PFY04 costs. Strikingly, this 1% of Pool users generated almost half (49%) of the total inpatient costs to the Pool, totaling over $121 million. This intense concentration of costs within the high-cost user population generated a great deal of interest and greatly informed further discussions.

Intervention Project

Once the quantitative analyses of the high-cost users were completed, discussions began regarding a possible intervention targeted specifically to these Pool users. The quantitative data clearly indicated that these users, and the Commonwealth, would benefit from their enrollment in private insurance. The UCP is not insurance and does not provide many of the benefits or potential cost savings of negotiated, guaranteed insurance. The UCP pays hospitals and CHCs for some of the costs provided to UCP patients, but patients do not receive the same level of benefit coverage as provided by private insurance.

Qualitative Research

The qualitative research aimed to investigate how providers—both insurers and hospital staff—dealt with high-cost patients. Our investigations introduced us to an innovative program within

the state Medicaid program, MassHealth. The Enhanced Coordination of Benefits team (ECOB) works within hospitals, identifying high-cost Medicaid users and investigating whether they have access to private health insurance. The team then tries to enroll those patients into private insurance. Since ECOB already works with Medicaid, we discussed the possibility of partnering with them to allow them to investigate UCP patients' eligibility for private insurance, and helping them to enroll when possible.

Additionally, we met with researchers at Partners Health Care, a large group of hospitals and physicians in Boston. They had done extensive research into their high-cost population, including their Pool patients. Their dataset included information about patients that was very helpful to us, including data about Pool patients' other payers during a two-year period. We discovered that many UCP patients cycle on and off health care insurance, including Medicaid; 52% of high-cost UCP patients at one hospital had more than one payer identified during this period. This supported our belief that these patients may, at some point, have had access to private or other insurance.

We also met with a team of administrators at Neighborhood Health Plan (NHP), a local private insurer that is also a Medicaid managed care provider. NHP has developed a care management program focusing exclusively on their high-risk population. Through the use of predictive modeling and referrals, current and potentially future high-cost users are identified. Nurse practitioners then manage their care through coordination, behavioral assistance, and health education. NHP has seen significant results from its program, including a reduction in inpatient admissions among the patients in the care coordination program. This program provided a useful model for the development of the UCP demonstration.

In an effort to better understand the care that UCP patients receive, particularly high-cost patients, we met with discharge planners at Massachusetts General Hospital. They discussed their difficulties in coordinating care for UCP patients, particularly those requiring rehabilitation care at a sub-acute level. The UCP does not reimburse sub-acute facilities, and MGH often subsidized these patients' care by providing it at one of their own facilities. They also discussed some difficulties they have encountered with the UCP eligible, low-income population. These challenges include a lack of stable housing, lack of primary care, and difficulties following pre- and post-surgery protocols. These factors were identified as sometimes being significant impediments to optimal care.

Our quantitative analyses identified cancer as one of the most common diagnoses among the high-cost users. To explore the specifics of care for this population, we met with oncology clinicians at Massachusetts General Hospital. These clinicians and researchers felt that the uninsured patients received cancer diagnoses later than insured patients, and that their treatment often required more aggressive, expensive care once a diagnosis was made. These clinicians believed that a lack of consistent primary care, due to the patient's lack of insurance, was a factor in these late-stage diagnoses.

Demonstration Project

The quantitative data combined with the qualitative analyses and insight we gained during our various discussions all influenced our decision to initiate a UCP demonstration project that would identify high-cost UCP patients and investigate their access to private health insurance. This project was based on the assumption that private insurance would provide the high-cost users with more comprehensive benefit coverage and better access to primary and preventive care. This project could also generate cost savings for the Commonwealth. The Division is in the process of contracting with the MassHealth ECOB team. This team approached Massachusetts General Hospital with a plan to study the UCP high-cost patients at that facility.

ECOB coordinators will have access to a comprehensive, dynamic dataset of demographic data, due to a recent integration of the UCP and MassHealth application systems. UCP patients' applications are now completed through the same process as Massachusetts Medicaid applications. Demographic information for UCP eligible patients is available in the same format as MassHealth patient data. The team will also have access to complete patient utilization data through hospital records. The coordinators will work within the hospital, taking referrals from nurses and physicians about possible high-cost patients, meeting with UCP patients, and investigating private insurance possibilities.

Project Summary

During this past year and a half, we have successfully completed many of the goals we initially developed for this HRSA planning grant. We have used the UCP data in sophisticated, complex ways to explore the sub-population of the high-cost Pool users. This resulted in a much more complete picture of the high-cost users than was previously available.

The UCP demonstration project, currently in its planning phase, will build and expand upon the data we have collected as a result of the HRSA planning grant. The project will continue to provide data on the characteristics of the UCP population, from a perspective that has previously been unavailable to us. By partnering with a leading institution and experienced coordinators, the UCP will develop a possible mechanism with which to move some of its costliest users into private insurance. Additionally, the information we learn from the hospital and the ECOB team may influence UCP policy in the months and years ahead. It will provide a valuable insight into the care of the uninsured in Massachusetts.

SECTION 4

Options for Expanding Coverage

4.1 Which coverage expansion options were selected by the state?

The Massachusetts Governor's health reform proposal focuses on expanding coverage as well as cost containment. The major components of this proposal incorporate an "individual" responsibility for obtaining health care insurance, access and affordability for individuals through the private market ("Commonwealth Care" insurance product), subsidies for those who cannot afford private coverage ("Safety Net Care" product), and greater transparency to consumers in health care costs and quality to facilitate better decision making in obtaining care.

4.2 What is the target eligibility group under the expansion?

Recognizing that the uninsured are not a homogenous group, the Governor's plan targets the Commonwealth's uninsured population using three approaches. First, targeted outreach and enrollment of people currently eligible for Medicaid but unenrolled. Second, for those earning 300% of the FPL or more, more affordable products will be made available through the non-group and small group markets. Third, for people earning between 100% and 300% of the FPL, a sliding scale subsidy for the more affordable product will be made available.

4.3 How will the program be administered?

The proposed administrative entity is called the "Health Insurance Exchange." The exchange will be a quasi-independent entity governed by a nine-member board. The Exchange will facilitate the purchase of health insurance through approving or certifying affordable products with the "Commonwealth Care Seal of Approval." Products that are board certified may be exempted from existing mandated benefits laws. The Exchange will create a system for collecting insurance premiums through payroll deductions and administer Safety Net Care for individuals earning between 100% and 300% of the FPL.

One of the strong advantages of this structure is that it will allow pre-tax payment of premiums, a tax break heretofore available only to employees that have employer-sponsored health insurance. In addition, as employees of small firms buying from the Exchange move from job to job, the health insurance they purchase through the Exchange will be portable, creating more continuity and less churning for insurers and the insured. Employers who wish to contribute to their employees' premiums can do so through the Exchange and if an employee has multiple part-time employers, any or all of them can contribute to the premium or not.

4.4 How will outreach and enrollment be conducted?

Outreach and enrollment efforts to the Medicaid eligible population will be made using bilingual and bicultural outreach efforts, along with school-based outreach efforts. In addition, since August 2004 Massachusetts has utilized a unified Gateway application for any uninsured person requesting health care. Rather than only screening for eligibility for the Uncompensated Care Pool, this unified application screens first for MassHealth eligibility and then (only if ineligible for MassHealth) for the Pool. In addition, $500,000 in funding was made available for community groups to conduct outreach efforts to enroll people into MassHealth. Outreach and enrollment for Commonwealth Care will be a private-market responsibility and efforts for Safety Net Care will be a combination of both public and private activities.

4.5 What will the enrollee (and/or employer) premium sharing requirements be?

Commonwealth Care permits private insurers to offer new, affordable policies to small businesses and individuals. Premium cost is reduced through pre-tax treatment of the premium as well as flexibility allowed in plan design, especially regarding insurance mandates. Copayments and deductibles will be used as well as moderate limitations in coverage. No enrollee or employer premium-sharing requirement is mandated. Safety Net Care is available to Massachusetts residents working for an employer who does not contribute at least 20% of an annual individual premium, or 30% for a family premium. Residents eligible for Safety Net Care will be subsidized on a sliding scale. The Safety Net Care products will not have a deductible and will have lower cost sharing than the Commonwealth Care products.

4.6 What will the benefits structure be (including copayments and other cost sharing)?

Commonwealth Care products have been designed with affordability in mind. In Massachusetts, the average small group monthly individual premium is approximately $365. Commonwealth Care products are expected to average just under $200 a month for an individual. This premium expense containment is derived by individuals receiving appropriate health care in an appropriate setting (limited network emphasizing community health centers and community hospitals), annual deductibles ranging from $250 to $1,000, copayments on inpatient care and office visits ranging from $20 to $40, pharmacy benefit management and the restriction of discretionary benefits. Safety Net Care will also be private insurance with the same benefits as Commonwealth Care, but with lower copayments and no deductibles. Monthly premium contributions will be set on a sliding scale based on individual income.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

The projected available funding is just under $1 billion. This money is in the Massachusetts health care system now, and is being spent on the Massachusetts uninsured population, mostly

through the Uncompensated Care Pool. An additional $400 million in spending (half state, half federal) is projected to enroll those currently eligible into the MassHealth program.

4.8 How will the program be financed?

The proposed reforms are based on a redistribution of funds currently spent on health care to the uninsured and underinsured populations in Massachusetts.

4.9 What strategies to contain costs will be used?

Two strategies for managing cost containment are through eligibility requirements and benefit design. For example, Safety Net Care will be available only to residents who have lived in Massachusetts for the previous 12 months, and new insurance products offered may apply for exemption from state benefit mandates through the Insurance Exchange. The Exchange will also facilitate the use of pre-tax contributions to health insurance premiums, thereby saving working individuals a significant amount of money. Other health care reform plans that will contain costs include ongoing verification and re-determination of Medicaid eligibility, aggressive auditing of providers, provider networks that focus on cost and quality initiatives, promoting the use of electronic medical records, improving individuals understanding of price and quality by providing up-to-date information on Massachusetts providers via the internet (www.mass.gov/healthcareqc) and medical malpractice reform to eliminate unnecessary costs caused by defensive medicine.

4.10 How will services be delivered under the expansion?

Services will be delivered through existing provider networks, although insurers may develop their own selected delivery networks. Current Medicaid Managed Care Organizations will be given a two-year period of exclusivity to enroll the Safety-Net-Care population.

4.11 What methods for ensuring quality will be used?

The Commonwealth of Massachusetts has sponsored a new website that enhances "transparency" around pricing and costs. This website enables individual access to more detailed and comparative information among competing providers. This, along with other marketplace competitive pressures will enhance quality efforts. This website, launched October 18, 2005 can be found at www.mass.gov/healthcareqc.

4.12 How will the coverage program interact with existing coverage programs and state insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer based coverage)?

The health care reform proposal interacts directly with the existing Massachusetts Medicaid program. First, low-income uninsured residents will be screened for eligibility for MassHealth (Medicaid health coverage). If a resident were not eligible for MassHealth, they would be referred to the Safety Net Care product or to the Commonwealth Care products. Legislation proposed to make this health care reform work includes merging the existing Massachusetts small group and non-group health insurance markets in order to provide greater product choice and more affordable rates to individuals and small businesses.

4.13 How will crowd-out be avoided and monitored?

The health care reform plans' eligibility determination, benefit design, and subsidies were chosen with careful consideration to mitigate crowd-out. Also, existing federal tax code provisions for non-discrimination coupled with new state provisions help avoid crowd-out. Other factors mitigating crowd-out include the prohibition of indirect measures that circumvent the purpose of the proposed law, state competition for labor, and the fact that most employees working for small firms earn more than 300% of the FPL.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Many of these details will be worked out pending the legislative debate.

4.15 How (and how often) will the program be evaluated?

Many of these details will be worked out pending the legislative debate, but program evaluation will be ongoing. Many of these ideas have not been tested and it is understood that adjustments may be needed moving forward.

4.16 For each expansion option selected (or considered) discuss the major political and policy considerations that worked for or against that choice. What factors ultimately brought the state to consensus on each of these approaches?

The Governor arrived at this proposal through careful analysis of the various pieces of data available to him including the economic modeling done by Dr. Gruber.

4.17 What has been done to implement the selected policy options?

Health care reform bills have been proposed in order to implement the Massachusetts Governor's health care reform proposal. Debate is currently ongoing.

4.18 Which policy options were not selected?

Legislative debate and house proposals are ongoing at this time.

4.19 How will your state address the eligible but not enrolled in existing programs? Describe state efforts to increase enrollment. Describe any collaborative arrangements with partners at the county/municipal levels.

Outreach and enrollment efforts to the Medicaid-eligible population will be made using bilingual and bicultural outreach efforts, along with school-based outreach efforts. Outreach and enrollment for Commonwealth Care will be a private market responsibility and efforts for Safety Net Care will be a combination of both public and private activities.

SECTION 5

Consensus Building Strategy

Not applicable.

SECTION 6

Lessons Learned and Recommendations to States

6.1 How important was state-specific data to the decision making process? Did more detailed information on the uninsured within specific subgroups of the state population help identify or clarify the most appropriate coverage expansion alternatives?

State-specific data were extremely important to the decision making process. Access to these data enabled more detailed information on the uninsured within specific subgroups and helped identify and clarify expansion opportunities. Massachusetts policy and decision makers relied heavily on data and information provided by the Commonwealth's Survey of Health Insurance Status (the household survey), Uncompensated Care Pool claims and eligibility data, the Employer Health Insurance Survey, as well as on the Hospital Inpatient Discharge Data, and Medicaid program data. Continuing data collection efforts are also extremely important for trend analysis activities. Federal data collections are too general for good decision making at the state level, especially in a state like Massachusetts that looks so different from the country as a whole. Federal data also tends to be older than the household and employer data that we collect biennially and analyze immediately.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

All of the data collection activities mentioned above are ongoing efforts. These efforts, both historically and presently, are well worth the resources expended in conducting the work. Collecting information directly from residents, providers and public program eligible residents is vital in maintaining, monitoring, and planning program efforts.

6.3 What data collection activities were originally proposed or contemplated that were not conducted and why?

The original proposal called for employee focus groups to gather information related to employee preferences, including such items as what role workers would like their employers to play in providing health care coverage, and what types of options might entice an employee to sign up for employer-sponsored coverage. However, employee focus groups were not conducted. It became clear that it was very challenging to find a diverse and broadly representative group of employees who were willing to participate.

We had also foreseen conducting employer focus groups, but due to the difficulty of assembling a disparate group of employers willing to discuss health insurance, we instead conducted structured telephone interviews of small employers purposively selected.

6.4 What strategies were effective in improving data collection? How did they make a difference?

For both the household insurance coverage survey and the employer survey, multiple attempts are made to contact a respondent. The household survey contractors made up to three separate telephone contacts to a respondent who initially refused to participate (the household survey is a telephone survey). This effort resulted in 35% of initial refusals converting to completed surveys. Overall, the 60.4% screening response rate compares favorably with the best response rates to Random Digit Dialing surveys that are obtained by top national survey research centers. Considering this survey was done during difficult economic times when interviews, in general, are more difficult to conduct, the effort was an overall success.

The employer survey was mailed to a specific individual pre-identified through a telephone call to that establishment asking who had primary responsibility for planning and administering health benefits. Included with the mailing were letters from the survey contractor and DHCFP (itself co-signed by a few prominent business leaders), a postage paid return envelope and a $10 bill. A reminder post card was mailed a few weeks later. After the reminder post card mailing, any remaining non-respondents were contacted via telephone. In addition, any firm unwilling to answer the survey as a whole was asked over the phone to answer only: "does this establishment offer health insurance to its employees?" Using this method, of the 1,521 employers who received a survey we achieved a response rate of 62.8% for the whole survey and 77.6% for a response to the one question regarding the offering of health insurance.

This year for the first time, DHCFP re-surveyed all small employers surveyed in 2003. Our response rate for this longitudinal survey was even higher (79.5%).

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under the HRSA grant? Does the state have plans to conduct that research?

Careful thought and consideration will continue to be given to measurement of underinsurance, a much harder status to define and measure, yet a very important one. As the Commonwealth considers initiatives to ease access to health insurance coverage to Massachusetts residents, it will be important to monitor any changes in benefits covered and any public health issues surrounding the possibility of lack of access to specific types of health care coverage, such as prescription drug or mental health coverage. Also, the Commonwealth is very interested in trying to find a way to measure what would convince a resident with access to employer-sponsored insurance to choose to take it. No specific plans are underway at this time to conduct this research.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the state proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The Governor of Massachusetts has authored a health care reform proposal incorporating a three-pronged approach for covering the uninsured, based in large part on an analysis of information provided by the Commonwealth's data collection efforts. See Chapter 4 for details.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your state?

Both the employer and insurance community in Massachusetts have welcomed the attention paid by the Governor to the problems in health insurance. The insurers have indicated their willingness to develop slimmer packages of benefits that would still be considered good protection by most of the uninsured. Health plans welcome the opportunity to develop products that might be affordable to a segment of the population that to date has been largely precluded from the market. Employers welcome the idea of large groups of the uninsured becoming insured because they see that as a welcome solution to the problem of ever-increasing cost shifting. The Governor has communicated to the employer community through association and business group leaders, through op ed pieces in major newspapers across the Commonwealth, and through other meetings held by his Secretary of Health and Human Services, his Secretary of Economic Development, and others.

6.8 What are the key recommendations that your state can provide other states regarding the policy planning process?

Data, data, data. The more facts policy makers can bring to a discussion, the more useful and less emotional a discussion will be. If data are gathered carefully, discussion can be about approaches rather than about the credibility (or lack thereof) of the data.

6.9 How did your state's political and economic environment change during the course of your grant?

The Massachusetts economy rebounded somewhat during the course of the grant, but because of several recent years of considerable growth in health insurance premiums, employers were still experiencing "sticker shock" and eager to hear some new ideas that would bring them some relief.

6.10 How did your project goals change during the grant period?

Our project goals did not change during the grant period.

6.11 What will be the next steps of this effort once the grant comes to a close?

The Governor's health reform proposal has been submitted to the Massachusetts state legislature and he hopes to have it considered before this session's close in mid-November.

SECTION 7

Recommendations to the Federal Government

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law?

Massachusetts recently completed an extension to the 1115 waiver under which our MassHealth program operates. In fact, federal requirements under this extension helped provide additional incentives to the state to develop a health care reform proposal. No changes in federal law are seen as necessary at this time.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

Not applicable.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in states?

State-specific data are extremely important to the decision-making process. Access to these data provides more detailed information on the uninsured within specific subgroups and helps identify and clarify expansion opportunities. It gets extremely expensive for federal-level surveys to obtain samples large enough to provide the most usable state-level data. In addition, there are timing issues. It may take significantly longer for a state to have access to federal-level survey data than data collected at the state level. In addition, a state has more flexibility to make changes or modifications to a survey of its own design. Financial support is always greatly appreciated as finding the dollars for data collection activities is always challenging.

7.4 What additional research should be considered (either by federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

It is very helpful to have other organizations monitoring the impact of changes in the health care marketplace such as "consumer driven" health insurance plans. In addition research related to the concept of "underinsurance," affordability of premiums to individuals (i.e., what would convince working uninsured individuals with available employer-sponsored coverage to take the health insurance?), and crowd-out are always appreciated.

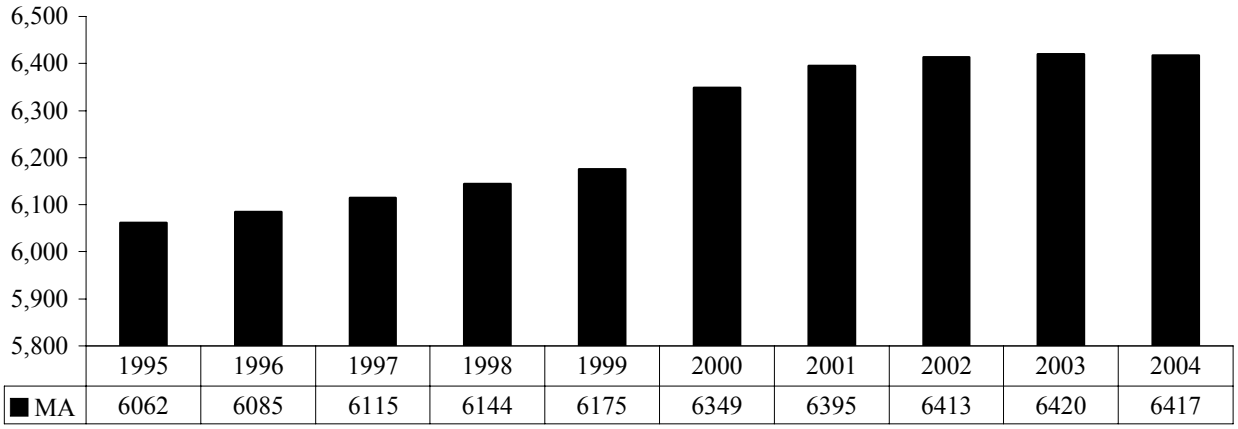
APPENDIX I

Baseline Information for Massachusetts

Massachusetts Population

Massachusetts experienced a 5.9% increase in resident population from 1995 to 2004. There was a slight decrease in the state's population from 2003 to 2004.

Massachusetts Population 1995-2004
(in thousands)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MA	6062	6085	6115	6144	6175	6349	6395	6413	6420	6417

Source: "Table 1: Annual Estimates of the Population for the United States and States, and Puerto Rico: April 1, 2000 to July 1, 2004," U.S. Census Bureau, http://www.census.gov/popest/states/tables/NST-EST2004-01.pdf

Average Age of the Massachusetts Population

The median age of the Massachusetts population in 2004 was 38.1. The percent of the state's population that was over age 65 exceeded the national average, 12.8% versus 12.0%.

	Massachusetts Population				
Age Group (years)	Under 18	18 to 24	25 to 44	45 to 64	65+
Percent of Total Population	23.5	7.9	30.3	25.5	12.8

Source: "Massachusetts General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder/census.gov/, and "United States General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder.census.gov/

Race/Ethnicity of the Massachusetts Population

The proportion of the Massachusetts population that is white is much higher than the national average (85.0% versus 77.1%). However, there has been an increase in the state's minority population over the last decade.

Race*	Percent (%)
White	85.0
Black or African American	6.1
American Indian and Alaska Native	0.3
Asian	4.6
Native Hawaiian and Other Pacific Islander	0.1
Persons Reporting Other	3.9
Persons Reporting Two or More Races	1.2

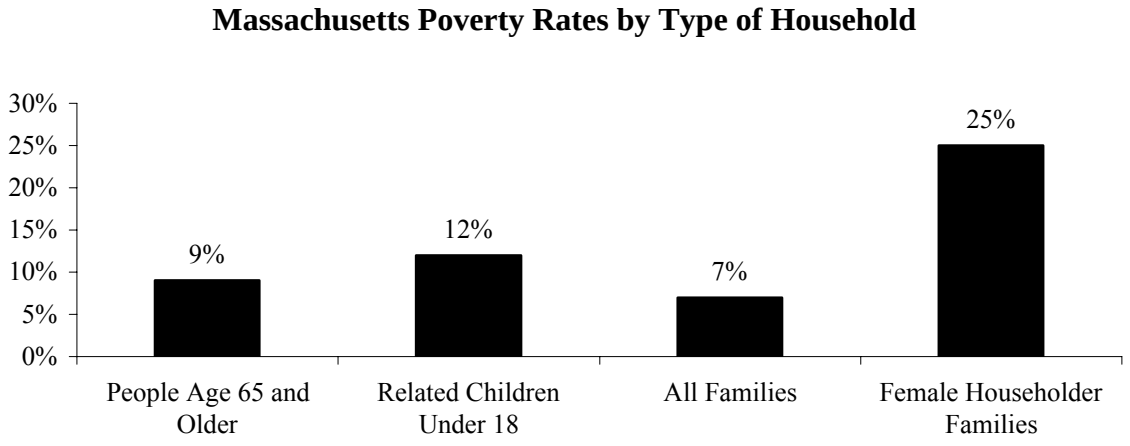
**Hispanics are included in the above figures as they may be of any race.*

Hispanic or Latino	Percent (%)
Hispanic or Latino of Any Race	7.7
Not Hispanic or Latino	92.3

Source: "Massachusetts General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder.census.gov/, and "United States General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder.census.gov/

Percent of the Massachusetts Population Living in Poverty (<100% FPL)

Approximately 10% of the state's population lives in poverty, with the greatest number residing in female householder families (no spouse present).



Source: "Massachusetts General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder.census.gov/, and "United States General Demographic Characteristics: 2004 Multi-Year Profile – Demographic," U.S. Census Bureau, http://factfinder.census.gov/

Number and Percentage of Uninsured
In 2004, 7.4% of Massachusetts residents were uninsured, up 10% from 6.7% in 2002. The rate of uninsurance, excluding the elderly, increased 12% from 7.4% in 2002 to 8.3% in 2004.

Household Income (%FPL)	% of the Uninsured
≤ 200	44.1%
> 200	55.9%
Total/Overall	**100.0%**

Source: Survey of Health Insurance Status of Massachusetts Residents, Massachusetts Division of Health Care Finance and Policy, 2004, http://mass.gov/Eeohhs2/docs/dhcfp/pdf/ins_status_04_chartbook.pdf

Primary Industries in Massachusetts

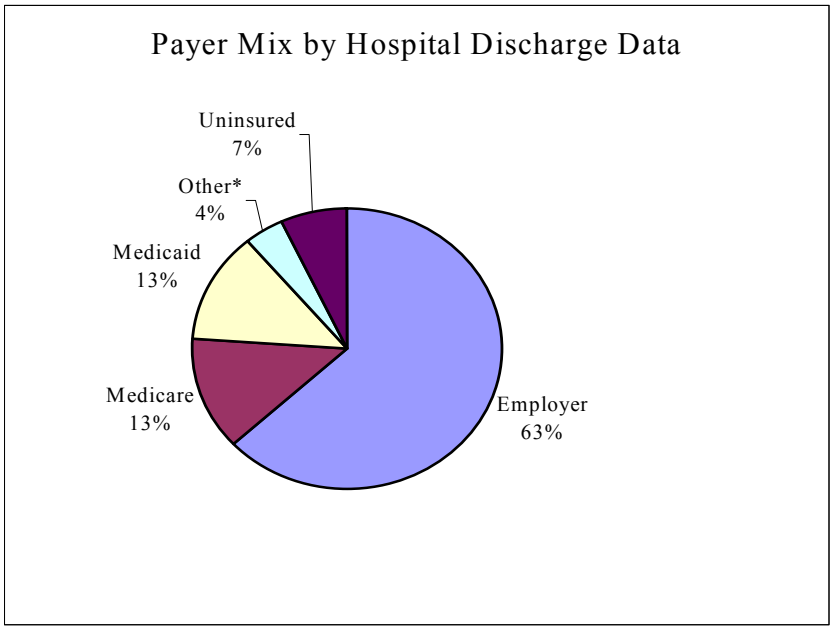
Industry	Number of Firms	Number of Employees
Professional, Scientific, & Technical Services	21,906	239,737
Retail Trade	25,761	359,149
Construction	17,107	165,596
Other Services (except public administration)	13,823	91,122
Health Care and Social Assistance	17,348	476,297
Accommodation and Food Service	15,175	241,451
Wholesale Trade	9,333	154,939
Manufacturing	8,859	349,184
Administrative and support and waste management and remediation services	9,393	208,118

Source: "2002 Economic Census," U.S. Census Bureau, http://factfinder.census.gov/

Percent of Massachusetts Employers Offering Coverage
According to DHCFP's 2005 Massachusetts employer health insurance survey, 70% of Massachusetts employers offer health insurance. The percent of employers offering coverage varies by establishment size; 97% of establishments with more than 50 employees offer insurance versus only 68% of establishments with 2 to 50 employees.

Percent of Self-Insured (Self-Funded) Firms in Massachusetts
According to DHCFP's 2005 Massachusetts employer health insurance survey, 12.8% of the employers that offer coverage have at least one self-insured health plan.

Payer Mix

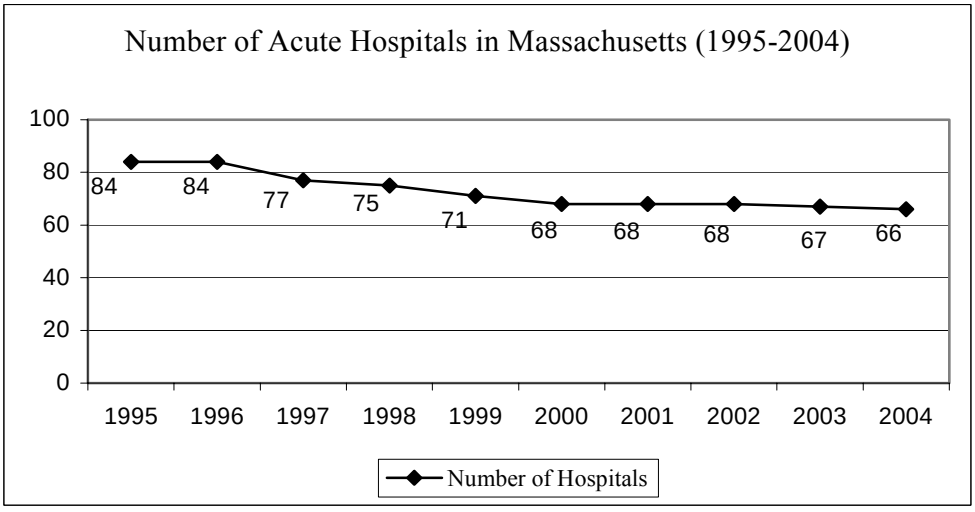


**Other—Includes payments made by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).*

Source: "2005 Massachusetts Employer Health Insurance Survey," Massachusetts Division of Health Care Finance and Policy, 2005, mass.gov/Eeohhs2/docs/dhcfp/pdf/survey/er_2005_core_results.pdf

Provider Competition

Due to closings, conversions, and mergers, there was a decrease in the number of acute care hospitals in Massachusetts from 1995 to 2004. In addition, the number of operating beds fell 2%, from 16,562 in 2000 to 16,190 in 2004.



Source: Massachusetts Department of Public Health, Division of Health Care Quality.

Massachusetts Insurance Market Reforms
There have been a number of significant reforms made to the Massachusetts insurance market over the past decade. Most notably were the changes that occurred in the small group health insurance market and the non-group (individual) market. The reforms sought to improve access to health care insurance.

Prior to 1991, few carriers offered coverage to small groups, coverage was medically underwritten, and it tended to have long waiting periods and pre-existing condition limitations or exclusions.

In 1991 and 1996, Massachusetts legislators and the governor approved significant reforms for regulating the small group market. In many regards, the laws go beyond the national protections established by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Massachusetts insurance reforms expanded the definition of a small group to include businesses with between 1 (self-employed) and 50 employees and required all carriers who elected to remain in the market to offer products on an equal basis to all small groups, without medical underwriting.

The passage of Chapter 297 of the Acts of 1996 created "the non-group law" (M.G.L. c. 176M), significantly reforming the non-group market in Massachusetts. Subsequent amendments to the law were recently enacted with the passage of Chapter 140 of the Acts of 2000. Carriers who participate in the small group market (1 to 50 employees) must offer a guaranteed issue non-group product on an equal basis to all eligible individuals.

Eligibility for Existing Coverage Programs
MassHealth (the Massachusetts Medicaid program), which is managed by the Division of Medical Assistance, pays or subsidizes the health insurance premiums for certain low- and medium-income residents of the Commonwealth who are "under age 65 and who are not living in nursing homes or other long-term care facilities. These include: families with children under age 19, children under age 19, pregnant women, people out of work for a long time, disabled people, adults who work for a qualified employer, and people who are HIV positive." Other individuals and families may qualify for benefits based on income and life situation.

Use of Federal Waivers
Massachusetts implemented its 1115 demonstration waiver in July of 1997. The 1115 waiver in combination with the State Children's Health Insurance Program (SCHIP) has enabled Massachusetts to simplify and streamline its eligibility process. In addition, the Commonwealth has been able to expand coverage to the following populations: children with incomes up to 200% of the FPL, parents with incomes up to 133% of the FPL, and long-term unemployed adults with incomes up to 133% of the FPL. Disabled individuals, regardless of income (based on a sliding scale premium), adults with incomes up to 200% of the FPL working for participating small employers through the Insurance Partnership, and HIV-positive individuals with income up to 200% of FPL also qualify under the 1115 demonstration waiver.

APPENDIX II

Links to Research Findings and Methodologies

For a comprehensive listing of and access to DHCFP's publications that either informed or grew out of this grant, please see www.mass.gov/dhcfp and click on Policy Analysis on the left side of the page. Click on Health Insurance to find reports on both the Household and Employer Health Insurance Surveys. For information and analysis on the Uncompensated Care Pool, click on that from the DHCFP home page.

APPENDIX III

Small Employers that Do Not Offer Health Insurance

Introduction
Results of the Massachusetts DHCFP's 2002 health insurance survey indicate that the majority (60%) of all Massachusetts residents obtain health insurance coverage through their employers. To find out more about this important source of coverage, the DHCFP also conducts a biennial survey of Massachusetts employers. Results of this survey indicate that small employers are less likely than large employers to offer coverage. The purpose of this project was to gather information from very small employers (ten or fewer employees) who do not offer coverage about whether, and if so how, their employees obtain health care coverage from other sources. We also assessed small employer willingness to participate in lower cost health insurance options. Information gathered from respondents included:

- Employer knowledge about employee coverage from other sources
- Reasons employers do not offer coverage
- Options available to the employer for offering health insurance
- Impact of health insurance coverage on hiring or other business practices

Methods
Respondents to the 2003 employer survey were asked if they would be willing to be contacted again to provide additional information about their company and their experiences with health insurance. We obtained a listing of all Massachusetts employers with fewer than ten employees who responded to the survey, reported that they did not offer health insurance, and agreed to be contacted following completion of the employer survey. We telephoned all 66 of the employers on this list in order to ask that they complete a telephone interview about their decisions related to health insurance coverage. We were able to complete interviews with 9 of these employers. An additional interview was completed with another small employer who provides health insurance coverage through his construction business.

Employers were asked a series of questions from a semi-structured interview protocol (see Appendix A for Interview Guide). Interviews were shaped by employer responses, using probes to understand specific employer responses as necessary.

Results
Written summaries of each interview are attached in Appendix B. Key results are highlighted here. The employers who agreed to be interviewed worked in a variety of fields, including:

- Insurance
- Trucking
- Software Development

- Restaurant - Sub Shop
- Auto Repair
- Psychologist Office
- Construction
- Musical Instruments
- Investor Consultation

Employees often have health insurance coverage: Five of the ten employers we interviewed have at least one uninsured employee. For the majority of the employers, however, their employees were not necessarily uninsured even though the respondent does not offer health care coverage. For seven of the employers, at least one employee had health care coverage through a spousal family policy. Two additional employers have employees who obtain health insurance coverage through the public health insurance program MassHealth.

Strategies for coverage: Although employees are often covered under another health insurance plan, employers have also developed other strategies to try to make sure their employees have health insurance, even though they do not offer coverage themselves. One employer reported that he will occasionally pay employee health care costs if he perceives that the employee cannot cover the costs him/herself. Another employer splits the costs of a policy for a particular family with the employee's spouse's employer. Employers also indicated they were fairly sophisticated in finding low cost or free preventive services such as mammograms or pap smears. They also pay for primary care services out of pocket; however respondents also indicated they put off seeking some types of care. One respondent has created a $10,000 "slush fund," which is approximately the cost of health insurance premiums for one year. This slush fund pays for primary and preventive care, and has so far been adequate to meet the couple's health care needs. If this respondent needs hospitalization, she intends to negotiate the price of the hospital stay up front.

Employers cite costs as the main reason they do not offer coverage: Half of the employers reported that they previously offered health insurance, but rising costs made it impossible for the business to continue sponsoring coverage. Employers stopped offering coverage because they felt they did not use the full value of the benefits they paid for in their premiums. In the words of one respondent: "health insurance costs are annihilating us." In addition, six of the respondents indicated that if given a choice, employees would prefer to receive the costs of coverage as a salary increase rather than as a health insurance benefit. According to one employer "employees do not understand the value of health insurance." The personal situation of employers often affects their decision making about whether to offer health benefits. For example, three respondents offered health insurance to their employees until their own children became old enough to not be covered under their family policy. The employers then stopped offering health care coverage because they felt it was important to have insurance for their children but less important for them to have it for themselves as adults. Two employers did not offer coverage because they were covered under their spouse's policy through another firm. However, due to one death and one divorce, the business owners were no longer going to be covered by the spouse's policy, and both were considering offering company sponsored coverage in the future.

Employers understand they are taking a risk: Although the respondents do not offer health insurance, they indicated that they understood the importance of health care coverage, and that they are taking a risk by not offering it. In the words of one respondent: "If I have an accident I will be in big trouble." However, the financial risk of offering coverage is greater than the risk of not having health insurance. And as one respondent indicated: "so far I am healthy."

Effect on the business: Respondents indicated that in certain industries, such as trucking, construction or auto repair, it is not the industry standard to offer health insurance. Therefore, the decision to not offer health insurance has little effect on their business. One of these respondents indicated that they have little difficulty hiring single men as employees, but that employees "leave when they have kids" since they look for employment that offers health benefits for their children. As described above, some employees do not understand the value of health insurance and would rather have the value of a health care policy in salary rather than health care coverage as a benefit. One respondent indicated that they have not pushed for company growth since they feel they should offer health care coverage if they hire additional employees.

Ideas about other health insurance options: Respondents were sophisticated in offering ideas about affordable alternative health insurance options. One employer indicated that "the private sector has been scared out of Massachusetts by mandated benefits. There used to be so-called 80/20 plans but these carriers have all left Massachusetts." He would be interested in a low cost indemnity insurance plan if it became available again. Another respondent indicated that she would like to see "a tax write-off for people who take care of themselves." Six of the respondents indicated that they would seriously consider purchasing a bare bones insurance policy that costs roughly $100 per month.

Summary

Among this sample of small employers who do not offer health insurance, interviews revealed that employees often have coverage through other sources. Employers were knowledgeable about issues related to health insurance and understand they are taking a risk by not having health insurance. In addition, employers report that not offering health insurance does impact some business decisions. However, the cost of purchasing coverage outweighs these risks. An interesting result is that small employers are creative in finding solutions to the problem of employee health care coverage. Strategies that employers use to obtain coverage for their employees are as varied as their values, job sector, health and work status, and income. These results suggest that there is not one solution to the problem of how to extend health care coverage to employees of small businesses.

APPENDIX A
Focus Group/Interview Guide
Employers Not Offering Health Insurance

1. Contact Information
   - Name of Contact Person
   - Name of Employer
   - Address
   - Telephone
   - Email
   - Position in company – Owner vs. employee
   - Family owned company? If so how many employees are family members?

2. How many individuals does your company employ at this site? Does this company have other sites? If so, how many? How many company employees are there all together?

3. What type of work does your company do (If not evident from name)? What is the educational/skill level of your employees?

4. Do you (the owner) have health insurance from another source such as a public program or spouse? What about your employees?

5. If you know they don't, where do they obtain care when they need it? Do you know if they apply for free care or pay out of pocket? What about for yourself?

6. Do you know whether your employees want health insurance from you?

7. Has your company ever offered health insurance? If yes, why did you stop offering health insurance?

8. If no, have you ever considered offering health insurance? Why did you decide not to offer coverage?

9. What options are available to you for offering health insurance currently – groups you could buy through? Individual coverage?

10. Could you afford to pay $100/month for a package that offers your employees the following benefits?
    - Hospital deductible of $250 per stay
    - 15 MH visits per year
    - 15 OP MD visits

- Limited pharmacy (3 prescriptions per month, 50% copayment)
- 20% co insurance for all OP services
- Cap OOP expenses at 5% of income

(limited physician and pharmacy coverage)

10. Do you think your currently uninsured employees could/would pay some of the premium and some cost sharing for this basic health insurance package? (that is, not those currently covered by a spouse.)

11. How does health insurance affect your hiring practices? How do you analyze the trade-offs between the expense and benefits of offering health insurance? Do you see any benefit to offering health insurance? What would the effect on your business be if you were required to pay a per employee fee of let's say $100 earmarked to a health insurance fund?

12. Have you had experiences with your business or employees that have affected your point of view on the issue of whether to offer health insurance? For example, have you had an employee whose personal situation made you decide not to offer coverage?

APPENDIX B
Interview Results

1. Auto Repair Company: Worcester County

A husband and wife own this auto repair business. They have five employees: the couple, their adult son, a fulltime male and a part-time male. The couple buys their own non-group policy, which they purchase independently (not through the company.) The adult son buys his own non-group policy. The full time worker is covered under his wife's employer's policy; the wife went back to work to get health insurance for the family. The part-time worker is covered under his other employer's policy.

"Health insurance costs are annihilating us." Their family policy costs $12,000 per year. There is a $2400 deductible and $350 copayment for an ER visit. The son's individual policy costs $250 per month.

The company did offer health insurance at one time. A decade ago, they covered 75% of the premium costs, and over time they cut back to 50%, and then to 25% and then finally stopped offering coverage all together.

The lack of health insurance hurts their hiring practices. Many of the people who work in the auto repair industry are young men who are not especially well educated. If they get married and have children, they need health insurance. Often their wife has to work if they are going to have access to affordable coverage.

The business is difficult, in that there is high turnover and absenteeism, and it is hard to find and retain good workers.

If there were a low cost, low benefit health insurance option they would "grab it."

2. Insurance Agency: Essex County

The respondent has owned his own insurance agency for more than a decade, after having worked for years for another, larger insurance agency. He now has 3 full time employees including himself. Two of the employees (including the owner) are covered under spousal coverage and one is uninsured. The uninsured employee is a 29-year-old healthy male.

The owner is covered under his wife's COBRA coverage. He pays $925 a quarter for coverage that includes an annual physical, $12 copayment for primary and preventive care, and $10 copayment for dental care.

He is beginning to investigate coverage options for the future. He expects that he will end up covering administrative costs of health insurance through the business.

The respondent believes that the private health insurance sector has been "scared out of Massachusetts by mandated benefits." There used to be so-called 80/20 plans, but these carriers have all left Massachusetts. He remembers the days when individuals could purchase "catastrophic coverage." He said that he would be interested in a policy like this going forward. He believes that health insurers get a "bad rap." The problem is that health care costs are rising so rapidly that it is difficult for carriers to keep up.

He is researching coverage now because he wants to get the new coverage lined up before his COBRA coverage expires. He does not want to be caught with any pre-existing condition problems. He also wants to have time for his business to plan to absorb this large expense.

Some of the options he is investigating include a group plan begin offered by a professional association of which he is a member. He is not going to enroll in a non-group individual plan since he is not willing to "give up the things" he will "have to give up to pay for it." He wants to be able to offer a good plan and he thinks the best strategy is to offer the coverage through the business, since the business can cover the expense and the price may be less.

He said that one problem is that employees do not really value health insurance the way they value cash. He gave an example of an employee that he had in his previous firm. The firm decided to increase the employer contribution for health insurance coverage to 100% from 50%, and to give employees a modest rise in salary. The employee nearly left the firm because she was so insulted by the offer. She wanted to have the salary increase instead.

This problem is squeezing middle class families. Families who save a lump sum with the idea that they can use the savings to pay for health care costs do not really understand how much health care can really cost. Also, young people do not understand that they may need health care coverage for unforeseen illness.

3. Psychologist Office: Berkshire County

This is a small company that employs psychotherapists. The company employs one full time and one part-time therapist, in addition to the owner, and the business manager. There are no other locations or employees. The business is not a family owned company.

All employees, except the business manager, have health insurance through their spouse. The business manager pays for health care when she needs it, but usually she just does not go to the doctor.

The company has discussed whether to get health insurance in the past, and the owner knows that the business manager would like to have health care coverage. According to the manager, health insurance "is not something they think about." The owners are "wrapped up in the business." Health insurance is "too much to think about." "They don't get it." The business manager has decided to leave the company to look for a job that has health insurance benefits.

The owners will then likely subcontract out for the services that the manager provides – bookkeeping, etc.

If a low cost health insurance option were available for purchase in Massachusetts, this employer would likely not buy into it. It is too difficult to set aside the money for health care coverage when there are so many other expenses to cover. The cost of individual coverage would be $250/month if the manager were to purchase coverage for herself, and that amount gets "pushed to the side" when she pays her bills each month. She would rather work at an employer where the premium costs are taken out of her paycheck before she sees the money.

The company's practices may be impacted in the future because one of the principals is getting divorced, and will no longer be covered by the spouse's policy.

4. Sub Shop: Middlesex County

A husband and wife own this small family business. They have one employee – a sister in law - who is covered under another policy.

The couple has two children – one who has just graduated from college, is now working and is covered under an employer based policy. The other child is in college and is covered under a college-sponsored plan.

She previously purchased health care coverage through an indemnity plan. However, when they went to the hospital, expecting that they would be covered, they found they still had high expenses. "They [the insurance company] pay nothing."

They decided health care coverage was not worth the cost of the plan when it did not meet their needs. So they stopped buying the plan.

Since that time, her husband has gone on disability and is covered through "the government." So, the wife is the only member of the family without health care coverage. She does go to the doctor, and pays out of pocket for "small things" like tests and mammograms. "So far I am healthy." She just hopes that she remains healthy and doesn't need more health care. She does not know what she will do if she needs more health care.

She would be interested in learning more about a low cost insurance plan. She could afford about $100 per month for coverage for herself. She probably would not be able to afford more than that, and her decision about how much to spend for coverage would be dependent on how well the business is doing. Right now, the business is not doing very well.

5. High Tech Consulting: Worcester County

This is a two person family owned high tech company: One person only works at the company and her spouse works part-time at the company and full time at another location. The family has health insurance coverage through the spouse's employer.

They have discussed the possibility of expanding the company and hiring one or more employees. A consideration in this decision making process is the need to offer health insurance. Also, if the spouse stopped working at the other position, they would need to deal with the issue of health insurance – for themselves.

Issues of health insurance coverage have definitely been a factor in their decision to not expand yet.

They would consider a low cost low benefit plan if they do need to offer their own coverage to an employee.

6. Trucking Company: Worcester County

A husband and wife who have been uninsured for the last four years own this trucking company. She is 53 and he is 50. Both are in good health, although he has asthma.

The trucking company has only these two family members as employees. They established the company 5 years ago, and were covered under a health insurance policy for the first year they owned the company. They had set aside $10,000 to cover the costs of health insurance. Within one year, they had spent $9,000 of this "slush fund" on premiums. During the same time period, she and her husband had been to the doctor one time each.

At this time, they decided that they would never "get ahead" in their business because of the costs of health insurance. They had $1,000 left in their fund, and they felt they had overpaid for what they had gotten in return.

She called her doctor, a family practice physician, and asked "How much would it cost to see you if I really need you?" The price of a routine visit was $35. So, they decided to drop their insurance. The couple now has a yearly physical each – the costs are about $125 each. She recently had a colonoscopy. The cost of the specialist was $85, and she paid on a sliding fee scale at the hospital where the procedure was done. She also researched where she could get a mammogram, and found a hospital that offered the test for $50. So, she has a mammogram every year. Their prescription costs are $21/month for her and $18 four times a year for him.

The family has a slush fund for health care costs, and pays for primary care costs out of this fund. She knows other businesses that follow this model of setting aside some funds to cover health emergencies. If you need to be hospitalized, you can negotiate with the hospital about the price of the stay, given the funds you have available. If you pay up front for insurance for this type of hospitalization, your business will never get ahead.

She sees herself as a sophisticated consumer. She and her husband try to take care of themselves, eat well, etc. She sees a chiropractor and practices her own type of holistic medicine. She would like to see a tax write-off for people who take care of themselves and have low health care costs.

She has had extensive experiences with the health care system because her second child has special health care needs. The daughter is now 24. She was covered under their family coverage until she was 19. This was a policy that was offered through their previous employer (i.e. before they established their own company.) The daughter is pretty functional, although she does not live independently. She does work and she has taken some college level classes. The daughter is now covered by MassHealth through SSI.

They have thought of hiring additional staff. However, their business is high risk, and it is hard to find people who will maintain the quality of work that they want to offer. If they were to hire someone, they would pay the person cash, with no benefits. This is the standard in the industry.

She would think about enrolling in a lower cost, lower benefit health insurance plan. The decision would be made by weighing how much the total cost is, and how much she is likely to spend on health care in a given year.

7. Musical Instrument Repair: Worcester County

This small company employs the owner and one other person. The owner has just recently enrolled in MassHealth and his employee is covered by his wife's policy.

He has never offered health insurance through his company. The cost has been prohibitive. He would like to be able to offer health insurance, and he has investigated this possibility several times. Over the long term he would like to be able to offer coverage, but the pricing just has made it impossible so far.

He does not have a lot of employee turnover in his company, because the work is so specialized.

He is currently 42 years old and has not had a great need for health care. Although he reported that he is on MassHealth, before he became eligible for MassHealth, when he needed health care, he paid for it himself.

He feels that he saved a lot of money by not having health insurance. He understands that he was taking a risk. "If I had an accident I would be in big trouble."

8. Construction: Worcester County

This construction company employs at various times from 3 to 5 people. Two of the employees are family members, but the company is not family owned.

The owner does not currently offer health insurance to his employees. He is covered through a family policy through his wife's employer. His employees often obtain coverage through their wives, and he suggested that many of his employee's wives have obtained part-time jobs just to get health care coverage.

The cost of health insurance is prohibitive, at $300 / month for individual coverage and at least $500/month for family coverage. When these costs are added to worker's compensation, taxes and other expenses, it is not worth it to pay for health care coverage.

He does have employees who are currently uninsured. If these employees need expensive health care, he pays for their health care out of pocket. This does not happen too often, but he has covered these costs in the past.

Also, he has offered his employees health care coverage in the past. He has offered to allow employees to get insurance through the company – the company would pay a minimal amount (one or two dollars), and the employees would pay the rest. But employees would rather have the salary.

He recommends that a health insurance pool be established for construction companies, in which construction companies pay into a fund to purchase group health insurance. He would prefer this type of model to a low cost bare benefit package.

9. Investor Consultation: Plymouth County

The respondent is the firm's only employee. He previously worked at a bank for 35 years. When the bank was taken over a few years ago, he was offered a severance package and decided to take it. The severance arrangement included health insurance coverage.

So, he was covered by his ongoing health care policy when he left the bank. The package expired last July. In the meantime, he had turned 65 and thus became Medicare eligible. Upon expiration of the severance package, he purchased a supplemental Medicare policy to remain fully covered.

He would not "go without health insurance." If he did not have the severance package he would have "reached out" to purchase coverage. He thinks that a scaled down health care coverage package would be attractive to small business owners, if they needed/wanted health care coverage.

He believes that small businesses have a variety of different strategies for accessing coverage, including spousal coverage.

10. Construction Company that offers coverage: Middlesex County

This construction company has about 10 employees. In the past, the owner has purchased health and dental insurance through a trade organization. Many trade organizations offer this service, such as The Builder's Association of Greater Boston or The National Association of Remodeling Industry. These plans are not great plans since they do not offer extensive coverage. And, his employees mostly need emergency coverage, which is not usually well covered in these types of plans.

He eventually started to look into other policies. He learned that with his current health plan, you are considered a group plan when you have ten employees, and so he switched to this plan. The company pays 50% of the premium and the employee has 50% deducted from his/her paycheck. Right now, family coverage is $1020/month and individual coverage is about $250. He thinks individual coverage is a good deal compared to family coverage – just look at the price differences. The health plan has suggested to him that his employees be asked to pay at least 50% of the premium, and also asks that all employees sign up for coverage.

He offers health coverage as a separate benefit. He does not want to get into negotiating pay levels based on how much health care coverage an employee wants, in part because of the difference in costs between individual coverage and family coverage. He does not want to have to change salaries based on marriage and divorce. So – he has a separate account to pay the 50% of the premium, and his employees can take it or leave it. Most of his employees take coverage, and this amounts to about 10-12% of his payroll. His health insurance costs have been stable, even when he had one employee with leukemia – this employee's costs were $2M for treatment of the leukemia. At that time the company's premium did not go up as a result. However, this year, premium costs went up 25%, but he believes currently, everyone is adapting to these huge cost increases.

He has had to learn all this information and figure out strategies around health care coverage on his own. This is a complicated system and there is a lot to learn. He is creative with his employees. For example, for one employee, he pays 50% of the premium and the employee's wife's employer pays the other 50%.

The idea of a bare bones plan will not work. People will not sign up for it. It would be better to mandate that employers offer coverage, and focus on keeping health care costs down. Most small builders do not offer coverage because the work is low cost and they cannot afford coverage. These companies are just getting by and there is nothing extra for health care coverage. He offers coverage because his family needs it and because he thinks it is the responsible thing to do as an employer. There is a trend toward subcontracting with smaller companies for specialized services rather than hiring additional staff. But, he thinks he retains employees longer because he offers coverage. Single guys make different decisions than people who have kids. If you have employees with kids, you might as well offer coverage.

Another major issue for him has been figuring out how to manage the administration of health care coverage. When he offered an indemnity plan, he had to do the management of the plan himself – i.e. checking claims, etc. With Tufts, he does not see any paperwork, and the plan offers a large provider network.