

The 2006 Massachusetts Health Reform Act:

Can a Politically and Economically Feasible Health Care Plan
Establish a Just Distribution of Health Care for the Poor?

Mickey Schmitt

Poverty Seminar
Professor Beckley

Washington and Lee University

1. Essay Focus

This essay considers whether the Massachusetts Health Reform Act (“Massachusetts Act” or “Act”) can solve the problem of health insurance for the poor and near poor? In coming to a conclusion, this essay will focus on Constitutional challenges one could bring against the Massachusetts Act and address issues of political and financial feasibility and adequacy.

2. No Insurance, Underinsurance, and Poverty

Health insurance is one way for families and individuals to promote health and protect themselves from exceptional costs often associated with medical emergencies or illnesses.¹ Yet, approximately 46 million Americans were without health insurance coverage for at least some period in 2004.² The reason is the high cost of health insurance.³ Individuals without health insurance “receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than insured individuals.”⁴ People living at or below the poverty line, over 1/3 of which are uninsured,⁵ have more chronic

¹ Committee on Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations*, p. 48 (National Academies Press 2004)

² Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, p. 20, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Government Printing Office, Washington D.C., 2006

³ The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts About Americans without Health Insurance*, Nov. 2004

⁴ Nchc.org, National Coalition on Healthcare, *Facts on Health Insurance Coverage*, (<http://www.nchc.org/facts/coverage.shtml>)

⁵ Kaiser Commission Report, *The Uninsured and Their Access to Healthcare*, September 2005, p. 1

illnesses and more frequent and severe disease complications.⁶ As a result, these individuals are more likely to incur medical expenses and are faced with severe financial repercussions for both themselves and their families.⁷ For example, families without health insurance are more likely than those with insurance to delay payments and risk being reported to collection agencies, use up all or most of their savings as a result of medical expenses,⁸ or declare bankruptcy.⁹

The problem is not limited to the uninsured. An estimated 16 million Americans are going without needed medical services because of inadequate coverage.¹⁰ Even those individuals with health insurance are not guaranteed financial protection from the high cost of health care.¹¹ A report funded by the Kaiser foundation found that one in six adults who were privately insured reported having substantial problems paying medical bills because of the high cost of premiums, deductibles and co-payments.¹² These “underinsured” Americans faced financial drains that affected their decisions on when and whether to seek health care.¹³ In this way, their situations are not much different from those that are uninsured.

⁶ Steven H. Woolf, Robert E. Johnson, and H. Jack Geiger, p. 332, *The Rising Prevalence of Severe Poverty in America: A Growing Threat to Public Health*, American Journal of Preventative Medicine, Vol. 31., Issue 4 (Oct. 2006)

⁷ Committee on Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations*, p. 48 (National Academies Press 2004)

⁸ Kkf.org, The Kaiser Family Foundation (<http://www.kff.org/spotlight/uninsured/index.cfm>)

⁹ Committee on Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations*, p. 50 (National Academies Press 2004)

¹⁰ Chicagotribune.com, (<http://www.chicagotribune.com/features/lifestyle/health/chi-060103insurance2-story,1,4544168.story?coll=chi-health-utl>); and Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, *Insured But Not Protected: How Many Adults Are Underinsured?* Health Affairs, Web Exclusive (June 2005)

¹¹ Catherine Hoffman, Diane Rowland, and Elizabeth C. Hamel, The Kaiser Commission on Medicaid and the Uninsured, p. 1, *Medical Debt and Access to Health Care*. Washington, D.C. (Sept. 2005)

¹² *Id.*

¹³ *Id.*

The problem associated with lack of health care coverage is not confined to the less affluent, according to Henry E. Simmons, President of the National Coalition of Health Care.¹⁴ Mr. Simmons believes the latest census data shows an increasing number of middle class Americans¹⁵ who are unable to afford health insurance.¹⁶ One problem is the high cost of private insurance, which even for families with annual incomes of more than \$50,000 can be a substantial financial burden. More commonly, the problem can be traced to erosion in employer-based insurance due to the rising cost to employers in providing coverage for their employees.¹⁷ A majority of Americans receive health insurance coverage through their employers or through their spouses' employers.¹⁸ Yet, more and more firms are refusing to provide employer-sponsored health programs. In 2006, 61% of employers offered health insurance or other benefits to at least some of their employees; this is down from 69 percent in 2000.¹⁹ Since 2000, employment-based health insurance premiums have increased 87 percent and workers are now paying \$1,094 more in premiums annually for family coverage, an increase of about 143 percent.²⁰ Thus, even if employees are offered employer-sponsored insurance, many of them cannot afford to participate.

For all of these families, the insured and uninsured, poor and middle class, the financial demands created by unexpected medical bills may force them into poverty or

¹⁴Nchc.org, (http://www.nchc.org/news/media_statements/Media%202006/Uninsured%20numbers.pdf)

¹⁵ Households with annual incomes of more than \$50,000

¹⁶ *Id.*

¹⁷ Nchc.org, National Coalition on Healthcare, *Facts on the Cost of Health Care*, (<http://www.nchc.org/facts/cost.shtml>)

¹⁸ The Henry J. Kaiser Family Foundation, *The Uninsured, A Primer*, (Oct. 2006), found at (<http://www.kff.org/uninsured/7451.cfm>)

¹⁹ *Id.*

²⁰ The Henry J. Kaiser Family Foundation. *Employee Health Benefits: 2006 Annual Survey*, (Sept. 2006), found at (<http://www.kff.org/insurance/7315/index.cfm>)

prevent escape from the clutches of poverty. The Massachusetts Act addresses this problem with the promise of health insurance for every Massachusetts resident.²¹

3. An Overview of the Massachusetts 2006 Health Reform Statute

Former Massachusetts Governor Mitt Romney implemented sweeping state health insurance reforms in April 2006²² with the goal of providing health insurance for virtually every citizen within three years.²³ This plan is being financed by individuals, employers, tax payers, and government subsidy. Already this effort is being touted as a “national model,”²⁴ partly because it is the product of bipartisan compromise. Of particular interest is the support the Act has garnered from a diverse mix of institutional players—a mix that might just lead to the Act’s success.

The Impetus for Reform

The Massachusetts Act was designed to restrain rising health care costs and change how Massachusetts provides health care for those who receive it at the taxpayer’s expense.²⁵ “People who don’t have insurance nonetheless receive health care. And it’s

²¹ See *Generally*, M. G. L., ch. 111M (2007)

²² Amended with technical corrections in October 2006

²³ Npr.org, (<http://www.npr.org/templates/story/story.php?storyId=5330854>)

²⁴ Press Release, Gov. Arnold Schwarzenegger, *Gov. Schwarzenegger Tackles California's Broken Health Care System, Proposes Comprehensive Plan to Help All Californians* (Jan. 8, 2007), GAAS:009:07; and Mittromney.com, *Extending Health Insurance to All Americans*, (http://www.mittromney.com/Issue-Watch/Health_Care)

²⁵ Mitt Romney, *The Boston Globe*, *My Plan for Massachusetts Health Reform*, Nov. 21, 2004. (http://www.boston.com/news/nation/articles/2004/11/21/my_plan_for_massachusetts_health_insurance_reform/?page=full)

expensive.”²⁶ What Mr. Romney was talking about when he made this statement was his State’s system of providing “free” care to the uninsured.²⁷ Free Care, or the Uncompensated Care Pool (UCP), is a health care “safety net” to make sure that all low income residents have access to emergency care, funded by companies – many of which already provide insurance for their own employees.²⁸ “We’re spending a billion dollars giving health care to people who don’t have insurance,” Romney says. “And my question was: Could we take that billion dollars and help the poor purchase insurance? Let them pay what they can afford. We’ll subsidize what they can’t.”²⁹ Whether the insurance that Mr. Romney mentions is adequate or even affordable will be addressed later.

The Massachusetts Act contains several prominent features that attempt to accomplish the goal of universal health care. First, the individual and group insurance markets were merged into the Commonwealth Health Insurance Connector Authority (“Connector”), which was established to act as a sort of a clearinghouse for insurance plans and payments. The Connector links individuals, as well as employers with 50 or fewer employees, with approved health insurance products provided by one of the seven approved insurance companies offered to provide coverage packages.³⁰ Second, there is an “individual mandate” that every resident have insurance by July 2007, so long as it is “deemed affordable.”³¹ ³² For those individuals who cannot afford health insurance

²⁶ Npr.org, (<http://www.npr.org/templates/story/story.php?storyId=5330854>)

²⁷ *Id.*

²⁸ Massresources.org,

(<http://www.massresources.org/pages.cfm?contentID=50&pageID=13&Subpages=yes>)

²⁹ Npr.org (<http://www.npr.org/templates/story/story.php?storyId=5330854>)

³⁰ M.G.L., ch. 176Q (2006)

³¹ 2006 Mass. Acts ch. 58, § 12

³² Beginning in 2008, individuals who don't have insurance will be subject to a penalty equal to half the cost of health insurance. Last year, coverage for an individual ran about \$4,000 a year, and nearly \$11,000 for a family, according to the Kaiser Family Foundation.

(http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm)

coverage,³³ a subsidized Commonwealth Care Health Insurance Program (C-CHIP), also administered through the Connector, provides private insurance health plans. How this is accomplished is discussed below.

There is also an “employer mandate” that applies to employers with more than 10 employees. These employers must set up and maintain a “cafeteria” plan.³⁴ Cafeteria plans, also known as Section 125 plans (because of the section of the IRS code that covers them), allow employees to use pretax dollars to purchase health coverage.³⁵ Employers that are required to provide cafeteria plans and fail to do so could be assessed a “free-rider” surcharge.³⁶ The surcharge will be assessed to any employer that does not offer a cafeteria plan, and whose workers use medical services that are paid by the Uncompensated Care Pool. The surcharge is not triggered unless a firm’s employees require state-funded services in excess of \$50,000.³⁷ The amount of the surcharge will be between 10 and 50 percent of the total amount paid by the Uncompensated Care Pool.³⁸ The free-rider surcharge is deposited in the State’s Free Care Pool.

Mandated firms must also offer health benefits and contribute a “fair and reasonable” amount³⁹ toward employee health insurance premiums. A “fair and reasonable” contribution has been defined by the state as having either 25 percent of employees enrolled in a group health plan, or contributing 33 percent of the total premiums.⁴⁰ If a firm fails to make a “fair and reasonable” contribution, it will be

³³ And meet certain guidelines

³⁴ 2006 Mass. Acts ch. 151F, § 2

³⁵ 26 U.S.C. 125

³⁶ If employees or dependants use more than three health care services in a year or a firm’s workers and dependants use at least five, and total costs exceed \$50,000

³⁷ 114.5 CMR 17.00 (2006)

³⁸ *Id.*

³⁹ Determined by the state Division of Health Care and Finance and Policy

⁴⁰ 114.5 CMR 16.00

required to make a Fair Share Contribution (“Contribution”) of no more than \$295 per worker per year. The Contribution was designed to equitably share the burden of funding free care among all employers.

According to a Kaiser Family Foundation survey, 97 percent of all U.S. firms contributed at least 50 percent of the total premium cost for employee health benefits, and 78 percent of all firms contributed more than 75 percent of the total premium cost.⁴¹ The Massachusetts definition of what a “fair and reasonable” contribution is clearly business friendly.

The Institutional Players

The main reason this effort is being touted as a national model is because it is supported by institutional players: the business community, hospitals and providers, and insurers. Several previous attempts at universal coverage garnered support from one or two of these groups, but few have achieved support of all three. It will be helpful to discuss how the Massachusetts Act has achieved this feat by looking at how each group will benefit.

The Business Community

Despite the “fair share” contribution and “free-rider” surcharge that will be assessed to employers that do not heed the Act’s “employer mandates,” “there's strong support in the business community for this measure,” says Michael Widmer, president of

⁴¹ The Kaiser Family Foundation And Health Research And Educational Trust, p. 2, *Employer Health Benefits – 2005 Summary of Findings* (available at kff.org)

the Massachusetts Taxpayer Foundation. “This equalizes the burden between companies who don't provide health care and those who do.”⁴²

One reason the business community has supported this reform effort is that the previous system was expensive. Health care expenses are the fastest growing cost component for employers.⁴³ In 2006, an employer’s average annual premium paid on behalf of a family of four was \$11,500.⁴⁴ The Act attempts to alleviate some of this expense for small businesses (fewer than 100 workers) by making subsidies and support available.⁴⁵ Putting quality and adequacy concerns aside for the moment, for businesses struggling to contain health insurance costs, the Massachusetts Act could mean big savings. This is the reason some analysts are saying that “big business could emerge as the force that finally brings about universal health insurance.”⁴⁶

Hospitals and Providers

Washington and Lee University

In the Commonwealth of Massachusetts, any hospital with an emergency facility must provide emergency services regardless of the patient's ability to pay.⁴⁷ Hospitals provide about \$34 billion worth of uncompensated care a year.⁴⁸ Although some of these expenses are reimbursed out of the “free care fund,” hospitals still have much to gain if the promise of universal coverage becomes reality. Under the previous system, hospitals were required to provide services to uninsured individuals in certain situations. The

⁴² Businessweek.com, (http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm)

⁴³ McKinsey and Company, The McKinsey Quarterly Chart Focus Newsletter, "Will Health Benefit Costs Eclipse Profits," (Sept. 2004)

⁴⁴ The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2006 Annual Survey (Sept. 2006) (<http://www.kff.org/insurance/7315/index.cfm>)

⁴⁵ Bluemassgroup.com, (http://bluemassgroup.typepad.com/blue_mass_group/2005/09/interview_with_.html)

⁴⁶ AARP.org, (http://www.aarp.org/bulletin/yourhealth/big_business_health_care.html) (March 2007)

⁴⁷ Mass. Gen. Laws Ann., ch. 111, 70E(k) (1979)

⁴⁸ Institute of Medicine. *Hidden Costs, Values Lost: Uninsurance in America*, The National Academies Press. (June 2003)

hospitals would absorb any costs associated with the care and apply for reimbursement out of the State's Uncompensated Care Pool. The Massachusetts Act reroutes funds from the Uncompensated Care Pool, meant for reimbursing hospitals for costs of providing uncompensated care, to subsidies aimed at helping poor Massachusetts residents purchase health insurance. The immediate impact for hospitals is an increase in cash flow as they are now able fund the costs of providing care with insurance money rather than their own.

Insurance Companies

Any feasible plan for universal health coverage almost certainly has to accommodate the insurance companies for both economic and political reasons. The Massachusetts Act appears to have reached such an accommodation. Karen Ignagni, president of America's Health Insurance Plans—the nations' largest health insurance lobby, praised the legislation as a “path-breaking attempt to apportion responsibility for expanding access among all stakeholders.”⁴⁹ She added that “policy makers left many of the details of implementing the new law to the regulatory process. We will be working with our members to help create the environment necessary for this legislation to succeed.”⁵⁰

Insurers will benefit most notably from this reform by avoiding total regulation of the insurance industry as would be necessary in a single-payer system. Insurers continue to be regulated by the state's Division of Insurance and are free to design and price

⁴⁹ Press Release, America's Health Insurance Plans, *Health Plans Will Work with Massachusetts Regulators to Help New Legislation Succeed* (April 2006)

⁵⁰ *Id.*

coverage plans under the Act.⁵¹ Some argue that insurance companies not only survived regulation but are gaining a windfall with the new system in place.

The Connector Authority issued a Request for Responses on December 6, 2006, to solicit proposals for fully insured health insurance products from commercial insurers.

⁵² Ten health insurance carriers submitted proposals in response to the Connector Authority's request.⁵³ These proposals addressed...

... four distinct types of health insurance products: (1) premier plans, with limited out-of-pocket cost sharing by enrollees; (2) value plans, with lower monthly premiums and higher out-of-pocket costs at the point of service; (3) basic plans, representing the lowest monthly premiums and highest level of member cost-sharing, which were initially established as the minimum amount of coverage needed to satisfy the individual mandate; and (4) a Young Adults Plan, which was designed as a more limited benefit to be offered solely through the Connector to individual, non-group purchasers ages 19 to 26 who did not have access to employer-sponsored insurance.⁵⁴

The insurance companies are not required to lower the costs of coverage they provide, only to provide plans that meet the above criteria. The insurance companies are still able to require higher "member cost-sharing" (or higher deductibles) in order to offset the low monthly premiums. The Massachusetts Act is not being financed by insurers; rather they are the burden of businesses, government and individuals.⁵⁵ Plus, there is an estimated 200,000 middle income individuals that lack health insurance and serve to enlarge the customer base upon which the insurance companies can draw more premiums.⁵⁶ In essence, uninsured individuals are sharing the burden of paying for

⁵¹ 2006 Mass. Acts ch. 58, § 7A

⁵² Memorandum from Jon Kingsdale, Executive Director, Commonwealth Health Insurance Connector Authority, *Staff Recommendations for Health Insurance Carriers for Commonwealth Choice* (March 2007)

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *See Generally*, 2006 Mass. Acts ch. 58

⁵⁶ Businessweek.com, (http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm)

universal coverage and this facet to the Massachusetts Act is what has all the institutional players on board.

Regardless of how the Massachusetts Act is being funded, if Massachusetts is going to prove effective as a model for universal coverage, it must first avoid the fate of Maryland's attempt at health care reform.

4. Maryland's Failed Attempt at Universal Health Coverage

In July 2006, the Fourth Circuit ruled that Maryland's Fair Share Health Care Fund Act ("Fair Share Act"), which was due to be implemented January 2007, was superseded by the Employee Retirement Income Security Act ("ERISA") and thus was without effect. Both the individual and employer mandates of the Massachusetts Act raise similar ERISA preemption issues. A brief discussion of how ERISA works and Maryland's Fair Share Act is necessary before the impact that this ruling will have on the Massachusetts Act can be addressed.

ERISA

The Employee Retirement Income Security Act was passed in 1974.⁵⁷ ERISA was enacted in order "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of

⁵⁷ 29 U.S.C. § 1001 (2000)

employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the federal courts.”⁵⁸ This was to be accomplished, in part, by reserving to federal authority the sole power to regulate the field of employee benefits plans in order to eliminate the threat of conflicting and inconsistent state and local regulation. ERISA is intended to foster the uniform structure of plan benefits, and uniformity of administrative decisions without reference to varying state laws.⁵⁹

ERISA does not require employers to provide any health insurance, but it does regulate the manner in which such health benefits plans operate.⁶⁰ With narrow exception, and within this purpose of uniformity, ERISA's preemption clause is intended to be applied in its broadest sense to foreclose any non-federal regulation of employee benefit plans.⁶¹ The federal law specifically saves from preemption those state laws that “regulate insurance”⁶²; however, all other state laws that “relate to” an employee benefit plan are superseded. The Supreme Court has developed two tests to be used in determining whether a state law is preempted by ERISA. A state law will be preempted if it:

- (1) refers to an ERISA plan, either explicitly or by requiring reference to an ERISA plan in order to comply with the state law; or
- (2) has a connection with an ERISA plan by substantially affecting its benefits, administration, or structure.⁶³

Furthermore, the federal supremacy clause of the U.S. Constitution preempts any “conflicting” state laws (including conflicting insurance regulation).⁶⁴

⁵⁸ 29 U.S.C. § 1001 (b)

⁵⁹ 120 Cong. Rec. 29197 (1974)

⁶⁰ *See Generally*, 29 U.S.C. § 1001

⁶¹ 120 Cong. Rec. 29933 (1974)

⁶² 29 U.S.C. § 1144(b)(2)(A)

⁶³ *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995)

⁶⁴ U.S. Const., Art. VI, § 2

The Maryland Fair Share Health Care Fund Act

The Fair Share Act applied only to non-governmental employers of 10,000 or more people in the State. Under this Act, for-profit employers that do not pay up to 8 percent of total employee wages on health insurance costs must contribute the difference to the Secretary of Labor. For non-profit employers, the benchmark was 6 percent. The Act was aimed primarily at Wal-Mart, which was one of the only four employers in the State with 10,000 or more employees, because Wal-Mart made only minimal contributions to employee health coverage. The Retail Industry Leaders Association, of which Wal-Mart is a member, brought suit against the Secretary of Labor seeking a declaration that the Act was preempted by ERISA⁶⁵ and an injunction against implementing the Act.

The Fourth Circuit found that the Fair Share Act had a “connection with” an ERISA plan and was therefore preempted. In coming to this conclusion, the Court looked to (1) the objectives of the ERISA statute; and (2) the nature of the effect of the state law on ERISA plans.⁶⁶ The Court determined that ERISA’s fundamental purpose was to permit multi-state employers to maintain nationwide health and welfare plans, providing uniform nationwide benefits and permitting uniform national administration, without being subject to varying state law requirements. The Court found that the nature and effect of the Fair Share Act was to require Wal-Mart to increase its health care benefits for Maryland employees and to administer its plan in such a fashion as to ensure that the 8 percent cap was met. The Court believed that the Fair Share Act frustrated interstate uniformity because the spending requirements “are not applicable in most other

⁶⁵ The suit also alleged violation of the Equal Protection Clause of the U.S. Constitution

⁶⁶ *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001)

jurisdictions” and pointed to two specific laws with which it was in direct conflict.⁶⁷ This required Wal-Mart to “segregate a separate pool of expenditures for its Maryland employees and structure its contributions—and employee’s deductibles and co-pays—with an eye as to how this will affect the Act’s 8 percent spending requirement.”⁶⁸

The Court also ruled that the Act was not a tax designed to raise revenue;⁶⁹ rather, it was a penalty designed to force Wal-Mart to provide health coverage to its workers, which ERISA prohibits.⁷⁰ The key to finding that the Maryland Act was preempted was the Court’s decision that the Act *required* Wal-Mart to increase its health care spending.⁷¹ The Court based this decision on affidavits provided by Wal-Mart executives which stated that Wal-Mart

would not pay the State a sum of money that it could instead spend on its employees' healthcare. This would be the decision of any reasonable employer. Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.⁷²

Because the Fair Share Act effectively “mandate[d] some element of the structure or administration of [Wal-Mart’s] ERISA plan,” the Court held that it was preempted by ERISA.⁷³

The Court made note that “a state law that creates only indirect economic incentives that affect but do not bind the choices of employers or their ERISA plans is

⁶⁷ *Retail Leaders Industry Assoc. v. Fielder*, 475 F.3d 180 (D. Md. 2006)

⁶⁸ *RILSA*, at 37

⁶⁹ *RILSA*, footnote 19

⁷⁰ 29 U.S.C. § 1001

⁷¹ *RILSA*, at 38

⁷² *RILSA*, at 34-35

⁷³ *RILSA*,32

generally not preempted.”⁷⁴ The Judge made specific mention of the Massachusetts legislative approach which he fashioned as “legislation that addresses health care issues comprehensively and in a manner that arguably has only incidental effects upon ERISA plans.”⁷⁵ The Judge did not give any reasons, but he did make a policy argument for permitting states to perform their traditional role of laboratories for experiments in improving quality and reducing costs.⁷⁶

Although no claims against the Massachusetts Act have been made as a result of the Fourth Circuit’s ruling in Maryland, there is a possibility that the employer mandates in the Massachusetts Act might also be preempted by ERISA. Without these mandates, a major source of revenue for funding this effort will be removed.

5. Why Massachusetts Won’t Follow Maryland’s Demise

William Schiffbauer, a health care attorney in Washington D.C. and member of the Advisory Board for Bureau of National Affairs’ Health Plan & Provider Report, has presented an interesting commentary on why the Massachusetts Act could be preempted by federal law because it “relates to” the benefit plan activities of employers.⁷⁷ He believes the Massachusetts Act contains three provisions which contravene ERISA’s purpose and would be preempted: (1) the mandate to maintain a “cafeteria” policy; (2)

⁷⁴ *Travelers*, 514 U.S. at 658

⁷⁵ *RILSA*, Footnote 15

⁷⁶ *Id.*

⁷⁷ William G. Schiffbauer, *Hiding in Plain View: ERISA Preempts Provisions Of Massachusetts 'Play or Pay' Health Care Reform Law*, Health Plan and Provider Report, Vol. 12, No. 38 (Sept. 2006); found at (<http://subscript.bna.com/SAMPLES/mac.nsf/5326c4678f83e0ca85256b57005b78aa/795c5d275bba4faa852571f50070f992?OpenDocument>)

the mandate of a group health plan; and (3) the “fair share” contribution.⁷⁸ An analysis of these claims is discussed in an issue brief provided by the National Academy for State Health Policy titled *ERISA Implications for State Health Care Access Initiatives*.⁷⁹

The Mandate to Maintain a “Cafeteria” Plan

Under the reasoning provided in *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997), the Massachusetts Act would not be preempted if employers could comply by means other than establishing an ERISA plan.⁸⁰ In Massachusetts, employers will avoid the free-rider surcharge if they offer cafeteria plans. The U.S. Department of Labor does not consider cafeteria plans to be ERISA plans, even when used to shelter the employee’s share of premium for an employer-sponsored plan because their function is to provide a method for paying premiums in a tax-favored manner, an advantage the Department of Labor says is not a “benefit” within the meaning of ERISA.⁸¹ While the Department of Labor’s classification is not binding, Courts tend to give great weight to such findings.

According to the Department of Labor, a cafeteria plan avoids ERISA preemption only if: (1) no contribution is made by an employer; (2) participation is voluntary for employees; (3) the employer does not “endorse” the arrangement; (4) the sole function of the employer is to permit the insurer to publicize the program to employees and to collect premiums through payroll deductions; and (5) the employer receives no consideration other than reasonable compensation for administrative services.⁸²

⁷⁸ *Id.*

⁷⁹ Patricia A. Butler, National Academy for State Health Policy, *ERISA Implications for State Health Care Access Initiatives* (Nov. 2006)

⁸⁰ *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr.*, 519 U.S. 316 (1997)

⁸¹ Department of Labor Advisory Opinion 96-12A (July 17, 1996)

⁸² 29 C.F.R. 2510.3-1

Mr. Schiffbauer points to the ambiguous “no endorsement” rule and believes it raises legal questions with respect to the Massachusetts law's cafeteria plan requirement.⁸³ He argues that “an objectively reasonable employee would conclude on the basis of the employer’s actions that the employer had not merely facilitated the program’s availability but had exercised control over it or made it appear to be part and parcel of the company’s own benefit package by providing the cafeteria plan arrangement.”⁸⁴ Although this argument has some bite, it is premature in that its effectiveness will rely primarily on how employers’ cafeteria plans are viewed by employees.

The Mandate of a Group Health Plan

Mr. Schiffbauer argues that the Massachusetts Act requires employers to provide a group health plan. His argument weaves the fair share contribution and free-rider surcharge together, and much of his argument is based on the effects of the fair share contribution. His argument is that the Massachusetts “free rider” surcharge is “directly levied on the employer and liability is triggered upon the absence of an employer’s offer of group health plan coverage... ”.⁸⁵ What Mr. Schiffbauer does not address is that employers who offer cafeteria plans are exempt from the free-rider surcharge. As discussed above, the Department of Labor does not label cafeteria plans as ERISA plans. Therefore, liability is not always triggered upon the absence of group health plan coverage. Mr. Schiffbauer’s argument is better addressed within the context of the fair share contribution.

⁸³ William G. Schiffbauer, *Hiding in Plain View: ERISA Preempts Provisions Of Massachusetts 'Play or Pay' Health Care Reform Law*, Health Plan and Provider Report, Vol. 12, No. 38 (Sept. 2006)

⁸⁴ *Id.*

⁸⁵ *Id.*

The Fair Share Contribution

Mr. Schiffbauer believes that the practical impact of the Massachusetts Act binds a benefit plan administrator to contribute to its employees' health plan.⁸⁶ ERISA clearly prohibits states from mandating that employers offer or contribute to their employees' health benefit plans.⁸⁷ In Massachusetts, employers who make a "fair and reasonable" contribution to their employees' group health benefit plans are exempt from the fair share assessment.⁸⁸ Because Massachusetts defined what constitutes "fair and reasonable," it is practically "setting a minimum standard for a premium contribution and level of benefits for otherwise 'voluntary' employer-sponsored health benefits."⁸⁹ If each state defined minimum contribution levels differently, then an employer with an interstate business would be subject to multiple and conflicting state rules.⁹⁰ This, he argues, interferes with ERISA's core purpose of providing for nationally uniform plan administration.⁹¹

In support of this argument, Mr. Schiffbauer compares the Massachusetts Act with the Fair Share Act that was preempted in the Wal-Mart case.⁹² That Court quoted from affidavits provided by Wal-Mart executives that "when faced with the choice of paying a sum of money to the State or offering an equal sum of money to their employees in the form of health care, no rational employer would choose to pay the State." This is not the case in Massachusetts.

A Massachusetts employer with 10 or more employees must either make a "fair share" contribution to its employees' health benefits or pay a fine to a State fund. In

⁸⁶ *Id.*

⁸⁷ 29 U.S.C. § 1001

⁸⁸ 114.5 CMR 16.00

⁸⁹ William G. Schiffbauer, *Hiding in Plain View: ERISA Preempts Provisions Of Massachusetts 'Play or Pay' Health Care Reform Law*, Health Plan and Provider Report, Vol. 12, No. 38 (Sept. 2006)

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

Maryland, non-complying employers would be forced to pay the difference between the statutorily required contribution and the actual amount contributed. So either way, the employer would be paying the same amount. In Massachusetts, a non-complying employer must decide between paying the fine, which could be up to, but no more than, \$295 per employee per year, or a “fair share” contribution. The difference is that in the case of the Massachusetts Act, it may cost some employers more than the statutory maximum \$295 to provide health coverage to their employees. In this circumstance, it is reasonable to think that some employers would rather pay the fine than provide health coverage.

Another difference between the two fact patterns is the number of potentially affected companies. In Maryland, only Wal-Mart would have been affected. Therefore, it was easier to determine the practical effect of the Fair Share Act. This task will be considerably more difficult when there are thousands of firms that must make the decision of whether to make a Contribution or pay the assessment. It is also worth mentioning that the Maryland Act was viewed as a penalty directed against Wal-Mart, while the Massachusetts Act is considered to serve a cost-sharing function.

6. Does Massachusetts Actually Provide Universal and Adequate Coverage for Poor Citizens?

In 2004, the Institute of Medicine of the National Academies issued a report offered as “the most comprehensive examination to date of the consequences of lack of health insurance on individuals, their families, communities and the whole society.”⁹³

The report, entitled *Insuring America's Health: Principles and Recommendations* (the

⁹³ Committee on Consequences of Uninsurance, *Insuring America's Health: Principles and Recommendations*, p. 48 (National Academies Press 2004)

“report”), provided a set of guiding principles offered for the stated purpose of “guiding the debate and evaluating various strategies” to extend coverage to uninsured.⁹⁴

Accepting the report’s invitation, this essay uses these principles to evaluate the Massachusetts Act and its overall effectiveness at helping the poor. The principles are:

- (1) Health care coverage should be universal;
- (2) Health care coverage should be continuous;
- (3) Health care coverage should be affordable to individuals and families;
- (4) The health insurance strategy should be affordable and sustainable for society;
- (5) Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.⁹⁵

Health Care Coverage Should Be Universal

The report links being insured with better access to appropriate and timely medical services and further links access to better health. Therefore, insurance is the key to improving an individual’s health.⁹⁶ The logical conclusion is that Massachusetts residents would be best served by adopting policies that result in everyone having coverage.⁹⁷ According to the report, in order for Massachusetts to truly achieve universal coverage, it will need to do more than just expand existing programs.⁹⁸ It will need to include an explicit goal and a rational plan, incorporate structural changes to correct existing gaps and inefficiencies, and set a definite schedule for making measurable progress.⁹⁹ Because implementing a new system of providing health care involves a massive undertaking, it must be the result of strong, bipartisan political support.¹⁰⁰

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*, at 153

⁹⁷ *Id.*, at 154

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

The Massachusetts Act does more than just expand existing programs. It is a comprehensive health care reform statute which with an entirely different structure within which individuals and employers will have access to insurance—the Connector. The Act requires that, as of July 1, 2007, all residents of Massachusetts must acquire health insurance coverage.¹⁰¹ The Act’s goal is clearly specific and designed to achieve universal coverage for all of its residents. The Act also incorporates structural changes to the insurance market by merging the individual and group markets, designed to reduce costs by spreading the risk over a larger pool of individuals. Finally, the Massachusetts Act is the result of bipartisan cooperation between then Republican Governor Mitt Romney and the Democratic-controlled state legislature.

The Act mandates that every individual shall obtain health insurance coverage “so long as it is deemed affordable.”¹⁰² The Connector will be responsible for setting a schedule of affordability, based on the percentage of income eligible to be spent on health care.¹⁰³ If there is a lack of “affordable plans” offered, then there is a very real chance that Massachusetts will fall short of its goal of universal coverage. Also, individuals have the option of paying a fine instead of purchasing coverage.¹⁰⁴ Depending on the premium price range, this option might be enticing to some individuals who would rather self insure. Even if Massachusetts is not able to achieve universal coverage, near universal coverage would be a giant step toward eradicating the problems attributed to lack of insurance—poor health and crippling debt that perpetuate poverty.

¹⁰¹ 2006 Mass. Acts ch. 58, § 2

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ 2006 Mass. Acts ch. 58

Health Care Coverage Should Be Continuous

Continuity of insurance and continuity of care go hand in hand. Uninsured spells can lead to poorer health, greater risk of early death, and exposure to significant financial risk. Health insurance is most likely to improve health outcomes if coverage is continuous rather than intermittent.¹⁰⁵

The Massachusetts Act requires all residents to obtain “creditable coverage” if affordable.¹⁰⁶ “Creditable coverage” is defined as “coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another’s plan with no lapse of coverage for more than 63 days[.]”¹⁰⁷ The Massachusetts Act therefore does not mandate continuous coverage.

Even though the Act does not mandate continuous coverage, the Connector makes health insurance portable by allowing employees to keep the same plan as they move from job to job. Employees that become unemployed also have the option of keeping their same insurance coverage they had while employed, minus the employer contribution. Increased portability will decrease the possibility that individuals might proceed without insurance while in between jobs. Whether this will reduce the number of people who spend part of the year without insurance will become evident as the Massachusetts Act matures.

Health Care Coverage Should Be Affordable to Individuals and Families

¹⁰⁵ Coverage Matters, 2001; Health Insurance Is a Family Matter, 2002; Hidden Costs, Value Lost, 2003; Insuring America’s Health, 2004. Institute of Medicine. Washington, DC: National Academies Press

¹⁰⁶ 2006 Mass. Acts ch. 111M, § 2

¹⁰⁷ *Id.* at § 1

If the Connector's board of directors issues its Seal of Approval to a range of health plans at its March 8 meeting, as is expected, then hundreds of thousands of Massachusetts residents will be eligible to purchase these plans for as little as \$175 per month.¹⁰⁸ For individuals that are able to purchase these plans on a pre-tax basis through their employers, the net cost of coverage is reduced to \$109 per month.¹⁰⁹ Specific prices vary based on plan, age and region.¹¹⁰

The Massachusetts Act is also structured to maximize efficiency. The Connector also allows employees to combine employer contributions, which individuals that work for multiple employers will be able to apply to one insurance plan. This also allows spouses to combine both of their employers' contributions to one plan, rather than having to choose between the two, or have different plans. Both of these features will also act to make purchasing insurance more affordable.

Individuals with a household income that does not exceed 100 percent of the federal poverty level will only be responsible for a co-payment¹¹¹ toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals¹¹² for non-emergency conditions.¹¹³ No other premium, deductible, or other cost sharing shall apply to these individuals.¹¹⁴ The board may waive co-payments upon a finding of substantial financial or medical hardship. Individuals with a household

¹⁰⁸ Press Release, The Commonwealth of Massachusetts, Executive Dept., *New Health Insurance Plan Will Be Available For Under \$200* (March 3, 2007) (on file with Mass. Gov.)

¹⁰⁹ Premium cost based on an annual income of \$50,000

¹¹⁰ *Id.*

¹¹¹ Co-payment will be equal to that required of enrollees in the MassHealth program

¹¹² "Acute hospital" is defined as the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under section fifty-one of chapter one hundred and eleven and which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the department of public health. ALM GL ch. 118G, § 1.

¹¹³ 2006 Mass. Acts ch. 118H, § 6(b)

¹¹⁴ *Id.*

income up to 300 percent of the federal poverty level will have access to subsidized private insurance products, with premiums determined by using a sliding scale based on the family's income.¹¹⁵ There will be no deductibles. With plans starting as low as \$175 per individual per month, and subsidized plans for qualified individuals, the Massachusetts Act is living up to its promise of affordable health care for all.

The Health Insurance Strategy Should Be Affordable And Sustainable For Society

Massachusetts is an anomaly when it comes to being able to offer the promise of universal coverage because it might actually be able to afford it. First, Massachusetts has a relatively low uninsured rate of about 7 percent¹¹⁶ when compared to the national average of 15 percent.¹¹⁷ In addition, Massachusetts can subsidize premiums with funds from its Uncompensated Care Pool Fund, which most other states don't have.

The vast majority of the money for the subsidy will come from the Uncompensated Care Pool by redirecting funds originally earmarked for reimbursing hospitals for uncompensated emergency care to helping subsidize insurance coverage for individuals that qualify. Employers will also help fund this effort via the "fair-share contribution." The creation of the Connector Authority has increased the bargaining power of consumers which will help defray some of the costs.

There are still some critics who question the financial feasibility of the Massachusetts plan. A statement by the PNHP (Physicians For A National Health

¹¹⁵ 2006 Mass. Acts 111M, § 132(a)

¹¹⁶ Amy M. Lischko, Commissioner of Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents*, Fifth Ed., Dec. 2006

¹¹⁷ DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Government Printing Office, Washington D.C., 2006, page 21

Program) declares that legislators have drastically underestimated the number of uninsured individuals for which funding must be provided.¹¹⁸ Politicians designed the Massachusetts Act based on an estimate for the number of uninsured individuals in Massachusetts of about 500,000 people.¹¹⁹ Yet the Census Bureau states the number is 748,000.¹²⁰ The authors of the PNHP statement account for this discrepancy by pointing to deficiencies in the Massachusetts Division of Health Care and Finance Policy's survey methods.¹²¹ The effect of this miscalculation, if true, could place a heavy burden on the State's Free Care Pool, necessitating alternative funding sources. Options for additional sources could include increased taxes, employer "fair-share" contributions, and higher deductibles and co-payments from some subsidized individuals. Higher deductibles and co-payments would also burden the poor with greater costs. Any of these options would upset the delicate balance that currently exists which makes the Act so attractive to the business community and legislators concerned about their constituents.

Health Insurance Should Enhance Health and Well-Being By Promoting Access to High-Quality Care That Is Effective, Efficient, Safe, Timely, Patient-Centered, and Equitable

Whether the Massachusetts Act will actually help the poor evade the negative effects associated with not having insurance will depend on whether the plans provide the necessary quality of care. The Connector will offer four distinct types of health insurance products: (1) premier plans; (2) value plans; (3) basic plans; and (4) a Young Adults

¹¹⁸ Pnhp.org, (http://www.pnhp.org/news/2006/april/massachusetts_health.php) (Apr. 2006)

¹¹⁹ Boston.com, (http://www.boston.com/news/nation/articles/2004/11/21/my_plan_for_massachusetts_health_insurance_reform/?page=full) (Nov. 2004)

¹²⁰ DeNavas-Walt, Carmen, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Government Printing Office, Washington D.C., 2006, page 27

¹²¹ Pnhp.org, (http://www.pnhp.org/news/2006/april/massachusetts_health.php)

Plan.¹²² These plans are assessed based on a “relative value” assigned to each. Premier plans will have a “relative value” of 1.00. Value plans will have a relative value of 80 percent (+/-7.5 percent) of the Premier plan, and the Minimum Creditable Coverage plans have a relative value of 60 percent (+/-2 percent) of the Premier plan.¹²³

On March 20, 2007, the Connector board of directors approved draft regulations that defined the minimum level of coverage that can be offered in any plan. A health insurance product meets the standards of minimum creditable coverage only if it:

- 1) provides a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, ambulatory patient services, and mental health services;
- 2) includes prescription drugs as a covered benefit;
- 3) covers preventive physician visits prior to any deductible;
- 4) caps any annual deductible at no more than \$2,000 (\$4,000 for a family);
- 5) caps an individual’s out-of-pocket spending for hospital and physician services at \$5,000 (\$10,000 for a family);
- 6) does not place limitations on benefits per year or per sickness; and
- 7) disallows placing daily reimbursement limits for hospital stays.¹²⁴

If this draft regulation is implemented, then the Massachusetts Act could make a noticeable impact on the health, welfare, and pocketbooks of the poor and near poor living in Massachusetts. It was noted earlier in this essay that individuals without health insurance “receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than insured individuals.”¹²⁵ Plus, one third of people living at or below the poverty line are uninsured,¹²⁶ have more chronic illnesses, and more frequent and severe disease

¹²² Memorandum from Jon Kingsdale, Commonwealth Health Insurance Connector Authority, *Staff Recommendation for Health Insurance Carriers for Commonwealth Choice* (March 2007)

¹²³ The Commonwealth Health Insurance Connector Authority’s Request for Responses, Dec. 2006.

¹²⁴ Draft Minimum Creditable Coverage, 956 CMR 5.00 (2007)

¹²⁵ Nchc.org, National Coalition on Healthcare, *Facts on Health Insurance Coverage*, (<http://www.nchc.org/facts/coverage.shtml>)

¹²⁶ Kaiser Commission Report, p. 1, *The Uninsured and Their Access to Healthcare* (Sept. 2005)

complications.¹²⁷ As a result, these individuals are more likely to incur medical expenses and are faced with severe financial repercussions for both themselves and their families.¹²⁸ The proposed regulation attempts to answer these problems by mandating preventive care and prescription plans.

A 2001 study presented in the *Journal of Health and Social Policy* presents evidence that “the uninsured receive less care than privately insured patients when they seek emergency treatment, even when the insured and uninsured had similar diagnoses.”¹²⁹ The Massachusetts Act does not offer the promise of equal care. It does, however, raise minimum care levels for the poor at an affordable cost. These minimum care levels may not guarantee treatment equal to that received under the premium plans, but it does provide needed benefits for the poor and near poor.

Washington and Lee University

7. Conclusion

The Massachusetts Act will likely pass Constitutional muster if challenged. The real concern is whether it can solve the problem of health insurance for the poor and near poor. The answer to this concern appears to center on the Connector. The Connector, through its board of directors, has taken significant steps toward providing adequate and affordable minimum creditable coverage through enacted and proposed regulations which address the primary concerns raised in this essay. If Massachusetts can finance this effort with the framework currently in place, the Massachusetts Act will improve the health and

¹²⁷ Steven H. Woolf, Robert E. Johnson, and H. Jack Geiger, p. 332, *The Rising Prevalence of Severe Poverty in America: A Growing Threat to Public Health*, *American Journal of Preventative Medicine*, Vol. 31., Issue 4 (Oct. 2006).

¹²⁸ Committee on Consequences of Uninsurance, p. 48 *Insuring America's Health: Principles and Recommendations*, (National Academies Press 2004)

¹²⁹ P. Jackson, *The Impact of Health Insurance Status on Emergency Room Services*, *J Health Soc Policy*. 2001;14(1):61-74

financial stability of hundreds of thousands of individuals living in Massachusetts that are currently at risk because of a lack of adequate health insurance.

Washington and Lee University