Revisiting Massachusetts Health Reform: 18 Months Later

December 2007

By Christine Barber and Michael Miller, Community Catalyst State Consumer Health Advocacy Program

This report was written with support from the Public Welfare Foundation.

Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

ABOUT COMMUNITY CATALYST

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

For more information about Community Catalyst projects and publications, please visit www.communitycatalyst.org.

Executive Summary

Enacted in April 2006, the recent Massachusetts health care reform law was landmark in its breadth and support from political coalitions. The law included a number of new and untested ideas, but also left certain critical decisions to implementation. These included:

⇒ Determining which employers must pay an assessment;
⇒ Moving toward standardized health plans for people purchasing insurance through the new Health Insurance Connector;
⇒ Expanding on key details of the individual mandate, in particular:
  - Identifying what it means to be insured under the mandate; and
  - Defining at what price health insurance is affordable.

This paper examines these decisions and the role of consumer health advocacy in each of them. We also look at enrollment and coverage in the first year-and-a-half of implementation. An examination of policies tested in Massachusetts health reform provides important lessons for other states.

Massachusetts has covered more than 216,000 people since health care reform passed, which alone shows some success of the law. While it is too soon to know the results of all of the pieces of Massachusetts reform, promising policies have emerged such as:

- Fully subsidized, comprehensive coverage for all adults below 150% FPL
- Expanding Medicaid for children up to 300% FPL and clearing the wait list for very low-income unemployed adults
- The creation of a "floor" of sufficient insurance coverage
- Steps toward creating standardized, transparent private insurance plans

Other aspects of the health reform law have not yet proven successful or have created questionable outcomes at this point in implementation:

- A low threshold for employers to either provide insurance or pay an assessment for uninsured workers is not likely to produce adequate revenue.
- Enrollment of people earning above 300% FPL in private insurance through the Health Insurance Connector has been sluggish; it is questionable whether people will perceive benefit from using the Connector.

Outcomes of other factors remain uncertain; time will tell their impact. These include:

- The individual mandate: It remains to be seen whether the exemption and appeals process will protect individuals who cannot afford insurance.
- Long-term financing: Without adequate revenue and a strong Medicaid waiver, Massachusetts may face distress in funding health reform.
- Impact on employer-sponsored coverage: Will ESI increase or decrease under the new requirements?

In each decision that has arisen in implementation, advocates led by the ACT!! (Affordable Care Today) Coalition played a critical role in bringing the voice of consumers to the table. A lesson for state advocacy groups is that campaigns do not end with enactment; implementation is just as important. Health advocates must remain engaged to ensure success in expanding coverage and protecting consumers.

Introduction[1]

When Massachusetts health reform was enacted in April 2006, many hailed the law as a milestone effort to cover the uninsured.

Key features of the new law:

- Medicaid expansions to cover children up to 300% FPL (federal poverty level);
- Fully subsidized Medicaid "look-alike" coverage for adults under 100% FPL;
- Insurance coverage with sliding scale subsidies for people under 300% FPL;
- Private insurance reforms, including merging the non-group and small group insurance markets;
- The creation of a Health Insurance Connector (or Exchange);
- An assessment on employers not offering health insurance to employees; and
- An individual mandate for health insurance, if it is affordable.[2]

The law was remarkable in its breadth and support from political coalitions, and included a number of new and untested ideas. In addition, certain critical decisions were not contained in the law, but rather left to implementation. These issues include:

⇒ Determining which employers must pay an assessment;
⇒ Moving toward standardized health plans for people purchasing *un*subsidized insurance through the Connector;
⇒ Expanding on key details of the individual mandate, in particular:
  - Identifying what it means to be insured under the mandate; and
  - Defining at what price health insurance is affordable

This paper examines these decisions, and their implications for health reform. We also discuss enrollment and changes to the state's safety net. A view of the early months of implementation of Massachusetts health reform provides valuable lessons for other states.

Consumer advocates who played a strong role in the passage of health care reform in Massachusetts continue to lend a consumer voice to implementation. In this paper, we examine ways the Affordable Care Today (ACT!!) Coalition, a group of stakeholders convened by the Massachusetts consumer health advocacy group, Health Care for All, monitors and advocates for consumer protections in implementation of the law. Finally, we look ahead to critical questions that Massachusetts will face in the future, particularly issues of financing health reform.

Implementation: What has happened in the past 18 months?

Determining which employers must pay an assessment

As one way to create "shared responsibility" for health reform, the law included an assessment on employers that do not offer insurance to workers. Employers with 11 or more employees are required to either provide a "fair and reasonable" contribution toward an employee's health insurance, or pay an assessment of $295 per employee per year. However, the legislation left a state agency, the Division of Health Care Finance and Policy (DHCFP), to define a "fair and reasonable" employer contribution.

---

[1] In April 2006, Community Catalyst released *Massachusetts Health Reform: What it Does; How it Was Done; Challenges Ahead*, providing an overview of the role of consumer health advocacy in the passage of comprehensive health reform in Massachusetts.

[2] Massachusetts General Law. Chapter 58 of the Acts of 2006. www.mass.gov/legis.

In October 2006, DHCFP, under the guidance of then-Governor Mitt Romney, set regulations that identify a "fair and reasonable" contribution as either an employer with 25% of employees enrolled in a group health plan, OR an employer that offers to pay 33% of a full-time employee's health premium.[3]

The question remains of whether this definition of "fair and reasonable" undermines the ideal of shared responsibility for health reform touted during the law's passage. An employer contribution of 33% of an employee's premium is far below the national market average (84% employer contribution rate for individual coverage; 72% for families).[4] Many fear that this low threshold for contributions to employee premiums could encourage employers to reduce their spending on health benefits.

The low standard may also negatively affect financing of reforms. Fiscal analysis from the Legislature at the time of enactment estimated collecting $38 million in FY08 and $22.5 million in FY09 in funds through the employer assessment.[5] Currently, the Governor's budget office only predicts $23.63 in revenue from the assessment in FY08.[6]

Moving toward standardized health plans in the Connector

Massachusetts's health reform made a number of changes to the private insurance market to improve access to insurance. One of the major changes was the creation of a Health Insurance Connector, a mechanism that allows individuals to purchase insurance, often with pre-tax dollars.[7]

A major decision for the Connector was the design of standardized health plans for *un*subsidized insurance, called Commonwealth Choice plans. The Connector planned to create benefit "tiers" based on similar actuarial value (the value of health benefits). The challenge of designing these plans was to offer adequate benefits and provide choice among plans, while keeping prices affordable for consumers.

The Connector Board, a 10-member group of state officials and community members appointed by the Governor and Attorney General, was charged with choosing standardized plans. With the power to appoint a majority of Connector Board members, the Governor holds significant weight in Connector decisions. In 2007, Deval Patrick, a Democrat, became Governor, taking over from Republican Mitt Romney. This change in leadership had critical implications for responsiveness to consumer interests.

The Connector set three categories of standardized coverage: Gold, Silver and Bronze. Gold plans have the most comprehensive benefits, with no deductibles and limited cost sharing; Silver plans

---

[3] Division of Health Care Finance and Policy Regulation 114.5 CMR 16.00.

[4] Kaiser Family Foundation. *Employer Health Benefits 2007 Annual Survey. Percentage of Premium Paid by Covered Workers, 1999-2007*.

[5] Massachusetts Legislature, Joint Committee on Health Care Financing fiscal documentation, April 2006.

[6] The Governor's Budget Office did not release data for proposed collections in FY09. Massachusetts Office of Administration and Finance, FY07 and FY08 Projected Costs of Health Care Reform. The assessment was due November 15, 2007, but a large number of businesses have not yet filed.

[7] People may purchase insurance pre-tax through Section 125 plans in the Connector. Section 125 of the federal tax code allows people, usually employees, to pay for health benefits with pre-tax dollars. Individuals may continue to purchase non-group insurance plans outside of the Connector, but may not necessarily have the benefit of Section 125 plans.

have no deductibles and some cost sharing; and Bronze plans have both deductibles (up to $2000/individual and $4000/family coverage) and cost-sharing.[8]

Plan	Network	Premium	Cost sharing
Gold	Comprehensive	High	No deductible; lowest copays
Silver	Fairly comprehensive	Medium	Some plans have deductibles; all have moderate copays
Bronze	May be limited	Low	Deductibles + copays, co-insurance

The Legislature intended the Connector to negotiate lower premiums for unsubsidized plans using leverage with insurance carriers. However, this proved difficult and premiums were mainly reduced through increased cost-sharing for consumers and, in some cases, allowing very narrow provider networks. Because plans with the lowest premiums, Bronze, have considerable cost-sharing and high deductibles, advocates are concerned that consumers may acquire insufficient insurance for their health needs.

The Connector's website clearly lists health plan choices, and provides information on benefits and pricing for a number of health plans in one place. The Massachusetts Connector offers the three benefit tiers through at least four insurers in each region of the state. But the Connector may provide consumers with too many choices—a search for health insurance in the Boston area turns up 22 plans among different tiers and carriers.[9]

The individual mandate

One of the most controversial components of Massachusetts's health care reform is the first-in-the-nation individual mandate. The law requires all people to acquire *creditable* (or deemed sufficient) coverage if it is *affordable* to them.[10] Therefore, to determine compliance with the mandate the Board of the Connector had two decisions:

- Identifying what it means to be insured under the mandate; and
- Defining at what price health insurance is affordable

Creditable coverage: Identifying what it means to be insured under the mandate

The individual mandate provision requires creditable coverage; not just any plan offered on the market fulfills this requirement. Consumers may still purchase plans with limited benefits, but these plans may not fit the "creditable coverage" provision under the mandate. The Connector examined both benefit and cost sharing limitations to determine "minimum creditable coverage" (MCC). MCC was difficult decision; if set at a level too comprehensive it may be unaffordable, while if set with very limited benefits it may create a class of underinsured people.

The Board of the Connector voted to delay enforcement of MCC rules until January 2009, to allow consumers and employers time to acquire adequate coverage. At that time, MCC will include: comprehensive benefits, such as preventative and primary care, hospitalization, mental health coverage, and prescription drugs. MCC also caps deductibles at $2000 ($4000 for families) and requires three primary care visits (6 for families) pre-deductible. Maximum out-of-pocket costs are

[8] While plans within tiers have similar actuarial value, cost sharing and benefit combinations vary quite a bit within tiers, especially at the Silver plan level. www.mahealthconnector.org

[9] Author's research, August 2007. See mahealthconnector.org

[10] Chapter 58 of the Acts of 2006.

capped at $5,000 ($10,000 for families)[11] and prescription drugs carry a separate deductible of up to $250 ($500 for families). The Bronze tier of unsubsidized plans closely mirrors MCC standards.

Defining at what price health insurance is affordable under the mandate

The individual mandate only applies to households who can afford a health plan. The Connector Board set an affordability standard for people earning below about 600% FPL. People with the lowest incomes (below 150% FPL) pay no premiums on the affordability scale. For people earning between 150% and 300% FPL, the affordability scale is set at the premium levels for subsidized health plans.[12] For people earning between 300% FPL and about 600% FPL, the Connector set a sliding scale of affordability based on premiums for insurance.[13] The Connector determined that all people earning more than about 600% FPL must purchase insurance, no matter the cost. Out-of-pocket costs are not included in the affordability schedule, despite being required by legislation.[14]

However, concerns remain about requiring people with moderate incomes to spend significant portions of their income on health insurance. Research on basic household budgets has determined that people earning less than about 250% FPL lack the discretionary income to pay anything after meeting basic needs.[15] In addition, research on "take-up rates" of insurance (or, the price at which a person voluntarily chooses to purchase insurance) shows that very few people between 250% and 300% FPL would purchase insurance voluntarily at current premium levels. Because even people with health insurance often have significant cost sharing, failure to take into account out-of-pocket costs in the affordability scale may harm families who are already struggling financially.[16] Insurance may be unaffordable for some people over 600% FPL, especially those who are older. Massachusetts law allows insurers to vary premiums based on age and geography, so some will pay more than others for the same health plan. For instance, a 19-year old in the Boston area may purchase insurance for as low as $155 per month, while a person 56 years old is charged $309 per month (and will likely incur greater cost sharing).[17]

Enrollment, so far

Since the passage of health reform, about 216,130 people have become newly insured.[18] Of these, about 73,012 have enrolled in MassHealth, the Massachusetts Medicaid program;[19] 132,919 people in Commonwealth Care, the sliding scale subsidized insurance program for people below 300% FPL; and 10,199 through Commonwealth Choice, unsubsidized private insurance plans offered

---

[11] Connector Board meeting March 20, 2007. For greater discussion of MCC, see Alan Raymond, *The 2006 Massachusetts Health Care Reform Law: Progress and Challenges After One Year of Implementation*. Blue Cross Blue Shield of Massachusetts Foundation, May 2007.

[12] People earning below 300% FPL who do not have an offer of employer-sponsored insurance are eligible for subsidized insurance, called Commonwealth Care. Minimum premiums for the subsidized plans: $0 up to 150% FPL; $35, 150% to 200% FPL; $70, 200% to 250% FPL; and $105, 250% to 300% FPL. In addition, there is no deductible for people in subsidized plans.

[13] Above 300% FPL, the affordability scale is based on income, not percentage of poverty. There is also a hardship waiver process for people with circumstances that prevent them from purchasing health insurance.

[14] See Appendix A for Affordability Schedule.

[15] See Massachusetts Family Economic Self-Sufficiency Standard at www.liveworkthrive.org/fess.php and Economic Policy Institute's Budget Calculator at www.epi.org/content.cfm/datazone_fambud_budget

[16] For greater analysis of affordability, see *Affordable Health Care for All: What Does* Affordable *Really Mean?* Community Catalyst, April 2007.

[17] Laurie E. Felland, et al. *Massachusetts Health Reform: Employers, Lower-Wage Workers and Universal Coverage*. Center for Studying Health System Change, July 2007.

[18] Connector Board meeting November 16, 2007.

[19] Includes children between 200% and 300% FPL; long-term unemployed adults; and people previously eligible, but not enrolled in MassHealth. Massachusetts Executive Office of Health and Human Services.

through the Connector.[20] According to reports, between 8,000 and 30,000 have enrolled in private insurance outside of the Connector, but this has been difficult to track among insurers.[21]

The majority of people who have enrolled since health reform are in fully subsidized plans. Projected enrollment for people below 150% FPL (who do not pay a premium) has exceeded estimates, while for higher income groups not as many have signed up as expected. Nearly 90% of the uninsured below 100% FPL have enrolled; 81% between 100%- 200% FPL; and only 29% of the uninsured between 200%-300% FPL.[22]

Of the 127,134 people enrolled in Commonwealth Care as of November 1, 2007: [23]

Plan	Eligible?	Premium	# Enrolled	% total enrolled
Type 1	>100% FPL	$0	76,220	58%
Type 2A	100%-150% FPL	$0	28,350	21%
Type 2B	150%-200% FPL	$35	16,825	13%
Type 3	200%-250% FPL	$70	8,586	6%
Type 4	250%-300% FPL	$105	2,938	2%

Because only a small number of the uninsured between 200% and 300% FPL have enrolled in subsidized plans, some argue that the premiums for these plans are unaffordable.[24] In a memo to the Connector, Charles DeWeese, a consultant and actuary finds through models of the subsidized plans that only 40% of people between 250% and 300% FPL would likely enroll in insurance without a mandate.[25] This is likely due to premium costs for this population. If people cannot afford the premiums for plans, the state may be faced with the decision to either: increase subsidies, exempt people from the upcoming individual mandate, or force people to pay unaffordable premiums.[26]

Unsubsidized plans (for people earning above 300% FPL) have only been on the market since July 2007, but enrollment to date has been sluggish. It is possible that people who are not eligible for subsidies do not perceive benefit from purchasing insurance through the Connector.

Of about 10,199 people enrolled in unsubsidized plans so far, the majority (40%) have chosen the lowest premium option (which has significant out-of-pocket costs), the Bronze tier of plans. Another 28% chose the lower-benefit Young Adult Plans (health plans only offered to people between the ages of 19 and 26, similar to Bronze, but with annual benefit caps). Only 23% of people chose Silver, and 9% Gold.[27] The low enrollment rate in Silver and Gold plans suggests that premiums for these plans may not be affordable.

Changes to Free Care

[20] Connector Board meeting November 16, 2007.
[21] New enrollment in private insurance is likely driven by the merger of the nongroup and small group markets, as well as the impending individual mandate. Most recent data reported as of July 1, 2007.
[22] Author's calculations based on percentage of uninsured adults by income level. Data from John Kingsdale, Defining Affordability. Connector Board meeting April 3, 2007.
[23] Connector Board meeting November 16, 2007.
[24] *Affordable Health Care for All: What Does* Affordable *Really Mean?* Community Catalyst, April 2007.
[25] DeWeese memo, March 28, 2007. Connector Board meeting April 3, 2007.
[26] Enforcement of the individual mandate begins December 31, 2007.
[27] Connector Board meeting November 16, 2007.

The Division of Health Care Finance and Policy (DHCFP) oversees free care, now called the Health Safety Net, the fund that reimburses Massachusetts hospitals for providing care for low-income uninsured. DHCFP recently revised regulations to fit the new health system. New regulations weaken the safety net to drive enrollment in new health insurance programs.[28] People who are eligible for subsidized insurance or MassHealth (the Massachusetts Medicaid program) but fail to pay premiums or are cut off due to administrative problems are now ineligible for Health Safety Net Care. Additionally, some of those still eligible will face cost sharing for the first time.

Although the most harmful provisions were eliminated from the final regulations, advocates still fear the changes will reduce care available to consumers, and will increase medical debt.[29] Some of the funds previously used for free care are now diverted to fund insurance subsidies. Health reform balances on the idea that as low-income people become insured, Health Safety Net use will decline. If not the case, health reform will face additional challenges, both in financing and care for the most vulnerable.

The role of advocacy in implementation

Assessing the role of consumer advocacy

Consumer advocacy continues to be vitally important and advocates have won some important victories including: convincing the Connector Board to reduce premiums for people earning below 150% FPL to $0; creating a compromise in the schedule of affordability; securing fairly comprehensive benefits for MCC and unsubsidized plans, and defeating the most onerous new provisions to the state's Health Safety Net (free care) regulations. The ACT!! Coalition, throughout these first months of implementation, has remained dedicated to making health care reform work and organizing support for the law, while also trying to improve it. This coalition of consumers, labor, single-issue health care groups, providers, and other advocates has come together to organize testimony, turn out at hearings, and stay engaged through working groups on different areas of implementation. The Coalition has met with officials from the Administration and Connector Board and remained intricately involved in the decision-making process.

Advocacy and the employer assessment

In June 2007, Blue Cross Blue Shield of Massachusetts, the largest insurer in the state, announced plans to provide a lower option of employer contribution, just 33% of premiums, for policies in the small group market starting July 2007.[30] Prior to this, all insurers in the state required employer contributions of at least 50% of premiums.

Advocates responded to the low threshold of employer contribution for the assessment, claiming that it undermined the ideal of "shared responsibility," central to health reform. The ACT!! Coalition contacted Governor Deval Patrick with concerns about the Blue Cross Blue Shield option for reduced employer contributions. The Governor then asked the insurer to repeal this option, which they did.[31]

---

[28] Massachusetts Regulation 114.6 CMR 13.00. The Health Safety Net Fund was previously the Uncompensated Care Pool.

[29] The more onerous Health Safety Net regulations proposed, but not adopted: $35/mo. accumulating deductible, more significant copays, and the elimination of coverage retroactive to the date of application.

[30] Jeffrey Krasner, *The Boston Globe*. "Some say Blue Cross plans to hurt health revamp: Lower contributions by firms could leave more without policies," July 6, 2007.

[31] Jeffrey Krasner, *The Boston Globe*. "Blue Cross to scrap policy with low employer contribution," July 13, 2007.

The ACT!! Coalition has filed legislation to alter a number of elements of the health reform law, including a change to the definition of "fair and reasonable" to 50% employer contribution AND having 50% of employees enrolled in a group health plan.[32] As Massachusetts faces challenges to fund health reform, advocates plan to continue strategies to increase the threshold for the employer assessment.

Advocating for robust benefits under MCC

During the Connector's process of defining minimum creditable coverage (MCC), a debate began over prescription drug coverage. The *Boston Globe* reported that 200,000 people currently without prescription drug coverage would have to purchase more robust, costly plans to comply with MCC.[33] Some health plans and business groups argued that prescription drug coverage is an optional benefit; the ACT!! Coalition mounted a campaign, calling prescription drugs an essential part of health coverage.[34]

The ACT!! Coalition achieved a victory in the final MCC vote, which included coverage for prescription drugs, as well as comprehensive benefits.[35]

Consumers and affordability

Consumer advocacy also played a critical role in the creation of the affordability standard. Greater Boston Interfaith Organization (GBIO), a membership organization (and ACT!! Coalition member) proposed exempting people earning below 500% FPL from the individual mandate.[36] Similarly, the ACT!! Coalition maintained that a sliding scale of affordability would protect people from financial hardship.

The Connector Board's decision on affordability was a compromise between consumer advocates, who wanted lower premiums and greater exemptions from the individual mandate, and business voices, who favored all people enrolling in insurance and paying premiums without exception. Advocates continue to monitor enrollment in plans, the hardship exemption process, and affordability of plans under the individual mandate.

What's next for Massachusetts health reform?

Success so far, but uncertainties remain

To date, implementation of health care reform has been largely successful—many people are newly insured. However, significant steps remain on the road to universal coverage. People for whom insurance has been deemed affordable, but who are not insured by December 31, 2007 will be penalized under the individual mandate, and face the loss of their personal exemption for 2007 tax filing.[37] The enforcement process, as well as a robust appeals review, will be critical but yet unknown factors. No other state has implemented a mandate, and many are watching the new policy closely.

---

[32] An Act Strengthening Health Reform, Massachusetts S. 661, H. 1166.
[33] Alice Dembner, *The Boston Globe*. "200,000 may need to get more insurance," January 30, 2007.
[34] See A Healthy Blog, http://blog.hcfama.org/?p=821, February 12, 2007.
[35] In a compromise, MCC requirements for prescription drug coverage do not begin until 2009.
[36] Greater Boston Interfaith Organization. *Mandating Health Care Coverage: What is* Truly *Affordable for Massachusetts Families?* www.gbio.org
[37] The penalty under the individual mandate escalates beginning in 2008, up to half of the premium for each month a person is uninsured.

In addition, the Connector has not yet undertaken steps to insure people who are eligible for subsidized insurance, but have access to employer-sponsored insurance (ESI) that is unaffordable to them. The health reform law allowed option to provide subsidies for people with ESI offers, but the Connector has not addressed the issue. A number of low-income workers are eligible for the Insurance Partnership (IP), a premium assistance program that predates health reform. However, not everyone is eligible for IP, and it is likely that a large number of low-income people will remain uninsured.[38]

Upcoming financing questions

The major question underlying the success of health care reform is sustainability of funding. In 2008, Massachusetts must negotiate its 1115 Medicaid waiver with the federal government, and attempt to expand federal funds that allowed for health reform.[39] As enrollment in subsidized plans continues to grow, greater resources are likely needed. Negotiations with hospitals and health plans that implement health reform continue to be critical factors in financing. Employer participation, the "third leg" of responsibility (along with individuals and government), is also vital to the success of this effort.

Going forward, the ACT!! Coalition continues to have concerns about the long-term financing of health care reform and views the lack of strong employer responsibility as a serious problem. As many pointed out when the bill was signed, the employer assessment of $295 per year is considerably less than the cost of employee health benefits. Continued monitoring of funds collected through the employer assessment is needed. If funding for health reform initiatives becomes uncertain in the future, changes to the employer assessment may become necessary.

At some point, financial constraints are likely to demand difficult decisions by policymakers. Under the individual mandate, there are only a few options to keep health reform successful: exempt more people from mandate penalties; add greater funding to subsidies to make plans more affordable; or impose an undue burden on residents. These tensions remain important to bear in mind for the future.

Other outstanding questions include:

- ⇒ Will health reform be sustainable if it becomes necessary to use a larger share of the General Fund, rather than dedicated revenue sources?

- ⇒ Will the number of people with ESI change over time because of health reform? Will ESI increase or decrease? What will the repercussions be?[40]

- ⇒ Will employer behavior change when new MCC rules take effect in 2009?

- ⇒ Unless strong cost containment measures are undertaken, will health insurance become more unaffordable for a significant number of people?

---

[38] While IP enrollment has risen by about 4,500 people in the past year, only low-income employees in firms with under 50 employees are eligible. See Mark Hollmer, *Boston Business Journal*, "State Insurance Program Gets Boost from Mandate," October 19, 2007.

[39] Federal dollars are capped in the current waiver; there are questions about future funding levels.

[40] Jon Gabel at the National Organization for Research is currently conducting a study on "How MA employers respond to the individual mandate and other reforms" to examine the effects and unintended consequences of the health reform on ESI. The study is slated for publication in early 2008.

Conclusion

Massachusetts's experience with health care reform demonstrates that implementation is often as important as the crafting of legislation. Significant decisions have been made by a diverse group of stakeholders, which seems to have strengthened support for reform. While there has been some opposition, overall policymakers, advocates, businesses and providers remain supportive of reform.

In addition, consumer health advocates have shown commitment to monitoring implementation of the law and have been able to keep members mobilized and engaged throughout the implementation process. Although uncertainties remain, especially regarding the individual mandate and financing, involvement of consumer advocates in the implementation of health reform has improved outcomes and helped expand to coverage to thousands of people.

APPENDIX A
Affordability Schedule for Individual Mandate
Accessed at: http://www.mahealthconnector.org

Commonwealth Health Insurance Connector Authority
AFFORDABILITY SCHEDULE

Individuals

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
$0	$15,315	$0			
$15,316	$20,420	$35	2.4%	2.7%	2.1%
$20,421	$25,525	$70	3.7%	4.1%	3.3%
$25,526	$30,630	$105	4.5%	4.9%	4.1%
$30,631	$35,000	$150	5.5%	5.9%	5.1%
$35,001	$40,000	$200	6.4%	6.9%	6.0%
$40,001	$50,000	$300	8.0%	9.0%	7.2%
$50,001+		Any			

Married Couples Without Dependents

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
$0	$20,535	$0			
$20,536	$27,380	$70	3.5%	4.1%	3.1%
$27,381	$34,225	$140	5.5%	6.1%	4.9%
$34,226	$41,070	$210	6.7%	7.4%	6.1%
$41,071	$50,000	$270	7.1%	7.9%	6.5%
$50,001	$60,000	$360	7.9%	8.6%	7.2%
$60,001	$80,000	$500	8.6%	10.0%	7.5%
$80,001+		Any			

Families

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
$0	$25,755	$0			
$25,756	$34,340	$70	2.8%	3.3%	2.4%
$34,341	$42,925	$140	4.3%	4.9%	3.9%
$42,926	$51,510	$210	5.3%	5.9%	4.9%
$51,511	$70,000	$320	6.3%	7.5%	5.5%
$70,001	$90,000	$500	7.5%	8.6%	6.7%
$90,001	$110,000	$720	8.6%	9.6%	7.9%
$110,001+		Any			