



April 10, 2007

Leslie Kirwan, Chair, Commonwealth Health Insurance Connector Authority
Secretary, Executive Office for Administration & Finance
State House, Room 373
Boston, MA 02108

Re: Affordability Standard

Dear Secretary Kirwan:

We are writing on behalf of business groups and health plans that are committed to the success of the Commonwealth's Health Care Reform Law, Chapter 58 of the Acts of 2006 ("Chapter 58" or "MA Health Insurance Reform) and the goal of providing high-quality health care coverage to all Massachusetts residents.

We are writing to share our perspective and suggestions on issues related to the affordability standard – as it applies to (a) people with incomes at or under 300% of the federal poverty level ("FPL") purchasing subsidized Commonwealth Care coverage through the Connector, and (b) people with incomes over 300% of the FPL purchasing commercial coverage either directly from carriers (or their intermediaries) or Commonwealth Choice through the Connector. The single most important point that we want to highlight is that blanket exemptions are not appropriate.

Background and Fundamental Principles

We recognize that the affordability standard raises complicated and controversial issues and expect strong public pressure on the Connector to adopt a lenient affordability standard and grant affordability waivers as people face the pressure of having to purchase health insurance. We urge the Connector to resist those pressures as we sincerely believe that it is in the collective best interest of the Commonwealth and its citizens for the maximum possible number of people to have health insurance coverage.

Our goal toward expanding health insurance coverage represents sound public policy. It is better for individuals because it offers access to comprehensive coverage and regular preventive care rather than only episodic, emergency care that leads to worse outcomes and higher costs. Even otherwise healthy people often experience unexpected injury or illness. Further, maintaining a

broad risk pool is essential to the success of MA Health Insurance Reform because the uninsured are subsidized when they need emergency care, both through taxes and through higher costs for insurance.

An individual mandate is an essential element of the shared responsibility principle underlying Chapter 58. Research has shown that voluntary measures are not adequate; regardless of the price of insurance, some people will hedge their bets and go without health insurance.¹ An individual mandate is intended to require that those who are healthy and currently uninsured enter the insurance risk pool – thus avoiding adverse selection and helping to stabilize the cost for everyone. According to Connector advisors², the more people can opt-out, the more health insurance costs will increase due to adverse selection and the greater the need for expenditure of safety net funds that should be redeployed to provide individuals with subsidized health insurance. This was the basis for receiving the federal waiver from CMS and is critical to the renewal of the waiver and continued federal funding.

We recognize that the cornerstones of Chapter 58, the principle of shared responsibility and the individual mandate, involve fundamental changes in behavior and require a significant cultural shift toward acceptance that expenditures for health insurance are a necessary, rather than a discretionary, purchase. As you articulated at the April 3rd Connector Board meeting, being able to opt-out on the basis of affordability eliminates the financial penalty for failing to carry creditable coverage but does not eliminate the need for health care services or the desirability of having health insurance coverage. Basing an affordability waiver on any of the health status factors that raise the income eligibility limit for MassHealth would mean that those with too much income but most in need of health insurance coverage simply get permission to continue to go without coverage.³

Affordability Standard

We agree with Jonathan Gruber⁴ that the affordability standard should be based on what is affordable to most, but not necessarily all, people at a particular income level and that there are important indicators that the health insurance that is available through the Connector will be affordable to most at all income levels.

Given the rates that the Connector has been able to negotiate and the significant subsidies that the Connector has approved under Commonwealth Care for those with income under 300% of the FPL, we urge that the Connector create affordability tables that presume that affordable health insurance is available to those earning less than 300% of the FPL unless extraordinary

¹ See <http://www.mass.gov/legis/presentation.pdf> for the April 3, 2006 Joint Caucus for House Members, Health Care Reform Conference Committee Bill, and <http://www.mass.gov/legis/summary.pdf> for the April 3, 2006 Health Care Access and Affordability Conference Committee Report.

² See, for example, the Memorandum dated March 28, 2007 from Charlie DeWeese to Bob Carey and distributed at the April 3, 2007 Connector meeting.

³ For example, MassHealth increases the income eligibility level for people based on HIV status, pregnancy, breast or cervical cancer, disability and the need for long-term care services.

⁴ Based on Jonathan Gruber's statements at the April 3, 2007 Connector Board meeting and on his paper entitled *Evidence on Affordability From Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance* prepared March 2007.

circumstances indicate otherwise. More than half of the uninsured non-elderly in Massachusetts earn less than 300% of the FPL.

Similarly, we urge that the Connector conclude that the top income earners, either the 28% of the Massachusetts population earning 500% or more of the FPL, or the 38% of the Massachusetts population earning 400% or more of the FPL, be presumed to be able to afford Commonwealth Choice insurance, unless very extraordinary circumstances indicate otherwise.

We recognize that, depending on their circumstances, those with incomes in excess of 300% of the FPL but under the level of the top earners may face the greatest challenge affording health insurance coverage. However, the vast majority of people with incomes between 200% and 500% of FPL (well over 80%) are insured through non-Medicaid coverage. In fact, according to a 2004 study, less than 7% of those earning over 300% of the FPL are uninsured.⁵ Further, we look to the evidence presented by Jonathan Gruber concluding that those earning over 300% of the FPL are able to afford Commonwealth Choice insurance, unless extraordinary circumstances indicate otherwise.

It is interesting to note that at present people can incur high costs even if eligible for partial reimbursement through the Uncompensated Care Pool (“UCP”). While families with income at or below 200% of FPL are eligible for “full free care,”⁶ those with income over 200% of FPL and at or below 400% of FPL must pay a deductible before getting any benefit from the UCP. The formula states that The Annual Deductible = (Gross Family Income – 200% FPL) x 40%. In other words, 40 percent of the family income in excess of 200% of FPL is expected to be spent as an annual deductible before a family can benefit from the UCP. People with incomes above 400% of FPL can benefit from the UCP in the case of extraordinary medical hardship after paying a Medical Hardship Contribution equal to Available Assets + 30% of Gross Income.

Many workers earning less than 500% of FPL are currently managing to include significant health care costs in their budgets. The Connector’s standard for affordability should assume at least similar cost-sharing. It would be inequitable and undermine the current health insurance market to adopt an affordability standard that does not consider expenditures that match today’s typical health care expenditures to be affordable.

Massachusetts health care costs are among the highest in the world and premiums reflect the cost of care. The products awarded the Commonwealth Seal of Approval provide different benefit levels for buyers to choose from with premiums that vary by plan design, network of providers and cost sharing.⁷ In many instances, the products represent a significantly lower cost option than what is currently available in the nongroup market. If the individual mandate is to work, these policies must be deemed affordable.

⁵ DHCFP Health Insurance Status of Massachusetts Residents, November 2004.

⁶ Of course, the Uncompensated Care Pool is not a coverage program and does not provide a defined set of benefits. It relieves eligible individuals from medical debt to acute care hospitals “for critical access services” and community health centers. It does not cover the cost of providers who bill separately from the hospital.

⁷ *New Health Insurance Plan Will Be Available for Under \$200*, March 3, 2007 at <http://www.mass.gov/Qhlc/docs/HelathInsurance.doc>

Waiver

There needs to be a fair and robust process for affordability waivers based on individual facts and circumstances. We suggest that the standards the Connector has developed for waiving or reducing premiums for extreme financial hardship (which corresponds to the information that MassHealth collects on its Application for Waiver or Reduction of MassHealth Premium) be the starting point. MassHealth asks for proof of extreme financial hardship indicating that a person:

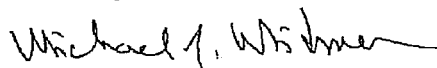
- is homeless, or more than 30 days behind in rent or mortgage payments, or has received a current eviction or foreclosure notice;
- has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone) – or has a large or long overdue utility bill but is protected from shutoff because of disability or because it is winter;
- has high medical and/or dental bills for someone in the immediate family that are not covered by MassHealth or other insurance; or
- has had a large unexpected increase in expenses within the last six months.

The last category is broad enough to allow for a waiver based on fire, flood or other unfortunate event beyond the control of the applicant. We do not support a formulaic approach or an automatic waiver based solely on income level or the percentage of income to be spent on health insurance. We understand that the Connector needs to set criteria that can avert a flood of applications but urge that the consideration be individualized.

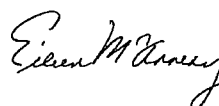
Conclusion

We understand the need to strike a sensible balance between assuring health security for Massachusetts residents and not being punitive. We also know that the individual mandate is critical to the successful implementation of MA Health Care Reform and its strength depends, at least in part, on narrow exemptions and limited waivers. We recognize that, in many respects, developing the affordability standard may be one of the most challenging steps in the implementation of Chapter 58. We urge that the Connector continue to focus on developing policies that (a) assure a large, broad-based risk pool without undue adverse selection; and (b) reflect the cost and value of health insurance coverage. We are concerned that failing to act on these fundamental principles will threaten the integrity of the balance created when Chapter 58 was enacted and undermine the long-term success of MA Health Insurance Reform.

Sincerely,



Michael Widmer, President
Massachusetts Taxpayers Foundation



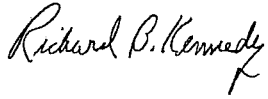
Eileen McAnney, Vice President, Government Affairs
Associated Industries of Massachusetts



Paul Guzzi, President & CEO
Greater Boston Chamber of Commerce



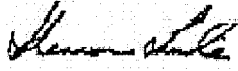
Alan G. Macdonald, Executive Director
Massachusetts Business Roundtable



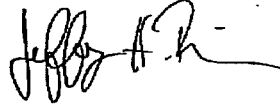
Richard B. Kennedy, President and CEO
Worcester Regional Chamber of Commerce



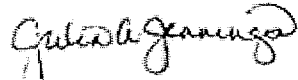
Peter Forman, President & CEO
South Shore Chamber of Commerce



Shannon Linde, Vice President
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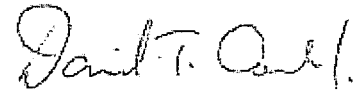
Jeff Rich, Vice President
Northeast Business Trust



Julie Jennings, President
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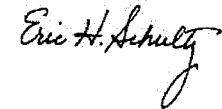
Robert A. Baker, President
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David T. Cowles, Principal
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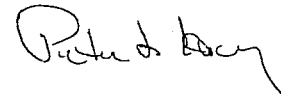
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Eric Schultz, President & CEO
Fallon Community Health Plan



Bruce Bullen, Chief Operation Officer
Harvard Pilgrim Health Care



Peter Straley, President & CEO
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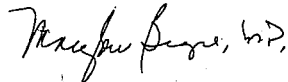
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Hon. Richard Moore, Senate Chair, Joint Committee on Health Care Financing
Hon. Patricia Walrath, House Chair, Joint Committee on Health Care Financing