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The Baker Administration's Proposed Fair Share Assessment

As health care costs continue to consume more of the state budget each year, Governor Baker's most recent budget proposal includes several bold policy provisions to curb this trend. Among the Baker Administration's initiatives are benefit changes and implementation of a new provider rate structure for the Group Insurance Commission, rate caps on the growth of provider reimbursements and additional tools to control cost for the commercial market. This is also a new employer assessment that is projected to raise \$300 million from employers in FY 2018 and more than \$700 million annually when fully implemented. The Administration's rationale for this new assessment is that, due to unintended impacts of the Affordable Care Act (ACA), MassHealth enrollment has skyrocketed due to a decline in employer sponsored insurance (ESI). Therefore, companies that do not meet insurance coverage standards should now be subject to an assessment to offset MassHealth's growing costs.

This brief summarizes the Administration's proposal, and highlights several conceptual and practical flaws that argue against its adoption.

Background – MassHealth Enrollment Growth

Among the many provisions included in federal health care reform, commonly called the Affordable Care Act (ACA), was an expansion of Medicaid eligibility for adults meeting certain income thresholds. Because the Medicaid program is a joint partnership between the federal government and the states, this eligibility expansion applies to the state's MassHealth program.

Key Takeaways

The employer health care assessment proposed in Governor Baker's budget would cost employers \$300 million in FY 2018 and more than \$700 million on an annualized basis. This money would be used to offset MassHealth cost growth.

MTF has four major concerns with the proposal.

- I. The proposed assessment far exceeds the original fair share contribution in size and scope making comparisons inapt.
- II. Data on MassHealth enrollment increases since the implementation of the ACA point to a complex mix of contributing factors and do not support a policy solution that relies solely on employers.
- III. Application of the assessment will be inequitable and not result in a change in MassHealth enrollment trends.
- IV. The assessment will likely be challenged in federal court as a violation of ERISA.

Given these concerns and the great uncertainty around the future federal funding of Medicaid, MTF is advocating against the adoption of this proposal in favor of a more comprehensive approach to controlling health care costs.

Beginning in 2014, this enrollment expansion meant that many single adults with income of up to 138 percent of the Federal Poverty Level (FPL) were eligible for health insurance benefits through MassHealth for the first time. Prior to this expansion, only low-income mothers with children, disabled adults and the elderly were generally eligible for MassHealth, while non-disabled adults without children were not.

Increased MassHealth enrollment resulting from the ACA was expected, but not to the extent Massachusetts has experienced. In a 2013 investment disclosure, the Commonwealth estimated that MassHealth enrollment would increase by 189,000 due to expansion of eligibility. According to those estimates, new enrollees were expected from four sources:

- 106,000 members migrating from the Commonwealth Connector;
- 36,000 members migrating from the state's Health Safety Net, which provides emergency care to the uninsured;
- 2,000 members migrating from the state's Medical Security Program; and
- 45,000 new members who had not previously received any state subsidized care.

In other words, 144,000 of the 189,000 total were people already receiving health care from public programs with the remaining 45,000 people representing newly insureds or those transitioning from non-public coverage.

Since the ACA's implementation began in 2014, the total MassHealth enrollment has increased by almost 500,000 members, with non-disabled adults comprising the vast majority of them. MassHealth enrollment has grown by more than 35 percent in just three years and costs have grown proportionally as well. Even with more generous federal reimbursement for these new ACA members, MassHealth costs have become unsustainable. MassHealth now consumes almost 40% of the state budget each year. In recent years, efforts have been made to more carefully review the eligibility of new enrollees to ensure that only those who meet program criteria are enrolled in MassHealth, but these efforts have not had long-lasting impacts on curbing enrollment or the cost trend.

There are several possible explanations for why MassHealth enrollment has far surpassed original estimates. The Baker Administration has focused on the theory that enrollment increases are due to working adults foregoing or not being offered employer-sponsored insurance and that premise forms the basis of the Governor's proposed fair share assessment.

The Fair Share Assessment Proposal

Under the Governor's proposal, businesses are subject to this new fair share assessment if they fail to meet minimum insurance contribution standards and uptake rates. Employers are assessed \$2,000 per employee if: (1) they do not provide insurance coverage to at least 80 percent of their full-time equivalent (FTE) employees or (2) if they contribute less than \$4,950 per employee to the health insurance coverage they offer. If coverage does not meet the \$4,950 standard, employers pay a \$2,000 assessment for each FTE. If the \$4,950 standard is met, but less than 80 percent of FTEs are covered, the assessment is paid for the difference between the employer's coverage rate and 80 percent.

Table 1. Employer Assessment Example

	Company A	Company B
FTEs	100	100
Employees covered through employer insurance	85	50
Value of insurance coverage	\$4,000	\$4,950
Assessment	\$200,000	\$60,000

Table 1 illustrates how the assessment would work. In this example, Company A provides coverage to 85% of its full-time equivalent workforce but is subject to a \$2,000 assessment per employee because the value of coverage does not meet the \$4,950 threshold. Company B meets the \$4,950 coverage standard, but pays a \$60,000 assessment because it falls short of the 80 percent coverage standard by 30 FTEs.

For purposes of the assessment, it does not matter if a company fails to cover an employee because that employee has spousal, dependent, veteran or Medicare coverage. Nor does it matter if non-covered employees are eligible for MassHealth. In spite of the basic premise of the assessment, the criteria for determining how much an employer pays has no direct connection to MassHealth enrollment.

This assessment, with a proposed effective date of July 1, 2017, is expected to generate \$300 million in revenue in FY 2018 and more than \$700 million when fully annualized.

Problems with Proposed Employer Assessment

The Foundation has identified four significant flaws with the proposed assessment:

1. Comparisons to original fair share assessments are inapt;
2. The evidence tying the increase in MassHealth to the drop of employer-sponsored insurance is not compelling;
3. The assessment impacts employers with no connection to MassHealth; and
4. The assessment is in potential violation of federal law.

1. Problems with historical comparisons

The Baker Administration has characterized this new assessment as a “reinstitution” of the Fair Share Contribution that was a part of the state’s 2006 Health Reform Law. However, this comparison ignores major differences. The Fair Share Contribution of 2006 was designed to ensure that non-offering employers contributed to the cost of medical care provided to the uninsured. It was not intended as an employer mandate; a requirement on individual employers to make a minimum contribution; a dictate on employers who they should cover; or a license for the state to set standards of coverage, as its design makes clear. It applied to employers who did not offer coverage to at least 25 percent of its workforce, and those that failed the primary test could still avoid the penalty so long as they offered to pay at least 33 percent of the cost of

coverage regardless of how many employees accepted the offer. The assessment was capped at \$295 per employee.

Table 2. Comparison of House 1 Proposal and Fair Share Contribution

	Fair Share Contribution	House 1 Proposal
Assessment per FTE	\$295	\$2,000
Minimum coverage threshold	25%	80%
Plan value threshold	33% of premium costs	\$4,950
Different standard for large and small business	Yes	No
Total revenue	\$18 million	\$300 million for 6 months of FY 2018; \$700 - \$800 million annualized

In every way, the new assessment proposal is markedly different than the original and more closely resembles an employer mandate. The coverage standard jumps from 25 percent to 80 percent, while the contribution value increases as well, making it far more difficult for a company to avoid the new assessment. Perhaps the clearest indication of the stark differences between the two assessments is the amount of revenue generated. The fully annualized revenue from the new assessment (between \$700 and \$800 million¹) represents more than 40 times the amount of annual revenue collected under the original Fair Share Contribution.

2. The assessment's theory of MassHealth enrollment growth is problematic

To support its contention that unexpected increases in MassHealth enrollment is due to employers dropping health insurance coverage, the Administration relies on data from the Center for Health Information and Analysis (CHIA). These CHIA data show a seven percentage point decline in commercial insurance coverage between 2011 and 2016 and a seven percentage point increase in MassHealth enrollment over that same timeframe. While a cursory glance may lead one to infer a causal connection, a closer look reveals a more complicated picture.

MassHealth enrollment increases over the last three years have been closely linked with the implementation of the ACA. Therefore, it's important to compare data from immediately prior to the ACA's implementation (January of 2014) to more recent data rather than making comparisons beginning with 2011 as the Administration has done. A much different enrollment picture emerges when insurance coverage information from December of 2013 is compared to data from December of 2015.

¹ –Annualized figures based on Administration estimates

Table 3. Comparison of CHIA Insurance Coverage Data

Insurance Enrollment Changes December 2013 - December 2015	
Change in MassHealth enrollment	374,962
Change in unsubsidized commercial	-92,081
Change in number of people insured	234,436

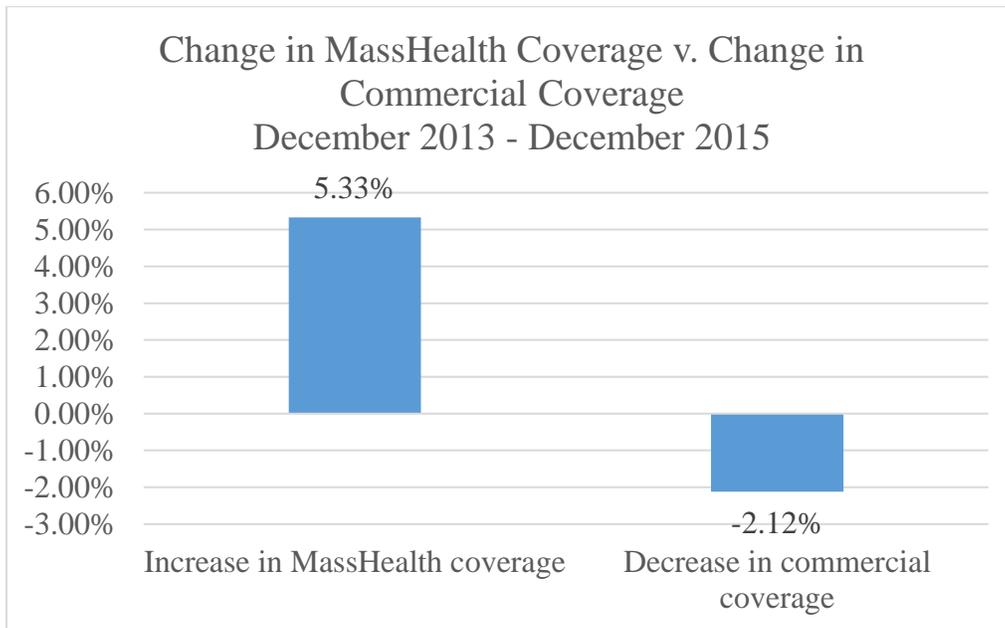
According to CHIA’s enrollment trends, MassHealth enrollment increased by 374,962 between December of 2013 and December of 2015, while, unsubsidized commercial insurance declined by just 92,081 members over the same timeframe.² At the same time, more than 200,000 residents became newly insured. These data suggest that a much smaller number of the newly enrolled MassHealth population migrated from employer-sponsored insurance and that an increase in the number of newly insured residents is likely a primary contributor to enrollment growth.

Ideally, any consideration of enrollment trends would account for changes in the state labor market, where the state has added close to 100,000 jobs and consider the number of MassHealth members who are employed. However, this analysis requires insurance coverage information to be connected with data on employment by sector, hours worked and insurance coverage history; these data are not publicly available. Per CHIA’s data, the number of residents with commercial insurance declined by just over 2 percentage points between the start of the ACA and the end of 2015, while at the same time MassHealth enrollment grew at more than twice that rate, another clear indicator that a decline in employer-sponsored insurance is not the sole reason MassHealth is growing.³

² It is likely that part of this drop in subsidized commercial coverage is due to increased membership in subsidized plans offered through the state’s Health Connector, which is not part of MassHealth.

³ Unlike the Administration, the Foundation’s data comparisons start right before the ACA and end in December of 2015, the last month before CHIA underwent major changes to its collection of commercial coverage data. Therefore, we believe that December offers a more reliable snapshot of enrollment than the March 2016 date utilized by the Administration.

Chart 1. Comparison of MassHealth & Commercial Coverage Change, 2013 – 2015



Census data paints a similar picture of insurance coverage. The American Community Survey (ACS) estimates that between 2013 and 2015 (the last year for which data are available) the number of residents covered through their employer declined by 40,000, while the commercially insured as a share of the total population decreased by 1.5 percent. Both of these data sources show a much smaller decline in commercial or employer coverage since the advent of the ACA than the numbers cited to support the assessment. In neither instance does the data suggest a decline in the number of employers *offering* insurance. They simply document that fewer employees are *accepting* their employer sponsored insurance.

The difference between an employer’s offer rate and its uptake rate is a critical distinction and highlights a key difference between the Massachusetts health care reform law and the ACA. Under the Massachusetts health care reform law (M.G.L.C. 58, section 45), adults were ineligible for subsidized care through the Health Connector if they had been offered employer-sponsored insurance. Under the ACA, there is no such prohibition. Therefore, an employee could be offered insurance through his/her employer but opt to enroll in the MassHealth program instead because it may be more financially advantageous to do so. The inability of employers to require employees to take the insurance impedes their ability to reach the 80 percent coverage requirement but becomes the grounds to penalize them under the Governor’s proposal.

Confounding efforts to analyze enrollment data, CHIA and MassHealth track enrollment in different ways. The CHIA data used to show the change in insurance enrollment trends cited above, and the EOHHS data showing a seven percentage point increase in MassHealth enrollment, consider only the primary source of a person’s insurance coverage; while MassHealth enrollment numbers include everyone receiving MassHealth, even if it is a secondary or tertiary source of insurance. When we use MassHealth’s more inclusive definition, enrollment has increased by just under 500,000 since the start of the ACA; however, a closer look at MassHealth’s enrollment changes over the last three years using either definition points to causes other than a decline in employer-sponsored insurance as the primary factors of enrollment growth.

Table 4. MassHealth Enrollment Change, 2013 – 2016 (MassHealth Data)

MassHealth population increase (11/13 - 11/16)	492,447
<i>Projected ACA increase</i>	<i>189,000</i>
<i>Non-ACA population increase</i>	<i>121,001</i>
<i>Unexpected ACA population increase</i>	<i>182,446</i>

About two-thirds (63 percent) of the almost 500,000 new MassHealth members were either expected from eligibility expansion (the initial 189,000 projection) or come from traditional Medicaid populations (such as low-income women and their children). This implies that the unexpected impact of eligibility expansion is 182,000 members.

The Administration’s assessment is built on the premise that reduced access to employer-sponsored insurance is the primary cause of this unexplained enrollment growth, but a more plausible explanation is that Massachusetts underestimated the populations impacted by Medicaid expansion. That fact, coupled with the successful public outreach campaign that encourages residents to sign up for insurance available through the ACA, are likely to have resulted in the MassHealth enrollment increases that far exceeded initial estimates.

Several factors support this notion that initial ACA projections undercounted the uninsured and other populations eligible for MassHealth. Originally, it was assumed that 36,000 residents receiving coverage through the state’s Health Safety Net (HSN) and 106,000 members receiving subsidized care through the state’s Health Connector would transition to MassHealth as a result of passage of the ACA. However, since ACA implementation began in 2014, HSN usage has declined by between 55,000 and- 80,000 members while 130,000 Connector members shifted to MassHealth. This means that actual migration from other subsidized coverage to MassHealth exceeded projections by 40 percent.

Prior to 2014, the state estimated that 81,000 uninsured residents would enroll in MassHealth. However, according to Department of Revenue data on the state’s insurance mandate, approximately 160,000 low income residents lacked sufficient insurance coverage in 2012. If a large percentage of those uninsured or underinsured low-income residents joined MassHealth after 2014, it would go a long way to explain the enrollment spike.

College students also appear to be enrolling in MassHealth at higher rates than expected. The expansion of Medicaid eligibility to low-income, single adults has enabled thousands of public and private college students across the country to enroll, a phenomenon that is more pronounced in Massachusetts given our large student population. The Administration recently received a waiver that will resolve this issue on a prospective basis by allowing the state to require these students to receive insurance through their college; however the allowance of students on MassHealth since 2014 could be another contributing factor to the program’s post-ACA enrollment growth.

Finally, ACA implementation was accompanied by a streamlined eligibility application and an extensive public outreach campaign. Starting in 2014, a single online application was employed to determine eligibility for MassHealth or other subsidized insurance options. In addition, the state and its community partners engaged in several high-profile outreach campaigns to make residents aware of the simplified process; both of these changes likely augmented MassHealth enrollment increases.

In summary, the most likely explanation for the MassHealth enrollment increase is that pre-ACA projections consistently underestimated the number of new enrollees while post-ACA outreach efforts and application improvements proved more successful than anticipated. Ignoring this combination of factors to focus solely on the decline in employer sponsored insurance is not supported by the evidence at hand.

3. *The Assessment Unfairly Penalizes Employers with No Connection to MassHealth*

The Foundation’s overarching concern with the fair share assessment is that it will subject employers with no direct role in the growth of MassHealth to substantial penalties while doing nothing to address the underlying enrollment trend.

Table 5. Example of How the Assessment Works

	Company A	Company B
FTE Employees	100	100
Average salary	\$100,000	\$20,000
<i>Employees participating in MassHealth</i>	<i>0</i>	<i>25</i>
Insured through company	35	50
Insured through spouse or parent	50	25
Insured through VA or Medicare	15	0
<i>Assessment</i>	<i>\$90,000</i>	<i>\$60,000</i>

The assessment applies to any employer who does not cover 80 percent of employees. By failing to account for employees with coverage through a spouse’s private insurance plan, Medicare or a parent’s plan, the assessment loses any connection to MassHealth. Consider the example presented above. In spite of the fact that one quarter of Company B’s employees participate in MassHealth, while all of Company A’s employees receive insurance through private or federal insurance, Company A’s assessment is 50 percent higher than Company B.

This example highlights how the application of the assessment bears no relationship to whether an employer’s workforce is enrolled in MassHealth. MassHealth’s income eligibility standards mean that the vast majority of full-time employees are not eligible for the program. The House 1 proposal, however, does not distinguish between employers whose workers could conceivably participate in MassHealth and those who could not, penalizing employers who are not contributing to the problem and doing little to curb the growth trend.

The proposed assessment’s broad application undermines its connection to enrollment changes in MassHealth. Instead, the proposal appears to be designed to efficiently generate a substantial amount of revenue from Massachusetts employers.

4. *ERISA Complications*

ERISA, the Employer Retirement Income Security Act, was enacted in 1974. A fundamental purpose of this federal law was to permit multi-state employers to maintain nationwide health and welfare plans,

providing uniform nationwide benefits and permitting uniform national administration.⁴ Therefore, ERISA preempts states from regulating employee health plans directly.

The Supreme Court of the United States has held that ERISA preempts state laws that either explicitly refer to ERISA plans or have a substantial or administrative impact on them⁵.

Court decisions have also made clear that states generally cannot:⁶

- directly regulate private employer-sponsored health plans;
- mandate that private employers offer or pay for insurance;
- tax private employer-sponsored health plans themselves;
- regulate self-insured private employee plan benefits or financial solvency; or
- indirectly affect employer-sponsored health plans by imposing substantial costs on plans.

The proposed assessment could potentially be found to violate ERISA on any one or more of the grounds listed above. While the test for whether or not an assessment based on insurance coverage violates ERISA is not clear cut, recent case law has strengthened the ERISA preemption and increased the likelihood that the current proposal would run afoul of the law. Unlike the original fair share contribution, the revenues from this assessment are not explicitly dedicating to providing care for the uninsured. Instead, the revenues are deposited into the state's General Fund with no explicit connection to health care costs. The high contribution amounts and high take-up rates of the proposed assessment more closely resemble an employer mandate than the original. These factors, and others, make this assessment the likely subject of a challenge on ERISA grounds.

Recent decisions by the federal courts related to state and local health care assessment challenges on ERISA grounds underscore the unsettled nature of case law on this topic. A case in Maryland demonstrates the consequences of failure to comply with ERISA. In 2006, Maryland passed an assessment, expected to generate \$32 million annually, on large employers that did not pay at least 8 percent of their payroll on health care costs. The federal Fourth Circuit Court of Appeals ruled the law invalid on ERISA grounds because the law provided employers with no effective way of complying with the statute other than amending their ERISA plans. More recently, the Ninth Circuit Court of Appeals upheld a San Francisco city ordinance requiring all covered employers to make a certain level of healthcare expenditures on behalf of their covered employees or pay an assessment.⁷ In contrast to the Maryland law, the Court held that employers subject to the San Francisco ordinance were provided with a meaningful alternative that allowed them to preserve the existing structure of their ERISA plans and therefore the ordinance did not violate ERISA's preemption.

Should the proposed assessment violate ERISA, self-insured employers – 60 percent of all employers – would not be subject to the assessment. Limiting the assessment to only those employers who are fully insured through the commercial insurance market would not only significantly reduce the amount of revenue the state is expected to generate, it would place the burden almost entirely on small businesses.

⁴ ERISA Implications for State Health Care Access Initiatives prepared for the AcademyHealth and the National Academy of State Health Policy by Patricia A. Butler, JD, DrPH, November 2006

⁵ Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) citing Dillingham, 519 U.S. at 324, 117 S.Ct. 832

⁶ ERISA Preemption Primer, National Academy for State Health Policy

⁷ Golden Gate Restaurant Association v. the City and County of San Francisco, (9th Cir 09/30/2008)

Conclusion

The proposed fair share assessment is based on a flawed premise, would be implemented in an inequitable manner and could be subject to a legal challenge. Most importantly, it will not address MassHealth enrollment growth and will have negative economic consequences on thousands of employers and employees. It is vital for the state to manage MassHealth cost growth, but it is important that those efforts get to the root causes of cost growth that are supported by data. Any MassHealth policy remedy should be designed to address major contributing factors to the cost growth rather than targeting only the employer community whose impact on the problem is unclear. A more comprehensive approach that includes incenting non-public insurance coverage, limiting MassHealth cost drivers and thinking long-term about how Massachusetts is positioned to respond to likely federal changes is the most prudent course for the state to take.