

# Massachusetts Medicaid buy-in:

Feasibility of establishing  
a small employer premium  
sharing plan for participation  
in MassHealth

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**Massachusetts Health Connector**  
**October 2018**



# Report on the feasibility of establishing a small employer premium sharing plan for participation in the MassHealth program

Pursuant to Chapter 47 of the Acts of 2017, Section 115

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## **Executive summary**

Pursuant to Chapter 47 of the Acts of 2017, this study examines the opportunities and challenges associated with allowing small employers to share premiums with or “buy into” MassHealth, the Commonwealth’s Medicaid program. Premium sharing would split the cost of covering employees who are eligible for the MassHealth program between MassHealth and the employer, while a buy in program would allow employees to enroll in a Medicaid benefit at any income but without subsidies and without federal “match” funding. Such a program could take many forms and achieve many different goals. This study outlines several approaches to premium sharing and buy-in programs and offers potential considerations for the General Court should it choose to approach this issue in the future.

There are two major approaches to premium sharing and buy in programs outlined in this study:

- 1) Design a Medicaid-based or Medicaid-like product for small employers to purchase alongside other group coverage
- 2) Allow employers to coordinate with MassHealth directly to defray the cost of employees’ coverage or leverage MassHealth’s provider network and claims infrastructure to provide coverage to non-MassHealth eligible employees

Either option comes with considerations related to costs, administrative ease, feasibility for the Commonwealth, employer interest, and impacts on the insurance market and health care providers. As noted in Option 1 below, many of the attractive features of a Medicaid-based or Medicaid-like product being available for sale to small businesses are already a hallmark of the Health Connector’s new Health Connector for Business program, which allows small businesses to shop for coverage from carriers that have historically participated in Medicaid as managed care organizations (MCOs), as well as commercial carriers. Early results from new groups indicate that the MCO-based offerings are gaining traction and small employers shopping through Health Connector for Business are saving on average 22% on premiums compared to small employers shopping off-Exchange.

## **Background on employer coverage in Massachusetts**

Health care reform in Massachusetts was predicated on the concept of “shared responsibility” among the state, individuals, and employers.<sup>1</sup> Together, these three groups have helped to create a stable and robust insurance coverage landscape where nearly 97% of state residents have health insurance.<sup>2</sup> However, the cost of coverage is increasingly a problem for all three groups.

While Massachusetts employers have long been national leaders in offering insurance coverage to their employees, Chapter 58 of the Acts of 2006 created new incentives to offer coverage and consequences for not offering coverage. Notably, the law created a new health insurance marketplace for individuals (and later for small businesses) through the Massachusetts Health Connector and also instituted the “Fair Share Contribution” requirement that assessed a small penalty on employers with 11 or more full-time equivalent employees and that were not deemed to be making a “fair and reasonable” contribution towards their employees’ health care costs (i.e., did not meet certain requirements related to enrollment in or subsidization of employer-sponsored health plans).<sup>3</sup>

Implementation of the Affordable Care Act (ACA) in Massachusetts brought many changes to the insurance landscape in 2014. Medicaid eligibility was expanded to include childless, non-disabled adults with income up to 133% of the Federal Poverty Level (FPL), and new subsidies were available to low- and middle-income individuals purchasing coverage through the Health Connector and other ACA Marketplaces across the country. A federal Employer Shared Responsibility Payment was required of large employers whose employees received subsidized coverage through Marketplaces. In order to avoid employers being subject to two side-by-side “employer mandates,” the state’s Fair Share Contribution was repealed in both statute in 2013 and regulation in 2014.<sup>4,5</sup>

Historically, many small businesses have faced barriers to offering coverage because of the financial cost and administrative burden.<sup>6</sup> In its periodic survey of Massachusetts employers, the Center for Health Information and Analysis (CHIA, formerly the Division of Health Care Finance and Policy) found that nearly 90% of respondents cited cost as a primary reason for not offering insurance between 2009 and 2014; that number dropped precipitously to 35% in the 2016 fielding of the survey.<sup>7, 8, 9</sup> In 2016, roughly 64% of respondents cited employees having access to coverage through another source, such as a spouse, MassHealth, or the Health Connector, as their primary reason for not offering coverage.<sup>10</sup>

Despite some declines in the percentage of the population with employer-sponsored coverage, Massachusetts employers have a strong history of offering coverage to full-time employees. However, there remain many segments of the workforce, like part-time workers, seasonal workers, contractors, and others, who do not fit into the typical benefits eligibility framework that has historically been a feature of the employer-sponsored coverage landscape. In many ways, Exchanges like the Health Connector serve as a coverage source to such individuals.

The options in this report seek to expand the choices available to employers as they contemplate how to support all of their employees in obtaining health coverage. The traditional employer-sponsored coverage model offers employers a binary “all or nothing” approach (i.e., all private financing, even if some employees would qualify for subsidies via public programs). The steep increases in commercial coverage premiums in recent years combined with new and affordable subsidized options under the ACA have made not offering coverage a more viable choice for many small businesses, while the number of individuals on MassHealth and ConnectorCare subsidized coverage has grown substantially.

## **What are “premium sharing” and “buy-in” programs?**

In requesting this evaluation from the Health Connector, the General Court primarily contemplated a premium sharing program by which employers could contribute to the cost of MassHealth coverage for their employees who are eligible for MassHealth under existing rules; however, it also requested that the Health Connector explore ways to expand such a program. Therefore, this report also considers “buy-in” programs, which would allow for individuals otherwise ineligible for Medicaid to access benefits through Medicaid structures but at full cost. The Health Connector’s exploration of this topic suggests this broader approach may be simpler to administer and more beneficial to stakeholders.

**Premium sharing:** The employer of an individual already eligible for MassHealth defrays the state's cost of covering that individual.

**Medicaid buy-in:** Individuals otherwise not eligible for MassHealth are able to receive coverage at cost that is designed by leveraging MassHealth's existing products and paid for directly by the individual or their employer.

## **What types of premium sharing and buy-in programs exist today?**

MassHealth currently offers several benefits that work with an applicant's employer sponsored insurance or otherwise allow individuals to access Medicaid coverage at incomes higher than usual income levels.

### **Small business employee premium assistance program**

The MassHealth Small Business Employee Premium Assistance Program helps individuals pay for employer-sponsored health insurance (ESI) coverage. Premium assistance reimbursements are provided to employees for the employee share of monthly health insurance premiums deducted from their paycheck. Along with the premium, MassHealth may also assist with other out-of-pocket costs associated with coverage such as copayments, deductibles, and coinsurance. Individuals who have access to qualifying ESI from a job may be eligible to enroll in Premium Assistance if they are non-disabled, non-pregnant adults with household income over the limit for MassHealth Standard or Care Plus (133% -300% FPL), working for an employer with 50 or fewer full-time employees. Additionally, eligible individuals must be uninsured, or if insured, individuals must have been a member of the former MassHealth Insurance Partnership program.<sup>11</sup> In practice, enrollment in the Small Business Employee Premium Assistance program is very low.

### **Premium assistance for employer-sponsored insurance**

When found to be cost-effective, MassHealth provides premium assistance to support an eligible individual's enrollment in qualifying employer-sponsored coverage. If an individual is eligible for a MassHealth coverage type that offers premium assistance benefits and indicates that they have or have access to employer coverage, MassHealth conducts a post-eligibility investigation of available employer coverage options. If the available option meets certain criteria, members are instructed to enroll in their employer's coverage, if not already enrolled, and MassHealth provides support for premiums as well as secondary coverage to reduce out of pocket costs and to provide any Medicaid benefits not offered by the employer's plan.

### **CommonHealth**

Most Medicaid buy-in programs that exist today allow working individuals with disabilities whose income exceed the limits for other Medicaid eligibility pathways to buy into Medicaid coverage. These options provide individuals with disabilities the opportunity to work and access the health care services they need, without having to choose between qualifying for

Medicaid and working. Approximately 44 states, including Massachusetts, had implemented such buy-in programs as of 2016.<sup>12</sup>

Since 1988, Massachusetts has operated CommonHealth, a Medicaid buy-in program offering health care benefits to disabled adults and children who are not eligible for MassHealth Standard (traditional need-based Medicaid).<sup>13</sup>

To be eligible, individuals must be disabled, and, if over age 18, must work at least 40 hours per month or meet a one-time deductible. Once eligible, members owe a monthly premium to continue their coverage, but this allows individuals whose income is much higher than would otherwise qualify for Medicaid to access robust services to meet their health needs.<sup>14</sup> Eligible individuals with existing health insurance may buy into CommonHealth at a lower premium rate to supplement their private coverage. Over 31,000 people are currently enrolled in CommonHealth.

## **What types of buy-ins have been proposed?**

A variety of proposals have been introduced at the state and federal level that would offer individuals the opportunity to buy into Medicaid or leverage the Medicaid program in some way to make coverage more accessible and affordable. As the cost of obtaining health insurance and health care has continued to outpace wage growth, such proposals have become increasingly considered as a pathway to offer quality, low-cost coverage to individuals for whom existing commercial coverage has become unaffordable.

## **ACA provisions**

Initially, the Senate version of the ACA included a Community Health Insurance Option (sometimes referred to as “the public option”) that would have been offered as a Qualified Health Plan (QHP) through the Exchanges at the discretion of the state. The Community Health Insurance Option would have required coverage of Essential Health Benefits (EHB) and set geographically adjusted premium rates to cover expected costs. Ultimately, the provision of a public option was omitted from the version of the ACA that was signed into law due to a lack of support.<sup>15</sup>

An “employee choice” voucher program was passed as part of the ACA but was repealed in 2011.<sup>16</sup> This program would have required employers to provide certain employees with the amount of money the employer would have put toward their health insurance and allowed the employee to use that money to purchase non-group coverage from a state marketplace. The voucher requirement would have been triggered for employees with income up to 400% FPL for whom the employee’s share of the lowest cost employer plan would be between 8 and 9.8% of the employee’s household income.<sup>17</sup> Those individuals would have had their employer’s coverage considered too expensive to require under the federal individual mandate but considered not so expensive that they could qualify for federal tax credit subsidies instead. The ACA allows individuals with employer coverage that costs more than 9.5% of the household’s income to be eligible for premium tax credits instead.

## **Other state and federal proposals**

Since the ACA, a variety of Medicaid buy-in programs have been proposed both in Congress and at the state level, including a proposal put forth by the Massachusetts Senate in 2017 (Section 157 of S.2211). This proposal would allow MassHealth to create an “expanded Medicaid plan” that employers could provide to all employees, regardless of their eligibility for MassHealth subsidies. MassHealth would be authorized to charge more than the cost of providing coverage and put the revenue toward increased provider rates or other MassHealth program needs. Employees otherwise eligible for MassHealth benefits would receive any additional subsidies to which they would be entitled. The proposal also authorizes applications for federal Section 1115 or Section 1332 waivers to apply additional subsidies to the plan.<sup>18</sup> Of note, most proposals have focused on buy-in programs for individuals, rather than small businesses. While the general principles of a buy-in program would be the same in group or non-group contexts, there are some complexities that come with offering employers the opportunity to buy into Medicaid. Additional buy-in proposals are summarized in Appendix 2 but should be evaluated with the knowledge that their frameworks may not be completely applicable to a small group buy-in.

## **Focus of this study**

The General Court expressed interest in understanding a variety of premium support and buy-in opportunities for small businesses, large businesses, and individuals both through MassHealth and the Health Connector. This report focuses on small businesses up to 50 employees, which, as noted above, face particular challenges in offering coverage. The majority of firms in Massachusetts are considered small businesses, although the majority of employees work for large firms. U.S. Census data from 2015 show that Massachusetts firms with fewer than 20 employees comprise 86% of all firms, but employ only 16% of all employees. Contrastingly, firms with more than 500 employees comprised only 2% of all firms but employed 54% of all employees.<sup>19</sup>

While the remainder of this study focuses on pathways by which small businesses could procure MassHealth or MassHealth-like benefits for their employees, the options examined could be expanded to individuals and large businesses as well. Individuals and small businesses are already able to purchase competitively priced plans through the Health Connector, though awareness of such opportunities for small businesses remains relatively low (but climbing) among the Massachusetts employer community.

While large businesses do not necessarily have the same structural challenges with affordability and resources as individuals and small businesses do, expansion of Medicaid premium support or buy-in programs to large groups could merit further study. Pathways to extend Health Connector group coverage to large businesses are available under the ACA, either by considering firms up to 100 employees as small businesses or by allowing the Health Connector to sell large group coverage.<sup>20</sup> However, changes to Massachusetts law would be necessary to effectuate either of these and would require further study to determine their impact on markets and risk pools.<sup>21</sup>



The options described in this report will be evaluated on a variety of factors, summarized in Figure 1. These criteria will apply practical considerations to policy proposals to aid the Legislature in its decision-making process.

**Figure 1: Evaluative criteria**

<b>Administrative ease for consumers</b>	Programs should have low barriers to entry and ideally would scale to serve small employers, large employers, and individuals with the same basic design.
<b>Interest among target consumers</b>	Programs should incentivize employers to continue offering insurance coverage or newly offer coverage. This includes addressing affordability of coverage.
<b>Cost for the Commonwealth</b>	Programs should neutralize or reduce state spending.
<b>Feasibility of implementation</b>	Programs should leverage existing infrastructure of the MassHealth and Health Connector programs to the extent possible with a minimum of new administrative work or technical development.
<b>Federal approval requirements</b>	Programs may require federal approval to implement; any option requiring federal approval should fall within existing parameters for modifications as outlined by federal agencies.
<b>Overall market impact</b>	Programs should have a positive effect on the insurance market in Massachusetts, including on the dimensions of risk, cost, and competition.

## **Federal approval requirements**

Federal statutes governing Medicaid programs and Exchanges include opportunities for states to request flexibility from federal rules to pursue innovative policy approaches not addressed in the law directly. Under Medicaid rules, these are known as “Section 1115” waivers. Massachusetts already has an “1115 waiver” in place that authorizes a variety of activities. The ACA offers Exchanges flexibility under its “Section 1332” waivers. Both waiver processes require states to adhere to certain “guardrails” to ensure that innovations are designed to maintain or increase coverage rates while keeping federal costs neutral.

## **Option 1: Offer Medicaid product alongside other group coverage**

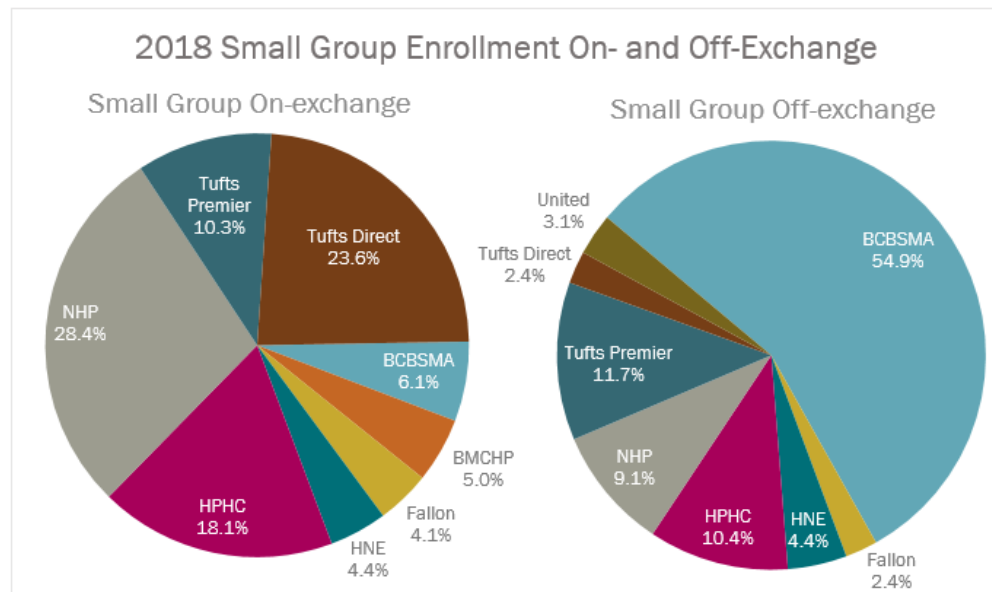
At a high level, this option would allow small businesses to choose a Medicaid or Medicaid-like product instead of group coverage offered from a commercial insurance carrier. Allowing consumers to see such a product alongside other options and to enroll in the product via a typical commercial coverage process offers administrative simplicity for employers. A premium support program for Medicaid-eligible employees would require that employers take different approaches to benefit choices based on the household income of their employees—information they are not likely to know. A Medicaid-based group plan could benefit enrollees at all income levels by using the buying power of MassHealth, while being financed by enrollees rather than the state.<sup>22</sup>

While a variety of channels exist for small businesses to enroll in health insurance, creating a Medicaid product unique to the Massachusetts Health Connector's product shelf offers several advantages. The Health Connector has over ten years of experience offering coverage to individuals and small businesses, particularly "micro" groups up to 5 employees, which are the groups least likely to offer coverage.<sup>23</sup> The Health Connector also has strong ties to MassHealth, given its integrated application for individual coverage.

A product offering exclusive to the Health Connector would dovetail with other unique tools that help keep costs down for businesses that purchase Health Connector coverage, such as "employee choice" purchasing options, apples-to-apples plan comparison opportunities, federal tax credits, and state-sponsored premium rebates for wellness activities. The "employee choice" models allow an employer to choose a level of coverage richness or a particular carrier and then allow employees to choose from a variety of plans at that level or from that carrier. This allows employers to make a set contribution that works for their budget, while also freeing employees to buy a plan that meets their needs.

To the extent that the Legislature's interest is in finding lower-cost ways for employers to offer health insurance, it bears noting that the Health Connector's new Health Connector for Business program is achieving that goal for its members, a dynamic that could have substantial implications for the small group market as the scale of Health Connector for Business grows. Employers who shop with the Health Connector tend to choose different plans than employers who purchase coverage outside the Health Connector, often choosing lower-cost carriers with a history of offering coverage through MassHealth and through the Health Connector's subsidized non-group programs. (See Figure 2.) Carriers like Neighborhood Health Plan, Tufts Health Plan – Direct, and Boston Medical Center HealthNet plan comprise a much larger share of the Health Connector's small group members than off-Exchange small group members. It is important to note that one way some of these carriers keep costs low is with narrow provider networks. Typically, employers tend to offer coverage with very broad networks to ensure all employees have access to their chosen providers. However, where the Health Connector is serving many "micro" groups, they may find that a narrower network suits their needs as well as keeps costs low. Additionally, the employee choice models allow each employee to choose the network that includes their preferred providers, avoiding the need to engage only one plan with a broad network.

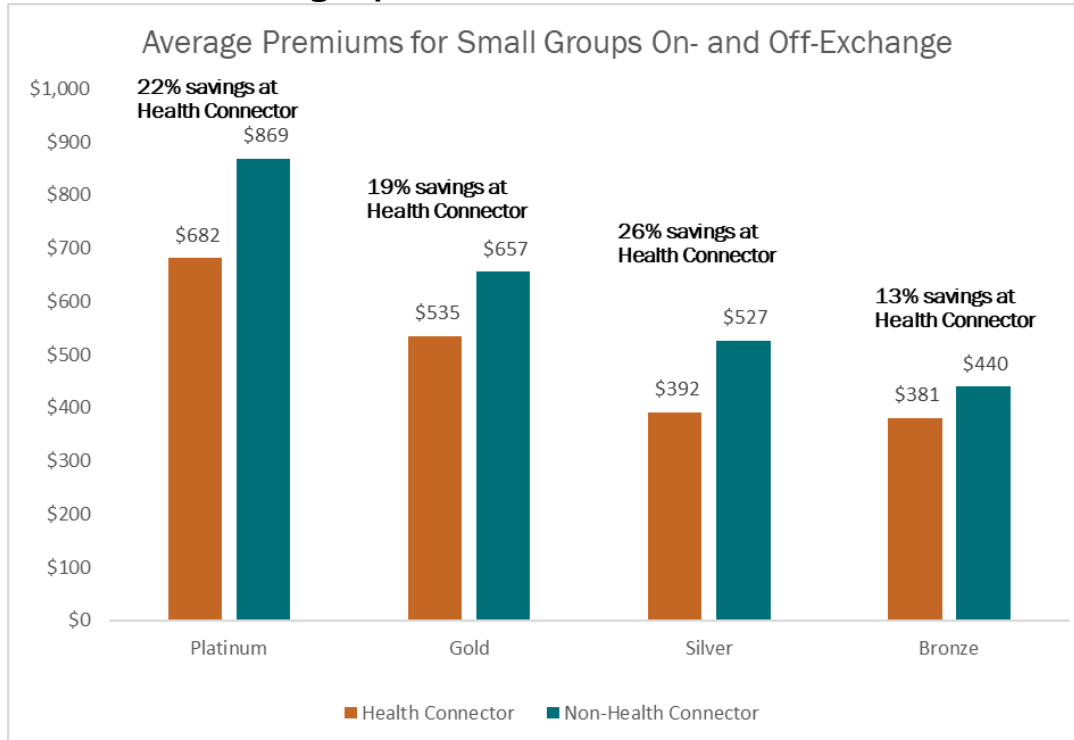
**Figure 2: Comparison of enrollment by carrier among Health Connector and non-Health Connector small groups**



Source: CHIA Enrollment Trends August 2018 Databook. Data from March 2018. <http://www.chiamass.gov/enrollment-in-health-insurance/>. Enrollment totals for On-Exchange Non-Group enrollment do not include ConnectorCare enrollment. Excludes carriers with negligible enrollment.

Compared to their peers who purchase outside the Health Connector, Health Connector groups spend 22% less in premiums, on average, just by virtue of choosing plans from lower-cost carriers. These savings are consistent across metallic tiers; employers purchasing any level of coverage from the Health Connector tend to choose lower-cost plans than employers choosing similar benefits outside the Health Connector. (See Figure 3.)

**Figure 3: Comparison of average premiums by tier among Health Connector and non-Health Connector small groups**



*Based on internal analysis of average premiums by the Health Connector for illustrative and comparative purposes only. Premiums reflect a group of 42-year-olds in Boston in the "Eating places" industry. Rates represent a simple average of 4Q 2018 rates for the products within a metallic tier offered on-exchange by each carrier participating in the exchange. Enrollment reflects all products in a given metallic tier, including the ones not offered on-Exchange for off-Exchange enrollment. Includes all regions and renewal months.*

A new Medicaid or Medicaid-like product would not change an individual's eligibility for MassHealth programs independent of their employer, but some employees may forgo applying for Medicaid individually in the event their employer offered them robust and affordable coverage. However, others may already be enrolled or choose to apply for other reasons, such as a family member who needs coverage. In that instance, MassHealth would coordinate benefits such that it paid only the difference between the employer's coverage and the Medicaid benefit package for which the employee was eligible.

Offering a Medicaid product through the Health Connector could take two forms, as outlined below: either a new product developed by the Commonwealth and approved for sale, or a product developed by an existing licensed health insurer. While the general process of plan design and sale is the same in either option, there are considerations specific to each pathway that merit discussion.

### **Considerations: State-administered product**

A state-administered Medicaid product would require federal approval to sell via the Health Connector. Under ACA rules, Exchanges like the Health Connector may only sell "Qualified Health Plans," or QHPs, that are licensed for sale by a state's insurance regulator. This product would not be considered a Qualified Health Plan under current rules because MassHealth is not offered by an issuer that is licensed by the state.<sup>24</sup> However, a Section

1332 waiver could be requested to offer a benefit plan that is tied directly to MassHealth's provider contracts, including its Accountable Care Organizations (ACOs). If designated as a QHP, subsidies could be available through the ACA Small Business Tax Credit for employers. Sale of a state-administered Medicaid product would require a significant administrative investment by the Commonwealth to design a product as well as to request federal approval, particularly on the parts of MassHealth, the Health Connector, and the Division of Insurance. In the implementation phase, there may be additional infrastructure needed on the Health Connector's website to process enrollments and payments in a state-administered product. Depending on the nature and disposition of the Section 1332 waiver, the state may obtain Small Business Tax Credit funds to use to defray the cost of premiums. Maintenance and application of that funding would also likely require modifications to the Health Connector platform. However, no federal reimbursement would be available for a Medicaid product purchased by individuals who would not otherwise qualify for MassHealth. Finally, once the product is available to enrollees, customer service support and claims administration would be required.

While creating a new insurance product leveraging MassHealth's provider rates and networks could produce more affordable options in the market, a state-administered product could also reduce the number of affordable options. A low-cost plan administered by the state would likely compete for members with existing low cost plans, which are often sold by carriers that participate in MassHealth managed care programs as well as the Health Connector's ConnectorCare program. Should those carriers find it no longer sustainable to participate in MassHealth or Health Connector programs because a state-administered product reduces their market share, there may be undesirable negative impacts to competition in those programs.

### **Considerations: Issuer-administered product**

While the Health Connector for Business platform already has low-cost plans available from Medicaid managed care organizations, the Commonwealth could leverage the Health Connector's annual plan certification process to enhance enrollment in Medicaid-like plans from existing licensed insurers. Where several carriers participate both in MassHealth and Health Connector programs today, they may be well-positioned to design QHPs using their expertise in Medicaid products, including possibly working to use contracts with their existing Medicaid providers in a QHP design. It is possible that their strategy to drive low premiums already relies on their experience in the subsidized coverage market. This option both eliminates the need for a section 1332 waiver as well as avoids introducing a new dynamic into the merged market at a time of uncertainty regarding federal policy actions. However, it also precludes at this time using certain innovative payment structures being implemented within MassHealth, like ACOs.

Adding affordable options that draw new lives into the merged market helps to provide stability, which could contribute to lower rates in the future. Plans sold via the Health Connector with its "Seal of Approval" that offer comprehensive coverage at a low premium provide quality options from a trusted source. Further, a plan exclusive to the Health Connector could increase the Health Connector's scale, drawing down costs market-wide. A similar trend has occurred in the individual market, where the ConnectorCare program has

helped Massachusetts's Marketplace unsubsidized premiums become some of the lowest in the country.<sup>25</sup>

Strategies that encourage low premiums on the non-group shelf could be applied to the small group shelf, as well. To administer the ConnectorCare program, the Health Connector issues a request for responses that includes Silver plan variations that are “compatible” with the extra subsidies Massachusetts provides. All carriers submit these Silver plans, but only some of them are chosen to receive the extra subsidies and be a ConnectorCare plan. The underlying Silver plans from all carriers are available to members who do not qualify for ConnectorCare, at the low premiums that carriers competing for a spot in the ConnectorCare program offer. Currently, the generous federal and state subsidies that make low Silver tier premiums even lower do not have analogues in the small group market. The federal tax credit for small businesses that purchase Exchange coverage is complex and under-utilized. A 1332 waiver through which the state draws down this tax credit money on behalf of small employers and uses it to subsidize a Medicaid-based Exchange product could result in a dynamic similar to that of ConnectorCare in the non-group space, but it would also require federal approval. Other state-level initiatives, such as revised small group wellness incentives or tax-based incentives, linked to enrollment in competitively priced Health Connector small group coverage could also have a positive impact on unsubsidized rates.

## **Option 2: Purchase Medicaid product directly from MassHealth**

As an alternative to purchasing a Medicaid product from the Health Connector, employees may be allowed to enroll in Medicaid through existing channels, with employers defraying part of the cost. This kind of a program could be designed as either a premium sharing arrangement, where only individuals who qualify for Medicaid benefits would be eligible for such a defrayal program, or as a combination premium sharing and buy-in program, which would defray the state's cost of covering Medicaid-eligible individuals but would also allow employers to purchase coverage for non-Medicaid eligible employees without subsidy.

Such a program could be employee-driven, where individuals apply to MassHealth for benefits and, if eligible, their employers contribute to coverage costs either through a premium assistance model or an assessment model. Alternatively, this could be an employer-driven program where employers proactively work with MassHealth to provide coverage to their employees with the appropriate allocation of funding.

In either case, this option could allow employers to expand the reach of their benefits to employees who typically are not eligible for employee benefits, such as part time workers or per diem workers. Employers may be able to make a smaller, proportional contribution to coverage for these types of workers, possibly in conjunction with other employers, if the individual has multiple jobs. Coordination between participating employers and MassHealth could help provide continuity of coverage as workers have changes in hours or wages, as well.

## **Employee-driven program**

In an employee-driven premium sharing program, individuals would continue to apply for and enroll in MassHealth as they do today. However, employers could coordinate with MassHealth to pay for some portion of their employees' costs. This could be done by MassHealth supplementing and subsidizing the employer's plan or by the employer paying MassHealth a periodic coverage cost.

One example of an employee-driven premium sharing arrangement is the current premium assistance model, as discussed above, where MassHealth provides a subsidy to its member to defray the cost of their enrollment in an employer's plan. Alternately, MassHealth could provide coverage directly through its provider contracts and have the employer provide a payment to MassHealth.

### **Considerations**

While a premium assistance model is one that MassHealth uses today for certain enrollees, it is predicated on an employer offering insurance to the MassHealth eligible employee; nothing about the program requires that an employer offer coverage or to which of its employees. It is unlikely that the existence of a premium assistance benefit alone would induce a firm to offer coverage or to expand coverage offers to employees not otherwise eligible, such as part-time workers. Expanded premium assistance benefits for employees would likely need to be combined with other incentives for employers to offer.

Providing a contribution to MassHealth for eligible employees could be attractive to employers who might want to support their employees but who do not want the burden of engaging and administering health coverage. However, where this would be a true premium sharing program, individuals would qualify for Medicaid regardless of their employer's participation. This option would also likely need to be combined with other incentives for employers to encourage a voluntary contribution.

Expanding the types of MassHealth enrollees who could use a premium assistance model would require federal approval, with a mandatory program subject to greater scrutiny under an 1115 waiver amendment than a voluntary program, which could be implemented via a State Plan Amendment.<sup>26</sup> Further, MassHealth would need to analyze the potential costs and benefits of such a program to determine its impact on the program's budget.

## **Employer-driven program**

In an employer-driven buy-in arrangement, employers could coordinate with MassHealth to provide a benefit package to all employees where Medicaid-eligible employees and their dependents could receive benefits with federal and state support and non-Medicaid eligible employees could be paid for entirely by employer and employee contributions, similar to a traditional employer sponsored plan.

In such a program, MassHealth would need to determine the amount an employer would be required to contribute. Methodologies could incorporate the number of Medicaid-eligible

employees, and, for non-eligible employees, use the average cost of a Medicaid member plus an administrative fee, or attempt to predict costs by “matching” employees to existing MassHealth members based on factors such as age, geography, or health status. Any methodology would need to be evaluated for budget neutrality as well as compliance with non-discrimination rules.

## Considerations

Prior to the ACA, the state’s Insurance Partnership program offered subsidies to employers to support the coverage of their low-income employees.<sup>27</sup> However, the ACA’s Medicaid expansion provides a new pathway for many of the employees previously served by the Insurance Partnership. A new program similar in concept to the Insurance Partnership would likely produce different outcomes given the different programs available to individuals outside their employer’s plan.

## Evaluation summary

Each of the options above comes with a series of considerations, and each may further particular goals better than others. Several recent publications about Medicaid buy-in programs have discussed the variety of goals such a program may aim for, such as reducing the cost of insurance, increasing access to coverage, and promoting competition.<sup>28,29</sup> Should the General Court be interested in pursuing a buy-in program further, a robust analysis of its overall market impact would be needed to predict costs and outcomes.

**Figure 4: Evaluation summary**

Criterion	State-administered Exchange product	Carrier-based Exchange product	Employee-driven Medicaid program	Employer-driven Medicaid program
<b>Administrative ease for employers</b>	Easy to use existing Health Connector for Business platform	Easy to use existing Health Connector for Business platform	Not especially predictable; often reactive rather than proactive	Predictable and proactive
<b>Interest among target consumers</b>	Depends on cost and network	Depends on cost and network	Not a clear impact on employer	Depends on cost and network, if Medicaid-based product
<b>State cost</b>	Would incur potentially significant design and administration costs; depends on any impact to availability of federal subsidies	No additional cost for small group offering; total cost impact depends on any impact to availability of federal subsidies	Would incur design and administration costs; depends on any impact to availability of federal subsidies	Would incur design and administration costs; depends on any impact to availability of federal subsidies



<b>Feasibility of implementation</b>	Significant effort for Commonwealth	Feasible; uses existing channels that currently offer similar products	Feasible; uses existing channels	Significant effort for Commonwealth
<b>Federal approval requirements</b>	Yes	No	Yes	Possibly; depends on program design
<b>Overall market impact</b>	Further study needed	Further study needed	Further study needed	Further study needed

## Conclusions

The cost of health care is a growing burden for individuals, employers, and the Commonwealth. The continued success of Massachusetts's significant health care policy initiatives relies on participation from all three of these groups.

Policy proposals to expand health insurance coverage or to change the source of an individual's coverage need to respond to state and federal rules, market dynamics among both insurers and providers, consumer preferences and needs, and the framework of the significant changes introduced by the ACA. Accordingly, incentives for employers must acknowledge the access to subsidized coverage available to low income employees without offers of employer coverage. A Medicaid buy-in program recognizes both the strength of the MassHealth program as well as the challenges faced by small businesses in purchasing and administering health benefits. However, its impact on the Massachusetts merged non-group and small group insurance market could have unintended consequences for payers, providers, and enrollees that warrant further study.

## **Appendix 1: History of employer-related health care policy in Massachusetts**

### **1988**

- The Medical Security Program, which used an assessment on employers to provide coverage to individuals collecting unemployment insurance was established by Chapter 23 of the Acts of 1988.<sup>30</sup>
- Chapter 23 also included an employer “pay or play” mandate applicable to employers with 6 or more employees whereby employers would have to pay up to \$1,680 per employee per year for not offering health insurance.<sup>31</sup>

### **1996**

- The employer mandate of 1988 was repealed without ever having gone into effect.
- The Insurance Partnership was created to support small businesses and their low income employees.<sup>32</sup>

### **2006**

- The Fair Share Contribution included in Chapter 58 of the Acts of 2006 assessed employers with 11 or more full time equivalent employees (FTEs) a fine of \$295 per employee per year if they failed to meet specific subsidy levels and take-up rates.<sup>33</sup>
- Employers with 11 or more FTEs were required to establish Section 125 plans to allow non-benefits eligible employees to make pre-tax contributions towards their own health coverage.
- The Free Rider Surcharge provision required employers that had (a) not complied with the state’s Section 125 requirement and (b) who had employees who were uninsured and had care paid for by the Health Safety Net uncompensated care pool to pay a fine.

### **2013**

- The Fair Share Contribution was repealed to avoid subjecting employers to two mandates as the Affordable Care Act’s employer shared responsibility payment was set to begin in 2014. The Free Rider Surcharge was repealed due to 2013 IRS guidance that made the state’s Section 125 requirement no longer permissible.

### **2014**

- The Medical Security Program was closed as unemployed individuals would be able to enroll in subsidized Health Connector or Medicaid coverage; however the assessment employers paid toward the program (formerly UHI) was maintained as the Employer Medical Assistance Contribution (EMAC) to support state subsidies for (a) unemployed workers and (b) other workers not covered by employer-sponsored coverage who are on state-funded coverage programs.

## Appendix 2: Other state and federal proposals

While this table highlights a select group of state and federal buy-in proposals, several other states are also examining opportunities to make coverage more accessible and affordable using various models to develop buy-in proposals.<sup>34</sup>

Federal proposals		
S.1970/H.R.4094 Kaine-Bennett <sup>35</sup> “Medicare-X Choice Act of 2017”	Introduced in Senate on: 10/17/17 Latest Action: 10/17/17 Referred to the Senate Committee on Finance.  Introduced in House on: 10/23/17 Latest Action: 10/27/17 Referred to the House Subcommittee on Health	Introduces a Medicare-like public option on exchange called “Medicare-X.” The public option would first be phased in to counties lacking providers or competition, then to the individual market at large, and finally, to small business employers. Medicare-X would leverage Medicare’s provider network and reimbursement rates.
S.2708/H.R.6117 Murphy-Merkley <sup>36</sup> “Choose Medicare Act”	Introduced in Senate on: 4/18/18 Latest Action: 4/18/18 Referred to the Senate Committee on Finance.  Introduced in House on: 06/14/18 Latest Action: 06/26/18 Referred to the House Subcommittee on Health	Creates a new Medicare plan, “Medicare Part E,” to be offered on both State exchanges and HealthCare.gov to individuals and employers of all sizes. The Medicare Part E plan would leverage ACA subsidies, the existing Medicare provider network, and Medicare’s low administrative costs. <sup>37</sup>
S.2001/H.R.4129 <sup>38</sup> Schatz-Lujan “State Public Option Act”	Introduced in Senate on: 10/24/17 Latest Action: 10/24/17 Referred to the Senate Committee on Finance.  Introduced in House on: 10/25/17 Latest Action: 10/27/17 Referred to the House Subcommittee on Health	Allows those who are ineligible for Medicaid and not enrolled in other health coverage to buy into a state Medicaid plan. The Medicaid buy-in plan would be treated as the second-lowest silver on Exchange and would leverage Medicare provider reimbursement rates.
State proposals		
SF 58/HF92 <sup>39,40</sup> Minnesota “MinnesotaCare Purchase Option”	Introduced in Senate on 1/9/17 Latest action: 1/9/17 Referred to Health and Human Services Finance and Policy  Introduced in House on 1/9/17 Latest action: 1/9/17 Referred to Health and Human Services Reform	Allows individuals with income above the eligibility level for MinnesotaCare (the state’s Basic Health Plan) to purchase one of two (Silver and Gold tier) MinnesotaCare-like plans on exchange. The buy-in option would leverage existing managed care contracts for Medicaid and MinnesotaCare as well as the broad network of MinnesotaCare doctors.
A.B. 374 <sup>41</sup> Nevada “SprinkleCare”	Introduced in Assembly on 3/20/17 Latest action: 6/16/17 Vetoes by the Governor	Offers Medicaid coverage commercially on Nevada’s State Health Exchange, leveraging the structure and negotiated rates of the existing Medicaid program. Nevada’s State Assembly and Senate passed the bill but it was vetoed by the Governor before it became law.



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