Backgrounder

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Massachusetts Health Care Reform Has Left Small Business Behind: A Warning to the States

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Abstract: *Implementation of the Massachusetts health care reform has largely failed to address the needs of small businesses and their employees. Given that small businesses generate most new jobs, this breakdown also constitutes poor economic policy. As other states take up health care reform under the implementation deadlines of President Barack Obama's health care law, they would be wise to implement health reforms that best address the needs of their states, including their small business communities. States should eliminate counterproductive health care mandates and craft reforms that promote market choice and competition, which will help to control the cost of providing coverage for the employer and help to provide affordable, quality coverage for employees.*

In implementing the Massachusetts health care reform, officials have let down the small business community. While the plight of the small business community was a central concern of former Governor Mitt Romney (R), the state's administrators, executive branch, and legislature have paid little attention to the pressing problems of small businesses. Worse, current Massachusetts officials have exacerbated the situation in how they have implemented the reform.

Small businesses in Massachusetts, especially those with 10 or fewer employees, remain close to the national average of employer-offered coverage of 67 percent, compared to 98 percent for the rest of Massachusetts businesses.[1] The Massachusetts Employer Survey shows the gravity of the situation for small

Talking Points

- The Massachusetts health care reform law was originally intended to assist small businesses with escalating insurance premiums, but its implementation has left them out of any meaningful reform.
- Leaving out small businesses makes little economic sense given that they constitute roughly 90 percent of businesses in Massachusetts and have historically driven job creation.
- Many of the policy proposals being implemented or discussed are shortsighted and anti-market and fail to address the many underlying issues of rising health care costs.
- State officials should allow defined contributions for health insurance to promote market choice and competition, create a mechanism to aggregate contributions for persons with more than one employer, reduce or eliminate health benefit mandates that drive up costs, and establish a risk-adjustment mechanism to cope with adverse selection.
- Instead of waiting for a one-size-fits-all federal plan, states should set up their own exchanges, but learn from Massachusetts's false starts with small business.

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companies with 50 or fewer employees. For example, the median monthly premium for a family health plan for small firms (50 or fewer employees) has risen 46 percent since 2001.[2] After adjusting for variations in geography, demographics, and benefits, small employers pay higher premiums on average than mid-sized and large-sized companies, and their premiums are rising more quickly.

The strain on small businesses has been documented in recent published accounts of small firms beginning to drop coverage.[3] While Commonwealth Care,[4] the state's subsidized program, has seen annual premium rate hikes of around 5 percent, rates for small businesses have increased 15 percent per year over the past five years, according to a survey commissioned by the Retailers Association of Massachusetts.[5] State-collected data from 2007 and 2008 also show a small decrease in premium contributions by small employers as costs continued to rise. [6] This trend could help to explain declining employee participation in employer-offered insurance at small companies.[7]

Given that 90 percent of the roughly 185,000 businesses in Massachusetts are small companies, which historically create two-thirds of all new jobs in Massachusetts, state officials' failure to consider the needs of small businesses is bad economic policy, especially during a downturn.[8]

An estimated 97.5 percent of Massachusetts residents are now covered by health insurance. For low-income persons, particularly those who previously had no health insurance, the 2006 law has been a positive experience. Yet the state's decision to offer virtually free insurance to these residents has come at the expense of helping small businesses, which could employ these same individuals if they had received rate relief in their health insurance. These implementation decisions have cost the state millions in additional subsidies that could have been averted if some of these individuals were covered under an employer-sponsored plan. Other states should closely examine Massachusetts's decisions during implementation to avoid making the same mistakes when designing and implementing their own reforms.

How Implementation Undercut Original Intent

Implementation of the Massachusetts health care reform has largely failed to address the needs of small businesses and their employees.

1. Data compiled from Massachusetts Office of Health and Human Services, "Massachusetts Employer Health Insurance Survey," Web site, at *http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Researcher&L2=Insurance+%28including+MassHealth%29&L3=Health+Insurance+Surveys&sid=Eeohhs2&b=terminalcontent&f=dhcfp_researcher_employer_survey&csid=Eeohhs2* (June 23, 2010).
2. *Ibid.*
3. Kay Lazar, "Firms Cancel Health Coverage," *The Boston Globe*, July 18, 2010.
4. Commonweath Care (CommCare) is a sliding-scale subsidized program offered through the Connector to help adults who are not offered employer-sponsored insurance; do not qualify for Medicare, Medicaid, or certain other special insurance programs; and earn less than 300 percent of the federal poverty level to buy private insurance.
5. Julie M. Donnelly, "Express Delivery: Connector Unveils Health Insurance," *Boston Business Journal*, March 12, 2010, at *http://boston.bizjournals.com/boston/stories/2010/03/15/story4.html* (August 4, 2010).
6. Massachusetts Executive Office of Health and Human Services, Division of Health Care Financing and Policy, "Fair Share Contribution Data Trend Analysis Filing Years 2007 and 2008," October 2009, at *http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/fair_share_trend_analyses_oct-2009.ppt* (August 10, 2010).
7. Employee participation levels for small companies with 11 to 50 full-time equivalents (FTEs) declined from 78 percent in 2007 to 75 percent in 2009. Amy M. Lischko and Kristin Manzolillo, "An Interim Report Card on Massachusetts Health Care Reform—Part 2: Equitable and Sustainable Financing," Pioneer Institute *White Paper* No. 51, February 2010, p. 5, at *http://www.pioneerinstitute.org/pdf/100218_interim_report_card2.pdf* (August 16, 2010).
8. Richard Lord and Bill Vernon, "Insurance Mandates Unhealthy for Business," *Boston Herald*, June 25, 2008. For more information on job creation during a recession, see James Sherk, "The Cause of High Unemployment: Still Due to Dwindling Job Creation," Heritage Foundation *Backgrounder* No. 2392, March 24, 2010, at *http://www.heritage.org/Research/Reports/2010/03/The-Cause-of-High-Unemployment-Still-Due-to-Dwindling-Job-Creation*.

Small Business–Friendly Elements of the Romney Reform Design. Governor Romney's original health reform proposal envisioned a statewide health insurance exchange that would have offered small businesses a robust choice of plans with a wide range of deductible and benefit levels.[9] His proposal provided for defined contributions from employers, used the exchange as a "premium aggregator," and created a pooling mechanism to allow employees of small businesses to purchase group insurance together to spread risk and provide greater premium stability. It was a market-oriented, consumer-centered agenda designed to promote personal choice and ownership of portable health insurance for employees in small businesses.

The design was informed by survey data showing that roughly 78 percent of the uninsured in the state were employed, a majority working full-time, but their employers were struggling to afford health insurance coverage.[10] The goal was to provide affordable plans to all residents by:

- Empowering consumers to pick their own insurance plans with innovative benefit designs that met their insurance needs;
- Promoting greater competition and price transparency; and
- When necessary, leveraging monies already being allocated for uncompensated care at hospitals to assist the poor in purchasing insurance instead.

The original proposal called for benefits that focused on value: preventive and primary care, emergency services, surgical benefits, hospitalization benefits, ambulatory patient care, and mental health benefits.[11] This value-driven standard is significant when juxtaposed with the minimum creditable coverage (MCC) that the Connector Board approved for 2011.[12] The MCC includes 17 coverage requirements and 28 benefit mandates for all health carriers that sell insurance.[13] These mandates have contributed to driving up the cost of coverage.

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Romney's proposal for an exchange provided incentives for small business participation, such as different rating standards for small businesses and a discount for low tobacco usage and participation in wellness programs.[14] The plan helped to level the playing field for small business employees by enabling them to purchase insurance with pre-tax dollars. Allowing small businesses to participate in the exchange would streamline the administrative burden and limit the minimum participation and contribution hurdles that had previously prevented many businesses from offering coverage.

The proposed policy was a thoughtful alternative to the heavily regulated and restrictive nature of the health care insurance market at the time.[15] It would have helped to elevate the individual employee as the primary decision maker and injected competition into the system to apply downward pressure on

9. An Act to Increase the Availability and Affordability of Private Health Insurance to the Residents of the Commonwealth, H. 4279, 184th Massachusetts General Court, at *http://www.mass.gov/legis/bills/house/184/ht04pdf/ht04279.pdf* (July 20, 2010).
10. Massachusetts Executive Office of Health and Human Services, "Safety Net Care," internal PowerPoint presentation, June 21, 2005.
11. H. 4279, § 87, amending Mass. Gen Laws, ch. 176Q, § 6(d)(1) (2005).
12. The Connector Board is the governing body of the Connector.
13. Massachusetts Health Connector, "Health Care Reform: Key Decisions," Web site, at *https://www.mahealthconnector.org/portal/site/connector/menuitem.9ccd4bd144d4e8b2dbef6f47d7468a0c* (August 27, 2010). See also Massachusetts Office of Consumer Affairs and Business Regulation, "Massachusetts General Laws Mandating That Certain Health Benefits Be Provided by Commercial Insurers, Blue Cross and Blue Shield and Health Maintenance Organizations," revised July 1, 2010, at *http://www.mass.gov/Eoca/docs/doi/Consumer/HealthLists/mndatben.pdf* (August 16, 2010).
14. H. 4279, § 60.
15. Heritage Foundation staff participated in the policy discussions during the formation of the original plan.

increasing costs. Even with the policy compromises required to pass the health care reform bill in 2006, the final version still included mechanisms that would have helped small business in the short term—if they had been implemented.

Altered During Implementation. During implementation, these mechanisms were altered in ways that changed the design and the outcome for small businesses.

Outcome. The 2006 health care reform law tasked the Connector[16] with developing a small business program. The originally planned launch date was July 1, 2007, but coverage was not finalized until January 2009, almost three full years after the health care reform bill was signed. Even with this lengthy delay, the Contributory Plan (CP), the original program, suffered from design and incentive issues.[17] Instead of engaging with the broker community that sells mainly to small businesses, the Connector allowed only 20 brokers to sell CP and then only to the companies that were already their clients. Because of budget restraints, the Connector offered these brokers a 2.5 percent fee, compared to the 4 percent standard commission that they could earn outside of the Connector.[18]

The designs of the health insurance products offered through the Connector lacked creativity, were very similar to options available outside of the Connector, and sometimes were more expensive.[19] While plans were required to be rated using a modified community rating similar to plans outside of the Connector, CP insurers were prohibited from re-rating a plan regardless of the characteristics of the final enrollees. Additionally, for employees choosing to deviate from the employer-selected benchmark plan, a list billing (or age rating) was used, making the switch unattractive to older workers.[20] The plans lacked network diversity as most plans allowed full access to all providers regardless of cost. At the time the legislature prohibited the Connector from offering mandate-lite plans to small businesses, prohibited pooling purchasing groups, and limited the program to employers with 50 or fewer employees. Finally, the Connector narrowly focused advertisements to employers not already offering insurance.

Not surprisingly, the program drew limited interest from the small business community and failed to reach its initial goal of 100 employers. As a result, the Connector launched a new small business program called Business Express (BE),[21] "put[ting] its resources into one effort for small businesses," and froze enrollment for CP.[22]

However, Business Express also suffers from design limitations and does little to address the underlying reasons behind premium increases. It does reduce the monthly fee that small employers typically pay to third-party administrators from $35 per subscriber to $10 per subscriber, saving employers roughly $300 per employee per year.[23] However, this reduced fee is not unique to the Connector. The Massachusetts Business Association

16. The Connector is Massachusetts's version of a health insurance exchange.
17. The Contributory Plan is the Connector's first pilot program targeted to small businesses with fewer than 50 employees. A company selects a benchmark plan within a benefit-level tier (gold, silver, or bronze), and then the employee can choose any plan within that tier. Enrollment has been frozen for this plan.
18. Suzanne Curry, "Connector Board Report—November 12th," Health Care for All, November 12, 2009, at *http://blog.hcfama.org/2009/11/12/connector-board-report-%E2%80%93-november-12th* (August 4, 2010).
19. Jim Stergios and Amy Lischko, "Health Care Fails Small Businesses," *The Boston Globe*, May 12, 2010, at *http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2010/05/12/health_care_fails_small_businesses* (August 16, 2010).
20. Curry, "Connector Board Report—November 12th."
21. Business Express is the latest program from the Connector targeted to small employers, especially the mini-group market (businesses with one to five FTEs).
22. Suzanne Curry, "A New Chapter for the Connector: 6/10/10 Board Report," Health Care for All, June 11, 2010, at *http://blog.hcfama.org/2010/06/11/a-new-chapter-for-the-connector-61010-board-report* (August 4, 2010).
23. Board of the Commonwealth Health Insurance Connector Authority, "Minutes," June 10, 2010, at *https://www.mahealthconnector.org/portal/site/connector/menuitem.be34eb79b090a7635734db47e6468a0c* (August 17, 2010).

contends that it offers a similarly low-priced plan. While BE has drawn more interest than CP, BE enrollment has been boosted largely by a deal with the Small Business Service Bureau to transfer its current membership to BE.[24]

Politics. The current policies reflect current political attitudes. The Connector Board, the governing body of Massachusetts's health insurance exchange, is composed of a voting majority of government officials and union representatives.[25] Its actions have reflected the interests of its membership, not the interests of the Massachusetts small business community.[26] The sum effect of the board's policy decisions is to provide expansive, high-cost, defined-benefit health insurance plans designed by state bureaucrats. The Connector and its governing board erred on the side of being proscriptive, instead of allowing flexibility and permitting market forces to operate.[27] The board's efforts have focused on offering heavily subsidized insurance plans for low-income individuals and raising the floor of what it deems the acceptable minimum level of coverage. By contrast, states interested in helping their small business employees gain access to affordable health insurance should pursue market-based policies that encourage health insurance as a means of protecting individuals and families from the financial disaster of a serious and costly illness. The composition of the governing board is an important factor in reaching this goal.

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Reduced Choice. Overregulation and an intentional limiting of health plans have left small businesses with few choices. In the most recent example, the Connector reduced the number of plan options in the Business Express program from 25 to seven.[28]

Early on, multiple board members expressed a desire to reduce the number of choices and to further standardize the plans offered in the Connector. The decision to reduce choice for employers seems to have originated not only from board members, but also from a handful of small focus groups conducted in 2007 and 2009, in which consumers expressed a desire for a simple process.[29] However, the focus groups' desire for plans with meaningful differences in benefits and prices was ignored.[30] The wishes and needs of small businesses were not surveyed and infrequently discussed. Leaders of the small business community have expressed a desire to have more information and diversity on the exchange.[31] However, the Connector failed to establish a system that offered competitive insurance products that were affordable to small businesses.

24. Suzanne Curry and Lindsey Tucker, "Connector Board Report—January 14th," Health Care for All, January 18, 2010, at *http://blog.hcfama.org/2010/01/18/connector-board-report-%E2%80%93-january-14th* (August 4, 2010).
25. Massachusetts Health Connector, "Leadership," at *https://www.mahealthconnector.org/portal/site/connector/menuitem.1f234617384794635734db47e6468a0c* (June 23, 2010).
26. See Laura Meckler, "How 10 People Reshaped Massachusetts Health Care," *The Wall Street Journal*, May 30, 2007.
27. One board member explicitly stated the need for being proscriptive in a board meeting on October 17, 2008.
28. Curry, "A New Chapter for the Connector."
29. Board of the Commonwealth Health Insurance Connector Authority, "Minutes," February 8, 2007, at *https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520board%2520meeting%2520February%25208%252C%25202007/Minutes.doc* (July 31, 2010).
30. Suzanne Curry and Catherine Hammons, "Connector Board Discusses CommCare and CommChoice," Health Care for All, April 9, 2010, at *http://blog.hcfama.org/2009/04/10/connector-board-discusses-commcare-and-commchoice* (August 4, 2010).
31. Bill Vernon, "Premium Caps Damage Small Businesses, Economy," *The Salem News*, July 2, 2010, at *http://www.salemnews.com/opinion/x1703946852/Column-Premium-caps-damage-small-businesses-economy* (August 17, 2010).

Finally, the executive branch's rejection of hundreds of actuarially sound premium increases prompted four major carriers to boycott the BE program, thereby reducing choices available for small businesses. These carriers represent 90 percent of the private insurance market, and their boycott reduced the Connector to sending letters to them requesting their return.[32]

Government Benefit Setting. The Connector Board sets minimum creditable coverage (MCC) for insurance, sets the state's sliding scale subsidy levels, and defines affordability standards for the state's individual mandate to purchase health insurance. The Connector's approval process requires plans to clear a much higher bar for covered benefits than what had historically been present in the state's general insurance market.[33] On the staff's recommendation, the Connector Board continued to raise the required minimum level of coverage, which was already very high.[34] For example, in 2007, the board voted to make Massachusetts the only state in the nation that mandated prescription drug coverage, requiring more than 250,000 residents to "upgrade" their coverage and pay more for insurance in perpetuity.[35]

In addition, board members have expressed a desire to classify more mandates as core services, to cap deductible levels, and to bar monetary limits on coverage.[36] The legislature has shown a willingness to support these efforts. The FY 2011 Senate budget included provisions to exempt early intervention services from co-payments and deductibles.[37] The concern for the small business community was not about the provision of early intervention services, but about the precedent set by starting to waive co-payments and deductibles that result in cost increases.[38] By removing the cost-sharing mechanism, such as co-payments and deductibles, employers are less likely to be able to control health care costs and maintain lower monthly premiums through innovative benefit design. Consumers are more likely to consume additional health care services further driving up costs.

Increasing MCC levels reduces the affordability of plans in the market. In the future, even if the Connector Board changes the definition of affordability without meaningfully reforming the MCC, they may spare some citizens a fine, but they will leave many without coverage, and everyone else will still pay more for their coverage. With a high

32. Board of the Commonwealth Health Insurance Connector Authority, "Minutes," June 10, 2010.
33. Amy M. Lischko and Kristin Manzolillo, "An Interim Report Card on Massachusetts Health Care Reform—Part 3: Administrative Efficiency," Pioneer Institute *White Paper* No. 55, March 2010, p. 9, at *http://www.pioneerinstitute.org/pdf/100324_interim_report_card3.pdf* (August 4, 2010).
34. As of January 1, 2009, creditable plans must offer a broad range of medical benefits, preventive and primary care, emergency services, hospitalization, ambulatory services, prescription drugs, mental health, and substance abuse treatment. In January 2010, the coverage mandates expanded to include diagnostic imaging and screening, maternity and newborn care, medical and surgical care, radiation therapy, and chemotherapy. Catherine Hammons, "10/17/08 Connector Board Report: Tensies Talk Onesies and Twosies (You Had to Be There)," Health Care for All, October 20, 2008, at *http://blog.hcfama.org/2008/10/20/101708-connector-board-report-tensies-talk-onesies-and-twosies-you-had-to-be-there* (August 4, 2010).
35. Alice Dembner, "State May Give Insured More Time to Upgrade: July Still Deadline to Have Coverage," *The Boston Globe*, March 16, 2007, at *http://www.boston.com/news/local/articles/2007/03/16/state_may_give_insured_more_time_to_upgrade* (July 13, 2010).
36. Board of the Commonwealth Health Insurance Connector Authority, "Minutes," July 10, 2008, at *https://www.mahealthconnector.org/portal/site/connector/menuitem.be34eb79b090a7635734db47e6468a0c* (August 17, 2010).
37. An Act to Making Appropriations for the Fiscal Year 2011 for the Maintenance of Departments, Boards, Commissions, Institutions and Certain Activities of the Commonwealth, for Interest, Sinking Fund and Serial Bond Requirements and for Certain Permanent Improvements, 2010 Mass. Acts, ch. 131, §§ 177–180. For the Senate version of the bill as amended (S2470), see *http://www.mass.gov/legis/bills/senate/186/st02pdf/st02470.pdf* (August 4, 2010). Early intervention services are provided to young children from birth until their third birthday.
38. Board of the Commonwealth Health Insurance Connector Authority, "Minutes," March 12, 2009, at *https://www.mahealthconnector.org/portal/site/connector/menuitem.be34eb79b090a7635734db47e6468a0c* (August 17, 2010).

MCC, the barriers to entry for new health plans also become increasingly complicated. Other states should note that flexibility in benefit design allows robust choice and competition, which help to keep plans reasonably priced.

Costly Mandates. State-mandated benefits disproportionately burden small businesses. Larger companies that span multiple states or countries and self-insuring companies are regulated under federal law and are therefore exempt from state mandates.[39] In 2005, Massachusetts health care mandates accounted for $1.32 billion (12 percent) of premium prices. That number has certainly risen as the Connector and the legislature have added numerous mandated benefits over the past five years. A report that examined plans exempt from state health care mandates estimated that "the marginal direct cost" of mandates in 2005 added at least 19 percent to the increase in premium costs of plans subject to state mandates.[40] Massachusetts business leaders have similarly argued that current mandates cost 15 cents of every new health care dollar spent.[41]

In 2005, Massachusetts health care mandates accounted for $1.32 billion (12 percent) of premium prices.

The Massachusetts legislature has responded by expanding the list of mandates to include prosthetic devices, hypodermic needles, mental health coverage,[42] and coverage of autism services.[43] The autism law, the most recent expansion, is expected to drive up annual spending per insured person by $14.64 to $29.40, adding $340 million in additional premium costs.[44]

Unfair Penalties Against Some Small Businesses. An additional source of cost pressure is the "fair share" contribution assessment on employers (the employer mandate). Putting aside the fact that employer-mandate penalties are passed onto employees in the form of lower compensation, the current assessment standards are adversely affecting many small and mid-sized businesses.

In 2006, the standard required of employers with 11 or more full-time equivalents (FTEs) to make a "fair and reasonable contribution" toward their employers' insurance—either 25 percent employee participation in an employer-provided group health plan or the employer paying 33 percent toward the cost of individual plans for full-time workers. The administration of Governor Deval Patrick proposed changing this to require all employers to meet both the participation and contribution standards. Under pressure, the policy was partially reversed to exempt employers with fewer than 50 FTEs.[45]

Yet anecdotal evidence indicates that businesses with 50 to 100 FTEs have been caught up in the regulatory mandate. These companies are being assessed a fine that is not in line with the spirit of the statutory law. One flaw in the regulation is that enforcement does not consider coverage that employees may have from other sources. For exam-

39. Federal Employee Retirement Income Security Act (ERISA).
40. Massachusetts Executive Office of Health and Human Services, Division of Health Care Finance and Policy, "Comprehensive Review of Mandated Benefits in Massachusetts," July 7, 2008, at *http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf* (June 23, 2010).
41. Lord and Vernon, "Insurance Mandates Unhealthy for Business."
42. 2006 Mass. Acts, chs. 172 and 292, at *http://www.mass.gov/legis/laws/seslaw06* (August 17, 2010), and 2008 Mass. Acts, ch. 256, at *http://www.mass.gov/legis/laws/seslaw08/sl080256.htm* (August 17, 2010).
43. Kay Lazar, "Governor Signs Autism Bill," *The Boston Globe,* August 3, 2010, at *http://www.boston.com/news/health/blog/2010/08/governor_signs.html* (August 4, 2010). See also An Act Relative to Insurance Coverage for Autism, 2010 Mass. Acts, ch. 207, at *http://www.mass.gov/legis/laws/seslaw10/sl100207.htm* (August 17, 2010).
44. National Federation of Independent Business, "Legislative Session (Mercifully) Ends," at *http://www.nfib.com/massachusetts/nfib-in-my-state-content?cmsid=52207* (August 4, 2010).
45. Massachusetts Executive Office of Health and Human Services, Division of Health Care Finance and Policy, "Analysis in Brief: Employers and Massachusetts Health Reform," at *http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mes_aib_2009.pdf* (August 4, 2010).

ple, an employee could have insurance through a spouse, Medicare, or the U.S. Department of Veterans Affairs. Furthermore, some companies could have numerous part-time or seasonal employees who are ineligible for the company insurance.[46] Consequently, the regulation gives companies an incentive to pry into potential and current employees' personal lives if the employer is close to the participation threshold, and this could lead to discriminatory hiring and firing.

Perhaps more troubling is that the "fair share" mandate gives companies an incentive to reduce their employees' working hours to qualify them for state-subsidized care. According to a recent *Fortune* article, home health care organizations and other companies have already shown a willingness to do just this.[47] The regulatory change places another burden on businesses with 50 to 100 employees, which drives up costs and drives down wages.

With an individual mandate in place, moving to a defined-contribution system would be a more transparent alternative than the fair-share contribution. A defined-contribution system would allow employers to assist their employees in purchasing insurance on the exchange, instead of penalizing employers (and employees) for not meeting arbitrary participation and contribution thresholds.

Shortsighted and Inadequate Solutions. States pursuing health care reform should be particularly wary of short-term solutions to control health care costs for small businesses. Increasing health care costs is not a problem that will be solved in the short term. It must be managed. Sadly, most of the proposed solutions in Massachusetts have been shortsighted at the expense of finding viable long-term solutions.

The Patrick administration's approach of capping premium rates and rejecting hundreds of premium increases, as seen earlier this year, is neither viable nor useful. Insurance companies may be easy political targets, but artificially capping rates without actuarial consideration is ultimately an ineffective method of cost control. It threatens the long-term viability of insurers and their ability to reimburse providers. Furthermore, if the state moved instead to set reimbursement rates for providers, experience has shown that many providers would simply respond by performing more procedures and tests.[48] Both methods fail to address the underlying causes of increasing health care costs.

Insurance companies may be easy political targets, but artificially capping rates without actuarial consideration is ultimately an ineffective method of cost control.

Governor Patrick recently signed into law a bill intended to provide relief for small businesses.[49] While the bill is a step in the right direction, it does not go far enough. Its most promising measures are provisions for up to six small-business group purchasing cooperatives to cover 85,000 lives, the addition of an insurance broker to the Connector Board, and a review of mandated benefits every four years.[50] However, there is serious concern that the cap on the number of lives to be covered (85,000) will be inadequate for the roughly 167,000 small businesses *and* their family members that would qualify. Further, having a big pool is not sufficient to realize meaningful savings. Pooling must be paired with market-based reforms that result in groups that mirror larger firms by being stable and random

46. For example, transportation companies that employ semi-retired individuals or day cares that have many younger part-time workers. National Federation of Independent Businesses, "Fair Share Contribution Criticized," at *http://www.nfib.com/tabid/598/Default.aspx?cmsid=51639* (August 4, 2010).
47. Shawn Tully, "5 Painful Health-Care Lessons from Massachusetts," *Fortune*, June 16, 2010, at *http://money.cnn.com/2010/06/15/news/economy/massachusetts_healthcare_reform.fortune/index.htm* (August 4, 2010).
48. Robert J. Samuelson, "As Massachusetts Health 'Reform' Goes, So Could Go Obamacare," *The Washington Post*, July 19, 2010, at *http://www.washingtonpost.com/wp-dyn/content/article/2010/07/18/AR2010071802733.html* (August 4, 2010).
49. An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses, 2010 Mass. Acts, ch. 288, at *http://www.mass.gov/legis/laws/seslaw10/sl100288.htm* (August 17, 2010).

in its membership. Without these features, pooling will not realize success.

The law also contains a few worrisome elements. The executive branch is granted the authority to reject premium rate increases if they are deemed "excessive…or unreasonable."[51] Furthermore, an automatic rejection is executed if carriers do not spend 90 percent of premium dollars on care or their administrative costs increase more than the rate of medical inflation in New England.[52] These arbitrary standards for rejection of actuarially sound premium increases do nothing to address the underlying cost of care and could increase health care spending as insurers try to meet the thresholds. These policy mechanisms are flawed short-term solutions in a state with many non-profit insurers with contractual agreements to honor, and the operating losses that they accept, could undermine long-term sustainability. RAND analysts have argued that savings from artificially limiting growth of premium rates will likely be very small and reduce the quality and availability of insurance products.[53] A temporary reduction of products did take place when insurers boycotted the Connector's small business program earlier this year.

Other provisions require insurers that sell to small businesses to offer at least one tiered network or limited-coverage network plan with a premium 12 percent below other full-network plans. Additionally, the law offers limited participation for a select few small businesses in wellness programs. The law codifies Governor Romney's desire for greater transparency of insurers and providers to educate consumers about carrier costs by specific group size, provider costs, and quality of care. Finally, one provision reduces the five-year age bands, which insurers use for risk rating and pricing, to one-year age bands to protect small businesses from large premium increases when employees move up to the next age band. However, while this policy prevents one-time spikes, it simply spreads out the cost of insurance and fails to address underlying cost issues.

Happily, the compromise bill passed by the legislature left out many of the misguided ideas included in earlier versions of the bill, such as a 5 percent state tax credit for small businesses modeled after the federal credit. The National Federation of Independent Business estimates that only 42 percent of Massachusetts small businesses would qualify for the federal credit. Nationally, CBO estimates that only 12 percent of businesses are expected to take advantage of it in 2016.[54] The legislature also wisely omitted an ambiguous cost-shifting "shared-sacrifice contribution" that would have imposed a $100 million assessment on providers and hospitals to "help" small businesses.[55]

Overall, the law will only marginally assist small businesses in the long run. True long-term savings cannot take hold from price controls. Massachusetts missed many opportunities that other states should use in their own reforms.

50. For more on the benefits of pooling arrangements, see Edmund F. Haislmaier, "State Health Reform: How Pooling Arrangements Can Increase Small-Business Coverage," Heritage Foundation *WebMemo* No. 1563, July 22, 2007, at *http://www.heritage.org/Research/Reports/2007/07/State-Health-Reform-How-Pooling-Arrangements-Can-Increase-Small-Business-Coverage*.
51. 2010 Mass. Acts, ch. 288, § 29(6)(c).
52. *Ibid.*, § 29(6)(c).
53. Christine E. Eibner, Peter S. Hussey, M. Susan Ridgely, and Elizabeth A. McGlynn, "Controlling Health Care Spending in Massachusetts: An Analysis of Options, August 2009, at *http://www.rand.org/pubs/technical_reports/2009/RAND_TR733.pdf* (August 4, 2010).
54. Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," November 30, 2009, p. 8, at *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf* (August 4, 2010), and National Federation of Independent Business, "Just the Facts: Small Business Healthcare Tax Credit," July 20, 2010, at *http://www.nfib.com/massachusetts/nfib-in-my-state-content?cmsid=52125* (August 4, 2010). See also John Ligon, "Obamacare: Impact on Businesses," Heritage Foundation *WebMemo* No. 2883, April 27, 2010, at *http://www.heritage.org/Research/Reports/2010/04/Obamacare-Impact-on-Businesses*.
55. The provision was gutted by making the contribution voluntary.

Building a Small Business–Friendly Exchange

Under the recently enacted Patient Protection and Affordable Care Act, Congress requires states to establish their own health insurance exchanges by 2014 or to accept a federally designed exchange. However, states should not wait until 2014 to reform their health insurance markets, and they should consider establishing their own health insurance exchanges.

In Massachusetts, the original vision for health care reform included provisions that would have directly assisted small businesses if they had been implemented wisely. To best address the needs of small businesses, states should:

- **Promote defined contributions through the exchange.** Moving toward a defined-contribution system in which consumers are given a fixed amount of money to purchase their own health care in an exchange would lower costs for both employers and employees. Instead of each employer being forced to offer the same insurance plans in the same tier to all of its employees whether they are 65 years old or 35 years old, individuals could choose the level of coverage that best met their individual needs and preferences. This type of system allows employees to take ownership of their health care spending and become shrewd consumers. The ease of administering this system permits more companies to use the exchange, expanding coverage and facilitating greater competition.
- **Set up a premium aggregator that allows contributions from multiple sources.** Coupled with a defined-contribution system, a premium aggregator can provide three robust benefits. First, it can reduce the administrative burden and costs of the normal premium payment process. Second, it can leverage all of the pre-tax contributions available to employees, such as contributions from multiple part-time employers or a spouse's employer. Finally, it can spread the cost of insurance across multiple employers, minimizing employees' out-of-pocket costs.
- **Implement risk-adjustment mechanisms.** A risk-adjustment system for carriers can reduce barriers to market entry and empower insurance companies to innovate with benefit designs. Risk-adjustment mechanisms can protect individual carriers from being saddled with higher costs resulting from adverse selection (i.e., a carrier that insures a more costly group of individuals in a given year). Risk-adjustment mechanisms also can dampen premium volatility for small employer groups.[56]
- **Allow greater choice of health plans with more information on price and quality.** Massachusetts did its small business community a disservice by limiting the diversity and number of plans.[57] Greater choice helps to tailor insurance to the employees' needs and to restrain costs by limiting overutilization. A far better policy would be to provide the broadest range of information in a user-friendly format to companies and consumers.[58] Making prices transparent will help both consumers and providers. Stakeholders should agree on a common standard for calculating the prices of services for providing that information to consumers. Greater price transparency is likely to lead to enhanced efficiency in the health sector.

56. For more on the purpose and function of a state health insurance exchange, see Edmund F. Haislmaier, "State Health Care Reform: An Update on Utah's Reform," Heritage Foundation *Backgrounder* No. 2399, April 9, 2010, at *http://www.heritage.org/Research/Reports/2010/04/State-Health-Care-Reform-An-Update-on-Utahs-Reform*. For more on risk adjustment mechanisms, see Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at *http://www.heritage.org/Research/Reports/2008/07/State-Health-Care-Reform-A-Brief-Guide-to-Risk-Adjustment-in-ConsumerDriven-Health-Insurance-Markets*.
57. Bill Vernon, "Premium Caps Damage Small Businesses, Economy," *The Salem News*, July 2, 2010, at *http://www.salemnews.com/opinion/x1703946852/Column-Premium-caps-damage-small-businesses-economy* (August 17, 2010).
58. Stergios and Lischko, "Health Care Fails Small Businesses." Regrettably, the Connector took roughly three years to publish basic provider network and participating provider information for small business on its Web site.

- **Reduce the number of mandates.** Small-sized employers should be allowed to choose high-deductible and mandate-lite plans. Given the desire for greater cost containment, legislators should revisit the mandated benefits and repeal those that impose unnecessary costs. For example, a better standard for MCC might be found in the federal Health Insurance Portability and Accountability Act of 1996.[59] Other states, such as Indiana, Utah, and Georgia, have acknowledged this concern by passing their own versions of low-premium, high-deductible plans or mandate-lite plans over the past five years. State legislatures, including the Massachusetts legislature, should allow for more flexibility for small business plans. One possibility is to make the broker fee a rating factor for small business plans instead of including it in the insurance rate.
- **Allow market forces to control the underlying health care costs.** Given the fragmented nature of the health care sector, policymakers need to realign incentives at the ground level to change the behavior of individual consumers and practitioners to control costs and improve quality. While time-consuming compared to bureaucratically derived decrees, using market forces to control costs will be more effective in maximizing value in the health system over the long run.

  A consumer-centered health care market would compel insurers to fundamentally alter their practices to offer better value than their competitors. Carriers would only remain viable if they offer better value coverage that is attractive to consumers. This would also encourage providers to introduce new products that integrate new benefits, such as "multi-year contracting, premium discounts for participation in wellness or disease management programs, and cash rebates to subscribers who successfully meet agreed-upon health improvement goals."[60] These and other innovative product designs would align incentives for all stakeholders to partner together to realize methods to keep patients healthier for less.

  A consumer-centered exchange shifts an employer's role from acting as the middleman in purchasing insurance for their employees to providing "financial engineering and decision-support services." It would change the government's role from mandating one-size-fits-all designs to providing financial assistance.[61] Government officials must acknowledge that not all consumers require the exact same coverage and that carriers must be allowed to innovate to serve different population subsets better. Finally, government officials need to abstain from price setting in any form because it unavoidably distorts the marketplace, harming both carriers and consumers. Consumers are key to making the health care system more rational and efficient.

Conclusion

States looking to create state health insurance exchanges that are friendly to small business should design exchanges that allow defined contributions for health insurance, which will promote market choice and competition. They should include a mechanism that allows people to aggregate health care contributions from different employers, both for employees with more than one job and for couples with different employers. Finally, state legislatures should reduce or eliminate health benefit mandates that drive up costs, and they should stabilize their health insurance markets by establishing risk-adjustment mechanisms to compensate for adverse selection.

Massachusetts's original design for health care reform held promise for small businesses, but policy

59. Robert E. Moffit, "The Massachusetts Health Plan: An Update and Lessons for Other States," Heritage Foundation *WebMemo* No. 1414, April 4, 2007, at *http://www.heritage.org/Research/Reports/2007/04/The-Massachusetts-Health-Plan-An-Update-and-Lessons-for-Other-States*.
60. For more on the patient-centered, consumer-based market reform, see Edmund F. Haislmaier, "Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market," Heritage Foundation *Backgrounder* No. 2128, April 23, 2008, at *http://www.heritage.org/Research/Reports/2008/04/Health-Care-Reform-Design-Principles-for-a-Patient-Centered-Consumer-Based-Market*.
61. *Ibid.*

decisions made during implementation have failed to deliver on that promise so far. Greater availability of state-subsidized coverage and rising premiums reduce employers' motivation to provide coverage for their employees, and the incentives in the new federal health care legislation will certainly intensify that problem.

The long-term sustainability of any reform plan will rest largely on the level of engagement with small businesses and cost relief delivered to them. It is imperative that each state move forward quickly in an informed manner to address the needs of the small businesses and their millions of employees. The future economic strength of the nation may be at stake given the depth of the current recession and the pressures placed on small businesses and their employees as they try to stay in business.

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