NONPROFIT HEALTH INSURANCE PROJECT

FINAL REPORT

August 2009

Prepared for MNN by: Molly Yuska, MM, Yuska Solutions

With Support from

Cathy Dunham, Executive Director, Ed.D., The Access Project

And

David Magnani, Executive Director, Ed.D., Massachusetts Nonprofit Network

This project is supported by the generosity of the Blue Cross Blue Shield Foundation of Massachusetts

Massachusetts Nonprofit Network

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Executive Summary

Nonprofit organizations represent a vibrant sector of the Massachusetts economy employing approximately 14% of the Massachusetts workforce and providing countless programs and services contributing to the quality of life in the Commonwealth. In a study of nonprofits across Massachusetts published in early 2009, the issue of quality, affordable health insurance was cited as the number one benefits issue facing nonprofits in the Commonwealth. Average premiums for family health insurance coverage have increased 119% nationally over the past 10 years, and Massachusetts' insurance premiums are some of the highest in the country. Despite these facts, health insurance is the most commonly provided employee benefit in nonprofit organizations in Massachusetts, and data show it is a benefit nonprofits are committed to providing even when the financial indications suggest doing so is a strain on the organization.

MNN launched the Nonprofit Health Insurance Project (NHIP) in January 2009 in collaboration with the Blue Cross Blue Shield of Massachusetts Foundation to identify strategies and inform policies to enhance the accessibility and affordability of health insurance coverage for Massachusetts nonprofits and their employees. To do this, MNN assembled a task force of highly knowledgeable and qualified experts from various organizations and sectors; membership was diverse and included representatives from both legislative and executive branches of state government, advocates, nonprofit leaders, and health policy experts. Additional expertise was sought on a consultative basis to further develop the group's deliberations.

The NHIP Task Force crafted policy and program options for further exploration within three broad categories: 1) policy options that would expand health insurance coverage and/or reduce insurance costs for nonprofits and nonprofit employees; 2) educational initiatives that would help nonprofits and their employees take fuller advantage of the programs and opportunities currently available; and 3) recommendations to stabilize employer sponsored insurance provided by nonprofits and to assist in nonprofits' pursuit of compliance with the requirements of health reform. Specific options include the following:

Policy Priority Option #1: Expand the employer buy-in options available through the Connector to include access to CommCare, or a comparable product, for low-wage workers of qualifying small businesses by leveraging existing employer and employee premium contributions and providing subsidy for any remaining premium to those under 300% FPL.

Policy Priority Option #2: Harness the administrative sophistication, management and purchasing clout of the GIC for the benefit of the nonprofit community by creating a pool within the GIC through which nonprofits can purchase health insurance.

Policy Priority Option #3: Explore the possibility of creating **one** small group purchasing pool overseen by the Division of Insurance for all nonprofits and other small businesses in Massachusetts that requires participating plans cover all state mandated benefits and disallows exclusions for preexisting conditions; create incentives for small business participation.

Education Priority Options: Establish a multi-lingual, literacy-sensitive, small employer-based curriculum for training owners and managers, and their employees, on the issues of health insurance coverage and health reform; explore the possibility of establishing a hotline specifically for nonprofits and other small businesses modeled after the Health Care For All helpline for individuals.

Priority Options for Stabilizing Employer Sponsored Insurance in Nonprofit Organizations: Further clarify and amend the Fair Share Contribution requirements to make the provisions more easily understood and to recognize the financial limitations of nonprofit businesses struggling to provide employer sponsored insurance; research ways of better coordinating the enrollment procedures and coverage opportunities for individuals within various state-sponsored health insurance programs – such as Commonwealth Care, MassHealth, the Medical Security Program, the Insurance Partnership, and others; add ways of tracking health insurance coverage in the Massachusetts employer base by tax status (nonprofit and for profit).

In the next phase of the Nonprofit Health Insurance Project, MNN will pursue funding for additional data collection and research to further inform the priority policy options and to begin developing an outreach and education strategy for nonprofit employers and their employees. Ultimately, a blue-ribbon commission will be assembled to pursue the relevant and appropriate policy and program options based on the additional research findings and the outcome of federal health reform.

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Background

Health insurance is one of today's most talked about public policy issues. Massachusetts was the first state to enact health reform legislation aimed at universal coverage in 2006. Today, a heated federal debate continues over similar legislation at the national level with many hoping for federal reform by the end of 2009. The focus on the issue is well founded. Health care spending accounts for roughly 17% of the country's gross domestic product and is projected to increase to upwards of 20% by 2017. (1) The costs are high, both financially and ethically. The discussion centers not only on the increase in real costs, which must be contained through creative, systemic solutions addressing the provision and payment of health care over the long term, but also the premiums borne by employers and individuals in the market today. Employer-sponsored insurance is the leading source of health insurance, covering roughly 158 million nonelderly people in the United States. (2) The premiums paid by employers for health insurance coverage continue to increase at rates becoming prohibitive for many employers, especially small ones, leaving many Americans underinsured even when they are covered by a plan.

Since 1999, average premiums for family coverage have increased 119% nationally. (3) In Massachusetts, health insurance premiums increased 8.9% per year between 2001 and 2007, faster than the U.S. average growth in premiums of 7.7% during the same period. (4) Furthermore, Massachusetts insurance premiums are consistently above the national averages for employer-sponsored insurance coverage. In 2006, Massachusetts premium rates were approximately 8% above the national average ($4,448 vs. $4,118 for single coverage and $12,290 vs. $11,381 for family coverage).(5)

Not only are premiums increasing but the out-of-pocket spending by individuals also is on the rise as insurance carriers and employers shift toward plans that better control premium growth by increasing deductibles and copayments paid by individuals. A recent study of trends in employer-sponsored health insurance found that plan enrollees' out-of-pocket expenses grew by more than one-third between 2004 and 2007. (6) This is particularly true for employees working at small firms. According to data released in the fall of 2008, 35% of workers in small businesses with three to 199 employees covered by their employer-sponsored health insurance have at least a $1,000 deductible that must be paid out of pocket before the plan generally starts to pay a share of the healthcare bills, up from 21% just one year prior. (7) The increasing rate of underinsurance also is contributing significantly to the number of personal bankruptcies being filed across America as sizable medical debt burdens a growing number of families.(8)

A growing number are underinsured and many more have no insurance coverage at all. Even in Massachusetts where almost all individuals are required to have health insurance or pay a fine, as a result of health reform efforts in 2006, approximately 76,000 individuals were granted exemptions from the requirement in 2007 due to individuals' inability to afford their employer-sponsored coverage and/or the lowest cost premiums in their geographic regions. (The number of exemptions for 2008 should be released by early fall.)

As the United States continues to fight its way through the worst economic recession in decades, businesses and their employees alike are making the decision every day whether or not to continue to pay the high costs for health insurance coverage or go without it in the hope that the savings will allow them to keep the doors open. It is not a decision taken lightly, but it *is* a reality many confront. Some of the businesses hit hardest during these times are small employers. According to the Bureau of Labor Statistics, 53% of all private-sector job losses between the second quarter of 2007 and the third quarter of 2008 were in businesses with fewer than 20 employees, even though this small business sector accounts for only 20% of the total workforce.(9)

Even before the current recession, workers in small businesses traditionally were less apt to have access to employer-sponsored health insurance, as an inverse relationship exists

Background continued

between the size of the employer and their propensity to offer insurance coverage. According to the Kaiser Family Foundation, only 49% of employers with 3-9 employees offered insurance coverage in 2008 compared to 99% of companies with 200 employees or more. (10) In addition, the share of firms with fewer than 10 workers that offer health benefits has declined by 16% since 2001. During the same time period, the rate in larger firms essentially stayed flat. (11)

In particular, the nonprofit community is struggling significantly in the current fiscal crisis. Facing reductions in giving, endowments, foundation grants and government funding, many nonprofits find themselves in a precarious financial situation, one exacerbated by increased health insurance costs and minimal opportunities to secure additional funding for such overhead. While the struggles of small businesses and nonprofits to secure and maintain adequate health insurance coverage may not be exclusively their own, the characteristics of these economic sectors *are* unique; and small businesses' place in the insurance market differs dramatically from that of larger firms.

Creation of the Nonprofit Health Insurance Project at MNN

The Massachusetts Nonprofit Network (MNN) was formed in 2007 to advocate for the needs of the nonprofit community in Massachusetts, a vibrant sector of the state's economy employing approximately 14% of the Massachusetts workforce and providing countless programs and services contributing to the quality of life in the Commonwealth. In a study of nonprofits across Massachusetts published in early 2009, a joint effort among the Boston Foundation, the Braver Group and MNN, the issue of quality, affordable health insurance was cited as the number one benefits issue facing nonprofits in the Commonwealth. (12) Even for those who do have such coverage, about 40% of the premiums are paid by the employees. While the data from the study highlight the sector's employee benefit challenges prior to the implementation of health reform and the major declines in the overall economy, it is the first significant look into the benefits provided by nonprofits specifically. Additional analysis, particularly of smaller nonprofits, certainly is needed, but evidence of nonprofits' struggle to provide and maintain health insurance coverage has begun to emerge.

Massachusetts' landmark health reform brought with it new health insurance coverage requirements for both employers and individuals. These requirements, along with escalating health insurance premiums and operational funding shortages, led nonprofits within the Network to begin voicing serious concern to MNN over their ability to continue to bear health insurance premium increases. They also expressed a deep desire to maintain such benefits, both in service to current employees and with the knowledge that the benefit is extremely important to attracting new ones.

In recent years, these pressures have produced several individual movements within the nonprofit community to seek relief under the current system of health insurance. The Massachusetts Council of Human Service Providers has filed legislation for the past several years seeking the opportunity for such providers to join the Group Insurance Commission (GIC) with the hope of realizing cost savings over time. A grassroots movement fueled by HealthcareforArtists.org and the Artists Health Care Working Group has been pushing for better information and increased access to state-sponsored programs for individual artists of all disciplines and for fair treatment of small arts businesses and small arts nonprofits; these groups are pushing for key legislation and regulatory changes that are needed to address the unintended consequences befalling these communities as a result of the implementation of Chapter 58. Other nonprofits have looked to group purchasing arrangements, higher cost sharing with employees, new insurance carriers, and many other options to help get a handle on health insurance costs. With this knowledge and given MNN's mission to advocate for the needs of the entire nonprofit sector, MNN launched the Nonprofit Health Insurance Project (NHIP) in January 2009 in collaboration with the Blue Cross Blue Shield of Massachusetts Foundation to identify strategies and inform policies to enhance access and affordability of health insurance coverage for Massachusetts nonprofits and their employees.

The NHIP Task Force

MNN assembled a task force of highly knowledgeable and qualified experts from various organizations and sectors to develop policy and program options for providing better health insurance coverage for the nonprofit sector. Membership was diverse and included representatives from both legislative and executive branches of state government, advocates, nonprofit leaders, and academic and health policy experts. Members included those with expertise in the Massachusetts insurance market, state-sponsored insurance programs, Massachusetts' health reform legislation, implementation and tracking of health reform since its enactment, and the nonprofit sector.

The Task Force held twelve meetings over the course of eight months beginning in January 2009. The first two months were spent gathering and analyzing available data and literature on the sector and relevant insurance issues. The second phase of the project focused on developing a better understanding of the variety of programs and structures already in place to provide health insurance within the Commonwealth, and the final three months were devoted to the development of the policy and program options outlined in this report.

This report represents the deliberations of the Task Force as a whole over an eight-month process. MNN and the Task Force wish to acknowledge the participation and contribution of key individuals who helped inform the deliberations of the group and the overall process. While not associated with the formal recommendations of this report, experts from numerous state agencies and others were consulted throughout the project including Kaitlyn Kenney, Manager of Policy & Research for the Commonwealth Connector; Nancy Turnbull, Senior Lecturer on Health Policy at the Harvard School of Public Health; Christie Hager, previously the Chief Health Counsel for former Massachusetts House Speaker Sal DiMasi and Adjunct Lecturer on Health Policy at the Harvard School of Public Health; and staff from the Division of Health Care Finance and Policy.

Members

Kathleen Bitetti	Artist & Activist, Co-Founder of Healthcareforartists.org
Danielle Chaplick	Group Insurance Commission, Municipal Coordinator
Cathy Dunham	NHIP Consultant; ACCESS Project, President
Patricia Edraos	Mass League of Community Health Centers, Health Resources/Policy Director
Liz Keating	Boston College, Visiting Assistant Professor
Paul Lanzikos	North Shore Elder Services, Executive Director
Dave Magnani	NHIP Staff; Massachusetts Nonprofit Network, Executive Director
Representative Smitty Pignatelli	Massachusetts General Court, State Representative
Geeta Pradhan	The Boston Foundation, Director of Programs
Carol Pryor	ACCESS Project, Policy Director
Brian Rosman	Health Care For All, Research Director
David Seltz	Office of Senate President Therese Murray, Senior Policy Advisor
Molly Yuska	NHIP Staff; Yuska Solutions, Principal

Task Force Policy & Program Options

The Task Force emerged with a much clearer picture of the health insurance problems facing nonprofits as a result of the time spent analyzing the literature and data currently available related to the provision of health insurance within the nonprofit sector, the current state of the Massachusetts insurance market, and the state-sponsored programs in place to support individuals and employers struggling to maintain health insurance coverage. Specific policy and program options surfaced aimed at addressing the struggles seen in the sector and within the overall small business environment.

Nonprofit organizations are unique business entities often with very different funding streams than traditional for-profit businesses. Many are dependent upon federal and state funding given the programs and services they provide, making them particularly vulnerable to budgets established within a complex context of competing interests. Many are heavily reliant upon charitable contributions and/or membership revenue. They also are required to maintain a strict focus on their incorporated charitable missions in order to maintain their tax-exempt status. As a result of these and other factors, nonprofits face challenges when it comes to fully funding their significant overhead costs, especially health insurance, through their funding structures. At the same time, health insurance is the most commonly provided employee benefit in nonprofit organizations, and data show it is a benefit nonprofits are committed to providing even when the financial indications suggest doing so is a strain on the organization.

While the characteristics of nonprofits may differ from for-profit businesses in these ways, among others, the realities nonprofits face in the insurance market are in many ways similar to those of for-profit companies. As outlined previously, small businesses (regardless of tax status) are particularly vulnerable when it comes to acquiring and maintaining adequate health insurance coverage given their size and limited ability to sustain economic fluctuations, and the workings of the insurance market. According to the Commonwealth Fund, administrative costs represent, on average, 41% of claims in the individual market and 15% to 36% of claims for small businesses with fewer than 100 employees (36% for businesses between 2 and 4 employees, 22% for businesses between 20 and 49, and 15% for businesses between 50 and 99). This compares to an average rate of 10% for employers with 500 – 2,499 employees and 4.5% for those with 10,000 employees or more.(13) These administrative costs are carried over to the policies and premiums paid by small businesses, businesses which also have minimal capacity to negotiate lower rates given their extremely limited market power.

With this knowledge, the NHIP Task Force set out to develop policy and program options relevant to the nonprofit sector and the insurance market in Massachusetts specifically.

Options were crafted within three broad categories:

- Policy options that would expand health insurance coverage and/or reduce insurance costs for nonprofits and nonprofit employees;
- Educational initiatives that would help nonprofits and their employees take fuller advantage of the programs and opportunities currently available; and
- Recommendations to stabilize employer sponsored insurance provided by nonprofits and to assist in nonprofits' pursuit of compliance with the requirements of health reform

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I. Policy Options

Given the complexity of the current health insurance system, it is impossible to identify a single policy option that would resolve all the struggles of nonprofits in acquiring and maintaining adequate coverage for their employees. It also is nearly impossible to develop policy recommendations that do not add to the current complexity or cost additional dollars. Nevertheless, the policy options discussed in this report were crafted with a belief that simplicity and cost containment are essential.

Numerous requirements have been established for businesses and individuals as a result of health reform in Massachusetts. Moreover, a myriad of programs has been put in place over the years to offer insurance coverage and assistance to individuals and small employers, particularly at the lower end of the wage scale. Adding more layers of complexity could be more of a hindrance than a help both in moving a policy agenda and in implementing one. Consequently, the options presented here propose to strengthen and leverage the dollars and structures already in place. Some would offer limited but potentially immediate relief, while others would offer the opportunity for more systemic reform and greater impact over the long term. Pursuit of more than one option may be possible depending on the time horizon, but are presented here in the order of priority as established by the Task Force. While the options are not necessarily mutually exclusive, simultaneous pursuit of more than one option outlined below would weaken the potential impact of any one, as part of the strength of the recommendations lies in broad support and utilization by the majority of the nonprofit sector.

Priority Option #1: Expand the Small Employer Buy-In Option Through the Commonwealth Connector to Include Commonwealth Care as an Option for Low-Wage Workers

Under Massachusetts health reform, the Commonwealth Connector was created to offer insurance coverage to individuals in Massachusetts who do not have health insurance coverage nor access to employer-sponsored insurance (ESI) through their employer. The Commonwealth Care (CommCare) program was established to provide insurance to individuals with incomes below 300% of the federal poverty level (FPL). CommCare offers comprehensive coverage and low out-of-pocket costs to eligible individuals. Because there was concern this new program might "crowd out" employer-sponsored coverage, strict protections were put in place to avoid that. Consequently, any individual who has access to ESI in which the employer's percentage of premium coverage meets the state minimums (33% for individual coverage and 20% for family coverage) cannot access the subsidized CommCare program, even when the cost to the employee for the ESI is well above what is considered "affordable" according to the state-established affordability index.

Maximizing the employer dollars dedicated to the provision of health insurance is critical. Employer-sponsored coverage remains the backbone of the country's health insurance system. However, low-wage workers who cannot afford their employer-sponsored coverage, as well as seasonal workers, flextime part time workers, and many self-employed individuals cannot access the subsidization through CommCare so many of them desperately need. Furthermore, for those moving between employers and insurance programs, the loss of continuity in coverage can be overwhelming. In the only state in the country where coverage for nearly everyone currently is now mandated, there are gaps in the current system that must be filled. With a deep recession currently underway, these gaps may grow larger.

Small employers with 50 or fewer eligible employees presently can enroll in the Commonwealth Choice (CommChoice) Contributory Plan currently in a pilot stage. A choice of plans are offered within three tiers of coverage with corresponding premium levels, and those premium rates must be the same as those found outside the Connector for comparable plans. This currently is the only employer buy-in option available through the Connector and offers no subsidies to employers or their workers. It also does not capitalize on the clout of the Connector as a purchaser, as rates must mirror those outside the Connector. Thus far, enrollment in this pilot is low and has not yet reached the pilot thresholds.

As mentioned previously, every day more employers are faced with serious decisions about how and whether to maintain health insurance coverage. For many, any further increase in insurance costs may be the final straw. Support-

ing those eager to continue but struggling to provide coverage may be the only way to keep their dollars on the table, before coverage is dropped and employees are forced to seek coverage through alternate sources. Undoubtedly the costs of such actions for the individuals, the state, and health reform's goal of universal coverage would be high.

Given this, the Task Force recommends the following:

- Expand the employer buy-in options available through the Connector to include access to CommCare, or a product comparable to CommCare, with subsidization provided to low-wage workers under 300% FPL (with a sliding scale subsidy between 150% and 300% as is offered currently under CommCare)
- Leverage employer and employee premium contributions, and minimize required subsidization, by directing existing premium dollars to the purchase of selected product(s) through the Connector, including CommCare or a CommCare-like product for low-wage workers. Phase in this new program option by first offering to small businesses with 50 or fewer employees (14) and those with greatest need (e.g., businesses with large numbers of lowest wage workers – those under 150% FPL, etc.)
- Thereafter, offer the subsidy to those nonprofits (with more than 50 full-time employees) with greatest need (e.g., organizations with large numbers of lowest wage workers – those under 150% FPL, etc.); expand as funding is available
- Coordinate the new benefit with the offerings currently available through the Insurance Partnership program or redirect the Insurance Partnership funding to such an expansion
- Increase the financial eligibility criteria for subsidization as funding is available so there is not a "cliff" at 300% FPL; expand the subsidy on a sliding scale up until the point at which coverage is deemed affordable according to the state-established affordability index

Word of Caution:

The Task Force acknowledges this recommendation may cost additional funds presently not available at the state level. However, the cost to the state could be significantly less than the current per capita cost of those already enrolled in CommCare if the expansion were based on a framework that leverages the private dollars already in play. Such dollars would be redirected to the purchase of Connector-based products. Furthermore, the **net** cost to the state could be substantially lower than if these employers were simply to drop coverage. The current fair share contribution assessment of $295 per full time equivalent (FTE) is far less than the cost to employers of providing health insurance. Most employers do not simply drop coverage so their employees can go onto state-sponsored programs. While crowd out remains a theoretical concern, real losses in coverage resulting from businesses' inability to sustain cost increases is far more likely. Stabilizing the employer-sponsored insurance system for those most at risk of dropping coverage due to unsustainable cost escalation would be a prudent policy course for a state mandating individual coverage and providing subsidy to low-income individuals with no alternate source of coverage, particularly until total health care spending can be controlled and the true costs of care lowered. That said more modeling is needed to better understand the projected cost to the state of such an expansion and the implications for the overall small

Priority Option #2: Create a Pool Within the Group Insurance Commission (GIC) for Nonprofits

The GIC provides health insurance to state employees, housing and certain other authorities' employees, the employees of some municipalities, as well as retirees of the above, and their survivors/dependents. The GIC is well known for its strong management and oversight in providing insurance coverage for over 300,000 lives in the Commonwealth, and routinely posts below-average premium increases for the plans it offers. (The average rate increase has varied over the past seven years from a high of 13.5% in FY 2006 to 3.19% for FY 2010.)

Unlike priority option #1 which recognizes the need to expand access to the subsidization offered through the Connector to low-wage workers of small businesses (regardless of tax status) and nonprofits, this recommendation is specific to the nonprofit sector. The GIC is a state agency charged with the management of these benefits for the employees of the state, as well as specified additional groups. Given the fiscal constraints of the nonprofit community discussed previously and the unique role nonprofits play in the provision of services and programs that contribute to the quality of life for the residents of the Commonwealth, the marginal additional cost of adding nonprofits to the GIC is an investment in a vital sector that could alleviate some of the health insurance struggles faced by nonprofits, both in terms of managing this benefit as well as securing rates superior to what many nonprofits can secure on their own.

While the GIC offers nine insurance plan options, the GIC is largely self insured. As such, the premium rates of the GIC are more reflective of their claims experience and related costs than their ability to secure better-than-average rates from insurers. Nevertheless, their aggressive benefits management and plan administration are good reasons to consider this an option that possibly could benefit the nonprofit community. Clearly if nonprofits were to join the GIC through the creation of a new self-insured pool, as opposed to joining the existing pool of state and municipal employees, the cost to the participating nonprofits would be driven by the experience of the nonprofits joining the pool, and incentives would need to be created for joining that would ensure an average risk profile. If the nonprofit pool were to be a fully-insured pool, the negotiating clout of the GIC could be utilized to garner rates better than the nonprofits otherwise can secure in the insurance market and would reduce administrative costs typically passed on to small (er) employer policies and premiums.

In summary, the Task Force recommends the following:

- Harness the administrative sophistication, management and purchasing clout of the GIC for the benefit by the nonprofit community by creating a pool within the GIC through which nonprofits can purchase health insurance
- Provide a state subsidy to the nonprofit community given its important role in the Massachusetts' economy and its contribution to the quality of life for Massachusetts' residents through the coverage of administrative expenses associated with the addition of nonprofits to the GIC and/or by covering or sharing in the cost of reinsurance (if a self-insured pool were to be created)
- Standardize and streamline the enrollment and premium collection process prior to the roll-out of a nonprofit pool within the GIC in order to address the administrative hurdles associated with such a pool and seek start-up funding to cover such costs

Word of Caution:
While the creation of a pool with the GIC would provide a central place for nonprofits to purchase insurance and potentially offer savings over current insurance offerings, it also would add administrative complexity for the GIC. The Task Force recognizes this challenge and believes start-up funding should be secured to cover the costs of identifying and establishing a streamlined premium collection mechanism to minimize this concern. Furthermore, it should be noted that the cost savings for an individual nonprofit would be dependent upon the richness and cost of their current insurance benefit, with some nonprofits not necessarily realizing a savings over current costs. Finally, long-tern cost savings are unknown since they would be dependent upon the risk profile of those joining the pool. If the pool were to attract a disproportionate amount of negative risk, the savings from strong management and central administration could be cancelled out.

Priority Option #3: Create a Small Group Purchasing Pool for Small Nonprofits and Other Small Businesses

As a part of health reform in 2006, the individual and small group insurance markets were blended to create one pool that operates with modified community rating rules. Individuals cannot be denied coverage due to pre-existing conditions and rates are only allowed to vary based on age, industry and geography (and not other factors such as claims experience or gender). While the merged market has offered relief to high-risk individuals, it has had a small effect on small group premium rates, increasing them slightly.

As noted previously, premium rates generally run high in Massachusetts and continue to spiral upward. Small businesses are additionally disadvantaged given their limited negotiating ability with insurers, the difficulty of self insuring with so few covered lives, and the high administrative loads tacked onto policy premiums. Consequently, the cost of maintaining health insurance coverage is escalating far faster than small businesses' ability to pay for it. While there are limited data presently available to detail this trend, Chapter 305 of 2008 ("Health Reform Part 2") charged the Division of Health Care Finance and Policy (DHCFP) with looking at premium growth within the health insurance market, with market size as one of the key variables for analysis. DHCFP will release its report later this year which should further clarify the current market realities small businesses face.

While ultimately steps must be taken to fortify the employer-sponsored health insurance system over the long run, creation of a small business purchasing pool could offer some immediate relief by leveraging the collective purchasing power of the many small businesses, both for profit and nonprofit, with the hope of negotiating better rates with insurers and reducing administrative and marketing costs.

The Task Force recognizes, however, there are several limitations to this approach. Many similar attempts have failed in other states. There are clear conditions and protections that must be put in place from the outset to make such a pool work.

Given this, the Task Force recommends the following:

- Create **one** small group purchasing pool overseen by the Division of Insurance (or new Division of Health Insurance, see below) for all nonprofits and other small businesses in Massachusetts
- Minimize selection issues and maximize pool size/clout by offering only one pool
- Require adequate pool size/strength before rolling out the pool to maximize the number of insurers and plan options available to participants in the pool and to ensure adequate choice
- Require all state benefit mandates be included in the plans offered by the pool and that no exclusions or premium variation be allowed based on prior conditions
- Offer incentives to small employers in the form of subsidies or credits to ensure adequate participation in the pool and to avoid adverse risk selection common with voluntary pools - failure to do so ultimately could create a pool with a negative risk profile, which in turn would eliminate the premium relief the pool otherwise could provide

Word of Caution:

Creation of a pool for small businesses without adequate protections related to participation likely would be unsuccessful. Even with such protections, the long-term benefit of such an option may be minimal, at best, depending upon the type of employers/risk attracted to the pool and the pool's ability to negotiate preferable rates over the long run. Furthermore, creation of a voluntary pool would disrupt the merged small group/non-group market established as a result of Massachusetts health reform in 2006, the consequences of which may be significant.

Additional Policy Options

While the aforementioned three policy options were the primary focus of the Task Force's deliberations, several additional state and federal policies were discussed during the group's meetings and merit mention. The Task Force additionally supports further exploration of the following:

- Establishment of a federal refundable tax credit, program credit or subsidy for small employers that provides a financial incentive to provide and maintain employer-sponsored health insurance, encourages high levels of employer premium contribution, and offsets the fundamental disadvantages faced by small employers in securing and maintaining coverage; the benefit should be equally accessible to nonprofit small businesses.

- Creation of a separate Division of Health Insurance with the Division of Insurance (with funding redirected from the Massachusetts Health Care Access Bureau) to better track and oversee the workings of the health insurance markets in Massachusetts; reinstitution of rate hearings also should be considered as a way to systematically gain more insight into the reasons for premium growth beyond established thresholds.

- Analysis of the Insurance Partnership (IP) program to better understand its historically low take-up rate and how the program could be enhanced to i.) ensure greater usability by qualifying small businesses, ii) remove barriers to utilization, and iii) provide greater financial support to small businesses trying to provide high quality employer sponsored insurance.

II. Educational Initiatives

One of the topics discussed routinely throughout the work of the Task Force centered on the information void that exists for many small businesses in Massachusetts around the issue of health insurance selection, health reform requirements, Fair Share Contribution (FSC) audit processes, and other related matters. Since many small businesses do not have the internal resources available to dedicate to such human resource issues, many spend only a few hours or days each year dealing with their health insurance plan. For some, this means they are not maximizing the cost-savings opportunities available through things like Section 125 plans. For others, it means they are not doing a thorough analysis each year to identify the most affordable health plans that will meet their employees' needs. For yet others, it means they are not compliant with the terms of the employer FSC requirements under health reform and are unprepared for the related audit process when it occurs. For some, it is all of the above.

Small businesses, both nonprofit and for-profit, are at a disadvantage. While some education has been done with select businesses through organizations like the Associated Industries of Massachusetts (AIM), many small businesses have received no training or education following the enactment of health reform in 2006. Individuals can access the Commonwealth Connector and community resources like Health Care for All to learn more about their opportunities for health coverage as an individual Massachusetts resident. However, nothing has been done to provide systematic information and education to nonprofit employers and other small businesses. This is a significant void.

Educational Initiatives continued

The Task Force highly recommends developing a strategy for providing such education and outreach. Undoubtedly, such a plan will require a phased process of implementation, with the goal of identifying those in greatest need of this information for first receipt of the training on a regional basis. Specifically, the Task Force recommends the following:

- Establish a multi-lingual, literacy-sensitive, small employer-based curriculum for training owners and managers on the issues of health insurance coverage and health reform, including the following topics:
- Implementation procedures and benefits related to Section 125 plans
- Both contribution requirements and opportunities resulting from Chapter 58 health reform (e.g., employer coverage requirements, Department of Unemployment Assistance compliance audit procedures, CommChoice Contributory plan, etc.)
- Information available through the Health Care for All (HCFA) Helpline
- How to select a high-quality, affordable health insurance plan (and a broker, if using one)
- Public programs available for individuals, especially for those who do not qualify for employer sponsored coverage (e.g., MassHealth, CommCare, CommChoice, Health Safety Net, Medical Hardship Program, Medical Security Program, etc.)
- Insurance Partnership opportunities and requirements
- Establish a similar curriculum geared to individual employees, detailing the unique opportunities for both those with employer-sponsored coverage and those without
- Explore the possibility of establishing a hotline specifically for nonprofits and other small businesses modeled after the HCFA helpline for individuals
- Identify a regional training strategy for disseminating the curricula and training, including association meetings and conference opportunities, as well as direct, on-site employer training, with subsequent support available via a helpline; identify potential partnerships with other member organizations serving small business such as the Retailers Association of Massachusetts, National Federation of Independent Business (NFIB), Small Business Service Bureau (SBSB), etc.
- Develop an online repository containing all of the curricula and training materials for access by small businesses (both owners/managers as well as individuals)
- Identify organizations capable of providing the curricula that already have expertise in the issues of insurance coverage and health reform (such as AIM) for possible partnership in the roll-out of such an initiative.

Word of Caution:
The cost of providing a strategic and systematic outreach and education campaign targeted to nonprofits and small employers is unknown. Currently, little funding is available for these activities, and the intended beneficiaries (nonprofits, small businesses, and their employees) have limited capacity, at best, to bear such costs. New funding would have to be secured to execute this option, which may be difficult in the current fiscal climate.

III. Improvements To Stabilize Employer Sponsored Coverage Around Health Reform Implementation

Massachusetts landmark health reform legislation has brought significant gains in the health insurance coverage of thousands of Massachusetts residents. As reform implementation efforts have progressed, there also have been some unintended consequences, as well as further indications of the need for more systemic change within the health care system, to make the gains in insurance coverage sustainable over the long term. The Task Force discussed several specific issues resulting from health reform implementation over the past 2+ years. Some of the recommendations that follow are merely administrative and/or regulatory in nature. Others could require some further legislative action.

It almost goes without saying that none of the recommendations in this report begin to address the most important factor in enhancing and retaining nonprofits' capacity to provide and maintain high quality health insurance coverage – containment of skyrocketing health care costs and related insurance premiums. Since the development of such strategies was beyond the scope of this project and already being carefully studied by the Massachusetts Special Commission on the Health Care Payment System which recently released its report, among others, the recommendations contained herein are based in an understanding of the current health insurance system as it stands today. The Task Force fully acknowledges the larger "landscape issues" such as the need to expand public health initiatives, provide incentives within the insurance system to reward healthy behaviors, tie provider payments to outcomes rather than units of care, and other such strategies. Significant gains in any of these directions may fundamentally begin to change the realities facing nonprofits and other businesses when it comes to covering their employees.

Nevertheless, there are specific and concrete actions that could help alleviate some of the struggles nonprofits face today in the wake of the Massachusetts health reform efforts. As such, the Task Force recommends the following:

- Expand the subsidies currently available to individuals below 300% FPL through the CommCare program to low-wage workers with access to employer-sponsored health insurance who struggle to afford their ESI and currently are blocked from receiving the subsidy, while maintaining employer premium contributions for coverage (as outlined in the Policy Recommendations section above)
- Further clarify and amend the Fair Share Contribution (FSC) requirements for businesses by:
- Providing better education and information on the requirements, like the definition of "full time" (full-time employee vs. full-time equivalent), how to account for seasonal and part-time workers in the required calculations, the appropriate methodology for the various calculations, and more; this should be done through systematic outreach and education for businesses, particularly small ones, as well as improved hotline and online resources
- Amending the Majority of Time Rule to account for the varied employment schedules of seasonal and flextime part time workers who may work more than 35 hours per week for more than seven weeks per quarter in select quarters while at the same time do **not** meet the requirements for employer-sponsored coverage because they are not full-time employees eligible for health benefits, per the provisions of their employer's plan
- Creating a hardship appeal and waiver process for those organizations that face FSC fines and/or Free Rider Surcharges when such additional costs literally may be more than the organization can bear
- Studying the implications of and considering an amendment to the FSC take-up requirement, that states employers with more than 50 full-time equivalents must demonstrate a 25% take-up rate of employer-sponsored insurance, in order to consider legitimate alternative sources of coverage, including Medicare

Improvements continued

- Study the issue of multiple source insurance coverage (for example, concurrent coverage through Medicare, an employer-sponsored plan and/or retiree health benefits) to see if policy opportunities exist to consolidate coverage and/or wrap coverage for individuals with more than one health insurance policy to avoid costly and duplicative premium payments
- Research ways of better coordinating the enrollment procedures and coverage opportunities for individuals within various state-sponsored health insurance programs (such as CommCare, MassHealth, Medical Security Program, etc.) as well as the employer-sponsored insurance system; ensure better articulation between these programs to avoid churn and periods of lapsed coverage
- Identify a way to capture employer's profit status (nonprofit vs. for profit) to better identify the types of employers and employees struggling to provide and maintain health insurance coverage (and to target outreach accordingly) through either a revision to the Health Insurance Responsibility Disclosure (HIRD) form, Division of Health Care Finance and Policy Employer Survey, or some other mechanism(s) that will allow for consistent reporting and tracking over time.

Word of Caution:

Many of the items above would cost additional state time and resources to research, amend and/or execute. In the case of some proposed options, changes to the regulations also may ultimately cost additional state funds. Nevertheless, health reform in Massachusetts was intended to be an iterative process, as it was passed. As new health reform initiatives continue to emerge, it is only natural also to continue to explore how existing reform efforts can be enhanced to further the goal of high quality coverage for all Massachusetts residents.

Endnotes

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14. Throughout this report, there are references to "small employers," defined as those with 50 employees or less.

Looking forward

The Massachusetts Nonprofit Network looks forward to analyzing the ongoing health care debate and the impact it will have on nonprofits' ability to provide health insurance coverage in the both the short and long terms.

A great deal has been learned over the past eight months as a result of this process. Many knowledgeable people came together to discuss the topics at hand, bringing with them varying and unique perspectives on the issues. The Nonprofit Health Insurance Project to date has underscored that further reforms are needed to expand access to and retention of high quality, affordable health insurance coverage for Massachusetts nonprofits (as well as small for-profit businesses) and their employees. More information is needed on exactly just how fragile portions of the nonprofit sector are in terms of their ability to sustain coverage under the current system and how best to support their attempts to offer continued coverage.

As mentioned previously, the Boston Foundation study released earlier this year was the first look into the benefits provided by nonprofits specifically. While the study provided a valuable first look at a wide range of benefits provided by a wide range of nonprofits, it was not designed to gather a great deal of information on the finer details and nuances of health insurance coverage and it also did not capture a large percentage of the smaller nonprofit landscape, the portion of the sector believed to be most at risk for not being able to sustain coverage. Furthermore, the data gathered in the study predates the implementation of health reform in the Commonwealth. Currently, no data are available documenting how the provision of insurance has changed within the sector over the past two years. Consequently, the Task Force highly recommends additional data and information be gathered on the sector's health insurance profile, focusing primarily on smaller nonprofits, to better assess the points of greatest weakness and highest need when it comes to support, education, and cost relief, and also to provide a basis for tracking this information over time. Modeling also is needed to project the impact the policy options outlined above would have on health insurance provision within the nonprofit community and the cost of such options.

More information will be forthcoming on the current state of the insurance market as the state continues to pursue multiple related projects and studies. The study currently underway at the Division of Health Care Finance and Policy looking at insurer and hospital reserves and surpluses, as well as the other study mentioned previously on health care costs/premium trends, will shed greater light on health insurance pricing and the underlying costs that drive them. The work of the Massachusetts Special Commission on Payment Reform also mentioned previously, and that of the Massachusetts Health Care Quality & Cost Council, will continue to inform the larger and longer-term goals of fundamental system reform and cost containment. The information coming from this important work will be pivotal to pinpointing effective strategies for further helping vulnerable organizations and individuals.

And finally, the implications of the federal debate remain unknown at this time, yet central to the direction state policy moves in the future. Should federal reform pass Congress, it undoubtedly will bring changes to insurance market regulations, specify the roles to be played by insurance connectors (or exchanges) in providing health insurance to individuals and small businesses, hopefully offer new subsidies for providing coverage to struggling small businesses, and more. While the Task Force felt there was not a need to wait to issue its recommendations until the federal debate is resolved, it is important to see where this dialogue ends and if/how the associated provisions will provide relief to nonprofits and other small businesses before pressing forward with major policy reforms at the state level.

While much will happen, the close of 2009 will be here quickly. The Massachusetts Nonprofit Network looks forward to analyzing the ongoing health care debate and the impact it will have on nonprofits' ability to provide health insurance coverage in the both the short and long terms. The reality of rising premiums and cuts in funding are forcing nonprofit employers to assess (or reassess) their immediate ability to continue coverage. MNN must continue to push for reform and assistance to stabilize the coverage offered through the nonprofit sector. In the coming months, there are clear steps to be taken to develop a better profile of nonprofit health insurance coverage in Massachusetts that will enable MNN to move the policy agenda, including some of the options outlined in this report, as soon as there is some federal resolution. Furthermore, critical outreach and education to small nonprofits about the system in place today must begin as soon as resources can be identified to do so.