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before the

SENATE COMMITTEE ON SMALL BUSINESS &
ENTREPRENEURSHIP

(February 13, 2007)

Good morning. I am Jon Kingsdale, Executive Director of the Commonwealth of Massachusetts' Health Insurance Connector Authority.

As part of an extensive reform to cover the uninsured in Massachusetts, the Connector contracts with private health plans and enrolls individuals and small employer groups in those plans. Since July 1, 2006, the Connector has enrolled 45,000 low-income, uninsured individuals, MassHealth (Medicaid) has added 55,000, and our expanded Insurance Partnership program added another 2,000 low-wage employees from small business. We have reduced the number of uninsured in Massachusetts by 102,000 or some 27%.

Massachusetts' health care reform is based on the principle of shared responsibility: that employers, individuals and government each participate financially in expanding coverage. Reform is built on these five pillars:

1. We require universal adult participation in health insurance;

2. We require employers of more than 10 workers to help finance their employee's health insurance;

3. We offer the small-group and non-group end of the market for health insurance more choice and better information;

4. We provide government-subsidized, private insurance for the uninsured who earn 300% or less of the federal poverty level; and

5. We are reducing the cost-shift from Medicaid onto private health insurance premiums.

The first three building blocks address issues especially relevant to the small end of the heath insurance market. First, insurance is designed to pool risk—pooling resources from many to support the few who really need them--but small-group and non-group insurance is susceptible to risk segmentation. Carriers can identify and select relatively healthy individuals and small groups--leaving the unhealthy unprotected--and small employers and individuals can try to participate at times and in ways such that their own medical costs exceed the premiums they pay.

To protect against both forms of discrimination, our health plans are required (a) to issue and renew coverage and (b) to insure individuals and small businesses under rate formulas that cross-subsidize between healthier and sicker populations; and all adults will soon be required to have insurance. This protects the sick and it keeps the healthy in the risk pool.

Second, while most large employers (98% nationally) offer health benefits, over 40% of small employers do not. (In Massachusetts, small business employs two-thirds of working, uninsured adults.) Group health benefits are designed not only to pool risk, but to subsidize coverage. To encourage group insurance, Massachusetts now requires that employers of more than 10 employees make a "fair and reasonable" contribution toward their workers' health benefits, and we will shortly require them to help workers with pre-tax, payroll deduction for the employees' share of premiums.

Our requirement that all adults, healthy or sick, buy a minimum level of insurance is designed to create a credible risk pool. The requirement that employers of more than 10 workers provide group health benefits and pre-tax, payroll deduction is designed to help finance coverage. Combined, these two provisions will encourage most employers to offer group insurance and most of their employees—even the young and healthy—to accept that offer.

Of course, medical care is expensive stuff, no matter how you divide it. Costs are especially burdensome for small business and low-wage employees. To assist them, our state's Insurance Partnership ("IP")

subsidizes premium costs for both the small employer of low-wage employees and his/her low-wage workers. I note the similarity to S. 99, the Small Business Health Care Tax Credit Act sponsored by Senator Kerry among others. Moreover, S. 99 offers the certainty and outreach associated with using the federal tax code, which would benefit our state program.

Third, we are addressing the problem that individuals, on their own and in small employee groups, often lack choice of health plans. Limited choice is, in itself, a cause of dissatisfaction. Moreover, it blocks innovative efforts to control costs and add value. To provide more choice, Massachusetts will require health plans to offer to (non-group) individuals the same options, at the same prices, that they offer small business, and the Connector will offer individuals—those who work for small business and those who buy on their own—the kind of broad choice of qualified health plans that the employees of many large organizations, including federal employees, currently enjoy.

The following table illustrates choice under the Connector. The small employer will make a defined contribution toward a "benchmark plan," and then his/her employees may apply that defined contribution toward any reasonably comparable option. The Connector will try to eliminate "hidden" variations among the plans and highlight important distinctions--for example, differences in premiums, costs to see a doctor, and which doctors and hospitals participate in each health plan.

The Connector's transparency is intended to stimulate competition among health plans, much as the FEHBP does. We are also working on state-of-the-art shopping tools, such as a way to virtually "test-drive" a health plan before finalizing an election to enroll in it.

The Connector also relieves small business of the burden of pricing, shopping, explaining and policing a plan each year. Instead of reacting to their plan's premium increase, as so many employers must do, by shopping for a new one, they leave it to the Connector to offer best in value, and to their employees to comparison shop through the Connector. This promises significant administrative savings to small business, while giving their workers truly informed choice.

Thank you for the opportunity to testify about the implications of health reform for small business in Massachusetts, and I would be pleased to answer your questions.