Community Catalyst

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Massachusetts Health Insurance Marketplace Affordability Fact Sheet

This fact sheet is intended to highlight the innovative strategies Massachusetts uses to improve affordability of insurance coverage on the Health Connector, their state insurance marketplace. This is one of a five-state series, presented by Community Catalyst, intended to share information with policymakers about innovations states can employ to make health insurance more accessible for low- and moderate-income individuals. Massachusetts defines "low- and moderate-income individuals" as individuals at or below 500% FPL. Massachusetts has a merged individual and small business market and, therefore, both are addressed.

Massachusetts' Insurance Environment

Massachusetts market characteristics:

- Population size: 6.981 million (2022)
- 294,000 covered (2024)
- 2.4% uninsured (2021)
- $96,505 median household income (2022)
- Individual mandate
- Plan standardization
- Medicaid-Marketplace integrated model
- Aligned Governor and legislature (D)

Massachusetts has a long history as a health care reform leader, establishing the first state-based marketplace, the Health Connector, in 2006. Since that time, Massachusetts has required residents to maintain health insurance or face a tax penalty (e.g., individual mandate)[1], which has helped the state achieve nearly universal coverage.[2,3] Massachusetts used $18 million in annual revenue from the penalty to help fund the state's marketplace affordability programs.[4]

Enrollment in the state's marketplace increased by 85,000 since February 2023, which is largely attributed to the state expanding eligibility for their standardized and subsidized plan program, ConnectorCare (further discussed below). The Health Connector is integrated with Medicaid, meaning the marketplace can complete Medicaid enrollment. Massachusetts is also an "active purchaser", meaning it sets guidelines for participating insurance carriers in terms of the number and design of plan offerings.[5] More context about the Health Connector and the political context can be found in **Appendix A**.

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[1] Massachusetts Department of Revenue. "Health Care Reform for Individuals". Nov 13, 2023. https://www.mass.gov/info-details/health-care-reform-for-individuals#requirements-

[2] The state's individual mandate penalty for non-compliance was suspended from 2014 through 2018, but was re-implemented in 2019 when the federal penalty was reset to $0.

[3] MA Health Connector. "Data on the Massachusetts Individual Mandate: State Coverage Gains Under the Affordable Care Act". Sep 2021. https://www.mahealthconnector.org/wp-content/uploads/DOR-Tax-Filers-Analysis-Coverage-Gains-Brief-092021.pdf

[4] MA Health Connector. "The Massachusetts Individual Mandate: Design, Administration, and Results". Nov 2017. https://www.mahealthconnector.org/wp-content/uploads/Individual-Mandate-Report-Nov2017.pdf

[5] MA Health Connector. "Striving for meaningful choice: Non-group health plans on the Massachusetts Health Connector product shelf". Jan 2019.

Policies driving coverage affordability and accessibility

Massachusetts has implemented several programs aimed at improving access to affordable health coverage, by lowering cost sharing for covered benefits, reducing premiums for older adults, and minimizing enrollment barriers.

Strengthening affordability of covered benefits

ConnectorCare

Massachusetts established its ConnectorCare program in 2014, which offers subsidized private health insurance plans and a standard set of benefits at each metal level. As of 2024, the program expanded premium assistance and cost-sharing reductions to enrollees with income up to 500% of the federal poverty level, an increase from the prior 300% FPL.[6] The premiums for these plans range from $0/month (for those with income up to 150% FPL) to $255/month (for those with income between 400% and 500% FPL). Co-pays are similarly scaled based on income and there are no deductibles.

In addition to premium and cost-sharing subsidies, the ConnectorCare program offers certain prescriptions for select chronic conditions for no co-pay.[7] The state's original intent was to choose the prescriptions and apply them unilaterally across all carriers. However, after pushback from insurers, a compromise was reached to allow insurers to select their own drugs that would be eligible for $0 copay. This means some enrollees could experience treatment disruptions if they switch plans.

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https://www.mahealthconnector.org/wp-content/uploads/Product-Shelf-Policy-Brief-Update-January-2019.pdf

[6] MA Health Connector. "Pilot expansion of ConnectorCare reshapes affordability and plan options through the Health Connector". Aug 14, 2023. https://www.mahealthconnector.org/pilot-expansion-of-connectorcare-release

[7] Massachusetts' Marketplace executives found that diabetes, asthma, and heart disease overlapped in terms of prevalence and equity implications in the state. Therefore, these are the conditions selected for $0 copays and visits.

Funding	ConnectorCare is funded by blending federal funds (50% federal match through an 1115 waiver) and state-funded subsidies (individual mandate revenue, a tobacco tax, and employer assessments).
Policy Levers	• Enrollment is open year-round for newly eligible applications, further reducing barriers to accessing the subsidies beyond the Open Enrollment period used federally and in other states. • Consumer feedback and survey research provided evidence for Massachusetts to appropriate extra funds that expand ConnectorCare to 500% FPL. • ConnectorCare has crafted benefit designs to improve health equity by eliminating copays for generic medications and office visits for chronic conditions that disproportionately impact populations of color.
Impacts	• 156,000 people were enrolled in ConnectorCare plans in 2023 and another 43,000 enrolled during the open enrollment period for 2024 coverage - largely due to the expansion to 500% FPL.[8,9] The expansion is expected to benefit up to 50,000 new or existing Health Connector enrollees. • ConnectorCare participants benefit from lower premiums, out-of-pocket costs, and no deductibles.

Massachusetts advocates originally requested the 500% FPL expansion to be permanent, but the state legislature questioned the source of sustainable funding. This uncertainty is what made this program a pilot, rather than a permanent provision. The Health Connector and Massachusetts Health Policy Commission leaders share priorities in coverage and health equity; advocates report that having innovative, "true [partners] at the top of the organization" has mattered a lot in the success of ConnectorCare. More background on ConnectorCare funding and considerations is provided in **Appendix B**.

[8] MA Health Connector. "Open Enrollment starts with new ConnectorCare eligibility delivering more affordable coverage to more residents". Nov 1, 2023. https://www.mahealthconnector.org/open-enrollment-starts-with-new-connectorcare-eligibility

[9] MA Health Connector. "Massachusetts Health Connector ends busiest Open Enrollment in a decade with more than 72,000 new enrollments". Jan 29, 2024. https://www.mahealthconnector.org/health-connector-ends-busiest-open-enrollment-in-a-decade

Medical Loss Ratio (MLR)[10] requirement

As another strategy to reduce premium costs, Massachusetts requires that individual and small group health plans spend 88% of premium revenue on medical costs and improvements to the quality of care. The state originally required 90% but reduced it in 2015.[11] Massachusetts' MLR requirement goes further than the federal Patient Protection and Affordable Care Act (ACA), which requires carriers to have an 80% MLR.[12] If insurers do not adhere to this spending rule, they must provide rebates to their enrollees. The MLR impacts premium rate review and imposes tighter limits on rate increases.[13] In 2024, Massachusetts marketplace's average full-price premium is $507/month, compared to the nationwide average of $605.[14]

Lowering premium costs for older adults

2:1 Age Rating

Because older enrollees tend to need more health services than younger enrollees, the ACA set a limit on premiums charged to older adults. This federal rule, followed by most states, is set at a 3:1 ratio, meaning that insurers cannot charge an adult aged 64 or older more than three times the premiums paid by a 21-year old for the same coverage.[15] Massachusetts, instead, has a long-standing rule limiting the age-rating ratio to 2:1 for individual and small-group plans; so older adults cannot be charged more than twice as

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[10] Healthinsurance.org. "What is the medical loss ratio?". https://archives.lib.state.ma.us/server/api/core/bitstreams/30c73037-355a-4830-878f-29cb1eb33e74/content

[11] Center for Health Information and Analysis. "Massachusetts Medical Loss Ratios". 2015. https://archives.lib.state.ma.us/server/api/core/bitstreams/30c73037-355a-4830-878f-29cb1eb33e74/content

[12] From 2021 through 2022, average national MLRs for the individual market were about 86% –well above minimum ACA standards, and nearly as high as the requirement in Massachusetts. But Massachusetts' rule helps to push MLRs even higher in the state.

[13] Centers for Medicare & Medicaid Services. "Medical Loss Ratio Search Tool". https://www.cms.gov/cciio/mlr#:~:text=About%20the%20Medical%20Loss%20Ratio&text=MLR%20requires%20insurance%20companies%20to,on%20health%20insurance%20rate%20increases.

[14] Centers for Medicare & Medicaid Services. "2024 Marketplace Open Enrollment Period Public Use Files". https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

[15] The Commonwealth Fund. "How the Affordable Care Act Has Affected Health Coverage for Young Men with Higher Incomes". April 2018. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2018_apr_glied_aca_young_men_ib.pdf

much as a 21-year-old.[16] For older enrollees who are not eligible for subsidies, the 2:1 age rating ratio helps to keep premiums lower than they would be otherwise. The tradeoff, however, is that full-price premiums for younger applicants are higher than they would be if a 3:1 age rating rule was in place. For a more complete discussion of the tradeoffs, see **Appendix C**.

Reducing barriers to enrollment

Simple Sign–Up Program (easy enrollment)

The Simple Sign-Up Program,[17] launched in 2022, gives uninsured tax filers an option to check a box on the state tax return to indicate that they would like their information shared with the Health Connector.[18] The Health Connector uses this information to assess one's eligibility for MassHealth (Medicaid), ConnectorCare coverage, or other marketplace plans. The Health Connector then reaches out to provide coverage options and assist with enrollment. This Simple Sign-Up program is intended to increase access to health insurance.[19] In particular, the program aims to improve coverage among communities of color who often face relatively higher rates of uninsurance.

Facilitated Enrollment <150% FPL

To mitigate remaining uninsurance, Massachusetts instituted a facilitated enrollment program in April 2022, which has since enrolled 10,000 individuals. An applicant can opt-in to the program and, if they have not yet chosen a plan and their income is at or below 150% FPL, the Health Connector will automatically assign them a $0 premium plan. The enrollee is notified throughout the process about being opted in, and about Advanced Premium Tax Credit (APTC) reconciliation, to mitigate the risks of unwanted enrollment.[20]

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[16] MA Health Connector. "Adult Massachusetts Residents Between 55 and 64, Health Coverage, and the American Rescue Plan". https://www.mahealthconnector.org/wp-content/uploads/ARP-and-55-64-year-old-FACT-SHEET.pdf

[17] MA Health Connector. "Simple Sign-up Program". https://www.mahealthconnector.org/learn/simple-sign-up

[18] Massachusetts is among 11 states that offer a way to connect uninsured residents with health coverage by leveraging the state tax return; otherwise known as "easy enrollment" programs. (https://www.healthinsurance.org/glossary/easy-enrollment-program/)

[19] MA Health Connector. "Simple Sign-up health insurance enrollment is as easy as checking a box on the state tax form". Feb 7 2022. https://www.mahealthconnector.org/health-connector-simple-sign-up-is-here

[20] Urban Institute. "Expanding Health Coverage through Marketplace Facilitated Enrollment Programs". Dec 12, 2023. https://www.urban.org/sites/default/files/2024-

Funding	• MA Health Connector executives report that the Simple Sign-Up program was about $55,000 in startup costs, and about $100,000 in outreach.
Policy Levers	• MA facilitates enrollment for individuals who complete a marketplace application but fail to select a plan as well as individuals who have lost Medicaid coverage and are eligible for coverage on the marketplace.[21]
Impacts	• Preliminary evidence suggests easy enrollment programs are cost-effective policies.[22] • MA auto-enrolled members were more likely to be "younger, noncitizen, and nonwhite compared with active enrollees."[23]

More information on both the Simple Sign-up and Facilitated Enrollment programs can be found in **Appendix D**.

Recommendations and lessons learned

> **"Spend time working on getting the right people into the agencies that you're working with.**

Massachusetts has implemented many recent policies addressing enrollment and affordability issues in the state, including its innovative ConnectorCare expansion pilot. Advocates emphasized the importance of having both technical experts and policy entrepreneurs as heads of agencies to push policy, direct communications with community members, and strong data evaluation components built into the policy. These aspects of their health policy environment allow advocates to monitor affordability data

01/Expanding%20Health%20Coverage%20through%20Marketplace%20Facilitated%20Enrollment%20Programs.pdf

[21] This includes lawfully present immigrants ineligible for Medicaid because of the five-year bar.

[22] Urban Institute. "Expanding Health Coverage through Marketplace Facilitated Enrollment Programs". Jan 2024. https://www.urban.org/sites/default/files/2024-01/Expanding%20Health%20Coverage%20through%20Marketplace%20Facilitated%20Enrollment%20Programs.pdf.

[23] Ibid.

and respond quickly and efficiently to problems when policy windows and resources arise.

For example, to evaluate the impact of policies such as the 88% MLR requirement, the state examines the annual rate filing to determine health of insurance reserves against premium increases/decreases each year and prior year MLRs. This type of data-driven approach provides effective accountability for issuer companies.

State advocates report that a major, though understated, aspect of their policy context is their approach to policy and working respectfully with stakeholders. They maintain good working relationships with their partners even though they may disagree on certain subjects. They focus on the policy and data, use evidence-based arguments when refuting opinion, and respectful public discourse.

Appendices

The following appendices provide additional detail about the information presented in the fact sheet for those who would like more context. For more information on Massachusetts Health Connector and related programs, policies, and legislation, see the following links:

1. Center for Health Information and Analysis (CHIA, https://www.chiamass.gov/)
2. Massachusetts Health Connector (https://www.mahealthconnector.org/)
    a. Health Connector reports (https://betterhealthconnector.com/about/policy-center/reports-publications#reportstothelegislature)
    b. Health Connector policies (https://betterhealthconnector.com/about/policy-center/policies)
    c. ConnectorCare (https://www.mahealthconnector.org/learn/plan-information/connectorcare-plans) (https://www.healthinsurance.org/states/health-insurance-massachusetts/)
3. Standardized information and private blog posts across states
    a. XpostFactoid (https://xpostfactoid.blogspot.com/search?q=massachusetts/)
    b. ACA Signups (https://acasignups.net/search/node/massachusetts)
    c. Health Insurance Marketplaces by State (https://www.healthinsurance.org/states)

d. State Marketplace Network: Collective group of 21 SBMs from across the country supported by the National Academy for State Health Policy (https://statemarketplacenetwork.org/)

Appendix A: Massachusetts Health Insurance Context

Merged Market

Massachusetts has a merged individual and small group market.[24,25] Merged markets can be controversial, because while they spread risk to a larger pool, outcomes differ for populations depending on which market is larger, more stable, and/or better risk prior to the merge.

Political Context & Public Opinion

Massachusetts' affordability policies and marketplace evolution take place within the context of a Democratically-controlled government.[26] The state legislature is historically 'blue', while the governorship tends to oscillate between the nation's two dominating parties.

Residents in statewide 2024 polling from Beacon Research for Blue Cross Blue Shield of Massachusetts report that they remain worried about high health care costs.[27] Forty percent put off care because of costs, half of which are younger, less affluent residents. Three-quarters of all respondents view co-pays or bills as a major problem–an increase of twelve percentage points from 2022. Overall, cost is the biggest health care issue in the state by far, with 51% of respondents reporting its importance when compared to other issues like access, quality, and equity. The state's marketplace policies, discussed in this brief, address mainly affordability and access for enrollees.

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[24] Commissioner of Insurance. "Report of the Merged Market Advisory Council". https://www.mass.gov/doc/final-report-of-the-merged-market-advisory-council/download
[25] Maine merged its markets starting in 2023. Vermont unmerged its markets in 2022 and extended that with legislation last year, but will re-merge them in 2026 unless additional state legislation is passed. Washington D.C. is the only other territory that has merged markets.
[26] Ballotpedia. "Party Control of Massachusetts State Government". https://ballotpedia.org/Party_control_of_Massachusetts_state_government
[27] Beacon Research. "MA Statewide Poll". March 2024. https://www.bluecrossma.org/aboutus/sites/g/files/csphws2321/files/2024-03/BCBSMA%20March%202024%20Statewide%20Poll%20-%20Public%20Charts.pdf

Appendix B: ConnectorCare Background

The Massachusetts representatives highlighted the unique federal funds that were vital to the feasibility of ConnectorCare expansion. As noted, the state had a history of health care innovation with an equity focus since 2006 through the Massachusetts Health Connector.[28] When the ACA was being negotiated, the state did not want to lose progress, as the federal coverage and cost sharing subsidies would be less generous than their state's program in 2006. Thus, Massachusetts negotiated an 1115 waiver (before ACA passage) to receive federal funds for ConnectorCare for at least 300% FPL rather than the federal limits in other states.

Later, the American Rescue Plan Act (ARPA) of 2021 and the Inflation Reduction Act (IRA) of 2022 expanded and extended federal APTC to a level Massachusetts had already been offering. The state, however, did not adjust their budget allocation for state funded subsidies and the resulting excess funds were kept in their Commonwealth Care Trust Fund.[29] These were allocated for several years towards subsidies the state no longer needed to fund. Executives eventually directed them towards the 500% FPL eligibility expansion.

Years of consumer experience feedback and survey data helped the state decide to expand ConnectorCare eligibility. To gather consumer experience, Health Connector maintains a helpline, which takes 20,000 calls a year. Through this helpline, the state received many complaints on the extreme coverage "cliff" for consumers oscillating around the original ConnectorCare income eligibility threshold (300% FPL). The state also partners with the Center for Health Information and Analysis (CHIA) to obtain survey data.[30] Their survey found that over "40% of residents" reported challenges affording health care. They also found the greatest racial disparities around health care affordability was for the population over 300% FPL. The state also observed a rise in high deductible health plan enrollment in their data. The helpline and CHIA data provided evidence to support allocating excess funds to the 500% FPL expansion, including

[28] MA Health Connector. "Massachusetts: The model for national health care reform". https://www.mahealthconnector.org/about/policy-center/history#:~:text=Massachusetts%20led%20the%20nation%20in,insurance%20available%20to%20more%20people.
[29] Commonwealth of Massachusetts. "Section 2OOO: Commonwealth Care Trust Fund". https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIII/Chapter29/Section2OOO
[30] Commissioned under Chapter 224 in Massachusetts health reform law after passage of ACA. This chapter primarily deals with cost containment, but commissions CHIA as a quasi-state agency to run health care analyses and report to the legislature.

addressing health equity goals. Though the expansion is currently a pilot, the state is requesting an 1115 waiver amendment for a federal match for the expanded eligibility group.[31]

Appendix C: Age Rating Considerations

According to a 2017 Millman Research Report, pre-ACA, the age rating ratio across states was 5:1 or higher.[32] Urban Institute researchers analyzed the impact of the ACA 3:1 age rating rule, and found that after implementation, premiums decreased for older adults, while they increased for younger people. Researchers simulating the impact of the 3:1 age rating structure compared to a 5:1 structure found that for the majority of the subsidized population, both younger and older adults experienced similar premium costs, since APTC is calculated based on premium levels.[33]

In contrast, younger adults in the unsubsidized population experienced higher annual premium costs (average of $470 for 21 to 27 year olds), since they receive no APTC to soften the impact of premium costs. Older, unsubsidized adults experienced lower premium costs (average of $1,400 in savings for those 57 or older) under the 3:1 structure. In other words, most subsidized enrollees do not “feel” the effects of a change in age rating, while the unsubsidized population does. Younger unsubsidized enrollees bear the brunt of increased premium costs, while older unsubsidized enrollees end up with lower premiums.

The tradeoff between wider versus narrower age ratings is complex with young unsubsidized and older subsidized buyers better off with wider age ratings while older unsubsidized and younger subsidized buyers in the individual market are better off with narrower age ratings.

The increase in enrollment among younger people is larger than the decrease in enrollment among the older population under this scheme, and most of this shift was among the unsubsidized population. This inelasticity is due to older adults' higher demand for health care. Older individuals are also more likely to qualify for APTC based on their

[31] Marketplace executives expect to receive a response in early summer of 2024.
[32] Milliman. “Impact of Changing ACA Age Rating Structure”. Jan 31, 2017. https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/millimanacaagebands_0131_final.ashx
[33] Specifically, 92% of adult singles aged 21 to 27, 85% aged 28 to 44, 79% aged 45-56, and 76% 57 or older, saw no change in their premiums between the two age rating structures.

income as premiums increase, so they did not move off market in the same magnitude as younger folks moved onto the market. The federal government bears most of the costs under wide age ratings, because of the increased subsidies for older individuals.

State policymakers should consider these tradeoffs along age group distinctions between subsidized and unsubsidized populations when adjusting age ratings, based on age and income demographics; as these can affect some younger enrollees' participation in the market.

Appendix D: Enrollment Program Background and Considerations

Easy Enrollment

Easy enrollment programs are less controversial than other policies such as subsidies, individual mandates, and public options. Tax filing itself reaches 41% of those uninsured and below 150% FPL; and it reaches 90% of those uninsured and between 150-200% FPL, nationally.[34] This means enrollment by leveraging the tax filing process is promising particularly for low-income filers. Maryland was the first state to institute such a program in 2020; and in its first year, over 60,000 people chose to share their information with the marketplace.[35] Over 4,000 people ended up enrolling in coverage, including 11% found eligible for subsidized marketplace plans (that, in 2020, were only available for households up to 400% FPL). The state saw a boost in enrollment among Black people: 23% of those who enrolled by easy enrollment were Black, compared to only 17% who signed up during the open-enrollment period. This preliminary evidence suggests that easy enrollment programs improve access by streamlining enrollment, and may be especially important for historically marginalized groups, which Massachusetts explicitly targets with its policy.[36] During interviews, state advocates emphasized health equity as a major focus in the Health Connector, so this policy aligns with their state goals.

[34] The Commonwealth Fund. "Automatic Enrollment in Health Insurance: A Pathway to Increased Coverage for People with Low Income". Mar 11, 2024. https://www.commonwealthfund.org/publications/fund-reports/2024/mar/automatic-enrollment-health-insurance-pathway-increased-coverage

[35] The Commonwealth Fund. "State "Easy Enrollment" Programs Gain Momentum, Lay Groundwork for Additional Efforts to Expand Coverage". Aug 3, 2021. https://www.commonwealthfund.org/blog/2021/state-easy-enrollment-programs-gain-momentum-lay-groundwork-additional-efforts-expand

[36] MA Health Connector. Feb 2022.

Facilitated Enrollment

A Commonwealth Fund study reports that people with income under 150% FPL (the population eligible for zero-premium coverage) make up 43% of those uninsured, and people below 200% FPL make up 56%.[37] Thus, automatically enrolling those eligible for zero -premium coverage through Medicaid or ACA marketplaces with their consent, could significantly reduce the number of people uninsured.

Facilitated enrollment poses unique issues in APTC reconciliation risk.[38] PTC is based on projected income, and later reconciled on tax returns based on actual income. So, consumers who are automatically enrolled in zero premium coverage with APTC, but later turn out to be eligible for less PTC or ineligible altogether (if they were enrolled in other coverage or had higher income than the marketplace believed), could owe back tax dollars during their tax filing. Because of this risk, consumers must clearly consent to receiving APTC when they create an account. States can conduct facilitated enrollment by collecting consent at an earlier encounter and beginning enrollment later. Massachusetts does this "for those who have completed the marketplace application but failed to choose a plan." These risks were studied by the Health Connector early in program implementation and found to be immaterial.

[37] The Commonwealth Fund. Mar 2024.
[38] Urban Institute. Jan 2024.