Proposed Health Reform in Massachusetts:

Net Gain for the Business Community

Families USA

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INTRODUCTION

The Massachusetts House of Representatives has passed a health reform bill (An Act Promoting Access to Health Care—H. 4479) that is designed to expand health coverage for people in Massachusetts who are uninsured. To achieve this goal, the bill seeks to build on the current system of employer-provided health coverage. It does so through a variety of provisions, ranging from a proposal that would impose an assessment on firms that have more than 10 employees and that do *not* offer health insurance to a series of measures that would provide relief to businesses that currently *do* provide coverage.

In evaluating the bill, a key concern is how these provisions will affect the state's employers. To assess the bill's net impact on businesses, this report examines three specific questions:

1. What types of employers would experience costs and benefits under the legislation?
2. How many Massachusetts employers would be helped—and how many would be hurt—by the bill?
3. What is the magnitude of these various costs and benefits?

KEY FEATURES OF PROPOSED REFORMS

A variety of provisions in the bill would have a significant direct or indirect impact on Massachusetts businesses.[1] Those provisions include the following:

- The bill would require all Massachusetts residents to obtain health insurance unless they lack affordable access to coverage.
- The lowest-income state residents would gain improved access to coverage through an expansion and restructuring of MassHealth (the state's Medicaid program).
- Medicaid reimbursements to health care providers would increase by $90 million per year.
- State residents whose incomes are too high to qualify for MassHealth but who have incomes below 300 percent of the federal poverty level ($48,270 for a family of three, $58,050 for a family of four in 2005) could purchase coverage through the Commonwealth Health Insurance Connector. The Connector would offer a variety of health plans, and individuals would receive subsidies on a sliding scale based on income.
- Employers with 50 or fewer workers could also purchase coverage through the Connector, which would handle all health insurance administration. Each employer would pay its *pro rata* share of the Connector's administrative costs.

- To help fund the subsidies required for coverage expansion, companies with more than 10 employees would be subject to an assessment if they did not provide health coverage for their workers. After a phase-in period, the assessment would reach 5 percent of payroll for firms with 11-99 workers and 7 percent for companies with 100 workers or more.[2]
- Since the legislation would significantly lower the number of uninsured in the state, the bill would repeal the $160 million insurance surcharge that currently helps fund the state's Free Care Pool. (The Free Care Pool, also known as the Uncompensated Care Pool, reimburses hospitals and community health centers for some of the costs of treating low-income patients.)

KEY FINDINGS

Overall, the bill would result in a net benefit for the state's business community. Specifically, the vast majority of businesses would receive financial relief, while only a small fraction would experience increased costs. In total, employers' gains would outweigh losses by hundreds of millions of dollars each year.

There are approximately 98,000 companies in Massachusetts, with about 2.7 million employees, that offer health coverage to their workers. As described more fully below, those companies would pay lower health insurance premiums if the bill were enacted.[3]

In contrast, there are approximately 5,400 firms that have more than 10 workers (totaling about 110,000 employees) that do *not* offer health insurance. Under the House bill, these firms would potentially be subject to increased costs—namely, an assessment of 5-7 percent of payroll.

The net result is that more than 18 companies would experience financial relief for each firm that would likely be subject to an assessment under the House bill.

Moreover, the likely savings realized by companies that currently cover their employees would exceed the projected costs imposed on those firms that do not cover their workers. The new costs to employers that do not currently provide coverage are projected to fall between $175 million and $356 million per year. The direct annual savings on health insurance premiums charged to companies that do provide health coverage are estimated to comprise between $501 million and $523 million per year. Those savings would be achieved through the following:

- Employers would save between $128 million and $145 million through the repeal of the current insurance surcharge that funds the state's Free Care Pool.

- Employers would save an estimated $336 million through a substantial reduction in uncompensated care that hospitals and others now furnish to the uninsured—care that many providers seek to finance by raising charges to insurers, which ultimately are reflected to some degree in health insurance premiums.
- Employers would save between $37 million and $42 million through the bill's $90 million aggregate increase in Medicaid provider reimbursement rates, which will reduce health providers' need to recoup reimbursement shortfalls by further shifting costs to employers and others who buy health insurance.

The bill would also provide an additional benefit for some of the 64,000 Commonwealth employers with 50 or fewer employees that currently offer health coverage. Under the proposal, these companies could purchase coverage through the Commonwealth Health Insurance Connector. Companies taking advantage of this offer could replace their current spending for health insurance administration with payment of their *pro rata* share of the Connector's administrative costs, which is likely (due to economies of scale) to be significantly lower.[4] The cumulative savings derived from this provision are difficult to project,[5] but those savings would be in addition to the savings estimated above. In addition, the Connector will give small business employees (and owners) a broader choice of health plan options. Currently, most small employers that cover their workers can offer only one plan option, which can place them at a disadvantage when they compete in hiring against larger companies, most of which offer multiple health insurance options to their employees.[6]

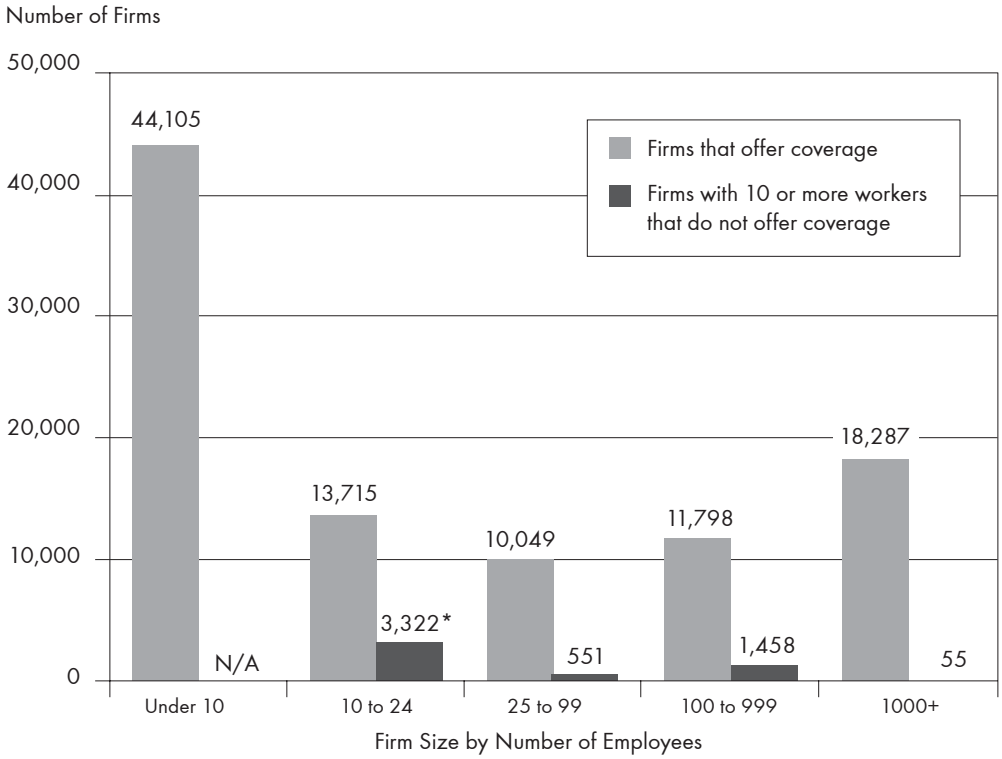
CALCULATING HOW MANY FIRMS WOULD BE HELPED AND HURT BY THE HOUSE BILL

Considerably more companies would benefit from the proposal (because they insure their workers) than would be subject to the assessment (because they have more than 10 workers but do not offer insurance). This is true not just for big businesses, but for small businesses as well.

As shown in Figure 1 below, among all firms with fewer than 25 employees, 57,820 companies offer health coverage, and they would be helped by the bill. In contrast, only 3,322 such businesses do not provide health coverage and would be subject to the assessment. This trend holds for larger companies as well. Of companies with 25 or more employees, 40,134 would be helped by the legislation, while only 2,064 would be subject to the assessment.

Figure 1

Massachusetts Firms That Offer Health Coverage vs. Firms with 10 or More Workers That Do Not Offer Coverage, by Size, 2003



Source: AHRQ, July 2005. Calculations by ESRI, January 2006.

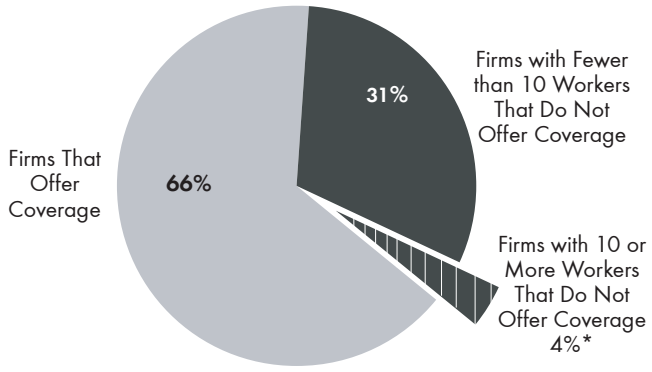
* This figure overstates slightly the number of firms potentially subject to the employer assessment under the bill. Because of the way AHRQ displays pertinent data, the firms listed as not offering coverage include some with exactly 10 employees. The bill exempts such companies from the employer assessment.

There are two reasons for the very high proportion of firms that would be helped by the bill. First, as mentioned above, employers that cover their workers greatly outnumber those that do not. Second, the vast majority of firms that do not offer health coverage employ 10 or fewer workers and would therefore be exempt from the assessment.

Altogether, nearly one-third (31 percent) of Massachusetts companies do not provide health coverage to their workers but have fewer than 10 employees and so would be exempt from the assessment. Approximately two-thirds (66 percent) of the state's employers offer their workers health insurance. It is only the relatively small remaining group—4 percent of Massachusetts companies—that would potentially be subject to the assessment (Figure 2).

Figure 2

Distribution of Massachusetts Firms by Size and Offers of Coverage, 2003



Source: AHRQ, July 2005. Calculations by ESRI, December 2005.

* This figure overstates slightly the number of firms potentially subject to the employer assessment under the bill. Because of the way AHRQ displays pertinent data, the firms listed as not offering coverage include some with exactly 10 employees. The bill exempts such companies from the employer assessment.

It is quite likely that this analysis overstates the number of firms that would be subject to the employer assessment. This is because some small businesses that currently do not offer health coverage might do so for the first time under the legislation. In particular, the bill could overcome the following obstacles that kept many small firms from insuring their workers in the past:

- Under the proposal, employers with 50 or fewer workers could purchase coverage through the Connector, which would handle all health insurance administration. The resulting administrative simplification could induce some firms to offer health coverage. According to one national survey, 53 percent of small companies that do not offer health coverage said that the administrative hassle of providing insurance was a very or somewhat important factor in their decision not to offer health coverage.[7]
- Subsidies for low-income workers and a mandate for individual coverage would impel many more workers to accept small firms' offers of health coverage, which would in turn make such offers more likely. According to another national survey, 43 percent of small employers that did not offer coverage reported that a major factor in their decision was their employees' inability to afford coverage, and 45 percent said they would be much or somewhat more likely to seriously consider offering coverage if their employees were likely to take it.[8]
- Today, companies that insure their workers suffer a competitive disadvantage in comparison to rivals that pay nothing for health insurance. Under the proposal, all but the smallest firms would pay something—they would either cover their workers or pay an assessment. As a result, offering health coverage would represent less of a competitive disadvantage, potentially convincing some employers to offer their workers insurance for the first time. Among small firms not offering health coverage, 46 percent cite their competitors' refusal to provide coverage as a very or somewhat important reason for deciding not to provide coverage themselves.[9]

THE APPROXIMATE MAGNITUDE OF NEW COSTS AND SAVINGS FOR EMPLOYERS

The preceding analysis shows that, under the bill, many more firms will experience gains than losses. That does not necessarily demonstrate, however, that the overall financial gains will exceed total losses of the state's business community. In theory, deep losses experienced by a small number of firms could exceed in total size the comparatively smaller gains experienced by a large number of companies.

In this section of the report, therefore, we estimate the total size of the gains and losses employers would experience. Since some of the factors that would contribute to the estimates are uncertain, this analysis, where relevant, provides a range for both costs and savings. For example, different authorities project the sum of all employer assessments to range from $175 million to $356 million a year.[10]

By contrast, when the bill repeals the $160 million insurance surcharge that helps fund the Free Care Pool, the total amount of surcharge payments is set by law. These charges are distributed, in proportion to hospital bill amounts, among all private payers of hospital bills. Based on regional and state-specific data about the proportion of hospital costs paid by employers, 90.5 percent of the $160 million surcharge is assessed to employer-based insurers[11] and ultimately reflected in employer premiums. When the surcharge is repealed, Section 111 of the bill requires insurers to pass on resulting savings to employers.[12] Thus, the approximate savings under the bill would be $145 million. If, using conservative projections, only 80 percent of the savings are reflected in reduced premiums, employers would still save $128 million.

Additional savings could be passed on to employers and other purchasers of health insurance when providers no longer need to furnish large amounts of uncompensated care to the uninsured *and* when Medicaid reimbursement shortfalls are ameliorated. Under the proposed legislation, those Medicaid reimbursement shortfalls would be lessened by $90 million per year.

Respected authorities disagree about the extent to which health care providers shift costs to private insurers and the amount by which insurers raise premiums as a result. Clearly, the extent of any cost-shifting varies greatly based on the characteristics of local health care markets, including the relative leverage of health care providers, insurers, and employers.[13] Equally clearly, cost-shifting that results from providing uncompensated care to the uninsured and

from low reimbursement rates under public programs is responsible for, at most, a small percentage of employers' health insurance premiums.[14] For example, Families USA recently found that two-thirds of national uncompensated care costs related to the uninsured are ultimately shifted to health insurance premiums, but in Massachusetts, that cost shift raises employer premiums by only 3.5 percent.[15] Even more recently, other health policy researchers found that, on average, hospitals increase their charges to private insurers by an amount that recoups 75 percent of uncompensated care costs that arise from either treating the uninsured or from low reimbursement rates from public payers.[16]

Applying these general conclusions to the House proposal first requires an estimate of the likely decrease in the number of uninsured. Despite the legislation's expanded subsidies and the requirement that residents obtain health coverage, two groups would likely remain uninsured. First, undocumented immigrants are ineligible for subsidies. Second, some uninsured state residents with incomes above the maximum income level for subsidies—300 percent of the federal poverty level—could still find health coverage unaffordable and might be exempted from the bill's coverage requirement. Virtually all state residents with incomes above 400 percent of poverty (in 2005, $64,360 and $77,400 for families of three and four, respectively) presumably could afford coverage and so would be required to purchase it.

In Massachusetts, undocumented immigrants comprise approximately 7.6 percent of the uninsured.[17] Approximately 11.1 percent of the uninsured have incomes between 300 and 400 percent of the federal poverty level.[18] If all of the former and half of the latter remained uninsured after the adoption of the bill, 86.8 percent of the uninsured would obtain health coverage.

As noted above, in Massachusetts, uncompensated care provided to the uninsured raises employer premiums by 3.5 percent. If this cost shift were reduced by 86.8 percent as a result of the proposed expansion in health coverage, employers would save approximately $336 million as of 2007.[19]

The costs shifted to employers would also be reduced by the additional $90 million in annual reimbursements that would be paid to health care providers in Medicaid. Again, based on the above-described research about the size of cost shifts from under-compensated providers and data about the proportion of health care costs that is paid by employers, the $90 million in additional reimbursements to Medicaid providers would lower employer premiums by approximately $37 million to $42 million per year.[20]

In sum, the total annual savings experienced by employers could range from $501 million to $523 million. The total costs to employers are predicted to equal from $175 million to $356 million. As a result, for the business community as a whole, the legislation would create net savings that may range from a minimum of $145 million per year to a maximum of $348 million per year.

Table 1

Amount of Employer Assessments vs. Employer Savings on Health Insurance Premiums under Proposed Legislation, 2007 projections (assuming full implementation of employer assessment)

	Costs (in millions)	Savings (in millions)
Employer Assessment	$175-$356	
Repeal of Insurance Surcharge		$128-$145
Reduced Cost Shift from Uncompensated Care		$336
Reduced Cost Shift from Medicaid		$37-$42
Total	$175-$356	$501-$523

Sources: Thorpe, 2005; Hoffman, et al., 2004; Cook, 2004; Passel, 2005; Holahan, et al., 2005; Dobson, et al., 2006; CMS, 2006. Calculations by ESRI, January 2006.

Note: To prevent the time frame for this table from extending beyond 2007, the estimate for the employer assessment assumes that it is fully phased-in at 5 and 7 percent rates, depending on firm size

IMPACT ON MASSACHUSETTS' ECONOMY OVERALL

Beyond lowering employers' health insurance premiums, the House bill would yield other economic gains. According to analysts at the Urban Institute, the economic benefits from increased health spending outweigh the economic drag resulting from higher revenues (such as the employer assessments) derived from the private sector. Revenue measures like employer assessments reduce private sector spending, but some of that spending would have taken place outside the state. By contrast, almost all health care spending stays in Massachusetts. As a result, total economic activity within the state's borders increases under the proposal, producing a modest net improvement in the state's economy. Taking both gains and losses into account, Urban Institute analysts concluded that fully-funded coverage expansions would spur growth in the state's economy of approximately $400 million a year, increasing net employment by 7,300 to 8,600 jobs.[21]

A much more important factor in evaluating the bill is its impact on access to health care and, ultimately, improved health status, which can be valued in dollar terms. When researchers at the Urban Institute applied to Massachusetts an analytic methodology developed by the U.S. Institute of Medicine (IOM),[22] they concluded that covering all the state's uninsured "would result in economic and social benefits due to improved health of $1.2 billion to $1.7 billion. These benefits are based on estimates of the effect of the lack of health insurance on health, including lower mortality and morbidity and lower wages and productivity."[23] The 86.8 percent reduction in uninsurance likely to result from the bill would thus yield improvements in morbidity and mortality valued at between $1.0 billion and $1.5 billion a year.

Would the Employer Assessment Prevent Small Companies from Increasing in Size?

Some suggest that, by limiting the businesses that would be exempt from the assessment to those with 10 or fewer employees, proposed reforms would deter small firms from growing. However, many factors that are entirely outside government subsidies influence each firm's decision concerning company growth.

Key factors include the anticipated market for the firm's service or product; the cost of obtaining capital; other costs of expansion; the firm's ability and desire to change management strategies to accommodate increased size; the labor market's ability to supply the staff needed for expansion; and other comparable factors.[24] It seems implausible that a modest assessment on firms not offering health coverage would significantly affect more than a tiny proportion of decisions to expand a business, especially since the assessment exemption would come into play only for firms that are considering increasing the number of employees from 10 or fewer to 11 or more.

Moreover, the suggestion that small business growth would be limited implies that the nation's extensive and longstanding subsidies for small firms impede such firms' growth, since these subsidies frequently end when business size exceeds specified levels. Such subsidies include $8 billion in annual tax preferences in the Internal Revenue Code,[25] $19 billion in annual loans and loan guarantees from the U.S. Small Business Administration, and preferential small business "set asides" resulting in $69.2 billion in federal contracts during fiscal year 2005.[26] We are unaware of any empirical evidence that these small business subsidies have prevented small firms from growing.

Would Proposed Reforms Cause Numerous Companies to Leave the State?

Some contend that the proposed employer assessment will cause numerous firms to leave Massachusetts and will deter employers from moving to the state.[27] This claim ignores the legislation's multiple provisions that help businesses. For example, firms that do cover their workers would experience a reduction in health insurance costs. Moreover, the economy as a whole would be slightly more vibrant under the proposed bill. To the extent that the bill influenced employers' decisions about where to locate, the state could be more likely to gain than to lose.

More importantly, as with firm size, decisions about where to locate a business are affected by many factors, including general business climate, public investments in education, local workforce characteristics, the condition of the area's infrastructure, local energy costs, the availability of desirable services, and other factors.[28] It seems highly unlikely that the proposed legislation would materially change, in either direction, the location decisions of more than a tiny number of firms.

Would the Proposed Employer Assessment Give Companies An Incentive To Drop Coverage?

Some suggest that imposing an employer assessment on firms that do not cover their workers gives businesses an incentive to drop coverage.[29] This claim makes little sense. Today, employers who drop coverage pay nothing. With the proposed assessment, they would pay something, giving employers a new incentive to *retain* coverage, not to drop it.

Of course, a rigorous estimate of the effects of this complex legislation on employer-based coverage would require detailed, microeconomic modeling of firm behavior.[30] Such a micro-simulation model has been developed by Prof. Jonathan Gruber of the Massachusetts Institute of Technology, who has applied his model to the bill. Dr. Gruber concluded that, while coverage as a whole would increase because of the legislation's combination of subsidies and individual responsibility requirements, the total level of employer-based coverage in Massachusetts would not change.[31]

CONCLUSION

Any fair analysis of proposed legislation needs to take into account both the proposal's benefits and costs. One-sided examinations of benefits or costs alone are not likely to yield an accurate overall assessment. When both costs and benefits are examined, it becomes clear that, overall, the business community as a whole would gain under proposed reforms. By an enormous margin, the firms that would save money on health insurance outnumber those that would be subject to employer assessments. For employers as a whole, total premium savings would exceed, by hundreds of millions of dollars, the likely cost of employer assessments. Moreover, under the bill, the state's economy as a whole would do modestly better than under current law.

ENDNOTES

[1] There are other potential implications for employers that are beyond the scope of this report, such as the bill's proposed changes to the state's small group market.

[2] In theory, every company is subject to the assessment. However, employer payments for health care (including premium costs) are subtracted from each firm's employer assessment obligations. Moreover, wage and salary costs for employees receiving health coverage from other sources are not counted as payroll subject to the assessment. During 2004 and the first three quarters of 2005, employer health insurance premiums in New England averaged 9 percent of total wages and salaries. Bureau of Labor Statistics, U.S. Department of Labor, *Employer Costs for Employee Compensation*, Series IDs: CMU2020000000211D.CMU2020000000211P (I), CMU2150000000211D,CMU2150000000211P (I), data extracted January 4, 2006. Calculations by ESRI, January 2006. Accordingly, it is likely that few companies paying the assessment will offer coverage.

[3] Another 46,000 firms do not cover their workers but would be exempt from the employer assessment because they have fewer than 10 employees. Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey (MEPS), *2003 Employer-Sponsored Health Insurance Data*, "Private-Sector Data by Firm Size and State (Table II Series)," July 2005, available online at http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Index203.htm. Analysis by ESRI, December 2005. All the report's statements about the number of firms, by size, that offer and do not offer coverage in Massachusetts, as well as the number of employees at such firms, are from this same source.

[4] While this may greatly reduce the administrative costs paid by employers, health plans' own administrative costs would remain. The latter costs include such expenses as marketing, claims processing, etc.

[5] This is so for at least two reasons. First, it is unclear how many of these 64,000 companies would arrange for the Connector to cover their workers. Second, the amount of administrative cost savings per firm is difficult to estimate.

[6] In Massachusetts, an insurer covering a firm with fewer than five workers may require that every worker in that firm enroll in a single plan. In firms with six to 50 employers, 75 percent of all workers can be required to enroll in a single plan. Massachusetts General Laws, Chapter 176J, Section 1. Among Massachusetts firms with 50 or more workers that cover their employees, 55 percent offer a choice of multiple plans. AHRQ, MEPS, Table II. A.2.d(2003), *Percent of private-sector establishments that offer health insurance that offer two or more health insurance plans by firm size and State: United States, 2003*, available online at http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIA2D.pdf. The MEPS data suggest that, among Massachusetts firms with fewer than 50 workers, only 8 percent offer more than one health plan option; but pertinent survey results do not meet AHRQ's standards for reliability and precision. (For example, 14.1 percent of firms with fewer than 50 workers that offer coverage provide two or more health plan options; other data show that 56 percent of firms with fewer than 50 workers offer coverage.) Nationally, only 19 percent of firms with fewer than 200 employees offer more than one health insurance option to their employees. At larger firms, a majority of companies offer multiple health insurance options. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey*, September 14, 2005, available online at http://www.kff.org/insurance/7315/sections/ehbs05-4-2.cfm.

[7] Kaiser Family Foundation, *National Survey of Small Businesses: Toplines*, April 2002, available online at http://www.kff.org/insurance/upload/National-Survey-of-Small-Businesses-Toplines.pdf.

[8] Paul Fronstin and Ruth Helman. *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*, EBRI Issue Brief Number 253 (Employee Benefit Research Institute and Mathew Greenwald and Associates), January 2003, available online at http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

[9] Kaiser Family Foundation, *National Survey of Small Businesses: Toplines*, op. cit.

[10] Massachusetts Taxpayers Foundation, *Health Care Reform: Expanding Access Without Sacrificing Jobs*, December 2005, available online at http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf.

[11] According to MEPS data for the Northeast in 2003, private insurance and out-of-pocket payments (the two payment sources for the Free Care Pool insurance surcharge) account for 53.8 percent and 1.0 percent, respectively, of inpatient hospital costs. Private insurance thus pays 98.1 percent of hospital bills subject to the surcharge. "AHRQ, MEPS, Hospital Inpatient Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2003," December 13, 2005, Medical Expenditure Panel Survey component data, available online at http://www.meps.ahrq.gov/CompendiumTables/TC_TOC.htm. Calculations by ESRI, December 2005.

MEPS classifies both nongroup coverage and federal health insurance for active-duty military as "private insurance," along with employer-based coverage. According to the Urban Institute's analysis of 2002-2003 health insurance coverage in Massachusetts, 69.2 percent of state residents have employer overage, 5.4 percent have nongroup coverage, 14.7 percent have Medicaid coverage, 9.8 percent are uninsured, and 1.0 percent have other coverage (including Medicare, coverage for veterans, coverage for active-duty military, etc.). Allison Cook, *Health Insurance Coverage and the Uninsured in Massachusetts* (The Urban Institute, prepared for the Blue Cross Blue Shield of Massachusetts Foundation), June 2005, available online at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/uninsuredChartbook05.pdf. Even if half of the population classified as "other" was active-duty U.S. military, 92.1 percent of private insurance, as defined by MEPS, would be employer-based coverage, yielding an estimate that ESI is responsible for 90.5 percent of all payments that qualify for the Free Care Pool surcharge (98.2 percent times 92.1 percent, plus rounding). If nongroup coverage or coverage for active-duty military involved average per capita hospital costs that are significantly different than those for ESI, then the above 92.1 percent estimate of the proportion of private insurance hospital costs comprised by ESI may be slightly too high or low.

[12] The section provides as follows: "The division of insurance shall require health insurers to submit information to the division to allow the division to determine if health insurance premiums are being appropriately adjusted to take into account the savings due to the repeal by this act of the surcharge imposed by section 18A of chapter 118G of the General Laws. If the division deems necessary, the division shall perform a market conduct study to examine premiums charged by health insurers after July 1 2006.Said study shall determine if insurance premiums were appropriately adjusted to take into account the savings due to the repeal by this act of the surcharge imposed by section 18A of chapter 118G of the General Laws. *The division shall order any health insurer determined not to have adjusted premiums to take such savings into account to adjust such premiums pursuant to an order of the commissioner of insurance"* (emphasis added).

[13] See, e.g., Allen Dobson, Joan DaVanzo, and Namrata Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications." *Health Affairs*, January/February 2006. That said, a recent study found that, even in California's highly competitive market, shortfalls in public program reimbursement translated into higher charges to private insurers. Jack Zwanziger and Anil Bamezai, "Marketwatch: Evidence Of Cost Shifting In California Hospitals," *Health Affairs*, January/February 2006.

[14] Institute of Medicine, *Hidden Cost, Value Lost: Uninsurance in America*, June 2003.

[15] Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington, Families USA, June 2005), available online at http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html. Quantitative Analysis by Dr. Kenneth Thorpe, Robert W. Woodruff Professor and Chair of the Department of Health Policy and Management, Rollins School of Public Health, Emory University.

[16] Allen Dobson et al., op. cit.

[17] In 2002-2003, 7.9 percent of Massachusetts state residents were non-citizens. Allison Cook, op. cit.; calculations by ESRI, January 2006. Nationally, an estimated 29 percent of non-citizens are undocumented immigrants. Jeffrey S. Passel. *Unauthorized Migrants: Numbers and Characteristics* (Pew Hispanic Center, prepared for the Task Force on Immigration and America's Future), June 14, 2005, available online at http://pewhispanic.org/files/reports/46.pdf. If that same percentage applied in Massachusetts, 2.3 percent of state residents would be undocumented immigrants. That number may overestimate the number of undocumented immigrants in Massachusetts, since the profile of Massachusetts immigrants differs significantly from that for the U.S. as a whole. For example, only 30.0 percent of foreign-born residents of Massachusetts are from Latin America, compared to 51.7 percent in the nation as a whole; 32.2 percent in Massachusets are from Europe, compared to 15.8 percent in the U.S.; 17.2 percent of foreign-born residents of Massachusetts are Hispanic or Latino, compared to 45.5 percent at the national level; 18.5 percent of non-citizens in Massachusetts have incomes below poverty, compared to 22.8 percent nationwide; etc. Migration Policy Institute, *Fact Sheet on the Foreign-Born: Massachusetts, 2004*, citing data from the 2000 U.S. Census, available online at http://www.migrationinformation.org/USFocus/statemap.cfm#. On the other hand, some observers suspect that between 200,000 and 250,000 Massachusetts residents may be undocumented. Jeffrey S. Passel, op. cit. Unfortunately, the latter estimate could not be incorporated into this paper because it is not part of a consistent set of population numbers for all Massachusetts residents, including demographic characteristics and coverage distribution. By contrast, the percentages reported by Passel can be and have been applied to the specific population numbers and coverage estimates reported by Cook for all Massachusetts residents, including non-citizens. Nationally, the likelihood of uninsurance among undocumented immigrants is 3.33 times that of non-elderly people as a whole. According to one analysis of March CPS data, 17.7 percent of all non-elderly were

uninsured in 2003. Catherine Hoffman, Alicia Carbaugh, and Allison Cook, *Health Insurance Coverage in America: 2003 Data Update* (Kaiser Commission on Medicaid and the Uninsured and the Urban Institute), November 2004, available online at http://www.kff.org/uninsured/upload/Health-Insurance-Coverage-in-America-2003-Data-Update-Report.pdf. According to Jeffrey S. Passel, op cit., 59 percent of undocumented immigrants nationally were uninsured in 2003, based on March CPS data. If that same ratio applied in Massachusetts, where 9.8 percent of residents were uninsured in 2002-2003, according to Cook, then 41,000 undocumented immigrants would have been uninsured, comprising 7.6 percent of all uninsured in the state.

[18] Based on findings reported by Allison Cook, op cit., 171,000 Massachusetts residents with incomes between 200 and 399 percent of poverty were uninsured in 2002-2003. Calculations by ESRI, January 2006. The report by Cook et. al. does not distinguish between uninsured state residents with incomes up to 300 percent of poverty, who could qualify for subsidies under the bill, and those with incomes between 300 and 399 percent of poverty, who would not receive subsidies and might, in some cases, have difficulty affording available coverage. National data show that, among the uninsured with incomes between 200 and 399 percent of poverty, 34.6 percent have incomes between 300-399 percent of poverty. Catherine Hoffman et. al., op cit. If that same proportion applies in Massachusetts, then 11.1 percent of the uninsured in Massachusetts have incomes between 300 and 399 percent of poverty.

[19] Employer insurance premium payments for 2005 are estimated at $11.1 billion. John Holahan, Linda J. Blumberg, Alan Weil, Lisa Clemans-Cope, Matthew Buettgens, Fredric Blavin, and Stephen Zuckerman, *Roadmap to Coverage: Synthesis of Findings* (The Urban Institute and NASHP, prepared for the Blue Cross Blue Shield of Massachusetts Foundation), October 2005, available online at http://www.roadmaptocoverage.org/pdfs/Roadmap_Synthesis.pdf. The dollars were updated to 2007 amounts based on projections by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS). According to those projections, health care costs are expected to rise by 7.1 percent in 2006 and 2007. CMS, *National Health Expenditure Data: Projected*, last modified January 3, 2006, available online at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage.

[20] Based on MEPS data for the Northeast about total health care expenditures in 2003, distributed by payment source, and Massachusetts-specific data about the relative prevalence of employer-sponsored insurance, nongroup coverage, and other insurance classified as "private" by MEPS, employers pay 61.5 percent of all health costs outside Medicaid and Medicare. AHRQ, *Total Health Services-Mean and Median Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2003*, Medical Expenditure Panel Survey Component Data, December 13, 2005; Allison Cook, op. cit. Based on research by Kenneth Thorpe, et al., and Allan Dobson, et al., between 67 percent and 75 percent of payment shortfalls are reflected in higher charges to private payors. Accordingly, lower premiums for employer-based coverage may ultimately absorb 61.5 percent times 67 to 75 percent of the $90 million increase in Medicaid reimbursement, or $37 to $42 million.

[21]These conclusions resulted from an analysis of specific proposals to achieve near universal coverage, funded through various increases in income taxes, sales taxes, and excise taxes, as well as responsibilities imposed on individuals and employers. While the House bill resembles closely some of the policies examined in the Urban Institute study, it is not identical to those policies. In particular, the employer assessment may raise less money than the revenue sources in the proposals analyzed by the Urban Institute, suggesting that the net positive impact of the bill would exceed the effects listed in the text. On the other hand, if the employer assessment provides too few resources to support the subsidies envisioned in the bill, additional state revenue could be required, reducing the level of net economic benefit to that stated in the text. Linda J. Blumberg, John Holahan, Alan Weil, Lisa Clemans-Cope, Matthew Buettgens, Fredric Blavin, and Stephen Zuckerman, *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications* (The Urban Institute and the National Academy for State Health Policy, prepared for the Blue Cross Blue Shield of Massachusetts Foundation), June 21, 2005, available online at http://roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf.

[22] Institute of Medicine, op cit.

[23] John Holahan, Randall Bovbjerg, and Jack Hadley, *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Medical Spending?* (The Urban Institute, prepared for the Blue Cross Blue Shield of Massachusetts Foundation), November 2004, available online at http://roadmaptocoverage.org/pdfs/roadmapReport.pdf.

[24] A vast literature discusses the strategy of small firm expansion. See, e.g., Erkko Autio and Elizabeth Garnsey, *Early Growth and External Relations in New Technology-Based Firms* (Helsinki University of Technology and Cambridge University), 1997; Emeric Solymossy and Atilio Armando Penna, *Sustainable Growth for the Small Business: A Theory of Organizational*

Transition, (Western Illinois University-Quad Cities and Atilio Penna & Assoc.), 2001.

[25] Gary Guenther, *Small Business Assessment Benefits: Overview and Economic Rationales* (Congressional Research Service), updated May 26, 2005,available online at http://assessmentprof.typepad.com/assessmentprof_blog/files/2005-13221-1.pdf.

[26] U.S. Small Business Administration, *FY 2005 Performance and Accountability Report*, "Results at a Glance," November 15, 2005, available online at http://www.sba.gov/PAR.pdf/docs/010_Results%20at%20a%20Glance.pdf.

[27] Massachusetts Taxpayers Foundation, op cit.

[28] See, e.g., Jason P. Martinek and Michael J. Orlando, "Do Primary Energy Resources Influence Industry Location?", *Federal Reserve Bank of Kansas City–Economic Review*, Third Quarter 2002, available online at http://www.findarticles.com/p/articles/mi_qa3699/is_200207/ai_n9109212#.

[29] Massachusetts Taxpayers Foundation, op cit.

[30] For examples of such modeling, see John Sheils and Randall Haught, *Cost and Coverage Analysis of Ten Proposals To Expand Health Insurance Coverage* (The Lewin Group, prepared for the Robert Wood Johnson Foundation and the Economic and Social Research Institute), October 2003, available online at http://www.esresearch.org/publications/SheilsLewinall/Sheils%20Report%20Final.pdf; John Sheils and Randall Haught, *Appendix A - The Health Benefits Simulation Model (HBSM): Uniform Methodology and Assumptions* (The Lewin Group, prepared for the Robert Wood Johnson Foundation and ESRI), October 2003, available online at http://www.esresearch.org/publications/SheilsLewinall/A-Methodology.pdf.

[31] Professor Jonathan Gruber, personal communication with Stan Dorn, January 3, 2006. For a brief description of Dr. Gruber's microsimulation model and some examples of the model's application, see Jonathan Gruber, "Evaluating Alternative Approaches to Incremental Health-Insurance Expansion," *AEA Papers and Proceedings*, May 2003, available online at http://econ-www.mit.edu/faculty/download_pdf.php?id=980.

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