Trends

How Have Employers Responded To Health Reform In Massachusetts? Employees' Views At The End Of One Year

Survey research shows that as of the end of 2007, Bay State employers had taken no steps to cut back the coverage they offer workers, as some critics feared they would.

by Sharon K. Long and Paul B. Masi

ABSTRACT: In April 2006, Massachusetts enacted legislation that seeks to move the state to near-universal health insurance coverage, with key components of the reform effort targeting the role of employers. Based on surveys of working-age adults ages 18–64 in Massachusetts in 2006 and 2007, this paper examines employers' responses to health reform as reported by their employees. Results suggest that at roughly the end of the first year under health reform, employers in Massachusetts had made few changes in the insurance coverage they offered to their workers. [*Health Affairs* 27, no. 6 (2008): w576–w583 (published online 28 October 2008; 10.1377/hlthaff.27.6.w576)]

Massachusetts enacted a comprehensive health care reform bill in April 2006, which has provided for near-universal health insurance coverage for Bay State residents. The legislation has many elements, including two requirements for employers: Employers with more than ten employees must set up a Section 125 plan (or "cafeteria" plan) for their workers, so that employees can pay their health insurance premiums with pretax dollars.[1] Pretax benefits lower payroll-related taxes for both the employer and employees. In addition, employers with more than ten employees must make a "fair and reasonable" contribution toward their workers' coverage or face an assessment not to exceed $295 per full-time-equivalent (FTE) worker per year.[2]

We know from earlier work that there was a significant increase in insurance coverage among working-age adults in the state as a result of health reform, with the level of employer-sponsored insurance increasing along with other insurance.[3] This paper builds on that work to describe employers' responses to health reform roughly one year after Massachusetts began implementing its reform initiative. Using data from surveys of working-age adults, we provide an assessment of employers' responses to the reforms from the perspective of their employees.

This work complements an earlier study by Jon Gabel and colleagues, which reported on the anticipated response to health reform among employers in Massachusetts in early 2007, based on a survey of employers.[4] That study found that few employers anticipated either dropping or restricting eligibility for em-

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ployer-sponsored coverage in response to health reform. This work confirms that employers have neither dropped coverage nor restricted eligibility in the first year. Further, we found no evidence that employers made major changes in the scope of benefits, network of providers, or quality of available care under their health plans as reported by their employees. Nor is there evidence that employers have shifted a greater share of the cost of health care onto their workers in response to reform.

Study Data And Methods

Data. The study uses two rounds of interviews with adults ages 18–64 in Massachusetts, conducted in fall 2006, just before the implementation of many of the key elements of reform, and fall 2007, approximately one year after the reform efforts began. The surveys were fielded by ICR/International Communications Research, using a computer-assisted telephone interviewing (CATI) system. Some key information on the survey is provided here, with more details available elsewhere.[5]

The surveys relied on a stratified random sample of households, with a response rate of 49 percent (sample size, 3,010) and a response rate of 45 percent (sample size, 2,938) in 2006 and 2007, respectively. The response rates are comparable to those of other recent social science and health surveys.[6] All of the analyses used poststratification weights that adjust for the complex design of the survey, undercoverage, and survey nonresponse.

As with all surveys that rely on self-reported data, there will be errors in recall and reporting in employees' responses to the survey questions. It is likely that such error will be greater for more difficult questions (for example, the employee's contribution to the premium) and more sensitive questions (for example, family income). However, it is unlikely that the extent of reporting errors is changing systematically over time, so our estimates of changes between 2006 and 2007 are unlikely to be affected by such errors.

Analysis. In this study, we compared access to employer coverage for a sample of workers in the period following the implementation of health reform (fall 2007) to a similar sample in the period just prior to the implementation of key elements of reform (fall 2006).[7] Under this pre-post framework, any differences between the two time periods are attributed to the state's reform efforts. The primary risk in the pre-post analysis is that other factors, beyond health reform, changed over the same time period (for example, there was an economic downturn).[8] These confounding changes, if they affected the outcomes of interest, would bias the estimates of the impacts of the reform efforts reported here. Available data suggest that the Massachusetts economy was fairly stable over the study period.[9] Nevertheless, the findings reported here may reflect underlying changes in Massachusetts that are attributable to factors beyond health reform.

Significance testing. In reporting the estimates of changes over time for different samples of workers (workers in small firms or part-time workers), we tested for the statistical significance of the differences between fall 2006 and fall 2007. When conducting significance tests for multiple outcomes (as we did here), we would expect to find a statistically significant difference at the 5 percent level for one in twenty outcomes as a result of chance alone, even if there were no differences over time. When examining multiple outcomes, it is important to consider the broader patterns of findings as well as individual tests of significance.

Study Results

Are employers dropping coverage? As noted above, one concern is that some employers could decide to stop offering coverage in response to Massachusetts' health reform initiative. We found no evidence of a drop in firms offering health insurance coverage (Exhibit 1). Overall, the share of workers in firms that offered coverage was constant over the period, at 90 percent. For workers in small firms (1–50 workers), where employers are less likely to offer coverage and where employers may be more likely to drop coverage under reform, we found no evidence that the share of workers in firms offering employer coverage dropped. In

EXHIBIT 1
Share Of Workers Ages 18–64 In Firms That Offered Employer-Sponsored Insurance To Any Workers In Fall 2006 And Fall 2007

	2006 (%)	2007 (%)	2006–2007 difference[a]	Sample size
Share of workers in firms that offer coverage to any workers	89.7	90.8	1.0	3,472
Workers in firms with				
1–50 employees	71.9	76.1	4.1	967
51–1,000 employees	95.9	96.3	0.4	1,171
1,001 or more employees	98.4	97.7	−0.7	1,148
Workers who usually work				
Fewer than 35 hours per week	79.3	81.2	1.9	1,030
35 hours per week or more	94.1	94.5	0.3	2,431
Workers who have worked for their current employer				
Less than one year	79.5	81.1	1.6	618
One year or more	92.2	92.8	0.6	2,849

SOURCES: Massachusetts Health Reform Surveys, 2006 and 2007.
NOTES: The sample for this exhibit is all workers. Variations in sample sizes across the exhibits are the result of missing data for some of the variables included in the exhibits.
[a] Percentage points.

fact, the share of workers in small firms who were working for a firm that offered coverage actually increased slightly over the study period, from 72 percent in fall 2006 to 76 percent in fall 2007, although the difference is not statistically significant.

■ **Are employers tightening eligibility for coverage?** A second potential response by employers to health reform could be to tighten eligibility for coverage by limiting the coverage offer to a subset of employees. We found no change in the share of workers who reported that they had a coverage offer from their employer between fall 2006 and fall 2007 (Exhibit 2). This holds true across all workers as well as for groups of workers who we would expect to be more likely to be dropped if an employer did decide to tighten coverage eligibility to a subset of employees, such as part-time workers or workers with shorter job tenure. Roughly 57 percent of both part-time workers and workers with less than a year of tenure on their current job reported that they were offered coverage through their job in both fall 2006 and fall 2007.

■ **Are employers increasing workers' premiums?** Instead of dropping coverage, employers could respond to increasing health insurance costs by shifting more of the costs to workers by either increasing workers' share of the insurance premium or lowering their wages. From the survey, we have information on the amount of workers' reported contribution toward premiums; we do not have the information on wages that would allow us to look at cost shifting via wages.

Data from the Insurance Component of the Medical Expenditure Panel Survey (MEPS IC), a national survey of establishments, indicates that in 2006, the average employee contribution toward employer coverage premiums in Massachusetts was about $1,000 for single coverage and $3,100 for family coverage—well above the national averages of $788 and $2,890 for single and family coverage, respectively.[10] Roughly half of our sample of working-age adults reported that their premium contributions were at or above the average levels in Massachusetts (Exhibit 3).

To examine increases in premiums over time under health reform, we focus on changes in the share of workers with relatively high premiums. We define *high premiums* in two levels: a worker's contribution toward premiums

EXHIBIT 2
Share Of Workers Ages 18–64 With Their Own Employer's Offer Of Health Coverage In Fall 2006 And Fall 2007

	2006 (%)	2007 (%)	2006–2007 difference[a]	Sample size
Share of workers who have a coverage offer from their employer	79.9	80.2	0.2	3,469
Workers in firms with				
1–50 employees	59.0	59.7	0.7	970
51–1,000 employees	87.6	87.5	–0.1	1,163
1,001 or more employees	91.2	91.1	0.0	1,145
Workers who usually work				
Fewer than 35 hours per week	57.0	57.2	0.2	1,030
35 hours per week or more	89.6	90.0	0.4	2,427
Workers who have worked for their current employer				
Less than one year	57.1	58.0	0.9	623
One year or more	85.5	85.1	–0.4	2,841

SOURCES: Massachusetts Health Reform Surveys, 2006 and 2007.
NOTES: The sample for this exhibit is all workers. Variations in sample sizes across the exhibits are the result of missing data for some of the variables included in the exhibits.
[a] Percentage points.

that is roughly 1.5 times the average contribution in Massachusetts or more (that is, at or above $1,500 for single coverage or $4,500 for family coverage) and 2.0 times the average or more (that is, at or above $2,000 for single coverage or $6,000 for family coverage).

We did not find any significant increases in the share of workers overall with relatively high premium contributions, at either level. However, when we looked across workers in firms of different sizes, we found some evidence of a decline in the share of workers with premium contributions of 1.5 times or more of the average for those in the smallest firms (1–50 workers) and an increase in the share of workers in the largest firms (more than 1,000 workers) who reported premium contributions of 2.0 times the average or more. We found no evidence that the latter increase is attributable to an expansion of health savings accounts (HSAs) among these workers (data not shown).

■ **Are employers scaling back their coverage?** Although we found no evidence of employers' dropping or tightening eligibility for coverage and little evidence of firms' shifting more of the premium costs onto workers, employers could decide to reduce their health insurance costs through other means, such as cutting covered benefits, limiting choice of providers, or increasing deductibles and copayments. If the scope of employer coverage were scaled back or cost sharing were increased in response to health reform, we would expect to have seen a greater share of health care costs shifted to workers during the study period.

Exhibit 4 reports on workers' assessment of their employer plans as very good or excellent on several important dimensions.[11] The first panel shows the share of workers who rated the range of services offered under their employer coverage as very good or excellent, the second panel reports on the rating of the choice of doctors and other providers under the plan, and the third panel reports on the rating of the overall quality of care available under the plan. On all three measures, the majority of workers continued to rate their employer plan as very good or excellent in fall 2007. We found no evidence of a drop in the scope of services covered, the range of provider choices, or the quality of care available under employer plans under health reform as viewed by workers.

EXHIBIT 3
Share Of Workers Ages 18–64 With Employer Coverage With Relatively High Employee Contributions To Premiums In Fall 2006 And Fall 2007

	2006 (%)	2007 (%)	2006–2007 difference[a]	Sample size
Share of covered workers with contributions to premiums of at least $1,000/year for single coverage or $3,000/year for family coverage[b]	47.8	48.8	1.0	2,497
Workers in firms with				
1–50 employees	46.1	45.5	−0.6	529
51–1,000 employees	51.1	54.6	3.5	905
1,001 or more employees	46.9	47.5	0.6	969
Share of covered workers with contributions to premiums of at least $1,500/year for single coverage or $4,500/year for family coverage	26.7	25.9	−0.8	2,497
Workers in firms with				
1–50 employees	32.0	23.6	−8.5*	529
51–1,000 employees	28.6	26.8	−1.8	905
1,001 or more employees	22.1	26.6	4.6	969
Share of covered workers with contributions to premiums of at least $2,000/year for single coverage or $6,000/year for family coverage	13.2	15.0	1.8	2,497
Workers in firms with				
1–50 employees	15.5	15.5	0.0	529
51–1,000 employees	15.9	14.4	−1.5	905
1,001 or more employees	9.6	15.4	5.7*	969

SOURCES: Massachusetts Health Reform Surveys, 2006 and 2007.

NOTES: The sample for this exhibit is all workers with employer coverage. Variations in sample sizes across the exhibits are the result of missing data for some of the variables included in the exhibits. Statistical significance denotes difference from zero (two-tailed test).

[a] Percentage points.

[b] Data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC) indicate that the average employee contribution toward employer coverage premiums in Massachusetts in 2006 was about $1,000 for single coverage and $3,100 for family coverage.

*$p < 0.10$

Further, the few statistically significant changes that we did see were all positive, with workers in very large firms (more than 1,000 employees) rating their employer coverage better in fall 2007 than fall 2006 on all three measures considered here.

Exhibit 5 examines several additional measures of employer coverage under health reform, focusing on high out-of-pocket health care costs over the year (more than $1,000 and more than $3,000, respectively), reported problems with high medical bills for services not covered by the employer plan, reported problems with a doctor charging a lot more for care than the employer plan would pay, and reported problems with not getting needed health care because of cost.[12]

We found no evidence of increases in the share of workers who reported high levels of out-of-pocket health care costs, the share of workers who reported medical bills for services not covered by their employer plan, the share of workers who reported doctor costs that were not covered by their employer plan, or the share of workers who reported high levels of unmet need for care because of cost.[13] Further, the few significant changes that we observed would suggest better coverage under employer-sponsored plans in fall 2007 than in fall 2006.

Discussion

■ **No evidence of dropping coverage.** This study focused on employees' assessment

EXHIBIT 4
Share Of Workers Ages 18–64 With Employer Coverage Rating Key Elements Of Their Health Insurance As Very Good Or Excellent In Fall 2006 And Fall 2007

	2006 (%)	2007 (%)	2006–2007 difference[a]	Sample size
Share of covered workers rating the range of services covered under their plan as very good or excellent	63.3	66.6	3.3	2,637
Workers in firms with				
1–50 employees	59.0	62.6	3.6	558
51–1,000 employees	64.5	64.3	−0.2	950
1,001 or more employees	68.3	74.4	6.1*	1,011
Share of covered workers rating the choice of doctors and other health providers under their plan as very good or excellent	69.4	72.6	3.2	2,626
Workers in firms with				
1–50 employees	66.6	69.7	3.0	550
51–1,000 employees	72.8	72.9	0.1	945
1,001 or more employees	69.7	76.7	7.0*	1,015
Share of covered workers rating the quality of care available under their plan as very good or excellent	68.9	71.8	2.9	2,633
Workers in firms with				
1–50 employees	65.6	64.8	−0.8	554
51–1,000 employees	69.3	71.6	2.3	949
1,001 or more employees	72.3	79.4	7.1*	1,014

SOURCES: Massachusetts Health Reform Surveys, 2006 and 2007.
NOTES: The sample for this exhibit is all workers with employer coverage. Variations in sample sizes across the exhibits are the result of missing data for some of the variables included in the exhibits. Statistical significance denotes difference from zero (two-tailed test).
[a] Percentage points.
*$p < 0.10$

of employers' responses to health reform in Massachusetts between fall 2006 and fall 2007. We found no evidence that concerns about employers' dropping or scaling back coverage under health reform have been realized.

Health reform in Massachusetts is intended to affect the decisions of both individuals and employers. Achieving near-universal coverage in the state will require the continued commitment of employers to provide access to high-quality health coverage. After one year of reform, the available evidence from the workers' perspective suggests that this support has thus far been realized. It will be important to continue to monitor employers' responses to health reform as Massachusetts moves toward full implementation of the reform plan.

■ **Limitations to the study.** First, the study provides estimates of the early impacts of health reform in Massachusetts, because the state's health reform initiative was not fully implemented by fall 2007. Further, data from an early 2007 survey of employers in Massachusetts by Gabel and colleagues suggests that many employers, particularly small employers, had only limited knowledge of health reform at the time of that survey, which could have slowed employers' responses to the reform.[14] Evidence from the broader literature on firms' behavior also suggests that small firms, in particular, are slow to adapt to change in the legal and regulatory environment.[15] Consequently, a longer follow-up is needed to capture the full effects of health reform on employers in Massachusetts. To begin to address longer-term impacts, a third round of the survey reported on here is to be fielded in fall 2008.

Second, the study design assumes that all changes between fall 2006 and fall 2007 reflect the impacts of health reform in the state, ignoring the possibility of confounding changes

EXHIBIT 5
Share Of Workers Ages 18–64 With Employer Coverage Reporting Problems With Health Care Costs In Fall 2006 And Fall 2007

	2006 (%)	2007 (%)	2006–2007 difference[a]	Sample size
Share of covered workers with out-of-pocket health care costs of at least $1,000 in past year	47.7	45.8	−1.8	2,622
Workers in firms with				
1–50 employees	42.2	44.8	2.6	557
51–1,000 employees	43.5	46.9	3.4	944
1,001 or more employees	54.6	46.2	−8.4*	1,010
Share of covered workers with out-of-pocket health care costs of at least $3,000 in past year	14.7	15.0	0.3	2,622
Workers in firms with				
1–50 employees	11.8	15.1	3.3	557
51–1,000 employees	12.9	14.8	1.8	944
1,001 or more employees	17.9	14.9	−3.0	1,010
Share of covered workers reporting expensive medical bills not covered by their plan in past year	15.2	14.5	−0.7	2,651
Workers in firms with				
1–50 employees	14.1	12.8	−1.2	562
51–1,000 employees	15.1	16.5	1.4	953
1,001 or more employees	15.3	12.8	−2.5	1,019
Share of covered workers reporting that their doctor charged a lot more than their plan would pay in past year	13.8	13.3	−0.5	2,647
Workers in firms with				
1–50 employees	10.9	12.3	1.4	559
51–1,000 employees	17.4	16.3	−1.1	953
1,001 or more employees	12.1	10.5	−1.7	1,017
Share of covered workers reporting unmet need for medical care or prescription drugs because of the cost of care in the last year	5.6	3.7	−1.9*	2,657
Workers in firms with				
1–50 employees	6.2	5.8	−0.4	563
51–1,000 employees	5.8	3.8	−2.0	956
1,001 or more employees	3.8	2.5	−1.4	1,019

SOURCES: Massachusetts Health Reform Surveys, 2006 and 2007.

NOTES: The sample for this exhibit is all workers with employer coverage. Variations in sample sizes across the exhibits are the result of missing data for some of the variables included in the exhibits. Statistical significance denotes difference from zero (two-tailed test).

[a] Percentage points.

*$p < 0.10$

that might have been occurring over the same time period. Addressing this issue will require making use of data from other national data sources (for example, the Current Population Survey) as they become available. Finally, the study relies on surveys of working-age adults in the state, with all of the limitations that arise from using survey data.

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NOTES

1. Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," http://www.mass.gov/legis/laws/seslaw06/sl060058.htm (accessed 15 August 2008). Failure to set up a Section 125 plan can lead to a "free-rider surcharge" if the employer's workers use substantial amounts of care under the state's health care safety net.
2. A *fair and reasonable contribution* is defined as either (1) covering at least 25 percent of employees or (2) contributing at least 33 percent of the total premium for coverage.
3. S.K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* 27, no. 4 (2008): w270–w284 (published online 3 June 2008; 10.1377/hlthaff.27.4.w270).
4. J.R. Gabel, H. Whitmore, and J. Pickreign, "Report from Massachusetts: Employers Largely Support Health Care Reform, and Few Signs of Crowd-Out Appear," *Health Affairs* 27, no. 1 (2008): w13–w23 (published online 14 November 2007; 10.1377/hlthaff.27.1.w13). This survey has been updated; see J.R. Gabel et al., "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs* 27, no. 6 (2008): w566–w575 (published online 28 October 2008; 10.1377/hlthaff.27.6.w566).
5. See S.K. Long, "The Massachusetts Health Reform Survey," 15 April 2008, http://www.urban.org/publications/411649.html (accessed 15 September 2008).
6. There has been a downward trend in response rates for telephone surveys occurring nationally. See R. Curtin, S. Presser, and E. Singer, "Changes in Telephone Survey Nonresponse over the Past Quarter Century," *Public Opinion Quarterly* 69, no. 1 (2005): 87–98. For information on recent survey response rates, see State Health Access and Data Assistance Center, "Are Low Response Rates Hazardous to Your Health Survey?," Issue Brief no. 13, February 2008, http://www.shadac.umn.edu/img/assets/18528/IssueBrief13.pdf (accessed 3 March 2008).
7. The fall 2006 sample was being fielded as the CommCare program was beginning for adults with incomes under 100 percent of the federal poverty level. Enrollment in that program started slowly and was relatively low in fall 2006.
8. L.B. Mohr, *Impact Analysis for Program Evaluation*, 2d ed. (Thousand Oaks, Calif.: Sage Publications, 1995).
9. The share of working-age adults in Massachusetts who were employed was stable at 64 percent in both fall 2006 and fall 2007 (and into spring 2008). Data available at Mass.gov, "Labor Force and Unemployment Data," http://lmi2.detma.org/Lmi/lmi_lur_a.asp (accessed 10 April 2008). Further, the Federal Reserve's *Beige Book*, which provides an assessment of local economic conditions, reported that the economy for the Boston region was generally stable in 2007. See Federal Reserve Board, "The Beige Book: Federal Reserve Districts: First District—Boston," 28 November 2007, http://www.federalreserve.gov/FOMC/BEIGEBOOK/2007/20071128/1.htm (accessed 18 April 2008).
10. Data from the 2006 Medical Panel Expenditure Survey Insurance Component (MEPS IC). See Agency for Healthcare Research and Quality, Summary Data Tables, Table II.C.2, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiic2.htm (accessed 15 September 2008); and Table II.D.2, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tiid2.htm (accessed 15 September 2008).
11. Workers were asked to rate their plans using a scale of excellent, very good, good, fair, or poor.
12. The information on problems with high health care costs is based on the following question: "I'm going to read you a list of problems some people experience with their health insurance coverage. Please tell me if you have had these problems with your health insurance coverage in the last 12 months. (1) 'You had expensive medical bills for services NOT covered by your health insurance.' Has this happened to you in the past 12 months? (2) 'Your doctor charged you a lot more than your health insurance would pay and you had to pay the difference.' Has this happened to you in the past 12 months?"
13. Out-of-pocket costs tend to be higher for those with family coverage than those with single coverage. Consistent with the findings for the overall population of workers, when we looked separately at changes in out-of-pocket costs by coverage type, we found no evidence of increases in these costs between fall 2006 and fall 2007.
14. Gabel et al., "Report from Massachusetts."
15. R.C. Heriot and R.D. Hatfield, "A Framework for Assessing the Need for Legal Readiness in Small and Entrepreneurial Firms," *Entrepreneurial Executive* 9 (2004): 17–30.