The Massachusetts Experience: Employer-sponsored health insurance post reform

Introduction

As implementation of the Affordable Care Act (ACA) presses forward, questions remain about how employers and workers will react to the law once it is in full effect. While each state and industry is different, Massachusetts’ experience with its 2006 universal coverage law offers clues into how some businesses and their workers might react to requirements in the federal law. In the seven years since Massachusetts enacted its law, the number of people covered by insurance through the workplace increased by about 1 percentage point, running counter to the rest of the nation, which saw employer-based insurance decline by 5.7 percentage points.1

Coverage in Massachusetts increased even among the smallest businesses, which were exempt from any requirement to provide coverage, and came in the midst of a recession. Interviews with executives in the state indicate a growing number of individuals sought employer-based coverage in an effort to comply with the new requirement to be insured.

“We had people who were now demanding insurance.” — Robert Carey, former Director of Planning and Development of the Massachusetts Connector

Employer-sponsored insurance has long been the bedrock of the US health system. About 150 million people get their health insurance through the workplace today.2 An analysis of tax law conducted by PwC’s Health Research Institute (HRI) underscores the value of employer-based insurance for both employers and employees.3

For most Americans earning more than 400% of the federal poverty level, about $45,960 for an individual in 2013, a combination of salary and health coverage is the most beneficial way to be compensated. Savings for some businesses can be in the thousands of dollars per worker and, depending on other tax deductions, employees may experience similar savings.4

First in a two-part series

At a glance
More than seven years after Massachusetts enacted its health reform law, data from the state reveal that employer health coverage rose, even as coverage declined nationally. The Massachusetts experience illustrates why employers contemplating benefits changes ought to consider a range of factors including recruitment and retention, absenteeism, tax implications along with the influence of an individual mandate.
The Massachusetts Experience: Employer-sponsored health insurance post reform

The Massachusetts healthcare overhaul was an unusual undertaking. The unlikely duo of Republican Gov. Mitt Romney and Democratic Sen. Edward Kennedy, two former political opponents, teamed up to push through a state law that would eventually provide near universal coverage to the state’s 6.6 million residents. Before his death Kennedy reprised the role, helping craft the ACA using a framework similar to the Massachusetts model.

Two of the most contentious provisions in the ACA echo Massachusetts’ law: the individual and employer mandates, which require individuals to carry insurance and employers to offer it. Failure to do so results in penalties. There are however distinct differences in the size of the penalties assessed under the ACA and the Massachusetts law. (See table 1)

There are other notable similarities. Both the state and federal law establish health insurance marketplaces known as exchanges in which individuals shop for insurance and may receive subsidies based on income. Small businesses may also use the online exchanges to purchase a group plan.

Coverage on the rise
For years, policymakers, politicians and industry leaders have debated the impact of the ACA on employer-sponsored coverage. In its most recent analysis, the nonpartisan Congressional Budget Office estimates it will shrink by about 3% by 2019, or 8 million people. ³

But the experience in Massachusetts tells a different story. According to an analysis by HRI of Census data, from 1999–2005 employer-based insurance was declining in Massachusetts much like the rest of the nation, albeit at a slower rate.⁷ After 2006, employer coverage across the country continued to fall. But in Massachusetts, employer-sponsored insurance stabilized and inched up, despite the recession.

Between 1999–2011 employer coverage in Massachusetts rose from a low of 70.8% in 2006 to 72.1% in 2011. Nationally, during the same period, employer coverage fell from 68.2% to 58.3%.

The increase in employer-based insurance was not uniform across all industries in Massachusetts. According to HRI’s analysis, there was a marked decline in the number of covered workers in the retail industry and the sales and services occupations. Alternatively, there were gains in the construction, transportation and utilities industries.

Perhaps more striking, the turnaround in employer-sponsored coverage occurred at a time when health insurance costs were rising rapidly in Massachusetts. Between 2003–2011, insurance premiums in the state increased by 67% for individuals and 72% for families, leaving Massachusetts residents and businesses paying the highest premiums in the nation.⁸

ACA tracks Massachusetts’ footsteps
The Massachusetts healthcare overhaul was an unusual undertaking. The unlikely duo of Republican Gov. Mitt Romney and Democratic Sen. Edward Kennedy, two former political opponents, teamed up to push through a state law that would eventually provide near universal coverage to the state’s 6.6 million residents. Before his death Kennedy reprised the role, helping craft the ACA using a framework similar to the Massachusetts model.

Two of the most contentious provisions in the ACA echo Massachusetts’ law: the individual and employer mandates, which require individuals to carry insurance and employers to offer it. Failure to do so results in penalties. There are however distinct differences in the size of the penalties assessed under the ACA and the Massachusetts law. (See table 1)

There are other notable similarities. Both the state and federal law establish health insurance marketplaces known as exchanges in which individuals shop for insurance and may receive subsidies based on income. Small businesses may also use the online exchanges to purchase a group plan.

Table 1. Employer provisions under the ACA and Massachusetts health reform

<table>
<thead>
<tr>
<th></th>
<th>ACA</th>
<th>Massachusetts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer coverage requirement/penalty</td>
<td>Businesses with 50 or more employees pay a penalty for not offering coverage, or if an employee receives a subsidy in an exchange. Penalties range from $2,000-$3,000 per employee annually.</td>
<td>Businesses with 11 or more employees must make a “fair and reasonable” contribution toward insurance coverage or pay up to $295 per employee annually.³</td>
</tr>
<tr>
<td>Individual coverage requirement/penalty</td>
<td>Individuals must carry insurance or pay a penalty. The tax equals a flat dollar amount or a percent of income, whichever is greater. In 2014 the penalty is $95 per adult, $47.50 per child, or 1% of family income. The penalty increases every year.</td>
<td>Individuals must carry insurance or pay a penalty equal to 50% of the lowest health insurance premium available for each month the individual didn’t have insurance. In 2012, penalties ranged from $228-$1,260 per year depending on income level.</td>
</tr>
<tr>
<td>Small Business Tax Credits</td>
<td>Provides tax credits between 35%–50% of the cost of coverage for small employers with no more than 25 employees and average annual wages of less than $50,000.</td>
<td>The state offers a 15% rebate to lower-wage small businesses that adopt wellness programs.</td>
</tr>
<tr>
<td>Exchange eligibility for small businesses</td>
<td>Businesses with 100 or fewer employees can shop for coverage on a state exchange. States can expand participation to businesses with more than 100 employees in 2017.</td>
<td>Massachusetts’ Health Connector is available to businesses with 50 or fewer employees.</td>
</tr>
</tbody>
</table>

Source: PwC’s Health Research Institute Analysis.

Figure 1. Changes in employer-based coverage between 2005–2011
In addition, it was costlier for small businesses to offer insurance after Massachusetts merged the individual and small group markets according to Jon Hurst, president of the Retailers Association of Massachusetts. Though intended to reduce premiums for individuals, the change came at a cost to small businesses which say their rates increased as the risk pool grew. Firms with a healthy workforce and fewer risks ended up subsidizing individuals and other companies that are more expensive to insure because of their healthcare needs.

It was a “very big mistake,” Hurst told HRI. Small businesses saw “double digit premium increases because of that.” In spite of the higher costs, more small employers offered coverage after the Massachusetts law passed. Even in businesses with 3–10 employees, the number of firms offering employer-sponsored insurance rose from 67% to 69%.9

**Tax implications of employer coverage**

Given the option to pay a modest fine rather than provide health benefits at a significantly higher cost, dropping coverage might seem like a no-brainer for many businesses. But when it comes to providing health insurance, Massachusetts demonstrates that employers must take into account a number of other factors, including the tax implications.

Under current federal law, businesses and their workers may exclude from income and payroll taxes money spent on health insurance obtained through the workplace.10 A tax model developed by HRI shows that an employee with household income above 400% of the federal poverty level receives higher take home pay when employer coverage is offered. That is because the worker has taken advantage of the tax exclusions, along with standard deductions. HRI’s analysis assumes workers and businesses value healthcare coverage as a type of compensation. (See HRI’s detailed case study on how federal tax rules impact employer-sponsored insurance: www.pwc.com/hi).

For companies with a high proportion of low-wage workers the tax consequences shift, particularly for the employee. While businesses may still benefit from the tax exclusion, low-income workers may fare better financially by shopping on new online marketplaces known as exchanges with the ACA’s premium and cost-sharing subsidies.

The exclusion for employer-based insurance is one of the largest in the US tax code, estimated to cost the federal government $1 trillion over the next five years.11 As policymakers grapple with the nation’s debt and deficit, some have suggested capping the exclusion, which could provide fresh revenue. It could also nudge medical spending downward as some employers offer less generous benefits in order to avoid the cap.

---

**Figure 2. The math on employer-sponsored insurance**

**Please see the Methodology section for a detailed explanation on the calculations used in this case study.**

**What it means for employers**

When it comes to compensating their workers, businesses save money when they provide a combination of salary and health insurance due to federal tax exclusions. In the example below, the company that provides coverage to a worker earning $52,000 per year in 2014 saves $2,746 because of the tax deductability of the insurance.

<table>
<thead>
<tr>
<th>Employer provides insurance</th>
<th>Employer does not provide insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to compensate a worker</td>
<td>$35,640</td>
</tr>
<tr>
<td>Difference</td>
<td>$2,746</td>
</tr>
<tr>
<td>Take home pay</td>
<td>$65,465</td>
</tr>
<tr>
<td>Difference</td>
<td>$3,098</td>
</tr>
</tbody>
</table>

**What it means for employees**

Take home pay for workers is higher when they obtain health insurance through their employer. In the example below, a family of three with combined income of $92,000 in 2014 that has employer-sponsored coverage takes home $3,098 more in pay by taking advantage of the federal tax exclusion for the insurance.

<table>
<thead>
<tr>
<th>Employer provides insurance</th>
<th>Employer does not provide insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to compensate a worker</td>
<td>$38,386</td>
</tr>
<tr>
<td>Take home pay</td>
<td>$62,367</td>
</tr>
<tr>
<td>Difference</td>
<td>$3,098</td>
</tr>
</tbody>
</table>
In an attempt to steer employers away from so-called Cadillac coverage, beginning in 2018, the ACA imposes a tax on plans that cost more than $10,200 for an individual and $27,500 for a family.

**Considerations for employers**

Businesses in Massachusetts were motivated to offer healthcare coverage by factors beyond the tax benefits, according to executives interviewed by HRI. Companies also used the lure of healthcare benefits to attract and retain employees. That’s a strategy likely to be shared by certain employers across the US, depending on firm size, industry, and market competition.

“It’s all about the benefits package you need to recruit people,” Carey told HRI.

The experience in Massachusetts also suggests that finding a job with health benefits may become more important under the ACA’s individual mandate. HRI’s analysis of Census data shows that the percentage of workers holding employer-provided plans increased even at firms not required to offer coverage, indicating the employer mandate was not the only consideration influencing businesses.

“It wasn’t so much that employers offering insurance increased although there was a marginal uptick, but there was an increase in individuals taking coverage from their employer, where they previously said no thanks,” Carey added.

Some small businesses may be motivated by other factors. In many instances, their workers are family members or friends whom they feel an extra responsibility toward. “In small businesses you have family members, or long standing employees. The law required them to have coverage and you want to help them get it,” said Hurst. “And that’s a bigger decision for small businesses because it’s more costly for us than larger companies.” Hurst’s insights shed light on why the percentage of small employers offering coverage in Massachusetts rose from 45% to 59% between 2005–2011.12

**Insights for national reform**

**It’s more than simple math**

For most employers, the decision to provide health insurance will be more than X versus Y. One new consideration under the ACA is payment of a new $2,000 per worker penalty for not offering coverage. That calculus comes on top of a number of other issues businesses must consider such as federal tax law.

As they prepare for 2014, businesses with less than 100 employees should examine how new state exchanges are structured, the types and prices of plans offered, and what tax benefits are available. Businesses in Massachusetts, for instance, continued to purchase plans outside of the state exchange because the availability and pricing of products wasn’t viewed as a better deal. (For more information see HRI’s paper Health Insurance Exchanges: Long on options, short on time).

**Mandates matter**

Requiring businesses to offer insurance or pay a penalty could increase employer coverage. That was the experience in San Francisco after it enacted a “play or pay” law in 2008.13

In Massachusetts, many experts say the individual mandate played a significant role in increasing employer-sponsored healthcare, as workers sought to follow the law. At $95 per adult or 1% of income, some argue that the penalties in the first year of the ACA’s coverage expansion are too low to compel individuals to buy insurance. Yet coverage increased in Massachusetts. The mere existence of the requirement to have insurance may have influenced individuals as much, if not more than, the financial consequences for not doing so.

**Supportive stakeholders**

The Massachusetts experience was distinct in many ways, including the alliance of disparate stakeholders involved in the initial legislation. Government, businesses, the healthcare industry, and consumers all supported the goal of extending coverage broadly.

States working to implement the ACA will benefit from the inclusion of a diverse selection of community representatives, including companies that provide care and sell insurance. Some states are already doing this as they move to establish their health insurance exchanges. In Colorado, the state held ten stakeholder forums to solicit feedback from underwriters, health plans, consumers, providers, business representatives, elected officials and members of the general public.

**Conclusion**

The 2006 Massachusetts healthcare overhaul achieved coverage for more than 98% of its residents, the highest rate in the nation. That is in large part due to the role businesses have played in providing insurance for their workers—both before and after the law.

Massachusetts’ experience does not foreshadow how every employer in every sector in every state will react as the ACA is fully implemented next year. But it does provide guideposts for employers considering a path forward. And even in an era of great uncertainty, at least one message from the Massachusetts story is clear: tax treatment of employer-sponsored health insurance remains a powerful force.
Methodology

All tax liabilities are calculated assuming 2012 federal individual, payroll, and corporate tax rates under federal law. State taxes are not included in these calculations. The business is assumed to owe the statutory corporate tax rate of 35%, has more than 50 full time equivalent employees and bears the full cost of the ACA penalty for not offering health insurance to employees. The payroll tax, while normally split evenly between the employer and employee, was 5.65% for the employee and 7.65% for the employer in 2012. For individual income taxes, it is assumed that the employee and family take advantage of the standard deduction and personal exemptions.

The employee is married and filing jointly, thus claiming a standard deduction of $11,900. They also claim two personal exemptions of $3,800 each and a dependent exemption of $3,800 for their child. The household income used in this example falls slightly below the national average for a family with two full-time workers. $15,000 is the average premium for private sector employer-provided family coverage in the US according to the 2011 Medical Expenditure Panel Survey.

When employer-sponsored insurance is offered, the employee's effective federal income tax rate, after accounting for the deductions and exemptions, is 9.3% on combined taxable income of $77,000. Under this scenario, take home pay for the household is: Total wages ($80,000) - health insurance premiums ($3,000) - payroll taxes ($4,351) - income taxes ($7,185) = $65,465. The employer owes payroll taxes ($2,831), but may deduct them and the full value of the employee's compensation ($52,000) from its corporate taxes. Thus, the total effective cost for the employer to hire the worker is: Wages ($40,000) + health insurance premiums ($12,000) + payroll taxes ($2,831) - corporate tax deduction ($19,191) = $35,640.

When health coverage is not offered, the employee's effective federal income tax rate is 10.3% on combined taxable income of $92,000. Under this scenario, take home pay for the household is: Total wages ($92,000) - payroll taxes ($5,198) - income taxes ($9,435) - direct purchase health plan premiums ($15,000) = $62,325. The employer owes payroll taxes ($3,978), but can deduct them and the full value of the employee's compensation ($52,000) from its corporate taxes. The employer now also pays a penalty ($2,000) for not offering health insurance. Thus, the total cost to the employer for hiring a worker is: Wages ($52,000) + payroll tax ($3,978) + penalty ($2,000) - corporate tax deduction ($19,592) = $38,386.

This illustrative example assumes that the family takes the standard deduction of $11,900 in both scenarios. In many cases, households at this income level itemize deductions and may deduct premiums and cost sharing that exceed 7.5% of Adjusted Gross Income in 2012 (10% of AGI in 2013 and beyond). In the extreme case, in which the couple itemize and are able to deduct the entire premium, they still pay $848 more in payroll taxes if the employer drops coverage. Regardless of whether the employee itemizes deductions, the employer continues to lose $2,746 in extra tax payments and penalties if coverage is discontinued.

Endnotes

2. Ibid.
3. The model develop by HRI uses 2012 federal poverty level guidelines and assumes 2012 federal individual, payroll, and corporate tax rates under federal law.
4. Conclusions based on the tax model developed by HRI. For a more thorough explanation of HRI’s tax model please refer to the “Methodology.”
5. Gov. Deval Patrick announced early this year that he would file legislation to repeal the employer fair share requirement under Massachusetts law, so that it would not conflict with the new federal requirement.
6. CBO’s February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf. The CBO’s estimate of employer sponsored insurance includes the net effects of recently enacted tax changes under the American Taxpayer Relief Act, as well as revisions to CBO’s projections of income and employment-based coverage.
Health Research Institute

PwC's Health Research Institute provides new intelligence, perspectives and analysis on trends affecting all health-related industries. The Health Research Institute helps executive decision makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions. The HRI regulatory team tracks legislative and regulatory issues across the health industries and delivers the most timely, relevant and thought-provoking business insights in a concise, easily-accessible format.

About PwC

PwC helps organizations and individuals create the value they’re looking for. We’re a member of the PwC network of firms with 180,000 people in more than 155 countries. We’re committed to delivering quality in assurance, tax and advisory services. Tell us what matters to you and find out more by visiting us at www.pwc.com/us.

HRI Regulatory Team

Ceci Connolly
HRI Managing Director
(202) 312-7910
ceci.connolly@us.pwc.com

Benjamin Isgur
Director
(214) 754-5091
benjamin.isgur@us.pwc.com

Matthew DoBias
Senior Manager
(202) 312-7946
matthew.r.dobias@us.pwc.com

Caitlin Sweany
Senior Manager
(202) 346-5241
caitlin.sweany@us.pwc.com

Bobby Clark
Senior Manager
(202) 312-7947
robert.j.clark@us.pwc.com

Galym Imanbayev
Research Analyst
galym.imanbayev@us.pwc.com

Contacts

Ceci Connolly
HRI Managing Director
(202) 312-7910
ceci.connolly@us.pwc.com

Kelly Barnes
US Health Industries Leader
(214) 754-5172
kelly.a.barnes@us.pwc.com

Mike Thompson
Global Human Resources Services, Principal
(646) 471-0720
michael.thompson@us.pwc.com

HRI Advisory team

Amy Bergner, Managing Director
Jack Rodgers, Managing Director
Kristen Soderberg, Manager