Roadmap to Coverage:
Synthesis of Findings

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Report for the Blue Cross Blue Shield of Massachusetts Foundation

October 2005

roadmap
TO COVERAGE

FOUNDATION
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

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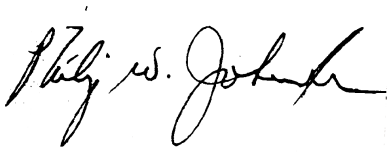
The *Roadmap to Coverage* is an initiative designed to inform the debate about how to provide health coverage for the uninsured in Massachusetts and generate a practical roadmap for achieving that goal. Major funding for the project has been provided by Blue Cross Blue Shield of Massachusetts with additional support from Partners HealthCare. The research and analysis has been conducted by the Urban Institute, a nonprofit, nonpartisan, policy research organization.

In November 2004, the Foundation released the first report of the *Roadmap* initiative. The report, *Caring for the Uninsured in Massachusetts, What Does It Cost, Who Pays, and What Would Full Coverage Add to Medical Spending?*, written by researchers at the Urban Institute, found that we are already spending more than $1 billion a year for health care for the uninsured in Massachusetts.

In June 2005, the Foundation released *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications*, a report which presented options for expanding coverage to everyone in the Commonwealth and analyzed the cost and coverage implications of those options. The analysis concludes that Massachusetts could cover all of the uninsured for between $700 and $900 million in new government spending, which would produce $1.5 billion in economic and social benefits due to improved health as well as other positive effects on the state's economy. The Foundation also released an accompanying chartbook intended to broaden our understanding of the more than half a million people who lack the security of health coverage in Massachusetts.

This final report synthesizes all of the research and analytic work of the *Roadmap* initiative. It describes three policy approaches that would achieve universal health insurance coverage in the Commonwealth and describes the steps that would need to be taken and issues that would need to be addressed in order to successfully implement the *Roadmap* options.

Our hope is that the information presented in these reports continues to support the discussion about how to improve access to health coverage for residents of the Commonwealth.



Philip W. Johnston
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Additional copies of this report are available upon request. Please contact the Blue Cross Blue Shield of Massachusetts Foundation at 617.246.3744 or info@bcbsmafoundation.org.

Introduction

In Massachusetts over half a million residents have no health insurance. The consequences of being uninsured are now well known—thanks to systematic reviews of the literature by the Institute of Medicine and by Jack Hadley.[1] The evidence is strong that the uninsured have less access to medical care and lower rates of medical care utilization than do those with coverage. This results in higher rates of morbidity and premature mortality, as well as increased pain and suffering and poorer quality of life. Lack of health insurance also has direct economic effects, making individuals less productive and the workplace less efficient. The total value of lost health due to the estimated 532,000 Massachusetts residents without insurance[2] will amount to about $1.5 billion in 2005 alone.[3]

This paper develops and analyzes three alternative approaches to bringing universal health insurance coverage to the Commonwealth. All three build on MassHealth expansions, income-related tax credits, and government-sponsored reinsurance, and all include a purchasing pool arrangement. We call these four strategies the building blocks of the *Roadmap*. Implementing them would make insurance accessible and affordable, and reduce the number of uninsured by about one-third. Covering the remaining two-thirds is only achievable if health insurance is made mandatory in the state. An employer mandate alone cannot do the job because it cannot reach those who decline the offer of coverage or are without a job. An individual mandate alone can achieve universal coverage, but there are reasons why some might prefer the two types of mandate combined. So, to these voluntary components of reform, we add an individual mandate in option 1, and an individual mandate combined with two versions of an employer mandate in option 2 and option 3.

[1] Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, May 2002, Institute of Medicine, Washington, DC. Jack Hadley, "Sicker and Poorer," *Medical Care Research & Review*, 60(2) (supplement): 3S-75S, June 2003.

[2] 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," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, June 2005. http://www.roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf

[3] 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," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, November 2004. http://www.roadmaptocoverage.org/pdfs/roadmapReport.pdf.

We begin by describing the reasoning behind the recently renewed policy interest in expanding coverage in the Commonwealth. We then describe each of the building blocks in turn, followed by our mandate alternatives. We provide estimated coverage and cost impacts for the building blocks alone, and for each of the three mandate alternatives. These estimates were produced using the Health Insurance Reform Simulation Model (HIRSM), developed by Urban Institute researchers.

We then discuss options for financing the coverage expansions and discuss the likely benefits from universal coverage. We follow this with a discussion of the broader economic impacts, i.e., effects on employment and state gross domestic product. We conclude with a brief review of the issues that must be addressed in achieving successful implementation of the broad health system reform envisioned in the *Roadmap*.

I. Rationale for a Reform Initiative in Massachusetts

The problem of the uninsured in Massachusetts, as in other states, is likely to grow. The number of uninsured has been increasing in recent years because health care costs are rising so much faster than wages that employers are becoming increasingly less likely to offer coverage and workers less likely to take up employers' offers. Slow economic growth is contributing to the difficulty employers have in continuing to offer coverage. Although the economy is now improving, health care costs are still increasing substantially faster than wages, and employers are requiring ever higher employee contributions in return for less and less comprehensive coverage. Absent reform, the numbers of uninsured and the associated adverse consequences of being without coverage will grow.

Health care providers in the Commonwealth of Massachusetts provide at least $1.1 billion in care to the uninsured, according to our estimates.[4] This care is paid for through a complex set of transactions involving the state's uncompensated care pool, the state's Medicaid (MassHealth) program's disproportionate share and supplemental payment programs that operate both within and outside the uncompensated care pool, and other direct subsidy programs that provide care directly to the uninsured or to safety net hospitals. The funding for these programs comes through a combination of federal and state funds, as well as hospital and insurer assessments. That there is a great deal of money already in the system supporting the uninsured makes the task of expanding insurance coverage more affordable in Massachusetts than in many other states.

The Commonwealth is currently well positioned to move toward universal coverage for other reasons as well. First, while there are 532,000 uninsured in the state as noted, Massachusetts has a lower uninsurance rate than most other states. This is because of its strong base of employer-based health insurance and MassHealth's success in serving a relatively high share of the state's low-income residents. In addition, as also noted, considerable funding is now in place for those without coverage, a

[4] 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," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, November 2004. http://www.roadmaptocoverage.org/pdfs/roadmapReport.pdf.

significant amount of which could be redirected to help finance an insurance coverage expansion. Without reform, however, pressures on the state's Uncompensated Care Pool will grow, as will the need for increased assessments on the insurers and hospitals that fund it.

Yet another concern argues strongly in favor of health reform at this time. The structure of the state's recent Medicaid waiver renewal requires the state to cease using intergovernmental transfers (IGTs) as a way of providing the state's share for much of the waiver expenditures. The federal government estimates that there is about $1.3 billion in total MassHealth funds for which the state's 50% matching portion is questionable. If $650 million can be made available through allowable state and local sources, the state can keep about $650 million of the federal dollars currently flowing into the state. The waiver agreement allows these funds to be used in a variety of ways, including the kinds of coverage expansions proposed in the *Roadmap*.

II. The *Roadmap*'s Building Blocks for Coverage Expansion

We propose to make health insurance coverage in the Commonwealth of Massachusetts more affordable through an expansion of MassHealth, tax credits that would be applied to the cost of insurance premiums, a purchasing pool open to all Massachusetts residents, and government-sponsored reinsurance to defray the costs attributable to those with exorbitant medical expenses. These strategies, taken together, yield the affordability and availability infrastructure necessary for moving to universal coverage.

MassHealth Expansion. The first building block is an expansion of MassHealth, which includes the state's Medicaid and State Children's Health Insurance Programs (SCHIP). Expenditures on both these programs are shared by the federal government (which pays 50% of Medicaid and 65% of SCHIP costs in the state). MassHealth offers a comprehensive set of health benefits with very limited cost sharing to some of the state's lowest income residents. An expansion of MassHealth would be consistent with one of the ways the federal government allows the state to use existing funds in its recent Medicaid waiver renewal. It is important to note also that MassHealth payment rates for certain providers in the state are generally considered inadequate to ensure appropriate care for MassHealth enrollees. Thus, any significant expansion of MassHealth would also require selected provider payment rate increases.

MassHealth expansion could be achieved in a variety of ways, including setting different income eligibility levels for children, their parents, and nonparent adults. The *Roadmap* proposes to extend coverage in MassHealth to children and their parents up to 200% of the federal poverty line and to nonparents up to 133% of poverty. (See Table 1 for 2005 poverty income levels.) Some of the expansion of public coverage for children and even their parents could be financed using existing but unallocated SCHIP funds. This would allow the state to obtain SCHIP's higher matching rate for what is essentially a MassHealth expansion.

Table 1. 2005 Federal Poverty Levels by Family Size

Family Size	Poverty Level
1	$9,570
2	$12,830
3	$16,090
4	$19,350
For each additional person, add	$3,260

Tax Credits. The second building block is income-related tax credits for the purchase of health insurance. These would be designed to limit health insurance premiums to a percentage of family income. Tax credits can be phased out at particular income levels or can be extended well up the income distribution. Our preferred strategy is to cap the amount a family must pay for health insurance on a sliding scale ranging from 6% of family income for families with incomes below 150% of poverty and rising to a cap of 12% of income for families with incomes between 300% and 400% of poverty. (See Table 2.) These tax credits would be available only to those enrolling in coverage through the newly organized purchasing pool, for administrative simplicity and public accountability.

Table 2. Structure of Sliding Scale Tax Credits

Family Income as a Percent of the Federal Poverty Line (FPL)	Premium Payment Capped at:
≤150% FPL	6% of Family Income
151%–225% FPL	8% of Family Income
226%–300% FPL	10% of Family Income
301%–400% FPL	12% of Family Income

Purchasing Pool. The third building block would be a new purchasing pool arrangement offering families and individuals easier access to and a broader choice of health plans. Private insurance plans would offer a standardized benefit package through the pool with premiums determined on an age-rated basis. The purchasing pool would be voluntary.

No individuals, families, or employers would be required to buy insurance through the pool. But the pool would be available to all, and both individuals and employers could make contributions toward the pool plans offered. Although available to all employers, it would probably be most attractive to small firms and to those employers with high concentrations of the low-wage workers who would be eligible for the income-related tax credits. No insurer would have to offer coverage through the pool, though there would be strong incentives for them to do so because of the size of the pool-based market.

One advantage of the pool would be reduced administrative costs of coverage (due to its large size) compared with the nonpool individual market, and perhaps compared with the nonpool small group market as well. Another advantage would be to allow

individuals to move from job to job while maintaining consistent insurance coverage.

The pool would also be the focus of the administration of tax credits, eliminating the complexities that would be inevitable in a system that provided subsidies in a dispersed and varied market. All individuals enrolling in pool plan coverage would have access to tax credits if eligible under the percentage of income caps. Pool administrators would enroll individuals in the plan of each family's choosing, remit payments directly to the plans, and determine eligibility for and the value of applicable credits. The Massachusetts Department of Revenue would advance credits to the pool. Pool administrators would then submit payments from individuals, employers, and governments to the appropriate insurance plan. The Department of Revenue would track advanced credits and determine, at the end of the year, any credit adjustment given the final income reported on the tax return.

While plans would not have to participate in the pool, those that did would be required to offer a standardized minimum benefit package with low in-network cost sharing. The intent of having low cost-sharing is to avoid the administrative burden of reimbursing large numbers of low-income individuals for out-of-pocket expenses for each of their provider contacts. Because cost-sharing would be minimal, plans participating in the pool would control costs through provider payment policy and the structure of their network. Because of benefit standardization, plans would compete on customer service, network attractiveness, and provision of less costly benefits (such as dental care, podiatry, vision, and hearing services).

Finally, the pool would provide an administrative structure to manage competition among the plans, and negotiate with plans over premiums if the competitive structure turns out to be unsuccessful in keeping premium growth at reasonable levels.

Reinsurance. The final building block would be government-funded reinsurance to reduce the risk problems that can bedevil small risk pools. Reinsurance accomplishes this by transferring a portion of the costs incurred in extraordinary cases from the purchaser of private insurance to the government. Because of the highly skewed distribution of health care expenditures, a small number of high cost individuals can have significant effects on premiums in small risk pools (given that there are relatively few people over whom such costs can be spread). This small risk pool danger is one of the reasons why many small employers do not offer coverage to their workers.

The *Roadmap* proposes to reimburse eligible insurers for 75% of an individual's annual medical expenses above $35,000. All of those purchasing nongroup insurance or purchasing employer-based coverage through firms with fewer than 100 workers would be eligible. The reinsurance would apply to coverage purchased inside or outside the pool in the individual or small group markets. Establishing the purchasing pool may, in and of itself, result in some risk selection. Those with higher than average health risks might be more likely to purchase pool coverage because it would be more comprehensive than that likely to be found in the nonpool market. This tendency would be mitigated by making tax credits available only through the purchasing pool, since credit eligibility is equally likely for the healthy and the less

healthy and by providing public reinsurance both inside and outside of the pool. However, it might still be necessary to redistribute some costs associated with this adverse selection back on to those obtaining insurance outside the pool. There may also be a need to adjust for selection across plans within the pool to help those plans that turn out to attract the enrollees with the most significant health issues.

Impacts on Coverage and Costs. If only these building blocks were put in place, i.e., coverage was voluntary but subsidized, the number of uninsured is estimated to fall by 211,000 people and the uninsurance rate from 9.4% to 5.7%. (See Table 3.) The amount of employer-based insurance as a whole would stay virtually constant, at slightly over four million individuals. But almost half a million (495,000) of those with employer-based insurance would enroll in employer-based coverage through the new purchasing pool. The remaining 3.6 million would continue to buy employer coverage outside the pool. The number of individuals purchasing coverage directly would increase by about one percentage point, with over 90% of them (310,000) obtaining coverage through the purchasing pool. Thus, the total number of people obtaining coverage through the purchasing pool would be about 805,000 individuals. The number of people in MassHealth would increase by 183,000 (from 13.8% to 16.9% of the population).

Table 3. Building Blocks

Health Insurance Coverage Pre- and Post-Reform						
	Pre-Reform		**Post-Reform**		**Change**	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Employer-Based Insurance	**4,108,630**	**70.8%**	**4,067,374**	**70.1%**	**-41,256**	**-0.7%**
Non-Purchasing Pool	4,108,630	70.8%	3,572,430	61.6%	-536,200	-9.2%
Purchasing Pool	0	0.0%	494,944	8.5%	494,944	8.5%
Direct Purchase	**271,380**	**4.7%**	**340,685**	**5.9%**	**69,305**	**1.2%**
Non-Purchasing Pool	271,380	4.7%	30,865	0.5%	-240,515	-4.1%
Purchasing Pool	0	0.0%	309,820	5.3%	309,820	5.3%
MassHealth	**799,287**	**13.8%**	**982,316**	**16.9%**	**183,029**	**3.2%**
Uninsured	**542,959**	**9.4%**	**332,408**	**5.7%**	**-210,551**	**-3.6%**

Under the voluntary building blocks alone, government expenditures would increase by $1.6 billion. (See Table 4.) Of this, $462 million would be attributable to the MassHealth expansion (a 14% increase in MassHealth spending), another $719 million to financing the tax credits provided in the new purchasing pool, and the remaining $446 million to the reinsurance program.

Overall employer spending under the building blocks would stay virtually constant. However, it would increase by $243 million for those not now offering coverage, and fall by $266 million for those now offering coverage. Spending by individuals and families would fall by $1.2 billion. Almost half of this—$540 million—would be a reduction for families with incomes below 200% of poverty; for this group, spending would fall by about 45%.

Table 4. Building Blocks

Total Spending Pre- and Post-Reform				
	Pre-Reform *(millions, 2005 $)*	**Post-Reform** *(millions, 2005 $)*	**Change** *(millions, 2005 $)*	*%*
Government Spending	**$3,333**	**$4,960**	**$1,626**	**48.8%**
MassHealth	$3,333	$3,795	$462	13.9%
Tax Credits		$719	$719	NA
Reinsurance		$446	$446	NA
Employer Spending	**$9,641**	**$9,618**	**-$23**	**-0.2%**
by Offer Status				
Offering Firms	$9,641	$9,375	-$266	-2.8%
Not Offering Firms	$0	$243	$243	NA
by Firm Size				
Less than 100 Workers	$2,771	$2,764	-$7	-0.2%
100 to 499 Workers	$1,539	$1,593	$54	3.5%
500+ Workers	$5,331	$5,261	-$70	-1.3%
Individual/Family Spending	**$9,641**	**$8,319**	**-$1,160**	**-12.2%**
by Income Level				
<200%of Poverty	$1,212	$672	-$540	-44.6%
>200%of Poverty	$8,268	$7,648	-$621	-7.5%
Total Spending	**$22,454**	**$22,897**	**$443**	**2.0%**

III. Achieving Universal Coverage

The statistics presented in the previous section make it clear that the voluntary building blocks alone would make considerable progress in reducing the number of uninsured, but would leave the Commonwealth well short of universal coverage. Implementing universal coverage requires an individual mandate, which may or may not be combined with an employer mandate. The *Roadmap* proposes three alternatives: (1) an individual mandate; (2) an individual mandate coupled with a mandate on employers with 10 or more workers (the broad mandate); and an individual mandate coupled with a mandate on employers with 500 or more workers (the narrow mandate).

The Individual Mandate

An individual mandate would require all residents of the Commonwealth to obtain coverage for themselves and their families at least to the minimum level set by the mandate. With the building blocks in place to make coverage accessible and affordable, this requirement could be met. How the minimum is defined requires an important tradeoff between adequacy, on the one hand, and so rich a benefit package that coverage becomes unaffordable to many without very high subsidy costs, on the other.

The *Roadmap* proposes that the minimum benefit have an in-network deductible no larger than $1,800 for a single policy or $3,600 for a family policy, with out-of-pocket maximums of $3,600 and $7,200, respectively (2005 dollars). The list of benefits would include inpatient and outpatient care, emergency room services, physician care, a range of preventive services and prescription drugs, but limited mental health services and no dental care. Individuals could meet the mandate with more generous policies (lower deductibles, lower out-of-pocket maximums) but not with less generous ones. This is a less generous set of defined benefits than is typical in the employer-sponsored insurance market today.

Allowing a high deductible policy to satisfy the mandate reduces the burden on high-income individuals who would not be eligible for the credit and do not need low deductible policies for protection against medical expenses. It also allows for those who might prefer to use health savings accounts to satisfy the mandate with those types of products. At the same time, low- and moderate-income individuals would be protected against high out-of-pocket costs through the availability of MassHealth and tax credits—both of which would guarantee all individuals and families a choice of affordable low cost-sharing plans.

For those who do not voluntarily enroll, the Commonwealth would guarantee that everyone meeting a residency requirement would automatically be covered. Individuals would be responsible for enrolling in a plan of their choosing, obtaining an insurance card, paying premiums, and receiving tax credits if eligible. Individuals could enroll in their employer's plan, purchase coverage through the purchasing pool or directly through other private nongroup insurance, or enroll in MassHealth. Providers would be required to assist in enrolling the otherwise uninsured and would be assured of payment by doing so. Ultimately, the mandate would be enforced through the tax system. Proof of insurance would need to be documented when taxes are filed. Those without health insurance would be assessed premiums for the past year, plus a modest penalty.

It is important to note that an individual mandate (even if not combined with an employer mandate) would not change the dominant role of the employer-based insurance system. Employer-based insurance would remain attractive to employers under an individual mandate because of the federal tax exemption for employer contributions. Middle- and high-income employees would still be better off financially by obtaining coverage through their employers, given that most would not be eligible for the income-related subsidies provided in the pool. Large employers would also be able to obtain insurance directly in the market with lower administrative loads than the plans offered in the purchasing pool. Furthermore, the provision of health benefits would remain, as it is today, one of the ways most employers compete for workers. Nothing in an individual mandate would change this.

Under an individual mandate combined with the building blocks described earlier, most people would continue to receive coverage through employers (Table 5). However, 1.0 million individuals (17.4% of the nonelderly population) would obtain employment-based coverage through the pool, while 3.1 million (53.9%) would receive coverage outside the pool. The direct purchase market would grow to account for 9.2% of the population, about three-quarters of which (388,000) would be attributable to insurance purchased through pool. In all, the purchasing pool would cover 1.4 million people (about 24% of the nonelderly population). MassHealth enrollment would increase 4.4 percentage points (by about 255,000 people). We recognize that certain subpopulations (e.g., undocumented immigrants, the homeless) may be outside the reach of any mandate and that programs or initiatives may be required to address the needs of these groups.

Table 5. Individual Mandate

Health Insurance Coverage Pre- and Post-Reform						
	Pre-Reform		**Post-Reform**		**Change**	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Employer-Based Insurance	**4,108,630**	**70.8%**	**4,133,060**	**71.3%**	**24,430**	**0.4%**
Non-Purchasing Pool	4,108,630	70.8%	3,125,160	53.9%	-983,470	-17.0%
Purchasing Pool	0	0.0%	1,007,900	17.4%	1,007,900	17.4%
Direct Purchase	**271,380**	**4.7%**	**535,851**	**9.2%**	**264,471**	**4.6%**
Non-Purchasing Pool	271,380	4.7%	147,849	2.6%	-123,531	-2.1%
Purchasing Pool	0	0.0%	388,002	6.7%	388,002	6.7%
MassHealth	**799,287**	**13.8%**	**1,054,260**	**18.2%**	**254,973**	**4.4%**
Uninsured	**542,959**	**9.4%**	**0**	**0.0%**	**-542,959**	**-9.4%**

Government spending under the individual mandate proposed in the *Roadmap* would increase by an estimated $2.0 billion (Table 6) compared with current MassHealth spending (state and federal contributions combined). Of this, MassHealth expenditures would increase by $616 million. Tax credits for insurance obtained in the new purchasing pool would cost $927 million. Government reinsurance would account for the remaining $484 million.

Table 6. Individual Mandate

Total Spending Pre- and Post-Reform				
	Pre-Reform *(millions, 2005 $)*	**Post-Reform** *(millions, 2005 $)*	**Change** *(millions, 2005 $)*	*%*
Government Spending	**$3,333**	**$5,360**	**$2,027**	**60.8%**
MassHealth	$3,333	$3,949	$616	18.5%
Tax Credits		$927	$927	NA
Reinsurance		$484	$484	NA
Employer Spending	**$9,641**	**$9,851**	**$210**	**2.2%**
by Offer Status				
Offering Firms	$9,641	$9,501	-$140	-1.4%
Non Offering Firms	$0	$349	$349	NA
by Firm Size				
Less than 100 Workers	$2,771	$2,927	$156	5.6%
100 to 499 Workers	$1,539	$1,618	$79	5.1%
500+ Workers	$5,331	$5,305	-$26	-0.5%
Individual/Family Spending	**$9,480**	**$9,558**	**$78**	**0.8%**
by Income Level				
<200% of Poverty	$1,212	$801	-$411	-33.9%
≥200% of Poverty	$8,268	$8,757	$489	5.9%
Total Spending	**$22,454**	**$24,768**	**$2,314**	**10.3%**

Employer spending under the individual mandate would increase by 2% ($210 million). Firms not now offering coverage would see their health expenditures increase by $349 million. Some firms would begin to offer health insurance coverage to their workers once all individuals are required to enroll in coverage of some kind, as workers in some firms would conclude that employer-based coverage is their preferred option in satisfying the mandate. In circumstances in which workers are willing to exchange wages for health insurance, employers will be more likely to offer such coverage under the mandate than they are under the current system.

Employers that now offer coverage would save $140 million. This is because some employers who have been offering coverage may opt to stop doing so because their workers prefer to obtain coverage independently through the pool, MassHealth, or elsewhere. Most of the increased employer spending would be borne by firms with fewer than 100 workers, but even this increase amounts to only 5.6% of current spending by these firms.

Spending by individuals and families would increase slightly in the aggregate. But as with the voluntary building blocks alone, those below 200% of the poverty level would still have substantial savings—amounting to $411 million (a 34% reduction compared with their current spending)—because of the MassHealth expansion and the tax credits. Those above 200% of poverty would spend more than under the purely voluntary building blocks because of the coverage requirement.

Employer Mandates—General Considerations

As alternatives to an individual mandate alone, the *Roadmap* proposes an individual mandate combined with one of two employer mandate approaches. An employer mandate alone would not achieve universal coverage because, as noted, employees could decline the coverage offered and those not in the labor market would have no coverage requirement.

A crucial issue facing any state enacting an employer mandate is the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA), which prohibits states from enacting laws related to employee benefits. An approach that is likely to avoid this problem, though it has not yet been tested in court, is a mandate that does not require employers to offer insurance, but requires them to pay a tax to the state ("pay") and offers a credit for the amount spent on health insurance by those that do offer ("play"). Revenues from those who pay instead of play would be combined with other revenues to provide insurance to those not covered through their employers.

When designing a pay or play model, many parameters require decisions. These include the payroll tax rate (e.g., 5%, 8%, 10%) and the proportion of the wage bill to which the tax is applied (e.g., total wages, wages up to the maximum of the Social Security wage base per employee, or a smaller amount). Another decision is whether the mandate should cover all firms as well as all workers, or whether firms with fewer than a specified number of workers, and/or part-time workers, should be exempt.

Under any pay or play model, employers would receive a credit against the tax for any payments they make for employee health insurance. Firms choosing to play could offer coverage within the pool. They could also choose to offer coverage outside the pool and make contributions to the pool on behalf of workers who would prefer to obtain coverage there. Firms could also offer plans within the pool alone and pay the required premium amount.

Under the terms of ERISA, as noted, the Commonwealth cannot define a specific benefit package that employers must provide in order to avoid the requirement to pay the tax. This means the state cannot guarantee that firms will offer a specific level of benefits. However, an individual mandate can specify a minimum level of benefits that must be held by each person, thus providing a strong incentive for employers to provide policies that would, at a minimum, allow their workers to meet that standard.

One result of the pay or play structure is that employers offering coverage have a strong incentive to make sure their coverage is sufficiently comprehensive to at least equal the value of the tax. The reason for this is that employers spending less on premiums than the amount of tax would be required to pay the difference to the state. In other words, premium payments would offset the tax liability dollar-for-dollar, but the total liability of the employer would be equal to the tax. The residual tax liability for a firm that offers insufficient benefits to satisfy the individual mandate is of no value to the firm's employees. But a comprehensive package would benefit employees with better coverage and a more favorable tax treatment of employee compensation. Thus, in the modeling results presented here, we assume employees of firms that play will be provided with coverage that meets or exceeds the value of the tax.

Firms that face increased costs under an employer mandate are likely to reduce wages and salaries commensurately, doing their best to keep overall compensation constant. Employees of firms that pay would not be directly provided with health insurance, but they may also see a reduction in wages or salaries as their employers compensate for the new tax. Since simple equity demands that these workers get a benefit from their employer's contribution to coverage in the purchasing pool, we assume that workers of employers who pay would receive pool coverage at a discount.

We look at two different "pay or play" policies. Each requires the employers to pay an 8% tax on the first half of the Social Security wage base per employee. Each provides that employers receive a credit against the payroll tax obligation for any contribution made to employer-based insurance on behalf of their workers. And each exempts employees who work less than 30 hours a week. In the first model (the broad employer mandate), firms with fewer than 10 workers are exempt from the "pay or play" policy. In the second (the narrow employer mandate), firms with fewer than 500 workers are exempt.

The Broad Employer Mandate. Under the broad employer mandate, the number of people receiving employer coverage would fall by about 5 percentage points (Table 7). Of those covered by employer-based insurance, 872,000 would receive coverage that their employers obtain through the purchasing pool. The remaining 2.9 million with

employer coverage would receive it outside the pool. The number enrolling in directly purchased health insurance plans would increase by 11.5 percentage points. Only a small share of those directly purchasing coverage would do so in the nonpool market, while 812,000 would purchase coverage directly in the pool, including many whose employers choose to "pay." In total, 1.7 million people (29% of the state's population) would receive coverage through the purchasing pool. MassHealth would expand by 173,000 people (3 percentage points). This increase in MassHealth is smaller than that under the individual mandate, as more individuals who are eligible for MassHealth would choose to obtain coverage in the pool because of the discounts available to the workers of employers who pay.

Table 7. Broad Employer Mandate, *Includes Individual Mandate*

Health Insurance Coverage Pre- and Post-Reform						
	Pre-Reform		Post-Reform		Change	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Employer-Based Insurance	**4,108,630**	**70.8%**	**3,817,823**	**65.8%**	**-290,807**	**-5.0%**
Non-Purchasing Pool	4,108,630	70.8%	2,945,350	50.8%	-1,163,280	-20.1%
Purchasing Pool	0	0.0%	872,473	15.0%	872,473	15.0%
Direct Purchase	**271,380**	**4.7%**	**937,370**	**16.2%**	**665,990**	**11.5%**
Non-Purchasing Pool	271,380	4.7%	125,405	2.2%	-145,975	-2.5%
Purchasing Pool	0	0.0%	811,965	14.0%	811,965	14.0%
MassHealth	**799,287**	**13.8%**	**972,309**	**16.8%**	**173,022**	**3.0%**
Uninsured	**542,959**	**9.4%**	**0**	**0.0%**	**-542,959**	**-9.4%**

(1) This simulation includes employer and individual mandates. Employer Mandate has 8% payroll tax, wage threshold = $43,950, exemptions for employers with fewer than 10 workers and for part-time workers, extra subsides for "paying" workers via 5% income cap.

The cost to the government would increase by $2.2 billion (Table 8). This includes $390 million in increased MassHealth costs, an 11.7% increase in program spending. The value of tax credits received would amount to $2.3 billion; but this amount is somewhat offset by payroll tax revenues of $1.1 billion from employers who pay the tax. Government-sponsored reinsurance would cost $632 million.

Employer spending would increase by $765 million. There would be a small (1.4%) increase in spending for firms that currently offer coverage. Most of the increased costs would be borne by firms that currently do not offer coverage. Since most firms that don't offer coverage have fewer than 100 workers, most of the increased costs would be borne by firms with 10 or more but fewer than 100 workers.

Individuals and families with incomes below 200% of the poverty level would save about $400 million, about a one-third reduction in their spending. There would be small increases in costs for individuals and families with incomes above 200% of poverty.

Table 8. Broad Employer Mandate, *Includes Individual Mandate*

Total Spending Pre- and Post-Reform				
	Pre-Reform *(millions, 2005 $)*	**Post-Reform** *(millions, 2005 $)*	**Change** *(millions, 2005 $)*	*(%)*
Government Spending	**$3,333**	**$5,556**	**$2,223**	**66.7%**
MassHealth	$3,333	$3,723	$390	11.7%
Tax Credits		$2,285	$2,285	NA
Less Payroll Tax Revenue		*-$1,084*	*-$1,084*	NA
Reinsurance		$632	$632	NA
Employer Spending	**$9,641**	**$10,406**	**$765**	**7.9%**
by Offer Status				
Offering Firms	$9,641	$9,775	$134	*1.4%*
Non Offering Firms	$0	$631	$631	NA
by Firm Size				
Less than 100 Workers	$2,771	$3,321	$550	19.9%
100 to 499 Workers	$1,539	$1,674	$134	8.7%
500+ Workers	$5,331	$5,411	$80	1.5%
Individual/Family Spending	**$9,480**	**$9,249**	**-$230**	**-2.4%**
by Income Level				
<200% of Poverty	$1,212	$808	-$403	-33.3%
≥200% of Poverty	$8,268	$8,441	$173	2.1%
Total Spending	**$22,454**	**$25,212**	**$2,757**	**12.3%**

(1) The costs of extra benefits for employers who "Play" have been distributed over the firm categories shown, and have been subtracted from the individual spending categories shown.
(2) This simulation includes employer and individual mandates. Employer Mandate has 8% payroll tax, wage threshold = $43,950, exemptions for employers with fewer than 10 workers and for part-time workers, extra subsidies for "paying" workers via 5% income cap.

Narrow Employer Mandate. For the employer mandate model that only applies to firms with 500 workers or more, the impacts move somewhat in the direction of the results of the individual mandate because many more workers would now be subject only to the individual mandate.

The share of the population receiving coverage through an employer would fall by 1.7 percentage points (Table 9). This is less of a reduction in coverage than under the broad employer mandate. The number receiving employer-sponsored insurance directly would decline by 1.1 million people, but the number receiving employer coverage through the new purchasing pool (994,000) would almost counteract this decline. The number who would obtain coverage directly outside the pool would fall by 124,000, while the number buying coverage individually through the purchasing pool would increase by 535,000. In total, the number in the purchasing pool would be 1.5 million people (26.3% of the state population)—lower than under the broad employer mandate but higher than under an individual mandate alone. The number of people receiving coverage through Medicaid would increase by 233 million. This number is higher than under the broader employer mandate because fewer MassHealth eligible workers would have the option to obtain discounted coverage through the purchasing pool.

Table 9. Narrow Employer Mandate, *Includes Individual Mandate*

Health Insurance Coverage Pre- and Post-Reform						
	Pre-Reform		**Post-Reform**		**Change**	
	Persons	% of Population	Persons	% of Population	Persons	% of Population
Employer-Based Insurance	**4,108,630**	**70.8%**	**4,010,245**	**69.2%**	**-98,385**	**-1.7%**
Non-Purchasing Pool	4,108,630	70.8%	3,015,850	52.0%	-1,092,780	-18.8%
Purchasing Pool	0	0.0%	994,395	17.2%	994,395	17.2%
Direct Purchase	**271,380**	**4.7%**	**682,667**	**11.8%**	**411,287**	**7.1%**
Non-Purchasing Pool	271,380	0.0%	147,306	2.5%	-124,074	-2.1%
Purchasing Pool	0	0.0%	535,361	9.2%	535,361	9.2%
MassHealth	**799,287**	**13.8%**	**1,031,856**	**17.8%**	**232,569**	**4.0%**
Uninsured	**542,959**	**9.4%**	**0**	**0.0%**	**-542,959**	**-9.4%**

(1) This simulation includes employer and individual mandates. Employer Mandate has 8% payroll tax, wage threshold=$43,950, exemptions for employers with fewer than 500 workers, extra subsidies for "paying" workers via 5% income cap.

Table 10. Narrow Employer Mandate, *Includes Individual Mandate*

Total Spending Pre- and Post-Reform				
	Pre-Reform *(millions, 2005 $)*	Post-Reform *(millions, 2005 $)*	Change *(millions, 2005 $)*	*%*
Government Spending	**$3,333**	**$5,427**	**$2,094**	**62.8%**
MassHealth	$3,333	$3,883	$550	16.5%
Tax Credits		$1,308	$1,308	NA
Less Payroll Tax Revenue		*-$320*	*-$320*	*NA*
Reinsurance		$556	$556	NA
Employer Spending	**$9,641**	**$9,976**	**$335**	**3.5%**
by Offer Status				
Tax Credits	$9,641	$9,615	-$26	-.3%
Less Payroll Tax Revenue	$0	$361	$361	NA
by Firm Size				
Less than 100 Workers	$2,771	$2,990	$219	7.9%
100 to 499 Workers	$1,539	$1,645	$106	6.9%
500+ Workers	$5,331	$5,341	$10	0.2%
Individual/Family Spending				
by Income Level	**$9,641**	**$9,976**	**$335**	**3.5%**
<200% of Poverty	$1,212	$801	-$410	-33.9%
≥200% of Poverty	$8,268	$8.811	$543	6.6%
Total Spending	**$22,454**	**$25,016**	**$2,561**	**11.4%**

(1) The costs of extra benefits for employers who "Play" have been distributed over the firm categories shown, and have been subtracted from the individual spending categories shown.
(2) This simulation includes employer and individual mandates. Employer Mandate has 8% payroll tax, wage threshold=$43,950, exemptions for employers with fewer than 500 workers, extra subsidies for "paying" workers via 5% income cap.

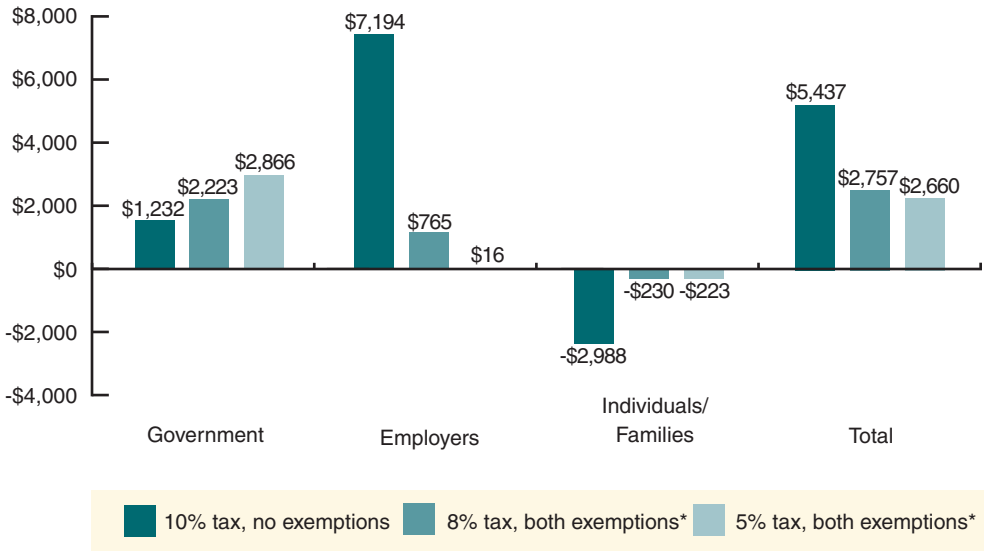
Government spending under the narrow employer mandate would increase by $2.1 billion (Table 10). MassHealth spending would increase by $550 million (16.5%). Tax credits would amount to $1.3 billion, which is offset by $320 million in payroll tax revenues. Spending for government-sponsored reinsurance would amount to $556 million.

Employer spending would increase by $335 million, all of which is attributable to firms not currently offering coverage. Interestingly, the increase in employer spending is borne entirely by firms not subject to the employer mandate. Because workers would still be subject to an individual mandate, some employees would find it worthwhile to have their employers provide coverage, even if it means some loss in wages and salaries. Spending by large employers as a whole would be virtually unchanged because most already provide coverage—although some would no doubt spend more than before and others less). Spending by individuals and families below 200% of the poverty level would also be reduced, although spending by those above 200% of poverty would increase.

Other Design Issues for an Employer Mandate. As we noted earlier, the effect of an employer mandate will vary with the payroll tax rate, the amount of wages to which the payroll tax applies, whether or not certain types of firms and workers are exempted, and whether workers whose employers choose to pay the tax should receive extra premium discounts. All these parameters can be altered and each choice leads to somewhat different results.

The following discussion illustrates some of the implications of these choices. In Figure 1, we compare the *Roadmap*'s broad employer/individual mandate with two different broad employer/individual mandate options. One imposes a 10% payroll tax, does not exempt either small employers or part-time workers, and doubles the wage base

Figure 1. Changes in Health Spending Compared with Pre-Reform — Under Three Broad Employer Mandate Alternatives, *(Millions of 2005 $)*



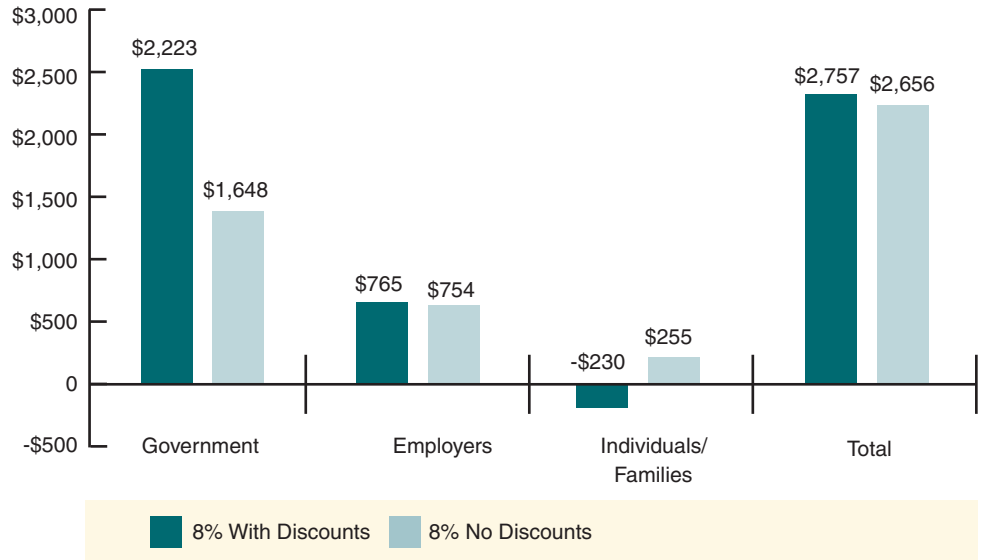
*Exemptions for part-time workers and firms with fewer than 100 workers.
Note: All alternatives include building blocks and individual mandate.

to which the payroll tax is applied up to the full social security wage base. The second keeps the exemption of small employers and part-time workers and imposes a 5% payroll tax on only half the Social Security wage base.

Because the 10% option brings in more payroll tax revenue than does the 8% option, the net change in government spending is lower. The fact that the 10% option does not exempt any employers or workers and uses a higher wage base also lowers government spending. Conversely, the 5% payroll tax option brings in less payroll tax revenue than does the 8% mandate. Consequently, it has a higher net government cost. The change in employer spending is particularly large under the 10% option, as the minimum spending requirement results in more spending than is done by most currently offering employers. Thus, not only does spending increase for those employers who do not currently offer coverage, but it also increases costs for those who do currently offer. Because employer spending is required to be so high under this option, employers who do offer coverage are likely to provide more generous policies than is the case today, leading to significant reductions in spending for individuals and families. Overall, the 10% option would increase total health care spending to a much greater extent than the other two options shown.

An employer/individual mandate could also be designed that altered or eliminated the more generous tax credits for workers whose employers choose to pay. Figure 2 shows the *Roadmap*'s broad employer mandate option with and without these additional subsidies. Eliminating these subsidies lowers new government spending from $2.2 billion to $1.6 billion, but increases individual and family spending by roughly $500 million in aggregate compared with the option with discounts. It should be noted that if the discounts were eliminated in the option that applied only to firms with fewer than 500 workers or more, the impact of the discount would be smaller. Fewer firms are subject to the mandate, thus fewer would choose to pay, and the discounts would be less of an issue.

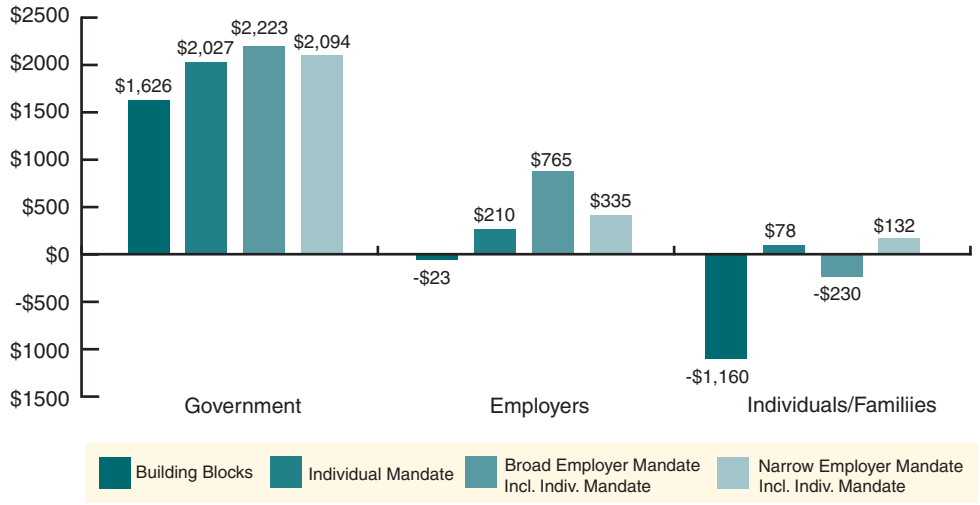
Figure 2. Changes in Health Care Spending Compared with Pre-Reform — Broad Employer Mandate with and without Discounts for Workers of Employers who Pay, *(Millions of 2005 $)*



IV. Summary of Universal Coverage Impacts

The data presented in the previous sections show that the voluntary arrangements by themselves would still leave 321,000 people without coverage. Each of the other three options would lead to universal coverage. Figure 3 summarizes the changes in health spending for each group under the different options. A voluntary plan, with all the provisions described above, would increase government costs by $1.6 billion per year. An individual mandate built on the subsidy structure we propose would increase government costs by $2.0 billion, compared with current spending on MassHealth. The employer mandate that includes all but the smallest firms would increase government costs by $2.2 billion. The employer mandate that exempts firms with fewer than 500 workers would increase government costs by $2.1 billion.

Figure 3. Changes in Health Spending Compared with Pre-Reform, *(Millions of 2005 $)*



Note: All mandate alternatives include the building blocks.

Government spending under the employer/individual mandate would exceed that in the pure individual mandate for several reasons. First, MassHealth is smaller under the employer mandate, with more people eligible for Medicaid choosing to enroll in the

purchasing pool instead, where they can obtain the more generous subsidies available to workers whose employers pay. MassHealth is less expensive than coverage obtained in the pool due to lower administrative costs and lower provider payment rates.

Second, under the employer mandate, more coverage would be obtained through the pool than under the individual mandate alone, due to the availability of the employer "pay" option. Third, because pool coverage is more comprehensive than nonpool private coverage, it leads to somewhat higher overall use and greater spending. Finally, the 8% payroll tax requirement under this option would lead some employers choosing the play option to buy more comprehensive coverage than they otherwise would have, in order to satisfy the terms of the mandate.

The cost increase to employers would also be higher under the employer/individual mandates ($765 million and $335 million, respectively) than under the individual mandate ($210 million. This is because firms are required to either provide coverage or pay the tax. For some firms, the tax rate is higher than the amount they otherwise would have spent.

Individuals and families would see a huge reduction in costs under the voluntary option ($1.2 billion) because those who prefer not to have coverage are not required to spend money on health insurance. Under any of the mandates, individuals and families overall would see relatively small changes in current outlays, although as we showed earlier, low income families would save under all of the policy options.

V. Financing

Although each mandate option would require new government spending, much of the increase can be offset by resources already in the system. As noted earlier, there is potentially $1.3 billion in federal and state dollars already available for coverage. That is, the Medicaid waiver renewal makes $650 million federal dollars available as long as the state can identify acceptable revenue sources to constitute state matching funds. But even with the funds currently in the system, some new spending would be needed. By our estimates, there would be a need for $700 million under an individual mandate and $800 to $900 million under the employer mandate, depending on firm size exemptions. There would also be a need, no doubt, for additional funds for selected MassHealth provider payment increases in areas that most observers feel are currently underpaid. Some residual funds for safety net providers would also be required because of the relatively few individuals who are likely to stay outside the new system (e.g., undocumented immigrants) for whom services must continue to be provided.

The additional funds needed to finance universal coverage could be secured in a number of ways. Structuring the expansion to maximize the state's SCHIP allotment would bring in federal dollars. The costs of the new MassHealth enrollees, who come into the program under current eligibility rules, could also be financed partially with federal dollars. These two steps together could bring in $75 million to $100 million in federal funds. There could also be increases in current assessments on insurers and hospitals, and additional provider taxes (such as on managed care plans). Funds could also be made available through increased taxes on cigarettes and alcohol or increases in sales or income tax.

While some new spending would be necessary, it is important to put these numbers in perspective. Universal coverage could be achieved in Massachusetts for an additional $700 to $900 million dollars. Adding to this a $400 million allowance for MassHealth rate increases and residual safety net funding brings the total new government spending needed to about $1.2 billion. This amount, while large, is only about 0.3% of the

state gross domestic product. Thus, Massachusetts could achieve universal coverage for a tiny fraction of current state GDP. Stated differently, $1.2 billion is about 2% of current health expenditures in the state and about 5% of the state budget. If a higher sales tax is the chosen revenue source, the increase required would be only 1.2 percentage points (from 5% to 6.2%). If an increase in the income tax rate is chosen, that would be only just over half a percentage point (from 5.3% to 5.85%), on the assumption of some additional revenues as well from increases in cigarette and alcohol taxes.

VI. Economic Impacts

Universal coverage would result in major increases in economic well-being from improved health. Using a methodology developed by the Institute of Medicine, we calculated that the estimated increase in economic well-being because of improved health resulting from universal coverage in Massachusetts would be about $1.5 billion. Several additional benefits potentially associated with universal coverage are more difficult to quantify. These include the reduced risk of financial problems for individuals and families due to bankruptcies; reduced demands in emergency rooms by the uninsured, assuring greater access in time of need for those with insurance; and finally, greater workplace productivity and higher tax payments from the many whose health would be improved.

In addition, some of the spending that would result in universal coverage would go to reduce the financial burdens on low-income individuals and families who currently purchase health insurance. It is not practical or even feasible to develop a new system targeted only to the uninsured. Many with the same incomes as the uninsured are currently obtaining coverage, though at great cost. Any equitable system would treat these individuals and families in the same way that it treats the uninsured in similar or economic circumstances even though it adds to the system's cost.

Moving towards universal coverage would also affect the cost of doing business and living in Massachusetts, as well as the demand for health care services—affecting employment, overall economic activity, and personal incomes. We used a regional macro-economic model[5] to analyze how a system of universal coverage that increases health care spending and finances it through increased employer and individual payments, as well as through tax increases, would affect the state's economy. The results suggest that the economic impact would be mildly positive under any of the three *Roadmap* mandates.

[5] Developed by Regional Economic Models, Incorporated

The increased health spending in itself would have positive effects, increasing employment, state GDP, and personal incomes by almost 1%. The tax increases implemented to finance the system would, by themselves, have a negative impact on employment, state GDP, and disposable incomes. But this negative effect is more than offset by the positive effects from increased health care spending. Stated differently, increased health care spending has a greater positive effect on employment, state GDP, and personal incomes than the negative impact of increased taxes—regardless of whether financing occurs through an increase in income taxes or a combination of higher sales and excise taxes. One reason for the positive economic impacts is that the new health spending would largely stay in the state, whereas much of the forgone consumption due to higher taxes would have gone to goods or services purchased out of state.

VII. How to Get There from Here: Implementation Steps

The design elements behind the *Roadmap* are not new to the policy debate. All four building blocks have been implemented in some form by one or more states, though never together. Coverage mandates have been considered for many years, though not yet implemented by any state.[6] The details of actual implementation are complex, however. Success requires a realistic sense of the roles to be played by all major actors, public and private; the resources required to get the job done; and the timeline of events. The *Roadmap* initiative has developed six detailed discussion papers that go through the specific steps that must be taken for universal coverage to succeed in a timely and cost effective manner. The papers are all available at www.roadmaptocoverage.org. Here are the major issues to be considered to ensure effective implementation.

Expanding Eligibility for MassHealth[7]

The first building block would expand MassHealth eligibility to 200% of the federal poverty level for children and their parents, and 133% of poverty for adults without children. The primary implementation issue here is to ensure that maximum federal funds are flowing into the state to help fund the expansion. Since the federal government pays 50% of Medicaid costs and 65% of the State Children's Health Insurance Program (SCHIP) costs in Massachusetts, this means maximizing the portion of the expansion eligible for these funds. The challenge is that the state currently operates MassHealth under a federal waiver. Such a waiver creates three types of constraints: budget neutrality, allowed sources of state matching funds, and permitted structure of coverage.

Budget Neutrality. The advantage to the Commonwealth of operating its MassHealth under a waiver is the flexibility it provides in program design and operation. The disadvantage is the requirement that the state spend no more under the waiver than it would have spent under regular Medicaid rules. This calculation is complex, subject to negotiation, and changeable over time. For the discussion here, the important point is that

[6] Hawaii has in place a mandate that employers provide health insurance to their employees. While there is much to learn from Hawaii's experience, the state has a statutory exception to the federal Employee Retirement Income Security Act of 1974 (ERISA) which enables it to adopt certain policies that are unavailable to any other state.

[7] See Mark Reynolds, 2005 "Maximizing the use of Federal Matching Funds to Help Finance Universal Coverage," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

MassHealth currently operates well under the budget neutrality cap; but the gap between expected spending and the neutrality ceiling is projected to narrow under the new waiver agreement. If the state hits the ceiling, no additional federal funds will be forthcoming even if state costs rise. This would put more of the financing burden on the state.

An important area of uncertainty is how much of the *Roadmap's* MassHealth expansion can take place outside the budget neutrality constraint. The state already has legal authority to increase eligibility for families up to 200% of poverty without a waiver, so those costs should not be constrained. The complication comes from the fact that family coverage is part of the existing waiver, which opens such an expansion to federal negotiation and the budget neutrality constraint.

The Source of State Matching Funds. Most of the revenues Massachusetts currently uses to match federal funds for MassHealth come from general sources, such as personal and business income taxes and sales taxes. But the Commonwealth also uses intergovernmental transfers (IGTs). These are essentially loans to the state from local governments, state universities, and some providers, that are then paid back in full when the federal matching funds come through. The problem is that the federal government is no longer willing to accept IGTs as a valid source of state matching funds. This prohibition[8] creates a shortfall in state spending that must be replaced if the state is not to lose about $650 million of federal funds. The state has developed a $700 million list of other potential sources of state matching funds, which would have to be agreed to in reopened waiver negotiations.

Structuring Coverage. The waiver is quite flexible in how Medicaid funds will be spent.[9] A possible source that could, in principle, fund a large portion of the MassHealth expansion (as well as the tax credit and reinsurance building blocks of the *Roadmap*) is the Safety Net Care Pool (SNCP) called for under the new waiver. The major impediment to this will be resistance on the part of existing recipients of the funds that would then go into the SNCP.

Another promising source for structuring new coverage would be to expand SCHIP. Since the Commonwealth believes it has sufficient funds within the federal SNCP cap to cover children up to 400% of poverty—and the *Roadmap* only calls for such coverage up to 200% of poverty—the state could seek a waiver to cover some share of families with SCHIP funds. The coverage would be identical to MassHealth, but the federal matching share would be 65% rather than 50%, and the funds would not count against the Medicaid budget neutrality cap.

Developing Tax Credits[10]

The second building block is a tax credit to subsidize coverage costs for persons and families with incomes up to 400% of poverty. At the low end of this range are people who are most likely to enroll in an expanded MassHealth, in the middle are those

[8] Along with a reduction in federal spending for adults living in Institutes for Mental Disease.

[9] The main exception is that supplemental payments that used to be allowed to certain managed care plans serving Medicaid patients are disallowed under a new waiver provision requiring an "actuarial soundness" standard for all such plans.

[10] See Alan Weil, 2005, "Implementing Tax Credits for Affordable Health Insurance Coverage," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

may move into and out of eligibility for MassHealth. At the high end are those with incomes below the state median but with substantial resources.

Unlike most tax credits, application for this health premium credit needs to be separate from the tax return since most people will need to obtain the credit over the course of the year to pay for their health plan. The credit value to the recipient is the price of the health insurance over and above the income cutoff for that recipient. The entity that processes the credit can ascertain this amount for the families on an ongoing basis, with any end-of-year reconciliation added to or subtracted from the family's overall tax liability.

With respect to the mechanisms through which recipients use the credit, the important point is that these will differ before and after the coverage mandate is implemented. Before it, there must be a system for collecting delinquent payments and disenrolling those who do not pay. When the mandate is in place this will not be necessary because back premiums will be collected through the tax system. Tax credit disbursements to the purchasing pool on behalf of recipients will be the responsibility of the Department of Revenue.

All these steps must be conducted with an eye to encouraging continuity of coverage as people change from one status to another (e.g., in and out of MassHealth). Before coverage is mandatory, this will require rules that cover preexisting condition exclusions and the like. Once coverage is mandatory, the focus can be on facilitating transitions from one coverage source to another.

Creating a Purchasing Pool[11]

The third building block is creation of a voluntary purchasing pool. Health plans could offer coverage through the pool, and an individual, family, or employer could choose to buy coverage through the pool. A key feature of the *Roadmap* is that those eligible for a tax credit could apply it only to coverage purchased through the pool.

Choosing Who Will Run the Pool. The pool can be operated by either a public or a private organization. The primary reason for it to be public is the need to closely integrate its functions with those of other public programs/agencies. Public administration has the advantage of ensuring public input and accountability. But whether the agency should be new or existing requires balancing the benefits of continuity against concerns about the "baggage" an existing agency may carry over to the new function. The main reason for choosing a private organization is more flexibility in hiring and decision-making. Also, employers, health plans, and brokers may all feel more comfortable with a private pool, most of which are nonprofit. Public accountability could be assured through public agency oversight and competitive selection, at least in principle, though the enormous amount of confidential income information involved may make private administration controversial in practice.

The pool will need a governing board, which should represent purchasers but must exclude insurers, agents, and health care providers to prevent possible conflicts of

[11] See Elliot Wicks, 2005, "Implementing a Health Plan Purchasing Pool," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

interest. The pool will also need a plan administrator, a function that most pools contract out because of the technical expertise needed.

Selecting Health Plans. Since the fundamental reason for the pool is to leverage the power of purchasers, health plans view such pools with trepidation. To alleviate this, health plans must be treated as partners, with their concerns heard and experience relied on in a way that encourages participation, even as they are forced to confront a well-organized purchaser. Important decisions include:

- *Whether to be a price taker or price negotiator.* All large pools take the latter approach.
- *Whether to accept all plans.* More plans mean more consumer choice, but also a heavier educational and oversight burden.
- *How to design the benefit packages.* Because pool coverage is targeted to moderate income groups, plans will need more limited copayments and deductibles than in a typical pool. The pool will also need to convert the *Roadmap* ideas into defined covered services and cost-sharing provisions.
- *How to vary premiums across people and groups.* A clear lesson from existing purchasing pools is the need to follow the same rating practices as in the broader health care market to avoid attracting unfavorable risk.
- *How to design the risk adjustment mechanism.* The risk that the pool as a whole will attract a more expensive population will be minimized by the tax credit and reinsurance building blocks. To avoid adverse selection within the pool, it would need to develop a risk adjustment mechanism that reallocates resources across participating plans based on the risk profile of their actual enrollees.[12]

Other tasks. Experience shows that the pool will need agents and brokers to assist in selling its products. It will also need to market itself explicitly (in close coordination with marketing efforts for the new tax credits) as a good new source of health insurance. In addition, it will need to develop a range of enrollment mechanisms to cover individuals and groups that come to it through different routes (e.g., affiliated with an employer or not). The pool will also need to coordinate with the entity that administers the tax credit, as well as handle the flow of funds between the state and the health plans.

Creating a System of Reinsurance[13]

The fourth building block is reinsurance to cover 75% of the costs above $35,000 a year for enrollees in the nongroup market and in firms with fewer than 100 workers.

Choosing the Locus of Responsibility. The first design issue here, as with the pool, is who should be responsible for implementation and operation. One option is the Division of Insurance since it already regulates insurance and oversees the state's existing small group reinsurance system. Another is the agency that administers the new

[12] To avoid adverse selection altogether, the pool would need to develop a risk adjustment mechanism that reallocates resources across participating plan based on the risk profile of their actual enrollees.

[13] See Randall Bovbjerg and Elliot Wicks, 2005, "Implementing Government-Funded Reinsurance in the context of Universal Coverage," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

purchasing pool since the reinsurance system must operate in close conjunction with the pool plans. Also possible would be a quasi-governmental agency operating outside the existing structure but with a publicly appointed board. Unlike for the pool, this board could include providers and health plans because there would be no conflicts of interest.

The reinsurer would then need to decide what functions to contract out. The most important function, of course, is to bear risk. Although it might seem obvious that the state itself should do this, there are advantages to purchasing it. The main one may be the message purchasing sends—that the state does not intend to become an even larger purchaser of health care services. This is likely to be an important message given that, if universal coverage becomes a reality, Massachusetts could exert substantial control over the purchase of a large share of the state's health care.

Deciding What to Cover. The system should cover all types of health plans, not just "insurers" as defined in existing state law. This needs to include firms that self-insure, even though including them adds considerable complexity. In defining the included (and excluded groups), the state should follow the Division of Insurance definitions as closely as possible. In defining what is covered by the reinsurance, the state may wish to be open to changing the amounts currently in the *Roadmap* (75% over a threshold of $35,000 per individual per year) based on experience in Massachusetts and elsewhere. The definition of a coverage "year" also needs to be defined, given that the reinsurance system will be an overlay on coverages that begin and end at different times.

Other issues that need careful attention include choosing an entity to receive claims from insurers, verification, claims processing, and auditing. Coordination of costs and care requires substantial data transfers between health plans and the insurer, which can be minimized if the system develops automated mechanisms for sharing data.

Enforcing Individual and Employer Mandates[14]

Since the four building blocks will reduce but not eliminate the number of Commonwealth residents without health insurance, the *Roadmap* also includes three mandate options: an individual mandate, an individual mandate combined with a mandate on employers with 10 or more workers (the broad mandate), and an individual mandate on employers with 500 or more workers (the narrow mandate). The type of employer mandate in the *Roadmap* gives employers the choice between offering acceptable coverage to their workers or paying a tax to the state.

Since the objective is to make health insurance affordable and available to all, the emphasis should be on encouraging voluntary enrollment to the maximum extent. The Commonwealth has a history of high participation rates in MassHealth, a record and a set of successful outreach and enrollment procedures on which the state can build. For all non-MassHealth residents (and firms for an employer mandate), the primary mechanism should be outreach and education. All likely contact points for families and individuals should be engaged in the outreach process for the mandate(s), (including Schools, Registries of Motor Vehicles, and Providers). Employers can also

[14] See Linda J. Blumberg, Randall Bovbjerg, and John Holahan, 2005, "Enforcing Health Insurance Mandates," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

play a pivotal role, even those that do not themselves offer coverage, although care should be taken not to overburden them in the effort.

Individual Mandate Enforcement. For those who persistently fail to obey the mandate, enforcement would be necessary. The primary enforcement mechanism for the individual mandate should be the tax system. For the few who do not file a tax return, providers should play a critical enforcement role—having the responsibility, when the uninsured seek care, to begin the enrollment process. Their participation in the enrollment process will have the benefit of ensuring the provider gets paid for this initial visit.

Employer Mandate Enforcement. Deciding which employers should be subject to the mandate is a critical decision involving a tradeoff between coverage and enforcement cost concerns. Fortunately, the relatively few large firms in the state employ the majority of the workers, so a suitable size cutoff would reduce political opposition and enforcement costs at the same time that it reached most workers. Responsibility for the enforcement function should go to the Division of Unemployment Insurance or the Department of Revenue, both of which have current responsibilities similar to those required for mandate enforcement. For those who cover their own employees ("play"), the primary monitoring mechanism would be effective reporting requirements and audits. For those who choose the payroll tax ("pay"), monitoring should be based on tax filings. In the early years, penalties should be limited to payment of back taxes with very small penalties imposed. Only for willful/persistent evasion should stronger sanctions be imposed.

Assuring Cost Containment[15]

There is no magic bullet for containing health care costs. It is appropriate, however, to consider how efficiency gains can minimize the cost of expansion. The *Roadmap* contains two inherent cost containing aspects—a purchasing pool with a competitive structure and a reinsurance system. More generally, universal coverage could provide the opportunity for all actors in the health care sector to work together on creative ways to contain costs while improving the quality of care delivered. Promising approaches include:

- A comprehensive approach to reducing medical errors with new data analysis, new investments in provider training and information technology, and changes in provider payment systems and incentives;
- A reexamination of payment methodologies, in the search for better incentives to deliver primary care and manage chronic conditions;
- A statewide effort to reconfigure how care is provided at the end of life, which could yield more compassionate care at the same time as savings;
- A vigorous effort, focusing on cost containment, to determine if and when new technologies should be paid for by health plans;
- Moving adjudication of certain avoidable adverse effects from the courts to a more consistent and timely administrative process.

[15] See Robert A. Berenson, 2005, "Cost containment Opportunities in the Roadmap to Coverage," for a complete discussion of these issues. The report is available at www.roadmaptocoverage.org.

VIII. Timing

VIII

By design, the *Roadmap* builds on the existing health care system in Massachusetts. It describes a gradual but steady path to insurance coverage for everyone with minimum disruption of existing relationships. The four building blocks are each based on policies in existence in various states around the country. Implementation of these can begin as soon as legislation is passed and signed into law. The MassHealth expansion could be implemented in Year 1. The tax credits, pool, and reinsurance rely on one another for successful implementation. Since setting up the pool is the most complex of these tasks, it makes sense to implement all three concurrently at the end of Year 2. When these are in place, affordability and availability concerns disappear. Mandating coverage, whether through an individual or a combined individual and employer mandate, then becomes an expression of a social contract that requires all to participate in a system that benefits all. If done carefully and with sensitivity, this final requirement for effective universal coverage should take an additional 2 years to implement, becoming effective at the end of Year 4. Thus, effective universal coverage in the Commonwealth of Massachusetts, if done according to the *Roadmap's* policy guidelines and implementation recommendations, should be achievable within four years after initial implementation has begun.

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Linda J. Blumberg is an economist and Senior Research Associate at The Urban Institute. Her research focuses on issues related to private health insurance and health care financing. She is the principal investigator in the development of the Health Insurance Reform Simulation Model (HIRSM), an individual and employer level model that can be used to simulate the effects of reforms affecting private and public insurance. Her research includes estimating the coverage and risk pool impacts of tax credit proposals, estimating price elasticities of employers offering health insurance and of workers taking up employer offers, the effect of the Medicaid expansions on private insurance coverage of children, and a series of analyses of the working uninsured. From August 1993 through October 1994 she served as Health Policy Advisor to the Clinton Administration.

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