EXECUTIVE SUMMARY

Roadmap to Coverage:
Synthesis of Findings

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Report for the Blue Cross Blue Shield of Massachusetts Foundation, October 2005

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The Time to Address the Uninsurance Problem Is Now.

The *Roadmap to Coverage* initiative develops three policy options that would provide universal health insurance coverage for the Commonwealth of Massachusetts. Within this overall objective, all three options are designed to minimize (a) disruptions in the employer-based coverage that is the basis of the existing health insurance market, (b) the need for new revenues, and (c) the expansion of government's role.

Lack of health coverage has been proven to adversely affect health, increase financial uncertainty for families and individuals, and contribute importantly to personal bankruptcy. Therefore, covering the uninsured has direct health and financial benefits to Commonwealth residents—at the same time that it reduces the strains on the overall health care delivery system by helping those who cannot pay.

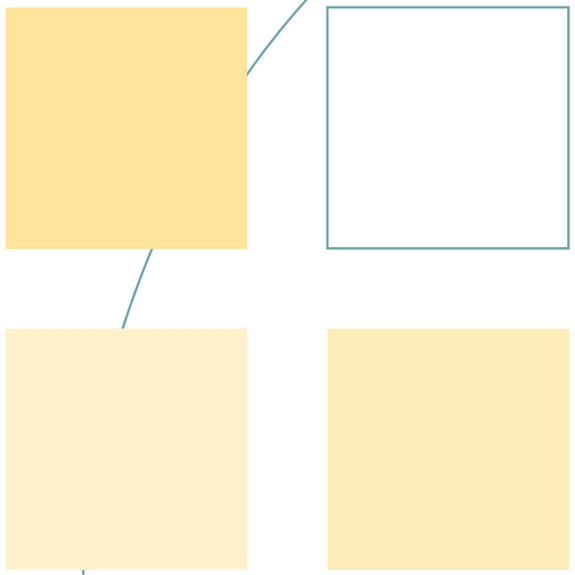
Why now? Even with renewed economic growth, health care costs are increasing substantially faster than wages in the state—causing employers to require higher worker contributions and to offer less comprehensive coverage. This trend will further increase the number of uninsured—making universal coverage ever more difficult to achieve. The time to act is now, while the problem is still within reach.

Achieving Universal Coverage in the Commonwealth Is Financially Feasible.

First, the Commonwealth already has a strong base of employer and public coverage and a lower proportion of residents without insurance than most states (13.2% of the non-elderly population, according to the Census Bureau, compared with the national average of 17.8%). Second, the state's substantial current spending on the uninsured ($1.1 billion in 2004)—through its Uncompensated Care Pool as well as other safety net programs—is potentially available to help fund universal coverage. Third, the recent renewal of the state's Medicaid waiver program, though limiting some of the current mechanisms used to access matching funds, still permits access to a continuing flow of federal funds as long as state matching funds can be found. This is crucial because every Commonwealth dollar spent on coverage within its Medicaid program (MassHealth) draws an additional dollar or more of federal funds to finance coverage.

Achieving universal coverage under the *Roadmap* plans would require between $700 million and $900 million in new government spending, some of which would be federal. *While universal coverage would require modest additional state spending, the Commonwealth would also gain an estimated $1.5 billion a year from the direct economic and social benefits of improved health as well as other positive effects on the state's economy.*

Each Roadmap Option Rests on the Same Four Building Blocks



To put in place a policy infrastructure that can provide universal coverage in the Commonwealth without imposing intolerable burdens on lower income residents and small firms, the *Roadmap* develops four building blocks.

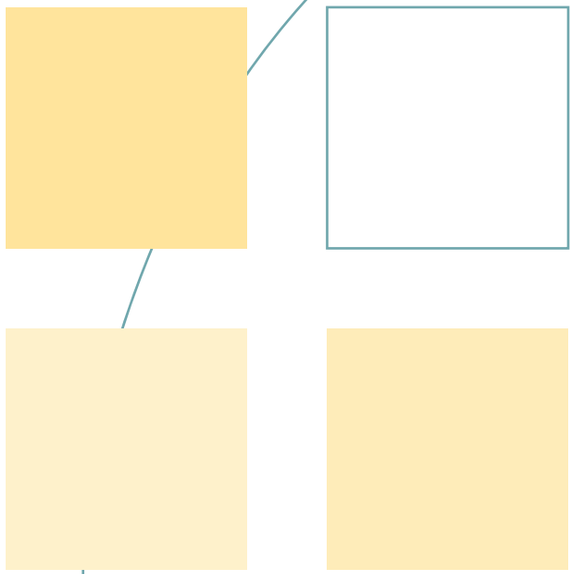
Building block #1: *Expand MassHealth eligibility* to cover children and parents with family incomes up to 200% of the federal poverty level, and childless adults with incomes up to 133% of poverty.

Building block #2: *Implement tax credits* for individuals with family incomes up to 400% of the federal poverty level. These credits would equal the difference between the health insurance premiums they pay and a specified percentage of income (on a sliding scale from 6–12% of income).

Building block #3: *Establish a purchasing pool* to provide access to increased plan choice for low-income individuals and small firms.

Building block #4: *Introduce government-funded reinsurance* to mitigate the effects of extraordinary medical expenses in small risk pools. This reinsurance would pay 75% of health care costs incurred above $35,000 for individuals with coverage either (a) in the nongroup insurance market or (b) through firms with fewer than 100 workers.

These building blocks, without any mandate, would reduce the number of uninsured in the Commonwealth by about one-third (from an estimated 532,000 individuals to an estimated 321,000), at a total government cost of $1.6 billion a year, although some existing spending could potentially be reallocated to help fund the expansion of coverage and some would be financed by federal matching payments.



Each Roadmap Option Includes a Mandate Requiring Individuals by Law to Have Health Insurance.

Achieving universal health insurance coverage requires mandates. Since employer-sponsored insurance is the cornerstone of the existing insurance market, many advocate an employer mandate. But requiring employers to offer their workers insurance is not enough to achieve truly universal coverage, because it does not require workers to take up the offered coverage and does not cover nonworkers—a group with particularly high uninsurance rates.

Two of the Roadmap Options Combine an Individual with an Employer Mandate.

The first *Roadmap* option includes an individual-only mandate. The other two combine an individual mandate with a mandate on some employers. The employer mandate would require employers to either offer their employees health insurance or pay an 8% payroll tax on half of the social security wage base for each employee.

We develop two employer mandate options. The broad mandate would cover all firms except the smallest (firms with fewer than 10 employers would be exempt). The narrow mandate would exempt all firms with fewer than 500 workers—increasing the role of the individual mandate in providing coverage to workers in smaller firms.

Although the Costs to Government Are Similar Under the Three Options, the Effects on Different Parts of the System Differ by Option.

Mandates would be required to cover the 321,000 Commonwealth residents who would remain uninsured after implementing the four building blocks. Following are highlights of the effects of the three *Roadmap* mandate options on different parts of the system:

MassHealth Enrollment: MassHealth enrollment would increase by an estimated 255,000 persons under the individual mandate, 233,000 under the narrow employer mandate, and 173,000 under the broad employer mandate. These represent increases in the share of nonelderly Commonwealth residents currently enrolled in MassHealth from 13.8% currently, to 16.8%, 17.8%, and 18.2%, respectively.

Coverage Through the Purchasing Pool: The purchasing pool would be used by an estimated 1.4 million persons under the individual mandate, 1.5 million under the narrow employer mandate, and 1.7 million under the broad employer mandate—24.1%, 26.4%, and 29.0% of the nonelderly population, respectively.

Government Costs: The four building blocks without a mandate would cost government an estimated $1.6 billion a year—leaving, as noted, over 300,000 Commonwealth residents uninsured. The individual mandate would add to this cost another $0.4 billion, the narrow employer mandate $0.5 billion, and the broad employer mandate $0.6 billion—yielding $2.0 billion, $2.1 billion, and $2.2 billion, respectively, as the estimated government cost of universal coverage. As noted, some existing spending could potentially be reallocated to fund the coverage expansion and some of the cost would be offset by an increase in federal matching funds.

Government spending would be higher under the employer mandates than under the individual mandate, primarily because more low-income people would enroll in the purchasing pool at a higher government cost than if they enrolled in MassHealth.

Employer Costs: Under the individual-only mandate, employer spending would increase by an estimated $210 million, because many people would judge themselves better off having their employers provide coverage than buying it themselves, even if it means some loss in take-home pay. Under the broad employer mandate, employer spending would increase a great deal more (by $765 million), primarily because virtually all employers would have to participate (either providing insurance or paying the tax), and some would have to spend more than previously to provide coverage up to the standards required by the mandate. The increase in employer spending under the narrow mandate would be lower, at $335 million, because it applies to fewer workers.

Individual and Family Costs: The three mandate options would not change overall individual and family spending. However, low-income families and individuals would save compared with their current spending because of the MassHealth expansions and the tax credits.

Universal Coverage Could Be Achieved Without a Major Revenue Increase

The Medicaid waiver renewal will continue to make $650 million in federal dollars available annually, as long as the Commonwealth identifies matching funds, for a total of $1.3 billion. Since the three *Roadmap* options range in cost from $2.0–$2.2 billion a year, $700–$900 million in additional revenues would have to be found. Adding in another $400 million for selected MassHealth provider rate increases and residual safety net funding, the overall additional government cost would be about $1.2 billion a year.

Covering Everyone Would Strengthen the State's Economy

This $1.2 billion amounts to only about 2% of total current health expenditures in the state and only 0.3% of gross state product and would yield an estimated $1.5 billion a year in benefits directly attributable to the economic and social benefits of improved health. It would also produce substantial, if unquantifiable, benefits in (a) worker productivity (and hence higher tax payments), (b) reduced pressure on emergency rooms and other parts of the public health care system, and (c) reduced financial strains on low-income families and the many small firms that now struggle to provide coverage for their workers.

We Can Get There from Here

None of the *Roadmap's* design features are new to the policy debate. All four building blocks have been implemented in some form by one or more states. Implementation details, though complex, can be worked through. 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. Here we highlight the most fundamental of the many implementation issues identified and clarified in the *Roadmap* papers, which can be downloaded at *www.roadmaptocoverage.org*.

Maximizing Federal Matching Funds: The federal government pays 50% of the cost of the state's Medicaid program (MassHealth) and 65% of the State Children's Health Insurance Program (SCHIP). One challenge in maximizing federal funds to the state is how to replace the state use of intergovernmental transfers (IGTs) as a source of Medicaid matching funds. IGTs currently fund a substantial portion of the state's Medicaid program. They have now been disallowed as a source of funds by the federal government and the state must find a way to replace them. Massachusetts has compiled a list of possible funding sources to do the job, but these must be approved by the federal government.

SCHIP can help fund expanded family coverage. Federal matching funds are available to expand SCHIP up to income cutoffs twice as high as those required by the *Roadmap* through a waiver. These funds could help fund the additional coverage of families envisioned in the *Roadmap's* expansion of MassHealth.

Developing Tax Credits: The application process for most tax credits (e.g., the federal earned income tax credit) is through the regular tax system. There must be a different application mechanism for any health tax credit, however, since people cannot wait until the end of the tax year to obtain the credit needed to pay their health insurance premium. Any end-of-year reconciliation can, as with other tax credits, be made through the family's overall tax liability.

Creating a Purchasing Pool: One of the fundamental issues here is whether the pool should be public or private. Although a public agency would facilitate integration with other parts of the system, employers, health plans, and brokers may all feel more comfortable with a private agency. Accountability could be assured through public agency oversight, at least in principle, although the amount of confidential income data that would be involved could make a private agency controversial in practice.

Creating a System of Reinsurance: The reinsurance system needs to cover all types of health plans, not just "insurers" as defined in existing state law. It should include firms that self-insure, for example, even though their inclusion adds considerable complexity. Another issue the state should consider carefully is which functions to contract out and to reserve for the state. The most important function of the system, of course, is to bear risk. Although this might seem an obvious function for the state, it may make better political sense to contract it out. Contracting out would give the message that the state's underlying intent is not to become an even larger purchaser of health care services.

Mandate Enforcement: Since the state's objective is to make health insurance affordable and available to all, the strong emphasis here should be on encouraging voluntary enrollment. All likely contact points for families and individuals should be engaged in outreach, including schools, motor vehicle registries, and providers. Employers can also play a pivotal role, even those that do not themselves offer coverage, although care needs to be taken not to overburden them in this effort.

The primary enforcement mechanism for individuals who remain uninsured should be the tax system (and providers for those who seek help while uninsured). For the employer mandate, it should be the Department of Revenue or the Division of Unemployment Insurance. Penalties on employers in the early years should be limited to payment of back taxes and very modest fines.

Assuring Cost Containment: There is no magic bullet for containing health care costs. Two of the *Roadmap's* building blocks should help control costs—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.

Timing: By design, the *Roadmap* builds on the Commonwealth's existing health care system. We describe a gradual but steady path to insurance coverage for everyone with minimum disruption of existing relationships. Implementation of the building blocks can begin as soon as enabling legislation is passed. MassHealth expansion should be feasible in Year 1. The other three building blocks rely on one another for implementation. All should be implementable by the end of Year 2. With these fully in place, concerns of availability and affordability disappear. The mandate(s), therefore, should be implementable in Year 4.

Thus, universal coverage in the Commonwealth of Massachusetts, if done according the *Roadmap's* policy and detailed implementation guidelines, should be achievable within four years after initial implementation has begun.

Note on Data and Methodology

The Urban Institute Health Insurance Reform Simulation Model predicts the effects of insurance reform options, compared with current law, on the basis of individual level data describing the characteristics of persons, families, and businesses that cause them to make their actual real-world decisions. This minimizes the number of assumptions required to estimate impacts. Adapted from a national model in order to reflect the distribution of individuals and employers in Massachusetts, the model also reflects the actual composition of risk pools in estimating the changes in costs to employers and individuals that would occur from a given health system reform.