You Can Get There From Here:
Implementing the Roadmap to Coverage

Alan Weil

Report for the Blue Cross Blue Shield of Massachusetts Foundation

October, 2005

roadmap
TO COVERAGE

FOUNDATION
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

October 7, 2005

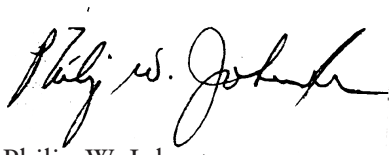
The *Roadmap to Coverage* is an initiative designed to inform the debate about how to provide health coverage for the uninsured in Massachusetts and generate a practical roadmap for achieving that goal. Major funding for the project has been provided by Blue Cross Blue Shield of Massachusetts with additional 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.

This report, the third in the series, provides an overview of the steps that would need to be taken to successfully implement the *Roadmap* coverage expansion options and the sequence and timeframe for completing them. It summarizes six reports which provide extensive detail on each of the following topics: expanding eligibility for MassHealth; creating a purchasing pool; creating a system of publicly financed reinsurance; developing tax credits to subsidize the cost of coverage; enforcing individual and employer mandates; and approaches to cost containment. Detailed reports on each of these topics are can be accessed at www.roadmaptocoverage.org.

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



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Contents

Introduction 5

I. Implementation of the Major Tasks 7

II. Expanding Eligibility for MassHealth 9

III. Creating a Purchasing Pool 13

IV. Creating a System of Reinsurance 19

V. Developing Tax Credits to Subsidize the Cost of Coverage 23

VI. Enforcing Individual and Employer Mandates 27

VII. Assuring Cost Containment 33

VIII. From Here to There 39

About the Author 41

Funding for this report was provided by the Blue Cross Blue Shield of Massachusetts Foundation. The views presented here are those of the author and should not be attributed to the Foundation or its directors, officers, or staff.

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

The *Roadmap to Coverage* describes a series of options that would enable Massachusetts to achieve universal health insurance coverage. These options represent a set of ambitious, but realistic, approaches for how one state can make substantial progress on an issue that has bedeviled the nation for decades. All the options start with four building blocks: (1) a MassHealth expansion, (2) a system of financial subsidies for low and moderate income families, (3) a purchasing pool, and (4) a publicly financed reinsurance mechanism. These building blocks would cover many people but would not achieve universal coverage. The *Roadmap* proposes three additional options that would yield universal coverage: an individual mandate to purchase coverage, an individual mandate combined with a broad employer mandate to provide or pay for coverage for employees, and an individual mandate combined with a narrow employer mandate that would only apply to large firms.

All four building blocks have been implemented in some form by one or more states, although never together and never as part of a comprehensive plan to attain universal coverage.[1] While the mandatory features of the *Roadmap* have been considered by policy analysts over the years, they have not been implemented by any state. Their familiarity makes such policy ideas seem straightforward, but they are actually quite complex when it comes time to implement them.

Thus, it is critical to consider the details of implementation before such policies are adopted so people have a realistic sense of the timeline of events, the roles to be played by many actors in the public and private sectors, and the resources required to get the work done. Legislators may set the broad course, but policy implementers make hundreds of small decisions that represent policy as surely as any statute. Policy design and implementation must be viewed together if we are to understand the real implications of any proposal.

[1] 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.

The first step in implementation is enactment by the General Assembly and signature by the Governor of legislation that includes the major provisions of the *Roadmap*. These provisions would need to include the four building blocks, selection of one of the options for mandatory coverage, and mechanisms to pay for the state's share of costs associated with the overall plan.

While the state's political leaders have expressed interest in expanding coverage in Massachusetts, their preferred methods differ. The importance Massachusetts voters ascribe to this issue, the existence of ambitious plans to expand coverage, and the Commonwealth's experience making progress on health coverage all point to the possibility of compromise to achieve universal coverage. Still, the political challenge involved is substantial.

I. Implementation of the Major Tasks

This paper describes the steps necessary to implement the *Roadmap* proposals. It sets forth a realistic schedule for completing the tasks necessary for successful implementation. It also discusses significant policy decisions that would need to be made along the way—decisions that would take the *Roadmap* from its broad policy outline to the specifics of public policy on the ground.

Much of this paper represents a summary of six papers, published at *www.roadmaptocoverage.org* that were commissioned by the Blue Cross Blue Shield of Massachusetts Foundation as part of the *Roadmap* initiative. For readers who wish to explore implementation issues further, these papers provide extensive detail on each of the major implementation areas highlighted in this summary.

The six major tasks involved in implementing the *Roadmap to Coverage* policy options are:

Expanding eligibility for MassHealth, described by Mark Reynolds

Creating a purchasing pool, described by Elliot Wicks

Creating a system of reinsurance, described by Randall Bovbjerg and Elliot Wicks

Developing tax credits to subsidize the cost of coverage, described by Alan Weil

Enforcing individual and employer mandates, described by Linda Blumberg, Randall Bovbjerg, and John Holahan

Assuring cost containment, described by Robert Berenson

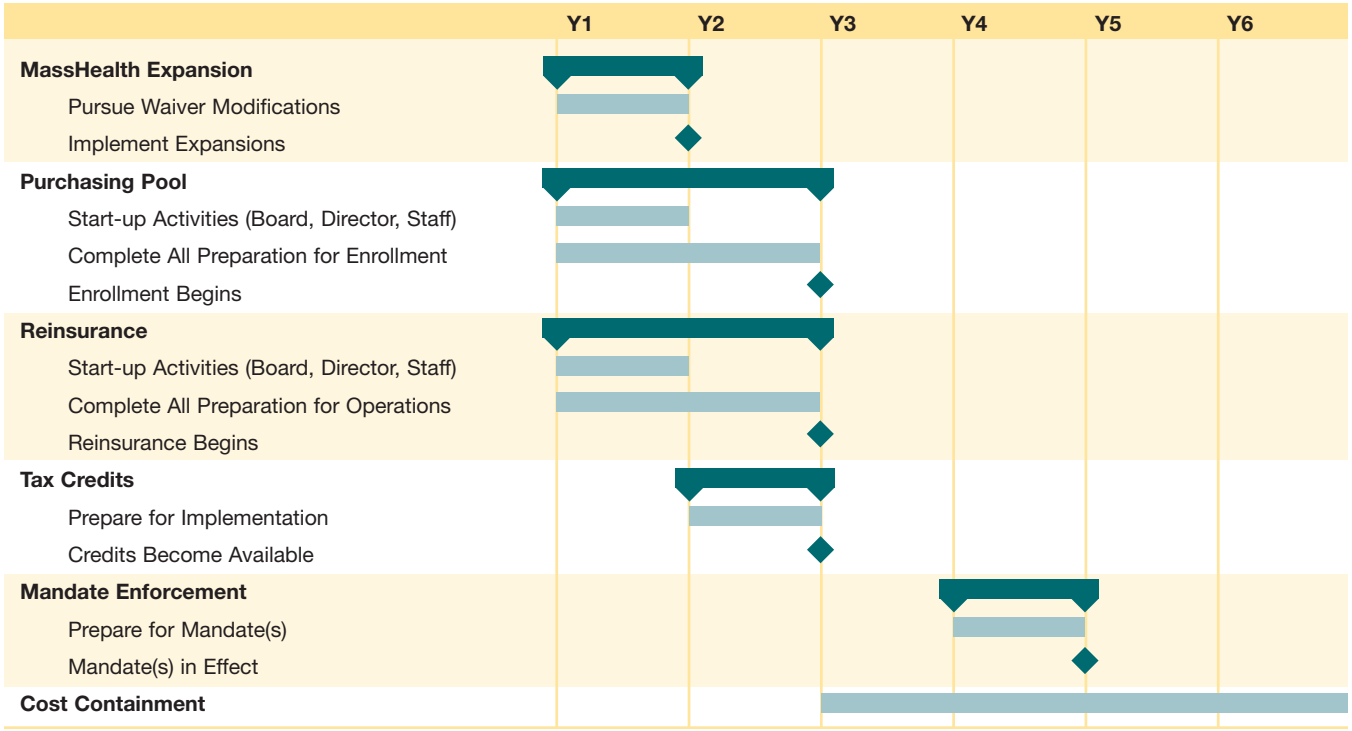
This paper summarizes the steps necessary to complete each of these tasks. Some of these steps can take place concurrently; others are sequential. The tasks are described in a slightly different order here than in other *Roadmap* papers. This reflects the fact that certain tasks build on others and presentation of some tasks is easier if other tasks have already been described.

The MassHealth expansion, purchasing pool development, reinsurance system, and system of tax credits can all be pursued simultaneously. The MassHealth expansion can be implemented fairly quickly—in the first year. The pool, reinsurance, and tax credits all rely upon each other for successful implementation. Preparation for the most complex of these tasks—setting up the purchasing pool—could take two years. Therefore, all three can be implemented at the end of the second year.

The mandates should follow the earlier tasks by two years to be sure that all of the building blocks are operating properly and any implementation concerns have been resolved. Whether the individual mandate is implemented in conjunction with an employer mandate or alone, all mandates should be put in place simultaneously to minimize disruption. Therefore, universal coverage, if done according to the Roadmap's policy guidelines and implementation recommendations, should be achievable within four years after initial implementation has begun.

Cost containment measures can be taken at any time. Since many of them would be most effective if implemented after the pool is operational and some would only be pursued if the pool is unsuccessful in controlling costs, the bulk of cost containment activities should be pursued in year three or later.

A Gantt chart showing the time line appears below.



II. Expanding Eligibility for MassHealth*

The first building block of the *Roadmap to Coverage* options is an expansion of MassHealth eligibility to 200% of the federal poverty level for children and parents and 133% of poverty for adults without children. This would take place through a combination of expanding Medicaid and SCHIP eligibility. While the proposed eligibility levels represent an increase for Massachusetts, they are not particularly high by regional standards.

From a technical perspective, expanding MassHealth is straightforward. Once legislation is enacted to change the eligibility threshold, the MassHealth agency would put into motion a series of changes. Computer systems would have to be modified to reflect the changes, and outreach would need to be conducted to inform citizens, providers, and other state agencies of the new standards. No new eligibility forms or processes would be required.

The primary consideration in implementing a MassHealth expansion would be to ensure that the maximum amount of federal matching funds flow to the Commonwealth to help pay for it. The federal government pays for 50% of Medicaid costs and 65% of SCHIP costs in Massachusetts, making the availability of federal resources a major consideration.

The challenge for Massachusetts is that it currently operates its Medicaid program (MassHealth) according to the terms of a federal waiver granted under Section 1115 of the Social Security Act. The waiver, granted initially in 1997 as a mechanism for achieving a substantial expansion of coverage, also gives the federal government a greater amount of control and discretion regarding MassHealth than would be the case if the waiver were not in place. To make matters more complex, the Commonwealth recently completed negotiations with the federal government on its second waiver renewal. Thus, decisions being made today or in the near future will affect the ability of the Commonwealth to pursue the policies described in the *Roadmap*.

*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.

The original waiver expanded MassHealth eligibility, brought in additional federal funds, and allowed the state to move some costs that had previously been borne entirely by the state under the Medicaid umbrella, thereby making them eligible for federal matching funds. The waiver included provisions that direct financial support to two of the state's key safety net hospitals (Boston and Cambridge) in conjunction with those hospitals developing managed care plans for their Medicaid-enrolled patients. In prior years, the state had recategorized financing for the Uncompensated Care Pool as payments under the Disproportionate Share Hospital program (DSH), thereby bringing in additional federal funds. When Massachusetts implemented its SCHIP program, that became part of the waiver.

The existence of the waiver creates three types of complications that must be resolved: budget neutrality, the source of state matching funds, and the structure of coverage for low-income families.

Budget Neutrality

According to federal Office of Management and Budget (OMB) rules, a waiver must be "budget neutral," meaning that the expected cost to the federal government of the program under the waiver cannot exceed what the cost would have been without it. MassHealth currently operates beneath its budget neutrality cap, but the current waiver renewal adopts a slowed rate of projected growth, meaning the gap between expected spending and the cap will narrow.

Budget neutrality calculations and negotiations are complex. The Centers for Medicare and Medicaid Services (CMS) currently estimates that the state will be within $800 million of its 11-year aggregate spending ceiling by the end of the new waiver. The state believes that it will be even closer to the ceiling. As the state approaches the ceiling, it loses flexibility that it might otherwise have in negotiating the terms of future waivers. When the state hits the cap, no additional federal funds are available even if state costs rise. This would increase the state's share of the burden of funding the *Roadmap*.

The waiver renewal contains a provision that requires the budget neutrality figure to be recalculated if there are federal statutory changes in the program. Changes such as a national reduction in DSH payments would automatically lower the spending ceiling for Massachusetts. Thus, the state must be prepared for the possibility that federal funds will decline below those agreed to in the waiver.

An important area of uncertainty is how much of the *Roadmap*'s MassHealth expansion can take place outside the budget neutrality constraint. Increased enrollment by those currently eligible for MassHealth certainly falls outside the budget neutrality constraint. Since Massachusetts has the legal authority to increase eligibility for families to 200% of poverty without a waiver, costs associated with such an increase should not be required to fall within budget neutrality. Under normal circumstances this argument would succeed, but it is complicated by the fact that family coverage is

part of the existing waiver. While being out from under the budget neutrality cap does not help Massachusetts come up with its share of the funding, it assures that federal funds will flow on a matching basis without being subject to a cap.

A portion of the MassHealth expansion can rely upon SCHIP funds. The Commonwealth believes it has sufficient funds within its federal SCHIP allocation to cover children up to 400% of poverty. Because the *Roadmap* only calls for coverage to 200% of poverty, Massachusetts could seek a waiver to cover some share of families up to this threshold using SCHIP funds. The coverage would be identical to MassHealth, making it transparent to the families, but the federal matching share would be larger and the funds would not count against the Medicaid budget neutrality cap.

Source of State Matching Funds

Most revenues Massachusetts uses to support its Medicaid program come from general sources, such as personal and business income taxes and sales taxes. However, the Commonwealth has undertaken a number of initiatives to generate revenue from narrower bases. Specifically, the state has used intergovernmental transfers (IGTs) from local governments and the state university, and assessments on providers, to generate some of the state's share of the Medicaid expenditure.

A key feature of the new waiver is the federal government's decision to no longer accept IGTs as a valid source of state matching funds, effective June 30, 2005.[2] The Commonwealth has two likely sources available to replace IGTs. One source is Certified Public Expenditures (CPEs) that, like IGTs, are made by a public entity. Unlike IGTs, that are a cash transfer from the local government to the state, CPEs represent a specific (and, therefore, auditable) expenditure by the local entity. Under the terms of the waiver, the source of funds for the CPE must be tax revenues, and the level of spending must be tied to Medicare cost reports.

The second likely source of funding is existing state expenditures that are consistent with the goals of the Medicaid statute in that they provide funding for services delivered to a low-income population. Possible sources include spending on the Children's Medical Security Plan, some spending by the Uncompensated Care Pool, and some programs administered by other state agencies. The Commonwealth has developed a list of $700 million dollars worth of such spending, but the federal authorities have a great deal of discretion in how much of this list they will accept.

The prohibition against IGTs, along with a reduction in federal funding for adults residing in Institutes for Mental Disease, create a shortfall in state spending of $606 million that must be replaced in order for the state to continue to draw down approximately $650 million of federal funds. If the strategies listed above are accepted by federal officials, the gap will be filled. If those strategies are rejected, the Commonwealth will need to commit another source of revenue in order to continue to receive matching federal funds.

[2] It is worth noting that the existing IGTs are not part of the current waiver, but the federal government would not renew the waiver unless the IGTs were eliminated.

Structure of Coverage for Low-Income Families

The Commonwealth currently makes Medicaid expenditures under the waiver in a variety of ways. One component of current expenditures is supplemental payments to certain managed care organizations that serve Medicaid patients. This component is disallowed under the terms of the waiver renewal. It is replaced with an "actuarial soundness" standard that applies to all Medicaid managed care plans.

While constraining the state in this manner, the terms of the waiver are otherwise quite flexible regarding how certain Medicaid funds will be spent. The waiver calls for creation of a Safety Net Care Pool (SNCP), which has not yet been defined. The SNCP could supplement Medicaid rates or pay for services for people who are uninsured. As with other aspects of the waiver, while the terms are flexible, they are subject to approval by CMS.

A large portion of the MassHealth expansion, tax credits and reinsurance in the *Roadmap* could, in principle, be funded through the SNCP. In practice there are two barriers. First, the size of the SNCP was calculated by looking at existing funds, which have existing recipients. These recipients—primarily safety-net providers—will resist reallocation of these funds to other purposes unless they are confident their uncompensated care burden will fall by an equal amount. This will be a difficult case to make until the Commonwealth has in place a system of truly universal coverage, which is still some years down the road. Second, if Governor Romney develops and obtains state legislative and federal administrative approval for his version of the SNCP, additional time will be required to obtain federal permission to modify the design to match that of the *Roadmap*.

It is important to note that the SNCP portion of the waiver has a cap of about $1.35 billion per year of combined state and federal funds. Since this amount is fixed in nominal terms over the life of the waiver, as health care costs rise, these funds will represent a declining share of the overall cost of the *Roadmap*.

Concluding Comments on the Expansion of MassHealth

The new waiver agreement presents a series of challenges and opportunities for implementing the MassHealth expansion component of the *Roadmap*. The primary challenge is substantial new restrictions on what state revenue sources are eligible for federal matching funds. In order for the *Roadmap* to be affordable to Massachusetts, the state must do all that it can to preserve the existing level of federal support, and identify additional sources of matching funds for the new commitments the state will be making. The primary opportunity is the high degree of flexibility CMS indicates it will give the state in defining the SNCP. If sufficient funding can be identified, it should be relatively easy to obtain approval for using federal funds to support the building blocks of the *Roadmap*.

III. Creating a Purchasing Pool*

In the *Roadmap* the purchasing pool proposed is not an insurer, but an entity that helps organize the health insurance market. Health plans could offer coverage through the pool, and any individual, family, or employer would be able to buy coverage through the pool, although coverage would also be available elsewhere and pool participation would be entirely voluntary. The pool would handle plan enrollment, premium collection, and disbursement to the health plans. A key feature of the pool is that individuals and families eligible for a tax credit would only be able to apply that credit against coverage purchased through the pool.

Purchasing pools of varying sizes exist around the country, and Massachusetts can learn a great deal from the experience of these pools in developing its own. The first lesson is that a larger pool has many advantages, and the *Roadmap* anticipates a sizable pool. The largest and most successful pools are the Federal Employees Health Benefits Program (FEHBP) and CalPERS, but a few private pools also have substantial enrollment and longevity.

First Design Issues

The first step in creating the pool is deciding who would run it. The pool can be operated by a public agency or private organization, and there are arguments for either choice.

A primary reason for selecting a public agency to run the pool is that the pool's functions would need to be closely integrated with other public programs and agencies, such as MassHealth and the Department of Revenue. Confidentiality and coordination would be paramount, and they may be easier to ensure in a public agency. In addition, the pool would make many decisions with substantial implications for the success of the *Roadmap* endeavor. Public administration would assure public input into and accountability for these decisions.

*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.

If public administration is preferred, there is still the choice of which agency should house the pool, or whether a new one should be created—a choice that must balance the benefits of continuity against concerns that an existing administrator has practices and "baggage" that will carry over to the new pool function. This is of particular relevance for the Group Insurance Commission (GIC), which purchases coverage on behalf of state employees. The GIC certainly has expertise in the functions the pool would need to perform. But it also has developed relationships and a reputation in the health care community that would have consequences both positive and negative in achieving success with the new pool.

A private organization would likely have more flexibility in hiring and making policy decisions. Also, as discussed below, the pool will need to have good relations with employers, health plans, and brokers, all of whom may feel more comfortable interacting with a private entity. Most private pools are operated not-for-profit. A private pool would still be overseen by a public agency and would be selected through an RFP or similar process, which would assure a level of public accountability.

Whether public or private the pool would need a governing board, staff director, staff, and other hired expertise. Because the pool's objective is to be an effective purchaser, the board should represent purchasers (employers, employees, and individuals) and have other expertise. At the same time, it would have to exclude insurers, agents, and health care providers whose interests may not align with those of purchasers. The board would then need to develop a job description for an executive director, conduct a search, and select a candidate. The executive director would hire staff and select additional sources of expertise such as legal counsel and actuarial knowledge.

The pool would also need to select a plan administrator to conduct certain functions for the pool: enrollment, premium collection, transfer of funds to health plans, and customer service. Purchasing pools generally contract out these functions to entities that have experience with them, because they are highly specialized functions, require substantial personnel, but are not policy making.

Selecting Health Plans

Many of the pool's implementation activities and design decisions would revolve around selecting health plans that would offer coverage through the pool. The experience of most pools is that once the key staff are in place these tasks take a minimum of a year. The pool envisioned in the *Roadmap* has more complex functions than are typical, meaning these functions may take longer.

The goal of such pools is to leverage the power of purchasers so health plans understandably approach them with some trepidation. Yet these pools offer health plans potential access to a large number of new customers, providing a strong incentive for participation. The experience of purchasing pools around the country is that health plans must be treated as partners from the outset. Their concerns must be heard and their experience relied upon to design the pool in a manner that encourages their participation, even as it forces them to confront a well-organized purchaser with whom they must negotiate.

Health plans for the pool would be selected through some sort of an RFP process that may be more or less formal depending upon whether the pool is public (and thereby required to follow certain procurement rules) or private (in which case it will still likely want to follow a structured process, even if a less formal one than state procurement rules require).

In designing the plan selection process, the pool will need to make some fundamental design decisions. One decision is whether to be a price taker or a price negotiator. The former implies that the pool accepts bids as submitted by plans; the latter implies that the pool uses the bids as a starting point in negotiation to obtain better terms. The evidence is not clear that one method is "better" than the other, but larger pools all operate as negotiators, not simply price takers.

Another decision is whether to accept all plans that meet the basic bidding requirements or to limit the number of plans the pool will select. More health plans mean more choices for consumers, but also a heavier educational and oversight burden for the pool. Limiting the number of plans gives the pool more leverage since it has the power to reject a plan entirely. But limiting participation also creates the risk that the pool becomes captive to the demands of a small number of plans. This risk can be reduced through regular rebidding of plan contracts to encourage new applicants and entrants. If the pool decides to limit the number of plans, it would have to define its basis for selecting from among the qualifying plans. In addition, since the *Roadmap* ties the value of the tax credit to the median plan selected by enrollees, allowing higher priced plans could drive up the cost of the credits, thereby increasing the *Roadmap's* overall cost.[3]

The third decision is to design the benefit packages to be offered in the pool. The pool described in the *Roadmap* will need to approach this issue somewhat differently than other pools have. Coverage offered in the pool is targeted to moderate income individuals and families, and therefore must have more limited cost sharing (copayments and deductibles) than existing pools in other states. Within that constraint, the pool would be responsible for taking the general outline of benefits described in the *Roadmap* (and presumably included in the enabling legislation) and converting it into a specific list of covered services and cost sharing provisions. This process would need to occur before the pool solicits bids from health plans, and would need to be repeated regularly to keep up with changes in the market.

The fourth decision is how to structure the way premiums vary across people and groups. One of the clear lessons from existing purchasing pools is that they must follow the same rating practices as exist outside the pool, or they run the risk of attracting unfavorable risks. The purchasing pool would need to adopt the same restrictive rating rules as are employed in the broader Massachusetts small group and individual markets.

The fifth decision is how to design the risk adjustment mechanism. Health plans are understandably concerned when they enter a new system of marketing that they will

[3] This concern could be addressed by changing the way the "benchmark" plan is defined.

attract an inordinate share of less healthy and more expensive enrollees. One risk is that the pool as a whole would attract a more expensive population, in which case all plans may bid too low and suffer losses due to participation in the pool. This risk is minimized in the *Roadmap* by the existence of substantial subsidies for many enrollees, thereby making the pool more likely to attract a broad range of risk. It would also be reduced substantially by the existence of a public reinsurance system (described in the next section). And, if an individual mandate were put into place, another possible source of risk selection would be eliminated. Ultimately, if adverse selection against the pool occurs, it may be appropriate to explicitly subsidize the higher cost of pool participants with public funds.

The risk that a particular plan within the pool would attract a higher risk population than other plans is best mitigated by adopting standard benefit packages that all plans must offer. Even this approach does not eliminate the possibility of risk segmentation, so the pool should develop a risk adjustment mechanism that reallocates resources across participating plans based on the risk profile of their actual enrollees. A number of options for risk adjustment systems exist and they would need to be reviewed and one selected.

Once all of these decisions are made the pool would be ready to solicit bids from plans, evaluate those bids, and select plans for inclusion in the pool.

Additional Tasks

The pool would need to recruit agents and brokers to assist in selling the products in the pool. Experience shows that building this link is critical to attract employers' participation.

The pool would also need to market itself to employers, employees, and other individuals and families. Since the pool is an unfamiliar method for obtaining health insurance people would need to understand how the pool works and why they would benefit from purchasing coverage through it. Marketing for the pool would need to be closely tied to marketing for the new tax credits since a primary benefit of purchasing through the pool would be the availability of subsidies.

The pool would need to develop enrollment mechanisms to cover different situations. Some employers would elect to cover their employees through the pool, and they would enroll as a group. Some individuals would enroll in the pool to obtain tax credits. Some of these individuals would be employees of firms, and others would be self-employed or unemployed and would have no relationship with an employer. If the Commonwealth adopts an employer pay-or-play requirement, some pool enrollees would work for firms that "pay." Each of these situations would require a somewhat different arrangement with the enrolling individual and the individual's employer.

The pool would need to coordinate its activities with the entity that administers the tax credits (to be discussed below). The price individuals and families face when they purchase coverage from the pool would be dependent upon the tax credit they receive. Therefore, the pool would need immediate and accurate access to tax credit

information as part of its enrollment processes. Similarly, the pool would need to report to the Department of Revenue information regarding who obtained coverage through the pool to enable the tax credit value to be reconciled.

The pool would also need to handle the flow of funds between the state and the health plans. Disbursement of funds, though a normal pool function, would be more complex under the *Roadmap* because of the need to combine individual and employer payments with tax credit funds. The pool and the state would need to develop a system of transferring tax credit funds to the pool so they can be disbursed to the enrollees' health plans.

Finally, in the case of an individual and/or employer mandates, the pool may need to share information with the entity enforcing the mandate. Since pool enrollment would be quite large, it would be efficient to rely upon the pool to report who has coverage (for the individual mandate) and which firms are purchasing coverage through the pool (for the employer mandates).[4]

Concluding Comments on the Purchasing Pool

The pool envisioned in the *Roadmap* performs many functions that are identical to those of existing public and private pools around the country. The experience of these pools provides a solid foundation for determining the steps necessary to complete implementation. But the new pool would also have functions that are not typical for existing pools—particularly those functions related to administering tax credits—the development of which would require particular attention as the pool begins operation.

[4]As discussed later, the necessary information could also be provided by the health plans.

IV. Creating a System of Reinsurance*

The *Roadmap* system of reinsurance would cover 75% of the costs above $35,000 per year for enrollees in the non-group market and in firms with fewer than 100 workers. This reinsurance would apply to all coverage sold, whether through the pool or outside, and would cover self-insured firms as well. Financing would come from general state revenues.

The reinsurance mechanism is designed to serve three purposes. First, by shifting the cost of high-cost cases from individual carriers to the broader tax base, the purchase price of coverage declines, making it more affordable. Second, the variability in claims costs for carriers declines, reducing the "risk premium"—another factor in insurance costs. Third, reinsurance reduces the risk that any carrier or the pool as a whole will experience adverse selection, making participation in the market more attractive for health plans and reducing the burden on the risk adjustment mechanism used by the purchasing pool.

The reinsurance system proposed in the *Roadmap* differs importantly from the reinsurance many insurance carriers purchase on their own in the private market. While both products shield the carrier from excess risk, private reinsurance is experience rated and paid for entirely by the purchasing health plan. This has the effect of spreading risk across time, which enables smaller plans to participate in the insurance market. The system proposed here also differs from mandatory or optional reinsurance that some states, including Massachusetts, include in their small group insurance reforms and their use of managed care plans in Medicaid. The existing systems are generally funded by an assessment on plans; they are not typically subsidized by the broader tax base.

*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.

Implementation would begin with passage of enabling legislation. This legislation should be fairly broad in its terms to give the reinsurance administrator sufficient latitude to make decisions along the way that are necessary for proper program design.

First Design Issues

The first design decision is which entity should be responsible for implementing and operating the reinsurance system. One possible location would be the Division of Insurance, because it already regulates insurance and oversees the existing small group reinsurance system in the state. Another option would be the agency that administers the new purchasing pool, because the reinsurance system must operate in close conjunction with the plans in the pool. The agency chosen to be responsible for general oversight for the *Roadmap*, whether new or existing, would also be a logical home for the reinsurance activities. A final choice for this responsibility could be a quasi-governmental entity that operates outside the existing agency structure but has a publicly appointed board.

As with the purchasing pool, the first step in setting up the reinsurance system involves selecting a board. Unlike the pool, which is designed to act specifically on behalf of purchasers, the reinsurance board could include providers and health plan representatives as well. The board would need a budget and should begin by hiring an executive director who would then hire appropriate staff and consultants.

The reinsurer would need to decide which functions to perform itself and which to contract out to other entities. As noted in the discussion of the purchasing pool in the prior section, contracting out can be a mechanism for obtaining expertise but also creates increased responsibility for oversight.

The primary function of the reinsurer is to bear risk. The state could bear that risk itself, appropriating necessary funds to cover the cost or creating a trust fund to smooth out annual fluctuations in cost. Alternatively, the state could purchase reinsurance as a private health plan would. While it may seem obvious that bearing risk should be a function performed by the state—the state certainly has sufficient resources to cover the risk—there are advantages to purchasing reinsurance. One advantage is that the premium cost for the coverage could be more predictable, although there are ways to stabilize the state's cost if it bears the risk itself. Perhaps more important is the message that purchasing reinsurance sends—that the state does not intend to become an even larger purchaser of health care services itself. Between the MassHealth expansion, the purchasing pool (if it is administered publicly) and the reinsurance system, the Commonwealth would exert substantial control over the payment of a large share of the health care costs in the state if the *Roadmap* were implemented. This control has its benefits, but it would certainly be viewed with concern by some.

What Does Reinsurance Cover?

An important design decision is defining the portion of the health insurance market to be covered by the reinsurance system. The system should cover all types of health plans, not just "insurers" as defined in existing state law. It should cover Blue

Cross/Blue Shield plans, health maintenance organizations (HMOs), and any other type of risk-bearing plan that fits within the *Roadmap's* definition of health plan coverage. It should also cover firms that self-insure even though including these firms adds substantial complexity.

The *Roadmap's* reinsurance system would cover individuals and groups up to 100 people. Determining the size of the group requires defining how to count part-time and seasonal employees, and whether or not to combine the employees of firms with multiple locations. The goal in making these decisions should be to adhere as closely as possible to existing definitions used by the Division of Insurance in regulating the small group market.

Another important design decision is to define what is covered by the reinsurance system. The *Roadmap* calls for coverage of 75% of costs above a threshold of $35,000. There is a good argument to be made that the Commonwealth should be open to modifying these amounts based upon experience in Massachusetts and elsewhere. Ceding more risk to the reinsurance mechanism could increase the benefits of having it in place. However, those benefits would need to be weighed against the greater cost the state would incur.

The reinsurance payer must define with precision which claims it will pay and how much it will pay for those claims. This requires defining covered services, any limitations on those services, and a payment rate for each service. These items should presumably be tied to a benchmark or other standard insurance contract offered through the pool. The reinsurer would also need to coordinate its coverage with a broad range of other policies purchased outside the pool or provided by self-insured employers.

Reinsurance covers costs that exceed a certain threshold for the year, which means that the "year" needs to be defined. While a calendar year makes intuitive sense, the reinsurance system would be an overlay on top of coverage that begins and ends at varying times throughout the year, and covers people who may have partial year coverage or coverage by different plans during the year. These definitions must be established and understood by the various health plans.

Additional Tasks

A major operational function of the reinsurer would involve interaction with health plans and firms that self-insure. These interactions include education regarding the terms of coverage, development of administrative systems to handle claims, resolution of disputes, and various data transfers. Relations with health plans will be complex, but should be manageable given the concentration of the market (five plans account for 85% of current small employer market enrollment in the state). A far greater challenge would be interactions with the many self-insured employers, although those interactions may be simplified by working through the employers' third-party administrators. The reinsurer could plan to conduct these functions itself or hire a contractor to perform the tasks.

The reinsurer would have to make a similar set of decisions regarding a broad range of operational tasks. Some entity must receive claims from health plans, verify the eligibility of the plans and covered lives for participation in the reinsurance system, review and process the claims, pay the claims, and audit them as necessary. States routinely contract out for functions such as these, particularly in their Medicaid programs, although the state could perform this function in-house if it chose to do so. If Massachusetts chose to contract out this function, it could turn to the experience of the two existing reinsurance pools in the state (for nongroup and small-employer coverage).

The reinsurer should consider adopting a practice used by private reinsurers, which is to require advance notice as people approach the reinsurance cost threshold. This notice permits the reinsurer to become engaged in how care is delivered to that person before the reinsurer becomes financially responsible for the costs. The reinsurer can propose various care and case management tools designed to hold down costs.

Coordination of costs and care requires substantial data transfers between health plans and the reinsurer. The costs of such transfers could be minimized if the reinsurer develops automated mechanisms for sharing data. Operational decisions, such as whether to pay reinsurance claims as they occur or only in the aggregate at year end, also have significant implications for the cost and efficiency of the system.

Concluding Remarks about Reinsurance

Many private health plans purchase reinsurance, some public purchasers provide participating plans with reinsurance, and some individual and small group markets, including those in Massachusetts, have a reinsurance component. These various systems differ in important ways from the reinsurance anticipated in the *Roadmap*. Even so, the steps they go through and the choices they make in developing their systems provide important information to guide implementation of a reinsurance system as part of the *Roadmap*.

V. Developing Tax Credits to Subsidize the Cost of Coverage*

The *Roadmap's* system of tax credits would subsidize the cost of coverage for individuals and families by capping the amount an eligible family must pay at between 6 and 12 percent of family income, with the percentage increasing as income increases. Once a family's income reaches 400% of poverty it would no longer be eligible for the credit. These cost caps are for a "benchmark" plan, which represents the median plan chosen by participants in the purchasing pool. Families wishing to purchase a more expensive plan would pay the full difference on their own.

A typical tax credit is obtained when a person files a tax return, and this credit can certainly be obtained in that manner. However, the goal of this credit would be to provide people with the funds they need during the course of the year so they could afford to purchase insurance coverage. This discussion focuses on how people would receive the credit in advance since that is the more complex aspect of implementation.

Since the *Roadmap* includes an expansion of MassHealth eligibility to 200% of poverty for families and 133% for adults without children, the bulk of the population using tax credits would have incomes between 200% and 400% of poverty. At the lower end of this range are families who may move into and out of eligibility for MassHealth; at the upper end are families with incomes below the state median, but still with substantial resources.

Families Using the Tax Credit

There are two ways families would become interested in using the tax credit to subsidize the cost of insurance obtained through the pool. Some people, particularly those with lower incomes, would seek assistance from the Commonwealth not knowing in what form it might come. They might believe they are eligible for MassHealth, but

*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.

upon application learn that they are not. This would be an excellent opportunity to inform them that they could obtain subsidized coverage through the pool. Other families, particularly those with higher incomes, would learn specifically of the tax credits and be interested only in them. Both of these situations need to be accommodated.

For people interested generally in obtaining assistance, the tax credit application should be tied to the existing Medical Benefit Request (MBR) that is used for MassHealth, the uncompensated care pool, and other related programs. Combining the applications has the advantage of enabling people who apply for one program to learn of their eligibility for a different program at the same time. Dissemination of the MBR is already quite broad. MassHealth eligibility processing, however, is centralized. Processing of tax credit applications should be integrated into the current MBR processing.

For people who are only interested in the tax credit, a separate, short application could be made broadly available. This would be an application to receive the credit in advance over the course of the year. It could be accepted at many locations and processed centrally as occurs with the MBR.

A critical implementation step would be to communicate with families the value of the credit. This step requires some clarification. The actual dollar value of the credit is somewhat difficult to explain, but it would not be the information that the family needs. From the applicant's perspective what matters is the price of health insurance net of the credit, and this calculation is fairly straightforward. For example, if a family of four has annual income of $45,000, the benchmark plan is available to them at a cost of $4,500 per year (10% of their income). The value of the credit would be the underlying cost of that plan, perhaps $11,000, minus $4,500, or $6,500. But it would be the $4,500 figure that is relevant to the family. If other plans are available through the pool with underlying costs of $10,500 and $12,000, the family would have to pay $4,000 and $5,500 for them, respectively.

The result of the tax credit application, whether submitted on its own or integrated into the MBR, would be a list of plan options for the applicant and the out-of-pocket premium cost of each option. With this information, the applicant could go directly to the pool and select a plan. The pool would invoice enrollees and establish procedures for collecting payments. At the outset, the pool would need to set policies regarding collecting delinquent payments and disenrolling people for failure to pay premiums. Once a mandate was in place, these policies would change since back-premiums would be collected through the tax system.

To assure that the pool had sufficient funds to pay the plans, the pool would submit a list of enrollees and the credits they are due to the Department of Revenue, which would transfer to the pool the value of the credits associated with these enrollees. The pool would then distribute tax credit funds, along with premiums paid, to the enrollees' health plans.

Employers and the Tax Credit

Some tax credit recipients would be enrolled in the pool because their employer purchases coverage through the pool. In this case the employer would pay the pool directly, but the employee's contribution toward coverage would be reduced by the amount of the credit. That means each employee must apply for the tax credit and on the application note that they will be obtaining coverage through their employer. The tax credit calculation would report the maximum premium the employee must pay. The employer would use that information to reduce withholding from the employee. The balance due to the pool would flow directly from the Department of Revenue to the pool.

Some tax credit recipients would purchase from the pool even though their employer provided coverage elsewhere. These employees would relate to the pool in the same manner as someone who buys coverage directly from the pool (described above), but the pool would seek payment from the employer to collect what the employer would have contributed to that employee's coverage.

If the Commonwealth adopts an employer pay-or-play approach, some tax credit recipients would work for firms that "pay." These employees would obtain coverage directly from the purchasing pool, but the price of their insurance would be discounted to reflect the fact that their employer would be making a contribution. In this scenario the tax credit application would need to include information on the employer's decision to "pay."

Year-End Reconciliation

There would need to be a process for reconciling the tax credits received by applicants during the year with the actual information they provide on their tax return due April 15. In most instances this would be straightforward. The tax return would show the family's income, while the pool would report the period of coverage. Any difference between the credits received during the year and the amount actually due would be added to or subtracted from the family's overall tax liability.

Some situations would require more complex rules, such as when family structure changes during the course of the year. These sorts of changes are not currently reported on the tax return, but they could have important implications for the amount of credit the family is due. While every effort should be made to keep the reconciliation process as simple and as closely tied to existing tax rules as possible, equity considerations may require supplemental information and more complex rules.

Concluding Remarks on Tax Credits

Tax credits are a common mechanism for encouraging certain types of behavior. Tax credits designed to encourage the purchase of health insurance face particular challenges. The credits must be large relative to family income, and they must be provided primarily during the course of the year so that families have the resources they need to pay monthly premiums. The *Roadmap* integrates tax credits with the purchasing

pool in a manner designed to make enrollment simple. Given the importance of the tax credits in assuring the availability of affordable health insurance coverage, a great deal of attention will need to be paid to their implementation.

VI. Enforcing Individual and Employer Mandates*

The objective of the *Roadmap* building blocks is to make health insurance coverage affordable and available to everyone. Nearly three-quarters of those currently without health insurance in Massachusetts would be eligible for free or subsidized coverage under the *Roadmap* provisions. It does not follow, however, that all residents would acquire coverage. The four *Roadmap* building blocks would reduce the number of Massachusetts residents without health insurance. However, full coverage requires mandating that every individual obtain health insurance coverage. This can be achieved with an individual mandate imposed either on its own or in conjunction with a mandate on employers. The *Roadmap* includes three mandate proposals: an individual mandate alone and an individual mandate combined with two alternative employer mandates.

Because coverage would be affordable and available to all, enforcement of the mandate should be necessary only for the few who do not obtain coverage through one of the pathways made available through the building blocks described earlier. To minimize this number, the first step in enforcement is designing each source of coverage to be as available as possible.

Massachusetts already has a very high rate of participation in MassHealth among those eligible for coverage. This participation rate is due to a combination of factors, including wide availability of the application process, a simple application, limited requirements for documenting income and assets, rapid processing of applications, and involvement of community-based organizations in program outreach. These attributes should be preserved and extended with respect to both MassHealth expansion and the purchasing pool.

All likely contact points for families should be engaged in the outreach process. This would encourage enrollment so long as coverage is voluntary, and provide a consistent message of the requirement to have coverage once it is mandatory. Schools, Registry of Motor Vehicles offices, Department of Transitional Assistance offices, and

*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.

health care providers would all have a role to play in promoting the message that coverage is required, and in making available the appropriate forms.

Employers could also play a valuable role in promoting coverage because almost 90 percent of the currently uninsured in Massachusetts are in working families. The employers' role needs to be carefully approached in a manner that does not impose an undue burden. Employers could provide their employees with information on MassHealth and options for coverage through the pool. Employers can also serve as a conduit for information that needs to be submitted to various agencies, including the pool, the MassHealth agency, and the Department of Revenue.

Ultimately, however, if coverage is mandated the Commonwealth must develop systems to enforce the mandate. The following subsections describe the steps necessary to create an enforceable individual and employer mandate.

Individual Mandate

The first issue in enforcing an individual mandate is defining who is subject to the mandate. A broad definition would yield the largest decline in uncompensated care, but would also make enforcement more complex. Full-year full-time residents should certainly be subject to the mandate. Part-year residents who move permanently into or out of the state during the year should be subject to the mandate during their tenure in Massachusetts. Part-year residents who are temporary or seasonal workers or those who have permanent homes elsewhere are a more complex matter. While they would certainly benefit from having health insurance coverage, enforcement of the mandate could pose a challenge. It would be important in this connection to align the timing of the mandate with the timing of the availability of tax credits. For example, the state might impose a waiting period to prevent people from moving to Massachusetts and immediately claiming a tax credit. If such a provision were adopted, it would be important to have a similar waiting period before imposing a coverage mandate, or the burden may be unaffordable to new residents.

Enforcement would also require reporting of relevant information by various parties. Health plans and self-insuring employers would be required to provide a form (like the federal 1098 form) listing the policy number and dates of coverage for everyone covered in a family.[5] This information, along with MassHealth enrollment information and tax credits provided through the purchasing pool, would be provided to the Department of Revenue. Tax filers would be required to report their coverage on their tax return.

Enforcement Through the Tax System

The primary mechanism for enforcing the individual mandate would be the tax system. For higher income families, enforcement would be straightforward. A return that shows an individual without coverage for part of the year would be subject to a tax

[5]The reporting requirement could be imposed on employers and the purchasing pool, rather than health plans, but this seems more complex.

to cover the cost of the premiums during that period, plus a penalty of perhaps 25% as a strong incentive for compliance.

For moderate income families that file tax returns the process must consider if the family was eligible for tax credits, received some advance credits, or was eligible for MassHealth during the year. If they had periods without coverage the appropriate premium is what they would have owed less any tax credit due. If the family was eligible for MassHealth during this period, no premium would be due. Modest penalties could also be imposed, but there would be no penalty for those who were eligible for MassHealth during their period without coverage.

Lower income families present yet another situation. Any family claiming a tax credit would have to file a tax return, so the amount could be reconciled even if the family would not otherwise be required to file a return. This should not change the filing status of many people, as the current income filing thresholds are quite low: $8,000 for a single person, $12,700 for a head of household, and $14,200 for married couples filing jointly. Families that do not file a return because their income is below these thresholds would most likely be eligible for MassHealth. Enforcement of the mandate for this group would be by other means, as discussed in a moment.

Anyone who fails to file a tax return even though they are required to do so would fall through the gaps in the tax system-based enforcement. However, people in this circumstance would be violating a broader set of rules regarding the state's tax code. Enforcement of the tax code would be the first step in enforcing the health insurance mandate.

Enforcement Through Provider Contact

Just as providers could play a critical role in enrolling people in a voluntary system, they could also help with enforcement of the mandate. When a person without health insurance seeks to obtain services, the provider would have the responsibility to obtain the information necessary to determine if the person is eligible for MassHealth or a tax credit. The provider would then begin the enrollment process, thereby becoming eligible for payment for the services delivered, and helping assure that the person obtained coverage. The information obtained at this time would be passed along to the Department of Revenue so it could be used to enforce the mandate in conjunction with the person's filed tax return.

Many providers are wary of playing a role in enforcement because they are legitimately concerned that people who need health care services may go without care if they fear that obtaining services will subject them to penalties (such as those related to immigration status). The provider role, therefore, would need to be defined in a way that balances these concerns with the need to assure the integrity of the overall system of universal coverage and the provider's desire to obtain payment. A key factor in this balance would be making sure that only modest penalties are imposed on those who seek care despite being uninsured.

Use of Penalty and Back-Premium Funds

The enforcement provisions requiring back-payment of premiums and penalties would generate some revenue. While these funds could go into the general fund or be applied toward the overall costs of the *Roadmap*, some consideration should be given to distributing these funds to the health plans in which people enroll. With an individual mandate in place, enrollment would need to be immediate when a person without insurance obtains services from a provider. The provider would bill the health plan, but the plan will not have received any premium payments for that person. The past premiums and/or penalties imposed on the new enrollee through the tax system represent the lost revenue the plan would have received had the person enrolled in a timely manner. Therefore, it would make sense for at least a share of these funds to be forwarded directly to the plan.

Enforcement of an Employer Mandate

An individual mandate could be paired with an employer mandate. Under federal law states cannot require employers to provide health insurance to their employees. Therefore, the employer mandate would need to be defined as a requirement that employers pay a fee to the Commonwealth and receive a credit against that fee for contributions they make toward the cost of health insurance for their employees—referred to as a pay-or-play mandate.

Defining the Employer Mandate

As with the individual mandate, definitions are critical to the enforcement process. The first issue is which employers should be subject to the mandate. Exempting smaller firms would reduce political opposition to the mandate and substantially lessens the enforcement burden by dramatically reducing the number of firms whose behavior must be monitored. This approach focuses attention on larger firms, which are already more likely to offer coverage. It would also place the burden on larger firms that generally devote more resources to personnel administration and are more able to comply with potentially complex rules. On the other side of the ledger, such an exemption would leave out the firms where health insurance is least likely to be offered and creates opportunities for gaming as firms consider breaking themselves into small enough segments to avoid becoming subject to the mandate. As a practical matter, some minimum size is probably appropriate, although where it should be set is subject to considerable debate. A related issue is how to define an employer doing business in Massachusetts; presumably existing tax rules can be relied upon to resolve this.

A second key issue is which employees should be subject to the mandate. The *Roadmap* proposes to apply the mandate only to full-time workers. "Full-time" is defined as those who work 30 or more hours per week. This definition would need to be refined to consider the status of seasonal and part-year full-time workers. It would also pose challenges for enforcement because other systems, such as the tax system, Social Security, and the unemployment compensation system do not differentiate between full-time and part-time workers. Thus, these other systems cannot be relied upon to inform the enforcement agency of which employees are subject to the mandate.

If the mandate is applied only to full-time workers, some other source would be needed to determine which employees meet the definition.

A third issue is which health insurance costs to consider in calculating the credit employers receive against the fee. Here, existing federal and state definitions for tax purposes could be relied upon to resolve any questions. Finally, the process would need to be clear for an employee with more than one employer. As with Social Security, a system would be needed to refund overpayments by employers when their separately calculated liability exceeds the actual annual liability for the employee.

Enforcing the Employer Mandate

The first step in enforcing the mandate is to decide which agency should be responsible for this task. There are a number of options. The payroll tax obligations of employers would closely resemble those imposed under the Unemployment Compensation system, which is administered by the Division of Unemployment Assistance. This division also collects funds for the Medical Security Plan, which was created as part of the effort made in the 1980s to achieve universal coverage through an employer pay-or-play system (which was never implemented). A possible alternative enforcement agency is the Department of Revenue, which already collects taxes on businesses. One advantage of this solution would be that the Department would play a substantial role in enforcing the individual mandate, which would need to be coordinated with enforcement of the employer mandate.

The enforcement system would require employers to state whether they are going to "pay" or "play" and then follow up with reporting and auditing to ensure that the employers have followed the course they said they would take. Thus, the first step would be to require covered employers to register, as they do with unemployment compensation. An effective registration system would be critical to the success of the monitoring system.

For employers who choose to pay the fee, monitoring would be based on tax filings. Actual filings could be compared routinely with the list of registered employers, and discrepancies could lead to enforcement steps ranging from delinquency notices to fines. For employers who choose to "play" by providing their employees' health insurance, some entity would need to verify the existence of the coverage and the amount paid. This could be done directly by health plans and third-party administrators that serve self-funded employers. An alternative would be to contract this function out to a private organization. For example, workers' compensation coverage in Massachusetts (as in other states) is verified through a private rating bureau licensed by the Division of Insurance. This model may be appropriate for accumulating information on health insurance coverage and assuring that employers who claim to be providing coverage are actually doing so.

All of these processes would need to be subject to periodic audits. In addition, the enforcement agency would need to follow up on reports by employees and health providers of instances where it appears that employers are not in compliance.

Enforcement should emphasize educating employers of their options and encouraging them to adhere to the provisions of the mandate. Particularly in the early years of the mandate, enforcement should be limited to the requirement to pay back-taxes with very small penalties imposed. Enforcement should occur through streamlined administrative procedures similar to those used for other employer taxes. Only in later years, and in instances of persistent and willful violation, should stronger sanctions such as criminal penalties and debarment from public contracts be imposed.

Concluding Comments about Mandate Enforcement

Attaining universal coverage requires imposing an individual mandate to obtain health insurance. This provision could either be combined with an employer mandate or made on its own. A mandate is only realistic in conjunction with substantial subsidies and purchasing opportunities designed to make health insurance affordable for and available to all Massachusetts residents. This is the purpose of the *Roadmap* building blocks. Once affordability is guaranteed, the Commonwealth can legitimately impose the mandate to assure that there are no "free riders."

The primary role of enforcement of the *Roadmap* mandates should be as a backstop to a range of outreach and educational activities designed to encourage participation by individuals and employers. Enforcement of the individual mandate could be primarily through the tax code, while the employer mandate would have to rely also on the Division of Insurance and other agencies. In either case, it would be possible to build enforcement into existing relationships that people have with various government agencies. This design should minimize the severity of enforcement actions that need to be taken, while still sending a clear message that everyone is required to have health insurance coverage.

VII. Assuring Cost Containment*

Cost containment is a necessary component of any plan for universal health insurance coverage. While the oft-stated opinion that coverage can be expanded to everyone simply by reallocating existing funds within the health care system is probably unrealistic, it is appropriate to consider how efficiency gains can minimize the cost of expansion. If employers and individuals are to be required to purchase their own health insurance coverage and to pay taxes to subsidize the coverage of others, it is reasonable for them to expect constraints on health care costs. It is also reasonable to ask something of the major players in the health care system as they are poised to receive substantial new resources.

A more rational system of coverage, such as the *Roadmap* poses, presents the Commonwealth with many opportunities for cost savings particularly due to administrative efficiencies. At the same time, new coverage would be provided to a population that has substantial unmet health needs, thereby increasing overall health spending. These two factors may offset one another somewhat, but it would be very risky to assume that the former will pay for the latter.

There are strong advocates for various approaches that claim to generate massive savings in health care, whether through new investments in information technology or disease management. While these and other ideas show promise, none has revealed itself to be the magic bullet for health care costs—indeed the best bet is that no magic bullet exists. Still the *Roadmap* provides an opportunity to pursue such ideas.

Health care in Massachusetts is expensive by national standards. While the state also scores well on quality measures, there is ample room for improvement. Views differ regarding the degree to which higher costs contribute to better quality or payment for unnecessary services. The Massachusetts health care system relies heavily upon academic

*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.

health centers and has a strong set of safety net hospitals and a broad network of community health centers. The state has a high supply of physicians, but many of them are affiliated with academic health centers and spend relatively little time in clinical practice. Physicians practice either solo, in small groups, or in large multi-specialty group practices, but not in large single-specialty groups. There is active competition across health plans, but large, national insurers have a limited presence. Hospital margins are low. High health care spending seems more closely tied to high utilization than high prices, which makes the system more amenable to cost saving strategies tied to utilization management than to price discounting. The provider community has strong leadership and has demonstrated a willingness to collaborate to promote innovation. Health plans have shown a similar willingness to work together. The state has a tradition of regulation and government involvement that, though not uniformly endorsed, creates an openness to options that would not even receive consideration elsewhere.

Three types of cost containment are associated with the *Roadmap*. The first is inherent in the design—forces or behaviors unleashed by the terms of the *Roadmap* itself that should encourage cost containment. The second type involves opportunities at least somewhat unique to the *Roadmap*—steps that are optional, but that are easier to take because of other changes made as part of the *Roadmap*. The third type is additional steps that show promise independent of other *Roadmap* provisions.

Cost Containment Inherent in the *Roadmap*

Two cost containment aspects are inherent in the *Roadmap*: a purchasing pool with a particular competitive structure and a reinsurance system.

The purchasing pool (combined with the tax credits) would function along the principles of "managed competition" meaning that individuals and families would receive a fixed subsidy and be required to pay the full difference in cost between that subsidy and the plan they choose. This structure creates competition at two levels. First, plans would submit bids knowing that purchasers will be highly sensitive to price, and that a low price will yield a high volume of enrollees. This gives plans strong incentives to bid low. Second, individual purchasers facing the full cost of their choices would have maximum incentive to purchase lower cost plans. Competitive forces would give plans a strong incentive to keep their own costs low and to pursue cost-saving improvements in the health care delivery system among the providers included in their plan. While these dynamics take place within the pool, their benefits extend outside the pool since products offered outside the pool must compete against those offered in the pool.

The pool would also structure the purchase of health insurance coverage in a manner that could reduce inefficiencies due to risk selection. When health plans compete, each has an incentive to attract enrollees who are healthier than average. While explicit efforts to achieve this goal are forbidden, more subtle efforts, if successful, can yield substantial benefits to the plan. By serving as an intermediary in how coverage is purchased, the pool would make such efforts less likely to succeed. The pool would

use a risk adjustment system that reduces the value to the plan of avoiding high-risk enrollees, since the plan will in the aggregate receive lower payments for people with lower risk. Ultimately, health plans that are paid appropriately for higher risk populations can be expected to put more of their resources into improving care for these populations and less into deterring them from enrolling.

The reinsurance system would further reduce the uncertainty facing health plans, thereby reducing their reserve requirements and the "risk premium" that would otherwise be built into the health care premium. The reinsurance system also defines a set of high-cost patients for whom specific strategies can be designed to improve their care with the goal of reducing costs.

Possibilities Created by the Building Blocks

Creation of the purchasing pool, the reinsurance system, and other features of the *Roadmap* would make it easier for Massachusetts to adopt certain cost containment approaches than would be available in the absence of the *Roadmap*. Just because Massachusetts could take these steps, however, does not mean that it should take all of them.

One option tied to the new purchasing pool would be to expand data collection. The pool would provide a potentially rich source of information on health care utilization by a large share of the Massachusetts population. These data could be combined with those from MassHealth and large purchasers and used for analytic purposes that could improve how health care is delivered.

While virtually every health plan uses some form of disease management or case management, most of these efforts are still at their developmental stages and have yet to demonstrate substantial savings. The purchasing pool could convene the participating health plans and discuss opportunities for improving care for high-cost patients and those with chronic diseases. With the large number of people expected to be enrolled in it, the pool could also pursue initiatives directly, investing in research regarding disease management, operating demonstration projects, and contracting with organizations that have proved to be effective care managers.

Massachusetts has been a leader in pursuing advances in health information technology (HIT). The key to generating savings through HIT is "interoperability," meaning that systems can readily share data with each other. The purchasing pool could encourage or require participating plans to meet certain HIT standards, thereby accelerating their use and the realization of their benefits.

The *Roadmap* calls for the purchasing pool to offer certain benefit packages. The more closely these benefits could be standardized across carriers, the more effectively the "managed competition" model could function by encouraging competition on the basis of price, quality, and service.

One important aspect of benefit design is patient cost-sharing. Some health care analysts argue that higher and variable levels of cost-sharing can promote more effective

health care use. The individual mandate could be satisfied with the purchase of a high-deductible plan. If these were popular, they could yield overall health system cost savings. The purchasing pool would have to be very careful in its use of cost sharing because it would serve a disproportionately low and middle income population. However, certain efforts, such as tiered copayments for prescription drugs, could be promoted in the pool if they were thought to generate cost savings without sacrificing access to needed services.

Purchasing pools can take a variety of approaches to how they select participating health plans. One option would be to accept bids as a starting point for negotiations and to use the leverage of the pool to bargain for better terms. This is the strategy used by most large pools, and would be an option available to the purchasing pool under the *Roadmap*.

A final option for cost containment would be to have the pool actually negotiate the underlying payment rates or set a fee schedule for services paid for by participating plans. Such an approach might be considered for high-cost items such as prescription drugs. Direct contracting would probably only be adopted if plans do not appear to be using their leverage to obtain lower prices from providers. The downside is that such an approach can be disruptive of existing plan payment policies, and it could be "too effective," resulting in cost shifts to other payers as MassHealth is now perceived to do. Still, the pool might need to consider this option if health plans do not demonstrate the ability to negotiate effectively with providers.

Other Possible Cost Containment Measures

The medical malpractice system generates direct (premium) and indirect ("defensive medicine") costs, although the magnitude of the latter is debated. Traditional tort reforms, such as caps on non-economic damages, have not been shown to have a significant effect on the practice of defensive medicine. A more creative approach is to move adjudication of certain avoidable adverse events to an administrative process that would be more consistent and timely. This kind of reform could have an effect on both the direct and indirect costs of the system.

A good deal of attention is currently directed at reducing medical errors, with the primary goal of improving patient safety. Error reduction can also reduce health care costs. A comprehensive approach to reducing medical errors would incorporate data analysis, new investments in information technology and provider training, and changes in provider payment systems and incentives.

Health economists often point to new technology as a primary driver of growing health care costs. New drugs, procedures, and devices face some scrutiny with respect to safety but much less with respect to cost. A wholesale effort to determine if new technologies should be paid for by health plans could only be carried out at the national level. However, Massachusetts could identify specific areas of concern and focus resources (funded, perhaps, by a portion of insurance premiums) on examining them.

Despite growing interest in concepts such as pay-for-performance, health plan payment methodologies remain largely unchanged. A more complete reexamination of how providers are paid could create better incentives to deliver primary care and manage chronic conditions. Such an effort could be led by the Commonwealth or the purchasing pool.

Yet another cost saving opportunity would be care at the end of life. The current system is expensive and often fails to reflect the preferences of patients and family members. No individual health plan wants to be viewed as rationing care. But a statewide effort to reconfigure how care is provided at the end of life could yield more compassionate care while also possibly saving money.

Concluding Comment on Cost Containment

While health plans currently have an incentive to keep their costs down, they also face limitations in the strategies they can use, in part due to the so-called "managed care backlash" of the late 1990s. The purchasing pool and reinsurance mechanism create some new incentives and opportunities for cost containment strategies. In addition, in the context of universal coverage, the Commonwealth or the pool could convene health plans to consider options that would be difficult for any one plan to adopt but that might benefit the state as a whole. Regardless of the precise mechanisms, cost containment strategies must be an integral part of the *Roadmap* to assure that the plan is affordable and to maximize the value Massachusetts residents obtain from their substantial investment in health care.

VIII. From Here to There

By design, the *Roadmap* builds upon 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—a MassHealth expansion, new tax credits to reduce the cost of coverage, an optional purchasing pool to help organize the market for coverage, and a system of reinsurance to cover high cost cases—are each based upon policies in existence in various states around the country. Implementation of these four steps could begin as soon as legislation is passed and signed into law. A realistic schedule provides two years for all of the building blocks to be in place.

Requiring every resident of Massachusetts to have insurance coverage is a bold step and one that is certainly controversial. Without the building blocks, it is unimaginable. It would be cruel as well as unrealistic to require people to purchase something they cannot afford. With the building blocks in place, concerns of affordability and availability are addressed. At that point the mandate becomes an expression of a social contract stating that all must contribute to a system that benefits all.

Implementing and enforcing an individual mandate, with or without an employer mandate, must be done with care. Enforcement represents a new challenge, but this paper describes the steps necessary to succeed at the challenge. Whether based on an individual mandate alone, or combined individual and employer mandates, a system of truly universal coverage is at least four years away.

About the Author

Alan R. Weil is the Executive Director of the National Academy for State Health Policy, a nonprofit, nonpartisan public policy organization dedicated to excellence in state health policy and practice. He spent seven years at the Urban Institute, directing Assessing the New Federalism, one of the largest privately funded social policy research projects ever undertaken in the United States. He was also Executive Director of the Colorado Department of Health Care Policy and Financing—the cabinet position responsible for Colorado's Medicaid and Medically Indigent programs, health data collection and analysis functions, health policy development, and health care reform. Mr. Weil is a graduate of the University of California at Berkeley; the John F. Kennedy School of Government at Harvard University; and Harvard Law School.