MMPI Massachusetts Medicaid Policy Institute

MassHealth: It's Good for Business

Ten Facts the Employer Community Should Know About the Massachusetts Medicaid Program

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A Report from the Massachusetts Medicaid Policy Institute

Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI) is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program (often referred to as "MassHealth"). MMPI seeks to promote broader understanding of the MassHealth program and a more rigorous and thoughtful public discussion of the program's successes and the challenges ahead.

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Executive Summary

MassHealth, the Massachusetts Medicaid program, is an important program for Massachusetts businesses. To many who associate MassHealth with poverty and the unemployed, this is a surprising fact. In reality, employers are a major beneficiary of the MassHealth program and, in particular, of the state's successful efforts to expand the program and reduce the number of uninsured people in the Commonwealth.

This report clarifies the role that MassHealth plays in the Massachusetts health care system, especially for low-wage workers, and presents 10 facts about how the program affects employers. The goal of the report is to encourage employers to develop a fuller understanding of the value of MassHealth to the business community and, equipped with the 10 facts, to become more involved in shaping MassHealth policy. Because, in fact, a well-designed and adequately funded MassHealth program benefits all of Massachusetts, including employers.

#1: MassHealth Plays a Vital Role in Addressing Gaps in Employer Coverage for Low-Wage Workers and Their Families

Many low-wage working families do not have health coverage through a family member's employer, because they do not have access to such coverage or cannot afford the premium. For these families, MassHealth provides vital support, covering over 400,000 workers and their families. Most of these workers are self-employed or work for small businesses, but many work for large employers or the government, where coverage may be more available but still unattainable for low-income families. For these families, MassHealth is at least as important as a source of health coverage as employers. This is particularly true for children in these families; they are more likely to be covered by MassHealth than by employer-based health plans. MassHealth is also important to adults who work part-time; even in low-wage families with a full-time worker, one in four adults has MassHealth coverage.

#2: MassHealth Complements and Supports Employer Coverage

MassHealth supports participation in employer-sponsored insurance for eligible low-wage workers and their families by providing public assistance to cover the out-of-pocket costs of the premium contribution, deductibles and copayments, and by providing financial assistance to small employers who provide health coverage to low-wage workers. About 33,000 MassHealth members have employer-sponsored, commercial health insurance. This is an attractive strategy because it reduces public spending on health coverage, mitigates the stigma often associated with public programs, allows parents and children to have the same source of coverage, and helps employers to continue offering coverage to their employees.

#3: MassHealth is a Major Reason Why Massachusetts Has a Relatively Low Percentage of People Without Health Coverage

From 1997 to 2002, more than 300,000 people were added to MassHealth. As a result, by 2002 Massachusetts had a significantly lower rate of people without health insurance than the US overall. The number of uninsured has risen since 2002, but the percent is still well below the national average. The better overall rate of insurance coverage in Massachusetts is due both to higher MassHealth coverage and to higher rates of employer coverage. For low wage adults and children, however, the lower percentage of people without insurance is due to much higher rates of Medicaid coverage.

#4: By Ensuring Health Coverage, MassHealth Helps Maintain a Healthy Workforce, Healthy Families and Healthier Communities

It is well documented that lack of health coverage has profound consequences for the health of individuals, families and communities. A recent study by the Urban Institute for the Blue Cross Blue Shield of Massachusetts Foundation estimates that the value to society of the improved health of people with insurance is $1,600 to $3,200 per person per year. By increasing the number of Massachusetts residents with health coverage, particularly low-wage workers and their families, the MassHealth program improves the health of workers in the state. Workers without health coverage are in poorer health, experience higher absenteeism and deliver lower productivity, leading to higher costs for employers. Healthier and more productive workers also have higher wages and pay more taxes, which benefits the state's economy.

#5: MassHealth Funds Vital Services that Support Workforce Participation for Many People with Disabilities and Their Families

While many people with disabilities have other forms of insurance, those plans usually exclude or limit many of the benefits that are essential for people with disabilities to live and work in the community. Access to Medicaid, with its broad range of community-based supports, is important for people with disabilities. MassHealth's CommonHealth program provides benefits that make it possible for people with disabilities to remain in the workforce. CommonHealth members are thus able to contribute to the cost of their care both through premiums and as taxpayers.

#6: MassHealth Helps Support the State's Economy by Bringing Billions of Dollars of Federal Revenue to Massachusetts

Health care is one of the most important employment sectors in the Massachusetts economy. Employment and spending in the health care sector have ripple effects on the rest of the state's economy, creating other jobs and spending — as much as $2.21 in additional economic activity for every dollar spent in the Medicaid program. Also, because of the joint federal-state financing of the Medicaid program, each state dollar spent on the MassHealth program is matched by at least

another dollar of federal revenue. The program is the largest generator of federal funds in the state's budget, bringing more than $4 billion in revenue to Massachusetts in 2004.

#7: By Helping to Lower the Number of People Without Insurance, MassHealth Reduces the Level of Uncompensated Care and Mitigates a Cost that is Borne in Part by the Business Community

In Massachusetts, a major mechanism for financing care delivered to people without health insurance is the Uncompensated Care Pool (UCP). The UCP is funded by a combination of sources, including employers that offer health insurance, through a surcharge on insurer payments to hospitals and ambulatory surgical centers. Most observers believe that employers also contribute to the Pool indirectly, through an assessment on hospitals and through higher premiums that may result from a shortfall in Pool funding. UCP costs declined in the early years of MassHealth expansion, though they have increased recently. Nevertheless, to the extent that MassHealth expansions have helped to reduce significantly the number of people without insurance, demand on the UCP is less than it otherwise would be and, so too, is the need for private sector funding for the Pool.

#8: A Strong and Adequately Funded MassHealth Program Reduces the Pressure on Providers to Shift Costs to Private Health Insurers and to Employers

Healthcare providers such as hospitals and physicians receive payments from a variety of sources. When certain payers pay less than it costs a provider to deliver care, the provider needs to fill this revenue gap and will try to negotiate prices with other payers that compensate for the shortfall. This is the phenomenon of cost shifting, and it is an important link between Medicaid and employer-sponsored health insurance. Using a range of reasonable assumptions, the potential magnitude of Medicaid underpayments to hospitals and physicians in 2003 was between $167 million and $376 million. These providers in turn pass some of this shortfall along to private insurers, who build this extra cost into the premiums they charge employers. Based on these estimates, cost shifting due to a MassHealth payment shortfall increases private premiums by 1 to 3 percent. The burden of the cost shift is unevenly distributed because of variations in the importance of Medicaid as a payer to different providers, in the extent to which Medicaid payments fall short of covering costs, and in the relative negotiating strengths of providers (hospitals and physicians) and insurers in local markets. Nevertheless, it is clear that employers' health benefit costs are inextricably linked with how MassHealth pays providers.

#9: Erosion of the Employer-Sponsored Health Insurance Market Contributes to MassHealth's Financial Challenges

The trends in the employer health insurance market are of keen interest and importance to MassHealth. As eligibility for MassHealth has expanded, the state increasingly assists individuals who are employed but do not have access to or cannot afford employer-based coverage. Recent

national data show a sharp decline in the level of employer-based coverage, especially for low-income workers. Though Massachusetts data do not yet mirror these trends, there are reasons for concern that more and more low-income employees will find coverage out of reach. MassHealth will fill some of these gaps. A rising level of uninsurance, especially among the low-income population, represents additional costs to the uncompensated care pool, additional challenges to MassHealth, and a growing problem for the health care community.

#10: The Business Community Has a Vital Stake in a Strong MassHealth Program

Medicaid has long been an important source of health care coverage for the poor. The business community has been a major beneficiary of expansions in the MassHealth program. Employers have a strong interest in the strategies and policies adopted by MassHealth and in ensuring adequate funding for the MassHealth program, in order to maintain coverage options for low income workers and workers with disabilities, reduce the cost of free care, and minimize cost shifting to employers that provide health coverage.

MassHealth…it's good for business.

Introduction

MassHealth, the Massachusetts Medicaid program, is an important program for Massachusetts businesses. To many who associate MassHealth with poverty and the unemployed, this is a surprising fact. In reality, employers are a major beneficiary of the MassHealth program and, in particular, of the state's successful efforts to expand the program and reduce the number of uninsured people in the Commonwealth.

The purpose of this report is to clarify for employers the role that Medicaid plays in the Massachusetts health care system, especially for low-wage workers, and to review the overall impact of the MassHealth program on employers. The goal is to encourage employers to develop a fuller understanding of the value of the MassHealth program for the business community, and to become more involved in shaping MassHealth policy. A well-designed and adequately funded MassHealth program benefits all of Massachusetts, including employers.

Ten Facts the Business Community Should Know About MassHealth

1 MassHealth Plays a Vital Role in Addressing Gaps in Employer Coverage for Low-Wage Workers and Their Families

Many low-wage working families do not have health coverage through a family member's employer, because they do not have access to such coverage or cannot afford the premium. For these families, MassHealth provides vital support.

Did you know that MassHealth:

- **Provides or subsidizes coverage for 437,000 workers and their families?**
- **Provides health coverage to one of four children in Massachusetts?**
- **Pays for more than one quarter of all births?**
- **Finances care for 7 of 10 nursing home residents?**
- **Covers one-third of adults with disabilities?**
- **Helps pay for medical care for 50% of adults and 90% of children with AIDS?**
- **Brings in $4 billion in federal revenue to the Commonwealth annually?**

The majority of non-elderly MassHealth members are workers and their dependents. Sixty percent of non-elderly MassHealth members — about 437,000 people in 2003 — were workers and their dependents. Most were children, but 195,000 were adults. Two-thirds of these families had at least one full-time worker (Table 1). The majority of these workers are self-employed or work for businesses with fewer than 50 employees (Table 2), which is not surprising since small businesses are much less likely to provide health insurance coverage. But thousands of MassHealth members live in households where workers are employed by large employers and by government, where coverage is much more common but still unattainable by many low-wage workers.

Table 1:
MassHealth Members in Working Families: Number of Non-Elderly MassHealth Members Who Live in Families with At Least One Worker, 2002-2003

	Total	Adults (>18)	Children
At least one worker	437,000	195,000	242,000
• Full-time worker	278,000 (64%)	115,000 (59%)	163,000 (67%)
• Part-time worker	159,000 (36%)	80,000 (41%)	79,000 (31%)

Source: 2005 Urban Institute analysis using merged Current Population Survey data for 2002 and 2003, with adjustment for Medicaid undercounting

Table 2:
Distribution of MassHealth Members in Working Families by Employer Size, 2002 (Members Who Live in Families with At Least One Worker)

Number of Employees	Total	Adults (>19)	Children
Self-employed	18%	23%	14%
1-49	34%	33%	34%
50-99	10%	7%	11%
100-999	23%	22%	24%
1000 +	3%	4%	3%
Government	13%	11%	13%

Source: National Survey of America s Families, Urban Institute, 2002. Preliminary, unpublished data.

MassHealth covers children from families with incomes up to twice the federal poverty line, and adults to slightly lower levels. (People with disabilities may have higher incomes.) This is by design, to make MassHealth available precisely to those working families for whom employer-based coverage is elusive.

In fact, for low-wage working families, MassHealth is at least as important as a source of health coverage as employers, particularly for children. As shown in Figure 1, children in low-wage families are more likely to be covered by MassHealth as by employer coverage; they are nearly four times as likely to have MassHealth coverage if they live in families with only a part-time worker. For adults in low-wage families, MassHealth is more important as employer coverage for families with a part-time worker, but less significant for full-time workers. Even so, one in four adults in a low-wage family with at least one full time worker has MassHealth coverage.

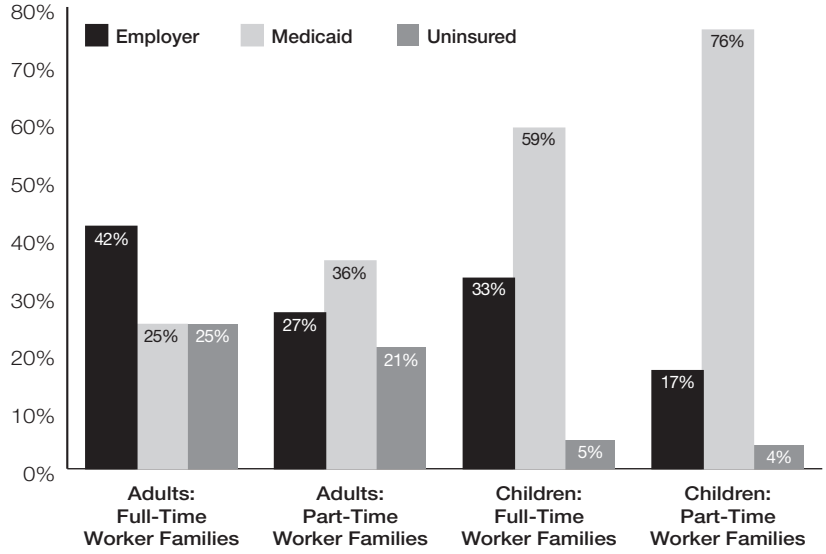
WHAT IS MASSHEALTH?

MassHealth is the Massachusetts Medicaid program. Medicaid is a joint federal-state program, created by Congress in 1965 as Title 19 of the Social Security Act. In 1997, the State Children's Health Insurance Program (SCHIP), another funding stream for MassHealth, was added to the Social Security Act as Title 21. Medicaid is a means-tested entitlement program, funded by state and federal governments. States administer the program and set rules for eligibility, benefits and provider payments within broad federal guidelines. As a result, there are wide variations in Medicaid programs across states.

MassHealth provides health care coverage to low-income children and families, pregnant women, long-term unemployed adults, seniors and persons with disabilities. Eligibility for coverage is different for each of these categories and is determined by a variety of factors, including income, age, immigrant status, and assets (for some categories of eligibility). In general, children in families with incomes up to twice the federal poverty line (FPL; see chart below) qualify for some form of coverage. Parents of these children are eligible with incomes up to 133 percent of the FPL. The eligibility limit is 200 percent of FPL for pregnant women, disabled adults, people with HIV, and employees of certain employers (for whom MassHealth subsidizes premiums for private coverage). Some of these members pay sliding scale premiums. Higher income children and adults with disabilities may enroll in MassHealth by paying a sliding-scale premium based on income. People over age 65 generally must have incomes at or below the federal poverty level and minimal assets, although they may qualify at higher incomes or assets if they have sufficiently large medical expenses.

The federal government mandates a set of services that all state Medicaid programs must cover with no more than minimal cost sharing (such as copayments) required of beneficiaries. These services include hospital care, physicians, skilled nursing facilities, home health care, and several other categories. In addition to the mandatory services, states may provide coverage for 30 other services for which they may receive federal matching funds. The most commonly offered optional services are prescription drugs, intermediate care facilities for individuals with mental retardation (ICF/MR), personal care, and targeted case management. Massachusetts covers 25 of the 30 optional services.

Figure 1:
Source of Health Coverage: Adults and Children in Low-Wage Families With at Least One Worker (Income <200% FPL), 2002-2003



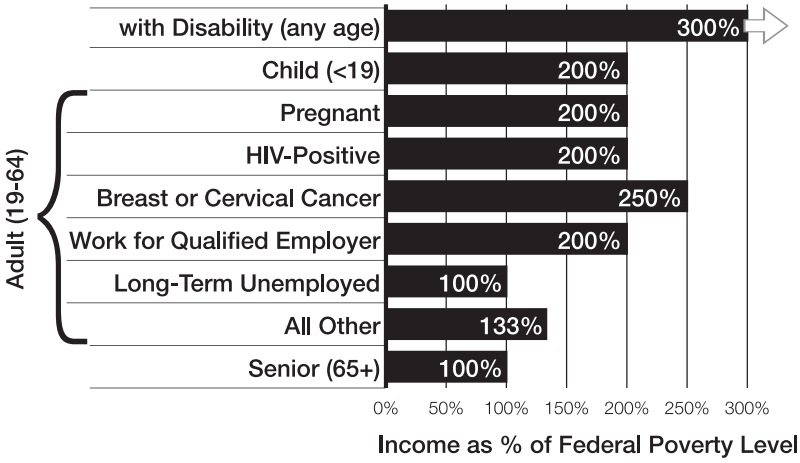
Note: 200% FPL in 2005 = ~$19,000 for individual; $39,000 for family of four
Source: 2005 Urban Institute analysis using merged Current Population Survey data for 2002 and 2003, with adjustment for Medicaid undercounting

Table 3:
2005 Federal Poverty Level (FPL) Guidelines for Selected Household Sizes

Size of Family Unit	100%	133%	200%
1	$9,570	$12,728	$19,140
2	$12,830	$17,064	$25,660
3	$16,090	$21,400	$32,180
4	$19,350	$25,736	$38,700

Source: Federal Register, Vol. 70, No. 33, pp. 8373-8375, February 18, 2005.

Figure 2:
MassHealth Eligibility Standards by Category of Coverage



MassHealth Member Profile: **Ann**

Even before divorce left her a single working mother, Ann never had much time for herself. "I had four girls in six years," she says. "And my kids are my life. I was always busy, so it was easy to ignore my own problems."

Her own problems — health problems, that is — began when she was just 16. Though her mother told the pediatrician about the pain that was persistently shooting down Ann's leg, the doctor couldn't find any cause for the trouble, and chalked it up to growing pains. Ann went on with her life, tuning out the pain even when it intensified during her first and second pregnancies. "I just assumed that there was nothing really wrong," she says, "because that's what they said when I was 16. I thought maybe it was because of the weight I gained with the babies."

By the time her third baby came along, however, Ann could no longer sweep away the issue. "That was when the doctors realized it was my hip," she says. "I had deteriorating arthritis. When they X-rayed, they found that my hip was 85 percent gone. It was just bone on bone."

At 25, Ann had her first hip replacement — which was complicated when doctors accidentally broke her femur during the operation. "It was awful," she remembers. "Very hard, especially with three little ones."

But once she healed, the procedure did help to keep her going. "I did nursing and housekeeping," she says. "But eventually I had to stop. I just couldn't do it anymore." She'd begun to have problems bending down to pick things up, and gradually lost the strength required to keep such physically demanding jobs. She now knows the difficulties stemmed from rheumatoid arthritis and osteoarthritis; and though she sees a doctor for those conditions and for asthma that causes periodic shortness of breath, she refuses to give in and seek help for the depression and anxiety that have nagged her for years.

"I should be going," she says of counseling. "But I won't go. I'd rather deal with it in my own way. Especially with all the other things I have to contend with."

Shortly after her second hip replacement three years ago, Ann applied for disability. "But they said I wasn't bad enough," she recalls, "and that I could work part-time." She got a less taxing job at a huge national discount store, where she has stayed for two and a half years, "working the floor" doing pricing, handling customer assistance, and stocking the shelves. "It's just as well," she says stoically, "because I'm not a person who likes to sit still by any means. And I want to be a good role model for my kids."

Unfortunately, health insurance is a luxury in much of the service industry. "It's about $240 every other week," Ann says, "which would eat up most of my paycheck. Even the cheapest plans they offer are too expensive, plus they don't cover anything. And I don't get food stamps or any other help." MassHealth is the only public assistance she receives, and without it, she says, "I don't know what I'd do." It not only covers doctor visits, hospital stays, and prescriptions, but also allows one of her daughters to receive treatment for depression and anxiety, and provides another with the security of knowing her health coverage is taken care of while she attends college at Holyoke Community.

Ann worries that the girls and she could get dropped from the program, even as her health continues to worsen. "Getting cut could happen to anybody," she says, "and if I was one of the unlucky ones, I'd just get sicker and sicker. I'm one of those people who wouldn't go to the doctor — not that I could afford it." She adds that she has no doubt her depression would flare up as her physical condition deteriorated, leaving her unable to maintain even the minimal level of activity that keeps her from dwelling on the negative.

"MassHealth has been a godsend," she concludes. "I need to stay busy, and keep up with four teenage girls. It helps me to do what I need to do to get through every day."

2 MassHealth Complements and Supports Employer Coverage

Although many low-wage workers do not have access to health insurance at work, many do but cannot afford to purchase it. MassHealth supports participation in employer-sponsored insurance for eligible low-wage workers and their families by providing public assistance to cover the out of pocket costs of the premium contribution, deductibles and copayments. Through its Insurance Partnership Program (IP), MassHealth also provides financial assistance to small employers who provide health coverage to low-wage workers. About 33,000 MassHealth members have employer-sponsored commercial health insurance.

Premium subsidies for employer-sponsored insurance are an attractive strategy for MassHealth for several reasons:

- combining public subsidies with employer contributions lessens the strain on public funds and allows available resources to cover more people
- because the subsidies build on employer-based coverage — the primary source of coverage for non-elderly adults — they help to mitigate the stigma often associated with public programs
- supporting employer coverage often allows children and parents to have the same source of coverage, which studies indicate increases the likelihood that families will access needed medical services[1]
- this approach helps to counter any tendency of employers who currently offer health insurance to drop coverage in favor of having employees qualify for public programs.

THE INSURANCE PARTNERSHIP

The *Insurance Partnership* helps make health insurance more affordable for small business and their employees. It provides financial assistance to firms with fewer than 50 employees, who offer qualified insurance plans and cover at least 50% of the cost. MassHealth contributes $400 to $1000 per qualified employee to help cover the employer portion of the premium.

The *Family Assistance Program* helps cover the employee portion of the premium for low-income families and childless adults, including the self-employed. The program will pay most of the monthly premium for qualified families.

There are currently 5,000 qualified small employers participating in the Insurance Partnership and 13,000 people receiving premium assistance, the majority of them adults (children may also receive MassHealth coverage through the Family Assistance Program). The vast majority (80%) of employers and employees are purchasing insurance for the first time.

[1] Leslie Conwell and Ashley Short "Premium Subsidies for Employer-Sponsored Health Coverage: An Emerging State and Local Strategy to Reach the Uninsured," Center for Studying Health System Change, Issue Brief No. 47, December 2001.

How Has MassHealth Changed in the Last Decade?

Originally, Medicaid eligibility was limited to a few categories of people (primarily single women with children, the elderly and the disabled) receiving cash public assistance or whose income and assets fell below the program standard. It was generally not available to working families. Beginning with the welfare reforms of the 1990s the role of Medicaid has substantially expanded, in Massachusetts and nationally, for a number of reasons including:

- Continuing access to health insurance coverage is critical to encouraging workforce participation and allowing low- income workers to succeed economically. Many of the jobs that former welfare recipients move into are relatively low paying and do not have health insurance benefits, especially for dependents. Concern about losing health insurance could discourage workers from pursuing employment. For jobs that offer insurance, affordability is a major concern. Making Medicaid available to low-income workers and their dependents eases the transition to work and relieves what might otherwise be a substantial economic burden.
- Medicaid expansion brings new federal dollars into the state. In the past, many states developed patchwork programs of coverage or care for targeted populations that were funded entirely through state dollars. The reformulation of the Medicaid program allowed much more latitude in defining Medicaid eligibility, and many states took the opportunity to include these programs under the Medicaid umbrella, ensuring that at least 50 percent of the cost of the program became federally funded.
- There is an evolving consensus that expanded coverage, with public financial support for low- income workers and small business, is one of the most cost-effective means to provide access to health care and minimize the cost. As the cost of health insurance continues to increase, states have become concerned about the impact on jobs and wages, the effects of lack of insurance on health care access and health status, and the cost to the community of providing free care for the low-income uninsured. Given the lack of progress at the federal level, state-based solutions like Medicaid expansion have been the major way to preserve health coverage.

The result of changes in income assistance and Medicaid policies over the past fifteen years have led to a significant drop in welfare caseload and a significant increase in Medicaid coverage.

Employer Profile: **Big Value Outlet**

Back in the mid-1950s, when Matthew Tatelbaum opened an innovative discount department store called Mars Bargainland in Boston's South Shore area, health care was not something a small-business owner really had to think too much about. There was one main carrier — the nonprofit Blue Cross and Blue Shield — and most employers paid their workers' premiums, period. Ninety-four percent of those premiums returned to employees in the form of benefits.

The world of health care is a lot more complex now, though. Matthew's grandson, Evan Tatelbaum — who helps his father, David, run Big Value Outlet, a subsidiary of the now-defunct Mars — has had to navigate a perplexing tangle of competing health care plans while trying to do his best for his three dozen or so full-time employees and also keep costs down. Which is why he was so enthusiastic when he heard about the MassHealth Insurance Partnership. "The Partnership is the best way to reward employees," he says, "the people who need it most. I want to offer something they can benefit from that's consistent with the way we do our business, which is very people-oriented. It gives life to something that's ordinarily just a monetary exchange."

In a field known for its low retention rate, many of Tatelbaum's employees have stayed with the company for eight, ten, 15, even 17 years. Several who worked for his grandfather in the 1980s have returned in recent years, and Tatelbaum credits the company's family atmosphere. "We have people say they love working at Big Value," he maintains, "because they meet people, it's a relaxed atmosphere, and they can come to my father any time about anything. Whatever he's doing he'll pardon himself and address the issue."

Still, retail has never been a high-paying field, and some workers at the five Big Value stores start at just around $20,000 a year. Even with the boss paying up to 77 percent of their healthcare premiums, it's tough for many of them to get by. But add the Insurance Partnership's sliding-scale stipend to the mix, and employees who might have been paying $10 a week for the security of broad coverage are now paying only $6.95. It may not seem like much, but for many families it can make all the difference.

"If they're staring at a nickel or dime at the end of the week," Tatelbaum says, "a few dollars can mean a lot." He cites one worker who previously refused coverage but recently signed up under the Insurance Partnership program, and another who buys her insulin with the $12 a month she saves. "I don't want to embellish," Tatelbaum adds. "She could buy it before and would buy it anyway, but at some point that $12 will pay for something else her family needs; maybe new mittens for her son or a bit toward a necessary car repair."

Tatelbaum prides himself on understanding his employee's difficulties and trying to help address them, and the Insurance Partnership provides a concrete way for him to do that.

"I can't walk up to a head cashier who needs a ride to work and offer her transportation or a raise," he says. "I can't bring my pay stub to them and say I know what it's like to be you. But I can offer them some acknowledgement. People in general are happier when they feel understood, appreciated, like you've been in their shoes. This gives the best possible access to that, because you know what? We're all getting hit with higher costs, so on some level I do understand what they're going through."

Tatelbaum mentions the reciprocity inherent in the kind of relationships he tries to engender. "When the employees know they're valued," he says, "we get the best employees — honest, loyal, faithful, invigorated." And that's a big value indeed.

Employer Profile: **Green River Lumber**

The Berkshire Mountains have been romanticized by generations of writers, artists, and musicians from Nathaniel Hawthorne to James Taylor, and for years have drawn increasing numbers of wealthy vacationers and summer residents to their verdant beauty and exceptional cultural offerings. But for those trying to eke out a living in western Massachusetts year-round, life isn't always so romantic.

"This is an increasingly affluent area," says Jill Johnson, general manager of Green River Lumber. "So the fact that we're a local industry that's not service-based is unusual. Our employees come from working-class backgrounds in local mill towns that are currently at the trailing end of a transitional economy. Real estate prices are going up, and it's becoming more and more difficult for lower- to middle-income families to live in this area. As an employer I need to find ways to retain those people, and the MassHealth Insurance Partnership is helping me do that."

For a hands-on business like Green River, founded by Johnson's brothers Will and Peter Barrett in 1974, experience makes all the difference. "We move our employees up through the ranks," she says. "To go from working in the mill to sales, warehouse manager, or supervisor doesn't require a college degree, but it does require savvy." Today's $20,000-a-year starting-level mill worker may become one of 2030's highly paid "key leaders" who "think on their feet and make an enormous contribution to our business by suggesting ways we can become more efficient."

But that day is hard to envision when the head of the family — all of Green River's 32 blue-collar employees are men — makes only $20,000 a year and budgeting for health care can seem an almost insurmountable challenge."I don't want to sound dramatic by saying our workers' lives are saner because of the Program," Johnson says, "but the truth is, they are. It's giving them a level of security and support they'd otherwise be lacking. We need to keep labor costs down in order for them to keep their jobs, and this is helping us do that. These families still have their struggles, but you can just see the difference in the way the men talk about their lives."

She mentions two families she knows of in which the employee's spouse has been able to go from a working to a stay-at-home mom because of the extra few dollars MassHealth is providing them, and a divorced millworker in his mid-50s who "wasn't looking after himself" and had let his health coverage slide. Currently on disability for a severe shoulder injury, he'll be back at work soon and "have a second shot at keeping himself going" thanks to the surgery and physical therapy he has been able to afford since signing on to the Insurance Partnership. Without it, she suggests, this still-vibrant laborer may have been forced to live out his remaining years on public assistance.

But these are not isolated incidents. "The Insurance Partnership has been a big boost for everybody," Johnson maintains. "It has contributed to our employees' thinking, 'Wow, this company is looking after us. We're getting concrete support here.' It has helped morale and productivity, which makes our people feel better about being here and better about what they're doing. Life is just not as marginal for them. There's less stress."

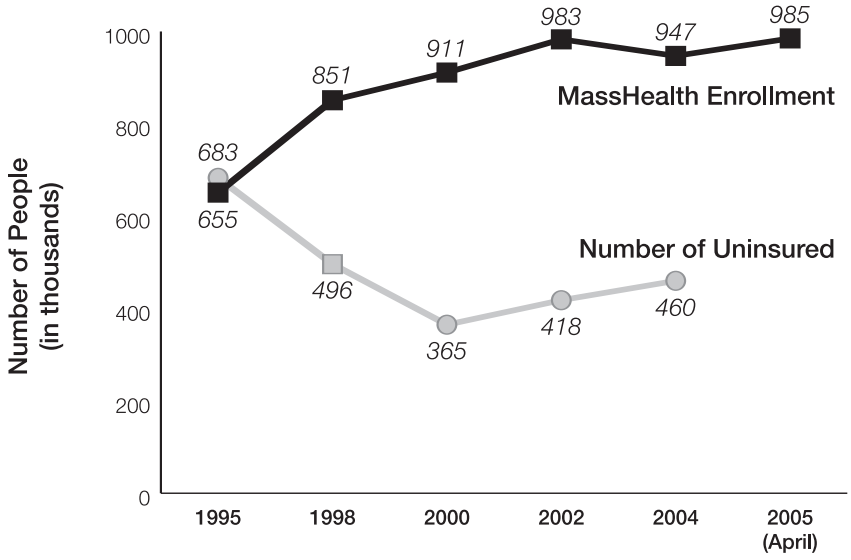
And in a classic goes-around-comes-around scenario, Johnson believes this will not only help Green River, but will also allow her to fulfill a personal dream. "Everyone in our office has their list of things they want to get to," she says. "One of mine is to get the company more involved in the community. I wear so many hats that I don't have time quite yet, but one of my goals is to be in the Rotary, sponsor a softball team, give something back. When we get bigger and more efficient and I can stop wearing so many hats, that's the first thing on my agenda."

3 MassHealth is a Major Reason Why Massachusetts Has a Relatively Low Percentage of People Without Health Coverage

Compared to most other states, Massachusetts has a relatively low rate of uninsurance. This is due primarily to expansions in MassHealth coverage.

Figure 3 shows the reduction in the number of uninsured in Massachusetts that resulted from the MassHealth expansion that began in 1997. From 1997 to 2002, more than 300,000 people were added to MassHealth. As a result, by 2002 Massachusetts had a significantly lower uninsured rate than the US as a whole — about 6.7 percent of the state's residents had no health insurance in 2002, compared to a national average of 15.2 percent.[2] With the poor economy and state budget pressure, MassHealth made a number of eligibility cutbacks beginning in 2002 and, as a result, the number of uninsured began to rise again, although the rate of uninsured among the nonelderly in Massachusetts, 8.3% in 2004, remains well below the national average of 18%.[3] The program has been particularly effective in enrolling uninsured children. Only 3 percent of children in Massachusetts were uninsured in 2004, one of the lowest levels in the country, and far below the national rate of 12%.

Figure 3:
Change in the Number of Uninsured in Massachusetts During MassHealth Expansion

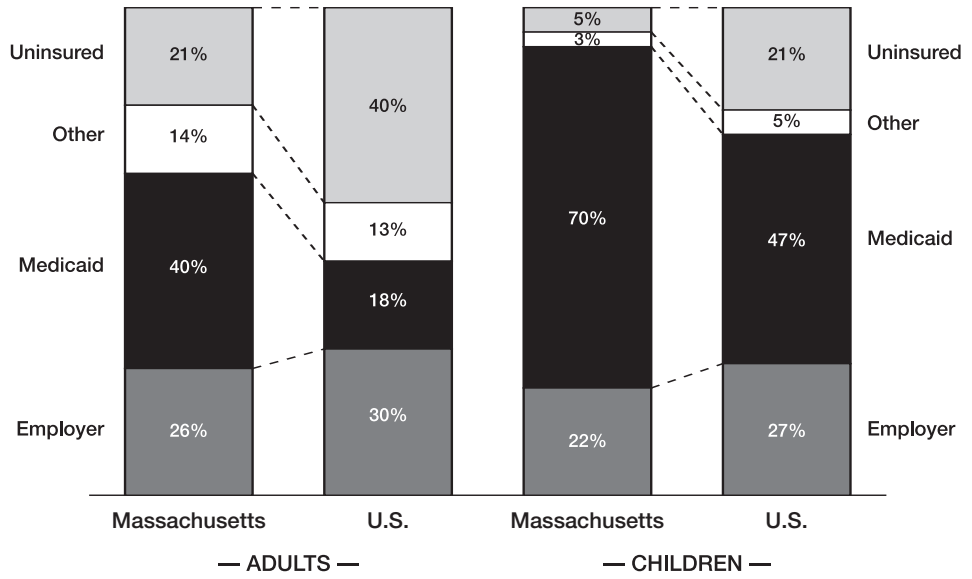


Sources: *Health Insurance Status of Massachusetts Residents,* 1998, 2000, 2002, and 2004, Massachusetts Division of Health Care Finance and Policy. *Massachusetts Residents Without Health Insurance,* 1995, Blendon, et al, Harvard School of Public Health; and Office of Medicaid, EOHHS.

[2] DHCFP Survey of Health Insurance of Massachusetts Residents, 2002 and CPS for 2002.
[3] DHCFP 2004 survey for Massachusetts; CPS for US.

The better overall rate of insurance coverage in Massachusetts is due both to higher MassHealth coverage and to higher rates of employer coverage. For low wage adults and children, however, the lower percentage of people without insurance in Massachusetts is due to much higher rates of Medicaid coverage (see Figure 4).

Figure 4:
Health Insurance Coverage for Low-Income People Under 65 by Type of Insurance, 2002-2003: Income <200% Federal Poverty Level



Source: Urban Institute analysis, CPS merged 2002-2003, with adjustment for Medicaid undercounting.

4 By Ensuring Health Coverage, MassHealth Helps Maintain a Healthy Workforce, Healthy Families and Healthier Communities

It is well documented that lack of health coverage has profound consequences for the health of individuals, families and communities.[4] For example, people without insurance receive less health care, are diagnosed at later disease stages, and have higher mortality rates. Health coverage is particularly important for children, helping them to develop and grow, remain healthy and to succeed in school. For families, lack of insurance not only impairs health but can result in a range of adverse financial consequences, including inability to meet other expenses, damaged credit, and bankruptcy. For communities, high rates of uninsurance can reduce access to emergency care and other medical services across the community, even for those who have health coverage, and strain the capacity and financial health of health care providers. It also diverts public resources away

[4] See, for example, the following reports from the Institute of Medicine: *Coverage Matters: Insurance and Health Care* (October 2001); *Care Without Coverage* (May 2002); and *A Shared Destiny: Community Effects of Uninsurance* (March 2003).

MassHealth Member Profile: **Rachael**

Though today she's a highly motivated printing-shop employee who lives for the little boy she's raising, when Rachael found herself pregnant at 16, she was a little nervous about what the future might hold. For one thing, the father-to-be — a young man she had been dating for about six months — shocked her by saying he wanted nothing more to do with her or the child she was carrying. Finishing her education would be a challenge, she knew, and so would being a working single mom. But it didn't take long for her to put her worries behind her in the excitement of bringing a new life into the world.

"The only thing I ever wanted to do was become a wife and mother," she says, adding wryly, "the wife part never came."

Her family helped out where they could. Her mother scoured the local second-hand stores for clean clothes and intact toys. Her sister would babysit occasionally, and her aunt dropped Baily off at preschool for a while, until the early hours began to take their toll. Rachael's father, a machinist, pitched in with expenses as she worked toward her GED, and encouraged her to apply for financial aid so she could enroll in the early childhood development classes offered by the local community college.

"I stayed with that a year and a half," she says. "School was never really my thing."

Over the years there have been a couple of other false starts, from a brief stint as a nanny at $5 an hour to a grueling job as a certified housekeeper for the elderly. There have also been a few major setbacks, including a short time Rachael spent back with Baily's abusive, alcoholic father; a while on unemployment; and a car accident that gave her whiplash. But Rachael persevered, and has finally nailed her dream job.

"I've been at it almost seven months now," she says. "I started as a printer's assistant, and have already moved up to training to be a printer. It's a great job. I love it. It's the people that really make it so much fun."

Unfortunately, sometimes even your dream job doesn't pay enough for life's necessities.

"I only make $240 a week, take-home," Rachael says of her full-time job, "and that's not always enough to put food on the table, much less pay for health insurance." When Rachael heard the rate for her company's family plan — $199 a week, "plus like $30 copays" — she applied for MassHealth. "Thank God I got it," she says. "Thank God."

Because even though she and Baily have never been seriously ill — knock wood — the family plan she is on provides her with a "wonderful sense of security" as her baby grows up.

"He's a very active kid," she says. "Extremely. Everything in God's creation, he likes to do. He goes once a week to acrobatics, and he's a professional couch jumper. He climbs the apple trees at my sister's. He loves the trampoline at my mother's friend's house. It makes me mental, because he jumps high, high, high! But he loves to do it."

"You've got to let kids loose," she continues, "let them do their thing. But if he falls, I know I won't have to worry about the medical bills. Or even if he just gets sick. He's had the croup three times, and scarlet fever. And I didn't have to worry about finding the money for a copay."

Which leaves her more time to spend with her son. "He's such a good boy," she says with pride. "He's got the brightest eyes and the biggest smile." And she knows her choices are paying off when Baily sees other little boys with their fathers and tells her what he wants to be when he grows up. "He always says to me, 'I'm going to be a good daddy just like you, Mommy!'"

from other important health and social programs. A recent study by the Urban Institute for the Blue Cross Blue Shield of Massachusetts Foundation estimates that the societal benefits from expanded health coverage in terms of the improved health of insured people is $1,600-$3,200 per person per year.[5]

By increasing the number of Massachusetts residents with health coverage, particularly low-wage workers and their families, the MassHealth program improves the health of workers in the state. Workers without health coverage are in poorer health, experience higher absenteeism and deliver lower productivity, leading to higher costs for employers. Healthier and more productive workers also have higher wages and pay more taxes, which benefits the state's economy.

5 MassHealth Funds Vital Services That Support Workforce Participation for Many People with Disabilities and Their Families

MassHealth's important role in supporting workforce participation applies to members with disabilities as well. While many people with disabilities have other forms of insurance (primarily Medicare), those plans usually exclude or limit many of the benefits that are essential for people with disabilities to live and work in the community (e.g., durable medical equipment, home health services, personal care attendant services). Consequently, access to Medicaid, with its broad range of community-based supports, is important for people with disabilities.

The MassHealth program has successfully pursued a number of deliberate strategies to support people with disabilities who are able to be employed work and to maximize their access to private health insurance. For example, the CommonHealth program functions essentially as a "buy-in" program for people with disabilities of any income level who have no access to other insurance, or whose insurance does not cover benefits that are important to their continued ability to live and work in the community. There are 6,500 working adults enrolled in the CommonHealth program.

Programs like CommonHealth successfully address health care barriers faced by people with disabilities who are seeking employment. For many people with disabilities, Medicaid coverage provides benefits that make work possible. People with disabilities who work contribute to the cost of their care not only through premiums but as taxpayers as well. State policies that encourage and support people with disabilities to participate in the workplace, and increase their income and independence without denying essential health care coverage, benefit employers and the entire Massachusetts community.

[5] Holahan, J et al., *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Medical Spending?* Report for Blue Cross Blue Shield of Massachusetts Foundation, November 2004.

MassHealth Member Profile: **Ray**

In 1968, Ray was a guy who had everything: a sociology degree from Harvard, a promising job at a startup research company, a beautiful young wife, robust health, and a brand new forest green English Ford Cortina he'd named Cedric. Until one winter day when he was driving that Cortina from Boston to visit his gravely ill grandmother in Ohio. "There was a blinding snowstorm," he recounts. "These two idiots in front of me had a minor fender-bender, and decided to back up to the turnpike exit to report it. So I come out of the snow and suddenly see white lights coming at me. I couldn't go around them because somebody was passing me."

Though he was going slow at the time, his car was totaled, and the impact was enough to fracture his wife's vertebra and Ray's skull. "When I opened my eyes," he says, "there was a broken tooth on my lap. I'd hit my chin on the steering wheel, and all my front teeth had come through my lower lip. So I said okay, I can live with that."

What he didn't know was that all the talking he was doing to the police who had arrived at the accident scene was causing a jagged edge of his skull to scrape against an artery in his brain, eventually severing it. He walked into the hospital's emergency room and collapsed, waking after a month in a coma to find himself paralyzed on his left side. He spent seven more months in Mass. General's rehab unit, and was released in a wheelchair to enter a world of barriers.

"The doctor said he had never seen such physically devastating brain injuries with no cognitive consequences," Ray says. "I said, 'You didn't know me before.'"

Kidding aside, IQ tests have shown Ray to be at full mental capacity — which he proved by returning to work part-time the week after he was discharged from the hospital. He would eventually become his firm's longest tenured full-time associate; and in 1999 he earned a social policy Ph.D. from Brandeis. Still, the intervening years have been rough, with bouts of severe depression, divorce, and even a couple of suicide attempts. With the small settlement he got from a lawsuit over the crash, Ray paid off his remaining hospital bills — having exhausted three insurance policies and finding himself 6,000 1970-dollars in debt — and put a down payment on a small house in Belmont.

Since 1970 he has had at least two personal care assistants at all times. Because employer health plans do not cover the help he needs to get out of bed and off to work each morning, he paid for the PCAs out of pocket until CommonHealth came along. "I was barely making it," he says, "even with a full-time job and my wife working." With CommonHealth as supplemental insurance coverage, Ray receives the paid in-home assistance he needs, and he credits it with allowing him to return to graduate school after a long hiatus and earn his doctorate. Since his wife divorced him four years ago, Ray finds his Medicaid coverage especially crucial. "Without CommonHealth," he says, "I'd be sunk. I'd be in a nursing home."

As it stands, he is the proud father of two sons, a dedicated member of the workforce, a Massachusetts taxpayer, and a leader in his community. "Your job defines who you are," he says, "and it's partly a social thing as well. My church activities are also very important to me, and I wouldn't have those if I couldn't live independently. I'm on a couple of town committees, and am chair of Belmont's Disability Access Commission."

He pauses, contemplating a future without these things. "If I were in a nursing home," he concludes, "I'd probably become suicidal again."

6 MassHealth Helps Support the State's Economy by Bringing Billions of Dollars of Federal Revenue to Massachusetts

Health care is one of the most important employment sectors in the overall Massachusetts economy, and in most communities in the state. As one of the biggest payers for health services, the Medicaid program helps support health care providers and their workers. Employment and spending in the health care sector have ripple effects on the rest of the state's economy, creating other jobs and spending. One study estimates that every dollar of Medicaid spending in Massachusetts produces another $2.21 in increased business activity.[6]

In addition, because of the joint federal-state financing of the Medicaid program, each state dollar spent on the MassHealth program is matched by at least another dollar of federal revenue. Overall, the federal share of MassHealth spending is about 54%. The program is the largest generator of federal funds in the state's budget, bringing more than $4 billion in state revenue to Massachusetts in 2004.[7] The MassHealth program has successfully pursued a variety of strategies to maximize the amount of federal support for the program, which has reduced the state's tax burden and helped provide health coverage to hundreds of thousands of additional Massachusetts residents.

7 By Helping to Lower the Number of People Without Insurance, MassHealth Reduces the Level of Uncompensated Care and Mitigates a Cost that is Borne in Part by the Business Community

The costs of medical care delivered to people without health insurance are borne by a variety of public and private funding sources, including the uninsured directly. In Massachusetts, a major mechanism for financing care for the uninsured is the state's Uncompensated Care Pool (UCP). The UCP pays acute care hospitals and community health centers for eligible services provided to low-income uninsured and underinsured people.

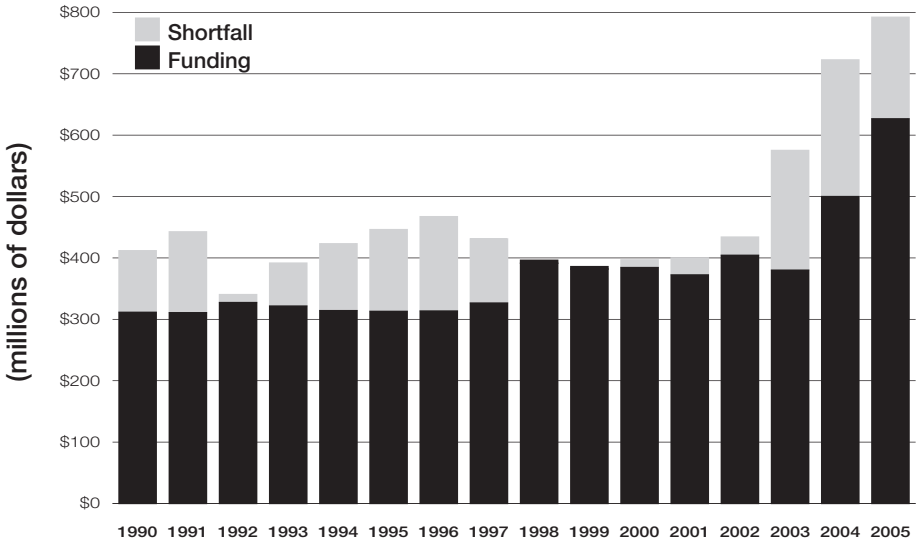
The UCP is funded by a combination of sources, including the federal and state governments, hospitals and private payers (e.g., HMOs, insurers and third-party administrators). The private payer contribution is made through a surcharge on insurer payments to acute care hospitals and ambulatory surgical centers. So, employers that offer health insurance help fund the UCP. In Pool Year 2005 (October 2004-September 2005), the surcharge is 2.9 percent, set to produce a total private payer contribution of $160 million-or about one-quarter of the Pool's funding. In addition to this direct assessment on private payers, most observers believe that employers that provide health

[6] Rachel Klein, Kathleen Stoll and Adele Bruce, *Medicaid: Good Medicine for State Economies, 2004 Update.* Families USA, May 2004.
[7] Source: Massachusetts Taxpayer's Foundation, *State Budget '05-'06: The Clash Between Expectations and Reality.* April 2005.

coverage also indirectly bear the cost of the hospital pool assessment, an additional $160 million, and the cost of any shortfall in pool funding, in the form of higher rates of payment to hospitals paid by private payers.[8]

In the early years of the MassHealth expansion, UCP costs declined.[9] But with the deterioration of the economy, MassHealth eligibility cutbacks and rising hospital costs, the costs of the pool rose again, particularly since 2003, and now exceed earlier levels. (See Figure 5.) Nevertheless, to the extent that MassHealth expansions have helped to reduce significantly the number of people without insurance, demand on the pool is less than it otherwise would be and, so too, is the need for private sector funding for the pool.

Figure 5:
Uncompensated Care Pool Demand



Source: Division of Health Care Finance and Policy.

[8] Many economists argue that all such employer costs are ultimately borne by employees in the form of lower wages.
[9] An analysis by a state Special Commission on Uncompensated Care in 2002 found that the MassHealth expansions had reduced demand on the Uncompensated Care Pool by $213 million through Fiscal Year 2002.

8 A Strong and Adequately Funded MassHealth Program Reduces the Pressure on Providers to Shift Costs to Private Health Insurers and to Employers

Healthcare providers such as hospitals and physicians receive payments from a variety of sources including MassHealth, Medicare, private insurance plans, and individual patients. Public payers like Medicare and MassHealth pay according to formulas set through a combination of legislation and regulation. In contrast, most private insurers negotiate payment rates with individual providers or with groups. When certain payers pay less than it costs a provider to deliver care, the provider needs to fill this revenue gap and will try to negotiate prices with other payers that compensate for the shortfall. This is the phenomenon of cost shifting, and it is an important link between Medicaid and employer-sponsored health insurance.

Despite the benefits of MassHealth for the business community, concerns are frequently expressed about whether the program shifts costs to employers, ultimately driving up the cost of private health insurance. In response to this concern, several of the current health reform proposals, including those of Senate President Travaligni and Health Care for All, include provisions to increase MassHealth payment rates to providers.[10]

How Might MassHealth's Provider Payment Policies Affect Employer Health Insurance Premiums?

MassHealth can be a factor in cost shifting only in situations where it accounts for a significant portion of a provider's revenues and where those revenues fall significantly short of the costs of providing services. The greatest potential for Medicaid cost shifting to affect employer premiums is where there is the largest overlap between Medicaid and private health plans in terms of their use of services, namely hospitals and physicians.[11]

Hospitals

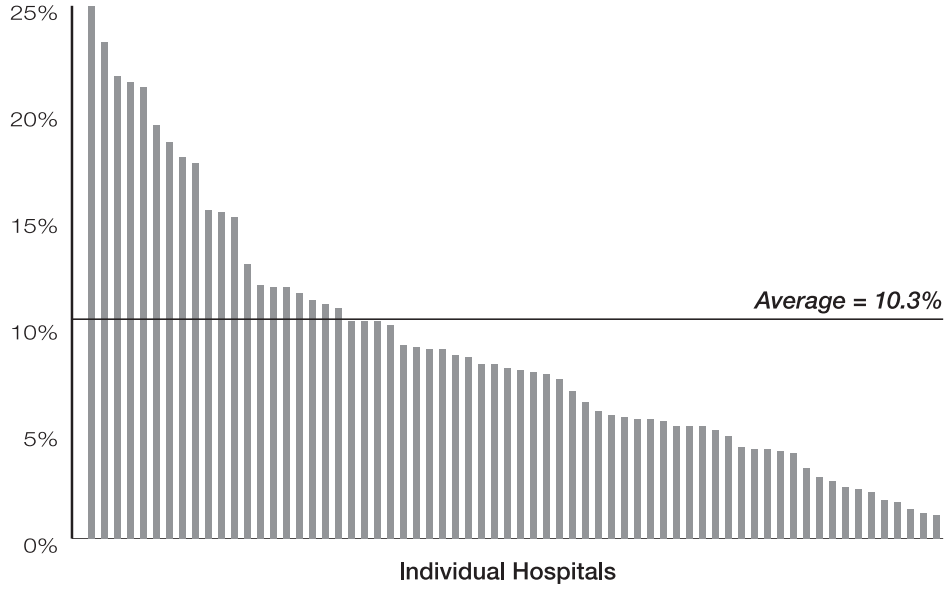
In 2003, MassHealth paid acute care hospitals in Massachusetts $1.3 billion, just over 10 percent of their total revenues.[12] For individual hospitals Medicaid's contribution ranged from one percent of revenue up to 25 percent (see Figure 6). The hospitals with higher Medicaid revenues have the greatest need to recoup from other payers any payment shortfalls that may arise from serving Medicaid patients. Hospitals at the low end of this distribution have little need to cost shift.

[10] *Health Care Access and Affordability Act* (H. 2777, S. 738) and *An Act Providing for Health Access, Affordability and Accountability* (S. 2042).

[11] Although community health centers are not included in this analysis, any inadequacies in Medicaid payments to health centers could indirectly affect the business community. For example, inadequate payments might constrain health center capacity, thereby requiring care for some Medicaid members to be delivered in higher cost settings.

[12] Division of Health Care Finance and Policy, Hospital 403 cost reports. Includes Medicaid fee for service payments and Medicaid managed care organizations.

Figure 6:
Medicaid Net Revenue as a Percent of Total Net Revenue, 2003



Source: Division of Health Care Finance and Policy

In addition to MassHealth's prevalence as a payer, the size of a hospital's Medicaid payment shortfall also depends on its Medicaid payments relative to its costs. The MassHealth hospital payment formula makes it likely that hospitals with higher overall costs will have a larger Medicaid payment shortfall.[13] The MassHealth shortfall is very concentrated, with five hospitals accounting for about fifty percent of the total. This concentration results both from differences in the payment to cost ratio across hospitals and the volume of Medicaid patients at individual hospitals.

There are no data available on the actual ratio of Medicaid payment to costs for hospitals. The most recent published analysis of Medicaid hospital payments, conducted by the Lewin Group in 2001, estimated the ratio of payment to cost was in the range of 70-80%.[14] Based on more recent interviews and unpublished analyses, there are indications that hospital payment to cost ratios may have increased significantly in recent years, at least for some hospitals, although there has been no

[13] For further detail on Medicaid hospital reimbursement methodologies see Massachusetts Division of Medical Assistance, Rate Year 2003 Acute Hospital Request for Applications; and The Lewin Group, *Analysis of the Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers,* June 25, 2001.

[14] Using 1999 state cost report data, Lewin estimated a payment-to-cost ratio of 74% for Medicaid fee-for-service and 84% for Medicaid managed care plans, for an overall ratio of 81%. Using 2000 survey data from 42 hospitals, Lewin estimated a payment-to-cost ratio of 69% for Medicaid fee-for-service and 86% for Medicaid managed care, for an overall ratio of 71%. (ibid)

detailed study of this issue that is publicly available.[15] In addition, some of the financing mechanisms that have resulted in higher Medicaid payment rates for some hospitals have an uncertain future.[16]

Physicians

According to state estimates, MassHealth paid physicians approximately $223 million in 2003. MassHealth is a less important payer for physicians than for hospitals, although the importance of Medicaid payments varies substantially across geographic areas.[17] There is no way to estimate directly physicians' costs of delivering services to MassHealth patients. On average, MassHealth physician fees were 80 percent of Medicare fees in 2003.[18]

Physicians likely differ in their ability to shift any MassHealth payment shortfalls to private payers. Independent physicians and those who practice in small groups generally have to accept the payment rates offered by private payers plans and cannot easily shift costs. In contrast, large physician groups and physician organizations affiliated with major teaching hospitals have substantially more power to negotiate fees with private insurers. However, assessing these differences is difficult because fee differentials across physician groups are proprietary and no public data describing these differences are available.

Estimating the Potential Impact of MassHealth Cost-Shifting on Employer Health Premiums

In the absence of any recent published analysis of MassHealth payment-to-cost ratios, we estimated the potential magnitude of MassHealth payment shortfalls for hospitals and physicians using a range of payment-to-cost ratio assumptions and estimates of the ability of providers to shift payment shortfalls to employers that provide health insurance. The appendix provides a detailed description of the methodology and results.

Table 4 shows the estimated effect of a MassHealth cost shift on private group insurance premiums for 2003. The table shows estimates based on a payment to cost ratio for hospitals and physicians

[15] Some hospitals receive additional funds to supplement patient-specific Medicaid payments. Medicaid "Disproportionate Share Hospital" (DSH) payments are intended to finance care for uninsured patients and to enhance historically low Medicaid rates. In 2003, Massachusetts reported to the federal government approximately $420 million in DSH payments. The majority of MassHealth DSH payments for acute care — $310 million in 2003 — were paid through the state's uncompensated care pool. Most of these payments went to Boston Medical Center and Cambridge Health Alliance. The availability of these payments would tend to mitigate a hospital's need to cost shift. MassHealth also made more than $100 million in DSH payments through eight other programs, though less than $10 million of these payments went to any acute care hospitals other than Boston Medical Center and Cambridge Health Alliance.

[16] For a more detailed discussion of this issue see the MMPI report, *The MassHealth Waiver* (April 2005).

[17] Interview with Elaine Kirshenbaum, Massachusetts Medical Society.

[18] Stephen Zuckerman et al, "Changes in Medicaid physician fees, 1998-2003: Implications for physician participation," *Health Affairs,* Web exclusive, June 2004; and S Norton and S Zuckerman, "Trends in Medicaid physician fees, 1993-1998," *Health Affairs,* July/August 2000.

of 80% and 90%, and presents a scenario in which the Medicaid payment shortfall is entirely shifted to private payers, and another in which only half is shifted. The rationale for these assumptions is described in the Appendix.

Using the 80% payment to cost ratio and the 100% assumption, hospitals and physicians shift $376 million in costs that MassHealth does not cover to the private sector. If only 50% of the shortfall is shifted, the amount is $188 million. Using a 90% payment to cost ratio, the amount is $167 million if the entire amount is shifted, and $84 million if only half of the shortfall is shifted.

In order to evaluate the impact of cost shifting on employers, we relate the amount of the cost shift to total group health care premiums in 2003, which we estimate were approximately $12.2 billion.

As shown in Table 4, a 100% cost shift would increase private health premiums by about 1.5 to 3 percent overall, depending on the payment to cost ratio. A 50% cost shift would increase premiums by 0.7 to 1.5%.

Table 4:
Potential Impact of MassHealth Cost-Shift on Private Sector Premiums
2003 Data, Assuming 80% and 90% MassHealth Payment to Cost Ratio

	— 80% —		— 90% —	
	100% Shift	**50% Shift**	**100% Shift**	**50% Shift**
HOSPITAL: Amount of Cost Shift	$319 M	$160M	$142M	$71M
As Percent of Total Massachusetts Group Health Premiums ($12.2 billion)	2.6%	1.3%	1.2%	0.6%
PHYSICIAN: Amount of Cost Shift	$57M	$28M	$25M	$13M
As Percent of Total Massachusetts Group Health Premiums	0.5%	0.2%	0.2%	0.1%
COMBINED Hospital and Physician Cost Shift	$376M	$188M	$167M	$84M
As Percent of Total Massachusetts Group Health Premiums	3.1%	1.5%	1.4%	0.7%

If providers are able to recoup some of the MassHealth payment shortfall through negotiations with private health plans, then low MassHealth payment rates mean higher premiums for employers. Alternatively, if provider efforts to shift costs are constrained by market forces (e.g., the size and negotiating power of private health plans), providers that serve a relatively large proportion of MassHealth patients may be threatened financially. The most likely reality is that both effects occur to some degree: partial cost shifting as well as financial stress for certain providers that rely substantially on revenue from MassHealth.

How these two effects balance out is complicated by the fact that there is an uneven distribution of both the shortfall and the cost shift, for the reasons previously discussed:

- The size of Medicaid market share varies widely from one hospital to another
- Medicaid payment to cost ratios also vary widely by hospital
- There is generally no relationship between a hospital's Medicaid market share and its payment-to-cost ratio
- The ability for hospitals to cost shift to the private sector depends on their local market position.

Employers' health benefit costs are inextricably linked with how MassHealth pays providers. Although the overall impact of any Medicaid payment shortfalls on employer premiums is fairly small at present — likely no more than 3% of total group health premiums in 2003 — MassHealth shortfalls and cost shifting have broad implications for the future. The size and effect of any shortfalls could increase if MassHealth enrollment grows or if MassHealth fails to adequately adjust its provider payment rates in the future. Further, while maintaining low MassHealth rates may be consistent with state budgetary goals, substantial cost shifting to private health plans runs counter to the state health policy goal of preserving and expanding the number of people with health insurance coverage. There is a direct relationship between health insurance costs and the number of people who are covered.[19] One analysis estimated that every 10 percent increase in health insurance premiums in Massachusetts leads to a 2 percent reduction in private coverage.[20] In addition, if MassHealth payment shortfalls impair the financial condition of providers, this will create access and quality problems not just for MassHealth members but for all residents of the Commonwealth.

Thus, the adequacy of MassHealth provider payments has widespread implications, for providers, for private payers, for MassHealth members, and for the state budget. Yet the dearth of up-to-date information about Medicaid payments and provider costs makes it difficult for policymakers to make well informed decisions about whether additional resources should be devoted to increasing MassHealth provider payment rates, particularly in times of limited resources and competing policy priorities. The state would benefit substantially from a more refined, up-to-date and on-going analysis of MassHealth provider payment rates and provider costs.

Finally, it is important to note that MassHealth is not the only source of potential cost shifting to employers. Underfunding of the state's Uncompensated Care Pool (UCP) results in payment shortfalls that hospitals must either recoup from other payers or absorb through cutbacks in operating costs. Demand on the UCP has increased in recent years, while UCP funding has not kept up, causing growing financial stress on hospitals and pressure to shift costs to private payers. In addition, an enormous cost shift occurs from employers who don't offer employee health coverage to those

[19] See, for example, T. Gilmer and R. Kronick, "Calm Before the Storm: Expected Increase in the Number of Uninsured Americans," *Health Affairs,* November/December 2001.
[20] Division of Health Care Finance and Policy, "Premium Increases Affect Health Insurance Coverage," *Analysis in Brief,* November 2001.

that do. Employers who do not offer health insurance coverage to their workers do not contribute to the cost of the UCP and do not help cover any Medicaid shortfalls. Although this issue is not addressed here, any comprehensive calculation of cost-shifting to private employers must include consideration of these costs as well.

9 Erosion of Employer-Sponsored Health Insurance Market Contributes to MassHealth's Financial Challenges

Because it operates at the nexus of public and private programs, MassHealth's spending and policies are increasingly influenced by what is happening in the private health insurance market. As eligibility for MassHealth has expanded, the state is increasingly offering assistance to individuals who are employed but who either do not have access to health insurance through their employer or cannot afford coverage. Moreover, the state's evolving strategy is to encourage participation in employer-sponsored coverage, with MassHealth being supplemental rather than primary coverage wherever possible. Therefore, the trends in the employer health insurance market are of keen interest and importance to MassHealth.

National data show a sharp decrease in the level of employer based coverage, especially for the low-income population. Among the major factors in the decline is a reduction in "take-up" (i.e., enrollment by eligible employees), and reduced offer rates by employers. Reduced offer rates reflect in part shifts from full-time to part-time work and from employment in large establishments to employment in small establishments.[21] In addition, the percent of low-income adults (both parents and childless adults) covered by Medicaid/SCHIP or uninsured continued to increase in 2002.[22]

The most recent information in Massachusetts show no decline in the percent of employers offering health insurance, although there are no detailed data for the low-income workers. However, there are reasons for concern: fewer employers are covering spouses and dependents, premiums are rising rapidly and employer contributions are declining as a percent of premium.[23] As these trends pull employer coverage beyond the reach of more low-income employees and their families, MassHealth will fill some of the gaps. A rising level of uninsurance, especially among the low-income population, represents additional costs to the uncompensated care pool, additional challenges to MassHealth, and a growing problem for the health care community.

[21] "Work, Offers and Take-up: Decomposing the Source of Recent Declines in Employer-Sponsored Insurance," Linda Blumberg and John Holahan, The Urban Institute, Health Policy Online, No. 9, May 2004

[22] "Gains in Public Health Insurance Offset Reductions In Employer Coverage Among Adults, Snapshots of American's Families III, Urban Institute, September 2003

[23] Massachusetts Division of Health Care Finance and Policy, *Health Insurance Survey of Massachusetts Employers: Comprehensive Results from Employer Survey* (2003)

10 The Business Community Has A Vital Stake in A Strong MassHealth Program

Medicaid has long been an important source of health care coverage for the poor. As a public program, it offers broad and accessible coverage, income related eligibility, an emphasis on prevention and primary care, consistent access during periods of employment and unemployment, and a broad funding base. The MassHealth program has demonstrated its value as a cost-effective way to reduce the cost of providing coverage — by using aggressive purchasing, making use of private insurance where available, and maximizing federal dollars.

A strong MassHealth program benefits the entire Commonwealth, and particularly employers. Indeed, the business community has been a major beneficiary of expansions in the MassHealth program. Employers have a strong interest in the strategies and policies adopted by MassHealth, and in supporting thoughtful attempts by the program to moderate cost increases while preserving access and quality of care. In addition, helping to ensure adequate funding for the MassHealth program is a way for businesses to help maintain coverage options for low-income workers and workers with disabilities, reduce the cost of free care, and minimize cost shifting to employers that provide health coverage.

MassHealth…it's good for business.

Appendix: Methodology for Cost Shifting Estimates

Developing an estimate of the actual amount of any MassHealth payment shortfalls to hospitals and physicians would require a level of detailed analysis that is beyond the scope of this paper. There are no comprehensive publicly available data on Massachusetts physician revenue and expense, and limited hospital data, so it is not possible to estimate the actual ratio of Medicaid payments to provider cost. In addition, it is very difficult to quantify the extent to which hospitals and physicians have sufficient market power to negotiate higher rates from private health insurers in the face of any Medicaid payment shortfalls. So instead we attempt to illustrate the potential magnitude of cost shifting, using a range of assumptions about both the ratio of MassHealth payments to provider costs and the "ability" of providers to shift these shortfalls onto employers.

Hospitals

Hospital data were obtained from the FY 2003 Hospital Cost Reports, filed with the state Division of Health Care Finance and Policy. MassHealth reimbursed acute care hospitals approximately $1.3 billion in 2003, accounting for 10.3 percent of total patient revenues. Roughly two-thirds of this amount came from MassHealth fee-for-service payments and one-third came from Medicaid managed care plans. For individual hospitals, MassHealth's share of patient revenue ranged between one and 25 percent.

Because there has been no recent published analysis of MassHealth payment-to-cost ratios, we conducted a sensitivity analysis to estimate the magnitude of recent hospital payment shortfalls under a range of payment-to-cost ratio assumptions. This analysis also calculates MassHealth shortfalls as a percentage of hospital revenue from private insurance plans to illustrate the average increase in private payer rates needed to cover estimated shortfalls. We used payer-specific revenues from 1999 through 2003 from hospital cost reports and payment-to-cost ratio assumptions ranging from 70% to 90%. The middle of this range, 80%, is consistent with the Lewin Group's estimate for 1999. The lower bound, 70%, was included to account for factors that may have reduced the ratio in subsequent years including the fact that the annual MassHealth update that has grown more slowly than hospital expenses, and that there has been a gradual shift in services from inpatient to outpatient settings over time where payment rates are less generous. The upper bound, 90% is consistent with anecdotal reports of the more recent experience of many hospitals.

Exhibit A-1 presents a range of estimates for MassHealth hospital payment shortfalls. If payment to cost ratios remained at the 1999 level of 80%, in 2003 the estimated shortfall would be $319 million or about 6 percent of private insurer payments to hospitals. If the ratio declined to 70% in 2003, the shortfall would increase to $547 million or about 10 percent of private payments. In

contrast, if the ratio of payment to costs were 90% in 2003, the MassHealth shortfall would be $142 million or about 3 percent of hospitals' private sector revenue.

Exhibit A-1
Estimated Range of Medicaid Payment Shortfall
in Massachusetts Acute-Care Hospitals: 1999–2003
(dollar amounts in millions)

	1999	2000	2001	2002	2003
Total hospital net patient revenues	$8,783	$9,288	$10,454	$11,402	$12,339
Medicaid net patient revenues	$862	$912	$1,143	$1,240	$1,277
Medicaid percent	9.8%	9.8%	10.9%	10.9%	10.3%
Private insurer payments to hospitals	$3,587	$3,842	$4,117	$4,941	$5,586
Private insurer percent	40.8%	41.4%	39.4%	43.3%	45.3%
Estimated Medicaid Shortfall					
Assuming pmt/cost = 70%	($369)	($391)	($490)	($531)	($547)
Assuming pmt/cost = 80%	($216)	($228)	($286)	($310)	($319)
Assuming pmt/cost = 90%	($95)	($101)	($127)	($137)	($142)
Medicaid shortfall as percent of private payments to hospitals					
Assuming pmt/cost = 70%	-10.3%	-10.2%	-11.9%	-10.8%	-9.8%
Assuming pmt/cost = 80%	-6.0%	-5.9%	-6.9%	-6.3%	-5.7%
Assuming pmt/cost = 90%	-2.6%	-2.6%	-3.1%	-2.8%	-2.5%

Source: Division of Health Care Finance and Policy Hospital 403 Cost Reports.

MassHealth Physician Payments and Costs

It is difficult to estimate MassHealth physician shortfalls because there are no publicly available data analogous to hospital cost reports that provide comprehensive physician revenue or cost information in Massachusetts. According to state estimates, MassHealth paid physicians approximately $223 million in 2003. However, there is no way to estimate the cost of services associated with this revenue. On average, MassHealth physician fees were 71 percent of Medicare physician fees in 1998 and 80 percent of Medicare in 2003.[24] Medicare fees are typically lower than private payer fees. Therefore we conducted a sensitivity analysis of potential MassHealth shortfalls using the same range of payment to cost estimates used in the estimate of hospital payment shortfalls, 70-90% These ratios lead to physician shortfalls ranging from $56 million to $149 million in 2003 (Exhibit A-2).

[24] Stephen Zuckerman et al, "Changes in Medicaid physician fees, 1998-2003: Implications for physician participation," *Health Affairs,* Web exclusive, June 2004; and S Norton and S Zuckerman, "Trends in Medicaid physician fees, 1993-1998," *Health Affairs,* July/August 2000.

Exhibit A-2
MassHealth Physician Payments and Estimated Shortfall
(dollar amounts in millions)

	2001	2002	2003
MassHealth physician payments	$203.0	$215.0	$223.0
Estimated MassHealth Shortfall			
Payment to cost = 70%	($87)	($92)	($96)
Payment to cost = 80%	($51)	($54)	($57)
Payment to cost = 90%	($22)	($24)	($25)

Source: Executive Office of Health and Human Services.

Estimate of Employer Health Insurance Premiums

There are no publicly available data on the total cost of employer health coverage in Massachusetts. So we developed an estimate, based primarily on health plan financial reports filed with the state Division of Insurance. From the year-end 2003 reports, we obtained data on total group health premiums for the major health plans licensed in Massachusetts.[25] For the plans that do not report membership for self-insured accounts, we obtained from the plans the number of self-insured members, and estimated total premiums for these accounts using the average per member group premium for each plan. This number included an estimate of premium for active employees and dependents enrolled in the Group Insurance Commission's own health coverage plan.[26]

Based on discussions with experts in the group health insurance market, we believe this is a conservative estimate of premiums. For example, a recent analysis estimated that the total amount of private health insurance premiums in Massachusetts in is $14-15 billion.[27] Our lower estimate of premiums results in a higher estimate of the impact of MassHealth payment shortfalls on employer premiums.[28]

Estimate of Impact of Payment Shortfalls on Employer Premiums

We estimated the impact on employers of the MassHealth payment shortfall under two different cost-shifting assumptions. While it is unlikely that the entire amount of any MassHealth payment shortfall is recouped from private health plans, it is equally unlikely that providers are unable to shift any of the shortfall. So we estimated the cost to private payers of a shift of 100 percent and 50 percent of any MassHealth payment shortfall. (See Exhibit A-3.)

[25] The list of plans included: Blue Cross Blue Shield of Massachusetts (including HMO Blue), Aetna/USHC, Fallon, United Health Care, Tufts Health Plan, Harvard Community Health Plan, CIGNA, Neighborhood Health Plan, and Health New England.

[26] Total health plan premiums reported on the 2003 year-end reports was $7.5 billion. An additional $3.7 billion was estimated for members in other self-funded arrangements.

[27] Unpublished analysis by PricewaterhouseCoopers. Estimate includes premiums for nongroup health insurance policies.

[28] Using $15 billion as the estimate for employer health premiums would result in an estimate of 2.5% as the impact of MassHealth cost-shifting on employer health premiums, assuming an 80% payment-to-cost ratio and that 100% of any shortfall is shifted to private payers.

Exhibit A-3
Potential Impact of MassHealth Cost-Shift on Private Sector Premiums
2003 Data
(dollar amounts in millions)

	Payment to Cost Ratio		
	70%	**80%**	**90%**
Hospital Payment Shortfall: 100% shift	$547	$319	$142
Physician Payment Shortfall: 100% shift	$96	$57	$25
Hospital and Physician Cost Shift: 100% shift	$643	$376	$167
As Percent of Total Massachusetts Group Health Premiums (=$12.2 billion)	5.3%	3.1%	1.4%
Hospital and Physician Cost Shift: 50% shift	$322	$188	$84
As Percent of Total Massachusetts Group Health Premiums	2.8%	1.5%	0.7%

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