Health Coverage in Massachusetts: Far to Go, Farther to Fall

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Report for the Blue Cross Blue Shield of Massachusetts Foundation

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Executive Summary

In the fall of 2002, Massachusetts finds itself at a critical health policy juncture. After a lengthy and nationally recognized period of health reforms designed to expand coverage and improve health care access, the state has experienced an economic downturn, a major loss of tax revenues, and tremendous growth in health care costs. Ironically, the size and strength of the Massachusetts health care enterprise may make it particularly vulnerable to these recent trends. Together, these developments threaten not merely to halt, but to actually reverse, the very gains that have made the state a health coverage policy paradigm.

We believe that there are immediate, important, and fiscally sensible steps that state policy makers can take to avoid major deterioration in both public and private health insurance coverage.

Throughout the country, Massachusetts is known for its leadership in the effort to creatively use available public resources to achieve the maximum possible health coverage for all residents. As in all states, Massachusetts' voluntary, employer-sponsored health system leaves out hundreds of thousands of workers and their families; indeed, a comparison of state, regional, and national statistics suggests that the employer system performs at about the national average. What has made the state stand out is its commitment to public investment in its residents, both those who are unable to secure coverage through work as well as those who because of illness or disability lack a nexus to employment. MassHealth, the state's uncompensated care pool, and the state's farsighted investment in safety net institutions are the foundation of the state's accomplishments in health policy.

Now, virtually all of the gains of the past several years are threatened as the public system stands on the brink of serious decline and the number of people without private coverage threatens to grow significantly. If decisive action is not taken to stem the erosion in public and private coverage and, indeed, to adopt additional protections for persons without—or at risk for the loss of—health coverage, the state could find itself in a few years in the "middle of the pack" nationally, where coverage and access are concerned. For a leader in national health policy to allow erosion and stagnation sends a message to the rest of the country. Moreover, from a financial and human vantage point, the choice to do nothing or—worse—cut back on coverage has enormous consequences.

How state policy makers navigate this crisis will be critical not only to Massachusetts' residents and its economy but to the nation as well, since other states look to Massachusetts and are likely to follow its lead. We believe that there are immediate, important, and fiscally sensible steps that state policy makers can take to avoid major deterioration in both public and private health insurance coverage. These steps would avert hardships to state residents, the further destabilization of one of the state's most important industries and sources of jobs, and a damaging cost shift onto the state's budget and its already beleaguered health care institutions, particularly those that furnish high levels of health care to lower-income residents. Budget resources may be scarce, but a small investment now may prevent large state costs later if the current system unravels and has to be put together again.

This analysis has been prepared to highlight the state's experience in health reform and describe the challenges that it now faces. It recommends a renewed commitment to maintaining and strengthening the reforms that have made Massachusetts one of the nation's health policy leaders. This analysis does not focus on comprehensive health reform, although we believe that the cost and coverage problems that plague the Massachusetts health system (as well as that of every other state) would be most effectively addressed through broader restructuring aimed at achieving universal coverage and more

decisive control over expenditures. In this report, we instead focus on shorter term reforms that can be achieved both politically and financially, which would offer important protections to the residents who most need the help.

Key Findings

The state's health coverage leadership stems principally from the achievements of MassHealth.

In 2000, approximately 69% of non-elderly residents in Massachusetts had employer-based health coverage—the same as the national average and less than all New England states except Vermont.

- Between 1998 and 2000, state surveys found that the number of uninsured residents declined by more than 25%, to 365,000. The state was able to achieve a remarkable rate of improvement, far in excess of the national trend. However, the state's most recent survey, released last month, showed that the number of uninsured has increased by 9% to 397,000 and is expected to continue to grow.
- Virtually all of the decrease in the proportion of uninsured residents between 1998 and 2000 was the result of coverage of low-income children and adults through MassHealth. Among non-elderly persons with incomes below 133% of the federal poverty line, the proportion without health insurance fell from 22.5% to 12.5%. For persons with incomes between 134% and 150% of the federal poverty line, the proportion without coverage fell from 26.5% to 11.9%.
- MassHealth's financial eligibility levels are relatively—but by no means the most—generous among comparable states. Eligibility levels are higher for infants in two comparable states and for children up to age 18 in one state. Four comparable states have higher eligibility levels for unemployed parents, and one sets a higher rate for medically needy persons. This suggests that the program has performed well for those it targets, but has left some low-income people behind.

Private health insurance coverage in Massachusetts is not exceptional and is subject to all of the structural problems that show up in all states.

- Massachusetts' achievements in health policy come from its commitment to public insurance, not from the private health insurance landscape. Like all states, the private health insurance system in Massachusetts leaves out hundreds of thousands of residents including many who work full time. In 2000, approximately 69% of non-elderly residents in Massachusetts had employer-based health coverage—the same as the national average and less than all New England states except Vermont.
- Many factors account for the state's average performance where private coverage is concerned, in particular the cost of coverage for smaller employers and the absence of affordable individual health insurance plans.

The return of health care cost inflation may hit Massachusetts harder, potentially causing private coverage to deteriorate significantly.

- Because Massachusetts' private coverage rate is no better than average, the return of high health care costs at a time of economic slowdown can be expected to affect private coverage substantially. Nationally, hospital costs have been named as one of the most important reasons for the rise in health care costs. Massachusetts hospitals—one of the state's most important industries—exist in greater numbers and offer services of greater intensity than in most states.
- The problem is not merely hospital costs. Prescription drug costs have been increasing at double-digit rates—which, coupled with Massachusetts' disproportionately older population, translates into a significant cost driver.
- Skyrocketing costs meant that employer-based health premiums grew by 15% in Massachusetts, compared to 11% nationwide in 2001. Benefits may be eroding as well.

- Increases in premiums, along with increased unemployment, could cause at least 65,000 residents to lose health insurance coverage, according to recent studies. Such increases in the number of uninsured persons could wipe out the gains made by the state in the late 1990s and would cause a major decline in the state's national standing.

At the time that it is needed the most, MassHealth coverage is deteriorating.

- The state plans on ending MassHealth coverage for 50,000 persons as of April 2003 and has already reduced benefits and limited outreach activities.
- Proposals such as increasing cost sharing on low-income beneficiaries could further reduce access to care, put pressure on the uncompensated care systems, and further strain Massachusetts' premier health care system.

Allowing this deterioration to take place has costly and serious consequences for the state.

- The relationship between coverage and insurance is well established. As lower income individuals with serious health problems lose coverage, their access to timely health care will also decline, resulting in serious health and economic consequences. Nationally, about half of the uninsured reported struggling to pay for such basic expenses such as food and rent, and the vast majority (70%) were forced to deplete their savings to pay medical bills.
- From both a financial and human vantage point, allowing coverage to deteriorate—or, worse, cutting back on coverage—has enormous consequences. A deterioration in health insurance coverage could lead to increased uncompensated care and excess hospital costs for problems that are preventable with primary care. Cutbacks also would strain already-vulnerable safety net health care providers and lead to employment reductions in the health care industry, a major employer in Massachusetts. Stagnation and reduction in coverage also could have broader economic effects, reducing worker productivity and ultimately leading to an exodus of firms in search of lower health costs.

Key Recommendations

Although universal health coverage remains the goal, stemming loss of coverage and adopting smaller and less costly reforms are possible. Several solid, incremental options would preserve and avert deterioration in existing public and private health coverage as well as strengthen the performance of current programs. These options have a relatively low cost and would, if adopted, keep Massachusetts poised to pursue longer term reform in more expansive economic times without first having to simply recover the ground it has lost.

Restoring reductions in MassHealth: Dismantling MassHealth could, in the long run, cost more than it saves as costly populations and services fall into the realm of uncompensated care and as serious health problems go untreated and unmanaged. Restoring coverage and benefits cannot wait until next year. Policymakers should examine interim steps that could be taken.

Helping low-income workers who risk the loss of private coverage because of cost increases: The state could establish a demonstration project for workers at risk of losing their employer coverage, which would serve as a companion to the Insurance Partnership. A demonstration program could provide time-limited financial relief to lower income workers who work for employers who have historically offered coverage but who now are experiencing health insurance premium increases large enough to threaten their ability to continue their coverage for themselves and their families. This demonstration would be a mechanism for preventing even more families from losing private insurance and becoming dependent on public coverage.

Strengthening the public-private Insurance Partnership: The amount of the assistance available under the Partnership to make private premiums more affordable could be increased. Outreach efforts could be enhanced and plan choices could be increased by linking to options in small business purchasing coalitions.

Taking small steps towards universal coverage through both public and private reforms: Several steps would make existing public and private systems more available and navigable.

1. First, simplifying MassHealth to create fewer eligibility pathways and a more integrated and user-friendly system would itself be a downpayment on comprehensive health reform, since the very complexity of MassHealth makes it difficult to use the program as a springboard to broader coverage. At this critical time, outreach and enrollment should be stepped up, not backed down.
2. Second, the state could consider requiring large employers to negotiate for and at least offer health insurance to their workers. While they would not have to contribute to coverage, these employers would at least be able to give their workers access to affordable coverage.
3. Third, the state could consider approaches to contracting and purchasing that favor employers, both large and small, that insure their workers.
4. Fourth, the state also could allow workers at public clinics and health centers to secure coverage through the state employee health benefit plan in order to maximize control over costs and increase coverage.

Each of these proposals for new interventions would need more detailed development as well as cost estimation. Although this paper does not include cost estimates, which were beyond the scope of the project, it does characterize options as having low or moderate public costs, based on our experience. We chose to present only low or moderate-cost and relatively low-controversy options that represent important approaches for keeping the goal of comprehensive coverage alive.

Introduction

In the fall of 2002, Massachusetts finds itself at a critical health policy juncture. After a lengthy and nationally recognized period of health reforms designed to expand coverage and improve health care access, the state has experienced an economic downturn, a major loss of tax revenues, and tremendous growth in health care costs. Together, these developments threaten not merely to halt, but actually reverse, the very gains that have made the state a national health leader. If decisive action is not taken to stem the erosion in public and private coverage and, indeed, to adopt additional protections for persons without—or at risk for the loss of—health coverage, the state could find itself in a few years simply in the "middle of the pack" where coverage and access are concerned. Budget resources may be scarce, but a small investment now may prevent large state costs later if the current system unravels and has to be put together again.

If decisive action is not taken to stem the erosion in public and private coverage and indeed, to adopt additional protections for persons without—or at risk for the loss of—health coverage, the state could find itself in a few years simply in the "middle of the pack" where coverage and access are concerned.

This analysis has been prepared to highlight the state's experience in health coverage and access and describe the challenges that it now faces. Most importantly, however, this paper argues for a continued commitment to maintaining and strengthening the reforms that have made Massachusetts one of the nation's true health policy leaders.

This analysis specifically does not recommend comprehensive health reform as the next step, although we believe that the cost and coverage problems that plague Massachusetts' health system (as well as that of every other state) would be most effectively addressed through aggressive reforms that are aimed at achieving universal coverage and greater controls over expenditures. Instead, we attempt to identify short-term, achievable reforms on the path to comprehensive coverage that would offer important protections to the residents who most need the help.

This is a critical moment in the evolution of the Massachusetts health policies and programs. Massachusetts has always been regarded as a health policy leader. Through its restructuring of public insurance over the past several years, the Commonwealth has enhanced its national reputation as a jurisdiction dedicated to fundamental principles of health equity for all state residents. These actions produced results: a drop in the number of uninsured and an increase in access and the health status of residents.

Now, however, the economic downturn and escalating health costs have combined to create serious challenges for state policy makers. Already, benefits in and eligibility for MassHealth coverage have been reduced. Further cuts, an erosion in private coverage, and a failure to protect existing coverage could jeopardize the access improvements that have had demonstrable effects on residents' health and the state's economy. A deterioration in health coverage will not simply reduce access to care and the health status of those directly affected. It will increase uncompensated care, strain already-vulnerable health care providers, and potentially reduce employment in the health care industry, which is a major employer in the state. It could also have broader economic effects, reducing worker productivity, causing workers and employers to move to other states with more affordable, comprehensive health systems, and limiting the potential of its future workforce, because uninsured children have more sick days and learning challenges.

Budget resources may be scarce, but a small investment now may prevent large state costs later if the current system unravels and has to be put together again.

How state policy makers navigate this crisis will be critical not only to Massachusetts residents and its economy but to the nation since other states will likely follow Massachusetts' lead. Public policy options could be adopted that not only protect but expand coverage to move towards the goal of health coverage for all residents of Massachusetts. Budget resources may be scarce, but a small investment now may prevent large state costs later if the current system unravels and has to be put together again. Alternatively, neglect or action to reduce health coverage could produce short-term savings but would have long-term consequences not only for Massachusetts but for the nation that looks to Massachusetts as a model.

This report, prepared for the Blue Cross Blue Shield of Massachusetts Foundation, describes the current health insurance coverage landscape in Massachusetts, recent changes and challenges, and options for reforming coverage and improving access to health services. It includes a series of tables and figures designed to enhance understanding of how Massachusetts compares to other states both in the New England region and throughout the country. Much of this information comes from the excellent data collection and reporting of state officials and health policy experts in Massachusetts. The options presented in this paper are designed to minimize cost and controversy and maximize the potential for implementation. As such, the report is meant to complement state efforts to study single payer systems and consolidated and streamlined health care options (the LECG study) and other approaches to health reform such as the state's studies conducted under a grant from the federal Health Resources and Services Administration (the HRSA planning grant).

PART I

The Massachusetts Health System: A Landscape

A Overview

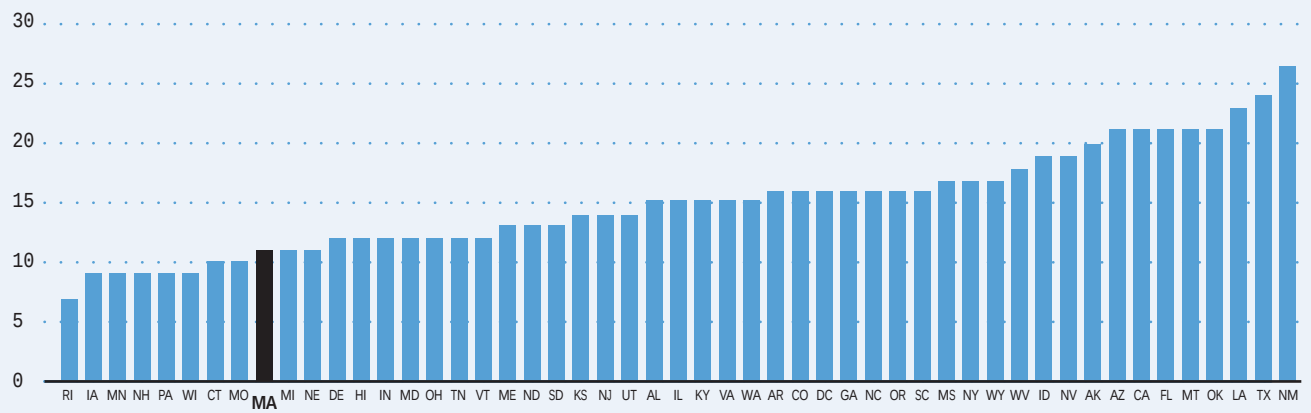
Where the state stands out is in its willingness to invest in public insurance and public programs aimed at securing coverage for state residents who—because of income, the nature of their employment, health status, or other reasons—are left out of the employer-sponsored health system.

Massachusetts is distinguished by its longstanding leadership in health policy. Whether from the vantage point of health care coverage, access to health care, or commitment to public health and safety, the Commonwealth is a state to which policy makers and researchers have turned over the years for guidance. It has a strong public insurance and safety net system; its employers generally offer workers affordable health coverage; and it boasts some of the best health care facilities and training centers in the nation, if not the world. Similarly, as all states struggle with new budget and health care cost pressures, Massachusetts' response—be it efforts to cut back, preserve, or expand coverage—will be watched and imitated by other states.

Massachusetts is not exceptional in the extent of health insurance coverage through its private employers; indeed, while most employers in Massachusetts offer health insurance as an employee benefit, Massachusetts ranks at about the national average where employer-sponsored coverage is concerned. Where the state stands out is in its willingness to invest in public insurance and public programs aimed at securing coverage for state residents who—because of income, the nature of their employment, health status, or other reasons—are left out of the employer-sponsored health system.

Because of this commitment to public coverage, which increased significantly during the latter half of the 1990s, Massachusetts enjoys one of the lowest rates of non-elderly persons without health insurance in the U.S. (Figure 1). Massachusetts also has made an important commitment to the direct financing of health services to safety net clinics and institutions that tend to serve those state residents (particularly individuals who are neither citizens nor permanent residents) who fall outside of existing public insurance programs. Finally, the state has invested in accountability in its health system, with strong data collection systems to monitor coverage and access of its residents. This report relies on Massachusetts' data and uses national data systems primarily when comparing the state's outcomes to that of other states and the nation.

Figure 1 Percent of Non-elderly Who Are Uninsured by State, 1999-2000



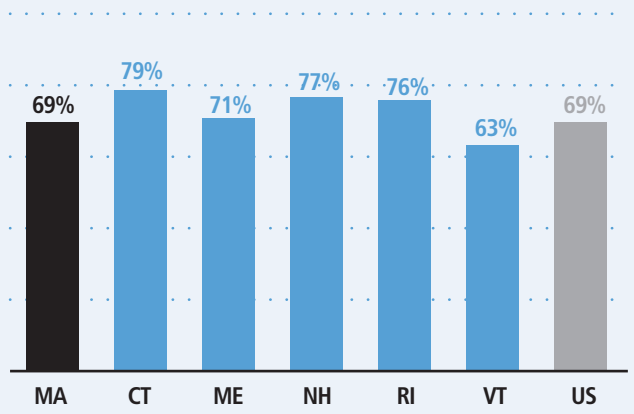
Source: State Health Facts Online, KFF

B Private Health Insurance Coverage

1. Employer-Sponsored Plans

As is true for the nation as a whole, about seven in ten non-elderly Massachusetts residents secure health insurance through their employers (Figure 2). Because certain types of jobs are more likely to provide health coverage, employment patterns in Massachusetts affect its health insurance profile. Even though it has increased from an all-time low of 2.5% in October 2000, Massachusetts' unemployment rate of 4.9% is below the national and northeast averages (5.9% nationwide and 5.3% in the northeast in July 2002).[1] In part, this relatively low unemployment rate relates to the structure of the state's business and industry. Compared to the national economy, Massachusetts has a higher proportion of jobs in the service industry overall (39% vs. 32%) and in particular, health care and education (14% vs. 9%), which tend to be unaffected by recessions. The proportion of Massachusetts' workers in small businesses is about the same as the U.S. average: 17% (compared to 18% nationally) work in firms with fewer than 20 workers.[2] Massachusetts' 2000 per capita personal income was second only to Connecticut in both New England and the entire U.S., at $37,704.[3]

Figure 2 Percent of Non-elderly with Employer-Sponsored Health Insurance, 1999-2000

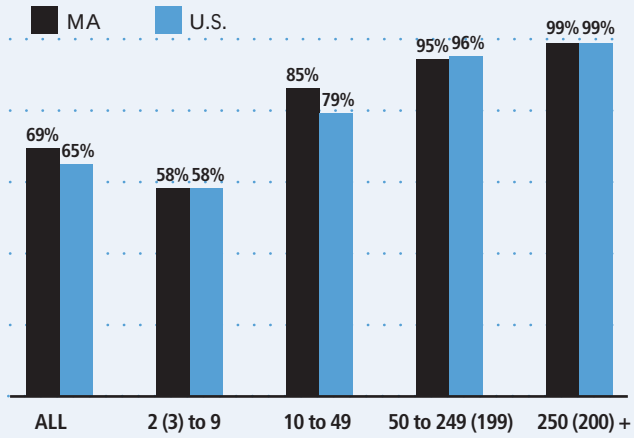


Source: AARP State Profiles 2001

Access to job-based coverage

Given the Commonwealth's health orientation, it might be surprising to some that the employer commitment to health coverage is not higher. It appears that Massachusetts employers, like those in other states, feel the economic ramifications of including health benefits in their employee compensation packages. As is true nationally, larger Massachusetts firms are far more likely to offer health insurance to their workers. Virtually all Massachusetts firms with 50 or more workers offer health insurance. Furthermore, Massachusetts firms with 10 to 49 workers are slightly more likely than their counterparts in other states to offer coverage (Figure 3). However, in Southeastern Massachusetts, where firms tend to be smaller, only 54% offer coverage, reflecting the fact that, like employers throughout the country, Massachusetts employers are highly sensitive to the economic consequences of including health coverage as an employee benefit.

Figure 3 Firms/Establishments Offering Health Insurance, 2001



Source: MA 2001 Employer Health Insurance Survey; Kaiser/HRET Employer Health Benefits 2001

Note: Establishments are different from firms; numbers in parentheses are the firm size breaks for the U.S. data.

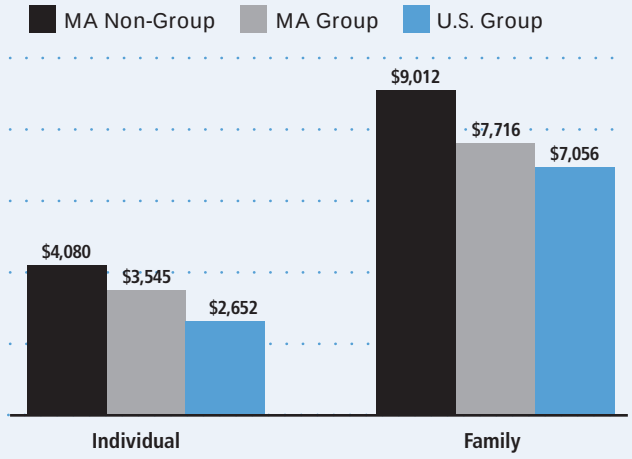
As with employers nationally, smaller firms with greater numbers of low-wage workers appear to struggle to offer health benefits. To encourage coverage through small employers, the state created the Insurance Partnership program. Financial assistance toward the cost of health insurance for low-income employees is available to employers who have 50 or fewer employees and subsidize at least 50% of the cost of comprehensive health insurance. Employees also receive assistance if their income is below 200% of poverty. Self-employed individuals (with annual income under 200% of poverty) may participate in the Partnership program and represent 65% of enrollment.[4] The actual amounts of the employer subsidies are determined by the state legislature, with Medicaid matching subsidies for employers offering coverage for the first time, and the state paying for other employers.[5] However, this program, to date, has had little impact on the rate of small businesses offering or its workers gaining health insurance. Among firms not offering coverage, the high cost of premiums was named as the most important deterrent.[6]

In other respects, the Massachusetts market also looks like the U.S. average. Like other workers, the vast majority of Massachusetts workers (77%) participate in company health plans when they are offered. However, as is true in other states, a majority of Massachusetts workers (59%) have to endure a waiting period before becoming eligible to participate in their employers' plans.[7] Nationwide, waiting periods averaged 1.6 months (longer in small firms).[8]

Benefits and premiums

Although benefits and cost sharing are considered reasonable in comparison to those offered by employers in other states, premiums are high. A recent survey of Massachusetts employers found that in 2001, the average annual premium for the employer's most popular health plan cost $3,545 for an individual and $7,716 for a family.[9] These figures are, respectively, about 34% and 9% higher than the national average for all firms (Figure 4).[10] In addition, between 2000 and 2001, health insurance premiums grew faster in Massachusetts than the national average: 15% for family policies compared to 11% nationwide (Figure 5). Massachusetts employers paid about 73% of the family health premium in 2001 (the same figure as nationally). This figure is a decline from 2000 when employers contributed 75% toward family premiums. As a result, the average family paid 24% or over $400 more for health coverage in 2001.[11]

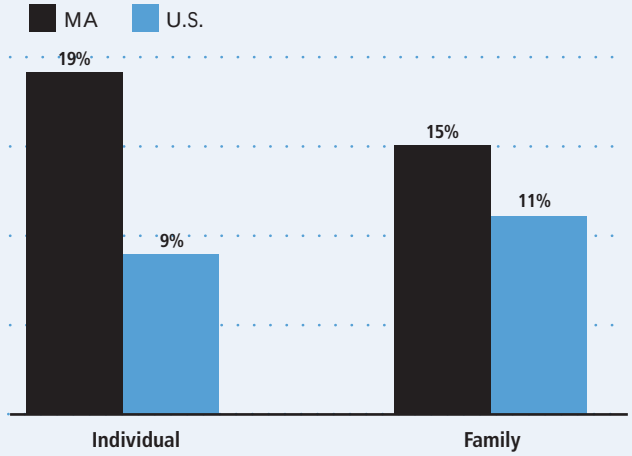
Figure 4 Health Insurance Premiums, 2001



Source: MA 2001 Employer Health Insurance Survey, Nongroup Survey; Kaiser/HRET Employer Health Benefits 2001

Note: Establishments are different from firms; numbers in parentheses are the firm size breaks for the U.S. data

Figure 5 Higher Premium Increases From 2000 to 2001



Source: 2001 Employer Health Insurance Survey, Turnbull, Kaiser HRET Annual Survey

2. Individually-Purchased Insurance Coverage

While employer-sponsored plans dominate the market for private coverage in Massachusetts, about 52,000 residents (less than 1%) were insured in the non-group, individual health insurance market in 2001—a 10% decline from 2000.[12] Even this low enrollment in the individual market is misleadingly large because a third of these enrollees are members of plans that are no longer open for individual enrollment.[13]

In general, people purchase individual coverage policies when they do not have access to employer-based health insurance because they do not work for an employer who offers coverage, are unable to work, or are no longer in the workforce. In 2001, non-group enrollees in Massachusetts were disproportionately older: Over 40% were between the ages of 50 and 64.[14] That year, the median premium for policies in the non-group market was about 15% higher than average policies in the employer market (Figure 4).[15] Although good comparison data do not exist, Massachusetts has a smaller non-group market than most states in part because of employment patterns (for example, in the Midwest a greater proportion of workers are self-employed) and in part because of the state's efforts to create a more affordable market for small employers and self-employed persons.

3. Regulation of Private Health Insurance

Massachusetts, like other New England states, has a relatively strong history of consumer-oriented insurance regulation. In the 1990s, the state strengthened regulation through the adoption of laws regulating benefits and coverage, access to care, access to health providers, and mental health parity. The state also has adopted laws requiring modified community rating in the small group market.[16] It has not adopted laws that provide the full range of policies in the Patients' Bill of Rights. In 1999, Massachusetts enacted legislation broadening the

authority of state regulators to intervene in the operations of health insurers in serious circumstances where solvency and continued functioning are threatened.

In the non-group market, individuals have access to guaranteed issue of a standard health insurance plan covering certain "core" and supplemental benefits and cost-sharing. However, there is very weak rate regulation in the non-group market. Rates are only subject to review and approval if they are vastly greater than the average rate, which has rarely been the case. The cost of non-group insurance in Massachusetts is high.

4. Summary

In sum, going into the economic downturn and recent period of dramatic health care cost escalation, the private health insurance picture in Massachusetts looked like that in most other states. Coverage in small firms was slightly more prevalent, but overall the proportion of state residents with private coverage was average compared to the nation. And, as in other states, Massachusetts had large numbers of smaller employers who remained outside of the insurance market primarily because of cost concerns. While the state made an effort to attract these employers to the market by providing them subsidies through the Insurance Partnership program, efforts showed no appreciable results. The state has pursued a fair amount of regulation of the private market relative to other states, but this regulation has been aimed at matters such as benefit design and health care access, not the cost of insurance itself.

C The State's Public Health Insurance and Health Care Programs

Massachusetts' leadership in health coverage policy is best seen in its efforts to build a wide range of public insurance and related offerings for persons outside of the private market. The Commonwealth has been a national leader in restructuring and expanding its Medicaid program to respond to the needs of the state's population. It also has provided direct financial support for health care providers whose services are considered important as a matter of public health policy.

1. MassHealth and Related Programs

The Commonwealth has been a national leader in restructuring and expanding its Medicaid program to respond to the needs of the state's population.

MassHealth, established in 1997 under special federal demonstration authority, combines a substantially redesigned Medicaid program with other existing state initiatives aimed at helping persons without insurance or access to health care.[17] In addition to traditional Medicaid populations such as children, pregnant women, single-parent-headed families, the elderly, and persons with disabilities, MassHealth extended coverage to long-term unemployed adults, lower-income families with children, persons with HIV, persons who do not satisfy citizenship and residency requirements applicable to the federal Medicaid program, and others. MassHealth also provides disproportionate share hospital funding to certain health care institutions, some of which in turn offer subsidized coverage to lower income residents who otherwise do not qualify for direct coverage under one of the MassHealth categories. In addition, as noted previously, MassHealth offers a premium assistance program for smaller employers and their low-wage employees. MassHealth exists alongside other state programs, such as coverage for the short-term unemployed.

Table 1 sets out the principal "traditional" and "new" population groups and coverage arrangements made available through MassHealth. One of the unique aspects of MassHealth is its Insurance Partnership, which offers subsidies to both small employers and their employees as an incentive to improve private coverage. However, as can be seen in Table 2, it has had only a modest impact on employer participation. The most notable group of individuals that is *not* directly covered under MassHealth is lower-income uninsured workers without children whose employers do not participate in the MassHealth Insurance Partnership program. These workers must rely on subsidized care offered by participating health care institutions in their communities.

Table 1 MassHealth Key Components

Standard (86% of enrollment): Health insurance for people who are eligible for traditional Medicaid, including pregnant women and infants under 200% of the Federal Poverty Level (FPL); children under 150% FPL, and parents and disabled adults under 133% FPL. This population is eligible for the full Medicaid benefit package, often provided through managed care plans.

Basic (7% of enrollment): Health insurance for long-term unemployed, disabled adults below 133% FPL. This population is eligible for coverage that largely mirrors the Medicaid benefit package, with the exception of hospice care, non-emergency transportation, and community long-term care (day habilitation, adult day health, adult foster care, private duty nurses, and personal care services). Scheduled for elimination April 1, 2003.

CommonHealth (1% of enrollment): Health insurance for disabled children and adults (children above 150% FPL, adults above 133% FPL) who are ineligible for Standard Medicaid. People with disabilities do not have to meet income criteria; however, eligible persons above 170% FPL must pay premiums. The CommonHealth benefit package is virtually identical to Standard Medicaid.

Family Assistance (3% of enrollment): Health insurance for children between 150-200% FPL and employed persons under 200% FPL. Children are eligible for the MassHealth Basic benefit package (with a $10/month premium per child) or employer-subsidized private insurance. Employed individuals under 200% FPL are eligible for assistance with premiums for employer-sponsored health insurance. Employers can also receive subsidies to provide health insurance to low-income workers.

Limited (3% of enrollment): Health services for undocumented immigrants, including pregnant women and children (under 200% FPL) and parents and disabled adults (under 133% FPL). Coverage is available for medical services to treat acute (emergency) medical conditions, including labor and delivery.

Premium Assistance: Health insurance for low-income (< 200% of poverty) employed adults. It provides financial assistance with employer-based insurance premiums, deductibles, and co-pays.

Prenatal: Presumptive eligibility for prenatal services for pregnant women under 200% FPL who are pending eligibility determination for MassHealth Standard.

Medical Security Plan: Health insurance for unemployed persons (eligible for unemployment benefits) under 400% FPL.

Source: MassHealth 1115 Demonstration Project Annual Report SFY 2001, prepared for the Center for Medicare and Medicaid Services. Enrollment for 2001.

Table 2 Enrollment in the Insurance Partnership

Year	Number of participating employers	Number of insurance policies	Number of covered lives
1999	160	n/a	n/a
2000	1311	2954	8,030
2001	3140	5697	13,485

Source: MassHealth 1115 Demonstration Project Annual Reports SFY 2000 and SFY 2001, prepared for the Center for Medicare and Medicaid Services.

Table 3 compares the financial eligibility rules for MassHealth to programs in other states in the Northeast as well as selected states (Illinois, Maryland, and New Jersey) with comparable economic climates and thus the same federal medical assistance percentage (50%) (i.e., federal match) as Massachusetts. These comparisons show that, among these states, Massachusetts' financial eligibility levels are relatively—but by no means the most—generous. Eligibility levels are higher for infants in two states and for children up to age 18 in one state. Four states have higher eligibility levels for unemployed parents, and one sets a higher rate for medically needy persons.

Table 3 Financial Eligibility for Selected Medicaid and SCHIP Enrollment Groups: A Nine-State Comparison

	Infants (0-1)	Children (1-5)	Children (6-17)	Pregnant Women	Unemployed Parents	Medically Needy (individual)
Massachusetts	200%	200%*	200%*	200%	133%	78%
Connecticut	185%	185%	185%	185%	150%	71%
Delaware	200%	133%	100%	200%	100%	n/a
Illinois	200%**	133%	133%	200%	31%	42%
Maine	200%	150%	150%	200%	150%	47%
Maryland	200%	200%	200%	200%	34%	52%
New Hampshire	300%	185%	185%	185%	49%	76%
New Jersey	200%	133%	133%	185%	200%	55%
Vermont	300%	300%	300%	200%	185%	110%

* Between 150%–200% FPL, there is a slightly reduced benefit package or premium assistance for employer-sponsored health insurance.

**Benefits are available to children born to women on Medicaid with income under 200% FPL—eligibility for other infants is set at 133%.

Sources: Donna Cohen Ross and Laura Cox, *Enrolling children and families in health coverage*, Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. (June 2002); Emily Cornell, *Maternal and Child Health Update 2000*, National Governor's Association, Washington, D.C. (February 2001); and Brian Bruen, Joshua Weiner, Johnny Kim and Ossai Mazzad, *State Usage of Medicaid Coverage Options for Aged, Blind and Disabled People*, Urban Institute, Washington, D.C. (August 1999).

MassHealth has played a key role in the state's efforts to reduce the number of uninsured. Enrollment has grown significantly over time, in great part because of aggressive outreach and assistance. Total Medicaid enrollment rose from 850,776 in 1998 to 954,841 by 2001. Between 1998 and 2001, eligibility under the state's coverage expansions increased by 57%, from 154,000 in 1998 to about 268,000.[18]

MassHealth's costs grew from $3.7 billion in 1998 to $5.5 billion in 2002. Some of this growth can be attributed to increases in enrollment, particularly among long-term unemployed adults, children, and their parents. Yet, program expenditures are disproportionately concentrated among the elderly and disabled. Even with the MassHealth expansions, the demographics of the state mean that its enrollees are relatively old compared to the nation and other New England states. People over age 65 comprise only 11% of Medicaid enrollment yet account for 37% of total program expenditures. The most significant expenditure for this population is nursing home care. The other major cost driver, as in many states across the county, is pharmacy costs. The costs of prescription drugs have increased at double-digit rates since MassHealth began.[19] Furthermore, the proportion of beneficiaries with disabilities is high, in part due to its strong home and community-based care waiver system.

It is also important to note that a companion to MassHealth is the Medical Security Plan, a program that operates as part of the state's unemployment compensation system and that aids persons experiencing short periods of unemployment affording COBRA continuation coverage.

2. Aid through the Uncompensated Care Pool

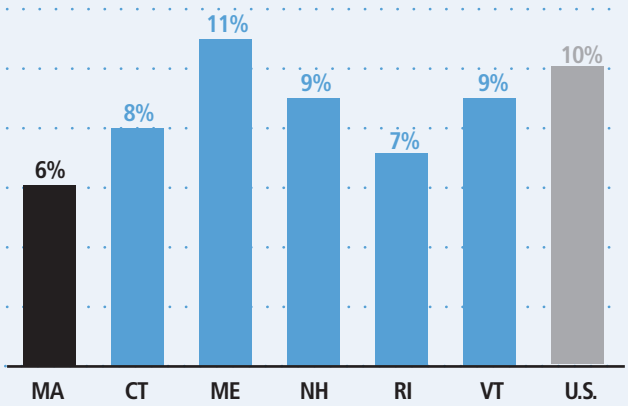
One of the most significant features of Massachusetts' overall health safety net is its Uncompensated Care Pool. Created in 1985, the Massachusetts Uncompensated Care Pool partially compensates health care providers for caring for low-income, uninsured, or under-insured people. Hospitals are paid for their uncompensated care from the capped Pool based on "the ratio of reasonable costs to charges" and availability of funding.[20] The amount of uncompensated care payments made to hospitals varies considerably depending both on the amount of free care they provide and their share of the hospital assessment, which is the largest source of funding for the Pool. Community health centers are paid by the Pool according to the 1995 federally qualified health center rate. The pool is funded through a hospital assessment, a surcharge on payments to hospitals by insurers and individuals, and state general funds. In 2000, most payments from the Pool went to hospitals, 3% to community health centers, and 1% for demonstrations.[21]

D Results: Health, Access, and Coverage in Massachusetts

1. Health status and outcomes

The strong and persistent focus in Massachusetts on health care has resulted in good health outcomes. In 2000, the Department of Public Health noted that Massachusetts' age-adjusted death rate was 6% lower and average life expectancy was 1.4 years higher than the national rate.[22] Against most Healthy People 2010 Mortality Objectives, Massachusetts nearly reached or achieved targets for immunizations, responsible sexual behavior, coronary heart disease, lung cancer, HIV/AIDS, and neonatal mortality.[23] Its aggressive anti-smoking efforts have paid off with steep declines in cigarette packs purchased and lower than average adult and teen smokers.[24] Its infant mortality rate is 25% below the national average and below all but one New England state (Maine). And, it ranks fifth in the nation for its high proportion of children receiving immunizations.[25] However, like many other states, Massachusetts' African-American and Latino populations tend to be in poorer health and, on other outcomes, the state's residents' health is closer to average.[26]

Figure 6 Access to Care: Proportion of People Not Visiting A Doctor Due to Cost, 2000



Source: AARP State Profiles 2001

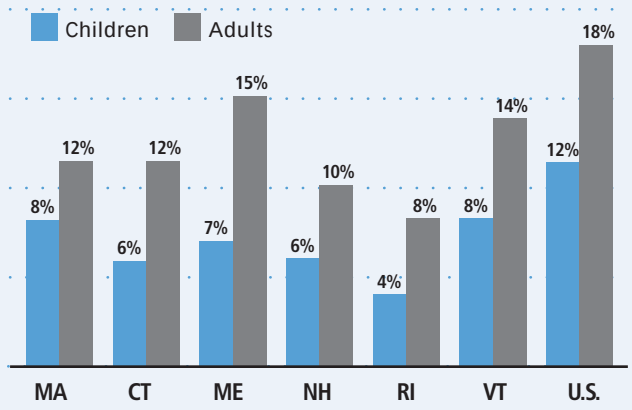
Equally important, access to health care appears to be improved by Massachusetts' investment in both insurance and safety net providers: only 6% of its residents reported not seeing a doctor due to costs—significantly lower than the national average and lower than all but two other states (Figure 6).[27]

2. Health coverage

Massachusetts has enjoyed a relatively low proportion of persons without health insurance, ranking ninth in the nation in 1999–2000.[28] A more recent state survey estimated that, in 2002, 6.4% of the population—about 397,000 people—in Massachusetts lacked health insurance coverage.[29] The rate of uninsured remained constant for children but rose among adults, especially older adults. The rate of lack of insurance among Massachusetts adults ages 40 to 64 rose by over 25% (from 4.9% in 2000 to 6.2% in 2002). Compared to other New England states, Massachusetts' overall performance is about average (Figure 7).

Many of these people are uninsured for short periods of time. Nationwide about 40 million Americans lack health insurance at a point in time, but about 62 million Americans lack health coverage for at least one month during a year.[30] Research shows that the access problems resulting from the lack of health insurance affect even those who are uninsured for short periods of time.[31] A recent study examining the duration of periods without coverage in Massachusetts found that 30%

Figure 7 Rate of Uninsured Adults and Children, 1999-2000



Source: March Current Population Surveys, 2000, 2001 as reported on State Health Facts Online, KFF.org

of uninsured adults lacked coverage for less than a year. Compared to a different study of the uninsured nationwide, it appears that Massachusetts has done a better job of covering the short-term unemployed, since a greater share of the uninsured nationwide are uninsured for less than a year.[32] The "long-term" uninsured in Massachusetts are typically men, work for small firms, and are older.[33]

3. Summary

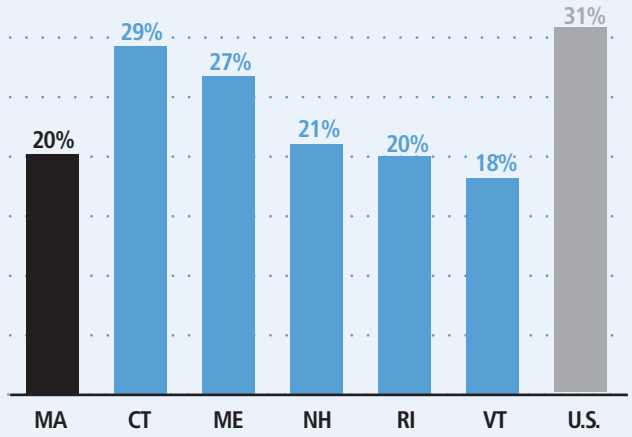
Thus, prior to this recent period, Massachusetts had made major strides in its health insurance coverage. It restructured public programs, helping to reduce the insurance gap. Through incremental reform, the state had succeeded in improving coverage through both direct coverage and investment in community health systems and safety net hospitals that themselves have been able to provide subsidized care. This has had a measurable, positive impact on health and access to care.

The uninsured rate in Massachusetts, while lower than the national average, was not significantly better than other New England states.

But important gaps remained. The uninsured rate in Massachusetts, while lower than the national average, was not significantly better than other New England states. Massachusetts' overall positive profile also has hidden the structural shortcomings in the private market. Similar to the national average, about 60% of all Massachusetts residents (69% of non-elderly residents) had coverage through an employer or the military. Similar to other states, about three-fourths of the working uninsured are employed by small firms. Lower-income workers employed in firms that neither offered health insurance nor participated in the premium support system remained vulnerable. This was particularly true in outlying areas of the state, where the wages are lower, smaller employers are concentrated in greater numbers, and there are fewer safety net providers.

What has made Massachusetts a leader in health insurance policy has been the performance of its public programs. Unlike most other states, as of 2001, more people in Massachusetts were enrolled in Medicaid than Medicare (15 vs. 11%). About 27% of children in the state were in MassHealth; only three states had a higher proportion of children covered through public programs.[34] Insurance statistics for the New England region suggest that MassHealth has successfully lowered the uninsured rate for lower-income people (Figure 8). Furthermore, Massachusetts' health insurance program for the short-term unemployed also appears to have shortened the period of time without health insurance; in Massachusetts a greater share of the uninsured are uninsured for less than a year. Yet Massachusetts' financial eligibility levels are relatively—but by no means the most—generous than other comparable states (Table 3). Eligibility levels are higher for infants in two comparable states and for children up to age 18 in one state. Four comparable states have higher eligibility levels for unemployed parents, and one sets a higher rate for medically needy persons. This suggests that the program has performed well for those eligible for it but it still has left some low-income people behind.

Figure 8 Rate of Uninsured Among Low-Income People, 1999-2000



Source: March Current Population Surveys, 2000, 2001 as reported on State Health Facts Online, KFF.org

Note: "Low-income" is defined as having income below 200% of the poverty line.

PART II

Shifting Sands: Threats to Health System and Access to Coverage and Care

A Overview

Recently, a confluence of trends has created volatility in the U.S. health system that has not been seen since the early 1990s. Beginning in the spring of 2001, a significant economic slowdown caused a spike in unemployment. The slowdown was further exacerbated by the events of September 11 and subsequent developments in the economy and stock market. Unemployment in Massachusetts, as in the nation in general, has risen dramatically.

Simultaneously, after a five-year lull, health care cost inflation returned, with enormous increases in the cost of health care intensifying problems caused by a sluggish economy. Driven by pent-up provider revenue needs, provider consolidation, the demise of tightly managed HMO-style insurance products in favor of more loosely configured benefit plans, and growing reliance on expensive pharmaceuticals, this health care cost growth has translated into double-digit increases in health insurance premiums. This health care cost spiral affects not only private payers but public programs as well—at the very time that state revenues are declining.

Because Massachusetts' private system mirrors the national average, there is no reason to believe that a sharp economic downturn will not have the same negative impact in the state as it will nationally. The number of employers contributing significantly to employee coverage can be expected to diminish. The number of employees who can afford to take up the slack in the face of stagnating wages and escalating costs also can expect to fall, particularly given the high burden of health costs in the Commonwealth.

Furthermore, the state budget outlook in Massachusetts has taken a sharp turn for the worse. With revenues declining at the same time that health care costs are rising, inevitable pressure has been placed on MassHealth. Both benefits and eligibility have already been cut. Additional proposals for scaling back coverage and/or increasing cost sharing have been put on the table. Even though these policy changes, by definition, increase uncompensated care, state funding for the pool has not kept pace. The state has, in recent years, increased its contribution to the pool to reduce the shortfall and lessen the hospital assessment. Despite the additional funding, however, shortfalls remain. Moreover, in the current budget climate, this assistance may not be sustainable. While similar crises are occurring in most states, the situation in Massachusetts may be worse, for a number of factors described in this section.

B Health Care Costs and Rising Health Insurance Premiums

Ironically, it is, perhaps, the very size and strength of Massachusetts' health care enterprise that makes it particularly vulnerable to the recent trends. Health costs are mounting in a system that historically has been identifiable by its higher costs. The nature of the state's health care industry, with its emphasis on renowned and complex teaching institutions, makes health care relatively costly at the start. As health costs escalated, the state began to experience spikes in insurance rates that were higher than the national average.

Ironically, it is, perhaps, the very size and strength of Massachusetts' health care enterprise that makes it particularly vulnerable to the recent trends.

Hospital costs. After over a decade of slow growth, hospital costs nationally (for both inpatient and outpatient services) have been rising, contributing to 43% of overall health care cost growth in 2000.[35] The rate increases that Massachusetts hospitals have been able to secure from private insurers, however, have not been sufficient to overcome what, according to at least one study, have been relatively low Medicaid payment rates in a state in which Medicaid is a principal form of health coverage.[36] The net result has been widespread hospital revenue losses with closures and conversions affecting nearly one-quarter of all hospitals in the state. Another dozen are facing serious financial problems.

Prescription drug costs. Although a small proportion of total spending, prescription drug expenditures have been one of the fastest growing components of health spending. In 2001, Massachusetts ranked 10th in the nation in terms of its average retail price of prescriptions ($52 compared to $50 nationwide). The state's overall growth in retail prescription sales was 17% between 2000 and 2001, 9.5% on a per capita basis (about the same as the national growth).[37] In addition to affecting private insurers, this trend has had a major impact on MassHealth, which is the single largest purchaser of prescription drugs in the state. Prescription drug costs have been a principal factor in the return of rapid MassHealth cost growth, particularly in light of the populations that it insures. Because Medicare does not now—and will not in the near future—cover prescription drugs, the state has created a Prescription Advantage program to help seniors afford needed medications. Consumers, too, have felt the impact of drug price increases. In a recent survey of Massachusetts residents, 20% of respondents raised concerns about increases in drug costs and another 21% said that costs prevented them from filling a prescription.[38]

Other issues. Like hospitals, nursing homes in the state have raised concerns about Medicaid payment rates. In January 2002, they filed suit against Massachusetts, claiming that the 1.5% payment rate was inadequate to pay for the costs of care.[39] Pharmacies have also been disgruntled about payment issues. In a last-minute attempt to close the budget gap, the Legislature and Governor supported a reduction in the amount paid to pharmacies for dispensing Medicaid prescription drugs. After the two major pharmacy chains that fill 60% of beneficiaries' prescriptions threatened to drop out of Medicaid, the state postponed this action.[40] In addition, both public and private payers may find fewer physicians in the state. A recent survey suggested that the high cost of practicing medicine in Massachusetts is affecting the ability to recruit new physicians and could result in shortages in certain specialties.[41] Finally, experiences in other states like Nevada have led to a federal focus on the role of malpractice insurance in overall health cost growth. Physician groups and a recent government report name it as major contributor to health cost growth.[42] However, others contend that, while undeniably high, malpractice insurance cost growth is not out of line with other types of insurance growth, and is actually down as a percent of total health spending.[43]

C The Impact of Escalating Costs on Private Coverage

Underlying increases in health care costs typically produce higher private premiums, strain on employers, and the potential loss of coverage. Massachusetts appears to be experiencing even higher premium increases than the national average. In 2001, Massachusetts employers reported that, although they planned to increase member cost sharing for covered benefits, most were considering expansion in benefits.[44] It is unlikely that this relatively modest reaction to cost increases will continue if poor economic conditions persist. While few experts expect employers to drop coverage altogether, they do anticipate changes in the employer/employee relationship in health care. Most expect that employees will bear a greater share of the premium costs—a serious blow to workers whose wages are not rising as fast as the premium increases. Thus, workers could face higher individual exposure for an increasingly expensive insurance product. Inevitably this confluence of trends can be expected to take its toll on private insurance rates, which could in turn increase the rate of uninsured in the state.

Another casualty of the cost explosion and shift of costs to employees could be the relatively broad coverage that Massachusetts residents have enjoyed. In recent months increasing publicity has been given to limited insurance/high deductible health plans coupled with consumer spending accounts. Somewhat euphemistically dubbed "consumer-driven" health plans, these products move employees away from traditional insurance coverage and toward cash health care accounts coupled with a more catastrophic type of insurance coverage. Such products already have emerged in employer plans around the country as well as the individual market. Recent rulings from the Treasury Department clarifying the tax deductibility of such plans is almost certain to spur their growth. There is no reason to think that Massachusetts employers, eager to maintain a health benefit (however scaled back), will not respond to this product.

D Health Costs, MassHealth, and State Budget Woes

The combined effects of escalating health costs and declining state revenues have already affected MassHealth, whose predicament has garnered national and state headlines. The underlying health cost trends as well as the state's demographics (tilting toward an elderly population) have combined with the structure of MassHealth to create a financial crisis.

The current budget crisis left the state, on July 1, 2002, with $2.5 billion less revenue than in the previous year, a shortfall caused by the economic slowdown, a stock market correction that reduced the state's capital gains revenue, and a large tax cut in 2000 that had been designed to move the state out of the ranks of the high-tax states.[45] An effort by the State Legislature to freeze further implementation of this tax cut was vetoed by the Governor. Her veto was overturned by the Legislature and the tax cut has been frozen at the current level, which will limit, but not eliminate, the budget problems for the coming year. Confounding this revenue shortfall was rapid cost growth in MassHealth. Massachusetts reported a 6% Medicaid shortfall for the state's 2001 fiscal year.[46]

As a result, lawmakers plan to eliminate the MassHealth Basic program for long-term unemployed adults in April 2003. This will reduce coverage by an estimated 50,000 and save the state, according to officials, about $20 million in state fiscal year 2003, and $100 million when fully annualized in state fiscal year 2004.[47] The state maintained coverage in this program for the 9,500 people who are state mental health clients or who are using emergency care. However, those losing coverage tend to have income below 40% of the poverty level, have mental health or substance abuse problems, or are awaiting disability eligibility determinations.[48] In addition, the state restrained provider payment levels, reduced adult dental benefits, and cut back on outreach activities.

Massachusetts policy makers have indicated their intent to seek a "Health Insurance Flexibility and Accountability" (HIFA) waiver to increase cost sharing on optional benefits. However, research suggests that cost sharing for low-income people could have a significant, negative effect on access to care.[49]

These cutbacks in both public and private coverage will likely have a major impact on Massachusetts' safety net infrastructure. In particular, they will affect the state's community health centers and safety net hospitals, which collectively have played an important role over the years in serving uninsured, publicly insured, and other vulnerable populations. Greater demands will be placed on the Uncompensated Care Pool, particularly as adults previously insured through MassHealth Basic are poised to become uninsured. Because mental health problems are particularly evident among those who will lose coverage, health care institutions with strong traditions of providing access to health services for lower income persons with mental illness may face especially hard situations. Cuts in dental services are also likely to have extensive spillover effects on safety net systems and health centers. Again, this places a strain on the system that cannot be alleviated by the state's uncompensated care pool.

E Potential Consequences

Preliminary results of the state's most recent survey of the health insurance status of its residents, released last month, showed that the number of uninsured in Massachusetts has grown to just under 400,000 people, a 9% increase in the number of uninsured from 2000. This number is likely to rise further, if only because of state actions to scale back MassHealth. Most of the 50,000 people who will lose coverage will have few, if any, affordable, accessible health insurance options and will likely become uninsured. In addition, both the rise in unemployment and the increase in health insurance premium costs will, according to economists, reduce private coverage. One study that looked at the relationship between premiums and coverage in Massachusetts found that, if the employee share of premiums were to increase by 10%, then 65,000 Massachusetts employees could become uninsured.[50] Another study found that, for every 100 people losing jobs, the number of uninsured grows by 85.[51] If this relationship holds in Massachusetts, then the increase in the unemployment rate between October 2000 and July 2002 could have increased the uninsured by about 65,000 as well.[52] Such increases in the number of uninsured persons as a result of deteriorating public and private coverage would wipe out the gains made by the state in the late 1990s and would cause a major decline in the state's national standing.

Deteriorating public and private coverage would wipe out the gains made by the state in the late 1990s and would cause a major decline in the state's national standing.

The lack of health insurance has negative effects on access and health care. One study found that over 50% of adults without health insurance did not see a doctor when sick, did not fill a prescription, skipped recommended medical tests, or did not see a specialist due to cost.[53] Uninsured people with cancer are more likely to die earlier due to delayed diagnosis and treatment; those with heart attacks are less likely to receive state-of-the-art treatment and are more likely to die while hospitalized or shortly thereafter.[54] Having a strong safety net may improve uninsured people's access to care relative to those in states without such systems, but this increase is not significant and access to care among the uninsured in all states—including Massachusetts—still lags far behind that of people with health insurance.[55]

It also has financial consequences. About half of the uninsured reported struggling to pay for such expenses such as food and rent, and the vast majority (70%) were forced to deplete their savings to pay medical bills.[56] Health costs are a major factor in personal bankruptcy, accounting for 40% of filings in 1999.[57] More broadly, lack of insurance cuts down on worker productivity and school attendance. One study found that uninsured children were 25% more likely to miss school than insured children.[58]

About half of the uninsured reported struggling to pay for such expenses such as food and rent and the vast majority (70%) were forced to deplete their savings to pay medical bills.

In addition, increased uncompensated care could strain Massachusetts' premier health system. In the late 1990s, with Medicare and Medicaid provider payment cuts, health services employment fell by nearly 10,000 after rising for 20 years—with only one state having a steeper decline (Louisiana).[59] While some of these rate reductions have been repealed, a similar effect could be felt by hospitals and other providers with a surge in the number of uninsured patients and uncompensated care. The loss of employment would not be restricted to the health sector. If health care jobs leave the state, so too does research funding and revenue from the goods and services that health care workers bring. In addition, a deterioration of access to private employer-based insurance will make it difficult for the state to attract workers.

In sum, in Massachusetts, as in other states, multiple forces tied to cost escalation and declining revenues are causing employers to rethink the extent of insurance coverage they provide, shifting more costs to workers whose wages are not keeping pace with health care cost increases. They also are causing serious reductions in the state's public insurance programs. Because Massachusetts has placed such emphasis on health policy reforms, particularly in the public sector, and has achieved major advances in the coverage of its poorest and most vulnerable populations, the distance the state has to fall appears to be even further than in states that have maintained far less of a commitment to health reform.

PART III

Maintaining and Strengthening Massachusetts' Leadership in Health Policy

A Overview

We believe that rather than allowing deterioration of health insurance coverage to set in, this is the time for policy makers to take important steps to preserve insurance coverage where it exists and expand the accessibility of coverage for critical groups. Our proposals are relatively modest and require additional detailed development and cost estimation. But we believe that in the current climate and in combination with one another, they would represent a significant effort by the state to maintain its primacy in health coverage. Together, they would keep the state from falling into "the middle of the pack" where access to health care is concerned.

This is the time for policy makers to take important steps to preserve insurance coverage where it exists and expand the accessibility of coverage for critical groups.

We have grouped our proposals into three principal categories. The first is protection of existing access to health care. The second is incremental expansion of public health insurance coverage. The final set of options puts Massachusetts on a path that, over time, would make coverage more stable and reliable. Generally, they aim to move the direct burden of arranging and paying for coverage off of the small employers and lower-income workers who are least able to absorb these costs and the most at risk for lack of coverage.

Our proposals are not intended to function as a comprehensive catalogue of options nor are they intended to be costly. Although this paper does not include cost estimates, it does characterize options as having low or moderate public costs, based on our experience with different program's costs (Table 4, page 31). We chose to present only low or moderate-cost and relatively low-controversy items in hope that they could be embraced by any new governor or set of legislators to address the real and growing problem of the uninsured.

B Protecting Access

1. Maintaining eligibility and benefits in MassHealth

Until the summer of 2002, Massachusetts had been systematically expanding coverage for low-income and vulnerable populations through its MassHealth Medicaid program. The recent budget crisis resulted in a plan to eliminate the limited coverage currently available for childless adults through the MassHealth Basic program. This program provides health insurance to long-term unemployed, disabled adults below 133% of poverty, many of whom have been denied or are awaiting a disability determination from the Social Security Administration in order to receive Supplemental Security Income (SSI) benefits. To reduce MassHealth costs in 2003, the governor and state Legislature agreed to dramatically scale back the MassHealth Basic program, reducing enrollment from 60,000 to less than 10,000 people in April 2003.[60] As described earlier, this would likely have consequences not just for the affected individuals but for the health care providers who will end up providing them uncompensated care from a limited and inadequate Pool.

Eligibility is not the only part of MassHealth at risk. Benefits have already been reduced and provider payment reductions also may lead to access problems. The Massachusetts adult dental program has been scaled back in critical ways, and the state's Medicaid reimbursement for dental services is

30–64% of the average fee for comparable services throughout New England.[61] The state also just eliminated funding of its outreach mini-grants. These grants, ranging from $10,000 to $15,000, went to 84 health care providers and community based organizations for MassHealth outreach and post-enrollment work. They totaled $1.2 million and were, as well, a casualty of the budget crisis.

Like Medicaid programs around the country, MassHealth continues to experience rapid growth in pharmacy costs. Massachusetts recently attempted to manage drug costs by modifying and reducing the pharmacy reimbursement methodology. As a result, three major chain drug stores in the state threatened to discontinue pharmacy services to Medicaid beneficiaries. Massachusetts has backed off the proposal and plans to hold public hearings to reconsider the proposed decrease in pharmacy reimbursement before issuing a revised proposal in October.[62]

The federal revenues lost to the state by allowing enrollment of some of the sickest residents to fall by 50,000 persons amounts to an estimated $21 million in state fiscal year 2003, and $100 million when fully annualized in state fiscal year 2004.[63]

Restoring coverage. It is important not to allow coverage to diminish. Maintaining coverage of long-term unemployed adults and restoring the dental program are of immediate importance, as is resolving the pharmacy fee problem. The federal revenues lost to the state by allowing enrollment of some of the sickest residents to fall by 50,000 persons amounts to an estimated $21 million in state fiscal year 2003, and $100 million when fully annualized in state fiscal year 2004.[63] The consequences of reducing dental coverage for adults are also far ranging. Dental health is essential to work and productivity and anecdotal evidence from welfare reform demonstrations around the country suggests that lack of adequate dental care takes an enormous toll on the employability of welfare beneficiaries. The health—and health cost—implications of reduced access to pharmaceutical benefits are simply so enormous that the most critical task becomes stabilizing the system as it now exists. Restoring coverage and benefits has moderate costs but is probably less controversial than coverage expansions in MassHealth.

2. Preventing loss of private insurance

Private as well as public coverage is at risk in the current economic climate. An increased number of uninsured is not the only potential, negative consequence of the times. The recent convergence of high health care cost growth and unemployment may result in increased employee premiums, increased cost sharing, and/or reduced benefits. This could lead to a class of "underinsured" people—who are technically insured but who incur significant, sometimes devastating, out-of-pocket costs and/or forgo needed health care due to costs. Several policy options could help stem this likely reduction and loss of coverage.

Preserving the value of coverage. Those with access to health coverage today may, increasingly, have less care covered by insurance and have more out-of-pocket cost liability. While the shift to "consumer-driven" health insurance products does not necessarily mean that the value of the coverage diminishes, it is likely to be the case. One policy option to address this issue is to create a state definition of minimum coverage. Massachusetts could require health insurance products sold in the state to meet a minimum actuarial value (e.g., 80% of the value of the state employee health benefits package). This type of option would maintain insurer and employer flexibility in benefit design and, for most plans, would still allow for some reduction in coverage.[64] However, it would provide a floor on the value of the coverage to ensure that people purchasing insurance are truly insured. This type of idea would require further development since it could be challenging to implement. It would have low public costs.

Demonstration to maintain employer-based coverage for low-income workers. Probably the people most vulnerable to losing private coverage in economic downturns are low-wage workers whose firms are increasing the employee share of premiums to constrain their own costs. It would be difficult—from a policy and political perspective—to prevent employers from cost shifting to workers. However, it might be possible to provide low-wage workers with assistance to maintain coverage. Individuals and families with income below a certain threshold could qualify for a refundable tax credit if they demonstrate that their share of the health insurance premium increased by a certain

amount. The amount of the credit could be either a flat dollar amount (phased out for those with higher income) or equal to the amount of the increase. Because this has not been tried before and could have high public costs, it could be structured as a demonstration limited either by geography or by enrollment caps. It could raise concerns about equity (e.g., which people or firms are excluded) and effectiveness (would people continue their premium payments without the credit?). Its cost could be calibrated by policy makers.

Massachusetts' rate of uninsured 19 to 24 year olds was 17% in 2000, nearly six times higher than the rate for children (3%).

3. Increasing uncompensated care financing

As described earlier, Massachusetts supports care provided by safety net providers in part through its Uncompensated Care Pool. The Pool was funded at $439 million in 2000 and $443 million in 2001. Although it is difficult to project the amount of funds necessary to cover future costs of providing free care, a shortfall currently exists. Although funds have been transferred into the Pool for the purposes of shortfall elimination over the past few years, they did not in fact eliminate the shortfall. This may be more difficult to do in the future given the state budget outlook. There is a special commission being convened to look at possible reforms of the Pool per the FY 2003 budget.

Reforming or refinancing the Uncompensated Care Pool. Massachusetts could reform the Uncompensated Care Pool in one of three ways: increasing existing financing, finding new sources of financing, or changing its rules for payment. Current statutory funding for the Pool is capped at $345 million; $215 million from hospital assessments, $100 million from surcharges on payments made to hospitals and ambulatory care centers by managed care organizations and patients; and $30 million appropriation from the General Fund. Raising the cap would allow for an increase the number of existing and new sources of financing such as an increased tax assessments on different providers, insurers or consumers (e.g., tobacco or alcohol tax). However, this begs the question: Should the state use any additional financing source for the Pool or for restoring MassHealth cuts? Some states have imposed fees and additional taxes to finance local and state indigent care programs with limited success.[65] And, finally, some experts argue that the formula for determining which providers get what amount of funding could be revisited. This may be sound and overdue policy, but it is unlikely to reduce the mounting pressure on the Pool.

C Incremental Expansions

1. Filling gaps in MassHealth

Despite its breadth, MassHealth does not cover all low-income people in Massachusetts. The major groups excluded from coverage are most childless adults and people with certain types of diseases or disabilities that do not qualify for SSI. The Uncompensated Care Pool and the safety net insurance products help pay for care for these groups. In addition, as described later in this report, a blanket approach to expanding MassHealth would likely sweep most of these people into eligibility. Alternatively, the state could narrowly target some of these people through incremental expansions.

Children aging out of Medicaid/SCHIP. Because Medicaid and SCHIP coverage ends at the age of 18, nationally the rate of uninsured in 2000 rose from 12% among children to 27% among those ages 18 to 24.[66] While lower than that of the nation, Massachusetts' rate of uninsured 19- to 24-year-olds was 17% in 2000, nearly six times higher than the rate for children (3%).[67] In fact, this age group has the highest rate of uninsured of any age group. In Massachusetts, children typically lose eligibility for MassHealth Standard when they turn age 19. They are likely to become uninsured because they often take low-wage jobs that do not offer health coverage. Massachusetts could adopt the federal option to extend coverage to children leaving foster care through age 21. It could also seek an amendment to its 1115 waiver to continue coverage for children who turn age 19 and remain income eligible for coverage. This may be a high-impact, low-cost policy since this age group is disproportionately uninsured and lost-cost.

Older, uninsured people. Although the rate of lack of health insurance is not high among people ages 55 to 64, their risk of illness and catastrophic health care costs is significant. Compared to people ages 18 to 44, people ages 45 to 64 are nearly three times more likely to have a disability, six times more likely to have high blood pressure, and 15 times more likely to die of cancer.[68] In 2000, only three percent of people ages 55 to 65 were uninsured.[69] As the baby boom generation moves through this age cohort, the number of Massachusetts residents in this age group is projected to increase by over 40% by 2010.[70] Massachusetts could extend MassHealth to cover this set of people, as did the District of Columbia in its recently approved 1115 waiver. Because this proposal would require a waiver, its costs would be constrained by the amount of savings that could be produced to offset it.

People with illnesses that make them uninsurable. People who currently have (or have a history of) diseases like cancer, HIV, or multiple sclerosis may have trouble accessing, let alone affording, health insurance. MassHealth could seek to build upon its existing options and demonstrations to help even more individuals facing these circumstances. For example, the state could extend MassHealth to all low-income uninsured people diagnosed with cancer through federal screening programs, not just those with breast or cervical cancer. Nearly 500 out of 100,000 Massachusetts residents have some type of cancer.[71] The state could also build on its HIV Medicaid demonstration program to cover people with other debilitating diseases. For example, it could seek federal demonstration funding to provide coverage a buy-in option to low-income, uninsured people with Parkinson's, multiple sclerosis, or other conditions requiring expensive medications. These options would require federal waivers through demonstration authorities and, again, would have to be budget-neutral.

2. Building on the Insurance Partnership

The Insurance Partnership, as described earlier, is an innovative MassHealth program to encourage employers to offer and employees to purchase employer-sponsored health insurance. While this program is unique in its provision of employer subsidies, enrollment to date has been modest and considerably less than expected (Table 2). The state initially described the program as a "cushion" that covers approximately half of the cost of each eligible employee's premium.[72] The actual amounts of the employer subsidies are determined by the state legislature.[73] Medicaid dollars are used to provide subsidies to employers who are offering health insurance to their employees for the first time. State funds are used to provide subsidies to employers already providing health insurance.

Increasing assistance. It is unclear whether the amount of subsidy available to assist both employers and employees in paying insurance premiums is sufficient to encourage coverage. In 2000, Massachusetts experienced significant health insurance premium increases in the small group market.[74] While this led to increases in Insurance Partnership enrollment, it is unclear how many employers were priced out of the small group market entirely. Some advocacy groups have maintained that the premium payments for employees, while subsidized, still present a barrier to participation.[75] The maximum family premium is $30 per family per month. Adults can be required to pay up to $25 per covered adult. Premium support could be increased to boost enrollment. Furthermore, the state might attract additional numbers of employers through reforms designed at stabilizing premium costs on a multi-year basis, with the state absorbing the difference between the premium increases and the employer's share during the multi-year period. On the employer subsidy side, the amount of premium assistance hasn't been increased since the program was implemented, and caps out at $1,000 per low-income family per year. To be effective, this proposal would have to make meaningful improvements in the subsidy, which would likely have moderate costs.

Increasing eligibility. Similarly, participation may be limited by the income eligibility standards. The Insurance Partnership has had some success in reaching areas of the state such as Western Massachusetts, while major urban areas such as Boston are underrepresented.[76] This may result from the higher cost of living in major urban areas, which forces individuals and families with incomes under 200% of poverty out of the area. The state could consider increasing the income requirements

for participation in the Insurance Partnership. Costs would depend on the extent of the eligibility changes (but without an increase in the amount of the assistance, could be low).

Improving outreach and administration. A simpler approach to increasing health coverage through the Insurance Partnership is refining its outreach and administration. The state has targeted specific industries such as day care providers and self-employed individuals. Advertising continues to be primarily directed at employees rather than employers, and has begun to target specific ethnic groups that are disproportionately uninsured. The program has become more aggressive in its outreach to employers over time, conducting outreach and education to insurance brokers in the state, Chambers of Commerce, and insurance companies. These efforts could be stepped up to generate greater enrollment increases. While there would be low cost to the outreach efforts, their success could yield moderate costs with increased enrollment.

A larger question raised by the limited success of the Insurance Partnership relates to its being housed within the state Medicaid agency. Although the Division of Medical Assistance has experience with contracts with insurers, other departments within state government may be better equipped to conduct outreach with employers. The employers who have enrolled in the program are predominately service industry firms such as beauty salons, day care centers, auto mechanics, and building cleaning services. Other major sectors represented in the Insurance Partnership are construction workers, retail stores, and restaurants.[77] MassHealth has worked with the Massachusetts Department of Revenue to conduct outreach to all self-employed individuals, who represent 65% of enrollment.

Fully half of the uninsured in Massachusetts have income above 200% of poverty (about $36,000 for a family of four). They mostly lack health insurance because they work for firms that don't offer it or, when offered, they cannot afford it.

3. Improving the accessibility of affordable private insurance

Fully half of the uninsured in Massachusetts have income above 200% of poverty (about $36,000 for a family of four). They mostly lack health insurance because they work for firms that don't offer it or, when offered, they cannot afford it. As described earlier, workers in small businesses, in the southeast part of the state, in the fishing industry, and in low-wage jobs are particularly vulnerable to lacking coverage. The options described below target such individuals.

Providing tax credits for small, low-wage businesses to offer coverage. An alternative to either promoting the pooling of small employers or rate regulation is to provide an incentive through the tax code for vulnerable businesses to offer coverage. One idea is to target tax credits to employer by firm size and average wage; smaller, low-wage firms would receive a higher credit for offering coverage than larger, higher wage firms.[78] It would provide an incentive to small firms to offer coverage without creating a major incentive for large firms to outsource workers to game the credit. Such a policy would benefit small businesses, for example, that rely on tourism. The amount of the tax credit could be calibrated to keep total costs within a budget target, but to be effective, costs would have to be in the moderate range.

Improving rate regulation. While Massachusetts has considerable benefit regulations, its rate regulation for its small group market is not significantly above average. Insurers that offer a plan to any small group (employers with 1 to 50 employees) must offer the same plan to all small groups. Rates are only allowed to vary by age, family type, industry, and size/participation in the group. Insurers are allowed to have pre-existing conditions and waiting periods.[79] One concern that has been raised by advocates is the lack of enforcement of existing rules. A low-cost option is to increase the budget of the Division of Insurance to review insurer filings and audit rates. Additionally, the Division could be given stronger enforcement tools (e.g., stiff sanctions for violations). A more aggressive option for making insurance more affordable would be to propose additional rate regulation. For example, insurers could be prohibited from charging different rates by industry. Their yearly increases in rates could be limited to promote premium stability—addressing the uncertainty in costs that forces many small businesses to forego offering coverage. If focused only on enforcement tools, this proposal would have little to no cost (except for an increased administrative budget to administer the sanctions).

Coverage as a condition of being a state employee or doing business with the state. Rather than mandating that firms offer health insurance coverage, the state could make either offering or having health insurance a precondition for its engagement with an individual or firm. At the individual level, the state could require all of its employees (and temporary or contract workers) to have health insurance, conditional on providing them access to the state employees' health plan. Similarly, Massachusetts could broaden this condition to organizations receiving state funds. For example, while Massachusetts has a higher than average proportion of workers in the health care field, some of these workers themselves are uninsured. The state could require hospitals, medical care organizations, clinics, or other organizations that receive state funding to offer health coverage to their employees and could offer a buy-in to the state employee health insurance program for health businesses that lack access to affordable plans. A softer version of this policy would allow certain types of workers, like those in public clinics and health centers, access to the state employee health plan. These types of policy options use the leverage that the state has as a major employer and payer of health care to improve access to private health insurance with little state financial investment. However, if a requirement, they could be viewed as hostile by the business community. These type of proposals would have little public cost.

Nationwide, 4.7 million uninsured children are eligible but not enrolled in public programs; about 44,500 of these children are in Massachusetts.

4. Reducing the gap between those eligible for and those enrolled in coverage options

Research suggests that millions of uninsured Americans would become insured if enrollment systems were easier to navigate. Nationwide, 4.7 million uninsured children are eligible but not enrolled in public programs; about 44,500 of these children are in Massachusetts.[80] Similarly, some argue that more people would be enrolled in private health insurance if the ease of accessing the employer-based system were improved. Public policy could ensure that individuals eligible for health coverage get enrolled in a number of ways.

Default enrollment in employer coverage. One option would be to require employers that offer health insurance to automatically enroll workers in their (lowest cost) health plan. Under this "default" enrollment system, workers would have to actively decline coverage rather than affirmatively join it. Employers that do not offer health insurance could be obligated to provide all minimum-wage hires with MassHealth applications, potentially raising awareness of insurance options. This option would have negligible public cost.

Automatic enrollment in public coverage. On the public insurance side, the state could make individuals eligible for other, related public programs like unemployment insurance, WIC, food stamps, or school lunch programs automatically eligible for MassHealth. While Massachusetts leads most states in its simplification and outreach efforts for MassHealth, more could be done. The first step would be restoring the mini-grants to communities for outreach. The next step could be creating more opportunities for automatic enrollment. Each of these ideas puts more responsibility on employers and other community members to help uninsured people sign up for coverage. There would be some administrative costs to creating the infrastructure to make these changes. To the extent that these proposals are successful, they would have moderate costs as they increase enrollment in MassHealth.

D Towards Universal Coverage

Generally, academics, advocates, and industry representatives alike—on all ends of the political spectrum—agree that public programs are best able to insure lower income people.

Massachusetts is one of the few states that has, for years, debated options for moving towards universal coverage in the state. The state has several studies (e.g., LECG, HRSA grant) to examine topics like the implications of moving to a single payer model. It also has an excellent system for tracking the uninsured. In the early 1990s, it was one of the states that was at the leading edge of pushing for national health reform. And, as described earlier, its Medicaid reforms provide more coverage for state residents than in most other states.

While the visions for expanding coverage have differed over the years, they all have two basic elements: an infrastructure that provides access to health coverage and a subsidy system that makes such coverage affordable. On the supply side, too many workers do not have the option of participating in employer-based health insurance; too many low-income or sick people cannot access MassHealth despite its advances. On the demand side, even when insurance options are available, a large share of the uninsured in Massachusetts have limited income and cannot afford insurance premiums.

Given other efforts to craft detailed plans for universal coverage, this paper does not attempt to do so. Instead, it describes concrete steps that state policy makers could take in the near term to prepare for a more fundamental set of reforms. The options described in this section are, in several instances, as incremental as those described in the previous section. They differ in that the policies described in the last section are terminal: Their focus is immediately helping uninsured people. The policies below may be less effective—or politically popular—than some of the incremental reform ideas, but would set the state on a path towards a broader set of reforms.

1. Preparing MassHealth for universal coverage

Generally, academics, advocates, and industry representatives alike—on all ends of the political spectrum—agree that public programs are best able to insure lower income people. Low-income individuals do not have sufficient savings, income, or tax obligations to make tax deductions or credits for health insurance work. Public programs allow for free or reduced-cost health insurance that prevents their already-limited income from either preventing use of needed health care or forcing choices between health care and rent or food. As such, most proposals for universal coverage include a broad, income-based eligibility system for public coverage options like MassHealth.

Simplification. A first step towards a broad-based, income-related MassHealth program would be to simplify the program. Its eligibility system is complicated because of the accretion of new options that have been added incrementally over time. This complication may reduce potential enrollment since individuals may not realize that they are eligible. A first step would be to simplify the system through: (a) consolidating eligibility categories, income definitions, and benefit packages; (b) allowing for self-verification of income and mail-in applications; and (c) and providing continuous 12-month eligibility to all enrollees. Massachusetts is far ahead of most states in the simplification of its Medicaid/SCHIP programs, but still has complexity that impedes it from achieving its coverage goals. These proposals would have start-up costs in changing eligibility systems and could, ultimately, result in administrative savings. If they succeed in increasing enrollment, then they will have moderate (to high) costs.

Straight income-based eligibility. An alternative to picking selected age or disease groups to add to MassHealth is to gradually fill in coverage for the lowest income people not currently eligible, namely childless adults. This could be done in increments to reduce cost (e.g., in the first year, eligibility is set at 25% of the poverty threshold, in the second year, at 50%, etc.). This type of expansion is targeted at people who are very likely to be uninsured; few very low-income adults have private coverage options. Given that 20% of low-income people in Massachusetts remain uninsured,[81] it could also be expensive. That said, locating and enrolling adults who have loose connections to both the workforce and other public programs (because they don't have children) could be a challenge. Costs could be calibrated depending on how such an option is phased in.

2. Creating private health insurance options for all workers

Given the small nongroup market in Massachusetts, most efforts to create more affordable, accessible, private insurance options in the state focus on its employer-based system. As described earlier, Massachusetts has made strong strides in expanding its public insurance options, but its employer-based coverage looks no better than the national average. This may reflect the state's labor market conditions, its employers' economic circumstances, demand for coverage from workers, and/or the high cost of insurance in the state. Alternatively, it could result from inertia on the part of employers or a sense that health coverage is a state rather than employer responsibility. In the health insurance debates in the early 1990s, most proposals included employer mandates in which most employers were required to both offer and contribute towards health coverage for their workers—usually with significant government subsidies. A similar proposal has been recently announced by the senior U.S. Senator from Massachusetts.[82] Although any type of new mandate placed on employers—especially during a slow economy—is likely to face fierce opposition, it was the employer contribution, not the required offering of coverage, that was the most contentious issue in the past. In fact, the leading Republican health reform proposals embraced a focus on the accessibility—rather than affordability—of coverage.[83]

Requiring large firms to offer (but not subsidize) health coverage. Over 95% of Massachusetts' firms with 50 or more employees offer health insurance and 78% of eligible workers in large firms take that coverage.[84] Yet, 25% of Massachusetts' working uninsured are employed by large firms.[85] This may be caused by employee premium contributions that are too high for low-income individuals. However, most studies show that, even among low-income people, a majority of workers offered health insurance will participate in it. This option would require large employers to offer their workers a group health insurance option. They would negotiate rates, provide employees with information, and allow payroll deductions for participation in health insurance. Employers would not, however, be required to contribute to this coverage. While the employer contribution is important in making coverage affordable, providing access to group rates and allowing workers to pay for it through payroll deductions could help some uninsured people. It would also create the infrastructure for subsequent reforms that could layer in premium subsidies to ensure that such coverage is affordable for all workers. While controversial, this policy would have negligible public costs.

Requiring small firms to offer coverage through group purchasing coalitions. Small firms are a major target—and challenge—in designing policies that lead towards universal coverage. About three-fourths of uninsured adults in the Commonwealth work in small firms (with fewer than 50 employees), and only about two-thirds of these firms offer coverage in the first place.[86] Premium cost is named as the most important deterrent—but the hassle for a small firm of administering health benefits is an important and often overlooked issue. As such, rather than requiring all small firms to offer health coverage, one policy option is to require them to participate in a group purchasing coalition. Employers would let their workers know about these options and, like large firms, would coordinate payroll deductions for them for health insurance. They would be under no obligation to contribute towards this coverage. However, this option could be paired with a proposal to create a stronger link between the MassHealth Insurance Partnership program and small business purchasing coalitions, thus encouraging employer contributions and making the workers' share more affordable for those with lower income. Again, while potentially controversial, this option would have negligible public costs.

Table 4 Policy Options for Health Insurance in Massachusetts

Options	Private	State Costs	Recommended
PROTECTING ACCESS			
1. Maintaining eligibility and benefits in MassHealth			
Restoring coverage		Moderate	✔
2. Preventing loss of private insurance			
Preserving the value of coverage	✔	Low	
Demonstration to maintain employer-based coverage for low-income workers	✔	Moderate*	✔
3. Increasing uncompensated care financing			
Reforming or refinancing the Uncompensated Care Pool		Moderate*	
INCREMENTAL EXPANSIONS			
1. Filling gaps in MassHealth			
Children aging out of Medicaid/SCHIP		Low	
Older, uninsured people **		Low	
People with illnesses that make them uninsurable**		Low	
2. Building on the Insurance Partnership			
Increasing assistance	✔	Moderate*	✔
Increasing eligibility	✔	Low*	
Improving outreach and administration	✔	Low	✔
3. Improving the accessibility of affordable private insurance			
Providing tax credits for small, low-wage businesses to offer coverage	✔	Moderate*	
Improving rate regulation	✔	Negligible	
Coverage as a condition of being a state employee or doing business with the state	✔	Low	
4. Reducing the gap between those eligible for and those enrolled in coverage options			
Default enrollment in employer coverage	✔	Negligible	
Automatic enrollment in public coverage		Moderate	
TOWARDS UNIVERSAL COVERAGE			
1. Preparing MassHealth for universal coverage			
Simplification		Moderate	✔
Straight income-based eligibility		Moderate*	
2. Creating private health insurance options for all workers			
Requiring large firms to offer (but not subsidize) health coverage	✔	Negligible	✔
Requiring small firms to offer coverage through group purchasing coalitions	✔	Negligible	

* Indicates that costs could be dialed up or down depending on policy choices.
** These policies would require 1115 waivers, which are required to be budget neutral.

E Recommendations

The assessment of Massachusetts suggests that policy makers could triage the problems and opportunities in order of ease and need. First, the easiest and most important option is to restore benefits and eligibility in MassHealth for those losing them. Dismantling MassHealth could, in the long run, cost more than it saves in terms of worse health outcomes, increased uncompensated care, and indirect effects on employment and the economic strength of the state. This action cannot wait until next year's budget, and policy makers should examine interim steps that could be taken to prevent the eligibility cut from going into effect.

Dismantling MassHealth could, in the long run, cost more than it saves in terms of worse health outcomes, increased uncompensated care, and indirect effects on employment and the economic strength of the state.

A second, equally important—but more difficult to implement—policy is to shore up existing private coverage for low-income individuals. The proposed demonstration project would provide financial relief to those whose income is being eaten away by rapidly rising health insurance premiums. The demonstration would require considerable effort to design and implement but holds the potential to prevent deterioration of private coverage and create a model for future expansions to workers without access to such coverage.

Third, we think that further development of the Insurance Partnership holds potential to increase participation and coverage. The amount of the assistance is low relative to the cost of policies and could be increased, as with outreach efforts. Equally important, it could be linked to—and perhaps increased as an incentive to join—policies offered through the small business purchasing coalitions. Making employer-based coverage affordable to low-income workers in small businesses would go a long way towards helping the uninsured.

Finally, several low-cost actions could be taken to lay the groundwork for comprehensive coverage. First, MassHealth could be simplified and begin a process where its eligibility is based purely on income. As in other states, many of the uninsured in Massachusetts are poor and either are not eligible for MassHealth or, because of its complexity, do not know about it or think that they are eligible. Second, large employers in the state could be required to negotiate for and offer health insurance to their workers. While they would not have to contribute to coverage, employers would at least be able to give their workers access to affordable coverage. Third, the state could consider approaches to contracting and purchasing that favor employers that insure their workers. And finally, the state could allow workers at public clinics and health centers to secure coverage through the state employee health benefit plan in order to maximize control over costs and increase coverage.

Most of these options will cost money. There may be additional savings in the Medicaid prescription drug benefit, through supplemental rebates from manufacturers or additional federal matching payments for the Prescription Advantage program through the Bush Administration's initiative known as Pharmacy Plus waivers. Although policy makers could scour the public health and health services funding in the state budget for additional savings, the fact remains that revenue loss—from both explicit policy changes and the economic slowdown—is a major contributor to the state budget crisis today. In 2002 alone, an estimated $1.1 billion in revenue was lost due to previously enacted tax cuts as well as the beginning of the phase-in of the income tax rate reduction.[87] As such, options to rescind some of the tax cut, or to consider specific new taxes to fund health coverage, should be on the table.

Conclusion

Regardless of which options are considered, it is clear that the twin problems of high health costs and a growing threat of lack of health insurance will be major public policy challenges confronting the state in 2003. Furthermore, it is fair to say that the task facing this state is unique because of the major investments that it has made and the advances that it stands to lose. Put bluntly, if Texas reduces its commitment to lower-income families, the results are no less tragic—but are perhaps less newsworthy. When Massachusetts considers reductions in the extent of its public coverage for its most vulnerable residents, the state makes national headlines. For a leader in national health policy to allow erosion and stagnation sends a message to the rest of the country.

A rise in the number of uninsured persons could result in increased uncompensated care, diminished worker productivity, and over time, a decline in key health care access and health outcomes measures.

But as difficult as the task of achieving coverage might be, we believe that failing to respond decisively would have even greater long-term consequences for the Commonwealth. Numerous studies over the years have documented the association between insurance coverage and access to health care and the importance of health care access to individuals' ability to avert more serious health problems as well as high-cost care that could have been prevented with appropriate preventive and primary care.[88] From both a financial and human vantage point, the choice to do nothing or, even more, the choice to cut back on coverage has enormous consequences.

There are some who might say that the presence of an Uncompensated Care Pool and a safety net mitigates the impact of reductions. But we believe that this is wrong. The best way to think about the state's essential systems investments such as the Uncompensated Care Pool is as a strong complement to insurance. Funding for health centers is key to anchoring comprehensive primary health care practices in communities and populations that otherwise could not afford on their own to support basic health care access. But neither is a substitute for health insurance.

In sum, an increase in the number of uninsured Massachusetts residents can be assumed to have real economic and health consequences for individuals as well as for the state's health care industry, which is such a vital part of the state's economy. A rise in the number of uninsured persons could result in increased uncompensated care, diminished worker productivity, and over time, a decline in key health care access and health outcomes measures. The potential negative impact is far-ranging and much greater, in our opinion, than the consequences of moving decisively to intervene at this critical juncture.

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