

# **THE MASSACHUSETTS PLAN: A MODEL FOR MISSOURI?**

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By  
The Saint Louis University State Health Policy Legislative Analysis Team

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**EXECUTIVE SUMMARY**  
**THE MASSACHUSETTS PLAN:**  
**A MODEL FOR MISSOURI?**

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In April 2006, the Massachusetts Legislature passed sweeping health reform legislation (An Act Providing Access to Affordable, Quality, Accountable Health Care, H4479) to achieve universal health insurance coverage. The legislation expands access to affordable coverage through several strategies. As this legislation enters the implementation phase, other states will look to Massachusetts as a possible model for health care reform.

This executive summary of “Massachusetts: A Map for Missouri?” compares the health care environments in both states and discusses opportunities and obstacles for Missouri to expand access to health insurance using Massachusetts’ approach. The report was prepared for the Missouri Foundation for Health by researchers at Saint Louis University.

**Landscapes in Massachusetts and Missouri: A Comparison**

The similarities and differences between health landscapes in Missouri and Massachusetts include the following:

- Massachusetts has a higher median income and a lower percentage of the population living in poverty than Missouri.
- A smaller proportion of Massachusetts’ uninsured adults live in poverty as compared to Missouri’s (31.2% vs. 37.1%).
- Massachusetts’ share of children living in poverty is smaller than Missouri’s (15% vs. 21%).
- Missouri covers a higher proportion of its children through its State Children’s Health Insurance Program (SCHIP) than does Massachusetts.
- In the 1990s, Missouri and Massachusetts used waivers to expand Medicaid eligibility. However, as a result of Missouri’s legislative changes in 2005, adult eligibility levels became stricter than those in Massachusetts.

**The Context for Reform in Massachusetts**

Several factors made it possible for the state of Massachusetts to achieve a bipartisan consensus around their unique approach to universal coverage:

- If Massachusetts had not passed reforms, it would have lost a significant amount of federal Medicaid matching funds.

- Massachusetts had an Uncompensated Care Fund which provided almost \$1 billion in state and federal funds available for expanding coverage.
- Community organizations had sponsored a ballot initiative which would have substantially taxed employers to expand state sponsored health care programs.
- Legislators had access to many perspectives in their decision-making process. Those resources included sophisticated policy analysis, a media campaign, and a coalition of business leaders, advocacy groups, and insurers.

### **The Context for Reform in Missouri**

Replicating the factors which led to reform in Massachusetts may be difficult in other states, especially Missouri. The challenges include:

- Missouri does not face the threat of loss of significant federal funds through federal action; however, state law requires that the Missouri Medicaid program sunset on June 30, 2008. Thus, the 2007 General Assembly will need to act to either reform Medicaid or delay the sunset provision.
- Compared to Massachusetts, Missouri's Uncompensated Care Fund has fewer funds available to finance an expansion of coverage. However, there are considerable public resources – between \$723 and \$898 million – currently available in Missouri to support the uncompensated care needs of the uninsured.
- No coalition focusing on the issue of private insurance coverage expansion unites Missouri's business groups, community activist organizations, and research groups.

### **Achieving Universal Coverage in Missouri**

A Massachusetts-style insurance reform involves several specific strategies: a premium assistance program, Medicaid expansion, an insurance purchasing pool, and individual and employer mandates.

In Missouri, these same strategies would produce the following results:

- **Premium Assistance Program.** The creation of a premium assistance program would help low- and moderate-income individuals below 300 percent of the federal poverty level (FPL) to afford private insurance by lowering the costs of premiums and out-of-pocket expenses. Such a program could cover approximately 47 percent of those presently uninsured.
- **Medicaid Expansion.** Using the Massachusetts approach, a plan for universal health insurance in Missouri would build upon the state's existing Medicaid structure raising income eligibility for those categories of adults – parents, elderly and disabled – to at least 100 percent of FPL, while maintaining the present 300 percent of FPL income cutoff for children. Additionally, the state would have to enroll those who are

presently eligible but not currently covered by Medicaid or SCHIP. These efforts could cover about 30 percent of the uninsured.

- **Insurance Purchasing Pool.** A state-sponsored insurance purchasing pool would allow individuals and small groups to lower the costs of purchasing health insurance. These savings would derive from combining the individual and small group private insurance markets and from instituting private insurance reforms.
- **Individual and Employer Mandates.** According to this approach, reaching universal coverage requires moving beyond the voluntary purchase of health insurance to a requirement that individuals purchase insurance either directly or through their employers. For employers, the mandate would require either contributing to their employee's health insurance or paying a penalty to the state. Estimates for Missouri indicate individual and employer mandates would bring coverage to 23 percent of the uninsured.

### **The Costs of Universal Coverage in Missouri**

The estimated net costs of covering the uninsured in Missouri under a Massachusetts plan is \$2.6 billion. The costs would be allocated in the following way:

- About 34 percent of the net costs would need to be covered by the state government.
- Approximately 54 percent of the costs would be covered by federal matching funds.
- Individuals would pick up 12 percent of net costs. Currently uninsured individuals would contribute, after premium assistance, \$544 million for their share of premiums. Premiums for those currently insured could experience a collective decrease of \$219 million in costs. The difference between the two groups, approximately \$326 million, would be the total net cost increase borne by individuals.
- In the aggregate, employers under this system could experience a small reduction in health care expenditures based on changes to the private insurance market. Employer health insurance costs for covering the presently uninsured would cost approximately \$599 million. However, this may be offset by approximately \$617 million in premium savings related to likely insurance market reforms, including larger risk pools that would occur as more individuals purchase insurance.

### **Financing of Universal Coverage in Missouri**

To adopt the Massachusetts model, the Missouri state government would need to redirect a number of current revenue sources in order to raise the \$892 million to finance public and private health insurance coverage. If the state redirected funds currently allocated for care for the uninsured, \$327.3 million would be available for coverage expansion. The remaining \$564.7 million could require new state funding sources.

Existing state funds that could be reallocated:

- Missouri's share of Medicaid Disproportionate Share Hospital (DSH) payments (\$175.5 million).
- State and local funds for care of the uninsured (\$151.8 million).

Potential new sources of revenue, include, but are not limited to:

- Funds from a tobacco tax (approximately \$290 million for health care access and treatment).<sup>1</sup>
- General Revenue surplus (approximately \$600 million in fiscal year 2006).
- Revenues from a provider tax on private insurers (potentially up to \$100 million).
- A sales tax on medical services (potentially yielding up to \$628 million).

### **Policy Considerations**

Although the health landscape and political context in Missouri pose implementation obstacles, the Massachusetts plan remains a plan worthy of consideration for increasing access to affordable health insurance in Missouri.

To do so, several policy issues must be addressed. In particular:

- Passage of a Massachusetts-style plan is contingent on universal coverage becoming an explicit health policy goal for Missouri.
- Achieving universal coverage for low- to moderate-income Missourians assumes the state secures federal matching funds through the Medicaid program.
- The affordability and availability of health insurance coverage through the Private Insurance Pool depends on whether the pooling of many small employers and individuals produces lower administrative costs and favorable premium rates.
- An individual mandate would only take effect if the definitions of affordable and adequate insurance receive wide popular support.
- The success of an employer mandate pivots on the public perception that the rules and regulations governing the definition and implementation of the mandate are fair and equitable.

## Chapter I. THE CONTEXT FOR REFORM

In April 2006, the Massachusetts Legislature passed a sweeping health reform bill (An Act Providing Access to Affordable, Quality, Accountable Health Care, H4479), expanding health coverage for people in Massachusetts who are uninsured. The legislation, passed overwhelmingly by the Legislature on a bipartisan basis, was signed into law by Massachusetts Governor Mitt Romney on April 12, 2006.<sup>2</sup> The legislation seeks to expand coverage through a range of initiatives including: government subsidies for private insurance, Medicaid expansions, a state purchasing pool, insurance reforms to make private insurance more affordable, and individual and employer mandates. (Details are provided in Appendix A.)

How was Massachusetts able to achieve bipartisan consensus around this approach? How did Massachusetts find the funds to pay for expanding coverage? Would this approach work in Missouri? This chapter addresses these questions.

### The Context for Reform in Massachusetts

Although Massachusetts achieved bipartisan consensus to pass H4479, achieving similar legislative cooperation for health care reform in other parts of the country has been difficult. In particular, analysts<sup>3</sup> have pointed to several factors as important reasons why Massachusetts was able to pass reform:

- If Massachusetts had not passed reform, the Commonwealth stood to lose federal Medicaid matching funds (almost \$400 million per year over two years).
- The existence of considerable state funds to provide medical care to the uninsured proved crucial to reaching an agreement, since funding of the coverage expansions was achieved mostly by allocating funds from existing resources (e.g. the Uncompensated Care Fund) to finance the coverage expansions in H4479.
- A ballot initiative, sponsored by a range of community activist organizations, would have required a much more substantial payroll tax based contribution from employers, but the organizations told the Legislature that this initiative would be dropped if legislation expanding coverage was passed.
- A range of organizations provided significant impetus for reform, including business leaders who argued that expanding insurance coverage was in the economic interest of the state, advocacy groups (e.g., Health Care for All) that pushed for reform, and a major effort organized by Blue Cross Blue Shield to provide analysis and ideas for reform options (many of these produced by the Urban Institute, in Washington, DC). These groups gathered together to provide sophisticated policy analysis, a media campaign, and linkages across the groups.

All these factors led to a broad bipartisan consensus and agreement over the goals of reform:

- **Universal Coverage.** Everyone should have private or public health insurance.

- **Fair share.** The costs of achieving universal coverage should be fairly shared by individuals, employers, and the government.
- **Public-private partnership.** Public-private partnerships could effectively reform insurance markets and increase the affordability and availability of health insurance.
- **Individual responsibility.** Individuals should ultimately responsible for obtaining health insurance as long as the coverage is affordable and available.
- **Employer responsibility.** Employers should share the responsibility for financing health insurance for their employees as long as coverage is available and affordable.
- **Market Reform.** Pooling mechanisms, insurance market reforms, and individual/employer could provide effective mechanisms for affordable coverage.

### The Missouri Context

The factors that made reform possible in Massachusetts may or may not be able to replicated in other states, especially Missouri. In Missouri some key differences exist in the context for reform, although opportunities for implementation and bipartisan consensus also exist:

- Missouri does not face the threat of loss of significant federal funds through federal action, but state law provides that the Missouri Medicaid program is to sunset on June 30, 2008.<sup>4</sup> The intent of the sunset provision is to force the legislature to act to replace the existing Medicaid program with a “new, innovative state Medicaid healthcare delivery system.”<sup>5</sup> A bipartisan Medicaid Reform Commission issued a final report in late 2005 that made recommendations on reforming redesigning and restructuring the state’s Medicaid program. The 2007 General Assembly will need to act to either reform Medicaid or delay the sunset provision.
- Although there is no ballot initiative in Missouri seeking to impose a payroll tax on employers to expand health insurance coverage such as the one that might have passed in Massachusetts, a ballot initiative in Missouri to increase the tobacco tax appeared on the November 2006 ballot. Although the initiative did not pass, raising cigarette taxes in Missouri remains a policy option in Missouri for funding universal coverage.<sup>6</sup>
- The lack of a significant Uncompensated Care Fund may be an obstacle to funding coverage expansions in Missouri. However, there are considerable public resources – between \$723 million and \$898 million – currently available in Missouri to support the uncompensated care needs of the uninsured.<sup>7</sup> In addition, to the extent that Missouri can be creative in tapping into potential new sources of revenue (e.g., revenues from the tobacco tax) or seeking new sources of revenue (e.g., additional federal matching funds), funding coverage expansions may be achievable.
- A notable difference between Missouri and Massachusetts is the current absence of a broad coalition of business groups, community activist organizations, and research groups focusing on the issue of private insurance coverage expansion. However, a

broad-based group of organizations has worked consistently on issues involving Medicaid and SCHIP coverage.

The differences between Missouri and Massachusetts clearly pose obstacles to reform. However, the opportunities available in Missouri could provide the momentum to create the bipartisan consensus for reform as eventually occurred between the executive and legislative branches in Massachusetts.

### **This Report: A Model for Missouri?**

This report serves as the second part of an analysis of the applicability and feasibility of the Massachusetts plan for Missouri conducted by the Saint Louis University State Health Policy Legislative Analysis Team. This document outlines the public-private partnership strategies for achieving universal coverage by lowering private insurance costs, facilitating purchase of private health insurance, subsidizing cost of health insurance for low-income working families, requiring all individuals obtain and maintain coverage, and mandating that employers either offer insurance or help contribute to the costs of public health insurance for their workers.

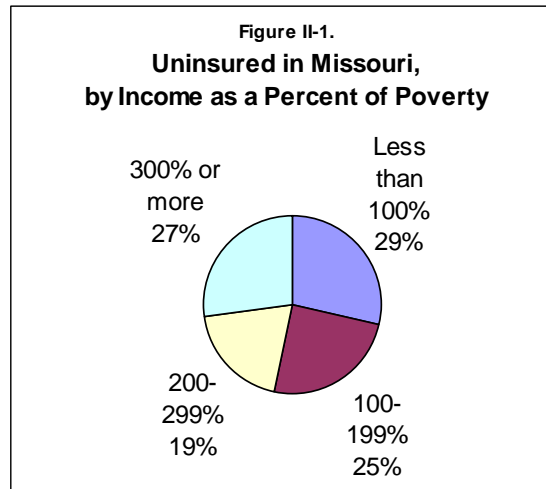
This report provides a detailed outline of the Massachusetts proposal, comparing and contrasting that plan to Missouri's current environment, outlining places where implementing a proposal along the lines of the Massachusetts plan in Missouri would lead to significant changes in health policy or the health system. In addition, the key issues for policymakers to focus on are identified. Finally, this report outlines the numbers of people that would be covered, the costs of covering those individuals, and the methods that could be used to finance that coverage under a Massachusetts-style plan.

This report is organized as follows. Chapter II describes the uninsured in Missouri and discusses the landscape for reform. Much of this analysis draws upon a previous Report titled "The Missouri Health Landscape: How Does it Compare to Massachusetts?" (Missouri Foundation for Health, 2006), which compares the health landscape in Missouri with that of Massachusetts on a variety of levels (e.g. insurance coverage, Medicaid, government subsidies to the uninsured, health provider supply and service use, demographics, and economics). Chapter III describes the possible effects of the legislation on access to health care in Missouri. Chapter IV discusses the implications of the proposed reforms for the costs of health care to consumers, businesses, and governments in Missouri, and how those costs would be financed. The final chapter describes the effects of the legislation on the quality of care that would be provided in Missouri and Massachusetts.

## Chapter II. THE UNINSURED IN MISSOURI

Achieving access to medical care depends crucially on the level of health insurance coverage people in Missouri currently have.

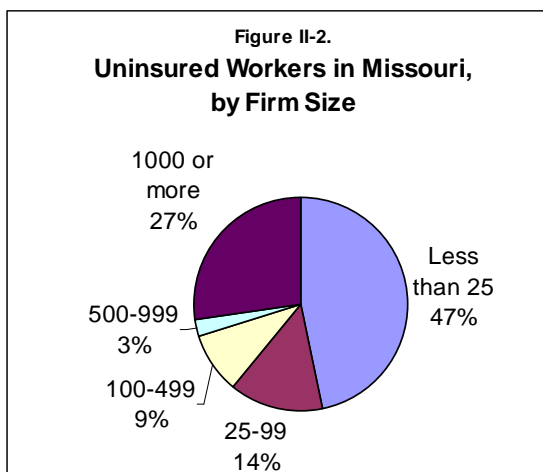
- The uninsurance rate among the non-elderly was 13.6 percent in Missouri in 2003-04, but this rate was lower than the uninsurance rate of 17.8 percent across the U.S and slightly higher than the rate of 12.7 percent in Massachusetts.<sup>8</sup>
- Missouri's relatively low uninsurance rate was achieved by higher Medicaid, public and individual insurance coverage rates than in Massachusetts.
- Missouri used a Section 1115 Medicaid waiver in the 1990s to expand Medicaid eligibility for children and the state has one of the highest SCHIP income eligibility levels in the country. However, as a result of 2005 Legislative changes, adult eligibility levels are now at the lowest levels allowed by federal law.
- As a result of changes to optional services, Missouri now offers a less generous Medicaid benefits package as compared to Massachusetts.
- The recently-enacted Medicaid legislation as part of Senate Bill 539, passed in Missouri in 2005 and implemented in 2006, will affect the number of uninsured. Previous research on Medicaid cutbacks indicates that most individuals that lose Medicaid coverage become uninsured. Missouri had an estimated 700,000 uninsured in 2005 but perhaps another 140,000 or more individuals formerly on Medicaid may have become uninsured as a result of legislative changes and other Medicaid changes.
- While Missouri operates a High Risk Pool to help the uninsured, Massachusetts operates a variety of pools and subsidies to assist the uninsured and underinsured, including an Uncompensated Care Pool with funds up to \$1 billion annually to pay for uncompensated care. Missouri has no such earmarked pool of funding for uncompensated care.
- Missouri has generous SCHIP coverage (up to 300% of FPL in Missouri).<sup>7</sup> As a result, a greater proportion of Missouri's children are covered by Medicaid – about 70 percent in Missouri as compared to 60 percent in the U.S.



Source: Saint Louis University Health Policy  
Legislative Analysis Team Simulations

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- About 30 percent of the uninsured in Missouri live in poverty. Poverty is defined as living with income less than the FPL: \$9,310 for an individual and \$18,850 for a family of 4 in 2004.<sup>9</sup> (see Figure II-1).
- About three-quarters of the increase in the uninsured between 2000 and 2004 in Missouri occurred among those living below 200 percent of FPL<sup>10</sup>
- Missouri covered a higher proportion of children in poverty, but a lower proportion of adults in poverty through Medicaid in 2003-04.
- In Missouri about 81 percent of the uninsured have someone in their family working full- or part-time and 65 percent of Missourians had employer coverage in 2004-2005.<sup>11</sup>
- Persons in Missouri experienced a significant drop in employer sponsored coverage (ESI) coverage from 2000-2004, largely due to economic decline. For nonelderly adults, ESI coverage dropped by over 7 percentage points in this period.<sup>12</sup>
- About 60 percent of the increase in the uninsured in Missouri between 2000 and 2004 was among adults between the ages of 19 and 34, largely due to declines in ESI coverage.<sup>13</sup>

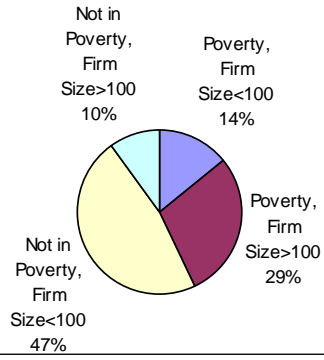


Source: Saint Louis University Health Policy

- To a large extent, the problems Missourians face in the employer-sponsored health insurance market result from the lower likelihood that their firms will offer them health insurance. Only 53 percent of Missouri private firms offer their employees health insurance as compared to about 57 percent in the U.S.
- The problems workers face in obtaining ESI have worsened in recent years as employment has shifted to smaller firms and firms less likely to offer insurance coverage.<sup>14</sup> In Missouri, almost half (47%) of uninsured workers worked for firms that employed fewer than 25 workers, and 61 percent of workers were employed in firms with fewer than 100 workers (Figure II-2).
- About 14 percent of uninsured workers are in poverty and working for small firms, with less than 100 employees (Figure II-3).

The Institute of Medicine (IOM) recently concluded that “the relationship between health insurance and access is well established.”<sup>15</sup> Moreover, this increased access would have a significant effect because “the health of the uninsured is worse than it would be otherwise if they

**Figure II-3.**  
**Uninsured Workers in Missouri,**  
**by Firm Size and Poverty**



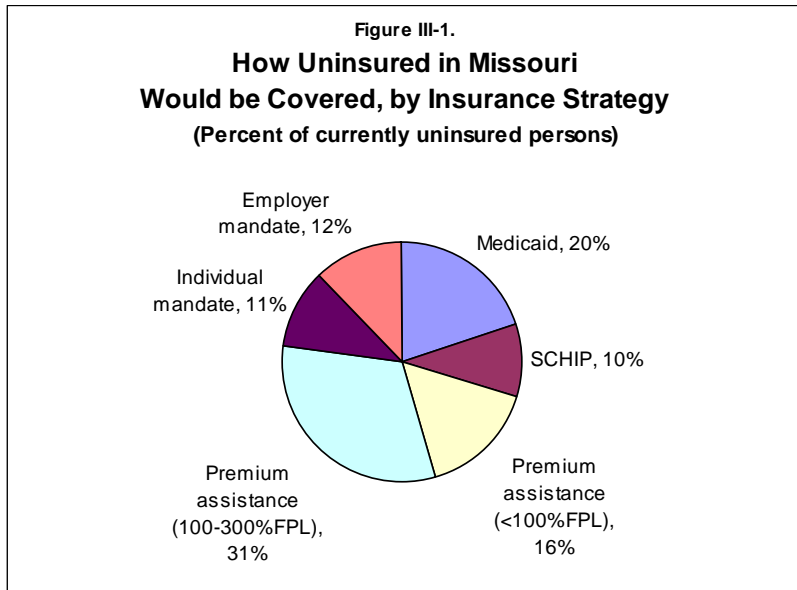
Source: Saint Louis University Health Policy

were insured” and increased access to “insurance would especially improve the health of those in the poorest health and most disadvantaged in terms of access to care.” The IOM concluded that as a result of uninsurance and underinsurance, uninsured individuals and families are less likely to receive preventive and screening services; receive fewer and less timely services; and have increased morbidity and are in poorer health. The result is that annually 18,000 people in the U.S. die prematurely.

### CHAPTER III.

## ACHIEVING ACCESS TO CARE IN MISSOURI THROUGH THE MASSACHUSETTS APPROACH

This chapter concentrates on the impact of importing a Massachusetts-style universal coverage system in Missouri on access to health insurance. As described generally in Chapter II, the Massachusetts legislation uses a number of strategies to achieve improved access to care. Therefore, this chapter discusses each of these strategies and their viability in Missouri.



Source: Saint Louis University Health Policy

### COVERING THE UNINSURED IN MISSOURI: A MASSACHUSETTS-STYLE APPROACH

A Massachusetts-style insurance health reform does not require anyone who has health insurance to change plans. Instead, it seeks to expand access to affordable health insurance through a variety of strategies. Figure III-1 shows how a Massachusetts-style health insurance reform would cover the roughly 847,000 uninsured in Missouri.<sup>16</sup> As shown, the uninsured in Missouri would be covered by the following strategies:

- **Premium Assistance Program (PAP).** The creation of a premium assistance program would help low- and moderate-income individuals below 300 percent of FPL to afford private insurance by lowering the costs of premiums and out-of-pocket expenses. Such a program could cover approximately 47 percent of those presently uninsured.

- **Medicaid Expansion.** Using the Massachusetts approach, a plan for universal health insurance in Missouri would build upon the state's existing Medicaid structure raising income eligibility for those categories of adults – parents, elderly and disabled – to at least 100 percent of FPL, while maintaining the present 300 percent of FPL income cutoff for children. Additionally, the state would have to enroll those who are presently eligible but not currently covered by Medicaid or SCHIP. These efforts could cover about 30 percent of the uninsured.
- **Insurance Purchasing Pool.** A state-sponsored insurance purchasing pool would allow individuals and small groups to lower the costs of purchasing health insurance. These savings would derive from combining the individual and small group private insurance markets and from instituting private insurance reforms.
- **Individual and Employer Mandates.** According to this approach, reaching universal coverage requires moving beyond the voluntary purchase of health insurance to a requirement that individuals purchase insurance either directly or through their employers. For employers, the mandate would require either contributing to their employee's health insurance or paying a penalty to the state. Estimates for Missouri indicate individual and employer mandates would bring coverage to 23 percent of the uninsured.

Will such reforms reach these individuals in Missouri? The rest of this chapter will describe the following strategies and assess the viability and challenges of offering the Massachusetts-style reform for Missouri.

#### **STRATEGY 1: EXPANDING PRIVATE INSURANCE THROUGH PREMIUM ASSISTANCE**

One of the ground-breaking features of the Massachusetts legislation is the Commonwealth Care Health Insurance Program which provides sliding scale premium assistance to uninsured residents with household incomes up to 300 percent of FPL to purchase private insurance coverage. This PAP is designed to help low- and moderate-income individuals who have trouble affording health insurance premiums in both the ESI and individual markets. This new subsidized private insurance program is predicted to insure an additional 207,500 people in Massachusetts by 2009.<sup>17</sup>

The Massachusetts PAP meshes with Medicaid and SCHIP expansion to provide access to subsidized health insurance for all Massachusetts' residents with household incomes up to 300 percent of FPL. The federal government has approved an amendment to the Massachusetts Section 1115 Medicaid Waiver to allow federal Medicaid matching funds to help pay the costs of the PAP.<sup>18</sup>

Uninsured individuals with household incomes up to 300 percent of FPL who are not eligible for Medicaid or Medicare, and whose employers do not offer subsidized insurance qualify for the PAP. Employees whose employers pay at least 20 percent of the cost for individual or 33 percent of the cost of family coverage may also participate, but the employer must contribute towards the cost of the PAP. The individual's premium contribution and copayments are to be based on family income. Policies offered to those with incomes below 100 percent of FPL are to have benefits and co-payments similar to those in Medicaid. Individuals with incomes

between 100 and 300 percent of FPL contribute a sliding scale premium contribution based upon their income. The sliding scale will be set by the Insurance Pool.

The PAP is administered by the Commonwealth's new Connector Authority in consultation with the state's Office of Medicaid, and only policies purchased through the Connector are eligible for premium assistance subsidies. The Connector Authority specifies the benefit package and negotiates rates with insurers who wish to sell policies through the PAP. To ease the transition to a private insurance-based system for the state's safety net providers, only managed care organizations that participate in MassHealth will be allowed to sell policies through the PAP for the three years of the program, provided they meet enrollment targets.

Individuals who purchase policies through the PAP have a choice of private insurance plans. Individuals pay their premium contribution, if any, to the Connector Authority which then pays the full premium amount to the private insurance plan.

### **Missouri**

In Missouri, a PAP should fill the gaps in health insurance coverage between Medicaid and ESI. Lower wage workers are less likely to be offered ESI health insurance and less likely to take it when offered because of the cost of coverage compared to wages.<sup>19</sup> Low- and moderate-income individuals are also more likely to face problems obtaining affordable and adequate health insurance in the individual market.

The PAP for Missouri would cover residents with incomes up to 300 percent of FPL who do not have insurance and who are not eligible for Medicaid or Medicare. Employees whose employers pay for health insurance may also participate, but the employer would need to contribute towards the cost of the PAP. The PAP would mesh with Medicaid and SCHIP expansions to provide access to subsidized health insurance for all Missouri residents under age 65 with household incomes up to 300 percent of FPL, \$49,800 per year for a family of three. Since Medicaid and SCHIP cover children with family incomes up to 300 percent of FPL, the PAP will primarily offer subsidized insurance coverage for adults.

Individuals with incomes up to 100 percent of FPL would have no premiums, and copayments and coverage would be similar to Medicaid. Those with incomes between 100 and 300 percent of FPL would have sliding scale premiums and a benefit package to be set by a regulatory board. Since premium assistance policies are designed for low- to moderate-income individuals, policies offered through the PAP would not have deductibles.

### **Achieving Access in Missouri**

The PAP would cover 47 percent of those who are currently uninsured in the state (See Figure III-1). A PAP in Missouri will need to cover a higher proportion of the state's low- income population than in Massachusetts because the state has a lower rate of ESI and a less generous Medicaid program. Even an expanded Missouri Medicaid program will not cover as many adults as does MassHealth.

## Issues for Policymakers

Whether a PAP would expand access to insurance in Missouri depends on several factors:

- **Costs of plans.** The cost of the subsidized plans needs to be competitive to keep the state's costs for providing subsidized premiums from escalating. A state health insurance purchasing pool should be able to negotiate plan rates that correlate with the rates offered through the Missouri Consolidated Health Plan, the state employee's health insurance purchasing pool. A PAP that covers a substantial number of working age, non-disabled adults and that is willing to negotiate and bargain for best rates – rather than merely passively accepting bids for coverage – should be able to negotiate similar rates. It is also worth noting that the anticipated premium costs for the PAP – for which estimates presented here include dental and mental health coverage – is almost identical to the per member, per month costs for the Medicaid plan after factoring into Medicaid rate increases.
- **Affordability.** Sliding scale premiums for those with incomes between 100-300 percent FPL will need to be set at a level that attracts participation. Some policy experts suggest that health insurance premiums need to be below 5 percent of income for individuals to consider premiums affordable. However, other studies have shown that even 5 percent may be too high a premium level for lower income Americans. A recent Urban Institute study of health insurance affordability concludes that the median employee contribution toward premiums represents 1.5 percent of income for single coverage and 3.0 percent for family coverage, a figure that some are now proposing as the appropriate premium contribution levels in Massachusetts.<sup>20</sup>
- **Crowd-out.** Crowd-out speaks to the concern that publicly subsidized health insurance will result in individuals dropping private coverage in favor of public coverage. Crowd-out results in public coverage displacing existing private coverage rather than expanding coverage. Massachusetts' PAP guards against crowd-out by providing that only those who are uninsured for at least six months are eligible. It also creates a mechanism by which those who are presently covered by ESI may also qualify for the PAP, but only if their employer continues to contribute to their premium costs. Along with the employer mandate, this provision offers an interesting approach to avoiding crowd-out by giving employees access to more affordable insurance products without imposing additional financial obligations on employers.
- **Federal Matching.** The key policy issue Missouri faces in trying to implement a PAP is obtaining Centers of Medicare and Medicaid Services (CMS) approval to use federal Medicaid matching funds to help pay the public costs. It is the availability of federal Medicaid matching funds that makes the Massachusetts program financially feasible; the same is likely to be true in Missouri. CMS is encouraging states to use Medicaid and SCHIP funds to support premium assistance programs through its 2001 Health Insurance Flexibility and Accountability (HIFA) Section 1115 Waiver initiative. The Deficit Reduction Act (DRA) of 2005 expands states' ability to implement premium assistance programs without the need for waiver approval. However, Missouri will need some sort of Section 1115 waiver to use federal Medicaid funds to support premium assistance for childless adults and it is unclear whether the federal agency would

approve such a waiver. CMS is encouraging states to develop PAPs that rely more on employer contributions, and less on state and federal dollars. To the extent that Missouri can develop a creative program that takes advantage of employer contributions, federal approval may be more likely.

## **STRATEGY 2: MEDICAID EXPANSION, RESTORATION, AND ENHANCEMENT**

A key feature of the Massachusetts health reform legislation is the Commonwealth's ability to use federal Medicaid and SCHIP matching funds to help subsidize health insurance costs for residents with incomes up to 300 percent of FPL. A Medicaid expansion extends health insurance to an additional 92,500 state residents, mostly children, while most adults will be covered by subsidized private insurance through a new PAP that qualifies for federal Medicaid matching funds. The Medicaid expansion builds upon the structure of Massachusetts' existing Medicaid program, while the PAP fills in the gaps.

Any effort to implement universal health insurance coverage requires some mechanism for subsidizing the cost of health insurance for low-income workers and families who cannot afford the full cost. In 2005, the average cost of ESI for a family of four was \$11,000, slightly more than the income for a full-time minimum wage worker, and almost 20 percent of the gross income of a family of four earning 300% percent of FPL, \$60,000 per year.<sup>21</sup> Even single coverage averages about \$4,000 a year, over 40 percent of the income of a person living at 100 percent of FPL (\$9,800 per year).

For states, Medicaid and SCHIP offer the most fiscally responsible mechanism for funding health insurance for low-income residents because they allow states to obtain federal funding to help defray the costs. In Massachusetts, the federal government contributes 50 percent of the cost of Medicaid and 61.6 percent of the costs for SCHIP. In Missouri, the federal share is even higher, 61.93 percent for Medicaid and 72.81 percent for SCHIP.<sup>22</sup>

Massachusetts has operated its Medicaid program, called MassHealth, pursuant to a Section 1115 waiver since 1997. This waiver allows the state to cover additional categories of adults and set income eligibility levels higher than that authorized by the federal Medicaid statute. As a result, prior to the reform initiative, MassHealth covered children and adult who were parents, disabled, elderly, long-term unemployed, and HIV+ with incomes generally up to 200 percent of FPL.<sup>23</sup> The Massachusetts Medicaid expansions build on this basic structure.

The Massachusetts reform legislation expands MassHealth to cover children up to 300 percent of FPL. The expansion also raises enrollment caps that had resulted in waiting lists for some categories of adults, and expands parent eligibility for Insurance Partnership Premium Assistance, a program that subsidizes employer provided health insurance from 200 to 300 percent of FPL. Altogether, the MassHealth expansion is expected to provide health insurance for an additional 92,500 people, mostly children.

Additionally, the reform restores Medicaid benefits for adult dental care, eyeglasses, and orthopedic shoes that were eliminated a few years ago. The reform legislation also creates incentives for individuals to be personally responsible for their own health by creating pilot incentive programs to encourage wellness and smoking cessation.

The Massachusetts plan responds to concerns about low Medicaid provider reimbursement rates by raising Medicaid rates for acute care hospitals and physicians. Future Medicaid rate increases will be tied to specific performance goals related to quality, efficiency, reduction of racial and ethnic disparities, and improved outcomes for patients.

## **Missouri**

Missouri also operates its Medicaid program pursuant to a Section 1115 waiver. However, the basic parameters of Missouri's Medicaid program are different from that in Massachusetts. While Massachusetts' Section 1115 waiver focused on creating eligibility for new categories of adults, the Missouri waiver focuses primarily on expanding Medicaid for children and parents.

Missouri already provides Medicaid and SCHIP coverage for children up to 300 percent of FPL. However, eligibility for parents and other adults is extremely limited: the income cut-off for parents is only 18-22 percent of FPL, and eligibility for adults with disabilities and the elderly is 85 percent of FPL.<sup>24</sup> While Missouri has Section 1115 approval to cover other groups of parents including non-custodial parents, Missouri does not have Section 1115 approval to cover childless adults or HIV+ individuals before they become permanently and totally disabled.

A plan for universal health insurance in Missouri logically builds on the state's existing Medicaid structure, focusing on raising income eligibility for those categories of adults who are presently eligible, while maintaining for the eligibility levels for children. Thus, the Medicaid expansion in Missouri focuses on raising income eligibility for those categories of adults who are presently eligible – parents, elderly and disabled – to at least 100 percent of FPL, while maintaining the present 300 percent of FPL income cut-off for children (Table III-1). Working disabled adults would be covered on a sliding-scale premium basis with no upper-income limit.

Given the costs of private insurance, single adults with incomes up to 300 percent of FPL and parents, elderly and the non-working disabled with incomes between 100 and 300 percent of FPL also need premium subsidy assistance. However, a PAP, rather than Medicaid, is envisioned as the vehicle to assist those with incomes between 100-300 percent FPL, partly because this mirrors the Massachusetts model and partly because a PAP model – rather than a straight Medicaid expansion – is more likely to be approved by CMS for federal Medicaid matching funds.

## **Achieving Access in Missouri**

Medicaid expansion would cover 10 percent of those who are currently uninsured in the state. All of these newly covered individuals are adults who are parents, elderly or disabled (See Figure III-1). Outreach to enroll children who are presently eligible for Medicaid but not enrolled would cover an additional 10 percent of those who are presently uninsured, and finally, outreach to children presently eligible for the SCHIP program but not enrolled would cover an additional 9.7 percent of the uninsured. Altogether, Medicaid expansion and outreach will cover roughly 30 percent of the uninsured.

## Issues for Policymakers

How well a Medicaid expansion would succeed in covering the uninsured depends on several factors:

- **Federal Approval.** To receive federal matching funds, state Medicaid programs must comply with federal Medicaid requirements and be approved by CMS. Missouri should be able to secure CMS approval to raise Medicaid eligibility to 100 percent of FPL for adults who are parents, disabled or elderly and to provide for sliding scale premiums for the working disabled because the federal Medicaid statute gives states the authority to use these eligibility levels. In fact, Missouri used 100 percent of FPL as the eligibility level for disabled and elderly, and had a sliding scale premium program for the working disabled until legislative changes in 2005 reduced the income limits and abolished the special eligibility rules for the working disabled. Moreover, Missouri's Section 1115 Waiver already authorizes parent eligibility up to, and in some cases above, 100 percent of FPL.
- **Covered Services.** Low-income families have little, if any, excess income to be able to pay out of their own pocket for medical services. A comprehensive Medicaid benefit package guarantees that low-income residents receive medically necessary services when needed and that providers will receive payment for services without the need to try to cost-shift to private patients and private payers. For these reasons, the cost simulations presented here assume that cuts to the Missouri Medicaid benefit package for adults made in 2005 are restored. Reinstating these Medicaid benefits for adults will reduce cost-shifting by providers and should ultimately result in more affordable private insurance in Missouri.
- **Reimbursement rates.** Medicaid physician fees are a particular problem in Missouri. The state has one of the lowest Medicaid physician reimbursement rates in the country, paying only 55 percent of Medicare rates. As a result, many physicians limit their participation in Medicaid creating access problems for those with Medicaid coverage.<sup>25</sup> Thus, the proposal here assumes a 10 percent increase in Medicaid physician and hospital rates to approximate the Massachusetts plan. This payment level should adequately reimburse providers for the cost of caring for Medicaid patients, particularly since historical safety net providers will no longer need to try to shift Medicaid funds to cover the cost of caring for the uninsured.
- **People with Disabilities.** Covering the working disabled on a sliding premium scale with no upper income limit through Medicaid improves the quality of care for people with disabilities and lowers the costs for those with private insurance. First, Medicaid is the only insurer that covers the long-term care services that people with disabilities. Using Medicaid as the primary source of insurance coverage for people with disabilities creates a program that can design integrated systems of care that meet the unique needs of people with disabilities. Second, people with disabilities tend to have more health care needs than other adults. The average monthly cost of Medicaid coverage for adults with disabilities is currently \$1,261 per person, compared with \$255 for adults who qualify as parents. Allowing people with disabilities to be covered by Medicaid rather than through the proposed state health insurance purchasing pool or the PAP should stabilize and

lower average private premium costs in both programs. In addition, sliding scale Medicaid premiums for people with disabilities should correspond to those charged by the PAP.

- **Enrollment Outreach.** In Massachusetts, most of those to be newly covered are individuals who are eligible but not enrolled in Medicaid and SCHIP. The same will be true in Missouri. Effective outreach efforts will be necessary to assure that all those who are eligible for the program are enrolled.
- **Affordability.** Experiences in Missouri and other states show that imposing Medicaid premiums can cause eligible individuals to forgo coverage. An Urban Institute study found that when Medicaid and SCHIP premiums were set at 1 percent of income, 57 percent enrolled; when the charge was 3 percent, 35 percent enrolled; and when the premium went up to 5 percent, only 18 percent participated.<sup>26</sup> If the goal in Missouri is universal coverage, policy makers will have to construct sliding scale premiums that will attract participation.

MEDICAID/SCHIP INCOME ELIGIBILITY	MASSACHUSETTS, 2006	MASSACHUSETTS PLAN	MISSOURI, 2006
Adults 19-64			
Parents	133%*	133%	18-22%
Long term Unemployed	100%*, enrollment cap, with 12,000 on waiting list	Enrollment cap raised to 60,000 which will eliminate waiting list	Not covered
Pregnant Women	200%*	200%	185%
HIV +	200%*, enrollment cap	200%, enrollment cap raised	Not covered until disabled
Breast & Cervical Cancer	250% *	250%	200%
Premium Assistance for employer sponsored insurance	200%*	300%, premiums will match those in new Premium Assistance program	Only if otherwise eligible and private insurance costs no more than Medicaid
Disabled	*no upper limit, sliding scale premiums start at 133%, and non-working disabled adults must pay a one-time deductible, enrollment cap	Same, although definition of "disabled" broadened and enrollment cap raised	85% those with higher incomes qualify if they spend down income above 85% on medical expenses
Children			
0-19	200%* premiums start at 150%	300%	300* premiums start at 185%
Disabled	*no upper limit premiums start at 150%	No upper limit, premiums will match those of new Premium Assistance program	85% those with higher incomes may spend down
Premium Assistance for	150-200%*	300%, premiums will	Only if otherwise

employer sponsored insurance		match new Premium Assistance program	eligible and private insurance costs no more than Medicaid
Elderly	100%	100%	85% those with higher incomes may spend down
<p>NOTE: *Indicates eligibility level or category over Title XIX levels authorized by existing 1115 waiver.  SOURCES: For Massachusetts: Commonwealth of Massachusetts MassHealth Waiver Extension Request (June 30, 2004); Massachusetts Medicaid Policy, Institute, the Mass Health Wavier, April 2005, available at <a href="http://www.massmedicaid.org/pdfs/MassHealth_Waiver.pdf">http://www.massmedicaid.org/pdfs/MassHealth_Waiver.pdf</a>; For Missouri: Mo. R. S. 208.151.</p>			

**STRATEGY 3: STATE-AUTHORIZED PRIVATE INSURANCE PURCHASING POOL**

One step towards universal coverage in Massachusetts is creation of a state-authorized private insurance purchasing pool, called the Commonwealth Health Insurance Connector.<sup>27</sup> This purchasing pool will help “connect” individuals and small employers with private insurance products to make it easier for individuals and small businesses to find affordable policies. Estimates are that 215,000 presently uninsured persons in Massachusetts will purchase private policies through the Connector either as individuals or through small groups.<sup>28</sup>

Individuals and businesses with up to 50 employees are eligible to purchase insurance through the Connector, although no one is required to use it. The individuals most likely to use the Connector are those who are self-employed, not eligible for coverage through work, or working at companies that do not offer insurance. One advantage of the Connector is that it will allow part-time and seasonal employers to obtain access to health insurance.

The Connector provides a mechanism by which individuals and small employers can easily identify quality coverage at an affordable cost. The Connector certifies products as “high value and good quality,” and only insurance products so certified will be available through the Connector. Massachusetts also intends to use this pool as a mechanism for developing new insurance products that are presently unavailable.

Moreover, the Connector reduces the cost of insurance by merging the individual and small group insurance markets. In Massachusetts, small group and individual health insurance plans already are sold on a modified community rated basis: Premiums may not vary due to the health status, claims experience, or gender. Although rates may vary based upon age, family size, geographic location, and occupation, the law significantly modifies the current small group regulations and the factors that health plans may use to adjust premiums. The merger of these two markets is predicted to substantially decrease the cost of individual insurance by as much as 25 percent.<sup>29</sup> The law also reduces waiting periods for those who have not had health insurance, while leaving in place existing limits on deductibles, co-payments, and coinsurance. Another advantage of offering a private purchasing pool is that it enables “portability” of coverage, allowing individuals to keep coverage even if they move from one job to the next.

The Connector also reduces the cost of insurance for individuals by allowing individuals to use pre-tax dollars to purchase insurance through the Connector. The health reform legislation requires employers with more than 10 workers to offer Section 125 “cafeteria plans” so that

workers can purchase health care with pre-tax dollars. Workers who are not offered ESI can use these pre-tax dollars to purchase insurance through the Connector. It also gives favorable state tax treatment for Health Savings Accounts attached to already permitted, high deductible plans.

Finally, the legislation authorizes reforms designed specifically to make health insurance more affordable for young adults. The legislation provides that young adults may continue on their parents' plans for up to two years past loss of dependency status or until age 25 whichever occurs first. It also authorizes the Connector to offer specially designed, lower cost products for 19-26 year olds who tend to have high rates of uninsurance.

## **Missouri**

A Missouri Private Insurance Purchasing Pool (Pool) would offer individuals and small businesses access to a choice of standardized private insurance plans with premiums set at a modified community rate that does not vary based upon medical risk. The Pool would need to be designed to create economies of scale and reduce administrative costs. Almost half (47%) the uninsured in Missouri are workers employed by firms with fewer than 25 workers and their dependents. Sixty-one percent of the uninsured are employed by or dependents of employees of firms with fewer than 100 workers. In the ESI market, only 34 percent of Missourians working for firms with less than 10 employees and only 41 percent of Missourians working for firms with less than 50 employees are offered health insurance by their firm.<sup>30</sup> The problems workers face in obtaining ESI have worsened in recent years as employment has shifted to smaller firms and firms less likely to offer insurance coverage.<sup>31</sup>

The Pool would negotiate premium rates with private plan that would offer policies through the Connector. Premiums would be fairly uniform allowing variations only for family size, geographic area, benefits structure, and, if desired, other factors such as age, tobacco use, or wellness programs. Individuals could purchase plans through the Pool using pre-tax dollars. Also, the Pool would be authorized to develop policies designed specifically for young adults, such as Health Savings Accounts tied to high deductible plans and lower-cost products targeted to young adults.<sup>32</sup>

By pooling together a large number of individuals, both the risks and the costs would be spread among much larger numbers of individuals. By reducing the administrative costs inherent in marketing to the small group and individual markets, the Pool should be able to reduce by 25 percent the amount spent on administrative overhead.<sup>33</sup>

A Missouri Purchasing Pool would need to do more than merely merge already community-rated individual and small group markets. Missouri does not regulate the premiums charged in either the individual or small group markets. While there is some regulation of premium rates in the very small group market – those firms with 2-25 employees – wide variations in premium pricing still occurs. While the average premium costs are lower in Missouri than Massachusetts, \$3,305 as compared with \$3,496 in Massachusetts, but the variability in rates is much greater.<sup>34</sup>

One of the primary problems that individuals and small groups face in Missouri is that health insurance premiums in both markets are set based upon the individual's or group's risk: Those who are likely to require more medical care are charged higher premiums while those who are

unlikely to need services are charged the least. The result of this “risk rating” is that those who need health insurance the most are charged high premiums that often make health insurance prohibitively expensive. Moreover, those who are presently uninsured can be refused coverage altogether because of their risk factors, only those who already have sufficient “creditable coverage” must be issued policies. While Missouri offers a subsidized High Risk Pool for those who are unable to purchase insurance because of pre-existing conditions, the cost of coverage through the High Risk Pool is so high – estimated at \$14,357 for premium, deductible and coinsurance for a 55 year old man – the Pool is one of the least used in the nation.<sup>35</sup>

Moreover, small businesses and individuals have difficulty comparison shopping among health insurance plans. There are no standardized benefit packages, and offerings vary widely in both the small group and individuals markets. Small businesses must invest substantial time and money to determine which policies might provide the best value.

### **Achieving Access in Missouri**

Strategies designed to make private insurance more affordable for those who are self-employed or work for small employers can have a dramatic impact on uninsurance rates. Almost half (47%) the uninsured in Missouri are workers employed by firms with fewer than 25 workers and their dependents. Sixty-one percent of the uninsured are employed by or dependents of employees of firms with fewer than 100 workers. It is estimated that almost one quarter (23%) of the uninsured in Missouri would use the Pool to purchase private health insurance plans, divided about equally between individuals and small businesses. In addition, another 31 percent of the uninsured are likely to use the Pool to purchase premium assistance policies. Altogether, the Pool would be likely to cover over half of those who are presently uninsured and in the process be able to exercise considerable market clout.

### **Issues for Policymakers**

How effectively a state-authorized insurance purchasing pool would expand access to insurance in Missouri depends on a number of factors. In particular:

- **Missouri Consolidated Health Care Plan (MCHCP).** The MCHCP is the mandatory purchasing pool for certain state employees, retirees, and dependents and a voluntary purchasing pool for local government entities that wish to join. The MCHCP has the experience and administrative structure to operate a large pool.<sup>36</sup> Designating the MCHCP as the state-authorized voluntary pool for individuals and small businesses would build on existing state institutions and state capacity.
- **Adverse risk selection.** A voluntary pool must attract enough low-cost individuals to be able to spread the risk and thus offer more affordable premiums.<sup>37</sup> Premiums must be low enough that low-cost individuals will use the pool rather than purchase policies on their own outside the pool. This adverse risk problem always arises when voluntary purchasing pools must compete with what individuals can buy on their own. The larger the pool – and the healthier its members – the better able it is to absorb the cost of less healthy enrollees. A number of design features that are part of the strategies for universal coverage help ensure that the pool size is large enough to help counteract adverse selection. These features include: (1) pooling premium assistance enrollees

with the private purchasing pool enrollees, (2) marketing special plans through the pool designed to attract healthier young adults, and (3) the individual mandate which requires individuals who would otherwise go without insurance to purchase insurance if affordable policies are available. On the other hand, the provisions setting up the Insurance Pool do not guarantee the viability or availability of affordable insurance products in Missouri.<sup>38</sup>

- **Pooling small businesses and individuals with premium assistance enrollees.** It is essential that the purchasing pool include lower income residents. When these individuals – who are all working age and not disabled – are part of the risk pool as the private purchasing pool, the pool size should be large enough to spread the risk broadly and negotiate less costly, more affordable premium rates. MCHCP presently covers 104,000 state employees, dependents and retirees and has been able to negotiate quite competitive per month premium rates
- **New insurance products for young adults.** In Missouri young adults are one of the primary groups who lack health insurance: about 60 percent of the increase in the uninsured between 200 and 2004 was among those 19-34 years of age.<sup>39</sup> Insurance reforms which would allow the purchasing pool exclusive authority to market special low-cost plans, as well as attracting less expensive enrollees who would help stabilize the pool. The state could also enact insurance reform which would allow parents to maintain children on their individual and groups policies until age 25 or until two years after dependency ends, whichever comes sooner.

#### **STRATEGY 4: INDIVIDUAL MANDATE**

As of July 1, 2007, residents will face financial penalties for failure to purchase insurance if an acceptably comprehensive plan is available at an affordable price. The determination of what coverage people must have and what “affordable” means will be made by the newly created Connector Board.<sup>40</sup> Although Massachusetts is the first state to pass an individual mandate to carry health insurance, an individual mandate bill was introduced in Maryland in 2005 and similar federal legislation has been introduced in the U.S. Congress (“American Health Benefits Program Act,” November 2005).<sup>41,42</sup> Maine enacted a voluntary universal insurance plan in 2003.<sup>43,44</sup>

Starting in 2007, the legislation requires that Massachusetts residents report on their income tax returns whether they had health insurance coverage for the taxable year. The state’s Department of Revenue will verify health insurance coverage through an insurance industry database. If affordable insurance is deemed to be available, the Department of Revenue will assess an income tax penalty equal to the loss of the personal exemption for tax year 2007 and rising in subsequent years to 50 percent of what the person would have paid for an affordable health insurance plan.

From a political perspective, the individual mandate represents a significant shift in state policy. This has been compared to state requirements that individuals who register cars and continually carry automobile insurance policies (although on average, the uninsured driver rate is 7% and some states exceed 12%).<sup>45</sup> It makes the purchase of health insurance coverage an individual responsibility and obligation for those who are able to afford to purchase coverage. It also

requires state policy makers to engage in a public debate about what is affordable and adequate health insurance, and to develop mechanisms for subsidizing health insurance costs for those deemed unable to afford the full price of coverage.

Proponents of the Massachusetts reform legislation viewed the individual mandate as a necessary component of a multi-strategy plan to move the state to near universal coverage. The three voluntary strategies that comprise the Massachusetts plan – Medicaid expansion, PAP, and a purchasing pool – make considerable progress toward expanding health insurance coverage but will still leave the Commonwealth far short of universal coverage.<sup>46</sup> The individual mandate also reduces the cost of health insurance per person by stabilizing the Connector Purchasing Pool (with the inclusion of generally younger, healthier workers) and eliminating the “free rider” problem of individuals who have access to health insurance, choose not to participate, but then eventually uses services.<sup>47,48</sup>

The individual mandate is also more likely to accomplish universal coverage than an employer mandate alone. An employer mandate cannot accomplish universal coverage because not all workers qualify for employer-sponsored coverage – part-time, temporary and seasonal employees are typically excluded from coverage. Even when employees qualify for ESI, in the absence of an individual mandate, they can “opt out” and decline employer provided health plans, defeating the goal of universal coverage.<sup>49,50</sup>

### **Achieving Access in Missouri**

The three voluntary strategies – Medicaid expansion, premium assistance and the purchasing Pool-should expand health insurance to 77 percent of those who are presently uninsured, reducing the number of uninsured in Missouri to 195,000. However, to reach universal coverage requires moving beyond the voluntary purchase of health insurance to a requirement that those who can afford to purchase insurance either directly or through their employer. In Missouri, estimates presented here are that an employer and individual mandate would apply to the remaining 23 percent of the uninsured (Table III-1). Of these persons, about 89,600 (roughly 13%) Missourians currently uninsured could not be covered by their employers, and thus would need to obtain health insurance as an individual. While the majority of these are able-bodied adults (62,900 or 8.9%), this number also includes approximately 18,300 children (2.6%) and 8,400 (1.2%) disabled adults.

### **Issues for Policymakers**

The extent to which an individual mandate for health insurance will solve the problem of the uninsured in Missouri depends on a number of factors:

- **Affordability**. The biggest challenge for lawmakers will be setting an affordability standard by which to determine if affordable coverage is available. An individual mandate would require all Missourians to obtain coverage for themselves and their families if “affordable” coverage meeting minimum standards is available. Annual reporting on income tax returns could be used to monitor compliance with penalties assessed through the State Department of Revenues. In Massachusetts, regulators are debating a variety of approaches to define affordability including using Medicaid and SCHIP standards, average household budgets to determine available income for health insurance, and current spending on private health

insurance coverage as an indicator of the amount that individuals and families are willing and able to pay. Whichever approach is chosen, affordability levels will need to be indexed to income, and rates must be set at a level that generates broad public support and acceptance by the public at large.<sup>51</sup>

- **Implementation.** The specifics of any legislation requiring an individual mandate and the rules and regulations governing its implementation are critical. Key factors include:
  - Monitoring and enforcement of an individual mandate and the levying of fines for violations.
  - Defining the requirements of a qualified plan to satisfy the mandate.
  - Safeguarding individuals/families who cannot afford to purchase health insurance are not penalized.
  - Designing programs to provide low-cost health insurance plans, connect individuals and families without coverage to plans, and to subsidize those below a certain percentage of FPL.
  - Defining health insurance plans that satisfy the health insurance mandate. Among many details that will need to be addressed are the minimum benefits package, out-of-pocket limits, and Healthcare Savings Accounts accompanied by catastrophic health insurance plans are part of the mandate.<sup>52</sup>
  
- **Dominant Role for Employer Insurance.** An individual mandate will not disrupt or change the dominant role of the employer-based insurance system in Missouri. ESI will remain attractive to employers because of the federal tax exemption for employer contributions, and health benefits will remain one of the ways employers compete for workers. Moreover, middle- and high-income employees will still be better off financially by obtaining coverage through their employers, given that most will not be eligible for income-based premium assistance subsidies provided in the purchasing pool.<sup>53</sup>
  
- **Enforcement.** Another important issue for policy makers is the appropriate penalty for those who violate the affordable health insurance mandate. Enforcement of the mandate will be necessary: In states that require automobile owners to carry auto insurance between 7 percent and 12 percent of owners violate the law and drive without insurance.<sup>54</sup> In Massachusetts, the penalty for violating the affordable insurance mandate is equivalent to only 50 percent of the cost of affordable insurance. When the cost of non-compliance is less than the cost of complying with the law, people are more likely to pay the penalty rather than obtain insurance. If Missouri lawmakers are serious about using an individual mandate to obtain affordable insurance as part of a plan for obtaining universal health insurance coverage, they need to consider setting a penalty at least equal to the cost of compliance.

## **STRATEGY 5: EMPLOYER MANDATE**

The Massachusetts plan also contains an employer mandate. This play or pay provision requires that businesses with 11 or more full-time equivalent employees provide a fair and reasonable premium contribution to an employee health insurance plan or pay an annual assessment of up to \$295 per employee.<sup>55</sup> The Massachusetts Division of Health Care Financing and Policy is responsible for developing regulations defining a fair and reasonable contribution which must be presented to the legislature prior to implementation.

The strategy proposed in Massachusetts is similar to the play or pay proposals introduced in a number of states across the country. These laws do not require employers to offer insurance, but instead require employers who do not offer insurance (play) to pay a tax to the state (pay). In 2005 alone, 19 states introduced “pay or play bills.”<sup>56</sup> In 2004, California voters rejected a law passed in 2003 that required businesses with more than 50 employees to pay a fixed fee toward health insurance.<sup>57</sup> Earlier this year, Maryland passed legislation (dubbed “the Wal-Mart bill”) requiring private employers who employ more than 10,000 employees to spend a minimum percentage of their payrolls on employee health care.<sup>58</sup> Vermont and Suffolk County, New York have also adopted pay or play mandates.

The reform plan also authorizes a Free Rider Surcharge that penalizes employers who do not provide insurance if their employees get free care that is reimbursed by the Commonwealth’s Uncompensated Care Pool. Employers are subject to the charge if their employees use the Free Care Pool a total of 5 times per year in the aggregate, or if any one employee uses free care more than 3 times. This surcharge “shall be greater than 10%, but no greater than 100 percent of the cost to the state” of the free care, with the first \$50,000 of costs exempted.<sup>59</sup> Employers will not be subject to this surcharge as long as they offer any insurance to their employees, regardless of whether the employer contributes toward the premium cost.

The fair and reasonable employer mandate, while small, sends an important signal that the state expects employers to contribute to the cost of health insurance for their workers. A mandate helps level the playing field within the business and employer community. Similar to the free rider problem of individuals, businesses that provide health insurance coverage pay higher premiums because the cost of caring for the uninsured gets shifted to those who pay for health insurance. In addition to this indirect subsidy, businesses that do not offer coverage may also benefit directly from the ability to offer higher wages than competitors who must balance wages and benefits or by offering lower prices than their competitors.

An employer mandate without an individual mandate cannot achieve universal coverage.<sup>60,61</sup> An employer mandate only reaches employees and their dependents, and it will not reach part-time, temporary, and seasonal workers who typically do not qualify for ESI. Alone an employer mandate is likely to leave thousands of employed individuals and their families without coverage, given the fact that many will choose to “opt out” of their employer’s health plan and remain uninsured.

### **Achieving Access in Missouri**

A fair and reasonable share employer mandate should help the uninsured who are workers and their dependents, both those who work for employers who presently do not offer health insurance and those who work for employers who do not subsidize employee insurance up to a fair and reasonable share. As shown in Figure III-1 and detailed in Appendix B, this includes about 102,400 (14.5%) of Missourians who are currently uninsured workers and their dependents.

### **Issues for Policymakers**

The extent to which an individual mandate for health insurance will solve the problem of the uninsured in Missouri depends on a number of factors:

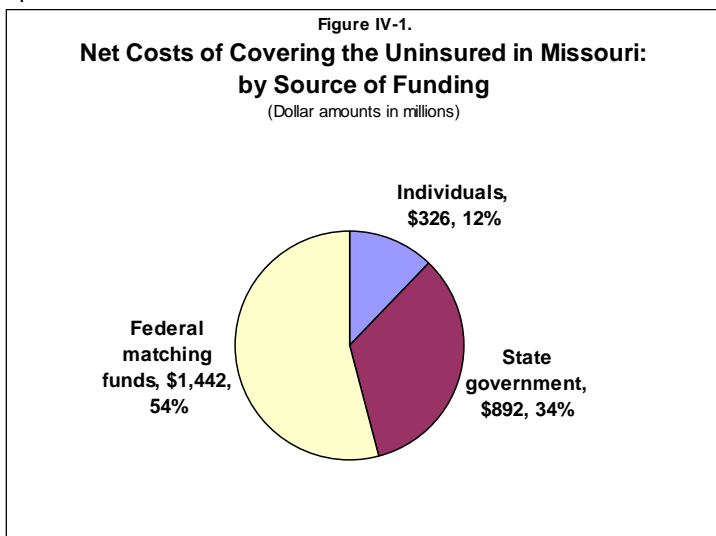
- **ERISA Preemption.** The crucial issue facing states considering an employer mandate is the preemption clause of the Employee Retirement Security Act of 1974 (ERISA). ERISA clearly prohibits states from enforcing laws that require employers to provide health insurance for the employees. Only Hawaii has such a law; Congress specifically granted Hawaii an exemption from ERISA's preemption provisions. As popular as play or pay provisions have become, it is unclear whether courts will uphold them. On July 15, 2006, a federal district court struck down Maryland's Fair Share Health Care Fund Act that requires large employers to contribute 6-8 percent of employee wages to health care or pay the difference to a public fund. The court held that the law violated ERISA preemption because it required employers to segregate a separate pool of expenditures for its Maryland employees and structure their health care contributions with an eye toward the law's spending requirement.<sup>62</sup>
- **Individual mandate's effect on employers.** While ERISA prevents states from legislating that employers offer their employees a specific level of health insurance coverage. An individual mandate can specify a minimum level of benefits that must be held by each person, thus providing a strong incentive for employers to provide policies that would, at a minimum, allow their workers to meet that standard.
- **Fair and Reasonable Contribution.** Defining the level of contribution that is fair and reasonable will be crucial because this defines the public's expectation of employers' role in a universal coverage system. At present, the debate in Massachusetts centers on whether a fair and reasonable contribution requires both that a minimum percentage of full-time workers accept coverage offered by the employer and the employer offer to pay at least a set minimum percentage of the cost, or whether meeting only one of these tests will be sufficient.<sup>63</sup> The employer share of cost presently being debated in Massachusetts ranges from 33 percent to 50 percent.
- **Effects on Employment and Wages.** Although there have traditionally been concerns about the effects of employer mandates on employment, several factors would be expected to mitigate the effects of the changes enacted here on employment and wages. First, as noted in Chapter IV, the small marginal additional costs imposed on some employers not now providing ESI will be offset by reduced costs for employers who are already providing health insurance who will gain from reductions in insurance premium costs through market effects on insurance premiums. Second, analysis of the implementation of the Massachusetts plan projects a small marginal impact of the overall plan on economic activity, employment and wages.<sup>64</sup>
- **Implementation Issues:** The specifics of any legislation requiring an employer mandate and the rules and regulations governing its implementation are critical. For example, key factors include:
  - The size of businesses included under any mandate.
  - The definition of a fair and reasonable employer contribution.
  - The required level of contribution per uninsured employee for businesses who choose to pay instead of play.

- A stand-alone employer mandate or one that is combined with an individual mandate.
- **Universal Coverage.** If the goal is universal coverage for all Missourians, an employer mandate will need to be combined with an individual mandate to reach truly universal coverage. Analysis of the Massachusetts landscape concluded that while enforced individual mandates for health insurance can achieve universal coverage, employer mandates alone cannot.<sup>65,66</sup> An employer mandate in the absence of an individual mandate would still leave potentially hundreds of thousands of employed individuals/families without coverage, given the fact that many will choose to opt out of their employer's health plan, remain uninsured, and contribute to the free rider problem.

## CHAPTER IV. COSTS AND FINANCING OF STRATEGIES FOR UNIVERSAL COVERAGE

The previous chapter outlined the policy strategies by which Missouri could achieve universal health insurance coverage through a Massachusetts-style approach. The next questions are (1) how much would it cost to insure all individuals who are currently uninsured and (2) how could it be financed. This chapter provides an estimate of the costs – to both public and private entities – that Missouri would likely incur if it were to move to a Massachusetts model. In total, the net costs are estimated to be \$2.6 billion with 88 percent of the costs financed by the government – state government (34%) and the federal government (54%) – and the remaining 12 percent from premium contributions by individuals.

The public financing to achieve universal coverage will require a commitment of funds by both the state (\$892 million) and the federal government (\$1.4 billion). The federal government contributions will be in the form of matching funds for state expenditures on Medicaid, SCHIP and the new PAP. Some of the state and federal shares of the costs can be financed by shifting existing government funds used to reimburse care for the uninsured to subsidizing insurance through Medicaid, SCHIP or the new PAP. However, new state and federal revenue will be required. The following discussion identifies several sources of new monies that the state could tap into.



SOURCE: Saint Louis University Health Policy Legislative Analysis Team Simulations

### Costs

As shown in Figure IV-1, the net costs of covering the uninsured in Missouri under a Massachusetts-style plan are estimated to be \$2.6 billion in private and public funds for 2006.<sup>67</sup> Net costs are the actual funds needed to institute the plan after taking into account the cost

savings that would occur with universal coverage. The net costs would be allocated in the following way:

- \$892 million in state funds.** These funds would be used for Medicaid, SCHIP and a new PAP to help subsidize the cost of public or private insurance coverage for those with incomes up to 300 percent of FPL. Approximately \$200 million of these costs are for rolling back the cuts to Medicaid from legislation passed in July 2005. Of the \$892 million that is needed by the State, \$327.3 million (37%) would be available upon redirecting state funds in the current system that are used to cover the cost of care for those who are uninsured. This leaves \$564.7 million (63%) in new state funding that is still needed. The state would then seek federal Medicaid and SCHIP matching funds to augment these expenditures.
- \$1.4 billion in federal Medicaid and SCHIP matching funds.** Currently, \$335.4 million in federal Medicaid and SCHIP matching funds already come to the State to help cover the cost of the uninsured.<sup>68</sup> New matching funds of \$1.07 billion would be needed, some of which would likely need to be approved pursuant to a Medicaid Section 1115 waiver.
- \$326 million in net costs for premium payments by individuals.** Individuals who are currently uninsured will pay an estimated \$544 million for their share of premiums (with the remaining portion paid for by government-paid premium assistance or employers). On the other hand, this would be offset by reduction in premiums for those who are currently privately insured who will see, on average, premium savings of 6 percent per year for a total estimated savings of \$219 million. These savings are the result of larger risk pools that are created when the currently uninsured purchase health insurance. For the new premium payments by the uninsured, most of the new out-of-pocket spending by the uninsured is borne by those above 300 percent of FPL. In contrast, only about 39 percent of the \$544 million is borne by those between 100 and 300 percent of FPL. Furthermore, Table 4-1 illustrates the burden of these costs for these low-income individuals. The premium shares (0-5.8%) that are required of these individuals are limited to relatively small shares of income. For example, a person at 200 percent of FPL would only pay about \$25 per month in premiums or roughly 2.9 percent of their income.

Table 4-1.  
Health Insurance Premiums for Individuals Under Premium Assistance Plan

Percent of poverty	Annual out of pocket premium	Monthly out of pocket premium	Income	Premium as Percent of income
100%	\$0	\$0.00	\$10,160	0.0%
125%	\$74	\$6.14	\$12,700	0.7%
150%	\$147	\$12.28	\$15,240	1.5%
175%	\$221	\$18.42	\$17,780	2.2%
200%	\$295	\$24.55	\$20,320	2.9%
225%	\$368	\$30.69	\$22,860	3.6%
250%	\$442	\$36.83	\$25,400	4.4%

275%	\$516	\$42.97	\$27,940	5.1%
300%	\$589	\$49.11	\$30,480	5.8%

SOURCE: Saint Louis University Health Policy Legislative Analysis Team Simulations

- Zero net cost to employers. While there are costs (approximately \$599 million) to employers for contributing to health insurance premiums to the presently uninsured, this is offset by savings (approximately \$617 million) to employers by way of reduced premiums. These premium savings are due to insurance market reforms including larger risk pools as more individuals purchase insurance.

This summary of costs shows that the majority of the net costs would be financed by the state and federal governments with the remaining share borne by individuals. These estimates raise the question: What sources of revenue and policy options are available for the state government to fund \$892 million to cover the uninsured under this plan? The rest of this chapter discusses these questions and outlines potential sources of revenue.

### Public Financing

Due to a confluence of economic and political factors, Massachusetts was able to finance universal coverage without a significant increase in costs for the state. Estimates are that Massachusetts will need to appropriate only an additional \$308 million in state revenues over three years to fund its reform plan. This is because Massachusetts already spends approximately \$1 billion a year from a Free Care Pool, to pay for care for the uninsured. That money is being shifted to help cover the costs of subsidized health insurance coverage for low- and middle-income residents. Having these public funds devoted to uncompensated care already gave Massachusetts a relatively large public funding base that could be shifted to pay for health insurance to aid in universal coverage. Moreover, the federal government was already contributing federal Medicaid matching dollars to the Free Care Pool and CMS has approved the Massachusetts plan to use the Free Care Pool funds for health insurance.

Missouri has approximately \$327.3 million in state funds that have been identified as being used to help fund uncompensated care for the uninsured (some of which currently receive federal matching dollars.) These state funds could be shifted away from reimbursement for uncompensated care in order to help fund the state's share for universal coverage. Thus, the state would need \$564.7 million (63 percent of the total state share \$892 million) in new state funding to finance a Massachusetts-style program. This assumes that CMS will agree to allow federal Medicaid/SCHIP matching funds to support a Medicaid expansion and PAP as it did for Massachusetts for both existing and new funds.

- Existing State funds (\$327.3 million) currently used to pay the costs of services for the uninsured that could be reallocated to a universal coverage plan.
  - \$175.5 million in Medicaid DSH payments.<sup>69</sup> Medicaid DSH payments are made to hospitals to compensate them for medical services to the uninsured. If all individuals in the state had public or private health insurance there would be no need to make DSH payments and such payments could be redirected to help fund a Medicaid expansion program or a premium assistance program. At present, \$160.7 million in state and local funds are used to support Medicaid hospital DSH payments

throughout Missouri and \$14.8 million local and state funds to support a special Medicaid Waiver that uses DSH money to pay for outpatient care for the uninsured in the St. Louis area.

- \$151.8 million, in state and local funds used to support health care services to the uninsured<sup>70</sup> The State, counties, and cities provide a variety of funds to support medical services for the uninsured, including funding for clinics and hospitals. Not only could this money be redirected to help fund coverage, but this money is presently not being matched by federal dollars. This money if used to expand Medicaid or support a PAP could draw new federal dollars to support universal coverage in Missouri.
- Possible new sources of state revenue to fund the additional costs of (\$564.7 million) universal coverage include:
  - State general revenues. The State recently reported an unanticipated increase of \$620 million in general revenues for fiscal year 2006<sup>71</sup> – an amount that could fully fund the balance of state funds needed for universal coverage, if all the funds were allocated to funding health care. It is also important to point out that one reason why the state has a revenue surplus is because of the Medicaid legislative changes enacted in 2005, which resulted in lower state spending and higher rates of uninsured.<sup>72</sup>

If the plan were implemented, on net, the State could expect to see an increase in tax revenues as a result of instituting universal health coverage. The plan will bring in over \$1 billion in new federal Medicaid dollars (\$335.4 million in federal match already received for uninsured) that will generate additional income, wages and ultimately increased tax revenue (via income tax and sales tax). At the same time Missouri will lose tax revenue due to its indirect contribution toward employer-based health insurance for those who now take-up through their employer. The net effect on state tax revenue upon instituting Massachusetts-style universal coverage is expected to be positive.

- \$100 million (net) from premium tax on all insurers. If a 2 percent tax on all private insurance premiums (equal to \$7.8 billion)<sup>73</sup> were to be assessed, preliminary calculations suggest that \$155 million would be raised. With universal coverage in place, new premiums<sup>74</sup> from as many as 461,000 individuals will be collected by private insurers (managed care providers or otherwise).

It is assumed that the net revenues raised by a premium tax are \$100 million (excluding \$50 million presently raised by the Reimbursement Allowance (RA) on the state's Medicaid managed care organizations (MCOs), 5.99 percent of total Medicaid revenues). The Deficit Reduction Act of 2005 amended the federal Medicaid Act to require that provider taxes on MCOs used as state Medicaid matching funds must apply to all MCOs or health insurers, not just to those with Medicaid contracts. Effective October 2009, Missouri may not use a Medicaid MCO-only RA tax as Medicaid matching funds. Only a broad-based insurance or

managed care tax like the tax discussed here will qualify as matching state revenue.

- \$290 million from tobacco tax increase. A Tobacco Tax proposition was on the November 2006 ballot in Missouri.<sup>75</sup> Although the initiative did not pass, the tax would have generated approximately \$290 million for year for “health care access and treatment.”<sup>76</sup> The ballot initiative designated that \$102 million is to be used to restore Medicaid cuts, and \$102 million for Medicaid physicians’ reimbursement rate increases. While the initiative did not pass, raising cigarette taxes in Missouri remains a policy option in Missouri for funding universal coverage.
- Sales tax on medical services. Currently, Missouri law taxes sales of goods but not sales of services. At present, only eleven services are taxed including services such as pet grooming, marina services, and residential gas. A sales tax on medical services at the current rate would raise \$628.4 million.<sup>77</sup> Sorting out the public policy issues on taxing medical issues requires balancing competing goals and issues. On the one hand, sales taxes tend to be regressive and impact low-income families more, and taxation of medical services can sometimes tax necessities or life-sustaining services. On the other hand, Medicaid, SCHIP and the PAP should help cushion the impact on those with incomes up to 300 percent of FPL. Also, much research shows that more medical spending is consumed as a result of incentives in the health care system such as health insurance and tax incentives, perhaps leading to inefficient medical spending. Moreover, the share of medical spending rises with income. Therefore, these are arguments in favor of taxing medical services.

## Summary

The ability to finance a Massachusetts-type expansion to universal coverage in Missouri depends on policymakers being able to address the critical factors outlined below:

- **Cost savings from universal health insurance coverage.** Individuals will be able to reap the health benefits of health insurance and likely increased access to the health care system. In addition, premium savings are likely to accrue to those who already have health insurance. Those who were previously uninsured are also expected to benefit. They are likely to face lower premiums than they would have before (if they would have purchased) because of the greater pooling of individuals in health insurance plans under universal coverage. This reduction in premiums is largely due to the reduction in administrative costs. Estimates of the size of this reduction range from 3 to 10 percent.
- **Requires increase in state funds.** The direct costs of expanding to universal health insurance coverage in Missouri could be achieved via a combination of financing mechanisms as suggested above. These include reallocation of existing funds for uncompensated care (41% of state financing) and new financing (59%) from sources such as increases in the allocation of State General Revenues, and changes to the Medicaid provider tax.

- **Ability of Missouri to obtain federal matching funds.** In order to achieve universal coverage in Missouri all new state funds spent on health insurance – either public or premium assistance for private insurance – would require securing federal matching funds. As in Massachusetts, the key to any state doing this is a Medicaid waiver that allows federal match for premium assistance.
- **Cost increases and cost-containment.** The cost estimates presented in this chapter are for 2006 and assume the initiative is adopted and implemented this year. Costs are not projected forward to future years. Once all individuals in the State are insured, the costs of the insuring these individual over time will certainly increase, but the growth has not been projected here. This Report does not discuss the extent to which there are any provisions for cost-containment in the Massachusetts plan that could be applied to Missouri. In fact, the Massachusetts plan only considers a three-year cost horizon and cost containment is a concern for that plan as well.

## **CHAPTER V. MASSACHUSETTS TO MISSOURI: IMPACTS OF QUALITY OF CARE**

This chapter concentrates on quality-related aspects of importing a Massachusetts-like universal coverage system into Missouri. Part I identifies the quality initiatives introduced by the Massachusetts legislation and compares them to any Missouri analogues. Part II examines the broader issue of the effects that universal coverage may have on the overall quality of care.

### **The Massachusetts Plan: Quality Initiatives**

Other than the fundamental and far-reaching introduction of universal coverage, two major quality initiatives are included in the Massachusetts legislation. First, systems are put into place to develop “performance measurement benchmarks” that may be applied, among other purposes, to Pay-for-Performance (P4P) programs. Under such programs, health care providers should become more attentive to the quality of care they deliver because it would directly affect the reimbursement they receive from insurers.

Second, the Massachusetts legislation begins the process of encouraging Consumer Directed Healthcare by initiating a comprehensive web-based resource for patients that reports the cost and quality of health care services in order to assist consumers in making informed cost and quality-based choices between healthcare providers. An efficient market for health care services is heavily contingent upon consumers making timely, appropriate decisions. Such information resources will also improve the accountability of health care providers by highlighting quality deficiencies in diverse parts of the health care system (see Appendix C for a detailed description of the provisions in the Massachusetts plan related to quality of care).

At the outset it should be noted that these are relatively narrow subsets of the modern health quality matrix. In this report they are analyzed in isolation. The initiatives specifically included in the Massachusetts legislation primarily address “Consumer Driven Health Care.” In this report they are analyzed in isolation. However, quality/safety initiatives incorporated into any Missouri universal coverage legislation likely would be the result of examining how such initiatives in Benchmarking, P4P, and consumer cost/quality systems should co-exist with other federal, state, and private quality regimes. These regimes include but are not limited to state licensure and discipline, quality and safety assessment and reporting models (including AHRQ’s Quality Indicators (QIs) and the Quality Interagency Coordination Task Force (QuIC)), state initiatives in quality/error reporting (the current benchmark being Minnesota’s Adverse Health Events Reporting Law) medical malpractice litigation, accreditation and payer standards, and provider investment in a raft of technology-based quality systems including surveillance systems and electronic medical records.

### **Achieving Quality in Missouri: Benchmarking and P4P**

Then-Governor Holden’s Missouri Commission on Patient Safety presented its report in July 2004. The report recommended that Missouri healthcare organizations adopt patient safety protocols in part to facilitate “contract incentives for those healthcare organizations and professionals that emphasize safety.”<sup>78</sup>

The report also recommended the establishment of a private patient safety organization to “provide leadership and serve as a clearinghouse for best practices, data collection and analysis, professional curriculum development and consumer resources.”<sup>79</sup> In response the Missouri Hospital Association (MHA), the Missouri State Medical Association and Primaris created The Missouri Center for Patient Safety, a private, not-for-profit corporation.

Some benchmarking already exists in Missouri through the MHA Hospital Performance Project. The project uses a subset of Quality Indicators (QIs) developed by AHRQ. A replacement for the MHA BENCHMARK Project, the Hospital Performance Project provides “individual, aggregate and comparative hospital data on selected, nationally defined indicators of inpatient health care quality and patient safety to assist participating hospitals in the evaluation of quality of care.”<sup>80</sup>

Many Missouri providers have experience with P4P programs because of the Blue Cross and Blue Shield of Missouri Physician Group Partners Program (PGPP). The Massachusetts legislation is not explicit on the type of P4P program contemplated; e.g., whether it involves a “bonus” or “withhold”, or whether it would condition such payments on achieving a “rank” or passing a “threshold.”

### **Achieving Quality in Missouri: Web-based Quality Information for Patients**

Some Missouri hospitals participate in the national level Hospital Quality Alliance (HQA), a public-private partnership of hospitals, government agencies, quality experts, etc., that provides data displayed at CMS’s “HospitalCompare” site. There are also private sites that also post Missouri data such as the National Committee for Quality Assurance (NCQA).

The Missouri Hospital Association posts comparative quality data on its “Focus on Hospitals” site. A recent Missouri bill (HB 2082) requires hospitals to compile and post daily staffing information in patient care areas for each unit of the hospital.

The development of improved quality assessment reporting systems and consumer-friendly decision-making aids are certainly important impacts of the extension of insurance coverage. These developments will certainly improve the accountability of health care providers across diverse parts of the health care system (e.g., hospitals, ambulatory care facilities, etc.).<sup>81</sup>

Importing Massachusetts-like quality measures into Missouri would likely have the following effects:

- Facilitate the growth and development of sophisticated quality assessment/ monitoring systems. They would in turn facilitate the spread of outcome-driven, P4P protocols in Missouri.
- Support the development and diffusion of consumer-friendly, web-based, quality-driven decision making informational aids that can be readily used by Missouri citizens who need health care services.

## The Impact of Universal Coverage on Healthcare Service Quality

During the last several decades there have been major advances significantly improving the understanding and measurement of the complex notion of quality in health care. Large scale, population based studies of the quality of care have repeatedly found that there is continued excessive variability of quality of care within populations. In other words, not all people receive the same level of health care.

A series of studies by the IOM show that the uninsured use health services less often than the insured, and receive lower quality care.<sup>82</sup> Moreover, the uninsured are less likely to fill prescriptions or to seek preventive care. Uninsured adults, particularly those with chronic conditions, have lower life expectancies than the insured. Uninsured children are at risk from long-term abnormal development.

As health care insurance becomes less affordable many Americans are forced to use insurance with lower levels of benefits (particularly regarding preventive care) and lower quality.

The IOM estimates that lack of insurance is responsible for 18,000 unnecessary deaths every year.<sup>83</sup> Thus, there is little doubt that a program to provide universal coverage to Missourians would improve health quality for the currently uninsured or underinsured. The continuity of care promoted by universal health care would lead to improved outcomes and increased preventive care.

Universal coverage may well have equally important positive effects on micro-level clinician-patient interaction that is the very foundation of high-quality health care delivery.<sup>84</sup> This is because in their view the current patchwork health care system inadvertently deters the efficient and effective delivery of health care services.

For example, clearly described how lack of adequate insurance coverage is a major obstacle to many of the recommendations from the landmark Institute of Medicine, *Crossing the Quality Chasm* report published in the same year.<sup>85</sup> In particular:

1. Lack of access creates major barriers to receiving necessary care and disrupts the continuity of health care services. Universal coverage should provide stable funding and pressures for accountability that will support the development of “care based on continuous healing relationships” that are essential to efficient and effective health service provision.
2. Universal coverage will support needed “customization based on patient needs, and patient values.” Thus, there will be less emphasis on mass marketing forces such as “branding” and more focus on clinician-influenced product differentiation based on the clinician’s recommendation and evidence of service efficacy. This is a direct result of having adequate access to a regular source of continuing care despite changes in work status.
3. Current lack of insurance coverage inhibits many citizens (especially the uninsured and under-insured) from influencing the delivery system. Universal coverage should increase the average “patient’s sense of control”, serve to empower the patient

population and ultimately improve the health care system's responsiveness to patient concerns.

4. Universal coverage should improve the amount of "shared knowledge and free flow of information." Such an open system of information will likely lead to less proprietary constraints on information flow and greater information sharing in accord with the greater pressures for accountability that were described above. A more open system will also allow health care providers to make more effective use of promising integrated information technologies.
5. "Evidence based decision making" was a major quality improvement initiative that the IOM targeted for improvement. It would likely be positively affected by universal coverage. This is because a universal coverage system will decrease proprietary constraints on information sharing and encourage the utilization of professional consensus methods (such as those employed by the NIH) to decrease excess demands for services while increasing their efficacy.
6. In a system with universal coverage, there will be greater emphasis upon "patient safety as a system property." This will occur because of the greater emphasis on quality monitoring discussed earlier and because of more equitable reimbursement and consequently less of a need by health care organizations to improve short term profits by compromising staffing levels or relaxing safety standards.
7. Universal coverage will also create a "greater need for transparency." That is because there will be fewer incentives to conceal information and greater oversight by the public sector (which already pays for a large proportion of health care services).
8. Improved coverage should also lead to more persistent "anticipation of consumer needs." This will largely result from the system's move toward a greater emphasis on health planning, epidemiological research, and health planning and resource allocation.
9. The contemporary health care delivery system is not only highly fragmented and inaccessible by many but also suffers from widespread waste and inefficiency.<sup>86</sup> The introduction of a universal system should support the IOM's argument that "waste needs to be continuously decreased." This important outcome will result from increased external quality monitoring that will prompt organizations to assess and improve their internal work processes and outcomes. It will also receive support from the increased emphasis upon disease prevention and continuity of care – two critical areas that are major area problems for the uninsured and underinsured in Missouri.
10. Last but not least, "greater cooperation" should prove to be a consequence of improved insurance coverage and patient access to medical care. This is because there will be less of an incentive for health care organizations to avoid sick, uninsured patients. Instead, according to Schiff and Young, there will be a "renewed emphasis on professional and caring relationships – relationships that have been disvalued in the current profit-driven system. All of the unmeasured and immeasurable ways in which patients and providers can be rewarded when they work together to deal with illness will have to form the foundation of these caring relationships."<sup>87</sup>

## Summary

During the past 20 years, there have been numerous but largely unrelated attempts to: (1) Improve the assessment of health care service quality; (2) Introduce Continuous Improvement concepts and methods that have proven to be very useful in manufacturing organizations and even certain types of service organizations; (3) Improve the amount and quality of information that can be used by patients in selecting health care providers; and (4) Develop more effective clinician-patient relationships (e.g., disease management programs for the chronically ill.) Certainly many major advances have been made but up to this point progress in each of these areas has been slow.

One of the reasons why health care service quality has received only modest attention is because inter-organizational competition based upon service quality has been slow to emerge in many health care markets. Instead the focus has been upon maintaining adequate prices and restricting access to care while meeting professional standards of quality. For the reasons cited above, importing a Massachusetts-like universal coverage system into Missouri would have very positive effects upon:

- The continued refinement of health care quality assessment tools
- Systematic appraisal and reporting of the quality of health care services in local markets
- Greater interest in health care organizations in continually improving the quality of their services via persistent process improvement in turn producing a higher level of service quality at lower levels of service costs (greater value to the consumer)
- The amount and types of information that are available to Missouri health care consumers and their families when they are seeking to find the most effective health care providers in their local market
- And last but not least, via improved access to a regular source of care and greater continuity of care, the quality of the doctor-patient relationship which serves as the very foundation of health care delivery.

Despite numerous often well-intentioned attempts to improve health care insurance coverage for Americans, only modest progress on the goals of quality has been achieved up to this point.<sup>88</sup> This has allowed for the continuation of a system of health care delivery that is inefficient, inequitable and increasingly unaffordable. The introduction of a Massachusetts-like universal coverage system into Missouri should over time enable its citizens to enjoy more equitable access to increasingly efficient and effective health care providers.

## **APPENDIX A. DESCRIPTION OF MASSACHUSETTS LEGISLATION**

The Massachusetts Legislature passed “An Act Providing Access to Affordable, Quality, Accountable Health Care” (H4479) in April 2006, and Massachusetts Gov. Mitt Romney signed the legislation on April 12, 2006.<sup>89</sup> Passage of the plan was spurred on by several factors<sup>90</sup>, especially the reauthorization of Massachusetts’s Medicaid waiver, since without passage of legislation the state would have lost approximately \$770 million in federal funds over two years.

The Massachusetts Legislation requires the participation of both individuals and employers in the state, mandating that everyone in the state purchase health insurance by July 1, 2007, if affordable insurance is available. Estimates are that over 93 percent of the uninsured (515,000 of the 550,000 uninsured) in Massachusetts would obtain health insurance through this plan.<sup>91</sup>

This act expands health coverage for people in Massachusetts who are uninsured through the use of a variety of policy changes, including but not limited to:

- The Commonwealth Health Insurance Connector, a public-private entity designed to increase access to affordable private health insurance.
- Medicaid expansions.
- Tax credits and/or public subsidies, designed to make private insurance more affordable;
- An Individual mandate requiring the purchase of health insurance if affordable insurance is available.
- An employer mandate requiring employers to contribute towards the purchase of affordable health insurance for their employees.

These provisions are outlined here in general terms and discussed in more detail in the next few chapters.<sup>92</sup> A detailed outline of the legislation is provided in the Appendix, and the full text of the legislation is available from the Commonwealth of Massachusetts.<sup>93</sup> What follows is a short description of the Legislation.

### **I.A. Commonwealth Health Insurance Connector**

The legislation creates the Commonwealth Health Insurance Connector, a public-private entity, which certifies affordable private insurance products for the purpose of “connecting” individuals and small employers with private insurance products. The Massachusetts legislation merges the individual and small-group insurance markets, effective July 2007. Both individuals and small businesses (defined as up to 50 employees) will be able to purchase health insurance through the Connector, using pre-tax dollars. Individuals eligible to purchase coverage through the Connector will include people who are self-employed, not working, not eligible for coverage through work, or working at companies that do not offer insurance.

The Connector will administer many of the private insurance aspects of the reforms, including the new subsidized and affordable policies, as well as the annual setting of a sliding scale for “affordable” coverage. The Connector will administer subsidies of health insurance products, and certify that products administered by the Connector are of “high value and good quality.” The Connector will also enable “portability” of coverage, allowing individuals to keep coverage

as they move from one job to the next, since they will purchase their insurance from the Connector.

### **I.B. Commonwealth Care Health Insurance Program**

The legislation creates an insurance program called the Commonwealth Care Health Insurance Program, providing individuals with incomes less than 300 percent of FPL (\$9,800 for an individual) subsidized private insurance products with no deductibles. Under the HIP, individuals with incomes below 100 percent of FPL will have no premiums and receive comprehensive benefits.

The Massachusetts legislation creates government-funded subsidies to assist with the purchase of private health insurance for lower income individuals not eligible for MassHealth (Medicaid). Individuals will be eligible for insurance through the Commonwealth Care Health Insurance Program if their income is less than 300 percent of FPL, if they are not eligible for government benefits (e.g. Medicare, Medicaid), have no employer insurance, and have no financial incentive from employer to decline coverage. The program will provide sliding-scale subsidies to individuals with incomes up to 300 percent of the FPL (or \$49,800 for a family of three) for the purchase of private health insurance. Premiums for the program will be set on a sliding scale based on household income, with the sliding scale determined by the Board of the Connector in 2006. Plans offered through Commonwealth Care will not have deductibles, and will be offered by managed care organizations that participate in the Medicaid program. The program will be operated through the Connector, and retain any employer contribution to an employee's health insurance premium.

Commonwealth Care is expected to subsidize coverage for 207,500 residents.

### **I.C. Medicaid Expansions**

The legislation includes expansion of Medicaid coverage for children up to 300 percent of FPL (current Massachusetts law cover children up to 200% of FPL). And for adult categories of eligibility, generally up to 200 percent of FPL, the Medicaid expansions will cover roughly 92,500 people (mostly children) not now covered by health insurance

### **I.D. Individual Mandate**

Under H4479, Massachusetts adults will be required to carry a minimum level of health insurance if "affordable" insurance is available. A sliding "affordability scale" will be set annually by the Board of the Connector.

Beginning in July 2007, if there is affordable insurance available, Massachusetts residents will be required to have health insurance. The mandate will be enforced through their state income tax returns – residents will confirm that they have health insurance coverage on their state income tax forms filed in 2008. In 2007, the penalty for not holding insurance will be the loss of the personal exemption, but in 2008 and beyond the financial penalty for not holding insurance will eventually reach 50 percent of what the person would have paid for an "affordable" health insurance plan. Coverage will be verified through a database of insurance coverage for all individuals. The Department of Revenue will enforce this provision with financial penalties

beginning with a loss of the personal exemption for tax year 2007 and then increasing to a portion of what an individual would have paid toward an affordable premium for subsequent years.

The “Individual Mandate” is designed to strengthen and stabilize health insurance risk pools include healthy people (who, if not offered employer-sponsored and -paid insurance, are more likely to take the risk of not having insurance).

### **I.E. Employer Mandate**

The Massachusetts Plan includes a requirement that employers with more than 10 employees provide health insurance coverage or pay a “Fair Share” contribution estimated to be \$295 annually per employee, which is calculated to reflect a portion of the cost paid by the state for free care used by workers whose employers do not provide insurance.<sup>94</sup>

Employers with more than 10 workers will be required to offer a Section 125 “cafeteria plan” that permits workers to purchase health care with pre-tax dollars. Using these pre-tax dollars, workers not offered insurance through their employer will be able to purchase insurance products through the Connector.

Employers with more than 10 employees who do not provide health insurance or contribute to it, will instead face a “Fair Share Contribution” (or “free-rider surcharge”) when their employees use more than a specified amount of care from the state’s health safety-net fund. Imposition of the fair share contribution will be triggered when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10-100 percent of the state’s costs of services provided to the employees, with the first \$50,000 per employer exempted. Revenue gained from the surcharge will be deposited in the Commonwealth Care Trust Fund.

### **I.F. Cost and quality measures**

Cost and quality data for physicians, hospitals, and specific procedures will be collected and made public. Hospitals will be required to collect and report data on racial and ethnic health disparities. A process of relating Medicaid payment rate increases to the achievement of performance goals, such as quality and efficiency goals, the reduction of racial and ethnic disparities, and improved outcomes for patients. To reduce health disparities, hospitals will collect and report on health care data related to race, ethnicity and language. The legislation creates a Health Disparities Council (to continue the work of the Special Commission on Racial and Ethnic Health Disparities by recommending appropriate Legislative steps to reduce health disparities) and a study of a sustainable Community Health Outreach Worker Program to target vulnerable populations in an effort to eliminate health disparities and remove linguistic barriers to health access.

### **I.G. Funding**

The financing of the legislation will be achieved through redirecting some of state and federal funds currently spent on “free care” provided through hospitals to subsidize health insurance for the uninsured. The existing Free Care Pool, which reimburses providers for uncompensated

care, will be converted into a new Safety Net Care Fund that will combine these funds with other Medicaid funds, including Medicaid Disproportionate Share Program funds. By shifting significant federal resources from supporting individual hospitals to funding health insurance coverage for uninsured individuals, and by living within a lifetime spending ceiling for waiver services, the bill meets the terms set by the Centers for Medicare and Medicaid for renewal of its 1115(a) MassHealth Demonstration Waiver.

In response to concerns that Medicaid has underpaid many of its providers in recent years, \$90 million in new funds will lead to expansions of payment rates in Fiscal Years 2007, 2008 and 2009. A new fee schedule will be developed to standardize provider reimbursement. As more uninsured gain coverage and uncompensated care drops, funds will be shifted into the health insurance subsidy program. In addition, the plan creates an Essential Community Provider grant program to support safety net hospitals and community health centers.

**Appendix B.**  
**Simulated Eligibility for Insurance and Costs of Coverage  
under a Massachusetts-Style Plan in Missouri**

**SOURCES AND METHODS FOR SIMULATION**

The simulations of the costs of covering the uninsured in Missouri are based on a combination of individual level data drawn from the Current Population Survey (CPS), supplemented by data from a number of other sources. In particular, the simulation starts with the estimates of the uninsured shown in Appendix Table B-1. We assume, for illustrative purposes that all individuals are insured by one of the strategies outlined in Chapter 3, with eligibility determined by income relative to poverty, employment status, disability status, age, and family status (see Appendix Table B-1). Then for each eligibility group, the simulation model makes an assumption about the costs of insuring persons in that eligibility group. The insurance premium estimates are drawn from a number of sources, including:

- **Non-disabled adults.** For those who would have to buy private insurance (whether through ESI, Purchasing Pool, or Premium Assistance) a figure of \$350 per member, per month (PMPM), is assumed. This figure is based on a range of possible estimates, but in particular the average premiums available through the Missouri Consolidated Health Plan (MCHP) were used.<sup>95</sup> For those whose income is above 300 percent of FPL, dental coverage would add another \$25 to the premiums. All figures assume that the Purchasing Pool uses community rating for premiums rather than a risk rating.
- **For non-disabled adults eligible for Medicaid and Premium Assistance up to 100 Percent of FPL.** Estimates of state spending under the Medicaid program, adult cost (adjusted for inflation) are used. The state's share of these costs (assuming that federal matching is available) is \$99 PMPM, while total costs (including that covered by the federal match) are \$255 PMPM.<sup>96</sup>
- **Disabled Adults.** For disabled adults using Medicaid and premium assistance up to 100 percent of FPL: Estimates of state spending under Medicaid are used: state cost of \$489 (with federal match: \$1261).<sup>97</sup> For disabled adults using tax subsidies, the Individual Mandate, or the Employer Mandate, we assume the costs are \$1261 PMPM, based on the costs of covering a Medicaid eligible.
- **Children.** For children eligible for Medicaid (up to 100% of FPL), the state's cost are \$58 PMPM (with federal match: total cost \$149). For children that are eligible for SCHIP coverage (up to 300% of FPL), the state's costs are \$30 PMPM (with federal match: \$111).<sup>98</sup> For children covered under the Individual and Employer mandate: estimates of the marginal costs for covering one additional child under a Blue Choice Blue Shield (BCBS) family plan are used, estimated to be approximately \$150 PMPM.<sup>99</sup> Dental coverage would add another \$25 to the premium cost of the latter group.

Table B-1.

Number of uninsured in Missouri, by age, disability and Income relative to Federal Poverty Line

Ratio of income to poverty line	Number of uninsured (thousands)				Percent of uninsured			
	Children	Disabled Adults	Other Adults	TOTAL	Children	Disabled Adults	Other Adults	TOTAL
<b>TOTAL</b>	<b>185.8</b>	<b>55.7</b>	<b>605.5</b>	<b>847.0</b>	<b>21.9%</b>	<b>6.6%</b>	<b>71.5%</b>	<b>100.0%</b>
Under 0.22	21.3	21.5	46.6	89.4	2.5%	2.5%	5.5%	<b>10.6%</b>
0.22-0.84	49.5	16.2	101.3	167.0	5.8%	1.9%	12.0%	<b>19.7%</b>
0.85-0.99	13.4	-	34.1	47.5	1.6%	0.0%	4.0%	<b>5.6%</b>
1.00-1.49	23.7	3.8	68.8	96.3	2.8%	0.4%	8.1%	<b>11.4%</b>
1.50-1.99	26.8	-	73.1	99.9	3.2%	0.0%	8.6%	<b>11.8%</b>
2.00-2.99	31.5	5.5	114.9	151.9	3.7%	0.6%	13.6%	<b>17.9%</b>
3.00 or more	19.5	8.7	166.7	194.9	2.3%	1.0%	19.7%	<b>23.0%</b>
How Uninsured								
Would be Covered:	<b>185.8</b>	<b>55.7</b>	<b>605.5</b>	<b>847.0</b>	21.9%	6.6%	71.5%	<b>100.0%</b>
Medicaid	84.2	37.8	46.6	168.6	9.9%	4.5%	5.5%	<b>19.9%</b>
SCHIP	82.0	-	-	82.0	9.7%	0.0%	0.0%	<b>9.7%</b>
Premium assistance (<100%FPL)	-	-	135.4	135.4	0.0%	0.0%	16.0%	<b>16.0%</b>
Premium assistance (100-300%FPL)	-	9.2	256.9	266.1	0.0%	1.1%	30.3%	<b>31.4%</b>
Individual mandate	18.3	8.4	65.8	92.5	2.2%	1.0%	7.8%	<b>10.9%</b>
Employer mandate	1.2	0.3	100.9	102.4	0.1%	0.0%	11.9%	<b>12.1%</b>

SOURCE: Saint Louis University Health Policy Legislative Analysis Team Simulations.

NOTE: Estimates include roughly 135,000 persons who lost coverage in Missouri after May 2005, mostly as a result of Senate Bill 539. (a) This assumes all adults under 100% of FPL would be eligible for Medicaid, or some public subsidy program covering all premiums and out of pocket costs.

(b) For individuals above 300% of the poverty line, insurance status based on employment status of individual, their spouse (if married), or parent. If the individual or spouse or parent is employed, then it is assumed the person will obtain employer mandate; otherwise it is assumed the person will need be under the individual mandate.

(c) The individual's share of the premiums faced by those receiving tax subsidies is determined by comparing premiums to incomes. Individuals are responsible for a sliding share of the premium starting at 0% at 100% of the FPL and reaching no more than 5.8% of income at 300% of FPL. The rest of the costs are covered by the state government.

It is assumed that the state will require individuals eligible for Medicaid but working for an employer that offers them access to employer sponsored health insurance (ESI) to obtain their insurance through ESI.

Adjustments to insurance premiums: Three adjustments are made to the premiums estimated above:

- Where premium data is from 2005, premiums are adjusted higher by 6% to incorporate increases in health care premium cost.
- With universal health insurance, cost shifting to the insured for the care of the uninsured will end. Providers will have reduced uncompensated care and bad debt. Further savings will occur because non-group individuals and small groups will be able buy insurance through a Massachusetts-type purchasing pool. We estimate that the currently insured will save anywhere between 3 to 10 percent on their health insurance premiums as cost shifting from the uninsured ends and as efficiency gains from buying insurance through a purchasing pool takes hold.<sup>100</sup> The middle scenario assumes premium savings of 6 percent.
- In its report, the Missouri Medicaid Reform Commission notes that Missouri provider reimbursement rates are low compared to other states, resulting in low provider participation. The commission specifically recommended increasing provider reimbursement rates.<sup>101</sup> Without appropriate adjustments to payment to health service providers, providers may not have the incentive to continue to serve Medicaid enrollees and enrollees in Medicaid type low cost health insurance plans. In our simulation, payments to hospitals and doctors are increased anywhere between 7.5 to 15 percent (which result in increase in overall Medicaid spending of 2.8% to 5.6%, respectively), and health insurance premiums are adjusted higher to reflect the higher reimbursement rates for hospitals and doctors. The middle scenario assumes a 10 percent increase in reimbursement rates to these service providers, which results in an increase in total Medicaid spending of 3.7 percent.

With these three adjustments, we compute premiums for the various eligibility groups. The premiums are shown in Table B-2, and all reflect inflation adjusted dollars. The LOW cost scenario assumes smaller increase in provider reimbursement rate and higher premium savings. The HIGH cost scenario assumes the opposite. These premiums are shown in the table below:

Table B-2. PREMIUM ASSUMPTIONS: SCENARIOS					
Premiums	Assumption: LOW	Assumption: MIDDLE A	Assumption MIDDLE B	Assumption: MIDDLE C	Assumption: HIGH
Premium savings assumption	-10.0%	-10.0%	-6.0%	-3.0%	-3.0%
Provider (hospitals and doctors) payment assumption	7.5%	15%	10%	7.5%	15%
Non-disabled adults <100% FPL	\$250	\$257	\$263	\$270	\$277
Non-disabled adults 100-300% FPL	\$250	\$257	\$263	\$270	\$277
Non-disabled adults >300% FPL (**)	\$338	\$338	\$353	\$364	\$364
Children <100% FPL (Medicaid)	\$146	\$150	\$154	\$157	\$162
Children 100-300% FPL (SCHIP)	\$109	\$112	\$115	\$117	\$121
Children >300% FPL (**)	\$158	\$158	\$165	\$170	\$170
Disabled Adults	\$1,237	\$1,270	\$1,303	\$1,333	\$1,369

### Mandates and Premium Assistance

The simulation of costs in a Massachusetts-type plan for Missouri require specific assumptions regarding individual and employer mandates as well as specific assumptions regarding eligibility and size of premium assistance. The mandates and assumptions on eligibility and extent of premium assistance are outlined below:

#### Mandates:

**Individual Mandate.** All individuals are required to be insured. Individuals who have ESI are assumed to acquire health insurance coverage by enrolling in ESI. Individuals without ESI but earning less than 100 percent of FPL are assumed to enroll in Medicaid. Individuals earning more than 100 percent of FPL are assumed to purchase insurance through the Purchasing Pool if ESI is not available. Individuals earning more than 300 percent of FPL without access to ESI purchase a non-group individual policy through the purchasing pool if they are currently uninsured or keep their non-group individual policy if they are currently insured.

**Employer Mandate.** Employers who currently offer health insurance to employees will continue to offer health insurance and maintain the corresponding employer contribution towards health insurance premiums. Such employers will pay at least \$295 per year per FTE employee towards health insurance premiums. No employer will drop ESI in response to universal health care legislation. Employers who currently do not offer health insurance are required to pay

\$295 per year per FTE employee to the Purchasing Pool to offset cost of insurance. Employers who currently employ less than 10 FTE employees and do not offer ESI are exempt from the requirement to pay \$295 to the Purchasing Pool.

**Premium Assistance.** Individuals who are not working and uninsured or working without employer sponsored health insurance may be eligible for premium assistance depending on the individual's income. Those with income below 100 percent of FPL will enroll in Medicaid with Medicaid premium cost covered by the state government with appropriate federal match for Medicaid enrollees. Individuals with incomes above 100 percent of FPL but below 300 percent of FPL are required to pay an affordable share of premium cost. For the purposes of these simulations, a sliding scale similar to the one proposed by Massachusetts Governor Romney is used. The distribution of costs, between individuals, employers and the government are sensitive to the sliding scale put in place. The sliding scale starts at 100 percent of FPL, where it is assumed that individuals are responsible for a premium limited to 0% of their income, with the limit growing to 5.8 percent of income at 300 percent of FPL (that is, individuals are responsible for a premium limited to 5.8% of their income at 300% of FPL). Premium costs above the sliding scale limits are assumed to be covered by the state government with a Medicaid matching rate from the federal government. For individuals above 300 percent of FPL, all premium costs are assumed to be covered by individuals or their employers, as a result of the individual and employer mandates, and no premium assistance is offered.

In all cases, insurance status is assigned by the employment status of the adults in the family. That is, the employment status of both spouses is checked to determine eligibility for ESI, and individuals now uninsured but living in a household where another individual has ESI are assumed to obtain ESI through that policy. Similarly, children are assumed to obtain ESI if either parent is working with access to ESI. However, if no adult in the household is working with access to ESI, and household income is less than 300 percent of FPL, then the children are assumed to enroll in state SCHIP program, with cost shared by family, state, and federal government according to current SCHIP cost sharing arrangement. If household income is greater than 300 percent of FPL, then it is assumed the adults and children in the household will obtain coverage through the individual mandate.

## **Simulation Results**

The aggregate cost of extending health insurance to the currently uninsured, as well as the distribution of that cost between employers, individuals, and the state and federal governments, depends on age, income, and the disability status of those who are uninsured. The tables presented here provide a detailed breakdown of number of individuals who are uninsured in Missouri and how the uninsured will be covered (Table A-1).

In the simulation, the premiums under LOW, MIDDLE, and HIGH Cost scenarios (Table A-3) along with the various assumptions regarding employer and individual mandates and premium assistance, are applied to the Missouri uninsured. The aggregate costs and the distribution of the cost depends on how the uninsured are going to be covered (Table A-1). The simulation results presented in Table B-4 show total costs, and net costs (net of premium savings for those currently insured) for the MIDDLE B scenario assumptions regarding premiums, with details shown for total costs for each strategy for covering the uninsured and each entity that must pay for the costs (individuals, employers, the state or federal government). Finally, the impact of the proposed is shown on the currently insured population and those currently in the Medicaid program (financed by the state and federal government through matching) since it is assumed, as noted above that there will be premium savings for those currently insured. The impacts on the currently insured are then netted out of the TOTAL costs to show NET COSTS on individuals, employers and the state and federal government. The results are presented and discussed in Chapter 4.

Table B-3.  
Net Costs of Insuring the Uninsured in Missouri

Costs of Covering Uninsured, by group (thousands of dollars)				
	Children	Disabled Adults	Other Adults	TOTAL
<b>TOTAL COSTS of Covering Uninsured (in thousands):</b>				
TOTAL	\$308,884	\$870,445	\$2,090,987	\$3,270,316
Employers	\$18,621	\$26,576	\$553,834	\$599,031
Individuals	\$19,999	\$124,263	\$400,208	\$544,471
State government	\$92,421	\$280,647	\$443,408	\$816,476
Federal matching funds	\$177,842	\$438,960	\$693,536	\$1,310,339
<b>MEDICAID ELIGIBLES (in thousands)</b>				
TOTAL	\$160,990	\$590,711	\$146,915	\$898,616
Employers	\$0	\$0	\$0	\$0
Individuals	\$0	\$0	\$0	\$0
State government	\$62,786	\$230,377	\$57,297	\$350,460
Federal matching funds	\$98,204	\$360,334	\$89,618	\$548,156
<b>PREMIUM ASSISTANCE (&lt;100% FPL) (in thousands)</b>				
TOTAL	\$0	\$0	\$427,292	\$427,292
Employers	\$0	\$0	\$0	\$0
Individuals	\$0	\$0	\$0	\$0
State government	\$0	\$0	\$166,644	\$166,644
Federal matching funds	\$0	\$0	\$260,648	\$260,648
<b>SCHIP (&lt;300% FPL) (in thousands)</b>				
TOTAL	\$109,273	\$0	\$0	\$109,273
Employers	\$0	\$0	\$0	\$0
Individuals	\$0	\$0	\$0	\$0
State government	\$29,635	\$0	\$0	\$29,635
Federal matching funds	\$79,638	\$0	\$0	\$79,638
<b>PREMIUM ASSISTANCE (100-300% FPL) (in thousands) (c):</b>				
OVERALL TOTAL COSTS	\$0	\$144,129	\$810,676	\$954,806
Employers	\$0	\$0	\$53,089	\$53,089
Individuals	\$0	\$15,233	\$194,849	\$210,083
State government	\$0	\$50,269	\$219,468	\$269,737
Federal matching funds	\$0	\$78,627	\$343,270	\$421,896
<b>EMPLOYER MANDATE (in thousands):</b>				
TOTAL	\$23,277	\$33,220	\$625,931	\$682,427
Employers	\$18,621	\$26,576	\$500,745	\$545,942
Individuals	\$4,655	\$6,644	\$125,186	\$136,485
State government	\$0	\$0	\$0	\$0
Federal matching funds	\$0	\$0	\$0	\$0

(Table continued)

Table B-3, continued

Net Costs of Insuring the Uninsured in Missouri

INDIVIDUAL MANDATE (in thousands):

TOTAL	\$15,344	\$102,385	\$80,173	\$197,902
Employers	\$0	\$0	\$0	\$0
Individuals	\$15,344	\$102,385	\$80,173	\$197,902
State government	\$0	\$0	\$0	\$0
Federal matching funds	\$0	\$0	\$0	\$0

IMPACT on Currently Insured (in thousands):

TOTAL	-\$80,055	\$63,266	-\$612,193	-\$628,982
Medicaid	\$45,332	\$83,265	\$77,900	\$206,497
Employers	-\$93,464	-\$15,093	-\$508,270	-\$616,827
Individuals	-\$31,923	-\$4,906	-\$181,823	-\$218,652

NET COSTS of Covering Uninsured (in thousands):

TOTAL	\$228,829	\$933,711	\$1,478,794	\$2,641,335
Employers	-\$74,843	\$11,483	\$45,564	-\$17,796
Individuals	-\$11,924	\$119,357	\$218,386	\$325,819
State government	\$104,715	\$313,120	\$473,789	\$891,624
Federal matching funds	\$210,881	\$489,751	\$741,055	\$1,441,687

SOURCE: Saint Louis University Health Policy Legislative Analysis Team Simulations, Middle Costs Scenario.

To see how the NET COST of extending health insurance to the uninsured will compare under alternative assumptions regarding premium savings and increased reimbursement rates for providers, the NET COST under the Low and High Cost scenarios along with the Middle Cost scenario are shown below in Table B-4. (Only aggregate net costs are shown; further details are not displayed here.) Results show that compared to the Middle Cost scenario, Net Costs decreases by about \$750 million if the Low Cost scenario is used while the Net Cost increases by about \$700 million if the High Cost scenario is used. The impact of alternative assumptions on the distribution of those NET COST among employers, individuals, and the state and federal governments are also shown below. Of particular interest may be the impact on state costs, which vary from \$813 million under the Low Cost scenario to \$891 million under the Middle Cost scenario to \$948 million under the High Cost scenario.

Table B-4.  
Net Costs of insuring the uninsured in Missouri, by age, disability and Income relative to Federal Poverty Line, and by simulation cost scenario

	Low Cost Scenario	Middle Cost Scenario	High Cost Scenario
NET COSTS (in thousands):			
TOTAL	\$1,875,868	\$2,641,335	\$3,320,161
Employers	-\$452,428	-\$17,796	\$308,132
Individuals	\$163,563	\$325,819	\$448,654
State government	\$813,189	\$891,624	\$948,553
Federal matching funds	\$1,351,544	\$1,441,687	\$1,614,822

SOURCE: Saint Louis University Health Policy Legislative Analysis Team Simulations.

NOTES: See Appendix A for a description of the assumptions under the cost scenarios.

**Appendix C. Outline of Quality Provisions in Massachusetts Plan,  
And in Contrast to current Missouri Law**

Mass.	Ch. 58, 2006	Mo.	
Sec.	Summary	Sec.	Summary
2A	Appropriation of \$500K for Center for Patient Safety and Medical Error Reduction. Funds clearinghouse for the development, evaluation and dissemination of best practices for patient safety and medical error reduction. Center established by Chapter 6A, §16E. <a href="http://www.mass.gov/legis/laws/mgl/6a-16e.htm">http://www.mass.gov/legis/laws/mgl/6a-16e.htm</a>	MO EO 6 Issued 2-3-04	Then-Governor Holden created the Missouri Commission on Patient Safety in 2004 "to study and recommend legislative, administrative, clinical, behavioral, and technological measures to improve medical outcomes, prevent errors, upgrade healthcare delivery, and improve education of medical providers and patients with the goal of reducing the incidence of preventable medical errors and reducing the number of medical malpractice claims."  The Missouri Commission on Patient Safety presented its report to the governor in July 2004. <a href="http://www.wopatientsafety.org/downloads/2004_Missouri_Report.pdf">http://www.wopatientsafety.org/downloads/2004_Missouri_Report.pdf</a> The report recommended that Missouri healthcare organizations adopt patient safety protocols in part to facilitate "contract incentives for those healthcare organizations and professionals that emphasize safety."
3	Adds §§16J, 16K to Chapter 6A, General Laws to establish Health Care Cost and Quality Council (§16J). Council goaled to "develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities" (§16L(a)).	RSMo §197.291	Established a "Technical Advisory Committee on the Quality of Patient Care and Nursing Practices" within the department of health and senior services to develop specific recommendations related to staffing, improving the quality of patient care, and insuring the safe and appropriate employment of licensed nurses within hospitals and ambulatory surgical centers.
	Pursuant to regulations to be promulgated by Council, insurers and health care providers placed under quality reporting obligations enforced by penalties. (§16L(d)).		
	The council is tasked with developing "performance	19 CSR	"Procedures for the Collection and Submission of Data to Monitor Health

<p>measurement benchmarks” that are “clinically important and include both process and outcome data,” will “allow and encourage physicians, hospitals and other health care professionals to improve their quality of care,” and advance “a common national framework for quality measurement and reporting” (§16L(g)), by referencing, e.g., NQF <a href="http://www.qualityforum.org/">http://www.qualityforum.org/</a> or HQA <a href="http://www.aamc.org/quality/hospitalalliance/start.htm">http://www.aamc.org/quality/hospitalalliance/start.htm</a> measures.</p>	<p>10-5.010</p>	<p>Maintenance Organizations” establishes the procedures for HMOs to collect and submit HEDIS data to the Department of Health pursuant to section 192.068, RSMo. Missouri Data and information about its dissemination to consumers is available at <a href="http://www.dhss.mo.gov/ManagedCare/Data.html">http://www.dhss.mo.gov/ManagedCare/Data.html</a></p>
<p>The Council is tasked with creating a “consumer health information website” for “information comparing the cost and quality of health care services ... to assist consumers in making informed decisions regarding the medical care and informed choices between health care providers.” The web site will include: “(i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (ii) general information related to each service or category of service for which comparative information is provided; and (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.” (§16L(h)(i)). Further detail as to the likely data may be gleaned from (§16L(c)). A</p>		

	timeframe for the operation of the website and minimum content is provided by Section 136.		
	Creates a "Health Disparities Council" to make recommendations "regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes." (§16O).		
25	Amends Ch. 118E, General Laws by inserting §13B, making hospital rate increases "contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care."		
77	Amends §1 Ch. 176J, General Laws (group policies) to change definition of "pre-existing condition" to "with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information."	RSMo Ch. 376	Provides more limited regulation of pre-existing condition clauses and the use of genetic information.

## APPENDIX D.

Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care <sup>102</sup> , a Section-by-Section Summary <sup>103</sup>			
Bill Section	MGL Chp	MGL Sec	Description
0			Emergency Preamble.
1			Appropriation language.
2			Contains FY06 supplemental spending of \$15.45 million related to bill.
2A			Contains FY06 supplemental spending of \$14.55 million related to bill.
3	6A	16J-L	Creates a Health Care Quality and Cost Council that will promote health care quality improvement and cost containment.
	6A	16M	Creates a MassHealth Payment Policy Advisory Board to review and evaluate Medicaid rates and rate methodologies, especially rates paid to Community Health Centers.
	6A	16N	Creates a special commission to study the feasibility of reducing or eliminating the surcharge payor assessment paid by insurers and self-insured employers into the Free Care Pool.
	6A	16O	Creates a Health Disparities Council within EOHHS to make recommendations to reduce racial and ethnic health disparities in the Commonwealth
4	10	35M	Allows Board of Registration in Medicine Trust funds to carry over into the next fiscal year.
5	17	3	Changes composition of Public Health Council to include members from public health schools, providers, and health advocates, none of whom will be appointed by the Governor.
6	26	7A	Creates a new Health Access Bureau within the Division of Insurance with responsibility for oversight of the small group and individual health insurance market and affordable health plans.
6A	26	7B	Establishes a database within the Bureau to track insurance coverage for purposes of complying with the individual mandate. All insurers must report monthly coverage to the Bureau for this database and the information will be shared with DOR.
7	26	8H	Directs the Division of Insurance, in consultation with the Connector, to establish and publish annually minimum standards for health insurance products.
8	29	2000	Creates a Commonwealth Care Trust Fund that will receive revenue generated from the Fair Share Contribution, the Free Rider Surcharge, and other revenue that will be used to pay for subsidized health insurance and Medicaid rate increases.

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

Bill Section	MGL Chp	MGL Sec	Description
	29	2PPP	Creates an Essential Community Provider Trust Fund that will replace the current Distressed Provider Fund. Funds will be used to make grant payments to hospitals and community health centers in accordance with criteria established by the new Health Safety Net Office.
	29	2QQQ	Technical change that reestablishes an existing fund used to maximize federal reimbursements.
	29	2RRR	Technical change that reestablishes an existing fund used to make payments to DMR facilities.
9	32	1	Allows board members of the Connector to receive pension benefits.
10	62	1	Changes current tax law definition of "Code" so that it includes section 223 of the Internal Revenue Code, which creates a deduction for health savings accounts.
11	111	24K	Establishes a pediatric palliative care program, administered by Public Health, to serve children with life-threatening illness, and their families.
12	111M*		Individual Mandate. Adds a new chapter 111M, establishing a requirement that residents for whom an affordable health insurance product is available must have "creditable coverage."
		1	Defines "creditable coverage" as a qualifying health plan type as listed in section and to be further defined by the board of the Connector. Also defines "resident" for purposes of the individual mandate.
		2	Establishes the procedure for implementation of the individual mandate. Effective July 1, 2007, qualifying individuals for whom "creditable coverage" is deemed affordable must have "creditable coverage" in place. Individuals must include information about health insurance status on their tax forms. Failure to meet the insurance requirement will result in a penalty, assessed by the department of revenue, which will be the loss of the personal exemption for tax year 2007. All penalties will be deposited in the Commonwealth Care Trust Fund.
		3	Establishes an exemption for individuals whose religious beliefs prevent them from using medical health care.
		4	Establishes a hardship exemption process.
		5	Authorizes the commissioner of revenue to promulgate regulations to carry out the individual mandate.
13	111M	2b	Creates a penalty for non-compliance with the individual mandate as equal to 50% of an available premium cost for each month the individual was not adequately covered beginning January 1, 2008.
14	118E	6	Requires Office of Medicaid to report on the previous year's activities of the Medical Care Advisory Committee.
15	118E	9A	Raises eligibility for children receiving MassHealth from 200% FPL to 300% FPL. Effective July 1, 2006.
16	118E	9A	Prevents MassHealth from establishing disability criteria for determining eligibility that is more restrictive than the federal Social Security standard.
17	118E	9A	Places in statute MassHealth eligibility standards for people with HIV at 200% FPL.
18	118E	9A	Adds a new clause to require the Office of Medicaid to provide a monthly list of MassHealth-enrolled individuals for whom they provided "creditable

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

Bill Section	MGL Chp	MGL Sec	Description
			coverage" to the DOI.
19	118E	9C	Expands employee eligibility for participation in Insurance Partnership Program to 300% FPL.
20	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
21	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
22	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.
23	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.
24	118E	12	States that MassHealth must provide public hearing and notice before restricting eligibility or benefits.
25	118E	13B	Makes Medicaid rate increases for hospitals contingent on hospitals' meeting certain quality standards and performance benchmarks.
26	118E	16C	Expands S-CHIP eligibility for children from 200% FPL to 300% FPL.
27	118E	16D	Places in statute MassHealth Essential eligibility for elderly and disabled special status immigrants, and prohibits sponsor deeming.
28	118E	23	Technical language change.
29	118E	53	Restores all MassHealth benefits cut in 2002, including dental, vision, chiropractic, and prosthetics, effective July 1, 2006.
	118E	54	Creates a Wellness Program for MassHealth recipients to encourage healthy outcomes by reducing premiums as goals are met.
30	118E	55	Health Safety Net Office definitions.
	118E	56	Creates Health Safety Net Office to replace current Uncompensated Care Pool administration.
	118E	57	Creates a Health Safety Net Trust Fund, to replace the current Uncompensated Care Trust Fund and Pool.
	118E	58	Sets out provisions concerning hospital liability to fund (similar to current provisions in MGL 118G:18).
	118E	59	Sets out provisions concerning surcharge payor liability to fund (similar to current MGL 118G:18A).
	118E	60	Sets out provisions concerning reimbursements to hospitals and community health centers from Health Safety Net Trust Fund.
31	118G	1	Technical language change.
32	118G	1	Adds definition of "non-providing employer" for purpose of Free Rider surcharge.
33	118G	1	Adds definition of "payments from non-providing employers" for purpose of Free Rider surcharge.
34	118G	1	Technical language change.
35	118G	1	Adds definition of "state-funded employee" for purpose of Free Rider surcharge.
36	118G	1	Technical language change.
37	118G	2	Technical language change.
38	118G	2	Technical language change.

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

Bill Section	MGL Chp	MGL Sec	Description
39	118G	3	Technical language change.
40	118G	5	Technical language change.
41	118G	6	Requires hospitals' uniform reporting to Division of Health Care Finance and Policy to include names and addresses of employers whose employees receive free care.
42	118G	6B	Requires applicants for free care to be enrolled in other publicly-funded health programs, if eligible; applicants deemed ineligible for such programs are required to provide the name and address of their employer and their own identifying information, including social security number.
		6C	Requires every employer and employee doing business in Massachusetts to sign, under oath, a Health Insurance Responsibility Disclosure form indicating whether the employer has offered insurance and whether the employee has accepted or declined it.
43	118G	18-18A	Technical language change.
44	118G	18B	Sets out provisions governing assessment of Free Rider surcharge on non-providing employers.
45	118H		Creates the Commonwealth Care Health Insurance program, which will provide subsidized insurance to people with incomes under 300% FPL who are not eligible for other publicly-funded programs. Subsidies will be paid based on a sliding scale for eligible plans that are procured by the Commonwealth Health Insurance Connector. The new chapter provides that enrollees with incomes under 100% FPL will not pay premiums or deductibles, and also contains other language protections for all enrollees.
46	149	6D 1/2	Prohibits employers from penalizing employees who use free care.
47	149	188	Creates the Fair Share Contribution, to be paid by employers who do not provide or make a reasonable contribution to health insurance for their employees. The contribution requirement will apply to employers with 11 or more employees, will be pro-rated for part-time employees, and will be capped at \$295 per employee.
48	151F		Establishes the requirement that all employers with more than 10 employees must maintain a Section 125 plan to give employees access to pre-tax health insurance payments. Employers who do not comply will be faced with a fine.
49	175	108	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
50	175	110	Insurers offering blanket or group insurance policies may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
51	175	110M	Requires commercial insurers to provide a monthly list to DOI of residents for whom they provided "creditable coverage" for the previous month.
52	176A	8 1/2	A corporation organized under this chapter may only contract to sell a

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

Bill Section	MGL Chp	MGL Sec	Description
			group non-profit hospital service contract to an employer if the group non-profit hospital service contract is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
53	176A	8Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
54	176A	34	Requires non-profit hospital services to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
55	176B	3B	A medical service corp can offer a group medical service agreement sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
56	176B	4Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
57	176B	22	Requires medical service corps to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
58	176G	4R	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
59	176G	6A	An HMO may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
60	176G	16A	An HMO can include a maximum deductible consistent with the maximum contribution requirements allowed for a federally-established Health Savings Account (HSA)
60A		16B	Allows HMOs to offer Coverage for Young Adult plans as long as the provisions are consistent with those established for those plans.
61	176G	30	Requires HMOs to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
62	176J	1	Eliminates "case characteristics" from the determination of "Adjusted average market premium rates" and uses "rate basis type" in its place. (In compliance with HIPAA)
63	176J	1	Establishes a "Base premium rate" as a midpoint rate for each rate basis type for each health benefit plan offered by a carrier.

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Bill Section	MGL Chp	MGL Sec	Description
64	176J	1	Modifies "benefit level" to include the service delivery and network of a health benefit plan
65	176J	1	Eliminates preferred provider arrangements (176I) from being considered carriers for the non-group and small group market.
66	176J	1	Eliminates "case characteristics" from being used in determination of pricing of health benefit plans leaving "rate basis type" as the primary price differentiation method.
67	176J	1	Adds definitions for "Connector Seal of Approval" regarding approval of the value of benefit plans by the Connector. Also defines "creditable coverage" for individuals as any one of eleven types of health coverage including group health plans, federal employee and military plans, Medicare and Medicaid plans, and any other plans that meet HIPAA requirements.
68	176J	1	Defines an "eligible individual" for health insurance as a resident of the Commonwealth
69	176J	1	Extends the definition of "eligible small business" to include as one affiliated companies with the "same corporate parent".
70	176J	1	Includes small businesses within a MEWA (multiple employer welfare agreement) in the definition of "eligible small business"
71	176J	1	Clarifies "emergency services" to include mental medical conditions and assistance to pregnant women.
72	176J	1	Adds consideration for rates of "eligible individuals and their dependents" (residents of MA) in setting "Group average premium rates"
73	176J	1	Adds tobacco usage as a factor for consideration in setting group base premium rates.
74	176J	1	Defines "group health plan" as "an employee welfare benefit plan" with specification given to defining medical care.
75	176J	1	Redefines "health benefit plan" to exclude MEWA (multiple employer welfare agreements) from being included in this definition. The definition further excludes hospital indemnity insurance policies if offered separately from a coordinated benefit plan, specific disease insurance purchased to supplement a health plan, and also excludes student health plans from this definition. The commissioner is given the authority to modify this definition.
76	176J	1	Adds a definition for "modified community rate" defining how carriers must offer the same premiums to members within a particular rate basis type and can only vary premiums on age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level. Specifically, this section adds wellness program usage and tobacco usage as rating categories.
77	176J	1	Specifies that genetic information in the absence of a related condition cannot be used against an individual as a preexisting condition. Eliminates prototype plans as it pertains to HMOs.
78	176J	1	Adds tobacco usage as insurance "rating factors."
79	176J	1	Provides a definition for "resident" as a "natural person living in the commonwealth" but providing exclusions for individuals to qualify as residents based upon their confinement to a MA nursing home or hospital. Also defines "Trade Act/Health Coverage Tax Credit" to allow affected individuals to qualify for federal funds.
80	176J	1	Requires providers to pay for emergency services during an insured's

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

Bill Section	MGL Chp	MGL Sec	Description
			"waiting period" if a waiting period exists within the health benefit plan.
81	176J	2	Opens the small group market to accept nongroup members as "eligible individuals" as of July 1, 2007.
82	176J	3	Changes requirements health benefit plans must meet with regard to premium setting and rate basis types. This section establishes a maximum rate band range from .66 to 1.32 for the following factors: age, industry, participation-rate, wellness program rate, and tobacco use rate. Additionally, carriers can apply only the following factors outside of the rating band in establishing premiums: benefit level, geographic region, adjustment for eligible individual rather than small group, and group size adjustment. Additionally, requirements are laid out for which carriers with 5,000 or more members will be required to file a plan with the Connector to be considered for the "Connector Seal of Approval."
83	176J	4	Modifies the current requirement of carriers to make health benefit plans available in the following ways: Requires carriers to offer coverage effective within 30 days to any eligible individuals if they request coverage within 63 days of prior creditable coverage. If the 63 day period has lapsed, carriers must offer coverage to eligible individuals but may impose a 6 month exclusion of coverage for pre-existing conditions and a 4 month waiting period for receipt of services with the exception of emergency services which must be covered. However, plans offered to individuals without coverage for 18 months prior to application may not be subjected to a waiting period. Additionally, a carrier can deny enrollment in any plan if the carrier files proof of intent to stop selling that plan with the Commissioner. Carriers can require individuals or groups of 1-5 to enroll in plans via the Connector or an intermediary.
84	176J	5	Specifies that plans offered to Trade Act/ Health Coverage Tax Credit eligible persons may not include a waiting period of more than 3 months or a preexisting condition exclusion. This brings these plans in line with federal regulations for federal reimbursement for qualifying individuals. Increases the period in which an eligible individual, employee, or dependent may go without coverage from thirty days to 63 days before a pre-existing condition may be excluded from coverage. Decreases the waiting period in which a newly insured member must wait for coverage from six months to four months. Eliminates waiting periods entirely for eligible individuals who have had no creditable coverage for the past 18 months. Specifies defined "creditable coverage" rather than general "coverage."
85	176J	6	Incorporates "eligible individuals" into those eligible for plans in the merged market.
86	176J	6	Allows plans to offer restricted networks that differ from the overall carrier's network.
87	176J	7	Requires electronic filing of rates and notification to DOI of actuarial methodology and any relevant changes prior to filing.
88	176J	8	Requires the governing committee of the carrier-funded small-group reinsurance plan to establish a plan to phase out the program by June 2007.
89	176J	9	Adds "eligible individuals" to those who do not qualify for "continuous

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Bill Section	MGL Chp	MGL Sec	Description
			coverage."
90	176J	10	Establishes "Coverage for Young Adults" as a health plan with exact specifications to be set by DOI. Only individuals between 19 & 26 who do not have employer -sponsored coverage are eligible for these products.
91	176M	1	Ends enrollment opportunities for non-group.
92	176M	1	Provides a definition for "Trade Act/Health Coverage Tax Credit Eligible Persons" to allow those who qualify to receive the federal benefit.
93	176M	3	Ends enrollment opportunities for non-group.
94	176M	3	Ends enrollment in non-group products aside from dependents of current enrollees. Requires nongroup insurers to notify members at least annually of all products and premiums for which they are eligible in the merged market.
95	176M	6	Phase-out proposal for non-group health reinsurance plan.
96	176N	1	Defines "emergency services" and "health plan."
97	176N	2	Excludes pregnancy as a pre-existing condition.
98	176N	2	Extends the time an individual can be without coverage from 30 days to 63 days.
99	176N	2	Changes the maximum waiting period on an individual from 6 to 4 months.
100	176N	2	Allows an individual who has been without coverage for 18 months to have no waiting period or pre-existing conditions exclusionary period.
101	176Q		Establishes the Commonwealth Health Insurance Connector Authority (the Connector).
		1	Definitions.
		2	Establishes the Connector as an Authority within the Exec Office of Administration and Finance. Establishes the governance of the Connector with the Secretary of A&F as the director of the 11-member Connector board.
		3	Authorizes actions of the Board including taking actions necessary to offer insurance products to individuals and small businesses, publishing a schedule for premiums at which individuals of varying ages are eligible, establishing a schedule for affordability to be used in enforcing the individual mandate (ch 111M) based upon percentage of income eligible to be spent on health care.
		4	Specifies that the Connector will offer products to eligible individuals and small groups.
		5	Establishes the criteria products must meet to receive the Seal of Approval and be offered through the Connector.
		6	Outlines requirements of small businesses who participate in the Connector
		7	Authorizes the Connector to administer Commonwealth Care health insurance program beginning October 1, 2006.
		8	Directs an interagency agreement with the department of revenue for purposes of determining eligibility for commonwealth care.
		9	Allows the GIC to allow employees and contractors into the Connector mechanism.
		10	Establishes further criteria for Connector Seal of Approval product specifications.

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Bill Section	MGL Chp	MGL Sec	Description
		11	Allows for intermediaries and producers to earn commission on individuals enrolled through the Connector.
		12	Connector operations will be financed through surcharge on all Connector health plans.
		13	Establishes financial liability of Connector.
		14	Reporting requirements for Connector.
		15	Establishes requirements for a study to report on the operations of the Connector.
		16	Implementation language.
102	Ch 47, Acts of 1997		Extends Fisherman Health Care Demonstration program through 2012.
103	Ch 241 of the Acts of 2004		Repeals Distressed Provider Expendable Trust Fund.
104	Acts of 2005	45	Adds language to 4000-0352 item in FY06 budget, regarding MassHealth outreach, to ensure community organizations receive the majority of funds.
105			Raises enrollment cap on MassHealth CommonHealth program by 1,600 people.
106			Raises enrollment cap on MassHealth HIV+ program by 250 people.
107			Raises enrollment cap on MassHealth Essential by 16,000 people, effective July 1, 2006.
108			Directs EOHHS to create a 2-year pilot program for smoking cessation benefits for MassHealth enrollees. This program will be funded by the Tobacco Trust Fund.
109			Directs EOHHS to study the creation of selective provider networks.
110			Directs DPH to study the role of Community Health Workers, and to develop a sustainable Community Health Worker program.
111			Directs EOHHS to seek maximum federal match of State Children's Health Insurance (S-CHIP) funds.
112			Directs EOHHS to seek an amendment to the Medicaid 1115 federal waiver, and to seek maximum federal matching funds. Mandates that all negotiations with CMS would necessarily involve members of the House and Senate.
113			Establishes a moratorium on changes to Medicaid behavioral health services, pending a report outlining and justifying proposed changes.
114			Creates a commission to study the merger of the non-group and small-group insurance markets. Report will be filed with legislature by December 2006 with any legislative recommendations which would be useful in implementing the merger.
115			Provides for an open enrollment period for purchase of health insurance through the Connector.
116			Authorizes transfer of funds to the Massachusetts Technology Park Corporation for implementation of a computerized physician order entry system initiative.

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Bill Section	MGL Chp	MGL Sec	Description
117			Authorizes transfer of balance in Uncompensated Care Trust Fund to Health Safety Net Trust Fund.
118			Authorizes transfer of funds remaining in Distressed Provider Expendable Trust Fund to the Essential Community Provider Trust Fund.
119			Authorizes funding transfer for partial funding reform implementation.
120			Authorizes transfer of funds from Commonwealth Care Fund to Uncompensated Care Trust Fund in FY07.
121			Authorizes transfer of funds for start-up costs for Commonwealth Health Insurance Connector.
122			Authorized continued payments of supplemental funding to Medicaid Managed Care Organizations operated by Cambridge Health Alliance and Boston Medical Center.
123			Provides exclusive rights to Medicaid Managed Care Organizations that are contracting with the state as of July 1, 2006 to offer plans under the Commonwealth Care subsidized insurance program, provided that they meet certain enrollment targets.
124			Sets out hospital and surcharge payor liability; Uncompensated Care Pool distributions for FY07.
125			Continues a moratorium on changes to Uncompensated Care Pool regulations.
126			Repeals above moratorium on Pool regulations, effective October 2007.
127			Establishes a legislative moratorium on new mandated health benefit legislation until the Division of Health Care Finance and Policy completes a comprehensive review of such benefits or until January 1, 2008, whichever is later.
128			Authorized funding for rate increases of \$90 million in each of the fiscal years 2007-2009.
129			Directs Secretary of the Executive Office of Health and Human Services to conduct a study determining the cost of allowing primary care family caregivers to obtain MassHealth benefits.
130			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
131			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
132			Directs EOHHS to develop a plan and timeline for implementing health care reform legislation.
133			Directs the Executive Director of the Connector to submit a plan of operation and recommendations for amendments to Chapter 176Q to the Board of the Connector by August 2006.
134			Directs the Department of Labor and the Division of Health Care Finance and Policy to report on the implementation and impact of the Fair Share Contribution.
135			Allows hospitals to appeal to receive rate increases before meeting quality standards.
136			Requires website with cost and quality information to be operational by July 2006.
137			Includes provisions governing the length of terms for the initial members of

**Appendix D. Massachusetts Legislation (H4479): An Act Providing Access to Affordable, Quality, Accountable Health Care<sup>102</sup>, a Section-by-Section Summary<sup>103</sup>**

<b>Bill Section</b>	<b>MGL Chp</b>	<b>MGL Sec</b>	<b>Description</b>
			the Public Health Council.
138			Includes provisions governing the terms of the initial members of the Board of the Commonwealth Health Insurance Connector.
139			Allows individuals to enter into the merged insurance market on and after July 1, 2007.
140			Effective Dates.
141			Effective Dates.
142			Effective Dates.
143			Effective Dates.
144			Effective Dates.
145			Effective Dates.
146			Effective Dates.
147			Effective Dates.

## REFERENCES

- R Barker, "Issue Brief: Japan and Massachusetts – A Comparison of Universal Health Care Systems" (Issue Brief, Missouri Foundation for Health), 2006.
- L Blumberg et al, "Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications," Blue Cross Blue Shield of Massachusetts Foundation, 2005. Available at [http://www.roadmaptocoverage.org/pdfs/BCBSF\\_Roadmap2005.pdf](http://www.roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf)
- R Bovbjerg, "Implementing Reinsurance: Health Insurance Reform in Missouri" (Cover Missouri Series, Report 11), Missouri Foundation for Health, 2006.
- B Garrett, "Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001," Kaiser Family Foundation Report, 2004. Available at <http://www.pophealth.wisc.edu/phs548/kaiseresi2001.pdf>
- California Healthcare Foundation, "Massachusetts-Style Coverage Expansion:What would it Cost in California," California Healthcare Foundation, 2006. Available at <http://www.chcf.org/documents/insurance/MASyleCovExpansionIB.pdf>
- Committee for a Healthy Future, Fact Sheet accessed 6/22/06. <http://www.healthymissouri.org/FactSheet.pdf>
- CMS (Centers of Medicare and Medicaid Services) "HospitalCompare," 2006. [www.HospitalCompare.hhs.gov](http://www.HospitalCompare.hhs.gov). Participating Missouri hospitals are listed at [http://www.aha.org/aha/key\\_issues/qualityalliance/](http://www.aha.org/aha/key_issues/qualityalliance/).
- Community Catalyst, Inc., "Massachusetts Health Reform: What it Does, How it Was Done, Challenges Ahead," Community Catalyst, Inc., 2006; Kaiser Family Foundation, "Massachusetts Health Care Reform Plan" (Issue Brief), 2006.
- A Cook, "Health Insurance Coverage in Missouri, 2003 – 2004" (Cover Missouri Project Data Book 1), Missouri Foundation for Health, 2006.
- K Davis, "Universal Coverage in the United States: Lessons From Experience of the 20<sup>th</sup> Century," *Journal of Urban Health* 78.1(2001): 46-58.
- K Davis, "Providing Health Insurance For All: What Can We Learn From Massachusetts?" From the President of the Commonwealth Fund, 2006. Available at [www.cmwf.org](http://www.cmwf.org).
- E Emanuel and V Fuchs, "Health Care Vouchers – A Proposal for Universal Coverage," *New England Journal of Medicine* 352.12(2005):1255-1260.
- K Fitzgerald, Kevin; Denise Rodriguez, Carl Rosenfield, and J. Mark Waxman, Foley & Lardner LLP. 2006. "Massachusetts Health Care Reform Legislation: An Overview," Foley & Lardner LLP; Massachusetts Senate. 2006.
- E Grossman, "Comparing the Options for Universal Coverage." *Health Affairs Spring (II)(1994):84-100.*
- J Hadley, "Consequences of the Lack of Health Insurance on Health and Earnings" (Cover Missouri Project Report 1), Missouri Foundation for Health, 2006.
- J Holahan, "Increasing Health Insurance Coverage in Missouri Through Subsidies" (Cover Missouri Project Report 9), Missouri Foundation for Health, 2006.
- J Holahan et al, "Roadmap to Coverage: Synthesis of Findings," Blue Cross Blue Shield of Massachusetts Foundation, 2005.
- J Holahan, R Bovbjerg, and J Hadley, *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Medical Spending* (Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, 2004). Available at <http://www.roadmaptocoverage.org/pdfs/roadmapReport.pdf>

- J Holahan and M Cohen, "Missouri Medicaid Spending Growth: 2001 – 2005" (Cover Missouri Project Report 4), Missouri Foundation for Health, 2006.
- J Holahan and A Cook, "The Missouri Economy and Changes in Health Insurance Coverage, 2000-2004" (Cover Missouri Project Report 3), Missouri Foundation for Health, 2006.
- J Holahan and T Coughlin, "The Quiet Medicaid Revolution: State Waiver Activity in the Early 2000s" (Cover Missouri Project Report 5), Missouri Foundation for Health, 2006.
- J Holahan and S Long, "Costs, Access, and Utilization Under Medicaid: A Review of the Evidence" (Cover Missouri Project Report 2), Missouri Foundation for Health, 2006.
- Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, (Washington, DC: National Academy Press, 2001).
- Institute of Medicine, "Coverage Matters: Executive Summary," National Academy Press, 2001.
- Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002).
- G Kenney, L Clemans-Cope and F Blavin, "High-Deductible Health Plans with Health Savings Accounts: Emerging Evidence and Outstanding Issues" (Cover Missouri Project Report 10), Missouri Foundation for Health, 2006.
- J Lemieux, "A Relevant Universal Coverage Proposal," *Health Affairs* (2003):216-218.
- Massachusetts Conference Committee on Health Care and Affordability, "Health Care Access and Affordability Conference Committee Redraft Report," Massachusetts State Legislature, 2006. Available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>
- T McBride, S Watson, and H Bednarek, "The Missouri Health Landscape: How Does it Compare to Massachusetts?," Missouri Foundation for Health, 2006.
- The Missouri Center for Patient Safety. <http://www.mocps.org/>
- Missouri Commission on Patient Safety, Final Report, Missouri Commission on Patient Safety, 2004. Available at [http://www.wapatientsafety.org/downloads/2004\\_Missouri\\_Report.pdf](http://www.wapatientsafety.org/downloads/2004_Missouri_Report.pdf).
- Missouri Hospital Association (MHA), "Missouri's Federal Reimbursement Allowance Program," MHA, 2006. Available at [http://web.mhanet.com/asp/Governmental\\_Relations/pdf/FRA.pdf](http://web.mhanet.com/asp/Governmental_Relations/pdf/FRA.pdf)
- Missouri Hospital Association (MHA), "Missouri's Safety Net" (7 Inside Connection), MHA, 2005.
- Missouri Hospital Association (MHA), "Comparative quality data," MHA, 2006. Available at <http://www.focusonhospitals.com/>
- Missouri Hospital Association (MHA), "Hospital Performance Project," MHA, 2006. Available at: [http://web.mhanet.com/asp/Health\\_Improvement\\_Quality/Hospital\\_Performance.asp](http://web.mhanet.com/asp/Health_Improvement_Quality/Hospital_Performance.asp)
- Missouri Medicaid Reform Commission, "Medicaid Reform Commission Report," Missouri State Legislature, 2006. Available at <http://www.senate.mo.gov/medicaidreform/MedicaidReformCommFinal-122205.pdf>
- Missouri Legislature, HB 2082 (Low), requiring Missouri hospitals to compile and post daily staffing information in patient care areas of each unit of the hospital, <http://www.house.mo.gov/bills061/bills/HB2082.HTM>.
- National Committee for Quality Assurance (NCQA), <http://www.healthchoices.org/>
- K Pollitz, "The Missouri Health Insurance Pool: Issues for Policymakers" (Cover Missouri Project, Report 6), Missouri Foundation for Health, 2006.

- Rekindling Reform Steering Committee, "Rekindling Reform: Principles and Goals," *American Journal of Public Health* 93:1(2003): 115-117.
- G Schiff et al, "A Better-Quality Alternative: Single-Payer National Health System Reform," *Journal of the American Medical Association* 272.10(1994): 803-808.
- G Schiff and Q Young, "You Can't Leap a Chasm in Two Jumps: The Institute of Medicine Health Care Quality Report," *Public Health Reports* 116 (2001): 396-403.
- R Steinbrook, "Health Care Reform in Massachusetts — A Work in Progress," *New England Journal of Medicine* 354.20 (2006): 2095-2098
- K Swartz and D Garnick, "Adverse Selection and Price Sensitivity When Low-Income People Have Subsidies to Purchase Health Insurance in the Private Market," *Inquiry* 37.1(2000): 45–60.
- K Swartz and D Garnick, "Lessons from New Jersey's Creation of a Market for Individual Health Insurance," *Journal of Health Politics, Policy and Law*, 25.1 (2000): 45–70.
- K Swartz and D Garnick, "Information Needs in State Health Insurance Programs: Lessons from New Jersey," *Medical Care Research and Review*, December 1999.
- K Swartz and D Garnick, "Can Adverse Selection Be Avoided in a Market for Individual Health Insurance?" *Medical Care Research and Review*, 56.3(1999): 373–388.
- K Swartz and D Garnick, "Hidden Assets: New Jersey's Reform of the Market for Individual Health Insurance," *Health Affairs* 18.4 (1999): 180–187.
- E Wicks et al, "Expanding Coverage Through the Missouri Consolidated Health Care Plan (MCHCP)" (Cover Missouri Project, Report 7), Missouri Foundation for Health, 2006.
- S Zuckerman et al, "Caring for the Uninsured in Missouri: What Does It Cost and Who Pays Data" (Cover Missouri Project Report 2), Missouri Foundation for Health, 2006.
- S Zuckerman and A Cook, "Geographic Variations in Health Insurance: A Profile of Missouri" (Cover Missouri Project Report 8), Missouri Foundation for Health, 2006.

## ENDNOTES

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<sup>1</sup> A tobacco tax initiative was put on the Missouri ballot in November 2006 that would have raised \$290 million for health care access and treatment. Although the initiative did not pass, raising cigarette taxes in Missouri remains a potential policy alternative, and attempts to raise Missouri's tax – the second lowest in the nation – will likely occur again.

<sup>2</sup> R Steinbrook, "Health Care Reform in Massachusetts — A Work in Progress," *New England Journal of Medicine* 354.20 (2006): 2095-2098.

<sup>3</sup> Community Catalyst, Inc., "Massachusetts Health Reform: What it Does, How it Was Done, Challenges Ahead," Community Catalyst, Inc., 2006; Kaiser Family Foundation, "Massachusetts Health Care Reform Plan" (Issue Brief), 2006.

<sup>4</sup> Mo. Rev. Stat. 208.014(6)

<sup>5</sup> Mo. Rev. Stat. 208.014(6)

<sup>6</sup> This ballot initiative was declared invalid due to lack of valid signatures by the Secretary of State) but proponents have filed suit claiming that they have sufficient signatures.

<sup>7</sup> R Bovbjerg et al, "The Cost of Care for Missouri's Uninsured" (Cover Missouri Project Data Book 2), Missouri Foundation for Health, 2006.

<sup>8</sup> T McBride, S Watson, and H Bednarek, "The Missouri Health Landscape: How Does it Compare to Massachusetts?," Missouri Foundation for Health, 2006.

<sup>9</sup> United States Department of Health and Human Services, "Prior HHS Poverty Guidelines and *Federal Register* References," DHHS, 2006. Available at <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>

<sup>10</sup> J Holahan and A Cook, "The Missouri Economy and Changes in Health Insurance Coverage, 2000-2004" (Cover Missouri Project Report 3), Missouri Foundation for Health, 2006.

<sup>11</sup> Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements). Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=rawdata>

<sup>12</sup> J Holahan and A Cook, 2006.

<sup>13</sup> J Holahan and A Cook, 2006.

<sup>14</sup> J Holahan and A Cook, 2006.

<sup>15</sup> Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002).

<sup>16</sup> Details of these estimates are provided in Appendix A.

<sup>17</sup> Building Toward Full Coverage, Health Care Reform Conference Report.

<sup>18</sup> Letter from Mark McClellan, Administrator, Centers for Medicare and Medicaid Services, 2006. Available at [http://www.hcfama.org/\\_uploads/documents/live/Waiver-Approval\\_Letter.pdf](http://www.hcfama.org/_uploads/documents/live/Waiver-Approval_Letter.pdf)

<sup>19</sup> B Garrett, "Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001," Kaiser Family Foundation Report, 2004. Available at <http://www.pophealth.wisc.edu/phs548/kaiserresi2001.pdf>

<sup>20</sup> J Holahan, JHadley and L Blumberg. "Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts," Blue Cross Blue Shield Foundation of Massachusetts, 2006.

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- <sup>21</sup> Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2005 Summary of Findings," Kaiser Family Foundation, 2005. Average annual premiums for employer-sponsored coverage: \$10,880 for family coverage and \$4,024 for single.
- <sup>22</sup> T McBride, S Watson, and H Bednarek, Missouri Foundation for Health, 2006, Table 8.
- <sup>23</sup> See Appendix A for details.
- <sup>24</sup> Mo. R. S. 208.151.
- <sup>25</sup> Missouri Medicaid Reform Commission, "Medicaid Reform Commission Report," Missouri State Legislature, 2006.
- <sup>26</sup> Institute of Medicine, 1998.
- <sup>27</sup> Section 101, H4479
- <sup>28</sup> Massachusetts Conference Committee on Health Care and Affordability, "Health Care Access and Affordability Conference Committee Redraft Report," Massachusetts State Legislature, 2006. Available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>
- <sup>29</sup> Health Care Reform Conference Committee Bill, Joint Caucus for House Members, April 3, 2006.
- <sup>30</sup> T McBride, S Watson and H Bednarek, 2006.
- <sup>31</sup> J Holahan and A Cook, 2006.
- <sup>32</sup> G Kenney, L Clemans-Cope and F Blavin. "High-Deductible Health Plans with Health Savings Accounts: Emerging Evidence and Outstanding Issues" (Cover Missouri Project Report 10), Missouri Foundation for Health, 2006.
- <sup>33</sup> S Woolhandler, "Costs of Health Care Administration in the United States and Canada," New England Journal of Medicine 349:8 (2003).
- <sup>34</sup> Robert Wood Johnson Foundation, "Shifting Ground: Changes in Employer-Sponsored Health Insurance," RWJF, 2006. Available at <http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?id=10408>
- <sup>35</sup> K Pollitz, "The Missouri Health Insurance Pool: Issues for Policymakers" (Cover Missouri Project, Report 6), Missouri Foundation for Health, 2006.
- <sup>36</sup> E Wicks et al, "Expanding Coverage Through the Missouri Consolidated Health Care Plan (MCHCP)" (Cover Missouri Project, Report 7), Missouri Foundation for Health, 2006.
- <sup>37</sup> E Wicks et al, Missouri Foundation for Health, 2006.
- <sup>38</sup> R Bovbjerg, "Implementing Reinsurance: Health Insurance Reform in Missouri" (Cover Missouri Series, Report 11), Missouri Foundation for Health, 2006.
- <sup>39</sup> J Holahan and A Cook, 2006.
- <sup>40</sup> Chapter 58, Section 12, Section 2.
- <sup>41</sup> BusinessWeek online, April 4, 2006. Available at [www.businessweek.com](http://www.businessweek.com)
- <sup>42</sup> Newshour Extra, April 17, 2006. Available at [www.pbs.org/newshour/extra](http://www.pbs.org/newshour/extra)
- <sup>43</sup> National Conference of State Legislatures, "An Act Providing Access to Affordable, Quality, Accountable Health Care," National Conference of State Legislatures, 2006. Available at [www.ncsl.org](http://www.ncsl.org)
- <sup>44</sup> National Conference of State Legislatures, "2006 bills on universal health care coverage – Legislatures fill in the gaps," National Conference of State Legislatures, 2006. Available at [www.ncsl.org](http://www.ncsl.org)

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- <sup>45</sup> Mintz Levin News and Press Releases, "Massachusetts enacts landmark health care reform bill: an overview of H 4850, Providing Access to Affordable, Quality, Accountable Health Care," Mintz Levin Cohn Ferris Glovsky and Popeo P.C., 2006. Available at [www.mintz.com](http://www.mintz.com)
- <sup>46</sup> J Holahan et al, "Roadmap to Coverage: Synthesis of Findings," Blue Cross Blue Shield of Massachusetts Foundation, 2005.
- <sup>47</sup> Massachusetts Conference Committee on Health Care and Affordability, 2006.
- <sup>48</sup> C Schur, M Berk, and J Yegian, "Workers' perspectives on mandated employer health insurance," Health Affairs, Datawatch: Employer Mandates—Web Exclusive, 2004. Available at <http://content.healthaffairs.org>
- <sup>49</sup> C Steuerle, "Implementing employer and individual mandates," Health Affairs, Spring (II), 1994.
- <sup>50</sup> The Commonwealth Fund, *The Commonwealth Fund Health Care Opinion Leaders Survey: Assessing Health Care Experts' Views on Health Insurance Issues*, The Commonwealth Fund, 2005. Available at [www.cmf.org](http://www.cmf.org)
- <sup>51</sup> J Holahan et al, Blue Cross Blue Shield of Massachusetts Foundation, 2006.
- <sup>52</sup> National Conference of State Legislatures, "2004-2006 State Legislation on Health Care Savings Accounts and Consumer-Directed Health Plans," National Conference of State Legislatures, 2006.
- <sup>53</sup> National Conference of State Legislatures, 2006.
- <sup>54</sup> Mintz Levin News and Press Releases, Mintz Levin Cohn Ferris Glovsky and Popeo P.C., 2006.
- <sup>55</sup> Chapter 589, Section 47.
- <sup>56</sup> National Conference of State Legislatures, "2006 'Pay or Play' Bills: Will states mandate employer health insurance benefits?," National Conference of State Legislatures, 2006. Available at [www.ncsl.org](http://www.ncsl.org)
- <sup>57</sup> A Sinaiko, "Employers' Responses to a Play-or-Pay Mandate: An Analysis of California's Health Insurance Act of 2003," Health Affairs, Datawatch, Play-or-Pay, Web Exclusive, 2004. Available at <http://content.healthaffairs.org>
- <sup>58</sup> National Conference of State Legislatures, "An Act Providing Access to Affordable, Quality, Accountable Health Care," National Conference of State Legislatures, 2006. Available at [www.ncsl.org](http://www.ncsl.org)
- <sup>59</sup> Chapter 58, section 44
- <sup>60</sup> Massachusetts Conference Committee on Health Care and Affordability, 2006.
- <sup>61</sup> J Holahan et al, 2005.
- <sup>62</sup> Retail Industry Leaders Assoc. v Fielder (2006).
- <sup>63</sup> (8 August 2006), A Healthy Blog, <http://blog.hcfama.org> (26 August 2006).
- <sup>64</sup> L Blumberg et al, "Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications," Blue Cross Blue Shield of Massachusetts Foundation, 2005.
- <sup>65</sup> Massachusetts Conference Committee on Health Care and Affordability, 2006.
- <sup>66</sup> J Holahan et al, 2005.
- <sup>67</sup> See Appendix X for further details of the net costs estimates and for the assumptions of the simulations used to derive the estimates shown here.
- <sup>68</sup> Additional federal funds flow into Missouri to cover the costs of the uninsured such as Medicare DSH and IME, and VA System however, these are not federally matched dollars on state spending. See R Bovbjerg et al, "The Cost of Care for Missouri's Uninsured," Missouri Foundation for Health, 2006, p 18.

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- <sup>69</sup> R Bovbjerg et al, "The Cost of Care for Missouri's Uninsured, Missouri Foundation for Health," 2006.
- <sup>70</sup> R Bovbjerg et al, "The Cost of Care for Missouri's Uninsured, Missouri Foundation for Health," 2006.
- <sup>71</sup> <http://www.oe.mo.gov/co/releases/GRreport070606.htm>
- <sup>72</sup> Joel Ferber, "Measuring the Decline in Children's Participation in Missouri Medicaid Program: An Update," Legal Services of Missouri, 2006. Available at [www.mobudget.org/Children's%20Participation%20in%20Medicaid%20Sept%2006.pdf](http://www.mobudget.org/Children's%20Participation%20in%20Medicaid%20Sept%2006.pdf)
- <sup>73</sup> Based on data from the Missouri Department of Insurance, premiums received by all insurers (excluding self-insured plans) is approximately \$6.6 billion ([www.insurance.missouri.gov/reports/suppdata.htm](http://www.insurance.missouri.gov/reports/suppdata.htm)). In addition, it is estimated that insurers would collect another \$1.15 billion in premiums for the newly insured under a plan of universal coverage. If a 2% tax on all private insurance premiums (equal to \$7.8 billion) were to be assessed, preliminary calculations suggest that \$155 million would be raised. After the repeal of the Medicaid MCO RA, net revenue from broadening the provider tax base would net approximately \$100 million.
- <sup>74</sup> This excludes those employers who self-insure.
- <sup>75</sup> This initiative proposed increasing the state tax on each cigarette by 4 cents (20% increase on all other tobacco) for an 80 cent increase per pack in addition to the current 17 cents per pack for a 97 cent tax on each pack of cigarettes.
- <sup>76</sup> According to the Committee for a Healthy Future – the group that spearheaded the initiative – the tax is estimated to yield \$351 million per year additional state funds with \$61 million allocated for smoking education and cessation programs and the remaining for health care expenditures. (Committee for a Healthy Future, Fact Sheet, <http://www.healthymissouri.org/FactSheet.pdf>).
- <sup>77</sup> <http://eparc.missouri.edu/Publication/TAXEXP/sales.pdf>
- <sup>78</sup> Missouri Commission on Patient Safety, Final Report, Missouri Commission on Patient Safety, 2004. Available at [http://www.wapatientssafety.org/downloads/2004\\_Missouri\\_Report.pdf](http://www.wapatientssafety.org/downloads/2004_Missouri_Report.pdf).
- <sup>79</sup> Missouri Commission on Patient Safety, 2004.
- <sup>80</sup> Missouri Hospital Association, "Hospital Performance Project," Missouri Hospital Association, 2006. Available at: [http://web.mhanet.com/asp/Health\\_Improvement\\_Quality/Hospital\\_Performance.asp](http://web.mhanet.com/asp/Health_Improvement_Quality/Hospital_Performance.asp)
- <sup>81</sup> J Lemieux, "A Relevant Universal Coverage Proposal," *Health Affairs* (2003):216-218; Rekindling Reform Steering Committee, "Rekindling Reform: Principles and Goals," *American Journal of Public Health* 93:1(2003): 115-117.
- <sup>82</sup> Institute of Medicine, "Coverage Matters: Executive Summary," National Academy Press, 2001.
- <sup>83</sup> Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002).
- <sup>84</sup> G Schiff and Q Young, "You Can't Leap a Chasm in Two Jumps: The Institute of Medicine Health Care Quality Report," *Public Health Reports* 116 (2001): 396-403; E Emanuel and V Fuchs, "Health Care Vouchers – A Proposal for Universal Coverage," *New England Journal of Medicine* 352.12(2005):1255-1260; Rekindling Reform Steering Committee, 2003; G Schiff et al, "A Better-Quality Alternative: Single-Payer National Health System Reform," *Journal of the American Medical Association* 272.10 (1994): 803-808.
- <sup>85</sup> G Schiff and Q Young, *Public Health Reports*, 2001.
- <sup>86</sup> Rekindling Reform Steering Committee, 2003.
- <sup>87</sup> E Schiff and Q Young, 2001.

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<sup>88</sup> E Emanuel and V Fuchs, *New England Journal of Medicine*, 2005; E Grossman, "Comparing the Options for Universal Coverage." *Health Affairs* Spring (II)(1994):84-100; K Davis, "Universal Coverage in the United States: Lessons From Experience of the 20<sup>th</sup> Century," *Journal of Urban Health* 78.1(2001): 46-58; K Davis, "Providing Health Insurance For All: What Can We Learn From Massachusetts?" From the President of the Commonwealth Fund, 2006. Available at [www.cmf.org](http://www.cmf.org).

<sup>89</sup> The entire text of the Legislation (H4479) as signed can be found at: <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm> See the Appendix for a summary of the Legislation, Section by Section.

<sup>90</sup> R Barker, "Issue Brief: Japan and Massachusetts – A Comparison of Universal Health Care Systems" (Issue Brief, Missouri Foundation for Health), 2006.

<sup>91</sup> Conference Committee on Health Care and Affordability, 2006.

<sup>92</sup> For good summaries of the legislation, see: K Fitzgerald, D Rodriguez, C Rosenfield, and J. Waxman, Foley & Lardner LLP, "Massachusetts Health Care Reform Legislation: An Overview," Foley & Lardner LLP, 2006; Massachusetts Senate, 2006; Conference Committee on Health Care and Affordability, 2006

<sup>93</sup> The entire text of the Legislation (H4479) as signed can be found at: <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm> See the Appendix for a summary of the Legislation, Section by Section.

<sup>94</sup> The Governor vetoed this provision of the plan; however, the Massachusetts House overrode the Governor's line item vetoes on April 25, 2006. As of June 2006, the Senate had not acted on overriding the Governor's vetoes. See R Barker, "Issue Brief: Japan and Massachusetts – A Comparison of Universal Health Care Systems" (Issue Brief, Missouri Foundation for Health), 2006.

<sup>95</sup> See <http://www.kansascity.com/mld/kansascity/news/local/14829706.htm>. Additional information is provided at [www.segalco.com/publications/surveyandstudies/2003statesurveyvev\\_medicalbenefits.pdf](http://www.segalco.com/publications/surveyandstudies/2003statesurveyvev_medicalbenefits.pdf) and <http://Auditor.mo.gov/press/2004-51.pdf>.

<sup>96</sup> Medicaid estimates were drawn from state sources, in particular data available at: [www.dss.mo.gov/mis/pdfs/expmx05.pdf](http://www.dss.mo.gov/mis/pdfs/expmx05.pdf)

State estimates for 2005 are:

2005: Disabled: Total spending \$1261, State share \$489

2005: MAF Adult: Total \$255, State \$99

2005: MAF Child: Total \$149, State \$58

2005: Medicaid Children: Total \$192 State \$75

2005: SCHIP: Total \$111, State: 30

<sup>97</sup> See the sources for Medicaid estimates provided above.

<sup>98</sup> See the sources for Medicaid estimates provided above.

<sup>99</sup> Four sources were consulted to derive these estimates: (1) [www.insurance.gov.mo/reports/2004/hmo/HMOAnnualReport.pdf](http://www.insurance.gov.mo/reports/2004/hmo/HMOAnnualReport.pdf), (2) Blue Choice: <https://www.ehealthinsurance.com/ehi/Quote.fs>; (3) Premiums charged at various Missouri Universities (Lincoln, Harris S, Missouri State), and (4) DSS Missouri: <http://insurance.mo.gov/reports/2004/hmo/HMOAnnualReport.pdf>

<sup>100</sup> In contrast, Massachusetts assumed premium savings of 24% for individuals due to efficiencies gained when non-group individuals and small groups are enabled to buy insurance through the Connector. Massachusetts Conference Committee on Health Care and Affordability, 2006.. A California study assumes a relatively conservative 3% reduction in employer premiums because providers will have reduced uncompensated care and bad debts. California Healthcare Foundation, "Massachusetts-Style Coverage Expansion: What Would It Cost in California," California Healthcare Foundation, 2006. Available at <http://www.chcf.org/documents/insurance/MASStyleCovExpansionIB.pdf>. Families USA reports that implementing universal coverage nationally would reduce private employer insurance premiums by 8.5%. Families USA, "Paying A

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Premium: The Added Cost of Care for the Uninsured," Families USA, 2006. Available at [http://www.familiesusa.org/assets/pdfs/paying\\_a\\_premium\\_rev\\_july\\_13731e.pdf](http://www.familiesusa.org/assets/pdfs/paying_a_premium_rev_july_13731e.pdf)

<sup>101</sup> Missouri Medicaid Reform Commission, 2006, p 15 -16 and p 25 – 26.

<sup>102</sup> This is a summary of the full legislation. The entire text of the Legislation (H4479) as signed can be found at: <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>

<sup>103</sup> This is drawn entirely from: Massachusetts Legislature, Joint Committee on Health Care Financing, "An Act Providing Access to Affordable, Quality, Accountable Health Care, Conference Committee Report, Section-by-Section Summary," Massachusetts Legislature, 2006.