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Universal Health Care in Massachusetts: Implications for New Jersey

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INTRODUCTION

On April 12, 2006, Massachusetts' Governor Mitt Romney signed into law legislation that requires all residents of the Commonwealth to have health insurance and establishes measures to expand access to coverage and restructure the insurance market to meet this goal. The purpose of this issue brief is to explain the major tenets of the new Massachusetts law, at least as they pertain to the issue of insuring the uninsured,¹ and to supply some pertinent considerations and statistics to generate discussion among policy makers as to whether or not the health care reform design heralded by Massachusetts – or some variation thereof – has potential applicability in New Jersey.

It is widely reported that the number of Americans without health insurance continues to grow: in 2006, the number is approaching 50 million. A recent report issued by the Robert Wood Johnson Foundation confirmed what we already knew: that there is a significant gap in the amount of health care accessed by people who do not have health care coverage.

Nationally, uninsured adults are nearly four times more likely *not* to see a doctor when they need to and far more likely to miss important health screenings and check-ups compared to people who have health coverage. Ultimately, they may require extensive and expensive care because early care was delayed. Many states, including New Jersey and Massachusetts, have used state, federal and health care industry funds to expand eligibility for their Medicaid programs through waivers from the Centers for Medicaid and Medicare Services (CMS), to increase the numbers of residents with insurance and to create Uncompensated Care (or Free Care) Pools to pay at least a portion of the care for those without. Efforts to ensure access to health care to residents in this manner has strained both state and federal budgets; are arguably self-defeating in part by adding to the ever increasing cost of health care through the use of provider surcharges and premium taxes to support the Free Care Pools; may not be the most efficient use of health care dollars and do not promote the autonomy of the individual in health care decision making.

Massachusetts has a long history of addressing these issues. In 1997, it implemented its MassHealth program under a CMS waiver to both reduce the number and cost of caring for the uninsured and to maximize contributions from the federal government in doing so. Notably, in addition to expanding the categories and income limits of traditional Medicaid, the 1997 waiver allowed enhanced payments, through a series of supplemental payment funds, to two Massachusetts Medicaid-only managed care organizations (MCOs), the Boston Medical Center (BMC) HealthNet Plan and Network Health, operated by the Cambridge Health Alliance (CHA).² The supplemental payments covered the cost of care of enrollees and generated funds to support the hospital systems that operated them through, among other things, higher claim payments. In addition, Massachusetts used “inter-governmental transfers” (IGTs) to make its payments to these MCOs, providing the state with matching federal funds of 50% without using any state budget dollars.³

Through the MassHealth waiver, the number of uninsured was reduced by almost half, largely through the addition of 300,000 MassHealth enrollees. Also the cost of the Uncompensated Care Pool decreased during the early years of the waiver, but then began to rise sharply through 2004.⁴ By 2005, however, Massachusetts had a conservative figure of 550,000 uninsured and a 32% increase in charity care visits and admissions from FY 2003 to FY 2005. The supplemental payments to the BMC and CHA MCOs for 2005 were projected to be \$385 million. In light of these figures, the CMS signaled the end of the IGT funding mechanism; capped the supplemental payments to the MCOs and directed Massachusetts to adopt measures by July 1, 2006 to substantially reduce the uninsured population or risk losing the \$385 million in federal funding. In the interim, CMS significantly restricted how Massachusetts could access federal funds under its waiver, but presented opportunities for increased flexibility in how allowable funds could be spent. It is in this environment that the debate began anew in Massachusetts about how to provide health care services to the uninsured in the most efficient, cost-effective way possible. As a result of this debate, Massachusetts passed the Health Care Reform law on April 12, 2006.





THE HEALTH CARE REFORM LAW: “AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE”

The Health Care Reform law, formally entitled, “An Act Providing Access to Affordable, Quality, Accountable Health Care,” addresses the issue of providing access to health care to the low-income uninsured through the conventional method of expanding Medicaid coverage. It provides \$3 million for comprehensive community-based outreach programs to reach people who are eligible for MassHealth, but not yet enrolled and expands eligibility for children from 200% of the federal poverty level (FPL) to 300%. It also restores all MassHealth benefits that were cut in 2002, including dental and vision services. Unconventionally, however, the law also shifts the focus, in part, from public programs and the financing of providers for the provision of uncompensated care to the uninsured individual. Instead of funneling all government subsidies to health care facilities for caring for those without insurance, the new Massachusetts system is designed to redirect these subsidies directly to low-income families and individuals in the form of premium assistance to enable them to purchase health care insurance for themselves. This represents a major restructuring in the method of financing of health care services for the uninsured in Massachusetts.

The Commonwealth Care Health Insurance Program

The law creates a premium assistance program called the Commonwealth Care Health Insurance Program (Commonwealth Care), within the Commonwealth Health Insurance Connector, also established by the law and discussed below. Commonwealth Care will be administered by the board of the Connector, in consultation with the office of Medicaid and the Health Safety Net office (also discussed below), and provide subsidies to assist eligible individuals in purchasing health insurance. The subsidies will only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the Connector. Subsidies will be made under a sliding-scale premium contribution payment schedule for enrollees, determined by the Connector, in coordination with, and using the procedures of, the office of Medicaid. After consultation with the office of Medicaid, representatives of any carrier eligible to receive premium subsidy payments, representatives of hospitals that serve a high number of uninsured individuals, and representatives of low-income health care advocacy organizations, the Connector board will develop a plan for outreach and education designed to reach low-income uninsured residents and maximize their enrollment in Commonwealth Care.

Commonwealth Care will provide sliding-scale subsidies to individuals with incomes up to 300% of the federal poverty level (currently \$49,800 for a family of three). Individuals with incomes less than 100% of FPL (\$9,800 for an individual) will not be required to pay any premiums. Plans offered through Commonwealth Care also will not have deductibles. An individual will be eligible to participate in the program if he/she has been a Massachusetts resident for at least the past six months; is not eligible for Medicare or a Massachusetts medical assistance program (e.g., Medicaid or child health insurance program) and the individual's employer has not provided health insurance coverage in the last six months for which the individual is eligible and for which the employer covers at least 20% of the annual premium for a family plan and 33% of an individual health insurance plan.⁵ If the Connector director determines that amounts in the fund are insufficient to meet the projected costs of enrolling new eligible individuals, the director may impose a cap on enrollment in the program.

The law expressly calls for the establishment of a specific program for its poorest residents, *i.e.*, those with a household income less than 100% of FPL. For this program, the Connector will procure health insurance plans that include, but are not necessarily limited to:

- Inpatient services
- Outpatient services and preventative care by participating providers





- Prescription drugs as provided under the MassHealth formulary
- Medically necessary inpatient and outpatient mental health services and substance abuse services
- Medically necessary dental services, including preventative and restorative procedures.

Enrollees in these plans shall only be responsible for a co-payment toward the purchase of each pharmaceutical product and for the use of emergency room services in acute care hospitals for non-emergency conditions equal to that required of enrollees in the MassHealth program. The Connector board may waive co-payments upon a finding of substantial financial or medical hardship. No other premium, deductible, or other cost sharing will apply to enrollees under this program.

Commonwealth Health Insurance Connector

Structure

A central piece of the Massachusetts Health Care Reform law is the creation of the Commonwealth Health Insurance Connector. The Connector is to be an independent public entity, not subject to the supervision and control of any other executive office, whose purpose is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups.

The Connector will be governed by an 11 member board, consisting of: the secretary for administration and finance, as chairperson; the director of Medicaid; the commissioner of insurance; the executive director of Massachusetts' group insurance commission; an actuary, a health economist and small business representative, each appointed by the governor; and an employee health benefits plan specialist, a health consumer representative, and a representative of organized labor, each appointed by the Massachusetts' attorney general. No appointee may be an employee of any licensed carrier authorized to do business in the Commonwealth. The board will hire an executive director to supervise the administrative affairs and general management and operations of the Connector. The law sets forth a lengthy list of powers and responsibilities of the Connector which is responsible for administering many of the insurance aspects of the reform. (See Appendix I for a pertinent sample.)

Individuals and small groups, *i.e.*, businesses with 50 or fewer employees, are eligible to "connect" to coverage. The Connector neither underwrites nor sets the standards for health insurance policies. Carriers, *i.e.*, state licensed insurers, health service corporations and health maintenance organizations, underwrite the health insurance plans and the State Commissioner of Insurance authorizes the plans that may be written, except that Connector plans need not meet health care delivery design provisions of state law. That is, for plans offered through the Connector, carriers are free to contract with, or determine not to contract with, any provider for the services covered under the plan. Ultimately, the Connector issues a "seal of approval" to the state authorized plans that it determines are of good value to the consumer, offer high quality and are offered through the Connector. The law authorizes the Connector board to "establish procedures for the selection of, and the seal of approval certification for, health benefit plans to be offered through the Connector."

Goal

Conceptually, the Connector has been likened to a stock exchange, which is just a single market organizing the sale and purchase of equities and securities. The basic insight behind a state-sponsored health insurance exchange like the Connector is that markets sometimes work more efficiently and effectively when there is a single place to facilitate diverse economic activity. The Connector does not purchase plans on behalf of individuals or businesses: it creates a marketplace to match buyers and sellers efficiently and to facilitate the collection and transmission of payments, often from multiple sources. Carriers offer their plans through the Connector and employees, not employers, become the customers for health insurance





policies. Theoretically, they will be able to pick from a variety of health insurance plans and pay premiums tax free (subsidized or not) out of flexible spending accounts. Plans that are purchased through the Connector are portable in that employees can keep the plan of their choice as they move from job to job. The Connector also is expected to enable non-traditional workers such as part-time workers, seasonal workers and independent contractors, to afford health insurance coverage by possibly obtaining contributions from multiple employers towards the premium.

Individual and Employer Mandate

Individual

The Massachusetts Health Care Reform law does not rely on the subsidies it provides for the low-income or the reforms it makes in the regulation of the health insurance marketplace (discussed below) to make the purchase of health insurance a viable, rational option for its currently uninsured middle-class residents. Rather, the law requires that as of July 1, 2007, all residents of Massachusetts aged 18 and over shall obtain and maintain health insurance coverage as long as it is deemed affordable under the schedule established by the Connector. The Connector may grant an annual certification to an individual if it determines that no available health plan is affordable for that individual, effectively waiving the mandate to obtain coverage. The Connector has yet to establish the standards that will govern this determination.

According to the conference committee report that accompanied the law, the purpose of the “individual mandate” is to strengthen and stabilize the functioning of health insurance risk pools by making sure they include healthy people who otherwise may opt for the risk of being uninsured, as well as people who know they regularly need health care services. It is designed as an assurance that the Uncompensated Care Pool funds will be available for the insurance subsidies under Commonwealth Care instead of as subsidies to providers who provide non-emergent “free” care in their emergency rooms. The law as originally drafted by Governor Romney proposed that residents who choose not to purchase insurance be required to post a \$10,000 bond to fund any hospital care they may not be able to afford. This idea evolved into the individual mandate as the bill passed through the legislative process.

Massachusetts residents will be required to have health insurance beginning in July 2007. Residents will confirm that they have health insurance coverage on their state income tax forms filed in 2008.⁶ Coverage will be verified through a database of insurance coverage for all individuals. The Massachusetts 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. The legislative committee states in its report that (i) no health care reform proposal without an individual mandate has ever been projected to enroll more than half of the uninsured and (ii) projections of the individual mandate show that the vast majority of the uninsured will take coverage.

Employer

The mandate for employers to offer insurance to employees was an addition to Governor Romney’s original reform proposal. Indeed, when the Governor signed the bill, he vetoed this provision, but the legislators overrode his veto. Since employers who are providers of health insurance currently pay into the Free Care Pool through a premium tax, an assessment on employers who aren’t health insurance providers was ultimately deemed a “fair share” of the health care costs by the legislature. “For the purpose of more equitably distributing the costs of health care provided to uninsured residents,” the bill as enacted, requires “each employer that (i) employs 11 or more full-time equivalent (FTE) employees in the Commonwealth and (ii) is not a ‘contributing employer’ to pay a per-employee contribution at a time and manner prescribed by the director of the department of labor, ...called the ‘fair share employer contribution.’”





An employer is a “contributing employer,” if it offers a group health plan as defined by federal regulation (26 USC 5000(b)(1)) that includes payment by the employer of a “fair and reasonable premium contribution.” The law does not specifically state whether this group health plan must be offered as well to part-time employees once the 11 FTE employee threshold is met. However, as the reform plan is billed as a means of providing coverage to previously uncovered part-time employees through the Connector, who could combine contributions from various employers, such a mandate may be the vehicle. The “fair and reasonable premium contribution” that must accompany the offer of a health plan of a contributing employer is to be defined by regulation of Massachusetts’ division of health care finance and policy.⁷ The “fair share employer contribution,” by contrast is calculated pursuant to a specific formula in the legislation that reflects a portion of the cost paid by “free care” of workers of employers who do not provide insurance and it cannot, in any event, exceed \$295 per full-time employee.

Employers may offer health care coverage through the Connector on a pre-tax basis, if they meet certain requirements such as the agreement not to offer competing non-Connector plans.

For those employers with 11 or more full-time employees that do not offer – not necessarily secure – health care coverage through the Connector, Massachusetts’ division of health care finance and policy may also assess a “free rider surcharge” if employees of those employers use free care. Imposition of the surcharge 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 formula will be established by regulation based on principles set forth in the law, and will range from 10% to 100% of Massachusetts’ costs of services provided to the employee, with the first \$50,000 per employer exempted.

The payments made by virtue of the fair share employer contribution and the free rider surcharge, as well as any penalties collected by virtue of noncompliance with the individual mandate, will be deposited in the Commonwealth Care Trust Fund.⁸

HEALTH INSURANCE REFORM

Massachusetts, like New Jersey, heavily regulates its health care market. In particular, insurers are required to offer individual insurance if they offer small group insurance and they are required to do so on a modified community rating basis that does not allow health rating. The state’s individual health insurance market regulations require insurers to provide a comprehensive standardized benefit package with little flexibility.

The Massachusetts reform law calls for the merging of the individual and the small group markets by July 1, 2007. It considers that groups of one are not that different from groups of two and requires addressing the affordability of the individual plans that are to be offered through the Connector. The merger is expected to produce an estimated drop of 24% in non-group premium costs and increase product choice.⁹ The success of Commonwealth Care is dependent upon the affordability of the individual plans offered through the Connector. Premiums won’t have to be low in order to attract young and healthy individuals into the merged market risk pool – a goal of insurance reform – it will be the law that one must have insurance. However, if the cost of the plans offered through the Connector are too high, state subsidies will have to be greater to permit the individual to become insured and eventually may be inadequate. High priced plans may also force the Connector to issue many waiver certificates, thereby defeating the purpose of the reforms.

The reform law attempts to address the issue of affordability of the offered insurance products by allowing for more flexibility in the design of the products.¹⁰ It does so by permitting state HMOs to include a maximum deductible consistent with the maximum contribution requirements allowed for a federally established Health Savings Account (HSA); and by adding wellness program usage and tobacco usage as rating categories to the current individual market rating categories for the entire merged market.¹¹





The law also creates a class of insurance products targeting 19 to 26 year olds. The division of insurance, with the advice and consent of the director of the Connector, shall issue regulations to define coverage for young adult health benefit plans. Eligibility for enrollment in a qualifying young adult health insurance program will be restricted to individuals between the ages of 19 and 26, inclusive, who do not otherwise have access to health insurance coverage subsidized by an employer. Coverage for young adults shall provide reasonably comprehensive coverage of inpatient and outpatient hospital services and physician services for physical and mental illness and shall provide all services that a carrier is required to include under applicable division of insurance statutes and regulations, including, but not limited to, mental health services, and emergency services. Any carrier offering young adult health plans must offer at least one product that includes coverage for outpatient prescription drugs. Coverage for young adults may impose reasonable co-payments, co-insurance and deductibles and may use cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting. Finally, such plans shall only be issued through the Connector.

Two final efforts aimed at insurance regulatory reform in the Massachusetts law are (i) the extension of the definition of dependent up to 25 years of age for family policies and (ii) the imposition of a moratorium on all new mandated health benefit legislation until the latter of either January 1, 2008, or until the division of health care finance and policy has concluded review of, and published results from, a comprehensive review of mandated health benefits in effect on January 1, 2006.

HEALTH SAFETY NET TRUST FUND

Massachusetts' Uncompensated Care Pool (also known as the Free Care Pool) was established in 1985 to provide payment to hospitals as a way of redistributing the burden of providing free health care. The pool pays for medically necessary services provided by hospitals and community health centers to low-income uninsured and under-insured individuals, with approximately 90% of the funds going to the hospitals. The funding for the pool in FY 2006 was \$526 million, funded roughly equally in thirds by an assessment on hospitals, a premium tax or surcharge on payors of hospital health care services, and the Massachusetts general fund.

The Free Care Pool is eliminated under the reform law effective October 1, 2007, replaced by the Health Safety Net Trust Fund. This Fund will be funded in a manner similar to the Free Care Pool, subject to further study by a special commission on the feasibility of reducing or eliminating the surcharge assessment paid by insurers and self-insured employers. The purpose of the fund is to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of health services provided to low-income, uninsured or underinsured residents of the Commonwealth. The Safety Net Fund will be administered by a newly-created Health Safety Net Office located within the Office of Medicaid. The Office is further charged under the law with developing a standard fee schedule for the uncompensated care reimbursement to the facilities based on the payment systems in effect for acute hospitals used by CMS to administer the Medicare Program.

Any annual balance remaining in the fund after such payments have been made shall be transferred to the Commonwealth Care Trust Fund. It is anticipated that less money will be needed for the Health Safety Net Trust Fund as more people in Massachusetts acquire health care insurance through the Connector and Commonwealth Care Health Insurance Program.

Massachusetts' two largest safety net providers, Boston Medical Center and Cambridge Health Alliance incurred 33% and 20% respectively of the statewide allowable Free Care costs in FY 2003. They, and the broad range of health care providers with whom their corresponding affiliated MCOs have contracted across the state to serve the MCO members, have depended on this source of revenue and the "supple-





mental payments” received under the 1997 Massachusetts Medicaid Waiver. Therefore, the reform law continues support of these systems in particular through FY 2009 by (i) holding the hospitals harmless for their net supplemental payments of \$287 million and (ii) giving them exclusive rights to receive the premium assistance payments from the Commonwealth Care Health Insurance Program. Twenty-five per cent of the payments in (i) for FY 2008 and 2009 are to be based on the following criteria: (a) the success of each entity in enrolling uninsured patients into the Commonwealth Care, other publicly funded health programs, or private insurance plans offered through the Connector and (b) reasonable progress made in minimizing the number of individuals utilizing the uncompensated care pool, or any successor thereto. The exclusivity of the Medicaid MCOs to participate in Commonwealth Care is dependent upon achieving the enrollment of 40,000 enrollees by June 30, 2007; and 80,000 enrollees as of June 30, 2008.

FINANCING

Existing Spending

Under the terms of the Massachusetts Medicaid Waiver, the state had historically been permitted to make supplemental payments to two public Managed Care Organizations. These supplemental payments allowed the state to exceed the upper payment limits normally imposed on Medicaid reimbursements. In fiscal 2006, these supplemental payments totaled \$770 million, attracting a 50% match from the federal government.

The Waiver also permitted Medicaid payments to so-called Disproportionate Share Hospitals (DSH); these hospitals serve a disproportionate number of Medicaid and uninsured patients. Like the MCO supplements, DSH payments also attract a 50% federal match. DSH payments are capped by the federal government at both the level of the individual hospital and also in the total amount the state can receive. In 2006 the state was permitted to make \$574.5 million in DSH payments.

As of July 1, 2006, CMS requires the state to cease to make supplemental MCO payments. In order to retain this vital revenue source, the federal government agreed Massachusetts could retain and redirect the federal match for health care reform, subject to several conditions:

- The state creates a new Safety Net Trust Fund, capped at \$1,344.5 million (the combined total of the 2006 MCO supplemental payments and the DSH payments).
- Approximately half of this will be funded by the federal government.
- The purpose of this fund is to provide services to the uninsured, in particular to lower the rate of uninsurance
- CMS must approve the use of the non-federal spending in order to generate the federal match
- This capped fund counts against budget neutrality

In addition to the \$1.35 billion generated by these two categories, the state also spent an additional \$450 million in Medicaid dollars on helping to finance the system for the under- and uninsured. These Medicaid dollars also attracted a federal match under the terms of the waiver (so net costs to the state are only \$200+ million). Ultimately this means that the state has a recurring new commitment of a minimum of \$200 million per year every year (which is actually what is contained in both the 2007 house and senate budgets currently in conference).





Post-Reform Spending

The health care reform legislation largely redeployed much of this collective \$1.8 billion across three areas:

- Commonwealth Care (the subsidy program)
- Health Safety Net Trust Fund (which includes the successor to the Uncompensated Care Pool)
- Medicaid (which includes ongoing commitments, eligibility expansions, and redirected hospital payments which were formerly received as DSH and MCO supplement spending)

In fiscal 2007 the program commitments, including grandfathered existing commitments and the new spending, are approximately \$2.2 billion, an increase of \$400 million over fiscal 2006. This \$400 million is essentially split equally between the federal share and non-federal share. In fiscal 2008 the majority of the changes in spending, for example, the transfer of free care funds to subsidized insurance, have no net cost. However, program costs are expected to increase by a further \$100+ million as the Medicaid programs continue to reach full maturity and see heavier program enrollment. Once again, this is split between the federal and non-federal share. At the same time the state is expected to receive new revenues of \$48 million from the fair share assessment on employers which will offset these additional 2008 costs almost entirely.

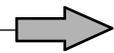
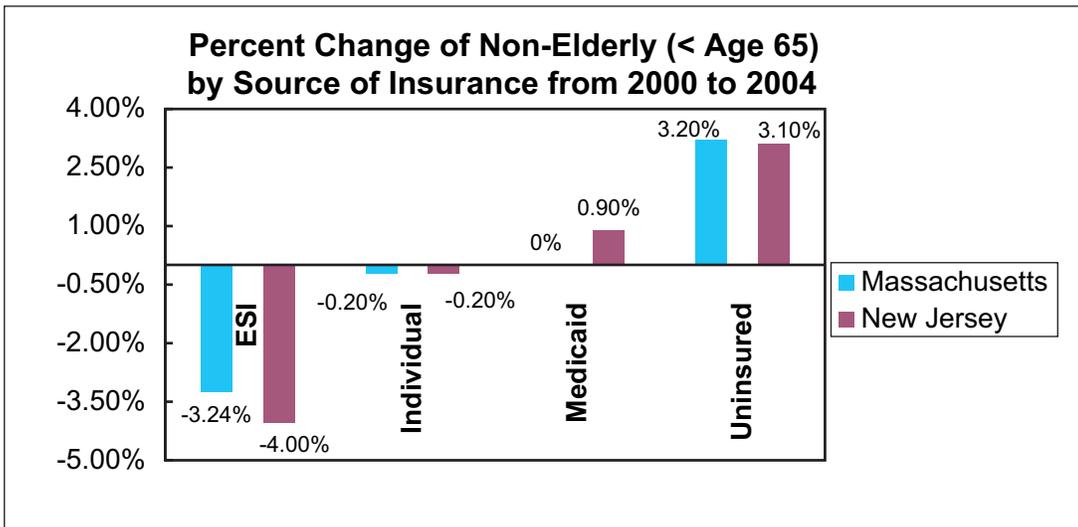
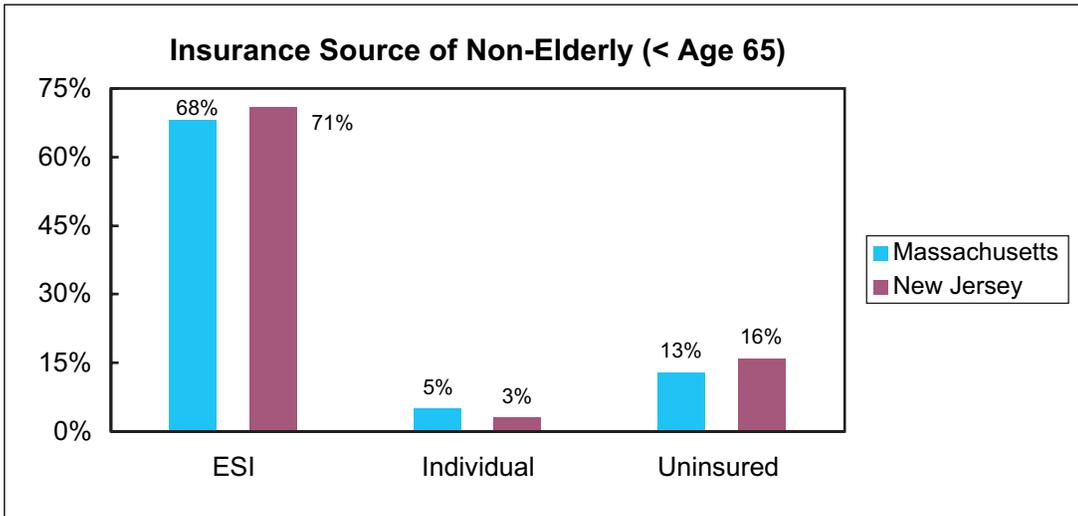
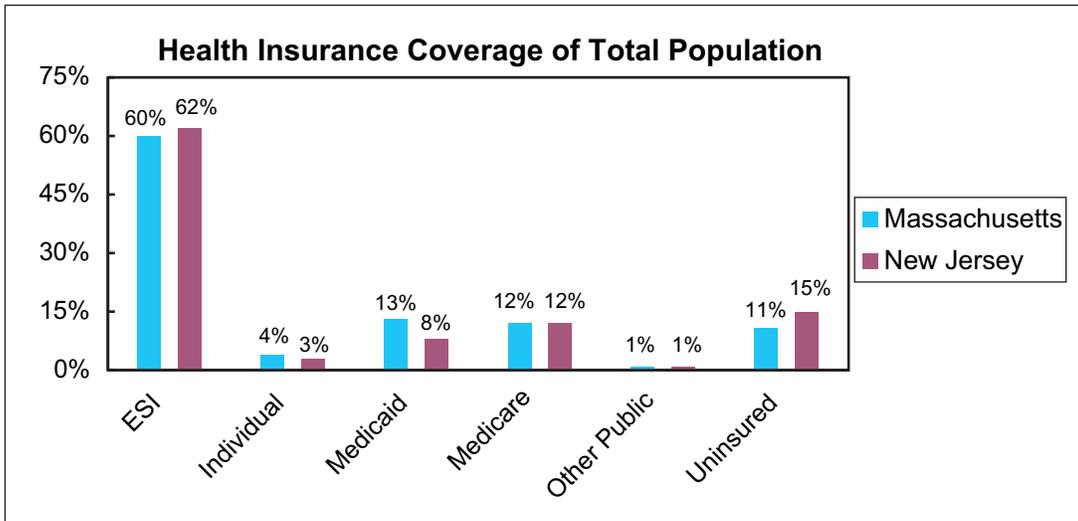
While 2009 is harder to estimate due to questions over the future of the waiver and rates of medical inflation, the assumption is that cost growth will be in the area of \$100 million as in 2008. This will require an additional \$50 million from the state.

COMPARING MASSACHUSETTS AND NEW JERSEY

Some of the prominent facts considered by the Massachusetts lawmakers in the passage of the reform law were the number and characteristics of the uninsured in the Commonwealth, the growth in Free Care expenditures, and the trend in health insurance coverage and Medicaid enrollment. Different sources of information on these considerations yield different statistics. For example, the estimated number of uninsured in Massachusetts based on an annual state survey is approximately 8%; whereas, the number provided by the Census Bureau for 2003-2004 is 11%. Therefore, for purposes of comparison between Massachusetts and New Jersey, the statistics used herein, unless otherwise indicated, are from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey.

Accordingly, out of Massachusetts' 6,360,110 residents, 60% have employer-sponsored health insurance (ESI); 4% have secured health coverage on an individual basis; 13% have Medicaid and 11% remain uninsured. A greater percent of New Jersey's 8,613,040 residents is uninsured at 15%; it has fewer residents enrolled in Medicaid and a slightly higher proportion of residents with ESI. When we remove the Medicare population from the perspective, ESI and the uninsured percentages increase¹² but the comparative relation between the states remains relatively the same. Further, the prevalence of ESI and individual health care coverage for the non-elderly has decreased similarly in both states from the year 2000 to 2004, resulting in an increase in the uninsured for Massachusetts and New Jersey of 3.2% and 3.1% respectively.





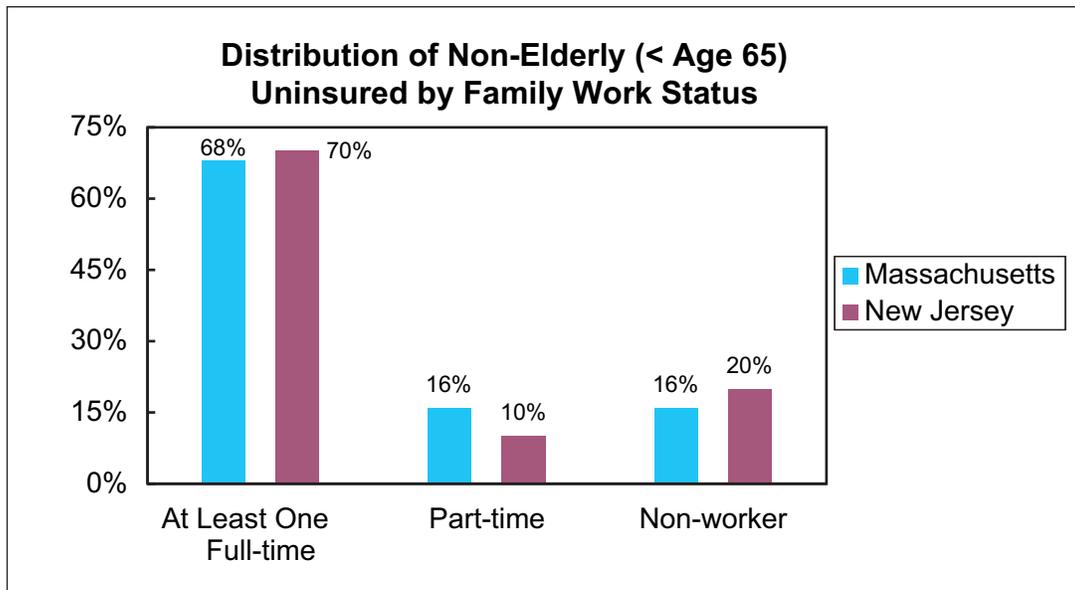


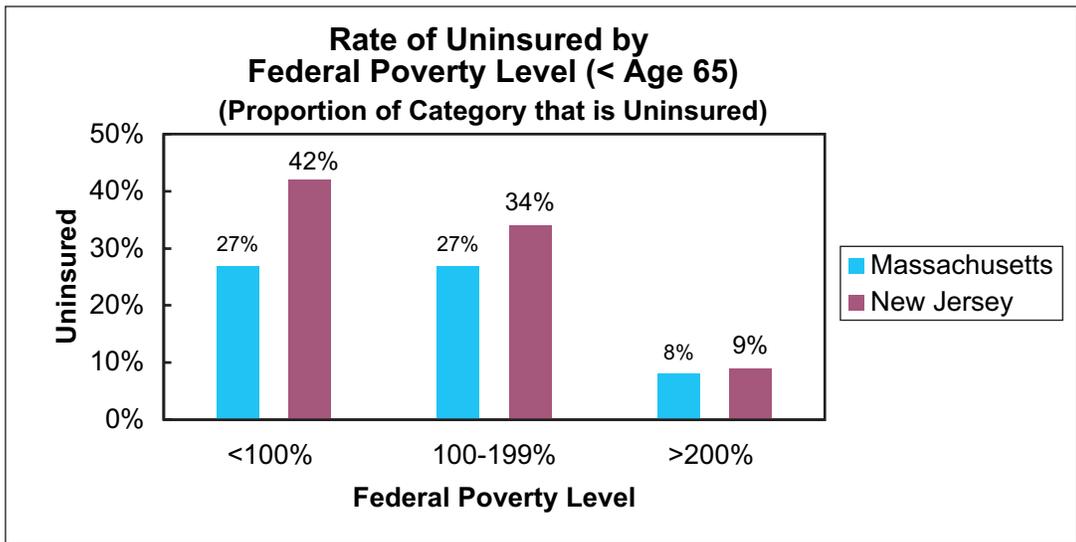
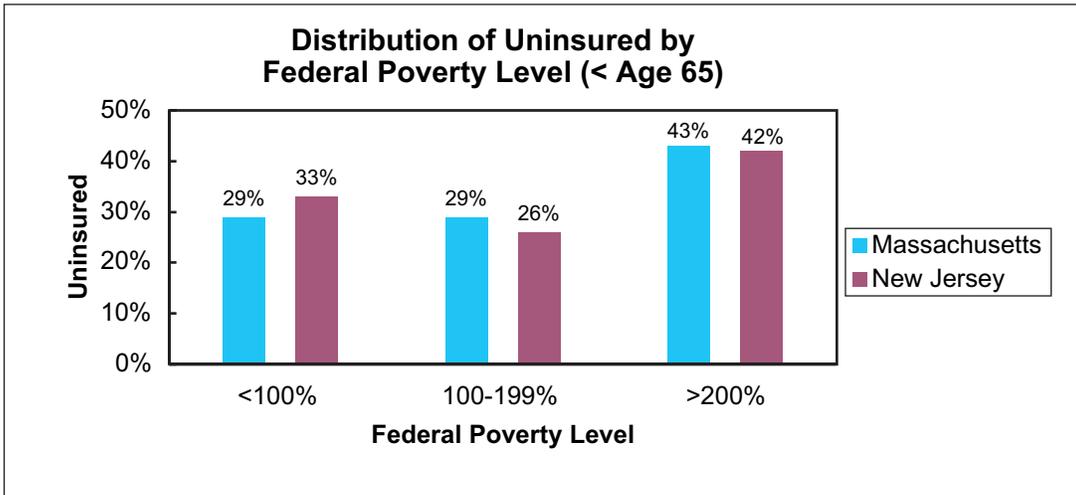
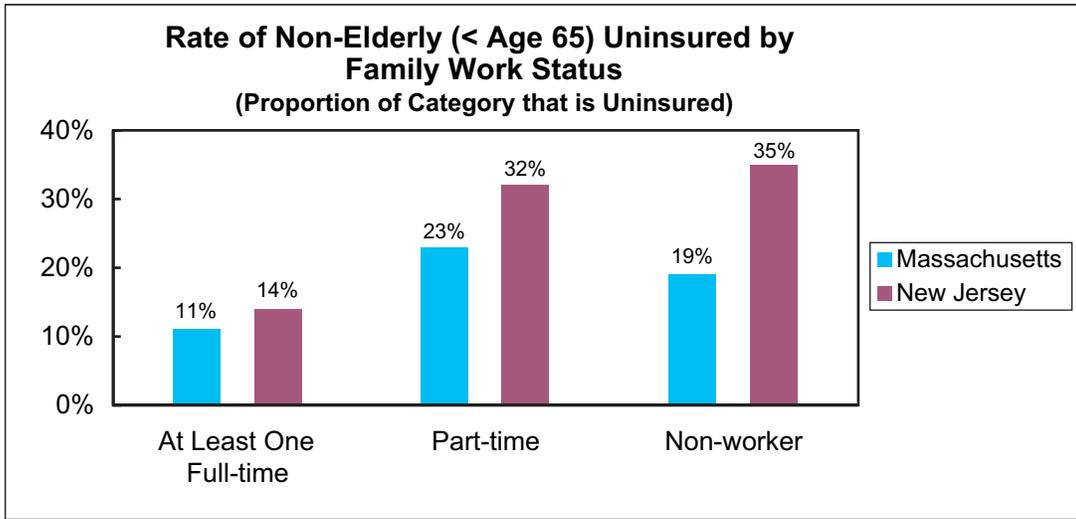
Understanding the characteristics of the uninsured population, of course, is essential to designing programs or assistance to provide them access to health care through insurance or otherwise. In Massachusetts, 17% of the non-elderly uninsured are children 18 and under compared to 21% in New Jersey. A corresponding 83% are adults (19-64) in Massachusetts and 79% in New Jersey. Even though children constitute a greater portion of the uninsured in New Jersey, the rate at which children and adults are uninsured in New Jersey are each 4 percentage points greater than the corresponding rate for Massachusetts. (Mass.: children, 8%; adults, 15% and New Jersey: children, 12%; adults, 19%)

As in Massachusetts, a large percentage of New Jersey's non-elderly uninsured are working, with the majority working full-time. Fewer of New Jersey's uninsured are part-time workers, but a greater proportion of New Jersey's part-time workers are uninsured than are those in Massachusetts. An employer mandate that requires some level of premium contribution toward the purchase of a health plan for part-time employees once a threshold of FTEs is met could help address this problem for New Jersey. In any event, the fact that the uninsured are largely employed and the stated fact that "the uninsured are representative of the statewide mix of race and ethnicity," was an important consideration for Massachusetts' approach of providing access to health care through the individual-employer partnership.

Kaiser reported insufficient data for a complete distribution of the non-elderly uninsured in Massachusetts by race and ethnicity. However, it did report that 66% are white compared with 38% in New Jersey; and 18% are Hispanic compared with 33% in New Jersey. Notably, the Urban Institute, using data from the National Health Interview Survey, reports that compared to their insured counterparts, both uninsured adults and children are more likely to be Hispanic and non-citizens. Further, the Institute reported that while "high costs" were a major factor for the majority of uninsured persons (*i.e.*, 79%), high cost as a reason for being uninsured was particularly prevalent among Hispanic individuals (as well as adults between 55-64 and non-citizens).¹³

Finally as to race and ethnicity, of the non-elderly uninsured in New Jersey, 21% are black. Six percent (6%) of Massachusetts' total residents are black, compared with 13% of New Jersey's total residents. These statistics indicate a more even "statewide mix of race and ethnicity" in New Jersey, especially among its uninsured.



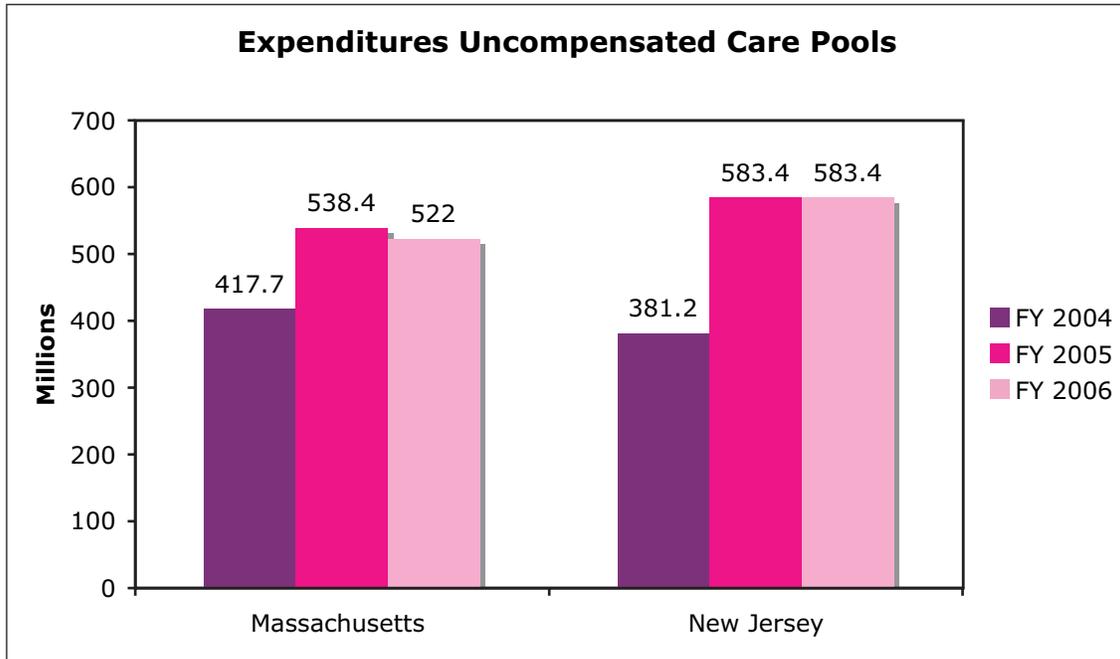




As to expenditures by the states' uncompensated care pools,¹⁴ the absolute figures, at least for the last two fiscal years, are not markedly different but the distribution is so. As noted above, approximately 50% of the total statewide free care distribution in Massachusetts goes to BMC and the CHA (with 33% going to BMC); the top 50% of New Jersey's charity care funds are distributed much more widely. In FY2006 the funds were distributed among the following seven hospitals:

- UMDNJ (14%),
- Jersey City Medical Center (8.9%)
- Cathedral Health System (6.1%)
- Newark Beth Israel Medical Center (6.0%)
- St. Joseph's Regional Medical Center (5.2%)
- Trinitas Hospital (5.2%)
- Cooper Hospital/University Medical Center (4.7%)
- Seven different hospitals, all receiving over \$10 million, shared the next 18% of the charity care dollars distributed.

This distinction may make a New Jersey transition from a focus on reimbursing providers for uncompensated care to assisting individuals in the purchase of health care coverage administratively more difficult and perhaps more expensive. The state may be concerned with maintaining the "safety-net" of at least the first seven hospitals/hospital systems, rather than two as in Massachusetts, until it increases enrollment of individuals in a health plan and that means maintaining the infrastructure of each as well. On the other hand, because of the wider distribution, the charity care dollars received may not represent too large a portion of the receiving hospital's annual gross revenue, relieving New Jersey of the concern that the hospital may fail during any transition period.





CONCLUDING REMARKS

So the question is whether New Jersey can or should enact comprehensive health care reform to address issues similar to Massachusetts, concerning access to health care services by its residents.

New Jersey is no stranger to the concept of providing public money subsidies for the purchase of private health care coverage as envisioned by the Commonwealth Care program. First, in 1992, it initiated Health Access New Jersey, a program of state subsidies for modest income individuals, married couples and families that did not have access to ESI and had income less than 250% of FPL. The subsidy was provided on a sliding scale based on income and was used for enrollment in the recently developed Individual Health Coverage Program. Reportedly, the program was halted because of the realization that federal matching funds, at that time and the way the program was configured, did not attach to the insurance subsidies that were drawn from the charity care fund, but did if the money was spent on hospital uncompensated care reimbursement.¹⁵ This also predated the federal Children's Health Insurance Program that did allow for a federal match for insurance subsidies. The program was closed to new enrollment in 1995; disbanded in 2002 and dedicated funds were reassigned to hospital charity care reimbursement.

More recently, however, in 2000 New Jersey established the Premium Support Program as part of its New Jersey Family Care Program, through a section 1115 Medicaid waiver to fund parents, adults and pregnant women up to 200% of FPL and children up to 350% of FPL.¹⁶ The premium assistance is paid to the individual to subsidize ESI. Families at the upper end of income eligibility are required to pay a fixed share of the premium. New Jersey requires a minimum employer contribution of 50% for a family to be eligible for a premium assistance subsidy and requires eligible individuals to enroll in premium assistance rather than receive direct Family Care coverage if they have access to ESI. Because the program provides wraparound coverage to ensure that families have the same benefits and are subject to the same cost sharing rules as families in direct Family Care, a significant employer contribution is deemed to be needed to ensure the cost-effectiveness of the program. New Jersey determines savings through a comparison of state costs for the premium subsidy plus the anticipated cost of the wraparound coverage and the cost of serving a family through the regular, direct Family Care program. On average the state data show that it is saving \$203.97 per family but the overall savings have been limited because of the low enrollment in the program. As of March 2005, only 791 family members were enrolled in the program. The Kaiser Commission suggests that the relative low enrollment in premium assistance programs is likely reflecting the limited availability of affordable ESI among low income workers.

New Jersey may want to explore the Massachusetts remedy of both an employer and individual mandate – the cornerstones of the Commonwealth's Health Care Reform. If the state continues its historical reliance on ESI, with over 90% of privately insured individuals receiving coverage from their own or a family member's employer (U.S. Census Bureau 2005), mandating that employers either offer coverage to their employees or pay an assessment to the state for the provision of care to residents is a possibility. It may also be viewed as fair because employers who are purchasers of coverage for their employees undoubtedly pay increased premiums to account for providers' increased charges to carriers to cover the cost of free care not compensated by the state.

Mandating as well that individuals procure health care coverage may function as a check on possible attempts by employers to circumvent the requirement (e.g. changing status of employees to independent contractors) and also may be a significant start to putting the individual in the driver's seat in making decisions concerning his or her own health care. Through the innovation of the Connector, the individual, not the employer and not the state, is the purchaser and owner of his or her health plan. This new consumer role for the individual, coupled with education at all levels on how to choose the best health plan for individual life circumstances and the dissemination of much more information on the quality of service area health care providers, may encourage individuals to not only increase participation in their own health care, but also, through market forces, to improve the efficiency and reduce the cost of the delivery of health care.





Neither the individual nor the employer mandate will succeed as a tool to provide health care coverage to more individuals if the plans offered for sale through the Connector are priced too high. How the plans will be priced is dependent in large measure upon the flexibility permitted carriers to respond to the need for affordable policies. Many commentators on the Massachusetts reform plan note that the administrative rules yet to be promulgated further governing the parameters of the health care coverage policies permitted to be offered, will determine the cost of the plans and whether government subsidies will prove adequate to provide the anticipated coverage to the uninsured.

New Jersey's insurance market is at least as heavily regulated as the market in Massachusetts and it too would have to negotiate the reform of its current statutory and regulatory structure if it wanted to consider Massachusetts' approach. The Commissioner of the state Department of Banking and Insurance (DOBI) under Governor McGreevy convened diverse groups of stakeholders in the health insurance market to suggest and evaluate ideas to increase the affordability of health coverage in the private, regulated small group and individual markets.¹⁷ Some of the recommendations of the groups were: reducing the number of required plans and allowing flexibility through riders in others; allowing modified, instead of pure, community rating in the individual market and increasing the rating bands to 3.5:1; allowing a "preventive + catastrophic" plan to be offered, and subsidizing coverage for the near poor (*i.e.*, <200% FPL).

Notably, one of the groups recommended against the merger of the individual markets, opining that the small group market alone should not subsidize the individual market. Neither group, however, considered the prospect of the individual mandate, even though one group noted that there was no data that established that lower premiums in the individual market will influence the purchasing decisions of young, healthy individuals. Perhaps if the market merger option was reconsidered in conjunction with an individual mandate, sentiment would change since the stakeholders' other recommendations encouraged much more similarity between the small and individual market. In any event, the recommendations of these groups and others could help inform policymakers considering health insurance reform in the context of a Massachusetts-like plan or otherwise.

Massachusetts has been lauded as much for the process that led to the enactment of the reform as for the plan itself. The Governor brought together numerous stakeholders from across the political, business, health care delivery and policy sectors to negotiate proposals and arrive at compromises. However, one cannot ignore the significance that the threatened loss of \$385 million in federal money had in encouraging communication and compromise among stakeholders. External factors such as this seem to help immeasurably in supplying the political will to seek new solutions. Indeed the last time New Jersey enacted wide sweeping health care coverage reform, it believed that a federal court had invalidated its method of funding uncompensated care through a surcharge on paying hospital patients' bills.¹⁸

ENDNOTES

¹ Other provisions of the law enacted to study or address the problem of escalating costs, health care disparities and health care quality will not be examined.

² The Boston Medical Center (BMC) is a 547-licensed bed, academic medical center located in Boston. In 1997, BMC and the Cambridge Health Alliance (CHA), comprised of The Cambridge Hospital, Somerville Hospital, and Whidden Memorial Hospital, created affiliated managed care organizations, HealthNet Plan and Network Health, respectively. BMC and CHA are often termed "safety net providers" in Massachusetts law and health care policies because they serve a disproportionate share of public patients and low income, uninsured individuals. The MassHealth Waiver at p. 4

³ The state would make a payment to the local public entity, like the Public Health Commissions with which each MCO is affiliated; the entity would pay 50% to the MCO and reimburse the state 50% and the state would still be able to claim 50% of its 100% payment to the public health entity in federal matching funds, leaving no net cost to the state.





- ⁴ Massachusetts Medicaid Policy Institute (MMPI) attributes this rise to the result of the increasing number of uninsured, more services billed to the pool as a result of expansion of services by the safety net providers and the rising costs of health care in general.
- ⁵ This requirement may be waived provided that the employer's health insurance premium contribution for the applying individual, which shall be the median health insurance premium contribution made by the employer to all of its full-time employees participating in the employer-sponsored health plan, must be paid to the Connector. The Connector shall use the employer's health insurance premium contribution payment for the individual to first offset the Commonwealth's premium assistance payment for the individual with any residual amount offsetting the individual's responsibility.
- ⁶ Clearly, the effectiveness of this particular enforcement mechanism depends on the actual filing of a state income tax return by the uninsured individual.
- ⁷ The law does set a standard for premium contribution (20% for family and 33% for an individual) of a plan that would make an individual ineligible for Commonwealth Care, but that standard is not adopted in the law as the "fair and reasonable premium contribution" that would qualify an employer as a contributing employer.
- ⁸ Amounts credited to the fund shall be expended for programs designed to increase health coverage, including Commonwealth Care and "rate increases to certain Medicaid providers and supplemental payments to certain publicly operated or public-service hospital entities." 29 Massachusetts General Law 2000.
- ⁹ An actuarial study of the merger is to be completed before the merger to assist insurers in planning for the transition.
- ¹⁰ Reportedly, the bill drafted by Governor Romney allowed for much more product flexibility than did the final version of the law, which more closely follows the bill introduced in the Massachusetts House of Representatives.
- ¹¹ Hence under the reform law, carriers may use the following rating categories as modified community rating: age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage or benefit level. Massachusetts General Law Ch. 176J, § 1.
- ¹² Medicaid and other public remain the same.
- ¹³ Data from *Shifting ground: Changes in employer-sponsored health insurance*. The State Department of Human Services in collaboration with the Rutgers Center for State Health Policy also noted that Hispanic ethnicity was among the top four factors that account for "urban coverage disparity" among New Jersey's urban population. *Disparity in health insurance coverage: Urban v. non-urban areas of New Jersey*.
- ¹⁴ Data for Massachusetts taken from Massachusetts uncompensated care pool, Division of Health Care Finance and Policy, November 4, 2005. The amount of the expenditures from the Massachusetts pool is the sum of the moneys funded for services at acute care hospitals and services at community health centers. Data for New Jersey taken from Charity Care Distribution Amounts, Health Care Quality and Oversight, NJ DHSS Web site, accessed June 2006.
- ¹⁵ Kathleen Brennan, former Director of Health Access, which was housed in the State Department of Health.
- ¹⁶ In response to state budget shortfalls, enrollment for adults without dependent children was closed in September 2001. In June 2002 enrollment was closed for parents as well. However, on July 13, 2005, The Family Health Care Coverage Act was enacted to restore these eligibility categories.
- ¹⁷ These groups were called the Existing Systems Group and the New Systems Group. Their reports were released in draft form to participants but never formally released by the Department of Banking and Insurance.
- ¹⁸ In fact, the 3rd Circuit Court of Appeals shortly thereafter overturned the district court's decision in the United Wire case that invalidated the uncompensated care surcharge.

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APPENDIX I

SAMPLE POWERS AND RESPONSIBILITIES OF THE COMMONWEALTH HEALTH INSURANCE CONNECTOR

The Massachusetts law sets forth a lengthy list of powers and responsibilities of the Commonwealth Health Insurance Connector, which is responsible for administering many of the insurance aspects of the reform. For example, the Connector will:

- a. develop criteria for plans eligible for premium assistance payments through the Commonwealth Care health insurance plan, initially publishing the criteria by July 1, 2006 for plans to be procured and implemented no later than October 1, 2006;
- b. administer Commonwealth Care health insurance program and remit premium assistance payments beginning on October 1, 2006 to those carriers providing health plans to Commonwealth Care enrollees;
- c. determine each applicant's eligibility for purchasing insurance offered by the Connector, including eligibility for premium assistance payments;
- d. charge, and equitably apportion among participating institutions, its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.
- e. create for publication, by September 30 of each year, the Commonwealth Care health insurance program consumer price schedule.
- f. review annually the publication of the income levels for the federal poverty guidelines and devise a schedule of a percentage of income for each 50 per cent increment of the federal poverty level at which an individual could be expected to contribute said percentage of income towards the purchase of health insurance coverage. The director will consider contribution schedules, such as those set for government benefits programs. The report shall be published annually beginning on June 1, 2007. Prior to publication, the schedule shall be reported to the house and senate committee on ways and means and the joint committee on health care financing.
- g. establish and evaluate requirements for plans issued through the Connector that do not necessarily follow state rules on health care delivery network design.