MASSACHUSETTS

PRELIMINARY
STATE PLANNING GRANT REPORT

FOR THE
HEALTH RESOURCES AND SERVICES ADMINISTRATION,
STATE PLANNING GRANT PROGRAM

TO:
TOMMY G. THOMPSON, SECRETARY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

October 2001

Jane Swift, Governor
Commonwealth of Massachusetts

Robert P. Gittens, Secretary
Executive Office of Health and Human Services

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This preliminary report was prepared by staff from the following Massachusetts agencies:

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EXECUTIVE SUMMARY: MASSACHUSETTS

Massachusetts has been one of the leading states in the country in providing health care and health care coverage to uninsured populations. Through its MassHealth expansions, reforms to its small group and non-group markets, and a strong employer base, Massachusetts now has one of the lowest rates of uninsurance in the country. In addition, Massachusetts has a strong safety net of community health centers and hospitals for the provision of care to low income uninsured individuals who are not eligible for, or choose not to enroll in public insurance programs.

Massachusetts now faces far different circumstances than when work began on this planning grant over a year ago. The state and national economies were still strong then. Massachusetts had a low rate of uninsurance (5.9%), and was optimistic about reducing it further. With recent events, most notably the September 11th attacks and the economic downturn, Massachusetts policymakers and others have new challenges facing them. Expanding health insurance coverage is challenging in the best of times, and in the coming months it may be equally challenging to maintain the ground that has been gained over the last several years. Nonetheless, we expect that Massachusetts will retain its position as a leader in maintaining and expanding access to health care services and insurance coverage, even in times of economic uncertainty.

Over the past year, through HRSA grant funding, Massachusetts has had the opportunity to look more closely at the complex issue of health insurance coverage. The grant work can be summarized in four broad phases: consensus building, data gathering and analysis, development of interim recommendations, and continued analysis of viable options. Each of these is discussed briefly below.

Consensus building around this issue in Massachusetts began long before the grant writing process began. All major stakeholders in Massachusetts have been interested in and have played a role in expanding access to affordable health insurance for many years. They continued to have a voice in this area through this grant process at various phases. Consumers, advocates, payers, providers, legislators, and state agencies participated either through the grant's steering or advisory committees, through surveys or focus groups and/or individual interviews. The breadth of involvement of these stakeholders is not unusual for Massachusetts. Broad-based task forces are frequently convened for discussion of important policy decisions in the state. During the early part of this grant, the steering committee developed principles against which policy options would be judged. The following are the principles upon which we built the options that made the most sense for Massachusetts.

1) The state should provide equal access to public insurance assistance to people:
   - With the same level of income (as defined by FPL)
   - Regardless of current insurance status
   - Regardless of occupation

2) We should be mindful of the impact of our recommendations on the currently insured and on those who purchase insurance on their behalf (e.g. employers, unions, etc).

3) To the extent that we propose an expansion of public insurance programs, assistance should be targeted to the most financially needy.

4) Model(s) should foster independence and self-reliance.

5) Our recommendations should encourage cost and quality-consciousness throughout the health care system.

6) The state has a special responsibility to assure access to affordable health insurance for those people who work under contract to the state or for organizations that are primarily dependent on state funding.

7) Options or models that would lead to care that is better managed (i.e. improving/maintaining quality while maintaining/lowering costs) should be encouraged.

8) Models should reflect the needs/characteristics of the multiple subgroups of uninsured.

9) Approaches should build upon existing public and private health insurance financing mechanisms; however, it may be necessary and/or appropriate to recommend changes to existing programs if doing so furthers the goal of expanding access to affordable health insurance.

10) The state should maximize the use of federal dollars.

11) "The perfect is the enemy of the good."

The data gathering and analysis phase of this grant continues. Thus far, our research has included literature reviews, survey research, and extensive data analysis. With the principles in mind, the team began by researching the myriad of expansion options considered at both the state and federal level over the years. The team researched the current state of the Commonwealth's health insurance marketplace. We developed a characterization of our uninsured population and the employer market through large surveys. Massachusetts had already conducted its own household survey in 2000. However, grant funding provided resources to perform extensive analysis of these data and to augment the data with specific analyses from the Urban Institute's National Survey of American Families (NSAF). The grant also provided funding for Massachusetts to conduct its first-ever employer survey. While encouraging employers to participate in the survey proved to be more difficult than anticipated, the survey results have been very useful thus far. In addition, Massachusetts conducted two smaller surveys: one of consumers purchasing health insurance in the non-group market and the other of Massachusetts physicians on the services they provide on a free or sliding-scale basis to uninsured patients.

Once the core team researched the potential options and completed preliminary data analysis, they were ready to synthesize the information and propose recommendations that met the principles and made the most sense for Massachusetts. These recommendations are preliminary in that we have not finished our data analysis and expect to have more refined recommendations in the upcoming months. The recommendations include:

- Continue, and improve, efforts to attain full enrollment of all currently eligible Massachusetts residents into existing public programs;

- Recommend that the federal government provide tax deductibility for the taxpayer's full cost of health insurance for self employed and those without access to employer sponsored health insurance; and tax credits in amounts that would significantly defray the cost of purchasing health insurance, to lower-income people in the same circumstances[1];

- Recommend that the federal government increase allotments to encourage states to further expand SCHIP to parents of children covered through SCHIP when those parents have access to employer sponsored health insurance;

- Recommend that preference be given, in the bidding process for state contracts, to organizations that both offer health insurance and pay for at least 50% of premiums;

- Encourage commercial development of catastrophic insurance plans when combined with medical savings accounts;

- Develop an educational approach to inform consumers of all of their health insurance coverage options;

- Adopt as a long-term objective the redesign of the administrative system supporting eligibility and enrollment activities for all state[2] programs that would enable people to apply for all social service programs at once through any of multiple points of entry;

We have not completed our qualitative data collection and analysis of the cost impact of the recommended options. At this juncture we are recommending that the following actions be taken to enable us to complete the analysis of remaining options in time for the final report to HRSA:

- Complete data analysis in order to recommend programmatic changes to the Insurance Partnership to increase the participation of employers and employees;

- Complete the data analysis necessary to make further recommendations for covering those populations for which, through its contracts, the state has a "special responsibility";

- Complete qualitative analyses to learn more about why people currently eligible for publicly sponsored health insurance do not apply or enroll in these programs;

- Project the impact (in dollars and number of people affected) of removing or modifying MassHealth's categorical eligibility requirements at various income levels;

[1] The state would consider a complementary measure should the federal government take action in this area.

[2] This would begin with state programs but would eventually involve all public programs (federal, county, municipal, etc.)

Although we have done a significant amount of work researching options, conducting surveys and performing data analyses, there is still a lot of work remaining. Over the course of the next 6-12 months, we will complete qualitative research to learn more about why some people do not enroll in health insurance programs available to them. In addition, we will continue to refine our options and provide cost estimates for all final recommendations made by Massachusetts.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

In researching the rate and characteristics of the uninsured in Massachusetts, several sources were used, including the Division of Health Care Finance and Policy (DHCFP) 2000 Survey of Health Insurance Status of Massachusetts Residents (data from the 1998 survey was also used). In addition, the Urban Institute's National Survey of American Families (NSAF) findings for Massachusetts (1999), Massachusetts hospital discharge data from the Uniform Hospital Discharge Data Set (1999), eligibility data from individual applications to the Massachusetts Uncompensated Care Pool (2001), and data from outpatient claims of the Boston Medical Center, the state's highest volume hospital provider to the uninsured, were analyzed. Although more heavily used in Section 2, Section 1 also draws upon the findings of DHCFP's 2001 Survey of Massachusetts Employers Regarding Health Insurance and the Massachusetts findings from the Agency for Health Care Research and Quality's Medical Expenditure Panel Survey (IC: 1996-1999). Please see Appendices II – IV and XI-XII for more detailed information, copies or links to the surveys.

1.1. What is the overall rate of uninsurance in your state?

Per the DHCFP's 2000 Survey of Health Insurance Status of Massachusetts Residents (non-institutionalized), the overall rate of uninsurance in Massachusetts for all ages, including the elderly, is 5.9%. This represents a 28% decline from the overall uninsurance rate per the first survey completed in 1998 of 8.2%. The rate of uninsurance, excluding the elderly, went from 9.9% (NSAF, 1997) to 6.5% (DHCFP, 2000), a 34% decline.

1.2. What are the characteristics of the uninsured?

Income: (Ages 0-64)

Household Income (%FPL)	% of the Uninsured	% Uninsured within Income Group
0-133%	14.4%	12.5%
134-150%	5.8%	11.9%
151-200%	23.0%	14.3%
201-400%	39.1%	8.0%
>400%	17.8%	2.0%
Total/Overall	***100.0%***	***6.5%***

Per the Massachusetts 2000 household survey, most Massachusetts uninsured, about 57%, reside in households with incomes greater than 200% of the federal poverty level (FPL). About 20% of the currently uninsured fall below 150% of the FPL.

People residing in low-income households (below 200% FPL) experienced the greatest decline in the uninsurance rate since 1998, illustrating the successful enrollment of those eligible into MassHealth (the name for Massachusetts Medicaid as expanded in 1997 through a Federal Sec. 1115 waiver). For people living in near-poor households (133-150% FPL), the uninsurance rate declined by over 50%, from 27% to 11.9%; and it dropped by nearly 50%, from 23% to 12.5% for individuals residing in poor households (below 133% FPL).

Uninsured adults are almost three times as likely as insured adults to reside in low-income households with incomes at or below 200% of the FPL (42% compared to 14.4%). Nearly 86% of insured adults reported residing in households with income above 200% of the FPL.

Most uninsured children (59.7%) live in households with incomes at or above 200% of the federal poverty level. However, uninsured children still are more likely than insured children to reside in low-income households with income below 200% of FPL, 40.3% versus 25.0%.

Uninsured black, Hispanic and Asian populations disproportionately reside in low-income households. The percentage of uninsured Hispanics living in households with incomes above 200% of the FPL has increased from 3% to 17% from 1998 to 2000. The percentage of uninsured blacks living in households with incomes above 200% FPL has decreased by over 75%, from 9% to 2%, between 1998 and 2000.

Information from "Free Care Applications": Data from eligibility applications for "free care" in Massachusetts were available for analysis beginning with the second calendar quarter of 2001. The average family income per the applications for the period April through June 2001, was $10,329 with an average family size of 1.61. The average household income of these applicants was well below 133% of the FPL, with most applications stating that the person was ineligible for MassHealth. The collection of this data is still in a preliminary stage, and has not yet been checked for accuracy.

Age: (Non-Elderly)

Age Group	% Uninsured within Age Group
0-5 years	3.0%
6-18 years	2.9%
19-39 years	11.3%
40-64 years	4.9%
Total/Overall	***6.5%***

The highest rate of uninsurance in Massachusetts (8.0%) is found among non-elderly adults, 19 to 64 years old. Among all adults, the largest percentage of uninsured adults falls between the ages of 19 and 34 (56%). Persons between the ages of 19 and 24 have the highest rate of uninsurance overall (17%). The 25 to 34 year old population has the second highest rate of uninsurance (10.5%).

The lowest rate of uninsurance in Massachusetts (3.0%) is found among children 18 years old and younger. Most uninsured children are between the ages of 6 and 18 (68.0%). Between 1998 and 2000, the largest decreases (almost 50% each) in the uninsured by age group were found among the infant (1 year old or younger) and 6 to 12 year old populations. During this same time period, the uninsured rate for 2 to 5 year olds changed only slightly. This group has the highest rate of uninsurance (3.6%) among all children.

Analysis of the 2001 second calendar quarter of "free care" applications revealed age demographics consistent with the household survey. 78% of the applicants were between the ages of 19-64, and well over half of those applicants were age 19 to 39.

Gender: Similar to 1998 survey results, 60% of all uninsured are male. The rate of uninsurance among males is 7.8%, among females 5.2%. Interestingly, however, substantially more females

applied for "free care" during the period that was analyzed (55% compared to 45%). This finding is even more significant given that over 60% of uninsured hospital inpatients during 1999 were male (see section 1.1 below).

Family Composition: About 55% of uninsured adults have never been married. Uninsurance rates are the highest for the never married population (16%) and lowest for those who are married (3%).

Health Status: Uninsured adults are more likely than insured adults to rate their quality of health as fair to poor and are less likely to utilize health care services such as doctor visits. While the majority of uninsured children are reported to have good to excellent health, they are still three times more likely to experience fair to poor health than insured children and are less likely to utilize health care services.

Employment Status: The majority of both uninsured (71.7%) and insured (81.9%) adults are employed. The working uninsured, however, are nearly three times as likely to be self-employed as the working insured (29.4% compared to 10.9%). In fact, the percent of working uninsured that reported being self-employed doubled between 1998 and 2000, from 15% to 30%. The working uninsured also are less likely to work for the same employer for more than a year, and are less likely to work full-time. Additionally, over 76% of the working uninsured work for small establishments (fewer than 50 employees) compared to 34% of insured workers.

Availability of Private Coverage: Employers (which also includes the military, unions, and professional associations) provide insurance for over 80% of all Massachusetts residents under the age of 65. However, according to preliminary data from the DHCFP's 2001 Survey of Massachusetts Employers Regarding Health Insurance, the percentage of employers who offer insurance to their employees varies by establishment size. As of 2001, 94.4% of employers with greater than 50 employees offer health insurance (and 99.4% of employers with 250+ employees offer it), but only 63.4% of employers with between 2 and 50 employees offer coverage. A large percentage of uninsured workers work for small establishments and thus, the likelihood of insurance being available to them is substantially lower. The Massachusetts 2000 household survey revealed that only about 25% of all working uninsured reported being eligible for health insurance through their employers. Of the uninsured who are ineligible for health coverage through their employer, 80% reported working for small employers. Of the uninsured who are eligible for health coverage through their employer, about 70% reported cost as the primary reason for being uninsured.

Availability of Public Coverage: About 12% of all Massachusetts residents receive their health insurance coverage through the Commonwealth's Medicaid program, MassHealth. Between mid-1997 and late 2000 MassHealth's enrollment increased by more than 230,000 residents to reach its current level of nearly 800,000 people under the age of 65. There are several different types of MassHealth coverage plans. Each plan has its own set of eligibility rules and benefits, but in general, due to the generous expansions in eligibility criteria over the past several years, public coverage is available to pregnant women, disabled people and all children up to age 19 in households earning up to 200% of the FPL. Depending on employment and parental status, public coverage is available to adults in households earning up to 133% of the FPL, with

premium assistance available to those with incomes up to 200% of the FPL who work for qualified employers.

Race/Ethnicity: Comparing data from 1998 and 2000, the proportion of uninsured declined across all race and ethnic categories. Yet, Hispanic and black populations remain disproportionately uninsured (19% and 11%, respectively).

The Hispanic adult population has the highest rate of uninsurance (24.2%). The white and Asian adult populations have the lowest rates of uninsurance, 6.0% and 3.2% respectively. While the rate of uninsurance among black adults has remained relatively constant (17.1% in 1998, 16.2% in 2000), the uninsured rate for white adults has declined by almost one-third since 1998.

Despite having the highest rate of uninsurance among children (5.5%), Hispanic children exhibited the largest decline in the rate of uninsured, with a 47% decrease between 1998 and 2000. White and black children have nearly equivalent rates of uninsurance, 2.7% and 2.8% respectively. While the rate of uninsurance among black children has remained relatively constant, the uninsured rate for white children has declined by almost half since 1998.

Immigration Status: According to the 1999 National Survey of America's Families (NSAF), 86.9% of Massachusetts residents are U.S.-born, 6.4% are foreign-born naturalized citizens and 6.7% are foreign-born non-citizens. Although the survey estimates for insurance status by citizenship for Massachusetts were too small for valid comparison, the NSAF survey does reveal a difference between the 1999 uninsurance rates of U.S.-born adult Massachusetts residents (7.9%) compared to foreign-born adult Massachusetts residents (11.2%). However, Massachusetts' pattern in this regard is not nearly as dramatic as the national picture, in which 32% of all foreign-born adults are uninsured. There is a 14% uninsurance rate for foreign-born naturalized citizens and a 45% uninsurance rate for foreign-born non-citizens.

The 1999 NSAF data also revealed differences in income between U.S.-born and foreign-born Massachusetts residents. Of the foreign-born residents, 28% have family incomes below 200% of the FPL, compared to 16.3% of U.S.-born residents.

Another revealing finding from the NSAF was the breakdown of Massachusetts Hispanic adults into Hispanic subgroups: 33% of Massachusetts Hispanics are from Puerto Rico as compared to only 12% nationally. Although survey estimates were too low to determine the insurance status of Massachusetts Puerto Ricans, national data reveals that the uninsurance rate for Puerto Ricans is significantly lower (12%) than the rate for all other Hispanic subgroups combined (37%). The large proportion of Puerto Ricans in Massachusetts coupled with the likelihood that their uninsurance rate is comparatively lower than other Hispanic groups may explain the lower overall Hispanic uninsurance rate in Massachusetts as compared to the national rate. However, Hispanics in Massachusetts still have the highest rate of uninsurance among non-elderly adults (17.0% compared to the overall statewide rate for non-elderly adults of 6.5%).

The 1999 NSAF also asked immigrant adults how long they had lived in the United States: less than 3 years, 3 to 10 years or 10 years or more. Sixty-nine percent of Massachusetts immigrant adults have lived in the United States for ten or more years, another 22% have been in the U.S.

for 3 to 10 years and only 8% have been in the U.S. for less than three years. Again the survey estimates were too small to determine the insurance status of Massachusetts immigrant adults based on length of time in the country, but it is possible to look at the same variable nationally. The national survey results indicate a much higher percentage of uninsurance among immigrant adults who have been here for less than 3 years: 51% at less than 3 years, 44% at 3 to 10 years and 25% at 10 years or more. These national findings coupled with the relatively small percentage of Massachusetts immigrants that have been in the U.S. for less than 3 years may also contribute to the state's low uninsurance rate.

Geographic Location:

Through the Massachusetts 2000 household survey, Massachusetts researched geographic differences within the state using two approaches. One was to divide the state into 5 regions: Metro Boston, Northeast, Southeast, West and Worcester (located in Central Massachusetts). The other was to oversample 5 urban areas: Boston, Fall River/New Bedford in the Southeast, Lawrence/Lowell in the Northeast, Springfield in the West and Worcester in the central region of the state. The following presents the findings under each approach.

Regional Analysis: To measure uninsurance trends across the Commonwealth, the state was divided into 5 regions: Metro Boston, Northeast, Southeast, West and Worcester (located in Central Massachusetts). Most of the uninsured reside in the Metro Boston (32%) and the Southeast (20%) regions of the state. Another 20% reside in the Northeast sector of the state. The lowest percent of uninsured are found in the Worcester and West regions (12% each). Overall rates of uninsurance have declined in each region with the exception of the Northeast, where the rate remained constant since 1998 at 7%. The West saw the largest decline from 9.5% in 1998 to 5.8% in 2000.

Adults: The largest proportion of uninsured adults resides in the Metro Boston (32.2%) and Southeast (23.9%) regions of Massachusetts. The Southeast has the highest uninsurance rate among adults (10.1%).

Children: The largest proportion of uninsured children is also found in the Metro Boston (29.7%) and Southeastern (27.8%) regions of Massachusetts. Among the specific regions, the Southeast and Worcester areas have the highest percentages of uninsured children, with 4.1% and 4.0% respectively.

Urban Area Analysis: All of the five oversampled urban areas (Boston, Fall River/New Bedford, Lawrence/Lowell, Springfield and Worcester) had uninsurance rates higher than the overall statewide rate of 5.9%, ranging from 7.2% in Worcester to 10.0% in Lawrence/Lowell. A breakdown by age follows:

Percent Uninsured by Age

	All Ages	**0-64**	**19-64**	**0-18**
Boston	8.0%	8.5%	10.1%	4.2%
Fall River/New Bedford	9.2%	10.5%	13.1%	5.0%
Lawrence/Lowell	10.0%	10.5%	13.3%	5.2%
Springfield	8.4%	9.5%	12.7%	3.8%
Worcester	7.2%	8.2%	10.1%	3.9%
Statewide Rates	***5.9%***	***6.5%***	***8.0%***	***3.0%***

The uninsured had significantly lower incomes in each of the five urban areas than the statewide levels. A much higher percent of the non-elderly adult uninsured had incomes below 200% FPL than the incomes of residents statewide:

Percent Uninsured by Income (Ages 19-64)

	Below 200% FPL	**Above 200% FPL**
Boston	52.6%	47.4%
Fall River/New Bedford	61.5%	38.5%
Lawrence/Lowell	52.7%	47.3%
Springfield	65.4%	34.6%
Worcester	50.0%	50.0%
Statewide Rates	***42.0%***	***58.0%***

Analysis of the employment status of non-elderly adult uninsured revealed variations among the urban areas and between the urban areas and the statewide percentage. In comparison to the statewide percentage of 71.7% of non-elderly uninsured adults being employed, Fall River/New Bedford and Worcester had higher percentages employed at 78.9% and 76.5% respectively and Boston, Lawrence/Lowell, and Springfield had lower percentages employed at 70.9%, 67.1% and 68.5% respectively.

Analysis of the uninsured by race reveals different composites in the urban areas than on a statewide basis, with most of the urban areas having higher percentages of blacks and/or Hispanics making up the uninsured populations than statewide.

Duration of Uninsurance: Per the Massachusetts 2000 household survey, over 32% of all uninsured adults were covered by health insurance at one time within the last year, and another 32% were covered at one time within the last decade. A full 30% have never been covered.

Other:

Reasons for Loss of Insurance**:** Among the most frequently cited reasons for loss of insurance coverage was a change in job status (55%). Another 7% cited the cost of insurance, and 6% explained that leaving school was the reason for a loss of insurance.

Knowledge of Health Plans: More uninsured adults were aware of specific state health programs in 2000 than in 1998. Nearly 86%, compared with 79% in 1998, had heard of the Commonwealth's Medicaid program, MassHealth. Another 43% had heard of "free care" compared with 30% in 1998. Free care refers to the Massachusetts Uncompensated Care Pool, which reimburses hospitals and community health centers for the medically necessary care they provide to low-income uninsured and underinsured people.

According to a May 2001 report by the Urban Institute, 70% of Massachusetts parents of low-income children had heard of the Medicaid/SCHIP program, compared to 47% of parents nationally. These parents were also aware that they did not need to be on welfare to qualify for the program's benefits. Massachusetts had the highest level of "basic awareness and understanding" among the states surveyed. [1]

Housing and Economic Hardship: Not surprisingly, the 1999 NSAF survey indicated significant differences between Massachusetts insured and uninsured adults with regard to economic hardship. Massachusetts uninsured adults were found to be twice as likely as their insured counterparts to worry about running out of food and were three times more likely to have been unable to pay their mortgage or rent within the last 12 months.

1.3. Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

The Massachusetts 2000 household survey, combined with the other data sources reported above, revealed several groups that could be targeted. Consistent with recent expansions in MassHealth, we found that most uninsured people in Massachusetts living in moderate-income households (200-400% FPL) and working. Of those working uninsured, 75% were either not offered or were ineligible for employer-sponsored insurance, and the rest simply could not afford it. As a result, it was reasonable to develop options specific to this group.

In addition, the Massachusetts 2000 household survey revealed that over 40% of the uninsured resided in low-income households. Analysis of our free care application data indicated that the low-income applicants who appear to have been eligible for MassHealth based on income were "characteristically" or "categorically" ineligible for public insurance. That is, they were not pregnant, disabled, HIV positive, children or did not belong to some other "category" that would enable them to qualify. This group presents an opportunity to examine what changes could be

made to the eligibility requirements of public insurance programs to better cover our most financially needy. There may also be some outreach opportunities in this group, particularly targeted at minority populations. However, one must note that the state is still in the early stages of free care application data collection, therefore the results are preliminary and may change.

DHCFP data revealed that minorities were disproportionately uninsured and 1999 NSAF findings indicated that the state's immigrants were as well. Therefore, it was apparent that any option that was developed needed to include an outreach component specifically targeted at minority and immigrant groups in the urban areas in which they most likely live.

1.4. What is affordable coverage? How much are uninsured willing to pay?

A number of methodologies were explored in the process of defining affordability. The average dollar amount Massachusetts' residents are paying for health insurance as an indicator of affordability was pursued[2], as was using state employee premiums as a benchmark.[3] A report by the Commonwealth Fund, which suggested that premiums should total no more than 5% of a poor or near poor family's income was also reviewed.[4] In addition, information gathered in the Massachusetts 2000 household survey was examined to extract information regarding the willingness of the uninsured to pay for coverage.

Per the Massachusetts 2000 household survey, almost 83% of all uninsured adults are willing to pay something for low cost health care coverage. Of those willing to pay, 57% are willing to pay less than $100 per month for coverage and another 43% would pay $100 or more per month for coverage. When examining those willing to pay for care by household income, only 24% of the low-income uninsured (below 200% FPL) are willing to pay $100 or more per month for coverage. In contrast, 50% of uninsured individuals with incomes over 200% FPL are willing to pay $100 or more per month for coverage. This data is preliminary and based on a relatively small sample size. As a result, follow-up research activities are necessary.

Qualitative research, such as focus groups and comprehensive literature reviews (beyond what has already been completed), of the target population will be performed to further explore the issue of affordability and willingness to pay. The Access Project will provide assistance in this effort. The Access Project is a Robert Wood Johnson funded initiative that operates in partnership with Brandeis University's Heller Graduate School and the Collaborative for Community Health Development. The project seeks to improve access to health care and coverage for the uninsured. It is hoped that these research efforts will provide more information about the amount low-income individuals and families are currently paying for health care and what they believe is affordable.

1.5. Why do uninsured individuals and families not participate in public programs for which they are eligible?

Data collection and qualitative research are currently being performed in coordination with The Access Project.

1.6 Why do uninsured individuals and families disenroll from public programs?

Data collection and qualitative research are currently being performed in coordination with The Access Project.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

Per the Massachusetts 2000 household survey, of the 25% uninsured that reported being eligible for health insurance through their employer, 70% reported cost as the primary reason for being uninsured.

In addition, the literature overwhelmingly cites cost as the number one reason health care coverage is declined by eligible employees. However, there are other factors that influence an employee's decision to decline coverage. According to a 1996-97 household survey performed by the Center for Studying Health System Change, individual preferences, age, race, level of educational attainment and family composition, in addition to cost, are also potential determinants in the decision to accept or refuse employer-sponsored coverage.[5]

Individuals that identified themselves as strong risk-takers were more likely to decline coverage, as were young adults age 18 to 24. This may have resulted from the young adults' perception that health care would not be utilized enough at such an age to justify the coverage costs. Blacks and Hispanics were more likely to decline coverage, even when socioeconomic status was controlled for. The authors attributed this possibly to cultural reasons or lower average educational attainment. It is worth noting that jobs available to those with high school diplomas versus college degrees may offer less generous health care benefits. Finally, when family composition was analyzed, single individuals without children were the most likely to decline employer-sponsored coverage.

A May 2001 report by the Urban Institute explored why children who were Medicaid or SCHIP eligible were not enrolled in the programs. The report revealed that the most common reason these children were not enrolled was due to parents' "knowledge gaps". Parents lacked information and as a result assumed that their children were not eligible for the programs.[6] It is evident that the dissemination of accurate information is necessary to ensure that the greatest number of children are covered.

Data collection and qualitative research are also being performed in coordination with The Access Project.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Data collection and qualitative research are currently being performed in coordination with The Access Project.

1.9 How likely are individuals to be influenced by availability of subsidies? Tax credits or other incentives?

Data collection and qualitative research are currently being performed in coordination with The Access Project.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

A number of barriers that prevent the purchase of health insurance were revealed in the Massachusetts 2001 employer survey. In addition to lack of affordability, offer rates, establishment size, and characteristics (employee income and part-time status) of an organization's workforce were factors that impacted the ability of employees to purchase health insurance. Of Massachusetts establishments surveyed, 65.7% offer health insurance, the remaining 34.3% do not. Therefore, a number of employees may simply not be offered insurance at their place of employment. Also, the size of the establishment where one is employed may determine whether insurance is offered. Smaller employers (50 or fewer employees) were less likely to offer insurance than larger employers (more than 50 employees), 63.4% versus 94.4%. In addition, establishments with a large number of low-wage workers (earning less than $40,000 annually) were less likely to offer health insurance to their employees. Part-time employees are frequently excluded from coverage programs. Of employers offering insurance, 43.8% stated that part-time employees were not eligible for coverage programs. Affordability remains the greatest barrier to the purchase of health insurance, which was supported by employer survey findings and the literature reviewed.

Data collection and qualitative research are currently being performed in coordination with The Access Project to identify other potential barriers to the purchase of health insurance.

1.11 How are the uninsured getting their medical needs met?

Adults:

According to the results of the Massachusetts 2000 household survey, there remain distinct differences in the utilization of health care services among uninsured and insured adults. While most uninsured adults (58.8%) and insured adults (73.4%) reported needing medical care in the past 12 months, insured adults were 26% more likely to seek this care than were uninsured adults. Almost 60% of uninsured adults paid out-of-pocket for the most recent medical care they sought. Another 21% of uninsured adults received their care through a financing mechanism called the Uncompensated Care Pool (UCP). The UCP reimburses hospitals and community health centers for the medically necessary care they provide to low-income uninsured and underinsured people.

Outpatient Visits: Insured adults were almost twice as likely to visit a doctor than uninsured adults (84.6% versus 46.8%, respectively). Nearly 80% of insured adults made between one and ten visits to the doctor in the last year compared with only 43% of uninsured adults. While only a small percentage of all adults visited the emergency room in the last year,

uninsured adults (32.2%) were more likely to make one or more visits than insured adults (25.3%). It is striking that even when the rate of emergency room utilization is comparable for insured and uninsured adults (24% vs. 29% making 1-4 visits/year), insured adults are far more likely to make physician office visits. Since physician office visits are traditionally less costly than emergency room care, these findings suggest that the uninsured either lack access or opt not to access a continual source of health care due to barriers such as cost.

Dental Visits: Uninsured adults were less likely to visit the dentist than were insured adults (46.1% compared to 83.3%).

Hospitalizations: An analysis of the 1999 Massachusetts Uniform Hospital Discharge Data Set (UHDDS) for non-elderly adults revealed similarities as well as differences between the uninsured and insured populations for hospital inpatient visits. Overall, the proportion of non-elderly hospitalized adults who were uninsured (8%) was consistent with the Massachusetts state survey findings on the percent of non-elderly adults who are uninsured (also 8%).

- The average charge per hospitalization, however, differed between the two groups, with both the mean and median charges for uninsured hospitalizations well below that of the insured ($10,514 vs. $13,361 and $6,415 vs. $7,653 respectively).
- Of total charges, the uninsured discharges represented only 6.5% of the total dollars, although they represented 8% of the discharges.
- An analysis of length of stay found little difference between the uninsured and the insured (after excluding outliers, a mean of 4.2 days for the uninsured vs. 4.6 days for the insured and a median of 3 days for both).
- The nature of the admissions differed. An examination of the top ten DRGs (diagnosis related codes) for each group, excluding pregnancy related diagnoses and mental hospital discharges, showed both groups' lists being headed by psychoses; the number two and three spots, however, were decidedly different. Where uterine procedures and chest pain took those spots for the insured, opioid abuse and alcohol abuse were second and third for the uninsured (chest pain was fourth).
- The percentage of hospitalizations of the uninsured that were preventable (ambulatory care sensitive conditions) was only slightly higher than for the insured (12% compared to 10%). The preventable hospitalization rate per the population was much lower for the uninsured (7 per 1000 compared to 8.9 per 1000), perhaps substantiating the difference in care-seeking behavior between the two groups.
- As might be expected, the source of admission for the uninsured was more likely to be the emergency room (53% of uninsured hospitalizations compared to 39% of insured hospitalizations).
- The percent of hospitalizations that were categorized as "elective" was much lower for the uninsured than for the insured (13% compared to 24%).
- Also, as might be expected, a greater percentage of the uninsured were "discharged to home" (81% vs. 72% of the insured) than to another health care facility.
- Finally, a striking difference appeared upon analysis of gender. Consistent with the gender breakdown found among the uninsured through the household survey, 62% of uninsured hospital inpatients were male, while the gender breakdown of insured patients was fairly even with 49% male.

These utilization trends are significant considering the slightly higher number of uninsured adults with chronic or specific medical conditions or disabilities. About 13% of uninsured adults reported having a medical condition or disability; such as, back or neck problems or eye complications, compared with only 10% of insured adults. Slightly fewer uninsured adults reported a chronic medical condition lasting 3 months or longer that requires monitoring, than did insured adults (23.9% compared with 29.2%, respectively). Insured adults were one and a half times more likely to make visits to the doctor for a particular chronic medical condition than were uninsured adults. Furthermore, only 43% of uninsured adults, compared with 78% of insured adults, have taken a prescription for this condition in the past 3 months. Detailed tables compiled from the analysis of the 1999 UHDDS can be found in Appendix III.

Children:

Per the Massachusetts 2000 household survey, while about the same percentage of uninsured children (73.8%) as insured children (76.1%) reported needing medical care in the past 12 months, uninsured children were twice as likely not to receive this care. For the most recent medical care sought, 27.3% of uninsured children had their care paid for through the Uncompensated Care Pool, suggesting that cost is a likely barrier.

Despite physician recommendations, uninsured children were less likely to visit a doctor than insured children (34.2% versus 11.7%, respectively). Over 80% of insured children made between one and ten visits to the doctor in the last year, compared to only 60% of uninsured children. While only a small percentage of all children visited the emergency room in the last year, the percentage of uninsured children (29.2%) that made one or more visits was similar to that of insured children (27.8%). Since emergency room services are not viewed as a "regular" source of care, it is interesting to note that the percentage of uninsured children visiting emergency rooms is comparable to that of insured children. This is especially striking since the percent of visits made to physicians by uninsured children is dramatically lower than the percent of visits made by their insured counterparts.

Consistent with national findings and similar to uninsured adults, uninsured children, age 3 and older, were also less likely to visit the dentist than were insured children. Almost 20% of uninsured children, compared with 12% of insured children, did not visit the dentist in the past year.

The overall trends in health care utilization by uninsured children, like uninsured adults, are particularly disconcerting considering the slightly higher number of uninsured children with chronic or specific medical conditions or disabilities. About 13% of uninsured children reported having a medical condition or disability, such as asthma or attention deficit disorder, compared with only 7% of insured children. About 16% of uninsured children have a chronic medical condition lasting 3 months or longer that requires monitoring, compared to 14% of insured children. Uninsured children are less likely to receive treatment for the particular condition than are insured children. 15% of uninsured children versus only 1% of insured children did not visit a doctor in the past three months for their condition. Similarly, 44% of

uninsured children compared with 32% of insured children did not fill a prescription for this condition in the past 3 months.

Analysis of a Local Population's Outpatient Visits:

Boston Medical Center (BMC) is the highest volume provider to the uninsured in Massachusetts. BMC accounted for 26% of the total charges submitted to the Uncompensated Care Pool by hospitals for Pool Year 2000. BMC served on the Advisory Committee of this grant and made their outpatient data available for limited analysis. BMC provided several spreadsheets based on outpatient claims for four payer categories that represented uninsured patients. The four payer categories were "self-pay," "homeless," "CareNet," and "free care." [Free care represents those charges eligible for reimbursement to the hospital by the state's Uncompensated Care Pool; CareNet is a managed care program administered by BMC for uninsured patients ineligible for Medicaid which is funded by the Uncompensated Care Pool.]

BMC outpatient data was analyzed to learn which health services the uninsured sought on an outpatient basis. BMC provided demographic data by payer category and the top ten areas of health service activity by number of visits for the fiscal year October 1, 1999 through September 30, 2000. It should be noted that the data was supplied by one service provider for one year, providing a limited snapshot of activity.

Interestingly, in contrast to the higher percentage of adult males than females without insurance per the household survey and an even higher percentage being admitted to the hospital per the discharge data, the BMC data revealed a higher percentage of adult females seeking care in an outpatient setting. Consistent with other data sources, most of the patients, 65.8% at BMC, were single. The majority of the patients listed English as their primary language (62.4%), followed by Spanish (12.4%), Haitian (5.4%), Portuguese (2.6%), Port Creole (0.9%), and Arabic at (0.7%). For those reporting their race/ethnicity, 42% were black, 17% were Hispanic and 16% were white.

Total visits for all four payer categories were combined and ranked by most utilized service area:

Most Utilized Service Areas	**Total Visits**	**% of Total Visits**
Primary Care	22,277	8.7%
ER	17,765	6.9%
Urgent Care	14,130	5.5%
Dental	14,116	5.5%
Pediatrics	12,137	4.7%
Women's Clinic	11,333	4.4%
Physical Therapy	7,134	2.8%
Family	6,604	2.6%
E Specialties[7]	6,461	2.5%
Laboratory	5,307	2.1%
All other	138,354	54.1%
Total Visits:	***255,618***	***100.0%***

A break down of service area ranking by payer category (self-pay, homeless, CareNet, and free care) revealed some differences between the groups. For example, for both the homeless and free care categories, dental visits topped the lists. For the self-pay group, emergency room visits were the highest, making up 11.2% of visits.

Physical therapy had the highest number of visits per patient at 3.2. The Women's Clinic and the Family Clinic had the second largest number of visits per patient at 2.0 each, and the Primary Care Clinic had the third largest number of visits per patient at 1.5.

1.12 What is a minimum benefit?

The Commonwealth of Massachusetts has a number of general laws requiring insurers operating in specified insurance markets to cover certain health care benefits. The laws regulate services and supplies, providers, contracting arrangements, eligibility requirements, and prohibit discriminatory practices against providers and the insured. Please see Appendix XV for the Massachusetts Division of Insurance's complete list of laws pertaining to mandated benefits. In addition, the nongroup health insurance market is regulated by the stipulations outlined in the Massachusetts Nongroup Law of 1996, which requires that a minimum set of standard benefits be covered by insurance carriers offering a nongroup product. Please see Section 3 for more detail on nongroup and small group insurance benefits.

Data collection and qualitative research are also being performed in coordination with The Access Project on this issue.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Data collection and qualitative research are currently being performed in coordination with the Access Project on this issue.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The purpose of this section is to document your state's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the state?

In an effort to gain an understanding of how the rising cost of health insurance affects the purchasing behavior of employers, employees and their families, the Division of Health Care Finance and Policy (DHCFP) developed an employer health insurance survey of Massachusetts establishments conducted by the University of Massachusetts Center for Survey Research. At the time of this report, 800 employers were surveyed. An additional 200-300 more employers will be surveyed in upcoming weeks. The sample, from Dun and Bradstreet, was randomly selected and stratified by size of establishment. It excludes all federal and state government agencies and town government offices including legislative offices and direct functional agencies such as police and fire. All schools are classified as educational, not governmental; therefore, they are included in the sample along with public libraries. The survey is primarily being administered by telephone, however if an employer is unavailable after multiple attempts by phone, the survey has been mailed to them to try to elicit a response. Please see Appendix XI for a link to the survey instrument.

The Division of Health Care Finance and Policy received a preliminary, weighted sample of data at the end of September (800 employers), which is being used for this report. The weight used for this report is based on employer size at the establishment level. During the grant extension period, further analyses will be completed on the entire data set although we do not expect results to change significantly.

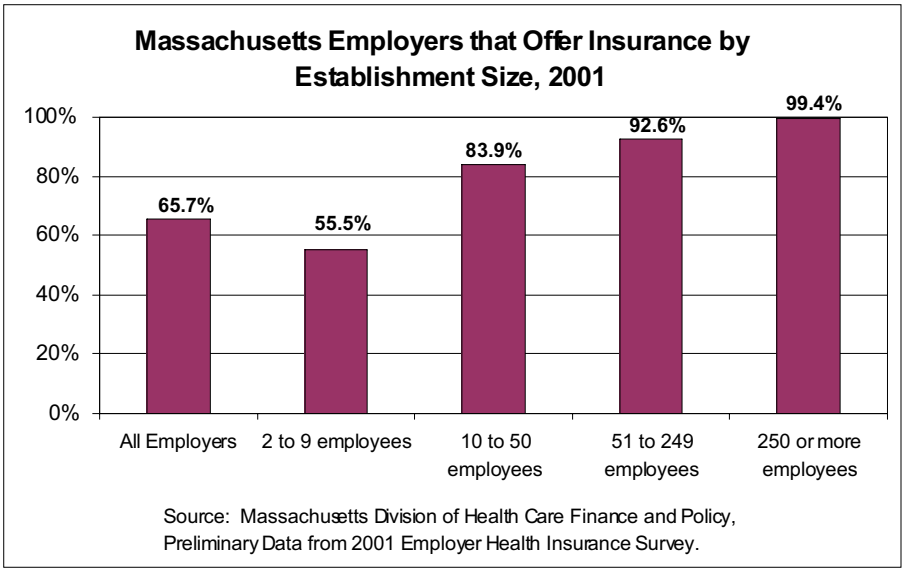
For additional information on the employer market in Massachusetts, the state looked to employer-sponsored health insurance data from 1996 through 1999 collected by the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS) of private-sector employers in Massachusetts. This data acts as a supplement as well as a point of comparison to the state's own data. Appendix IV includes much of the analysis from the MEPS data. In addition, Appendix IV provides some information from the Massachusetts Division of Employment and Training regarding the number of establishments in the state by firm size and the number of employees in establishments by firm size.

Note: *The data cited in Section 2, unless otherwise indicated, are derived from preliminary results from the DHCFP 2001 Survey of Massachusetts Employers Regarding Health Insurance. Neither the MEPS data nor the preliminary Massachusetts 2001 employer survey data include people who are self-employed without any employees. Therefore, the smallest employer size for both surveys is two.*

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Note: *The Massachusetts 2001 employer survey is a survey of establishments in Massachusetts, therefore all preliminary data pertains to establishments (a single location) as opposed to firms.*

Employer size: Preliminary data from this year show that 65.7% of the employers in the Commonwealth of Massachusetts offer insurance coverage to their employees (the types of employers included in the sample are described above—the sample primarily includes private-sector establishments). Generally, employers that do not offer insurance coverage have fewer employees. Only 63.4% of employers with 50 or fewer employees offer insurance, whereas 94.4% of employers with greater than 50 employees offer it. When employers are placed into even smaller size categories, as in the graph below, the difference in offering insurance by employer size is even more pronounced.

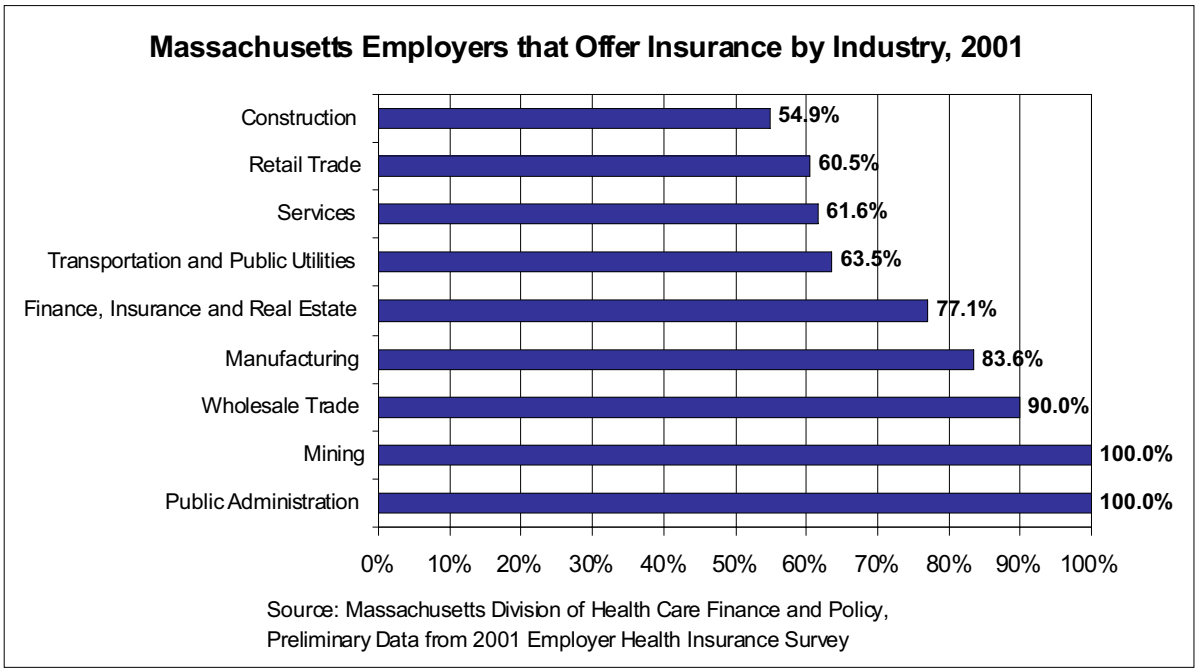


The two most common reasons small employers (those with between 2 and 50 employees) offered for not offering coverage were that insurance premiums were too high (65.5%) and that most employees were covered under other plans such as through Medicaid, a spouse or a union (59.6%).

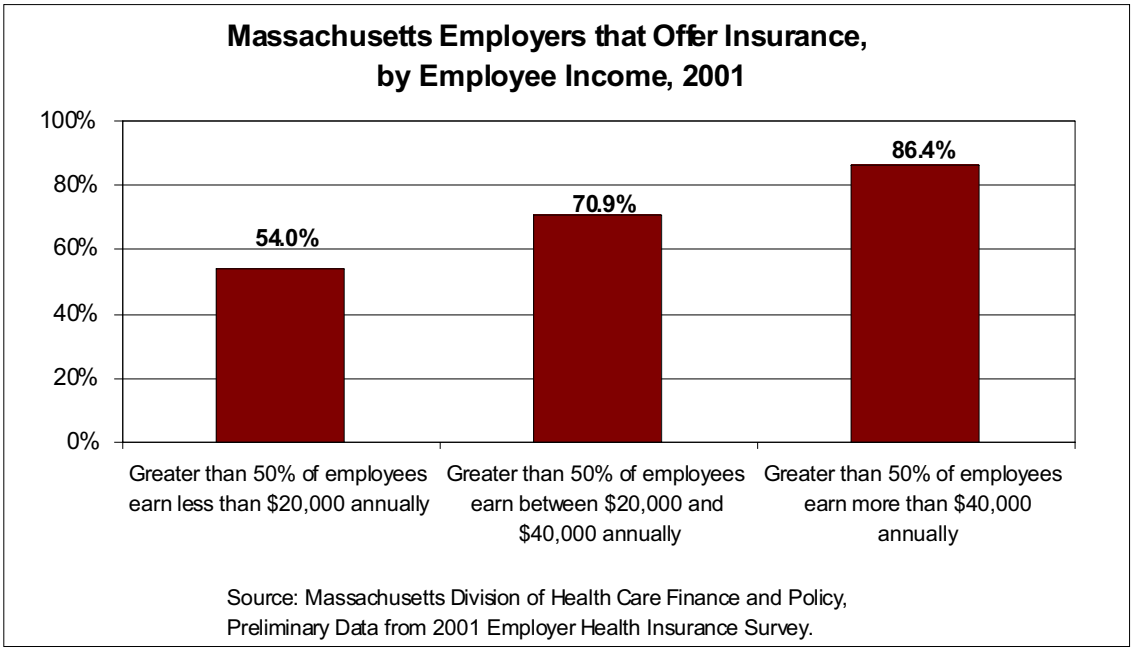
MEPS data indicated that in 1998, 63.9% of Massachusetts employers offered coverage and in 1999 that number increased slightly to 65.7% (the same percent as this year's data show).

Industry sector: Coverage rates vary by industry. In Massachusetts, the public administration and mining industries have the highest offer rate at 100% of employers (although there are very few mining operations in Massachusetts and sample sizes for these industries are low). The wholesale trade industry has the second highest offer rate at 90% of employers. Construction has the lowest rate at 54.9%. However, unions were not surveyed, so their coverage was not included which might partially account for the low offer rate in the construction industry. (Please see Appendix I for a list of the primary industries in Massachusetts.)

The 1999 Medical Expenditure Panel Survey (MEPS) found that only 54.5% of Massachusetts employers in the agriculture, fishing, forestry and construction industries offered insurance, while 89.2% of the employers in the manufacturing and mining industries offered it. Sixty-six percent of employers in the retail/other industries offered coverage, while 60.4% of employers in the services industry offered it. These offer rates are similar to the state's 2001 employer survey findings (which are shown in the graph below).



Employee income brackets: Data from MEPS and the preliminary data from the Massachusetts 2001 employer survey show that in Massachusetts there is a relationship between the wage of employees and whether or not the employer offers coverage. Employers with a large number of low-wage workers are less likely to offer health insurance coverage. Those with a greater percent of high-wage workers (defined as more than $40,000 per year) are more likely to offer health insurance to employees. *Note: The Massachusetts 2001 employer survey asked the employer to estimate how many or what percent of their employees earned less than $20,000 per year, between $20,000 and $40,000 per year and greater than $40,000 per year. Therefore, the following data are derived from these estimates.*



In addition, 1999 MEPS data show that 52.3% of employers with 50% or more low-wage employees (defined as employees who make $6.50 per hour or less) offer health insurance and 65.2% of employers with less than 50% low-wage employees offer insurance.

Percentage of part-time and seasonal workers:

Preliminary data from the Massachusetts 2001 employer survey found that 43.8% of employers offering coverage do not offer it to part-time employees. Sixty-one percent of employers who do not offer insurance to certain types of employees (e.g. part-time, seasonal, temporary, etc) answered that part-time status was the most common reason for an employee to not be offered health coverage.

Type of Employee	Offered Coverage	Not Offered Coverage	No such Employees
Part-time	30.3%	43.8%	25.6%
Temporary	3.7%	34.1%	62.0%
Seasonal	2.9%	20.1%	76.7%
Hourly	62.4%	11.3%	25.6%
Union	74.3%	7.1%	17.1%

The survey also asked respondents how many hours an employee must work to be eligible for health insurance, and results indicate that employers require employees to work an average of 30.3 hours per week to be eligible.

The Massachusetts 2001 employer survey did not differentiate between part-time and full-time employees when asking how many workers were employed by the organization (the two were combined). However, MEPS data show that in 1999, 71.1% of Massachusetts employers with 75% or more full-time employees offered health insurance but only 43.3% of employers with 50% or fewer full-time employees offered it. These findings illustrate that it is more likely for an employer with a large percent of full-time employees (and therefore fewer part-time, seasonal or temporary employees) to offer health insurance than an employer with fewer full-time and more part-time staff.

(Please see Appendix IV for MEPS data on the percent of part-time and full-time employees who are offered health coverage in Massachusetts.)

Geographic location: In order to examine employer-sponsored insurance coverage by geographic location, Massachusetts was divided into five regions (Metropolitan Boston, Northeast Massachusetts, Southeast Massachusetts, Western Massachusetts, and Central Massachusetts). One important thing to note is that the sample of employers for the survey was only stratified by the size of the establishment, not by geographic location. Therefore, since the largest concentration of businesses in Massachusetts is in Metropolitan Boston, there are more employers in the sample from that region.

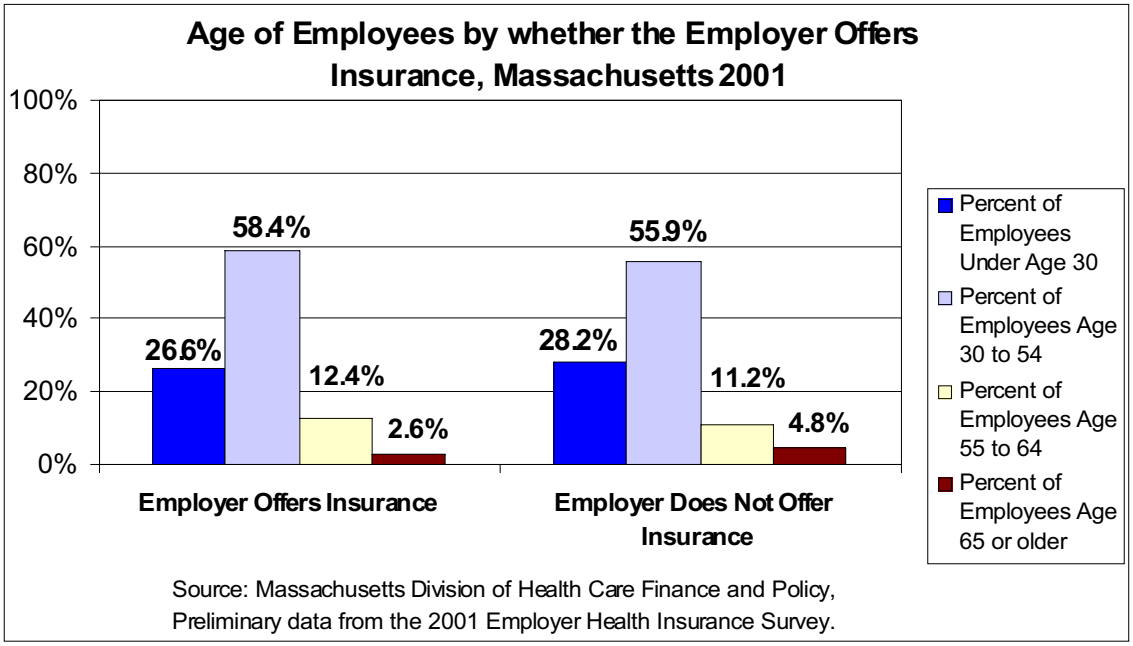
The Massachusetts 2001 employer survey found that employers in Metropolitan Boston and Northeastern Massachusetts are most likely to offer health insurance coverage to employees, at 70.2% and 72.3% respectively. Central Massachusetts (66.2%) and Western Massachusetts (65%) also had relatively similar offer rates. However, 49.8% of the employers in the Southeast region of Massachusetts offer coverage. According to the 2000 Massachusetts Household Survey, the Southeast also has the highest rate of uninsurance of people aged 0 to 64 at 8.2%.

Metropolitan Boston was found to have a slightly higher percent of employers offering insurance than the rest of the state as a whole (70.2% versus 63.0%).

Age: In general, the Massachusetts 2001 employer survey found that there is virtually no difference in the age of employees working for employers that offer insurance versus employers that do not offer insurance. Approximately the same percent of workers aged 55 and older work for employers that do and those that do not offer insurance.

Slightly more employees under age 30 work for employers that do not offer insurance (28.2%) than those that do offer insurance (26.6%), while fewer employees between 30 and 54 work for employers not offering coverage (55.9%) than those that do offer coverage (58.4%). These differences may not be statistically significantly different.

The data were also examined to determine whether a correlation exists between age of employees and the size of the establishment in which they worked. There was no difference found in age of employees between establishments with fewer than 50 employees and those with 51 or more.



Gender: The Massachusetts 2001 employer survey found that the proportion of males and females working for employers that offer insurance is the same as the proportion of males and females working for employers that do not offer insurance. Within organizations that offer insurance, 46.4% of employees are female while 53.6% are male; and within organizations not offering insurance, 46.8% of employees are female while 53.2% are male.

The data also show that there is no correlation between the gender of employees and the size of the employer where employed.

Cost of policies: Employers reported that the average annual premium cost of single (individual) health insurance coverage for employers' most popular insurance plan (the plan with the most enrollees) increased by 13.9% from twelve months ago. Last year the average annual premium cost for single coverage under the most popular plan was $2,964, while this year that annual premium was $3,376. The survey found that the average premium for family coverage under the employers' most popular plan rose by 21.2% from twelve months ago, a significant jump from $6,277 to $7,605. (For the purposes of this premium cost examination, a family has four members.)

Level of contribution: Generally, the survey found that employees pay a larger portion of family coverage than they do for single (individual) coverage. The employee share of the premium for single coverage is currently 17.7% of the total premium (17.1% twelve months

ago). This year, employees paid an average of $49.80 per month or $597.60 per year for single coverage, while last year employees paid an average of $42.12 per month or $505.44 per year for single coverage. Therefore, those employees with individual coverage only absorbed a small amount of the premium increase.

However, the employee share of the premium for family coverage increased considerably from twelve months ago, from 22% to 27.5%. The employee absorbed more of the premium increase for family coverage. This year, employees paid an average of $174.06 per month or $2,088.72 per year for family coverage, while twelve months ago employees paid an average of $114.91 per month or $1,378.92 per year for family coverage.

According to 1999 MEPS data, 42.5% of all Massachusetts establishments offering coverage offer at least one plan for single coverage that requires no employee contribution, and 31.1% of establishments offering coverage offer at least one plan for family coverage that requires no employee contribution. It is interesting to note that employers with fewer than 50 employees are more likely to offer a plan with no employee contribution required (55.9% offer one for single coverage and 43.1% offer one for family coverage) than employers with 50 or more employees (only 16.7% offer one for single coverage and 10.7% offer one for family coverage). It would be interesting to see if this is true in other states.

Percentage of employees offered coverage who participate: The Massachusetts 2001 employer survey found that 78.3% of employees who are eligible for employer-sponsored coverage actually enroll in that coverage. Or, approximately 1,900,528 employees in the private-sector are enrolled in employer-sponsored coverage in the Commonwealth of Massachusetts (number does not include dependents). Most (85.9%) of the employers answered that the take-up rate has remained constant over the past three years. Only 4.3% answered that fewer employees were taking up insurance over the past three years and 9.8% answered that more employees were taking up insurance during that timeframe.

Approximately twenty percent of employers offering coverage require an employee to provide proof of coverage from another source before they are allowed to refuse the coverage offered by the employer.

Waiting period: More than half of all employers that offer insurance coverage (61.3%) have a waiting period before new employees are covered by health insurance. Two-thirds of employers with a waiting period have one that is greater than one month.

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

The Massachusetts 2001 employer survey specifically asked employers the reasons that influenced their decision not to offer health insurance. High premiums were the most common reason an employer gave (65.6% of employers called this reason "very important" in the employer's decision to not offer coverage). Employees generally being covered under other plans (such as through a spouse, union or Medicaid) ranked second in employers' decisions not to offer coverage (60.1%). The fact that most employees are part-time, temporary or seasonal

ranked third (44.7% of employers named this as very important in making their decision to offer coverage).

The following table lists the possible reasons for not offering insurance and the percent of employers answering how important the reason was in their decision not to offer insurance coverage. The reasons are listed in the order of the highest percent of employers responding "very important" to the lowest.

	Very Important	Somewhat Important	Not Important At All
Premiums are too high	65.6%	14.6%	16.0%
Employees generally covered under other plans (spouse, Medicaid, union, etc)	60.1%	17.6%	21.0%
Most employees are part-time, seasonal, temporary, etc.	44.7%	9.8%	44.4%
Financial status of organization prohibits it at this time	40.4%	15.7%	42.7%
Can attract good employees without offering coverage	17.2%	22.9%	57.3%
Organization is too newly established	16.4%	7.6%	74.8%
Employee turnover too high	15.9%	19.1%	61.1%
Providing coverage is an administrative hassle	14.1%	12.5%	72.3%
Either past negative claim or catastrophic cost	7.5%	3.6%	86.3%

2.3 What criteria do offering employers use to define benefit and premium participation levels?

Will pursue at a later date.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Currently, the entire country is experiencing an economic downturn and premium costs are on the rise. The state has seen some employers pass on more health insurance and health care costs to employees by raising the employee premium contribution and also increasing co-payments, coinsurance and deductibles that employees pay. The Massachusetts 2001 employer survey asked whether employers have changed the overall design of the most popular health plan over the past twelve months to expand benefits, reduce them, or install certain cost-control measures. The survey found that 27.1% of all employers offering insurance increased the co-payment for physician services (slightly fewer (22.5%) of the employers with over 50 employees did so). Of all employers offering insurance, 36.6% answered that they had introduced a new pharmacy co-payment structure such as a tiered structure as a cost control measure (no difference in answer by

size of employer). Only 4.1% of employers answered that they reduced benefits over the past year, while 11.5% answered that they had increased benefits (more employers with over 50 employees increased benefits (15.7%) than those with 50 or fewer employees (10.9%)).

The state has not completed other research in this topic area, although it is anticipated that if the economy continues to decline and costs continue to rise, more employers would pass on at least some of the additional costs to their employees.

2.5 What employer and employee groups are most susceptible to crowd-out?

Employers with a large number of low-wage employees are most susceptible to crowd-out because their employees might become eligible for state and/or federal programs designed for low-income residents. The challenge for policymakers is to create an environment that encourages private-market coverage perhaps by partially subsidizing low-wage employees and employers while possibly expanding eligibility for some public programs. By doing so, hopefully only those with low-incomes and without access to other coverage (such as employer-sponsored insurance) would enroll in a new or expanded program, thereby limiting crowd-out.

Massachusetts already has a program called the Insurance Partnership (IP), which makes health insurance more affordable for qualified small businesses (those with 50 or fewer employees who cover at least 50% of the premium cost) and their employees. Massachusetts is examining this program closely to determine whether changes to this program are warranted. (Please see Section 4.)

Focusing on sustaining and increasing the rate of employer-sponsored coverage while simultaneously widening eligibility requirements for certain public programs would provide a needed balance. By concentrating on both, hopefully low-wage earners will be encouraged to enroll in employer-sponsored insurance with the help of subsidies instead of pursuing coverage through a public program. (For more information on the Insurance Partnership, please see the following website: www.state.ma.us/dma and click on Information for Businesses).

2.6 How likely are employers who do not offer coverage to be influenced by expansion/development of purchasing alliances, individual or employer subsidies, additional tax incentives, etc?

Only 19.2% of employers not currently offering insurance had offered health insurance to employees at some point in the past. These employers estimated that they had stopped offering coverage an average of 6.1 years ago. Only 12.3% of the employers not currently offering coverage responded that it was "very likely" that they would begin to offer coverage during the next two years, whereas 57.6% responded that it wasn't likely at all (27.7% answered "somewhat likely"). Therefore, one might assume that a fairly significant change in the insurance market or the economy would have to take place for them to begin to offer coverage.

Expansion/development of purchasing alliances?: Purchasing alliances are not likely in Massachusetts due to a number of reforms to our nongroup and small group markets. Massachusetts reformed its small group insurance market and the state has insurance

intermediaries that act as purchasers for member small employers. However, these intermediaries generally only reduce the administrative hassle of providing insurance and do not reduce the cost to the small employer.

Despite the above information, the Massachusetts 2001 employer survey asked employers who do not offer insurance coverage whether the implementation of a small business purchasing alliance would motivate them to offer insurance. Of those responding, 31.4% answered that it was "very likely" to motivate them to offer insurance, 25.6% answered it was "somewhat likely" and 34.2% answered that it was "not likely at all."

Individual or employer subsidies?: As explained in the answer to question 2.5, Massachusetts has a program called the Insurance Partnership (IP) which makes insurance more affordable for employees and employers by providing subsidies to employers for low-wage employees working for qualified employers. Of the employers who were aware of the IP and who had 50 or fewer employees, 42% responded that the IP subsidies were too low.

Of employers not offering insurance, 39.8% answered that a government subsidy of premiums for low-income employees would very likely motivate them to start offering coverage, 21.6% answered it would motivate them somewhat, and 36.1% answered it would not be likely to motivate them to offer coverage.

Additional tax incentives?: Over 70% of employers not offering coverage answered that tax credits for offering health insurance would be "very likely" (46.1%) or "somewhat likely" (26.6%) to motivate them to offer coverage. Only 26.1% answered that tax credits were "not likely at all" to motivate them to offer insurance.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Currently, a carrier in Massachusetts could choose to require a minimum employee participation rate for small employers which cannot exceed 100% for a group of 5 or fewer and 75% for a group of 6 or more. Employers not offering coverage were asked if eliminating the carrier's option of having minimum participation levels would motivate them to offer coverage. About a third (36.1%) answered that it was "very likely" to motivate them to offer coverage and 26.2% answered that it was "somewhat likely" to motivate them to offer coverage, while 31.9% answered that it was "not likely at all" to motivate them to offer coverage.

Employers not offering coverage were asked whether being able to offer a very basic catastrophic hospital-coverage plan would motivate them to offer coverage and two-thirds answered that this was "very likely" or "somewhat likely" to be a motivator.

Finally, approximately 75% of employers not offering coverage answered that lower premiums would be very likely or somewhat likely to motivate them to offer coverage; however, 25% still responded that lower premiums would not be likely at all to motivate them to offer coverage.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Several sources were used in researching the health care marketplace in Massachusetts. Findings from the Division of Health Care Finance and Policy's (DHCFP) Nongroup Insurance Survey (2001), DHCFP's 2001 survey of Massachusetts Employers Regarding Health Insurance, DHCFP's Massachusetts Physician Survey (2001) and DHCFP's Massachusetts Community Health Center Survey (2000) were analyzed. In addition, reforms to Massachusetts state laws regarding the small group and nongroup health insurance markets were examined. Data from the Massachusetts 2001 employer survey is considered preliminary as DHCFP is expecting additional surveys to be completed in the coming weeks. Please see Appendix VII to XV for additional information regarding the survey instruments and results, and Massachusetts state laws.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

Several factors were considered in our definition of adequate, as a result of information gathered in surveys of subscribers and employers, and through a review of minimum coverage requirements stipulated by the Massachusetts Division of Insurance in its regulation of the nongroup insurance market.

Adequacy as defined by regulation: Massachusetts nongroup laws require that carriers of nongroup insurance products offer a minimum set of standard benefits. These benefits include "reasonably comprehensive physician services, inpatient and outpatient hospital services, emergency health services, the full range of effective clinical preventive care, and prescription drugs administered on an outpatient basis."[8] Nongroup products must also include all state-mandated benefits.

No minimum set of benefits is required for the small group market or the remainder of the fully insured market in Massachusetts. Yet the passage of the federal Health Insurance Portability and Accountability Act and mandated benefits laws at the state level make it somewhat safe to assume that the coverage offered in those markets is adequate. The survey results described below address issues and concerns regarding adequacy of coverage from the point of view of the subscriber and the employer.

Adequacy as defined by subscribers and employers:

Subscribers

The Division of Health Care Finance and Policy surveyed 5000 Blue Cross and Blue Shield of Massachusetts (BCBSMA) and Harvard Pilgrim Health Care (HPHC) nongroup policyholders in July of 2001. As of September of 2001, 33.8% (1,691) of the surveys were completed and returned to the Division. The Division sought to learn more about the demographics and experiences of individuals and families participating in the nongroup health insurance market.

Policyholders were surveyed and asked to rate their satisfaction with the coverage and price of their plan. The amount of out-of-pocket expenses reported by policyholders in the household and nongroup survey was also examined. Large out-of-pocket expenses may indicate a problem

with adequacy; however, expenses would have to be considered in relationship to household income and the nature of the expense, i.e. a large out-of-pocket expense for cosmetic surgery would not necessarily indicate that a plan was inadequate.

There were slightly more females responding to the survey than subscribers (68% versus 61%). Also, respondents to the survey tended to be older than the average age of subscribers illustrated by the fact that 58% of respondents were 50 years of age and older compared with 46% of subscribers. In addition, a response bias may exist if those who responded to the survey were more involved or concerned with issues related to their health insurance coverage at the time of the survey's completion. The effect of this potential bias is unknown.

The majority of respondents were enrolled in a health maintenance organization (HMO 89%), followed by a preferred provider organization (PPO 9%) and a point of service plan (POS 1%). There was no notable difference in level of satisfaction by plan type. Most policyholders (76%) were "very satisfied" or "somewhat satisfied" with the coverage provided by their plan. Only 9% reported feeling "dissatisfied" or "very dissatisfied". Of that 9% there were no notable differences among income groups.

Almost two-thirds (62%) of the respondents felt that they were paying "much too much" for their premiums, and 31% believed their premiums cost a "little too much". The median monthly premium paid was $416; the mean was $554. In Massachusetts, premiums paid in the nongroup market can be rated by age of the subscriber; hence, since the respondents to this survey tended to be somewhat older than the nongroup subscriber population for these two insurers, these premium costs could be a little higher than those for a younger population. However, nongroup subscribers do tend to be an older population overall.

Policy Coverage	**Median Premium Paid Per Month**
Single	$340
Couple (individual and spouse)	$768
Family (2 parents and children)	$751
Family (1 parent and children)	$500

Median monthly payments were lower for HMOs ($416) than for PPOs ($526). POS and indemnity plans had too few subscribers to calculate reliable medians. Two-thirds (67%) estimated that their out-of-pocket medical expenses were under $1,000, but 16% paid $1,000 to $1,999, and 17% paid $2,000 or more. Three-quarters of those who paid over $2,000 in out-of-pocket expenses rated their monthly premiums as costing "much too much".

Employers

The Massachusetts 2001 employer survey asked benefits buyers a series of questions designed to explore the "adequacy" of their most popular health plan (the plan with the most enrollees). Of the employers who offered coverage, 57.7% stated that their most popular plan was also the least expensive plan for the employee. 29.1% reported that the most popular plan was not the least expensive plan for the employee, and 13.3% did not know.

The majority of the most popular self-funded and fully insured plans provided coverage for maternity care, well-child visits, inpatient and outpatient mental health services, substance abuse treatment, and mammograms. Contraception (47.0% of the plans covered) and infertility treatment (36.0% of the plans covered) were less likely to be reported as covered under the plans. However, these numbers may be misleading, as the employers completing the survey may be unaware of specific benefits covered by their establishment's most popular plan. For example, 40.1% of employers did not know whether contraceptives were covered by the plan and approximately half of them, 51.1%, did not know if infertility treatments were covered. An examination of the policies themselves would have been necessary to ensure the most accurate results.

Of the employers surveyed that offered health insurance, 93.2% of the most popular plans included prescription drug coverage. Of those plans, 25.1% had a maximum annual out-of-pocket amount above which insurance paid for all of the costs of prescription drugs. Some of the plans (8.8%) had a maximum annual out-of-pocket amount above which the insurance plan did not cover prescription drugs, but the majority (91.2%) did not.

Co-payment amounts for physician office visits and emergency department visits were also examined to explore the issue of adequacy. According to the employers surveyed, the mean co-payment for a physician office visit was $10.59. The mean co-payment for a visit to the emergency department was $34.88. Co-payment amounts for prescription drugs varied; the mean co-payment was $7.97 for a generic drug, was $14.44 for a preferred plan drug, and was $30.05 for a non-preferred plan drug.

Many would have also included provider choice in their definition of adequacy. However, in Massachusetts this is not considered a significant problem due to each plan's extensive network and the considerable overlap of practitioners among plans. The majority of insured people in Massachusetts have a broad choice of practitioners.

Adequacy of Products for Persons of Different Income Levels: For individuals and families with incomes low enough to be eligible for MassHealth (Massachusetts Medicaid), coverage also may be considered adequate. The MassHealth Standard benefit package covers a wide range of health care services, including dentist visits and prescription drugs. The MassHealth Basic benefit package also covers a broad number of services, although it is not as comprehensive as the Standard package.

Persons with income levels that exceed MassHealth eligibility requirements, but whose incomes are too low to afford private insurance have the biggest problem obtaining coverage, and make up the majority of Massachusetts uninsured. State law limits the premium rates for nongroup and small group policies to no more than two times the lowest rate in the same geographic area; therefore, premiums generally are similar for small employers and most subscribers in the nongroup market, although they might be slightly higher in the nongroup market for some subscribers. In all likelihood, the reasons that nongroup coverage may be difficult for some Massachusetts residents at certain income levels to afford include: 1) subscribers in the nongroup market are paying for the entire premium without a premium contribution from an employer, and

2) since premiums in the nongroup market can be rated by age, older people would have to pay higher premiums which could become unaffordable for some.

Adequacy of Products for Persons with Pre-Existing Conditions: In Massachusetts, nongroup and small group laws address pre-existing conditions, complementing HIPAA. Pre-existing condition limitations or exclusions may not last more than six months and the carrier cannot "look-back" more than six months into the patient's medical history. Credit for immediately prior continuous coverage must be given. Also, a waiting period may not be imposed on a new employee who had coverage under a previous qualifying health plan immediately prior to or until employment in the small business.

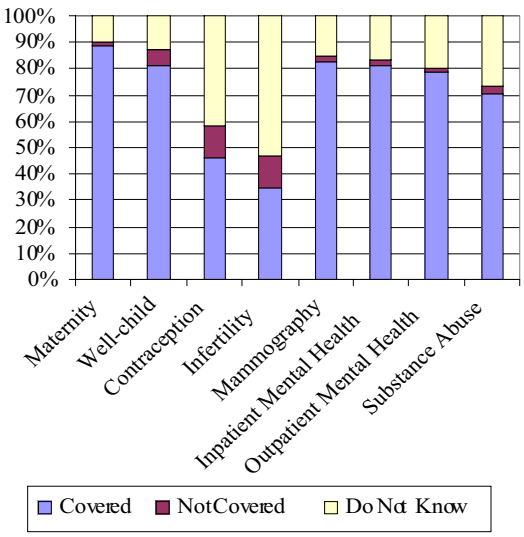
3.2 What is the variation in benefits among nongroup, small group, large group and self-insured plans?

Most of the information on benefit variation among plans was obtained through the Massachusetts 2001 employer survey and the nongroup subscriber survey. The nongroup market, as described in section 3.1, is the only market in which a minimum set of benefits and cost-sharing requirements is specified by Massachusetts' law. The benefits mandated by the law are quite broad (please see Appendix XV). Self-funded plans, including MassHealth and some Group Insurance Commission offerings, are the only health plans that are not required to include each of the state mandated benefits in their plans.

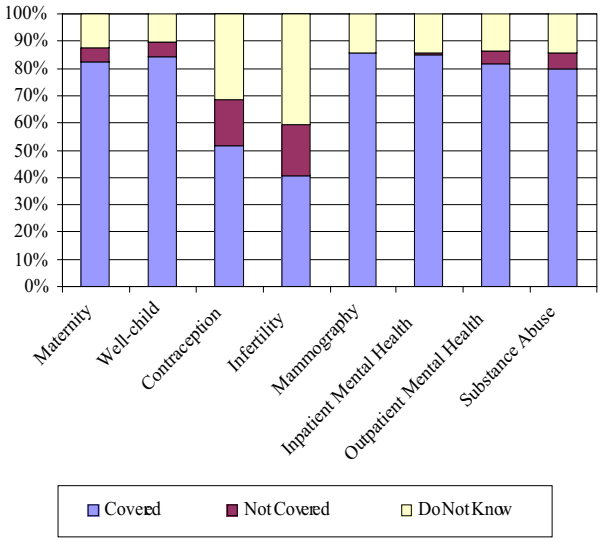
Massachusetts 2001 employer survey results regarding an establishment's most popular health plan were analyzed to determine if there were notable benefit variations between self-funded and fully insured plans. It is important to remember that the information gathered regarding benefit variation is preliminary and relied on the knowledge of the person answering the survey. As a result, the benefit variations cited below may change slightly as the data is refined, and as more surveys are returned and included in the analysis.

Sizable differences were not detected among the plans. The majority of self-funded and fully insured plans provided some type of prescription drug coverage, 93.5% of fully insured and 91.6% of self-funded employers. Most also provided coverage for maternity care, well-child visits, mammograms, and mental health and substance abuse treatment. A sizable number of employers lacked information regarding contraception and infertility treatment coverage for both fully insured and self-funded plans. The following tables provide additional information regarding benefit variation by service or treatment type and plan.

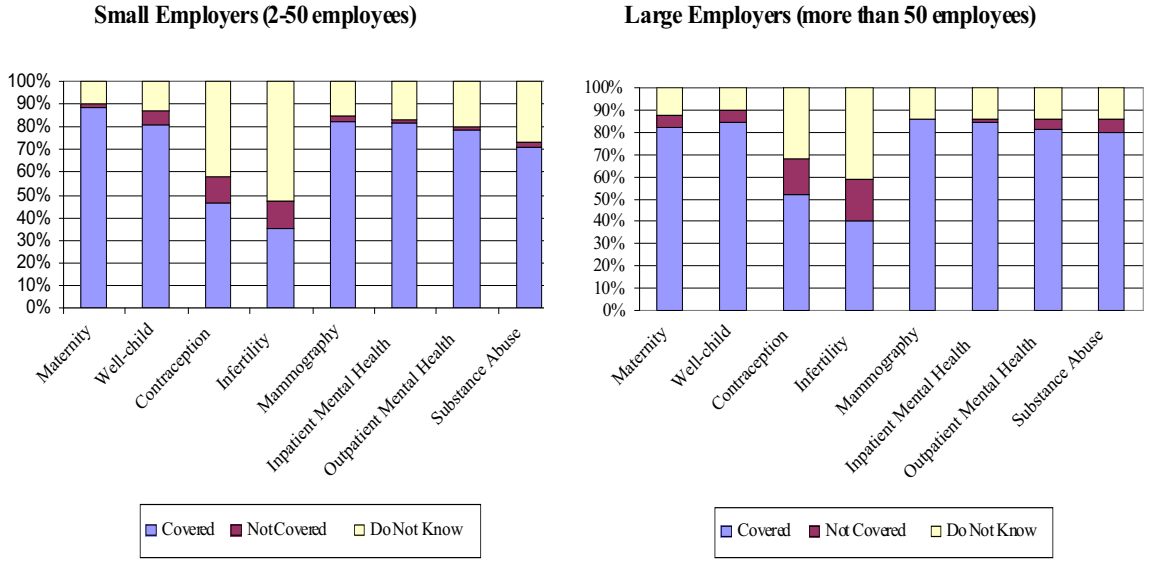
Fully Insured Plans



Self-funded Plans



Data on the types of benefits covered was also examined by employer size. Establishments with 2 to 50 employees were considered "small employers" and establishments with more than 50 employers were considered "large employers". Employers from small establishments, more frequently than employers from large establishments, did not know if a particular service or treatment was covered. This may be a result of the tendency of small employers not to employ full-time benefit coordinators. Therefore they lack a staff member that is familiar with the particulars of the organization's health care policies. The majority of the most popular plans offered by small and large employers provided some type of prescription drug coverage, 92.6% of small employers and 98.5% of large employers. The majority of large and small employers' most popular plan also included provisions for maternity care, well-child visits, mammograms, and mental health and substance abuse treatments. Both small and large establishments appeared to lack information regarding a policy's provision for contraception and infertility treatments. The following graphs provide additional information on employer size and benefit coverage:



3.3 How prevalent are self-insured firms in your state? What impact does that have in the state's marketplace?

Per the Massachusetts 2001 employer survey, 32% of all employees enrolled in an employer-sponsored plan are enrolled in a self-funded plan, even though only 14.5% of the employers surveyed offer at least one self-funded plan. This is because larger employers (with more employees) tend to self-fund, yet there are fewer large employers.

Employers that self-fund also were queried about their purchase of stop loss insurance, a lack of which could be a sign of trouble for employees and health providers if an employer experiences significant financial hardship. Surprisingly, only 23.7% of employers who have at least one self-funded plan purchase stop-loss insurance. However, this may be due to the small number of employers offering a self-funded plan that were included in the sample, or a lack of knowledge regarding stop-loss insurance on the part of the individual completing the survey.

Very little data are available on self-funded plans (the Division of Insurance is not required to collect information on these plans). However, given that nearly a third of Massachusetts residents are enrolled in a self-funded plan, it will be important to monitor such plans in the future.

3.4 What impact does your state have as a purchaser of health care?

After the federal government, the Massachusetts Medicaid program and the Group Insurance Commission (GIC) are the largest purchasers of health insurance in Massachusetts. The GIC purchases benefits for all active and retired state employees. These two purchasers combined represent more than 1 million covered lives in a state whose total population is just over 6 million. Therefore, the actions of these two purchasers have a substantial impact on the marketplace.

The Massachusetts Medicaid program and the GIC are active members of the Massachusetts Healthcare Purchaser Group. Both participate in the initiatives of the Leapfrog Group, which is a national organization comprised of Fortune 500 companies and other large health insurance purchasers. The Leapfrog Group promotes improvements in patient safety and health care quality. Both purchasers also participate in the New England HEDIS Coalition, a group that promotes the use of quality measurements in healthcare purchasing decisions. The Massachusetts Medicaid program and the GIC were early proponents of managed care. Their contractual arrangements have had much to do with the state's extremely high managed care penetration rate.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

Please see Section 4 for a description of the various options.

3.6 How would universal coverage affect the financial status of health plans and providers?

The effect of universal coverage on our health plans and providers would largely depend on how universal coverage was obtained, i.e. through expansion of public programs, increased private coverage, etc. Massachusetts has very few citizens who remain uninsured. Currently, 365,000 individuals do not have health care coverage. As a result it is unlikely that the addition of these lives to existing publicly and privately insured rolls, spread across health plans and providers, would have a dramatic effect. However, if those 365,000 people were all added to one program or a small number of programs, the impact could be significant.

An examination of the effect on the state's safety net providers is specifically warranted. Massachusetts has an Uncompensated Care Pool (the "Free Care Pool"), which is financed by an assessment paid by all Massachusetts acute care hospitals based on their gross patient revenues; a surcharge paid by every insurer levied on each hospital bill issued by a Massachusetts acute care

hospital; and a lump-sum payment made by the Commonwealth. This fund reimburses hospitals and community health centers for the medically necessary care of the uninsured and underinsured who meet certain eligibility criteria.

Differences exist between Massachusetts hospitals regarding the number of uninsured they serve. Hospitals that serve relatively few uninsured patients contribute more funds to the Free Care Pool than they receive back in reimbursement. As a result, hospitals that treat a large number of uninsured patients receive a greater proportion of the Free Care Pool funds. Universal health insurance would probably not obviate the need for the Pool, but it would certainly lessen the hospitals' dependence on it.

3.7 How did the planning process take safety net providers into account?

Safety net providers played a large role in the planning process of the HRSA state grant. Massachusetts has done a number of things to ensure that safety net providers are included in the planning process of reform efforts. The Commonwealth's community health centers were surveyed in the spring of 2000 by DHCFP to assess the impact of previous state reform efforts on their operations. In addition, Massachusetts physicians were surveyed to gain a greater understanding of their role as safety net providers. Finally, the Massachusetts Uncompensated Care Pool (described in section 3.6) is analyzed annually by DHCFP to ensure efficient and effective fund distribution, and to ensure quality, cost-conscious care is available to the state's uninsured and underinsured residents.

Community health centers are one of the state's most important safety net providers. The number of community health centers in Massachusetts declined from 56 in 1990 to 46 in 1999, despite a 93% increase in the number of visits to these centers in the same time period.[9] DHCFP's 2000 survey results of 29 community health centers revealed that the level of debt of these organizations has almost doubled between FY 1994 and FY 1999. 40% of the health centers reported that there had been an increase in the number of uninsured clients they served between 1994 and 1999. Currently, community health centers rely on a limited number of sources for funding. It is evident that the financial stability of community health centers must continue to be monitored. In addition, community health centers must be considered in the formulation and implementation of reform efforts.[10]

DHCFP worked with the Massachusetts Medical Society to develop a survey of practicing physicians to measure the amount and type of free, discounted and self-paid care provided to patients in their offices. The survey was sent to 8000 primary care and specialist physicians, with an over-sampling of the former. Hopefully upon further analysis the results will provide information about the type of ambulatory care uninsured and underinsured people seek out, as well as the care they may pay for out-of-pocket even while insured. In addition, the data should provide general information regarding the role of safety net providers in the care of the uninsured.

Almost 11% (n=874) of surveys were returned as of September, when the survey concluded. Physicians, as opposed to office staff, filled out most (89%) surveys. The top five medical specialties accounted for 67% of respondents and 69% of all physicians sampled. These included

internal medicine (23% and 33%), pediatrics (16% and 13%), psychiatry (9% and 9%), obstetrics-gynecology (10% and 7%), and family medicine (8% and 7%).

Most (81%) practices accepted new patients regardless of their ability to pay. Almost all (95%) practices currently have patients who do not have health insurance. An estimated 8% (mean) of their patients were uninsured. Almost all (94%) of the practices reduce or waive fees for patients who are uninsured and have financial hardship. However, most (73%) have no formal mechanism for determining a patient's financial hardship.

Most (80%) practices inform patients about the availability of public assistance programs, and 42% assist patients with determining MassHealth eligibility and/or completing a MassHealth application.

Well visits (59%) and sick visits (17%) were the most frequent services practices provided to uninsured patients on a free or discounted basis last year.

3.8 How would utilization change with universal coverage?

Universal coverage would surely influence utilization patterns, which was demonstrated by the recent Medicaid expansion in Massachusetts, thereby affecting our safety net providers. As a result of the expansion of Medicaid, community health centers saw a downturn in utilization of their services as newly insured individuals accessed a wider range of providers. These health centers, with few reserves and virtually no others payers to cost shift to, would be jeopardized by an exodus of their long-time patients. Finally, overall utilization would probably increase at first due to a "pent-up demand" for services by the previously uninsured. This increase in demand would be expected to level off.

3.9 The experience of other states:

Historically, Massachusetts has looked to other states for guidance in policy and program development for the uninsured population. However due to the great strides the Commonwealth has made in reducing the number of residents who lack health care coverage, the state has emerged as a leader in this area. Expansion of the state's Medicaid program, the development of the Insurance Partnership, and legislative activity surrounding the small and nongroup markets, have contributed to a reduction in the number of Massachusetts' uninsured to only 5.9% of the population. Massachusetts will continue to examine other states when developing health care policies, as their experiences may provide valuable information and direction, but it worth noting that an increasing number of states have started to look to the Commonwealth for answers.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. Those states that have not reached a consensus on a coverage expansion strategy may answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The state researched potential options and has completed preliminary data analysis. The recommendations noted below reflect some synthesis of the options. These recommendations are preliminary in that we have not finished our data analysis and expect to have more refined recommendations in the upcoming months. The recommendations include:

- Continue, and improve, efforts to attain full enrollment of all currently eligible Massachusetts residents into existing public programs;

- Recommend that the federal government provide tax deductibility for the taxpayer's full cost of health insurance for self employed and those without access to employer sponsored health insurance; and tax credits in amounts that would significantly defray the cost of purchasing health insurance, to lower-income people in the same circumstances[11];

- Recommend that the federal government increase allotments to further encourage states to expand SCHIP to parents of children covered through SCHIP when those parents have access to employer sponsored health insurance;

- Recommend that preference be given, in the bidding process for state contracts, to organizations that both offer health insurance and pay for at least 50% of premiums;

- Encourage commercial development of catastrophic insurance plans when combined with medical savings accounts;

- Develop an educational approach to inform consumers of all of their health insurance coverage options; and

- Adopt as a long-term objective the redesign of the administrative system supporting eligibility and enrollment activities for all state[12] programs that would enable people to apply for all social service programs at once through any of multiple points of entry.

Continued Analysis of Viable Options: We have not completed our qualitative data collection and analysis of the cost impact of the recommended options. At this juncture we are recommending that the following actions be taken to enable us to complete the analysis of the remaining options in time for the final report to HRSA:

- Complete data analysis in order to recommend programmatic changes to the Insurance Partnership to increase the participation of employers and employees;
- Complete the data analysis necessary to make further recommendations for covering those populations for which, through its contracts, the state has a "special responsibility;"
- Complete qualitative analyses to learn more about why people currently eligible for publicly sponsored health insurance do not apply or enroll in these programs; and
- Project the impact (in dollars and number of people affected) of removing or modifying MassHealth's categorical eligibility requirements at various income levels.

For answers to questions 4.2 through 4.17, please refer to the approaches that follow. Each approach overview addresses these questions.

Full Enrollment of Currently Eligible

[This approach, in its entirety, is included in our preliminary recommendations as described in question 4.1.]

Maximize outreach and enrollment activities to enroll all Massachusetts residents that are currently eligible for existing public programs. Target the outreach activities to groups with a high uninsured rate including minority populations.

Target Population

The target populations are all those -- adults, children, insured, uninsured and especially minority populations -- who currently fall within income and categorical guidelines for existing programs.

Mechanism

How will the program be administered?

Focus group and other research activities would be employed to study the barriers that currently exist to enrollment and develop strategies to more effectively enroll Massachusetts residents. However, there are currently strong DMA and provider initiatives that would continue. One avenue currently underway at both the Division of Medical Assistance and Department of Public Health ensures outreach to those not currently enrolled and retention of those MassHealth members who are currently enrolled. The Project for Health Care Access Mini-grant Program (Mini-grants) is a collaboration between the Department of Public Health and the Division of Medical Assistance. Mini-grants are awarded to community-based organizations throughout Massachusetts to help develop and operate outreach programs. The outreach programs inform at-risk populations about eligibility for MassHealth and CMSP. The programs also provide application and other assistance for enrollment and assistance in completing redetermination forms for maintaining coverage in publicly funded programs.

DMA also currently employs outreach workers, who visit such sites as hospitals, doctor's offices and schools to assist residents with applications. Providers often have their own staff that assist residents with completing applications or directing them to assistance. Both of these practices would continue under this option.

Also, the Express Renewal Pilot is a streamlined redetermination process for those currently enrolled in MassHealth and who have had little or no change in their circumstances during their eligibility.

How will outreach and enrollment be conducted?

The mini-grantees use various methods for outreach, including attending health fairs, visiting community centers, visiting door-to-door, and collaborating with schools, charitable organizations, etc. Enrollment processes in place would continue.

How will services be delivered under the expansion?

Services would continue to be delivered in the same way as currently delivered.

What methods for ensuring quality will be used?

Quality will continue to be monitored through evaluations of the mini-grantees as well as an evaluation of the Express Renewal Pilot.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer based coverage)? How will crowd-out be avoided and monitored?

As the residents enrolled under this option are currently eligible for public programs, private sector options and crowd-out would not be an issue.

What enrolment data and other information will be collected by the program and how will the data be collected and audited? How (and how often) will the program be evaluated?

Mini-grantees are required to submit monthly reports on their activities, which include information on types of outreach conducted that month, approximate number of residents reached, number of referrals to programs other than MassHealth and CMSP, and number of MBRs submitted. One formal evaluation of the program has been completed.

Since Express Renewal is considered a pilot program, an evaluation will be conducted at the completion of the pilot. Some items to be reviewed would include the number of MassHealth members that used the Express Renewal process and how many members stay enrolled.

Finally, standard member services enrollment reports would continue.

Impact

What impact would the option have on the current healthcare market?

If outreach is successful, more people would be enrolled in public programs. Therefore, there would be an increased cost to the state. In addition, some crowd-out might occur when newly reached people that are already insured transition to less expensive public coverage for which they are eligible.

How would the option affect health plans and providers?

This option could increase the number of enrollees with providers and plans that contract with the public programs. To what extent this would affect service is unknown.

Would utilization change?

Ideally, the utilization would move away from emergency or inpatient care to primary care and outpatient care, as residents would be continuously enrolled in a health plan.

Advantages

- The advantage of this option is that it is intended to reach those that are eligible for existing programs therefore; no systematic changes would be necessary to implement. It does not require a change in policy considerations, as these programs are operational. Financially, by enrolling these residents in MassHealth or CMSP the option would decrease the burden on hospitals and non-hospital providers who provide free/discounted care.
- Another advantage of this option is that by reaching out to and retaining enrollees, health status among the enrollees might improve.
- Finally, by having full enrollment of those currently eligible for public programs, it will be easier to identify those Massachusetts residents that remain uninsured as truly uninsured.

Limitations

- The financial limitation of this option is that budgets are developed based on an estimated take-up rate of those eligible for these programs. Full enrollment would put constraints on an already tight budget and/or may force decision-makers to reduce expansions or the full range of services covered by MassHealth.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

Any premium sharing requirements would be as they currently exist in Family Assistance and CommonHealth Programs.

What is the projected cost of the coverage expansion? How was this estimate reached? (Include the estimated public and private cost of providing coverage.)

To be determined.

How will the program be financed?

Additional funds will need to be allocated through the budget process. Any changes to the budget would need to remain within the limits of state budget neutrality requirements.

What strategies to contain costs will be used?

Quality and cost control mechanisms currently employed would continue.

Extent to which Principles are Met

This option builds on the following principles and assumptions: the state should provide equal access to public insurance assistance, all those currently eligible not matter the reason would be enrolled. We are mindful of the impact of our recommendations on the currently insured and on those who purchase insurance on their behalf. This option only affects those that are eligible for MassHealth and CMSP, therefore not affecting those who are insured. The use of already existing programs directed at the most financially needy meets that principal to target the most financially needy. This approaches also builds upon existing public and private health insurance financing mechanisms, particularly the maximization of federal dollars.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc.

Current enrollment data will be collected by the Division of Medical Assistance. Take-up rates are also being researched to determine a feasible "full enrollment." Also, qualitative analysis of barriers to enrollment currently is being conducted by The Access Project.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

This option is basically implemented, however, additional staff focus and funds may be required if targeted programs such as the mini-grants and Express Renewal continue.

Tax Incentives: Individual/Family

[This approach, in part, is included in our preliminary recommendations as described in question 4.1.]

Currently 60% of a health insurance premium is federally deductible for those who are self-employed. For the federal tax year beginning in 2002, the deductible will increase to 70%. After tax year 2002, the federal government has authorized another deductibility increase, which will make the full cost of a self-employed taxpayer's health insurance premium deductible (100%).

This option recommends the expansion of the federal government's provision for the deduction of the full cost of health insurance (currently only the self-employed qualify) to include all individuals/families that lack access to employer sponsored health insurance. In addition, tax credits in amounts that would significantly defray the cost of health insurance to low-income individuals in similar circumstances are recommended.

Note: A refundable tax credit is given if the credit amount exceeds the taxpayer's tax liability. The taxpayer would be sent a check for the difference. Current Massachusetts tax law limits individual tax to "Not less than 0" (see Form 1 Massachusetts Resident Income Tax Return – line 28).

Target Population

Incentives would be available to self-employed individuals, and those individuals and families who lack access to employer-sponsored health insurance and do not qualify for existing public programs.

Mechanism

How will the program be administered?

The program would be administered through the same mechanisms currently used for tax incentives, by the Internal Revenue Service and at the state level by the Massachusetts Department of Revenue.

How will marketing/outreach and enrollment be conducted?

Tax incentives of this magnitude would receive wide press coverage. Tax practitioners would be informed of the incentives through existing channels. If necessary, television and radio public service announcements could be developed and targeted at the populations most eligible for the incentives. Consumer advocacy groups, community health centers, and other relevant providers could also publicize information regarding the incentives.

How will services be delivered under the expansion?

New tax incentives would require no change in the delivery of health services.

What methods for ensuring quality will be used?

Not applicable.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer based coverage)?

Tax incentives would enhance the affordability of all existing coverage options for eligible taxpayers. Self-employed taxpayers and taxpayers without access to employer-sponsored insurance would be able to defray the cost or a portion of the cost of the premiums paid for nongroup and small group policies.

How will crowd-out be avoided and monitored?

The possibility that taxpayers already covered in any market would move to a different product/market to take advantage of a tax incentive is highly unlikely. However, if the incentives were available to all taxpayers below, for example, 400% FPL, regardless of insurance status, those taxpayers already purchasing insurance through the small or non-group market would likely avail themselves of the credit to the maximum allowed. As a result, the incentives would reduce private contributions to health insurance premiums, replacing them with public funds.

Including individuals and families that do not have access to employer-sponsored insurance would be challenging to monitor and would increase the likelihood of crowd-out. In fact, the Commonwealth already decided, with the institution of its Premium Assistance Plan and the Insurance Partnership, that direct subsidies were more efficient and effective than tax incentives, specifically tax credits. (This program is only available for those working for participating small employers who offer health insurance and self-employed people.)

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

No additional data and information gathering activities would be performed. Existing Internal Revenue Service and Massachusetts Department of Revenue procedures for data collection and auditing would be utilized.

How (and how often) will the program be evaluated?

The impact of the tax incentives both on the ranks of the uninsured and on the state budget would be calculated annually at the conclusion of the tax-filing season. The tax return itself would serve as the data collection tool, with a new separate schedule created for filing tax incentives.

The new "Schedule HIC" would include check-off boxes indicating the taxpayers' insurance status prior to paying for the health insurance eligible for the deduction or credit.

What will the benefits structure be (including co-payments and other cost-sharing)?

Not applicable.

Impact

To be determined. It is not known how many previously uninsured taxpayers would be sufficiently enticed to take advantage of the incentives and therefore purchase health insurance in the small group or nongroup markets. According to the Pauly and Herring article noted below, "The strength of risk aversion turns out to be a relatively minor determinant of what proportion of people buy insurance. What is much more important is the expected amount of out-of-pocket expense; this value is reduced considerably by access to free care by the uninsured [italics added]." In Massachusetts the uninsured have access to a variety of safety net providers, and as a result tax incentives may not sufficiently promote the purchase of health insurance.

What impact would the option have on the current healthcare market? How would the option affect health plans and providers? Would utilization change?

Not applicable.

What are the political or policy implications?

Similar to this option, many tax incentive proposals call for a partnership between states and the federal government, requiring policy changes at both the state and federal level. According to these proposals, state and federal revenue would finance tax incentives for the purchase of health insurance. Federal and state cost sharing would make this a more affordable option for Massachusetts. In addition, administration at the federal level would reduce discrepancies in state and federal taxable income guidelines. It would also allow for the uniform regulation of the health insurance products that could be purchased with the credit, "states could chose either to adopt the federal 'default' system of regulation or to agree with the federal government on a functionally similar state-designed rate regulation system."[13]

However, the size of a tax incentive necessary to make a significant impact on the number of uninsured must be very high, especially with regards to a tax credit. For example, many argue that typical tax credit amounts are insufficient, and as a result premiums remain unaffordable to low-income individuals and families.[14] It is unlikely that the size of the tax incentives necessary to make a large impact on Massachusetts' uninsured, even in conjunction with activity at the federal level, will be politically feasible given the present economic climate.

In addition, a tax policy change of this magnitude at the state level rather than at the federal level, is daunting given the potential overall cost (see Financing below for estimate.) The lopsided fiscal commitment combined with the uncertainty of its effectiveness in reducing the number of uninsured may seem to some policymakers like an expensive gamble. Attempting to

limit the type of taxpayers who are eligible for the incentives may also invoke equity concerns. Finally and most importantly, maintaining the tax incentives during lean federal and state budget years may prove difficult.

Advantages

- Tax incentives are a "simple straightforward tool. They do not require changing the health care regulatory structure, negotiating with providers, reorganizing the delivery system, or altering the philosophy of medical treatment...They do not require enormous investment in fixed administrative structures, which are difficult to change later in the face of experience, and their financial design parameters can be modified easily and quickly."[15]
- Low-income populations would be able to purchase insurance like everyone else. A buy-in to a Medicaid product would not be necessary and there would be no need to complete Medicaid eligibility paperwork.
- Benefits both working and non-working individuals.
- If Congress passes additional federal tax incentives, the combination could make health insurance affordable.

Limitations

- State tax incentives rely on activity at the federal level.
- Loss of state tax revenues would be great (see "Financing" below).
- Tax incentives may not help very low-income.
- Massachusetts has generally believed that direct subsidies are a better way to pay for insurance than tax incentives because of the complexity of the tax system.

Financing

What will enrollee (and/or employer) premium sharing requirements be? What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.) How will the program be financed? What strategies to contain costs will be used?

Data is currently being gathered to determine the costs and financing mechanisms associated with this option at the state and federal level.

Extent to which Principles and Assumptions are Met

- This approach would not build upon the systems, structures, etc. that already exist in Massachusetts.
- This approach fits with the principles and assumptions developed by the steering committee, but it may make more sense to make changes to the Insurance Partnership.
- This approach would foster independence and self-reliance.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

- Cost estimates at the state and federal level associated with the tax incentive will be performed.
- Conduct focus groups to learn if consumers would take advantage of the incentives.

Expand Family Assistance to All Parents of Eligible Children

[Approach B was made part of the preliminary recommendations as described in question 4.1.]

This option would expand Family Assistance to all parents of eligible children. Two approaches are offered under this option.

Approach A would extend eligibility to all parents, regardless of their access to ESI. Currently, parents of children eligible for MassHealth and who have access to qualified employer sponsored insurance through a small employer are eligible for MassHealth Premium Assistance. Parents with access to qualified employer sponsored insurance through a large employer, however, obtain premium assistance by default, because in order to enroll their children in ESI they must purchase dual or family coverage. Thus, some parents (working for a large employer) gain coverage by default, while others (working for a small employer) are intrinsically eligible for MassHealth. And, parents without access to ESI with income between 134% to 200% FPL, whether working for a large or small employer, are not eligible for MassHealth benefits, though their children are eligible for coverage under Family Assistance Direct Coverage. In order to expand the number of parents eligible for coverage, and to end the inherent inequity in making eligibility for coverage dependent on either access to ESI, or the size of their employer, Approach A would extend coverage to all parents in the 134% to 200% FPL income-range. Under this option, those who were uninsured when they sought MassHealth eligibility may be eligible under SCHIP rules, while those who were insured at the time of application would be covered under the 1115 waiver. This option would necessitate requesting an amendment to the 1115 waiver, and requesting a waiver under the SCHIP State Plan.

Approach B would limit the expansion to Family Assistance Premium Assistance, and would include all eligible parents with access to ESI regardless of the size of their employer. Currently, only parents who work for small employers and have access to qualified ESI are eligible for MassHealth Family Assistance benefits, while parents who work for larger employers only receive coverage by default by virtue of the fact that their children are eligible. As a result, MassHealth is limited in its ability to market and outreach to parents in this income range, and is only able to claim FFP for the children of parents with access to ESI through larger employers, though the entire family unit benefits from premium assistance.

Target Population

What is the target eligibility group under the expansion? Describe in terms of findings from household, employer survey, or other source(s) – and cite source of estimate. The Working Group will determine methodology for identifying populations.

The target eligibility group under this option is the parents of eligible MassHealth children. Under *Approach A*, parents between 134% and 200% FPL would be eligible for Family Assistance, either Direct Coverage or Premium Assistance. Under *Approach B* the expansion would be limited to those with income between 150% and 200% PL who have access to ESI, regardless of the size of their employer's workforce.

Mechanism

How will the program be administered?

MassHealth would administer the program as an expansion of Family Assistance, upon receipt of federal approvals that would be required.

How will marketing/outreach and enrollment be conducted?

Marketing/Outreach and enrollment would be conducted through MassHealth Member Services.

How will services be delivered under the expansion?

Parents would be eligible for Family Assistance Premium Assistance [directly or through contractual arrangements] for enrollment in ESI regardless of the size of their employer under both *Approach A* and *Approach B*, or for Family Assistance Direct Coverage, under *Approach A* only.

What methods for ensuring quality will be used?

MassHealth quality assurance activities would encompass this expansion.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer based coverage)?

The expansion of Family Assistance to parents of eligible children would be commensurate with existing programming.

How will crowd-out be avoided and monitored?

Parents with access to ESI would be required to enroll in their employer's coverage. DMA has developed a process for assessing the adequacy of ESI to ensure it meets DMA and CMS requirements.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

All MassHealth applicants are required to complete an MBR, with the information collected and audited in a standardized manner. All newly eligible parents would be counted as MassHealth enrollees, where previously some were only receiving Family Assistance Premium Assistance benefits by default.

How (and how often) will the program be evaluated?

There are several mechanisms through which MassHealth programs and activities are evaluated. These include outside evaluations conducted by CMS, as well as a range of other evaluation activities, including collaborative activities conducted with the Center of MassHealth Evaluation and Research, at UMASS Medical School.

What will the benefits structure be (including co-payments and other cost-sharing)?

The benefits structure, including co-payments and other cost-sharing requirements, would be the same as those already defined for Family Assistance.

Impact

What impact would the option have on the current healthcare market?

Expansion of Family Assistance to include parents of eligible children as envisioned under *Approach A* would result in a significant increase in the number of adults receiving MassHealth Family Assistance Direct Coverage benefits and enrolled ESI through Family Assistance Premium Assistance.

Expansion of Family Assistance Premium Assistance to parents of eligible children regardless of employer size, as proposed in *Approach B*, would increase participation in ESI only. Expansion would be expected to result in moving significant numbers of children from Family Assistance /Direct Care to Premium Assistance and enrollment in ESI. This change would result from the ability to include parents as well as children in calculating the cost-effectiveness of ESI, regardless of whether the parent works for large or small employer.

How would the option affect health plans and providers?

Expansion under both *Approach A and B* would increase the number of individuals enrolling in health plans through ESI. It would also increase the number of adults with coverage under through MassHealth Family Assistance Direct Care (Approach A), as those without access to ESI also were eligible for coverage.

Would utilization change?

Primary and preventive services would be expected to increase under both Approach A and Approach B, as would an initial surge in demand for services to address pent up demand unable to be addressed because of lack of financial access.

What are the political or policy implications?

Expansion would increase costs for MassHealth expenditures as enrollment and utilization increase. This increase in costs would be greater under *Approach A*, as individuals without access to ESI would be eligible for coverage, and including those not now receiving coverage, even by default. Under *Approach B*, cost increases are not expected to be as large, since some of

these individuals are already be receiving coverage through ESI by default. In addition, the state may be able to claim increased FFP under SCHIP for parents who are not currently eligible.

Advantages

Discuss the major considerations that worked in favor of, or against, the option (e.g. financing, administrative ease, provider capacity, focus group and survey results).

- It would be relatively easy to enroll parents at the time their kids are enrolled in MassHealth.
- Children and their parents are insured under the same program.
- Parents would be more likely to enroll their children if they received health insurance at the same time.
- Add clarity to outreach and marketing campaigns, eliminating source of confusion that results when only some of family members are recognized as eligible for MassHealth, but all are covered in ESI.
- Keeps private dollars in market.

Limitations

- Additional state cost (but not as costly as other options)
- There may be a stigma associated with enrolling in MassHealth.
- Impact on state and federal budget neutrality may be very large, particularly under Approach A.

Financing

This approach would require additional funding at both the state and federal level.

What will enrollee (and/or employer) premium sharing requirements be?

As is currently required, in order to qualify for Premium Assistance, an employer's plan must cover at least 50% of the premium cost. Parents are asked to contribute $10 per child up to $30 per month. Cost-sharing and premium contributions under this expansion may be expected to remain the same.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit.)

To be determined.

How will the program be financed?

The expansion would be financed through state appropriation, and through FFP in conjunction with an amendment to the 1115 MassHealth waiver, and through a waiver to the SCHIP State Plan, pending federal approvals.

What strategies to contain costs will be used?

The full range of strategies employed by MassHealth to contain costs would be extended to this expansion group.

Extent to which Principles are Met

This approach moves us forward toward our principle of providing equal access to public assistance within the same level of income because it provides eligibility for parents. It does, however, leave adults without children as dependents at the same income level, without similar access to coverage.

This approach builds upon existing public and private health insurance financing mechanisms by tapping into ESI whenever possible by providing Premium Assistance to those who are eligible.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

We would need to identify number of income-eligible parents, with access to ESI, all of whom would be eligible. Then we would need to distinguish who are uninsured from those who are who are currently insured (to distinguish between rates of FFP).

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

This option would be an expansion of existing programming. It would require federal approval of an 1115 Health Care Demonstration Waiver amendment, and/or a waiver of the SCHIP State Plan.

Special State Responsibility: Contracted Organizations and Industries

[Approach 1, in its entirety, was made part of the preliminary recommendations and continued analysis will be performed on Approach 2 as described in question 4.1.]

The Commonwealth of Massachusetts regularly contracts with thousands of organizations, some of which receive the majority of their revenue from the state. We believe that there exists a "special state responsibility" to ensure that those organizations with which the state contracts offer affordable insurance to their employees. This special responsibility extends to both individual contracting organizations and also to a subcategory of certain industries (described below).

We assessed two different approaches, as follows, that could be taken regarding organizations that contract with the state:

Approach 1: The state would require all organizations bidding for a state contract to inform the state as to whether or not they offer health insurance to their employees and the percent of the total premium the employer pays. The state would then give contracting preference to organizations who offer their employees affordable health insurance (those that cover at least a specified amount/percent of the premium). This would mean that those employers that offer insurance would get more credit in the bidding process. This approach might only apply to those organizations with state contracts that total at least a certain dollar amount. In addition, the type and amount of preference given would have to be determined.

Approach 2: The state would require all organizations bidding for a state contract to inform the state as to whether or not they offer health insurance to their employees, the percent of the total insurance premium the employer pays, and detailed employee salary information. The state would contract only with organizations that provide their employees with affordable health insurance (those that cover at least a specified percent of the premium cost). Therefore, this option would, as a condition of contracting, require organizations bidding for state contracts to offer affordable insurance.

> ***Subcategory of Approach 2: Industries*** In special cases where an industry is primarily supported by state dollars, such as the nursing home industry and community mental health centers, the state has an even greater responsibility to ensure that those employed by the contracting organizations within that industry have access to affordable insurance. (Note: The state is researching the day care industry and the personal care attendant field to ascertain whether certain employers or locations within those industries are primarily supported by state dollars, whether they provide affordable health insurance, and whether special financial assistance might be necessary.) More research would need to be completed to identify all such industries, but from preliminary research it seems that certain types of provider organizations within the human services industries would be affected. A survey of employers within these identified industries may be conducted to identify how many employers within these industries offer health insurance as well as how much of the premium those employers cover.

If research shows that most of the employers within these industries do offer affordable insurance, then the industry piece of this approach could remain the same as Approach 2. It would simply require, as a condition of receiving money from the state, that all employers (including those within identified special responsibility industries) offer affordable insurance to their employees.

However, if research shows that a significant portion of employers within these special responsibility industries: 1) do not offer health insurance, 2) do not offer health insurance at an affordable price, or 3) do not pay their employees enough to enable them to purchase insurance, then under this option the state might need to increase contract payments or reimbursement to the organizations within the industry. This extra money would be earmarked specifically for employee or employer insurance premiums. Preliminary review of studies conducted by various trade associations have found that a large majority of human service providers (the industry on which this option might focus) already provide health insurance. It is argued however, that many of their employees do not earn enough money to afford the coverage.

Target Population

Employees of organizations that have contracts with the state; Employees of organizations in special responsibility industries. During fiscal year 2001, there were approximately 15,000 employers who had state contracts or who received Medicaid reimbursement.

Mechanism

How will this program be administered?

If Approach 1 was implemented, all state agencies that contract with organizations would receive instructions regarding the changes to the bidding process.

If Approach 2 was implemented, the state would require all employers who are bidding for state contracts to turn in with their bid a statement regarding whether they provide health insurance and to what extent the employer subsidizes the premiums. The same information must be submitted by all organizations that receive Medicaid reimbursement. If they do not provide health insurance at an affordable price, their bid would not be considered.

How will marketing/outreach and enrollment be conducted? How will services be delivered under the expansion? What methods for ensuring quality will be used? How will crowd-out be avoided and monitored? What enrollment data and other information will be collected by the program and how will the data be collected and audited? What will the benefits structure be (including co-payments and other cost-sharing)?

Not applicable.

How will the coverage program interact with existing coverage programs and state insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

Not applicable.

How (and how often) will the program be evaluated?

The approach would be evaluated on an annual basis to determine its effect on state contract costs and on insurance levels among contractors' workers.

Impact

What impact would the option have on the current healthcare market? How would the option affect health plans and providers? Would utilization change?

The option would not have a significant effect on the healthcare market as a whole because it only directly impacts those employers receiving state dollars. One impact that Approach 2 might have is that if increased payments are not found to be necessary, some employers who can't afford to offer insurance would lose state business. This might force those employers out of business entirely or it could limit the types of patients they accept (by not allowing them to accept Medicaid patients).

What are the political or policy implications?

This option would only assist employers that receive state dollars, therefore if those companies are given more money to help them provide health insurance, there might be some opposition since other similar employers in Massachusetts (operating without state dollars) are not receiving the same assistance. In addition, business groups and trade associations might oppose either approach.

Advantages

- This option might encourage some employers who do not offer health insurance to start offering coverage, thereby increasing the number of employers that offer health insurance
- If no extra state payments were made to these employers to help them afford to provide health insurance, this option would not incur significant cost to the state.
- If premiums were subsidized through additional state contract funds for employees in special responsibility industries, this option would help to make insurance more affordable for them.

Limitations

- Would not reach employees of employers who sub-contract with a company which contracts with the state
- Might force some employers who cannot afford to offer insurance out of business if the state chooses not to work with them anymore (without providing additional funds) and they depend on state dollars as a significant part of their revenue
- Might be administratively cumbersome and will have administrative costs because the review of bids would be more complex and might take longer.

- There might be costs to the state, if research finds subsidies for companies within certain industries necessary.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

To be determined.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

To be determined

How will the program be financed?

To be determined.

Extent to which Principles are Met

This option meets the principle stating that "the state has a special responsibility to assure access to affordable health insurance for those people who work under contract to the state or for organizations that are primarily dependent on state funding."

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

- Establish a specified percent that an employer receiving state dollars must pay of the health insurance premiums for its employees.
- Determine how much credit or preference a contracting employer who offers health insurance should receive.
- Identify all special responsibility industries through thorough research and surveys.
- Survey employers within all special responsibility industries regarding the health insurance coverage they offer their employees and the salary levels of their employees.
- Determine whether additional reimbursement is necessary for the employers within special responsibility industries. Estimate the total cost.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

No current legislation relative to this option exists at this time. However, the Division of Medical Assistance has done this for certain contracts.

CATASTROPHIC COVERAGE WITH MEDICAL SAVINGS ACCOUNTS

[This approach, in its entirety, is included in the preliminary recommendations described in question 4.1.]

Under this option, insurers would sell catastrophic policies with high deductibles in the individual and group markets. The state would encourage that these policies be combined with Medical Savings Accounts (MSAs) that policyholders could use to purchase primary and preventive services.

Target Population

The target population for catastrophic coverage with MSAs would include members of the currently uninsured population who are relatively healthy, knowledgeable about their health care needs, and unlikely to buy standard policies.

Mechanism

How will the program be administered?

To be determined.

How will marketing/outreach and enrollment be conducted?

Insurance carriers would market this option through their own marketing and enrollment practices. State enrollment and outreach staff could also help educate residents who are not eligible for public programs about this option.

How will services be delivered under the expansion?

Health care services would be delivered through the existing provider system. This option would simply serve as another source of reimbursement for these services.

What methods for ensuring quality will be used?

Not applicable.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer-based coverage)?

Residents who select this option may have access to other sources of health insurance, but have not purchased more comprehensive coverage, most likely due to the costs of the policy and the belief that purchasing the policy would result in overinsurance for their particular health care needs. Residents with income levels that are too high for most publicly sponsored programs may also purchase this option. Individual decisions about which coverage to select would depend on

a number of things, including the price of the option. Catastrophic coverage combined with MSAs would give people more choice regarding how to allocate their health care insurance dollars, in order to better meet individual needs. If healthier, younger people selected this option in large numbers, their departure from the risk pool could prove costly, as sicker, older people would be left behind, resulting in adverse selection.

How will crowd-out be avoided and monitored?

Crowd-out would not be a large concern as this option would operate primarily in the private market.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Data about enrollment, claims paid and MSA amounts would be maintained by individual insurance carriers and by the Division of Insurance, consistent with current procedures.

How (and how often) will the program be evaluated?

The approach should be evaluated to assess the integrity of the products, and to determine the impact of the option on related public programs such as the Uncompensated Care Pool, as well as its effect on the cost of private coverage. In addition, attention must be paid to indicators of people foregoing care to increase the value of their MSAs.

What will the benefits structure be (including co-payments and other cost sharing)?

Residents who purchase this option would be responsible for covering costs up to a deductible threshold, which would be set at a relatively high level. People who enroll in a catastrophic plan would also be required to have an MSA that would be used to cover primary and preventive services, and thus provide an incentive for the careful use of health services. The option would then cover costs for services that exceed the deductible.

Impact

What impact would the option have on the current healthcare market?

If MSAs were not required in combination with catastrophic plans, residents might opt to purchase the catastrophic option in place of more comprehensive coverage, which might result in inadequate coverage of other services such as primary and preventive care or diagnostic services. Combining catastrophic policies with a requirement to use an MSA would reduce this negative incentive. For residents who have sufficient income and low health care risks, this type of plan might be a viable option. These residents would use the MSA to cover primary and preventive care, and would access the catastrophic coverage in the unlikely situation that they experience a catastrophic health event. If the option was sufficiently attractive, some currently uninsured individuals might decide to purchase the policies, and thus these individuals would become insured.

How would the option affect health plans and providers?

To be determined.

Would utilization change?

Residents who purchase catastrophic coverage alone may have greater incentives not to use primary care or preventive services. Combining catastrophic policies with MSAs will likely minimize this tendency. Since many catastrophic health care costs are not planned before they occur, often resulting from accident, injury or accumulated health care deficits, it seems unlikely that residents covered by these policies would significantly alter their health care seeking behavior with respect to more expensive health care utilization. MSAs may encourage a more thoughtful use of primary care and preventive services.

What are the political or policy implications?

Regulatory changes would be required to implement this option. The Division of Insurance would also need to develop new regulatory guidelines to cover these polices. In addition, MSA amounts and criteria outlining what services the dollars could be used for would have to be determined.

Advantages

Discuss the major considerations that worked in favor of, or against, the option (e.g. financing, administrative ease, provider capacity, focus group and survey results).

- Provides a new insurance mechanism for residents of the Commonwealth to purchase an insurance policy that meets their individual needs.
- This option is fundamentally more like insurance than a managed care plan, in that residents pay into an insurance pool that is used to cover catastrophic costs, only if they occur.
- This product might be less expensive than other insurance options, and so it may be an appropriate, lower cost product for residents who can afford to purchase the policy, and who forsee a limited need for health care expenditures in the short term.
- MSAs provide consumers with more control over their health care dollars, allowing them to purchase primary and preventive services at their own discretion.

Limitations

- Catastrophic policies and MSAs do not necessarily encourage residents to obtain preventive care.
- Employers may be tempted to provide this coverage option in place of plans that are currently offered which may have richer benefit packages.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

Residents who purchase these policies would be required to absorb a greater level of first dollar coverage; thus enrollee cost sharing would increase. If employers decide to offer this type of coverage because it is a less expensive option than more comprehensive plans, a greater portion of the cost may be shifted on to the employee. The structure of the catastrophic plan with MSA would largely determine enrollee premium sharing requirements.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

Costs of the option would be absorbed by residents of the Commonwealth, or alternatively by employers.

How will the program be financed?

The program would most likely be financed through private expenditures, either personal expenditures from consumers or from employers.

What strategies to contain costs will be used?

Not applicable.

Extent to which Principles are Met

The catastrophic coverage option is related to several of the principles identified by the Steering Committee. In particular, this option:

- Would promote the availability of multiple insurance coverage options that reflect different consumer needs/preferences: A catastrophic option promotes individual decision making about the best insurance coverage option for residents in the target population
- May be best option for younger uninsured who are healthy: For individuals who are healthy, a comprehensive insurance policy may result in overinsurance.
- Would be mindful of impact on employers: The catastrophic option may provide a sensible alternative for employers, especially those whose workforce is young and relatively healthy
- Does not include expansion of public coverage.
- May encourage cost and quality consciousness: By increasing individual choice about how health care dollars are spent, the MSA option might promote cost consciousness in health care purchasing

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

It would be helpful to involve various stakeholders in discussion about the particulars of this option. For example, it would be beneficial to discuss the feasibility of this option with private insurance carriers who operate in the Commonwealth. It would also be useful to determine how this option might intersect with the IP. Moreover, it will be important to determine the most appropriate combination of catastrophic costs and benefits along with the appropriate balance of MSA costs and benefits.

Single Process for Applying to all Public Programs

[This approach, in its entirety, was determined to be a long-term objective of the state, as described in question 4.1.]

A single process for individuals to enroll in public programs.

Target Population

The target population includes all those currently enrolled in public programs in the Commonwealth, as well as additional low-income under and uninsured adults and children who are identified as eligible for these programs.

Mechanism

How will the program be administered?

One state agency would be identified to create the system through which the single process system is operationalized. Workers from all state agencies would need a method of accessing a central database to determine which programs people are eligible for, and whether they are already enrolled.

How will marketing/outreach and enrollment be conducted?

Marketing/outreach and enrollment would occur through the ongoing eligibility determination process and enrollment activities of each state agency.

How will services be delivered under the expansion?

Health care services would continue to be delivered through ongoing systems, and marketing/outreach and enrollment activities for each program would continue. However, marketing, enrollment and outreach staff as well as providers would have access to a centralized database that confirms eligibility for all public programs within the Commonwealth.

What methods for ensuring quality will be used?

To be determined.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer based coverage)?

If the single process system is effectively administered, then enrollment in public programs should increase somewhat.

How will crowd-out be avoided and monitored?

To be determined.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Information about each resident enrolled in any public program would be entered into a centralized database, which would be made available to program workers across state departments. Privacy issues must be explored to determine if there were some programs for which it is not appropriate to share eligibility information. It will be necessary to determine the minimum amount of information that will be requested of applicants for public programs, in order to ensure accuracy and at the same time not overburden applicants.

How (and how often) will the program be evaluated?

The program should be routinely evaluated to determine whether efficiency and accuracy are being maintained, and also to determine the impact of the single process system on enrollment in public programs. The impact of the program on applicants should also be monitored.

What will the benefits structure be (including co-payments and other cost-sharing)?

The benefits available would be the same as those already available through other public programs. The single process system would not have any stand-alone benefits.

Impact

What impact would the option have on the current healthcare market?

Under one possible scenario, publicly sponsored programs, or those that receive public reimbursement, could anticipate increases in eligible populations as a result of the single process system. Eligibility information for each public program would be more widely available and may be more accurate. Therefore errors involving eligibility information may decrease.

How would the option affect health plans and providers?

To be determined.

Would utilization change?

Although utilization on a per capita basis may not increase, it is likely that overall volume of services provided through publicly sponsored systems of care would increase.

What are the political or policy implications?

Careful decisions would need to be made regarding the minimum amount of information applicants would be required to provide in order to implement a single process for applying for all public programs. Moreover, policymakers would need to collaborate in the development of standardized definitions for different programs and data elements. The implications of a single process system for people who are not citizens would also need to be considered. People may be hesitant to provide information if it may impact their citizenship possibilities. It would also be expensive and time consuming to develop a centralized data system. However future savings gained, as a result of the development of a single application process, are likely to offset implementation costs.

Advantages

The primary advantage of the single application process is that residents of the Commonwealth who are eligible for public programs may be more likely to be enrolled in these programs, and thus more likely to have coverage. The rate of under and uninsurance may thus decrease. In addition, by developing the data system that would be necessary to implement a single process system, the Commonwealth would gain the advantage of accurate and timely information about enrollment for various state programs. Moreover, the data system would provide consistent information about eligibility for various state programs across all outreach and enrollment locations, minimizing errors in enrollment and eligibility. The system would be easier for consumers to use, as consumers would only have to interface with state eligibility workers once in order to gain information about the range of programs for which they may be eligible. Finally, a single process would reduce the amount of duplicated work that currently exists in the application process, resulting in savings to the system.

Limitations

There are several limitations to this option that should be considered. First, each additional resident who is enrolled in a publicly sponsored program, who was not previously enrolled in that program, represents an additional cost to the Commonwealth. Also, if residents forgo any available private coverage in order to enroll in a public program, simply because it is more accessible to them, then crowd-out would result. The Commonwealth would thus absorb the costs of coverage previously shouldered by a private source.

In addition, the data system necessary to implement the single process system would be sophisticated. In order for the system to be implemented appropriately, it would need to be available to all outreach and eligibility workers. Thus the resources required to implement this system would be extensive, even considering the labor expenses that might be reduced if information currently provided by workers was available on-line. Significant resources would need to be directed toward standardizing data elements and identifying the information that must be collected in order to determine eligibility for various programs. Federal funds would be necessary to support this effort. Finally, the level of detailed personal information required

might act as a disincentive for people to apply for programs, especially those that are not citizens.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

Not applicable.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

To be determined.

How will the program be financed?

To be determined.

What strategies to contain costs will be used?

The strategies that would be used to contain costs include those that are currently used to limit crowd-out. Eligibility and enrollment workers would be responsible for exploring whether residents have access to private coverage, and helping residents access those sources of coverage.

Extent to which Principles are Met

The single application process encompasses several of the principles identified by the Steering Committee. In particular, the single process system would help promote:

- Efforts to provide equal access to coverage: A centralized database would ensure that applicants are provided with one system that provides equal access to coverage.
- Targeting of outreach and enrollment efforts to those who are most financially needy: Eligibility workers would be able to target outreach and enrollment efforts to those who are determined eligible for various programs.
- Improved care management: Eligibility and enrollment determined by one worker would help insure that people are triaged to all programs for which they are eligible, and promote communication among various state programs
- Full enrollment in current models / programs: Outreach and eligibility workers will be able to direct applicants to the programs for which they are eligible, thus promoting full enrollment
- Maximization of programs for which there are available federal dollars: Priority in enrollment could be given to programs for which there are available federal dollars.

- Reflect needs of multiple subgroups: The needs of multiple subgroups could be met through one system that contained information about various public assistance programs.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

It would be helpful to have data related to the number of residents who are eligible for but not currently enrolled in public programs. Estimates of the additional enrollment that would result from this option might be determined through an analysis of take-up rates. Information should also be gathered about computer systems that other states have developed for this purpose, in order to estimate the costs associated with this option.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

The Commonwealth has made significant strides toward increasing the availability of information about various state programs. For example, applicants to the Uncompensated Care Pool are triaged through a system that directs them to MassHealth if it appears that they are eligible for this program. The strengths and weaknesses of this system should be assessed to determine the feasibility of the proposed single process system.

Privacy issues must be considered in the implementation of a single process system. For example, should information contained in a central database be made available to all state workers? Can an applicant request that certain information be protected if he or she does not want it disclosed to other government agencies?

Modifications to the Insurance Partnership

[Continued analysis will be performed on this approach as stated in question 4.1.]

This option consists of one or more of three types of modifications to the Insurance Partnership (IP):

- raising the maximum employer size from 50 to 100
- raising the maximum income for an eligible employee from 200% to 250% FPL
- increasing the subsidy amount for employers

Target Population

The target population is low-income employees and their families, who work in firms with fewer than 100 employees. Many of these individuals either are not offered health insurance through work, or find premiums and cost-sharing to be prohibitive, and are not eligible for other state-sponsored insurance programs.

Mechanism

How will the program be administered?

The program will continue to be administered by the Division of Medical Assistance

How will marketing/outreach and enrollment be conducted?

Marketing/Outreach will continue to be conducted through outreach efforts currently underway.

How will services be delivered under the expansion?

What methods for ensuring quality will be used?

Market forces and state mandates will determine the quality of insurance product offered to employers and employees.

How will crowd-out be avoided and monitored?

Crowd-out describes the substitution of public for private insurance. The IP is a partial state subsidy for the purchase of private insurance. As such, employers and employees who purchase insurance with the help of the IP subsidies are not "crowded-out" of the private insurance market.

A. Effect of Increasing Income and Employer Size Eligibility Criteria

Based on the 2000 DHCFP Survey of Health Insurance Status of Massachusetts Residents, about 1.2% of the working insured (or 29,700 individuals) are ineligible for the IP because their firm employs from 50 to 99 employees. About 9.22% (or 228,387 individuals) work for small employers (less than 50), but earn from 201-400% FPL. Another 2.3% (or 56,971) work for

employers with 50-99 employees and earn from 201-400% FPL. Based on 1999 March Supplement CPS data, the number of working insured earning 201-300% FPL is relatively close to those earning 301-400% (306,000 and 351,000 respectively). If we assume that the distribution of working insured is equally uniform within the 200%-300% FPL income group as it is between the 201%-300% and 301-400% FPL groups, than approximately one quarter of those who are ineligible for the IP because they earn 201-400% FPL will be newly eligible if income eligibility is raised to 250% FPL. As such, of those who currently have employer-sponsored insurance, approximately 57,000 would be newly eligible for the IP due to a change in income eligibility, about 29,700 due to a change in employer-size eligibility, and 14,000 due to a combination of both changes. Thus, approximately 100,700 individuals who currently have employer-sponsored insurance would become eligible for the IP.

B. Effect of Increased Employee Subsidy

Because the employee premium contribution is fixed ($25 for individual coverage; $50 for couple coverage; $10 per child), those who earn less must pay a greater percentage of their income towards the premium. An employee earning 85% FPL contributes 4.1% of his/her gross earnings towards his premium, while an employee earning 200% FPL contributes 1.75%. However, those earning less than 133% FPL constitute a disproportionately high number of policy holders via the IP. According to the 2000 DHCFP Health Insurance Survey 25.3% of the under 200% FPL working uninsured earn less than 133% FPL, but 62.5% of the policy holders (representing 65.8% of covered lives) under plans purchased via the IP are by employees earning less than 133% FPL. Conversely, 61.8% of the under 200% FPL working uninsured earn 151-200% FPL, but only purchase 28.2% of the policies (representing 24% of covered lives) via the IP. The inverse relationship between percent of income contribution and take-up rate suggests that reducing the employee premium contribution would not have a significant effect on IP participation.

C. Effect of Increased Employer Subsidy

The IP makes payments of $400, $800 or $1000 per year depending on coverage type, (individual, couple or family) for each qualified employee. The employer subsidies have not been subject to an inflationary adjustment, nor have they been increased since the amounts were established seven years ago. This, the relative value of the employer subsidy has significantly decreased. In order to regain the level of incentive that existed when the IP was first established, an increase in the employer contribution would need to reflect the increase in private insurance premium inflation over the past seven years. An inflation-adjusted employer subsidy would create a stronger incentive for employers to purchase insurance through the IP.

D. Projected Take-Up Rate Effect

Current IP enrollment shows that only 31.6% of policies (and lives covered) are for individuals and families who were insured prior to purchasing insurance through the IP. Based on preliminary results from the Massachusetts 2001 employer survey, only 36% of employees with employer-sponsored insurance from employers with 50-99 employees would have a lower premium contribution if their employer participated in the IP. These numbers suggest that if income and employer-size eligibility is changed, far fewer than the 100,700 newly eligible employees will purchase insurance through the IP.

IP enrollment can be monitored by analyzing data collected via the MBR. Using estimates of how many individuals are newly eligible, we can determine take-up rates using income and employer-size information necessary to make an IP eligibility determination.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

Eligibility and enrollment data is currently collected and analyzed by the Division of Medical Assistance and this would continue.

How (and how often) will the program be evaluated?

The program would be monitored annually by DMA policy analysts. The evaluation would assess actual to projected enrollment and costs, participation by employer-size and income.

What will the benefits structure be (including co-payments and other cost-sharing)?

The IP requires monthly premium contributions by the employer and employee. The amount of employee contribution ranges from $10-$50, depending on the number of people covered under the given plan. Premium contributions would be based on a sliding-scale (a percentage of income) for those earning 200-250% FPL. The benefits offered by each plan is determined by the market and state mandates.

Impact

What impact would the option have on the current healthcare market? How would the option affect health plans and providers? Would utilization change?

Insurance is purchased in the private market, and the IP population is small relative to the employer-sponsored market. Thus, the IP expansion should have little effect on the current healthcare market.

What are the political or policy implications?

Expanding IP eligibility criteria would require an increase in state funding for the program. For each newly purchased plan. Massachusetts would contribute approximately half of the non-employer contribution. However, for most of the working uninsured, non-group premiums are simply unaffordable. Expanding the IP would provide working individuals with a good option.

Advantages

- The cost associated with starting and establishing the IP is already realized, and there would only be marginal increases in administrative costs.
- Takes advantage of employer contributions and federal reimbursement.

- Providing subsidies to employers and employees encourages the purchase of health insurance as most working uninsured report cost as the primary reason they do not purchase health insurance.
- Data necessary to monitor enrollment and cost are collected as part of the administration of the program. No further data collection needs to be done in order to make timely and accurate assessments.
- Expansion of employer-sponsored family coverage may decrease the number of children enrolled in other (and potentially more costly) state-sponsored programs.
- Health insurance status is strongly correlated with health status and preventative care utilization. An increase in the percent of low-income people who are uninsured may alleviate some of the uncompensated care burden on Massachusetts hospitals.
- The IP is consistent with the implicit understanding in our healthcare system that insurance is provided through the workplace.

Limitations

- "Medicaid stigma" may be a disincentive for people that fall in the upper range of income eligibility.
- Participating employers must offer insurance to all employees regardless of the employees' income, but receive a subsidy only for the income-eligible employees.
- Even minimal premium contributions may make health insurance cost-prohibitive for some income levels.
- Substitution of some public for private contribution.
- For those employers not currently offering health insurance to their employees, the IP contribution may not be sufficient to encourage employers to pay for 50% of their employees premium.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

Income Eligibility Raised to 250% FPL
The IP requires employees to contribute from $10 to $50 towards the premium, depending on the number of people covered under the policy. For those earning 200% FPL, the premium contribution ranges from 1% to 2.6% of gross earnings. For an employee earning 100% FPL the premium contribution ranges from 3.5% to 7% FPL.

For those earning 200-250% FPL, a sliding scale premium contribution, equal to the percent of gross income contributed by those earning 100% FPL would be equitable and would provide an incentive to purchase insurance. For those in the 200-250% FPL range, non-group insurance is the most viable (if not only) private health insurance option. For a family earning 250% FPL, non-group premium rates require a family to pay 11-28% gross income for an HMO plan, 16-41% for a PPO plan, and 19-57% for an indemnity plan. (DOI Consumer Information Guide; Non-Group Health Insurance Plans as of 8/30/00). Clearly, non-group premiums are not affordable for the majority of working adults in this income group. The sliding scale premium would provide those earning 200-250% FPL group with a legitimate option, while maintaining

equitable premium contribution amounts with lower income group. Furthermore, because the employee dollar contribution would be greater, the state contribution per covered person would be less for those earning 200-250% than those currently eligible for the IP.

Increased Employee Subsidy
As discussed above (see 'crowd-out'), increasing the employee subsidy would have little effect on IP participation. The IP requires a minimal employee premium contribution, and is comparable (as a percent of gross income) to the contribution required by other state-sponsored premium assistance programs (i.e.TennCare (0-7.8% gross income contribution); MinnesotaCare (1.5-8.8%); Arizona Premium Sharing Program (6%)).

Increased Employer Subsidy
The IP requires an employer to contribute at least 50% of the cost of the premium to be eligible for the IP employer subsidy. As of 7/31/01, 3,140 employers participate in the IP. About 2/3 of those employers (or 2,050) did not previously offer insurance.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

Based on IP enrollment and payment trend data, DMA projects the average state contribution per policy (includes employer and employee subsidy) will increase from $191 in July 2001, to $219 per month in June 2002 (this reflects the faster growth in family and couple policies than in individual policies). The following projected costs are based on this mean state premium subsidy.

A. Projected Crowd-Out Cost
Based on the crowd-out projections (see 'crowd-out' above), 100,700 employees who currently have employer-sponsored insurance would become eligible for the IP due to increase in the employer size and income eligibility standards. 31.6% of policies are for individuals previously insured, or about 1,402 policies. Based on the 2000 DHCFP Health Insurance Survey, 92,047 working insured were eligible for the IP. Thus the current 'crowd-out rate' is 1,402 / 92,047, or 1.5%. If we assume that the take-up rate for those currently insured is equal to the current crowd-out rate than approximately 1,510 employed will participate in the IP. The total state subsidy per month due to the increase in employer size and income eligibility would be approximately $288,505-$330,690.

As discussed above, the projected increase in take-up rate due to an increase in the employer subsidy (short of a full subsidy with no cost to the employee) would probably be negligible. Similarly, increasing the employer subsidy for employers who already offer insurance would also probably be negligible. One would expect that requiring an employer to pay only 50% of the health insurance premium would be a sufficient incentive for an employer who currently offers insurance to participate in the IP.

B. Projected Newly Eligible Cost

According to the 2000 Massachusetts household survey, approximately 238,000 working adults are uninsured. Of those, approximately 96,000 earn 201-400% FPL. If we again assume that the number of individuals is equally distributed throughout this income group (see 'Crowd Out' part A), approximately 24,000 working uninsured earn from 201-250% FPL. In addition, about 6.5% of the working uninsured earning 201-400% FPL work in establishments with 50-99 employees. Thus, about 1,560 working uninsured would become eligible due to in increase in *both* income and employer size eligibility. A number of working uninsured would become newly eligible due solely to an increase in income eligibility (those working for small employers (less than 51 employees) and earning 201-250%). If we again assume uniformity with the 201-400% FPL group, approximately 15,600 working uninsured would become eligible due to an increase in income eligibility. Similarly, some working uninsured would become eligible due to establishment size alone. Approximately 8,300 working uninsured earn less than 200% FPL and work in establishment with 50-99 employees. Summing the three newly eligible population groups, 25,460 working uninsured would become newly eligible.

The current take-up rate for those who were previously uninsured is approximately 3.7% (2,900 policy holders previously uninsured/ 79,250 working uninsured working at small establishments (<50 employees) and earning less than 200% FPL). If we assume the same take-up rate for the newly eligible population, then 942 newly eligible working uninsured would participate in the IP, at a monthly state subsidy of $180,000- $206,000.

As discussed above, the projected increase in take-up rate due to an increase in the employer subsidy (short of a full subsidy with no cost to the employee) would probably be negligible. However, an increase in the employer subsidy would provide a greater incentive for those employers who currently don't offer insurance but would be newly eligible. Approximately 42% of 2-9 employee establishments, and 9.2% of 10-50 employee establishments do not offer health insurance. Virtually all of these firms report cost as a primary factor in their decision not to provide health insurance. The impact of an increased employer subsidy would probably have a negligible effect on employers with 51-100 employees, as the vast majority of those establishments currently offer insurance to their employees.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

A number of survey instruments can be used to continue assessing the IP. The Massachusetts 2001 employer survey, the Massachusetts 2000 household survey, and data collected by DMA for IP eligibility determinations provide valuable income, employer size, and insurance status, information about the Massachusetts working population.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

The proposed options would require legislation and a commitment to increase IP funding.

Individual Responsibility

[Continued analysis will be performed on this approach as stated in question 4.1.]

In addition to the state having a special responsibility to ensure that all employees working for contracted employers have access to affordable insurance, individuals who work directly for the state under contract should have similar access. This option would allow individuals who have a contract with the state lasting 12 months or longer and who work at least 18.75 hours per week to have access to health insurance. The simplest way, administratively, to provide access would be by allowing contracted individuals to participate in Group Insurance Commission Plans that are available to state employees. However, staff are examining other possibilities. If contracted individuals had the same opportunity to participate in GIC plans as state employees, they would be able to enroll at the start of their contract or at any time during open enrollment. However, there would be a 2-calendar month waiting period before GIC coverage would begin and the individual must contribute 15% of the total premium cost (both requirements are the same as for state employees).

Currently, individuals with a state contract often are paid an add-on of up to 25% of their salary in lieu of benefits. Therefore, those who make a higher contracted salary receive a larger benefit (since the benefit is a percent of salary) and would be more financially able to pay for health insurance coverage on their own. The add-on is meant to compensate for benefits not received such as sick or vacation time and health insurance; however, the individual may spend the money as he or she wishes and is not required to purchase health insurance.

This option would remove the portion of the 25% add-on that is meant for health insurance (even if the contracted individual chose not to take the GIC coverage.) This portion of the add-on would only be removed from the salaries of contracted individuals who are eligible for GIC coverage. The portion would be converted and used to offset the state's cost of providing insurance to these additional people (each agency would be responsible for budgeting and paying for the state's portion of the premium cost for its own contracted employees). If the contracted individual chose not to participate in an available GIC plan, that person would simply forfeit the benefit. The same benefit forfeit exists for state employees. It is possible that the benefit add-on could just become a straight dollar amount which would total 2 or 3 weeks (for example) of that person's pay to compensate for the lack of vacation or sick time. The details for this option are being examined further.

Target Population

Those individuals (and their families as beneficiaries) who have state contracts lasting 12 months or longer and who work at least 18.75 hours per week. During FY2001 there were approximately 43,000 of these individuals with approximately 47,500 contracts. Only approximately 3,000 of these contractors were paid more than $20,000 annually; therefore, one could assume that many contracted individuals work on a part-time basis. The total dollar amount paid to contracted individuals was $268,131,034, with an average contract size of $5,651 and with the average contracted individual making $6,236. The average contract size ranges

significantly from an average of $102,361 for a highway/lateral construction contractor to $120 per contract for weather reporting services.

Mechanism

How will the program be administered?

Each agency would be responsible for its own contracted employees and for the state's share of the insurance premium. All newly contracted individuals would have the opportunity, at the time of the contract signing, to participate in an approved GIC plan (or another plan). All currently contracted individuals would have a special two-month open enrollment period when this new program begins.

If contracted individuals were permitted to participate in approved GIC plans or another type of plan, they could enroll in a health insurance plan at their contract's start date or during open enrollment. When this new policy is first in effect, there would be a special two-month open enrollment period for all existing contracted individuals and state employees to enroll in health insurance.

How will marketing/outreach and enrollment be conducted?

All currently contracted individuals and those applying for jobs for 12 months or longer and who work at least 18.75 hours per week would be informed of the availability of insurance to them.

How will services be delivered under the expansion?

Services would be the same for contracted individuals as they are for state employees.

What methods for ensuring quality will be used?

If coverage were provided through the Group Insurance Commission (GIC) plans, GIC would monitor coverage, just as for state employees.

How will the coverage program interact with existing coverage programs and state insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage option (especially employer-based coverage)?

This option does not entail starting a new program; it would simply open up the coverage program for state employees to state contracted individuals. By allowing long-term contracted employees to participate in health insurance plans, more people who the state pays directly would have access to affordable health insurance.

How will crowd-out be avoided and monitored?

To be determined.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

The state would monitor contracted employees in a more efficient way (how many, what salaries, how long are their contracts, etc) and would collect data on the number that are participating in GIC/other plans as well as which plans they choose.

How (and how often) will the program be evaluated?

To be determined.

What will the benefits structure be (including co-payments and other cost-sharing)?

The benefits structure would be the same for contracted individuals as it is for state employees.

Impact

What impact would the option have on the current healthcare market? How would the option affect health plans and providers? Would utilization change?

Offering certain contracted employees access to affordable health insurance could shift some of those employees already covered under other private plans into GIC/or other coverage made available by the state; however this would not impact the market negatively. On a positive note, the option would provide affordable access to health insurance for those without coverage or with very expensive nongroup coverage.

Since state contracted employees are long-term contracted individuals, the state has a special responsibility to provide them with affordable health insurance just as it is provided to state employees.

What are the political or policy implications?

Politically this option is not very objectionable since individuals contracted for a year or longer generally perform the same jobs as state employees; therefore, many believe that they deserve the same benefits. The only political hurdle would be that of finding more money in the state budget for the additional benefits. However, this amount of money would be partially or fully offset by lowering the salary add-on for contracted individuals. This is being studied in further detail.

Advantages

- Since the state contracts directly with these individuals for work, this option would satisfy the state's special responsibility of making sure its contracted employees have access to affordable health insurance.
- This option would be administratively simple if GIC plans were used because GIC coverage is already in place for state employees.
- This option would help contracted employees better afford health insurance coverage.

- This option would level the playing field for contracted employees and state employees by providing the same affordable access to health insurance for both.
- Since a portion (as yet undefined) of all contracted individuals' add-on would be removed and used to offset the state's cost of providing health insurance to contracted individuals, this option might not require any additional state funds.

Limitations

- This approach will likely cover only a very small number of uninsured individuals, depending on how many contracted individuals were uninsured before the coverage became available.
- Depending on how many uninsured contracted employees already have coverage or actively choose not to have coverage, this option may not reduce the uninsured rate at all. There would be no change in the insured rate if contracted employees simply drop current coverage to join GIC plans available to them.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

Premium sharing requirements would be the same as for state employees.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

To be determined.

How will the program be financed?

Through reducing the employee's benefit add-on and other to be determined.

What strategies to contain costs will be used?

Reducing the salary add-on received by the eligible contracted individuals will contain costs significantly.

Extent to which Principles are Met

This option meets the principle stating that "the state has a special responsibility to assure access to affordable health insurance for those people who work under contract to the state or for organizations that are primarily dependent on state funding."

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

It might be necessary to survey contracted employees to find out how many already have health insurance through a spouse, Medicaid, or other means. The take-up rate must be estimated as well, which could be done by asking in the survey whether the contracted individual would take the GIC coverage if it were offered. Ideally, staff would want to arrive at a number/percent of contractors with insurance, the type of insurance it is (private, public), and the estimated take-up rate of GIC coverage (including an estimation of crowd-out.) This would help to determine approximately how many people would shift from being uninsured to having access to affordable insurance and enrolling in it.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

There is no legislation currently pending that is similar to this proposed option. It has not been determined whether legislation or new regulations would be necessary.

Extend Medicaid Eligibility Using Only Income Requirements

[Continued analysis will be performed on this approach as stated in question 4.1.]

Eliminate categorical eligibility below a certain income level (not yet determined) and allow all people below that income level to enroll in MassHealth (Medicaid). Categorical eligibility requirements above that income level would remain.

Massachusetts expanded Medicaid coverage under a Section 1115 Medicaid Research and Demonstration waiver. This waiver established MassHealth, which expanded coverage to children (through 18 years of age), pregnant women and their newborns, and "categorically eligible adults up to a certain household income level." To be categorically eligible, one must meet income requirements, as well as other requirements set by federal and state guidelines. Categorical eligibility is granted if a person is determined disabled, HIV positive, employed by an Insurance Partnership participating employer, unemployed for a certain period of time, or a parent or adult caretaker of children under age 19. MassHealth does not cover residents who do not fall into any of the above categories. The state's surveys of the uninsured have revealed that the greatest portion of uninsured adults are between the ages of 19 and 39, many of whom are without children and thus do not meet categorical eligibility requirements for MassHealth. This option would directly assist the poorest of these people.

Target Population

The target population is low-income uninsured adults without children who currently do not meet categorical eligibility requirements for MassHealth.

Mechanism

How will the program be administered?

DMA would continue to serve as the state agency responsible for MassHealth and would administer the program using the new eligibility rules.

How will marketing/outreach and enrollment be conducted?

MassHealth would sustain the ongoing outreach and eligibility determination activities.

How will services be delivered under the expansion?

Services would be delivered under the current infrastructure for health services delivery, eligibility determination and Medicaid enrollment.

What methods for ensuring quality will be used?

DMA would be responsible for monitoring quality of care using its ongoing systems for ensuring quality. Other public agencies that monitor quality of health care in the Commonwealth would continue these programs.

How will the coverage program interact with existing coverage programs and State insurance reforms (e.g.. high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-sponsored coverage)?

This option would not create a new coverage program; it will simply adjust the eligibility requirements of a current public program, MassHealth. Hence, removing categorical eligibility requirements for MassHealth below a certain income level will not change or disrupt other public programs and will have a minimal influence on private sector coverage. Some residents in low-wage jobs who have employer-based coverage may find the MassHealth coverage to be more comprehensive, therefore they might move from the private to the public market. However, the number of people transferring from private to public coverage probably will be small because many people in very low-wage jobs are not offered coverage. Crowd-out will be discussed further in the answer to the following question.

In addition, the burden on physicians and community health centers throughout Massachusetts of providing free care might be reduced somewhat because MassHealth would cover more of the state's very poor people.

How will crowd-out be avoided and monitored?

Crowd-out would occur if some low-wage residents who have private market coverage become eligible and enroll in MassHealth due to the expansion of eligibility requirements. Crowd-out can be monitored if outreach, program and enrollment staff inquire about other sources of coverage when beneficiaries encounter the system. The workers would need to be knowledgeable about various benefit packages, or have a desk-top computer program that lays out the various programs for which each resident is eligible based on income and other eligibility information. Overall, crowd-out probably would be minimal since many very low-wage workers do not have coverage. There would be a requirement to utilize employer coverage if it proves cost effective for the state.

What enrollment data and other information will be collected by the program and how will the data be collected and audited?

The state would continue current enrollment data collection including gathering demographic, income and asset information. The data is gathered by DMA eligibility workers and would be audited by ongoing DMA mechanisms for ensuring data quality.

How (and how often) will the program be evaluated?

The cost and utilization experience of the residents enrolled under new eligibility guidelines should be monitored to help to determine whether utilization is within budget expectations. The program should be routinely evaluated, especially to determine the impact of expanding eligibility to all people below a certain income on other public programs such as the uncompensated care pool. By monitoring the number of people moving from private insurance coverage to MassHealth specifically due to the removal of categorical eligibility requirements for certain low-income people, trends in private coverage will be known.

What will the benefits structure be (including co-payments and other cost-sharing)?

The benefit structure, including co-payments and other cost sharing would be determined by the Division of Medical Assistance (who administers Medicaid), consistent with overall program goals and policies. However, maintaining the current structure and standard is most likely because it would be costly and unnecessarily complex to establish a new benefit plan for a certain category of people under MassHealth.

Impact

What impact would the option have on the current healthcare market?

Enrollment in MassHealth would increase if categorical eligibility requirements below a certain income level were eliminated. Residents aged 19 to 64 who currently utilize the Uncompensated Care Pool are, for the most part, uninsured, and nearly half of these are not eligible for MassHealth because they do not meet categorical eligibility requirements. An additional 16% of pool users declined to apply for MassHealth. Some of these residents might be eligible for MassHealth if categorical eligibility requirements below a certain income level were removed. Overall, the number of uninsured in the state would probably drop somewhat, due to this expansion of eligibility.

How would the option affect health plans and providers?

The residents who would become eligible for MassHealth due to this option would receive services through the network of health plans and providers that currently provide health care to residents eligible for MassHealth. Health plans and providers would serve a larger MassHealth patient population if categorical eligibility requirements below a certain income level were eliminated. The advantages and disadvantages for health plans and providers of serving Medicaid clients would thus be enhanced, in terms of, for example, desirability to the plan or provider of increasing patient populations, reimbursement levels and complexity of cases.

Would utilization change?

Although utilization on a per capita basis would likely not increase for those already covered by MassHealth, the overall volume of services provided through MassHealth would increase due to the additional lives covered under MassHealth.

What are the political or policy implications?

Extending MassHealth coverage to a new group of residents would require approval by the federal government through the waiver approval process. In addition, state funds would need to be appropriated by the state legislature to support the cost associated with extending coverage to more people. The amount of state funds available for this effort would determine the federal poverty level below which categorical requirements would be eliminated.

Advantages

The primary advantage of extending MassHealth coverage to be based only on income requirements below a certain income level is that it would be a relatively straightforward way to expand health insurance coverage. The program under which these residents would be entitled is already operational; therefore, it would not require significant resources to develop the organizational capacity to implement this option. In addition, more federal funds would become available to the Commonwealth to help support the expansions due to federal financial participation in the Medicaid program.

By offering MassHealth coverage to residents who are currently uninsured, newly entitled enrollees would have access to a greater range of health care services including primary and preventive care. These enrollees might be more apt to use health care services for routine care before health problems become exacerbated, and the need for more costly health care services might be avoided.

Limitations

The primary limitation of the option of removing categorical eligibility requirements for MassHealth is that it would be a costly option. However, the cost could be limited by carefully evaluating and setting the federal poverty level at which all those below that level would be covered. In addition, both regulatory and legislative approval would be required. For example, the federal government would need to approve the expansion of the 1115 waiver under which the current MassHealth program operates. The Massachusetts legislature would also need to appropriate more funds for the program and approve the expansions.

Financing

What will enrollee (and/or employer) premium sharing requirements be?

The benefit structure, including co-payments and other cost sharing would be determined by the Division of Medical Assistance, consistent with overall program goals and policies. However, maintaining the current structure and standard is most likely because it would be costly and unnecessarily complex to establish a new premium sharing requirement for a certain group of people under MassHealth. Also, since all the residents newly entitled under the expansion would be poor, it is not feasible to require extensive enrollee cost sharing.

What is the projected cost of the coverage expansion? How was this estimate reached? (If it is not possible to estimate actual costs, describe methodology that will be used to make such an estimate when time and data permit. Include the estimated public and private cost of providing coverage.)

In order to estimate costs of the expansion, various data sources might be utilized. Health care expenditures for the target population under the Uncompensated Care Pool could be analyzed, and the size of the target population could be estimated using data from the Massachusetts 2000 household survey. These analyses would provide useful data to estimate projected costs of the expansion.

How will the program be financed?

The program would be financed by appropriations from the state legislature and federal financial participation and also could use tobacco settlement funds.

What strategies to contain costs will be used?

The strategies that would be used to contain costs would be those that DMA currently uses, such as enrollment in managed care plans, utilization review strategies and so on. In addition, limiting crowd-out would reduce costs. Eligibility and enrollment workers would be responsible for determining whether residents have access to other coverage through private sources, and helping these residents access these sources of coverage.

Extent to which Principles are Met

By extending Medicaid eligibility to a group of residents using income as the only criteria several principles would be met:

- Equal access to public insurance would be provided to people (a) with the same level of income, (b) regardless of current insurance status, and (c) regardless of occupation. This option would provide a relatively straightforward way of ensuring equal access to health care coverage for residents who do not meet typical MassHealth eligibility categories.
- Assistance would be targeted to the most financially needy: the income limit that would be used to determine eligibility would be set at a level which stakeholders agree targets those who are most financially needy, for example those with incomes less than 100% of the FPL.
- Utilizes existing public insurance financial mechanisms: this option would be developed through the existing DMA infrastructure, and would not require significant additions of staffing
- Quality of care and costs is more likely to be managed: By enrolling low-income residents into MassHealth, there is a greater likelihood that these residents would receive higher quality and better managed health care.
- Creates an additional health coverage model that meets the needs of a specific subgroup of Massachusetts residents: The target population for this option is currently uninsured, and does utilize the Uncompensated Care Pool. By extending MassHealth to this group, the specific needs of the target population can be met.

- Requires additional state spending that otherwise is not supported legislatively: A concern in developing this option would be the additional cost involved. (Although this could be limited by setting a low FPL under which everyone would be covered).
- The proposed option does not necessarily foster independence, since people who would enroll in this option would begin to receive public assistance.

Next Steps and Questions

Data Collection and Analysis: What data and information is available, or being collected, that will be developed if this option is selected for further pursuit i.e., Household survey, employer survey, MEPS analysis, etc. What else do we need to know to further pursue this as an option?

See below.

Feasibility and Implementation Issues: Are any steps currently underway to support this option? Describe the actions already taken to move this initiative toward implementation (including legislation proposed, considered or passed), and the remaining challenges. If nothing is currently in place, what will need to be done to support this option? Legislation, regulation, etc.

In order to determine the feasibility of this option, the following steps could be taken:

- Determine the federal policy implications and barriers to this option
- Analyze uninsured survey further to identify how many additional residents would be eligible
- Conduct focus groups to understand the type of insurance "package" needed to assist these residents
- Commission a cost-benefit analysis to assess how much additional funding would be needed to expand MassHealth
- Determine estimates of take up rates
- Determine feasibility of additional legislative appropriations for this model

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, federal restrictions, constituency/provider concerns)?

Preliminary research was conducted for a few options that were subsequently dismissed by the Steering Committee. These options included: buy-in to Group Insurance Commission (GIC) plans for state employees, buy-in to the Federal Employee Benefit Program (FEHBP), buy-in to MassHealth (Medicaid), development of an adult medical security plan, availability of limited benefit insurance for primary care, expansion of MassHealth to children above 200% of the federal poverty level, tax incentives for employers, an individual mandate, an employer mandate, creation of an unsubsidized small employer health insurance purchasing cooperative and creation of a state-level "single-payer" system. A brief description of each approach, the policy considerations surrounding the approach, and the primary factors leading to the rejection of the approach follows.

Buy-in to Group Insurance Commission (GIC) Plans (plans currently available to state employees only): This approach would have allowed specified low-income individuals and families without access to employer health insurance to buy-in to GIC plans. The benefits of this approach are that it requires little new administrative structure, it takes advantage of current systems and risk pooling, it removes the stigma of participating in a welfare program and gives the state the ability to control costs and influence the system.

However, there are significant limitations to this approach including that it would probably create adverse selection and would provide relatively little cost savings to the uninsured. Since those near-retirement and those with large families probably would see a cost savings by buying into GIC plans rather than buying in the nongroup market, they would be more likely to buy-in to the GIC plans than would young single adults who are traditionally less expensive to insure. In addition, without a subsidy for premium assistance, uninsured people in lower-income brackets would probably not be able to afford GIC coverage. Creating a buy-in program also might cause significant crowd-out of people migrating from nongroup plans (most likely the higher-risk people as described above) to GIC coverage. Finally, politically, state employees and their unions might have objected to a buy-in to GIC plans for fear that rates would increase due to a potentially higher-risk population. All of these factors led to the Steering Committee's decision to reject this option.

Buy-in to Federal Employees Health Benefits Program (FEHBP): This approach would have allowed all individuals and families who are not covered by employee sponsored plans or public programs and who are eligible for tax credits to buy-in to FEHBP. The benefits of this approach are the same as those described in the GIC plan buy-in option. The primary factors leading to the rejection of this approach are the same as those described in the GIC plan buy-in option.

Buy-in to MassHealth (Medicaid): This approach would have extended MassHealth on a buy-in basis to individuals and families who met certain income guidelines. The benefits of this option included that added administrative costs would be minimal, it takes advantage of federal reimbursement, and that data are already collected as part of the administration of the program

hence further data collection would not be needed. The primary factors leading to the rejection of this approach include: 1) crowd-out is likely (people will move from private coverage to the relatively inexpensive MassHealth public coverage), 2) there would be a significant cost to the state, 3) new enrollees buying-in might utilize more services than current enrollees thereby increasing the average cost per member/per month, and 4) the minimal premium contributions that would be required to buy-in might still be cost-prohibitive for people at lower income levels.

Development of an Adult Medical Security Plan: This approach would have created a limited insurance plan that covers preventive and primary health care services for uninsured adults (without access to employer-sponsored insurance or eligibility for public programs) with household incomes below a certain level. The primary advantage of this approach is that it would make primary and preventive care more accessible and could improve the health status of some people while possibly reducing the demand for emergency care and hospital services. However, this approach was not pursued for many reasons, most notably: 1) it would foster continuing coverage gaps (by only covering primary and preventive care), 2) there is a strong possibility of crowd-out because those with access to more expensive comprehensive coverage could choose this less comprehensive plan, 3) creating the plan would duplicate services offered by the state's Center Care program, and 4) the design of this program imitates the Children's Medical Security Plan which has high operating and administrative costs and is less desirable than MassHealth.

Limited Benefit Insurance—Primary Care: This approach would have permitted and encouraged insurers to sell "bare-bones" policies in the individual and group markets that would only cover primary and preventive services. The approach would have required the legislature to pass a bill waiving mandated benefits requirements. The benefits of this option are that it might encourage people to seek out primary and preventive care and the coverage would be less expensive than full-benefit insurance plans. Many limitations led to the rejection of this approach including: 1) a primary care insurance plan is not really "insurance" since it lacks coverage for catastrophic events, 2) the plan might increase the burden on the state's Uncompensated Care Pool which covers hospital visits for the uninsured because some people currently with full insurance coverage might switch into this type of primary care only plan, 3) waiving mandated benefits might be politically problematic, and 4) the price might still not be low enough to reach low-income individuals.

Expand MassHealth to Children above 200% of FPL: This approach would have increased the income cap for eligibility above 200% of the federal poverty level. The benefit of this option is that more children would have been covered by insurance, under MassHealth. However, limitations of this option include that it requires significant additional state funds and children above 200% of the FPL already have access to the Children's Medical Security Plan. In addition, the approach contradicts some of the principles adopted by the Steering Committee (see Appendix V). These factors led to the rejection of the approach.

Tax Incentives—Employers: This approach would have required the state to provide a tax credit to employers that offer health coverage to employees. The incentive would have been for employers with low-wage workers and the employer would have needed to pay for part of the premium. This option builds on an employer-based insurance model. However, employers

already have a tax incentive to offer health insurance and small employers in Massachusetts have access to the Insurance Partnership (IP). Steering Committee members believed that we should focus on improving the IP instead of creating a competing approach. In addition, small employers may not benefit enough from these incentives to induce them to begin offering insurance.

Individual Mandate: This approach would require that everyone in the state acquire health insurance; people who failed to purchase coverage would be taxed. The state would probably have to provide subsidies for people with low-incomes. Assuming a high compliance rate, this mandate would probably capture some people who currently choose not to purchase health insurance and would therefore increase the number of people covered. Also, if this option were chosen, there would be less reliance on providers for free or discounted care. The major factors that led to the Steering Committee's decision not to pursue the approach were that providing subsidies would be very expensive, enforcement would be difficult and the option would face very strong political opposition.

Employer Mandate: This approach would have required all employers to offer coverage to their employees and pay a minimum proportion of the premium or pay a tax approximately equal to the employer's portion of the insurance premium. The approach builds on the existing employer-based insurance system and would have leveled the playing field for all employers. However, there were many limitations to this approach which led to its rejection, including: 1) it would not be politically feasible; 2) it could be challenged under ERISA; 3) low-wage workers might still not be able to afford the coverage; 4) it could discourage employers from locating their business in Massachusetts; 5) the option would only assist those people in the labor force; and 6) it would be very expensive if subsidies to certain employers were found to be necessary.

Unsubsidized Small Employer Health Insurance Purchasing Cooperative: This approach would have created a health insurance purchasing cooperative for small employers which would shop for, select and monitor the health insurance plans it makes available to its members. Employees of member employers would have been able to select from all plans available to the cooperative instead of only the plans that their employer offered. The major advantage of this approach is that it would increase consumer (employee) choice by allowing them to select from all plans available to the cooperative. In addition, premiums might be reduced since there would be a larger group purchasing the coverage, thus creating more buying power. However, the primary factors leading to the rejection of this approach include: 1) the state has already reformed the small group market and has insurance intermediaries that level the playing field for small employers; 2) there may be adverse selection; 3) research has suggested that purchasing cooperatives generally appeal to employers who might already offer coverage and who simply want to reduce the administrative hassle of having their own plans, therefore the ability of cooperatives to penetrate the uninsured population in small groups would probably be low.

State-Level "Single Payer": This approach would have guaranteed that all Massachusetts residents are automatically covered for a defined set of health care benefits and the coverage would be publicly financed. The advantages of this option are obvious, including that it guarantees universal coverage, creates no stigma since everyone is in the same system, eliminates the need for safety-net providers, and it may simplify quality of care monitoring.

However, this approach is precluded under the HRSA planning grant stipulations. In addition, there is great potential for an influx of sick residents from border states, there would potentially be a loss of federal funds tied to current law, and setting up the system for administration would be daunting. Finally, an examination of the feasibility of a single-payer system in Massachusetts is underway, made possible by funds appropriated by the state legislature. Results are forthcoming.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

Please see the option to enroll all those eligible for public programs (Full Enrollment of Currently Eligible). Please note that qualitative research is currently being performed to determine the barriers to enrollment in public programs and also to determine how most people (whether or not they are eligible for public programs) learn about the public and private coverage options available to them.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

A Steering Committee has served as the primary decision-making body for the planning process, while an Advisory Committee has provided important input on all aspects of the project. The Steering Committee includes senior level representatives of agencies/executive branches that are involved in some aspect of the health care or insurance market, including: Division of Medical Assistance, Division of Health Care Finance and Policy, Division of Employment and Training, Department of Public Health, Department of Mental Health, Department of Revenue and the Division of Insurance. In addition, the Steering Committee has senior level representation from the Group Insurance Commission which purchases health insurance for all state workers, the Executive Office of Elder Affairs, The Executive Office of Health and Human Services and the Governor's office. The core work team (comprised of staff from the Division of Medical Assistance, and the Division of Health Care Finance and Policy) serves as staff for the Steering Committee. Members of the work team have provided the Steering Committee with data, background information on the policy options Massachusetts considered, and much of the information needed by the Steering Committee for them to be able to make informed decisions. Steering Committee representatives from these agencies have supplied the core work team with useful information, offered their expertise and have served as the decision-makers throughout the planning process. The collaborative and inclusive nature of the Steering Committee has made it an extremely effective decision-making structure.

The grant's Advisory Committee is composed of key representatives from the Massachusetts health care, health insurance, and business industries, in addition to academic experts and representatives from consumer advocacy groups. State legislators also attended some Advisory Committee meetings and have been approached individually to provide input and political guidance on the policy options being considered. (See Appendix VI for the complete lists of Advisory and Steering Committee members.)

Overall, the governance structure for the planning process has worked well. The process ran smoothly with the assistance of core work team members on both logistical aspects of meeting arrangement and in gathering and organizing the data and information needed by the Steering Committee for decision-making. The most difficult aspect of sustaining the governance structure proved to be simply finding suitable times when committee members could meet.

Both the Steering and Advisory Committees met separately on multiple occasions throughout the grant process. They both assisted with developing the grant's guiding principles and assumptions (attached as Appendix V) as well as the potential policy options. Advisory Committee members participated in brainstorming sessions to develop and edit possible options, while Steering Committee members made decisions on which options to remove from consideration, which to continue to research and which to recommend.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Thus far, surveys have been the primary information gathering method used in Massachusetts to add public input into the planning process. Massachusetts has conducted separate surveys of the state's nongroup subscribers, physicians (to estimate what and how much free care is provided), and employers. Massachusetts fielded a 2000 Survey of Health Insurance Status of Massachusetts Residents prior to the grant award that contained several questions seeking more qualitative input from the public. The nongroup survey was mailed by the nongroup market's two primary carriers to 5000 of their subscribers in an effort to learn why they are purchasing nongroup plans, how much they are paying for coverage, as well as to gauge their satisfaction with the plans. There was a 34% response rate for this survey, higher than was expected. With assistance from the Massachusetts Medical Society, a survey about free care and self-pay services provided was mailed to 8000 of the state's primary care and specialty physicians. There was an 11% response rate for this survey. The state also conducted a 2001 Survey of Massachusetts Employers Regarding Health Insurance, which was described in more depth in Section 2 of this report. (See appendixes XI and XII for weblinks to the survey instruments.)

During the grant extension period, Massachusetts will continue to involve the public in the planning process. Consumer focus groups will be convened to learn more about the motivations and opinions of people buying insurance and those that either choose not to buy or cannot afford coverage. Separate focus groups may be conducted to bring together employers to learn more about their views regarding offering employees health insurance. Depending on the final options the state decides to pursue, we may seek input from the broader public.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

In June 2001, Massachusetts created a HRSA grant website (www.state.ma.us/hrsa) that has been used as an information warehouse for Advisory and Steering Committee members, as well as a vital link to the public. The existence of the site as well as its changing contents has been advertised on the Division of Health Care Finance and Policy's website as well as the Commonwealth of Massachusetts homepage. Subscribers to the Division of Health Care Finance and Policy's monthly electronic newsletter (including legislators, providers, advocacy groups and others) have been notified of new postings to the HRSA website.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The planning effort undertaken upon the award of this grant has allowed the state to bring together key state agencies and staff to work toward one goal: determining how to provide access to affordable health insurance to all Massachusetts residents. In addition, the planning process has encouraged state agencies to reach out to private sector representatives and advocacy groups to continue the dialogue around improving access to affordable health insurance coverage for all Massachusetts residents. Organizations such as the Massachusetts Medical Society and insurers

including Blue Cross and Blue Shield of Massachusetts (BCBSMA) and Harvard Pilgrim Health Care (HPHC) have directly assisted Massachusetts in completing surveys in exchange for the use of survey results.

The events of September 11th and the fallout of the economy since then have had a dramatic effect on the state's budget. Although some of the options being pursued do not require a large output of money from the state or federal government, some do, and they will likely be postponed until the state is on firm financial ground once again. Massachusetts biggest challenge moving forward is how to maintain the coverage successes we have experienced even with a declining economy. Massachusetts is somewhat unique because it already has a low uninsured rate, significantly due to efforts that expanded MassHealth (Medicaid) coverage a few years ago. To maintain current coverage levels through an economic slowdown would be a significant success. The grant extension period will provide us with some additional time to explore other possibilities regarding this maintenance goal moving forward.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was state-specific data to the decision-making process?

In regard to the health care and insurance markets, Massachusetts is quite different from many other states; therefore the use of state-specific data is especially crucial. The state already performs extensive routine data collection, which, in addition to supplemental data collection activities performed specifically for the planning grant, allowed us to rely mostly on Massachusetts data while filling in some gaps with national statistics. These state-level data allowed the state to design suitable options specifically for the health care marketplace in the Commonwealth.

Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives?

The Division of Health Care Finance and Policy's 2000 Survey of Health Insurance Status of Massachusetts Residents found that nearly 60% of all uninsured are between the ages of 19 and 39 and nearly 60% of all uninsured are males. Approximately 70% of the uninsured between the ages of 19 to 64 are working, and many of those people are self-employed. A significant percent of the state's uninsured are living in households with incomes between 200% and 400% of the federal poverty level (FPL) and a large percent of the uninsured have an even lower income but are categorically ineligible for MassHealth (Medicaid). This type of information allowed Massachusetts to focus on these people when designing some of the possible policy options. Examples of options the state is still researching and considering which directly assist these people include removing categorical eligibility for MassHealth below a certain income level, recommending the federal government provide full tax deductibility for the self-employed and those without access to employer-sponsored insurance, and making programmatic changes to the Insurance Partnership to increase the participation of employers and employees.

How important was the qualitative research in identifying stakeholder issues and facilitating program design?

Massachusetts has primarily used quantitative data in researching its policy options to date. We have contracted with The Access Project to conduct focus groups and/or interviews that will assess barriers to gaining coverage. We did perform a number of interviews with members of the Advisory Committee early on in the grant process to assess the feasibility of several options. In addition, several of the surveys conducted by the state had some qualitative questions. The responses to these questions helped us understand the problems many Massachusetts residents are facing when attempting to purchase coverage. The state did not generate policy options specifically based on the qualitative information; however, proposed options were adjusted to incorporate some of the qualitative data.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Massachusetts household surveys completed in 1998 and 2000 (and to be conducted again in 2002) were essential to policymaking surrounding coverage of the uninsured. The value of the information gleaned from these surveys certainly outweighed the cost. The 2001 Survey of Massachusetts Employers Regarding Health Insurance has also yielded important information, however it has been challenging and difficult to contact employers due to the inherent difficulties in reaching and speaking with busy employers. In addition, Massachusetts nongroup subscribers proved to be especially responsive to a mail survey which was not very resource intensive to distribute or analyze. Thirty-four percent of respondents returned their surveys, which included useful information on subscribers' motivations for purchasing nongroup insurance, the cost of premiums, and demographic data. Many respondents also expressed interest in participating in focus groups.

Massachusetts has ongoing data collection efforts that have proved to be useful for this project, while adding little additional cost. The DHCFP regularly collects hospital discharge data, observation stay data, and free care application and claims data. These data sources were analyzed specifically for the grant (to compare uninsured and insured populations and study those seeking free care), and only required staff time for the additional analyses.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

A few qualitative data collection activities that were planned have not taken place yet due to staff turnover, time constraints and the enormity of the project work. As mentioned in the answer to 6.2, we recently contracted with The Access Project to conduct some of this work.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

To improve response rates for both the physician and nongroup subscribers' surveys, cover letters explaining the survey and the grant were included along with self-addressed and postage paid envelopes. The response rate for the physician survey was about what the Massachusetts Medical Society expected (11%), while the response rate for the nongroup survey exceeded the health plans' expectations of a 25 percent response rate. (We received 34 percent of the surveys).

We contracted with The Center for Survey Research (CSR) at the University of Massachusetts Medical School, to conduct the 2001 Massachusetts employer survey. They have had difficulty getting responses, especially from very large multi-state companies and very small single location organizations. CSR felt that it was important to continue pursuing as many of the employers in the initial sample for as long as possible in order to reduce response bias. Although primarily a phone survey, they are allowing businesses that prefer not to answer the survey by

phone to answer it on paper by mail. The vendor began mailing surveys with $10, which has helped to improve the response rate.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

As explained in the answer to question 6.3, there are a few data collection activities that will soon be underway due to the grant extension awarded to Massachusetts. The most important questions remaining revolve around qualitative issues including the motivations and situations of people and employers. These issues will be addressed through focus groups and qualitative research.

Special surveys of state contracted employers and of individuals who have contracts with the state will be conducted to further inform policy options related to these "special responsibility" groups.

In addition, the state still must accurately estimate the financial impact of policy option being further pursued, including the size of the population that will be impacted the estimated crowd-out effect. This work will be completed in the upcoming months with the help of Dr. Jonathan Gruber, a renowned health economist at the Sloan School.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

After discussing the various eligibility and enrollment requirements for all of the state programs, we were struck by the complexity of the current system. Therefore, one long-term proposal that the state will continue to research during the grant extension period is a redesign of the administrative system that creates points of entry which support eligibility and enrollment activities for all state programs. The state will not propose other structural changes in any health care programs at this time.

Our collaborative process has again affirmed the importance of including a broad range of stakeholders in planning for insurance options, in order to have the greatest likelihood of success. We have also affirmed the importance of using data to make informed decisions, and support the appropriateness of using data that are specific to Massachusetts in our collaborative work.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Generally, we learned from the employer community (and especially small employers) that because premiums are rising rapidly, it is becoming increasingly difficult to provide health insurance to employees. In the current economy, many businesses are straining to sustain

themselves financially and thus cannot afford to expand or increase benefits. The data from our employer survey has just recently become available and we haven't had time yet to fully investigate how the results will inform our options moving forward. This will certainly be an area to focus on with a declining economy. The other lesson we learned is that people do not generally know what insurance options are available to them. While awareness of public programs is very good in this state, people not eligible for public programs and without access to employer sponsored insurance are less aware of their options in the nongroup and small group markets. One of our biggest challenges will be to educate people about their health insurance options.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

- Involve a broad-based Advisory Committee early on in the process. It is essential that their input is heard and that they are kept informed and aware of the planning process.
- Try to reach agreement (which will not always be unanimous) among state agencies, legislators and the governor's office on the process, as well as on the final decisions made by the group.
- Having members involved in the planning process that have different political backgrounds allows for thought-provoking discussions and keeps everyone on a realistic, non-partisan track.
- Recognize that each state is different, know your state's health care market history, and take that into account when deciding which options to pursue. A method for expanding affordable insurance coverage in one state might not work in another.
- Finally, don't underestimate the work that must be done during the planning process or the cost and buy-in necessary to implement any recommendations!

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require federal waiver authority or other changes in federal law (e.g., SCHIP regulations, ERISA)?

Massachusetts preliminary recommendations do not include any further waiver authority. Our recommendation that the federal government provide tax deductibility for the taxpayer's full cost of health insurance for self employed and those without access to employer sponsored health insurance; and tax credits in amounts that would significantly defray the cost of purchasing health insurance to lower-income people in the same circumstances, would require changes in federal income tax law. One option that Massachusetts is still considering involves removing categorical eligibility requirements for MassHealth's enrollment at various income levels. This would require federal waivers.

There are several other recommendations are making to the federal government which would not necessarily require changes to federal law or further waiver authority. We recommend that the federal government increase allotments to further encourage states to expand SCHIP to parents of children covered through SCHIP when those parents have access to employer sponsored health insurance. Massachusetts does this in many cases where cost neutrality calculations are met, but is not able to do this for all parents of kids covered by SCHIP who have access to employer sponsored health insurance.

Another longer-term recommendation that Massachusetts is making which would involve cooperation from the federal government is the redesign of the administrative system supporting eligibility and enrollment activities for all state programs to achieve a simple, unified point of entry. It will be critical to have federal participation in defining the criteria used, so that we are consistent in our treatment of people across programs regardless of funding streams. Eventually Massachusetts would like to have one enrollment system for all federal, state and local programs.

The Steering Committee also suggested that there are many opportunities for administrative and operational efficiencies in state-run, federally-funded programs that are impeded by federal inflexibility. These efficiencies could save large sums of money that could, in turn, be used to fund further expansions.

7.2 What coverage expansion options not selected require changes in federal law? What specific federal actions would be required to implement those options, and why should the federal government make those changes?

Massachusetts considered several buy-in options, one of which was a buy-in to the Federal Employee Health Benefit Program (FEHBP). While this seemed appealing to us on several fronts, the risk-pooling problems it would create seemed to out-weigh any benefits incurred. This option would have required some federal action to allow buy-in to a benefit offered at this time to federal employees only. We do not recommend action on this option by the federal government at this time.

7.3 What additional support should the federal government provide in terms of surveys or other efforts to identify the uninsured in States?

While it may be useful to have a consistent survey on health insurance conducted at a federal level, Massachusetts has had very good experiences collecting our own data on the uninsured through bi-annual household surveys. We do not feel it makes sense to collect these data at a national level for our purposes of identifying and targeting programs at the uninsured. Although most would argue that the recent changes made to the CPS are good, they still do not accurately portray the level of insurance coverage in our state. The survey remains a labor survey and the sampling, data collection, and timing remain out of the control of states. We see it as useful only for looking at trends and even then, because of sample size issues, it is not very useful. It might make sense for the federal government to subsidize state data collection efforts, instead.

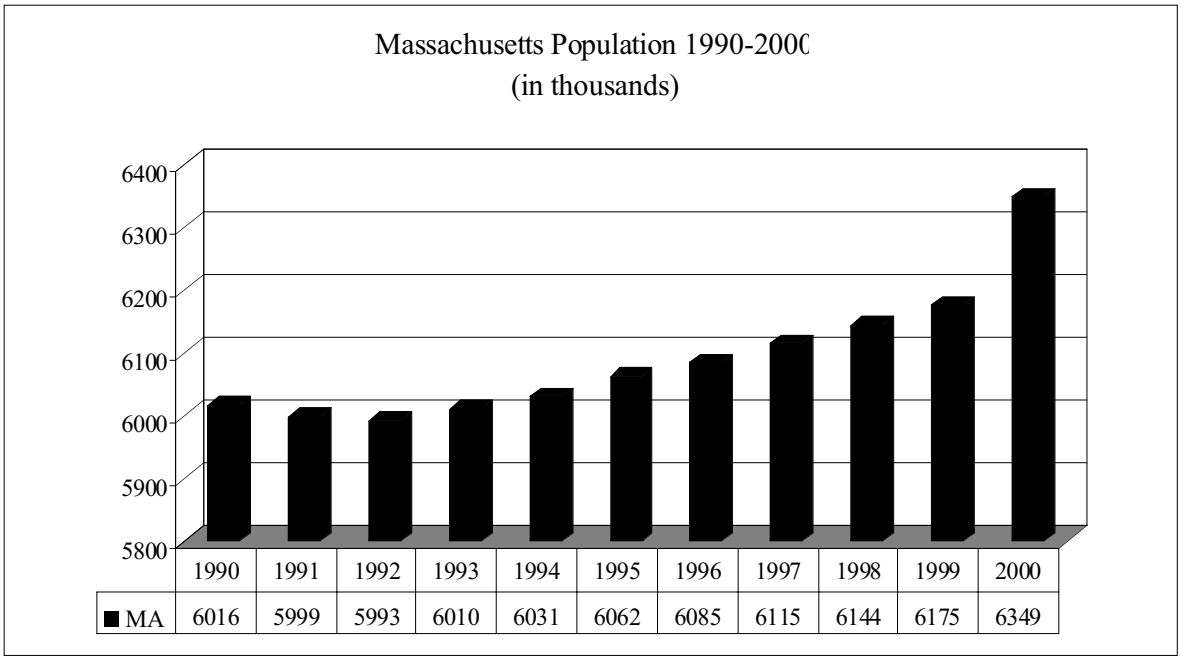
7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

The insurance markets, uninsured residents, and health care systems vary significantly by state. Therefore, Massachusetts has traditionally found data at the state-level to be more useful than national data and research. Massachusetts circumstances, in having a low rate of uninsurance make it unlikely that national approaches will work here. While we do see some benefit from more flexibility from the federal government and, of course, more funds, Massachusetts needs to understand why those Massachusetts residents who are eligible for programs or employer-sponsored insurance, do not participate, which we hope to learn during the second phase of the grant period. During the grant extension, we will continue to think about additional ways that the federal government or other foundations may be able to help the states.

APPENDIX I: BASELINE INFORMATION FOR MASSACHUSETTS

Massachusetts Population

Massachusetts experienced a 5.5% increase in resident population from 1990 to 2000 (6,016,425 to 6,349,097). There was a slight decrease in the state's population in 1991 and 1992.



Source: "State Population Data: Annual Time Series, July 1, 1990 to July 1, 1999," U.S. Census Bureau, www.census.gov/population /estimates/state/st-99-3.txt and "Resident Population of the 50 States, the District of Columbia, and Puerto Rico: April 1, 2000 (Census 2000) and April 1, 1990 (1990 Census)," U.S. Census Bureau, www.census.gov.

Average Age of the Massachusetts Population

The median age of the Massachusetts population is 36.5 years. The percent of the state's population that is over age 65 exceeds the national average, 13.5% versus 12.4%.

	Massachusetts				
Age Group	Under 18 years	18 to 24 years	25 to 44 years	45 to 64 years	65 years and over
Percent of Total Population	23.6	9.1	31.3	22.4	13.5

Source: "Profile of General Demographic Characteristics for Massachusetts: 2000," U.S. Census Bureau, and "Profile of General Demographic Characteristics for the United States: 2000," U.S. Census Bureau, www.census.gov/Pres-Release/www/2001/demoprofile/html.

Race/Ethnicity of the Massachusetts Population

The proportion of the Massachusetts population that is white is much higher than the national average. However, there has been an increase in the state's minority population over the last decade.

Race*	Percent
White	84.5
Black or African American	5.4
American Indian and Alaska Native	0.2
Asian	3.8
Persons Reporting Other	3.7
Persons Reporting 2 or More Races	2.3

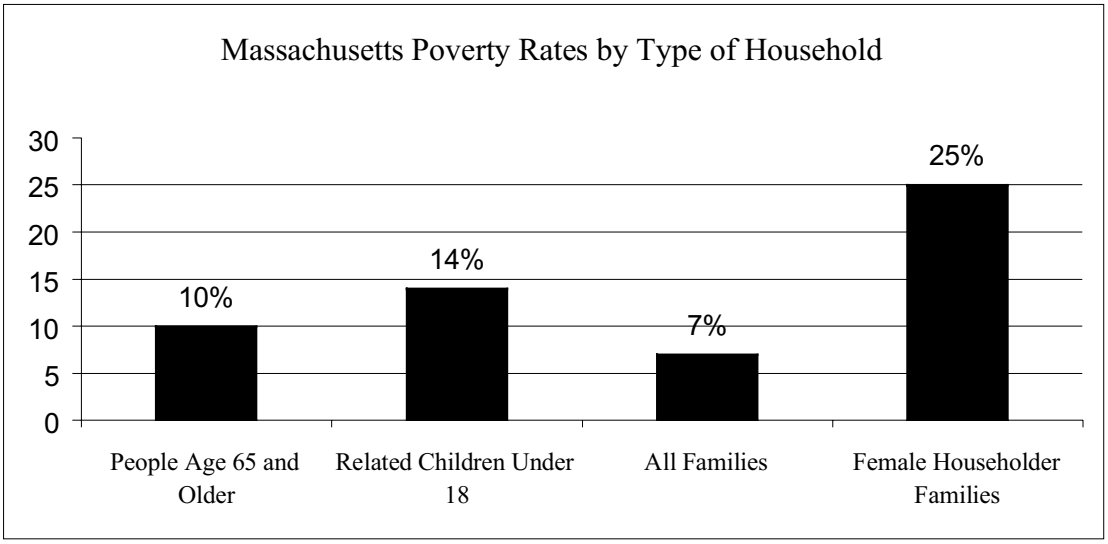
*Hispanics are included in the above figures as they may be of any race.

Hispanic or Latino	Percent
Hispanic or Latino of Any Race	6.8
Not Hispanic or Latino	93.2

Source: "Race and Hispanic or Latino: 2000", Census 2000 Summary File, U.S. Census Bureau, www.census.gov.

Percent of the Massachusetts Population Living in Poverty (<100% FPL)

Approximately 10% of the state's population live in poverty, with the greatest number residing in female householder families (no spouse present).



Source: "Population and Housing Profile: Massachusetts," Census 2000 Supplementary Survey, U.S. Census Bureau, www.census.gov/c2ss/www/Products/Profiles/2000/Narrative/NP04000US25.htm.

Number and Percentage of Uninsured

5.9% of Massachusetts residents are uninsured, a 28% decrease from 1998's rate of 8.2%. The rate of uninsurance, excluding the elderly, decreased 34% from 9.9% to 6.5%. The greatest numbers of uninsured reside in households with incomes between 200-400% of the FPL. Since 1998, the largest reduction in the number of uninsured has occurred in individuals with incomes below 200% of the FPL as a result of the expansion and increased enrollment efforts of the state's Medicaid program.

Household Income (%FPL)	**% of the Uninsured**	**% Uninsured within Income Group**
0-133%	14.4%	12.5%
134-150%	5.8%	11.9%
151-200%	23.0%	14.3%
201-400%	39.1%	8.0%
>400%	17.8%	2.0%
Total/Overall	***100.0%***	***6.5%***

Source: Survey of Health Insurance Status of Massachusetts Residents, Massachusetts Division of Health Care Finance and Policy, 1998 & 2000.

Primary Industries in Massachusetts

Industry	**Employees**
Services	1,191,000
Wholesale and Retail Trade	744,000
Manufacturing—durable goods	269,000
Local Government	264,000
Finance, Insurance and Real Estate	228,000
Manufacturing—nondurable goods	162,000
Transportation and Public Utilities	140,000
Construction and Mining	126,000
State Government	103,000
Federal Government	61,000

Source: "New England Economic Indicators", Federal Reserve Bank of Boston, August 2000 Edition Reflecting June 2000 Results, Massachusetts Department of Employment and Training.

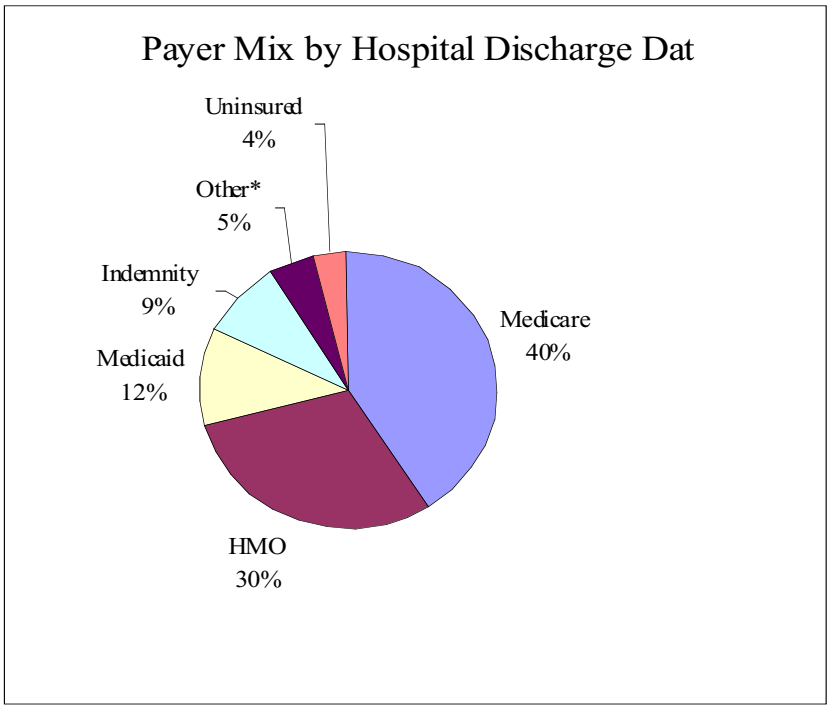
Percent of Massachusetts Employers Offering Coverage

Per DHCFP's 2001 Survey of Massachusetts Employers Regarding Health Insurance, 65.7% of Massachusetts employers offer health insurance. The percent of employers offering coverage varied by establishment size. Of establishments with more than 50 employees, 94.4% offer insurance, 5.6% do not. For those employers with 2-50 employees, 63.5% offer coverage, 36.7% do not.

Percent of Self-Insured (self-funded) Firms in Massachusetts

Per the Massachusetts 2001 employer survey, 14.5% of the employers that offer coverage have at least one self-insured plan. Of all people participating in an employer sponsored plan, 32% are enrolled in a self-insured plan.

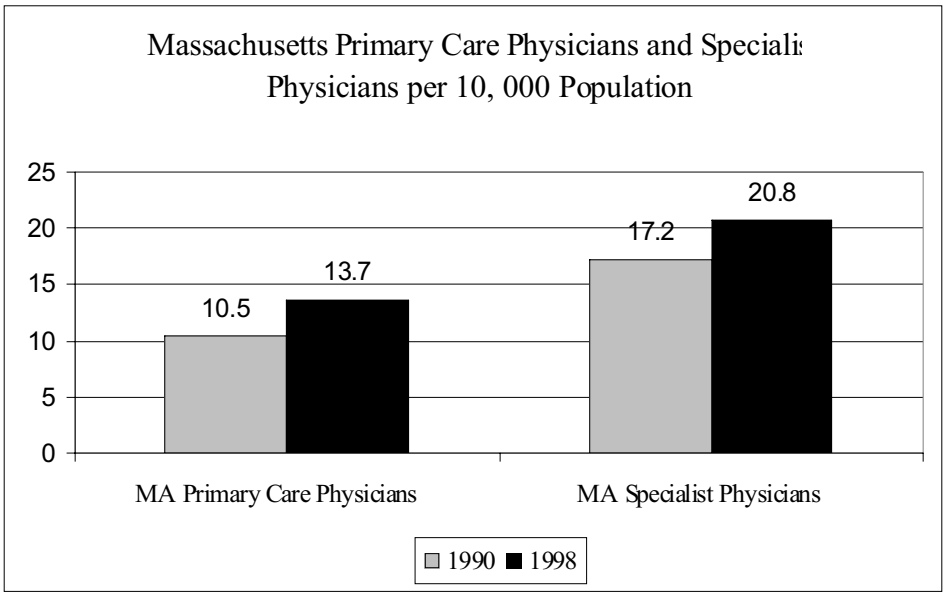
Payer Mix



*Other—Includes payments made by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
Source: Hospital Discharge Data, Massachusetts Division of Health Care Finance and Policy, 1999.

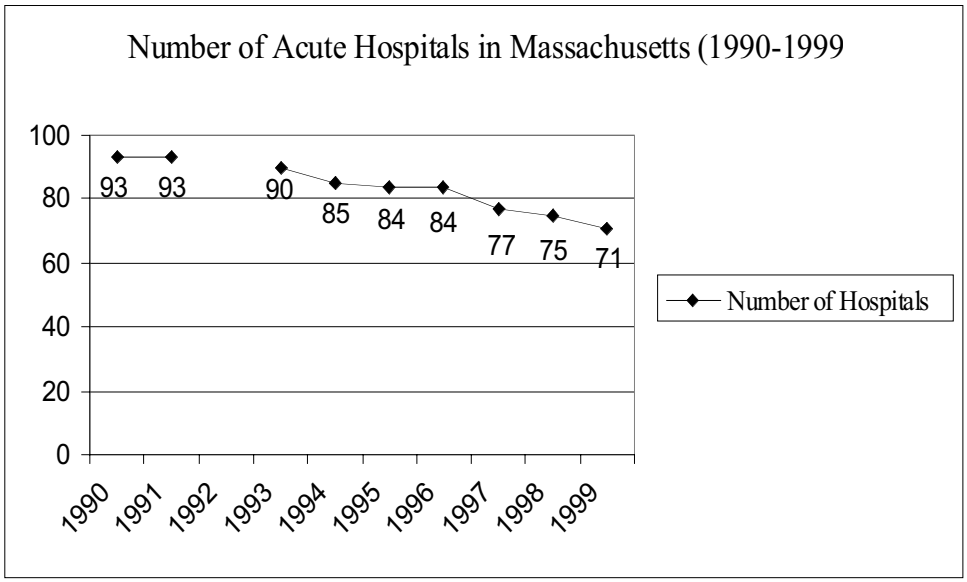
Provider Competition

Over the past decade Massachusetts experienced a growth in the number of primary care and specialist physicians practicing medicine in the state. Massachusetts has a greater number of primary care and specialist physicians per 10,000 population than the United States. In 1998, the U.S. had 9.9 primary care physicians per 10,000 population versus Massachusetts' 13.7. The same year, the U.S. had 13.3 specialists per 10,000 population versus Massachusetts' 20.8.



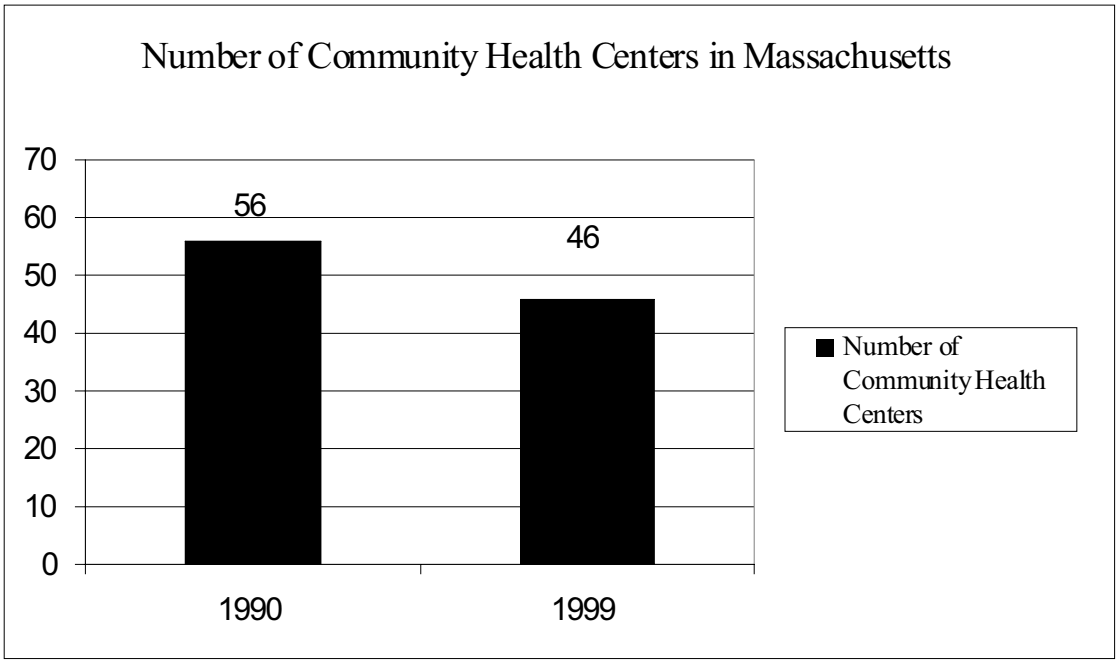
Source: "Physician Characteristics and Distribution in the U.S." (1992 and 2000-2001 edition), American Medical Association; " State Population Estimates: Annual Time Series, July 1, 1990 to July 1, 1999", U.S. Census Bureau, www.census.gov/population/estimates/state/st-99-3.txt.

Due to closings, conversions, and mergers, there has been a significant decrease in the number of acute care hospitals in Massachusetts from 1990 to 1999. In addition, the number of operating beds fell 26%.



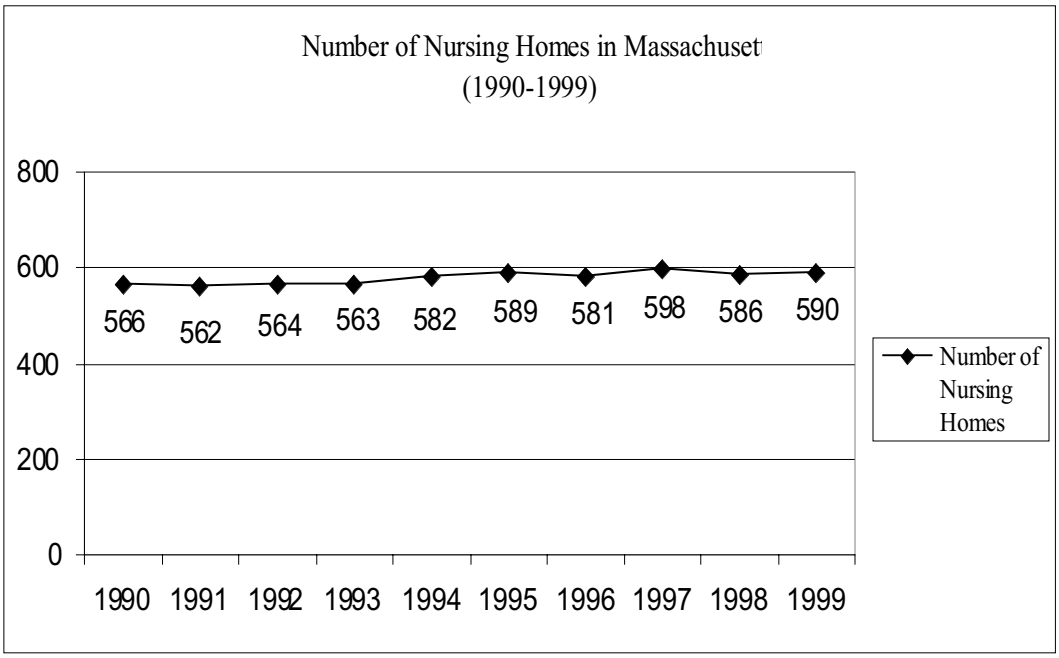
Source: "Hospital Statement for Reimbursement, DHCFP 403", Massachusetts Division of Health Care Finance and Policy.
Note: Complete data was not available for 1992.

The number of community health centers in the state decreased 18% from 1990 to 1999. However, during the same time period, the number of visits to community health centers increased 93% from 1.5 to 2.9 million visits.



Source: "Massachusetts Community Health Centers in Crisis: Facts, Trends and Strategic Solutions for Investing in the Safety Net, 2000 and Transitional Issues Report", Massachusetts League of Community Health Centers, January 1991.

There was a slight increase in the number of nursing home facilities over the past decade. The number of nursing home beds increased 16%.



Source: Massachusetts Department of Public Health, Division of Health Care Quality

Massachusetts Insurance Market Reforms

There have been a number of significant reforms made to the Massachusetts insurance market over the past decade. Most notably were changes that occurred in the small group health insurance market and the nongroup (individual) market. The reforms sought to improve access to health care insurance.

Prior to 1991, few carriers offered coverage to small groups, coverage was medically underwritten, and it tended to have long waiting periods and pre-existing condition limitations or exclusions.

In both 1991 and 1996, Massachusetts legislators and the governor approved significant reforms for regulating the small group market. In many regards, the laws go beyond the national protections established by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Massachusetts insurance reforms expanded the definition of a small group to include businesses with between 1 (self-employed) and 50 employees and required all carriers who elected to remain in the market to offer products on an equal basis, to all small groups, without medical underwriting. After the 1991 reform, 38 carriers decided to write small group business and today 27 carriers are participating in the small group insurance market. The number has decreased following the departure of several smaller carriers from the market and the consolidation of other companies.

The passage of Chapter 297 of the Acts of 1996 created "the nongroup law" (M.G.L. c. 176M), significantly reforming the nongroup market in Massachusetts. Subsequent amendments to the law were recently enacted with the passage of Chapter 140 of the Acts of 2000. Carriers who

participate in the *small* group market (1-50 employees) must offer a guaranteed issue nongroup product on an equal basis to all eligible individuals. As of December 31, 2000, there were 26 carriers in Massachusetts offering guaranteed issue nongroup products, covering 24,000 subscribers and representing 34,000 covered lives.

For a more detailed description of nongroup and small group insurance market reforms please see Appendix XIII and XIV.

Eligibility for Existing Coverage Programs

The Massachusetts Medicaid program, MassHealth, managed by the Division of Medical Assistance, pays or subsidizes the health insurance premiums for certain low- and medium-income residents of the Commonwealth who are, "under the age of 65 and who are not living in nursing homes or other long-term care facilities. These include: families with children under the age of 19, children under the age of 19, pregnant women, people out of work for a long time, disabled people, adults who work for a qualified employer, and people who are HIV positive". Other individuals and families may qualify for benefits based on income and life situation. Please see Appendix XVI for a detailed description of eligibility requirements.

Use of Federal Waivers

Massachusetts implemented its 1115 demonstration waiver in July of 1997. The 1115 waiver in combination with the State Children's Health Insurance Program (SCHIP), has enabled Massachusetts to simplify and streamline its eligibility process. In addition, the Commonwealth has been able to expand coverage to the following populations: children with incomes up to 200% of the FPL, parents with incomes up to 133% of the FPL, and long-term unemployed adults with incomes up to 133% of the FPL. Disabled individuals, regardless of income (based on a sliding scale premium), adults with incomes up to 200% of the FPL working for participating small employers through the Insurance Partnership, and HIV-positive individuals with income up to 200% of FPL also qualify under the 1115 demonstration waiver.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Please refer to the Massachusetts State Planning Grant web site at www.state.ma.us/hrsa for information related to research conducted by the state and for survey instruments and some survey results.

In addition, please see our References for sources we consulted (with web links) and a list of all survey instruments created and used in Massachusetts.

APPENDIX III: 1999 DISCHARGE DATA ANALYSIS – AGES 19-64

(EXCLUDES: PREGNANCY RELATED STAYS AND PROCEDURES, DISCHARGES FROM 3 MENTAL HEALTH HOSPITALS AND PATIENTS RESIDING OUTSIDE MASSACHUSETTS.)

This analysis of the Massachusetts 1999 Uniform Hospital Discharge Data Set (UHDDS) examines several variables for both uninsured and insured patients. In addition, insured patients are further broken down into two categories: Medicaid and all other insured.

Total number of 1999 discharges, Ages 19-64 = 241,498

Payer	Number of discharges	Percent of discharges
Uninsured	19,617	8.1%
Insured	221,881	91.9%
	241,498	100.0%
Uninsured	19,617	8.1%
Medicaid	40,551	16.8%
All other Insured	181,330	75.1%
	241,498	100.0%

Average/Median charge & Percent that uninsured represent of total charges

Payer	Mean charge	Median charge	Percent of all charges
Total (all payers)	$13,132	$7,554	
Uninsured	$10,514	$6,415	6.5%
Insured	$13,361	$7,653	93.5%
Uninsured	$10,514	$6,415	6.5%
Medicaid	$12,730	$6,809	16.3%
All other insured	$13,473	$7,841	77.2%

Average length of stay

Mean and median lengths of stay are presented for both total hospital discharges and total discharges excluding outliers of >33 days length of stay. Outliers represent less than 1% of total discharges.

Payer	All Discharges		Excluding stays of >33 days	
	mean	***median***	***mean***	***median***
Total (all payers)	5.1 days	3 days	4.6 days	3 days
Uninsured	4.6 days	3 days	4.2 days	3 days
Insured	5.1 days	3 days	4.6 days	3 days
Uninsured	4.6 days	3 days	4.2 days	3 days
Medicaid	6.2 days	4 days	5.4 days	4 days
All other insured	4.9 days	3 days	4.5 days	3 days

Top Ten DRGs for each payer based on number of discharges

Uninsured

1. Psychoses *(1,860)*
2. Opioid abuse or dependence w/o complications or comorbidities *(843)*
3. Alcohol abuse or dependence w/o complications or comorbidities *(658)*
4. Chest pain *(488)*
5. Esophagitis, gastroent and misc. digest discord age > 17 w/o complications or comorbidities *(373)*
6. Skin, subcutaneous tissue and breast plastic procedures *(343)*
7. Alcohol abuse or dependence with complications or comorbidities *(334)*
8. Depressive neuroses *(309)*
9. Appendectomy w/o complicated principal diag w/o complications or comorbidities *(275)*
10. Bronchitis & asthma age > 17 w/o complications or comorbidities *(266)*

Insured (all payers including Medicaid)

1. Psychoses *(18,957)*
2. Uterine and adnexa proc for ca in situ and non-malignancy w/o complications or comorbidities *(7,336)*
3. Chest pain *(4,304)*
4. Chronic obstructive pulmonary disease *(3,898)*
5. Esophagitis, gastroent and misc. digest discord age > 17 w/o complications or comorbidities *(3,713)*
6. Percutaneous cardiovascular proc w/o ami, heart failure or shock *(3,327)*
7. Simple pneumonia pleurisy age > 17 with complications or comorbidities *(3,311)*
8. Back and neck procedures except spinal fusion w/o complications or comorbidities *(3,261)*
9. Alcohol abuse or dependence w/o complications or comorbidities *(3,009)*
10. Maj joint and limb reattach proc of low ext exc for complications *(3,001)*

Medicaid only

1. Psychoses *(5,666)*
2. Chronic Obstructive pulmonary disease *(955)*
3. Opioid abuse or dependence w/o complications or comorbidities *(906)*
4. Alcohol abuse or dependence w/o complications or comorbidities *(776)*
5. Chest pain *(773)*
6. Simple pneumonia pleurisy age > 17 with complications or comorbidities *(700)*
   Uterine and adnexa proc for ca in situ and non-malignancy w/o complications or comorbidities *(700)*
7. Disorders of pancreas except malignancy *(635)*
8. Neuroses except depressive *(572)*
9. Depressive neuroses *(569)*

Insured, excluding Medicaid

1. Psychoses *(13,291)*
2. Uterine and adnexa proc for ca in situ and non-malignancy w/o complications or comorbidities *(6,636)*
3. Chest pain *(3,531)*
4. Esophagitis, gastroent and misc. digest discord age > 17 w/o complications or comorbidities *(3,204)*
5. Percutaneous cardiovascular proc w/o ami, heart failure or shock *(3,114)*
6. Back and neck procedures except spinal fusion w/o complications or comorbidities *(3,082)*
7. Chronic obstructive pulmonary disease *(2,943)*
8. Maj joint and limb reattach proc of low ext exc for complications *(2,766)*
9. Simple pneumonia pleurisy age > 17 with complications or comorbidities *(2,611)*
10. Alcohol abuse or dependence w/o complications or comorbidities *(2,233)*

Source of Patient Admission

Source of Admission	Percent of uninsured discharges	Percent of insured discharges *incl. Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl. Medicaid*
Direct physician referral	28.0%	35.6%	27.1%	37.6%
Within hospital clinic referral	2.8%	4.2%	2.6%	4.6%
Direct health plan referral / HMO referral	.1%	2.5%	.5%	2.9%
Transfer from acute hospital	4.6%	5.4%	4.9%	5.5%
Transfer from a skilled nursing home	.9%	1.3%	1.2%	1.3%
Transfer from intermediate care facility	.3%	.5%	.9%	.4%
Outside hospital emergency room transfer	52.6%	39.3%	49.2%	37.1%
Within hospital emergency room transfer	.2%	.2%	.2%	.3%
Court/law enforcement	.1%	0%	.1%	0%
Other (includes lev. 4 nursing facility)	1.3%	2.0%	4.5%	1.5%
Outside hospital clinic referral	0%	0%	.1%	0%
Walk-in/ self-referral	3.6%	3.6%	4.0%	3.5%
Transfer from outside ambulatory surgery	0%	0%	0%	0%
Within hospital ambulatory surgery	.7%	.9%	.4%	1%
Observation	4.6%	4.4%	4.4%	4.4%
Information not available	.1%	.1%	.1%	.1%
Total Discharges	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source of Admission	**Total Ages 19-64** *(#discharges)*	**% Uninsured** *(#discharges)*	**% Insured *incl.Medicaid*** *(#discharges)*	**% Medicaid** *(#discharges)*	**% Insured *excl.Medicaid*** *(#discharges)*
Direct physician referral	100.0% *(84,572)*	6.5% *(5,495)*	93.5% *(79,077)*	13.0% *(10,996)*	80.5% *(68,081)*
Within hospital clinic referral	100.0% *(9,851)*	5.5% *(546)*	94.5% *(9,305)*	10.7% *(1,052)*	83.8% *(8,253)*
Direct health plan referral / HMO referral	100.0% *(5,512)*	.5% *(28)*	99.5% *(5,484)*	3.3% (184)	96.2% *(5,300)*
Transfer from acute hospital	100.0% *(12,826)*	7% *(902)*	93% *(11,924)*	15.4% *(1,978)*	77.6% *(9,946)*
Transfer from a skilled nursing home	100.0% *(3,032)*	5.9% *(178)*	94.1% *(2,854)*	15.4% *(468)*	78.7% *(2,386)*
Transfer from intermediate care facility	100.0% *(1,090)*	5.8% *(63)*	94.2% *(1,027)*	32.5% *(354)*	61.7% *(673)*
Outside hospital emergency room transfer	100.0% *(97,512)*	10.6% *(10,310)*	89.4% *(87,202)*	20.5% *(19,943)*	69% *(67,259)*
Within hospital emergency room transfer	100.0% *(584)*	7.2% *(42)*	92.8% *(542)*	13.4% *(78)*	79.5% *(464)*
Court/law enforcement	100.0% *(81)*	14.8% *(12)*	85.2% *(69)*	27.2% *(22)*	58% *(47)*
Other (includes lev. 4 nursing facility)	100.0% *(4,739)*	5.5% *(261)*	94.5% *(4,478)*	38.6% *(1,827)*	55.9% *(2,651)*
Outside hosp clinic referral	100.0% *(73)*	11% *(8)*	89% *(65)*	37% *(27)*	52.1% *(38)*
Walk-in/ self-referral	100.0% *(8,687)*	8.2% *(701)*	91.9% *(7,986)*	18.7% *(1,621)*	73.3% *(6,365)*
Transfer from outside ambulatory surgery	100.0% *(4)*	25% *(1)*	75% *(3)*	0% *(0)*	75% *(3)*
Within hospital ambulatory surgery	100.0% *(2,034)*	6.7% *(136)*	93.3% *(1,898)*	8.9% *(180)*	84.5% *(1,718)*
Observation	100.0% *(10,674)*	8.5% *(904)*	91.5% *(9,770)*	16.6% *(1,776)*	74.9% *(7,994)*
Information not available	100.0% *(227)*	13.2% *(30)*	86.8% *(197)*	19.8% *(45)*	67% *(152)*
Total Discharges	**100.0% *(241,498)***	**8.1% *(19,617)***	**91.9% *(221,881)***	**16.8% *(40,551)***	**75.1% *(181,330)***

Patient Disposition at Discharge

Disposition at Discharge	Percent of uninsured discharges	Percent of insured discharges *incl. Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl. Medicaid*
Discharged to home	81.4%	71.7%	67.3%	72.7%
Discharge/transfer to another short term general hospital	2.2%	3%	2.4%	3.1%
Discharge to SNF	.8%	3.7%	3.9%	3.7%
Discharge to intermediate care facility	.1%	.2%	.4%	.2%
Further care – inpatient or OPD	1.5%	1.1%	.9%	1.1%
Discharge to home under care of home health agency	4.4%	11.5%	11.2%	11.6%
Left against medical advice	4.5%	1.8%	4.3%	1.3%
Discharge/transfer to home for IV drug therapy	.1%	.2%	.1%	.2%
Discharge/transfer to chronic hospital	.5%	.7%	1.2%	.6%
Discharge/transfer to mental health facility	.8%	.8%	1.5%	.7%
Discharge other	1.9%	1.4%	2.6%	1.2%
Discharge/transfer to rehab hospital	.7%	2.4%	2.4%	2.4%
Discharge/transfer to rest home	0%	.1%	.2%	0%
Expired	1%	1.5%	1.6%	1.4%
Hospice-home (only 82)	<1%	<1%	<1%	<1%
Hospice-medical facility (only 2)	0%	0%	0%	0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Disposition at Discharge	**Total** ***Ages 19-64*** *(#discharges)*	**% Uninsured** *(#discharges)*	**% Insured** ***incl.Medicaid*** *(#discharges)*	**% Medicaid** *(#discharges)*	**% Insured** ***excl. Medicaid*** *(#discharges)*
Discharged to home	100.0% *(175,049)*	9.1% *(15,970)*	90.9% *(159,079)*	15.6% *(27,288)*	75.3% *(131,791)*
Discharge/transfer to another short term general hospital	100.0% *(7,093)*	6.2% *(440)*	93.8% *(6,653)*	13.8% *(981)*	80% *(5,672)*
Discharge to SNF	100.0% *(8,395)*	1.8% *(151)*	98.2% *(8,244)*	18.7% *(1,569)*	79.5% *(6,675)*
Discharge to intermediate care facility	100.0% *(510)*	4.5% *(23)*	95.5% *(487)*	29.6% *(151)*	65.9% *(336)*
Further care – inpatient or OPD	100.0% *(2,624)*	11.6% *(303)*	88.5% *(2,321)*	14.3% *(374)*	74.2% *(1,947)*
Discharge to home under care of home health agency	100.0% *(26,386)*	3.3% *(864)*	96.7% *(25,522)*	17.2% *(4,541)*	79.5% *(20,981)*
Left against medical advice	100.0% *(4,913)*	18.1% *(887)*	82.0% *(4,026)*	35.4% *(1,739)*	46.6% *(2,287)*
Discharge/transfer to home for IV drug therapy	100.0% *(382)*	2.9% *(11)*	97.1% *(371)*	14.7% *(56)*	82.5% *(315)*
Discharge/transfer to chronic hospital	100.0% *(1,590)*	5.9% *(93)*	94.2% *(1,497)*	31.7% *(504)*	62.5% *(993)*
Discharge/transfer to mental health facility	100.0% *(1,938)*	8.3% *(160)*	91.7% *(1,778)*	31% *(601)*	60.7% *(1,177)*
Discharge other	100.0% *(3,523)*	10.8% *(381)*	89.2% *(3,142)*	29.4% *(1,036)*	59.8% *(2,106)*
Discharge/transfer to rehab hospital	100.0% *(5,391)*	2.4% *(129)*	97.6% *(5,262)*	17.8% *(960)*	79.8% *(4,302)*
Discharge/transfer to rest home	100.0% *(159)*	1.9% *(3)*	98.1% *(156)*	48.4% *(77)*	49.7% *(79)*
Expired	100.0% *(3,460)*	5.7% *(198)*	94.3% *(3,262)*	19.2% *(665)*	75.1% *(2,597)*
Hospice-home	100.0% *(82)*	4.9% *(4)*	95.1% *(78)*	11% *(9)*	84.2% *(69)*
Hospice-medical facility	100.0% *(2)*	0% *(0)*	0% *(2)*	0% *(0)*	0% *(2)*
Total	**100.0%** ***(241,498)***	**8.1%** ***(19,617)***	**91.9%** ***(221,881)***	**16.8%** ***(40,551)***	**75.1%** ***(181,330)***

Admission Type

Type of Admission	Percent of uninsured discharges	Percent of insured discharges *incl.Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl.Medicaid*
Emergency	58.9%	47.7%	54.4%	46.2%
Urgent	28.0%	28.5%	33.7%	27.4%
Elective	13.1%	23.8%	11.8%	26.4%
Unknown	<1%	<1%	<1%	<1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Type of Admission	Total Ages 19-64 *(#discharges)*	% Uninsured *(#discharges)*	% Insured *incl. Medicaid* *(#discharges)*	% Medicaid *(#discharges)*	% Insured *excl.Medicaid* *(#discharges)*
Emergency	100.0% *(117,330)*	9.9% *(11,555)*	90.2% *(105,775)*	18.8% *(22,073)*	71.3% *(83,702)*
Urgent	100.0% *(68,775)*	8% *(5,492)*	92.01% *(63,283)*	19.9% *(13,675)*	72.1% *(49,608)*
Elective	100.0% *(55,301)*	4.6% *(2,564)*	95.4% *(52,737)*	8.7% *(4,788)*	86.7% *(47,949)*
Unknown	100.0% *(92)*	6.5% *(6)*	93.5% *(86)*	16.3% *(15)*	77.2% *(71)*
Total	**100.0%** ***(241,498)***	**8.1%** ***(19,617)***	**91.9%** ***(221,881)***	**16.8%** ***(40,551)***	**75.1%** ***(181,330)***

Teaching status of hospital from which patient is discharged - by payer

Teaching status	Percent of uninsured discharges	Percent of insured discharges *incl. Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl. Medicaid*
Non-teaching hospital	52.1%	49.9%	53.3%	49.2%
Teaching hospital	47.9%	50.1%	46.7%	50.8%
***Total* (241,498)**	**100.0%**	**100.0%**	**100.0%**	**100%**
Subset: Boston metropolitan area non-teaching hospitals (37,498)	35.9%	32.3%	28.2%	33.0%
Subset: Boston metropolitan area teaching hospitals (77,518)	64.2%	67.7%	71.8%	67.0%
***Total* (115,016)**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Teaching status	Total Ages 19-64 *(#discharges)*	% Uninsured *(#discharges)*	% Insured *incl.Medicaid (#discharges)*	% Medicaid *(#discharges)*	% Insured *excl.Medicaid (#discharges)*
Non-teaching hospital	100.0%	8.5%	91.6%	17.9%	73.7%
Teaching hospital	100.0%	7.8%	92.2%	15.7%	76.5%
(subset: Boston metropolitan area non-teaching hospitals – 37,498)	100.0%	9.8%	90.2%	12%	78.2%
(subset: Boston metropolitan area teaching hospitals – 77,518)	100.0%	8.5%	91.5%	14.7%	76.8%
Total	**100.0%** ***(241,498)***	**8.1%** ***(19,617)***	**91.9%** ***(221,881)***	**16.8%** ***(40,551)***	**75.1%** ***(181,330)***

Average age of patients by payer

Total average age (all payers) – 45.6 years

Uninsured:	39.3 years	Medicaid:	42.4 years
Insured:	46.2 years	All other insured:	47.0 years

Gender of patients by payer

Gender	Percent of uninsured discharges	Percent of insured discharges *incl. Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl. Medicaid*
Female	37.8%	51.5%	56.9%	50.3%
Male	62.2%	48.5%	43.1%	49.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

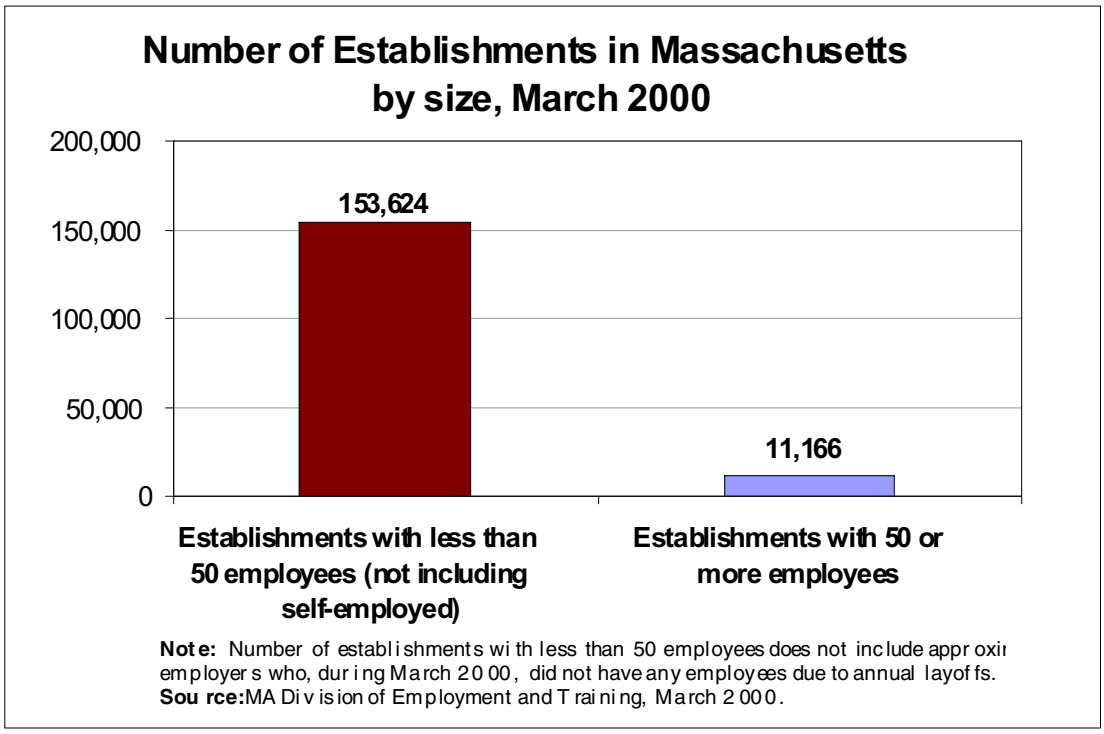
Gender	Total Ages 19-64 *(#discharges)*	% Uninsured *(#discharges)*	% Insured *incl. Medicaid* *(#discharges)*	% Medicaid *(#discharges)*	% Insured *excl. Medicaid* *(#discharges)*
Female	100.0% *(121,727)*	6.1% *(7,415)*	93.9% *(114,312)*	19.0% *(23,089)*	74.9% *(91,223)*
Male	100.0% *(119,764)*	10.2% *(12,200)*	89.8% *(107,564)*	14.6% *(17,459)*	75.2% *(90,105)*
Total	**100.0% *(241,498)***	**8.1% *(19,617)***	**91.9% *(221,881)***	**16.8% *(40,551)***	**75.1% *(181,330)***

Patient race by payer

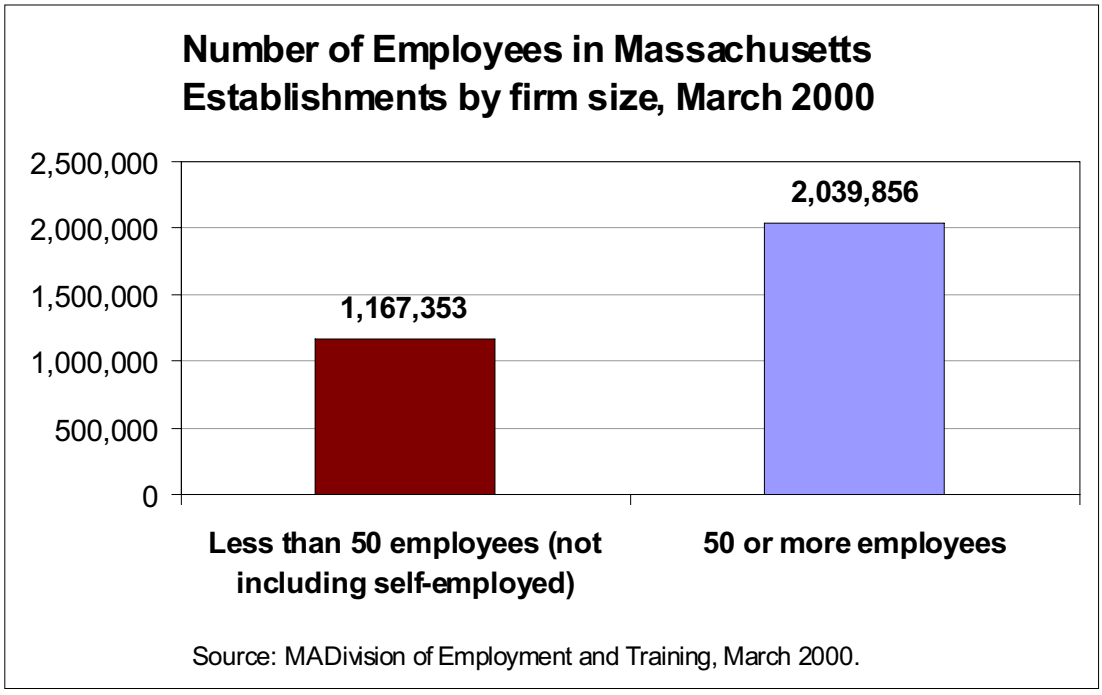
Race	Percent of uninsured discharges	Percent of insured discharges *incl. Medicaid*	Percent of Medicaid discharges	Percent of insured discharges *excl. Medicaid*
White	63.2%	79.9%	65.1%	83.2%
Black	12.3%	7.1%	12.6%	5.8%
Other	2.7%	.9%	1.2%	.9%
Unknown	7.6%	5.8%	5.1%	5.9%
American Indian	.2%	.1%	.2%	.1%
Asian	2.2%	1.1%	2%	.9%
Hispanic	11.8%	5.1%	13.8%	3.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Race	Total Ages 19-64 *(#discharges)*	% Uninsured *(#discharges)*	% Insured ***incl. Medicaid*** *(#discharges)*	% Medicaid *(#discharges)*	% Insured ***excl. Medicaid*** *(#discharges)*
White	100.0% *(189,670)*	6.5% *(12,401)*	93.5% *(177,269)*	13.9% *(26,380)*	79.5% *(150,889)*
Black	100.0% *(18,134)*	13.3% *(2,416)*	86.7% *(15,718)*	28.3% *(5,126)*	58.4% *(10,592)*
Other	100.0% *(2,546)*	20.7% *(528)*	79.3% *(2,018)*	18.8% *(478)*	60.5% *(1,540)*
Unknown	100.0% *(14,235)*	10.4% *(1,485)*	89.6% *(12,750)*	14.4% *(2,055)*	75.1% *(10,695)*
American Indian	100.0% *(274)*	12.8% *(35)*	87.2% *(239)*	21.9% *(60)*	65.3% *(179)*
Asian	100.0% *(2,866)*	14.8% *(424)*	85.2% *(2,442)*	28.5% *(818)*	56.7% *(1,624)*
Hispanic	100.0% *(13,671)*	16.9% *(2,314)*	83.1% *(11,357)*	41% *(5,603)*	42.1% *(5,754)*
Missing data	100.0% *(102)*	13.7% *(14)*	86.3% *(88)*	30.1% *(31)*	55.9% *(57)*
Total	**100.0% *(241,498)***	**8.1% *(19,617)***	**91.9% *(221,881)***	**16.8% *(40,551)***	**75.1% *(181,330)***

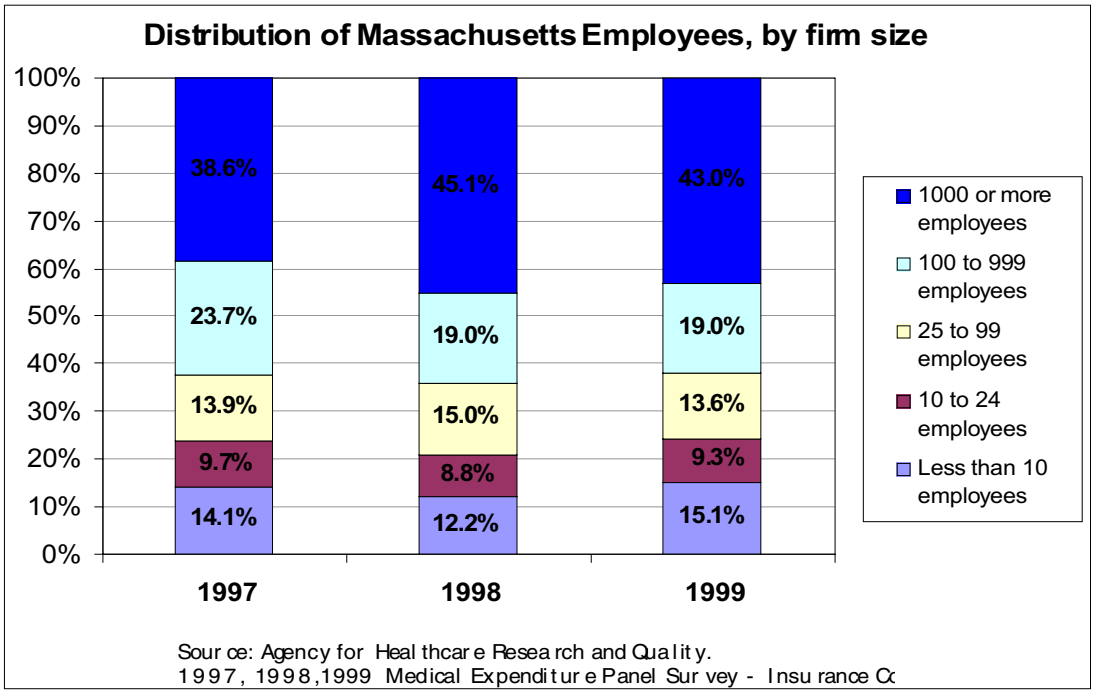
APPENDIX IV: MASSACHUSETTS EMPLOYER DATA

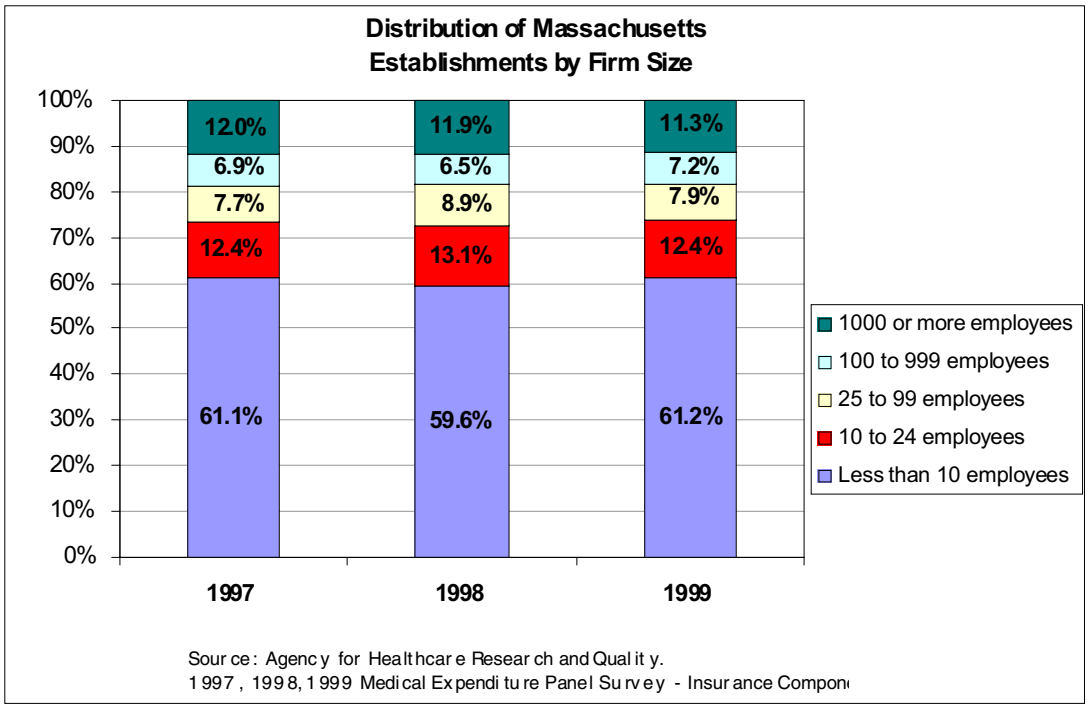


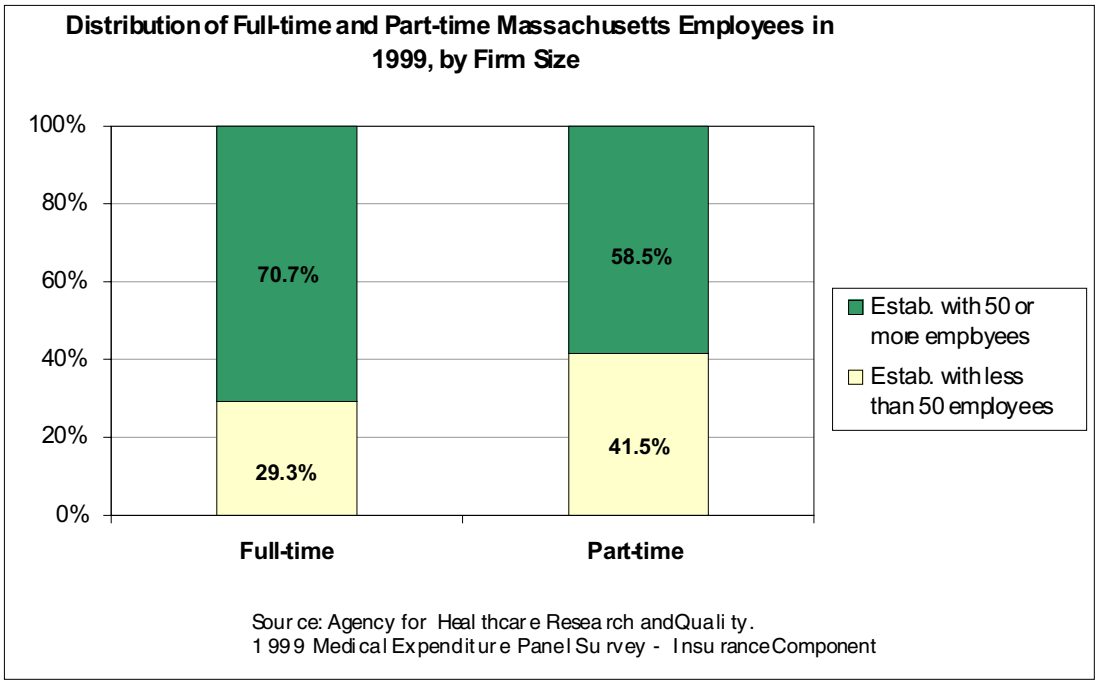
Note: Number of establishments with less than 50 employees does not include approximately employers who, during March 2000, did not have any employees due to annual layoffs.
Source: MA Division of Employment and Training, March 2000.



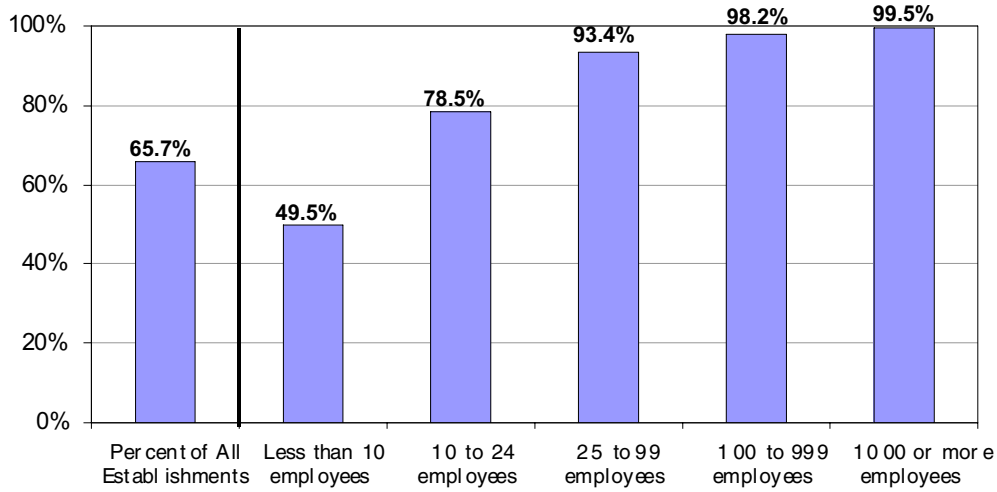
Source: MADivision of Employment and Training, March 2000.


Distribution of Massachusetts Employees, by firm size
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
38.6%
23.7%
13.9%
9.7%
14.1%
45.1%
19.0%
15.0%
8.8%
12.2%
43.0%
19.0%
13.6%
9.3%
15.1%
1997
1998
1999
1000 or more employees
100 to 999 employees
25 to 99 employees
10 to 24 employees
Less than 10 employees
Source: Agency for Healthcare Research and Quality.
1997, 1998,1999 Medical Expenditure Panel Survey - Insurance Cc


Distribution of Massachusetts
Establishments by Firm Size
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
12.0%
6.9%
7.7%
12.4%
61.1%
11.9%
6.5%
8.9%
13.1%
59.6%
11.3%
7.2%
7.9%
12.4%
61.2%
1997
1998
1999
1000 or more employees
100 to 999 employees
25 to 99 employees
10 to 24 employees
Less than 10 employees
Source: Agency for Healthcare Research and Quality.
1997, 1998,1999 Medical Expenditure Panel Survey - Insurance Compon

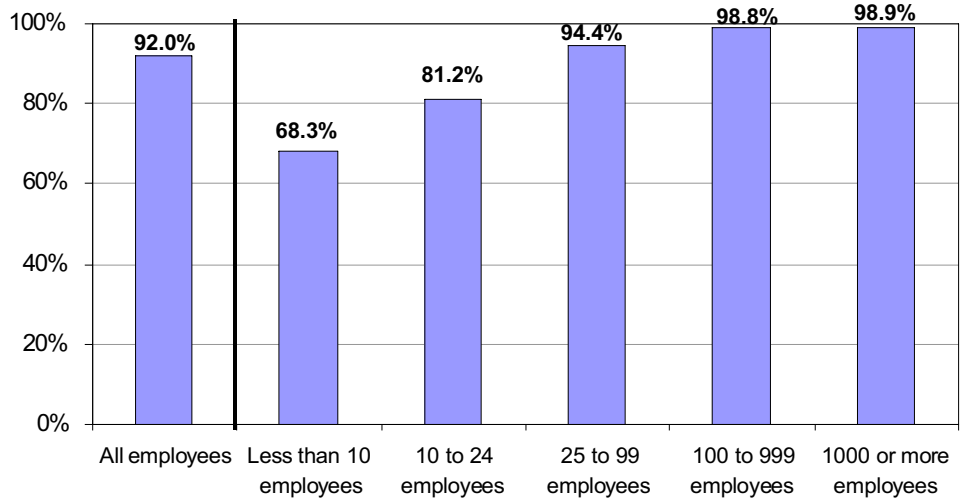

Distribution of Full-time and Part-time Massachusetts Employees in 1999, by Firm Size
100%
80%
60%
40%
20%
0%
70.7%
29.3%
58.5%
41.5%
Full-time
Part-time
Estab. with 50 or more empbyees
Estab. with less than 50 employees
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component

Percent of Massachusetts Establishments that Offer Health Insurance, by Firm Size, 1999

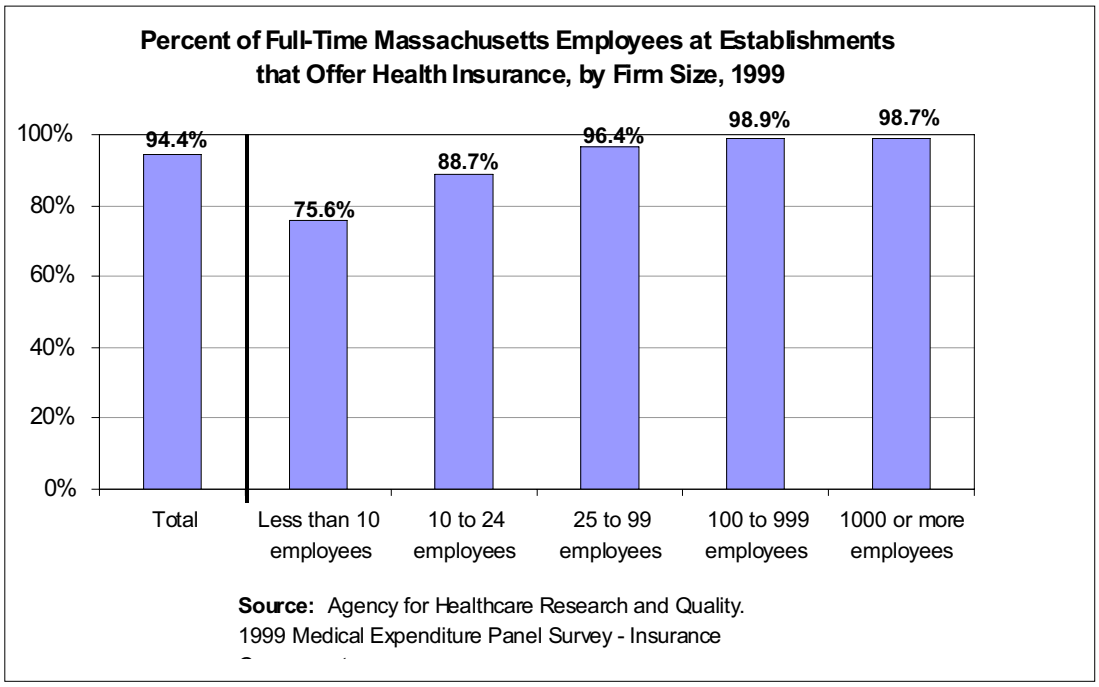


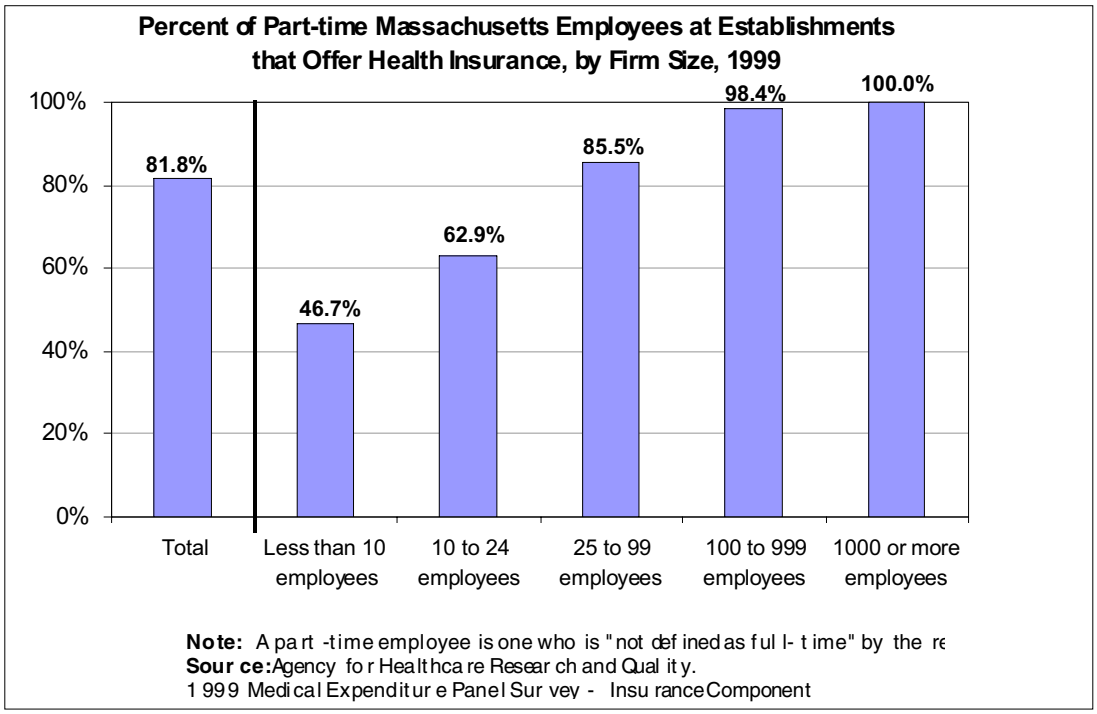
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component

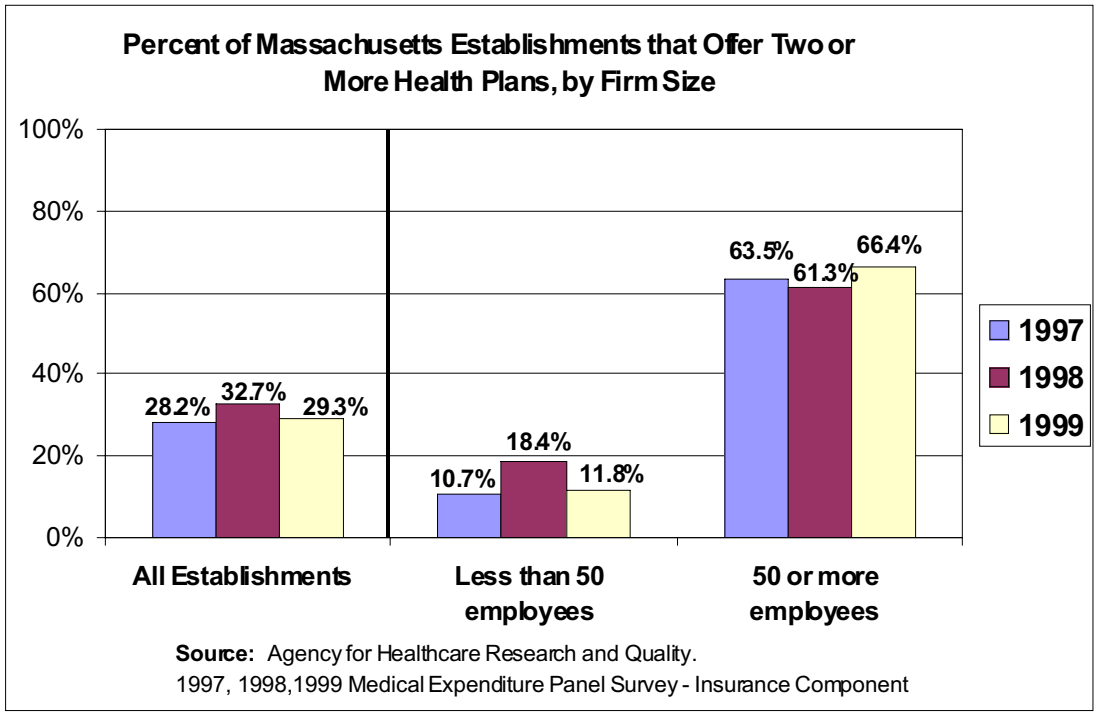
Percent of Massachusetts Employees who are Offered Health Insurance, by Firm Size, 1999

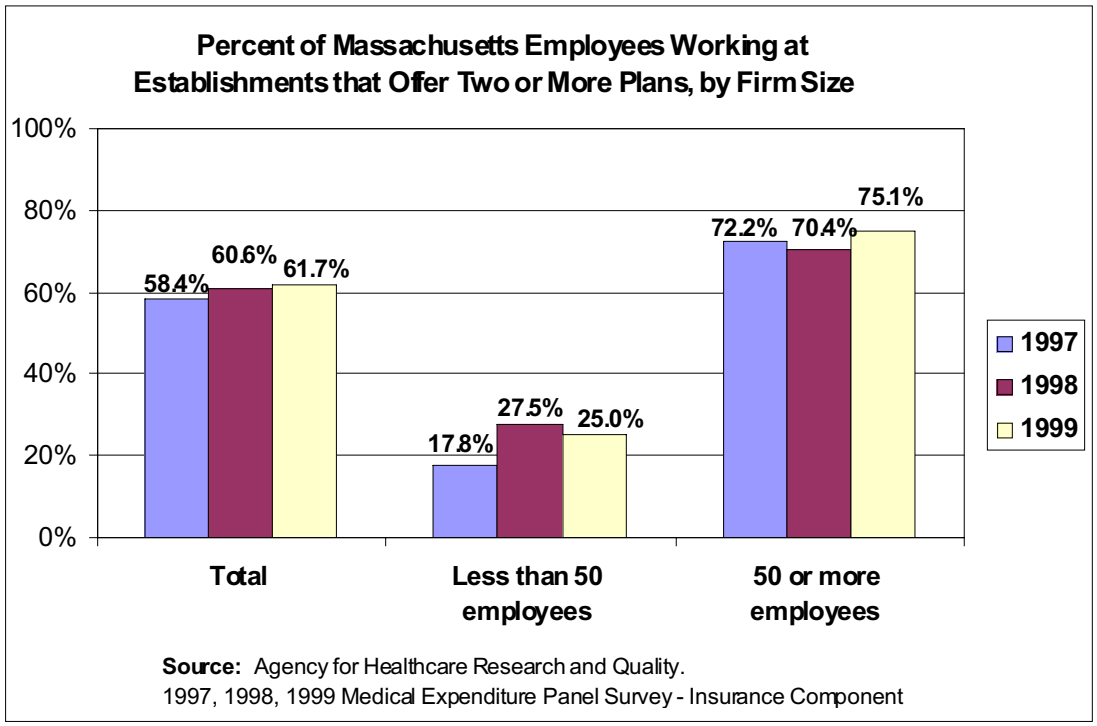


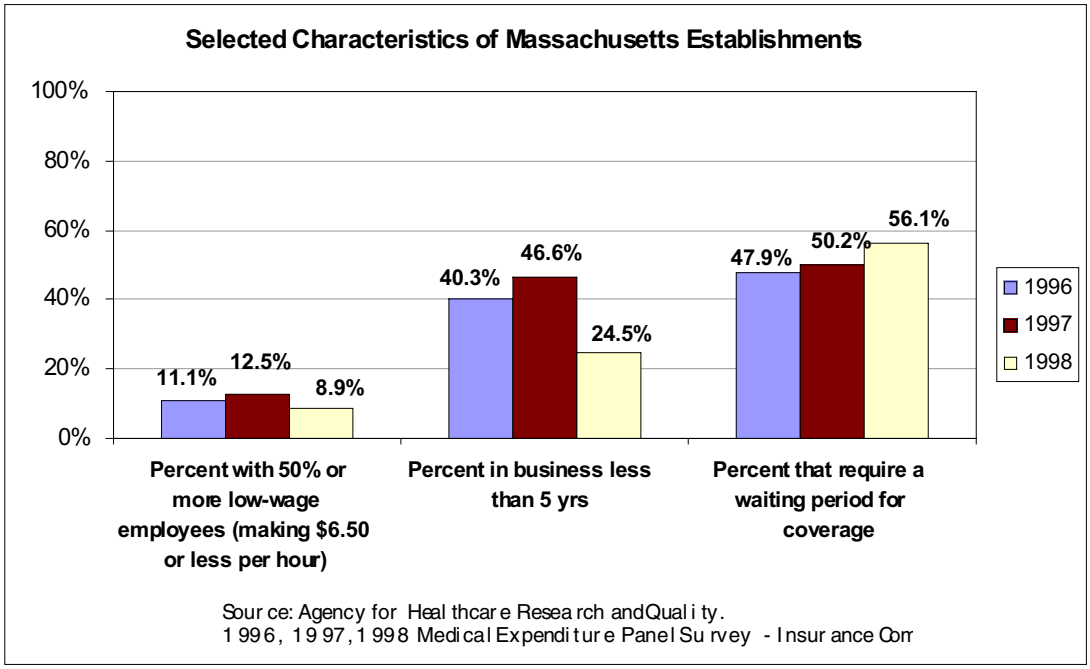
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component

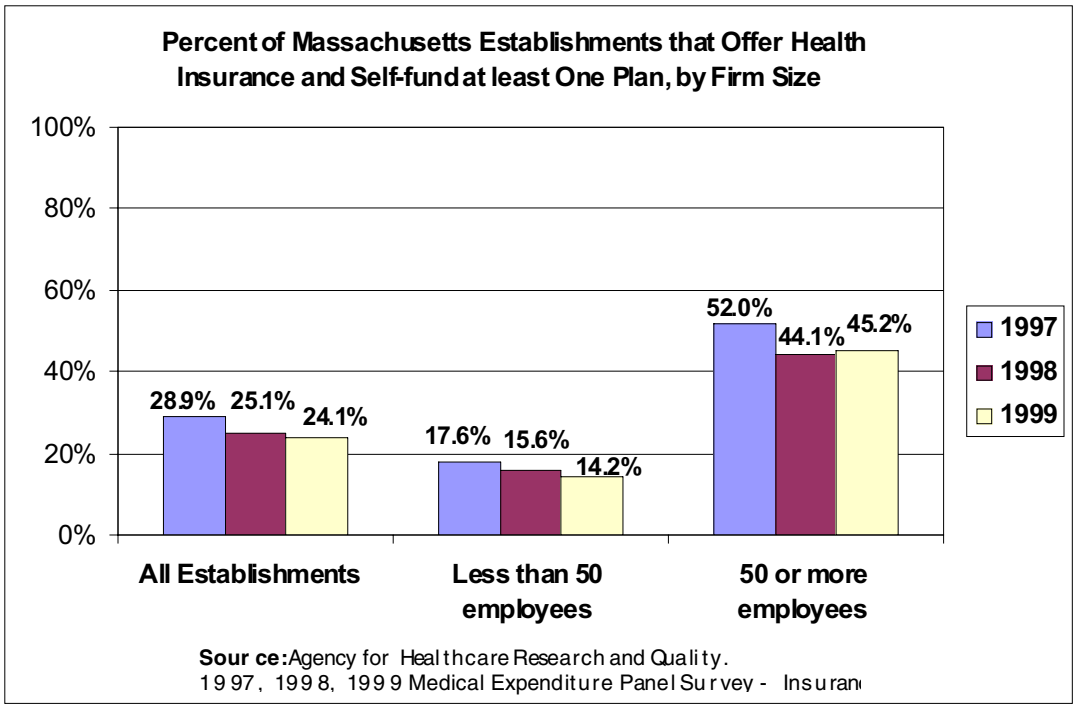

Percent of Full-Time Massachusetts Employees at Establishments that Offer Health Insurance, by Firm Size, 1999
100%
80%
60%
40%
20%
0%
94.4%
75.6%
88.7%
96.4%
98.9%
98.7%
Total
Less than 10 employees
10 to 24 employees
25 to 99 employees
100 to 999 employees
1000 or more employees
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance

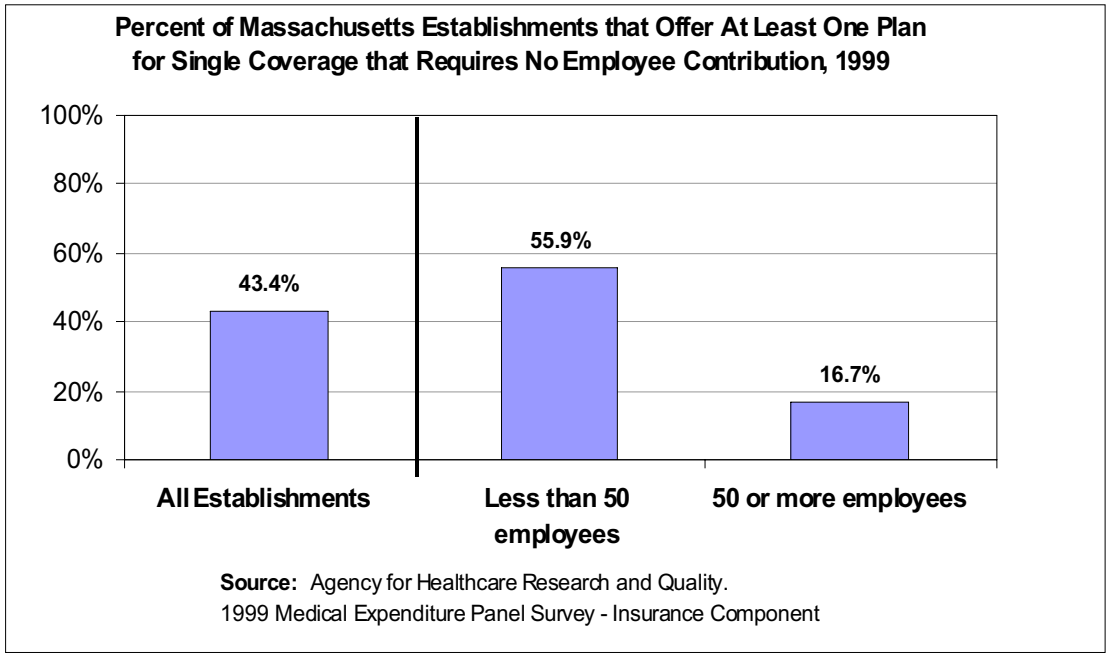

Percent of Part-time Massachusetts Employees at Establishments that Offer Health Insurance, by Firm Size, 1999
100%
80%
60%
40%
20%
0%
81.8%
46.7%
62.9%
85.5%
98.4%
100.0%
Total
Less than 10 employees
10 to 24 employees
25 to 99 employees
100 to 999 employees
1000 or more employees
Note: A part-time employee is one who is "not defined as full-time" by the re
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component

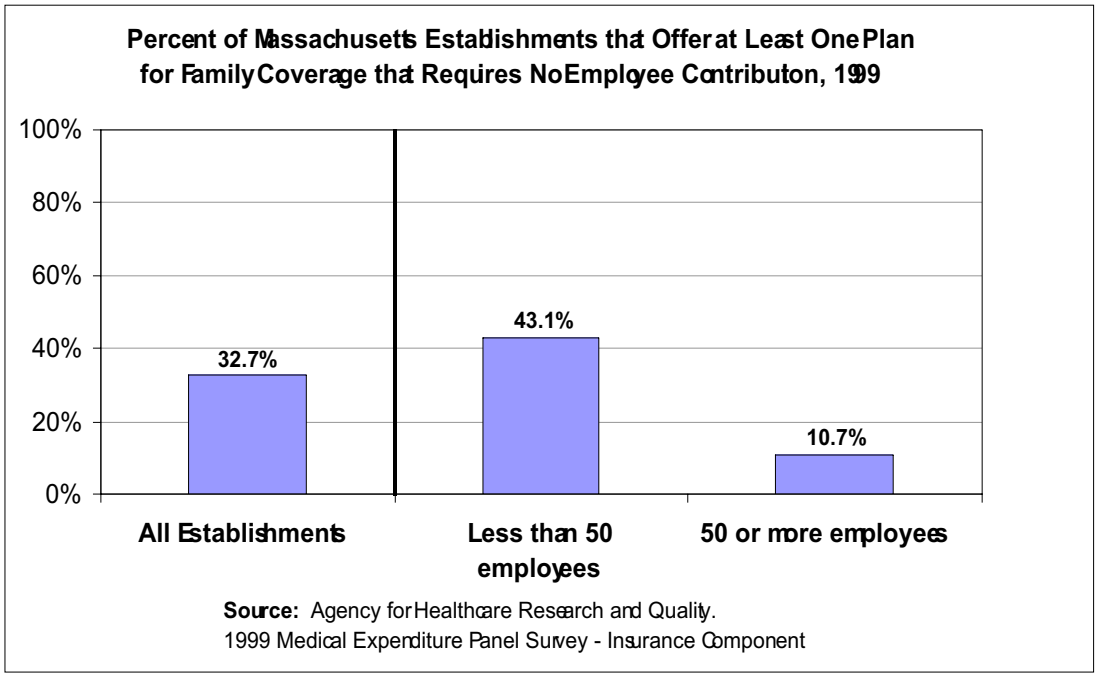

Percent of Massachusetts Establishments that Offer Two or More Health Plans, by Firm Size
100%
80%
60%
40%
20%
0%
28.2%
32.7%
29.3%
10.7%
18.4%
11.8%
63.5%
61.3%
66.4%
All Establishments
Less than 50 employees
50 or more employees
1997
1998
1999
Source: Agency for Healthcare Research and Quality.
1997, 1998,1999 Medical Expenditure Panel Survey - Insurance Component


Percent of Massachusetts Employees Working at Establishments that Offer Two or More Plans, by Firm Size
100%
80%
60%
40%
20%
0%
58.4%
60.6%
61.7%
17.8%
27.5%
25.0%
72.2%
70.4%
75.1%
Total
Less than 50 employees
50 or more employees
1997
1998
1999
Source: Agency for Healthcare Research and Quality.
1997, 1998, 1999 Medical Expenditure Panel Survey - Insurance Component


Selected Characteristics of Massachusetts Establishments
100%
80%
60%
40%
20%
0%
11.1%
12.5%
8.9%
40.3%
46.6%
24.5%
47.9%
50.2%
56.1%
1996
1997
1998
Percent with 50% or more low-wage employees (making $6.50 or less per hour)
Percent in business less than 5 yrs
Percent that require a waiting period for coverage
Source: Agency for Healthcare Research and Quality.
1996, 1997, 1998 Medical Expenditure Panel Survey - Insurance Com


Percent of Massachusetts Establishments that Offer Health Insurance and Self-fund at least One Plan, by Firm Size
100%
80%
60%
40%
20%
0%
28.9%
25.1%
24.1%
17.6%
15.6%
14.2%
52.0%
44.1%
45.2%
1997
1998
1999
All Establishments
Less than 50 employees
50 or more employees
Source: Agency for Healthcare Research and Quality.
1997, 1998, 1999 Medical Expenditure Panel Survey - Insuran


Percent of Massachusetts Establishments that Offer At Least One Plan for Single Coverage that Requires No Employee Contribution, 1999
100%
80%
60%
40%
20%
0%
43.4%
55.9%
16.7%
All Establishments
Less than 50 employees
50 or more employees
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component


Percent of Massachusetts Establishments that Offer at Least One Plan for Family Coverage that Requires No Employee Contributon, 1999
100%
80%
60%
40%
20%
0%
32.7%
43.1%
10.7%
All Establishments
Less than 50 employees
50 or more employees
Source: Agency for Healthcare Research and Quality.
1999 Medical Expenditure Panel Survey - Insurance Component

Employee Eligibility for Health Insurance through Employment*

All Employees				
Year	At establishments that offer	Eligible at establishments that offer	Eligible and Enrolled at Establishments that offer	Enrolled (of the total number of employees at the establishment-whether eligible or not eligible)
1996	89.6%	83%	83.7%	69.4%
1997	89.1%	78%	81.9%	64%
1998	91.7%	76.4%	79.8%	60.9%
1999	92%	77.2%	81%	62.6%

Full-Time Employees				
Year	At establishments that offer	Eligible at establishments that offer	Eligible and Enrolled at Establishments that offer	Enrolled (of the total number of employees at the establishment-whether eligible or not eligible)
1996	92.9%	91.4%	85.6%	78.2%
1997	92.5%	89.8%	84.5%	75.9%
1998	93.9%	84.7%	81.7%	69.2%
1999	94.4%	87.2%	82.6%	72.0%

Part-Time Employees				
Year	At establishments that offer	Eligible at establishments that offer	Eligible and Enrolled at Establishments that offer	Enrolled (of the total number of employees at the establishment-whether eligible or not eligible)
1996	75.9%	39.4%	60.5%	23.9%
1997	77.1%	28.7%	48.4%	13.9%
1998	81.6%	31.3%	52.6%	16.5%
1999	81.8%	28.4%	57.9%	16.4%

* Source: Agency for Healthcare Research and Quality. 1996, 1997, 1998, 1999 Medical Expenditure Panel Survey – Insurance Component.

APPENDIX V: PRINCIPLES AND ASSUMPTIONS
(GUIDING THE DEVELOPMENT OF POLICY OPTIONS)

Desired Outcomes of HRSA State Planning Grant Project

- Develop policy options that result in:
  - All residents of the state having access to adequate and affordable health insurance
  - Publicly financed health insurance programs being available to all of the most financially needy residents
  - A greater variety of insurance products being available
- On-going systematic collection and analysis of data and information to better inform policymakers

Principles Guiding the Development of Options/Models

- The state should provide equal access to public insurance assistance to people:
  - With the same level of income (as defined by FPL)
  - Regardless of current insurance status
  - Regardless of occupation.
- We should be mindful of the impact of our recommendations on the currently insured and on those who purchase insurance on their behalf (e.g. employers, unions, etc).
- To the extent that we propose an expansion of public insurance programs, assistance should be targeted to the most financially needy.
- Model(s) should foster independence and self-reliance.
- Our recommendations should encourage cost and quality-consciousness throughout the health care system.
- The state has a special responsibility to assure access to affordable health insurance for those people who work under contract to the state or for organizations that are primarily dependent on state funding.
- Options or models that would lead to care that is better managed (i.e. improving/maintaining quality while maintaining/lowering costs) should be encouraged.
- Models should reflect the needs/characteristics of the multiple subgroups of uninsured.
- Approaches should build upon existing public and private health insurance financing mechanisms; however,
- It may be necessary and/or appropriate to recommend changes to existing programs if doing so furthers the goal of expanding access to affordable health insurance.
- The state should maximize the use of federal dollars.
- "The perfect is the enemy of the good."

Assumptions Underlying the Development of Options/Models

- The more comprehensive the benefits, the more expensive the coverage is, and the fewer people who are covered.
- Short of legal compulsion, there is no way to ensure that 100% of the population will have insurance. For many, remaining uninsured is a choice.
- Given the current climate, there will not be a massive expansion of state spending in this area.
- A state-only single-payer approach is not considered to be a feasible option.
- Many consumers and potential consumers need to be educated about their options.

APPENDIX VI: STEERING AND ADVISORY COMMITTEE MEMBERS

Steering Committee Members

This committee serves as the primary decision-making body for the planning grant.

Robert P. Gittens
Secretary, Executive Office of Health and Human Services

William D. O'Leary
Former Secretary, Executive Office of Health and Human Services

Debra Chaison
Special Assistant to Secretary, Executive Office of Health and Human Services

Wendy Warring
Commissioner, Division of Medical Assistance

Louis Freedman
Commissioner, Division of Health Care Finance and Policy

John A. King, Esq.
Director, Division of Employment and Training

Lisa Levine
Director, Division of Maternal, Child and Family Health, Department of Public Health

Dolores Mitchell
Executive Director, Group Insurance Commission

Elizabeth Morse
Assistant Chief of Staff, Office of the Governor

Pat Rivard
Home Care Program Director, Executive Office of Elder Affairs

Nina Rosenberg
Assistant Commissioner, Department of Mental Health

Audrey Rushton
Director, Disclosure and Procurement Unit, Department of Revenue

Linda Ruthardt
Commissioner, Division of Insurance

Advisory Committee Members

This committee advises the Steering Committee and the core work team on various aspects of the planning process.

Barbara Ferrer, Ph.D., MPH
Deputy Director, Boston Public Health Commission

Josh Greenberg, Esq.
Manager, Children's Division, Health Care For All

Charles Joffe-Halpern
Program Administrator, Ecu-Health Care

Brian Rosman
Senior Research Associate, Schneider Institute for Health Policy, Brandeis University

Eileen McAnneny, Esq.
Vice President, Legislative Services, Associated Industries of Massachusetts

Shannon Linde
Senior Vice President, Massachusetts Business Association

Anuj K. Goel, JD, MPH
Manager, Corporate and Regulatory Compliance, Massachusetts Hospital Association

Alan Macdonald
Executive Director, Massachusetts Business Roundtable

Elmer P. Freeman
Executive Director, Center for Community Health Education, Research and Service

Murray Frank
Vice-Chair, Dukes County Health Council

David G. Tuerck, PhD
Executive Director, Beacon Hill Institute
Professor and Chairman, Department of Economics, Suffolk University

Marylou Buyse, MD
President, Massachusetts Association of Health Plans

Tom Louie
MA Immigrant and Refugee Advocacy Coalition

Barbara W. Frank
Director of State Health Policy, Paraprofessional Healthcare Institute

Elaine Kishenbaum, MPH
Director of Health Policy, Massachusetts Medical Society

Walter Morris
Senior Counsel, Legal Department, UNICARE Life and Health Insurance Company

Andrew Dreyfus,
President, Blue Cross Blue Shield of Massachusetts Foundation

James W. Hunt, Jr.
President/CEO, Massachusetts League of Community Health Centers

Judith Erdman
Associate Director, Latin American Health Institute

Eduardo Aguilu
Director of Operations, Latin American Health Institute

John Auerbach
Executive Director, Boston Public Health Commission

Nancy Turnbull
Adjunct Lecturer in Health Policy Management, Harvard School of Public Health

Elaine Ullian
President/CEO, Boston Medical Center

Bob Carey
Senior Policy Analyst, Massachusetts Taxpayers Foundation

Zoila Torres Feldman
Executive Director, Great Brook Valley Health Center

David Colby
President, Massachusetts Association of Chamber of Commerce Executives

Ann Aaberg
Executive Director, Massachusetts Healthcare Purchasers Group

Daniel Roble
Ropes & Gray

Joseph M. Carrillo, M.D.
Vice President for Community Health Services, Children's Hospital

Nicole Prudent, M.D.
Pediatric Primary Care ACC5, Boston Medical Center

David Green, VP
Massachusetts Association of Health Plans

State Legislators participating on the Advisory Committee

Sen. Richard Moore
Senate Chairman, Joint Committee on Health Care

Hon. Mark Montigny
Chairman, Senate Committee on Ways and Means

Hon. John H. Rogers
Chairman, House Committee on Ways and Means

Hon. Therese Murray
Senate Chair, Joint Committee on Insurance

Hon. Harriett L. Stanley
House Chair, Joint Committee on Health Care

Hon. Ronald Mariano
House Chair, Joint Committee on Insurance

Senator Harriette Chandler
Senate Chairperson, Joint Committee on Federal Financial Assistance
Member, Joint Committee on Health Care

Rep. Nancy Flavin
Asst. Vice-Chair, House Committee on Ways and Means

APPENDIX VII: 2001 NONGROUP SUBSCRIBER HEALTH INSURANCE SURVEY

1. What type of plan is your current non-group health insurance policy?
   ___ HMO (Health Maintenance Organization)
   ___ PPO (Preferred Provider Organization)
   ___ POS (Point-of-Service)
   ___ Traditional Indemnity Medical Plan
   ___ Don't know

2. Overall, how satisfied are you with the ***coverage*** provided by your current plan/policy?
   ___ Very satisfied
   ___ Somewhat satisfied
   ___ Neither satisfied nor dissatisfied
   ___ Dissatisfied
   ___ Very dissatisfied

3. How long have you been covered under your current non-group policy?
   ___ Less than 1 year ___ Between 1 and 3 years ___ 3 years or more

4. Immediately before you were covered by this health insurance policy, did you have health insurance? ___ Yes ___ No
   If you answered NO, please skip to question #6.

5. If you answered YES to question #4, how did you obtain the health insurance you had immediately prior to your current policy?
   ___ Through a family member
   ___ Through an employer
   ___ Through COBRA continuance after leaving a job
   ___ Through MassHealth, Medicaid or CommonHealth
   ___ Through a MassHealth or Medicaid sponsored program or HMO such as Neighborhood Health, Fallon, Boston HealthNet or Cambridge Network Health
   ___ Through CHAMPUS, CHAMPUS VA, VA or other military plan
   ___ Purchased it directly from an insurance agent or company other than the one I use now
   ___ Through a group such as a labor union, professional association or other group
   What group was that? _____
   ___ By some other method What was that? _____

6. If you answered NO to question #4, how long were you uninsured before you purchased this insurance?
   ___ Less than 1 year ___ Between 1 and 3 years ___ 3 years or more

7. What changed in your circumstances that you currently purchase your health insurance policy directly from this company?

_____

_____

8. What is the current premium that you pay for this health insurance policy?
$_____ **PER (please check one):** ☐ month ☐ quarter ☐ year

9. Who does this policy cover?
___ Myself only
___ Myself plus my spouse
___ Myself plus my spouse and children

10. In general, do you think the premium amount you pay is:
___ about right, ___ a little too much, or ___ much too much?

11. Out-of-pocket expense is all money paid by you for health care, excluding the cost of premiums. This includes the costs of deductibles and co-payments, which are partial payments made in order to receive medical care or prescriptions. Would you say that out-of-pocket expenses ***for yourself and all family members*** covered under this policy in the year 2000 were approximately:

___Less than $200	___$1,000-$1,999
___$200-$499	___$2,000 or more
___$500-$999	___ Don't know

12. Has a doctor or other medical caregiver ever suggested a test or treatment for you (or another family member covered by this health plan) that the health plan would not cover or pay for?
___ Yes ___ No
If YES, What were these tests or treatments?_____
Did you or other family member have that test or treatment anyway?
___ Yes ___ No

13. If it were available to you at a lower cost than your current premium, would you buy health insurance that:
- covered you/your family for only catastrophic medical expenses such as hospitalizations, but you paid out of pocket for routine and less expensive services (such as check-ups, vaccines, office visits, most prescription drugs, etc.) ___ Yes ___ No
- *covered you/your family for most medically necessary services, but only after you paid an annual deductible of $1,000* ___ *Yes* ___ *No*

Please complete the following about yourself:

___ Male ___ Female ___ Age on last birthday ZIP code where you live: _____

___Married ___ Never married ___ Divorced ___ Separated ___ Widowed

Number of people living in your household: ___ Adults ___ Children under 18

Your annual household income:

___ Below $20,000 ___ Between $40,000 and $49,999
___ Between $20,000 and $29,999 ___ Between $50,000 and $59,999
___ Between $30,000 and $39,999 ___ Above $60,000

___ Self-employed? ___Retired? ___ Not Employed? ___ Student?

OR

___ Employed full time (35 or more hours per week with one employer)? **OR**

___ Employed part time (less than 35 hours per week or 2 or more jobs totaling 35 hours per week)?

If employed, does your employer offer health insurance that you are eligible for?
___ Yes ___ No

If YES, why don't you obtain it through your employer?
_____

Would you be willing to participate in a focus group (an in-person small group discussion) later this year about the availability and cost of health insurance in Massachusetts? ___ Yes ___ No

If YES, please fill out the information below.

Name: _____

Address: _____

_____

Telephone Number:

Daytime: _____ **Evening:** _____

Email address: _____

Thank you very much for answering this important survey. Please return your survey in the enclosed postage-paid reply envelope.

If envelope is misplaced, please return to: Commonwealth of Massachusetts
Division of Health Care Finance & Policy
2 Boylston Street
Boston, MA 02116
Attn: HSMIG

APPENDIX VIII: FINDINGS FROM A 2001 SURVEY OF NONGROUP HEALTH INSURANCE SUBSCRIBERS IN MASSACHUSETTS

Method

Surveys were mailed to 2,500 Blue Cross Blue Shield (BCBS) and 2,500 Harvard Pilgrim Health Care (HPHC) nongroup policyholders in June 2001. These two insurers account for most of the nongroup market. 1,691, or 34%, of the surveys were returned.

To determine whether respondents were representative of all policyholders, the demographics for all BCBS and HPHC nongroup policyholders obtained from BCBS and HPHC were compared with the demographics for respondents. Sixty-eight percent of respondents were females compared with 61% of subscribers. More than half (58%) of respondents were 50 years of age and older compared with 46% of subscribers; few respondents (9%) or subscribers (15%) were under age 30. A much higher percent of respondents (80%) were nongroup subscribers for more than a year than were all subscribers (58%).

The following findings are based on an analysis of survey responses.

Demographics of Survey Respondents

Female: 68%
Male: 32%

Married:	43%
Previously married:	24%
Single:	33%

Respondents ranged in age from 19 to 88. The most common age group was 55-64 (45%). Females 55-64 accounted for a third (33%) of all respondents.

Median age: 53 years
Mean age: 50.5 years

53% live in households with annual incomes below $40,000
47% live in households with annual incomes of $40,000 or greater

46% of the respondents were retired, students, or not employed
54% were self-employed, employed part-time or employed full-time

Among those employed, only 13% worked for employers who offered health insurance. Some of the reasons these people declined employer coverage were coverage is minimal, waiting period, part-time status, and too expensive.

People from all 14 counties in the state responded, although the largest number of respondents were from Middlesex County (which is also the most populous county).

Survey Results

Type of Coverage

- 89% of respondents chose a health maintenance organization (HMO)
- 9% chose a preferred provider organization (PPO)
- 1% chose a point of service (POS) plan.

Who does the nongroup policy cover?

- 76% of policies covered the policyholder only
- 11% covered couples
- 13% covered families with one or two parents and children

Satisfaction with Coverage and Cost

- 76% were somewhat or very satisfied with the coverage provided by their plan. Only 9% were dissatisfied or very dissatisfied.
- 62% of respondents felt they were paying much too much and 31% considered their premiums a little too much.*

  * Note: Both the mean and median age of respondents were over age 50, and since nongroup policies can be rated by age, the premium cost for these people would be greater than that for a younger subscriber. 46% of subscribers are over the age of 50, while 58% of respondents were over that age; therefore, more older people purchase nongroup coverage which increases the average cost of a policy.

Length of Coverage

- Most of respondents were long-term policyholders. 44% were covered under their nongroup policy for three years or more; 36% for 1-3 years; 20% for less than one year.
- A higher percent of self-employed policyholders (52%) had nongroup coverage for three years or more.

Coverage status prior to Non-group Coverage

- 88% had health insurance before their current nongroup coverage.
- More than half were covered through employment:
  26% through employer 33% through COBRA
- 16% had coverage through their families
- 16% previously had nongroup policies
- 21% of those employed full-time did not have previous coverage.
- 12% were previously uninsured and three-quarters of those people were uninsured for one year or longer.

Monthly Premium Cost**

Type of monthly premium	Monthly Cost
Median premium of all policies	$416
Mean premium of all policies	$554
Median premium for policies covering only the policyholder	$340
Median premium for family coverage	$751
Median premium for coverage of couples	$768
Median premium for policy covering one parent and child(ren)	$500
Median premium for HMOs	$416
Median premium for PPOs	$526

** Since the average age of respondents is somewhat higher than the average age of subscribers, the median premium amounts above are probably somewhat higher than the median premium cost of a nongroup policy.

Out-of-pocket Costs

- 67% estimated their out-of-pocket medical expenses to be under $1,000
- 16% estimated they paid $1,000-$1,999
- 17% estimated they paid $2,000 or more
- A higher percent of those with $2,000+ out-of-pocket expenses rated their premiums as much too much (75% vs. 62%).

Denial of coverage

- 12% were denied approval for tests or treatments (e.g., chiropractic, colonoscopy, eye exam, physical therapy, prescription drugs, psychiatric visit). Although, 78% of these people had the test or treatment anyway.

Other types of coverage the respondent indicated they might choose

- More of the respondents would opt for a $1,000 deductible than for catastrophic coverage (56% vs. 38%).
- Higher percents of those with household incomes of $60,000 or greater would choose the above options (68% and 43%).

APPENDIX IX: 2001 SURVEY OF MASSACHUSETTS PHYSICIANS

INSTRUCTIONS – PHYSICIAN SURVEY

Please complete the survey and return it in the enclosed postage paid envelope. Please do not write your name on the survey. Thank you in advance for your help and cooperation with this important project.

1. For the questions in this survey, please indicate whether you are providing data for (check one):

   ☐ Yourself (a single physician)

   ☐ A Practice (a group of physicians)

2. What is the total number of physicians in this practice? _____

3. Please indicate the type of practice this is: (Check as many as apply)

☐ Academic/Teaching ☐ Community-Based Private Office ☐ Community Health Center
☐ Single specialty practice ☐ Multi-specialty practice ☐ Solo practice
☐ Integrated Delivery System
☐ Group practice
☐ Other (please specify): _____

4. Of the total number of patients in this practice, what percentage do you estimate are covered by:

MassHealth/Medicaid:	_____%
Medicare:	_____%
Managed care:	_____%
Indemnity:	_____%
Workers' compensation:	_____%
Other:	_____%

5. Please provide the following information for yourself and any physicians for whom you are answering:

	Gender	Specialty	Year graduated medical school	Hrs/week providing direct patient care
Physician #1	_____	_____	_____	_____
Physician #2	_____	_____	_____	_____
Physician #3	_____	_____	_____	_____
Physician #4	_____	_____	_____	_____
Physician #5	_____	_____	_____	_____
Physician #6	_____	_____	_____	_____

6. Apart from medical emergencies, does this practice accept new patients regardless of their ability to pay?

   ☐ YES ☐ NO

7. Does this practice currently have patients who do not have health insurance?

   ☐ YES ☐ NO ☐ DON'T KNOW

8. If yes, what is your best estimate of the percentage of your practice's patients who do not have insurance at this time?

   _____%

9. Does this practice ever reduce or waive fees for patients who are uninsured and have financial hardship?

   ☐ YES ☐ NO

10. Does this practice have a formal mechanism for determining a patient's financial hardship?

    ☐ YES ☐ NO

11. Please describe this practice's financial hardship determination process.

    _____

    _____

12. Do you or a staff member inform patients about the availability of public assistance programs?

    ☐ YES ☐ NO

13. Do you, or a staff member, assist patients with determining MassHealth eligibility and/or completing a MassHealth application?

    ☐ YES ☐ NO

Please answer the following questions for the patients in your practice who have no health insurance (for whom you are unable to bill *any* third party for their care, including MassHealth) and for whom you provide services on a *free or discounted* basis due to financial hardship. Please exclude those patients who pay in full ("self-pay") out of their own pocket.

14. Please check the services and procedures that this practice has provided to uninsured patients on a free or discounted basis last year:

☐ Well Office Visits ☐ Sick Office Visits
☐ Family Planning Services ☐ Immunizations
☐ Laboratory Tests ☐ X-Rays
☐ Procedures (please specify): _____
☐ Other (please specify): _____

15. Please estimate the average *monthly* dollar amount this practice provided in free or discounted services to uninsured patients last year. Do not include the value of free drug samples: (NOTE: In calculating your estimate, please use your average third-party reimbursement amount as the basis for your answer. For example, if your usual office visit reimbursement is $50 and you reduced this fee to $25 for 5 patients and charged nothing for 1 patient, you provided $25 x 5 = $125 and $50 x 1 = $50 or $175 in free/discounted office visits).

☐ Well Office Visits: $_____
☐ Sick Office Visits: $_____
☐ Family Planning Services: $_____
☐ Immunizations: $_____
☐ Laboratory tests: $_____
☐ X-Rays: $_____
☐ Procedures (please specify): _____ $_____
☐ Other (please specify): _____ $_____
Total: $_____

Please answer the following questions for the patients in this practice who may or may not have health insurance but who pay <u>in full</u> out of their own pocket ("self-pay") for the services you provide.

16. To the best of your knowledge, please state the primary reason why these patients "self-pay" for care.

☐ Lack of health insurance
☐ Health insurance doesn't cover service(s)
☐ Patient does not want service to be reported to insurance carrier
☐ Don't know
☐ Other (please specify): _____

17. Please check the services and procedures that this practice provided to "self-pay" patients last year:

- ☐ Well Office Visits
- ☐ Sick Office Visits
- ☐ Family Planning Services
- ☐ Immunizations
- ☐ Laboratory Tests
- ☐ X-Rays
- ☐ Procedures (please specify):

  _____
- ☐ Other (please specify):

  _____

18. Please estimate the average monthly dollar amount of services and supplies this practice provided to "self-pay" patients last year:

☐ Well Office Visits:	$_____
☐ Sick Office Visits:	$_____
☐ Family Planning Services:	$_____
☐ Immunizations:	$_____
☐ Laboratory tests:	$_____
☐ X-Rays:	$_____
☐ Procedures (please specify): _____	$_____
☐ Other (please specify): _____	$_____
Total:	$_____

19. Title of person completing the survey:

☐ Physician ☐ Administrator ☐ Other -- Please specify: _____

20. What is the ZIP code of the city or town in which this practice is located? _____

Please use this space to offer your comments or additional information on uninsured and "self-pay" patients encountered in this practice.

_____

_____

_____

_____

Thank you very much. Please return the completed survey in the postage paid envelope provided. If envelope is misplaced, please return to:

Massachusetts Division of Health Care Finance & Policy
2 Boylston St.
Boston, MA 02116
Attn: HSMIG

APPENDIX X: FINDINGS FROM A 2001 SURVEY OF MASSACHUSETTS PHYSICIANS

The Massachusetts Division of Health Care Finance and Policy worked with the Massachusetts Medical Society to develop a survey of practicing physicians to measure the amount and type of free, discounted and self-paid care provided to patients in their offices. The survey was mailed to 8000 primary care and specialist physicians in June 2001. Primary-care physicians were over-sampled. The state hoped to learn more about the type of ambulatory care uninsured and under-insured people seek out as well as care they may pay for out-of-pocket even while insured.

Almost 11% (n=874) of surveys were returned as of September, when the survey concluded. Physicians, as opposed to office staff, filled out most (89%) surveys.

The following five medical specialties accounted for 67% of respondents and 69% of all physicians in the sample.

Specialty	Percent of Respondents	Percent of Total Physicians in Sample
Internal Medicine:	23%	33%
Pediatrics:	16%	13%
Psychiatry:	9%	9%
Obstetrics-gynecology:	10%	7%
Family Medicine:	8%	7%

Six of the top ten zip codes for respondents were also among the top ten for those in the sample. They are located in Boston, Cambridge and Worcester.

*** The data which follows was collected through survey responses and reflects the information provided by those who responded, therefore it is not necessarily representative of Massachusetts physicians as a whole.***

Practice type

- 72% of the respondents indicated that they were providing data for themselves
- 28% provided data for a group practice

The most common types of practices:

- Community-based private: 25%
- Single specialty: 21%
- Academic/teaching: 19%
- Solo: 17%

Practice size

- Median number of physicians in a practice is 2
- Three-quarters work in practices of six or fewer
- 90% belong to groups of 20 or fewer physicians

Insurance Coverage

Mean estimates of the type of insurance coverage by patients served*:
*Note: This data was calculated using only those responses adding to 100%.

- Managed Care: 41%
- Medicare: 23%
- MassHealth: 17%
- Indemnity: 9%
- Other: 7%
- Workers' Compensation: 2%

Uninsured Patients

- Eighty-one percent of the practices accept new patients regardless of their ability to pay.

Types of practices and their acceptance of new patients regardless of ability to pay:

Community Health Center:	100%
Academic/teaching practice:	92%
Group-practice:	89%
Solo-practice:	70%

- Ninety-five percent of practices currently have patients who do not have health insurance. An estimated 8% (mean) of their patients are uninsured.

- Ninety-four percent of the practices reduce or waive fees for patients who are uninsured and have financial hardship. However, 73% have no formal mechanism for determining a patient's financial hardship.

- Eighty percent of practices inform patients about the availability of public assistance programs. Forty-two percent reported assisting patients with determining MassHealth eligibility and/or completing a MassHealth application.

- The services most frequently provided to uninsured patients on a free or discounted basis last year were well visits (59%) and sick visits (17%).

Self-Pay Patients

- Practices estimate that three-quarters of self-pay patients have no health insurance. The remaining self-pay patients are either insured but are not covered for the services provided (16%), do not want services to be reported to their insurance carriers (4%), or have other reasons for paying out-of-pocket (5%).
- The services most frequently provided to self-pay patients last year were well visits (63%) and sick visits

APPENDIX XI: DHCFP 2001 SURVEY OF MASSACHUSETTS EMPLOYERS REGARDING HEALTH INSURANCE

Please refer to http://www.state.ma.us/hrsa/pages/pdf/empsurvy.pdf to read the Division of Health Care Finance and Policy's 2001 Survey of Massachusetts Employers Regarding Health Insurance.

APPENDIX XII: DHCFP 2000 SURVEY OF HEALTH INSURANCE STATUS OF MASSACHUSETTS RESIDENTS

Please refer to http://www.state.ma.us/dhcfp/pages/dhcfp119.htm to read the Division of Health Care Finance and Policy's 2000 Survey of Health Insurance Status of Massachusetts Residents and to see a report on the results.

APPENDIX XIII: SUMMARY OF NONGROUP (INDIVIDUAL) INSURANCE MARKET IN MASSACHUSETTS

Background and Summary of Provisions

Prior to 1996, nongroup health insurance in Massachusetts was medically underwritten and offered by very few carriers in the market.

The passage of Chapter 297 of the Acts of 1996 created "the nongroup law" (M.G.L. c. 176M), significantly reforming the nongroup market in Massachusetts. Subsequent amendments to the law were recently enacted with the passage of Chapter 140 of the Acts of 2000. Carriers who participate in the *small* group market (1-50 employees) must offer a guaranteed issue nongroup product on an equal basis to all eligible individuals. As of December 31, 2000, there were 26 carriers in Massachusetts offering guaranteed issue nongroup products, covering 24,000 subscribers and representing 34,000 covered lives.

The key provisions of the nongroup law (as amended to be effective November 1, 2001) can be summarized as follows (see discussion below for specific information):

- An eligible individual is defined as any natural person who is a resident of Massachusetts and is not enrolled for coverage under Part A or Part B of Medicare or under Medicaid
- To participate in the market, carriers must offer a "guaranteed issue product" with a minimum standard set of benefits as established by the Nongroup Health Insurance Advisory Board (with certain exceptions for specific disease insurance)
- A carrier *may* offer an "alternative guaranteed issue health plan" in addition to the standard benefits guaranteed issue plan that it offers with different benefits and cost-sharing requirements
- Carriers must offer continuous open enrollment for nongroup guaranteed issue products
- Only under certain circumstances may a carrier impose up to a six-month pre-existing condition exclusion or waiting period, but must credit the time the enrollee was covered under prior creditable, actuarially equivalent coverage
- Rates charged by carriers may vary based only on age, family type, place of residence and premium payment mode and are restricted to a 2:1 rate band
- Carriers must join the Massachusetts Nongroup Health Insurance Reinsurance Plan

When the nongroup law first took effect in October, 1997, rather than offer the required standard benefit plan, many carriers who were offering medically underwritten plans at that time elected to close their existing plans to new enrollees. These are now referred to as *"closed plans"* and have experienced steadily decreasing enrollment since 1997 and presently cover about 23,000 lives. The amended nongroup law requires closed plans to remain in effect until subscriber membership falls below 25 percent of 1999 enrollment.

A third type of nongroup plan created by the nongroup reform law is the *"conversion only guaranteed issue plan"* which carriers are allowed to offer if they wish. If a carrier elects to do

so, it may offer a guaranteed issue nongroup health insurance plan on a group conversion basis only – that is to former employees who are no longer eligible for group health coverage. In this case, the carrier is not required to offer to other eligible individuals, but still must offer the required standard set of benefits.

Standard Benefits

The standard set of benefits required to be included in guaranteed issue plans are emergency, hospital and physician services, preventive care, and prescription drugs administered on an outpatient basis that meet the minimum standards established by the Nongroup Health Insurance Advisory Board. The Advisory Board's minimum standards also include cost-sharing requirements for guaranteed issue plans, including maximum deductibles, coinsurance, copayments and lifetime maximums. If they choose, carriers may offer an enhanced plan with more than the standard benefits, but they must offer at least the standard benefits as designed by the Nongroup Health Insurance Advisory Board. A detailed table of the required standard benefits is attached.

There are three types of standardized plans offered in the market: *medical plans* (no restrictions on choices of medical providers), *preferred provider plans* (with incentives to go to preferred providers) and *managed care plans* (offered by HMOs with closed networks of providers).

Eligibility and Enrollment

The most recent amendent to the nongroup law changing the definition of an eligible individual may have significant impact on the small group market. Up until the November 1, 2001 effective date of the new definition, eligible individuals were restricted to those who did not have access to group health coverage through their or their spouses' workplace, who were no longer eligible for COBRA and who were not self-employed. Self-employed individuals were considered small groups of "one" and had access to small group products.

Typical Rates

Rates may vary based only upon age, family type, place of residence and premium payment mode. The Division of Insurance publishes "sample monthly rates" for use by consumers on its web site. See attached for a sample of rates for guaranteed issue plans effective for 12/1/00 through 11/30/01 for Blue Cross Blue Shield, CIGNA, Guardian Life and Harvard Pilgrim.

Membership Statistics

At December 31, 2000, according to data collected by the Massachusetts Division of Insurance, membership in nongroup plans totaled 57,511, with 23,524 being in closed plans, 33,966 in guaranteed issue plans and 21 in group conversion only plans, representing 0.9% of the Massachusetts population.

Since M.G.L. c.176 M became effective in 1997, closed plans have showed a steady significant decline in membership, from 66,896 covered lives at the end of 1998 to 47,431 at the end of

1999 to 23,524 at 12/31/00. The number of covered lives under guaranteed issue plans, however, has grown from 18,136 at the end of 1998 to 31,826 at the end of 1999 to 33,966 at 12/31/00.

Of note also is that over 90% of members in guaranteed issue plans are in HMO plans, with the remainder in preferred provider plans and virtually none in medical plans. Blue Cross Blue Shield and Harvard Pilgrim Health Care account for nearly 90% of the guaranteed issue market at 47% and 41% respectively at 12/31/00.

Of the 23,871 guaranteed issue plan subscribers at the end of 2000, 18,774 – nearly 80% - were individual subscribers (no spouse or family coverage). The spread of subscribers across age groups reveals 44% of the total subscribers to be 50 years old and older. The geographic location of total subscribers across counties in Massachusetts is not evenly spread, with a higher amount of subscribers (as compared to the general population) in Dukes and Nantucket Counties.

Alternative Guaranteed Issue Health Plans

Chapter 140 of the Acts of 2000, sections of which took effect on April 30, 2001, amended the existing nongroup law, among other provisions, allowing participating carriers to "additionally make available to eligible individuals one alternative guaranteed issue health plan with benefits and cost-sharing requirements, including deductibles, that differ from the said standard guaranteed issue health plan. A carrier shall not make available an alternative plan unless said plan has been filed with and approved by the commissioner of insurance. The commissioner shall approve of an alternative plan if said plan: (1) includes at least the following medically necessary services: reasonably comprehensive physician services; inpatient and outpatient hospital services; emergency health care services; and a full range of effective, clinical preventive care administered on an outpatient basis; and (2) contains a disclosure form, which shall be provided to any potential insured, that clearly and concisely states the limitations on the scope of health services and any other benefits to be provided, including an explanation of any deductible or copayment feature; and (3) offers a ten day free look period…"

Carriers planning to offer alternative benefit plans on December 1, 2001, had to have submitted their rate filings to the Division of Insurance by May 1, 2001. The two major carriers in the nongroup market, Blue Cross Blue Shield (HMO Blue) and Harvard-Pilgrim Health Care, submitted rate filings for alternative benefit plans: HMO Blue Direct Alternative Plan and Harvard Pilgrim Nongroup Low Option Coverage, both managed care plans. The benefit packages of the alternative plans are the same as the respective carriers' standard nongroup benefit packages with two important differences: higher copays and no prescription drug benefit. The base premiums of the alternative plans are 80% and 75.78% of the standard nongroup benefit plans of BCBS and Harvard Pilgrim respectively. Although both carriers have projected member months and premium revenues for the new products, it is impossible to tell what impact, if any, these new options will have in the Massachusetts nongroup and small group markets.

Subscriber Survey Results

Please see Appendix VIII for the results of the Massachusetts nongroup subscriber survey.

APPENDIX XIV: SUMMARY OF THE SMALL GROUP HEALTH INSURANCE MARKET IN MASSACHUSETTS

Background and Current Provisions

Throughout the past decade, considerable reform to improve access to the health insurance market for small businesses has taken place. As of March 2000, businesses with fewer than 50 employees accounted for approximately 94% of business establishments and 36% of employees in the Commonwealth of Massachusetts.

Prior to 1991, few carriers offered coverage to small groups, coverage was medically underwritten, and it tended to have long waiting periods and pre-existing condition limitations or exclusions.

In both 1991 and 1996, Massachusetts legislators and the governor approved significant reforms for regulating the small group market. In many regards, the laws go beyond the national protections established by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Massachusetts insurance reforms expanded the definition of a small group to include businesses with between 1 (self-employed) and 50 employees and required all carriers who elected to remain in the market to offer products on an equal basis, to all small groups, without medical underwriting. After the 1991 reform, 38 carriers decided to write small group business and today 27 carriers are participating in the small group insurance market. The number has decreased following the departure of several smaller carriers from the market and the consolidation of other companies.

Basic Information

Small Group Health Plans may be offered by: (1) a company licensed by the Commonwealth of Massachusetts to provide accident and sickness insurance pursuant to M.G.L. c. 175; (2) a Non-profit Hospital Corporation and Medical Service Corporation licensed pursuant to M.G.L. c. 176A and 176B; or (3) a Health Maintenance Organization licensed pursuant to M.G.L c. 176G.

All carriers doing business in the Massachusetts small group health insurance market must file with the Division of Insurance on or before March 31st of each year. This includes carriers currently marketing small group products, as well as companies who are no longer selling new coverage, but continue to renew existing policies or contracts.

Definition of Eligible Employee

Every carrier covering lives in the small group market must provide coverage to all eligible employees and all eligible dependents within each eligible small business with some exceptions. Under small group reform law, an eligible employee is an employee who: (a) works on a full-time basis with a normal work week of thirty or more hours, and

includes an owner, a sole proprietor or a partner of a partnership, and (b) is hired to work for a period of not less than five months. This is interpreted to mean that regarding health insurance the business should count only those employees who were full-time employees working at least thirty hours per week and who worked at least five months during the previous calendar year. Therefore, temporary or seasonal employees are not "eligible" employees.

Rating Requirements

Small group premiums must be set using a uniform "base premium rate". The premium rate charged can vary from group to group only by a limited number of actuarially based reasons. These reasons are the business location, industry, size, participation rate and the age of employees. A carrier can also establish a benefit level rate adjustment for all groups, an intermediary discount or a wellness program discount. In addition, a "Small Employer Health Reinsurance Plan" premium rate surcharge might be required. A rating band of 2:1 is permitted (i.e. the highest rate can be no more than two times the lowest rate charged).

Guaranteed Issue and Renewal

Carriers who elect to participate in this market must make plans available to all eligible small groups and every plan must be renewable at the option of the small business (unless the carrier is leaving the market). Carriers can limit the enrollment period for small groups to three months in the year. Finally, a carrier can deny enrollment to a group of five or fewer eligible persons unless the group enrolls through an intermediary. An intermediary is defined in law as "a chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, which offers as a service to its members the option of purchasing a health benefit plan" (such as the Massachusetts Business Association).

Waiting Period/Pre-existing Conditions

Pre-existing condition limitations or exclusions may not last more than six months and the carrier cannot "look-back" in the patient's medical history longer than six months. Credit for immediately prior continuous coverage must be given and no waiting period may be imposed on a new employee who had coverage under a previous qualifying health plan immediately prior to or until employment in the small business.

Participation requirement

A carrier is not required to have a participation requirement for its plans. However, if one chooses to have one, the required participation rate cannot exceed 100% for a group of 5 or fewer eligible persons and 75% for a group of 6 or more.

Small Employer Health Reinsurance Plan

In Massachusetts there is established a nonprofit entity known as the "Massachusetts Small Employer Health Reinsurance Plan." All commercial carriers in the state that were issuing health benefit plans to eligible small businesses on or after April 1, 1992 must be members of the plan. However, non-profit hospital and medical service corporations and health maintenance organizations do not have to participate. Reimbursement requirements and premium rates for coverage reinsured by the plan are established according to state law.

Membership Statistics

According to data collected by the Massachusetts Division of Insurance, in 1997 there were 708,731 lives covered in small group plans and in 2000 that number increased almost 8% to 763,712. Since 1997, health maintenance organizations have consistently held the largest share of the small group market in Massachusetts. Their share has increased from 74% in 1997 to 85% in 2000. The market share represented by commercial carriers has decreased from 22% in 1997 to 8% in 2000 while Blue Cross Blue Shield's share has increased 3% to 6.5% within the same time span. (This membership data does not include those members of self-insured plans for whom the carrier only administers the benefits.)

Insurance Partnership

Administered and funded in part by the Division of Medical Assistance, the Commonwealth of Massachusetts offers a unique program called the Insurance Partnership that is designed to help qualified small businesses with 50 or fewer employees pay for health insurance. The Partnership is not a health insurance plan; it is a program that provides direct subsidies to qualified small businesses for the insurance they offer to their employees. The Insurance Partnership can reduce costs by up to $1000 a year for each qualified employee for whom the business provides health insurance, including the business owner. In addition to direct subsidies to businesses, qualified employees may also be eligible for help in paying for their share of the health insurance premium through MassHealth Family Assistance**.**

Mini-COBRA

Massachusetts abides by the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) to provide continuation of health insurance benefits for between 18 and 29 months for employees in businesses with 20 or more employees. In addition, Massachusetts has a small group continuation of coverage law (Mini-COBRA). This law requires small group carriers to provide for the continuation of health benefits to employees of small businesses with 2-19 employees. Mini-COBRA allows employees and their dependents to continue coverage in their small group health benefit plan and to pay group rates for a specified time period under circumstances where they previously would have lost coverage.

Employer Survey Results

Massachusetts contracted with the University of Massachusetts' Center for Survey Research to perform an employer health insurance survey during the Spring and Summer of 2001.

Please see Section 2 of this report for information on the employer market and see question 3.2 in Section 3 for information on the difference in benefits offered by small and large employers.

Interaction with other Insurance Markets

As a condition of doing business in Massachusetts, a carrier that participates in the guaranteed issue small group health insurance market must also participate in the nongroup health insurance market. A carrier may be exempt from this requirement if, at the close of the preceding calendar year, the combined statewide total of eligible employees and dependents in health plans offered by it to small businesses did not exceed 5,000 individuals.

APPENDIX XV: MASSACHUSETTS MANDATED HEALTH BENEFITS

Please refer to www.state.ma.us/doi/Consumers/css_health_Mandates.html for the document titled, Massachusetts General Laws Mandating that Certain Health Benefits Be Provided by Commercial Insurers, Blue Cross and Blue Shield and Health Maintenance Organizations, which describes state mandated benefit provisions.

APPENDIX XVI: MASSACHUSETTS INSURANCE RESOURCE GUIDE

University of Massachusetts Medical School Center for Health Policy and Research, and University of Massachusetts Commonwealth Medicine, in collaboration with the Division of Medical Assistance, "Massachusetts Health Insurance Resources", www.umassmed.edu/healthpolicy/roadmap/, April 2000.

APPENDIX XVII: DHCFP COMMUNITY HEALTH CENTER REPORT

DRAFT

March 15, 2001
The Impact of Health Reform on Safety Net Providers:
Results of a Survey of Community Health Centers

Introduction

Since 1997, Massachusetts has implemented a series of health reform measures in order to expand and improve health benefit coverage for Massachusetts residents who are low-income uninsured. The primary focus of these reform initiatives has been expansion of MassHealth, the Massachusetts Medicaid program. However, other reforms have also been implemented, including expanded coverage of the Children's Medical Security Plan (CMSP), a state-funded program whose benefits include primary and preventive care for children. CMSP premium rates are adjusted on a sliding fee scale so that coverage can be provided for all children. In addition, Massachusetts created the Senior Pharmacy Assistance Program (SPP), now known as the Pharmacy or Pharmacy Plus Program, making drug coverage available for seniors and people with disabilities who meet means testing criteria.[3] Under health reform, the operation of the Commonwealth's Uncompensated Care Pool was also changed in an effort to improve its efficiency. Additional reforms included the development and implementation of the federally sponsored state Children's Health Insurance Program (CHIP) as well as the Massachusetts Insurance Partnership Program (IP), developed to encourage small employers to offer insurance to their employees or assist them in retaining coverage.

We conducted a survey to assess the impact of these health reform initiatives on a particular type of safety net provider: community health centers. Safety net providers have been defined as providers that are legally obligated to provide health care services to persons who cannot afford to pay for these services. This definition might include public and teaching hospitals, federally funded community health centers and local health departments (Lipson and Naierman, 1996.[4]) Regardless of the specific definition of safety net providers, providers that routinely serve indigent populations, such as the state's community health centers, might be impacted by Massachusetts' health reform initiative since health reform impacted nearly every state sponsored health benefit program for the poor and uninsured. For example, under health reform, new incentives for private entities to pursue Medicaid financing have been created. As a result, safety net providers may be at risk of losing Medicaid dollars that they have traditionally relied on to provide health care services to vulnerable populations. At the same time, however, community health centers are coping with other factors in the Massachusetts health care environment that are not necessarily attributable to health reform. It will be important to monitor these trends to determine whether the critical role safety net providers play is impacted by the major policy changes being implemented through health reform.

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[3] The Perscription Advantage Plan to be implemented in April of 2001 replaces the existing Pharmacy and Senior Pharmacy Plans.

[4] Lipson, Debra J. and Naierman, Naomi (1996). Effects of Health System Changes on Safety net providers. Health Affairs. 15(2). 33-48.

Methods

We conducted a survey to gather information from community health centers about how Massachusetts health reform initiatives have impacted their operation. The study was designed to address the following research questions:

- Which of the Massachusetts health reform initiatives are having the biggest impact on community health centers?

- How are health centers adapting to these changes?

- Are health centers participating in various managed care arrangements? How does the impact of these arrangements compare to the impact of health reform?

- What impact has state health reform had on the financial stability of community health centers?

Survey of Safety Net Providers

There were no models of survey instruments developed to gather information from community health centers in the literature, although we were able to obtain one instrument that was created for an Oregon survey of safety net providers. In discussing this survey with key stakeholders from Oregon, we learned that their survey was not successful in gathering data about the impact of health reform on safety net providers. Providers in Oregon found it difficult to complete the survey and offer the technical information requested by the state. Policymakers in Oregon gave us specific guidance about how the survey instrument could be improved. Working with this information, we designed a draft of a survey instrument, which we shared with representatives of the Massachusetts League of Community Health Centers and individuals in state government who work with community health centers; we revised the instrument to reflect feedback from these sources. We pre-tested the draft instrument with two community health centers, and incorporated final revisions based on their responses prior to distributing the survey to the study sample.

The completed survey asked respondents to provide information about a range of issues such as the organizational structure of the center, sources of revenue, types of services provided, service utilization, as well as perceptions of the impact of health reform. Respondents were asked to provide financial information from the most recently completed fiscal year. In March and April, 2000, we mailed the revised survey to the Chief Executive Office or the Chief Financial Officer of each health center in the state and followed up the mailing with a telephone call to centers that had not responded to the mailed survey. Data from completed surveys were entered into a computerized data file; we used a statistical package to conduct simple descriptive and bivariate statistical analysis.

In addition, the Massachusetts Division of Health Care Finance and Policy gathers cost reports from major health care providers in the state, including all hospitals and community health centers. Division staff regularly consolidates and analyzes these data to monitor the financial status of Massachusetts health care providers. We compared our survey results with selected indicators gathered from Massachusetts community health centers by the Division. We

also examined the results of financial analyses that the Division routinely conducts and include the results here to provide additional context for understanding survey results.

Descriptive Survey Results

We distributed surveys to 51 Community health centers, which represented all community health centers operating in Massachusetts regardless of their organizational structure or affiliation. Results of completed surveys are displayed in Table 1. We received completed surveys from 29 community health centers (57%). Of these 29 respondents, Division records indicate that 23 (79%) are free-standing community health centers, and the remaining 6 centers operate under a hospital license. We know there were more obstacles preventing health centers that are not free-standing from responding to the survey, since it was difficult for many of these centers to obtain the requested information about their individual operating location.

The majority of completed surveys were completed by the director of the center (48%), although about one-third of the surveys were completed by the chief financial officer, and the remainder by a variety of other staff. About three quarters of the centers reported that they are federally qualified health centers or look-alikes; hospital based centers were less likely to report being federally qualified health centers. These results closely matched Division records.

An average of about 60% of the patients served by the responding centers are adults, about 20% are children (up to age 12), 13% are adolescents (ages 12 through 18) and 7% are seniors (ages 65 and older). The majority of patients speak English, almost 60%, and about 23% speak Spanish. A variety of other languages are also represented in health center patient populations, including Portuguese, Haitian, Chinese, Vietnamese, Cambodian, and other Asian languages. Centers reported that about 37% of their patients are eligible for MassHealth (Medicaid). Almost half of health center patients who are covered by Medicaid are enrolled in Medicaid's fee-for-service managed care option called the Primary Care Clinician Plan and about a quarter of center patients covered by Medicaid are enrolled in one specific managed care plan, the Neighborhood Health Plan. Most (70%) Medicaid beneficiaries receive their benefits through the traditional MassHealth benefit package, called MassHealth Standard. However, more than 20% of Medicaid patients receive benefits through a new benefit package instituted as part of health reform, MassHealth Basic. MassHealth Basic offers a more limited benefit package than the traditional MassHealth Standard, and targets eligibility to individuals who have been unemployed for long periods of time.

Health centers reported having a variety of contracts with managed care plans, with the average number of contracts being 2.5 (SD=1.2; Range = 0 to 4). Nearly all of the health centers reported having a contract with Neighborhood Health Plan (NHP); this plan utilizes community health centers as a key provider type in its provider network. In addition, more than half of the centers have a contract with the Massachusetts Behavioral Health Partnership: the behavioral health provider that offers substance abuse and mental health services to a large proportion of Massachusetts Medicaid enrollees. About a third of responding health centers reported they had a contract with Boston Health Net, a managed care plan affiliated with the Boston Medical Center, a public service hospital that provides the largest proportion of uncompensated care in the state. Other managed care plans are not well represented among this sample of community health centers.

Health centers that responded to the survey reported a range of revenues, from just under a million dollars to more than $23M, with an average of about $7M. Most health centers reported a slight increase in revenues over the past year, due primarily to an increase in the

number of patients served and an increase in grant funding. Average reported expenses (about $6.6M) were similar to reported revenues. About 90% of health centers reported an increase in expenses over the past year, due primarily to serving more patients, increases in personnel costs, and increased expenses for technology. No health centers reported a decrease in expenses. About one quarter of health centers reported that their expenses were greater than revenues, and the deficit for these centers ranged from about $6100 to about $680,000. The remainder of the centers that did not report an operating deficit reported an excess of revenues compared to expenses ranging from $0 to more than $2M. Health centers with the largest excess of revenues compared to expenses are also more likely to have larger revenues from unrestricted grant sources.

Most health centers reported receiving Medicare fee for service (ffs) revenue in relatively small amounts (less than 10% of total revenue). Only six centers reported receiving any revenue from Medicare HMOs, and for these centers, Medicare HMO revenues amounted to just one percent of all revenues. Nearly all health centers reported receiving Medicaid ffs and HMO revenue. Medicaid ffs revenue comprised up to 50% of total revenue for the centers (with an average of 19%), while Medicaid HMO revenue was less than 20% of total revenue for all centers (with an average of 6%). Revenue received from the Uncompensated Care Pool averaged about 10% of total revenue and ranged from none to over $3M, while revenue received from CMSP ranged from none to about $65,000, but was less than five percent of total revenue. A majority of centers received revenue from CenterCare, a program which uses state dollars to fund per capita treatment "slots" for low-income adults receiving care from health centers. CenterCare revenue ranged from about $2000 to more than $400,000, averaging about 11% of total revenue. Most centers received less than 20% of their revenue from CenterCare, although one center received about two-thirds of its revenue from this program. Health centers also reported large amounts of grant revenue: restricted grant revenue ranged from about $3000 to more than $16M, while unrestricted grant revenue ranged from about $100,000 to more than $3M. A handful of centers receive a large proportion of revenue from restricted and unrestricted grant sources. It is interesting to note that the two largest average percentage categories of revenue are Medicaid fee for service revenue (19%) and unrestricted grant funds (19%).

The range in health center size was reflected in the number of visits provided during the last year, which ranged from about 2500 to more than 200,000, with an average of 31,291 visits for adults and 12,217 visits for children. Similarly, the number of adult patients ranged from 70 to more than 18,000, (Mean=6,704, SD=3,876) while the number of child patients ranged from 140 to almost 15,000 (Mean=3,425 SD= 3,098).

About a quarter of health centers reported that they serve both children and adults who do not have insurance. About 40% of health centers reported serving more uninsured patients than in the last year, and about 70% said that they felt they serve more than their fair share of uninsured patients. About 30% of respondents report that there has been a decrease in the number of uninsured patients served at the center.

Health Centers reported providing an average of 24 different types of services to their patients. At least three-quarters of health centers report providing each of the following services:

- Prenatal
- GYN
- Family Planning
- Well child

- Primary Care
- Triage
- Referral, follow up and tracking
- Lab
- Nutritional Services
- Health education
- Community Outreach
- Adolescent Services
- Case management
- Interpreter Services
- Eligibility Assistance

There was no relationship between the number of health services a center provided and the total amount of revenue received by the center. However, it is interesting to note that centers providing chemical dependency services were more likely to be large centers and to report more revenue from restricted grants. These revenues are likely to be granted from the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.

Although a variety of staff are available at the different health centers, including some dentists, psychologists, social workers, and others, at least three quarters of the health centers reported having the following types of staff available:

- Physician
- Administrative staff
- Nurse Practitioner
- Nurse-Technical staff
- Aides/Outreach staff
- Clerical staff
- Medical Record staff

Health Centers were asked to rate the impact of several health reform or environmental factors on the viability of their organization over the past fiscal year, using a Likert Score of one to five, with one being extremely positive and five being extremely negative. The changes listed on the survey and mean scores for each factor are:

Expanded Medicaid eligibility	2.0
Strategies for patient retention	2.3
Availability of MassHealth Basic	2.4
Growth in the number of Medicaid HMOs	2.6
Increased MassHealth enrollment	2.7
Changes in enrollment for CMSP	2.7
Shifting demographics	3.0
Eligibility verification for the UCP	3.1
Changes to the UCP	3.2
Increase in underinsured patients	3.3
Changes in Medicare reimbursement policies	3.3
Increased pressure for better MIS	3.4
Health Care Market Changes	3.8
Labor Market Changes	3.9

Expanded Medicaid eligibility and the availability of the MassHealth Basic benefit package are thus the health reform initiatives that are perceived as being the most positive factors impacting health centers over the past year. Factors that most negatively affected health centers are overall changes in the health care market and changes in the labor market. Pressures to improve information systems are also perceived to have a somewhat negative impact on health centers.

Regional Differences in Survey Responses

Most Massachusetts state agencies manage the delivery of health and social services through a system in which the state is divided into five regions: Boston; Northeast; Southeast; Central; and West. These regions vary according to several characteristics such as population density, cultural diversity, location of provider networks and so on. We examined whether respondents had a differential perception of the impact of health reform according to the region of the state in which the center was located. We used ANOVA tests to examine variation among regions for several variables, including expenses and revenue, number of visits, number of contracts, number of patients, as well as health center perceptions of the different possible effects of health reform as described above.

The results suggest that health center responses did not vary by region for most of the variables. However, a regional difference in terms of the impact of expanded Medicaid eligibility and number of contracts health centers had (See Table 1). A critical component of Massachusetts health reform was expanded eligibility for MassHealth benefits. Expanded eligibility could impact health centers either positively if they receive additional revenues as patients become insured, or negatively if they lost newly insured patients to other health care providers. In our survey, expanded Medicaid eligibility was viewed more positively in the Boston region and in the Western part of the state than in the other regions.

Results also suggest that health centers in Boston were much more likely to contract with multiple managed care plans than health centers in the rest of the state. Boston health centers averaged about three managed care contracts, compared with two in all other regions of the state, with the exception of the western part of the state, where health centers typically have only one managed care contract.

We also found variation between Boston and the rest of the state in the perception of whether there has been a change in the number of uninsured patients the health center serves. Health centers outside of Boston were more likely to report an increase in the number of uninsured patients they saw, in comparison to health centers within Boston.

Comparing Survey Results to Division Data

In order to validate our results, we obtained selected financial data from community health center cost reports submitted to the Division of Health Care Finance and Policy, including:

- Total revenue
- Restricted grant revenue
- Bad debt
- Funding from the Uncompensated Care Pool

We compared the financial data submitted to the Division with the responses community health centers gave to our survey. There was a high correlation between the two sources of data with respect to the total revenues reported by the community health centers.

We also compared survey data to other financial variables available from the Division. The proportion of revenue health centers receive from restricted grants is significantly associated with the overall revenue received by the Center ($r=.77$; $p<0.0001$). Therefore, health centers with a greater proportion of revenue from restricted grant sources are also more likely to have greater total revenue. Moreover, health centers with larger amounts of restricted grants are more likely to have positive perceptions about expanded enrollment and eligibility for MassHealth under health reform ($r=-0.59$, $p<0.01$). Similarly, these health centers are also more likely to have positive perceptions about enrollment and eligibility for the Uncompensated Care Pool under health reform ($r=-0.51$, $p<0.05$). There was no association between the amount of unrestricted grant revenue and the amount of restricted grant revenue a health center receives.

We also determined that health centers with larger amounts of bad debt reported receiving a larger amount from the Uncompensated Care Pool ($r=0.49$, $p<0.05$). Health Centers with larger amounts of bad debt were also less likely to have negative perceptions about the impact of shifting demographics on the health center ($r=-0.44$, $p<0.05$). These centers were significantly less likely to report negative effects of labor market changes on the center ($r=-0.43$, $p<0.05$).

Health Centers reporting the largest amounts of revenue were also the centers with the largest number of managed care plan contracts ($r=.40$, $p<0.05$).

A Context for Understanding Survey Results

As described above, we examined secondary data available from the Division of Health Care Finance and Policy to understand trends in the financial status of Community Health

Centers over the last five years. Most recent data from fiscal year 1999 reveal that health centers are experiencing a decline in operating margins and total margins. Median operating margins decreased from about 1.4% in FY94 to 0.8% in FY99, while median total margins decreased from about 3.9% in FY94 to 1.1% in FY99. (DHCFP, Unpublished analysis of CHC Data, 2000). In addition, according to these data, in FY99, median total expenses were greater than median total revenues for the first time. Level of debt also increased nearly two fold between FY94 and FY99. During this time period, the median number of full time equivalent staff increased from 70.9 to 104.5, reflecting more than 30% growth in staff. Massachusetts health centers thus experienced significant growth but at the same time encountered greater challenges in maintaining their financial health.

Discussion

We gathered data from Massachusetts' community health centers in an effort to learn more about the impact of health reform on this specific type of safety net provider. We addressed four research questions; in the paragraphs that follow, we connect the results that were obtained from each research question. It is important to remember that the health centers responding to our survey represent a broad range of centers, operating under a variety of circumstances and serving many different types of patients across Massachusetts. Although this variety undoubtedly creates certain unique circumstances for each health center, we use our survey results to draw broad generalizations about the impact of health reform on these institutions.

- **Which of the Massachusetts health reform initiatives are having the biggest impact on Community Health Centers?**

Respondents indicated that expanded Medicaid eligibility and the availability of the MassHealth Basic benefit package are perceived as being the most positive factors related to health reform that impacted health centers over the past year. As one respondent said the biggest impact of health reform has been the "increase in Medicaid coverage including the increase in visits and users. Patients staying on when they get insurance." Factors that most negatively affected health centers are overall changes in the health care market and changes in the labor market. Pressures to improve information systems are also perceived to have a somewhat negative impact on health centers. Factors that health centers identified as having a more negative impact do not appear to be directly related to health reform. According to one respondent: "Safety net providers find sources of revenue to support the increasingly complex provision of health care to be inadequate. Efforts to rationalize and standardize care often puts an administrative burden on safety net providers, especially smaller ones."

In our survey, expanded Medicaid eligibility was viewed more positively in the Boston region and in the Western part of the state than in the other regions. Health centers outside of Boston were more likely to report an increase in the number of uninsured patients they saw, in comparison to health centers within Boston.

- **How are health centers adapting to these changes?**

It appears that not all health centers are adapting well to the changing health care environment in Massachusetts. One health center said that they are adapting to health reform

"With a great deal of difficulty and pain. Revenue squeezes are requiring programs to dip into reserves and cut back on program development. We are all moving in this direction."

Overall, total and operating margins are declining, and about 90% of health centers reported an increase in expenses over the past year, due primarily to serving more patients, increases in personnel costs, and increased expenses for technology. No health centers reported a decrease in expenses. Although some health centers reported a slight increase in revenue, about one-quarter reported that expenses were greater than revenues. These responses may be attributed to a variety of factors including health reform, overall changes in the market, demands for labor and other factors that we did not measure in our survey. Health center responses to reform may be different in other states that are using other methods to undertake health reform. In general: "Health Reform has had both a positive and a negative impact on our financial viability. Negatively, the reimbursement for services has been reduced. We are expecting a reduction in our reimbursement from the free care pool, which is our best payer. Additionally, capitated MassHealth managed care does not pay as well as fee for service. Positively, we have been able to emphasize access to health care with financial support from Medicaid and other funding sources which has helped bring visibility of our services to the community. And we have been forced to examine our practices and implement operational improvements."

- **Are health centers participating in various managed care arrangements? How does the impact of these arrangements compare to the impact of health reform?**

Most health centers reported having multiple contracts with managed care plans, averaging 2.5 managed care contracts per health center. Nearly every health center (97%) has a contract with Neighborhood Health Plan, which uses Community Health Centers as a key component of its provider network. There was regional variation in managed care arrangements: Boston health centers averaged about three managed care contracts each, compared with two in all other regions of the state, with the exception of the western part of the state, where health centers typically have only one managed care contract. Although there is variability in the degree to which health centers are contracting with managed care plans, health centers appear to be more likely to contract with managed care plans that enroll a publicly insured population. As one respondent reported: "The expansion of Medicaid eligibility had been modestly helpful financially, but there have been offsetting losses as Managed Care plans have assumed control of payments to vendors."

- **What impact has state health reform had on the financial stability of community health centers?**

"Health centers in MA are extremely fragile. Most are losing money. Administrative requirements, especially for eligibility and enrollment are overwhelming since we don't have adequate revenues to staff these responsibilities adequately. Staff are very stressed by overwhelming workloads in all departments because we can't afford the staff we need. "

It does not appear that health reform, in isolation, has had a major positive impact on the financial stability of community health centers. Prior to health reform, measures of financial stability had already begun to become increasingly unstable. Between FY 94 and FY99, there was a decrease in operating margins and total margins and median total expenses became greater

than median total revenues. Level of debt also increased nearly two fold between FY94 and FY99. During this time period, the median number of full time equivalent staff increased from 70.9 to 104.5, reflecting more than 30% growth in staff (DHCFP, Unpublished Data, 2000). There is little evidence from the survey that these indicators have improved as a result of health reform. And, current financial stability of health centers appears to be impacted by factors other than health reform. For example, health centers that had the greatest excess of revenues compared to expenses were also more likely to have larger revenues from unrestricted grant sources.

It is interesting to note that most health centers report that they are serving more than their fair share of individuals who are uninsured. Only 30% of health centers report that they are seeing fewer patients who are uninsured, while 40% of health centers report seeing more patients without insurance than in the past year. Moreover, Medicaid fee-for-service revenue, while comprising one of the largest sources of revenues for health centers, still only comprises less than 20% of revenue for a typical health center. However, it is also important to note that Medicaid HMO revenue comprises another 6% of health center revenue.

However, at the same time, health centers with larger amounts of restricted grants are more likely to have positive perceptions about expanded enrollment and eligibility for MassHealth under health reform. Similarly, these health centers are also more likely to have positive perceptions about enrollment and eligibility for the Uncompensated Care Pool under health reform. There was not a significant correlation between whether centers had large amount of restricted income and the proportion of revenues derived from MassHealth or the Uncompensated Care Pool. Perhaps for these centers, the expanded Medicaid and Uncompensated Care Pool eligibility is viewed as a potential new source of income.

Our results suggest that although health centers have had some positive responses to Massachusetts' health reform initiatives, these strategies have not significantly affected the downward trend in financial health indicators for health centers that was evident prior to health reform. It may be too early for community health centers to register the impact of the changes brought on by health reform. However, it appears that community health centers serve a variety of patients and receive a range of revenues to cover the costs of providing these services. Although health centers may in theory be satisfied with the changes brought on by health reform, because none of the health reform programs form the mainstay of health center fiscal stability, the impact of health reform on community health centers does not appear to be significant. Since the data were collected for this report, the State has made additional funds available for the year 2001 to community health centers through Medicaid fee for service rate increases of $3.4 million and grants totaling $9.1 million.

Community Health Center Survey
Descriptive Statistics

Organizational Status	**F**	**%**
Free-Standing	22	76
Hospital Based	4	14
Satellite to Hospital Based	1	3
Other	2	7
Respondent		
Director	14	48
CFO	9	31
Other	6	21
Federally Qualified Health Center?		
Yes	18	62
Look Alike	5	17
No	6	21
Region		
Boston	16	55
Northeast	5	17
Southeast	3	11
West	3	11
Central	2	6
Percent of Patients in Age Categories	**Mean (SD)**	
Seniors	7.3 (6.6)	
Adults	58.9 (15.7)	
Adolescents	13.3 (6.4)	
Children	20.5 (12.3)	
Percent of Patients Speaking Various Languages	**Mean (SD)**	
English	59.2 (30.6)	
Spanish	23.2 (25.6)	
Portuguese	9.9 (12.1)	
Haitian	7.5 (13.0)	
Chinese	9.5 (25.7)	
Vietnamese	4.3 (9.7)	
Cambodian	1.7 (1.9)	
Other Asian	0.2 (0.4)	
Other Languages	5.2 (5.1)	

Percent of Patients in Various Health Plans	**Mean (SD)**
MassHealth	36.7 (19.9)
Neighborhood Health Plan	24.0 (20.4)
HealthNet	12.0 (15.3)
Network Health	0.3 (0.7)
Harvard Pilgrim	8.2 (11.1)
Primary Care Clinician	49.1 (32.3)

Percent of MassHealth Enrollees in Various Benefit Plans	**Mean (SD)**
Standard	70.4 (24.2)
Basic	21.6 (26.6)
Limited	9.1 (10.8)
Family Assistance	4.2 (2.3)
Commonhealth	4.0 (4.4)
Prenatal	2.2 (2.6)

Contracts with Managed Care Plans?	**F**	**%**
Neighborhood Health Plan		
Yes	28	97
No	1	3
Boston Health Net		
Yes	9	31
No	20	67
Cambridge Network Health		
Yes	2	7
No	27	93
Fallon Health Plan		
Yes	1	3
No	28	97
Harvard Pilgrim Health Care		
Yes	16	55
No	13	45
Massachusetts Behavioral Health Partnership		
Yes	17	59
No	12	41

Percent of Revenue from Various Sources	**Mean (SD)**
Medicare FFS	4 (4)
Medicare HMO	1 (3)
Medicaid FFS	19.4 (12.8)
Medicaid HMO	6 (5)
Self Pay	4 (6)
Uncompensated Care Pool	10 (8)
CMSP	4 (7)
CenterCare	11 (15)
Restricted Grants	16 (16)
Unrestricted Grants	19 (13)

Do you Serve More than Your Share of Uninsured Patients?	**F**	**%**
Yes, definitely	19	70
A little more	2	7
About our share	5	19
Don't Know	1	4

How has the Number of Uninsured Patients Changed?		
Increased	12	41
Decreased	9	31
No Change	5	17
Don't Know	3	10

Analysis of Variance Among Regions

Perception of Expanded Medicaid Eligibility (One is most Positive)

Region	**Mean (S.D.)**
Boston	1.87 (0.5)
Northeast	2.20 (0.8)
Southeast	3.00 (1.4)
West	1.33 (0.6)
Central	2.67 (0.6)

F=2.97, df=4,23, p<0.05

Number of Managed Care Contracts

Region	**Mean (S.D.)**
Boston	3.06 (0.9)
Northeast	1.80 (0.8)
Southeast	2.00 (1.4)
West	1.00 (1.0)
Central	2.33 (0.6)

F=3.97, df=4,24, p<0.05

Have you experienced an increase in the number of uninsured you serve?

Have you experienced an increase in the number of uninsured you serve?		**Yes**	**No**	**Total**
Is the Health Center in Boston?	**No**	8	5	13
	Yes	4	12	16
Total		**12**	**17**	**29**

Chi-Square: 3.95, df=1, p<0.05

APPENDIX XVIII: CHAPTER 140 LEGISLATION INFORMATION

Chapter 140 of the Acts of 200, sections of which took effect on April 30, 2001, amended the existing nongroup law. Among other provisions, it allows participating nongroup policy carriers to "additionally make available to eligible residents one alternative guaranteed issue health plan with benefits and cost-sharing requirements, including deductibles, that differ from the said standard guaranteed issue health plan. A carrier shall not make available an alternative plan unless said plan has been filed and approved by the commissioner of insurance. The commissioner shall approve of an alternative plan if said plan: (1) includes at least the following medically necessary services: reasonably comprehensive physician services; inpatient and outpatient hospital services; emergency health services; and a full range of effective, clinical preventive care administered on an outpatient basis; and (2) contains a disclosure form, which shall be provided to any potential insured, that clearly and concisely states the limitations on the scope of health services and any other benefits to be provided, including an explanation of any deductible or copayment fature; and (3) offers a ten day free look period…"

Two such plans were filed with the Division of Insurance, by Blue Cross and Blue Shield of Massachusetts and Harvard Pilgrim Health Plan. Both of these plans were filed as Non-Group Low Option Coverage. These plans were quite similar to the standard plans offered by these carriers, with the following exceptions:

- Higher co-payment amounts.
- Lower premiums (low-option premiums are approximately 80% of the standard premium cost).
- No prescription drug coverage in the low-option plans.

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