December 30, 2002

Representative Nancy Flavin
Senator Mark Montigny
Chairs, Advisory Committee on Consolidated Health Care Financing and Streamlined Health Care Delivery

Dear Representative Flavin and Senator Montigny,

The study conducted by LECG, *"The Feasibility of Consolidated Health Care Financing and Streamlined Delivery Health Care Delivery in Massachusetts", December 17, 2002*, for the Advisory Committee has made a significant contribution to the state's efforts to address comprehensive health reform. The study provides a detailed cost analysis of the current public and private health care sector in the state and similar analyses of three potential models for expanding health care coverage. LECG was also required to provide a modeling tool that could be used by the Committee and Commonwealth to explore these and related models. This tool should help us better understand LECG's underlying assumptions and allow us to manipulate the factors in the tool and analyze the results. This tool has not been submitted as yet, and some of the questions raised in this letter might be answered when it is available.

**Areas of Consensus**

An important observation which LECG makes based on its interviews with stakeholders and the public input process is that there were several areas of "general agreement" (pg. 70), including that:

- The right to health care has not yet been agreed to in the Commonwealth, but that if it is asserted, it must be balanced with the recognition that resources are limited.
- Citizens should contribute to the cost of care up to their ability and that medically necessary care should not be withheld because of inability to pay.
- High cost individuals (e.g. those with chronic diseases) should not be responsible for the increased cost of their care.
- Employers benefit from a healthy work force and should continue to directly contribute to the health care costs of employees as a cost of doing business.

Despite these areas of agreement, the Advisory Committee was unable to make recommendations on a particular model or sequence of policy changes based on the LECG study. This undoubtedly reflected the widely divergent views of the many stakeholders on the Committee. In addition, however, there are weaknesses in the LECG study itself which made it difficult to fully evaluate the implications of the models and understand the implementation challenges that each entails. However, the above areas of agreement could be an important basis on which to continue to this work in the future, using the LECG study, further analysis and discussion.

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## Selection of Models

The three models presented by LECG are a Medicaid Expansion to 300% of the Federal Poverty Level; an expansion of Medicaid to 200% or 300% FPL with an individual mandate on those above this income level to purchase a Basic Benefit Package; and a Single Payer System. LECG recommended these models after a public input process that included interviews, a limited survey and several public hearings. While the commitment of LECG to a broad-based input process was laudable, the process did not lead to full discussion and debate of some of the most fundamental problems that the Commonwealth must face in planning comprehensive health reform.

The Medicaid Expansion and Individual Mandate models described by LECG include assumptions of significant employer participation and financing without a detailed analysis of the likelihood of voluntary participation at the levels assumed in the models or alternative regulatory means to achieve that participation. Perhaps reflecting divisions among the stakeholders in the Advisory Group itself, LECG did not chose to develop an "employer mandate" model as one of the reform models, which would be one means of regulating the employer role in the system. Given the important role employers currently play in providing and financing health coverage, Health Care For All would recommend further study of these critical issues, particularly given the fact that employers are increasingly eliminating coverage or requiring increased employee cost sharing that is unaffordable by many low income workers. The Single Payer option clearly delineates the employer obligations for financing a universal system, but we would need a far more detailed analysis of the way this new financing mechanism would affect different parts of the employer sector, compared to current costs and arrangements, in order to understand the implementation challenges that would be involved.

Overall, further study is needed to address the complexities of implementation of the models presented by LECG and other models. The LECG study does not address in detail the impact of providing expanded or universal coverage on the health of individuals, on the potential to better coordinate care and regulate the delivery system in the interests of improving quality of care and containing costs, or on the economy as a whole. It does, however, provide an estimate of new jobs created by each model, which will be helpful in ongoing discussions of the role of the health care sector, including Medicaid, in the state's economy.

### Baseline Case

*Number of Uninsured (p. 63)*
LECG first produced a "base case" model which describes the ways in which health coverage is provided by both public and private payers and individuals. After estimating the number of residents covered by all public and private sources, the residual was the estimated number of uninsured. The total estimate of 399,400 uninsured (6.2% of Massachusetts residents) is very close to the latest report released two weeks ago by DHCFP, which showed 6.4% uninsured rate based on their household survey. DHCFP did report a lower rate of uninsurance for children (3.3%) than the LECG report (4.6%).

*Health Care Expenditures (pg. 65, Figure 7)*
LECG estimated the total current private and public expenditures in Massachusetts for health care as $41.4B. Public expenditures include Medicare and all state programs, including the costs of services provided by DMH, DMR and DPH. (e.g. CMSP and Healthy Start programs). The Medical Security Program for those on unemployment and Prescription Advantage for seniors and those with disabilities, long-term care, the medical expenses in auto insurance and workers compensation are included in this estimate. Also, included are out of pocket medical expenses (separately listed for Medicare pharmacy) as well as employer expenditures.

- Health Care For All had recommended in comments on previous drafts that the report disaggregate the number of people covered and the expenditures in the employer sector (totaling $13.5B) so that the current contribution of employers who provide insurance can be understood. LECG has included a chart on those insured and offered insurance by sector and firm size. (Appendix G). However there is still no discussion in the description of the models as to the impact of the new models on these employment sectors, which provide insurance at varying rates. This merits further study, because understanding the impact of each model on types of employers and their employees is critical for building a political consensus to pursue reform and to designing targeted reforms as a transition to universal coverage.
- The overall expenditures on MassHealth and the federal matching funds generated across various state departments outside of DMA are included but not described in enough detail to understand how they might change under new models.
- The expenditures included for non-group insurance seem to be low, given that average premium prices should be at least as high as those in the employer sector.

*Program design*
LECG does not link its description of the Medicaid program in the Baseline Model to the commonly used descriptions of the programs in Massachusetts (e.g. Standard, Basic, Commonhealth, etc). This makes it difficult to compare the cost figures and enrollment figures it has developed to other recent studies of Medicaid (e.g. Nancy Turnbull's analysis written for the Massachusetts Health Policy Forum) or the state budget. It is also difficult, for this reason, to understand exactly how each model would change the current public programs, particularly Medicaid, in terms of eligibility rules, administrative changes and the impact on clients benefits and ease of entry into the system.

*Long term care*
The role of long term care in each of the models is not well described. In the case of the Medicaid expansion model, we assume that long term care is included in the benefit package for all those up to 300% of the poverty level and is part of the program that individuals and employers can purchase above that income level. However, that is not explicitly discussed, and the implications of this expansion of long term care coverage is not explored in comparing the model to the existing system. In the case of Model 2, long term care is not included in the mandated plan, but presumably is included for those on MassHealth, as in Model 1. This needs more discussion as well in comparing the model to the others. In the Single Payer Plan, the long term care benefit is described as "limited." This is not explained or compared to the other models or the current MassHealth benefit. We would request that a separate follow-up memo be

produced by LECG on this issue, since the issue of financing long-term care will increasingly be on the agenda for the state and, hopefully, for the federal government.

**Model 1A and IB. Medicaid Expansion to 300% with two assumptions on provider rates.**

Overall, this model would be improved by including specific descriptions of current Medicaid programs and the new program. What are the old rules and what would be the new rules? Is it one program or would federal rules make other arrangements necessary or prudent?

- What would be the administrative savings of combining current programs and enrollment rules into a more streamlined system?

- An employer contribution to the program is included, but the mechanism that would lead to this contribution is not described. A preliminary discussion with LECG indicates that this contribution is an estimate of employer contributions for plans that have currently been offered to low income employees but not taken up because of the cost of the employee contribution. These mechanisms and assumptions are not laid out in detail. Given the fact that there has been low enrollment in the Insurance Partnership, which only requires a 50% contribution from employers, would we be able to expect the 77% employer contribution estimated by LECG?

- What is the impact of crowd-out for the newly eligible who are working, particularly between 200-300% of poverty? In responding to this question raised by Health Care For All about previous drafts, LECG states that crowd-out has not been a major issue in the previous MassHealth expansions. While we would agree with that analysis, those expansions were for people below 200% of the poverty level. The potential for crowd-out would be higher for expansions of MassHealth to higher income levels where more uninsured people may have more access to employer based insurance. Both the cost and regulatory issues that arise in this situation need to be addressed.

- We asked LECG to describe in more detail the waivers required for this program and any experience from other states that would indicate that we could be successful. This was not done in the final draft. In particular, the high FFP model seems unlikely to be approved. How would the program be modified to address this problem? How would the various possible structures of this model meet budget neutrality requirements? To our knowledge, no state (with the possible exception of Tennessee) has received a waiver for expanding Medicaid to this income eligibility level for non-categorical populations—i.e. non-disabled, non-parent adults.

**Model 2A and 2B. Individual Mandate**

This model is an expansion of Medicaid to all residents, either to 200% of poverty or 300% of poverty, with an individual mandate for other residents. The report did not make it clear as to whether the full Medicaid package of benefits would be included for the Medicaid group—

personal communication from LECG confirms that this is the case. The MSP-type benefit package therefore applies to those above the Medicaid eligibility level.

- The questions raised about Model 1 also apply to this model, since it is starts with a Medicaid floor that is higher than the current Medicaid program.

- A major issue that is not addressed in the description of the model or in the potential impacts is the high cost of insurance for those who have low or moderate incomes but are above the Medicaid eligibility level. For instance, a family of three just about 300% of poverty is making about $45,000 per year and would be required to purchase family coverage for $9,600 for a family plan or nearly 25% of their gross income. This would be impossible, and therefore to be credible, the model needed to include a discussion of potential subsidies for these individuals and families. The individual mandate would have some positive effects in bringing everyone into one or another pool, but it cannot work nor would passage of such legislation be imaginable without addressing the affordability issue.

- This model also assumes significant ongoing employer contributions and participation, and the means to maintain these are not discussed. Again, as in the Medicaid expansion model, crowd-out could be significant unless some sort of mandated participation by employers prevents it.

**Model 3: Single Payer**

- The Single Payer model is the most comprehensive model, which guarantees universal coverage and involves major changes in the organization of the financing and delivery of care. The implications of this model were not fully explored by the Advisory Committee. For instance, the greatly reduced role of insurers was never discussed, and the study itself does not describe the political or implementation issues that would be involved. However, this is only one of the issues which would have been helpful to have described in the LECG study. Health Care For All sees this model as one potential model for providing universal coverage in the Commonwealth. We see the MassHealth expansion as a more likely transitional stage to such broader coverage. We discussed the need to link the models in the study and explore the possible ways in which models that do not provide full coverage could be transitioned to a more comprehensive model such as Single Payer. This analysis was not done in the LECG study.

- As in the other models, we need a far more detailed analysis of the way in which the single payer financing mechanisms would affect different parts of the employer sector and payroll levels, comparing it to current costs and arrangements. A more detailed description of the benefits for residents at various income and employment scenarios compared to today's situation would also be important.

- We do not see why we would need an ERISA waiver for this model, since it only requires a business tax, with the state then providing a publicly financed health care program.

This is not an employer mandate, requiring businesses to provide insurance. Self-insured companies would be free to continue to provide insurance, but except for supplemental benefits, they should have no reason to do so.

## Conclusion

Health Care For All supports a publicly financed health care system as a long term goal while working on incremental health expansions in the interim. As we have described above, the LECG study leaves many questions unresolved concerning how to best move forward. Since the Advisory Committee began its work over a year and a half ago, the crisis in health care that led to its formation has been dramatically heightened by new increases in health care costs and the state budget crisis. The legislature and the Governor have made dramatic cuts to the MassHealth program which will undermine much of the progress we have made in recent years to cover the uninsured. There are over 420,000 uninsured in Massachusetts today, which will rise by 50,000 if the MassHealth Basic program is cut on April 1, 2003. Another 65,000 may lose coverage this year due to reduced coverage by employers, according to a recent study commissioned by the Blue Cross/Blue Shield Foundation. The issue of health care coverage and financing was debated in the Uncompensated Care Pool Commission and will be central to the next budget deliberation. Both the health of the people of the Commonwealth, particularly those most vulnerable, and the health delivery system itself are at risk.

LECG concludes, after its analysis of the Massachusetts health care system and given the current state budget crisis, that the state should focus on "maximizing federal matching by expanding the Medicaid program to provide coverage for all residents" and that it "reconsider the current budget cuts and programs retrenchments in light of community health and cost impacts that further disruption in the delivery of care may have upon the more vulnerable elements of society." (pg. 123) We would agree with this general conclusion, although, as we have outlined here, the details of such a plan need more refinement. In addition, the share of financial obligations which would be required to preserve current programs and reach a goal of coverage for all Massachusetts residents must be addressed. An important part of this equation is, as LECG suggests, the federal matching funds that flow through the Medicaid program. Given the fact that federal action for universal coverage does not appear to be on the agenda, the Medicaid program remains a critical vehicle for garnering federal support for solving the crisis of coverage at the state level. The state should aggressively pursue recent proposals in Congress to increase FMAP, and we encourage the new administration, which has suggested that it would seek similar increases, to work with the legislature, the congressional delegation and advocates toward this goal.

LECG suggests that "public sentiment be polled as to whether the expansion [as suggested above] should be based on mandatory or voluntary participation". The means by which participation will be assured in such a new system must be addressed not only for individuals, if that is the implication, but also for all the major contributors to our current system and a future system. This includes the state, the federal government, employers, providers, insurers, and individuals. Health Care For All supports, for instance, requiring mandatory contributions from employers because even the current system benefits all employers, even those that do not

currently provide insurance for their employees, by financing the health care safety net—public insurance and the Uncompensated Care Pool.

We will have to gage "public sentiment" in reaching any consensus on such new initiatives to preserve and expand coverage, because new funding sources will be needed and reorganized programs and systems of health care delivery will be required. Finding the appropriate means to engage the public on these issues is part of the continuing challenge all stakeholders face—those that were involved in the Advisory Committee as well as the legislature and the administration as a whole—in negotiating new solutions and protecting the health of the residents of the Commonwealth. We would also agree with LECG that further work toward more dramatic restructuring of the system is critical and that their analysis indicates that "finance, administrative and delivery system efficiencies can be realized with restructuring the system", one that is grounded on a commitment to universal coverage.

Sincerely yours,

Marcia Hams
Deputy Director