THE MASSACHUSETTS PLAN: A MODEL FOR MISSOURI?

September 2006

By
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The authors thank Tanchica Terry, Rebecca Friggy, Sarah Kaufman, and Tameka Stigers, for their expert research assistance on this report. The authors also thank the other members of the Saint Louis University State Health Policy legislative Analysis Team for their suggestions and guidance on this report, in particular Kathy Gillespie, Rick Kurz and Kanak Gautum for comments on the work as it has proceeded, and Thomas McAuliffe and Leslie Reed at the MFH for their additional extremely helpful suggestions. All remaining errors, of course, remain the responsibility of the authors.

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The work of the Saint Louis University Health Policy Legislative Analysis Team is funded by the Missouri Foundation for Health (MFH) and focuses on the analysis of health policy legislation for the State of Missouri. The views represented here are those of the analysts and do not represent the views of the Missouri Foundation for Health or Saint Louis University.

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EXECUTIVE SUMMARY

THE MASSACHUSETTS PLAN: A MODEL FOR MISSOURI?

The sweeping health reform bill (An Act Providing Access to Affordable, Quality, Accountable Health Care, H4479), to achieve universal health insurance coverage passed the Massachusetts Legislature in April 2006. The legislation expands access to affordable coverage through several strategies, including premium assistance, Medicaid expansions, a government-sponsored Insurance Purchasing Pool, individual mandates to purchase insurance, and mandates for employer contributions. This analysis compares and contrasts the Massachusetts legislation in Missouri's current environment, and provides conclusions about areas where implementation presents both opportunities, as well as obstacles, to achieving universal coverage in Missouri.

Key Findings and Conclusions

The Massachusetts Plan represents a feasible plan for increasing access to affordable health insurance in Missouri. While the findings presented here point to significant challenges to the passage and implementation of such a proposal, opportunities for improving the well-being of Missouri citizens are achievable. In particular:

- Passage of a Massachusetts-style plan in Missouri is predicated on the proposition that universal coverage is an explicit state health policy goal. Not only does universal coverage mean that previously uninsured individuals will be able to reap the health benefits of health insurance and increased access to the health care system, but universal coverage also creates premium savings for those who already have health insurance;

- In order to achieve universal coverage in Missouri, within the cost estimates presented here, state funds used to subsidize health insurance for low to moderate income state residents – either public or premium assistance for private insurance – must secure federal matching funds;

- Although implementation of the legislation requires an increase in spending by the state, nearly half these costs could be covered by using funds presently allocated to cover the costs of care for the uninsured;

- The affordability and availability of health insurance coverage in Missouri through the Private Insurance Pool depends on whether the pooling of many small employers and individuals together can lead to lower administrative costs and more favorable premium rates;

- The effectiveness of Medicaid expansions for those who are currently eligible or will become eligible in Missouri depends on effective outreach to enroll those who are eligible;

- An individual mandate will only take effect if the new Private Purchasing Pool, the new Premium Assistance Program, and Medicaid make “affordable” and adequate insurance available. An individual mandate will only receive wide popular support if the definitions of affordable and adequate are viewed as fair and appropriate by voters;

- Whether an employer mandate that requires that businesses either contribute a “fair and reasonable” contribution towards the costs of employee health insurance or pay an annual assessment to the state is perceived as fair and equitable will depend on the rules and regulations governing the definition and implementation;

- The introduction of a Massachusetts-like universal coverage system into Missouri should improve access to a regular source of care and create greater continuity of care, enabling Missourians to enjoy more equitable access to increasingly higher quality, efficient and effective medical care.

Achieving Universal Coverage in Missouri

A Massachusetts-style insurance reform does not require anyone who has health insurance to change plans. Instead, it seeks to expand access to affordable health insurance through a variety of strategies. In Missouri, the following strategies would be used to cover the uninsured:

- The **Premium Assistance Program** (PAP) would help low- and moderate- income individuals (below 300% of the Federal Poverty Level) afford private insurance by lowering the costs of premiums and out of pocket costs, covering 47% of the presently uninsured.

- **Medicaid Expansion** extends eligibility to adults who are parents, disabled or elderly. In addition, outreach efforts would be needed to enroll those who are presently eligible but not enrolled. These Medicaid expansions and outreach efforts would cover about 30% of the uninsured.

- A State-Sponsored **Insurance Purchasing Pool** allows individuals and small groups to lower the costs of purchasing by combining the individual and small group private insurance markets and instituting private insurance reforms;

- **Individual and employer mandates.** The three voluntary strategies listed above would expand health insurance to 77% of those who are presently uninsured, reducing the number of uninsured in Missouri to 195,000. However, to reach universal coverage requires moving beyond the voluntary purchase of health insurance to a requirement that those who can afford to purchase insurance either directly or through their employer. In Missouri, estimates are that an employer and individual mandate would apply to the remaining 23% of the uninsured.

The Costs and Financing of Universal Coverage in Missouri

The net costs of covering the uninsured in Missouri under a Massachusetts-style plan (estimated to be $2.6 billion) would be allocated in the following way:

- About 34 percent of the net costs would need to be covered by the **state government**.

- Approximately 54 percent of the costs would be covered by federal revenues – the **federal "matching" funds** on state expenditures for existing and new Medicaid approved expenditures.

- **Individuals** will contribute 12 percent of net costs. Individuals who are currently uninsured will pay an estimated $544 million for their share of premiums (with the remaining portions paid for by government-paid premium assistance or employers). This is offset by reductions in premiums for those who are currently privately insured who will see, on average, premium savings of 6% per year for a total estimated savings of $219 million.

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

The Missouri state government would need to cover approximately $892 million to finance public and private health insurance coverage, but substantial current revenue sources are available which can be redirected to fund these expansions. In particular, of the $892 million that is needed by the State, $362.7 million would be available after redirecting state funds in the current system that are used to cover the cost of care for those who are uninsured. This leaves $529.3 million in new state funding that is still needed.

Existing State funds that could be reallocated toward universal coverage include:

- Disproportionate share hospital (DSH) payments ($175.5 million);
- An uncompensated care fund ($35.4 million), and
- State and local funds for care of the uninsured ($151.8 million). Note that only the first two sources of existing funds receive federal matching funds.

Potential new sources of revenue exist as well, including, but not limited to: funds from a tobacco tax initiative (approximately $290 million for health care access and treatment); a portion of the General Revenue surplus (approximately $600 million); revenues from a provider tax on private insurers (potentially up to $100 million), and a sales tax on medical services (potentially yielding up to $628 million).

Chapter I.
THE CONTEXT FOR REFORM

In April 2006, the Massachusetts Legislature passed a sweeping health reform bill (An Act Providing Access to Affordable, Quality, Accountable Health Care, H4479), expanding health coverage for people in Massachusetts who are uninsured. The legislation, passed overwhelmingly by the Legislature on a bipartisan basis, was signed into law by Massachusetts Gov. Mitt Romney on April 12, 2006.[1] The legislation seeks to expand coverage through a range of initiatives including: government subsidies for private insurance, Medicaid expansions, a state purchasing pool and insurance reforms to make private insurance more affordable, and individual and employer mandates. Details of the legislation are provided in Appendix A.

How was Massachusetts able to achieve bipartisan consensus around this approach? And how did Massachusetts find the fund to pay for expanding coverage? And would this approach work in Missouri? This chapter addresses these questions and outlines the rest of this report.

The Context for Reform in Massachusetts

Massachusetts achieved a bipartisan consensus to pass H4479 that has been difficult to achieve in other parts of the country. In particular, analysts[2] have pointed to several factors as important reasons why Massachusetts was able to pass reform:

- If Massachusetts had not passed reform, the Commonwealth stood to lose a large amount of Medicaid matching funds from the federal government (almost $400 million per year over two years), stemming from the requirement Massachusetts' federal Medicaid waiver redirect funds that were being used to support safety net hospitals to pay for insurance coverage instead;

- The existence of considerable state funds to provide medical care to the uninsured proved crucial to reaching an agreement, since funding of the coverage expansions was achieved mostly by allocating funds from existing resources (e.g. the Uncompensated Care Fund) to finance the coverage expansions in H4479;

- A ballot initiative, sponsored by a range of community activist organizations, would have required a much more substantial payroll tax based contribution from employers, but the organizations told the Legislature that this initiative would be dropped if legislation was passed expanding coverage;

- A range of organizations provided significant impetus for reform, including business leaders who argued that expanding insurance coverage was in the economic interest of the state, advocacy groups (e.g., Health Care for All) that pushed for reform, and a major effort organized by Blue Cross Blue Shield to provide analysis and ideas for reform options (much of these produced by the Urban Institute, in Washington, DC). These groups gathered together to provide sophisticated policy analysis, a media campaign, and linkages across the groups.

All these factors led to a broad bipartisan consensus from the Republican Governor, working with a Democratic majority Legislature to pass the legislation, though it is notable that the legislation passed overwhelmingly with broad support from both parties. In part that was

because there was broad bipartisan agreement over the goals of reform:

- **Universal Coverage** – everyone should have private or public health insurance;
- **Fair share** – the costs of achieving universal coverage should be fairly shared by individuals, employers, and the government;
- **Public-private partnership** – the best way to achieve universal coverage is through both private and public efforts, but especially a private-public partnership to reform insurance markets and increase the affordability and availability of health insurance;
- **Individual responsibility** – requiring that individuals are ultimately responsible for obtaining health insurance as long as the coverage is affordable and available;
- **Employer responsibility** – requiring that employers share in the responsibility for financing health insurance for their employees as long as coverage is available and affordable;
- **Political feasibility** – use strategies that maximize the possibility for success, especially building on existing programs and funding mechanisms;
- **Market Reform** – maximize the feasibility of the insurance market for providing affordable coverage available to everyone through creation of pooling mechanisms, insurance market reforms, and mandates;
- **Stability** – maintain stability in the insurance market by making sure that no one who has health insurance is forced to change to other coverage, only that they are given more options from which to choose from.

The Missouri Context

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

- Missouri does not face the threat of loss of significant federal funds through federal action, but state law provides that the Missouri Medicaid program is to sunset on June 30, 2008.[3] The intent of the sunset provision is force the legislature to act to replace the existing Medicaid program with a “new, innovative state Medicaid healthcare delivery system.” A bipartisan Medicaid Reform Commission issued a final report in late 2005 that made recommendations on reforming redesigning and restructuring the state’s Medicaid program. The 2007 General Assembly will need to act to either reform Medicaid or delay the sunset provision.

- Although there is no ballot initiative in Missouri seeking to impose a payroll tax on employers to expand health insurance coverage such as the one that might have passed in Massachusetts, a ballot initiative in Missouri to increase the tobacco tax may still appear on the November 2006 ballot, requiring some of the revenues from this tax to be used for improving access and quality of health care and for reinstituting Medicaid cuts made by the 2005 General Assembly..[4]

- The lack of a significant existing pool of resources such as the Uncompensated Care Fund may be an obstacle to funding coverage expansions in Missouri. However, to the extent that Missouri can be creative in tapping into potential new sources of revenue (e.g., revenues from the tobacco tax) or seeking new sources of revenue (e.g., additional federal matching funds), funding coverage expansions may be achievable.

- A notable difference between Missouri and Massachusetts is the current absence of a broad coalition of business groups, community activist organizations, and research groups focusing on the issue of private insurance coverage expansion. However, a broad-based group of organizations has worked consistently on issue involving Medicaid and SCHIP coverage.

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

This Report: A Model for Missouri?

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

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

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

Chapter II.
THE UNINSURED IN MISSOURI

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

- The uninsurance rate among the non-elderly was 13.6% in Missouri in 2003-04, but this rate was lower than the uninsurance rate of 17.8% across the U.S.[5]

- Missouri's relatively low uninsurance rate was achieved by higher Medicaid, public, and individual insurance coverage rates.

    - Missouri used a Section 1115 Medicaid waiver in the 1990s to expand Medicaid eligibility for children and the state has one of the highest SCHIP income eligibility levels in the country. However, as a result of 2005 Legislative changes, adult eligibility levels are now at the lowest levels allowed by federal law. incomes;

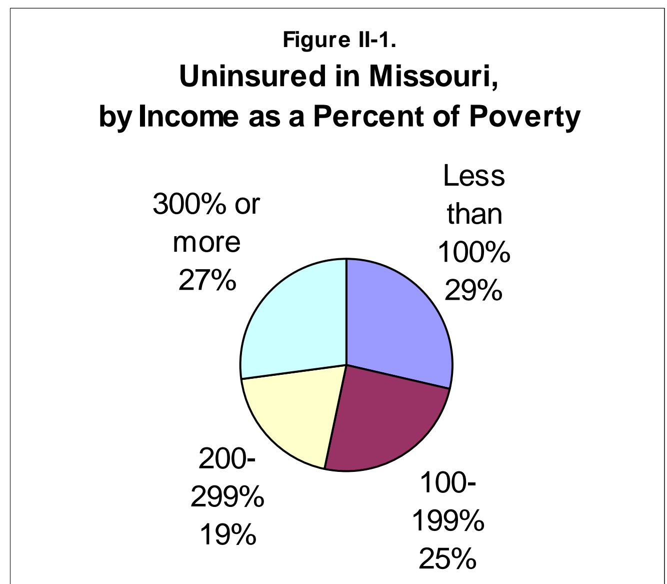
    - Missouri now offers a less generous Medicaid benefits package as compared to Massachusetts, as a result of changes to optional services;

    - The recently-enacted Medicaid legislation as part of Senate Bill 539, passed in Missouri in 2005 and implemented in 2006, will affect the number of uninsured. Previous research on Medicaid cutbacks indicates that most individuals that lose Medicaid coverage become uninsured. Missouri had an estimated 700,000 uninsured in 2005 but perhaps another 140,000 or more individuals formerly on Medicaid may have become uninsured as a result of legislative changes and other Medicaid changes.

    - While Missouri operates a High Risk Pool to help the uninsured, Massachusetts operates a variety of pools and subsidies to assist the uninsured and underinsured, including an Uncompensated Care Pool with funds up to $1 billion annually to pay for uncompensated care. Missouri has no such earmarked pool of funding for uncompensated care.

- Missouri has generous SCHIP coverage (up to 300% of the federal poverty line in Missouri).[7] As a result, a greater proportion of Missouri's children are covered by Medicaid--about 70 percent in Missouri as compared to 60 percent in the U.S.).

- About 30% of the uninsured in Missouri live in poverty (poverty is defined as living



with income less than the Federal Poverty Line, $9,310 for an individual and $18,850 for a family of 4 in 2004[6]), (see Figure II-1).

- About three-quarters of the increase in the uninsured between 2000 and 2004 in Missouri occurred among those living below 200% of the FPL[7]

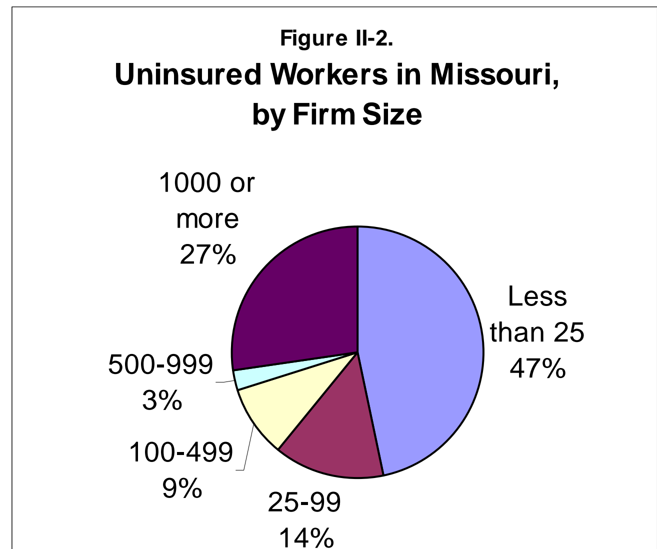
- Missouri covered a higher proportion of children in poverty, but a lower proportion of adults in poverty through Medicaid in 2003-04.

- In Missouri about 81% of the uninsured have someone in their family working full or part time and 65% of Missourians had employer coverage.[8]

  - Persons in Missouri experienced a significant drop in employer sponsored coverage (ESI) coverage from 2000-2004, largely due to economic decline. For nonelderly adults, ESI coverage dropped by over 7 percentage points in this period.[9]

  - About 60 percent of the increase in the uninsured in Missouri between 2000 and 2004 was among adults between the ages of 19 and 34, largely due to declines in employer-sponsored insurance coverage.[10]

  - To a large extent, the problems Missourians face in the employer-sponsored health insurance market result from the lower likelihood that their firms will offer them health insurance. Only 53% of Missouri private firms offer their employees health insurance as compared to about 57% in the US.

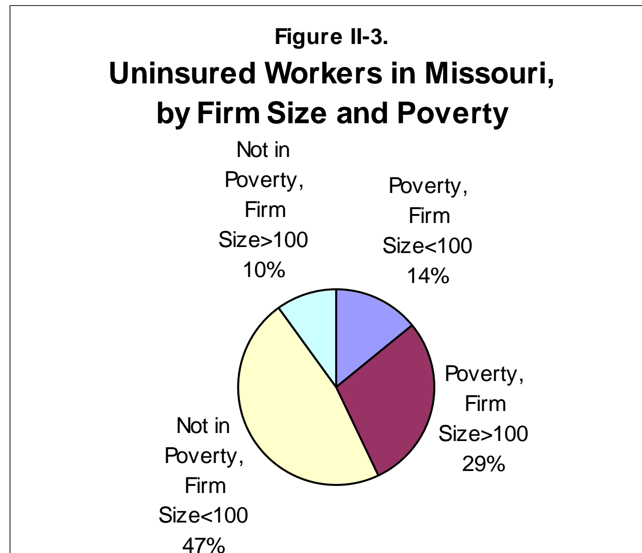


  - The problems workers face in obtaining ESI have worsened in recent years as employment has shifted to smaller firms and firms less likely to offer insurance coverage.[11] In Missouri, almost half (47%) of uninsured workers worked for firms that employed fewer than 25 workers, and 61% of workers were employed in firms with fewer than 100 workers (Figure II-2).

  - About 14% of uninsured workers are in poverty and working for small firms, with less than 100 employees (Figure II-3).

The significant number of uninsured in Missouri carries with it significant consequences. The Institute of Medicine, in their exhaustive study of the uninsured, recently concluded that “the relationship between health insurance and access is well established”[12] Moreover, this increased access would have a significant effect because “the health of the uninsured is worse than it would be otherwise if they were insured” and increased access to “insurance would

especially improve the health of those in the poorest health and most disadvantaged in terms of access to care." The IOM concluded that as a result of uninsurance and underinsurance, uninsured individuals and families are less likely to receive preventive and screening services; receive fewer and less timely services leading to increased morbidity and worse outcomes, and those with chronic illnesses receive fewer services and have increased morbidity and worse outcomes. The result of all this is that 18,000 people die prematurely in the U.S. annually as a result of uninsurance.



CHAPTER III.
ACHIEVING ACCESS TO CARE IN MISSOURI THROUGH THE MASSACHUSETTS APPROACH

This chapter concentrates on the impact of importing a Massachusetts-style universal coverage system in Missouri on access to health insurance. As described generally in Chapter 2, the Massachusetts legislation uses a number of strategies to achieve improved access to care. Therefore, this Chapter discusses each of these strategies in turn and addresses the viability or feasibility for these strategies to work in Missouri for improving access to health insurance. However, the Chapter first starts by describing the overall uninsured population in Missouri and identifying how many individuals would likely be captured by each policy strategy.

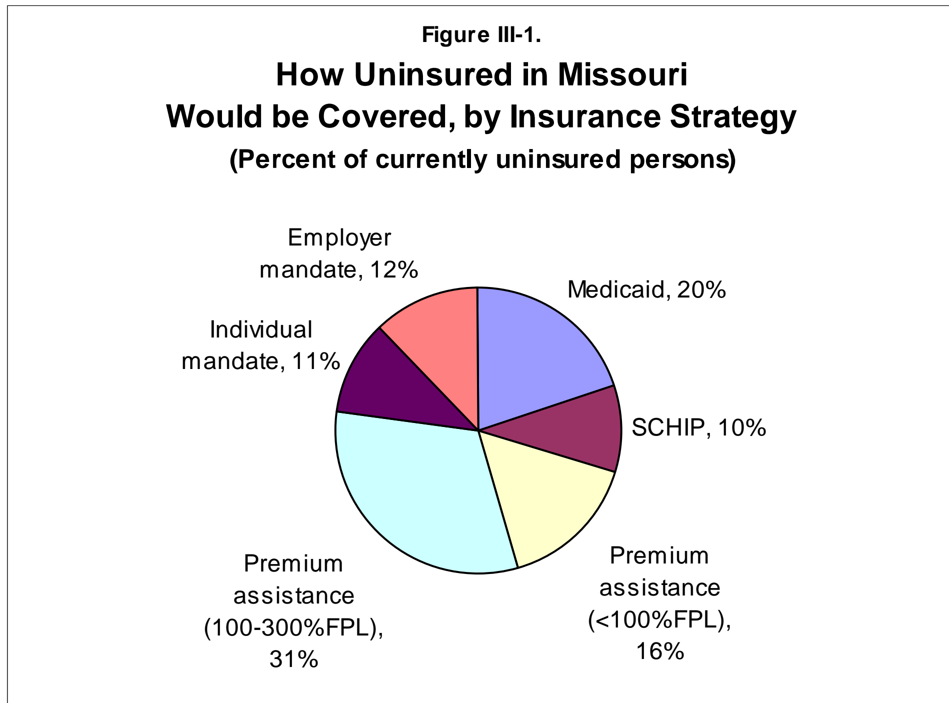


Figure III-1.
How Uninsured in Missouri Would be Covered, by Insurance Strategy
(Percent of currently uninsured persons)

SOURCE: SLU Health Policy Legislative Analysis Team Simulations -- see Appendix A, Table 1.

COVERING THE UNINSURED IN MISSOURI: A MASSACHUSETTS-STYLE APPROACH

A Massachusetts-style insurance health reform does not require anyone who has health insurance to change plans. Instead, it seeks to expand access to affordable health insurance through a variety of strategies. Figure III-1 shows how a Massachusetts-style health insurance reform would cover the roughly 847,000 thousand uninsured in Missouri.[13] As shown, the uninsured in Missouri would be covered by the following strategies:

- The **Premium Assistance Program** (PAP) would help low and moderate income residents (with incomes below 300% of the Federal Poverty Level) afford private insurance by lowering the costs of premiums and out of pocket costs, covering 47% of the presently uninsured.

- **A Medicaid Expansion** extends Medicaid eligibility to additional adults who are parents, disabled or elderly. In addition, outreach efforts would be needed to enroll those who are presently eligible for Medicaid but not enrolled (through Medicaid and SCHIP). These Medicaid expansions and outreach efforts would cover approximately 30% of the uninsured.

- A State-Sponsored **Insurance Purchasing Pool** allows individuals and small groups to lower the costs of purchasing health insurance by combining the individual and small group private insurance markets and instituting private insurance reforms;

- **Individual and employer mandates.** The three voluntary strategies would expand health insurance to 77% of those who are presently uninsured, reducing the number of uninsured in Missouri to 195,000. However, to reach universal coverage requires moving beyond the voluntary purchase of health insurance to a requirement that those who can afford to purchase insurance either directly or through their employer do so. In Missouri, estimates are that an employer and individual mandate would apply to the remaining 23% of the uninsured.

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

STRATEGY 1: EXPANDING PRIVATE INSURANCE THROUGH PREMIUM ASSISTANCE

One of the ground-breaking features of the Massachusetts legislation is a program, called the Commonwealth Care Health Insurance Program, which provides sliding scale premium assistance to uninsured residents with household incomes up to 300% of the FPL to purchase private insurance coverage. This Premium Assistance program is designed to help low and moderate income individuals who have trouble affording health insurance premiums in both the employer sponsored and individual market. This new subsidized private insurance program is predicted to insure an additional 207,500 people in Massachusetts by 2009.[14]

The Massachusetts Premium Assistance program meshes with Medicaid and SCHIP expansion to provide access to subsidized health insurance for all Massachusetts' residents with household incomes up to 300% of the federal poverty line. The federal government has approved an amendment to the Massachusetts Section 1115 Medicaid Waver to allow federal Medicaid matching funds to help pay the costs of the Premium Assistance program.[15]

Uninsured individuals with household incomes up to 300% of the FPL who are not eligible for Medicaid or Medicare, and whose employers do not offer subsidized insurance qualify for the Premium Assistance Program. Employees whose employers pay at least 20% of the cost for individual or 33% of the cost of family coverage may also participate, but the employer must contribute towards the cost of the Premium Assistance policy. The individual's premium contribution and copayments are to be based on family income. Policies offered to those with incomes below 100% of the FPL are to have benefits and co-payments similar to those in Medicaid. Individuals with incomes between 100 and 300% of the FPL contribute a sliding scale premium contribution based upon their income. The sliding scale will be set by the Insurance Pool.

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

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

Missouri

In Missouri, a Premium Assistance Program should fill the gaps in health insurance coverage between Medicaid and employer-sponsored insurance (ESI). Lower wage workers are less likely to be offered ESI health insurance and less likely to take it when offered because of the cost of coverage compared to wages.[16]. Low and moderate income individuals are also more likely to face problems obtaining affordable and adequate health insurance in the individual market.

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

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

Achieving Access in Missouri

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

Issues for Policymakers

Whether a Premium Assistance program would expand access to insurance in Missouri depends on several factors:

- **Costs of plans**: The cost of the subsidized plans need to be competitive to keep the state's costs for providing subsidized premiums from escalating. A State Health Insurance Purchasing Pool should be able to negotiate plan rates that correlate with the rates offered through the Missouri Consolidated Health Plan, the state employee's health insurance purchasing pool. A Premium Assistance program that covers a substantial number of working age, non-disabled adults and that is willing to negotiate and bargain for best rates—rather than merely passively accepting bids for coverage -- should be able to negotiate similar rates. And it is also worth noting that the anticipated premium costs for this Premium Assistance program—for which estimates presented here include dental and mental health coverage--is almost identical to the per member, per month costs for the Medicaid plan after factoring into Medicaid rate increases.

- **Affordability**: Sliding scale premiums for those with incomes between 100-300% FPL will need to be set at a level that attracts participation. Some policy experts suggest that health insurance premiums need to be below 5% of income for individuals to consider premiums affordable. However, other studies show that even 5% may be too high a premium level for lower income Americans. A recent Urban Institute study of health insurance affordability concludes that the median employee contribution towards premiums represents 1.5% of income for single coverage and 3.0% for family coverage, a figure that some are now proposing as the appropriate premium contribution levels in Massachusetts. [17]

- **Crowd-out**. Crowd-out speaks to the concern that publicly subsidized health insurance will result in individuals dropping private coverage in favor of public coverage. Crowd-out results in public coverage displacing existing private coverage rather than expanding coverage. Massachusetts' Premium Assistance Program guards against crowd out by providing that only those who are uninsured for at least six month are eligible for the program, but also creates a mechanism by which those who are presently covered by employer subsidized health insurance may qualify for the Premium Assistance program, but only if their employer continues to contribute to their premium costs. This provision – along with the employer mandate—offers an interesting approach to avoiding crowd-out while, at the same time, giving employees access to more affordable, sliding scale insurance products without imposing additional financial obligations on employers.

- **Federal Matching:** The key policy issue Missouri faces in trying to implement a Premium Assistance program is obtaining CMS approval to use federal Medicaid matching funds to help pay the public costs. It is the availability of federal Medicaid matching funds that makes the Massachusetts program financially feasible; the same is likely to be true in Missouri. CMS is encouraging states to use Medicaid and SCHIP funds to support Premium Assistance programs through its 2001 Health Insurance Flexibility and Accountability (HIFA) Section 1115 Waiver initiative. The Deficit Reduction Act (DRA) of 2005 expands states' ability to implement Premium Assistance programs without the need for waiver approval. However, Missouri will need some sort of Section 1115 waiver to use federal Medicaid funds to support Premium Assistance for childless adults and it is unclear whether the federal agency would approve such a waiver. CMS is encouraging states to develop Premium Assistance programs that rely more heavily on employer contributions, and less on state and federal dollars, so to the extent that Missouri can develop a creative program that takes advantage of employer

contributions, federal approval may be more likely.

STRATEGY 2: MEDICAID EXPANSION, RESTORATION, AND ENHANCEMENT

A key feature of the Massachusetts health reform legislation is the Commonwealth's ability to use federal Medicaid and SCHIP matching funds to help subsidize health insurance costs for residents with incomes up to 300% of the federal poverty line. A Medicaid expansion extends health insurance to an additional 92,500 state residents, mostly children, while most adults will be covered by subsidized private insurance through a new Premium Assistance Program that qualifies for federal Medicaid matching funds. The Medicaid expansion builds upon the structure of Massachusetts' existing Medicaid program, while the Premium Assistance Programs fills in the gaps. This section discusses Medicaid expansion and Strategy 3 explains the new Premium Assistance Program.

Any effort to implement universal health insurance coverage requires some mechanism for subsidizing the cost of health insurance for low-income workers and families who cannot afford the full cost. In 2005, the average cost of employer-sponsored health insurance for a family of four was $11,000, slightly more than the income for a full time minimum wage worker, and almost 20 percent of the gross income of a family of four earning 300% of the federal poverty line, $60,000). [18] Even single coverage averages about $4,000 a year, over 40% of the income of a person living at 100% of the federal poverty line, $9,800 per year.

For states, Medicaid and SHIP offer the most fiscally responsible mechanism for funding health insurance for low-income residents because they allow states to obtain federal funding to help defray the costs. In Massachusetts, the federal government contributes 50% of the cost of Medicaid and 61.6% of the costs for SCHIP. In Missouri, the federal share is even higher, 61.93% for Medicaid and 72.81% for SCHIP.[19]

Massachusetts has operated its Medicaid program, called MassHealth, pursuant to a Section 1115 waiver since 1997. This waiver allows the state to cover additional categories of adults and set income eligibility levels higher than that authorized by the federal Medicaid statute. As a result, prior to the reform initiative, MassHealth covered children and adult who were parents, disabled, elderly, long-term unemployed, and HIV+ with incomes generally up to 200% of the federal poverty line.[20] The Massachusetts Medicaid expansions build on this basic structure.

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

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

The Massachusetts plan responds to concerns about low Medicaid provider reimbursement rates by raising Medicaid rates for acute care hospitals and physicians. Future Medicaid rate

increases will be tied to specific performance goals related to quality, efficiency, reduction of racial and ethnic disparities, and improved outcomes for patients.

Missouri

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

Missouri already provides Medicaid and SCHIP coverage for children up to 300% of FPL. However, eligibility for parents and other adults is extremely limited: the income cut-off for parents is only 18-22% of the FPL, and eligibility for adults with disabilities and the elderly is 85% of the FPL.[21] While Missouri has Section 1115 approval to cover other groups of parents including non-custodial parents, Missouri does not have Section 1115 approval to cover childless adults or HIV positive individuals before they become permanently and totally disabled.

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

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

Achieving Access in Missouri

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

Issues for Policymakers

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

- **Federal Approval.** To receive federal matching funds, state Medicaid programs must comply with federal Medicaid requirements and be approved by CMS, the federal

agency that administers the Medicaid program. Missouri should be able to secure CMS approval to raise Medicaid eligibility to 100% of the FPL for adults who are parents, disabled or elderly and to provide for sliding scale premiums for the working disabled because the federal Medicaid statute gives states the authority to use these eligibility levels. In fact, Missouri used 100% of the FPL as the eligibility level for disabled and elderly, and had a sliding scale premium program for the working disabled until legislative changes in 2005 reduced the income limits and abolished the special eligibility rules for the working disabled. Moreover, Missouri's Section 1115 Waiver already authorizes parent eligibility up to, and in some cases above, 100% of the FPL. The budget neutrality calculations that govern that waiver will likely accommodate a higher income limit for parents than is presently in place.

- **Covered Services.** Low income families have little, if any, excess earnings to be able to pay out of their own pocket for medical services. A comprehensive Medicaid benefit package guarantees not only that low income residents receive medically necessary services when needed, but that providers can obtain payment for services without the need to try to cost shift to private patients and private payers. For these reasons, the cost simulations presented here assume that cuts to the Missouri Medicaid benefit package for adults made in 2005 are restored and that adult recipients are eligible for dental care, rehabilitation services, durable medical equipment, physical, occupational and speech therapy as well as the services presently covered by Missouri Medicaid. Reinstating these Medicaid benefits for adults will reduce cost shifting by providers and should ultimately result in more affordable private insurance in Missouri.

- **Reimbursement rates.** Medicaid physicians fee are a particular problem in Missouri. The state has one of the lowest Medicaid physician reimbursement rates in the country, paying only 55% of Medicare rates. As a result, many physicians limit their participation in Medicaid creating access problems for those with Medicaid coverage.[22] Thus, the proposal here assumes a 10 percent increase in Medicaid physician and hospital rates. This level of rate increase brings monthly Medicaid costs per recipient to levels about equal to that paid by the Missouri Consolidated Health Plan for state employee coverage. This payment level should adequately reimburse providers for the cost of caring for Medicaid patients, particularly since historical safety net providers will no longer need to try to shift Medicaid funds to cover the cost of caring for the uninsured.

- **People with Disabilities.** Covering the working disabled on a sliding premium scale with no upper income limit through Medicaid improves the quality of care for people with disabilities and lowers the costs for those with private insurance. First, Medicaid is the only insurer in the public or private sector that covers the long-term care services that people with disabilities need to live independently. Using Medicaid as the primary source of insurance coverage for people with disabilities creates a program that can design integrated systems of care that meet the unique needs of people with disabilities. Second, people with disabilities tend to have more health care needs than other adults. The average cost of Medicaid coverage for adults with disabilities is currently $1,261 per person, per month compared with $255 for adults who qualify as parents. Allowing people with disabilities to be covered by Medicaid rather than through the proposed State Health Insurance Purchasing Pool or the Premium Assistance Program should stabilize and lower average private premium costs in both programs. In addition, sliding

scale Medicaid premiums for people with disabilities should correspond to those charged by the Premium Assistance program.

- **Enrollment Outreach**. In Massachusetts, most of those to be newly covered are individuals who are eligible but not enrolled in Medicaid and SCHIP. The same will be true in Missouri. Effective outreach efforts will be necessary to assure that all those who are eligible for the program are enrolled.

- **Affordability**: Experience in Missouri and other states show that imposing Medicaid premiums can cause eligible individuals to forgo coverage. An Urban Institute study found that when Medicaid and SCHIP premiums were set at 1 percent of income, 57 percent enrolled when the charge was 3 percent, 35 percent enrolled; and when the premium went up to 5%, only 18 percent participated.[23] If the goal in Missouri is universal coverage, policy makers will have to construct sliding scale premiums that will attract participation. For a discussion of this issue and the issue of the potential for displacement of private insurance for children with incomes between 200-300% FPL, see the Premium Assistance Plan.

Table III-1. Comparison of Present Medicaid and SCHIP Coverage In Missouri and Massachusetts with Massachusetts Expansion Plan

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

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

STRATEGY 3: STATE-AUTHORIZED PRIVATE INSURANCE PURCHASING POOL

One step towards universal coverage in Massachusetts is creation of a state-authorized private insurance purchasing pool, called the Commonwealth Health Insurance Connector.[24] This Purchasing Pool will help "connect" individuals and small employers with private insurance products to make it easier for individuals and small businesses to find affordable policies. Estimates are that 215,000 presently uninsured persons in Massachusetts will purchase private policies through the Connector either as individuals or through small groups.[25]

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

The Connector provides a mechanism by which individuals and small employers can easily identify quality coverage at an affordable cost. The Connector certifies products as "high value and good quality," and only insurance produces so certified will be available through the Connector. Massachusetts also intends to use this pool as a mechanism for developing new insurance products that are presently not available.

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Moreover, the Connector reduces the cost of insurance by merging the individual and small group insurance markets. In Massachusetts, small group and individual health insurance plans already are sold on a modified community rated basis: Premiums may not vary due to the health status, claims experience, or gender, although there are variations in rates based upon age, family size, geographic location, and occupation. The law significantly modifies the current small group regulations and the factors that health plans may use to adjust premium and establish. The merger of these two markets is predicted to substantially decrease the cost of individual insurance—possibly by as much as 25%.[26] The law also reduces waiting periods for those who have not had previous health insurance, while leaving in place existing limits on deductibles, co-payments, and coinsurance. Another advantage of offering a Private Purchasing Pool is that it enables "portability" of coverage, allowing individuals to keep coverage even if they move from one job to the next.

The Connector also reduces the cost of insurance for individuals by allowing individuals who purchase insurance through the Connector to use pre-tax dollars. The Health Reform legislation requires employers with more than 10 workers to offer Section 125 "cafeteria plans"

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

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

Missouri

A Missouri Private Insurance Purchasing Pool would offer individuals and small businesses access to a choice of standardized private insurance plans with premiums set at a modified community rate that does not vary based upon medical risk. The Pool is designed to create economies of scale and reduce administrative costs. Almost half (47%) the uninsured in Missouri are workers employed by firms with fewer than 25 workers and their dependents. Sixty-one percent of the uninsured are employed by or dependents of employees of firms with fewer than 100 workers (Chapter 2). In the employer-sponsored health insurance market, only 34 percent of Missourians working for firms with less than 10 employees and only 41 percent of Missourians working for firms with less than 50 employees are offered health insurance by their firm.[27] The problems workers face in obtaining ESI have worsened in recent years as employment has shifted to smaller firms and firms less likely to offer insurance coverage.[28]

The Purchasing Pool would negotiate premium rates with private plan that would offer policies through the Connector. Premiums would be set at fairly uniform allowing variations only for family size, geographic area, benefits structure, and, if desired, other factors such as age, tobacco use, or wellness programs. Individuals could purchase plans through the Purchasing Pool using pre-tax dollars, and the Purchasing Pool would be authorized to develop policies designed specifically for young adults, such as Health Savings accounts tied to high deductible plans and lower-cost products targeted to young adults.[29]

By pooling together a large number of individuals, the Purchasing Pool would spread the risk—and cost—among much larger numbers of individuals. By reducing the administrative costs inherent in marketing to the small group and individual markets, the pool should be able to reduce amounts spent on administrative overhead, estimated at up to 25% in the small group and individual markets.[30]

A Missouri Purchasing Pool would need to do more than merely merge already community-rated individual and small group markets. Missouri does not regulate the premiums charged in either the individual or small group markets. While there is some regulation of premium rates in the very small group market--those firms with 2-25 employees--wide variations in premium pricing still occurs. While the average premium costs are lower in Missouri than Massachusetts, $3305 as compared with $3496 in Massachusetts, but the variability in rates is much greater.[31]

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

need health insurance the most are charged high premiums that often make health insurance prohibitively expensive. Moreover, those who are presently uninsured can be refused coverage altogether because of their risk factors, only those who already have sufficient "creditable coverage" must be issued policies. While Missouri offers a subsidized High Risk Pool for those who are unable to purchase insurance because of pre-existing conditions, the cost of coverage through the High Risk Pool is so high—estimated at $14,357 for premium, deductible and coinsurance for a 55 year old man—that Missouri's High Risk Pool is one of the least used in the nation.[32]

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

Achieving Access in Missouri

Strategies designed to make private insurance more affordable for those who are self-employed or work for small employers can have a dramatic impact on uninsurance rates. Almost half (47%) the uninsured in Missouri are workers employed by firms with fewer than 25 works and their dependents. Sixty-one percent of the uninsured are employed by or dependents of employees of firms with fewer than 100 workers (Chapter 2). It is estimated that almost one quarter (23%) of the uninsured in Missouri would use the Purchasing Pool to purchase private health insurance plans, divided about equally between individuals and small businesses. In addition, another 31% of the uninsured are likely to use the Purchasing Pool to purchase Premium Assistance Policies through the Pool. Altogether, the Purchasing Pool is likely to cover over half of those who are presently uninsured, a significant Pool that should have considerable market clout.

Issues for Policymakers

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

- **Missouri Consolidated Health Care Plan (MCHCP)**. The MCHCP is the mandatory purchasing pool for certain state employees, retirees, and dependents and a voluntary purchasing pool for local government entities that wish to join. The MCHCP has the experience and administrative structure to operate a large purchasing pool.[33] Designating the MCHCP as the state-authorized voluntary Purchasing Pool for individuals and small businesses would build on existing state institutions and state capacity.

- **Adverse risk selection**. A voluntary Purchasing Pool must attract enough low cost individuals to be able to spread the risk and thus offer more affordable premiums.[34] Premiums must be low enough that low cost individuals will use the Pool rather than purchase policies on their own, outside the Pool. This adverse risk problem always arises when voluntary purchasing pools must compete with what individuals can buy on their own. The larger the pool—and the healthier its members—the better able it is to absorb the cost of less healthy enrollees. A number of design features that are part of the strategies for universal coverage help ensure that the pool size is large enough to help counteract adverse selection. These features include: (1) pooling Premium

Assistance enrollees with the private Purchasing Pool enrollees, (2) marketing special plans through the Pool designed to attract healthier young adults, and (3) the individual mandate which requires individuals who would otherwise go without insurance to purchase insurance if "affordable" policies are available. On the other hand, the provisions setting up the Insurance Pool do not guarantee the viability or availability of affordable insurance products in Missouri.[35]

- **Pooling small businesses and Individuals with Premium Assistance enrollees.** It is essential that the Insurance Pool include lower income residents is to create a private insurance Premium Assistance Program designed to cover over 500,000 state residents. When these individuals —who are all working age and not disabled – are part of the risk pool as the Private Purchasing pool, the pool size should be large enough to spread the risk broadly and negotiate less costly, more affordable premium rates. The Missouri Consolidated Health Care Plan (MCHCP) presently covers 104,000 state employees, dependents and retirees and has been able to negotiate quite competitive per month premium rates

- **New insurance products for young adults**. In Missouri young adults are one of the primary groups who lack health insurance: about 60 percent of the increase in the uninsured between 200 and 2004 was among those 19-34 years of age.[36] Insurance reforms which would allow the Purchasing Pool exclusive authority to market special low cost plans designed for young adults would help extend health insurance to this group while helping the Purchasing Pool attract less expensive enrollees who would help stabilize the pool. The state could also enact insurance reform which would allow parents to maintain children on their individual and groups policies until age 25 or until two years after dependency ends, whichever comes sooner.

STRATEGY 4: INDIVIDUAL MANDATE

As of July 1, 2007, residents will face financial penalties for failure to purchase insurance if an acceptably comprehensive plan is available at an affordable price. The determination of what coverage people must have and what "affordable" means will be made by the newly created Connector Board.[37] Although Massachusetts is the first state to pass an individual mandate to carry health insurance[38,39], an individual mandate bill was introduced in Maryland in 2005 and similar federal legislation has been introduced in the U.S. Congress ("American Health Benefits Program Act," November 2005). Maine enacted a voluntary universal insurance plan in 2003.[40,41]

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

From a political perspective, the individual mandate represents a significant shift in state policy. This has been compared to state requirements that individuals who register cars and continually carry automobile insurance policies (although on average, the uninsured driver rate is 7%; and some states exceed 12%).[42] It makes the purchase of health insurance coverage an individual

responsibility and obligation for those who are able to afford to purchase coverage. It also requires state policy makers to engage in a public debate about what is "affordable" and adequate health insurance, and to develop mechanisms for subsidizing health insurance costs for those deemed unable to "afford" the full price of coverage.

Proponents of the Massachusetts reform legislation viewed the individual mandate as a necessary component of a multi-strategy plan to move the state to near universal coverage. The three voluntary strategies that comprise the Massachusetts plan—Medicaid expansion, Premium Assistance, and a Purchasing Pool—make considerable progress toward expanding health insurance coverage but will still leave the Commonwealth far short of universal coverage.[43] The individual mandate also reduces the cost of health insurance per person by stabilizing the Connector Purchasing Pool (with the inclusion of generally younger, healthier workers);[44] and eliminating the "free rider" problem of individuals who have access to health insurance, choose not to participate, but then eventually uses services.[45]

The individual mandate is also more likely to accomplish universal coverage than an employer mandate alone. An employer mandate cannot accomplish universal coverage because not all workers qualify for employer-sponsored coverage — part-time, temporary and seasonable employees are typically excluded from coverage. Even when employees qualify for employer sponsored health insurance, in the absence of an individual mandate, they can "opt out" and decline employer provided health plans, defeating the goal of universal coverage.[46,47]

Achieving Access in Missouri

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

Issues for Policymakers

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

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

amount that individuals and families are willing and able to pay. Whichever approach is chosen, "affordability" levels will need to be indexed to income, and rates must be set at a level that generates broad public support and acceptance by the public at large.[48]

- **Implementation**: The specifics of any legislation requiring an individual mandate and the rules and regulations governing its implementation are critical. Key factors include:
    - Monitoring and enforcement of an individual mandate and the levying of fines for violations;
    - Definitions regarding the requirements of a qualified plan to satisfy the mandate;
    - Safeguards to ensure that individuals/families who cannot afford to purchase health insurance are not penalized;
    - A program or programs designed to provide low-cost health insurance plans, connect individuals and families without coverage to plans, and to subsidize those below a certain percentage of the FPL;
    - Definitions of the kinds of health insurance plans that satisfy the health insurance mandate. Among many details that will need to be addressed are the minimum benefits package, out of pocket limits and whether Healthcare Savings Accounts (HSAs) accompanied by catastrophic health insurance plans will satisfy the mandate.[49]

- **Dominant Role for Employer Insurance**: An individual mandate will not disrupt or change the dominant role of the employer-based insurance system in Missouri. ESI will remain attractive to employers because of the federal tax exemption for employer contributions, and health benefits will remain one of the ways employers compete for workers. Moreover, middle-and high-income employees will still be better off financially by obtaining coverage through their employers, given that most will not be eligible for income-based Premium Assistance subsidies provided in the Purchasing Pool.[50]

- **Enforcement**: Another important issue for policy makers is the appropriate penalty for those who violate the affordable health insurance mandate. Enforcement of the mandate will be necessary: In states that require automobile owners to carry auto insurance between 7% and 12% of owners violate the law and drive without insurance.[51] In Massachusetts, the penalty for violating the affordable insurance mandate is equivalent to only 50% of the cost of affordable insurance. When the cost of non-compliance is less than the cost of complying with the law, people are more likely to pay the penalty rather than obtain insurance. If Missouri lawmakers are serious about using an individual mandate to obtain affordable insurance as part of a plan for obtaining universal health insurance coverage, they need to consider setting a penalty at least equal to the cost of compliance.

STRATEGY 5: EMPLOYER MANDATE

The Massachusetts plan also contains an employer mandate. This "play or pay" provision requires that businesses with 11 or more full time equivalent employees provide a "fair and reasonable" premium contribution to an employee health insurance plan or pay an annual assessment of up to $295 per employee.[52] The Massachusetts Division of Health Care Financing and Policy is responsible for developing regulations defining a "fair and reasonable" contribution which must be presented to the legislature prior to implementation."

The strategy proposed in Massachusetts is similar to the "play or pay" proposals introduced in a number of states across the country. These laws do not require employers to offer insurance, but instead require employers who do not offer insurance ("play") to pay a tax to the state ("pay"). In 2005 alone, 19 states introduced "pay or play bills."[53] In 2004, California voters rejected a law passed in 2003 that required businesses with more than 50 employees to pay a fixed fee toward health insurance.[54] Earlier this year, Maryland passed legislation (dubbed "the Wal-Mart bill") requiring private employers who employ more than 10,000 employees to spend a minimum percentage of their payrolls on employee health care.[55] Vermont and Suffolk County, New York have also adopted "pay or play" mandates.

The reform plan also authorizes a Free Rider Surcharge that penalizes employers who do not provide insurance if their employees get free care face that is reimbursed by the Commonwealth's Uncompensated Care Pool. Employers are subject to the charge if their employees use the free care pool a total of 5 times per year in the aggregate, or if any one employee uses free care more than 3 times. This surcharge "shall be greater than 10%, but no greater than 100% of the cost to the state" of the free care, with the first $50,000 of costs exempted.[56] Employers will not be subject to his surcharge as long as they offer any insurance to their employees, regardless of whether the employer contributes toward the premium cost.

The "fair and reasonable" employer mandate, while small, sends an important signal that the state expects employers to contribute to the cost of health insurance for their workers. A mandate helps level the playing field within the business and employer community. Similar to the "free rider" problem of individuals, businesses that provide health insurance coverage pay higher premiums because the cost of caring for the uninsured gets shifted to those who pay for health insurance. In addition to this indirect subsidy, businesses that do not offer coverage may also benefit directly from the ability to offer higher wages than competitors who must balance wages and benefits or by offering lower prices than their competitors.[8]

But an employer mandate without an individual mandate cannot achieve universal coverage,[57,58] An employer mandate only reaches employees and their dependents, and it will not reach part-time, temporary, and seasonal workers who typically do not qualify for employer sponsored insurance. And an employer mandate alone--in the absence of an individual mandate—is still likely to leave thousands of employed individuals and their families without coverage, given the fact that many will choose to "opt out" of their employer's health plan and remain uninsured.

Achieving Access in Missouri

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

Issues for Policymakers

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

- **ERISA Preemption**. The crucial issue facing states considering an employer mandate is the preemption clause of the Employee Retirement Security Act of 1974 (ERISA). ERISA clearly prohibits states from enforcing laws that require employers to provide health insurance for the employees. Only Hawaii has such a law, and Congress specifically granted Hawaii an exemption from ERISA's preemption provisions.[7] As popular as "play or pay" provisions have become, it is unclear whether courts will uphold them. On July 15, 2006, a federal district court struck down Maryland's Fair Share Health Care Fund Act that requires large employers to contribute 6-8% of employee wages to health care or pay the difference to a public fund. The court held that the law violated ERISA preemption because it required employers to segregate a separate pool of expenditures for its Maryland employees and structure their health care contributions with an eye toward the law's spending requirement.[59]

- **Individual mandate's effect on employers.** While ERISA prevents states from legislating that employers offer their employees a specific level of health insurance coverage. An individual mandate can specify a minimum level of benefits that must be held by each person, thus providing a strong incentive for employers to provide policies that would, at a minimum, allow their workers to meet that standard.

- **Fair and Reasonable Contribution.** Defining the level of contribution that is "fair and reasonable" will be crucial because this defines the public's expectation of employers' role in a universal coverage system. At present, the debate in Massachusetts centers on whether a "fair and reasonable" contribution requires both that a minimum percentage of full time workers accept coverage offered by the employer and the employer offer to pay at least a set minimum percentage of the cost, or whether meeting only one of these tests will be sufficient.[60] The employer share of cost presently being debated in Massachusetts ranges from 33% to 50%.

- **Effects on Employment and Wages:** Although there have traditionally been concerns about the effects of employer mandates on employment, several factors would be expected to mitigate the effects of the changes enacted here on employment and wages. First, as noted in Chapter IV below, the small marginal additional costs imposed on some employers not now providing ESI will be offset by reduced costs for employers who are already providing health insurance who will gain from reductions in insurance premium costs through market effects on insurance premiums. Second, analysis of the implementation of the Massachusetts plan projects a small marginal impact of the overall plan on economic activity, employment and wages.[61]

- **Implementation Issues:** The specifics of any legislation requiring an employer mandate and the rules and regulations governing its implementation are critical. For example, key factors include:
    - The size of businesses included under any mandate
    - The definition of a "fair and reasonable" employer contribution
    - The required level of contribution per uninsured employee for businesses who choose to "pay" instead of "play"
    - A stand-alone employer mandate or one that is combined with an individual mandate

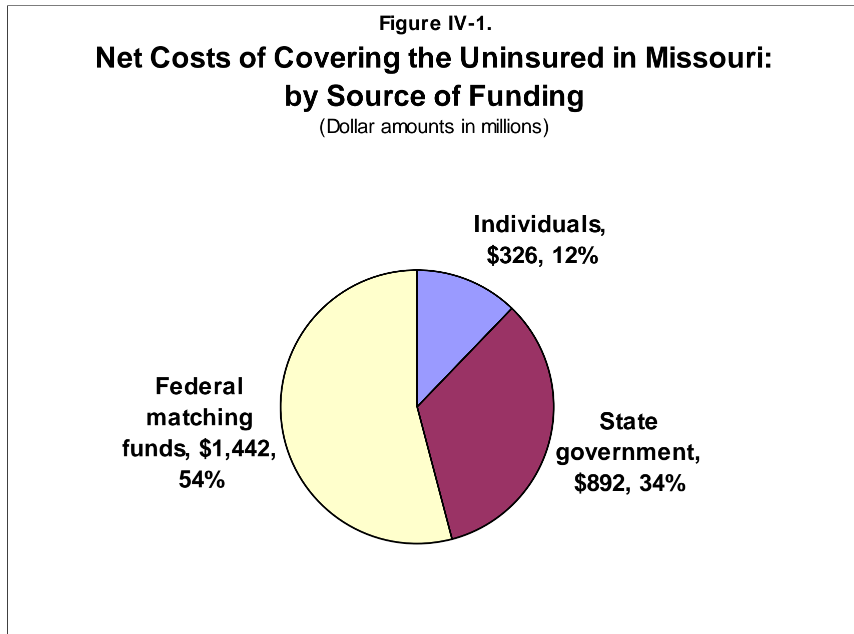
- **Universal Coverage.** If the goal is universal coverage for all Missourians, an employer mandate will need to be combined with an individual mandate to reach truly universally coverage. Analysis of the Massachusetts landscape concluded that while enforced individual mandates for health insurance can achieve universal coverage, employer mandates alone cannot.[62,63] An employer mandate in the absence of an individual mandate would still leave potentially hundreds of thousands of employed individuals/families without coverage, given the fact that many will choose to "opt out" of their employer's health plan, remain uninsured, and contribute to the "free rider" problem.

CHAPTER IV.

COSTS AND FINANCING OF STRATEGIES FOR UNIVERSAL COVERAGE

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

The public financing to achieve universal coverage will require a commitment of funds by both the State of Missouri ($892 million) and the federal government ($1.4 billion). The federal government contributions will be in the form of matching funds for state expenditures on Medicaid, SCHIP and the new Premium Assistance Program. Some of the state and federal shares of the costs can be financed by shifting existing government funds used to reimburse care for the uninsured to subsidizing insurance through Medicaid, SCHIP or the new Premium Assistance Program (discussed in greater detail below). However, new state and federal revenue will be required. Several sources of new monies that the state could tap into are identified.



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

Costs

As shown in Figure IV-1, the net costs of covering the uninsured in Missouri under a Massachusetts-style plan are estimated to be $2.6 billion[64] in private and public funds for 2006. Net costs are the actual funds needed to institute the plan after taking into account the cost

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

- $892 million in State funds. These funds would be used for Medicaid, SCHIP and a new Premium Assistance Program to help subsidize the cost of public or private insurance coverage for those with incomes up to 300 percent of FPL. Approximately $200 million of these costs are for rolling back the cuts to Medicaid from SB 539 passed in July 2005. Of the $892 million that is needed by the State, $362.7 million (41%) would be available upon redirecting state funds in the current system that are used to cover the cost of care for those who are uninsured. This leaves $529.3 million (59%) in new state funding that is still needed. The state would then seek federal Medicaid and SCHIP matching funds to augment these expenditures.

- $1.4 billion in federal Medicaid and SCHIP matching funds Currently, $335.4 million in federal Medicaid and SCHIP matching funds already comes to the State to help cover the cost of the uninsured.[65] New matching funds of $1.07 billion will be needed, some of which would likely need to be approved pursuant to a Medicaid Section 1115 waiver.

- $326 million in net costs for premium payments by individuals. Individuals who are currently uninsured will pay an estimated $544 million for their share of premiums (with the remaining portion paid for by government-paid premium assistance or employers). On the other hand, this is offset by reduction in premiums for those who are currently privately insured who will see, on average, premium savings of 6% per year for a total estimated savings of $219 million. These savings are the result of larger risk pools that are created when the currently uninsured purchase health insurance. For the new premium payments by the uninsured, it is worth noting, that most of the new out-of-pocket spending by the uninsured is borne by those above 300% of the poverty line (that is, those facing either the individual or employer mandates). In contrast, only about 39 percent of the $544 million is borne by those between 100% and 300% of the poverty line. Furthermore, Table 4-1 illustrates the burden of these costs for these low income individuals. The premium shares (0-5.8%) that are required of these individuals are limited to relatively small shares of income. For example, a person at 200% of the FPL would only pay about $25 per month in premiums or roughly 2.9% of their income.

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

Percent of poverty	Annual out of pocket premium	Monthly out of pocket premium	Income	Premium as Percent of income
100%	$0	$0.00	$10,160	0.0%
125%	$74	$6.14	$12,700	0.7%
150%	$147	$12.28	$15,240	1.5%
175%	$221	$18.42	$17,780	2.2%
200%	$295	$24.55	$20,320	2.9%
225%	$368	$30.69	$22,860	3.6%
250%	$442	$36.83	$25,400	4.4%
275%	$516	$42.97	$27,940	5.1%
300%	$589	$49.11	$30,480	5.8%

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

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

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

Public Financing

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

Missouri has approximately $362.7 million in state funds that have been identified as being used to help fund uncompensated care for the uninsured (some of which currently receive federal matching dollars.) These state funds could be shifted away from reimbursement for uncompensated care in order to help fund the state's share for universal coverage. Thus, the state would need $529.3 million (59% of the total state share $892 million) in new state funding to finance a Massachusetts-style program. This assumes that CMS will agree to allow federal Medicaid/SCHIP matching funds to support a Medicaid expansion and premium assistance program as it did for Massachusetts for both existing and new funds.

- Existing State funds ($362.7 million) currently used to pay the costs of services for the uninsured that could be reallocated because of universal coverage.

  - $175.5 million in Medicaid DSH payments [66] Medicaid DSH payments are made to hospitals to compensate them for the costs of caring for the uninsured. If all individuals in the state had public or private health insurance there would be no need to make DSH payments and such payments could be redirected to help cover the cost of health insurance. At present, $160.7 million in state and local funds are used to support Medicaid hospital DSH payments throughout Missouri and $14.8 million local and state funds to support a special Medicaid Waiver that uses DSH money to pay for outpatient care for the uninsured in the St. Louis area. Note that these monies already qualify for federal Medicaid match.

- $35.4 million in Uncompensated Care Fund for Medicaid providers.[67] For the last two years, the Uncompensated Care Fund is Missouri has been $91 million, which includes state funds of $35.4 million with the remaining as federal matching funds. These general revenue funds have been appropriated specifically to help Medicaid providers cover the costs of care for the uninsured. These monies could be redirected to aid in financing universal coverage.

- $151.8 million, in state and local funds used to support health care services to the uninsured[68] The State, counties, and cities provide a variety of funds to support medical services for the uninsured, including funding for clinics and hospitals. Not only could this money be redirected to help fund coverage, but this money is presently not being matched by federal dollars. This money if used to expand Medicaid or support a Premium Assistance program could draw new federal dollars to support universal coverage in Missouri.

- Possible new sources of state revenue to fund the additional costs of ($529.3 million) universal coverage include:

  - State general revenues The State recently reported an unanticipated increase of $620 million in general revenues for fiscal year 2006[69]--an amount that could fully fund the balance of state funds needed for universal coverage, if all the funds were allocated to funding health care. It is also important to point out that one reason why the state has a revenue surplus is because of the Medicaid legislative changes enacted in 2005, which resulted in lower state spending and higher rates of uninsured.

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

  - $100 million (net) from premium tax on all insurers If a 2% tax on all private insurance premiums (equal to $7.8 billion)[70] were to be assessed, preliminary calculations suggest that $155 million would be raised. With universal coverage in place, new premiums[71] from as many as 461,000 individuals will be collected by private insurers (managed care providers or otherwise).

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

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

- $290 million from tobacco tax increase. Currently, the Tobacco Tax Initiative[72] in Missouri is under dispute and may still appear on the November 2006 ballet. The initiative, if approved by the voters, is expected to generate approximately $290 million for year for "health care access and treatment"[73] This money, as long as it is used in ways that are consistent with the initiative language, can help fund a Massachusetts-style universal health insurance coverage. The ballot initiative designates that $102 is to be used to restore Medicaid cuts, and $102 million for Medicaid physicians' reimbursement rate increases. Both these amounts are included in the calculations of the cost of universal coverage though any future initiative could be drafted with universal coverage explicitly in mind.

- Sales tax on medical services Currently, Missouri law taxes sales of goods but not sales of services. At present, only eleven services are taxed including services such as pet grooming, marina services, and residential gas. A sales tax on medical services at the current rate would raise $628.4 million.[74] Sorting out the public policy issues on taxing medical issues requires balancing competing goals and issues. On the one hand, sales taxes tend to be regressive and impact low-income families more, and taxation of medical services can sometimes tax necessities or life-sustaining services. On the other hand, Medicaid, SCHIP and the Premium Assistance program should help cushion the impact on those with incomes up to 300% of the FPL. Also, much research shows that more medical spending is consumed as a result of incentives in the health care system such as health insurance and tax incentives, perhaps leading to inefficient medical spending. Moreover, the share of medical spending rises with income. Therefore, these are arguments in favor of taxing medical services.

Summary

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

- **Cost Savings from universal health insurance coverage:** Individuals will be able to reap the health benefits of health insurance and likely increased access to the health care system. In addition, premium savings are likely to accrue to those who already have health insurance. Those who were previously uninsured are also expected to benefit. They are likely to face lower premiums than they would have before (if they would have purchased) because of the greater pooling of individuals in health insurance plans under universal coverage. This reduction in premiums is largely due to the reduction in administrative costs. Estimates of the size of this reduction range from 3 to 10%.

- **Requires increase in State funds:** The direct costs of expanding to universal health insurance coverage in Missouri could be achieved via a combination of financing mechanisms as suggested above. These include reallocation of existing funds for uncompensated care (41% of state financing) and new financing (59%) from sources such as increases in the allocation of State General Revenues, changes to the Medicaid provider tax, and/or new funds generated by an increase in the tobacco tax.

- **Ability of Missouri to obtain federal matching funds:** In order to achieve universal coverage in Missouri all new state funds spent on health insurance – either public or premium assistance for private insurance – would require securing federal matching funds. As in Massachusetts, the key to any state doing this is a Medicaid waiver that allows federal match for premium assistance.

- **Cost increases and cost-containment:** The cost estimates presented in this chapter are for (2006 and assume the initiative is adopted and implemented this year. Costs are not projected forward to future years. Once all individuals in the State are insured, the costs of the insuring these individual over time will certainly increase, but the growth has not been projected here. This Report does not discuss the extent to which there are any provisions for cost-containment in the Massachusetts plan that could be applied to Missouri. In fact, the Massachusetts plan only considers a 3 year cost horizon and cost containment is a concern for that plan as well.

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

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

The Massachusetts Plan: Quality Initiatives

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

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

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

Achieving Quality in Missouri: Benchmarking and P4P

Then Governor Holden's Missouri Commission on Patient Safety presented its report in July 2004. The report recommended that Missouri healthcare organizations adopt patient safety protocols in part to facilitate "contract incentives for those healthcare organizations and professionals that emphasize safety."

The report also recommended the establishment of a private patient safety organization to "provide leadership and serve as a clearinghouse for best practices, data collection and

analysis, professional curriculum development and consumer resources." In response the Missouri Hospital Association (MHA), the Missouri State Medical Association and Primaris created The Missouri Center for Patient Safety, a private, not-for-profit corporation.

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

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

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

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

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

The development of improved quality assessment reporting systems and consumer-friendly decision-making aids are certainly important impacts of the extension of insurance coverage. These developments will certainly improve the accountability of health care providers across diverse parts of the health care system (e.g., hospitals, ambulatory care facilities, etc.)[75]

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

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

The Impact of Universal Coverage on Healthcare Service Quality

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

A series of studies by the Institute of Medicine show that the uninsured use health services less often than the insured, and receive lower quality care.[76] Moreover, the uninsured are less likely to fill prescriptions or to seek preventive care. Uninsured adults, particularly those with chronic conditions, have lower life expectancies than the insured. Uninsured children are at risk from long-term abnormal development.

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

The Institute of Medicine estimates that lack of insurance is responsible for 18,000 unnecessary deaths every year.[77] Thus, there is little doubt that a program to provide universal coverage to Missourians would improve health quality for the currently uninsured or underinsured. The continuity of care promoted by universal health care would lead to improved outcomes and increased preventive care.

Universal coverage may well have equally important positive effects on micro-level clinician-patient interaction that is the very foundation of high-quality health care delivery.[78] This is because in their view the current patchwork health care system inadvertently deters the efficient and effective delivery of health care services.

For example, clearly described how lack of adequate insurance coverage is a major obstacle to many of the recommendations from the landmark Institute of Medicine, Crossing the Quality Chasm report published in the same year.[79] In particular:

1. Lack of access creates major barriers to receiving necessary care and disrupts the continuity of health care services. Universal coverage should provide stable funding and pressures for accountability that will support the development of "care based on continuous healing relationships" that are essential to efficient and effective health service provision.

2. Universal coverage will support needed "customization based on patient needs, and patient values." Thus, there will be less emphasis on mass marketing forces such as "branding" and more focus on clinician-influenced product differentiation based on the clinician's recommendation and evidence of service efficacy. This is a direct result of having adequate access to a regular source of continuing care despite changes in work status.

3. Current lack of insurance coverage inhibits many citizens (especially the uninsured and under-insured) from influencing the delivery system. Universal coverage should increase the average "patient's sense of control", serve to empower the patient population and ultimately improve the health care system's responsiveness to patient concerns.

4. Universal coverage should improve the amount of "shared knowledge and free flow of information." Such an open system of information will likely lead to less proprietary constraints on information flow and greater information sharing in accord with the greater pressures for accountability that were described above. A more open system will also allow health care providers to make more effective use of promising integrated information technologies.

5. "Evidence based decision making" was a major quality improvement initiative that the IOM targeted for improvement. It would likely be positively affected by universal coverage. This is because a universal coverage system will decrease proprietary constraints on information sharing and encourage the utilization of professional consensus methods (such as those employed by the NIH) to decrease excess demands for services while increasing their efficacy.

6. In a system with universal coverage, there will be greater emphasis upon "patient safety as a system property." This will occur because of the greater emphasis on quality monitoring discussed earlier and because of more equitable reimbursement and consequently less of a need by health care organizations to improve short term profits by compromising staffing levels or relaxing safety standards.

7. Universal coverage will also create a "greater need for transparency." That is because there will be fewer incentives to conceal information and greater oversight by the public sector (which already pays for a large proportion of health care services).

8. Improved coverage should also lead to more persistent "anticipation of consumer needs." This will largely result from the system's move toward a greater emphasis on health planning, epidemiological research, health planning and resource allocation.

9. The contemporary health care delivery system is not only highly fragmented and inaccessible by many but also suffers from widespread waste and inefficiency.[80] The introduction of a universal system should support the IOM's argument that "waste needs to be continuously decreased." This important outcome will result from increased external quality monitoring that will prompt organizations to assess and improve their internal work processes and outcomes. It will also receive support from the increased emphasis upon disease prevention and continuity of care – two critical areas that are major area problems for the uninsured and underinsured in Missouri.

10. Last but not least, "greater cooperation" should prove to be a consequence of improved insurance coverage and patient access to medical care. This is because there will be less of an incentive for health care organizations to avoid sick, uninsured patients. Instead, according to Schiff and Young, (2001), there will be a "renewed emphasis on professional and caring relationships—relationships that have been disvalued in the current profit-driven system. All of the unmeasured and immeasurable ways in which patients and providers can be rewarded when they work together to deal with illness will have to form the foundation of these caring relationships."[81]

Summary

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

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

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

Despite numerous often well-intentioned attempts to improve health care insurance coverage for Americans, only modest progress on the goals of quality has been achieved up to this point.[82] This has allowed for the continuation of a system of health care delivery that is inefficient, inequitable and increasingly unaffordable. The introduction of a Massachusetts-like universal coverage system into Missouri should over time enable its citizens to enjoy more equitable access to increasingly efficient and effective health care providers.

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[3]Mo. Rev. Stat. 208.014(6)

[4] This ballot initiative was declared invalid due to lack of valid signatures by the Secretary of State) but proponents have file suit claiming that they have sufficient signatures.

[5] McBride, Timothy; Sidney Watson, and Heather Bednarek. 2006. "The Missouri Health Landscape: How Does it Compare to Massachusetts?," prepared by the Saint Louis University State Health Policy Legislative Analysis Team for the Missouri Foundation for Health (MFH), May 2006.

[6]United States Department of Health and Human Services, Prior HHS Poverty Guidelines and *Federal Register* References, http://aspe.hhs.gov/poverty/figures-fed-reg.shtml

[7] John Holahan and Allison Cook. 2006. "The Missouri Economy and Changes in Health Insurance Coverage, 2000-2004," Cover Missouri Project Report 3, Missouri Foundation for Health, March 2006.

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

[9] John Holahan and Allison Cook. 2006. "The Missouri Economy and Changes in Health Insurance Coverage, 2000-2004," Cover Missouri Project Report 3, Missouri Foundation for Health, March 2006.

[10] John Holahan and Allison Cook. 2006. "The Missouri Economy and Changes in Health Insurance Coverage, 2000-2004," Cover Missouri Project Report 3, Missouri Foundation for Health, March 2006.

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[12] Institute of Medicine. 2002. "Effects of Health Insurance Coverage on Health," Care Without Coverage: Too Little, Too Late. Washington: National Academy Press, pp. 47-90.

[13] Details of these estimates are provided in Appendix A.

[14] Building Toward Full Coverage, Health Care Reform Conference Report

[15] Letter from Mark McClellan, Administrator http://www.hcfama.org/_uploads/documents/live/Waiver-Approval_Letter.pdf

[16] Garrett, 2004

[17] John Holahan, Jack Hadley, Linda Blumberg, Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts, Blue Cross Blue Shield Foundation of Massachusetts (August 2006).

[18] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2005 Summary of Findings, p. 1. Average annual premiums for employer-sponsored coverage $10,880 for family coverage and $4,024 for single.

[19] McBride, Timothy; Sidney Watson, and Heather Bednarek. 2006. "The Missouri Health Landscape: How Does it Compare to Masschusetts?," prepared by the Saint Louis University State Health Policy Legislative Analysis Team for the Missouri Foundation for Health (MFH), May 2006,Table 8.

[20] See Appendix A for details.

[21] Mo. R. S. 208.151.

[22] Medicaid Reform Commission Report, at 25.

[23] Institute of Medicine, 1998.

[24] Section 101, H4479

[25]Massachusetts Conference Committee on Health Care and Affordability, "Health Care Access and Affordability Conference Committee Redraft Report," Massachusetts State Legislature, April 10, 2006. http://www.mass.gov/legis/laws/seslaw06/sl060058.htm

[26] Health Care Reform Conference Committee Bill, Joint Caucus for House Members, April 3, 2006.

[27]McBride, Watson, Bednarek, 2006

[28] Holahan and Cook 2006.

[29] Kenney et al. 2006

[30] Woolhandler, S. 2003. "Costs of Health Care Administration in the United States and Canada,"

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[31] Robert Wood Johnson Foundation (RWJF). 2006. "Shifting Ground: Changes in Employer-Sponsored Health Insurance" http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?id=10408

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[37] Chapter 58, Section 12, Section 2.

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[41] National Conference of State Legislatures. 2006 bills on universal health care coverage—Legislatures fill in the gaps. www.ncsl.org

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[43] John Holahan, et al, Roadmap to Coverage: Synthesis of Findings, at 15.

[44] Massachusetts Legislature, Conference Committee Report, April 3, 2006, at page 1 (emphasis on the original report)

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[48] John Holahan, et al., Setting A Standard of Affordability for Health Insurance Coverage in Massachusetts, at 6.

[49] National Conference of State Legislatures (2006). 2004-2006 State Legislation on Health Care Savings Accounts and Consumer-Directed Health Plans, June 16, 2006.

[50] Id.

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[64] See Appendix X for further details of the net costs estimates and for the assumptions of the simulations used to derive the estimates shown here.

[65] Additional federal funds flow into Missouri to cover the costs of the uninsured such as Medicare DSH and IME, and VA System however, these are not federally matched dollars on State spending. See Randall R. Bovbjerg, et al., The Cost of Care for Missouri's Uninsured, Missouri Foundation for Health (2006), p.18.

[66] Randall R. Bovbjerg, et al., The Cost of Care for Missouri's Uninsured, Missouri Foundation for Health (2006), at 18.

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[68] Randall R. Bovbjerg, et al., The Cost of Care for Missouri's Uninsured, Missouri Foundation for Health (2006)

[69] http://www.oa.mo.gov/co/releases/GRreport070606.htm

[70]Based on data from the Missouri Department of Insurance, premiums received by all insurers (excluding self-insured plans) is approximately $6.6 billion (www.insurance.missouri.gov/reports/suppdata.htm). In addition, it is estimated that insurers would collect another $1.15 billion in premiums for the newly insured under a plan of universal coverage. If a 2% tax on all private insurance premiums (equal to $7.8 billion) were to be assessed, preliminary calculations suggest that $155 million would be raised. After the repeal of the Medicaid MCO RA, net revenue from broadening the provider tax base would net approximately $100 million.

[71] This excludes those employers who self-insure.

[72] This initiative proposed increasing the state tax on each cigarette by 4 cents (20% increase on all other tobacco) for an 80 cent increase per pack in addition to the current 17 cents per pack for a 97 cent tax on each pack of cigarettes.

[73] According to the Committee for a Healthy Future – the group that spearheaded the initiative – the tax is estimated to yield $351 million per year additional state funds with $61 million allocated for smoking education and cessation programs and the remaining for health care expenditures. (Committee for a Healthy Future, Fact Sheet, http://www.healthymissouri.org/FactSheet.pdf).

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[78] Schiff and Young (2001), Emanuel and Fuchs (2005), the Rekindling Reform initiative (2003) and Schiff, et al (1994).

[79] Schiff and Young (2001)

[80]Rekindling Reform Committee, 2003

[81] Schiff and Young (2001).

[82]Emanuel & Fuchs, 2005; Grossman, 1994; Davis, 2001, 2006.