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Can the Massachusetts Health Care Reform Work in the District of Columbia?

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The District of Columbia has taken significant steps in recent years to expand health insurance coverage for its low-income residents. However, 12.4 percent of D.C. residents (about 66,000 people) remain uninsured at any point in time (2004–2006). The state of Massachusetts enacted major health reform legislation on April 12, 2006. We examine the reforms being implemented in Massachusetts and assess which pieces may be of policy interest to the District.[1]

The District should be prepared to face different challenges if it tries to replicate the Massachusetts health care reform.

Key Elements of Reform in Massachusetts

The Massachusetts reform seeks to achieve universal coverage by instituting an individual requirement to have insurance, expanding access to both public and private coverage to help individuals meet the requirement, and combining new and old revenue sources to finance these changes. The most important components of the reform legislation are the following:

- *subsidized coverage*, with both public and private options, for those below 300 percent of the federal poverty level (FPL);
- *a purchasing arrangement* designed to make affordable insurance available to individuals and small businesses;
- *an individual mandate* requiring that every adult resident of the state have health insurance if affordable coverage is available; and
- *a small assessment on employers* with more than 10 employees that do not provide coverage to their workers.

The legislation was a compromise among Governor Romney's administration and the legislature's House and Senate, each of which had a different vision of reform. The compromise passed almost unanimously in both legislative chambers, and Governor Romney's veto of some key elements was easily overridden.

Medicaid expansion. The state's Medicaid program, MassHealth, was expanded to give individuals and families broader access to public coverage. The state raised its income eligibility ceiling to 300 percent of FPL for children (about $41,000 a year for a two-person family in 2007). In addition, it ended enrollment caps on Medicaid coverage for certain groups of individuals with disabilities, HIV/AIDS patients, and the chronically unemployed. Together, these changes added about 50,000 adults and children to the program. The legislation also increased MassHealth payment rates to doctors and hospitals and restored some benefits that had previously been cut, such as dental, vision, and hearing services for adults.

New subsidized coverage for non-Medicaid low-income people. For those not eligible for MassHealth, a new program—the Commonwealth Care Health Insurance Plan (CommCare)—provides subsidized insurance coverage to adults with incomes below 300 percent of FPL. CommCare coverage is free for adults with incomes below 150 percent of FPL. Enrollees with incomes between 150 and 300 percent of FPL must pay a share of premiums, set on a sliding scale. Premiums are available for 2.4 percent of income for single adults at 200 percent of FPL or 4.5 percent of income for singles at 300 percent of FPL. Premium contribution requirements are slightly higher for couples as a percentage of income.

The subsidized plans have no deductibles, only copayments, which increase somewhat with income. CommCare is only available to those who are not eligible for MassHealth or Medicare and who have not had access to employer-based insurance in the past six months toward which the employer contributed at least 33 percent of the cost of an individual plan and 20 percent of the cost of a family plan. For the first three years, CommCare will only contract with managed care plans now serving the Massachusetts Medicaid program. After this, other plans can compete to enroll low-income beneficiaries through the program. As of mid-2007, over 100,000 people had enrolled in CommCare.

A new connector for purchasing insurance. The primary vehicle for expanding access to private coverage is the Commonwealth Health Insurance Connector.

The Connector links individual purchasers and businesses with fewer than 50 workers with a selection of affordable health care plans. The Connector also determines whether coverage is affordable given a family's financial circumstances, sets the minimum level of coverage that adults must have to comply with the individual mandate (described below), and runs CommCare.

The Connector also operates an unsubsidized program for higher income people called Commonwealth Choice. Plans in Commonwealth Choice must offer comprehensive coverage, but they also offer plans with high deductibles (up to $2,000 for individuals, $4,000 for families) and are encouraged to establish more limited provider networks. These health plans are required to offer all state-mandated benefits as well as prescription drug coverage.

Workers who do not have access to employer-sponsored insurance can buy coverage through the Connector with pretax dollars via their employer's "Section 125" plans (see below). In addition, insurers are allowed to offer separate products that do not cover all state-mandated benefits for individuals age 19 to 26. These plans can only be offered through the Connector.

Individual mandate. Adults for whom available coverage is deemed affordable must obtain coverage, and people eligible for public coverage must enroll. If affordable coverage is not available, purchase is not mandatory. Free MassHealth and CommCare's income-related premium subsidies make coverage affordable for those below 300 percent of FPL. The Connector defines the standards for affordability for those with incomes above 300 percent of FPL. At 350 percent of FPL, adults can be required to spend up to 5.5 percent of income on health insurance; at 500 percent of FPL and above, up to 8.1 percent of income. If individuals cannot obtain coverage for these amounts or less, they will be exempt from the mandate.

The individual mandate will be enforced through the tax system. In the first year, noncomplying individuals will lose their state tax exemption (roughly $219). In the second year, they will pay a penalty equal to half of the applicable health insurance premium. Both low-income subsidies and the mandate are needed for the reform to achieve nearly universal coverage.

Employer role. Employers of more than 10 workers are required either to offer coverage to their workers or to arrange for them to buy coverage on a pretax basis through a Section 125 plan. Tax-free purchase effectively lowers premiums by shifting costs to federal and state treasuries via reduced tax revenues. Employers that do not make contributions to health insurance premiums defined as fair and reasonable must pay an assessment of $295 per worker per year (with the amount prorated for part-time workers).

Insurance market reform. In addition to making new and expanded insurance options available, the reform also changed regulations for the existing insurance market to increase the availability of insurance. Insurance products offered to small employers are now also available to individual purchasers, and premiums must be set on the same basis for all buyers. This merges the health risks of small group and individual buyers. Premiums for small group insurance are projected to increase somewhat, but individual premiums will fall considerably.

Protections for safety net providers. These providers, particularly the two major safety net institutions in Boston and Cambridge, believed that they would continue to have to provide free care to numerous uninsured people even after reform. Undocumented noncitizens, in particular, may remain uncovered. The new law protects these institutions in two major ways. First, only the plans offered by those now serving Medicaid, including the safety net hospitals' plans, can sell the subsidized CommCare product. Further, the hospitals retain about $900 million in public funding to care for the uninsured in 2007 and about $500 million in 2009.

Funding. The estimated state cost for insurance expansion was $1.3 billion in 2007, only about 10 percent of which is new general revenue financing.[2] One source of financing is about $600 million in federal safety net payments. These are payments that had been made directly to hospitals and managed care plans and are now used to help finance coverage for the otherwise uninsured. Higher federal payments will also be forthcoming to the state due to the increase in Medicaid provider payment rates and added benefits.

The uncompensated care pool that was in place in Massachusetts prior to reform was financed through assessments on hospitals and health plans. These assessments ($320 million per year) remain but are now used in part to finance health reform. The assessment on employers not providing coverage to their workers will also contribute funds to the reform. Individuals in CommCare pay premiums determined by the affordability schedule established by the Connector. Finally, there was a general revenue contribution of $125 million in the first year.

Could the District of Columbia Adopt the Massachusetts Plan?

The District already has in place some of the elements of the Massachusetts plan, particularly public offerings for the low-income population. Other provisions, notably in private coverage availability and insurance market regulation, would have to be enacted to approach universal coverage. Even near-universal coverage is unlikely to be achieved in the absence of an individual mandate.

Available public and subsidized coverage. The District, like Massachusetts, already provides extensive coverage through Medicaid and HealthyFamilies. These programs cover children up to 300 percent of FPL and parents up to 200 percent FPL. Under current law, the District may be able to expand coverage for parents with incomes above 200 percent FPL, and the 70 and 79 percent federal matching rate available for these programs, respectively, makes this an attractive option. Moreover, the District also provides free coverage up to 200 percent FPL under its Alliance program that covers people not eligible for Medicaid. It could build upon the Alliance to expand coverage further. In order to make coverage affordable, sliding-scale subsidies would have to be extended, at least to 300 percent of FPL. But unlike the case in Massachusetts, the administrative structure for doing so is already in place through the Alliance.

Massachusetts's policymakers decided to provide free coverage only to adults with incomes below 150 percent FPL. In principle, the District could also impose a sliding-scale premium schedule starting at 150 percent of FPL, which is below the current Alliance standard for free coverage. This would increase costs to those between 150 and 200 percent of FPL, which might prove politically infeasible, but it would provide some of the funding needed to extend subsidized coverage above 200 percent of FPL. Alternatively, the District could increase general revenues to finance such an expansion. Some assurance of continuous residency, for example, six months prior to enrollment in the new program, would probably be necessary to minimize border crossing into the District to obtain subsidized coverage.

Individual mandate. The city could impose an individual mandate on its residents, whereby all adults or all adults and children would be required to obtain coverage through the expanded Alliance or through some other mechanism. Such a mandate could exempt people whose premiums exceed specified shares of income, as in Massachusetts. Alternatively, D.C. could structure premium subsidies such that individuals are required to pay premiums up to a limit set as a percentage of income, with the government paying any remaining cost. With subsidies, an individual mandate can apply to *all* residents—thus getting close to universal coverage—without imposing excessive financial burdens on individuals and families. Exemptions for unaffordability would leave more of the population uncovered; subsidies to reduce unaffordability would place greater financial responsibility on the District than does the Massachusetts approach.

Employer role. The Massachusetts reform imposes only a very modest employer financial responsibility. Even so, it probably does not make sense for the District to consider a similar employer mandate. First, most employers that would be affected already provide coverage. The largest employer in the city is the federal government, and it already provides coverage. The high-income law firms and trade associations in the city also largely provide health insurance. Second, employers that do not offer coverage are mainly smaller retail establishments and some nonprofit organizations.

The Massachusetts approach already exempts the smallest employers, and many of the others could easily move across the District line into Maryland or Virginia to escape an employer mandate, or else would be placed at a competitive disadvantage relative to similar firms across the borders. There are other insurance and labor-market factors specific to Massachusetts that make the required employer contribution more defensible. However, if the District is committed to achieving universal coverage, it is probably more effective to impose a mandate on individuals, requiring them to have insurance if they are District residents.

Insurance market. In the Alliance, the District already has an administrative structure that determines income eligibility and contracts with private health plans. These are functions for which Massachusetts had to create its Connector. The District could consider establishing an unsubsidized portion of the Alliance to provide standardized insurance plans to small groups and individuals without access to employer-based insurance. Doing so would likely necessitate contracting with more health plans in order to attract sufficient enrollment.

One important concern in considering an expansion of the Alliance to higher-income purchasers is that the District currently has little insurance regulation in the private nongroup market. For example, there are no limits on what can be charged to individual purchasers, and premiums can vary substantially based on health status, age, gender, and other factors. The District allows nongroup insurers to deny coverage outright based on health status or to exclude any benefits for particular conditions or even body parts and systems.[3]

As a consequence, providing open enrollment into new coverage through the Alliance while continuing to permit nongroup insurers outside of the Alliance to exclude or limit coverage to those with health problems will undoubtedly lead to adverse selection inside the Alliance. Healthier purchasers could avoid sharing in the costs associated with sicker purchasers by continuing to obtain coverage outside the Alliance. Depending on the Alliance's subsidies and pricing rules, less healthy purchasers might be no better off than they are today. Such problems could be ameliorated by combining the individual and small group markets and enacting the kind of other

insurance market reforms adopted by Massachusetts, by requiring all individual purchasers to obtain coverage through the Alliance, and providing direct subsidies funded with general revenues to reduce the costs associated with higher-cost Alliance enrollees.

Low-income subsidies can take the form of individual tax credits or direct subsidies paid to health plans. Subsidies for the excess costs associated with individuals with high medical needs could be paid directly to health plans participating in the Alliance. The District could finance a Massachusetts-like expansion by redirecting some of the revenues that now flow directly to safety net providers, although these are smaller in D.C. than in Massachusetts. But such a reform would inevitably require an increase in general revenues to finance the extended subsidies and the higher participation in the Alliance and in Medicaid that would follow if a mandate is imposed. General revenues could come from an increase in income tax rates or a dedicated income stream that would come from taxes on health care providers. Alternatively, an increment to the city's sales or other tax could be added and dedicated to a trust fund for health reform-related expenses.

Discussion

As the District considers the Massachusetts experience, it should take into account the similarities and differences between the two jurisdictions. Like Massachusetts, the District has a relatively small uninsured population. In addition, the Alliance provides an existing administrative structure on which to build an expansion of both public and private coverage with subsidies tied to income. On the other hand, the District has a largely unregulated insurance market. In addition, its current payments to safety net providers are substantially lower and so provide a smaller financial base to redistribute to finance reform. For these reasons, the District should be prepared to face different challenges if it tries to replicate the Massachusetts health care reform.

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Endnotes

[1] This brief is based upon the authors' expertise on Massachusetts developments (see authors' note above). Facts were checked by Massachusetts sources in September 2007. A project called Roadmap to Coverage helped inform the Massachusetts pre-reform debate. See, for example, John Holahan, Linda J. Blumberg, Alan Weil, Lisa Clemans-Cope, Matthew Buettgens, Fredric Blavin, and Stephen Zuckerman, *Roadmap to Coverage: Synthesis of Findings*, Report for the Blue Cross Blue Shield of Massachusetts Foundation, October 2005, accessible at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/RoadmapSynthesisSummary.pdf.

For more recent analyses, see John Holahan and Linda Blumberg, "Massachusetts Health Care Reform: A Look At The Issues," *Health Affairs*, November/December 2006; 25(6): w432-w443; Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, Setting A Standard Of Affordability For Health Insurance Coverage, Health Affairs, July/August 2007; 26(4): w463-w473; and Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured And The Affordability Of Health Insurance Coverage," *Health Affairs*, January/February 2007; 26(1): w22-w30.

[2] John Holahan, Randall Bovbjerg, and Jack Hadley, *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Medical Spending?* Urban Institute Report for the Blue Cross Blue Shield of Massachusetts Foundation, November 2004, accessible at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/uninsured Chartbook05.pdf.

[3] CareFirst BlueCross BlueShield of the District of Columbia is required to offer open enrollment into one of their insurance policies (also called guaranteed issue). However, there is no limit on what an individual can be charged for this policy, and a 10-month pre-existing condition exclusion period can apply to the guaranteed issue policy for those individuals who are not HIPAA eligible.