Massachusetts Enrolls More of Its Uninsured

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WASHINGTON — Don't believe what you read in the national media: The Massachusetts health coverage plan enacted in 2006 is actually doing quite well, thank you very much.

That was the message from John McDonough, D.P.H., executive director of Health Care for All, a consumer health advocacy organization in Boston that has supported the plan. "We've expanded affordable coverage to 325,000-350,000 of the [state's] estimated 550,000 uninsured," he said at a diabetes meeting sponsored by Avalere Health.

But significant challenges are ahead. The state government recently announced that the program will cost "significantly" more than the proposed $869 million budgeted for it in 2009.

One reason for the increase is that state regulators approved a 10% increase in payments to private insurers for each person enrolled in the program, in which the state subsidizes the insurance premiums. The insurers had sought a 15% increase but agreed to settle for 10% after lengthy negotiations.

Richard Powers, a spokesman for the program, said in an interview that the real driving force behind the increased cost is growing enrollment. "Certainly, the rate increases will factor into the final figure—which has yet to be determined—but it is minor in comparison to the enrollment," he said.

The payment increase will take effect July 1.

In addition, the state said it would be willing to take on additional financial risk if enrollees end up using more medical care than expected.

Also, premiums will be increased for about one-fourth of enrollees—the other three-fourths will continue to pay no premiums—while copays will go up for half of those enrolled. (See box.)

Dr. McDonough said cost increases were not unexpected.

"Yes, it's true. …When you enroll a ton of people, costs do go up," he said during his talk, which was given before the announcement but after state officials had projected an increase in the program's budget. "Most of [those costs] were expected and, by the way, most of those costs are being paid by the federal government, not by Massachusetts."

The Massachusetts plan has engendered dislike on both extremes of the health care reform debate, he said.

"You have health care fundamentalists on the left who worship at the shrine of the perpetual single payer, and you have fundamentalists on the right who bow down before the consumer-driven goddess of the unregulated market," Dr. McDonough explained.

"They agree on absolutely nothing, except for one thing: They hate Massachusetts' ecumenical experiment," he continued. "We're just doing our best; we know we're in radically experimental terrain, and we hope we're providing some ideas and some paths for [the] system [to] advance."

Health Care for All receives financial support from the Massachusetts state government to support its enrollment and outreach efforts.

Details of Massachusetts' Coverage Plan

Under its health coverage plan, the state of Massachusetts has expanded Medicaid eligibility for children from those families making 200% of the federal poverty level to those families making 300%, Dr. McDonough explained.

The state also set up Commonwealth Care for adults making less than 300% of the poverty level who can't get insurance anywhere else. In that program, there are no premiums for those under 150% of the poverty level, and there is a sliding-scale premium structure for those between 150% and 300% of poverty, up to $107 per month. This program "gets at a significantly uncovered group: childless adults," he said.

For people above 300% of poverty who are having difficulty finding affordable coverage, the state offers coverage plans through a variety of private insurers, Dr. McDonough continued. Some plans have higher premiums in exchange for lower cost sharing, while others offer the opposite approach. In addition, employers are required to set up "cafeteria plans" that allow workers to deduct their health insurance premiums from their paychecks pretax.

As of July 1, 2007, the state also requires all residents to be insured, provided that there is affordable coverage available to them. Residents who do not comply with the law must pay penalties. Because some people "made a calculated decision to pay the penalty" rather than pay for coverage, the Massachusetts plan is not considered a universal coverage plan, he said. The state also exempts some residents who would normally pay the penalty from having to do so, if they are unable to find affordable coverage.

In 2007, the penalty for not having coverage was a standard $219. This year, the maximum penalty jumps to $76 per month, or $912 per year; penalties are now on a sliding scale based on the individual's income. However, if a person signs up for coverage sometime during the year, he or she can stoppaying the monthly penalty, Dr. McDonough pointed out in an interview.

POLICY & PRACTICE

Ga. Docs Collaborate on EHRs

Georgia physicians are collaborating with the state's Department of Community Health on adoption of Medicare electronic health records, the department said. The department intends to apply to the Centers for Medicare and Medicaid Services to participate in an EHR demonstration project, and department officials said they met with Georgia physicians in March to develop the program. Over a 5-year period, the demonstration project will provide financial incentives to small and medium-size physician groups using certified EHRs to meet certain clinical measures. Bonuses will be provided each year, based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care.

Consumer-Directed Enrollment Low

More employers are offering consumer-directed health plans in efforts to shift greater responsibility to workers for health care costs, lifestyle choices, and treatment decisions, according to a new survey on the plans. However, enrollment still constitutes only a small percentage of those enrolled in all employer-sponsored health plans, because large employers have not yet structured their premium contributions to favor the consumer-directed options, according to the survey from the Center for Studying Health System Change. Survey respondents were optimistic that consumer-directed health plans would become more prominent in health benefit offerings, but the report said plans and employers seeking to foster greater enrollment may need to make health savings accounts and health reimbursement arrangements more appealing to enrollees.

MA, Part D Changes Announced

The out-of-pocket threshold for a beneficiary enrolled in a standard Medicare Part D drug plan will rise from $4,050 to $4,350 next year, while the initial deductible rises from $275 to $295, CMS announced. The out-of-pocket threshold is the point at which the Part D "doughnut hole" is satisfied and Medicare begins paying for most drug expenses, minus 5% copayments. At the same time, health insurers running Medicare Advantage plans will see average increases of about 3.6% in capitation rates in 2009, CMS said. This increase in capitation rates is slightly lower than the estimated 3.7% Medicare growth trend for 2009, CMS said. In addition, CMS said it will audit records from a sample of Medicare Advantage plans in an effort to determine if the plans are reporting diagnosis code information correctly. Diagnosis code information is used in setting capitation and payment rates for the plans.

Workers Struggle With Health Costs

Almost all of those polled in a recent AFL-CIO survey said they were struggling with the cost of health care, even though most were insured and employed and more than half were in union jobs or were college graduates. One-third of respondents to the online survey, sponsored by the AFL-CIO and Working America, reported skipping medical care because of cost, and one-quarter had serious problems paying for the care they needed. In the past year, 76% of people who lacked insurance themselves and 71% of people with uninsured children said someone in their family did not visit a doctor when sick because of cost. In addition, about two-thirds of those without insurance reported skipping medical treatment or follow-up care, and more than half said they had to choose between paying for medical care or prescriptions and other essential needs, such as the rent, mortgage, or utilities. Nearly four out of five said health care is a very important voting issue.

Side Effects Underreported

One in six Americans who have taken a prescription drug experienced a side effect serious enough to send them to the doctor or hospital, but only 35% of consumers said they know they can report these side effects to the FDA, according to a Consumer Reports poll. Additionally, 81% of respondents said they had seen or heard an ad for prescription drugs within the last 30 days, almost all on television. Consumers Union, the nonprofit publisher of the magazine, gave the FDA a petition signed by nearly 56,000 consumers asking that a toll-free number and Web site be included in all television drug ads so people can easily report their serious side effects. "What better way for the FDA to let consumers know how to report serious problems with their medications than putting a toll-free number and Web site in all those drug ads we're bombarded by each day?" asked Liz Foley, campaign coordinator with Consumers Union, in a statement.

AAMC Adopts Medical Home

The Association of American Medical Colleges has adopted a formal position stating that every person should have access to a medical home. "We believe the medical home model holds great promise for improving Americans' health by ensuring that they have an ongoing relationship with a trusted medical professional," Dr. Darrell Kirch, AAMD president and CEO, said in a statement. The AAMC position also said that further research and evaluation of the medical home model is needed and more evidence must be gathered on how the model is best implemented. In addition, payment for the model should "appropriately recognize and reward providers for prevention, care delivery, and coordination," and "health care providers should be trained to understand and implement the medical home model within a team environment," the AAMC said.

—Jane Anderson