Mass. Governor Seeks to Mandate Health Insurance

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE — The governor of Massachusetts is proposing to cover the uninsured in his state by creating lower cost health insurance options and requiring individuals to obtain coverage.

This effort is aimed at providing affordable coverage for the approximately 460,000 or 7% of Massachusetts residents without health insurance, Amy Lischko, assistant commissioner of the Massachusetts Division of Health Care Finance and Policy, said at the annual conference of the National Academy for State Health Policy.

"We really feel like this is the year to get something done, and we're hopeful that parts at least of the governor's proposal will be moved on," Ms. Lischko said.

This plan is one of a few proposals being considered by the state's legislature. Under the governor's plan, individuals would be required to have a minimum level of insurance or proof of their ability to pay for care on their tax return.

Those who do not comply could see a loss of their personal tax exemption and withholding of a portion or all of their income tax refund for deposit in a state personal health care expenditure account.

Individuals without coverage who use medical services would be required to pay, and there would be more up-front billing by providers. If patients are unable to pay, the provider may request payment from the state personal health care–expenditure account.

Coupled with the proposed individual insurance mandate, Gov. Mitt Romney (R) is also proposing to create two new low-cost health insurance options designed to appeal to the 7% of uninsured residents in the state.

But John McDonough, executive director of the advocacy group Health Care for All, noted there are a lot of unanswered questions about Gov. Romney's plan.

For example, there is no guarantee that private insurers step up to offer the new insurance plans envisioned by the governor, Mr. McDonough said in an interview. Also unstated is whether there are sufficient existing funds in the health care safety net to pay for the subsidies required for low-income residents.

Mr. McDonough's group instead favors an approach that would require employers to offer health insurance or pay a fee to the state, as well as expanding Medicaid eligibility and offering subsidies to moderate-income workers.

One program—called Commonwealth Care—will be aimed at the approximately 204,000 uninsured residents who have incomes of more than 300% of the federal poverty level. The other coverage option—called Safety Net Care—is aimed at the 150,000 residents whose salaries are between 100% and 300% of the federal poverty level but who do not qualify for Medicaid.

The Commonwealth Care program tries to ease the burden of rising health care premiums that has hit some individuals and small businesses, Ms. Lischko said. The proposal would allow private insurers to offer new, more affordable health plans.

The proposal would reduce costs for individuals through pre-tax treatment of premiums and make it easier for businesses to offer insurance to their contractors and part-time workers by allowing employers to pay a smaller portion of the health insurance.

The Commonwealth Care plan would include coverage for primary care, hospitalization, mental health, and prescription drugs. But the provider network would be limited and insurers would be able to apply for exemptions from the state's 27 mandated benefits.

The annual deductible for the plan would be between $250 and $1,000, and copayments would be moderate but somewhat higher than what is seen in the marketplace right now, Ms. Lischko said. And the monthly premium would be less than $200, compared with more than $350 a month in a standard small group.

The Safety Net Care program is designed for individuals who can't afford current insurance products or Commonwealth Care but who don't qualify for Medicaid. Unless subsidized by employers, these individuals would typically be uninsured and receive "free" health care, Ms. Lischko said, at a cost of about $1 billion a year.

This program would feature private insurance with the same benefits as Commonwealth Care, but with lower copays and no deductibles. The monthly premiums would be set according to a sliding

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scale based on individual income.

For example, a single individual with an income at 300% of federal poverty who earns $28,710 a year would be required to pay a weekly premium of $32.31, and the weekly state subsidy would be $36.92.

Under Gov. Romney's proposal, the Safety Net Care program would be funded with existing resources of about $922 million that are currently used to pay for care for the uninsured.

It's been a balancing act, Ms. Lischko said, in figuring out how to make the plans attractive without incentivizing employers to drop coverage. ■

Medicaid: Getting Rid of 'One Size Fits All'

BY JENNIFER LUBELL

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WASHINGTON — States should have the flexibility to experiment with innovative measures to improve the Medicaid program, Rep. Nathan Deal (R-Ga.), said during a meeting sponsored by the Center for Health Transformation.

"One size fits all" was the concept at Medicaid's inception, but the truth is "no one size fits everybody, every state," said Rep. Deal, chairman of the House Committee on Energy and Commerce Subcommittee on Health. States over the years have gotten out of this one-size-fits-all approach by applying for waivers, which has resulted in a patchwork of Medicaid programs, he said.

States are the testing ground for what works, he said. For that reason, the congressional role in Medicaid reform should be to make broad program outlines, to allow "states the ability to tailor their programs as best as they think meets their needs, without having to come to Washington to ask for waivers all the time," he said.

Medicaid is the single largest component of every state's budget, Rep. Deal noted. Even though it's technically a federal/state partnership, many states can't pay their portion. "It's breaking their budget."

The nation's governors have proposed a framework that Congress has been working to implement, he said. One of the things the governors asked of Congress "is to be more selective in the way we allow them to present and manage their programs."

Instilling a sense of personal responsibility in the beneficiaries and giving them more choice in their care will help the states achieve that goal, he said.

The irony about Medicaid is that "we have created a tax-supported health delivery system that's much more generous than what any of us can buy in the private insurance market. And certainly much better than what you could buy as an individual insurance policy."

The problem is that once you cross the Medicaid eligibility threshold, "all of sudden you're in a vast land of health care delivery, where you have all of these benefits whether you need them or not." This entitlement structure does not allow the health delivery system to do things like disease management, to focus resources on particular medical needs, to do overall management on the health care system, he said.

Medicaid also has limited deductibles and copays built into its federal formulation. "The governors have asked us to change that," he said. Making copays mandatory or enforceable "goes a long way for putting the idea of personal responsibility back into the system."

Obviously, the mandate would have to exclude certain categories, such as children below the poverty level and certain disabled beneficiaries. However, for those with eligibility levels in the upper categories, "that's certainly an appropriate place to go," he said.

Instead of walking behind that "magic curtain" and being eligible for everything, the governors are saying "let us make the benefits flexible, tailored to the needs of the beneficiary, and thereby allow us to save money, and in the process do a better job of delivering better health care," Rep. Deal said.

A difficult area in need of reform is reimbursement for drugs, he said. The current system "is very complicated and, I think, subject to manipulation."

The hope is to abandon the old formulas and convert to the "average manufacturer's price," he said. "The AMP is an effort to come at a price formulation that is as close to reflecting the true cost [of the drug] as possible," he said. Differentiations between chain drug stores, community pharmacists, and mail-order drug companies are distorting the actual cost of the drug.

The goal of the AMP is to arrive at a realistic reimbursement number, "so we don't make pharmacists bear the brunt of reforms. Expecting the dispensing agent to absorb the cost differentials, I don't think that's fair or realistic," he said. ■

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