# Massachusetts Health Reform: Implications for Other States

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## Different Strategy

- Previous approach
  - Assume basic system structure
  - Design products to fill gaps
- New approach
  - Improve system structure
  - Assume product response

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# Each State is Different

- Key elements can be replicated in other states
- But details will vary based on:
  - Demographics
  - Delivery system structure/issues
  - Design of insurance markets and public funding
  - Politics and constituencies



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# Two Key Elements

- Restructure insurance markets
  - Create true portability and continuity of coverage
- Restructure public subsidies
  - Shift from provider-focus to consumer-focus

## "Connector"

- A clearinghouse/exchange
- Standardizes administration, not products
- Not the product regulator
- Not a purchaser
- Content: state regulated, portable, individual coverage
- Wrapper: 'employer-group plan' status = tax-free premiums



## "Commonwealth Care"

- Premium support for working families <300%FPL & not categorically eligible
- Uses existing uncompensated care funding
- Buys same portable, private coverage
- Other states could expand to include some of the categorically eligible

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# Mandates?

- Supplement, not starting point
- Employers - With Sec. 125 plans no need for minimum contribution
- Individuals - A rating trade-off
  - Broad variation = less need to require coverage, more need for risk adjuster
  - Little or no variation = more need to require coverage, less need for risk adjuster
- Increases support for funding shift?



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# Synergistic Reform

- Connector improves coverage continuity and plan competition
- Connector offers administrative platform for premium support
- Premium support shifts focus from providers to consumers
- New incentives to seek value from plans and providers
- Value seeking = cost ⇩ benefit ⇧

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# Coverage Instability Problem

| Coverage Patterns of Uninsured (48 month period) | Number (millions) | Share | Potential to Solve |
|---|---|---|---|
| **Repeatedly uninsured** | 28.2 | 33% | Easiest (62%) |
| **One coverage gap** | 24.4 | 29% | |
| **Transition in or out of coverage** | 17.2 | 20% | Varied |
| **Temporary coverage** | 4.8 | 6% | Hardest (18%) |
| **Always uninsured** | 10.1 | 12% | |
| **TOTAL** | 84.8 | 100% | |

**Source:** 1996-1999 SIPP data as reported in: P. F. Short and D. R. Graefe, "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs* 22, no.6 (2003): 244-255.



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# Implications

"The overarching implication of these data is that stability merits consideration as an explicit and important goal of coverage reforms."

"Continuity of coverage is also likely to facilitate continuity of care."

"One can imagine arrangements where employers might sometimes contribute to the cost, when a person's employment situation warrants, without actually administering the coverage."

P. F. Short and D. R. Graefe, "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs* 22, no.6 (2003): 244-255.

# Conclusions

- The more people that never lose coverage, the fewer the uninsured.
- Covering the remaining ‘hard to insure’ becomes easier and cheaper.
- More stable health care financing is the precondition for realigning system incentives toward better value and outcomes.