Massachusetts: A Case Study in Childless Adult Coverage

State Report

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OVERVIEW

During the 1990s, a strong economy and bipartisan support allowed Massachusetts officials to expand health coverage to many vulnerable populations. With a primary emphasis on its Medicaid program, MassHealth, various programs offered some form of assistance to children with household incomes up to 200 percent of the federal poverty level (FPL), parents up to 133 percent of FPL, disabled persons under age 65 without an income limit, and many adults without dependent children currently living at home – "childless adults".[1]

By the end of the 1990s, Massachusetts was among the more generous states in terms of coverage to childless adults. The state included this group among the beneficiaries of five distinct programs, the first three of which received federal matching funding under Medicaid waivers:

- First, MassHealth Basic covered childless adults who were *long-term unemployed* with low incomes. This program provided direct coverage with relatively comprehensive benefits. Beneficiaries were generally very poor, often with chronic care needs that include mental health and substance abuse problems. Facing strong budget pressures, Basic was drastically cut back in April 2003.[2] A new program, MassHealth Essential, began in October 2003 to cover many of those who lost coverage – but with somewhat less generous benefits, stricter eligibility, and enrollment capped at 36,000.
- Second, the Family Assistance Program provides premium assistance for low to moderate-income workers (including childless adults) who are either self-employed or work for small businesses. By subsidizing both the employee and employer share of premiums, this program builds on the employer-based system and leverages workplace dollars to maximum effect by combining them with federal and state funds. The employed population served by this program is relatively healthy, more often than not. In 2003, a cap was proposed for adult enrollment due to budget constraints.
- Third, the Medical Security Plan helps laid-off workers and their families who receive unemployment insurance payments. Depending on the workers' circumstances, the program either provides direct, state-based coverage or helps pay the cost of coverage available through former employers. This is a short-term program that serves a relatively healthy population.
- Fourth, the Uncompensated Care Pool reimburses hospitals and certain other providers for the cost of serving uninsured state residents with low or moderate incomes.

This multi-faceted approach recognizes that the uninsured (including uninsured, childless adults) are not a homogenous group, and that more than one approach is needed for populations with distinctly different health care needs. However, one risk of this approach was realized when budget pressures surfaced in 2002-2003. Perceived by some as serving a "less-deserving" population than workers or parents, MassHealth Basic coverage for the long-term unemployed was drastically cut in early 2003. Yet

[1] The Federal Poverty Level (FPL) was $15,260 for a family of three in 2003.
[2] MassHealth Basic was limited to disabled recipients of state-funded cash assistance, cutting 33,000-43,000 childless adults from coverage.

pressure from some legislators, consumer advocates, and the hospital association led to the formation of a new – albeit more limited – replacement program for this population.

This paper provides an overview of Massachusetts' public programs for low-income childless adults. It is based interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults. This profile focuses mainly on the Family Assistance program and MassHealth Basic as Massachusetts' two largest coverage programs serving childless adults during recent years.

KEY PROGRAM FEATURES

Table 1. Key Public Health Care programs serving Childless Adults in Massachusetts

Program Name	Enrollment	Eligibility Requirements	Benefits	Cost Sharing
MassHealth Basic	12,870 Childless Adults with disabilities eligible for EAEDC, in April 2004; before major reduction in program, Basic had 53,664 childless adults in March 2003	Until April 2003: 1. Income at or below 133% FPL; 2. Unemployed at least 12 months; and 3. State resident Since April 2003, individuals must also receive state-funded cash assistance for people with disabilities.[3]	Inpatient and outpatient services, prescription drugs, mental health services; excludes long-term care, non-emergency transportation.	Premiums: None. Copayments: Nominal.
MassHealth Essential	23,966 Childless Adults as of April 2004	1.Income up to 100% FPL; 2.Unemployed at least 12 months; 3. State resident	Similar but somewhat less generous benefits than under Basic	Premiums: None Copayments: Nominal.
Family Assistance Premium Assistance	4,394 Childless Adults as of April 2004	1. Self-employed or working in firm with no more than 50 full time employees; 2. Family income	Benefits offered through employer-sponsored plans (must meet basic level).	Premiums: None, if family income at or below 133 percent FPL. If higher income, $27 per month

[3] Note: people must be eligible for EAEDC but they don't meet DMA/TXIX disability standards or be a DMH client.

Program Name	Enrollment	Eligibility Requirements	Benefits	Cost Sharing
		up to 200% FPL; 3. Employer offers insurance meeting state standards; 4. Employer pays at least 50% of premium; 5. 19-64 years old; and 6. MA resident.		$27 per month per adult without children. Copayments: as under employer plan.
Medical Security Plan	6,723 UI recipients (childless adults and parents) and 6,127 dependents as of 9-30-03	1. Income up to 400% FPL; 2. Receiving unemployment benefits; 3. State resident; and 4. Former employer based in MA.	Coverage through former employers, for people with access to COBRA. For others, Direct Coverage with broad benefits through Blue Cross Blue Shield. Individuals under 200% FPL may choose between delivery systems.	Premiums: 25 percent cost-sharing for Premium Assistance, $20/$30 per week premiums for Direct Coverage. Copays: COBRA plan for Premium Assistance enrollees. For Direct Coverage: 20% physician services, $250 inpatient deductible, $100/200 major medical deductible, $40 ER deductible.

MassHealth Basic

Until April 1, 2003, MassHealth Basic covered adults who had been unemployed for at least 12 months and whose household incomes were at or below 133 percent FPL (with earned income below $3,000 a year). All of these individuals were childless adults,

since parents of Medicaid-eligible children up to 133 percent of FPL are eligible for MassHealth Standard, the state's general Medicaid program. The highest enrollment in MassHealth Basic was recorded in June 2001, at 63,939 individuals. Just before it was severely cut back in April 2003, enrollment stood at approximately 54,000.

The Basic benefit package is comprehensive, covering inpatient and outpatient services, prescription drugs, dental and vision services, emergency transportation, mental health services, and home health care. The benefits are, however, slightly less comprehensive than the Standard package, which is the state's Medicaid program covering infants, children to age 18, disabled adults, seniors, pregnant women, and low-income parents. Basic excludes a number of Standard services, including non-emergency transportation and long-term care (such as nursing home or home health care, hospice, day habilitation, and private duty nursing). Unlike Standard coverage, Basic does not pay for services until the enrollee has chosen a primary care provider, and there is no retroactive coverage of services obtained shortly before applying for benefits. The program requires nominal cost sharing from its enrollees. A small number of individuals who qualify for MassHealth Basic and have access to private health insurance (e.g., through a spouse) are enrolled in MassHealth Buy-In, through which the state pays all or most of the cost of the private coverage.

Applications for enrollment into MassHealth Basic, as well as other MassHealth direct service programs, are available at provider sites such as hospitals, health centers, emergency rooms, state agencies, and community based organizations. Individuals can mail, fax, or hand-deliver applications to a MassHealth Enrollment Center (MEC). Consumers can also call a toll free number for application information, including help filling out forms. The Division of Medical Assistance, which oversees MassHealth, outstations 27 eligibility workers throughout the state and provides mini-grants to community-based organizations and providers to conduct outreach and provide enrollment assistance.

MassHealth operates under a mandatory managed care system. The state contracts with four fully-capitated managed care organizations (MCOs) and one primary care case management group called the Primary Care Clinician Plan (FQHCs and CHCs are participating providers in all of the MCOs and the PCCM plan). Basic enrollees are required to choose a managed care provider or have one auto-assigned if the choice is not made within the allotted time frame.

MassHealth Essential

In the summer of 2003, the Massachusetts legislature authorized the creation of MassHealth Essential, a scaled down program to restore coverage for many poor, long-term unemployed childless adults who lost MassHealth Basic when it was drastically cut earlier in the year. The new program began October 2003. The primary differences between Basic and Essential are the following:

- The maximum income for eligibility for Essential is 100 percent of FPL, versus 133 percent for Basic. Whereas Basic's enrollment was unlimited (for those meeting eligibility criteria), Essential enrollment is capped at 36,000 individuals, and coverage is authorized only through September 2004. After reaching the cap, applicants will be placed on a waiting list.

- Essential members are required to enroll with a Primary Care Clinician (PCC), while Basic members can enroll with a PCC or a managed care organization. Essential does not cover the following benefits that are included in Basic's benefit package: audiologist, hearing aid, chiropractor, nurse midwife, orthotic, vision, home assessment, and home health care services. Spending for Essential will be limited to $160,000 for FY 2004. Legislative authorization is required to extend the program beyond September 2004.

Family Assistance-Premium Assistance

The Family Assistance Premium Assistance program offers subsidies to help low-wage workers and small firms pay their respective shares of employer-based insurance premiums. Both worker and employer subsidies are offered to low-income, self-employed individuals.

Premium assistance for workers is available to both parents and adults without dependent children. To qualify, a childless adult must:

- Either be self-employed or work for a participating business that (a) has no more than 50 full-time employees; (b) pays at least half of health insurance premiums; and (c) offers coverage that meets the state's benchmark standards, described below.
- Have family income at or below 200 percent of FPL;
- Be between 19 to 64 years old; and
- Live in Massachusetts.

Eligibility for parents is slightly broader. Parents can receive premium assistance even if their employer is large. Further, the state provides premium assistance on behalf of eligible children regardless of who the parent's employer is as long as the employer contributes at least 50% of the cost and benefits meet the basic benefit level.

Adults without children contribute $27 per month per adult ($54 per couple), and the subsidy covers the remaining employee premium contribution. Families with children pay $10 per month per child, up to a maximum of $30 per family (including parents).[4] Medicaid funds finance premium assistance for childless adults, while a combination of Medicaid and SCHIP funds (depending on family income and other factors) finance premium assistance for parents and children.[5]

As of April 30, 2003, 4,394 childless adults received premium assistance for employer-based insurance. Including children and family members who obtain coverage through these insurance policies (e.g., non-eligible parents with eligible children), more than 16,000 people benefit from insurance under Premium Assistance. The benefits and cost sharing are defined by each employer's insurance package.

[4] People who are eligible for MassHealth Standard or CommonHealth who receive Premium Assistance are subsidized the entire cost of the employee's share of the premium, and receive wrap-around coverage of services included in the Medicaid program that are not part of the employer's benefit package.

[5] The state receives SCHIP funds for premium assistance only for SCHIP-eligible children.

To administer the program, the state contracts with Employee Benefit Resources (EBR), a billing and enrollment intermediary that helps insurers serve firms with between 10-50 employees. EBR conducted a major marketing campaign to inform small businesses of the program. In addition, the Division of Medical Assistance conducted outreach to employers and employees through Chambers of Commerce and business associations such as the Associated Industries of Massachusetts (AIM).

Despite multiple marketing efforts, enrollment was slower than expected. State officials attribute this to employer wariness of government programs and resistance to the rules involved. In 2002, the state made some changes to boost enrollment, including increasing outreach. From March 2001 to January 2003, enrollment grew from roughly 2,500 to 4,300 adults. While it is growing steadily, premium assistance reaches few people relative to the other expansions.

In 2003, caps were proposed for adult enrollment in two MassHealth programs: Family Assistance (both for HIV and non HIV adults) and CommonHealth (adults with disabilities). The state received CMS approval for these caps in January 2004. The cap for non-HIV adults in Family Assistance was set at 4,750, about 115 more than enrollment on September 30, 2003. The cap is expected to be reached in December 2003, after which time applicants would be placed on a waiting list. The cap for HIV adults in Family Assistance is 620, and CommonHealth adult enrollment is capped at 11,850.[6]

Medical Security Plan

The Medical Security Plan (MSP), run by the Division of Employment and Training (DET), provides either Premium Assistance or Direct Coverage to state residents who have family incomes up to 400 percent of the FPL, whose former job was in Massachusetts, and who receive unemployment insurance. Their dependents also receive coverage.

MSP eligibility does not distinguish between childless adults and other laid-off workers. Originally under the state's Division for Medical Security and enacted in the first phase in Governor Dukakis's plan for universal coverage, MSP was preserved but shifted to DET when the universal coverage law was repealed in 1996.

The state's 1115 waiver provides federal Medicaid matching funds for all enrollees. Individuals with income up to 400 percent of FPL who have access to COBRA continuation coverage are subsidized by the DET for 75 percent of the actual premium paid. The subsidy is capped at 100 percent of the previous year's average COBRA premium; the 2003 cap is $598/month for a family plan and $250/month for an individual plan. Those without access to COBRA continuation coverage receive so-called Direct Coverage, via a Blue Cross/Blue Shield preferred provider product funded by the state.

MSP enrollees do not pay premiums for Direct Coverage, which includes fairly comprehensive benefits, subject to cost sharing and annual caps.[7] MSP beneficiaries

[6] See http://www.cms.hhs.gov/medicaid/1115/mamhcapapvltr.pdf

[7] Direct Coverage applies deductibles and co-insurance as follows: Major Medical coverage has a $100 per member, $200 per family annual deductible; visits with physicians and other providers

with access to COBRA may enroll in Direct Coverage by showing financial hardship. Those with incomes below 200 percent of FPL are automatically granted financial hardship waivers upon request and may choose to receive Direct Coverage.

As of the end of September 2003, there were 6,723 unemployment insurance recipients and 6,137 dependents on MSP. Of these, 3,610 UI recipients (with 3,521 dependents) are in the Premium Assistance program, and 3,113 UI recipients (with 2,616 dependents) receive Direct Coverage.

A tax on employers, determined based on the number of employees, provides the state portion of the program's budget. It generates approximately $40 million annually. This has generally exceeded operating costs and expenses. In fact, the state has transferred $155 million from its MSA account surplus into the Uncompensated Care Pool (described below) and $35 million into Medicaid. But according to DET staff, higher unemployment rates and federally extended unemployment benefits stressed the program's financial resources. The DET renegotiated Blue Cross/Blue Shield's administrative fee and raised Direct Coverage copayments, saving $2.1 million. In addition, DET imposed temporary measures to get it through their fiscal difficulties. It reduced its premium subsidy to 75% from 80% in July 1, 2003, and in September 2003 it began to charge a premium ($20/week for individuals, $30/week for families) for Direct Coverage. According to a DET administrator, these temporary changes will be reviewed every 90 days and discarded when the program is back on sound financial footing.[8]

Administrators and advocates contend that program beneficiaries are now paying the price for policymakers' departing from MSP's original plan to accumulate surpluses in good times that are available to fund health coverage in bad times.

Uncompensated Care Pool

Outside of MassHealth, one of the main safety net mechanisms is the state's Uncompensated Care Pool (UCP), which reimburses hospitals and community health centers (CHCs) for medically necessary services to qualified individuals. Eligibility for UCP depends on income, encompassing low-income childless adults and parents alike. The UCP does, however, screen applicants for MassHealth eligibility, which places many parents in MassHealth rather than the UCP. Individuals with incomes below 200 percent of FPL qualify for full free care from the UCP, while those with incomes between 201 and 400 percent qualify for partial free care. Partial free care requires the enrollee to pay an annual deductible. By demonstrating extraordinary medical hardship, individuals of any income level can have the pool pay for services beyond the patient's ability to pay. The two largest UCP hospital providers developed coverage-type programs and issue membership cards that offer access to primary care.

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require 20 percent co-insurance; ER visits without hospital admissions have $40 co-pays; and inpatient care has an addition deductible of $250 per admission.

[8] In contrast, the changes to the Direct Coverage schedule of benefit were "permanent," designed to bring the schedule in line with health care insurance industry norms. DET will review the schedule at least annually to ensure it remains in line with what the employers in MA typically offer their employees.

The pool is funded by hospital assessments, payer surcharges, state appropriation, inter-government transfer, and transfer from a Medical Security Trust.[9] While the pool has achieved much success in improving access to care for vulnerable people, it has suffered chronic funding shortfalls. There have been many revisions to the pool structure/financing, including a recent switch to prospective reimbursement, and it is scheduled for a major overhaul in the coming year.

HISTORY AND BACKGROUND

Implementation of the 1115 waiver

In 1994, Massachusetts submitted a proposal to the Health Care Financing Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), to implement a significant Medicaid-based public coverage expansion. At that time, the Clinton administration and Department of Health and Human Services were actively encouraging states to use Section 1115 of the Social Security Act to develop comprehensive health care reform initiatives that could be operated through the Medicaid program. The state also preferred the 1115 approach (as opposed to a state-only program) to maximize federal funding.

HCFA approved the waiver in 1995, the state legislature approved the plan in 1996, and implementation began in July 1997. Under the waiver, the state renamed its Medicaid program "MassHealth," expanded coverage for children and pregnant women, created MassHealth Basic and Family Assistance/Premium Assistance, and integrated care for the uninsured by the state's two big safety net hospitals in Boston and Cambridge.

The legislature shifted DSH funds and increased the state's tobacco tax to obtain the state's share of Medicaid funds for the expansion. By transferring population into managed care, the state demonstrated budget neutrality for the federal contributions. Also, with a booming economy, the need for Medicaid and other state services was not projected to be high.

Despite the favorable financial environment, however, some key stakeholders felt that it was neither appropriate nor cost-effective to provide the very comprehensive MassHealth Standard benefit package to the Basic population. One goal of MassHealth Basic was to reduce the uncompensated care burden on hospitals; thus preventive care, inpatient care, and other services intended to keep people healthy were deemed the most important benefits to provide. Others, such as expensive long term care services, were not included. Between the less comprehensive benefit package and the narrowly defined eligible population, some policymakers intended Basic to start relatively small, as not to over-promise. Yet the demand was great, and enrollment exceeded many people's expectations.

Response to economic downturn

In 2002, CMS authorized the state to continue the MassHealth waiver for another three years. By this time, however, the economic situation had deteriorated nationwide, and

[9] Pool payments to hospitals qualify for federal matching DSH funds, which cover the state share. (*The Uncompensated Care Pool: Saving the Safety Net,* Massachusetts Health Policy Forum Issue Brief #16, October 23, 2002.)

Massachusetts identified a deficit of approximately $3 billion in the projected FY 2004 budget. In response to the dire budget situation, the Massachusetts legislature enacted a change in the eligibility requirements for MassHealth Basic that effectively eliminated coverage for the bulk of the Basic population. The new requirements, which took effect April 1, 2003, limit Basic coverage to the approximately 10,000 enrollees who are eligible for Emergency Aid to Elders, Disabled and Children (EAEDC) and certain Department of Mental Health (DMH) clients who are long-term or chronically unemployed and have income at or below 100 percent of FPL. Additional MassHealth changes that took effect April 1, 2003 include cuts in Medicaid reimbursement for inpatient "outliers" (more than 20 days), outpatient outliers, and psychiatric services.

In January 2003, all MassHealth Basic enrollees losing benefits were notified and given the opportunity to apply for other coverage programs related to disability, pregnancy, parental coverage, or HIV. Nevertheless, officials estimated that about 40,000 people have lost public coverage. Many of these likely became uninsured.

The Medicaid program, the state's hospital association, and consumer advocates lobbied against this change, arguing that it would increase the burden on the uncompensated care pool and other state programs, and reduce access to needed care. In particular, it would stress the already fragile mental health care system. Many legislators, however, concluded that MassHealth was becoming unsustainable, and that some cuts were needed to address the state's budget shortfall. The perception of being "less deserving" made the MassHealth Basic population more vulnerable to cuts than others. Advocates and some legislators, however, have spoken out against the cuts, stressing the shift in burden to the Uncompensated Care Pool and potential for higher health costs in the long term. As a result, the governor's office and legislators have worked out a way to restore some coverage for the majority of this population through a more limited program, MassHealth Essential, described above.

Budget constraints also led to enrollment caps on adults in Family Assistance (childless adults, parents, HIV population) and CommonHealth (adults with disabilities) in 2003. The caps were set slightly higher than current enrollment, so existing beneficiaries will not lose coverage. But the caps are expected to be reached, after which time there will be waiting lists.

Finally, the economic slowdown led to a federal extension of unemployment benefits to 26 weeks, which increased enrollment in MSP and put stress on the MSP Trust Fund. In response, DET temporarily reduced its premium assistance subsidies and imposed weekly fees (premiums) for direct coverage. According to a DET administrator, these changes will be reviewed every 90 days and will presumably be discarded when the program is back on sound financial footing. It is acknowledged, however, that the new fees may lead some people to drop MSP coverage.

Roles played by key stakeholders

According to former Massachusetts legislator John McDonough's book, *Experiencing Politics: A Legislator's Stories of Government and Health Care*, the Governor plays a significant role in policymaking in Massachusetts. Governor Weld worked closely with his Secretary of Health and Human Services and his Commissioner of Medical Assistance to develop the Medicaid waiver proposal and negotiate its approval by HCFA. Key motivating factors were: the prior failure of the Clinton Health Security Plan

to institute universal coverage; the activity among some policymakers to delay or prevent the pending implementation of a health coverage employer mandate that had been passed by previous Governor Dukakis; and the increasing cost of uncompensated care that was burdening the state's public hospitals. After HCFA's approval in May 1995, the legislation was put before the legislature for a vote. It passed in 1996.

A host of stakeholders played an important role in the legislation's passage, including business interests and health care advocates. There was much legislative debate about the cost and other features, but legislators were overwhelmingly supportive of the MassHealth Basic portion of the bill and there was reportedly no vocal opposition to the coverage of adults without dependent children.

Since 1995, many legislators had become interested in the opportunities to leverage limited public funds being spent on Medicaid with private dollars available through employer contributions in the premium assistance program. Consumer advocates were very supportive of Basic, but were less supportive of the premium assistance program because the benchmark for employer-sponsored insurance does not include the full set of Medicaid benefits, and there are no wrap-around benefits for most adults.

The business community, represented in the negotiations by the Associated Industries of Massachusetts (AIM), were in favor of the premium subsidies from the beginning, and believed it to be a cost-effective coverage strategy. This was crucial to its passage. In recent years, AIM has made suggestions for changing some parameters on both the employer and employee ends of the program in order to increase participation. It proposed an increase in the income threshold among employees to 300 percent FPL. Also, AIM favors increasing the premium subsidy for employers by 50 percent in order to keep up with the ever-creeping increases in private sector premiums. While these have been debated, business representatives acknowledge that in the current economic environment, such changes are unlikely.

HEALTH CARE NEEDS AND UTILIZATION

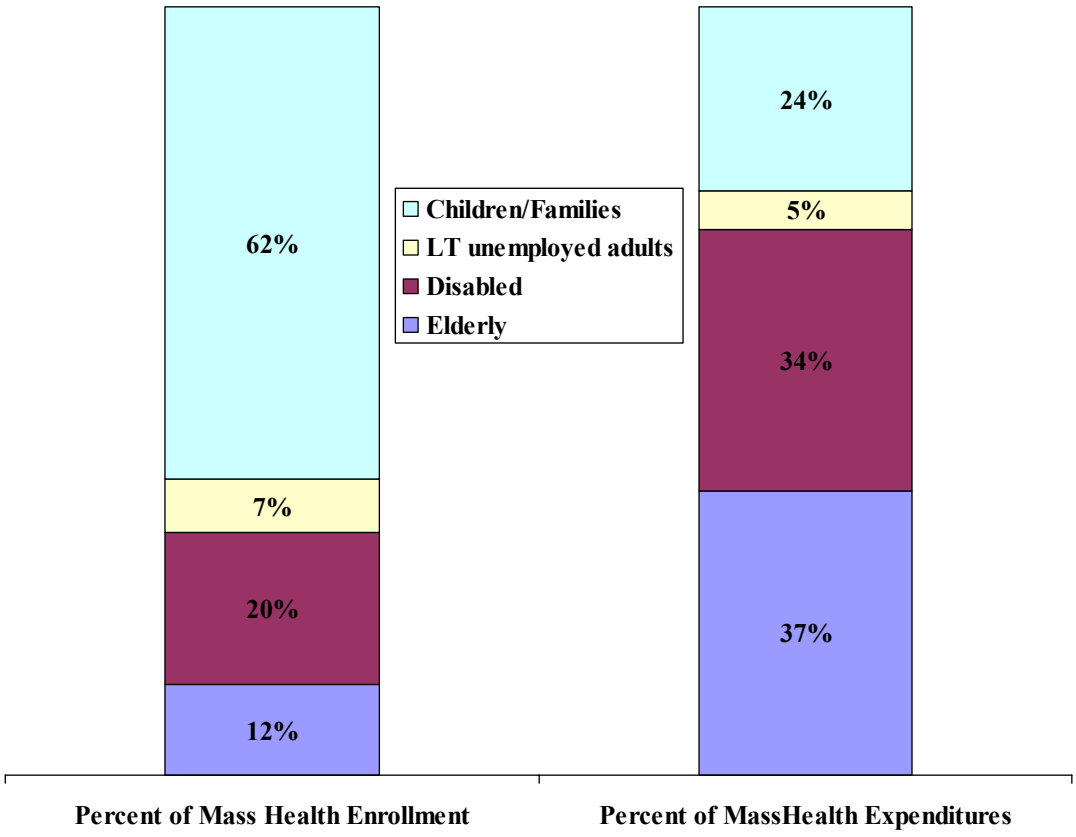
Childless adults appear to fall into two very different groups, with different health care needs and utilization patterns. As discussed below, the working or recently unemployed population tends to have fewer needs and lower costs, on average. The Basic population of long-term unemployed childless adults, on the other hand, has higher costs, with more chronic care needs that include substance abuse, mental health and other conditions, all of which obviously contribute to long-term unemployment. Yet even this population has relatively low cost compared with average Medicaid per capita spending for people with disabilities.

Long-term unemployed, low-income childless adults

Data from the Division of Medical Assistance -- as well as anecdotal evidence – indicate that the Basic population exhibits high health care needs, particularly in the areas of mental health, substance abuse, and mild but chronic disabling conditions that are not severe enough to qualify them for SSI-based CommonHealth, MassHealth's program for disabled persons. Further, the Basic population costs more than parents because, according to some observers, they tend to enroll when they need care, rather than as a preventive measure.

In FY 2002, the average Medicaid expenditure per long-term unemployed (childless adult) was $3,460, or 26 percent more than the $2,743 average per 'family' member, which includes both children and parents. Given that children are generally less expensive than adults, however, the actual difference in cost between childless adults and parents is smaller. Of course, the average expenditures for both of these populations were significantly lower than for the disabled Medicaid population ($8,723) or elderly ($17,515) – the latter groups are generally high-cost users and utilize expensive long-term care services, which are not part of the Basic benefit plan. Overall, the long-term unemployed childless adults comprised 7 percent of the MassHealth population, but only 5 percent of the cost (see Figure 1).

Figure 1. Enrollment and Expenditures, MassHealth FY 2002



Source: Division of Medical Assistance, in Mass. Health Policy Forum Issue Brief No. 15.

Inpatient and outpatient acute care hospital services, and prescription drugs comprised the most significant costs among the Basic population. In 2002, approximately 22,000 Basic enrollees used substance abuse program services. Compared with parents and children, the long-term unemployed childless adults used a much higher proportion of pharmacy benefits and a smaller proportion of acute care hospital and professional services.

Recently unemployed, low-moderate income persons

For the Medical Security Plan (recently unemployed persons up to 400 percent of FPL), the DET reported spending $1,516,749 on Direct Coverage benefits (excluding administrative costs) for a total of 11,009 covered lives in January 2003. This translates to $138 per month, or an equivalent of $1,653 per year. It spent $1,724,750 on Premium Assistance benefits for a total of 14,725 covered lives, or $117 per month, or $1,405 per year.

These figures include costs of covering children, who are generally less expensive than adults. The figures are significantly lower than the MassHealth family costs per member (and, as expected, much lower than MassHealth Basic costs per member). One explanation is that the higher income, more recently employed population is less likely to have long-term, chronic conditions. Another is that coverage may be less generous.

IMPACT OF COVERAGE

There is anecdotal evidence that coverage through MassHealth Basic and employer-sponsored insurance enables previously uninsured people to obtain primary care and needed pharmaceuticals, and reduce utilization of emergency room services. There is also anecdotal evidence that health outcomes are improved with coverage, and that coverage enables Family Assistance enrollees to obtain needed care and return to work sooner than they would without insurance, thereby improving productivity.

Implementation of MassHealth Basic, CommonHealth, and other waiver programs resulted in MassHealth providing coverage for some services previously provided by other state agencies such as the Department of Transitional Assistance and the Department of Mental Health. As a result, funds were freed up, enabling these agencies to broaden their programs, either by expanding eligibility to people at higher incomes, or by providing more services to existing beneficiaries. Officials suggest that Basic coverage also lessened the demand for services by the state's uncompensated care pool. The actual costs of the uncompensated care pool increased following the waiver's implementation, however, largely due to the enhanced publicity and streamlining of the application process, and the transition of immigrants (under federal rules) from Medicaid to the pool. In other words, additional policy changes, unrelated to Basic, strengthened the UCP and increased costs. Officials contend that there would have been a larger increase in the demand on the uncompensated care pool had Basic not been enacted; it is not clear, however, whether the mitigating effect was enough to cover the costs of the Basic program.

LESSONS LEARNED

"Surprises" or unintended consequences of program

When MassHealth Basic opened its doors, enrollment was much greater than it had anticipated. This is likely due to the great need for coverage among long-term unemployed, low-income childless adults, accompanied by a strong outreach campaign aided by community outreach grants to community-based organizations, and eligibility workers 'outstationed' at hospitals and other settings. With no enrollment cap, enrollment peaked in March 2001 at about 64,000 enrollees. The state was able to

handle the high enrollment and remain budget neutral because of the slower-than expected enrollment in the Family Assistance/Insurance Partnership.

The slow enrollment and growth of the premium assistance program may be related in part to its administrative complexity – keeping track of eligibility and tying each subsidy with the appropriate funding stream, ensuring health plans meet basic requirements, tracking employer contributions and calculating appropriate subsidy amount per individual, keeping up with changes in employment and income status, etc. A work group is currently looking at ways to improve the program and reduce the administrative burden. It is also considering whether the payments to employers, which have not been updated since the program's inception, provide enough of an incentive.

Dual treatment of childless adults

Massachusetts recognized that childless adults were not a homogenous group, and that more than one approach was needed, with workers (and recent workers) treated differently than non-workers, who have a higher likelihood of chronic conditions. Thus, it developed premium assistance programs for low-income workers (both childless adults and parents), and it developed a direct coverage program for the long-term unemployed (MassHealth Basic). However, one consequence of taking this dual approach was the virtual elimination of the more vulnerable program when budget pressures surfaced in 2002-2003. Long-term unemployed childless adults, perceived by some as "less-deserving" than workers or parents, were the first to lose coverage.

Certain stakeholders expressed that treating childless adults as a separate eligibility category is confusing and unfair. One suggested that it may be more equitable and simpler administratively to cover everyone up to 100 percent FPL in one program, regardless of age, parental or employment status.

Implications for federal policies

State officials do not think that the ability to expand coverage through state plan amendments (versus 1115 waivers) would encourage states to cover childless adults, because this route would require states to cover all mandatory services, and make the new coverage an entitlement. Some flexibility and constraints on spending are important to states. For example, the large differences in cost of living across states suggest that income-based eligibility should be state-appropriate.

Given the economic downturn, officials acknowledge that it will be a while before states have the courage and capacity to try new coverage for the childless adult population. Whereas an enhanced federal match would be helpful, coming up with the state's share and making that financial commitment are the biggest challenges for states.

Making premium assistance work

A premium assistance program that leverages employer and employee contributions may be a more feasible option than expanding public coverage during the current economic climate. It is important, notes a state administrator, for the federal government to allow the states to implement a premium assistance program for adults without requiring wrap-around coverage, which is administratively complex. On the other hand,

advocates contend that wrap-around coverage is essential to preventing loss of essential benefits and cost-sharing protections.

Even without wrap-around coverage, premium assistance programs can be administratively complex, and states should be aware of this. Massachusetts' experience indicates that it is easier to make payments directly to employees rather than employers directly. Another difficulty is obtaining information from employers about the coverage offered; it would be much easier if the states could *require* employers to provide such information.

Further complexity arises from frequent changes in jobs, income, and eligibility status. And finally, there exists much confusion among potential enrollees concerning the different eligibility status within a single family where each person may or may not be eligible for different programs. Also, to maintain the incentives for employers to offer coverage and for workers to accept coverage, subsidy levels should be reviewed and updated periodically so that they are in-synch with actual premiums in the private market.

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