Remarks for the New England Public Finance Conference
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Thank you. I'm honored to be here this morning as you begin what looks to be a very productive couple of days addressing the key public finance issues facing New England. Looking at the agenda, you will be hearing from some of the leading experts in the region and delving into the details of recent developments on the policy front as well as best practices in terms of new investment strategies.

I. Introduction: Fiscal challenges on the horizon

A key theme that underlies many of these sessions is how best to make use of the limited financial resources of the state given the large fiscal challenges on the horizon – whether it be funding pension liabilities, financing infrastructure improvements, investing in renewable energy projects, or addressing rising healthcare costs. Given the economic and demographic trends on the horizon, it does not seem likely that states will be able to "grow" their way out of facing these difficulties head-on—particularly in New England where population and employment growth has been slow in recent years. With limited options in terms of new revenue streams, these looming challenges will require innovative solutions as well as some difficult tradeoffs.

But more importantly, as states move to tackle these fiscal challenges there is a clear and immediate need for accurate and unbiased information that can be used to assess the magnitude of the problem, identify the tradeoffs involved, and develop feasible solutions. It's often difficult for policymakers to sift through the cacophony of statistics and reports issued by various interest groups to come up with a cogent analysis on a given issue. Conferences such as this that are educational, informative, and allow for the productive exchange of ideas on key issues play a vital role in filling that gap.

Similarly, I would be remiss if I did not call your attention to the work that my colleagues and I are doing at the New England Public Policy Center at the Boston Fed. Created in early 2005, the Center is dedicated to enhancing access to high-quality, clear, and objective analysis of the economic and policy issues confronting New England. To that end, we have been seeking new ways for the Federal Reserve Bank to reach out to policymakers and opinion leaders, to help them get the information and analysis they need to make informed decisions about economic policies. What does that mean practically speaking? Well, in addition to conducting our own independent research on policy issues affecting the region, we also respond to individual requests for assistance from policymakers and analysts such as yourselves.

We also host a conference every fall on a topic of particular importance to the region. This year's conference, "Financing Municipalities in New England: Revisiting the State-Local Relationship," will be held on December 5th here in Boston. Participants will investigate the fiscal relationship between New England's state and municipal

governments and discuss potential solutions that could help fiscally-strapped municipalities. Specifically, speakers will examine the design of municipal aid formulas and address the potential impact of adopting local option sales taxes.

II. What are the tradeoffs states face in expanding coverage?

No where is the need for clearly articulating the key issues, identifying difficult tradeoffs, and crafting innovative solutions more apparent than in the healthcare arena. Given that a comprehensive solution to the issue of health insurance coverage is unlikely to come through federal leadership any time soon, states are facing the challenge alone, and they are stepping up to the plate.

At the Federal Reserve Bank of Boston, we maintain a very active interest in health care issues as they are so vital to the country's and the region's future fiscal situation. Last year, the Bank hosted a conference on the cost, benefits, and policy alternatives for covering the uninsured in New England, bringing together the major stakeholders in health policy from around the region to engage in a productive dialogue on the challenges of reforming the health care system.

One of the key themes addressed at that conference was the difficulty of achieving universal (or near-universal) health insurance coverage with the reality of skyrocketing health care costs—even recognizing that the uninsured pose high costs that will only continue to increase if not managed in some way. Until recently, the question of how best to expand coverage was postponed while policymakers wrestled with the more immediate problem of how to contain healthcare costs.

Yet as the number and percentage of people without insurance continues to climb, many governors and state legislatures are making health insurance coverage a high priority. They are finding new ways to expand health coverage with impressive creativity and persistence and have embarked on new initiatives that vary widely in scope, innovation, and ambition. Some states are pursuing incremental changes, while others are opting for more ambitious new initiatives that aim for nothing less than universal health insurance coverage.

Understandably, the design and implementation of these new initiatives entails many tradeoffs that will require making some hard choices. How can states be successful in providing greater access to health insurance without having resolved the question of how to control the growth of health care spending? How can states provide affordable coverage without disrupting private insurance markets? And finally, how will states be able to sustain these reform efforts in the face of changing fiscal conditions or an economic slowdown?

III. How far do we have to go?

In order to make these hard choices, policymakers need to be equipped with the facts. To that end, the Boston Fed recently released a report exploring the progress being made in New England to achieve broader health insurance coverage. The report sheds light on the magnitude of the problem as well as the potential impact of initiatives currently being pursued in Maine, Massachusetts, Rhode Island, and Vermont. Much of the rest of my discussion will draw heavily from the material in that report.

So, how far do we have to go to achieve universal coverage in New England? Although the rate of uninsured in the region is lower than that of the nation, it has been increasing since 200, following national trends. As of 2005, the percentage of people without coverage in New England ranged from 9 percent in Massachusetts to 12 percent in Rhode Island compared to 15 percent nationwide. Still, this amounts to nearly 1.5 million New Englanders who lack access to affordable health insurance. Since 2000, their ranks have risen by 300,000—a 20 percent increase—and include middle-income households as well as those farther down the economic ladder.

Much of this increase is among the working-age population: 14 percent of them lack coverage in New England compared to 20 percent nationwide. This is primarily due to a decrease in the number of individuals who are insured through their employer, both nationally and here in New England. This is due in part to structural shifts in employment from full-time to part-time, from permanent to temporary and contractual, and from union to non-union—job statuses that are much less likely to come with health insurance benefits.

Moreover, high and rising healthcare costs, driven in large part by advances in medical technology, have led many firms to shift more of the premium cost to employees, raising worker contributions and making coverage unaffordable. Among those with access to employer-sponsored insurance who choose not to enroll, over half say that the required employee contributions were too high.

Yet research shows that the main reason uninsured workers lack coverage is that their employers do not sponsor health benefits. Since 2000, the share of private establishments offering health insurance coverage declined in every New England state except Connecticut. As of 2004, coverage in the private sector ranged from 50 percent of establishments in Maine to 69 percent in Connecticut, compared to 55 percent nationwide.

Fortunately, we've done a better job of covering our most vulnerable populations such as children, seniors, individuals with disabilities, and low-income families. Coverage through government-sponsored programs like Medicare, Medicaid and the State Children's Health Insurance Program has been steadily increasing. Currently 27 percent of the population gets its health coverage through a government program, up from 24 percent in 2000. Yet the sustainability of federal funding in the face of changing demographics and rising health costs is at best uncertain, as witnessed by the recent tussle between the white house and congress over reauthorizing S-CHIP. At some point,

federal policy makers will have to take seriously what will be increasing deficits caused by Medicare and Medicaid.

IV. What new initiatives are underway in NE?

Our region has led the search for remedies to the health coverage situation, moving beyond the debate at the federal level in seeking a practical solution to a very intractable problem. Over the past several years, four New England states—Maine, Massachusetts, Rhode Island, and Vermont— have enacted extensive reforms including new health insurance programs, often with the goal of achieving near-universal coverage.

The main thrust of these new initiatives has been to expand coverage in the individual and small group markets – often relying on public/private partnerships to provide coverage options. Unlike more incremental approaches, these new programs offer comprehensive coverage, including prescription drugs, to qualified enrollees. In order to make coverage affordable, cost-sharing is limited with low or no deductibles, small co-pays, and some coinsurance. Three states (Maine, Massachusetts, and Vermont) subsidize premiums for those earning less than 300 percent of the federal poverty level (FPL).[1] In an effort to boost participation, two of these states (Massachusetts and Vermont) have chosen to levy fees on employers that do not offer health insurance coverage. Massachusetts has gone so far as to mandate that individuals purchase coverage—either from the state, through their employer, or in the private market.

With the exception of DirigoChoice in Maine, most of these programs are still in the design stages or have only been partially implemented, so there is limited evidence to date on their effectiveness. Yet Maine's path to universal health coverage has been a rocky one. To date, DirigoChoice has enrolled roughly 14,000 individuals—less than one-half the enrollment goal of 31,000 for the first year. And although few individuals leave DirigoChoice, those who do are more likely to be young and healthy citing costs, inadequate benefits, and a feeling that "Dirigo wasn't going to last." In addition, costs under the program have been higher than anticipated reflecting greater enrollment among those qualifying for the most generous subsidies as well as among those with the greatest medical needs.

Finally, funding for the program is also in jeopardy as the program's financing mechanism has been criticized as too expensive and ineffective, resulting in a law suit brought by insurers against the state. In response, a Blue Ribbon Commission appointed by Governor Baldacci last year recommended replacing the current assessment on insurers with money from the general fund or possibly new revenues from higher sin taxes. The dispute over financing has also led the state to change which insurer it will partner with to provide benefits—as of January 2008 Harvard Pilgrim will step into that role as Anthem BCBS steps down.

[1] See Appendix Table 4 for 2007 federal poverty limits by household size.

Massachusetts made headlines nationwide in April 2006 when, after months of heated negotiations, former Massachusetts Gov. Mitt Romney signed into law landmark legislation designed to achieve nearly universal health care coverage among state residents. The unique provisions of the bill place the responsibility for coverage on the government, individuals, and employers alike by providing public subsidies to ensure affordability for low-income residents, creating a mandate requiring individuals to purchase health insurance, and imposing financial penalties on employers that do not offer health insurance coverage.

Components of the Massachusetts plan include the creation of two insurance programs. The first, Commonwealth Care, is a subsidized insurance program expected to serve over 200,000 uninsured individuals earning up to 300 percent FPL. As of June the program covered nearly 79,000 people. The second, Commonwealth Choice, is a non-subsidized insurance program for individuals and small employers that is expected to serve another 200,000 Massachusetts residents. The Commonwealth Health Insurance Connector will oversee both programs, serving as a bridge between eligible individuals, small employers, and health plans while also setting standards for minimum creditable coverage.

The most innovative component of the Massachusetts reform plan is the mandate requiring individuals who can afford health insurance to purchase it. The purpose of the individual mandate is to strengthen and stabilize the functioning of health insurance risk pools by making sure they include young and healthy people, who are more likely to go without insurance if it is not offered (and paid for) by their employer. Failure to do so will result in loss of their state personal income tax exemption in 2007 with larger financial penalties in 2008.

The final component of the Massachusetts health care reform plan is to require participation by employers. All employers with more than 10 full-time equivalent employees are required to make a "fair and reasonable" premium contribution towards the cost of their employees' health insurance. Interestingly, the greatest impact on employers will likely come from the imposition of the individual mandate. If more employees suddenly enroll in their employers' plans, it may significantly increase costs for those employers currently offering coverage and have large consequences for small businesses who may not have budgeted for such a cost increase.

More recently, we have seen health care reforms being implemented in both Rhode Island and Vermont as enrollment in new health insurance programs begin this month in both states. In Rhode Island, the state health insurance commissioner, working with insurance companies, has developed HealthPact RI—a more affordable insurance product for small businesses. To keep premiums low, the program offers financial incentives to enrollees who actively manage their own health care and use more cost-efficient providers. The state estimates that about 27,000 people, or about one-quarter of the state's 120,000 uninsured individuals who are eligible for the plan, will enroll.

In Vermont, private insurers have agreed to offer lower-cost, reasonably comprehensive policies to the uninsured meeting conditions mandated by the state in terms of benefit levels and cost-sharing. The new program, Catamount Health, is expected to serve roughly 25,000 uninsured individuals who meet certain income eligibility requirements. The state will subsidize premiums for program participants on a sliding scale up to 300 percent FPL. Like Massachusetts, the Vermont plan imposes financial penalties for employers who do not offer health insurance coverage, requiring employers that don't provide health insurance benefits to pay annual assessments of $365 per employee.

V. How feasible are these new initiatives? Remaining challenges to expanding coverage

Going forward, there are a number of tradeoffs that the New England states will face in their efforts to expand coverage. For example, policymakers will need to be cautious in setting subsidies for individual premiums, balancing the need to make coverage affordable while minimizing the potential for disruption in the group insurance market. In addition, negotiating premium discounts with insurers may prove difficult in the future if the state is unable to attract a large enough share of the individual and small-group market. Finally, many of the new programs rely on cooperation between states and insurers which can be difficult to sustain over time—particularly in states where there are few players in the private market.

Yet even with the best program design, there are other obstacles to overcome that are largely out of the hands of state policymakers. Given that previous public insurance expansions have shown that voluntary take-up rates are low, a key question is whether these programs will be able to attract enrollees and actually reduce the number of uninsured. Even states that have imposed employer and/or individual mandates cannot predict whether firms will opt to drop coverage and pay the fee or whether individuals will find coverage affordable relative to the individual penalty. Moreover, greater participation in health care coverage does not necessarily guarantee greater access to care.

An equally important concern is whether the current reforms will be sustainable in the long-run as economic and fiscal conditions change. New England states that have passed new insurance programs have had some unique sources of funding that helped provide seed money for new initiatives. However, even with improving fiscal conditions these programs may face significant shortfalls in future funding in the face of changing economic and fiscal conditions, rising health care costs and changing demographics. Moreover, changes in policy at the federal level that affect the financing and administration of both Medicaid and SCHIP also impose additional cost concerns for states.

VI. Conclusion

These questions are difficult to answer. The same answer may not work for every state, and the same solution may not work as well in one situation as it does in another. But there are valuable lessons we can learn from our experiences so far. Certainly the rest of the nation is watching to see how these reforms are implemented and learn from both the successes and challenges that each state will endure.

Yet despite these caveats and concerns, the New England states are forging ahead and the rest of the country is watching to see how these experiments will play out. Elements of these plans may be useful to other states interested in expanding coverage. Moreover, as these new programs are implemented, we will be able to monitor how individuals and firms respond to different benefit levels and premium costs in terms of take-up, crowd-out, and adverse selection. Understanding better how these factors affect enrollment and costs under these new programs will be important for discussions in other states and at the national level regarding how best to reduce the number of uninsured.

- As professionals specializing in pubic finance, you more than anyone, understand the old saw: "There ain't no free lunch"
- While it would be nice to find a "win, win, win" answer to our governments' most pressing problems, they rarely, if ever, exist
- Still, that's no reason to become so cynical as to conclude that intelligent, careful analysis of alternative solutions is a waste of time
- More than ever, policymakers need to understand clearly the tradeoffs they face; and people like you a me need to give them the best possible evidence concerning the terms of those tradeoffs. This is true whether one is looking at health care, business taxation, energy sources, casinos, or public transit.
- Now is the time for clarification, not obfuscation. We need tough, honest informed debate.
- If there is evidence out there that is relevant to a fiscal policy issue, policymakers should know about it. It should be presented to them in clear understandable terms.
- If there is not evidence out there but it could be obtained, then someone should go out and get it. The best indicators should be devised, not the simplest or ones that, valid or not, support only one side or are bogus but cloaked in an aura of scientificity
- If evidence cannot be obtained, then policymakers should not latch on to indicators just because they have been offered by contending interests. They have to understand that ultimately they must rely on their values, instincts, and common sense.
- No one said fiscal policy at any level of government is easy. But, analysts can ease the burden by offering dispassionate, honest clear analysis based on the best information available.
- And to this we say, "Amen"

Nobel prize for mechanism design has greatly enhanced our understanding of the properties of optimal allocation mechanisms in such situations, accounting for individuals' incentives and private information. The theory allows us to distinguish situations in which markets work well from those in which they do not. It has helped economists identify efficient trading mechanisms, regulation schemes and voting procedures. Today, mechanism design theory plays a central role in many areas of economics and parts of political science.

A number of pitfalls and tradeoffs remain as the New England states expand health insurance coverage. Some of these challenges can be ameliorated by incorporating specific elements into the design of the programs. Others are more macro in nature and are beyond the scope of the program or even beyond the control of the state.

In terms of program design issues, the devil is really in the details. Getting the incentives right is critical for the success of these initiatives. For example, can subsidies be set so as to make coverage affordable without disrupting the private market? Will insurance exchanges, such as the Commonwealth Health Insurance Connector in Massachusetts, be able to attract enough of the individual and small group market to keep premiums low? Given the experience in Maine, how can states sustain the public/private partnerships they were able to broker during the launch of these new programs to ensure their long-term viability?

Currently Maine, Massachusetts, and Vermont all subsidize individual premiums on a sliding scale for those earning below 300 percent of the federal poverty line. By lowering the cost of health insurance for low-income individuals, these states hope to encourage more families to purchase coverage while also reducing the financial burden of those who are currently insured. Yet, for those who are currently uninsured, these subsidies may not be high enough to encourage significant take-up. This has certainly been the experience in Maine where only 14,000 of an estimated 100,000 individuals eligible for the program have actually enrolled. On the other hand, these subsidies may be too high, causing some individuals to drop their current private coverage and opt for cheaper, publicly provided insurance. Approximately 60 percent of individuals signing up for DirigoChoice in Maine previously had coverage. This means that to some extent then, the reduction in the number of uninsured would be offset by those switching from employer-based coverage.

In an attempt to ameliorate this tradeoff, Massachusetts has implemented another approach to making coverage more affordable while being mindful of the impact on the private insurance market. The Commonwealth health Insurance Connector acts as an insurance exchange offering unsubsidized coverage from private insurance carriers to individuals and families, as well as small business, through the Commonwealth Choice program. Enrollees have four different levels of coverage to choose from, each with varying degrees of cost-sharing, and all the plans satisfy the state's requirements for minimum creditable coverage—e.g. they have the basic benefits the state considers essential for good coverage. Moreover, Massachusetts was able to provide the program while keeping insurance premiums affordable as mandated by legislation by negotiating discounts with insurers based on the first year's expected enrollment. It remains to be seen whether the Connector will actually be able to attract a large enough share of the market, with the expected risk profile, to be able to negotiate similar premium discounts with insurers going forward.

Finally, many of these new programs rely on some degree of cooperation between states and insurers that can be difficult to sustain over time—particularly in states with few players in the individual and small group insurance markets. For example, in Vermont

the initial premium rates for Catamount Health were based on benefit levels and cost-sharing set forth in the legislation. Yet the ultimate cost of the program to the state each year will depend on how closely the proposed premium rates submitted by insurers match the state's initial estimates. Because the law also stipulates individual premium contributions by income bracket, any gap between these contribution levels and the actual premiums charged by insurers will be borne by the state. The state is set to review the cost effectiveness of the private plans in two years and may choose to self-insure at that point, only relying on private insurers to administer benefits.

Even with the best program design, states face additional challenges as fundamental as whether these new programs will be able to attract enrollees and actually reduce the number of uninsured. Expanding coverage does not in itself ensure 100 percent participation. Indeed, voluntary take-up rates have been low in previous public insurance expansions, typically on the order of 50 percent, and can lead to greater crowding out of private insurance as individuals move up the income ladder. To boost participation among workers, Massachusetts and Vermont will levy fees on employers that do not offer health insurance coverage. Massachusetts goes one major step further, also requiring that individuals purchase coverage, whether from the state or their employer.

Yet states can do only so much to affect the behavior of employers and individuals. Among employers, firms may choose to pay the annual fee, thereby limiting the availability of employer-sponsored insurance. Among individuals, participation can be hindered by a number of factors, including a lack of knowledge about eligibility rules, the burden of application and enrollment procedures, and the level of perceived value of health insurance coverage. Moreover, young and healthy adults, after weighing costs and benefits, may choose to go without insurance and instead pay the individual penalty.

Second, greater participation in health care coverage does not guarantee access to care. Many low-income people cycle on and off health insurance throughout the course of a year, limiting their access to regular care. Other barriers, such as transportation costs, an inability to navigate the health care system, language and cultural differences, and racial/ethnic disparities in care all also serve to reduce access. Moreover, expanding access to care may be limited by the existing resources of the healthcare system such as the availability of community health centers to the number of primary care physicians accepting new patients.

Third, coverage expansion is subject to changing budget constraints. Between 2001 and 2004, states experienced severe fiscal stress, with revenues falling even as Medicaid spending and enrollment peaked. Many states responded by freezing provider payment rates, cutting benefits and restricting eligibility. The good news is that in FY 2006, state revenue growth exceeded Medicaid cost growth for the first time since 1998.

Yet it is unclear that current reforms will be sustainable over the long-run as economic and fiscal conditions change. Some of the insurance initiatives in New England had unique sources of funding, such as matching Medicaid funds, an uncompensated care pool, or a large tobacco settlement, to help provide initial seed money. Going forward,

states plan to rely on a variety of sources, including enrollee premium contributions, employer assessments, higher sin taxes, and general fund revenues. However, in the face of changing economic and fiscal conditions, rising health care costs and changing demographics, states may face significant shortfalls in future funding of these programs, even with improving fiscal conditions.

Finally, changes in federal policy that affect the financing and administration of both Medicaid and SCHIP impose additional cost concerns for states. President Bush's Vaeto… proposal for the upcoming reauthorization of SCHIP provides less than half of the funding states need to maintain their existing SCHIP caseloads, resulting in an estimated funding shortfall of $7 billion over the next five years.[2]

[2] Park, Edwin and Matthew Broaddus. 2007. "SCHIP Reauthorization: President's Budget Would Provide Less than Half the Funds that States Need to Maintain SCHIP Enrollment," Center on Budget and Policy Priorities, March.