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## MASSACHUSETTS HEALTH CARE REFORM: SIX YEARS LATER

### Executive Summary

In 2006, Massachusetts passed comprehensive health reform designed to provide near-universal health insurance coverage for state residents. Building on a long history of health reform efforts, the state embarked on an ambitious plan to promote shared individual, employer, and government responsibility. This brief examines Massachusetts' implementation efforts over the last six years and looks to what lies ahead under federal health reform.

### ***Massachusetts succeeded in expanding coverage to nearly all state residents.***

Within a year of implementation the state experienced an unprecedented drop in the number of uninsured and, despite the economic recession, continues to retain the lowest rate of uninsured residents in the country. While Massachusetts has sustained gains in coverage, the rate of uninsured has continued to climb nationally [Figure 1].

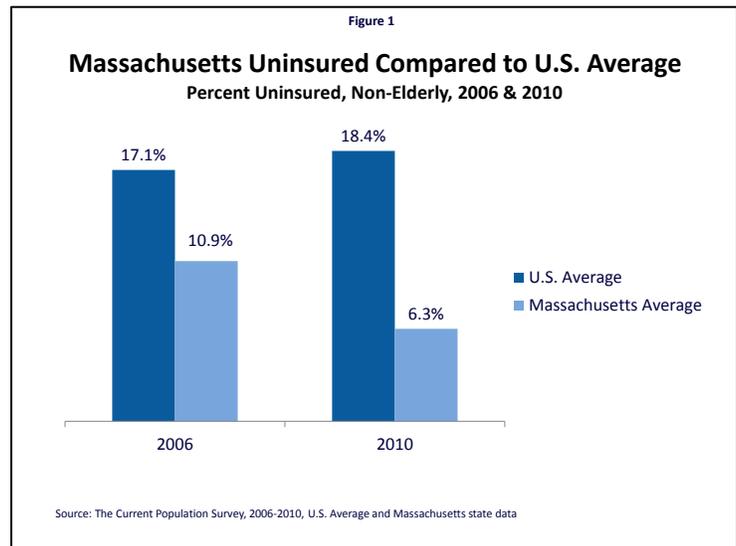
### ***Residents have experienced gains in access to health care services.***

More adults in Massachusetts receive preventive care services and report a usual source of care since health reform. With more residents gaining insurance coverage, demand for health care, particularly in underserved communities, has increased. Safety net providers have seen an increasing number of patients and the state continues to improve residents' access to care by expanding primary care provider capacity. The state has increased medical school enrollment for students committed to primary care and created loan repayment opportunities for providers in underserved areas.

***The state continues to struggle with rising health care costs.*** State health reform in 2006 purposefully focused on expanding coverage to residents while leaving the thornier task of cost containment for future years. As a result, affordability continues to be an issue. Per capita health spending is 15% higher than the national average and although premium growth has slowed in recent years, Massachusetts has the highest individual market premiums in the country. Legislation focused on comprehensive provider payment reform and endorsed by the Governor is currently pending in the state's legislature.

### ***Massachusetts must make some changes in order to fully comply with federal health reform.***

While federal reform was modeled on the Massachusetts experience, key differences remain. As a result, implementation of federal reform will require significant interagency coordination, the potential shifting of existing programs, and the creation of new information technology systems. Having demonstrated that state reform efforts can reduce the number of uninsured, Massachusetts offers important insights into the potential of federal health reform.



## Introduction

In 2006, Massachusetts passed comprehensive health care reform designed to provide near-universal health insurance coverage for state residents. Building on a long history of health reform efforts and on a strong stakeholder commitment to reform across both public and private sectors, Massachusetts embarked on an ambitious plan to promote shared individual, employer, and government responsibility. Through a series of reforms, including the expansion of public programs and the creation of a health insurance exchange, Massachusetts succeeded in expanding coverage to nearly all state residents.

Within a year of implementation the state experienced an unprecedented drop in the number of uninsured and, despite the economic recession, continues to retain the lowest rate of uninsured residents in the country. While Massachusetts has managed to sustain the gains in coverage made under health reform, the rate of uninsured since 2006 has continued to climb nationally.

However, the state still struggles to control the growth of health care costs. State health reform purposefully focused on expanding coverage to residents while leaving the thornier task of cost containment for future years. Escalating health care costs are not unique to Massachusetts, nor are they driven by the state's health reform efforts, yet increasing costs have created a significant burden for employers, public programs, and consumers.

The state is now simultaneously moving to address cost containment through provider payment reform and preparing for the implementation of federal health reform. While much of the Affordable Care Act (ACA) was modeled on Massachusetts reform, the state must still make significant changes before 2014 in order to fully comply with the new provisions. Given the parallels between Massachusetts' health reform and federal reform, the state's experience can provide valuable insights into the future of ACA implementation.

## Overview of Massachusetts Health Reform Components

The Massachusetts health reform law established new structures and requirements to promote the expansion of health insurance coverage in the state.

*Commonwealth Health Insurance Connector:* The Connector is the health insurance exchange website through which residents can access both subsidized and non-subsidized private health insurance. The subsidized coverage is offered through the Commonwealth Care Health Insurance Program and the non-subsidized coverage is offered through the Commonwealth Choice Health Insurance Program. The Connector is governed by an 11-member Board which operates as an independent state agency. The Connector Board includes representatives of business, labor, and consumers, as well as content experts.

- The Commonwealth Care Health Insurance Program provides sliding-scale *subsidized* health coverage for individuals with incomes below 300% of the Federal Poverty Level (FPL). Individuals up to 150% FPL are eligible for fully subsidized coverage through the program. By the fall of 2011, over 158,000 low-income adults were enrolled in

Commonwealth Care plans and more than four out of five members reported high levels of satisfaction with the program.<sup>1</sup>

- The Commonwealth Choice Health Insurance Program provides *non-subsidized* insurance that meets certain coverage and cost standards. The Connector Board approves all participating Commonwealth Choice plans. In 2012, eight insurers offered plans within the state's approved benefit designs (bronze, silver, and gold). As of August 2011, almost 40,000 residents were enrolled in Commonwealth Choice plans.<sup>2</sup>

*Insurance Market Reforms:* Prior to 2006, Massachusetts enacted several reforms to the private insurance market including, requiring guarantee issue, whereby insurers have to issue plans to any eligible applicant regardless of health status, and community rating, which allows for only limited variation of policy price within a given area and prohibits insurers from charging people more based on their health status or claims history. As part of health reform, the state created coverage and affordability standards- defining what is considered minimum credible coverage and the maximum amount residents are expected to pay for it. In addition, the state also merged the individual and small group markets into a single risk pool.

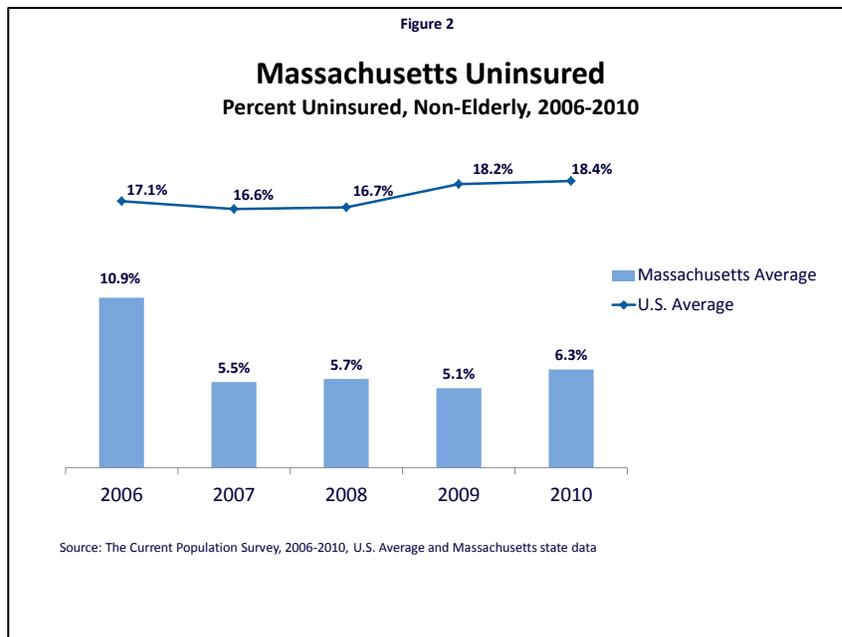
*MassHealth Expansion:* The state's Medicaid and Children's Health Insurance Program (CHIP) was expanded to cover children with family incomes up to 300% FPL (\$32,670 for an individual and \$67,050 for a family of four in 2011). Enrollment caps on existing Medicaid programs for adults were also raised. While most of the growth in MassHealth since health reform has been within eligibility categories that existed prior to 2006, it is estimated that approximately 61,000 residents are receiving coverage as a result of the expansion.<sup>3</sup>

*Employer Requirements:* Employers with 11 or more employees must contribute toward health insurance coverage for their employees or pay a "Fair Share" contribution of up to \$295 annually per employee. Employers are also required to offer a "cafeteria plan" that permits workers to purchase health care with pre-tax dollars or face a free-rider surcharge if employees make excessive use of uncompensated care. Evidence suggests employers have maintained coverage and benefit levels since the state's implementation of health reform and the vast majority of residents continue to receive coverage through the private group market.

*Individual Mandate:* All adults in the state are required to purchase health insurance or face a financial penalty of up to 50% of the lowest cost premium an individual would have qualified for through programs offered by the Connector. The mandate does not apply to individuals with incomes below 150% FPL or others who face substantial financial hardship as a result of purchasing insurance. Those with religious objections are also exempt. In 2009, approximately 4 million adults complied with the mandate and only 1% of the state's taxpayers paid a penalty. Seventy percent of people uninsured for any part of the year were not subject to the penalty.<sup>4</sup>

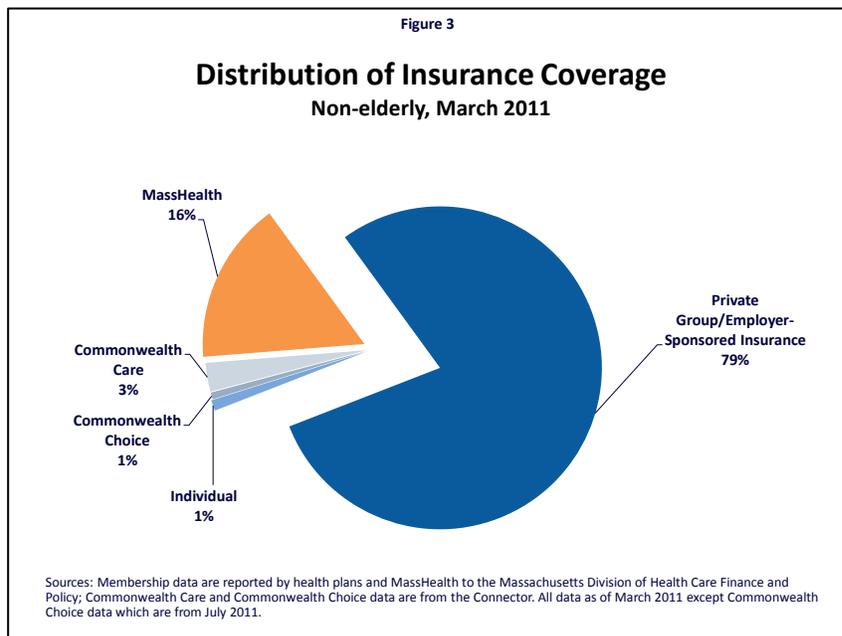
**Coverage Trends**

While existing surveys have generated varying estimates of the number of Massachusetts' residents who are uninsured, most available state and national survey data show Massachusetts' uninsured rate dropping by approximately half following the implementation of health reform. Further, the state's uninsured rate consistently ranks lowest in the country. According to the Current Population Survey, the uninsured rate for non-elderly



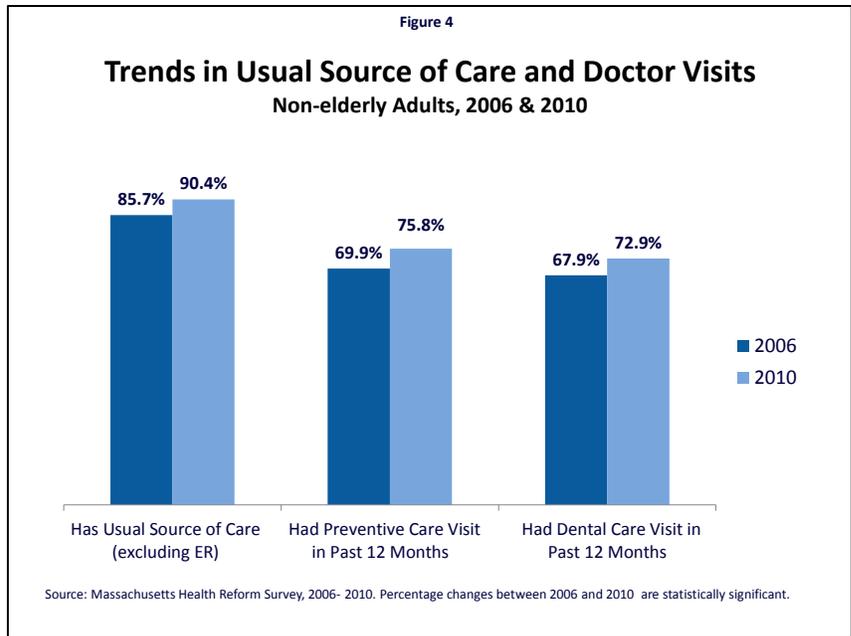
residents in Massachusetts dropped from 10.9% to 5.5% in the year following reform, while national data for the same period show a drop of less than one percent [Figure 2]. The uninsured rate remained low throughout the early years of the economic recession; however, there was a slight uptick in the number of uninsured in 2010. This may be explained by a near doubling of the state's unemployment rate from 2008 to 2010 (4.6% to 8.8%).<sup>5</sup> Data from the Massachusetts Health Insurance Survey also show that low income residents in the state (below 300% FPL) are more likely to be uninsured than higher income residents, despite qualifying for Commonwealth Care.<sup>6</sup> Nationally, the number of uninsured nonelderly Americans increased by nearly a million people between 2009 and 2010.

Gains in coverage since health reform have been most notable for non-elderly adults through Commonwealth Care and Commonwealth Choice. However, employer-sponsored insurance remains the dominant source of coverage for Massachusetts residents [Figure 3].<sup>7</sup> Since the economic recession, MassHealth enrollment has increased but there is no evidence that public coverage is "crowding out" employer-sponsored health insurance.



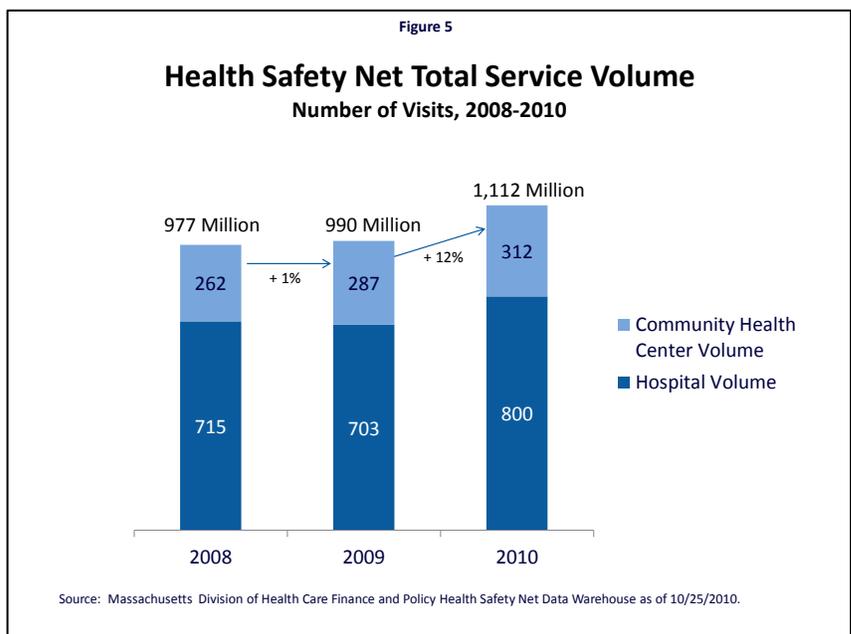
**Health Care Access and Affordability**

Ensuring access to health care services is critically important for comprehensive health reform. Results from the Massachusetts Health Reform Survey show that non-elderly adults reported sustained gains in health care access and use between 2006 and 2010 [Figure 4]. Greater percentages of adults received preventive care visits and reported a usual source of care than before health reform. The number of unnecessary emergency department visits and hospital inpatient stays fell, suggesting improvements in health care delivery. In the same period, fewer adults reported high out-of-pocket spending and unmet needs for care because of costs. However, affordability continues to be an issue with nearly half of the uninsured reporting having access to employer coverage but not enrolling due to costs.<sup>8</sup>



As more residents enroll in insurance coverage, the demand for health care- particularly in underserved communities- has increased. Safety net providers such as community health centers and safety net hospitals experienced a 12% increase in patient volume from 2009 to 2010- with almost 100,000 more visits to safety net hospitals during that time [Figure 5]. Visits to community health centers rose by 50,000 between 2008 and 2010. Additionally, an increased demand coupled with a decline in payments to safety net hospitals has strained providers who experienced a \$70 million shortfall in 2010.

The supply of primary care physicians in the state continues to be an issue, with about one in five adults reporting problems finding a doctor who would see them in 2009, either because the provider was not taking new patients or did not accept the patient’s insurance. To address this problem, the state has



begun to pursue a number of initiatives to increase provider capacity including, primary care physician recruitment programs, expanded medical school enrollment for students committed to primary care, and a public-private program to repay loans for physicians and nurses who agree to practice in underserved areas.<sup>9</sup>

### **Outreach and Enrollment**

Over the years Massachusetts has undertaken aggressive outreach and enrollment efforts successfully utilizing broad networks of community partners in the state. During the first four years following reform, the state awarded \$11.5 million in grants to community health centers, hospitals, and non-profits to assist residents in obtaining coverage. While the state did not include additional appropriations for outreach in the 2012 budget, private foundations continue to provide funding for outreach and enrollment programs. Community partners and providers can assist residents in applying for coverage through a “Virtual Gateway” system that determines eligibility for MassHealth, CHIP, and Commonwealth Care. Six in ten families have enrolled in public coverage with the assistance of a community-based partner or provider.<sup>10</sup> Early enrollment in Commonwealth Care was jumpstarted by the state automatically enrolling residents who had received uncompensated care at hospitals or community health centers.

Massachusetts has continued to adopt enrollment simplifications and make greater use of technology, which state officials report was critical for keeping pace with applications since health reform. In 2012, the state secured approval via a waiver to begin an “Express Lane Eligibility Program” to reduce the rate at which eligible residents lose coverage in MassHealth at the point of renewal. The program will facilitate renewed eligibility for parents with children in the Supplemental Nutrition Assistance Program. This type of program has been used successfully in several states to renew children’s coverage, but this will be the first time it is used for parents.

### **Health Reform Financing**

The current economic recession has led to a steep decline in state revenues as well as significant increases in enrollment for public programs. Despite these constraints, popular support for health reform remains high and the state continues to commit financially. For fiscal year 2012, the state appropriated \$1.3 billion in funding for health care reform and the health safety net. In December 2011, the Centers for Medicare and Medicaid Services renewed the state’s Medicaid 1115 waiver for \$26.75 billion over three years. The waiver is the primary source of funding for subsidies provided through Commonwealth Care. With an operating budget of approximately \$32.5 million the Connector is financially self-sustaining through fees assessed on all health benefit plans offered through the Exchange. In April 2012, the Massachusetts Taxpayers Foundation estimated that additional state spending attributable to health reform accounted for 1.4% of the state’s budget in fiscal year 2011.<sup>11</sup>

### **Cost Containment**

Massachusetts made the decision in 2006 to focus health reform on expanding insurance coverage not on controlling health costs. As a result, rising costs remain a serious problem. Per

capita health spending is 15% higher than the national average and the state has the highest individual market premiums in the country at an average of \$437 per person per month. Over the past year however, premium growth in the individual and small group market has slowed markedly, possibly the result of decreased consumer utilization following the recession and increased pressure by state regulators on the industry. Fee-for-service payment methods dominate throughout the state and make it difficult for providers to coordinate care or deliver more cost-effective services.<sup>12</sup> Given the size of the health care sector and the concentration of highly specialized medical personnel and academic medical centers in the state, it has been difficult for Massachusetts to control health care costs. Nearly one in five households in the state has earnings from a health-care related job.<sup>13</sup>

Massachusetts passed additional health reform legislation in 2008, to initiate cost containment and delivery system improvements. The legislation included new requirements on statewide adoption of electronic medical records by 2015; a standard for uniform billing and coding among health care providers and insurers; a ban on gifts to physicians from pharmaceutical companies; a ban on payment to providers for “never events”; and implementation of a program educating providers on the cost-effective utilization of prescription drugs. The legislation also required annual public hearings with providers to investigate cost drivers and recommend cost-reduction mechanisms.

As part of the state’s cost containment efforts, the legislature also created a Special Commission on the Health Care Payment System. In 2009, the Commission released final recommendations on the development of a transparent payment methodology and endorsed a shift away from a fee-for-service system where providers are paid per visit and procedure, to a global payment system where providers work together to share the responsibility for the patient’s care.<sup>14</sup> The Commission anticipated that when fully implemented, a global payment model would provide appropriate incentives for the delivery of services and include the development of Accountable Care Organizations with a strong focus on primary care.

Building on recommendations from the Commission, Governor Deval Patrick (D) proposed legislation in February 2011, which encourages the formation of integrated care organizations and moves toward comprehensive payment reform, gradually shifting most state employees, MassHealth beneficiaries, and Commonwealth Care enrollees to global payments for all services a patient receives. In May 2012, the Massachusetts Legislature introduced and began debating new cost containment legislation. With health care as the state’s largest industry, any shift in provider payment structure could have broad implications for the state’s economy.

### **Federal Health Reform**

The reforms adopted in Massachusetts became the model for comprehensive federal health reform enacted in March 2010. Federal reform aims to expand health insurance coverage nationally through many of the same mechanisms employed in Massachusetts. Most similarly, the ACA requires significant reform of the private insurance market- requiring guaranteed issue and community rating by 2014- as well as requiring the creation of state-based health insurance exchanges which will allow consumers to compare standardized benefit packages.

While the similarities between Massachusetts health reform and the ACA are numerous, key differences remain and the state must make some significant changes before 2014 in order to fully comply with the new provisions [Table 1]. The ACA will alter eligibility and enrollment for MassHealth and Commonwealth Care, requiring the creation of a seamless ‘no wrong door’ system with the capability to perform online eligibility determinations and enroll individuals in coverage. Building this system will require additional coordination between the state’s Medicaid agency and the Connector. In addition, the broad expansion of Medicaid eligibility under federal health reform (up to 138% FPL) will affect many residents currently enrolled in Commonwealth Care. As Massachusetts prepares for the full implementation of federal health reform, the structure of the state’s already existing benefit programs may have to change.

Notably, some benefits in the state will be enhanced under federal reform such as the expansion of subsidy assistance to individuals and families with incomes from 300% to 400% FPL in the Exchange, the extension of insurance protections to consumers enrolled in self-funded employer plans, and the extension of federal premium subsidies to legal immigrants. In 2009, due to budget shortfalls, Massachusetts ended coverage for legal immigrants through Commonwealth Care, though a recent state Supreme Court ruling will require Massachusetts to restore this coverage. Beginning in 2014, federal funds will begin to subsidize coverage for this population, as well as others currently supported through state funds.

While some benefits will improve under federal health reform, others may be reduced. Federal subsidies to purchase coverage in the Exchange will be less generous than those residents currently receive through Commonwealth Care. Under Commonwealth Care, individuals up to 150% FPL do not contribute towards their premium. However under federal reform, an individual’s expected contribution to the insurance premium will range from 2-9.5% depending on household income (up to 400% FPL). For example, an individual earning about \$16,000 now receives coverage through Commonwealth Care with no premium, but in 2014 under the federal law would be required to pay an annual premium of \$530 or about 3.4% of the individual’s income. The state may consider several options for ensuring more affordable premiums. It can restructure Commonwealth Care into a Basic Health Program, which could reduce health insurance premiums for enrollees with incomes between 139-200% FPL, or it can provide premium subsidies in addition to the federal ones, paid for with state-only dollars.

## **Conclusion**

After six years of implementing an ambitious health reform initiative, Massachusetts has clearly demonstrated the potential for reducing the number of uninsured through strong stakeholder commitment and by embracing a model of shared responsibility. With the lowest rate of uninsured in the country, the Massachusetts experience became the model for federal health reform. However, major challenges still lie ahead for a state struggling to contain the growth of health care costs. As those within Massachusetts continue to debate the most appropriate way to slow health care spending, other states moving forward with the implementation of federal reform, can draw on some of the state’s early successes and challenges.

**Table 1: Overview of the ACA and Massachusetts Health Reform Major Components**

	<b>Massachusetts Health Reform</b>	<b>Affordable Care Act</b>
Insurance Market Reforms	The state requires guarantee issue, community rating, and created coverage and affordability standards. The state also merged the individual and small group markets into a single risk pool.	The ACA requires guaranteed issue, community rating, and the creation of coverage standards through the essential health benefits by 2014. Early market reforms are already in effect, including the expansion of dependent coverage to age 26 and the elimination of lifetime limits.
State-based Exchange	The Connector was established as a marketplace for individuals and small businesses to compare and purchase private insurance which meets certain coverage and cost standards.	State Exchanges will be a marketplace for low to moderate income individuals and small businesses to compare and purchase private health insurance which meets certain coverage standards.
Subsidies for Private Coverage	Commonwealth Care provides subsidized private health coverage on a sliding scale for individuals with incomes up to 300% FPL. Individuals with incomes below 150% FPL are eligible for fully subsidized coverage. For those between 150-300% FPL, individual monthly premiums range from \$39- \$116.	Premium subsidies will be provided on a sliding scale for individuals with incomes up to 400% FPL to purchase private insurance in an Exchange. Cost-sharing subsidies will be available for those up to 250% FPL. An individual’s expected contribution will range from 2-9.5% depending on household income.
Expansion of Public Coverage	Medicaid was expanded to cover children with family incomes up to 300% FPL. Eligibility levels for adults (parents –133% FPL, pregnant women– 200% FPL and long-term unemployed –100% FPL) remained the same, though enrollment caps for certain Medicaid programs for adults were raised.	Medicaid will be broadly expanded to all individuals under age 65 with incomes up to 133% FPL (plus a 5% automatic income disregard) based on modified adjusted gross income.
Individual Coverage Requirement	Individuals must have health insurance or face a financial penalty of up to 50% of the lowest cost premium an individual would have qualified for through the Connector.	Individuals must have health insurance or face a financial penalty of \$695 per year up to a maximum of 3 times that amount per family or 2.5% of household income- whichever is greater.
Employer requirements	Employers with 11 or more employees are required to provide insurance or pay a “Fair Share” contribution of up to \$295 annually per employee. Employers are required to offer a “cafeteria plan” that permits workers to purchase health care with pre-tax dollars or face a “free-rider surcharge” if employees make excessive use of uncompensated care.	Employers with 50 or more full-time employees that do not offer coverage are required to pay a fee of \$2,000 per employee, excluding the first 30 employees. Employers with over 200 employees must automatically enroll employees into plans offered by the employer. Employees may opt out of coverage.

**Endnotes**

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