



Forum Session Meeting Announcement

Tuesday, June 20, 2006
11:45am–12:15pm — Lunch
12:15–2:00pm — Discussion

Health Care for All in Massachusetts: Implications for a Changing Safety Net

A Discussion Featuring:

John Holahan

Director, Health Policy Research Center
The Urban Institute

Andrew Dreyfus

Executive Vice President, Health Care Services
Blue Cross Blue Shield of Massachusetts

William Walczak

Chief Executive Officer
Codman Square Health Center

Location

Hyatt Regency on Capitol Hill
400 New Jersey Avenue, NW
Capitol A Room

Registration Required

Space is limited. Please respond
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Health Care for All in Massachusetts: Implications for a Changing Safety Net

OVERVIEW

The recent passage of Massachusetts health reform has reignited national discussions about how to provide care to people who do not have health insurance. The Massachusetts governor and legislature, with considerable input from residents and from the insurer and provider communities, developed a plan to expand insurance coverage to most of the commonwealth's uninsured. The strategy involves a gradual shift from direct financial support of the hospitals and community health centers that comprise the safety net to expanded insurance coverage for individuals. How the new approach in Massachusetts plays out will depend on the adequacy of financing and on the participation of individuals, providers, employers, and insurers. Even before its success can be evaluated, the Massachusetts experiment presents an opportunity for policymakers to examine the types of trade-offs that were needed to bring all stakeholders together to address the goal of universal coverage.

SESSION

Massachusetts Governor Mitt Romney signed landmark legislation in April that will extend health insurance coverage to most Massachusetts residents.¹ (See the Appendix for a summary of major components of the law.) Massachusetts has a history of grassroots advocacy for vulnerable populations and legislative initiatives to cover the uninsured.² Many will recall the passage in 1988 and subsequent repeal of “play or pay” legislation to impose an employer mandate to provide coverage. The more recent effort builds on this history and on analyses funded by the Blue Cross Blue Shield (BCBS) of Massachusetts Foundation. Powerful political players were actively involved in forging an approach that includes something for everyone: well-established safety net providers, mainstream provider groups, employers, and insurers, as well as residents who lack health insurance. Ensuring that the law benefits a range of providers and insurers may be particularly important in Massachusetts because its economy is so dependant on the health care industry—one stakeholder’s cost is another’s income. Although questions remain about the implementation of the plan and its potential for success, there seems to be widespread agreement that the law itself is an achievement to be celebrated.

The commonwealth’s commitment to providing health care to its residents is reflected in its broad Medicaid (known as MassHealth) coverage and a free care pool that reimburses providers for uncompensated care.³

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Boston is home to the first community health center (CHC), established 40 years ago to fill a primary care void when physicians exited certain neighborhoods. Now, the city boasts a strong safety net with many of its CHCs supporting electronic medical records that are linked with Boston Medical Center. The commonwealth has a total of 53 CHCs dedicated to ensuring access for underserved populations.

Massachusetts' history of supporting care for the low income and uninsured was important to the passage of the health reform legislation, but the reform efforts were especially urgent given the possible loss of \$385 million in federal Medicaid funds. The commonwealth's Medicaid section 1115 demonstration project, originally implemented in July 1997, was extended in 2004 only on condition of restructuring the payments for uncompensated care that had been established under the demonstration waiver. The \$385 million represented the federal government's share of these payments. Redirecting free care pool funds from providers to individuals through insurance coverage is expected to meet the terms and conditions of the demonstration and ensure the continuation of federal funding.⁴

Although the Massachusetts reform effort makes a conscious shift from supporting institutions to supporting individuals, part of the compromise in the law centered on continued support for safety net providers—primarily Boston Medical Center and Cambridge Health Alliance. These providers will continue to receive uncompensated care payments in the short term, which are designed to hold them financially harmless to the reform changes. In fact, their financial condition may be bolstered because the health plans offered by these two hospitals will be among the four plans initially eligible to offer newly subsidized insurance products to low-income individuals. Boston Medical Center and Cambridge Health Alliance, along with all other providers, also will benefit from substantially higher Medicaid payment rates that were included in the law.

The availability of acceptable, affordable insurance products will be critical to the success of the commonwealth's law. Several features were designed to reduce the cost of coverage for individuals. These include enabling employees of small firms to purchase coverage with pre-tax dollars, subsidizing private insurance for low-income residents, and implementing health insurance market reforms. Individuals who do not obtain insurance will face a financial penalty if affordable products are available. Employers with more than 10 workers will face an annual per-worker assessment if they do not provide coverage. They will also be assessed a surcharge if their employees receive a significant amount of health care funded by the free care pool.

This Forum session focuses on the Massachusetts health reform experience and options to expand access to health care coverage for the growing number of Americans without insurance. Many have argued that the situation in Massachusetts was unique and that the commonwealth cannot be used as a model for reform in other places. Indeed, Massachusetts

has a considerably smaller uninsured population than the national average, a record of broad-based Medicaid coverage and strong safety net providers, and an economic reliance on health care as an industry, which may have increased public awareness of the plight of the uninsured. Nonetheless, what may be universal in efforts to cover the uninsured is ensuring that all stakeholders walk away from the bargaining table with something.

SPEAKERS

John Holahan, head of the health care team at the Urban Institute, will set the stage for this discussion. The Urban Institute, under contract to the BCBS of Massachusetts Foundation, developed *Building the Roadmap to Coverage*.⁵ The *Roadmap* analyzed various building blocks to achieve universal coverage and simulated the cost and coverage impacts of each option. **Andrew Dreyfus**, executive vice president of health care services for Blue Cross Blue Shield (BCBS) of Massachusetts, will bring his unique perspective to the conversation. Prior to his current position, Mr. Dreyfus was with the BCBS of Massachusetts Foundation and was instrumental in the development of the theoretical underpinnings of the Massachusetts approach. He will present the perspective of the largest private insurer in the state and will discuss the role of the insurance industry in ensuring the success of this endeavor. **William Walczak** is the chief executive officer of the Codman Square Health Center, a CHC in the Dorchester neighborhood of Boston. He will discuss the potential effects of the Massachusetts law on his organization and clients, how safety net providers will need to change, and whether there are likely to be holes in the safety net.

KEY QUESTIONS

- The Massachusetts reform law envisions a reallocation of funds over time from paying providers to care for the uninsured to helping individuals purchase insurance coverage. What was needed to reach consensus on this overall approach to covering the uninsured? What will need to happen to ensure that this law reduces the number of uninsured in the commonwealth? What factors could threaten the success of this law?
- Insurers—those with Medicaid contracts and those with private products—are expected to develop low-cost plans for people currently without coverage. Subsidies for these plans aim to lower premiums for low-income residents. Will the subsidies be enough to ensure take-up of the new plans? How will these plans be designed to be priced at an affordable level? Under these plans, will provider payments be sufficient to attract mainstream providers?
- Payments to Boston Medical Center and Cambridge Health Alliance for uncompensated care will continue at the same time that the state

will incur the added costs of an expanded Medicaid program and subsidizing new insurance products. Why was it necessary to continue to support the safety net providers while expanding insurance coverage? Will the uncompensated care pool be allowed to shrink over time?

- Individuals who are provided health care services through insurance coverage may choose to use different providers and services than those who receive care through the uncompensated care pool. How will this affect the traditional safety net providers? How will it affect mainstream providers? With more people insured, how will the use of services and overall health care spending be affected? What cost controls are contemplated?

ENDNOTES

1. Massachusetts State Legislature, *Acts of 2006*, "An Act Providing Access to Affordable, Quality, Accountable Health Care," chapter 58; available at www.mass.gov/legis/laws/seslaw06/s1060058.htm.
2. Health Care For All, an organization dedicated to universal, comprehensive health care, and the Greater Boston Interfaith Organization, a group of religious leaders and faith communities committed to social justice, among others, played an important role in elevating and maintaining focus on the uninsured.
3. See, for example, John F. Hoadley *et al.*, "Community Report: Boston, Massachusetts, Health Care Market Stabilizes, but Rising Costs and State Budget Woes Loom in Boston," Center for Studying Health System Change, Community Report 12, Fall 2003, available at www.hschange.org/CONTENT/611; and Aaron Katz *et al.*, *Community Report: Boston, Massachusetts, Blue Cross Influence Grows in Boston as State Revisits Reform Debates*, Center for Studying Health System Change, Community Report 11, December 2005, available at www.hschange.org/CONTENT/802/.
4. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid, Section 1115 Waiver Amendment, submitted May 1, 2006; for more information see www.mass.gov/?pageID=eohhs2modulechunk&&L=1&L0=Home&sid=Eeohhs2&b=terminalcontent&f=eohhs_cms_waiver_chunk&csid=Eeohhs2.
5. John Holahan *et al.*, *Roadmap to Coverage: Synthesis of Findings*, Report for the Blue Cross Blue Shield of Massachusetts Foundation, October 2005; available at www.urban.org/UploadedPDF/411327_roadmap_synthesis.pdf.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

APPENDIX

Massachusetts Health Reform: An Act Providing Access to Affordable, Quality, Accountable Health Care

Massachusetts health reform relies on several building blocks to extend health insurance coverage to the widely estimated 550,000 uninsured residents of the commonwealth.* Through mandates to both employers and individuals, the law is intended to achieve near-universal coverage. Reforms are structured to maintain federal Medicaid funds that had been used to pay for uncompensated care. New state funding is also included.

Medicaid

Enrollment in the commonwealth's Medicaid program, called MassHealth, is expected to increase by 198,500 beneficiaries. People who are eligible for, but not enrolled in, MassHealth will be encouraged to sign up for the program. Under the Act, Medicaid eligibility for children will be expanded to include children in families with incomes up to 300 percent of the federal poverty level (FPL), which is \$49,800 for a family of three in 2006. MassHealth provider payment rates will also be increased.

Employer Mandate

The commonwealth intends for employer-sponsored insurance to remain the cornerstone of coverage. Employers with more than ten employees will be required to offer their employees health insurance, although they will not be required to contribute to its cost. They must implement a section 125 cafeteria plan to allow employees to purchase insurance with pre-tax dollars. If they do not offer such a plan, they will be assessed an annual per-employee "fair share contribution" of \$295. A "free rider" surcharge will be required of employers with more than ten employees whose

employees use free care services above a certain level during the year.

Individual Mandate

Starting July 1, 2007, individuals will be required to obtain insurance coverage, if affordable plans are available. Employees that have access to employer-based coverage must take this coverage. All others will need to purchase coverage on their own. The availability of affordable plans will be facilitated by insurance market changes and the state-sponsored entity called the Connector (see next page).

A new program, called Commonwealth Care, will provide premium assistance on a sliding scale basis for those making less than 300 percent of the FPL who are not eligible for MassHealth. For those making less than 100 percent of the FPL (\$9,600 for an individual), premiums and cost sharing will be waived entirely. About 150,000 people are expected to receive assistance through Commonwealth Care. For the first three years, plans for these low-income people can only be offered by one of the four managed care organizations with current Medicaid contracts. After that time, other insurers will be allowed into this market.

The individual mandate will be enforced via the state's tax code, with those deemed able

Appendix / continued ►

* Conference Committee Report, "Health Care Access and Affordability," April 3, 2006, available at www.mass.gov/legis/summary.pdf; and Massachusetts State Legislature, *Acts of 2006*, "An Act Providing Access to Affordable, Quality, Accountable Health Care," chapter 58, available at www.mass.gov/legis/laws/seslaw06/s1060058.htm.

Appendix / continued

to afford insurance, but who do not purchase it, losing their personal exemption in 2007. Additional penalties will be imposed in 2008 equal to half the cost of affordable coverage.

Insurance Market Reforms

The individual and small group insurance markets will be merged. This move is intended to lower premiums for individual policies with little effect on premiums in the small group market. Young adults up to the age of 25 will be able to stay on their parents' policies. New products will be developed for healthy individuals between the ages of 19 and 26. There will be an expansion of health savings accounts by allowing them to be used in conjunction with an HMO (health maintenance organization) plan. An additional 204,000 individuals are projected to purchase affordable insurance because of these market reforms.

Connector

A new state-funded entity, Common Health Insurance Connector, will be critical to the success of this reform effort. The Connector will determine premium and income levels that

will be used in defining affordability for implementation of the individual mandate.

In addition, the Connector will act as a facilitator or clearinghouse for purchasing insurance with pre-tax dollars. Individuals or employees of small businesses (50 or fewer employees) will be able to choose among multiple products offered through the Connector, which the Connector will have certified as being of high quality and value. Use of this entity will facilitate the purchase of insurance for individuals with more than one job and will allow individuals to keep their coverage if they change jobs.

Financing

The funds to expand Medicaid eligibility and increase Medicaid payments, subsidize private insurance plans, and pay uncompensated care costs for safety net providers will come from several sources. The employer mandate is expected to bring in \$50 million. State general revenues will add \$125 million. Federal Medicaid matching payments will increase by \$180 million. Uncompensated care pool funds, currently about \$680 million, will be redirected over time to fund insurance subsidies.