

ACCESS. ENROLLMENT.
OUTREACH. SHARED
RESPONSIBILITY.



HEALTH CONNECTOR.
AFFORDABILITY.



NAVIGATION. NEARLY
UNIVERSAL COVERAGE.

MASSACHUSETTS HEALTH REFORM: A FIVE-YEAR PROGRESS REPORT



ACKNOWLEDGMENTS

Many individuals who have been intimately involved in Massachusetts health reform contributed directly or indirectly to this report. The author would especially like to thank Dick Powers, Brian Rosman, Bob Seifert, Lindsey Tucker, and Nancy Turnbull for sharing their knowledge, insights, and invaluable suggestions along the way.

Design: Hecht Design

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INTRODUCTION

The overarching goal of the 2006 Massachusetts health reform law was to achieve nearly universal health insurance coverage for the state's 6.5 million residents.* In the five years since the law's enactment, that goal has been effectively achieved. An estimated 98.1 percent of Massachusetts residents have health insurance coverage, including 99.8 percent of children. The gains in coverage, most of which occurred during the first two years of health reform implementation, have been maintained despite the effects of the nation's severe and sustained economic downturn.¹

Expanded coverage has been accompanied by improved access to care, especially among low-income adults, with significant increases in physician office visits and the use of preventive care, and in the percentage of adults with a usual source of care. Fewer residents report they have unmet needs for care, with decreases especially notable among middle- and low-income residents, racial and ethnic minorities, and people with chronic diseases.²

Almost 78 percent of insured Massachusetts residents receive their coverage through an employer and, although the number of enrollees in employer-based coverage has fallen since the start of the economic recession, employer participation in offering health insurance has risen under health reform. Seventy-seven percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2010, up seven percentage points since 2005. This compares with 69 percent of employers offering health coverage to their workers nationwide.³

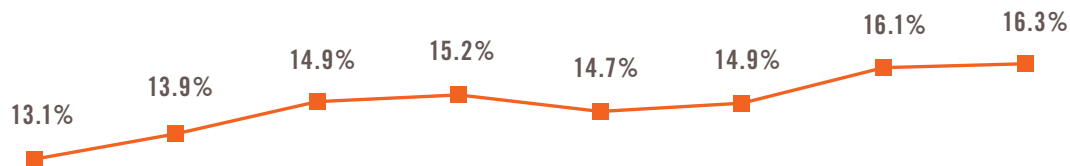
Public support for health reform has remained stable since the law was enacted. Two-thirds of the state's adults say they support Massachusetts health reform, and levels of support are similar among men and women, younger and older adults, and people with higher and lower incomes.⁴ The stakeholders and interest groups that helped forge an agreement on the 2006 law, including political leaders, consumer advocates, business groups, labor unions, hospitals, physicians, and health insurers, have remained engaged and largely supportive.

This report is an update of the Blue Cross Blue Shield of Massachusetts Foundation's 2007 progress report on the first year of health reform implementation.⁵ It examines how the major components of the law are working, and assesses remaining challenges, especially the burden of rising health care costs.

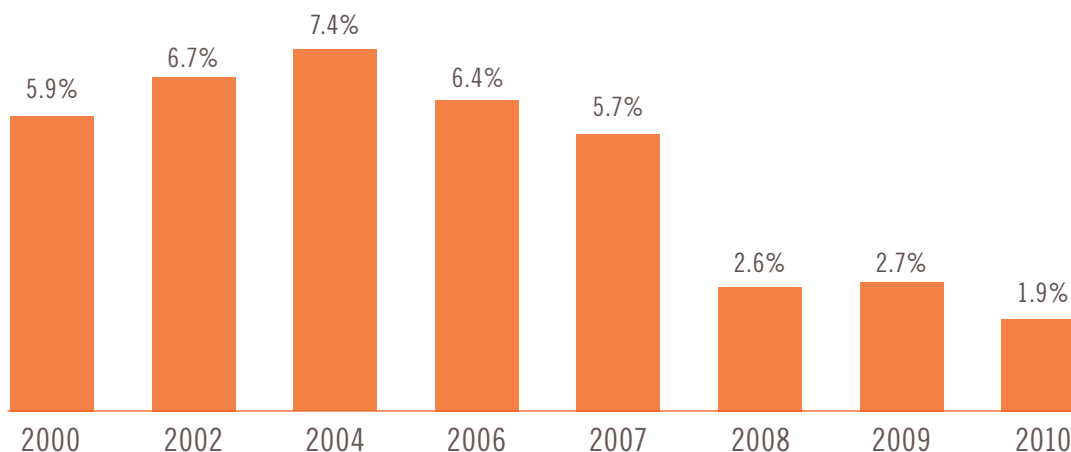
*The Blue Cross Blue Shield of Massachusetts Foundation website includes a comprehensive section dedicated to the history, implementation, and progress of Massachusetts health reform.

CHART: MASSACHUSETTS NOW HAS THE LOWEST RATE OF UNINSURANCE IN THE COUNTRY
 (PERCENT UNINSURED, 2000–2010, ALL AGES)

U.S. AVERAGE



MASSACHUSETTS AVERAGE



NOTE: The Massachusetts-specific results are from a state-funded survey, the Massachusetts Health Insurance Survey (MHIS), which estimated that 372,000 Massachusetts residents were uninsured in 2006, or 6.4 percent of the state's population. Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

SOURCES: Urban Institute, *Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on 2005 Current Population Survey Data In Massachusetts*, 2007; Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Insurance Survey 2000, 2002, 2004, 2006, 2007, 2008, 2009, 2010*; U.S. Census Bureau, *Current Population Survey 2010*.

CHAPTER ONE

WHAT'S IN THE LAW AND HOW IS IT WORKING?

In many respects, Massachusetts health reform was more evolutionary than revolutionary. Enactment of the 2006 law was preceded by two decades of legislative and regulatory changes that reflected a commitment by lawmakers and other health care stakeholders to make coverage more accessible to uninsured residents. Prior reforms prohibited insurers from denying, limiting, or rescinding an individual's coverage, or charging a higher premium, based on a preexisting medical condition. Massachusetts also had in place a mechanism to fund uncompensated care provided by hospitals and community health centers to low-income uninsured and underinsured residents.

In 1997, Massachusetts was granted a federal Section 1115 “research and demonstration” Medicaid waiver that enabled the state to expand coverage programs for low-income adults and children, with roughly half of the dollars coming from federal matching funds. This led to the creation of MassHealth, which includes Medicaid and the Children's Health Insurance Program (CHIP).

After several years of discussion and debate over whether and how to make health coverage nearly universal in Massachusetts, the concept of “shared responsibility” among government payers, employers, and individuals emerged as a framework for the law's components.⁶ Consistent with this principle, the 2006 health reform law:

- Expanded public health insurance programs for low-income residents who do not have access to employer-sponsored health insurance;
- Requires adult residents to obtain health insurance if affordable coverage is available to them or else pay a penalty;
- Established new obligations for employers with 11 or more full-time workers to participate in health care coverage for their employees or else pay a per-worker assessment to the state; and
- Created a new government mechanism – the Commonwealth Health Insurance Connector Authority – through which individuals and small businesses may purchase private health insurance plans that meet state standards for adequacy of coverage and overall value.

Since health reform was launched, the state has adopted and revised numerous regulations to support implementation and the law has been subjected to several amendments, but the major provisions that are examined in this section of the report have not changed.

GOAL

Make coverage affordable for uninsured, low-income residents who do not have access to employer coverage and who do not qualify for Medicaid.

COMMONWEALTH CARE: EXPANSION OF SUBSIDIZED COVERAGE FOR LOW-INCOME RESIDENTS

The health reform law established Commonwealth Care, a new, publicly funded health insurance program for low-income adults earning up to 300 percent of the federal poverty level.*

→ **Goal:** Make coverage affordable for uninsured, low-income residents who do not have access to employer coverage and who do not qualify for Medicaid.

Prior to health reform, nearly three-quarters of the state’s uninsured were from low- and moderate-income families whose earnings were too high to qualify for Medicaid coverage. This included many part-time workers and employees of very small businesses – the “working poor” – who were not offered employer-sponsored health coverage.⁷ In order to make health insurance more affordable for these segments of the population, the health reform law used the flexibility allowed by the federal MassHealth waiver to expand subsidized coverage through a new program called Commonwealth Care. As is the case with MassHealth, undocumented immigrants are ineligible.

Commonwealth Care members enroll in private health plans selected through an annual procurement process conducted by the Commonwealth Health Insurance Connector Authority (Connector), and pay subsidized, sliding scale premiums based on income.** Initially, membership was limited by statute to the four health plans that had enrolled Medicaid managed care members prior to health reform; a fifth health plan was added in 2010.

The number of newly insured Commonwealth Care members grew at a much faster rate than expected during the first two years of health reform. In fact, the early growth spurt raised

* Examples of the Federal Poverty Level (FPL) Guidelines

	100% OF FPL	300% OF FPL
TABLE: Gross Annual Income Limit: Effective March 1, 2011 – February 28, 2012		
SOURCE: U.S. Department of Health and Human Services		
FAMILY SIZE		
1	\$10,890	\$32,670
2	\$14,710	\$44,130
3	\$18,530	\$55,590
4	\$22,350	\$67,050

** See p. 17 of this report for more on the Connector’s roles and responsibilities.

fears that the state had underestimated the number of uninsured residents who might be eligible for Commonwealth Care and that the program would therefore be underfunded. However, membership growth slowed in 2008 and reached a fairly stable plateau in mid-2009. A fall 2010 survey found that more than four out of five Commonwealth Care members reported high levels of satisfaction with the program, including satisfaction with their choice of doctors and other health care providers, the range of services covered, the quality of care available, the application process, and the ease of enrolling in a health plan.⁸

OUTREACH AND ENROLLMENT INITIATIVES WERE A KEY TO SUCCESS

Massachusetts jump-started Commonwealth Care in fall 2006 by automatically enrolling many of the state's lowest-income uninsured residents – those who qualified for fully subsidized Commonwealth Care premiums – based on the database of individuals who had been eligible to receive uncompensated care at hospitals and community health centers. The second phase of enrollment, which was for uninsured residents eligible for sliding-scale premium subsidies, was piggybacked onto the existing MassHealth enrollment process. Prior to reform, the state had developed an online “Virtual Gateway” system that allows hospitals and other community providers to quickly and easily help uninsured, low-income individuals apply for coverage. Applicants can fill out a single application form – the Medical Benefit Request (MBR) – and the state's unified eligibility system places them in the program with the highest benefit level for which they qualify.⁹

The state also undertook a statewide outreach and enrollment effort, with MassHealth given lead responsibility for coordinating public and private initiatives. The law included funds for grants to nonprofit groups that provide outreach and enrollment assistance to residents who may be eligible for public coverage and “who may require individualized support due to geography, ethnicity, race, culture, immigration or disease status.”

During the first four years of health reform, MassHealth awarded a total of \$11.5 million in grants, but additional appropriations were not included in the 2012 state budget, so funds are scheduled to run out on December 31, 2011. The Blue Cross Blue Shield of Massachusetts Foundation has provided private sector funding for outreach and enrollment programs in support of health reform as well. The Foundation has awarded \$2.4 million in community grants for outreach and enrollment since 2006, and will continue awarding new grants for this purpose in 2012.

Grantees have typically included community health centers, hospitals, and other nonprofit human service agencies that employ outreach workers hired for their familiarity with the diverse racial, ethnic, and linguistic communities they serve. Several consumer groups and public agencies established dedicated phone lines where counselors can answer enrollment and coverage questions and help callers identify insurance programs for which they may be eligible. An added benefit of the grants is that outreach and enrollment workers have been able to identify front-line health reform implementation problems and quickly bring them to the attention of relevant state agencies.¹⁰

STATE BUDGET SHORTFALL AFFECTS COVERAGE FOR LEGALLY DOCUMENTED IMMIGRANTS

An important variable in the number of Commonwealth Care members has been the state's policy on subsidized coverage for legally documented immigrants. The federal government does not provide matching funds for extending public coverage to several categories of legal immigrants, most of whom have been in the U.S. for fewer than five years. The state calls this group aliens with special status (AWSS). Although federal reimbursement is not available, state policymakers initially decided to include low-income members of the AWSS population in the eligibility guidelines for Commonwealth Care with full funding by the state. When state revenues collapsed as a result of the recession, however, the program became a target for budget cuts.

Instead of eliminating AWSS coverage altogether, the governor and legislature agreed to freeze AWSS enrollment as of August 31, 2009, and the state contracted with a single private health plan to offer a lower-cost alternative program called Commonwealth Care Bridge (Bridge). Bridge was designed with a more limited statewide provider network, higher cost-sharing, and some benefit limitations compared to Commonwealth Care. About 26,000 AWSS members were converted from Commonwealth Care to Bridge by the end of 2009, but, as of August 2011, Bridge membership had fallen to 15,000 because of turnover and the freeze on new enrollment.¹¹

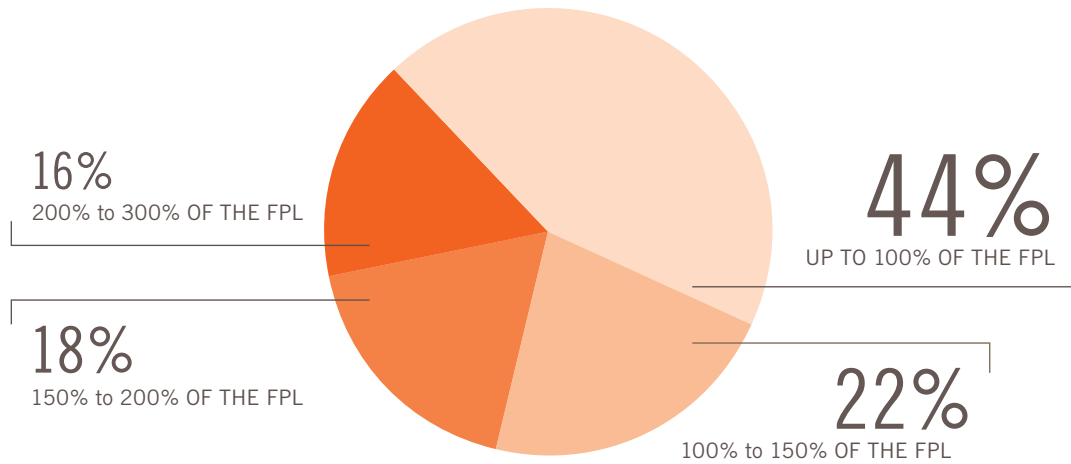
It has been estimated that another 15,000-23,000 low-income, legally documented immigrants would qualify for coverage under the eligibility rules that were in place prior to the enrollment freeze. In February 2010, consumer advocates filed a class action lawsuit aiming to restore eligibility for full Commonwealth Care coverage to the AWSS population.¹² The Massachusetts Supreme Judicial Court has issued a preliminary opinion that the decision to remove legal immigrants from the Commonwealth Care program might be a violation of anti-discrimination protections in the state constitution, and is scheduled to hear arguments from both sides of the class action lawsuit in fall 2011.

ANNUAL PROCUREMENT PROCESS YIELDS SAVINGS

By taking an active role in the design and procurement of Commonwealth Care plans, the Connector has helped to keep program costs in check. Other than during its initial growth spurt, Commonwealth Care has been at or below budget, and the average annual increase in per capita payments for member coverage has been about 3 percent – significantly lower than the rate of growth in commercial health insurance.¹³

During its 2011-2012 procurement process, the Connector pressed the health plans to produce savings by improving provider contracts, directing members' care to lower-cost settings, enhancing medical management, and improving administrative efficiency. All five managed care organizations made bids within the Connector's permissible range, and most proposed rates that were the same as, or lower than, 2010-2011 rates, without benefit reductions or net increases in member copayments. The two plans that offered the lowest rates exclude several high-cost hospitals from their networks, but the Connector determined that all of the health plans' proposed networks meet the program's standards for members' access to care. The Connector has also managed the cost of Commonwealth Care by requiring that new

CHART: COMMONWEALTH CARE MEMBERSHIP BY HOUSEHOLD INCOME (AUGUST 2011)



TOTAL MEMBERSHIP: **158,174**

SOURCE: Commonwealth Health Insurance Connector Authority, Board Meeting Presentation, September 8, 2011

enrollees whose incomes qualify them for fully subsidized coverage (paying no premium) may only choose between the two lowest-cost plan options.¹⁴

Massachusetts uses a “coordinated payment model” to administer Commonwealth Care subsidies. Enrollees pay their portion of the premium to the state, which then takes subsidy dollars from the Commonwealth Care Trust Fund and makes payments to the participating health plans. This method simplifies administration of subsidies and allows the Connector to verify in real time that members are paying their share of premiums.¹⁵ Federal matching dollars account for approximately half of the amount allocated for Commonwealth Care subsidies.

GOALS

- 1 Maximize the enrollment of low-income residents eligible for Medicaid and CHIP and take full advantage of federal matching dollars available through the state’s MassHealth waiver.
- 2 Maintain a mechanism to pay acute care hospitals and community health centers for “essential health care services” provided to low-income, uninsured and underinsured Massachusetts residents.

MASSHEALTH: EXPANSION OF ELIGIBILITY AND RESTORATION OF PROGRAMS

The 2006 health reform law expanded MassHealth (Medicaid and CHIP) eligibility and restored programs and benefits that had been suspended during a state budget crisis several years earlier.

→ **Goals:** Maximize the enrollment of low-income residents eligible for Medicaid and CHIP and take full advantage of federal matching dollars available through the state’s MassHealth waiver.

When health reform was enacted, MassHealth had about one million members, the majority of whom were enrolled either in health plans designated as Medicaid Managed Care Organizations (MMCOs) or in the state-run Primary Care Clinician Plan. The law reopened or expanded Medicaid enrollment for several categories of non-elderly members, including people living with HIV/AIDS, adults and children with disabilities, and the long-term unemployed. In addition, the family income ceiling for CHIP eligibility was raised from 200 percent of the federal poverty level to 300 percent.

During the first two years of reform, MassHealth membership grew by about 72,000, including 27,000 additional children.¹⁶ As the economic recession deepened, overall MassHealth membership growth accelerated and, by the end of 2010, MassHealth membership was up to almost 1.3 million, 40 percent of whom are children. An estimated 25 percent of the increase can be attributed to provisions in the health reform law; the remainder of the growth has been in categories that pre-dated the 2006 law and would have occurred in the absence of reform.¹⁷

THE HEALTH SAFETY NET: MAINTAINING PAYMENT TO PROVIDERS FOR UNCOMPENSATED CARE

The 2006 law created the Health Safety Net Trust Fund to replace the state's Uncompensated Care Pool, with continued funding from a combination of private and public sector revenue sources.

→ **Goal:** Maintain a mechanism to pay acute care hospitals and community health centers for “essential health care services” provided to low-income, uninsured and underinsured Massachusetts residents.

The Health Safety Net (HSN), which is administered by the state's Division of Health Care Finance and Policy (DHCFP), makes payments to hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured. To qualify for the HSN, individuals must demonstrate that they are ineligible for publicly funded coverage, temporarily uninsured while waiting to qualify for coverage, or unable to pay medical bills even though they have health insurance. The HSN is funded through assessments on acute care hospitals, surcharges on payments made by insurers and self-insured employers for hospital and ambulatory surgery services, and government appropriations.

When tens of thousands of the state's previously uninsured, low-income residents were converted to coverage at the outset of health reform, the use of HSN care fell dramatically, as expected. In fact, the number of HSN patient visits at hospitals and community health centers declined by 36 percent in the first full HSN fiscal year of health reform. (The HSN fiscal year is October 1 to September 30, in line with hospital fiscal years.) Over the past three years, HSN utilization has trended upward but is still below pre-reform levels.¹⁸ (See table on page 12.)

Part of the increase in HSN use during the past two years can be linked to state policies related to low-income health coverage. For instance, an estimated 15,000-23,000 legally documented immigrants (AWSS) who are now excluded from any kind of publicly subsidized coverage are eligible for HSN instead. There has also been an increase in the number of individuals eligible for Health Safety Net dental services at community health centers since a restructuring of MassHealth and Commonwealth Care dental benefits in 2010. Rising unemployment has influenced Health Safety Net use as well, by driving up the number of individuals who are eligible for HSN services while awaiting enrollment in publicly funded health insurance.

The amount of money available to pay HSN providers each year is established by the state budget, and since providers' HSN 2010 billings exceeded the amount of funding allocated, a \$70 million funding shortfall occurred that year. Under state law, the shortfall is distributed among hospital providers in a way that is intended to protect hospitals that care for most of the state's uninsured and underinsured residents from the financial shock of having to absorb most of the shortfall.

TABLE: HEALTH SAFETY NET USE SINCE HEALTH REFORM (AUGUST 2011)

The number of inpatient discharges and outpatient visits for which Health Safety Net (HSN) payments were made fell dramatically during the first two years of reform, then started an upward trend.

	UCPO6*	HSN07	HSN08	HSN09	HSN10
TOTAL	2,059,000	1,526,000	977,000	990,000	1,112,000
Hospitals	1,613,000	1,184,000	715,000	703,000	800,000
Comm. Health Ctrs	446,000	342,000	262,000	287,000	312,000

*Prior to health reform, the HSN was called the Uncompensated Care Pool (UCP).

SOURCE: Division of Health Care Finance and Policy: Health Safety Net/Uncompensated Care Pool annual reports

INDIVIDUAL RESPONSIBILITY

The law requires all Massachusetts residents 18 and older to obtain health insurance if affordable coverage is available, or else be subject to a state income tax penalty.

→ **Goals:** Create the largest possible pool of insured in order to spread the financial risk among healthy and sick residents; discourage “free-riders” who do not pay into the system even though they cannot be denied needed care; and encourage more workers to accept their employer’s offer of coverage.

Two important principles are attached to the so-called individual mandate – that it applies only if an affordable health plan is available to the individual in question, and that health benefits must meet a standard of minimum creditable coverage (MCC). In other words, people should not be required to purchase coverage they cannot afford, nor should they be able to meet the requirement by obtaining a plan that, while affordable, offers unacceptably low coverage.*

Massachusetts residents are required to include information about their health insurance status on their annual state income tax filings, and penalties for failure to comply with the coverage requirement are assessed by the Department of Revenue. Since individuals with incomes less than 150 percent of the FPL are eligible for fully subsidized coverage through MassHealth or Commonwealth Care, they are exempt from the penalty. An exemption is also available for people whose religious beliefs prevent them from enrolling in a health plan and for certain other hardship situations. Uninsured residents who are found to be out of compliance have the right to appeal the penalty based on hardship or other mitigating factors.

For the first year of the requirement, the penalty for non-compliance was \$219, which was the amount of the state’s personal income tax credit. As of the 2008 tax year, the penalty was increased to 50 percent of the lowest health insurance premium available for each month the individual did not have minimum creditable coverage. Penalties for those below 300

* See p. 20 of this report for more details on minimum creditable coverage and affordability standards.

GOAL

Create the largest possible pool of insured in order to spread the financial risk among healthy and sick residents; discourage “free-riders” who do not pay into the system even though they cannot be denied needed care; and encourage more workers to accept their employer’s offer of coverage.

percent of the FPL are half of the applicable Commonwealth Care premium; for those above 300 percent, separate penalties are applicable above and below age 26. Penalties collected are transferred to the Commonwealth Care Trust Fund and used to support the state’s contribution to subsidized health insurance coverage.

The most recent data provided by the Department of Revenue, which are for the 2008 tax year, show that approximately 4 million adult tax filers, or 97 percent of those who were required to verify their health insurance status, complied with the requirement. Of these, only about 30,000 filers were found to be out of compliance with the individual mandate because they were deemed able to afford health insurance for the period they were uninsured, and 26,000 were assessed a penalty. The other 4,000 filers sought relief from the penalty by filing an appeal through the Connector. Most uninsured tax filers were exempt from the individual mandate due to their low income (less than 150 percent of the FPL), inability to afford coverage, or religious exemption.¹⁹ The Department of Revenue collected a total of \$66.6 million in penalties for non-compliance with the individual mandate during the first four years of reform, with the amount collected falling sharply from 2009 to 2010.²⁰

TABLE: FINES COLLECTED FOR FAILURE TO COMPLY WITH THE INDIVIDUAL MANDATE

TRANSFERS TO COMMONWEALTH CARE TRUST FUND	
TAX YEAR	
2007	\$19,728,211
2008	\$19,051,657
2009	\$17,067,840
2010	\$10,760,950

SOURCE: Massachusetts Department of Revenue, email correspondence, July 29, 2011

GOALS

- 1 Make employers financially accountable for failing to participate in their employees' health coverage.
- 2 Spread the financial risk of insuring the individual and small-group populations over a larger pool of insured and help make individual insurance more affordable.

THE STATE'S HIGHEST COURT HAS UPHELD THE COVERAGE REQUIREMENT

In 2009, a taxpayer's legal challenge to the Department of Revenue's right to collect the penalty for non-compliance was dismissed in Essex County Superior Court, and the dismissal was upheld by the Massachusetts Appeals Court in 2010. In its decision, the Superior Court said the state's constitution "provides the Legislature with full power and authority...to make, ordain, and establish all manner of wholesome and reasonable orders, laws, statutes, and ordinances, directions and instructions, either with penalties or without," a view which the Appeals Court upheld.²¹

EMPLOYER RESPONSIBILITY

Employers with 11 or more full-time equivalent (FTE) employees are required to make a "fair and reasonable contribution" to employee coverage or pay a "fair share assessment" of \$295 per worker per year to the state.

→ **Goal:** Make employers financially accountable for failing to participate in their employees' health coverage.

The "fair and reasonable contribution" standard, which was subject to regulatory definition, generated considerable debate prior to its implementation. Business advocates argued that "fair share" was not meant to be a "play or pay" mandate on employers; rather, it was a way to assess non-complying employers for their fair share of the amount contributed to the funding of uncompensated care by employers that offer coverage. At the time the law was passed, this amount was calculated to be approximately \$295 per worker per year. Consumer advocates, on the other hand, wanted a high standard, and were concerned that the \$295 assessment would fail to encourage greater employer participation. Ultimately, the state decided to impose two "fair and reasonable contribution" tests annually, and to give small businesses more leeway in meeting the standard:

At least 25 percent of full-time employees must be enrolled in the employer's health insurance plan, and the employer must be making a financial contribution to that plan.

Employers must pay at least 33 percent of the premium cost of the individual health insurance plan offered to its employees.

Employers with 11-50 FTE employees need to meet *one* of these tests to avoid an annual assessment of up to \$295 per employee. Employers with 51 or more FTE employees need to meet *both* tests unless 75 percent of their full-time employees are enrolled in their health plan.

Data from the Commonwealth's 2010 fair share contribution filings show that more than 95 percent of employers subject to the requirement are meeting the "fair and reasonable contribution" standard. Massachusetts had approximately 188,000 employers during this period, 22,324 of which had 11 or more FTE employees and were therefore subject to the fair share contribution policy. As of June 30, 2011, only 1,017 of those, or 4.6 percent, were liable for the fair share assessment. Among the largest employer categories subject to the requirement, the highest levels of compliance were among law offices, religious organizations, elementary and secondary schools, and new-car dealers (all above 99 percent), and the lowest levels of compliance were among full-service restaurants (79 percent). During the first four years of the fair share contribution policy, assessments to non-contributing employers averaged approximately \$15.7 million per year.²²

MAKING HEALTH INSURANCE PREMIUMS A PRE-TAX EXPENSE

Another provision of health reform related to employer participation is a requirement that employers with 11 or more FTE employees must offer employees who work at least 64 hours per month, on average, a Section 125 "cafeteria plan" that allows employees to save money by paying their share of health premiums and other employee benefits on a pre-tax basis. (Section 125 refers to the plan's designation in the IRS Code). An employer that fails to meet this requirement may be assessed a "free-rider surcharge" if one or more of its workers receives more than \$50,000 in medical care through the state's Health Safety Net.

According to state fiscal year 2010 data, 95 percent of employers with 11 or more FTE employees reported that they have adopted a Section 125 plan in accordance with the law. This represents an increase from 2009 when 89 percent reported that they had adopted a Section 125 plan. To date, no employers have been found liable for the free-rider surcharge, meaning none have met the two criteria of failing to offer a Section 125 plan and also having one or more employees receive HSN care costing in excess of \$50,000.²³

MERGER OF THE INDIVIDUAL AND SMALL-GROUP INSURANCE MARKETS

Massachusetts health reform restructured the private insurance market by requiring insurance carriers to merge their individual and small-group memberships into a single pool, using the same rating methodologies for the entire population.

→ **Goals:** Spread the financial risk of insuring the individual and small-group populations over a larger pool of insured and help make individual insurance more affordable.

During the 15 years leading up to the 2006 law, Massachusetts had enacted a series of reforms in the regulation of private insurance products sold to individuals (non-group) and

GOAL

Create a “health insurance exchange” that makes it easier for individuals and small businesses to find and purchase affordable coverage.

small groups (employers with up to 50 eligible employees). The reforms included, most notably, prohibiting insurers from using an individual’s medical condition as a reason to refuse, limit, or terminate coverage, and limiting the factors insurers could use to set different premium rates for different individuals. These requirements, commonly referred to as *guaranteed issue* and *modified community rating*, opened the private insurance market to anyone who could afford coverage. However, since coverage was not required by law, individuals had the option of deferring the purchase of health insurance until they needed medical services.

Prior to reform, residents who bought non-group coverage were, on average, significantly older and less healthy than the population at large, and the average claims cost for non-group members was 40 percent higher than for small-group members.²⁴ After the individual and small-group markets were merged on July 1, 2007, coverage for non-group members became significantly more affordable. A state report on health care cost trends found that, on average, premiums per member per month in the individual merged market were 33 percent lower in 2008 than premiums in the pre-reform, non-group market.²⁵

ENROLLMENT PERIODS ARE NOW LIMITED

In 2011, Massachusetts instituted fixed enrollment periods that limit, with some exceptions, when individuals can sign up for non-group coverage. Previously, eligible individuals could enroll at any time during the year, and some insurers raised concerns with the legislature that, despite the individual mandate, people were buying insurance only when they needed expensive medical care and then dropping coverage after their insurer paid the bills. The new open enrollment period only applies to residents purchasing insurance for themselves or their families, not to those who are eligible for employer- or government-subsidized coverage. The law allows for exceptions for people who lose coverage when an open-enrollment period is not in effect or who are determined to have made a good faith effort to remain insured, but miss the open-enrollment period.

THE HEALTH CONNECTOR: A NEW WAY FOR INDIVIDUALS AND SMALL BUSINESSES TO BUY PRIVATE COVERAGE

The health reform law created the Commonwealth Health Insurance Connector Authority (Connector) to facilitate the purchase of health insurance by non-elderly adults who lack access to employer-sponsored coverage and by companies with up to 50 employees.

→ **Goal:** Create a “health insurance exchange” that makes it easier for individuals and small businesses to find and purchase affordable coverage.

The Connector is a quasi-public entity with a board of directors that includes four ex-officio representatives from state government and seven non-government members representing various interests and areas of expertise. It was financed initially through a \$25 million appropriation from the state’s general fund and is now self-sustaining, funded through an administrative fee it levies on participating health plans. The Connector’s current annual operating budget is approximately \$32.5 million and it has a staff of 45 full-time employees.²⁶

In addition to administering subsidized public coverage through the Commonwealth Care program, the Connector acts as a vehicle for individuals and small businesses to purchase non-subsidized products through a program called Commonwealth Choice. In order to participate in Commonwealth Choice, health plans must receive the Connector’s “Seal of Approval,” which certifies that they meet or exceed standards for quality, value, and the adequacy of their provider networks. At the outset of the program in 2007, six carriers representing about 90 percent of the state’s commercial health insurance market received the Seal of Approval. A seventh plan – a new entry to the Massachusetts market – was added in 2010 and an eighth will be offered in 2012. As of August 2011, there were 39,767 members enrolled in Commonwealth Choice, comprising 27,319 subscribers and 12,448 dependents.

CHART: AFTER HEALTH REFORM: LOWER PREMIUMS, MORE COMPREHENSIVE NON-GROUP COVERAGE

LOW-COST COVERAGE FOR A 37-YEAR-OLD BOSTON RESIDENT, PRE REFORM (JUNE 2007)

\$5,000 deductible with no prescription drug coverage (not minimum creditable coverage under health reform)

Monthly non-group premium = \$335

LOW-COST COVERAGE FOR A 37-YEAR-OLD BOSTON RESIDENT, POST REFORM (JUNE 2009)

\$2,000 deductible with prescription drug coverage (meets the minimum creditable coverage standard)

Monthly non-group premium = \$211

LOW-COST COVERAGE FOR A 37-YEAR-OLD BOSTON RESIDENT, POST REFORM (JUNE 2011)

\$2,000 deductible with prescription drug coverage (meets the minimum creditable coverage standard)

Monthly non-group premium = \$252*

SOURCE: Email correspondence with Richard R. Powers, Commonwealth Health Insurance Connector Authority, August 31, 2011

*Applying an annual inflation rate of 8 percent, the monthly premium for the pre-reform non-group plan would have reached \$455 by 2011.

Commonwealth Choice Individual Products

Although the individual plans offered by the Connector may also be purchased directly from the participating insurance carriers at the same price, Commonwealth Choice lets consumers make side-by-side comparisons of all their options while shopping online. Commonwealth Choice plans are grouped in three tiers (bronze, silver, and gold) according to their benefit levels.

When Commonwealth Choice was launched, the Connector asked participating insurers to submit benefit designs in each tier, based on a range of actuarial values.* There were many possible benefit designs within each actuarial value range and tier, so the program began with a wide array of options. In 2010, the Connector decided to standardize cost-sharing for certain kinds of health services and reduce the number of choices in each tier to allow for easier comparison shopping. The new standardized designs were based on the most popular Commonwealth Choice plans already offered, their potential ability to moderate price increases, and the results of consumer research on the right balance between an adequate choice of products and ease of comparison. For 2011-2012, consumers can choose from among six benefit designs: three in the bronze tier, two in the silver tier, and one in the gold tier.²⁷ Since each health plan offers multiple options, individuals and families can choose from a total of 35 products.

The Connector is also the exclusive seller of Young Adult Plans (YAP), which can be purchased only by Massachusetts residents 18 to 26 years of age who are not eligible for employer-sponsored insurance or subsidized coverage. Young Adult Plans were designed to offer affordable products to younger individuals, a demographic group that was more likely to go without coverage before health reform. Premiums are significantly lower than Commonwealth Choice plans because the plans are allowed to include higher out-of-pocket costs and optional prescription drug coverage. Since they are included in the merged risk pool, the relatively low utilization (and therefore cost) of the YAP population helps moderate premiums for the entire pool of insured.

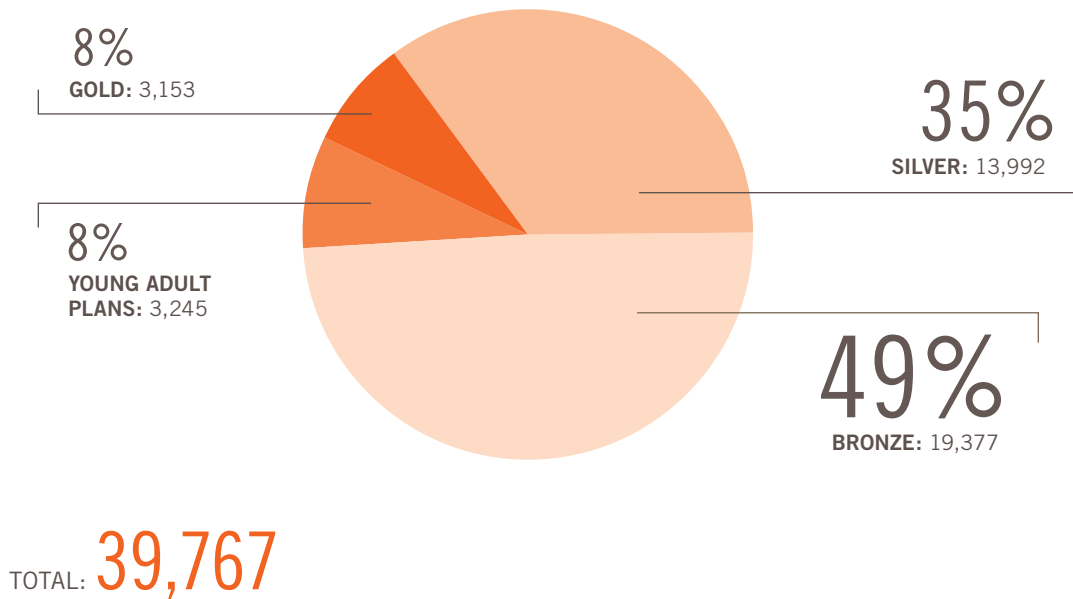
Commonwealth Choice Small Business Products

The small business health insurance market in Massachusetts has traditionally been dominated by direct sales from insurers and sales through insurance brokers and other intermediaries. A goal of the Connector has been to offer small businesses a simpler and less costly way to purchase employee coverage, but, as of August 2011, small business sales accounted for only about 6,500 of the almost 40,000 people enrolled in Commonwealth Choice plans. Two-thirds of those – 4,217 – were covered through the Connector’s Business Express program, which is available to small businesses that want to offer a Commonwealth Choice plan to their employees and contribute to the premium.²⁸

Launched in early 2009, Business Express has been hampered by limited participation among the Connector’s Seal of Approval health plans along with opposition from some

* Actuarial value is used to compare health benefit plans based on the percentage of total health care costs that a plan would be expected to pay across a standard population. Plans with higher actuarial values pay a higher percentage of members’ covered costs and are usually correlated with higher premiums.

CHART: COMMONWEALTH CHOICE MEMBERS BY BENEFIT LEVEL (AUGUST 2011)



Source: Commonwealth Health Insurance Connector Authority

members of the state's broker community who believe the Connector should not be involved in selling small business insurance.* After extensive negotiations with the state, all of the Seal of Approval health plans agreed to participate in Business Express during the 2011-2012 contract period. The Connector has lowered its administrative fee, which is deducted from premium payments, from 3.5 to 2.5 percent and, starting in 2011, small businesses that purchase coverage through the Connector may be eligible for state-funded premium subsidies of up to 15 percent if they offer an employee wellness program that meets certain evidence-based criteria. As of August 2011, 1,554 small businesses were using Business Express to buy employee coverage.

The Connector also offers a coverage option called the Voluntary Plan, which allows part-time workers or other employees who are either not eligible for or not offered employer-sponsored insurance to purchase Commonwealth Choice coverage with pre-tax dollars. The employer does not contribute to the purchase of health insurance, but creates an IRS Section 125 plan to allow workers to deduct premium payments from their gross wages on a pre-tax basis. As of August 2011, 2,200 members were enrolled through 666 small businesses.

A third product that the Connector hoped would give it a unique niche in the small-group market is currently on hold. The concept behind the Contributory Plan is to give small-business workers a broad choice of insurance carriers rather than limiting their choice to a single carrier as most small businesses do. A participating employer selects a Commonwealth

* A 2010 state law added a seat for a broker representative to the Connector board as of July 2011.

Choice plan within a benefit-level tier (gold, silver, or bronze) and uses the cost of the plan as a benchmark to establish the amount it will contribute toward its employees' coverage. Employees can then select the benchmark plan or apply the employer's contribution amount to any other carrier's plan within the same benefit tier. Employees that choose a higher-cost plan pay more; those choosing a lower-cost plan pay less. The Contributory Plan was introduced as a pilot program in 2009, but new enrollment was frozen in February 2010 to allow the Connector to reassess the program's operating requirements, which proved to be far more complex than expected. In August 2011, just 168 members were enrolled through 29 small businesses.

Defining Affordable Coverage

Each year, the Connector board approves a schedule that specifies the maximum amount residents at various income levels should be able to afford for coverage. If a plan is not available within the range set in the affordability schedule, the individual is not subject to the coverage mandate. At the low end of the affordability schedule, for example, an individual with an annual income up to 150 percent of the FPL (\$16,249) is considered not to be able to afford a premium of any size for health insurance. At the high end, an individual earning from \$44,201 to \$54,600 (504 percent of the FPL) is considered able to pay a premium of \$354 per month. Individuals with incomes above \$54,600 are deemed able to afford health insurance regardless of price. Separate affordability schedules have been created for couples and families.²⁹

Applying the principle that low-income residents must have affordable coverage available in order to comply with the individual mandate, the Connector uses the same schedule to determine what Commonwealth Care members should pay for their subsidized coverage. Under the current affordability schedule, a single individual earning up to 150 percent of the FPL is not required to pay a premium, while the maximum monthly premium for someone earning up to 300 percent of the FPL is \$116, with the state paying the remainder of the premium directly to the member's health plan. As an added incentive for members to select the least expensive plan, the Connector bases Commonwealth Care subsidies on the lowest-priced plan available, and members who select a higher-cost plan pay the difference.

Defining Minimum Creditable Coverage

Broadly speaking, Massachusetts lawmakers envisioned minimum creditable coverage (MCC) as a way to make sure that the state's residents would have reasonably comprehensive insurance benefits, including coverage for routine, preventive, and catastrophic care. The Connector board was authorized to fill in the specifics about what should be covered to meet the MCC standard, as well as what levels of cost-sharing would be allowed. (See spotlight.)

The Connector board's most controversial MCC decision, reached after considerable debate, was to include prescription drug coverage. Proponents argued that prescription drugs are essential to comprehensive medical care; opponents said including them in MCC would make coverage more expensive than it needed to be for individuals and companies that had previously chosen to do without drug coverage. Ultimately, the board adopted the requirement on

a unanimous vote, but delayed the effective date to give individuals and employers time to adjust their coverage accordingly.

Once the standards were in place, some employers asked the Connector to recognize as MCC-compliant benefit plans that did not meet the exact regulatory requirements but did meet the spirit of what MCC intended to accomplish. (Although the MCC standard applies to an individual's obligation to obtain coverage, not to employers, Massachusetts employers need to offer MCC in order for their employees to be in compliance with the state's individual mandate.) Subsequently, the Connector board revised the MCC regulations to allow Connector certification of MCC compliance in instances where a plan that does not meet every element of the regulations provides sufficiently comprehensive coverage so as to fulfill the intent of the standards.

SPOTLIGHT: AN OVERVIEW OF MINIMUM CREDITABLE COVERAGE (MCC)

MCC REQUIRES COVERAGE FOR A BROAD RANGE OF MEDICAL SERVICES (THE FOLLOWING LIST IS NOT ALL-INCLUSIVE):

- Ambulatory patient services, including outpatient day surgery and related anesthesia
- Diagnostic imaging and screening procedures, including x-rays
- Emergency services
- Hospitalization, including, at a minimum, inpatient acute care services
- Maternity and newborn care
- Medical/surgical care, including preventive and primary care
- Mental health and substance abuse services
- Radiation therapy and chemotherapy
- Prescription drugs

COST-SHARING RESTRICTIONS INCLUDE:

- No deductibles for preventive care visits
- A cap on annual deductibles of \$2,000 for an individual and \$4,000 for a family for services received in-network
- No caps on total benefits for a particular illness or for a single year
- No policy that covers only a fixed dollar amount per day or stay in the hospital, with the patient responsible for all other charges
- No fixed-dollar cap on prescription drug benefits
- When policies have a separate prescription drug deductible, it cannot exceed \$250 for an individual or \$500 for a family for services received in-network

SOURCE: Minimum Creditable Coverage, Commonwealth Health Insurance Connector Authority website

GOALS

1 Increase the public’s access to cost and quality information and act as a catalyst for health system changes that enhance the quality and affordability of health care in Massachusetts.

2 Understand and begin to address the various factors, both inside and outside the health care system, that contribute to disparities.

HEALTH CARE QUALITY AND COST COUNCIL

The law established a Health Care Quality and Cost Council (QCC) to involve public and private stakeholders in promoting quality improvement and cost containment.

→ **Goal:** Increase the public’s access to cost and quality information and act as a catalyst for health system changes that enhance the quality and affordability of health care in Massachusetts.

The Health Care Quality and Cost Council is an independent public entity made up of nine state officials (ex-officio) and ten non-governmental representatives with expertise in health care cost and quality matters. A formal advisory committee includes consumer representatives and members from business, labor, health care providers, and health plans.

The QCC has created a website called MyHealthCareOptions, which allows consumers to compare hospitals and physician groups using quality- and cost-related information. The council has also produced statewide goals related to lowering or containing the growth in health care costs, and is responsible for compiling information on programs throughout the state that are designed to improve patient safety; reduce preventable hospital readmissions; improve prevention, treatment, and coordination of care for chronic diseases; and reduce variations in care.

HEALTH DISPARITIES COUNCIL

The law created a Health Disparities Council to examine the causes of racial and ethnic disparities in health care and health outcomes and to recommend policies and actions to eliminate them.

→ **Goal:** Understand and begin to address the various factors, both inside and outside the health care system, that contribute to disparities.

The Health Disparities Council includes 37 members – six are members of the state legislature, five are state officials serving ex-officio, eight are from communities disproportionately affected by health disparities, and eighteen are from designated health care associations and provider organizations. To guide its work, the council has adopted a framework for planning, implementing, and evaluating efforts to eliminate racial and ethnic health disparities.

The objectives the council recognized as necessary to end disparities include: adopting social policies that increase equity, promoting healthy communities, promoting institutional transformation, promoting provider transformation, promoting healthy individual behaviors, and improving access to and quality of health care and health outcomes. The council is expected to use this framework to develop an annual statewide report card that will include assessments of health status indicators, associated social determinants, and policy proposals aimed at reducing disparities.

CHAPTER TWO

WHAT DOES HEALTH REFORM COST AND HOW IS IT FUNDED?

In fiscal year 2011, the state's share of spending for health reform amounted to just over one percent of the state's \$32 billion budget.³⁰ This includes funding for Commonwealth Care, Commonwealth Care Bridge, MassHealth expenditures attributable to the health reform law, and the state's contributions to the Health Safety Net Trust Fund.

Since the Health Safety Net pre-dated health reform as the Uncompensated Care Pool, the major *new* categories of government spending that resulted from the law are Commonwealth Care and Commonwealth Care Bridge premium subsidies and MassHealth eligibility expansions and program restorations. These added costs have been partially offset by the reductions in spending for uncompensated care that occurred when previously uninsured residents enrolled in Commonwealth Care or other coverage. The Massachusetts Taxpayers Foundation, an independent research group, has reported that the net amount of new state spending attributable to health reform increased by an average of \$88 million per year during the first four years of the law, which was "well within early projections of how much the state would have to spend to implement reform."³¹

The funding sources for health reform include Federal Financial Participation under the Section 1115 Medicaid demonstration waiver, an annual private sector contribution to the Health Safety Net Trust Fund through hospital and private payer assessments, and money from the state's general fund. Federal Financial Participation was enhanced during the state's 2009, 2010, and 2011 fiscal years by the higher federal Medicaid match rate stipulated in the 2009 stimulus law (the American Recovery and Reinvestment Act). In addition, when state revenues plummeted in 2008 as a result of the recession, the legislature enacted a \$1 per pack increase in the cigarette tax to help fund Commonwealth Care.

Massachusetts entered its 2012 fiscal year in July with a state budget that holds Commonwealth Care spending at the same level as 2011. Although the budget anticipates modest growth in Commonwealth Care membership, due in part to the expected impact of extended federal unemployment benefits expiring, it also assumes per-member savings from the Connector's health plan procurement process. The budget for Commonwealth Care Bridge assumes a continued freeze on AWSS enrollment and the continued exclusion of an estimated 15,000-23,000 legal immigrants from either Commonwealth Care or Commonwealth Care Bridge – a policy that could be reversed by the state's highest court. Overall, the amount of pressure the health reform portion of the state's budget is under in FY2012 will depend on whether the Massachusetts economy can recover at a pace that results in rising revenues, job growth, more people able to take advantage of employer-sponsored health insurance, and, therefore, less of a need for publicly subsidized coverage.

CHAPTER THREE

HOW HAS HEALTH REFORM AFFECTED COVERAGE AND ACCESS TO CARE?

HEALTH INSURANCE COVERAGE

Massachusetts now has the highest rate of health insurance coverage in the nation, with 98.1 percent of residents insured, including 99.8 percent of children. Most of the coverage gains during the first two years of the law were in Commonwealth Care, the new, government-subsidized program for low-income residents. Membership in employer-sponsored insurance and individual non-group insurance rose during this period as well. Since the sharp economic downturn in 2008, private coverage has declined while enrollment in public coverage programs has increased. Overall, an estimated 411,000 more Massachusetts residents have health insurance than before implementation of the law began in fall 2006.³²

Of the approximately 120,000 people who remain uninsured, young adults (ages 19-25) have the highest rate of uninsurance, at 5 percent. In 2010, the uninsured rate among unemployed residents was 4.7 percent, compared to an uninsured rate of 3 percent among part-time workers and 1.9 percent among full-time workers. While there are few disparities in coverage between white and other residents of non-Hispanic ethnicity, Hispanic residents in Massachusetts were more likely to be uninsured than residents in other groups, with 3.9 percent of Hispanic residents uninsured in 2010.³³

Many of the remaining uninsured cite cost-related reasons for not obtaining coverage. Of the non-elderly adults who remain uninsured, 47 percent say they have access to employer-sponsored insurance but did not enroll because of its cost. (They are ineligible for MassHealth or Commonwealth Care because their employers offer coverage.) Seventy percent say they tried to purchase individual coverage but found it to be too costly.³⁴

ACCESS AND USE OF CARE

Access to care has increased for all Massachusetts adults, with significant increases in the use of doctors and preventive care, and in the percent of adults with a usual source of care. Racial and ethnic disparities in access to and use of care have decreased significantly. The incidence of residents failing to have their health care needs met because of cost has declined between 30 and 40 percent among low-income adults and adults with chronic health conditions.³⁵

Some residents who have health insurance continue to face significant barriers to getting the care they need, however.³⁶ About one in five insured, non-elderly adults have reported problems finding a doctor who would see them, and similar proportions report having unmet

needs for health care and problems paying medical bills. Family income was a particularly strong predictor of whether cost was a barrier to getting needed health care.

The most common types of unmet needs for medical care were prescription drugs (6.8 percent), specialist care (4.1 percent), and doctor care (3.3 percent). Dental care, where coverage is more limited for most types of insurance, was the number one unmet need related to cost, at 13.3 percent.

Among the difficulties related to access to providers, being unable to get an appointment when needed was the most common (16.1 percent of all insured residents), followed by being told that a provider was not accepting new patients (9.4 percent), and being told that a provider did not take the person's type of insurance coverage (5.9 percent).

Research suggests that provider access issues are likely related to levels of provider participation in public insurance programs, and cost barriers are related to the copayments, deductibles, and other out-of-pocket costs that accompany most insurance plans.

TABLE: NON-MEDICARE HEALTH INSURANCE ENROLLMENT SINCE ENACTMENT OF HEALTH REFORM

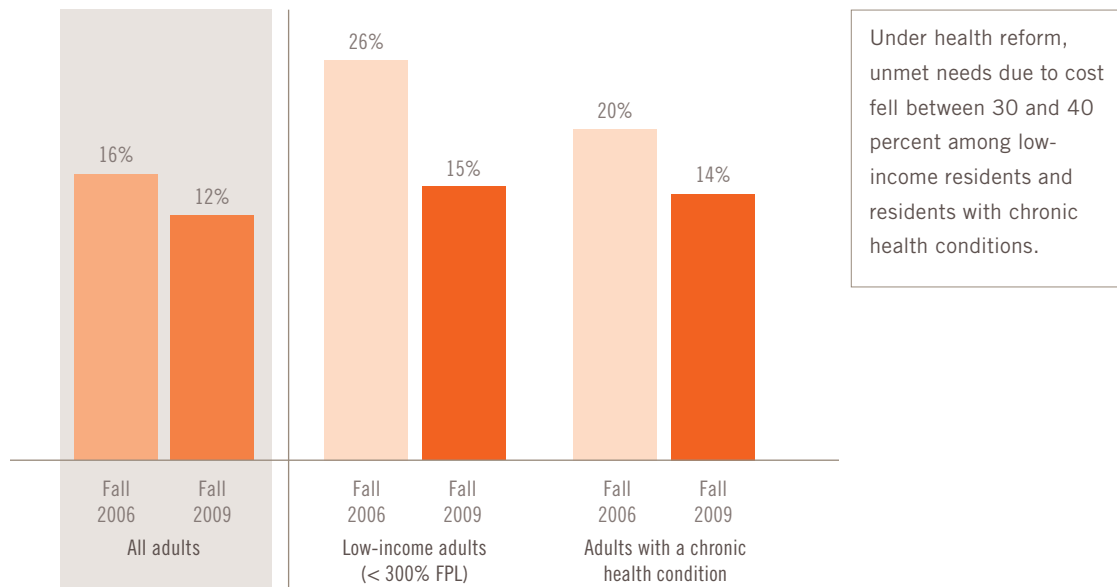
	JUNE 2006	DEC. 2007	DEC. 2008	DEC. 2009	DEC. 2009
TYPE OF COVERAGE					
Private Group	4,333,014	4,457,157	4,474,466	4,358,867	4,315,040
Individual Purchase	40,184	65,465	81,073	88,541	95,186
MassHealth	705,179	764,559	780,727	848,528	898,572
Commonwealth Care	0	158,194	162,725	150,998	158,973
Comm Care Bridge *	N/A	N/A	N/A	26,127	21,616

NOTES ON CHART CATEGORIES: Private Group includes large group, small group, and self-insured employers. Individual Purchase includes Commonwealth Choice and other non-group plans. Insured individuals with partial coverage or premium assistance are counted with group and individual plan members. MassHealth numbers exclude individuals who also have Medicare or subsidized, employer-sponsored coverage.

* On October 1, 2009, low-income legally documented immigrants, categorized by the state as Aliens With Special Status, were moved from Commonwealth Care to Commonwealth Care Bridge, and new enrollment for this population was frozen.

SOURCE: Division of Health Care Finance and Policy *Key Indicators Reports, Health Connector Bridge Enrollment Reports*

CHART: FEWER MASSACHUSETTS ADULTS HAVE UNMET HEALTH CARE NEEDS DUE TO COST
 PERCENT OF NON-ELDERLY ADULTS REPORTING UNMET NEEDS DUE TO COST,
 SELECTED POPULATIONS



SOURCE: Urban Institute, *Massachusetts Health Reform Survey*, 2010

CHAPTER FOUR

WILL MASSACHUSETTS FIND A WAY TO CONTAIN HEALTH CARE COSTS?

Although Massachusetts has consistently been among the states with the highest per capita health care spending, drafters of the 2006 law decided that the essential first step in bringing about system reform would be to expand access to coverage. Two years into the implementation of health reform, with the number of uninsured residents falling steadily, attention started to shift to cost containment.

In 2008, as the continuing rise in health insurance premiums was placing a growing burden on individuals, businesses, and government, the Massachusetts legislature enacted an array of measures related to health care costs and quality. These included new data collection and public hearing requirements; incentives to encourage the adoption of electronic health records; the development of uniform coding and billing standards; prohibitions against hospitals seeking payment for preventable complications from medical errors; new regulation of certain pharmaceutical industry marketing practices; and support for training, recruitment, and retention of primary care providers.

Over the course of the next two years, the state produced a series of reports on the underlying causes of high health care costs in Massachusetts and the feasibility and possible impact of a range of solutions. A report by RAND for the Division of Health Care Finance and Policy assessed a wide range of cost containment strategies and their potential effect on the health care system in Massachusetts, and the state's Health Care Quality and Cost Council issued a "Roadmap" report, with recommendations for "sustainable containment of health care costs."³⁷

In July 2009, a special payment reform commission that included public- and private-sector representatives unanimously recommended that Massachusetts move away from fee-for-service payments and make "global" payments based on quality, outcomes, and efficiency the predominant form of provider payment within five years. In addition, the commission recommended that providers form accountable care organizations that could deliver high-quality, coordinated care within a global payment system.³⁸

The legislature also authorized the state's Attorney General to examine the Massachusetts health care market, with particular emphasis on what might be behind the state's high per capita costs. The Attorney General found that prices paid to hospitals and physicians vary significantly and that price differences are correlated with size and market leverage, not with quality of care or the complexity of cases.³⁹ The Division of Health Care Finance and Policy issued similar findings in a 2011 report on price variation in health care services.⁴⁰

PAYMENT REFORM LEGISLATION PROPOSED

As of this writing, Massachusetts lawmakers have before them legislation Governor Deval Patrick proposed in early 2011 that envisions the state moving from fee-for-service provider payments to alternative payment systems based on quality and efficiency.⁴¹ According to the governor, his bill would significantly expand the use of global and bundled provider payments in Massachusetts, expand state oversight of insurance premium increases and underlying provider payment rates, accelerate the formation of accountable care organizations and other integrated delivery system models, and reduce direct and indirect medical malpractice costs by focusing on the use of prompt resolution and apology.

Two influential advocacy groups that took the lead in organizing consumer support for the 2006 health reform law have turned their attention to costs as well. Health Care For All and the Greater Boston Interfaith Organization (GBIO) have issued a challenge to insurers to keep health insurance premiums level for 2012, without reducing benefit packages or increasing patient out-of-pocket costs. The groups also challenged hospitals and doctors to reduce costs by promoting integrated care, prevention, and wellness; to end wasteful and inefficient treatments; and to be willing to re-open existing contracts with insurers.⁴²

In addition to the consideration of further legislative action to address rising costs, there have been numerous private-sector initiatives designed to improve the safety, effectiveness, and efficiency of care in Massachusetts. Some health plans and providers have entered into contractual arrangements that employ global and bundled payments as alternatives to fee-for-service payments, various provider organizations are engaged in the development of medical homes and accountable care organizations, and hospital-based care management and patient-safety programs have proliferated.

SPOTLIGHT: AN OVERVIEW OF MASSACHUSETTS HEALTH CARE COSTS

Health care expenditures in Massachusetts are growing more rapidly than other economic indicators such as wages, consumer prices, and per capita GDP.

The relative difference in premiums between Massachusetts and the U.S. has increased over time.

By 2007, health care expenditures were estimated to account for 15.2 percent of GDP in Massachusetts compared to 13.7 percent for the nation as a whole.

By 2018, if current trends continue, health care in Massachusetts is projected to cost \$16,000 per person, \$3,000 more than the projected national average.

If cost containment efforts result in a slowing of the growth of health care expenditures in Massachusetts to the same growth rate as per capita GDP, the potential annual savings would be about \$2,800 per capita for a total accumulated savings of \$91 billion over 10 years.

SOURCE: *Massachusetts Health Care Cost Trends: Historical (1991-2004) and Projected (2004-2020)*, Massachusetts Division of Health Care Finance and Policy, November 2009

CHAPTER FIVE

CONCLUSION

As a result of its pioneering health reform law, Massachusetts has achieved nearly universal health care coverage. The principle of shared responsibility and the combination of public programs and private requirements and incentives appear to have overcome the primary barriers to coverage, especially the inability of many low- and moderate-income individuals to afford adequate health insurance and the willingness of some people to forgo coverage even if they could afford it. Expanded coverage has been accompanied by improved access to needed care, and racial and ethnic disparities have been greatly reduced.

So what lies ahead? To a large extent, the future of Massachusetts health reform will be shaped by two major questions: Can the state's high rate of health care spending be moderated? And what will be the impact of the national Patient Protection and Affordable Care Act (ACA)?* In each case, the answers should become much clearer during the next two years.

All of the stakeholders involved in shaping the 2006 health reform law now agree that the top priority for Massachusetts health care is to make it more affordable. There is also a broad consensus that reforms in provider payment need to be accompanied by significant improvements in the efficiency, effectiveness, and coordination of patient care and by an increased commitment to prevention, wellness, and public health. Still to be determined is what, if any, combination of legislative action and private sector initiatives on the part of providers, insurers, employers, and consumers can “bend the trend” and make high-quality health care more affordable.

Although Massachusetts health reform clearly provided a model and framework for the ACA, there are significant differences in the two approaches that need to be resolved. For instance, the ACA will affect eligibility, enrollment, and federal funding for the MassHealth and Commonwealth Care programs, as well as employer obligations and the responsibilities of the Connector in its role as an insurance exchange under the ACA.

Overall, however, implementation of the ACA is expected to result in substantial benefits for Massachusetts health reform, including enhanced federal financing for public coverage programs; expansions in public coverage to reach more Massachusetts residents; federal insurance subsidies for small businesses and people with low-to-moderate incomes; increased Medicaid primary care payments; additional health insurance protections; and new funding for pilot programs, demonstrations, and grants to test innovative ideas for improving quality and reducing costs.⁴³

* The Blue Cross Blue Shield of Massachusetts Foundation has developed an ACA tracking tool that details provisions of the federal law, decisions needed, responsible state agencies, and timing related to implementation of the ACA in Massachusetts. The latest version is available at www.bluecrossfoundation.org.

The ACA also provides Massachusetts with an opportunity to advance key initiatives such as integrating care for the dual eligible (Medicare and Medicaid) populations, and to reconsider the way the state has structured its public coverage programs. For example, Commonwealth Care coverage through the Connector was intentionally differentiated from MassHealth in terms of the effective date for eligibility, premium payment requirements, and benefit packages. This has led to potentially avoidable gaps in coverage, made transitions across programs challenging for individuals to navigate and understand, and even caused members of the same family to be placed in different programs.⁴⁴

If Massachusetts is able to moderate future increases in health care spending while continuing to expand access to coverage and care, its status as a pioneer in transforming the U.S. health care system will be assured. The ultimate test of success, however, will be whether the state can achieve sustainable, measurable statewide improvements in the health and well-being of its residents regardless of income, race, ethnicity, or employment status.

ENDNOTES

1. Massachusetts Division of Health Care Finance and Policy. *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. December 2010.
2. The Urban Institute, Sharon K. Long and Karen Stockley. *Health Reform in Massachusetts: An update as of Fall 2009*. June 2010.
3. Massachusetts Division of Health Care Finance and Policy. *Employers Health Insurance Survey*. July 2011.
4. The Urban Institute, Sharon K. Long and Karen Stockley. *Health Reform in Massachusetts: An update as of Fall 2009*. June 2010.
5. Blue Cross Blue Shield of Massachusetts Foundation. *The 2006 Massachusetts Health Reform Law: Progress and Challenges After One Year of Implementation*. May 2007.
6. Irene M. Wielawski. *Forging Consensus: The Path to Health Reform in Massachusetts*. July 2010.
7. The Urban Institute for Blue Cross Blue Shield of Massachusetts Foundation, Allison Cook. *Health Insurance Coverage and the Uninsured in Massachusetts*. June 2005.
8. The Commonwealth Health Insurance Connector Authority. *Commonwealth Care Survey Results*. Presentation at Board Meeting. March 10, 2010.
9. The Commonwealth of Massachusetts, MassHealth. *Massachusetts EOHSS Virtual Gateway: Health Insurance and Health Assistance Programs*. Presentation. June 2010.
10. UMass Medical School, Center for Health Policy and Research for MassHealth. *Evaluation of the MassHealth Enrollment and Outreach Grant Program, Executive Summary*. July 2011.
11. Email correspondence with Richard R. Powers, The Commonwealth Health Insurance Connector Authority. September 12, 2011.
12. Details on the Aliens With Special Status (AWSS) class action lawsuit can be found at the *Health Law Advocates* website.
13. Email correspondence with Richard R. Powers, The Commonwealth Health Insurance Connector Authority. September 12, 2011.
14. The Commonwealth Health Insurance Connector Authority. Board Meeting Minutes. July 14, 2011.
15. The Commonwealth Health Insurance Connector Authority, officials. *Letter to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services*. October 4, 2010.
16. Health Care For All and Community Catalyst. *Massachusetts Health Reform: Implementation Update*. August 2008.
17. Massachusetts Medicaid Policy Institute. *Growth in MassHealth Enrollment Since Reform*. May 2011.
18. Massachusetts Division of Health Care Finance and Policy. *Health Safety Net 2010 Annual Report*. December 2010.
19. The Commonwealth Health Insurance Connector Authority and Massachusetts Department of Revenue. *Data on the Individual Mandate Tax Year 2008*. December 2010.
20. Email correspondence with Massachusetts Department of Revenue. July 29, 2011.
21. *George Fountas vs. Commissioner of the Massachusetts Department of Revenue*. Essex County Superior Court. February 10, 2009.

22. Massachusetts Division of Health Care Finance and Policy. *Fair Share Contribution: Filing Year 2010 Results and Analyses*. September 2011.
23. Massachusetts Division of Health Care Finance and Policy. *Employer Free Rider Surcharge: Policy, Objectives, and Results*. July 2011, and email correspondence with Sarah O'Toole, Massachusetts Department of Unemployment Assistance. July 22, 2011.
24. Gorman Actuarial, LLC; DeWeese Consulting, Inc.; Hinckley, Allen & Tringale Health Strategies. *Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets*. December 2006.
25. Massachusetts Division of Health Care Finance and Policy. *Massachusetts Health Care Cost Trends 2007-2009 Executive Summary*. May 2011.
26. Email correspondence with Richard R. Powers, The Commonwealth Health Insurance Connector Authority. September 15, 2011.
27. The Commonwealth Health Insurance Connector Authority. Board Meeting Minutes. July 14, 2011.
28. The Commonwealth Health Insurance Connector Authority. Board Meeting Minutes. September 8, 2011.
29. Massachusetts Department of Revenue. *Schedule C Worksheets and Tables 2010*.
30. Massachusetts Taxpayers Foundation. *Massachusetts Health Reform: The Myth of Uncontrollable Costs*. May 2009.
31. Email correspondence with Alex Zaroulis, Executive Office for Administration and Finance. September 27, 2011.
32. Massachusetts Division of Health Care Finance and Policy. *Key Indicators Report*. May 2011.
33. Massachusetts Division of Health Care Finance and Policy. *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. December 2010.
34. Massachusetts Division of Health Care Finance and Policy. *Health Insurance Coverage in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys*. December 2010.
35. The Urban Institute, Sharon K. Long and Karen Stockley. *Health Reform in Massachusetts: An update as of Fall 2009*. June 2010.
36. Massachusetts Division of Health Care Finance and Policy. *Barriers to Obtaining Health Care Among Insured Massachusetts Residents*. May 2010.
37. Massachusetts Health Care Quality and Cost Council. *Roadmap to Cost Containment*. November 2009.
38. The Special Commission on the Health Care Payment System. *Recommendations of the Special Commission on the Health Care Payment System*. July 2009.
39. Office of Attorney General Martha Coakley. *Examination of Health Care Cost Trends and Cost Drivers*. March 16, 2010.
40. Massachusetts Division of Health Care Finance and Policy. *Price Variation in Massachusetts Health Care Services*. June 2011.
41. CommonHealth, Carey Goldberg. *Introducing Massachusetts Health Care Reform, Part 2*. February 17, 2011.
42. A Healthy Blog, Brian Rosman. *HCFA, GBIO Issue Cost Control Challenge to Health Care System*. April 5, 2010.
43. Robert Seifert and Andrew Cohen. *Re-Forming Reform: What the Patient Protection and Affordable Care Act Means for Massachusetts*. June 2010.