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Massachusetts Health Reform

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Background

As national health reform took center stage in the Obama administration in 2008, policymakers turned the spotlight on Massachusetts, where a model that virtually achieved universal coverage had been pioneered two years earlier. The path that Massachusetts took resulted in near-universal coverage (97.4%)¹, and some predict that the new policies that emphasize preventative care may result in savings down the road.

Health care reform wasn't new to the state of Massachusetts. In the late 1980s, Democrat Michael Dukakis, then governor, made an attempt to institute universal coverage through a "pay-or-play" mandate. Under his proposal, an employer mandate forced even midsized employers to pay a large premium for their employees' health insurance. Businesses were turned off by what they perceived to be an unfair and intrusive "tax" against employers. They mobilized effectively against Dukakis via lobbying and donations to political opponents, and his plan was never implemented.

A decade later, Mitt Romney would succeed in passing a health care reform bill by approaching the task from a different angle. Having learned that alienating businesses made too many powerful enemies, he employed an individual mandate: the individual was held responsible for securing health care insurance. A cheap insurance plan for the young-adult group (ages 19–26) was created so that these payments could help offset the higher costs incurred by their senior counterparts. This new setup minimized adverse selection and the free-rider effect. In order to make the process as transparent and understandable as possible, the Commonwealth Health Insurance Connector was created. The Connector serves as a marketplace where individuals can easily compare and choose certified insurance plans. By rating and standardizing plans as Bronze, Silver, and Gold, depending on their actuarial values (Bronze plans have a \$2,000 deductible for single coverage, whereas Gold plans have none), the Connector increased transparency for buyers.

Yet it took more than just Mitt Romney's adjustment combined with business support for the bill to come to fruition. Massachusetts had been a long-time beneficiary of federal funding used to supplement their Medicaid program. Due to reported abuses of funds, in 2006 the federal government demanded that Medicaid funds be disbursed in a more accountable manner. This threat—the potential loss of up to \$385 million—elevated health care reform to a top priority on the state's agenda. Additionally, The Blue Cross Blue Shield Foundation played no small role in advocating for health reform. Having had enjoyed many years of financial success, Blue Cross Blue Shield started this foundation as a way to increase health care coverage. Given the clout of the foundation's parent company, its voice was heard.² Other grassroots efforts also made a splash: Health Care for All (HCFA), a well-reputed advocacy organization, formed the Affordable Care Today (ACT) coalition. This alliance, which included large groups such as the Greater Boston Interfaith Organization (GBIO), helped to amass more than 135,000 signatures for their own bill. Even more ambitious in scope, ACT's ballot initiative included a cigarette tax and a larger expansion of the Medicaid eligible population. Though the intent was never to actually pass the bill, it set the tone of engagement. All of these factors worked together to bring about reform. The 2006 bill,

entitled “Chapter 58 of the Acts of 2006: An Act Providing Access to Affordable, Quality, and Accountable Health Care,” was passed to much fanfare.

Within a few years, Chapter 58 made some serious strides. By August 2008, 439,000 people were newly insured in Massachusetts.³ Use of the Free Care Pool, the safety net fund for the uninsured, dropped by 41%. Significantly, there was no evidence that the subsidized insurance plans crowded out private insurance coverage.⁴ For most, access to care improved, and public support for the bill remained high.

However, the bill was not without its critics. The sudden expansion of health care for virtually everyone caused a large spike in demand. Average wait time for patients to see their doctors increased, and the issues caused by PCP shortage were exacerbated.⁵ Cost became the centerpiece issue. Short-term costs were greater than the original projections, primarily because more people signed up than expected.⁶ Perhaps more worrisome, long-term costs may threaten the viability of Chapter 58: Massachusetts’s per capita spending is more than 26% higher than the national average.⁷ Part of the reason is that just a handful of health care providers and insurers, notably Partners Healthcare and Blue Cross Blue Shield, dominate the market and prevent effective competition.⁸

Holahan and Blumberg of the Urban Institute propose a few potential solutions to address these cost issues.⁹ Perhaps CommCare, the new subsidized health plans run by the Connector which currently have restricted enrollment, can be made open to everyone. With only 30,000 members, CommChoice wields no influence in driving the market. This would allow the Connector to grow and for the managed-competition model to work. Alternatively, a new Public Plan can be revisited, with the purpose of containing cost of plans by creating more competition.

Regardless of what the next steps may be, health reform in Massachusetts has successfully expanded coverage without compromising quality. Ironically, much of the spike in short-term costs can be attributed to the reform’s great success in recruiting applicants, whereas the long-term costs reflect some of the unique market environment in the state.

Part I: Unemployed and Uninsured

At the end of a long week, Dr. Shah walked into her office to see her last patient of the day: Mr. Manning, a 53-year-old man with a past medical history notable for hypertension and diabetes. Thanks to a combination of diet, exercise, and a daily regimen of metformin and lisinopril, he had stayed in relatively good health. He was diligent about coming to Dr. Shah's office every six months for a regular checkup, and his sense of humor and keen interest in understanding his health made him a patient whose visits Dr. Shah enjoyed greatly.

When she walked into the room, however, it was immediately clear that Mr. Manning was not his typically cheerful self. He had recently been laid off from his reporter's job at a Boston newspaper, and while he was currently covered under COBRA, he didn't know what he was going to do once his eligibility expired. His wife, who had rheumatoid arthritis, worked as a freelance journalist, and had thus relied on his generous insurance plan for her medical care.

"As if I didn't have enough to worry about already, now that I've lost my job, I don't know how I'm going to afford my medical bills. Thank goodness my kids have jobs already, I don't know what I would do if they were still in college."

Dr. Shah knew that Massachusetts had introduced several reforms to the health insurance market while she had been a resident in one of Boston's teaching hospitals in the early 1990s. The Mannings' preexisting conditions would not stop them from finding a plan, but Dr. Shah knew that Mr. Manning would still have considerable difficulty finding an affordable plan on the individual market, especially with his diabetes and hypertension and his wife's rheumatoid arthritis. Even if he did find a plan, she was concerned about how they would afford their prescription medications and was worried about the long-term impact of a disruption of his careful management of his health.

Discussion Questions

- What are the challenges faced by individuals who want to buy health insurance?
- Why do employers have such a prominent role in the insurance market in Massachusetts and the rest of the United States?
- Why did insurers in other states exclude patients with preexisting conditions?

Part II: Laboratories of Democracy

Ever since she had established her practice in the relatively affluent suburbs of Boston, Dr. Shah had seen relatively few uninsured patients, and Mr. Manning's visit left her frustrated. She had gone into medicine to provide her patients the best care she possibly could, and while she occasionally got frustrated in her negotiations with health plans, she generally felt that she could meet this goal for her insured patients. As she drove back home, she thought about ways to help patients like Mr. Manning.

Dr. Shah was surprised to find out that Blue Cross Blue Shield, through their foundation, had recently sponsored an initiative called the Roadmap to Coverage, which was going to be run by the Urban Institute. Although Dr. Shah had never cared a great deal about politics, she decided to attend their first event, a summit of local leaders in health care, on November 16, 2004 at the JFK Library in Boston.

Although she was initially skeptical, the Roadmap seemed like a good-faith effort to bring care to everyone in Massachusetts. She wished that she had learned more about health policy during medical school and residency but, after looking around the Internet, she found a number of resources from the various interest groups who were involved in the debate.

Health Care for All, an advocacy group, led the Affordable Care Today (ACT!) coalition, which gave the legislature additional incentive to reach a compromise by collecting 138,000 signatures to place a ballot initiative on health insurance reform on the November 2006 ballot. The coalition included a broad range of support, including the Greater Boston Interfaith Organization, the Coalition for Social Justice, unions, and other groups. Governor Romney and the Democratic leadership introduced proposals in 2004 and 2005 and worked within the framework created by the Roadmap and with various groups to come up with a compromise.

Dr. Shah knew that both Massachusetts and the federal government had tried to pass legislation to expand insurance coverage and had failed in the past and she wondered what, if anything, would be different this time.

Discussion Questions

- What were the strengths and weaknesses of the Massachusetts health care system during the reform debate? How did this set the stage for the eventual passage of Chapter 58?
- How should legislators balance the interests of various pressure groups? What were the stumbling blocks faced by the Dukakis administration in Massachusetts and by American presidents since Truman?
- How are patients (particularly the uninsured) represented in the political process?
- How should physicians participate in the political process? To what extent are they ethically obligated to act as representatives of their patients?

Part III: Changes

Thanks to the cooperation of the Republican administration, Democratic legislature, physicians and hospitals, patient advocacy groups, and health insurers, Massachusetts passed Chapter 58 of the Acts of 2006, a comprehensive bill that incorporated many elements of the Roadmap to Coverage. The legislation established an individual mandate to purchase health insurance, with subsidies for those with low incomes. The bill also merged individual and small-group coverage and created the Commonwealth Connector, an independent state agency that rates plans based on their actuarial value and establishes standards of insurance.

These reforms encouraged Massachusetts residents to either utilize the insurance plans offered by their employer or facilitated their purchase of a plan. The Connector soon introduced a requirement for pharmaceutical coverage and introduced open enrollment periods to prevent people from selectively enrolling in more comprehensive plans for the months when they wanted expensive procedures.

Mr. Manning had joined his wife as a freelance writer and took advantage of the Connector to select a Gold plan. He had come to Dr. Shah's office less often in the past three years, and while his HbA1c had gone above his target of 7% as he had cut back on his medications, he hoped that his insurance would allow him to prevent any further adverse outcomes. He did note, however, that his eldest son, who was 25 and had just returned to Massachusetts to start his new job, was frustrated that he had to purchase health insurance while in good health. "I used to think I was invincible at that age, too," Mr. Manning said.

Now fully immersed in issues surrounding access, Dr. Shah saw that Chapter 58 had achieved its goal of increasing coverage—the state insurance rate stabilized at around 98%, a considerable improvement over 2006 and far ahead of the rest of the United States—but the continued rise of health care costs threatened to ultimately undo many of the gains of the legislation. As the reforms made what had been largely a problem for insurers and providers a public problem, the state legislature had motivation to pass two bills aimed at lowering costs between 2007 and 2010.

Discussion Questions

- Why did Massachusetts implement the individual mandate along with the other reforms included in Chapter 58?
- How should the health care system adapt to the increased demand for primary care that will inevitably accompany the expansion of access?
- What complementary services should the state, hospitals, and doctors provide to improve quality, increase access, and lower disparities?

Part IV

Since becoming engrossed in the passage of Chapter 58, Dr. Shah had taken a lead role in keeping her fellow physicians at her group practice up to date on the impact of the legislation on Massachusetts. The Commonwealth Connector was set up quickly and efficiently and gave consumers an easily used tool to select coverage, but some insurers expressed concerns over Beacon Hill's ability to oversee the Connector's activities. While many had expected the demand for emergency rooms to decline as patients found primary care physicians, ER utilization remained constant in Massachusetts; insured patients still found it easier to seek physician services in an ER.

In 2007, as Massachusetts began to implement the provisions of Chapter 58, the campaigns for nomination to the presidential tickets began in earnest, and plans to implement universal health care were dominating the domestic policy debates in the Democratic Party. Soon after being elected, President Obama made it clear that health care reform would be his top domestic priority. Although he had rejected the idea of an individual mandate during the fierce primary campaign against then-Senator Hilary Rodham Clinton, President Obama ultimately supported a comprehensive bill that included a mandate similar to that found in Massachusetts. The President also initially came out strongly in favor of the creation of a "public option," a not-for-profit insurer that would receive its initial funding from the federal government to introduce competition in insurance markets dominated by a single insurer; this provision was ultimately not included in the bill. After nearly a year of vigorous and sometimes rancorous debate on Capitol Hill, the Democratic majority gathered the votes required to send a bill to President Obama, relying on the budget reconciliation process to pass the final version of the bill after Senate Republicans refused to break ranks to vote for the bill.

Dr. Shah watched the progress of the bill through Congress with great interest. Her friends from medical school, who practiced across the US, called her with questions about how the new legislation might have an impact on their patients. She couldn't be sure—after all, many of her friends practiced in states with lower rates of insurance and fewer physicians per capita than Massachusetts, and for-profit insurers dominated the weakly regulated insurance markets in those states—but she did know that the passage of Chapter 58 had changed the discussion about the provision of health care. Coverage rapidly became accepted as a norm, and Massachusetts continued to refine the legislation to address the challenges of cost and quality. Based on her experience in Massachusetts, she encouraged her friends and colleagues to become more involved in shaping future legislation.

Discussion Questions

- What are the differences between the challenges faced by Massachusetts and the United States in increasing access to health care? What factors facilitated the intraparty cooperation in Massachusetts that could not be achieved in Washington, DC?
- How would the "public option" have changed the impact of the legislation? What other strategies can the US government try to expand access?
- What is the impact of PPACA on patients, physicians, hospitals, and employers?

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