

Massachusetts Health Reform:

What it Does; How it Was Done; Challenges Ahead

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On Tuesday April 4th, by overwhelming margins, the Massachusetts House and Senate voted to approve legislation that will extend health insurance coverage to hundreds of thousands of Massachusetts residents. At the same time, the legislation leaves many critical questions about the scope and cost of benefits and the obligations of individuals to purchase coverage unanswered.

Already the commentaries are flying thick and fast—some are calling the bill a national model, others unconscionable and misguided. What does the MA legislation really do? What are the factors that led to its passage? What are the important unknowns? What are the lessons for other states?

The following is Community Catalyst's brief overview of these critical issues. It will be revised and updated in the days ahead as we further analyze the provisions in the legislation.

What the legislation does:

Restores, preserves and expands Medicaid coverage and benefits

The legislation restores important benefits and coverage that were cut during the recent state fiscal crisis including adult dental care. It expands the number of low-income unemployed who can receive MassHealth (Medicaid) and preserves eligibility coverage for immigrants and people with disabilities. The legislation also allocates funding to help reach out to people who are currently eligible but not enrolled in state coverage programs. Eligibility for children is increased up to 300% FPL (about \$60,000 for a family of four) and Medicaid-like coverage is extended to all adults below 100% FPL (\$9,600 for an individual), who are eligible for comprehensive benefits with no premiums or deductibles.

These new provisions add to the already generous Medicaid eligibility in Massachusetts, which provides an important foundation for other aspects of the legislation. Because of Medicaid's reach, fewer families will need subsidized private coverage, and with children covered to 300% FPL, many parents will only have to cover themselves, reducing costs for them and the cost of the subsidies.

Makes health insurance more affordable for the working uninsured

Based on a preliminary analysis, the legislation will make available substantial sliding-scale subsidies for adults between 100-300% FPL (about \$29,000 for an individual and \$40,000 for a couple). Benefits in these subsidized plans will be comprehensive, containing all mandated benefits and no deductibles. The legislation will also reduce the cost of individual (non-group) insurance by allowing people to buy health insurance with pre-tax dollars and combining the small and non-group insurance markets. Two provisions aim to make coverage more affordable for young adults: one would raise the age to which children can be covered under their parents' plan and the other would create a new low-benefit coverage plan for young adults.

Expands public health measures

The legislation increases funding for a host of important public health measures including smoking cessation and breast and prostate cancer screening.

Creates financial incentives to purchase insurance

One of the most controversial provisions is the “individual mandate.” Much of the commentary to date that has focused on this provision has misrepresented what the legislation actually says. There is no absolute mandate on individuals to purchase (nor any automatic financial penalties if they do not). People will face financial penalties for failure to purchase only if an acceptably comprehensive plan is available at an affordable price. The determination of what coverage people must have and what affordable means has been left to a new state agency.

What this means is that the “individual mandate” provision cannot be categorized as good or bad at this point. It’s ALL in the implementation. If the plan is implemented fairly and adequate funding is made available, thousands will gain coverage and no one will have to pay unaffordable premiums for low-quality insurance. Effectively, the individual mandate will be the equivalent of a progressive tax-based coverage system. On the other hand, if benefits are not protected, a reasonable standard for affordability not established and adequate subsidies not made available, the individual mandate will be highly problematic to say the least.

Creates a financial penalty for employers who do not provide insurance

The legislation requires employers with 11 or more workers who do not provide health insurance to pay \$295 per full time equivalent worker (FTE). Contributions are pro-rated for part time and temporary workers. This contribution, while small, establishes the principle that employers should contribute to the cost of health insurance for their workers. Given that the payment is structured as a flat per worker fee, a larger contribution would actually be a more regressive financing source than the federal and state dollars that now provide the bulk of the insurance subsidies.

Provider payments

The legislation increases Medicaid payments to providers (subject in part to meeting quality improvement goals that include reducing racial and ethnic health disparities) and provides funding guarantees for safety net hospitals.

Factors that led to reform

There are a number of critical factors which led to passage of the bill. One, which has received the most attention, is that the state stood to lose significant Medicaid funds (\$385 million per year for two years) if it did not pass a reform plan. This potential loss resulted from a requirement in Massachusetts’ federal Medicaid waiver that the state redirect funds that were being used to support safety net hospitals to pay for insurance coverage instead.

The second factor was the presence on the ballot of a question that would require a much more substantial payroll tax based contribution from employers. The question was sponsored by the Mass ACT (Affordable Coverage Today) coalition led by Health Care For All, with powerful grassroots support from Greater Boston Interfaith Organization (GBIO), Neighbor to Neighbor Coalition for Social Justice and others. The role of the churches and synagogues in GBIO is particularly noteworthy, as they brought a powerful moral voice and organizing base. This coalition, relying entirely on thousands of volunteers, collected 112,000 signatures to place an initiative on the November ballot. The legislature was told that the initiative would be dropped if a bill passes that meets the sponsors' approval.

Complementing the grassroots effort was a core of enlightened business leaders. While far smaller than the established business organizations, this group was able to make the case forcefully that expanding coverage was in the economic interest of the state.

A third critical factor was a strong, institutionalized consumer health advocacy voice in state health policy that has been built over the last twenty years. Health Care For All provided strategic guidance, sophisticated policy analysis, strong media systems, and linkages with local coalitions and grassroots groups. With a staff of 22, Health Care For All assures a consumer presence in most aspects of state health decision-making. Strong working relationships between consumers and other health stakeholders have been built through successful collaboration on campaigns around community benefits, children's health expansion, preservation of Medicaid, and other issues. HCFA provided the strategic guidance, the depth of policy knowledge and the credibility that made it possible to build and hold together the ACT coalition. This was a vital role and underappreciated in media accounts.

A fourth factor was the role played by the Blue Cross Blue Shield Foundation of *Massachusetts' Roadmap to Coverage* initiative, which commissioned the Urban Institute and others to develop policy options to achieve near universal coverage. These options became the core building blocks for the legislation, including a Medicaid expansion, subsidized insurance, purchasing pools, an employer mandate, and an individual mandate. The Foundation also convened all major stakeholders periodically for three years, contributing to the readiness of all interests to engage in forging and supporting a compromise.

These factors influenced all of the parties to join the debate. They gave the legislature a powerful incentive to act. Furthermore, a progressive new Speaker of the House, Salvatore DiMasi, embraced the ACT approach, added the individual mandate, and ensured that the employer assessment, substantial Medicaid improvements and insurance subsidies survived the conference committee process. Also, the risk of losing federal funding plus the prospect of fighting a bitter and expensive ballot campaign with an uncertain outcome gave Massachusetts employers an incentive to come to the table on the employer contribution issue. The significant role in the Massachusetts business community played by non-profit hospitals and insurers was also an important factor in getting the business community to agree to a plan.

Uncertainties remain

Before the ink was dry at the bill signing, Governor Romney broke ranks and vetoed the employer assessment, the restoration of dental, vision and other benefits in Medicaid, and coverage of legal immigrants. It is expected that the legislature will override the vetoes, given the near majority support in both branches. In addition, the business community is publicly maintaining its support for the compromise, including the assessment.

While the legislation represents a major coverage expansion, many questions remain unanswered. Uncertainty surrounding the individual mandate is perhaps the biggest, but not the only issue that must be resolved. Key questions remain about the financial viability of the plan. The ongoing commitment of state and federal funds is critical. The plan projects that more than \$200 million over three years will be raised from employer contributions and this funding is also essential. In addition, the employer contribution requirement could be subject to a legal challenge. The effects of a number of changes in insurance law as well as how individuals and employers will respond to the new financial incentives remain unclear.

Important lessons

Policy lessons

Certain features of the MA legislation are not easily replicable. Foremost among them is the availability of the federal matching money. While it is not necessarily impossible for any other state to replicate this aspect of the program, special circumstances arising from the Massachusetts waiver put that money on the table and led CMS to insist that it be used for coverage.

On the other hand, (giving credit where it's due) a provision promoted by Governor Romney to allow purchase of health insurance with pre-tax income could be adopted elsewhere. The principle of an employer contribution has been established even though the contribution level is low. Along with the near success of California legislation and recent adoption of a Fair Share bill in Maryland it is clear that there is growing political interest in addressing the role of employers in solving the problem of the uninsured.

The individual mandate is a new and as yet untested approach. Its success will depend on the affordability of plans, the subsidies available to those that must purchase plans and the contributions from state government and employers that fund the subsidies.

Political lessons

Even where support for coverage is broad, it is all too easy for reform efforts to get bottled up in the legislative process. The necessity of passing legislation to address the waiver coupled with the ballot proposal created the political environment where something had to happen. Creating similar "must do" scenarios will be important in other states pursuing reform.

The provisions to increase Medicaid payments to the providers were important and build support among providers and insurers. Some hospitals and Blue Cross Blue Shield played an important role in lobbying the business community to accept a compromise on the employer assessment.

Organizing lessons

The grassroots base was critical to the success of the campaign. However, grassroots alone would not have been enough. Without the combination of the grassroots base organized by longstanding seasoned groups, the policy expertise provided by the HCFA staff, and the broad coalition that HCFA was able to build, including both providers, unions and some business leaders, the result would have been much less sweeping and less consumer-friendly legislation.

Conclusion

The passage of major health care legislation in Massachusetts indicates that political momentum for health care reform is growing. The combination of a powerful coalition and favorable environment can lead to significant state level change. One cautionary note is that even with these advantages, the Massachusetts legislation contains significant compromises and many critical issues have not been resolved but merely deferred.

Community Catalyst

Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable healthcare for all.

We believe that health care is a basic human right and that all people--including children, the poor, the elderly, minority communities, and others who are vulnerable--should have access to quality health care. Our work is aimed at strengthening the voice of consumers and communities wherever decisions shaping the future of our health system are being made. We work in partnership with consumer and community groups around the country to promote health care justice. For almost ten years, our staff of experienced policy analysts, attorneys, organizers, and organizational development specialists have been advocating on behalf of consumers in both small communities as well as in high profile court cases.

Community Catalyst is a member of the ACT Coalition.