

Lessons from the Implementation of
**MASSACHUSETTS
HEALTH REFORM**



FOUNDATION
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Author: Alan G. Raymond

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About the Blue Cross Blue Shield of Massachusetts Foundation: The mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to health care. It focuses on collaborating with public and private stakeholders to develop measurable and sustainable solutions that benefit uninsured, vulnerable, and low-income individuals and families in the Commonwealth. The Foundation was formed in 2001 with an endowment from Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

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INTRODUCTION

Since its groundbreaking health reform law was enacted in 2006,¹ Massachusetts has achieved nearly universal coverage and greatly improved residents' access to needed care. About 98 percent of residents had health insurance in 2010, including practically all (99.8 percent) of the state's children.² The most vulnerable residents, including lower-income adults and those coping with chronic health conditions, have reported steady gains in their ability to get the care they need. Nearly two-thirds of the public favor the state's health reform, virtually the same level of support as when the law was enacted. What's more, there is no evidence that subsidized coverage is "crowding out" employer-sponsored insurance—76 percent of Massachusetts employers now offer health insurance to their employees, compared with 71 percent in 2007.³

The insurance coverage provisions of the federal Patient Protection and Affordable Care Act (ACA) were modeled in many respects after the Massachusetts law's key provisions—expanded Medicaid eligibility, new subsidized coverage options for people with low and moderate incomes, new insurance exchanges through which individuals and small businesses can purchase health coverage, and new individual and employer requirements. This report presents an overview of key lessons from Massachusetts that could be relevant to policymakers, advocates, providers, health plans, foundations, and community members working to implement health reform in other states and nationally.

As they consider these lessons, readers should note that Massachusetts started implementation in a particularly favorable policy environment for expanding coverage. This included a relatively low rate of uninsured residents (about 10 percent) and high levels of employer-sponsored coverage. In addition, insurance market reforms were already in place; safety-net care was supported by a well-functioning Uncompensated Care Pool; and the state had been operating for almost a decade with a federal Section 1115 waiver that allowed for creativity and flexibility in expenditures for MassHealth, which encompasses Medicaid and the Children's Health Insurance Program (CHIP). Further, much of the impetus behind passage of the Massachusetts law had come from health care, business, and consumer groups that helped push through a bipartisan legislative solution. Five years later, health reform continues to garner broad support.

But even in Massachusetts, implementation of health care reform has taken much time and the efforts of many individuals and institutions. We believe that the lessons our state has learned along the way can provide valuable guidance to supporters of reform in other states and nationally. ♦

LESSON 1

Ongoing stakeholder engagement in health reform facilitates implementation and helps overcome inevitable obstacles.

RECOMMENDATION

Bring health care stakeholders to the table as quickly as possible to find common ground and keep them engaged.

From the outset, Massachusetts health reform has been supported by a wide spectrum of interest groups willing to transcend policy differences in the interest of a common goal—nearly universal health insurance coverage for the state’s residents. When potentially divisive implementation issues arose, consumer advocates, business groups, insurers, providers, and state policymakers came together to find common ground and design solutions. Stakeholder groups also helped educate their own constituents about how health reform would affect them, and gathered feedback that state officials used to improve the implementation process.

Following are examples of the types of stakeholder engagement that helped Massachusetts implement health reform:

- **Community Coalitions** have been crucial in informing and mobilizing support among advocacy groups. Several years prior to the enactment of reform, a statewide coalition, *Affordable Care Today (ACT!!)*, was formed to press for expanded health care access for low-income and uninsured residents. The coalition included consumer advocates, public health, mental health and disease advocacy groups, labor unions, religious organizations, community health centers, and members of the physician and hospital communities. After the law passed and implementation began, ACT!! continued to coordinate advocacy around policy decisions that affected consumers, such as the affordability and adequacy of coverage and the continuation of state funding for outreach and enrollment. A second group, the *Massachusetts Health Care Reform Coalition*, brought together business and labor groups, providers, insurers, and advocacy organizations to promote successful implementation of the law through advertising and public relations campaigns and a dedicated website. Formed as a non-profit organization, it remained active through the first eighteen months of implementation.
- **Faith-Based Coalitions** have played a vital role in both the enactment and implementation of health reform. In particular, the Greater Boston Interfaith Organization (GBIO), which includes congregations of many faiths from communities that range from among the richest to some of the least affluent in the state, has worked to demonstrate that access to health insurance is an issue that crosses economic, ideological,

“Our goal is to shine a light on how important access to affordable, high-quality health care is to real people’s everyday lives. Once GBIO began to educate and organize the members of our congregations, I’d say the keys to success were collaboration, transparency, compromise, and definitely perseverance!”

Rev. Hurmon Hamilton, President, Greater Boston Interfaith Organization (GBIO)

“The business community has been very involved in health reform from the outset because there was broad support for the goals, if not always for the means. Once the law passed, we really got down into the weeds with employers on what they needed to do to comply, and, as a result, implementation went very smoothly.”

Rick Lord, President and CEO, Associated Industries of Massachusetts (AIM)

and racial lines. Drawing upon the real-life experiences of its members, GBIO has worked closely with state officials and the Health Connector board to ensure that the state’s affordability standards are realistic for low- and middle-income residents.

- **Business Groups** representing both large and small businesses were intimately involved in the negotiations leading to passage of the Massachusetts health reform law and have maintained an important education and information

function. The Associated Industries of Massachusetts (AIM), Greater Boston Chamber of Commerce, the Massachusetts Business Roundtable, the Massachusetts Taxpayers Foundation, and a number of individual business leaders played key roles in shaping the law and have continued to support health reform through education, research, and advocacy. During implementation, the business groups continued to work in concert to advocate for their constituents’ interests as policy decisions were made on issues such as the employer “fair share” obligation and the “minimum creditable coverage” standards attached to the law’s individual mandate. Moreover, business organizations worked with state government to help educate employers about their new responsibilities. AIM, for instance, whose members are mostly small and mid-sized companies, conducted a series of regional workshops to prepare employers for compliance with the health reform law and to gather feedback that policymakers and regulators used to improve and clarify the nuts and bolts of employer compliance.

- **Health Plans** supported the 2006 health reform law and collaborated with the state to help shape important aspects of implementation. A particularly prominent issue was verification of coverage for the individual mandate. Although they joined with segments of the business community in opposing some of the state’s policy decisions and have pressed for several amendments to the law, the state’s health plans have remained engaged and supportive.
- **Provider Associations** have consistently supported and helped spread information about health reform. These include the Massachusetts Hospital Association, Massachusetts Medical Society, and Massachusetts League of Community Health Centers, which have also been very active in educating their constituents about the law.

Massachusetts has also given several stakeholder groups an ongoing role in health reform implementation through the governing board of the Commonwealth Health Insurance Connector Authority (Health Connector), the state’s insurance exchange.⁴ Although board members have frequently expressed very different points of view on key implementation issues, they have worked with the Health Connector’s staff to develop compromise solutions and have achieved unanimous votes on virtually all the board’s major policy decisions. ♦



The Role Foundations Can Play in Health Reform

Based on the Massachusetts experience, foundations can play a critical role in encouraging and sustaining stakeholder engagement. Specifically, foundations can:

- Bring together key stakeholder groups to discuss the law and its requirements and implications, and help forge agreement on what successful implementation would look like.
- Lend weight and credence to groups and points of view that might not otherwise be at the table, such as consumer advocates and representatives of disadvantaged populations.
- Sponsor research to provide baseline data on coverage, access to needed care, racial and ethnic disparities, etc.; track the effect of health reform on the state's population over time; and provide information and data for key implementation decisions.
- Award grants that help consumer advocates and community groups develop the systems, infrastructure, and leadership capabilities they need to participate in health reform implementation.
- Award grants that community organizations, health centers, and other provider groups can use to engage in outreach, education, and enrollment activities that enhance access for low-income and underserved populations.
- Provide general operating support to advocacy organizations to ensure their ongoing involvement in the discussions around reform implementation and to bolster their ability to provide "on-the-ground" feedback on reform's impact and operations.

LESSON 2

Strong, centralized coordination among government agencies helps to overcome the fragmentation often inherent in the health care system and in government functions.

RECOMMENDATION

Create processes to facilitate collaboration and accountability among all parties responsible for the implementation of health reform.

Implementation of Massachusetts health reform started almost immediately after Republican Governor Mitt Romney signed it into law on April 12, 2006. His administration set up the Health Connector and its board, established standards for employers' responsibilities under the law, and oversaw education, outreach, and enrollment for the first phase of coverage expansions before turning the reins over to his Democratic successor, Deval Patrick, in what proved to be a nearly seamless transition.

Implementation of the law involved countless moving parts and required close coordination, both inside and outside government. Health reform forced agencies to think differently about their own responsibilities and about interagency cooperation and data sharing. In some cases, new functions had to be supported with additional staff and funding. Governor Patrick gave his Secretary of Health and Human Services the lead coordinating role, and she soon began to convene weekly meetings where health reform project leaders from across state government shared information and reported on progress, challenges, and resource needs. In addition to the agencies in her own department, which includes MassHealth (Medicaid and CHIP), the Division of Health Care Finance and Policy, and the Department of Public Health, she brought together staff from the Health Connector, the Executive Office for Administration and Finance, the Department of Revenue, the Division of Unemployment Assistance, and the Division of Insurance.

Coordination was especially crucial because the Health Connector, where many of the implementation decisions were made and carried out, was set up as a quasi-independent public authority. In addition, some of the agencies involved in implementation, such as the Department of Revenue, had little or no prior experience with health insurance issues.

Following are examples of how Massachusetts' state agencies collaborated among themselves and with the private sector during implementation:

- The **Office of Medicaid** created a Health Care Reform Outreach and Education Unit to coordinate the state's activities and to work with the private sector in developing strategies for informing and assisting consumers and employers. As a result, officials from the many state agencies involved in implementation collaborated with the state's Medicaid Managed Care Organizations, and with corporate and civic groups and state legislators, to undertake a massive educational effort. This included hundreds of seminars and forums at which members of the public, providers, and employers learned about the new law.
- **MassHealth** and the **Health Connector** held joint training sessions throughout the state for community outreach and enrollment workers. These meetings provided eligibility information, details of the implementation process, and communication strategies.
- The **Division of Insurance**, as the agency with principal regulatory responsibility for the state's health plans, worked with the **Health Connector** on the design, implementation, and oversight of several of the Massachusetts law's provisions. These included the merger of the small-group and non-group/individual markets; the extension of dependent coverage to age 26; and the development of new, young-adult plans sold exclusively through the Health Connector.

“There was a really good all-hands-on-deck approach in state government. Everyone worked very hard to make the best possible decisions with input from all stakeholder perspectives, to learn from experience and bring issues back to the table, avoid finger-pointing, and make course corrections when needed.”

Glen Shor, Executive Director, Massachusetts Health Connector, who was Assistant Secretary for Health Care Policy in the Executive Office for Administration and Finance during early implementation

- The **Division of Insurance** and **Department of Revenue**, in conjunction with the **Health Connector** and **Executive Office for Administration and Finance**, developed a simple tax filing form for individuals to show that they are in compliance with the mandate. They also consulted with the state’s health plans on a process for verifying their members’ coverage.
- The **Health Connector** and **Department of Revenue** collaborated to create and mail a post card to state income tax filers informing them about the law’s individual coverage requirement and tax penalties for non-compliance. The campaign was developed and funded by the Connector, but the Department of Revenue did the mailing in order to protect the confidentiality of tax filer data.
- The **Division of Health Care Finance and Policy** and the **Division of Unemployment Assistance** consulted with employer groups to develop tools and methods for enforcing the requirement that employers make a fair and reasonable (“fair share”) premium contribution to the health costs of its employees or pay a penalty. For instance, they jointly developed an online tool employers use to comply with the law’s Fair Share and Health Insurance Responsibility Disclosure (HIRD) requirements.

State officials were also given ongoing responsibilities for Massachusetts health reform as ex-officio members of the Health Connector’s board of directors. The board is chaired by the state Secretary of Administration and Finance, who represents the governor from an overall policy perspective. Other designated members include the heads of Medicaid, the Division of Insurance, and the Group Insurance Commission (the agency that manages health insurance and other benefits on behalf of state employees and retirees). ♦

LESSON 3

Close coordination between Medicaid and new public insurance programs is needed to maximize enrollment and retention while also reducing redundancy and administrative costs.

RECOMMENDATION

Build on existing public programs, and structure eligibility and enrollment rules and processes in ways that will maintain continuity of care and coverage for people at all income levels, and as their income changes.

Most Massachusetts adults under age 65 can gain access to health insurance through one of four channels—employer-based coverage, individual non-subsidized coverage, individual subsidized coverage (Commonwealth Care), or Medicaid. In addition, through the Health Safety Net (formerly the Uncompensated Care Pool), the state provides reimbursement to certain providers that care for low-income residents who are uninsured or underinsured. A key factor in expanding coverage has been the availability of a single

“front door” for eligibility determination and enrollment in all the state’s subsidized health programs. The goal has been to make the enrollment and reenrollment processes as simple and seamless as possible, while at the same time ensuring the integrity of the program.

The first phase of Massachusetts health reform implementation focused on enrolling low-income uninsured residents who had already been receiving uncompensated care at hospitals and community health centers. Under the new law’s coverage expansions, many of these low-income residents became eligible for fully subsidized health insurance. The state was able to use a database of past uncompensated care users to convert them automatically to public insurance.

In the second phase of implementation, Commonwealth Care began accepting applications from uninsured residents who would be required to pay a part of their premium, and whose eligibility and premium subsidy levels would be determined by their incomes. Rather than develop a new process for determining eligibility, the state built again on the existing Medicaid program, using a common application form – the Medical Benefit Request (MBR) – for both MassHealth (Medicaid and CHIP) and Commonwealth Care. Applicants – either individuals or families – file a single MBR and the state’s combined eligibility system places each person in the best program for which he or she is eligible. This relieves applicants from having to understand the complicated eligibility rules governing each of the programs. Low-income residents who do not qualify for MassHealth or

Commonwealth Care are automatically assigned to the Health Safety Net as long as they meet the eligibility criteria.

“States should think of Medicaid, the health exchange, and private employer-sponsored insurance as interconnected systems, and build the exchange as a glide-path between each system. People move between each level regularly, so you need to avoid dramatic changes in benefits and costs between types of coverage.”

Celia Wcislo, Assistant Division Director, 1199SEIU United Healthcare Workers East, and member of the Health Connector Board

Most applicants fill out the MBR online application at hospitals, health centers, or community agencies, although a paper version is also available. The online system, called the “Virtual Gateway”,

allows authorized organizations and providers to offer uninsured patients assistance with an MBR application whenever they show up for care. This helps prevent errors and allows the state system to process applications expeditiously. More than half of all successful applications for subsidized coverage are completed with the assistance of community-based organizations and health care providers.⁵

Following are additional examples of how the state built on the public coverage system already in place prior to health reform:

- The Massachusetts health reform law specified that, for the first three years of Commonwealth Care, health plan participation would be limited to the state’s existing Medicaid Managed Care Organizations (MMCOs)—four private health plans that contracted with the Medicaid program to serve MassHealth members. The reasoning behind this requirement was that MMCOs had the most experience marketing to,

enrolling, and serving low-income individuals and families, and that MMCOs' provider networks would be more likely than most commercial plans to include safety-net hospitals and community health centers. The requirement allowed newly insured, low-income adults with children already covered by MassHealth (CHIP) to choose the same health plan for the whole family. It also meant that people who moved between MassHealth and Commonwealth Care would not be required to change health plans.

- Commonwealth Care benefits were modeled on the comprehensive benefit plans available not only through Medicaid but also through most employer-sponsored plans in Massachusetts. This consistency of coverage means that people who move from one kind of coverage to another as their incomes change do not face dramatic changes in what is covered.
- The Health Connector implemented key administrative functions (such as customer service support, enrollment, and premium billing) using the vendor already in place for MassHealth. Once enrollment of the uninsured began to level off, the Health Connector moved to a separate, formal bidding process for these services.

While Massachusetts has successfully developed a largely seamless initial enrollment process for its public programs, the reenrollment process continues to be challenging. People who qualify for public health insurance are subject to periodic eligibility verification, including income determination. A change in income or employment status could disqualify someone from public coverage altogether, or it could trigger a change in the level of premium subsidy for which he or she is eligible. Unless public insurance programs are in sync, these transitions can cause gaps in coverage that affect continuity of care and increase administrative costs. For instance, MassHealth membership is retroactive to the first of the month during which enrollment takes place, while Commonwealth Care follows what is common practice for private coverage, making the effective date the first day of the month after enrollment. Furthermore, administrative issues such as an enrollee's failure to fill out required paperwork on time can lead to temporary disenrollment and additional administrative expense. ♦



The Market Role of the Insurance Exchange

The ACA offers states a variety of options for setting up insurance exchanges that are intended to make it easier for individuals and small businesses to buy health coverage. Some states may choose to create exchanges designed primarily to allow consumers to compare costs and benefits among all the plans offered to their residents; others may follow the path of the Massachusetts Health Connector, which has taken a more active role in shaping the market.

Health plan procurement: The Health Connector uses a competitive bidding process to select the health plans that are offered to individuals, families and small businesses through its non-subsidized Commonwealth Choice program. In order to be sold through Commonwealth Choice, health plans must receive the Health Connector's "Seal of Approval" by meeting or exceeding standards for quality, value, and the adequacy of their provider networks. Health plan products offered through Commonwealth Choice must meet the health reform law's

“minimum creditable coverage” standard. Initially, six carriers, representing about 90 percent of the state’s commercial health insurance market, received the Seal of Approval, and a seventh plan—a small new entry to the market—was added in 2010. Although the Health Connector does not regulate premiums, member costs including premiums and typical out-of-pocket payments, are among the criteria considered in the selection process. Health plans cannot submit bids for only one segment of the market; with some exceptions, they are required to participate in both the individual (non-group) and small group-markets.

Choice of products: The Health Connector requires health plans to offer three product tiers for Commonwealth Choice (Bronze, Silver, and Gold) with a range of options grouped by level of benefits and cost-sharing, plus the lower-cost Young Adult Plans designed by the Division of Insurance. Although, initially, each product tier had the same actuarial value, actual benefit designs within the tiers varied so much that consumers had difficulty comparing plans and were overwhelmed by the choices. In response, the Connector has switched to fewer (down from 27 to 8), simpler, standardized offerings that allow for direct comparisons between plans with parallel benefits.

Consumers may choose to buy any of the Commonwealth Choice benefit options from the Connector or, at the same price, directly from a health plan. In addition, health plans that participate in Commonwealth Choice may sell coverage plans directly to consumers and small businesses that they do not offer through the Connector. Although benefit plans sold outside Commonwealth Choice are not regulated by the Health Connector, the law’s minimum creditable coverage requirement effectively sets a floor to ensure adequate coverage.

LESSON 4

Connecting uninsured residents to coverage and care requires an intense, statewide effort that draws upon the knowledge and experience of local service groups and organizations.

RECOMMENDATION

Develop and support a broad array of community-based outreach, enrollment, and retention activities that help uninsured residents sign up for, and maintain, health coverage.

“The purpose of outreach is to have a person explain the convoluted way insurance coverage works or help you get access to a doctor. It is very different from advertising. Billboards or TV ads cannot be individualized.”

Meg Kroepflin, Executive Director, Community Partners, Inc.

One of the great success stories of Massachusetts health reform has been the ongoing collaborative effort by the state and an array of community and provider groups to enroll hundreds of thousands of uninsured residents from the most underserved and vulnerable parts of the population. Outreach workers from scores of organizations

across the state have helped bring the rate of insured residents to record highs by identifying and connecting with people who are uninsured, counseling them on their coverage options, assisting with enrollment, helping them understand how their insurance works, and assisting with the redetermination of eligibility and reenrollment.

During the first four years of health reform implementation, Massachusetts appropriated \$11.5 million in grants for community groups to provide outreach and education activities and enrollment assistance statewide. In 2006 and 2007, MassHealth used a competitive procurement process to award annual grants. Then, to enhance continuity, the program switched to multi-year grants based on available funding.⁶ Another significant source of funding has been the Blue Cross Blue Shield of Massachusetts Foundation, which has awarded more than \$2.4 million in outreach grants since 2006.

“Massachusetts hospitals played a huge role in the enrollment process. With the Virtual Gateway [the Massachusetts online enrollment system] in place, the hospitals were well positioned to help get uninsured patients into the system quickly.”

Lynn Nicholas, President and CEO, Massachusetts Hospital Association

Grantees have included community health centers, hospitals, and other non-profit human service agencies that typically employ outreach workers who are members of, or who have a deep understanding of, the diverse racial, ethnic, and linguistic communities they serve. The four MMCOs that participated in MassHealth prior to health reform were also instrumental in outreach and enrollment activities in support of Commonwealth Care, for which they were the exclusive health plan providers in the early stages of reform.

Independent consumer assistance programs and telephone “helplines” have also been invaluable in the successful implementation of Massachusetts health reform. Counselors answer consumers’ insurance questions, identify free and lower-cost programs people may be eligible for, help them with their applications for coverage, explain how their coverage works, and help them solve coverage problems. The helplines have also played an important early warning role, often helping to identify consumer-related implementation problems before policymakers were aware of them.

A related lesson from Massachusetts is that coverage does not always lead to adequate access to care. Massachusetts community health centers and other provider groups have helped tens of thousands of low-income people make their way into, and navigate through, the health care system. They typically assist the newly insured with determining which health plan is most appropriate for them; understanding how the health plan works, including which providers are available, the role of primary care, and how much they will need to pay in premiums, deductibles, and copayments; finding and selecting providers; and scheduling appointments for needed services. Even with these efforts, economic, social, linguistic, and cultural barriers continue to make it difficult for some low-income residents to get the care they need. ♦

Understanding and Reaching the Uninsured

Many low-income, uninsured people have never had coverage and are therefore unfamiliar with what it takes to establish eligibility, enroll in a health plan, get connected to the health care system, and maintain coverage. In addition, they may face language or cultural barriers, or be hampered by severe financial problems, difficult living conditions, limited access to transportation, and/or poor health. In order to maximize coverage of the uninsured, agencies and organizations engaged in outreach and enrollment need to know:

- What segments of the population are most likely to be uninsured
- Where the uninsured are likely to live
- What barriers they face in trying to gain and maintain coverage and access to care
- How to contact and connect with them
- How to help them understand the advantages of coverage, the enrollment process, finding a primary care provider, and using the health care system
- How to keep in contact with them for periodic eligibility redetermination and renewals

In Massachusetts, the outreach and enrollment effort benefited from the deep understanding gained by those who serve uninsured and disadvantaged residents, ongoing feedback from the field, and formal data collection and analysis conducted by the Urban Institute, the Massachusetts Division of Health Care Finance and Policy, and the Health Connector.

LESSON 5

Successful implementation requires high levels of awareness and understanding among individuals and businesses about their opportunities and responsibilities under health reform.

RECOMMENDATION

Create a comprehensive, ongoing communications campaign that draws on both public- and private-sector resources.

Although Massachusetts health reform has enjoyed broad public support since its enactment, hardly anyone fully understood the law's provisions when implementation began. To build awareness, understanding, and support for the Massachusetts law, the Health Connector, state agencies, and a coalition of private-sector stakeholders developed a multifaceted communications campaign that began nine months after enactment and continued through the following year. A hallmark of the effort was the involvement of one of the state's hugely popular professional sports teams, the Boston Red Sox.

The campaign took a "carrot and stick" approach to explaining health reform, using real-life and hypothetical examples of why coverage is beneficial, along with messages about

the need to comply with the individual mandate in order to avoid tax penalties. An important point here is that the campaign was deliberately aimed more widely than just at uninsured residents. The reform law also gave employers and individuals who already had insurance new rights, benefits, and obligations under the law. These groups were also included in the ongoing communications strategy.

“I think Massachusetts’ collaborative approach to public education and outreach could be a blueprint for other states in many respects. We learned that you can’t leave any stone unturned – it’s amazing who will collaborate with you if you just ask.”

Joan Fallon, former Chief Communications Officer,
Massachusetts Health Connector

Following are major elements of the statewide communications campaign:

- The **Health Connector** produced radio and television advertising, and used social media, speaking engagements, and workshops to get the message out. The Health Connector’s website and toll-free phone line were heavily promoted as the best places to find new, more affordable health insurance options that were certified by the state for quality and value.
- The **Boston Red Sox** produced public service announcements with their players, supported advertising at games and on game broadcasts, and allowed the Health Connector to operate an information booth at Fenway Park.
- The **Massachusetts Health Care Reform Coalition**, with broad-based representation from business and labor groups, providers, insurers, and advocacy organizations, funded a \$3 million public education and media campaign that focused on the law’s benefits to both individuals and the state as a whole.
- Grocery chains and pharmacies placed signs and informational fliers in their stores across the state and even printed information about health reform on customers’ receipts.
- The **Department of Revenue** sent postcards to 3.1 million tax filers and letters to 193,000 employers to inform them of their obligations under the law.
- The **Division of Unemployment Assistance** placed inserts in their mailings to employers.
- The **Massachusetts Bay Transportation Authority** placed advertising on subway cars, trains, and buses.
- The **Registry of Motor Vehicles** sent notices about the law to new Massachusetts residents when they registered their vehicles.

At every opportunity, the campaign sought to give reform a human face, using stories about real, newly insured people with medical needs that had gone unmet when insurance was unaffordable to them. In addition, supporters of reform publicized steps taken toward implementation and publicized successes, both big and small, in order to reinforce the overall public information messages and create a sense of momentum for reform. ♦

“#) *!(%i@**&!”

Get insured. It's good for your health. And it's the law.
1-877-MA-ENROLL
MAhealthconnector.org

HealthConnector

1-877-MA-ENROLL
MAhealthconnector.org

HealthConnector

Good thing he's got health insurance.

Avoid tax penalties: up to \$912 this year. Sign up today.

Since young adults—especially males—have rates of uninsurance that are much higher than those of other population segments, much of the Health Connector’s marketing was targeted at this group. Along with the threat of a tax penalty, two messages were most effective in convincing “young invincibles” that they would benefit from health coverage—protection from financial ruin in the event of an unexpected illness or accident, and access to preventive care.

Ellas lo tienen. Usted lo necesita.

Ahora, se exige que todos los residentes de Massachusetts tengan seguro de salud. Y el Health Connector del Estado lo hace más fácil y económico para usted. Si usted no tiene seguro de salud, llame o use el internet para escoger entre una variedad de nuevos planes que ofrecen beneficios comprensivos y cuidado preventivo. Seis aseguradoras ofrecen pólizas que tienen la garantía de aprobación del Health Connector del Estado: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, y el Tufts Health Plan.

Protéjase — médicamente y económicamente. Inscríbase ahora a un económico seguro de salud, por medio del Health Connector del Estado.

1-877-MA-ENROLL
MAhealthconnector.org

HealthConnector

“They have it. You need it.” This advertisement alerts readers that health insurance is required in Massachusetts and encourages them to shop on the Health Connector website, where they can choose among a variety of affordable health insurance products that offer comprehensive benefits and preventive care.

Urgent Message to Massachusetts Income Tax Filers ACT NOW TO AVOID TAX PENALTIES!

The Health Care Reform Law requires most Massachusetts residents age 18 or older to have health insurance. To avoid a penalty of \$219 per individual when you file your 2007 Massachusetts income tax return, you must have health coverage by the end of the year. You should enroll in a health plan by November 15th to make sure you do not miss this important deadline.

The penalty for being uninsured will increase significantly in 2008, accumulating each month you do not have health coverage.

If you are uninsured, please visit www.MAhealthconnector.org for more information or to sign up. Or you can contact a health carrier directly. The time to act is now!

If you already have health coverage, please disregard this notice.



Para ver este mensaje en español por favor visite www.MAhealthconnector.org.

In 2007, the Massachusetts Department of Revenue mailed this postcard to 3.1 million tax-filing residents. (The tax penalty was increased in 2008, the second year of the individual mandate.)

LESSON 6

No matter how successful health reform proves to be, there will still be uninsured and underinsured people who need access to medical care.

RECOMMENDATION

Maintain a strong safety-net system that can meet the needs of patients who remain uninsured and that supports safety-net providers who provide care for low-income patients.

“We’ve found that community health centers are well-positioned to work with state agencies, health plans, hospitals, and other community providers in developing better approaches to prevention, social support and care coordination for newly insured patients and also for those most likely to remain uninsured or underinsured.”

Jim Hunt, President and CEO, Massachusetts League of Community Health Centers

Even with nearly universal coverage in Massachusetts, almost two percent of adults remain uninsured. Anticipating that the need for “free care” would continue, the Massachusetts health reform law maintained the state’s Uncompensated Care Pool—renamed the Health Safety Net (HSN)—to pay community health centers and acute care hospitals for essential health care services provided to low-income uninsured and underinsured residents. The HSN continues to be funded through a combination of hospital assessments, payer surcharges, and government payments. The program helps ensure that low-income residents who remain without coverage or have inadequate coverage still have access to needed care, and that the hospitals and community health centers that care for these patients receive payments for the services they provide.

“I think the lesson for safety-net hospitals is that they need to build their capacity to serve both insured and uninsured patients; look for partnerships that can broaden their networks; and reinvent themselves around a medical home or accountable care organization model.”

Christina Severin, President, Network Health, a Medicaid Managed Care plan based at Cambridge Health Alliance, one of the state's major safety-net providers

This has not proved easy. Massachusetts safety-net providers have faced multiple challenges in adjusting to the new realities of health reform. As many of their patients transitioned from being uninsured to having coverage, the ways safety-net providers are paid have changed. For example, payments from the old Uncompensated Care Pool differed from the rates now being paid by MassHealth and Commonwealth Care for these

same patients. Moreover, safety-net hospitals contend that the state underpays them relative to their costs for the care they provide to low-income patients who receive coverage through both MassHealth and Commonwealth Care. In addition, they have found themselves continuing to care for a high proportion of uninsured patients, many of whom have complex medical and social needs, but they are doing so under different rules. Eligibility standards for the HSN were tightened under the law and the previous cost-based payment system was replaced by one reflecting Medicare payment principles and rates. For some, this resulted in higher payments, but for others, the rates of payment fell.

The hospitals that have traditionally provided a high level of free care to uninsured patients, especially Boston Medical Center and Cambridge Health Alliance, have struggled financially despite the continued existence of the HSN; three years of supplemental payments, averaging \$250 million per year, to bolster the two hospital systems during the transition; and an additional, short-term infusion of federal stimulus funds through Medicaid.

What almost everyone has agreed on is the critical need for an ongoing safety net that protects access to care for people who remain without coverage and also supports providers serving uninsured and low-income patients. The experience in Massachusetts suggests that rapid changes in the financing of care for low-income patients requires continuous monitoring of the financial stability of safety-net providers and a willingness to make mid-course corrections. ♦

LESSON 7

Health reform implementation is an ongoing process that requires continuous improvement based on feedback from consumers, employers, providers, and other stakeholders.

RECOMMENDATION

Track the impact of health reform, report results, and make changes in policies, processes, and operations as needed.

Massachusetts officials had to build reform with tight timelines and imperfect data. The approach they took was to experiment, monitor progress, encourage feedback from private-sector stakeholders and consumer advocates, evaluate and report results, and continuously improve. Community organizations, consumer advocates, provider groups, health plans, and business associations all worked closely with the state to gather feedback that policymakers and regulators could use to clarify and improve various aspects of implementation and compliance.

“Sometimes it felt like we were building the train while chugging along, but with ongoing formal and informal information loops among stakeholders and a rigorous evaluation process, we’ve been able to fine tune assumptions and make needed changes.”

Deborah Enos, President and CEO,
Neighborhood Health Plan

Since the state realized from the start that transparency and accountability are essential to maintaining stakeholder involvement and trust, policy-making meetings are publicized and open to the public, as is the procurement process for subsidized health plans. Regular media briefings are held after Health Connector board meetings, and the Secretary of Health and Human Services and Executive Director of the Health Connector provide periodic progress reports to the legislature and the public.

Private foundations, watchdog groups, academic researchers, and state agencies have also monitored and reported on the progress of Massachusetts health reform since its inception, and policymakers have used the resulting studies and data to guide implementation decisions and make adjustments and improvements.

The state’s Division of Health Care Finance and Policy periodically publishes a wide array of reports that provide an overview of Massachusetts health care using data from providers, health plans, and government, and surveys of residents and employers. The reports track such factors as:

- Changes in health insurance enrollment since the implementation of health care reform in 2006, including the insured population by type of insurance—group insurance, individual purchase, Medicaid, and Commonwealth Care—and enrollment for each of the state’s insurers
- Percent of employers offering insurance, percent of eligible employees enrolled in insurance, and employer contribution to premiums
- Uninsured by age, race/ethnicity, sex, and income level

- Percent who needed care but for whom cost was an obstacle, self-reported health status, percent with a personal health care provider, and utilization of preventive care
- Cost of health insurance by type—employer sponsored, private direct pay, Commonwealth Choice, Commonwealth Care—compared to the definition of affordability for purposes of the individual mandate
- Health Safety Net payments to hospitals and community health centers for uninsured and underinsured residents
- Financial performance of health plans, acute care hospitals, and community health centers

In addition, the Blue Cross Blue Shield of Massachusetts Foundation sponsors *The Massachusetts Health Reform Survey*, which has been conducted by the Urban Institute annually since 2006, to assess health reform’s

impact on the state’s low- and moderate-income residents. The survey tracks changes that have occurred in: insurance coverage, health care access and use, affordability of personal health care, consumer ratings of health care quality, racial and ethnic disparities, consumer assessments of their own health, provider availability, and public support for Massachusetts health reform generally. ♦

“An ongoing process of listening to constituent groups and learning from experience enables Massachusetts health reform to evolve over time and respond to changing needs. Those served by the program have an opportunity to contribute their ideas, and the program continues to improve.”

Brian Rosman, Research Director, Health Care For All

LESSON 8

Moderating future growth in health care spending is far more difficult than achieving nearly universal coverage, but without cost control, coverage expansions are unsustainable.

RECOMMENDATION

Press for continued health system reforms that will reduce the burden of health care costs while supporting expanded access to coverage and care.

Although per capita spending for health care in Massachusetts has consistently been the highest in the nation, lawmakers decided to focus the 2006 health reform law on expanding access to insurance coverage, not on controlling costs. Now that the state has achieved nearly universal coverage, supporters of reform have shifted to a clear consensus that it will be unsustainable unless health care inflation is brought under control.

Discussion among stakeholders about how to make the state’s health care system more affordable started in earnest in 2008. A newly enacted “cost containment law”⁷ triggered a series of in-depth studies of the underlying causes of high health care costs in Massachusetts and the feasibility and possible impact of a range of solutions.

In July 2009, a Special Commission on the Health Care Payment System, which included representatives from state government and stakeholder groups, 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.⁸

A subsequent report by RAND researchers for the Division of Health Care Finance and Policy assessed a wide range cost containment strategies and their potential effect on the health care system in Massachusetts.⁹ And the state’s Health Care Quality and Cost Council issued a “Roadmap” report, with recommendations for the sustainable containment of health care costs¹⁰

The Massachusetts Attorney General was authorized by the 2008 law to examine the Massachusetts health care market, with particular emphasis on what might be behind the state’s high per-capita costs. Her office’s March 2010 report found that (1) prices paid to hospitals and physicians vary significantly; (2) the higher prices are not tied to quality, complexity, the proportion of public-pay patients, or academic status; (3) price differences are instead correlated with market leverage; and (4) more highly paid providers are gaining market share at the expense of less costly providers.¹¹

“Just as it was a moral imperative to enact Massachusetts health reform in 2006, it is similarly a moral imperative to reform the payment and delivery system to bring down the crushing burden of health care costs.”

JudyAnn Bigby, Massachusetts Secretary of Health and Human Services

The state took no formal action on these reports and recommendations in 2010. The legislature did, however, enact a new law intended to address the problem of rising premiums for small businesses and set the stage for increased oversight of insurance rates and provider pricing.¹² In addition, several of the state’s health plans, physician groups and hospitals started to collaborate around new contract models that replace fee-for-service with payment systems based on quality and efficiency.

Governor Deval Patrick, who was reelected in 2010, has stated that controlling health care costs will be a top priority for his second term in office. In February 2011, he filed legislation to expand the use of alternative provider payment methods such as global and bundled payments and significantly reduce the use of fee-for-service payments in Massachusetts by the end of 2015. According to the governor, his bill would also: accelerate the formation of accountable care organizations and other integrated delivery system models; expand state oversight of insurance premium increases and underlying provider payment rates; redirect the system of medical malpractice in favor of apology and prompt resolution in order to reduce so-called defensive medicine; set up a new state office to encourage and test innovative ways to control health care costs; and create an advisory council of stakeholders and consumers to monitor how payment reform is implemented.¹³ ♦

CONCLUSION

After almost five years of experience with health reform, Massachusetts policymakers and advocates have confirmed that implementation is a complex, ongoing process. It has taken a sustained, community-wide effort to enroll virtually all eligible residents, help connect them to the health care system, and maintain unprecedented levels of coverage, even in the face of the worst recession in decades.

There have been plenty of bumps along the way, but the numerous and diverse stakeholders that united around the law understood there would be a need to experiment, monitor, learn, and improve. Without exception, they have remained supportive, sustained by a shared belief that access to affordable health insurance is not just a matter of fairness; it will also result in a healthier, more productive commonwealth.

The lessons enumerated in this report offer just a glimpse at what successful health reform has entailed. Many of the people who have been engaged in Massachusetts health reform have spent countless hours working with their colleagues in other states and in the nation's capital to provide far more detailed information on the nuts and bolts of implementation. In addition, the Blue Cross Blue Shield of Massachusetts Foundation has created a special website dedicated to Massachusetts health reform that is proving to be a valuable resource for supporters of reform. (www.bluecrossfoundation.org/health-reform.aspx)

Massachusetts has demonstrated that nearly universal coverage is a realistic and achievable goal. Now, the foremost challenge for Massachusetts is to find ways to gain greater control of health care costs without adversely affecting access or quality of care. ♦

ENDNOTES

1 An annotated text of Chapter 58 of the Acts of 2006 is available at <http://chapter58.bluecrossfoundation.org>.

2 *Health Insurance Coverage in Massachusetts, 2008-2010*, Massachusetts Division of Health Care Finance and Policy, December 2010

3 These are among the findings from the Massachusetts Health Reform Survey, which has tracked the impact of reform since fall 2006. Detailed results from the survey, which is supported by the Blue Cross Blue Shield of Massachusetts Foundation and conducted by the Urban Institute, are available at www.bluecrossfoundation.org.

4 The 2006 law specified that the Massachusetts Health Connector Board would include 10 members: the secretary of Administration and Finance, the Medicaid director, the commissioner of insurance, and the executive director of the Group Insurance Commission (the state employee health plan); plus three members appointed by the governor—an actuary, a health economist, and a representative of small businesses; and three members appointed by the attorney general—an employee health benefits plan specialist, a representative of a health consumer organization, and a representative of organized labor. Effective July 1, 2011, an insurance broker representative will be added to the board by appointment of the governor.

5 *The Secrets of Massachusetts' Success*, Stan Dorn, Ian Hill and Sara Hogan, SHADAC/Robert Wood Johnson Foundation, November 11, 2009

6 *Evaluation of the MassHealth Enrollment and Outreach Grant Program*, Center for Health Policy and Research (CHPR), UMass Medical School, February 2010

7 *Chapter 305 of the Acts of 2008: "An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Healthcare"*

8 *Recommendations of the Special Commission on the Health Care Payment System*, July 16, 2009

9 *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Massachusetts Division of Health Care Finance and Policy, August 2009

10 *Roadmap to Cost Containment*, Massachusetts Health Care Quality and Cost Council Final Report, October 21, 2009

11 *Examination of Health Care Cost Trends and Cost Drivers*, Office of the Attorney General, March 16, 2010

12 Chapter 288 of the Acts of 2010: "An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Healthcare for Individuals and Small Businesses"

13 *Patrick-Murray Administration Proposes Comprehensive Health Care Cost-Containment Legislation*, Press Release, Office of the Governor, February 17, 2011

