

Forging Consensus



THE PATH TO HEALTH REFORM IN MASSACHUSETTS

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About the Author

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Funding for this report was provided by the Blue Cross Blue Shield of Massachusetts Foundation. The analysis presented here is that of the author and should not be attributed to the Foundation or its directors, officers, or staff.

The ink was barely dry

on Massachusetts' new

health reform law before commentators began to hold forth.

The 2006 legislation's promise—access to affordable health insurance for virtually all residents—was certainly commendable but would it ever be realized? After all, Massachusetts had been down this road 18 years before under the administration of Democratic Governor Michael S. Dukakis. His 1988 law similarly grabbed first-in-the-nation headlines but foundered soon after Dukakis left office. That history, combined with Massachusetts' reputation as a bastion of liberal—and expensive—social programs, tempered initial reaction from academic, policy and media observers.

“It is an inspiration for the rest of the nation, but not necessarily a model,” said Drew Altman, president of the Kaiser Family Foundation in a *Los Angeles Times* article under the cautious headline, “Expansive Health Plan Won’t Fit All States.”¹ The *Wall Street Journal’s* front page story emphasized potential financial burdens on employers.² The *New York Times* reported favorably but used a defensive quote from Brandeis University health policy professor Stuart H. Altman (no relation to Drew Altman) to highlight local sensitivity to outside skeptics: “It is not a typical Massachusetts-Taxachusetts, oh-just-crazy-liberal plan...It isn’t that at all.”³

In just over a year, however, caution has morphed into imitation. The governors of two of the largest states, California (36.1 million residents, 19% uninsured) and New York (19.3 million, 13.3% uninsured), have announced health reform initiatives, including Massachusetts-style expansions of coverage. Numerous states are moving to insure more children, and former U.S. Senator John Edwards has incorporated this and other core elements of the Massachusetts plan into his platform for the Democratic presidential nomination. Political success in Massachusetts helped break an impasse in Vermont, where a similar reform package was stalled between a Democratic legislature and Republican governor. Minnesota, New Jersey and California, meanwhile, are considering Massachusetts’ “individual mandate,” which requires all residents age 18 and over to buy health insurance, provided its “affordable,” or face tax penalties. And, Arizona, Kansas, Montana, West Virginia, Arkansas, New Mexico and Oklahoma have imported ideas to shore up employer-sponsored coverage and help individuals and small businesses buy lower cost insurance through the state.⁴

Why such a crowded bandwagon when Massachusetts has yet to prove its plan workable? The reform law’s boldest aspects—requirements that businesses and individuals participate in the insurance system or pay fines—won’t seriously be tested until 2008. And, while the state so far has signed up close to 150,000 (as of July 1, 2007) previously uninsured people, most were eligible for no-cost coverage through expansions of Medicaid (called MassHealth) and a new, subsidized program called Commonwealth Care. The tougher job will be convincing some 300,000 uninsured individuals earning more than 150% of the federal poverty level to pay premiums and establish relationships with physicians’ offices or health centers rather than use emergency rooms—a critically important reorientation if potential cost savings are to be realized. This isn’t done overnight, as anyone who’s worked to

change ingrained health attitudes and behavior will testify. Nevertheless, states are on the move, hoping to achieve Massachusetts-style consensus among the interest groups that control health care constituencies and dollars.

The Massachusetts law emerged from a process that saw three of the state's then-most powerful political leaders—former Republican Governor Mitt Romney, former Senate President Robert Travaglini and House Speaker Salvatore DiMasi—championing three different approaches to reform. How Massachusetts forged a consensus is the subject of this report. It is based, in part, on interviews with pivotal business leaders, insurance executives, advocates, state officials, health industry representatives and elected officials. The account that follows is by no means the last word to be written. Health reform in Massachusetts continues to be a live-action drama as the state's public and private sector leaders strive to implement the 2006 law. Yet, the resolve to overcome obstacles appears strong—a legacy, many say, of the political, professional and personal commitments that forged the reform law.

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“It's not a finished product but it's a good start,” says State Sen. Richard T. Moore, co-chair of the state legislature's Joint Committee on Health Care Financing. “It doesn't solve all the problems in health care but it will improve the quality of life for a significant number of our citizens.”

This report is broken into six sections to highlight aspects of the Massachusetts process that are potentially adaptable to other states, even those with different health care systems and percentages of uninsured residents. The sections are:

Lessons—and Opportunities—of History. Massachusetts drew on nearly two decades of expertise and personal relationships among public and private sector health care, political and civic leaders. The majority held positions that enabled them to see the consequences of health insurance gaps from multiple vantage points, and took a practical rather than ideological approach to reform. A significant number were veterans of the failed effort at universal coverage initiated by the 1988 law.

Why Even Go There? The support of business leaders was pivotal to passing the 2006 reform law in Massachusetts, no less than nationally, where private sector employers provide most of the nation's health insurance coverage to people under age 65.

Carrots and Sticks. A number of opportunities and potential threats as well as simmering discomfort with the status quo combined to bring together health care constituencies in Massachusetts that formerly saw each other as opponents.

People Power. Advocates for universal coverage organized broadly and brought new grassroots voices into the Massachusetts reform debate.

Forging a New Dialogue. A new not-for-profit foundation undertook research to pinpoint how much public and private money was being spent on care for the uninsured, and how that money might be redeployed to expand coverage. The research was presented at public forums attended by health industry, business, government, advocacy and political leaders.

Sausage-making. Innovative restructuring of legislative committees brought new sophistication to the analysis of the state's health care system and financing, and buttressed the political will of lawmakers to address coverage inequities.

Opinions vary as to which of the above elements had more influence, and debate continues among and within health care constituencies about what event, conversation, leverage, relationship, threat, alliance or tactic won the day. But beyond these specific disagreements—many of them destined to become part of the political folklore of the 2006 reform law—is remarkable agreement on one key point. Virtually everyone who slogged through the two years of idea-trading that preceded the law's passage credit the evolving spirit of the dialogue—a conversation that became anchored by a goal of “getting to yes” rather than shooting down the other guy's case.

“People didn't stand on their fears,” says James Roosevelt Jr., president of the state's third largest health insurer, Tufts Health Plan, and a former trustee of the Massachusetts and American Hospital Associations. “The difference from other reform attempts—the Dukakis Plan, the Clinton effort—is that every group that might be affected by this ultimately felt they had some wins and could also see the others' interests.”

From this base of mutual respect emerged a path to compromise that is a solidly first-in-the-nation achievement however specific reforms play out over the next few years.

Participants speak with emotion bordering on awe of initial gingerly conversations that evolved into relationships of trust sufficient to galvanize individual and collective action. A sampling:

Rabbi Jonah Dov Pesner, co-chair of a grass-roots interfaith organization that pushed for action on behalf of the uninsured: “I’m not a famous guy, I’m just this random rabbi, but it got to the point where I couldn’t go into the State House without legislative aides saying, ‘Oh, Hi, how are you?’ My ego is intact enough that I knew it wasn’t about me but about what we collectively were doing.”

State Rep. Patricia A. Walrath, tapped to co-chair a new joint legislative committee that held hearings on the reform proposals: “I did not want this job—in all my years in the legislature, I’ve avoided health care like the plague! But we had to figure out how to pay for this, so when the Speaker asked me, well, I said, ‘OK.’”

Michael J. Widmer, president of the Massachusetts Taxpayers Foundation, an employer-sponsored non-profit research group that analyzes state spending and other public interest issues: “I’ve been in and around Massachusetts state government for 35 years and, for me, this is the greatest piece of legislation I’ve ever seen. I’m actually still kind of incredulous that we pulled this off.”

Philip W. Johnston, chair of the Blue Cross Blue Shield of Massachusetts Foundation, which sponsored a series of forums to help get interest groups talking to one another: “I feel that it’s a national scandal that every man, woman and child doesn’t have access to high quality health care—the job has been left to the states. Massachusetts has been willing twice now to step up to the plate.”

U.S. Sen. Edward M. Kennedy, who helped negotiate federal money to pay for the insurance expansion, and made dozens of late night and weekend phone calls to urge leaders back home to stay the course: “It is one of those situations... where they all held hands and jumped. That is sort of antithetical to modern politics, but the people who were involved in this actually believed it and made it work.”

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No state writes law in a vacuum.

Nor do states organize their health care systems according to some master blueprint dictated from Washington, DC. The health reform debate is fundamentally driven by local economics: how to divvy up health care resources among people of varying personal means and life circumstances. It's a philosophical question, of course, but also a practical one that no two states answer alike. History, geography, health care infrastructure, tax base and political and social culture are among many influential factors. Montana, for example, with its vast, sparsely populated terrain and bare bones public health network, sets different priorities than tiny Rhode Island, where hardly anybody lives more than 15 minutes from a hospital or health center. And neither one of them resembles California, which, despite an extensive public hospital and clinic system, must contend with unusually high numbers of uninsured residents and many undocumented immigrants in need of medical care.

Massachusetts, by contrast, seems awash in health care riches. This was emphasized by commentators in early analyses of the 2006 law, suggesting an easy path to reform. Only 6% of Bay Staters (372,000 people) were uninsured in June 2006,⁵ compared to 15.3% (44.8 million people) nationally.⁶ The community health infrastructure is extensive, 70% of employers provide insurance,⁷ and MassHealth ranks among the most comprehensive of state Medicaid programs, insuring over 1 million of the state's 6.4 million residents and reaching more than 90% of the eligible population.⁸ The state also is home to four medical schools whose 21 affiliated hospitals and numerous research and support facilities offer easy access to sophisticated medical services. All this, coupled with a history of liberal politics, helped fuel initial skepticism that a plan for near universal coverage in Massachusetts could be replicated elsewhere.

The view at street level, however, is quite different. Liberal voices in Massachusetts tend to cluster in the university enclaves of Boston and Cambridge, but public dialogue actually ranges far more widely than the state's image suggests. The high cost of living—including medical care expenses—has long been a concern. Employee health care costs are among the highest in the nation; Massachusetts ranked 4th among the 50 states in a 2006 Mercer Health & Benefits survey.⁹ Taxes, housing costs and business tariffs also are hot-button issues, especially in the coastal fishing communities and factory towns of southeast, central and western Massachusetts where people generally earn less than in greater Boston. The result is an almost constant tug of war between social-welfare advocates and business interests. Their battles tend to be zero-sum games, with one side or the other determined to claw back ground lost in the previous legislative session. Recession, while painful, is also a natural ally of pro-business forces intent on beating back expensive government mandates.

Which is how the first comprehensive health reform effort in Massachusetts came to fall so short of what the headlines promised in 1988.

Democrat Michael S. Dukakis was in his second consecutive term as governor in 1988, intent on a run for the White House and hoping for a bounce onto the national stage from successfully addressing the needs of Massachusetts residents without the means to pay for health care. Dukakis's reform package included an aggressive financing and political strategy that came to be known as 'play-or-pay.' Businesses with more than six employees were required to provide health insurance or pay an annual per-employee

tax of \$1,680 to fund coverage expansions. The law also expanded public coverage for pregnant women, young children and teens, and continued requirements on hospitals to pay into an Uncompensated Care Pool (a tariff later extended to health insurance companies). Pool money was used to reimburse hospitals and community health centers for treating uninsured people earning less than 200% of the federal poverty standard.

But the reform plan's key element—the play-or-pay provision underpinning universal coverage—never was implemented. The coalition of interest groups that endorsed the 1988 law looked like the one behind the 2006 law: insurers, health care providers, some employer groups and consumers. But observers say the unanimity of their endorsement in 1988 was more window-dressing than real. “The business community was totally opposed,” says Richard C. Lord, president of an employer organization called Associated Industries of Massachusetts, who was chief of staff of the House Ways and Means Committee during the Dukakis years. Political support in 1988 was equally chimerical: the bill passed the House and Senate by a combined margin of six votes. “It was incredibly divisive,” recalls Widmer of the Taxpayers Foundation. “There was a huge amount of arm twisting and a lot of bitterness.” Even gubernatorial staff lobbying for passage “privately believed it was all going to fall apart as soon as Dukakis left the State House,” according to Barbara Waters Roop, an advocate for universal health insurance who helped draft the 1988 law's employer mandate as legal counsel for economic affairs under Dukakis.

And so it did fall apart. Mounting state deficits from a severe recession beginning in 1990 shredded support for the universal coverage elements, and business groups publicly demanded repeal of the employer mandate.¹⁰ Citing the shaky economy, Dukakis's successor, Republican Gov. William Weld, refused to implement it on schedule in 1992. The legislature drove in the final nail, repealing the mandate in 1996. But important parts of the 1988 law survived, including categorical coverage expansions through MassHealth that later would underpin a new round of reforms in 1996 and, eventually, the 2006 law. (See Appendix B)

Fast forward to the current health reform law, which swept the House and Senate with a combined vote of 192 to 2 and continues to have broad support. Signed by former Gov. Mitt Romney, a Republican now running for president, the reform plan is a priority of his successor, Gov. Deval Patrick, a Democrat. Like the 1988 law,

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the 2006 law relies on expansions of existing public and private sector systems of coverage—Medicaid and employer-sponsored insurance. But the 2006 law largely pays for the coverage expansions with existing health care dollars and through a mandate on individuals to buy insurance. It creates a new public agency, called the Commonwealth Health Insurance Connector Authority, through which small businesses and individuals will be able to buy lower cost insurance as well as subsidized plans. The law also mandates extensive data reporting, and creates a Health Care Quality and Cost Council to publicize this information and set statewide goals. (See Appendix A)

Probably the most attention-grabbing aspects of the 2006 reform law are its twin mandates on employers and individuals to participate in the insurance system. Companies with more than 10 employees that don't contribute a "fair and reasonable" amount towards the cost of insurance must pay an annual assessment of up to \$295 per full time worker. Individuals are obligated to buy coverage, beginning July 1, 2007, or pay tax penalties. National commentators have cited these mandates as evidence of the Massachusetts law's bipartisan nature, incorporating liberal and conservative notions of social responsibility.

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To the law's architects, however, such hackneyed labels fall short of the mark. Consensus-building, they say, was a long-term process, requiring a new language of debate as well as new tools to address coverage inequities. Defying their cartoonish image as health reform's cheapskates looking only to duck and run from escalating health costs, business leaders emerged as key players in Massachusetts. The descriptive they and other participants favor over "bipartisan" is "mature," an amalgam of the collective wisdom of employer, insurance, health industry, government, consumer and political leaders who have grappled in one way or another and over many years with the consequences of coverage gaps. Critical to this consensus building effort was new data on state expenditures for the uninsured, and a new understanding of the potential benefits to all from redirecting the money spent on medical services for the uninsured towards providing them with coverage.

"We got very excited about being able to do something about the uninsured," says Paul Guzzi, president of the Greater Boston Chamber of Commerce, and Secretary of State (an elected office) during the Dukakis years. "It wasn't so much about being first in the nation as we just wanted to do something and make things right."

Given the tough play-or-pay^{requirements}

of the 1988 law and the acrimonious eight-year battle to rescind them, you wouldn't expect Massachusetts business leaders to step up again for universal coverage. But the intellectual maturity they and others cite in describing the path to reform also applies personally. Whatever hat reform leaders currently wear—business leader, advocate, health industry executive, analyst—many of them cut their teeth on health reform in the Dukakis administration. Their collective failure to achieve universal coverage was painful but, many say, also educational.

“Psychically, you can’t underestimate how deeply disappointed we were, having worked so hard, to see that Dukakis plan fail,” says Nancy Turnbull, former deputy commissioner of insurance under Dukakis and, until recently, the president of the Blue Cross Blue Shield of Massachusetts Foundation, a corporate philanthropy created in 2001 by the state’s dominant insurer to address issues of health care access. In the intervening 18 years, however, these former staffers kept the conversation going, joining forces every now and then to push for health system improvements. Their shared interests and background, Turnbull and others say, were a potent force in discussions leading to the 2006 law.

“There’s a certain generation of health care people who all sort of grew up together and while that can become incestuous, there are also a lot of people who really know and trust each other,” says Turnbull. “At numerous points in the health care discussion here, these relationships were critical. You know how much you can push, and you know who the people are who can cross constituencies.”

Others now in the private sector similarly emphasize these relationships, along with the perspective they’ve gained through seeing the impact of coverage gaps from multiple vantage points. The result, says the Chamber’s Guzzi, was a refreshing departure in Massachusetts’ latest reform debate from the rutted arguments that have divided interest groups since President Clinton’s national reform plan fizzled more than a decade ago.

“We all realized it wasn’t enough simply to be against things; the question was, ‘What were we for?’ recalls Guzzi. The Chamber’s membership, for example, was determinedly opposed to a 1988-type employer mandate. “But having said that, we then had to tackle what we were going to propose as an alternative in order to get to yes.”

Matt Fishman, assistant secretary of Human Services under Dukakis and now vice president for community health at the state’s largest health system, Partners HealthCare, points to the near unanimous passage of the 2006 law as evidence of the soundness of achieving reform through consensus rather than by political fiat. “We weren’t saying this is going to be done on the backs of the business community,” Fishman says. “We said this is going to be done by all of us on behalf of our community’s health care system.”

Robert Restuccia, who heads Community Catalyst, a national group working for greater consumer participation in U.S health reform, recalls his and other advocates' uphill battle in the mid-1980s to get the Dukakis Administration to consider universal coverage, only to end up with a divisive and ultimately gutted law. By contrast, Restuccia says, the 2006 law and the "respectful rhetoric" that forged it nets out as "a public good that connects us all." He also thinks the law has staying power because of the way compromises were achieved—by consensus rather than coercion. Speaking of his own experience, Restuccia says he was dead-set against the individual mandate but over time became convinced that it was part of the overall solution. "Citizens have a duty to support the health care infrastructure," Restuccia says. "It's not free after all."

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To be sure, the give and take wasn't always genial. Businessman Jack Connors Jr., co-founder of the advertising giant Hill Holliday, Connors, Cosmopolos, Inc., and a broker of early discussions between key interest groups recalls heading off for a golfing weekend in Florida in February 2006 confident of the reform bill's passage only to return to a *Boston Sunday Globe* headline: "Hopes Fade on Reforms in Healthcare."¹¹ At issue was the play-or-pay mandate in the House version of the bill, subjecting employers who didn't offer health insurance to a tax based on a percentage of payroll. Senate President Robert E. Travaglini and Gov. Mitt Romney opposed the payroll tax, and the business coalition stoked things further by counter-offering a flat \$60 per uninsured employee. House Speaker Salvatore F. DiMasi was not pleased. Crafting a bill that fairly apportioned risks and benefits wasn't just politics to DiMasi, it was also personal.

"I grew up in a community where everyone helped each other," DiMasi says, recalling an impoverished childhood in Boston's Italian North End, where he lived in a third floor cold-water flat with no central heat. To shower before school, DiMasi says he walked two blocks to a public bathhouse. Stronger memories, however, are of neighborly generosity that prevailed over poverty. "If someone was sick, the neighbors brought food over. If the husband was sick, the community helped with the rent. That's the background I came from and that's what I expected on this bill: everybody pitch in."

Connors has considerable clout in Massachusetts business circles. During negotiations over the reform law, he was chairman of Hill Holliday (now emeritus). He also chairs \$6-billion Partners HealthCare, and is trustee of three Boston-area colleges, chairman of the Board of Fellows at Harvard Medical School and a well-known civic philanthropist. As such, he's on a first name basis with most of the state's power brokers, who are as likely to call him as he them. Connors immediately grasped the depth of the business coalition's tactical blunder, and hoped humor would defuse the Speaker's ire. He called DiMasi's office to ask for 15 minutes, and before heading over to the State House, ordered up a film clip from the Hill Holliday archives. It was the scene from the classic 1978 comedy about campus fraternity life, "Animal House," in which Bluto Blutarsky exhorts his dejected Delta House frat brothers to rally in defiance of the menacing Dean Wormer. Arriving at DiMasi's office, Connors popped the videotape into the Speaker's VCR player, stopping it at Bluto's famous declaration: "What, over? You say over? Nothing is over till we decide it is over!"

And then Connors gave his version: "With all due respect Mr. Speaker, it's not over till I say it's over." DiMasi and Connors shared a laugh, and by the end of the meeting they'd agreed to work together towards a per-worker assessment of \$300. Connors kept his part of the bargain, meeting over the next few weeks with business leaders, insurers, health industry executives and Senate Pres. Travaglini to sell the compromise.¹² The deal was cemented at a Sunday night meeting with business leaders in DiMasi's office and, a month later, the reform bill became law with the employer tax adjusted down to \$295 to match an estimate by the Massachusetts Taxpayers Foundation of the cost to the state's Uncompensated Care Pool per uninsured worker.

As in all things political, “getting to yes” requires

more than simply good will. Tangible inducements were needed to keep interest groups at the table and open to compromise. Reform leaders say everyone knew from the outset what was at stake for the state and for themselves, making Massachusetts’ path to health reform a textbook example of 19th century economist Adam Smith’s famous principle of human motivation: enlightened self interest.

The biggest stick, most agree, was the potential loss to the state of \$1.2 billion over three years (\$385 million annually, or 9% of the MassHealth budget¹³) in federal health care revenue. The threatened withdrawal of this money by the federal Centers for Medicare and Medicaid Services (CMS) had been looming since early 2004. At issue was federal renewal of a Section 1115 Medicaid waiver implemented in 1997 that enabled the state to expand MassHealth and obtain federal matching money for state and local government contributions to “safety net” health care providers.¹⁴ Much of this money went to two safety net health care systems—Boston Medical Center and Cambridge Health Alliance. It served to offset what these major safety net providers would otherwise have drawn from the state’s Uncompensated Care Pool to care for uninsured patients. The pool was created in 1985 as a mechanism to help pay for medical services for the uninsured and spread costs among hospitals, health plans, and government. How the money got divvied up, however, was a source of tension among hospitals in the state. And federal officials were increasingly unhappy with mechanisms in Massachusetts and other states to obtain federal matching dollars for safety net programs through intergovernmental transfers. As a matter of policy, federal officials also were moving away from institutional reimbursement for care of uninsured patients in favor of expanding coverage.

“To keep that \$385 million, we had to find a way to show that the money would be used to increase coverage and not just be used as an intergovernmental transfer,” says Sen. Moore.

In addition to a potentially crippling revenue shortfall from loss of the waiver, state officials also were under pressure to restrain double-digit increases in health insurance premiums. The financial pressures flowed in part from the state’s system of financing care for uninsured patients. The Uncompensated Care Pool drew not only federal and state health dollars, but also private sector money in the form of surtaxes on hospitals and health insurers—a total of \$160 million from each industry. Hospitals, in turn, built the assessments into their rates, causing insurers to bump up premiums. This made health insurance less affordable, especially to small businesses and individuals. The pattern, called cost shifting, is well known in U.S. health care—the controversial legacy of discounts built into the fee structures of Medicare and Medicaid. But an ominous up tick in the number of uninsured

adults in Massachusetts from a celebrated low of 8.0% in 2000 to 10.6% four years later heightened anxiety.¹⁵ No one even wanted to guess at the collective bill if that trend continued. Nor were they eager to watch two decades of painstaking work to improve health care access undone.

“The necessity of why we had to do something was very clear,” says Speaker DiMasi. “The federal government had changed the rules on the waiver, we were going to lose it.”

Timothy Murphy, head of the state Health and Human Services department at the time, remembers a lot of high level scrambling—governor’s staff, legislative leaders, members of the Congressional delegation—to assess the waiver situation. Early feelers returned nothing but bad news. “The feds simply wanted the money off the table,” recalls Murphy. “They were running deficits—they could use the money.”

The urgency of changing this mindset brought Massachusetts’ Democrat-dominated legislature into unusual alliance with its Republican governor. Gov. Romney, in turn, joined forces with U.S. Sen. Kennedy to double team everyone in Washington who might be able to influence the waiver decision. While Romney worked connections in the Republican White House, Kennedy began discussions with federal health officials, and also lined up political leaders back home in case State House action was needed. Kennedy staffers, meanwhile, organized strategy sessions with state health care leaders.

“Genuinely, I’d been in meetings with the Senator where basically (federal officials) said, ‘You are getting too much money, you are not getting the waiver,’” recalls Stacey Sachs, a health policy aide to Kennedy. The magnitude of the threat helped forge accord within the sometimes fractious health care community. “If this became a food fight about different providers, we were not going to succeed,” Sachs says. “We needed to stay together and everybody needed to be on board, working collectively toward a common goal because all the money was at risk.”

A grueling two-hour meeting with outgoing U.S. Secretary of Human Services Tommy Thompson in January 2005 extracted provisional agreement to extend the

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waiver on the condition that Massachusetts submit a plan to increase coverage. It literally was Thompson's last day in office, with a retirement party planned that evening. At the conclusion of the meeting, he invited Kennedy and Romney to attend, according to Sachs. She recalls the two men hopping up at the party and entertaining the crowd with a comedy routine in which they billed themselves as "the Odd Couple."

Inherent in the Massachusetts plan to expand coverage were carrots not only for consumers, (most of the uninsured earning less than 300% of the federal poverty level annually would qualify for free coverage or sliding-scale premium subsidies) but also for health care providers and businesses. Hospitals and community health centers had long complained about inadequate Medicaid fees; the 2006 law authorizes \$540 million in cumulative hospital and physician rate hikes over three years to bring reimbursement from 80% to 95% of costs.¹⁶ Business leaders, meanwhile, hoped that broader insurance coverage would reduce the surcharges built into insurance premiums to cover Uncompensated Care Pool tithes on hospitals and health insurers. This was a divisive issue in the business community. Employers that offered their employees health insurance were helping fund the Pool; businesses that didn't provide insurance, meanwhile, escaped all costs while their workers utilized "free-care" safety net services. "It was a fairness issue," says AIM's Lord. "We didn't like the status quo."

Nor did consumers, who were gaining clout in Massachusetts health care circles. Two groups began collecting signatures in 2003 to put health coverage mandates on the November 2006 ballot. One of them, called Health Care for Massachusetts Campaign and co-chaired by Barbara Roop, backed a constitutional amendment guaranteeing affordable and comprehensive health coverage for all Massachusetts residents. The other group, called Affordable Care Today (ACT), favored a ballot initiative with more specific requirements for increasing coverage, including a payroll tax on employers who didn't provide health insurance.

Both advocacy organizations successfully collected the initial number of signatures needed to advance their proposals. This accomplishment, combined with a 2003 public opinion survey by Robert J. Blendon and colleagues at the Harvard School of Public Health, suggested a significant base of public sentiment for reform. In the

Blendon survey—commissioned by the Blue Cross Blue Shield of Massachusetts Foundation—58% of respondents said the Massachusetts health care system had “major problems;” an additional 14% picked the harsher descriptive offered by pollsters, saying it was “in a state of crisis.”¹⁷

According to Roop, Health Care for Massachusetts chose to address health reform through constitutional amendment in order “to force change and lock in change as it occurred” while cutting off the possibility of “retreat” by any single constituency. The strategy emerged from Roop’s experiences during the 1988 reform effort. “I think everyone who was involved in that process took away a different lesson,” she says. “Mine was you have to lock in all the stakeholders to sustain it.” The proposed amendment, however, did not clear legislative review in time for the 2006 ballot. It failed again on January 2, 2007 to win the votes necessary for placement on the 2008 ballot.¹⁸

The ACT group had a broader base of support than Health Care for Massachusetts. Still active today, it counts among a long list of members several unions as well as influential health care organizations, including the Massachusetts Hospital Association, the Massachusetts Medical Society, UMass Memorial Health Care, (clinical base of the state university’s medical school and the dominant health system in central Massachusetts), Boston Medical Center, Cambridge Health Alliance, Children’s Hospital, and Partners HealthCare, the largest private health care system in Massachusetts. But ACT’s popular base largely resides in the advocacy group, Health Care for All (HCFA), which has pushed for universal coverage since the mid-1980s, and the Greater Boston Interfaith Organization (GBIO), which supplied new grassroots vigor. An activist arm of religious congregations, GBIO historically had worked on fair housing and other anti-poverty initiatives. In 2004, with members increasingly voicing concern for the medically uninsured, it shifted its mission to health reform.

There are 70 institutions affiliated with GBIO,

most of them churches and synagogues. Its co-chairs during the period leading to the 2006 law were the Rev. Hurmon Hamilton, pastor of Roxbury Presbyterian Church, and Rabbi Jonah Pesner, who at the time was one of the rabbis at Temple Israel of Boston, the largest synagogue in New England. GBIO's shift to health care activism came about through a series of meetings among congregants on "how do we make the world better," according to Pesner, now a community organizer for the Union for Reform Judaism. Every organization solicited members' ideas a little differently; Pesner says his congregation held meetings in people's homes coincident with Temple Israel's 150th anniversary. "We read about Jewish teachings on justice, and raised the question: How can we commemorate our anniversary with action on behalf of social justice," Pesner recalls. At first, participants talked in general terms about ameliorating poverty but gradually honed in on action to improve access to health care.

“People were standing up and telling their own horror stories, about a family member or neighbor or someone else they knew without insurance and about the consequences they’d witnessed in terms of preventable illness,” Pesner says. “You could see that this was an animating issue across congregations.” Animating issues are what GBIO leaders listen for because they convert best to action. Indeed, the health reform cause motivated GBIO members to gather initiative signatures, pack public meetings, carry placards and testify at legislative hearings.

Says Pesner: “Frankly, legislators are not used to seeing citizens testifying and demonstrating at the State House with the full weight of their congregations behind them.”

A subsidiary of the ACT coalition, called MassACT, collected nearly double the number of required signatures (about 66,000) to clear the first hurdle to putting its play-or-pay initiative on the November 2006 ballot. In April, however, the legislature’s compromise bill, with the negotiated \$295 per worker penalty on non-participating employers, became law. Cheryl Andes, GBIO’s chief organizer, says the organization had collected the second group of signatures but, in deference to the compromise law, chose not to turn them in, effectively killing the ballot initiative.

“We were never ideological about the employer assessment,” says Andes, whose group is an affiliate of the Chicago-based Industrial Areas Foundation. “We also weren’t trying to make all employers offer health insurance. As laudable as that might be, that’s not our issue. The thing we are ideological about is increasing the number of people with health insurance and making sure it is affordable.”

John E. McDonough, executive director of HCFA, refers to the 2006 law as the “third wave” of health reform in Massachusetts. A legislator during the Dukakis years, McDonough says remnants of the 1988 law (including strengthening the Uncompensated Care Pool) combined with MassHealth expansions in 1996 created a foundation on which to construct the 2006 law. And he asserts that the threat of a play-or-pay ballot initiative forced employers to become serious about reform discussions.

Business leaders dispute this. Some say the public could have easily been turned against the ballot initiative by a campaign raising the specter of job loss and other economic consequences. Others acknowledge discussion of this tactic but contend it was never seriously considered, given the overriding interest across constituencies in comprehensive reform. A year later, such disputes over who forced whom to do what linger between interest groups. Suffice to say every constituency clearly spent a great deal of time in private debate over tactics before ideas gelled sufficiently for public airing.

“People were standing up and telling their own horror stories, about a family member or neighbor or someone they knew without insurance...”

A critically important

leavening agent in the reform debate was a series of research reports produced by the Blue Cross Blue Shield of Massachusetts Foundation, a corporate charity set up in 2001 by the state's dominant insurer to address issues of health care access. The Foundation makes the customary grants to organizations that provide services to uninsured patients and other vulnerable populations. But in 2004, it also began investing in research to test the economic feasibility of universal coverage, publishing three reports between November 2004 and October 2005 under the logo "Roadmap to Coverage." The data, analysis and proposals in the reports were prepared by the Urban Institute, a policy research organization in Washington D.C.

The idea of putting health reform to an economic litmus test belongs to William C. Van Faasen, chairman of the Foundation's parent corporation, Blue Cross Blue Shield of Massachusetts. Van Faasen is an oddity in the chummy world of Massachusetts health reformers. An unapologetic businessman, he wasn't even in the state when Dukakis's plan made news. Instead, Van Faasen was working for the

Blues in Michigan, where he negotiated health insurance contracts with the Big Three auto makers and their unions. Simultaneously he tracked the national health reform debate, losing tolerance over the years for some of the arguments. Stripped down, he says, they were no more than self-serving proposals masquerading as high-minded charity.

"This thing has been so morally subdivided in so many ways over the years, and you can see people building residences around their position in a broken system," Van Faasen says. "This should not be a debate over good or bad intentions—no one desires for 10% or 20% of the population to be uninsured. The question really is, 'How can we get this done?'"

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When he joined the Massachusetts Blues in 1990, Van Faasen looked for an opportunity to rationalize the debate. He created the Foundation primarily to address the needs of uninsured Massachusetts residents, recruiting as chairman Philip W. Johnston, former Human Services secretary under Dukakis and head of the state Democratic party. Johnston, in turn, recruited as Foundation president his former aide from the Dukakis years, Andrew Dreyfus. The re-teaming of Johnston and Dreyfus is yet another example of how Massachusetts exploited homegrown health care expertise—present in every state—to lay the groundwork for reform. Both Johnston and Dreyfus had stayed in health care after leaving state government. Johnston served as a regional administrator for the federal Department of Health and Human Services under President Clinton, and subsequently founded a national health care consulting and lobby firm. Dreyfus joined the Massachusetts Hospital Association, and was executive vice president when Johnston and Van Faasen tapped him to lead the Foundation.

The Foundation's first years were devoted to assembling a clearer picture of the uninsured. The "Roadmap" series and the Foundation's involvement in discussions leading to the 2006 reform law evolved out of these early research projects.

Massachusetts, like all states, collects statistics about the uninsured—number, age, income, and so on. But less is known about how they manage their health and health care spending, where they turn for help in crisis, what programs exist to help them, who qualifies and who falls through the cracks. “Usually people start with the political case or the moral case,” says Dreyfus. “It was Bill Van Faasen’s idea to start with the business case.”

Building that business case required far more precise analysis of the flow of public and private health care dollars than had ever been undertaken publicly in Massachusetts. Dreyfus moved incrementally towards this goal. The Foundation’s first report in late 2001 was essentially a primer on the uninsured for legislators and health care leaders. The report assembled available data, listed safety net programs and profiled four uninsured Massachusetts residents and two health professionals. The latter described medical and financial consequences they’d witnessed in patients and the health care system due to lack of insurance.¹⁹

In 2003, the Foundation sponsored the Blendon public opinion survey on the Massachusetts health care system, presenting the results at a forum for invited guests from the state’s public and private health care industry.²⁰ During a panel discussion, Van Faasen threw out a challenge from the podium; the words were somewhat cryptic, but tantalizing to a Dukakis administration alumni like Dreyfus:

“If we could figure out a way and recognize that we’re really all very much interested in arriving at the same destination, I think that we could make great progress,” Van Faasen said.²¹ Dreyfus approached Van Faasen a few days later, and got approval for the Foundation to explore the possibility of affordable universal coverage. Discussions with health care leaders on how to proceed pinpointed a need for better data on the uninsured. The Foundation strategically hired the Urban Institute to produce this and propose ways to provide them with insurance because, according to Johnston, “no one in the state was sufficiently objective to come up with options that would have credibility.”

The biggest unknown was how much money Massachusetts already was spending on medical services for the uninsured. Traditional arguments for universal coverage emphasize benefits to patients and potential cost-savings from early preventative

treatment. Studies show that uninsured patients tend to delay care until crisis forces them to seek treatment, often in hospital emergency rooms, the most expensive setting for care. But there is little documentation of costs or benefits in these scenarios. Employers in Massachusetts had long complained about having to pay insurance surcharges to cover uninsured patients without evidence of how their money was being used.

The “Roadmap” reports generated by the Foundation provided new detail about specific and overall costs, as well as the reach of existing safety net programs. They also laid out strategies—with price tags—to achieve universal coverage, and projected potential benefits from doing so. For example, Bay Staters learned from the first “Roadmap” report, released in November, 2004, that they already were paying \$1.1 billion for medical services to the uninsured. Universal coverage would require an additional \$700 to \$900 million, the report said, but could yield an economic benefit of \$1.5 billion from improved health and productivity.^{22 23}

These numbers ended up being useful tools in the reform debate. Participants say they subdued long running—and distracting—cost/benefit arguments between interest groups. Nick Littlefield, a Boston lawyer who was on Kennedy’s staff during the Clinton health reform debacle and now sits on the Foundation board, says the data had instant credibility across constituencies. Widmer, of the Taxpayers Foundation, agrees, adding that reform strategies outlined in the reports—including controversial ones—got the same reception. A case in point is the individual mandate. Derided by some as a fringe notion of the political right when Gov. Romney proposed it, its inclusion in a 2005 Foundation report²⁴ led to calmer deliberation. The 2006 law ultimately incorporated the individual mandate as a logical complement to employer responsibilities for insurance.

As legislative hearings got underway in mid-2005,

three major health reform proposals contested for favor, backed by three of the state's most influential politicians: Gov. Romney, Senate President Travaglini, and House Speaker DiMasi. Substantive issues divided them. Romney wanted an individual mandate but none for employers. Travaglini favored insurance market reform and penalties on employers whose workers used the uncompensated care pool, but opposed a payroll tax as economically unsound. DiMasi wanted universal coverage through Medicaid expansions and subsidies for low income workers, and favored a payroll tax plus individual mandates.

All three men used the Foundation’s “Roadmap” forums to unveil their proposals. The forums typically attracted about 350 health care insiders, including people from academia, provider organizations, the state legislature, government agencies, think tanks, insurance companies, consumer groups, and programs serving the uninsured. Travaglini, keynote speaker at the November 2004 meeting, startled the audience with a pledge to introduce legislation that would cut the number of uninsured by half. The Medicaid waiver was still uncertain at this point, and while

And so the political contest began—but with an innovative twist to legislative business as usual.

it looked like the state might have to propose some type of coverage expansion, no one expected Travaglini to move so quickly. Within the week, Gov. Romney went public with his plan, outlined in an op-ed column in the *Boston Globe*. Romney added detail in his keynote address at a subsequent Roadmap forum in June 2005, and then it was DiMasi’s turn. The Speaker broke his long silence on health reform in October

2005, announcing at the third Roadmap forum that his bill would propose universal coverage, backed by an employer assessment and individual mandate. And so the political contest began – but with an innovative twist to legislative business as usual.

Traditionally, the Massachusetts legislature assigned all financing bills, including those pertaining to health, to the Ways and Means committees of each chamber. Another committee, called the Joint Committee on Health Care, with members from both chambers, reviewed the non-financing aspects of health-related bills. As momentum for reform legislation built during 2004, Travaglini and DiMasi decided to overhaul the legislative committee structure in part so reform proposals wouldn’t overload busy Ways and Means budget generalists. The Health Care Committee was divided into three new joint committees: Health Care Financing, Public Health, and Mental Health and Substance Abuse. Health Care Financing was designated as the lead committee on health financing and policy, meaning that bills favorably reported out by other committees also had to pass muster with Health Care Financing. The new committee quickly became known among State House regulars as the “Ways and Means of health care,” according to Rep. Walrath, its House chair. Sen. Moore, a college administrator from central Massachusetts who previously co-chaired the disbanded Health Care Committee, is Senate chair.

Walrath, a veteran legislator and former math teacher, says she wasn't overjoyed at her new assignment. She'd heard horror stories about health care financing—where numbers always seemed to be followed by asterisks and disclaimers. She describes her previous leadership assignment—co-chair of a committee overseeing state long term debt and capital expenditures—as her “psychic home,” a place where the rows and columns add up and she could use her debt-management acumen to improve the state's bond rating.

Recalls Walrath: “The only thing I could think of to say was, ‘Mr. Speaker, why me?’”

But DiMasi says he wasn't about to let her out of the assignment. Walrath is detail-minded, analytical and sophisticated about finance; DiMasi considered her lack of health care background to be an additional credential. “I wanted a fresh look at this,” he says. Anticipating that testimony on the health reform proposals would likely be voluminous, complicated and intense, DiMasi and Travaglini authorized Moore and Walrath to hire new staff with expertise in the issues that would dominate the debate so committee members could stay on top of the testimony. It was a formula DiMasi had used to staff his own office after he was elected Speaker in the fall of 2004, hiring, among others, a respected health policy instructor from the Harvard School of Public Health, Christie L. Hager. In presenting his staff, DiMasi identified health reform as a top priority of his leadership, though he personally had scant background in health care issues. “I then spent 14 hours a day learning about them,” DiMasi recalls. He became so proficient over the next year in both theoretical and operational reform minutiae that he was able to hold his own in discussions with providers, insurers, advocates, business leaders or regulators. “His comprehensive knowledge of the details I think gave him the credibility to drive the negotiations,” Hager says.

While all this was going on at the State House, numerous meetings were being organized around the state by various health care constituencies, reform leaders say. Initial conversations took place within traditional interest groups, then branched out. Guzzi's Chamber, for example, began meeting with Lord's employer group, (AIM), the Massachusetts Business Roundtable and also with Widmer's Taxpayers' Foundation. Advocates assembled under the ACT banner. Health insurers got together as did hospitals and community health centers.

There was as at least as much horse-trading going on among the private interest groups as among the politicians. The big question in health care circles was which reform approach Blue Cross Blue Shield and Partners HealthCare would endorse. Because they dominate private sector health care, their influence on state policy is considerable. Blue Cross's market share is by far the largest among health insurance carriers. Partners owns 11 hospitals in Massachusetts, including the renowned Massachusetts General and Brigham and Women's hospitals, community and specialty hospitals, health centers, a physician network, and home health and long-term care services, and is one of the state's largest employers.

Winter and early spring, 2006, tested the staying power of reform proponents. *The Boston Globe*, *State House News Service*, *Boston Business Journal*, and various other media outlets chronicled each tempest: Travaglini pronouncing health reform dead over the impasse on the employer mandate; DiMasi hotly accusing Romney, who was near the end of his term, of threatening to scuttle the waiver negotiations. Kennedy monitored the ups and downs from his office in Washington and via numerous phone calls to state officials and legislative leaders. In late March, he arranged to meet with Travaglini and DiMasi at the State House, and ended up accepting invitations to address each of their chambers.

A long time health reform proponent in Congress, Kennedy wanted the effort to succeed in Massachusetts. In addressing each chamber of the legislature, he acknowledged the difficulty of the task before them, but urged the lawmakers to stay the course to compromise. And then he got personal, speaking of his son, Edward Jr., who lost a leg to bone cancer, and the agony Kennedy had witnessed in parents with equally sick children but inadequate insurance.

"I can remember being in the hospital here [Dana-Farber Cancer Institute in Boston] with my son, Teddy, and he was in an NIH experimental treatment program for treating osteosarcoma after he lost his leg," Kennedy said, speaking extemporaneously and without notes. "Halfway through the treatment, they took it out of the NIH protocol, which meant you or your insurance would have to pay for it. As you can imagine, other insurance companies would not pay it, but the federal insurance that I had did pay for it.

“I can still remember the parents out there wondering since it was \$3,200 for [each] treatment and it was going to take 2 years, if they sold their house at \$40,000—and they could get the treatment for eight months or twelve months or 15 months—what chance did their child have to be able to survive?”²⁵

The compromise bill passed both houses of the Massachusetts legislature on April 4, 2006. The signing ceremony took place eight days later in Boston’s historic Faneuil Hall, site of much fiery oratory during Revolutionary War. Kennedy, Romney, Travaglini and DiMasi stood together on the stage before a jubilant crowd. With the stroke of a pen, Massachusetts had a new law, Chapter 58 of the Acts of 2006: “An act to provide access to affordable, quality, accountable health care,” and a new challenge: proving it can deliver on the law’s promise.

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Key Components of Chapter 58 – An Act Providing Access to Affordable, Quality, Accountable Health Care

by Kate Nordahl

Individual Mandate

- Requirement that all adults 18 and older have health insurance if it is affordable.
- First year penalty: if the adult cannot demonstrate that he/she had health insurance as of December 31, 2007 on his/her tax return, he/she will forego the personal tax exemption estimated at \$200.
- Penalty in subsequent years: tax penalty of 50% of the cost of the lowest priced health insurance available to the tax filer for all months during which he/she was uninsured, excluding transition periods of 63 days or less.

MassHealth Expansions and Restorations

- Expansion of Medicaid (“MassHealth”) for children up to 300% FPL (from previous limit of 200% FPL)
- Expansion of Insurance Partnership Program (program which provides insurance subsidies and employer tax credits to low-income workers of small firms (<50)) from 200% FPL to 300% FPL
- Increasing of enrollment caps on program for long term unemployed (“MassHealth Essential”), CommonHealth program for disabled, and HIV waiver program.
- Restoration of dental, vision, chiropractic and other benefits to adults.
- Creation of new wellness benefit/incentive program.

Subsidized Health Insurance Program

- Creates new Commonwealth Care Health Insurance Program which provides subsidized insurance for adults up to 300% FPL. They must not have access to employer sponsored insurance unless a waiver of this requirement is provided and employer’s contribution goes towards state cost of Commonwealth Care.

- Sliding scale monthly premiums are paid by enrollees. Law specifies there will be no premiums for those with incomes <100% FPL. Connector Board subsequently has proposed to waive monthly premiums for those up to 150% FPL as of July 1, 2007.
- Program to be provided exclusively by currently participating MassHealth-contracted managed care organizations until June 30, 2009.
- Covered services and copays for those with incomes <100% FPL are comparable to MassHealth program.
- Deductibles are prohibited.

Commonwealth Health Insurance Connector

- New state authority with 10 member governing board, with 3 members appointed by Attorney General, 3 members appointed by Governor, and 4 ex-officio members.
- Connector responsible for:
 - administering Commonwealth Care Program,
 - creating new health insurance purchasing vehicle for individuals and small employers (with fewer than 50 employees),
 - reviewing and providing Connector “seal of approval” to health plans it offers which are deemed to be products of quality and value. These products are called “Commonwealth Choice”,
 - establishing affordability schedule and defining of minimum creditable coverage for purposes of the individual mandate,
 - creating mechanism for employers of all sizes to create Section 125 plan (provides mechanism for employees to pay for health insurance on a pre-tax basis regardless of whether or not employer contributes), and
 - offering Young Adults products to 19-26 year olds who don’t have access to health insurance through an employer.

Employer Responsibilities

- Employers with 11+ employees must provide access to Section 125 plan to its employees or face potential of a “free rider surcharge” if employees utilize substantial amounts of free care through the Uncompensated Care Pool.
- Employers with 11+ employees must make a “fair and reasonable” contribution towards the cost of health insurance or pay a “fair share” assessment of \$295 per employee (prorated for part-timers).

Insurance Market Reforms

- Non-group and small group markets are merged in an effort to reduce premiums for the non-group market.
- Young Adults products are created and offered solely through the Connector to adults 19-26 years of age who don't have access to employer sponsored insurance. To encourage development of lower cost products, products have certain benefit flexibility unavailable through other insurance products.
- Dependent coverage rules raised to 26 years of age or two years after loss of IRS dependent status, whichever is earlier.
- Non-discrimination provisions prohibit insurance carriers from selling to employers who contribute more towards the cost of health insurance for higher paid employees.

Provider Rate Increases

- Hospitals and physicians are given Medicaid rate increases totaling \$540 million over three years. Hospital rate increases are contingent on meeting pay-for-performance benchmarks. New MassHealth Payment Policy Advisory Board. Massachusetts Medicaid Policy Institute (MMPI) named as member of the Advisory Board.

Uncompensated Care Pool

- Maintains the pool, with modifications:
- New name: Health Safety Net Trust Fund
- Reimbursement rates are to be based off of modified Medicare reimbursement rates.

Quality and Cost Council

- Creates new council, and companion Advisory Committee, to develop cost and quality goals and to create mechanisms to make cost and quality information more transparent and easily available and understandable to the public.
- MMPI named on member to the Council and Blue Cross Blue Cross Blue Shield of Massachusetts Foundation has seat on its Advisory Committee.

Other Components

- Makes permanent a Health Care Disparities Council.
- Restores \$20 million for public health prevention programs.
- Convenes an advisory council to study Community Health Worker Outreach to reduce barriers to health care, particularly in ethnic and racially diverse communities.

Key Components of Dukakis Law – Chapter 23 of the Acts of 1988 – “An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing”

by Kate Nordahl

Major Coverage Programs Created in the Law That Remain in Place Today

CommonHealth – sliding-scale health insurance program for adults and children with disabilities. Program provides “wrap around” benefits to those with access to employer-sponsored insurance or Medicare and full benefits to those without such access. Benefits include critical community long term care benefits, such as Personal Care Attendant services, which can be critical to the lives of people with disabilities. Allows disabled adults and parents of children with disabilities to maintain employment since health insurance through their employer may be unavailable or inadequate. In subsequent years, the MassHealth Program has folded CommonHealth into its 1115 waiver allowing for federal matching funds on expenditures under this program.

Expanded Medicaid Eligibility for Pregnant Women and Young Children – law expanded the financial eligibility rules for pregnant women and young children. Since the Dukakis law, Medicaid has further expanded eligibility for these populations through its waiver programs.

Healthy Start – provides pregnancy related care for low-income women who are not eligible for Medicaid. Under the Dukakis law this pilot program became permanent. Since then, MassHealth has folded this program into its State Children’s Health Insurance Program (S-CHIP) allowing for federal matching funds on its expenditures.

Qualified Student Health Insurance Program (Q-SHIP) – requirement that three-quarters to full-time students obtain qualified health insurance either through their parents or school.

Mandated Well-child Coverage – requirement that all insurance products cover well-child visits for children under 6.

Center Care – program to provide primary care services to uninsured patients at community health centers. Over the years, funding for this program has been limited, but it remains in place.

Program for those Receiving Unemployment Insurance – new health insurance program now called the “Medical Security Plan” for persons receiving unemployment insurance compensation and their families.

Insurance for General Relief Population – offered health insurance to indigent citizens not covered by Medicaid. Subsequently, this population was folded into Medicaid under new 1115 waiver programs MassHealth “Basic” and MassHealth “Essential.”

Major Coverage Components of the Law That No Longer Exist or were never implemented

Small Business Insurance Programs – The law created a demonstration program to provide a low-cost insurance to employees of small businesses. A very small program was implemented and then phased out.

State-administered Health Insurance Program for Individuals and Families not Offered Health Insurance through their Employers – this program was to be funded in part by employers who do not offer health coverage to their workers.

“Play” or “Pay” employer responsibilities – employers were to be required to either provide coverage to their employees (“play”) or “pay” an annual assessment of \$1680 per employee. This provision was delayed many times and finally repealed in 199X.

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