New England Journal of Public Policy

Volume 20
Issue 1 *The War on Poverty: Unfinished Business*

Article 9

9-21-2004

The Road to Universal Health Coverage in Massachusetts: A Story in Three Parts

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In 1988, the Massachusetts Legislature passed a new law, a "play or pay" employer mandate, requiring all employers with six or more workers to provide health insurance coverage for their employees. A few years later, with Medicaid identified as a "Budget Buster," the Weld administration sought deregulation as the way to cut costs and expand access by establishing MassHealth, which dropped the employer mandate and expanded Medicaid, and eventually distinguished Massachusetts as the state with the greatest percent of covered citizens. But MassHealth enrollment has declined as premium costs have risen, and the Uncompensated Care Pool is once again faced with providing for large numbers of uninsured — a solution more expensive than providing health insurance. It appears that the Romney administration may be on the verge of launching another initiative.

Before 1985, few imagined Massachusetts might be a leader in providing health insurance to the uninsured. Then again, few Americans imagined any state would pursue such a vision. Providing all Americans with health insurance coverage had been a federal preoccupation since the nineteen teens, with pivotal moments that included the following:

- President Franklin Roosevelt's refusal to make health insurance part of the Social Security plan in the mid-1930s;
- President Harry Truman's inability to overcome opposition from the American Medical Association and other groups to pass his national health insurance proposal in 1948;
- President Lyndon Johnson's incremental expansion of coverage to all elderly and some poor in 1965;

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- President Richard Nixon's inability to pass a law requiring employers to insure their workers in the midst of the 1973 Watergate scandal; and
- President Bill Clinton's catastrophic failure to expand coverage and transform the health insurance market in 1994.

State governments had always been a backwater of the American federal system, the dumb cousin not to be trusted with complex responsibilities. Yet the growth and professionalization of government in the 1960s also affected states. Governors and legislators embraced bigger visions and policy challenges.

It was not surprising that Massachusetts, with a reputation for liberalism and experimentation, was an early universal coverage innovator, though not the first. Hawaii earned that honor in 1974 when, in anticipation of a federal law to mandate employer health insurance, it required all employers to cover individual workers who toil at least twenty hours per week. That law stands today, though on ground as shaky as the Hawaiian economy.

Fourteen years later in 1988, Massachusetts became the second innovator. And in 1996 Massachusetts embraced a major reform law, which built on — and broke from — the earlier effort. At this writing in the fall of 2004, the Commonwealth may be heading for another reform phase in 2005–06. This article describes the two earlier reform efforts in the context of the next opportunity, and identifies lessons from the recent past to inform the next phase.

Phase One: The Dukakis Era, 1975–90

Involvement by states in providing health coverage dates to the 1965 creation of Medicaid, which was added as an afterthought to the law that established Medicare. Because states are reimbursed between 50 and 79 cents for every dollar they spend on Medicaid, the financial incentive to participate proved irresistible to all fifty states — Arizona was the last to join in 1981. But the deal had an unexpected downside — all states now have a sizable part of their budgets linked to a medical system that experiences cost growth far in excess of tax revenue growth. Worse still, medical inflation peaks most acutely during economic downturns when state revenues are least able to cope.

Massachusetts' first dose of this formula came with the national recession of 1974–75, the latter year being the first of Michael Dukakis' twelve as governor. State leaders concluded that medical inflation could not be addressed by cutting Medicaid alone, and that the Commonwealth's problems were shared by all medical care consumers and purchasers. Because hospitals were considered the principal source of inflation, states such as Maryland, New York, and New Jersey began regulating total hospital budgets. Massachusetts joined them in 1975 creating a hospital rate-setting program that set annual revenue caps for every acute care hospital in the Commonwealth. Importantly, this

experiment in government regulation began with the full support of business groups seeking relief from high rates of health insurance premium inflation.

As is true of many regulatory mechanisms, what began as a straightforward formula became more complex as accommodations were made to changing circumstances, special needs, and political demands. The most important of these accommodations was the creation, in 1986, of the Uncompensated Care Pool, a financing mechanism to share the cost of providing hospital services to individuals without health insurance, then estimated at about 600,000 in Massachusetts.

Several factors in the mid-1980s spurred interest in expanding coverage to the uninsured. The regulatory and political requirements of hospital rate setting kept a spotlight on the health system's shortcomings. The creation of the Uncompensated Care Pool publicly focused particular attention on the costs of caring for uninsured individuals. Business leaders, notably Nelson Gifford of Dennison Manufacturing, called for universal coverage as a precondition to move from a regulatory toward a market oriented system. Consumer activism evolved in a more organized direction with the founding of Health Care for All in 1985. And powerful Senate Ways and Means Chairwoman Patricia McGovern from Lawrence made universal coverage a front tier issue in March 1987 by filing legislation to mandate employer health insurance.

Though Dukakis initially resisted calls for a state universal coverage plan, in August 1987 he embraced the campaign, unveiling a plan with two major components: first, a "play or pay" employer mandate requiring all employers with six or more workers to cover them or else pay a $1680 per worker tax to be used by the state to provide coverage; second, a continuation of tight rate-setting controls on hospital revenues.

The final version of the law, signed in April 1988, included the employer mandate, though implementation was delayed until January 1992. The rate-setting law also continued, though the revenue controls were so significantly relaxed that little cost control remained. In the Senate, continuing support for the law was firm because of McGovern's commitment. In the House, where the final version passed by a slender margin, support was tenuous and was attributed largely to loyalty to Dukakis' presidential campaign.

In November 1988, Dukakis lost his race against Vice President George H. W. Bush in a campaign that lampooned the progressive image of the Commonwealth and weakened the Governor's popularity in his home state. In January 1989, Dukakis announced he would not stand for reelection in 1990. More significantly, the state's economy began a precipitous slide into deep recession. A lame duck, discredited governor was in a weak position to defend the employer mandate from repeated assaults in the Legislature, spurred on by a newly mobilized small business community. In January 1991, Governor

Dukakis was replaced by William Weld, as committed to repealing the universal coverage law as Dukakis had been to implement it.

Important components of the 1988 law were implemented and survive today. The Medical Security Plan helps tens of thousands of uninsured workers obtain coverage during spells of unemployment. The CommonHealth program enables disabled adults to go to work and maintain insurance coverage, and it makes it possible for disabled children to receive coverage outside of a family's policy. Healthy Start provides stable coverage to lower income pregnant and post-partum women. All full-time college and university students are required to have insurance coverage, reducing their demands for uncompensated care. Yet the heart and soul of the 1988 law, the employer mandate, faced an uncertain future.

Phase Two: The Weld/Cellucci Era, 1991–2002

Fascination with using market strategies to address the problems of access and cost control grabbed the interest of policy makers on the national and state levels in the early 1990s. The regulatory regime — with governmental price setting, red-tape requirements, and endless process — lost legitimacy in the wake of hyperinflation during the economic recession between 1989 and 1991. Once again, a recession featured Medicaid's rate of growth as a key villain, this time dubbed a "budget buster." In the 1975 recession, the answer to out-of-control health spending growth was regulation; in the early 1990s, the answer to the same problem was deregulation of the 1975 "answer." Deregulation proponents predicted the removal of heavy-handed government controls would unleash market forces that would drive down health insurance premiums.

Deregulation was enacted in 1991, and was followed by strikingly low levels of medical inflation between 1993 and 1998, not just in Massachusetts, but across the nation (dispelling the nexus between Massachusetts inflation and deregulation). For a time, it seemed the answer to medical inflation had been discovered in the magic of market forces and managed care.

The savings were real, just not long-lasting. Responding to the emergent power of payers and purchasers, providers began unprecedented consolidation, epitomized by the 1993 affiliation of Massachusetts General and Brigham & Women's hospitals into Partners Healthcare. In a public showdown in 2000, Tufts Health Plan was compelled to accept all of Partners' contractual demands after their threats to exclude Partners from its network were rejected by employer purchasers. By 2000, health care inflation had returned with a vengeance.

Another aspect of deregulation that did not turn out as planned was access to health insurance. Deregulation champions promised that lower costs would lead to expanded access. Instead, by 1995 the number of uninsured had risen to 680,000, including 160,000 children. In 1993, two Weld administration

officials, Health and Human Services Secretary Charles Baker and Medicaid Commissioner Bruce Bullen, began working on an administration initiative to expand access to coverage. Their plan involved complex financing arrangements to bring hundreds of millions in new federal dollars into the state through a federal Medicaid waiver. They also proposed subsidizing employer coverage for lower income workers in a unique program now called the "Insurance Partnership" and repealing the 1988 employer mandate. They advertised the plan as "universal coverage without an employer mandate."

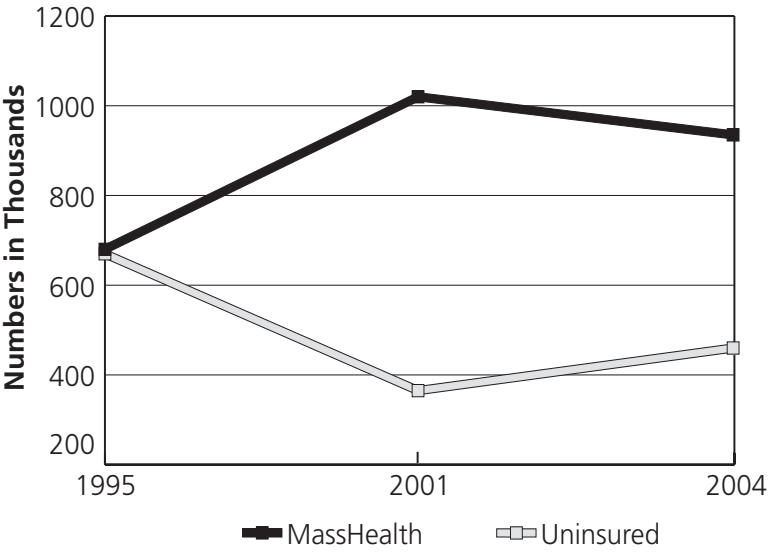
The 1988 mandate had not taken effect as scheduled in 1992, nor was it repealed. Instead, the legislature three times delayed implementation in hopes it could be a bargaining chip with the Weld administration in negotiations over expanding coverage. The Baker/Bullen access plan required approval by the Legislature, which changed the plan in ways displeasing to Governor Weld. One change in particular, increasing the tobacco tax by 25 cents to finance coverage for uninsured children and a prescription drug program for lower income seniors, resulted in a veto of the final legislation by Governor Weld. In July 1996, the Legislature passed the health access reform law over his veto. In order to obtain political support for the bill from the business community, the legislation also repealed the Dukakis employer mandate. Another statute, approved in the summer of 1997, further expanded access by increasing children's eligibility for Medicaid and fixing financing issues with the Uncompensated Care Pool.

The expansions in Medicaid (now called MassHealth) implemented between 1997 and 2001 were the largest since the establishment of the program in 1965. At its peak, more than 350,000 individuals were admitted to the program, swelling enrollment from about 670,000 in 1995 to 1,020,000 in 2002. This dramatic increase drove down the number of Massachusetts residents without health insurance from an estimated 680,000 in 1995 to 365,000 in 2000 — one of the lowest rates of uninsurance of any state. A coordinated campaign involving state officials, providers, and community/consumer organizations worked effectively to identify and enroll uninsured persons.

Phase Three: The Romney Years, 2003

The chart on the following page shows the interrelated growth and decline in MassHealth enrollment and numbers of uninsured residents between 1995 and 2004. The relationship between the two sets of numbers is striking. A dramatic increase in MassHealth enrollment between 1995 and 2001 was accompanied by a striking drop in numbers of uninsured; losses in access to MassHealth since 2001 have been accompanied by increasing numbers of uninsured. While increases in uninsured since 2001 also include many who have lost employer-sponsored coverage, it is the lower-income population most at risk of being without insurance for extended periods.

Uninsured MassHealth Enrollment, 1995-2004



Sources: MassHealth enrollment data: Division of Medical Assistance; Uninsured estimates: Division of Health Care Policy and Finance.

The increase in the number of uninsured between 2000 and 2004 reflects both drops in public coverage and private employer sponsored coverage. The significant increases in health insurance premiums between 2000 and 2004 have led to some employers no longer offering coverage and to workers declining coverage. Rising numbers of individuals without coverage have placed pressure on the tenuous financing of the Uncompensated Care Pool, and have led to the financial instability of those safety net providers that care for large numbers of uninsured.

Lower income individuals and families dependent on MassHealth paid in many ways for the medical inflation affecting the health system between 2001 and 2004. About 36,000 very low-income individuals were disenrolled in April 2003, only to have coverage restored in October 2003 — as of this writing about 30,000 have been re-enrolled. About 10,000 legally residing immigrants were disenrolled in August 2003. All outreach activities were suspended, and premiums and other cost sharing were imposed on many clients. Dental services, dentures, eyeglasses, and other benefits were also eliminated for most MassHealth adults.

Beginning in 2003, Governor Mitt Romney's Secretary of Health and Human Services, Ronald Preston, began working on a plan to expand access to coverage — a plan that includes creation of a lower cost insurance product for the uninsured, subsidization of the product for lower income residents, and requirements for all employers to pay some portion of the cost of insurance.

As of this writing in the fall of 2004, a decision by the administration to move on this or an alternate plan has not been made. What is clear, is that the twin problems of health care costs and access to coverage cannot be ignored for long. The fragile interrelationships among the uninsured, MassHealth clients, and privately insured individuals require continuous attention and care.

Conclusions

This brief overview of Massachusetts access and cost-control efforts since 1975 offers several conclusions.

First, access and cost control are inextricably linked. Cost-control efforts done poorly affect access in ways that splash back on those seeking to control health budgets. Because of the odd financing structure of the Medicaid program — federal reimbursements of 50 cents or greater for every dollar spent — it is often the case that it is less expensive for Massachusetts government to cover folks through MassHealth than to leave them uninsured.

Second, Massachusetts government cannot avoid for long deep involvement in the access and cost-control challenges facing our health care system. The significant dollars, the large federal reimbursements, the huge health care workforce, the economic impact of the foregoing — all combine to make health care policy an unavoidable and vitally important preoccupation for policy makers in the legislative and executive branches.

Third, Massachusetts seems to have the appetite for one major reform effort per decade. The years 1988 and 1996 are watershed years for health policy and access improvement in the Commonwealth. Governor Romney's stated interest in finding a way to cover all the state's uninsured suggests that the once-per-decade access opportunity (like a policy comet) may be coming into view again.

Fourth, unity within the broad health care community — including patients/consumers, providers, health plans, coverage purchasers, and public health professionals — is an essential ingredient for success. In 1988 and 1996, such broad unity was evident and critical in achieving reform. Similar unity will be essential looking forward to the next opportunity in 2005 or 2006.

Before I started going to VOC I was so bored *sitting in my house doing nothing at all. I was baby-sitting every day, and I didn't know what to do next. My children would tell me to go out and have fun. But I was so sad because my husband died on me and left me alone in the big bad world. Now I am working to get my GED. Also I am meeting new people. My diploma will help me get a good job. I am learning better skills. I read much better now. I even like math and science now. My writing is getting much better now. For me, taking a risk was a good thing.*

Sharon Alston
Valley Opportunity Council

I was born in Salinas, Puerto Rico. *I got married at the age of fifteen and I had my first child at seventeen and every year after that until I had five children in total. I had to grow up very quickly, but I think I did pretty fine with them. I put my children through school here in Massachusetts and that's how they learned English. I am very proud of them.*

I continued my education in order to receive my diploma. Most of my kids have graduated from high school and have been a great influence on me reaching that goal also. After I receive my high school diploma, I would like to continue educating myself. Since I started working at VOC daycare, my English has become more clear and I feel that I will speak even better someday. I am not ashamed to learn English, even if at times I may sound funny. It is very important for me to learn English in order to reach the goal of teaching at early childhood centers.

Daisy Pacheco
Valley Opportunity Council