Expanding Health Access in Massachusetts

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This is a summary of a landmark legislative event in Massachusetts to expand access of health care to almost all our state's citizens. Approximately 7 percent of Massachusett's citizens are uninsured. You are welcome to take our process steps and ideas, and then see if you can apply, incorporate and/or improve them, as California seeks a solution to increase health care access for its 7 million uninsured citizens.

The Massachusetts Medical Society is pleased to report the enactment of Chapter 58 of the Acts of 2006, "An Act Providing Access to Affordable, Quality, Accountable Health Care," which was a major legislative priority of the Massachusetts Medical Society. The primary objective of the measure is to provide health insurance coverage to at least 90 percent of the state's approximately 550,000 uninsured over the next three years through a variety of mechanisms. The measure also provides substantial Medicaid reimbursement increases for physicians and hospitals over that period. The bill was signed into law by Governor Mitt Romney on April 12, 2006.

Background

The MMS has long supported universal access to health care. In 1995, the Society adopted a policy that:

> The fundamental goal of any change to the American health care system should be to provide universal access to medical care for all Americans.
>
> Any proposed change to the American health care system that will decrease the likelihood of movement towards universal access to health care for all Americans will be strongly opposed. ...

For those individuals unable to access private health insurance, the MMS has long advocated the expansion of coverage through changes in Medicaid eligibility requirements. In fact, the Society has been a part of every successful major initiative to expand health access in the Commonwealth.

The MMS Role

Despite our past success, over 500,000 Massachusetts residents still lacked fundamental health insurance coverage in 2004. That year, the MMS engaged

in a number of parallel activities aimed at addressing the problem. First, the Society participated in informal discussions with an array of organizations concerned with developing a consensus approach to solving the problem. As a result, the MMS joined with Health Care For All and the Affordable Care Today coalition—an alliance of health advocates, providers, labor unions and employers—in drafting a comprehensive measure (House Bill 2777/Senate Bill 738, "Health Care Access and Affordability Act") that included both near-universal coverage and substantial increases in Medicaid reimbursement rates for physicians and other health care providers. It was determined that participation in such a broad-based coalition, in addition to our regular lobbying activities, would be the most effective means of achieving all of the Society's objectives. This proved to be the case, as the ACT coalition also adopted as one of its principles that adequate payment to providers was a key element of health access.

Later that year, the MMS established a Task Force on Universal Access to Health Care to explore the variety of options for providing such access. In May 2005, at the recommendation of the Task Force, the MMS House of Delegates voted unanimously in favor of a resolution "supporting the achievement of universal insurance coverage." The House also adopted the five principles from the Institute of Medicine's report "Insuring America's Health: Principles and Recommendations." The IOM recommended that:

- Health care coverage should be universal.
- Health care coverage should be continuous.
- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

Twice during the legislative session, I testified before legislative hearings considering the major comprehensive bills filed on behalf of the ACT coalition, the governor and the Senate president, articulating the position of the Society within the context established by the MMS House of Delegates. In addition to advocating for the IOM's five principles, the Society's testimony also addressed the larger context of issues facing the health care delivery system, with the understanding that without a strong infrastructure of physicians and health care providers, "the enactment of health insurance itself could prove to be a hollow victory."

On November 2, 2005, the MMS's "Doctor's Day at the State House" brought about 200 physicians to Beacon Hill, advocating for health access and other MMS priorities. Within a week, the House and Senate passed differing versions of legislation aimed at expanding health insurance coverage. Both versions also included provisions to increase Medicaid reimbursement rates for physicians. Soon thereafter, a Conference Committee reconciled the differences between the House- and Senate-passed bills, and the compromise bill was enacted on April 14.

The Scope of the New Law

The major focus of the law is the expansion of health insurance access. The goal of covering 90 percent of the uninsured over three years is to be achieved by a variety of means. An additional 85,000 patients are projected to be added to the Medicaid system through expanding eligibility for children, increasing outreach to currently eligible but unenrolled adults, and raising enrollment caps on certain programs. A new Commonwealth Care Health Insurance initiative would provide Medicaid-like private insurance coverage to another 215,000 lower-income adults, with a sliding-scale premium schedule. The current Insurance Partnership Program would also be expanded to include 7,500 more low-wage participants. The remainder of the uninsured would be required to purchase coverage by July 1, 2007, so long as "affordable" coverage is available.

In order to promote the affordability of insurance products, the law establishes the Commonwealth Care Health Insurance Connector. This new public authority is designed to encourage the creation of affordable health plans, certify their quality, and link individuals and employers to them. Plans purchased through the Connector would be bought with pre-tax dollars. In addition, the law merges the small- and non-group markets, which is designed to reduce individual costs by 25 percent, and it allows independent young adults to stay on family plans for longer periods.

A key victory for physicians and hospitals was achieved in the mandated increase in Medicaid reimbursement rates. The MMS has long advocated for rates that meet the cost of serving Medicaid patients. The new law provides $81 million in additional funding for physicians in escalating amounts over a three-year period. An additional $459 million will also be provided to hospitals during this period, although the bulk of those payments will require achieving "pay for performance" benchmarks. A MassHealth Payment Policy Advisory Board is established to review and evaluate rates and payment systems; the MMS is a member of that Board. The law also creates a new Health Care Quality and Cost Council (of which the MMS is a statutory member of its

Advisory Committee) that has the authority to gather data from health care providers and insurers in order to set quality improvement and cost containment goals and benchmarks. The Council will also establish a health information Web site with comparative data for consumer use.

The Law would replace the Uncompensated Care Pool with a new Safety Net Care Fund in the Office of Medicaid (as of October 1, 2007). It is anticipated that this will meet the requirements for renewing the state's waiver agreement to secure $385 million in federal funding. An assessment of up to $295 per employee per annum would be charged to employers (of 11 or more) who do not offer health insurance coverage, and an additional "free rider" surcharge will be assessed if "free care" is accessed beyond a statutory threshold. Other provisions of the law include $14.5 million in additional public health funding and a $5 million investment in a Computerized Physician Order Entry System; a restoration of adult oral health, eyeglasses and other Medicaid benefits; the establishment of a new smoking cessation benefit; and the creation of a Health Disparities Council (with MMS membership).

Monitoring Implementation

The Council's Advisory Committee plans to review the implementation of this legislation on an ongoing basis. It is anticipated that areas of concern would include:

- The adequacy of funding to assure implementation of all aspects of Chapter 58—health access and Medicaid reimbursement alike.
- The nature, scope and use of data collected by the HCQCC—to assure that data collection is not onerous, that benchmarks are valid, and that the information provided to consumers is meaningful.
- The affordability and scope of the insurance products certified by the Connector—to make sure that the new insurance products really do allow patients to access affordable and comprehensive care.

With the passage of this legislation in a true bipartisan fashion, the key dynamic has now shifted to getting all stakeholders on the same side of the table, to put issues of implementation on the other side of the table, and to work together in making this happen.

It has been an incredible honor, as the first anesthesiologist as President of the MMS, to be immersed in this effort over the past two years. Please feel free to contact me for any additional information on this universal access legislation and implementation as we move forward.

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Commentary on Dr. Harvey's article by Mark Singleton, M.D., CSA President: Dr. Harvey has outlined the process through which leaders in Massachusetts, both medical and political, have effected an ambitious overhaul of their state's health care delivery and financing system. The details are intricate and its success is yet to be evaluated, but between the lines one can appreciate several necessary elements for the success of any proposal that attempts to rebuild our present dysfunctional and inequitable model. Like many things in modern life, it's all about money. For the Massachusetts initiative or any other to work, there has to be enough money to motivate providers to want to care for all patients (not just the well off) and that money has to be sequestered from the elements of the system that would otherwise devour it—administrative bureaucracy and wasteful expenditures that only enrich the big corporations—and have become parasites on our medical system.

Here in California, we continue to labor under an inherently inequitable, profit-driven, wasteful and bureaucratically strangled health care system. The much-ballyhooed universal health insurance coverage bill, SB 840, authored by State Senator Sheila Kuehl (D-Santa Monica), passed the Legislature on strict party line votes. Even before SB 840 reached his desk, the Governor announced his plan to veto the measure. This bill proposed a system that would provide health insurance for every citizen of our state but was missing a plan for its financing among many other uncertainties necessary for implementation. It would have cost a staggering amount of money that would supposedly have come from employers, patients, and government, and it assumed many billions of dollars in savings through elimination of waste. SB 840 should not be compared to the Massachusetts plan, although its legislative passage reflected the growing frustration with California's present health care system. In his pre-veto announcement, the Governor pledged to work with Senator Kuehl and other interested parties to advance a better balanced proposal next year.

Our fate is in the political wind.