Massachusetts Taxpayers Foundation

Massachusetts Health Reform Spending, 2006-2011: An Update on the "Budget Buster" Myth

APRIL 2012

MTF

The Massachusetts Taxpayers Foundation is a nationally recognized, nonprofit research organization whose purpose is to promote the most effective use of tax dollars, improve the operations of state and local governments, and foster positive economic policies. Our credibility is based upon independent, objective, and accurate analysis of state and local spending, taxes, and the economy. Over the past decade the Foundation has won fourteen national awards for our work on transportation reform, business costs, capital spending, state finances, MBTA restructuring, state government reform, and health care.

Massachusetts Taxpayers Foundation
333 Washington Street, Suite 853
Boston, MA 02108-5170

617-720-1000 Fax: 617-720-0799
Email: mtf_info@masstaxpayers.org
Website: www.masstaxpayers.org

Massachusetts Health Reform Spending, 2006-2011: An Update on the "Budget Buster" Myth

We would like to recognize Alan G. Raymond as the principal author of this report.

Funding for this report was provided by the Blue Cross Blue Shield of Massachusetts Foundation.

MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011: AN UPDATE ON THE "BUDGET BUSTER" MYTH

Table of Contents

MASSACHUSETTS HEALTH REFORM SPENDING, 2006-2011: AN UPDATE ON THE "BUDGET BUSTER" MYTH

Overview

Six years after Massachusetts enacted its groundbreaking health reform law, Chapter 58 of the Acts of 2006, more than 98 percent of the state's residents have health insurance, access to needed care has improved, and the percentage of employers offering coverage to their workers has climbed despite the national recession.

The gains of health reform have been achieved without placing an unexpected or unmanageable burden on the state's budget. Annual spending for programs affected by Chapter 58 grew from $1.041 billion in fiscal 2006 to $1.947 billion in fiscal 2011, an increase of approximately $906 million (Table 1). The state's share of this spending increase is $453 million, or 50 percent of the total. While critics periodically claim that health reform has been a "budget buster," additional state spending attributable to the health reform law accounted for only 1.4 percent of the Commonwealth's $32 billion budget in fiscal 2011.

Over the five full fiscal years since the law was implemented, the incremental additional state cost per year has averaged $91 million, an amount that is well within projections made prior to the law's enactment.[1] These figures are consistent with the findings in the Taxpayers Foundation's 2009 report, *Massachusetts Health Reform: The Myth of Uncontrolled Costs*.

Table 1: Spending on Health Care Reform (Fiscal 2006-2011, in millions)

Program	2006	2007	2008	2009	2010	2011	Total Change 2006-2011	State Share of Change
Commonwealth Care and Commonwealth Care Bridge	$0	$133	$628	$805	$749	$835	$835	$442
MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases	$0	$224	$355	$569	$399	$391	$391	$196
Health Safety Net Trust Fund	$656	$665	$416	$417	$420	$420	$(236)	$(118)
Supplemental Payments to Medicaid MCOs	$385	$0	$0	$0	$0	$0	$(385)	$(193)
Supplemental Payments to Safety Net Hospitals	$0	$287	$287	$287	$307	$301	$301	$125
Total	**$1,041**	**$1,309**	**$1,686**	**$2,078**	**$1,875**	**$1,947**	**$906**	**$453**

[1] Four months before enactment of the law, the Massachusetts Taxpayers Foundation recommended that the state earmark an additional $100 million per year for implementation of health reform (*Health Care Reform: Expanding Access Without Sacrificing Jobs.* December 2005).

Key Provisions of the Law

Based on the concept of "shared responsibility" among government payers, employers, and individuals, the programs and incentives in the 2006 Massachusetts health reform law have worked in concert to expand access to affordable coverage while encouraging enrollment in employer-sponsored and individual health insurance plans.[2]

As Table 1 indicates, the calculation of spending for health reform does not start at zero in 2006 because the state's investment in expanded coverage for low-income adults and children had, in fact, begun almost a decade earlier. In 1997, Massachusetts was granted a federal Section 1115 "research and demonstration" waiver that gave the state greater flexibility to develop health insurance programs for low-income adults and children, with roughly half of the dollars for subsidized coverage coming from federal matching funds.[3] This led to the creation of MassHealth, a public insurance program that includes both Medicaid and the Children's Health Insurance Program (CHIP). Even earlier, the state had set up an Uncompensated Care Pool to pay hospitals and community health centers for certain types of medical services provided to low-income residents who were uninsured or underinsured.

In 2005, federal and state officials agreed on the terms of a renewed Section 1115 MassHealth waiver that provided the financial underpinnings for health reform, based on the premise that state and federal money that was funding uncompensated care should be redirected to provide subsidized health insurance coverage for low-income uninsured residents. To accomplish this, the health reform law created a new public health insurance program called Commonwealth Care for low-income adults who do not have access to employer-sponsored health insurance or Medicaid. The law also expanded and restored certain categories of MassHealth coverage for adults and children and transformed the Uncompensated Care Pool into the Health Safety Net Trust Fund, with new eligibility and payment rules.

The health reform law also created a quasi-public agency – the Commonwealth Health Insurance Connector Authority – to oversee the Commonwealth Care program and act as an "insurance exchange" through which individuals and small businesses may purchase unsubsidized, private health insurance plans that meet state standards for adequacy of coverage and overall value.

The most debated provision of the law, nationally if not in Massachusetts, is the individual mandate – a requirement that all Massachusetts residents 18 and older obtain health insurance if affordable coverage is available to them, or be subject to a state income tax penalty. And while lawmakers rejected creating an equivalent employer mandate, employers with 11 or more full-time equivalent employees are required to pay a "fair share assessment" to the state if they do not make a "fair and reasonable contribution" to their employees' coverage. The amount of the assessment, $295 per employee, is based on the estimated cost of uncompensated care for employees who work for employers that do not meet the fair and reasonable contribution standard.

[2] An annotated text of Chapter 58 of the Acts of 2006 is available at bluecrossfoundation.org.

[3] Section 1115(a) of the Social Security Law allows states to obtain "research and demonstration" waivers from the federal government to experiment with new ways of structuring and running their Medicaid programs. These waivers are time limited, usually for 3 to 5 years, and renewable if the U.S. Department of Health and Human Services and the state can reach agreement on terms and conditions.

What Has Massachusetts Health Reform Accomplished?

The positive impact of health reform on access to coverage and needed care has been documented through numerous studies and reports.* The most recent data show that:

- Health insurance coverage is nearly universal in Massachusetts. Fewer than two percent of residents lack health insurance, compared with a nationwide average of more than 16 percent uninsured.
- Expanded coverage has been accompanied by improved access to needed care, especially among middle and low-income residents, racial and ethnic minorities, and people with chronic diseases.
- Seventy-seven percent of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2010, up seven percentage points since 2005. This compares with 69 percent of employers offering health coverage to their workers nationwide.
- Surveys consistently find that about two-thirds of residents support Massachusetts health reform, the same as when the law passed in 2006.
- The affordability of health care, which was not directly addressed by the health reform law, remains a concern for many residents. More than a quarter of adults reported that their health care spending in 2010 had caused financial problems, including the need to cut back on health care services and other spending or to reduce savings.

**The Blue Cross Blue Shield of Massachusetts Foundation is a sponsor of the Massachusetts Health Reform Survey, which has been conducted annually by the Urban Institute since fall 2006. Results of this research and a five-year progress report on health reform are among the comprehensive resources available at bluecrossfoundation.org.*

Increases in State Spending

Commonwealth Care

As an entirely new program, Commonwealth Care accounts for the largest increase in state spending for health reform—approximately $442 million of the increase between fiscal 2006 and fiscal 2011 (Table 1). The program uses a combination of state funds and the federal matching dollars available through the state's MassHealth waiver to provide income-based premium subsidies for adult residents earning up to 300 percent of the federal poverty level (Appendix B). As a condition of eligibility, the applicant cannot have access to employer-sponsored health insurance or Medicaid coverage. The state enrolls Commonwealth Care members in private health plans that are selected through an annual procurement process conducted by the Health Connector. Approximately half of all Commonwealth Care members pay a partial premium and half pay no premium.

Most of the enrollment and spending growth in Commonwealth Care occurred during the first two years after the program's launch in mid-2006 thanks to a comprehensive outreach, education, and enrollment effort by state agencies, community organizations, and providers that serve low-income residents.

Enrollment in the program has leveled off, although the numbers for the next fiscal year will increase because of a court-ordered change in eligibility rules for documented immigrants. At the outset of health reform, policymakers decided to include low-income, documented immigrants in Commonwealth Care even though the federal government does not provide matching funds for this population. However, when the state was faced with a severe revenue shortfall in mid-2009 as a result

of the national recession, the governor and Legislature agreed to stop new enrollment of documented immigrants in Commonwealth Care and developed a scaled-back coverage plan called Commonwealth Care Bridge for those already enrolled. Advocates mounted a court challenge, and in January 2012 the Massachusetts Supreme Judicial Court ruled that the cutbacks were an unconstitutional denial of equal protection. As a result, the state is restoring full Commonwealth Care coverage to an estimated 40,000 eligible immigrants – approximately 13,000 will be transferred from Commonwealth Care Bridge, with the remainder coming from a waiting list. In fiscal 2014, federal matching funds for coverage of documented immigrants are due to become available under the provisions of the Patient Protection and Affordable Care Act.

MassHealth Coverage Expansions, Benefit Restorations, and Rate Increases

Although MassHealth (Medicaid and CHIP) spending has grown significantly since 2006, an estimated three quarters of the increase in enrollment has been in categories that predated the 2006 law and would have occurred in the absence of reform.[4] Table 1 shows that the five-year increase in the state's share of MassHealth spending that can be attributed directly to provisions in the health reform law was $196 million.

When health reform was enacted, about one million residents were receiving MassHealth coverage, but cutbacks during a prior state budget crisis had resulted in a loss of coverage for certain categories of low-income residents that had once been eligible for membership. The reform law restored eligibility and reopened enrollment for several of these categories, which include people living with HIV/AIDS, adults and children with disabilities, and the long-term unemployed. In addition, the law raised the family income ceiling for CHIP eligibility from 200 percent of the federal poverty level (FPL) to 300 percent. This allowed the state to take full advantage of federal matching dollars and close the remaining gaps in coverage for low-income uninsured residents.

In addition to these eligibility changes, the health reform law included a three-year increase in MassHealth provider reimbursement rates. Without some relief from historically low MassHealth payments, physicians and hospitals would have faced a growing financial burden as MassHealth membership rose. Business groups, concerned that continued government underpayment would result in greater cost shifting to the private sector in the form of higher premiums, supported the increases as well. The health reform law increased MassHealth provider payment rates by approximately $90 million per year for fiscal years 2007, 2008, and 2009, but the recession led to state budget cuts that have effectively eliminated the increases. As a result, the shortfall in MassHealth payments to providers has returned to pre-reform levels.

Supplemental Payments to Safety Net Hospitals

The health reform law included special provisions to assist the two Massachusetts hospitals that had traditionally provided the highest level of free care to uninsured patients, Boston Medical Center and Cambridge Health Alliance. As Table 1 indicates, the hospitals received $287 million in annual supplemental payments for three years, starting in fiscal year 2007, to help them through the transition to providing more insured care to their low-income patients and to support their continued role as safety net providers for a disproportionate share of people who remain uninsured or under-insured. The two hospitals faced the prospect of significant financial losses after the health reform law's three-year authorization of supplemental payments expired, but the state was able to secure an amendment to the MassHealth waiver that allowed supplemental payments to continue in fiscal 2010 and 2011.

[4] Massachusetts Medicaid Policy Institute. *Growth in MassHealth Enrollment Since Reform*. May 2011.

Decreases in State Spending

Uncompensated Care Pool/Health Safety Net Trust Fund

A major premise behind the Section 1115 MassHealth waiver renewal that preceded enactment of health reform was that the added costs of expanding public health insurance coverage would be largely offset by reductions in spending for uncompensated care that would occur as previously uninsured residents enrolled in Commonwealth Care or other coverage. As Table 1 illustrates, annual state spending for uncompensated care dropped by $118 million over the first five years of reform.

Annual Health Safety Net (HSN) spending fell by one-third from fiscal 2006 to fiscal 2008, reflecting a more than 50 percent decline in the number of inpatient discharges and outpatient visits for which HSN payments were made during that period. Since fiscal 2008, the use of the HSN has trended back up as a result of the economic downturn, but it is still well below pre-reform levels (Appendix C). Another factor contributing to the increased use of the HSN was the 2009 change in Commonwealth Care coverage for documented immigrants described earlier. The combined effects of a freeze on new enrollment and the scaled-back benefits in the Commonwealth Care Bridge program meant that an increasing number of low-income documented immigrants were uninsured or underinsured, and therefore eligible for the HSN.

The Health Safety Net is funded through a combination of assessments on acute care hospitals and surcharges on payments made by insurers and self-insured employers for hospital and ambulatory surgery services, and state and federal funds available through the MassHealth waiver. The private sector contributions are fixed at $320 million annually. The state's contribution is subject to appropriation, and, as Table 1 indicates, combined state and federal spending did not increase from fiscal 2010 to fiscal 2011 despite an increase in HSN use during that period. When the amount owed to providers for safety net care exceeds the amount of HSN funds available, the shortfall is distributed among hospitals using a formula that is intended to cushion the impact for the hospitals that care for most of the state's uninsured and underinsured residents. The shortfall is estimated at $134 million in fiscal 2012 and at least that amount in fiscal 2013.

Supplemental Payments to Medicaid Managed Care Organizations

The 1997 MassHealth waiver that triggered the first round of expanded public coverage for low-income adults and children led to the creation of Medicaid managed care organizations (MCOs) operated by the state's two largest safety net hospitals, Boston Medical Center (at the time called Boston City Hospital) and Cambridge Health Alliance (formerly Cambridge City Hospital). The waiver authorized additional financial support in the form of supplemental payments to the MCOs because they were expected to enroll a disproportionate number of people with complex medical and social needs, while at the same time accepting payments for members that would be less than the hospitals had received for providing uncompensated care. The MCO supplemental payments, which totaled $385 million in fiscal 2006, were eliminated as part of the waiver renewal that preceded the health reform law, but Massachusetts was allowed to retain the federal dollars to help fund expanded insurance coverage for low-income, previously uninsured individuals.[5] Table 1 shows that the net effect on state spending for health reform was a reduction of approximately $193 million.

[5] Stephanie Anthony, J.D., M.P.H., Robert W. Seifert, M.P.A., Jean C. Sullivan, J.D. Center for Health Law and Economics, University of Massachusetts Medical School. *The MassHealth Waiver:2009-2011…and Beyond.* February 2009.

Conclusion

Summarizing the net effect of the increases and reductions in state spending that can be attributed to the 2006 health reform law, this analysis shows that incremental state spending attributable to the law was approximately $453 million, or 1.4 percent of the state's $32 billion budget in fiscal 2011. The average annual increase in state spending for health reform between fiscal 2006, prior to implementation of the law, and fiscal 2011, which ended on June 30, 2011, was just under $91 million.

The 2006 health reform law was designed to expand access to affordable coverage, not to address the cost of care. It did, however, help trigger a series of legislative, regulatory, and private sector initiatives directed at controlling the state's historically high costs, and there is early evidence that a transformation is underway, centered around provider payment reform. A majority of the state's primary care physicians are now participating in health plan contracts based on some form of "global payment," which rewards the quality and efficiency of care rather than quantity, and several long-term contracts between health plans and hospital systems have been renegotiated at lower rates of payment. Payment reform has, in turn, been an added catalyst for hospital systems and physician groups to invest in better coordination of care and in improving outcomes for their sickest patients. In addition, Massachusetts has seen the rapid proliferation of health insurance products that allow employers and consumers to save money by using lower-cost providers or by choosing limited provider networks.

It would be premature to claim that the state's historically high health care costs have been tamed, but there are encouraging signs of progress. For example, in the latest round of proposed premiums for the merged health insurance market for small businesses and non-group individuals, health plans sought average increases of just two to three percent, compared with increases of 15 to 20 percent two years ago. Although the trend of slower premium growth is currently a nationwide phenomenon and may be, in part, a function of the economic recession, Massachusetts is experiencing a notably slower rate of growth than the national average. In fact, recent data show that family premiums for private, employer-sponsored coverage in Massachusetts fell by an average of nearly one percent from 2009 to 2010, while the country as a whole saw a six percent increase. As a result, the state's ranking for family premiums fell from the highest in the country in 2009 to ninth place in 2010. Similarly, individual premiums for Massachusetts workers rose by just 2.8 percent in 2010 versus 5.8 percent for the nation as a whole.[6]

Governor Deval Patrick and the leaders of the Massachusetts House and Senate have said they expect to approve some form of cost containment legislation in 2012 that would accelerate reform of provider payment and health care delivery and set the stage for sustainable reductions in the underlying trend. If passed, it would build on a 2008 law that created a process to examine the causes of the state's high health care costs, and a 2010 law aimed primarily at giving small businesses more options for managing their health insurance bills. While the state's private sector stakeholders hold divergent views on some of the issues under consideration, the broad coalition of providers, health plans, business groups, and consumer advocates that formed during the first round of health reform has remained engaged and united around the shared goals of expanding access to coverage, improving quality and outcomes of care, and reducing the growth of health care spending.

[6] C. Schoen, A. Fryer, S. Collins, and D. Radley, *Realizing Health Reform's Potential*, The Commonwealth Fund, November 2011, and MTF analysis of data from the Agency for Healthcare Research and Quality.

Appendix A

Methodology

Estimates of government spending attributable to the 2006 Massachusetts health reform law are based on a Massachusetts Taxpayers Foundation analysis of data provided by the Commonwealth's Executive Office for Administration and Finance.

The state share of health reform spending was calculated using a conservative assumption that federal support was 50 percent, even though the actual federal match was temporarily increased during FY2009, 2010, and 2011 by the American Recovery and Reinvestment Act, thereby reducing the state share during those years. MTF's estimates account for the fact that the state has paid the full cost of Commonwealth Care, and subsequently Commonwealth Care Bridge coverage, for eligible documented immigrants (see page 4). The Supplemental Payments to Safety Net Hospitals category includes special federal payments that did not require a state share because they were funded through Intergovernmental Transfers (see page 4).

The Foundation's analysis does not include adjustments for the rate of health care inflation from 2006 to 2011, which was significantly higher than the overall rate of inflation. As a result, the effect of health reform on state spending is most likely less than the data indicate. It should also be noted that, starting in fiscal 2009, the economic recession became a factor in driving health reform spending as more residents became eligible for MassHealth and Commonwealth Care.

Appendix B

Federal Poverty Level Guidelines

Gross Annual Income Limit: Effective March 1, 2012 – February 28, 2013

Family Size	100% of FPL	300% of FPL
1	$11,170	$33,510
2	$15,130	$45,390
3	$19,090	$57,270

Source: U.S. Department of Health and Human Services

Appendix C

Health Safety Net Use
Since Health Reform (in thousands)

	2006*	2007	2008	2009	2010
Hospitals	1,613	1,184	715	703	800
Community Health Centers	446	342	262	287	312
Total HSN Use**	2,059	1,526	977	990	1,112

** Prior to health reform, the HSN was called the Uncompensated Care Pool (UCP).*
*** Health Safety Net use includes hospital inpatient discharges, hospital outpatient visits, and community health center outpatient visits. Health Safety Net use fell dramatically during the first two years of reform, then started an upward trend that continued into HSN fiscal 2011.*

Source: Division of Health Care Finance and Policy: Health Safety Net/Uncompensated Care Pool annual reports