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The 2006 Massachusetts Health Care Reform Law

By Victoria Pulos

Victoria Pulos
Health Law Attorney

Massachusetts Law Reform Institute
99 Chauncy Street, Suite 500
Boston, MA 02111
617.357.0700 ext. 318
vpulos@mlri.org

Massachusetts in April 2006 enacted a health care reform law intended to achieve near universal insurance coverage for its residents within three years.[1] The new law, a complex mix of public programs and market reforms, is generating national attention as a bipartisan model for expanding coverage. It is far too early to say whether the 2006 health care reform law will achieve its goals, but its passage has contributed to momentum for health care reform across the country and elevated the "individual mandate" in the policy debate. Despite major implementation challenges ahead, in its first nine months the new law has already provided coverage to over 60,000 Massachusetts residents who were uninsured. In this article I review how competing interests were reconciled in the passage of the 2006 health care reform law, analyze in more detail some of its key concepts, describe the role of consumer advocates in the law's passage and implementation to date, and suggest some lessons for advocates in their states. For a summary of the key features of the law see Table 1.

I. Background

Massachusetts has several advantages in tackling the problem of the uninsured: a low rate of uninsurance, relatively generous Medicaid eligibility criteria, a high rate of employer-sponsored insurance, and an existing reimbursement pool to pay hospitals and health centers for treating the uninsured.[2] Massachusetts' highly regulated insurance market also guarantees to individuals and small groups the right to buy insurance and prohibits charging people more because of their health status.[3]

Since 1997, Massachusetts has operated MassHealth, a Medicaid demonstration waiver program that expanded financial eligibility criteria for families with children and people with disabilities and extended eligibility to certain other nonelderly

[1]An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch.58, amended by 2006 Mass. Acts chs. 324, 450.

[2]Massachusetts assesses a fee on hospitals, insurers, and self-insured employers; together with an appropriation of state funds, the fee is paid into a pool and redistributed to community health centers and hospitals that treat the highest proportion of uninsured patients. Mass. Gen. Laws ch. 118G, § 18.

[3]Mass. Gen. Laws ch. 176J.

adults not otherwise eligible for Medicaid.[4] Today MassHealth accounts for over 300,000 additional children and adults covered by Medicaid and the state children's health insurance program.

Massachusetts' strong health advocacy community, led by an organization called Health Care for All, played an important role in expanding coverage. After twenty years of campaigning for health care reform, Health Care for All now has more than thirty employees with expertise in health policy, grassroots organizing, and Massachusetts' legislative process. Once a client of the Massachusetts Law Reform Institute, Health Care for All now has its own law firm.

II. Momentum for Health Care Reform 2004–2006

Political scientists list the preconditions for significant reform as perception by those in power of a serious problem, the existence of practical policies to solve the problem, and political support for change.[5] These three factors began to converge around health care reform in 2004. The problems included half a million residents without health insurance, increasing shortfalls in the pool that reimbursed hospitals for caring for the uninsured, and one of the most expensive health care systems in the country. However, the most visible and pressing problem was renewal of the Medicaid demonstration waiver. The compromise negotiated with federal officials was that Massachusetts would come up with a new plan for covering the uninsured in order to preserve $385 million in federal revenue.

On the policy front a large health foundation initiated a series of well-publicized reports from a leading think tank on policy options to cover the uninsured. Massachusetts' three most powerful political figures all had a vested interest in championing health care reform. It promised to be the achievement that the ambitious Republican governor needed to raise his visibility on the national stage, and two traditional liberals who had lately taken office as House speaker and Senate president in the Democratic-controlled legislature were also looking for a defining achievement. Massachusetts' leading consumer advocacy organization had organized a broad-based coalition to push for reform; another coalition was partway toward getting a right to health care into the Massachusetts constitution, and the powerful hospital industry had hundreds of millions of dollars at stake.

A. The Blue Cross Blue Shield Foundation and the "Roadmap to Coverage"

Endowed in 2001 by the largest insurance carrier in Massachusetts, the Blue Cross Blue Shield Foundation's mission was to deal with the problem of the uninsured. In 2004 it initiated the "Roadmap to Coverage." The foundation engaged the Urban Institute, a national think tank, to prepare a series of reports documenting the uninsured's costs to the commonwealth and policy options for coverage. From November 2004 to October 2005, the foundation assembled a who's who of the Massachusetts health policy elite at the John F. Kennedy library for the release of each report.[6] The Senate president, the House speaker, and the governor each addressed the assembled audience before introducing competing bills to cover the uninsured in the 2005–2006 legislative session.

The Roadmap to Coverage made three primary contributions to health care reform in Massachusetts. First, the Urban Institute's reports showed that Massachusetts was already spending substantial sums on treating the uninsured and that much of this funding could be

[4]42 U.S.C. § 1315; Mass. Gen. Laws ch. 118E, § 9A. Under MassHealth, poverty-level adults who have been unemployed for twelve months or more are eligible for a lesser level of medical benefits than full Medicaid offers. Also, low-income employees of certain participating small-business or small-organization employers are eligible for reimbursement toward the employee share of premium costs. There is no asset test for those under 65. The upper income limit for parents with children is 133 percent of the federal poverty level.

[5]John Kingdon, Agendas, Alternatives, and Public Policies (2d ed. 1995).

[6]The Urban Institute reports are available at www.roadmaptocoverage.org.

Table 1.—Key Features of the 2006 Massachusetts Health Care Reform Law: An Act Providing Access to Affordable, Quality, Accountable Health Care

Medicaid Eligibility

- Raises children's income eligibility from 200% to 300% of poverty level in non-Medicaid state children's health insurance program (§§ 15, 26)
- Raises enrollment cap in program for long-term unemployed from 44,000 to 60,000 (§ 107)
- Raises income eligibility for self-employed and employees of small-business or small-organization employers in Insurance Partnership from 200% to 300% of poverty level (§ 19)
- Appropriates $3 million for grants to community groups for enrollment assistance, education, and outreach (§ 104)

Insurance Connector

- Creates "Health Insurance Connector"—new independent authority governed by board of 10 public and private members appointed by governor and attorney general and including representative of health consumer organization (§ 101)
- Assigns Connector to market approved insurance products to individuals and small groups with 50 or fewer employees; offers plan choice, portability, and payment with pretax dollars (approved plans are subject to rules applicable to small-group market and must provide all mandated benefits)
- Assigns Connector to determine affordability and extreme-hardship standard for individual mandate
- Assigns Connector to determine sliding-scale premium schedule and approve plans for Commonwealth Care

Subsidized Insurance (Commonwealth Care)

- Creates "Commonwealth Care Health Insurance Program" within Connector to offer sliding-scale premium assistance for uninsured people ineligible for Medicaid or Medicare and whose incomes are up to 300% of poverty level (§ 45)
- Requires that, to be eligible, must be Mass. resident and U.S. citizen or legally present noncitizen and lack access to employer-subsidized insurance in past 6 months
- Requires that insurance eligible for subsidy must be purchased through Connector and have no deductible
- Requires that if income is under 100% of poverty level, no premium, no copayments higher than nominal Medicaid copayments, benefits must include drugs and dental; if income is 100–300% of poverty level, Connector must determine premium contribution and benefits
- Allows enrollment to be capped on basis of appropriation
- Allows only Medicaid managed care organizations to offer insurance eligible for subsidy so long as enrollment meets targets (§ 123)

Individual Mandate

- Requires that all Mass. residents 18 and older must have "creditable coverage" if cost, as defined by Connector, is "affordable" (§ 12)
- Enforces mandate through Mass. income tax system; first-year penalty is loss of exemption, then fee not to exceed 50% of minimum insurance cost for the year
- Directs Connector to establish affordability appeals procedure including extreme hardship standards (§ 101)

Employer Mandates

- Assesses fee against employers who have more than 10 full-time equivalent employees and do not make "fair and reasonable" contribution to a group insurance plan; per-employee fee is up to $295 per year (*veto overridden*) (§ 47)
- Requires employers with more than 10 employees to offer cafeteria plans under 26 U.S.C. § 125; this enables workers to buy insurance with pretax dollars (§ 48)
- Imposes "free rider surcharge" penalty of 10–100% of Mass. share of uncompensated care pool costs for employers with more than 10 employees if employer does not offer insurance or comply with Section 125 mandate, and employees' use of services charged to pool exceeds threshold amount (§ 44)

Insurance Market Changes

- Merges nongroup and small-group markets (§§ 82–89).
- Requires insurers to offer low-cost plans for young adults, 19–26 (§ 90)
- Imposes moratorium on additional mandated benefits (§ 127)

(Continued on page 613)

Table 1.—Key Features of the 2006 Massachusetts Health Reform Law: An Act Providing Access to Affordable, Quality, Accountable Health Care

(Continued from page 612)

- ☐ Requires that dependent coverage include children up to age 26 or 2 years after ceasing to be Internal Revenue Service dependents (§ 49)
- ☐ Allows health maintenance organizations to sell high-deductible plans with health savings accounts (§ 60)
- ☐ Directs the Department of Insurance and Connector to set minimum standards for health plans (§ 7)
- ☐ Bars insurers from selling group coverage to employers who fail to offer coverage to all full-time employees or contribute as great a percentage of premiums for lower-wage employees as for higher-wage employees (except per-collective-bargaining agreement) (§ 50)

Medicaid Benefits

- ☐ Restores adult dental benefits, eyeglasses, chiropractic, orthotic shoes and other benefits cut in Jan. 2002 (*veto overridden*) (§ 29)
- ☐ Creates 2-year pilot program for smoking cessation (§ 108)
- ☐ Creates wellness program (*veto overridden*) (§ 29)

Medicaid Rates

- ☐ Appropriates $90 million for rate increase in 2007 fiscal year: 85% to hospitals, 15% to physicians, and rate increases in next 2 years (§ 128)
- ☐ Makes hospital rate increases contingent on meeting performance benchmarks, including reducing racial disparities (§ 25)
- ☐ Creates Medicaid payment policy advisory board (§ 3)

Uncompensated Care Pool

- ☐ Replaces pool with Health Safety Net Trust Fund (§ 30)
- ☐ Continues to reimburse hospitals and health centers for eligible uninsured Mass. residents but moves administration to Office of Medicaid (§ 30)
- ☐ Reimburses hospitals and community health centers on Medicare fee schedule based on actual claims (§ 30)

Cost and Quality Controls

- ☐ Creates Health Care Quality and Cost Council (§ 3)
- ☐ Creates Health Disparities Council (§ 3)

Source: An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch.58, amended by 2006 Mass. Acts chs. 324, 450.

diverted to payment for health insurance.[7] Second, the reports identified a variety of approaches to coverage for uninsured individuals in different circumstances: Medicaid expansion for those with the lowest incomes, subsidies or tax credits for the low- and moderate-income uninsured, and a purchasing pool and other measures to lower costs in the small-group and nongroup market.[8] And, third, with the considerable resources and prestige of the Blue Cross Blue Shield Foundation behind it, Roadmap helped keep attention focused on the goal of universal coverage.

B. MassHealth Renewal

Massachusetts' Medicaid demonstration waiver was due to expire in June 2005. Renewal of the waiver was crucial in the health care reform debate in assuring both that some plan to cover the uninsured was enacted and that plan elements appealed to both the Democratic legislature and the Republican executive authorities. The U.S. secretary of health and human services and the Centers for Medicare and Medicaid Services were insisting on a plan to cover the uninsured as a condition of allowing Massachusetts to

[7]John Holahan et al., Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays and What Would Full Coverage Add to Medicaid Spending? (2004).

[8]Linda J. Blumberg et al., Building the Roadmap to Coverage: Policy Choices and the Costs and Coverage Implications (2005); Alan Weil, You Can Get There from Here: Implementing the Roadmap to Coverage (2005).

continue receiving hundreds of millions of federal dollars under MassHealth. The plan for covering the uninsured required authorizing legislation from a legislature with a veto-proof Democratic majority. However, the plan also required the support of both the state and federal Republican administrations, which were negotiating the terms of the waiver renewal.

In June 2004 Massachusetts' Medicaid agency, hoping for an extension on the same terms, requested another three-year extension of the Medicaid demonstration waiver. However, with ballooning federal deficits, federal officials had adopted a harder line on Medicaid financing arrangements.[9]

In January 2005, in the midst of the health care reform debate, the secretary of health and human services approved the Medicaid demonstration for three more years starting in July 2005. Many complex financing issues were at stake in the negotiations over MassHealth's renewal.[10] The bottom line was that $385 million in federal revenue that Massachusetts had been able to match without having to use state general funds would remain available after July 2006, but only on new terms.[11] The waiver created a new fund, in a capped amount, which may be used for "expenditures for uninsured individuals and unreimbursed Medicaid costs through any type of provider or through insurance products." However, the Centers for Medicare and Medicaid Services had to approve both the sources of the state match for the new fund and its uses.[12]

C. The Role of Consumer Advocates

In 2004 Health Care for All organized a new coalition with a broad-based agenda for health care reform. The Affordable Care Today (ACT!) Coalition's principles for reform were Medicaid restoration and expansion, sliding-scale subsidies to enable moderate-income families to afford private insurance, fair payment for Medicaid providers, meaningful employer responsibility, and fair and sustainable funding. The coalition comprised health care providers, organized labor, religious organizations, and grassroots antipoverty organizations; its legislative proposal included a payroll tax on employers and a cigarette tax hike.

One tactic of Health Care for All and the coalition was a ballot initiative. Polls showed strong support for requiring employers to offer health insurance. The possibility that key features of the ACT! bill, with its 5 percent to 7 percent payroll tax, would be presented to the voters gave the coalition added leverage to push the legislature to come through with a comprehensive health care reform bill. The petition drive began in the fall of 2005, and by December an all-volunteer force had gathered about 100,000 signatures, more than enough to win ballot certification. Business trade organizations later identified the threat of the ballot initiative as one of the reasons that they accepted some form of employer assessment.

However, consumer advocates in Massachusetts did not speak with a single voice. Some were committed to funda-

[9]As of June 2005, twenty-six states had revised Medicaid financing arrangements to meet federal objections. Peter Harbage & Andy Schneider, Medicaid Hospital Waivers: Comparing California, Florida and Massachusetts (2006) (California HealthCare Foundation Issue Brief), available at www.chcf.org. For a description of the ways in which the federal agency has been renegotiating Medicaid waiver financing arrangements, see Theresa Sachs et al., Uncharted Territory: Current Trends in Section 1115 Demonstrations (2006) (State Coverage Initiatives Issue Brief), available at www.statecoverage.net.

[10]The Massachusetts Medicaid Policy Institute has produced a series of issue briefs addressing waiver financing issues in MassHealth; see The MassHealth Waiver (2005), The Role of MassHealth "Budget Neutrality" Requirements in Designing Policies to Expand Health Coverage (2006), and The MassHealth Waiver: An Update (2006), available at www.massmedicaid.org.

[11]Under the original waiver, Massachusetts was able to receive federal funds for supplemental payments to two safety net hospitals that set up managed care plans for the Medicaid population. Intergovernmental transfers from the hospitals provided the state matching funds. In 2005 net federal revenue from these supplemental payments was $385 million. Now the gross amount of the supplemental payments in 2005, along with the state's disproportionate share hospital allotment, are allocated to a new capped fund. Federal matching funds for the new subsidized insurance program and the pool for reimbursing hospitals for the uninsured are now limited to the amount of the new fund.

[12]The documents approving the waiver and the special terms and conditions are all available at the link for MassHealth and Health Care Reform at www.mass.gov/masshealth.

mental change in the health care system and saw little value in further incremental reforms. Others, including Health Care for All, took a more pragmatic view and sought to accommodate competing interests in order to form a broad-based coalition to support reform. Still others—including a Medicaid Defense Group in which legal aid advocates were active—focused on narrower issues and looked to health care reform as the vehicle for enacting their policy goals.[13] While there were tensions between some proponents of the perennial single-payer bill and supporters of the ACT! bill, many grassroots organizations supported both: single payer as the best long-term solution and the ACT! bill as the approach with the best chance of passage in 2006.

D. Competing Bills Favoring Different Interests

Gov. Mitt Romney, like Massachusetts governors before him, saw comprehensive health care reform as the issue that might catapult him onto the national stage. The governor took the individual mandate and combined it with the idea of a "health insurance exchange"—endorsed by the Heritage Foundation—to facilitate plan choice, portability, and tax savings in the private insurance market. He proposed to cover the uninsured by replacing the pool from which hospitals were reimbursed for treating the uninsured with a sliding-scale subsidy for basic coverage. Business and the insurance industry favored his plan; hospitals and consumer advocates opposed it.

The Senate president's bill proposed to cover the uninsured by expanding the insurance reimbursement program created by the 1997 Medicaid demonstration. This plan appealed to hospitals, health centers, and physicians by increasing Medicaid payment rates and keeping intact the reimbursement pool for treating the uninsured. To encourage employer responsibility, the plan imposed a "free rider" surcharge on employers who did not offer insurance and whose employees used the pool. It promoted individual responsibility through an individual mandate. More generous provisions for restoring Medicaid benefits and expanding Medicaid eligibility were added on the Senate floor.

The House Health Financing Committee heard testimony on all the other bills and, in close concert with the Speaker's office, made the first attempt to draft a compromise. The bill that passed the House in November took from the governor's bill the idea of the health insurance exchange (named "Health Insurance Connector" in the legislation) and a sliding-scale subsidy. It included an individual mandate but, unlike the governor's bill, imposed tax penalties only if the new Connector board determined that coverage was affordable. Like the Senate bill, the House bill raised Medicaid payment rates for hospitals and physicians and retained the reimbursement pool. And, like the ACT! bill, the House bill restored and expanded Medicaid benefits and imposed a payroll tax on employers who do not offer insurance. Further compromises preceded enactment: employer interests succeeded in substantially weakening the House provisions for an employer mandate, and federal officials intervened to defeat any substantial Medicaid expansion.

III. The Health Care Reform Law

From November 2005 until April 2006, major legislative activity came to a standstill as the House and Senate conference committees locked horns on the final shape of health care reform. Deadlock was not an option. Under the terms of the waiver renewal, Massachusetts had to enact a new plan to cover the uninsured or forgo significant federal revenue.

A. Medicaid Expansion

Michael Leavitt, the U.S. secretary of health and human services, visited legislative leaders twice during the conference impasse. He came not just to urge agreement on a bill but also to warn leg-

[13]The Medicaid Defense Group focused on expanding and improving Medicaid and specifically sought to restore services that had been cut during the 2002–2003 recession.

islators not to expand Medicaid eligibility.[14] The House leadership and Medicaid advocates were outraged at the secretary's position barring Massachusetts from using Medicaid funds to expand Medicaid to cover the uninsured. Both the House and Senate bills had agreed on expansion for parents with incomes up to 200 percent of the federal poverty level; this provision had not been in dispute before Leavitt's visit, and the House bill had proposed coverage of all adults with incomes up to 100 percent of the poverty level in Medicaid. However, the secretary had broad authority over Medicaid demonstration waivers, and no one was prepared to risk disapproval. Consumer advocates did succeed in winning Medicaid-like protections for poverty-level adults enrolled in the new subsidized insurance program. However, the provision for raising the Medicaid income eligibility level for parents did not make it into the final bill.

1. Children Under 19

On July 1, 2006, the new law expanded the upper-income limit for uninsured children in Massachusetts' non-Medicaid children's health insurance program from 200 percent to 300 percent of the federal poverty level ($49,800 for a family of three in 2006). Premium charges and measures to reduce crowd-out were left to the Medicaid agency.[15]

2. Medicaid-Eligible but Unenrolled

The health care reform law contained two provisions designed to reach the estimated 90,000 residents who were eligible for Medicaid but not enrolled. One provision raised the enrollment cap for long-term unemployed adults under MassHealth from 44,000 to 60,000. The other provision appropriated $3 million for outreach grants to community organizations to find and enroll hard-to-reach individuals.

3. Other Medicaid Changes

The final bill restored for adults all the optional Medicaid benefits including dental benefits and eyeglasses (the top priority of the Medicaid Defense Group) that had been cut since January 2002. The bill also expanded financial eligibility for the existing program to subsidize the employee share of premium costs for employees of participating small-business or small-organization employers, by raising the employee income limit from 200 percent to 300 percent of the federal poverty level.[16]

B. Employer Mandates

Probably the most contentious issue dividing the House and Senate was the employer payroll tax. Business interests attacked it as a drag on Massachusetts' economy still emerging from recession. Almost twenty years earlier, with support of the big-business community, Massachusetts enacted an employer mandate that promised near-universal coverage by requiring employers either to "play" by providing employee coverage or to "pay" $1,680 per worker into a health security fund.[17] However, the "pay or play" mandate never took effect. It was twice delayed and eventually repealed, the victim of a severe economic recession, organized opposition from small business, and spiraling health care costs.

1. Divergent Business Interests

As in past reform initiatives, the interests of big business—most of which provided insurance and which included representatives of the powerful hospital industry—and the interests of small business diverged. In 2006 Massachusetts' largest hospital system, its largest insurer, other big-business interests, and a taxpayers' foundation brokered the compromise struck by the conference committee. However, the extent of

[14]Steve LeBlanc, *Leavitt: State Lawmakers Need to Speed Work on Health Care Bill*, Boston Globe, Feb. 7, 2006.

[15]Monthly premium charges are $20 per child up to a family cap of $60 for families with incomes from 200 percent to 250 percent of the poverty level, and $28 per child up to a family cap of $84 for families at 250 percent to 300 percent of the poverty level. Subject to certain exceptions, a waiting period applies to children who were insured in the six months before application. Mass. Code Regs. tit. 130, § 505.005 (2006).

[16]The insurance reimbursement program had never made much of an inroad into covering the uninsured. By June 2006 only about 5,000 employers had participated in the program, and almost three-fourths of them were self-employed. Office of Medicaid, Commonwealth of Massachusetts Executive Office of Health and Human Services, MassHealth 1115 Demonstration Project Annual Report for SFY 2006 29 (2006).

[17]1988 Mass. Acts ch. 23.

employer responsibility was far less than in 1988. The compromise provided for an annual assessment of up to $295 per employee on employers who had more than ten full-time-equivalent employees and did not make a "fair and reasonable" contribution toward the costs of group coverage.[18]

The formula for calculating the fee was not intended to reflect the cost of employee coverage but rather to impose on noninsurance-offering employers their share of the costs of the reimbursement pool. Insurers and self-insured employers had been paying an assessment to support the pool since 1997. One of the factors that made the annual $295-per-employee contribution the lesser evil for some business interests was the prospect of the payroll tax returning through a ballot initiative and a potential constitutional right to health care. However, in its present form, the employer fee acknowledges the principle of employer responsibility but will contribute only modestly to the costs of reform.[19]

2. Employer Behavior and Crowd-Out

One significant unknown is the effect on employers of the fair-share contribution. Critics claim that the $295-per-year fee gives employers an incentive to pay the fee rather than offer coverage. Supporters point out that employers offer insurance in order to compete successfully for workers when there is no fee at all.

The availability of the new subsidized insurance program for uninsured adults with incomes at or below 300 percent of the poverty level runs the risk of "crowding out" employer-sponsored insurance. Crowd-out occurs when new public coverage replaces existing private coverage. The law addresses crowd-out in two ways. First, workers who had access to employer-subsidized coverage in the previous six months are not eligible for the new subsidized insurance program.[20] Second, the law includes provisions to prevent employers from dropping insurance only for low-wage workers.[21]

C. The Individual Mandate

The most novel feature of the 2006 health care reform law is the individual mandate. The Urban Institute and other experts working with the state all concluded that reliance on voluntary participation would not lead to universal coverage without an individual mandate. The governor's support for the idea improved the chances that the executive office and the Bush administration would strike a deal in the ongoing Medicaid demonstration negotiations. In a strategic decision the ACT! Coalition did not oppose the idea of the individual mandate so long as employers paid their share and comprehensive coverage was truly affordable.

Proponents argue that, with the mandate in place, employers who do not offer insurance will face greater pressure to offer coverage in order to compete successfully for workers, and employers who do offer insurance will see more of their workers choosing to enroll. A mandate will also bring into the risk pool young healthy individuals who now constitute the largest share of those without insurance. Some opponents believe that the mandate intrudes on personal liberties, while, for others, support of the mandate is contingent on specific guarantees of affordability. The American Medical Association, for example, endorsed an individual mandate only for those whose incomes exceed 500 percent of the federal poverty level.[22]

[18]Defining a "fair and reasonable contribution" was left to the state agency that regulates the pool for reimbursing hospitals for covering the uninsured.

[19]Specialists disagree on whether the fee and other employer mandates in the health care reform law may be preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, a federal law that regulates employer pension and benefit plans and precludes some state health care reform initiatives. See, e.g., Patricia A. Butler, *A Different View: ERISA Does Not Preempt Massachusetts' New Health Care Law,* Pension & Benefits Daily Report (BNA) (2006).

[20]The Connector is authorized to waive this bar, in which case the employer must make its contribution to the Connector. Mass. Gen. Laws ch. 118H, § 3(b).

[21]2006 Mass. Acts ch.58, § 50.

[22]Council on Medical Services, American Medical Association, Individual Responsibility to Obtain Health Insurance (2006) (report and resolution), available at www.ama-assn.org/ama1/pub/upload/mm/372/a-06cmsreport3.pdf.

The final bill contained an individual mandate to take effect July 1, 2007; the mandate requires all Massachusetts residents 18 or older to have "creditable coverage" by December 31, 2007, or face Massachusetts tax penalties, unless the Connector determines that coverage is not affordable.[23] Primarily because of the low percentage of uninsured children in Massachusetts, the individual mandate was not extended to children.[24] Rather than attempting to define the key terms "minimum creditable coverage" and "affordable," the legislature left this exceedingly difficult task to the newly created Health Insurance Connector board of directors.

Without several essential safeguards, the individual mandate could not have been enacted in Massachusetts. First, the legislation supplemented Medicaid with a sliding-scale subsidy program available to a majority of the uninsured adults who are subject to the mandate. Second, the law recognized that at certain income levels individuals must be exempt from the mandate because insurance is not affordable and hardship exemptions must be available on a case-by-case basis. And, third, existing Massachusetts law precluded insurers from denying coverage or charging higher rates based on individual health status.

D. Commonwealth Care: New Subsidized Insurance Program

The legislature enacted the House plan for a new subsidized insurance program for uninsured Massachusetts residents whose incomes are at or below 300 percent of the federal poverty level; called Commonwealth Care, the new program is administered by the Connector. Over 70 percent of nonelderly uninsured adults in Massachusetts have incomes at or below 300 percent of the poverty level. The legislation prohibited deductibles in the new subsidized insurance plans but otherwise left the details of Commonwealth Care to the Connector for those with incomes between 100 percent and 300 percent of the poverty level. For those at the poverty level or below, in lieu of Medicaid itself the legislation spelled out Medicaid-like protections: no premiums, no higher copayments than Medicaid, and comprehensive benefits including dental coverage. The health care reform law also provided that, for its first three years, Commonwealth Care would be offered exclusively by the four Medicaid managed care organizations; safety-net hospital systems operate two of these, and the other two are local commercial plans.

E. The Health Insurance Connector

The Health Insurance Connector is a new authority governed by a ten-member board. It is charged with administering the new subsidized insurance program that began on October 1, 2006, and with defining "minimum creditable coverage" and "affordability" before the individual mandate takes effect in July 2007. It is also responsible for acting as an insurance clearinghouse to facilitate the purchase of approved insurance products by individuals and small groups.[25]

IV. Implementation of Major Provisions of the Law

Recognizing the importance of implementation decisions in the ultimate success or failure of health care reform, the

[23]In the first year the penalty is loss of the state income tax exemption (an annual cost of roughly $150 to $200). In future years the penalty is up to half the cost of minimum coverage, an amount estimated at $100 to $150 per month. 2006 Mass. Acts ch. 58, § 12.

[24]The rate of uninsured children in Massachusetts in 2006 was only 2.5 percent based on a state survey of the uninsured. Massachusetts Division of Health Care Finance and Policy, Health Insurance Status of Massachusetts Residents (5th ed. 2006), available at www.mass.gov/dhcfp. The Urban Institute, based on 2002–2003 data, estimated that 6.8 percent of children were uninsured in Massachusetts compared to a national rate of 11.9 percent. Allison Cox, Health Insurance Coverage and the Uninsured in Massachusetts (2005), available at www.roadmaptocoverage.org.

[25]Individuals can purchase insurance with pretax dollars through the Connector. The law requires employers with more than ten employees to offer cafeteria plans under Section 125 of the Internal Revenue Code. This and changes in the private insurance market, most to take effect in July 2007 and designed to lower the costs of private insurance, are listed in Table 1 but not discussed in this article.

ACT! Coalition and the Medicaid Defense Group combined as a new coalition, called ACT!! (ACT 2), to focus on the implementation of the new law. The range of decisions that would be made in short order by both existing agencies and newly created authorities, boards, and councils was daunting. ACT!! rapidly formed a steering committee, an executive committee, and working groups to research and develop policy positions and advocate key implementation decisions: the premium charges and benefit structure of the new subsidized insurance program; the definition of "affordability" and "minimum creditable coverage" for purposes of the individual mandate; the criteria for unsubsidized plans to be marketed through the Connector; and private insurance market reforms.[26]

A. Creating a New Subsidized Insurance Program: Commonwealth Care

The health care reform law specified Medicaid-like protections in Commonwealth Care for those at the poverty level or below (see Table 3, Plan Type 1). Except for the prohibition of deductibles, the statute left to the Connector the benefit structure for people with incomes from 100 percent to 300 percent of the poverty level (up to $29,412 for an individual in 2006).

The Connector board's decision on the structure of the health insurance to be offered under Commonwealth Care was in many ways a prelude to decisions that the board will have to make on defining "insurance coverage" and "affordability" for purposes of the individual mandate. Much was at stake for the estimated 200,000 uninsured residents who might qualify for Commonwealth Care but also for the remaining 200,000 uninsured residents who would be required to purchase "affordable" private coverage.

To develop a position on premiums and cost sharing, the ACT!! Coalition first looked to the premium and cost-sharing rules imposed by other public programs. Community Catalyst, a national organization affiliated with Health Care for All, helped the coalition analyze research on voluntary participation in public programs at various percentages of the poverty level. The coalition also considered Massachusetts cost-of-living studies and the average premium and out-of-pocket costs for Massachusetts residents as a percentage of Massachusetts' median income.

One coalition member, the Greater Boston Interfaith Organization, convened a series of focus groups across Massachusetts. The 500 participants were asked to complete a budget worksheet and answer survey questions about how much they could afford to pay for health insurance. The results were a significant contribution to grounding the policy discussion in reality—many families with incomes between 100 percent and 300 percent of the poverty level were already struggling with a negative balance at the end of every month.

In the end, with data from a variety of sources, the ACT!! Coalition arrived at a position that it could defend: comprehensive benefits with no premium for those with incomes below 150 percent of the poverty level, premiums no higher than 1 percent to 2 percent of income for those with incomes between 150 percent and 300 percent of the poverty level, and total costs, including premiums and cost sharing, of no more than 5 percent of income at 300 percent of the poverty level.

Ultimately the Connector board chose comprehensive benefits (except dental coverage) with a premium and cost-sharing structure higher than the ACT!! Coalition's recommendation but lower than the administration's proposal. See Table 2 (premiums) and Table 3 (cost sharing). One concern that the board had about a lower contribution schedule was the steep increase in the costs of private coverage for individuals when their income exceeded the upper limit for the subsidy. A subsidized insurance program that had

[26]Materials developed by the ACT!! Coalition and Health Care for All's daily blog of health care reform developments are available at www.hcfama.org/act. For Health Care for All's view of Chapter 58, see John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform,* Health Affairs (Nov.–Dec. 2006), available at www.healthaffairs.org.

Table 2.—Monthly Contributions in Commonwealth Care (2006)

Income as a Percentage of the Federal Poverty Level	Monthly Contribution for One Adult	Contribution as a Percent of Income	Monthly Contribution for Two Adults	Monthly Contribution for Two Adults with Two Children in MassHealth
100 % or less	None	N/A	None	None
100.1–150 %	$18	1.76 %	$36	$36–$51
150.1–200 %	$40	2.8 %	$80	$104
200.1–250 %	$70	3.8 %	$140	$180
250.1–300 %	$106	4.7 %	$212	$268

Note: Contributions shown are for the lowest-cost plan available in Plan Types 1, 2, and 3 (see Table 3).
Source: Mass. Code Regs. tit. 956, § 3.11(8) (2006).

a higher upper-income level (400 percent or 500 percent of the poverty level) would have allowed for more graduated premium contributions as income approached the subsidy ceiling. Another concern was that if the subsidies were too deep, the program might be forced to limit enrollment to stay within its budget.[27] Note that the premium contribution schedule in Commonwealth Care, particularly to the extent that the contribution is driven by budget constraints, does not determine "affordability" for purposes of the mandate.

Commonwealth Care rolled out Phase 1 on October 1, 2006, for those at or below the poverty level; Phase 2 for those from 100 percent to 300 percent of the poverty level began on January 1, 2007. Applicants use the joint application process already in place for Medicaid, the children's health insurance program, the reimbursement pool, and certain state-funded programs, with the Massachusetts Medicaid agency making eligibility determinations for each program.

The Massachusetts Medicaid agency identified and will automatically enroll more than 50,000 individuals who were already eligible for the reimbursement pool and who satisfied the eligibility criteria for the first phase of Commonwealth Care. The agency estimates that an additional 70,000 pool users with incomes between 100 percent and 300 percent of the poverty level will be eligible for Commonwealth Care *if* they pay a premium. Whether pool users who must pay premiums choose to enroll in Commonwealth Care will be one measure of whether the new program is affordable in the eyes of its target population.

B. Remaining Major Implementation Challenges

As of early December 2006, some 13,000 children and 54,000 adults had comprehensive affordable coverage as a direct result of the health care reform law, and an additional 600,000 adults had access to more comprehensive benefits in Medicaid.[28] However, remaining major challenges will determine not only the sustainability of the accomplishments to date but whether hardships for other low- and moderate-income residents of Massachusetts when the individual man-

[27]For the recommendations and reasoning of the Health Insurance Connector Board's affordability committee, see Analyses & Options Regarding Affordability (Aug. 25, 2006), available at www.mass.gov/connector. See also John Holahan et al., Blue Cross Blue Shield Foundation of Massachusetts, Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts (2006), available at www.bcbsmafoundation.org.

[28]Ten thousand long-term unemployed adults have been enrolled in MassHealth, while 44,000 poverty-level adults have been determined eligible for Commonwealth Care and 18,000 of them have so far been enrolled. The remainder will either choose a plan or be automatically enrolled.

date takes effect will offset the accomplishments.

1. Defining "Minimum Creditable Coverage" and "Affordability" in the Individual Mandate

When the individual mandate takes effect in July 2007, uninsured adults will face Massachusetts tax penalties if "creditable coverage" is available to them at an "affordable" rate. In defining "minimum creditable coverage," the Connector must decide what counts as insurance for purposes of the mandate: whether to require comprehensive coverage that will be more costly or allow less comprehensive high deductible plans that will cost less. The next issue will be defining "affordability." The legislation requires the Connector to determine a schedule of affordability as a percentage of income and to take into account the cost of premiums and deductibles.

The ACT!! Coalition and other stakeholders are mobilizing for this next stage of implementation. Much depends on how "creditable coverage" and "affordability" will be defined. However, once made, implementation decisions are certain to be revisited over time. The legislature has already passed two technical corrections bill and in 2007 is likely to have before it several proposals for refining the 2006 law. A new Democratic governor took office in January and will appoint new people to the Connector board.

Currently support for the health care reform bill is broad, but views are divided over the individual mandate.[29] As the public becomes aware of the mandate's consequences, and depending on how the Connector defines "affordability," political support for health care reform may shift.

2. Cost Containment

Critics on both the right and left attacked the 2006 health care reform law for not facing the underlying problem of rising health care costs. The annual rate of increase in Massachusetts health expenditures from 2000 to 2004 was 8.5 percent, compared to 5.7 percent in the 1990s.[30] The per-capita health expenditure in 2004 was 33 percent higher than the national average.[31] Massachusetts' four major insurers are planning premium increases of more than 10 percent in 2007.[32]

In the short term the new law increases health care spending. The law raises Medicaid reimbursement rates for hospitals and physicians. It also provides for additional payments to the safety-net hospitals to make up for the loss of supplemental payments to their Medicaid managed care plans. Indeed, if one follows the money, most of the spending authorized by the health care reform law goes to hospitals. However, to the extent that private insurance subsidizes the costs of treating the uninsured, reducing the number of uninsured should have a moderating effect on private health insurance premiums.[33] The law handles cost and quality by creating a new council charged with designing quality improvement and cost-containment goals.[34] Whether the work of the new council will succeed in driving down health costs over time remains to be seen.

3. Other Unknowns

The long-term sustainability of health care reform in Massachusetts depends on many other factors as yet unknown. The source of funding for the new subsidized insurance program is the capped fund created by the Medicaid waiver. By the end of the most recent extension of

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[29] Robert J. Blendon et al., Blue Cross Blue Shield Foundation, The Massachusetts Health Reform Law: Public Opinion and Perception (2006), available at www.bcbsmafoundation.org

[30] Massachusetts Division of Health Care Financing and Policy, Massachusetts Health Expenditures Accelerating: Analysis in Brief (2006), available at www.mass.gov/dhcfp.

[31] *Id.*

[32] Jeffrey Krasner, *Medical Insurance Hikes Loom in Mass.*, Boston Globe, Sept. 10, 2006.

[33] See Families USA, Paying a Premium: The Added Cost of Care for the Uninsured (2005), available at www.familiesusa.org.

[34] 2006 Mass. Acts ch. 58, § 3.

the Medicaid demonstration in 2008, the Massachusetts Medicaid agency projects that little will be left of the early demonstration savings. Negotiation of a further waiver extension will occur in 2007 under the current administration in Washington; coming to terms on budget neutrality will be a challenge.[35] Reauthorization of the children's health insurance program in 2007 will also be critical. Massachusetts is among states projecting a shortfall in its current children's health insurance program allotment.

In the late 1990s the administration that initially proposed the insurance reimbursement program in the Medicaid demonstration predicted high levels of enrollment among the uninsured, but since the program began, participation rates have been low.[36] Whether the new subsidized insurance program will be more successful in signing up and retaining members at the premium and benefit levels established by the Connector board remains to be seen.

One final caution: it was just three years ago that the Massachusetts Medicaid program was experiencing major cuts in eligibility and services. Another downturn in the economy and reduced revenue to Massachusetts could consign the 2006 reform to the same fate as the 1988 "pay or play" reform.

V. Lessons for Advocates

Take the Bitter with the Sweet. Is the policy approach taken in the new law a useful model for other states? In answering this question, both supporters and critics of the Massachusetts compromise overlook some key facts. Conservatives who champion the law as a model misrepresent the importance of the public sector: Massachusetts has a generous Medicaid program, federal funding for a comprehensive new subsidized coverage program, and a highly regulated insurance market. A state without these features should be wary of an individual mandate. However, critics on the left who dismiss the new law too easily brush aside the undeniable benefit of the compromise: expanded public coverage for up to 200,000 low- and moderate-income Massachusetts residents. The Massachusetts law is a delicate balance with many provisions still undefined and untested. In the words of the director of Health Care for All, "We tell people not to look at our law as a policy blueprint. It's a political blueprint. You can take the dynamic and the ideas to trigger a new and more ambitious conversation in your state."

Protect Vulnerable Populations: Immigrants and the Poor. One value that legal aid advocates add to the campaign for universal coverage is a focus on protecting the interests of the most vulnerable and disenfranchised Massachusetts residents. Medicaid advocates were able to hitch a ride on the rising star of health care reform to obtain many long-sought protections. Besides restoring the optional benefits cut in 2002 and 2003, the law provides for a public hearing before any future eligibility or benefit restrictions in Medicaid, prohibits sponsor deeming in state-funded medical benefits for immigrants, and bars the Massachusetts Medicaid agency from proceeding with a pending waiver request to use a more restrictive standard of disability than that of the Supplemental Security Income program.[37] The health care reform law provides for state-funded coverage in the new subsidized insurance program for legal immigrants who do not meet Medicaid immigration-related eligibility rules.[38] The law also preserves the reimbursement pool to cover services for those—including undocumented immigrants—still without access to comprehensive coverage.[39]

[35]The U.S. secretary of health and human services requires demonstration projects to be budget-neutral. This means that a demonstration must not be more costly to the federal government than a Medicaid plan that a state could adopt without a waiver.

[36]See *supra* note 15.

[37]2006 Mass. Acts ch. 58, §§ 16, 24, 27.

[38]Mass. Gen. Laws ch. 118H, § 1.

[39]2006 Mass. Acts ch. 58, § 30.

For the very poor, health care reform is an unqualified improvement largely due to the Medicaid-like protections that the statute prescribes for the subsidized insurance program for those with incomes that do not exceed the poverty level. Now the challenge is to ensure that the near poor who cannot afford the premiums in the new subsidized insurance program are not financially penalized under the individual mandate and that the premium and cost-sharing structure is revisited to provide full access to all those who cannot afford private insurance in the commercial market.

Beware of Budget Neutrality. No state can contemplate a significant expansion of coverage for the uninsured without financial support through the Medicaid program. However, in order to achieve budget neutrality in Medicaid demonstrations, a requirement of the Centers for Medicare and Medicaid Services is for states to take on risks that effectively convert Medicaid into a block grant at the state level. In Massachusetts every campaign to improve and expand Medicaid now will confront the brake of budget neutrality. Whether the proposal is to raise the reimbursement rate for dentists whose Medicaid participation rate remains low or to provide more intensive services for mentally ill children, federal matching funds can no longer be taken for granted. Medicaid developments at the federal level define in large part the conditions for reform at the state level.

The history of health care reform in Massachusetts includes advances and retreats and a steady progression toward more affordable public programs for more of the uninsured. For other states contemplating health care reform, much is at stake for the low- and moderate-income clients of legal aid programs, and our clients and their interests must be part of the political and policy debate.

Table 3.—Commonwealth Care Plans

Plan Type 1 is for individuals whose incomes are up to 100 percent of the federal poverty level.
Plan Type 2 is for individuals whose incomes are more than 100 percent and up to 200 percent of the federal poverty level.
Plan Type 3 is for individuals whose incomes are more than 200 percent and up to 300 percent of the federal poverty level and who choose the "low premium, high copayment" option.
Plan Type 4 is for individuals whose incomes are more than 200 percent and up to 300 percent of the federal poverty level and who choose the "high premium, low copayment" option.

SERVICES	COPAYMENTS		
	Plan Type 1	**Plan Types 2, 4**	**Plan Type 3**
Outpatient medical care			
Abortion services	$0	$50	$100
Community health center visits (primary care provider/specialty)	$0	$5/$10	$10/$20
Office visits (primary care provider/specialty)	$0	$5/$10	$10/$20
Outpatient surgery (outpatient/hospital/ambulatory surgery centers)	$0	$50	$100
X-rays/labs	$0	0	0
Inpatient medical care			
Room and board (including deliveries/surgery/x-rays/labs)	$0	$50	$250
Prescription drugs			
Medication via pharmacy (1-month supply)	$1/$3 (generic/brand)	$5/$10/$30	$10/20/40
Emergency care	$3*	$50*	$75*
Inpatient mental health and substance abuse	$0	$50	$250
Outpatient mental health and substance abuse	$0	$10	$20
Rehabilitation Services			
Cardiac rehab	$0	0	0
Home health care	$0	0	0
Inpatient in skilled nursing facility (100-day maximum)	$0	0	0
Inpatient in rehab hospital (100-day maximum)	$0	$50	$250
Short-term outpatient/rehab (physical therapy/occupational therapy/speech)	$0	$10	$20
Other Benefits			
Ambulance (emergency only)	$0	0	0
Dental (restorative/preventative/radiography/ diagnostic/prosthodontic/oral surgery)	$0	Not covered	Not covered
Durable medical equipment/ supplies/prosthetics/oxygen and respiratory therapy equipment	$0	0	10%
Hospice	$0	0	0
Orthotics (diabetics only)	$0	$10	$20
Podiatry (diabetics only)	$0	$5	$10
Vision (exam and glasses every 24 months)	$0	$10 for exam	$20 for exam
Wellness (family planning/nutrition/prenatal/nurse midwife)	$0	0	0
MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES			
Pharmacy	**$200**	**$250**	**$500**
Inpatient medical or outpatient surgery		**$250**	**$500**
Durable medical equipment/supplies/prosthetics/ oxygen and respiratory equipment			**$500**
Total by special request			**$750**

*Emergency room copayment is waived if one is admitted to an inpatient unit. In Plan Type 1 copayment applies only to the use of emergency room services for nonemergency conditions.

Source: Commonwealth Care, www.mass.gov/?pageID=hichomepage&L=1&L0=Home&sid=Qhic.

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