Assessing the New Federalism

An Urban Institute Program to Assess Changing Social Policies

THE URBAN INSTITUTE

State Update No. 17, March 2002

Recent Changes in Health Policy for Low-Income People in Massachusetts

Randall R. Bovbjerg and Frank C. Ullman

There is strong bipartisan support for low-income coverage, owing to political ideology, influential nonprofit hospitals, ample state revenues, and a generous federal waiver.

Overview

Major expansions of public coverage for low-income people have dominated Massachusetts's health policy since the mid-1990s. The state in 1997 expanded Medicaid enrollment by almost a third. The expansions, along with high rates of employer-sponsored insurance, have dramatically reduced uninsurance. Only 6 percent of residents lacked coverage in 2000, under 3 percent for children. The state has also increased pharmaceutical coverage for seniors; continued to expand community services in mental health, developmental disabilities, and long-term care; dealt with the insolvency of the state's largest health maintenance organization (HMO) that also owns the largest Medicaid HMO; and convened a high-level, bipartisan task force to systematically reconsider state health policies.

Health care has always loomed large in Massachusetts—in the state economy, in its politics, even in culture. With only slight hyperbole the state public health commissioner has remarked, "This is the medical and public health capital of the world."[1] There is strong bipartisan support for low-income health coverage and—very unusually—much popular support for universal, government-overseen health coverage for all. In general, late-1990s expansions occurred through public sector programs targeted at the low-income uninsured without workplace insurance coverage, as supported by the overwhelmingly Democratic legislature. There has been some new support for private coverage, often espoused by three successive Republican governors. Health policy has been driven not only by political desires to expand coverage but also by market developments as well as the financial condition of hospitals, insurers, and nursing homes.

The state's economic boom in the 1990s was especially strong, allowing repeated tax cuts, a strong gubernatorial priority, to accompany increases in spending. Now being implemented is the biggest income tax cut in state history, promoted by the governor and mandated by voter referendum in November 2000. In addition to health coverage expansions, education and public safety have been the top spending priorities since the mid-1990s.

Massachusetts's health care spending has long been high and until 1992 was addressed by thoroughgoing regulation. The state then abandoned hospital rate setting in favor of managed care, whose market penetration rose in the mid-1990s to among the country's highest rates and helped hold down growth in overall health spending. Medicaid also successfully constrained costs with managed care and administrative price setting, but costs rose faster after the large enrollment expansions of 1997.

The expansions came in three main parts, all under a Section 1115 federal waiver. First, Medicaid—called MassHealth—expanded to higher income levels for traditional categories of recipients, later adding more children and families after the passage of federal State Children's Health Insurance Program (SCHIP) legislation. This part added the most new enrollees.

The second part of the waiver was new support for those uninsured not directly

reached by the coverage expansions. The vehicle was integrated hospital systems management of uninsured care by the state's two big safety net hospitals, in Boston and Cambridge.

The third part was some help for childless working adults, mainly in the form of modest premium support and employer incentive for some workplace health coverage. Targeted at employees in small firms, this aspect of expansion took effect by stages, fully implemented only in January 2000. As yet, it reaches few people relative to the other expansions but was growing steadily as of mid-2001.

Medicaid and other reform also helped shore up funding for the state's unusual free-care pool, which reimburses hospitals for care to uninsured people of low and moderate income and draws down federal Medicaid matching funds under the disproportionate share hospital (DSH) payments program. Deficits have since returned, however, and hospitals are seeking more relief from the assessments they pay to support the pool.

Managed care is required for most enrollees, mainly through primary care case management and separate management for behavioral health services, which appear to be satisfactory to state officials. In the mid-1990s, the state planned to move ever more beneficiaries into capitated managed care organizations (MCOs). That strategy has receded; MCOs have left MassHealth, capitated participation has declined, and enrollees have concentrated in Medicaid-oriented plans. Conflicts are emerging among the four remaining MCOs; two competitors complain about the higher rates paid to the two safety net hospital plans. Managed care is slowly being extended to the disabled population.

For senior and disabled beneficiaries, institutional care continues to dominate spending. Nursing home census has declined slightly since the mid-1990s, however, and spending on community services is growing much faster. Community services are a high state priority in MassHealth, as in mental health, but progress has lagged advocates' desires, and some *Olmstead*-like litigation has forced acceleration of state action.

Cost pressures in MassHealth are growing. Pharmaceutical increases are already a major concern, and state officials expect soon to have to increase payment rates for hospitals, nursing homes, physicians, and others. MassHealth has frequently needed mid-year supplemental appropriations in the past, partly owing to conscious under-budgeting, but also because of unexpected cost increases. The future could see more difficulties as economizing through managed care and price setting becomes more difficult.

Beyond MassHealth, the state has also expanded drug coverage, first in 1997 and twice more since. Starting in 2001, all elderly and younger disabled persons are eligible for a new "Prescription Advantage" program, evidently the nation's first to offer unlimited benefits for any senior, subject to cost sharing based on income.

Recent developments in insurance markets have drawn considerable high-level attention and heavy media coverage. The state has seen increased concentration among the HMOs that dominate health coverage, then the near-failure in January 2000 of the then-largest plan, Harvard Pilgrim Health Care. That crisis required major state intervention, which, along with provider-patient backlash against managed care, also generated more regulation of managed care.

Prominent issues as of mid-2001 included raising provider rates, implementing prescription drug expansions for aged and disabled persons, expanding long-term care alternatives, further strengthening the state's uncompensated care pool, and implementing intensified oversight of health plans and patient protections. Fiscal year 2002 began in July with further expansions still planned. By September, economic slowdown was threatening fiscal crisis, and major cuts were needed for the state's final 2002 budget, cuts which largely spared health spending. Health spending seems likely to face some cuts, if only because it is so large, but will probably fare relatively well in Massachusetts even in a cutback mode.

The foregoing are the main findings of this case study of recent health care policy affecting low-income people in Massachusetts, building on a 1997 baseline study.[2] This

TABLE 1. *Selected Massachusetts Characteristics*

	Massachusetts	United States
Population Characteristics		
Population (2000) (in thousands)[a]	6,349	281,422
Percent under age 18 (1999)[a]	23.6%	25.7%
Percent Hispanic (1999)[b]	7.3%	12.5%
Percent black (1999)[b]	5.9%	12.8%
Percent Asian (1999)[b]	3.8%	4.1%
Percent nonmetropolitan (1999)[b]	1.3%	20.3%
State Economic Characteristics		
Per capita income (2000)[c]	$37,992	$29,676
Percent change per capita Income (1995–1999)[d]	15.9%	10.8%
Unemployment rate (2001)[e]	3.2%	4.5%
Family Profile		
Percent children in poverty (1998)[f]	12.4%	17.5%
Percent change children in poverty (1996–1998)[f]	–22.5%	–15.0%
Percent adults in poverty (1998)[f]	7.5%	11.2%
Percent change adults in poverty (1996–1998)[f]	–19.4%	–10.4%
Political		
Governor's affiliation (2001)[g]	Republican	NA
Party composition of senate (2001)[h]	34D-6R	NA
Party composition of house (2001)[h]	135D-23R-2V	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC)[i]	71.0%	59.3%
1998 (TANF)[i]	63.6%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996[j,k]	101%	124%
1998[j,l]	200%	178%
2000[j,m]	200%	205%

Table 1 notes begin on page 33.

report and others like it examine representative states' responses to the new opportunities and challenges of the last half decade.[3] Information came from in-person interviews on site in early May 2001, supplemented by telephone and written responses, as well as documents, newspapers, and Web sites.[4] Massachusetts is unusually rich in state data and documentation, and many private groups regularly generate information as well. Interviewees were given the opportunity to comment on a draft, and key issues were followed through final enactment of the 2002 budget in December 2001.

The following presentation tracks the five key issues studied: First, how have political and fiscal circumstances changed in Massachusetts? Second, how has the state changed its public or private health insurance coverage? Third, how have Medicaid managed care and other acute care issues changed? Fourth, how did Massachusetts policymakers respond to pressures to expand home- and community-based services for persons with disabilities? Fifth, what other issues were prominent?

Background to Policymaking

Demographics, Insurance Coverage, and Politics

Massachusetts is a wealthy, high-growth, heavily urbanized state (see table 1). Its ethnic and racial composition is less diverse than the nation. A smaller share of the population

lives in poverty than in the nation at large, and poverty dropped faster in Massachusetts between 1996 and 1998 than it did nationwide. The state has very few uninsured residents, mainly because of a strong base of private insurance but also because of public coverage, especially for children (see table 2). Almost four-fifths of all adult residents under age 65 have employer-sponsored insurance (ESI), about 7 percent higher than the national average. Residents with incomes under twice the federal poverty level (FPL), however, have lower than average ESI rates, relying instead on generous public coverage that covers about twice the average share of the low-income population.

Public expansions since mid-1997 have boosted coverage for families with incomes below 200 percent of FPL. From 1997 to 1999, public coverage rose by 14 percentage points to fully 60 percent among low-income children; their uninsurance rate fell to under 7 percent, a drop of over 7 percentage points. Among low-income adults, public coverage rose to 30 percent (up 8 points), and uninsurance dropped to 19 percent (almost 11 points down).[5]

By tradition and voter registration, Massachusetts is a heavily Democratic state, long noted for liberal support of health coverage, high taxes, and strong regulation. Under Republican governors and Democratic legislatures in the 1990s, the state cut taxes and regulation while expanding state health care coverage. There is strong, bipartisan support for incremental expansions; private health advocacy groups are numerous and influential; and state agencies compete to share in coverage-promoting programs. Unlike almost any other state, Massachusetts politics features strong support for even greater intervention—mandatory universal coverage. A citizen initiative for universal coverage nearly won voter approval in 2000 despite high-placed and well-funded opposition.

Health policymaking appears unusually consensus-based and often relies on expert commissions, including today's influential Massachusetts Health Care Task Force. Unusually, the governor and the Democratic legislative leaders hold regular monthly working sessions. Medical providers enjoy great political "clout," and the governor and legislative leaders see education and health care as the two top priorities. The budgetary climate was benign through fiscal year 2001; a strong economy and success in maximizing federal Medicaid funding eased partisan disputes, making it possible to expand health coverage while cutting taxes repeatedly. One interviewee noted that the near-failure of the state's biggest HMO also provided a "wake-up call" that promoted bipartisanship.

Three consecutive Republican governors have succeeded Democratic Governor Michael Dukakis. First was William Weld, who won election in 1990 as a fiscal conservative and social liberal. Under his administrations, the state by mid-decade had repealed the Dukakis mandate for universal coverage, replaced hospital rate setting with managed care, repeatedly cut taxes, boosted education, reformed welfare, then won federal approval for broad Medicaid expansion. The last five years have seen two gubernatorial transitions but little change in political climate or expansionism in health policy. In July 1997, just after the start of MassHealth expansions, Weld resigned in an unsuccessful bid to become ambassador to Mexico.

Lieutenant Governor Paul Cellucci became acting governor and immediately proposed a billion-dollar-plus tax cut to roll back the 1989–1990 income tax hike that had been passed to maintain services during the last recession. Medicaid expansions continued under Cellucci, and the state was also quick to take advantage of new federal support under SCHIP. Cellucci won election in his own right in 1998 and engineered a voter referendum in November 2000 that supported his full tax cut over the far smaller legislative proposal. Forgoing about 5 percent of state revenues, this was the biggest state tax cut of many made in 1999 and 2000 and the largest in Massachusetts history.[6] Massachusetts is no longer one of the very high tax states.[7]

Cellucci was still widely perceived as politically less adroit than Weld. In April 2001, he followed Weld in resigning early, to become ambassador to Canada. Lieutenant Governor Jane Swift became the state's first female governor. Initially seen as a weak can-

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, Massachusetts and the United States, 1999

	Children (Ages 0–18)[a] (%)		Adults (Ages 19–64)[b] (%)	
	Massachusetts	United States	Massachusetts	United States
Below 200% FPL				
Employer-sponsored	**32.2**	38.7	40.1	41.7
Medicaid/SCHIP/state	**59.2**	35.2	**29.6**	14.7
Other coverage	**2.1**	3.8	11.0	8.8
Uninsured	**6.5**	22.4	**19.4**	34.9
Above 200% FPL				
Employer-sponsored	**89.0**	85.3	**87.5**	83.7
Medicaid/SCHIP/state	**5.6**	3.8	**2.0**	1.1
Other coverage	**3.2**	4.9	4.6	5.8
Uninsured	**2.2**	6.0	**5.9**	9.4
All Incomes				
Employer-sponsored	**72.9**	66.7	**79.1**	72.3
Medicaid/SCHIP/state	**20.8**	16.4	**6.9**	4.8
Other coverage	**2.9**	4.5	5.7	6.6
Uninsured	**3.4**	12.5	**8.3**	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families.* Washington, D.C.: The Urban Institute.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program
Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

didate for 2002, as acting governor her visibility rose; her "first ever" gubernatorial childbirth (twins) got positive press coverage, she has assertively pursued her main priorities in her first budget battles, she has amassed a sizable campaign war chest, and her ratings have improved dramatically. Like her predecessors, she has made a no-new-taxes pledge but supports health care expansion.

Fiscal Circumstances of the State

Massachusetts's economy performed robustly through state fiscal year 2001 after emerging from an especially deep recession in the early 1990s. The state ranks second in per capita income—at $37,992 in 2000, some 28 percent above the national average (see table 1).[8] Its annual growth in per capita income has been high, exceeded by only two other states in 1999–2000. The economy seemed to have slowed as of summer 2001, however, and will likely suffer in the aftermath of the September 11 terrorist attacks.[9] Health care has long been a major contributor to economic growth,[10] and health expenditures statewide have always been high, both per capita and as a share of gross state product, although in the 1990s growing more slowly than average.[11]

The state budget has also done well since the mid-1990s, boosted by strong growth in revenues and controlled growth in spending—6 percent a year, exactly the national average—despite large expansions in health and education (see table 3). The state's surpluses have helped decrease pension liabilities, increase "rainy day" funds, and cut taxes.[12] Bond rating agencies have upgraded the state's ratings.

TABLE 3. Massachusetts Spending by Category, 1995 and 2000 ($ in Millions)

	State General-Fund Expenditures[a]				Total Expenditures[b]			
	Actual	Estimated	Annual Growth (%)		Actual	Estimated	Annual Growth (%)	
Program	**1995**	**2000**	**MA**	**U.S.**	**1995**	**2000**	**MA**	**U.S.**
Total	$13,282	$17,130	5	5	$19,015	$25,682	6	6
Medicaid[c,d]	$1,700	$2,426	7	5	$3,900	$5,176	6	4
% of Total	13%	14%			21%	20%		
K–12 Education	$2,020	$3,194	10	7	$2,404	$3,769	9	7
% of Total	15%	19%			13%	15%		
Higher Education	$704	$1,032	8	5	$944	$1,311	7	5
% of Total	5%	6%			5%	5%		
Public Assistance	$727	$457	–9	–6	$1,054	$614	–10	–5
% of Total	5%	3%			6%	2%		
AFDC/TANF	*$389*	*$191*	*–13*	*–9*	*$693*	*$298*	*–16*	*–7*
% of Total	*3%*	*1%*			*4%*	*1%*		
Corrections	$285	$752	21	6	$292	$795	22	6
% of Total	2%	4%			2%	3%		
Transportation	$641	$772	4	5	$2,266	$2,945	5	6
% of Total	5%	5%			12%	11%		
All Other[e]	$7,205	$8,496	3	5	$8,155	$11,073	6	8
% of Total	54%	50%			43%	43%		

Source: National Association of State Budget Officers. 1997. *1996 State Expenditure Report* and 2000. *1999 State Expenditure Report.*
a. State general-fund expenditures exclude other state funds and bond expenditures.
b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.
c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as other state funds. In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.
d. Total Medicaid spending will differ from data reported on the HCFA-64 for three reasons: First, NASBO reports on the state fiscal year and the HCFA-64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA-64.
e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.
Note: Figures may not add to totals shown due to rounding.

Revenue projections have vacillated during the course of this case study. The governor's state fiscal year (SFY) 2002 budget projected growth in revenues of 4.9 percent, slowing but still strong. FY 2001 revenue ended strong, leaving a $453 million surplus—quite unlike many states' shortfalls—which Acting Governor Swift proposed to split between a modest tax cut and social priorities, including $40 million for distressed hospitals.[13] Collections worsened thereafter, down fully 13 percent in September, and recession hit hard, especially after the attacks of September 11.[14] The SFY 2002 budget did not pass the legislature until the day before Thanksgiving, and after some gubernatorial vetoes, final spending plans for 2002 were not set until early December. The state had to close a revenue shortfall of about $1.4 billion, using a mix of program cuts and tapping of surplus funds.

The budget shows overall state priorities. It grew from about $19 billion in 1995 to $26 billion in 2000, rising fastest for corrections (see table 3), well above national rates of increase, mainly for new prison space. Funding for K–12 education also surpassed national norms, but by much less than for corrections. Higher education also outgrew national

norms. Massachusetts reformed welfare in 1995, and recipients have declined by 50 percent since. Total cash assistance (AFDC/TANF) enrollment dropped more than twice as fast as the national average. As a result of the MassHealth expansions, growth in Medicaid spending in 1995–2000 was higher than nationally.

State finances also benefit from the November 1998 tobacco settlement.[15] Massachusetts got $240.3 million in FY 2001 and expects to get over $7 billion through 2025. By December 1999 legislation, 30 percent of funds support current health-related spending, along with interest on the other 70 percent, placed in a trust fund. Governors unsuccessfully sought to put somewhat less into trust, and since September 11, Governor Swift has proposed temporarily using tobacco funds for local assistance instead. (The attorney general's office also used general consumer protection authority to curb tobacco advertising more than the national settlement did; the effort survived an industry challenge in two lower courts, but lost in the U.S. Supreme Court.[16])

In the rewriting of the final 2002 budget to cope with recession, Medicaid did much better than the rest of state government. Things may worsen later in the year or in SFY 2003. One bond rating agency has marked down the state fiscal outlook from stable to negative.

Medicaid Trends

Medicaid's huge spending dominates health policy, accounting for about one budget dollar in five (see table 3).[17] The state is among the most generous states in terms of eligibility and benefits and has long had very high spending per enrollee compared with the nation as a whole.[18] Different cost drivers have emerged over time, and administrative strategies have evolved. This section compares Massachusetts with the rest of the nation for 1995–1998 using data from the federal reporting system; 1998 is the most recent year available for such consistently generated data. Some post-1998 comparative data (like those in table 3) come from state sources and budgetary tracking.[19]

In terms of enrollment, children account for nearly half; just over one-fifth of enrollees are nondisabled adults, another one-fifth disabled, and approximately one-tenth elderly (see table 4). Massachusetts's enrollment rose faster in nearly all categories than did the nation during 1995–1998. Medicaid enrollment stayed about level for three years after welfare reform was implemented in 1995, then rose markedly after MassHealth was implemented in 1997 and has continued to climb since 1998.

In terms of expenditures, Massachusetts has always ranked high, but kept 1995–1998 growth very low, well below half the national average (see table 4), continuing the success of 1990–1995.[20] Spending rose faster after MassHealth expansion, driven by increases in enrollment.[21] Massachusetts spending per enrollee actually decreased in 1995–1998, whereas the national average increased by 6 percent a year. Since 1998, other cost drivers have been increases in provider rates, pharmaceutical costs, and changes in MassHealth demographics toward sicker enrollees, resulting in higher utilization.

Massachusetts spending per enrollee in 1998 remained 23 percent above the national average, 12th highest in the nation. The disparity was greatest for long-term care services. As in other states, long-term care services account for nearly half of state spending; growth in long-term care spending between 1995 and 1998 was attributable to increased expenditures on home health services. Nursing home and other institutional expenditures decreased. Home care (including home- and community-based waivers) rose rapidly but at only half the rate of the entire country.

The fastest growing acute care service since the mid-1990s has been prescription drugs, rising half again as fast in Massachusetts as in the entire United States. Overall, pharmaceutical expenditures more than doubled between 1995 and 2000, from $300 million to $686 million. Prices and utilization have both risen, and consumption is moving "upscale" to newer and more expensive drugs, little checked by state policies facilitating generic substitution.[22] State officials believe federal regulation constrains their cost control.

TABLE 4. Medicaid Enrollment and Expenditures in Massachusetts, 1998

	Massachusetts, 1998			Average Annual Growth (%), 1995–1998					
				Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
	Total Annual Expenditures (in millions)	**Avg. Monthly Enrollment** (in thousands)	**Avg. Annual Expenditures per Enrollee**	**Massachusetts**	**United States**	**Massachusetts**	**United States**	**Massachusetts**	**United States**
Total Expenditures	**$5,753**	**–**	**–**	**1.5**	**3.9**	**–**	**–**	**–**	**–**
Medical Services									
By Eligible Group	**$5,103**	**857**	**$5,955**	**2.2**	**5.1**	**5.4**	**–1.0**	**–3.0**	**6.1**
Elderly	$1,597	89	$17,950	–1.1	4.3	–1.5	0.1	0.4	4.2
Blind and disabled	$2,458	191	$12,854	5.8	8.5	5.6	3.6	0.1	4.7
Adults	**$418**	**189**	$2,206	1.3	–1.4	8.0	–4.4	–6.2	3.1
Cash assistance	$170	74	$2,282	–14.9	–10.4	–11.0	–14.9	–4.4	5.3
Other enrollees	$248	115	$2,156	25.3	7.8	36.9	9.3	–8.5	–1.4
Children	**$630**	**387**	$1,627	–0.7	2.7	5.9	–1.5	–6.2	4.3
Cash assistance	$292	168	$1,734	–6.0	–8.8	–5.1	–12.2	–0.9	3.9
Other enrollees	$338	219	$1,545	4.9	12.4	19.2	9.8	–12.0	2.4
By Type of Service	**$5,103**	**–**	**–**	**2.2**	**5.1**	**–**	**–**	**–**	**–**
Acute care	$2,653	–	–	3.3	4.0	**–**	–	–	–
Long-term care	$2,451	–	–	1.1	6.5	–	–	–	–
DSH	**$497**	**–**	**–**	**–6.6.**	**–7.3**	**–**	**–**	**–**	**–**
Administration	**$153**	**–**	**–**	**11.1**	**8.5**	**–**	**–**	**–**	**–**

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Note: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. “Cash assistance” refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. “Other enrollees” include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. “Acute care” services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to managed care organizations (MCOs), and payments to Medicare.“Long-term care” services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. “DSH” stands for disproportionate share hospital payments.

Note: Figures may not add to totals due to rounding.

Massachusetts gets the lowest prices for drugs by participating in the federal rebate program, but this also requires the state to cover all the drugs a company produces. As of mid-2001, the state was planning to lower the maximum supply of medications per prescription and the number of refills, to mandate prior approval for brand name drugs with generic equivalents, and to modify its pharmacy pricing methods.[23]

Looking forward, expansions and price inflation are making future budgetary control look harder. Already in recent years Medicaid has needed supplemental appropriations, to a considerable extent because of intentional legislative under-funding, according to a local tax watchdog foundation, but also because of unanticipated rises in utilization and prices. Most types of providers—including hospitals, nursing homes, and community health centers—have been given provider rate increases, both by legislative mandate and by administrative initiative.

State Medicaid officials described three main potential cost-drivers not yet fully accounted for in the state's Medicaid budget as of mid-2001. The first is provider rate increases that may be enacted in part as a response to findings from the state's Health Care Task Force. Second are further utilization increases expected to follow the state's new managed care law, which will increase patients' ability to argue that desired care should be covered.[24] Third, policymakers are expanding community long-term care services in response to political pressures and to the Americans with Disabilities Act and the *Olmstead* decision (discussed under long-term care below).

Expansions in Health Insurance Coverage from 1997

The Extent of Coverage Expansion

Two things stand out about recent developments in Massachusetts's publicly provided or subsidized health coverage. First, coverage has expanded markedly since the state began implementing its large Section 1115 Medicaid waiver in mid-1997. Second, the state has moved from a patchwork of programs toward a jointly administered family of coverages known as MassHealth and from different income ceilings toward more consistent targeting of low-income residents.

The recent expansions are among the largest in the nation in terms of income ceilings for eligibility and comprehensiveness of benefits provided. Through June 2000, after two fiscal years of expansion, Massachusetts had increased enrollment by about one third—230,000 people beyond the pre-expansion level of almost 700,000 enrollees—reaching about 15 percent of the state's population. Projections indicate a slower rate of increase since then and into the future.[25] As a result of the expansions, public assistance extends almost universally to low-income children and parents, including expectant mothers; childless adults are less well covered. The state's expansions are credited as a major factor in reducing the state's uninsurance rate in the late 1990s.

MassHealth has moved far toward being a single, seamless program of assistance. Although separate categorical funding programs compose MassHealth, enrollment and administration are jointly administered, and underlying complexities are seldom visible to applicants or enrollees. Taken together, the programs now offer some form of assistance to all low-income children (those with household incomes up to 200 percent of FPL), all parents up to 133 percent of FPL (with some help up to 200 percent), many childless adults up to 133 percent of FPL, and to disabled persons under age 65 without an income limit. Other state programs also help uninsured and underinsured people, including by referral to other sources of coverage or care.[26] Finally, for those still without any coverage, public or private, the state runs an uncompensated care pool that provides free or reduced-fee care in hospitals and community health centers. The level of state effort is quite remarkable.

The Path to Expansion

Massachusetts has a long tradition of trying to expand health coverage. In 1988, the state was the first in the continental United States to legislate universal health coverage, starting with some small, public, gap-filling programs and intending to move to an employer mandate over time.[27] The mandate was first postponed and then repealed under the new Weld administration in 1991, but public coverage for disabled and long-term unemployed persons survived. As the state's rate of uninsurance rose through the early 1990s, so did support for some larger public expansion, and in April 1995 the governor obtained a federal Section 1115 waiver. Its goals were to expand coverage, relieve growing pressure on the state's uncompensated care pool and disproportionate share hospital (DSH) spending, and to increase management of care under public programs while also holding down substitution of public coverage for employer-sponsored insurance (ESI). Fortunately for the state, the projections of baseline growth built into waiver funding proved to be quite generous.[28]

Enabling legislation was passed in 1996 and again in 1997 after a commission report helped resolve modest differences between the Weld administration and the legislature about how much to rely on boosting workers' private insurance as against public coverage. State funding came from traditional Medicaid appropriations, shifts in DSH funds, and new tobacco taxation. Federal SCHIP support was added in 1998, and qualifying MassHealth enrollees draw the higher SCHIP federal match.

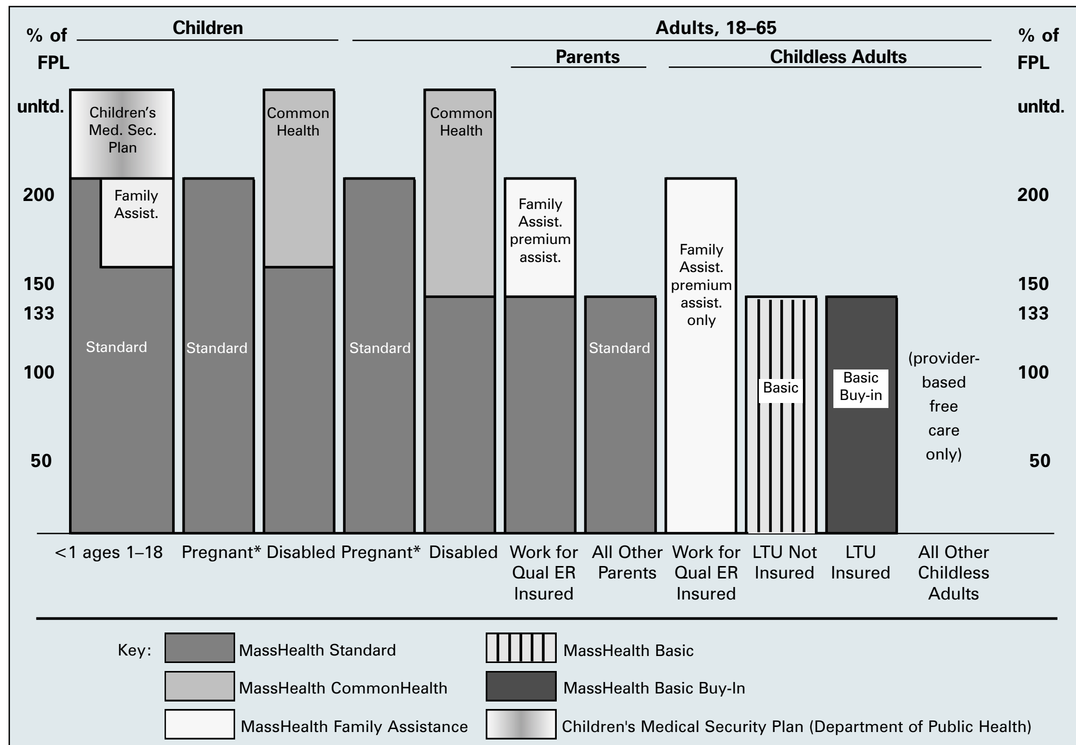
The first step toward basing eligibility more on income than on welfare categories occurred in 1993, when Medicaid administration was removed from the welfare department to become the new Division of Medical Assistance. Some conscious efforts were made to reduce welfare stigma by changing the enrollment process and changing the name from Medicaid to MassHealth for managed care enrollees. Thereafter, welfare reform severed the legal tie between actual receipt of cash assistance and Medicaid eligibility. Massachusetts did much more than other states to keep people who were losing cash assistance enrolled in Medicaid, instituting an automatic system to prevent loss of coverage. The result was continued enrollment growth over 1995–1998, compared with a decline nationally (see table 4). In designing its Medicaid waiver, policymakers sought to reduce income differentials for eligibility, especially for children older than infants. The goal was for all of a family's children to qualify together. All of Medicaid was rolled into MassHealth in 1997, together with other, smaller programs, and eligibility was expanded in phases. New increments of eligibility continued to be added as of mid-2001.

MassHealth: The Dominant Source of Coverage

MassHealth includes most of the sizable state programs, including traditional Medicaid, as well as original waiver, SCHIP, and other expansions. MassHealth pays for health care services for many categories of low- and medium-income residents, including children under age 19, families with children under age 19, disabled people, people out of work for a long time, adults who work for a MassHealth qualified employer, pregnant women, and HIV positive people. MassHealth benefits are provided directly or by paying part or all of health insurance premiums. Most eligible people are under age 65, although certain low-income seniors qualify. Figure 1 gives an overview of how the state has targeted aid to residents with family income below 200 percent of FPL.[29] Eligibility and support vary somewhat by category of beneficiary.

MassHealth is broadest for children. It provides comprehensive health insurance coverage for children up to 150 percent of FPL, with a few small exceptions, and slightly less coverage for those at 150–200 percent of FPL (see figure 1). Prior to the expansions, ceilings had been at about 100 percent of FPL. Adult coverage is also among the most generous in the nation, although it varies not only by income but also by parental status, citizenship status, disability, and access to other health insurance. Parents are eligible up to

FIGURE 1. Massachusetts Coverage by Income Eligibility Ceilings and Assistance Category



Source: Division of Medical Assistance, Program and Budget Issues for FY 2002, see endnote 19.
Notes: Chart shows programs for citizens and qualified aliens under age 65; lesser benefits apply for other aliens, special status, and nonqualified.
FPL = federal poverty level; unltd = unlimited income, cost share; LTU = long-term unemployed; Qual ER = qualified employer
* May receive prenatal coverage for up to 60 days when income is not verified prior to becoming eligible for the appropriate benefit.

133 percent of FPL, with some exceptions, and even higher income ceilings apply for disabled adults and pregnant women. Benefits are generous as well.

Childless adults are least well covered. Coverage is available for those who are long-term unemployed or disabled, which accounts for a high share of low-income childless adults. For others, the main aid is premium assistance to help pay for workplace coverage if they are low income (up to 200 percent FPL) and work for qualified employers. Employers qualify and can also get a subsidy for each employee if they are small (under 50 employees), pay half or more of premiums, and meet other standards.

Administration and Outreach. The Massachusetts Division of Medical Assistance administers MassHealth, presenting it to beneficiaries as a single program. Much effort has gone into streamlining eligibility requirements and expanding outreach. Numerous quality improvement and measurement activities are also under way, some related only to one aspect of MassHealth, many system-wide.[30]

All MassHealth programs use a uniform application. The state has sought to boost enrollment in many ways. As early as 1993, traditional Medicaid had moved to a mail-in application and was providing assistance by phone. Enrollees no longer needed to meet a state employee face-to-face, which had been a practical although not a legal requirement because enrollees could not navigate the process and its heavy verification requirements on their own. Now 60–70 percent of applications are mailed in. The application form was simplified under the MassHealth roll-out in 1997, then cut to four pages, with four supplements relating to access to health insurance, disability status, absent parent status, and

immigration status. Eligibility is determined centrally. In 1997, the state also dropped its asset test for noninstitutionalized applicants under age 65, basing financial eligibility on gross income alone.

Massachusetts has a broad system for outreach to applicants that consists of four main parts coordinated by the Division for its main programs: (1) MassHealth collaborates with community-based organizations, social services agencies, religious and civic leaders, local schools and governments, and health care advocacy groups. Mini-grants averaging $10,000 to $20,000 each go to more than 50 community organizations per year that seek to bring MassHealth education and assistance to participants in their other activities. School-based campaigns work with the Department of Public Health, which funds school-based clinics and lunch programs. School nurses identify eligible children, and nutritionists help with education. The goals are to educate many diverse subsets of the target population and help them obtain and retain coverage. The state seeks to evaluate differing strategies tried in different efforts so as to improve statewide.

(2) The program collaborates with primary care providers. The Division distributes enrollment kits with information for clinicians and for potential enrollees, and Division outreach workers rotate through many hospitals and clinics to assist them. Hospitals and community health centers are required to check for eligibility before claiming care as uncompensated charity for reimbursement from the state pool. Over time more enrollment has been initiated through providers.

(3) Media campaigns also seek to reach targeted populations. This has included not only promotional spots but also sponsoring a health educational program on a TV station with large Hispanic/Latino viewership. In addition to printed, Internet, and broadcast information, various promotional materials are given away—from magnets to drinking cups. Much literature and many materials are available in Spanish, and some are available in nine other foreign languages.

(4) Other outreach activities include 24 out-stationed Division employees in four regional offices. The offices manage regional activities of enrollment and case maintenance and travel to other sites as well. A toll-free number, operated by a contracted vendor, is available for potential applicants to call. Over half of its operators are bilingual. A complementary outreach program is run by the Insurance Partnership vendor to reach low-income workers and their employers.

Since the delinking of coverage from cash assistance, the Division has begun regular redeterminations of eligibility. These are meant to be user-friendly; beneficiaries are sent up to four mailed notices and given 79 days to respond. Recently, the Division began including prepaid return envelopes. Their HMOs, if any, are also notified. Officials think that too many people still drop out of MassHealth at the time of redetermination.

Enrollment procedures are designed to place all MassHealth applicants in the most generous program of coverage for which they qualify, including those not run by the state. A comprehensive catalog of assistance and a flowchart brochure have been produced to educate everyone involved, and intake workers use a special computer program to check for the highest eligibility level. The Division monitors enrollment by geographic area and target group and has also contracted for continuing assessment of its process, which uses member interviews, focus groups, and administrative data analysis. The Children's Defense Fund ranked Massachusetts second among states in success at enrolling eligible children in SCHIP and Medicaid.

Administrative costs as a percentage of MassHealth spending have declined slightly. Division employment is up only 3 percent since 1996; outside contracts and information systems appear to constitute over half of administrative costs.

Despite the unified administration under the MassHealth umbrella, however, there remain many differences in benefits and requirements for the six main underlying categorical programs. MassHealth cannot yet be one fully integrated program because of its

mix of funding flows and requirements for federal matching and state line-item funding. MassHealth members also receive services from 11 other state agencies.

Principal Programs within MassHealth. The extent of state commitment to low-income health care shows in the careful phasing in of the MassHealth expansions and dovetailing across the six main constituent programs to form quite comprehensive coverage—Standard, CommonHealth, Basic, Family Assistance (for children, adults without children, and workers through the insurance partnership), Limited, and Buy-In. Enrollment and expenditure trends differ across the programs and for different types of members. Table 5 summarizes.[31]

Of these six components of MassHealth, two were completely new in the waiver expansion: Family Assistance and Basic.[32] The waiver also made major expansions to pre-existing MassHealth Standard and Limited coverage. The components of expansion were introduced in phases. The first year of expansion, starting July 1997, included children, their parents, disabled adults, and long-term unemployed adults with family income at or below 133 percent of FPL. Based upon 1997 state and federal enabling legislation, the second year of expansions included raising eligibility for children, pregnant women, and newborns up to 200 percent of FPL, supported in part by SCHIP funding. The second expansions, which occurred in August 1998, also included premium assistance for eligible families and employer incentive payments to eligible small employers; the latter was not fully implemented until January 2000.

Some operational features are common to all of MassHealth, including enrollment, which increasingly comes through medical providers. Services to enrollees under age 65 are managed. Enrollment uses brokers, and enrollees may select their own managed care plan or primary clinician case manager. Fee-for-service mental health and substance abuse services are managed through the "carve out" Behavioral Health Program run by a vendor under contract. Originally the state sought to move ever more people into capitated plans but seems to have dropped this goal over time.

MassHealth Standard is essentially the traditional Medicaid program plus SCHIP, expanded to as high as 200 percent of FPL, as far as possible under the waiver with federal financial participation. Standard is by far the largest component of MassHealth. It also provides the most comprehensive benefits, equivalent to the state's traditional Medicaid benefits. Standard grew rapidly in the first expansion year, by over 20 percent, and covers some 85 percent of all MassHealth enrollees (see table 5) but makes up less than 30 percent of MassHealth spending. Some 78 percent of Standard enrollees receive care under the Primary Care Clinician plan (PCCP), 22 percent through an MCO.

MassHealth CommonHealth offers comprehensive Medicaid benefits to disabled individuals ineligible for Standard coverage. Most are disabled children with household incomes above 150 percent of FPL and disabled adults with incomes above 133 percent of FPL.[33] There is no income ceiling, but cost sharing is required for those above 200 percent of FPL, based on a sliding scale. CommonHealth members account for only about 1 percent of the MassHealth total, even after very rapid growth in the first two years, but they are largely nonworking disabled adults with high costs per person.

MassHealth Basic offers lesser benefits mainly to long-term unemployed adults who are uninsured or underinsured, below age 65, and below 133 percent of FPL. Some low-income elderly immigrants are also eligible, along with some homeless individuals; enrolling them and keeping them enrolled is said to be a challenge, as people may "move on" before completing the process, and mail correspondence is ineffective. Basic eligibles who have third-party health insurance receive "buy-in" support—that is, MassHealth pays all or part of their premium. Basic experienced higher-than-expected early growth but has now stabilized at about 8 percent of total MassHealth members, two-thirds managed under PCCP and one-third under MCOs.

MassHealth Family Assistance has three parts: (1) direct coverage or premium assistance to children, (2) direct coverage or premium assistance to some parents and other

TABLE 5. MassHealth: Summary of Its Six Main Constituent Programs

MassHealth Coverage	Key Provisions (Eligibility & Benefits)	Members
Standard	Low-income pregnant women and infants up to 200% FPL; children to 150%; parents and disabled adults to 133%; comprehensive benefits (resembles former Medicaid, plus SCHIP)	790,000
CommonHealth	Higher-income disabled children and disabled adults; sliding-scale premiums and cost sharing apply above 200% FPL; benefits identical to Standard	11,000
Basic	Low-income, long-term unemployed adults, up to 133% FPL; less than Standard benefits (if privately insured, assistance with premiums)	61,000
Family Assistance	Children with higher incomes (150–200% FPL) —get either (a) direct public coverage with Basic benefits and monthly copay or (b) for those in qualified ESI plan, assistance with premiums* Low-income workers (up to 200% FPL)—assistance with premiums if at qualified small employer, mainly for childless adults Small businesses (with low-income workers) —assistance with premiums up to $1,000 a year for family coverage ("insurance partnership")	32,000
Limited	Undocumented immigrants who would otherwise qualify for Standard; benefits for medical emergencies	22,000
Buy-In	Medicare-eligible senior or disabled members with assets above Standard limits; provides assistance with premiums, deductibles, and copays	10,000
		Total = 926,000

Sources: State program and budget report, catalog of programs (see endnote 31).
Notes: ESI = employer-sponsored insurance; FPL = federal poverty level; SCHIP = State Children's Health Insurance Program.
Health Table includes seniors dually enrolled with Medicare and not subject to usual MassHealth rules, which makes them larger than those in some accounts that focus on the federal waiver population of under 65; seniors up to 100% FPL and meeting asset tests may qualify for Standard. *: Family Assistance also covers persons with HIV up to 200% FPL.

working adults unable to qualify for Standard or CommonHealth coverage, and (3) incentive payments to small employers of qualified workers.[34] The direct public coverage was relatively straightforward to implement. Assistance related to ESI was implemented in phases through January 2000 as the waiver expansion progressed because of the need for new processes, and it has grown slowly. Operations are largely privatized, under state oversight, through contracts with private vendors.

Unlike direct coverage of services, premium subsidy and employer incentives were new forms of assistance, so implementation was slow. Moreover, public administrators had to relate to many different employers with many different approaches to purchasing coverage. Substantial negotiations were required with the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), about how to operate it to qualify for SCHIP and Section 1115 waiver funding.[35] State officials also acknowledge that they faced a steep learning curve to understand the workings

of the private health insurance market. Premium assistance and employer incentives are expected to grow more in the near future.

MassHealth Limited covers emergency services, including labor and delivery, for people who are ineligible only because of immigration status. Limited enrollees constitute only about 2 percent of MassHealth members but are expected to increase in the near future. Two-thirds of Limited enrollees are adults, one-third are children.

MassHealth Buy-In resembles Basic coverage and is available to Medicare-eligible enrollees. Buy-in subsidizes enrollees' premiums, deductibles, and copayments. Seniors or persons with disabilities whose income or assets exceed standard eligibility ceilings may be eligible. Buy-In has about 1 percent of MassHealth membership. (Long-term unemployed persons with access to ESI also receive Buy-In support, as noted above.)

Smaller and Newer Parts of MassHealth. The Prenatal program is another, very small piece of MassHealth. It confers immediate benefits to pregnant women for up to 60 days while eligibility is being determined for other MassHealth categories. Most later qualify for MassHealth Standard. Enrollment has been steady throughout the expansion; some 270 women were enrolled as of June 30, 2000. Under a recent HIV Expansion to its Section 1115 waiver, Massachusetts has begun to expand MassHealth eligibility to cover persons living with HIV before onset of AIDS, under age 65 and up to 200 percent of FPL. The state was evidently the first to create such coverage. The goal is to intervene early so as to slow the progression to AIDS. Early treatment benefits the member and is believed to be less costly than providing treatment at the end stages of disease. About 1,200 people are expected to qualify. Enabling legislation passed in 1999, a federal waiver came on January 19, 2001, and the state began accepting applications in April.[36] Coverage is provided under Family Assistance—either direct coverage or insurance premium assistance. During SFY 2002, this addition is expected to cost $16 million.

Other State Coverages

Children's Medical Security Plan. The Department of Public Health runs the Children's Medical Security Plan (CMSP), begun in 1991 and more important before being considerably displaced by the MassHealth expansions.[37] CMSP retains a role in providing limited coverage to uninsured children under age 19, complementing and coordinating with the much more generous MassHealth. All children may qualify, but those with family incomes above 200 percent of FPL must pay modest per-child premiums, which rise sharply when household income is above 400 percent of FPL. Benefits consist of basic outpatient services, and utilization and payment limits apply. Copayments are required for most services. Tiny in comparison with MassHealth, CMSP enrolled some 22,000 children and cost about $14 million in SFY 2000.

CMSP benefits were increased along with the MassHealth expansions, which eventually cut CMSP by more than half. The CMSP and MassHealth application processes are coordinated; each refers appropriate applicants to the other. Those who qualify for MassHealth cannot enroll in CMSP; the state wants them in MassHealth so that they get more generous benefits, and the state benefits from federal match. Prior to MassHealth, over three-quarters of enrollees were below 200 percent of FPL, only about one-third thereafter. Most enrollees are now between 200 and 400 percent of FPL, above MassHealth and below heavy cost sharing; enrollees below 200 percent are mainly undocumented aliens eligible only for emergency services from MassHealth.

Medical Security Plan. The Division of Employment and Training runs a different Medical Security Plan, for adults who are eligible for unemployment compensation and have family incomes up to 400 percent of FPL. (MassHealth Basic covers long-term, low-income uninsured persons.) Although the Division of Employment and Training runs the program, the state receives federal match under the Section 1115 waiver. For enrollees who can buy continuation coverage from their former employers, the plan provides partial

subsidy. Other enrollees receive "direct coverage," relatively comprehensive services from the Blue Cross Blue Shield preferred providers, subject to cost sharing and annual caps.

Additional State Assistance. A number of other, nonentitlement health programs exist. Most of these are public health–style payment programs for primary and preventive care—paying only for specific services at specific locations—not really insurance coverage. For instance, the Department of Public Health administers CenterCare, which pays community health centers (CHCs) for a specified number of "slots" each year for wholly uninsured adults up to 200 percent of FPL. CHCs manage care, and recipients may not have even partial insurance from another source. CenterCare is funded at under $4 million a year, and the number of funded "slots" is declining. Such programs play a very marginal role compared with the much larger, more comprehensive assistance of MassHealth.

Finally, the state attempts to help all applicants for assistance find and qualify for numerous federal, local, or private sources of funding if ineligible for MassHealth or another state program. Comprehensive resource materials help state employees, medical providers, and private outreach workers identify all potential sources of support.

Acute Care Issues

Medicaid Managed Care

Massachusetts implemented statewide enrollment in managed care in 1992.[38] Most MassHealth beneficiary groups are required to enroll in either the Primary Care Clinician plan (PCCP), a primary care case management system, or in capitated managed care organizations (MCOs). About one quarter of the MassHealth population is exempt from mandatory participation. This includes individuals dually enrolled in Medicaid and Medicare, individuals with commercial health insurance, and residents in health care institutions. The latter may receive traditional fee-for-service MassHealth benefits, but are subject to benefits coordination to ensure that any other coverage pays first.

Over 70 percent of MassHealth-managed enrollees are in the PCCP program, over 400,000 people. Their care is managed by primary care physicians except that mental health and substance abuse services are managed by the Behavioral Health Program, begun in 1992. (In addition to PCCP enrollees, some 20,000 clients of senior services and youth services are also included.) Despite management, behavioral health spending is growing faster than other MassHealth spending. Utilization is up, partly because of the scarcity of outplacement slots for institutionalized patients, and provider fees have been increased. Nonetheless, state officials appear satisfied with PCCP performance and have never pressed ahead with the mid-1990s plan to move most enrollees to MCOs.

The other managed care members, about 200,000 of them, enroll in one of four MCOs. Two of the four are long-standing participants in Medicaid. Fallon Community Health Plan is the only mainly commercial HMO remaining in MassHealth. It began as the first federally qualified HMO in central Massachusetts, based on a medical group practice begun in 1929. Fallon has expanded its commercial business to most of the state but serves MassHealth enrollees in central Massachusetts. The other long-time plan is Neighborhood Health Plan. NHP was the nation's first HMO founded by community health centers, in the 1980s. NHP has grown to statewide operations from roots in and around Boston. It was sold in 1997 to Harvard Pilgrim, then the state's largest commercial HMO, but still operates in its own name as a separate line of business. The sale raised capital for modernization of NHP and some of its center owners, especially to upgrade information systems. NHP also expanded its scale of operations by absorbing Harvard Pilgrim's Medicaid membership the next year. NHP now serves over 100,000 public beneficiaries, some 60 percent of the MassHealth MCO total; only about 5 percent of its enrollees are non-Medicaid.

The other two MCOs serve only MassHealth and were recently created by the state's two largest safety net hospitals in expectation of new funding under the waiver. Boston HealthNet Plan is run by Boston Medical Center, the former city hospital now merged

with a university hospital. The Network Health plan is run by the still-public Cambridge City Hospital, now merged with other hospitals. These plans began in their home cities but have expanded to serve much more of the state.

Somewhat confusingly, the two safety net hospitals run parallel, MCO-like plans outside of MassHealth, for low-income people who cannot qualify for MassHealth or any other source of coverage. Eligibility standards are those of the uncompensated care pool because the plans are designed to substitute for the pool by supplanting episodic institutional care with managed comprehensive services. For Medicaid, the rationale for funding the plans is that they will reduce costly unmanaged free care in emergency rooms, thus unburdening the hospitals and relieving their draw on the state's uncompensated care pool, already under Medicaid DSH. For the two safety net hospitals, the MCO arrangement brought them new funding and a way to channel newly covered patients to themselves and their affiliated clinics and physicians.

The hospital plans must qualify people first for MassHealth, only then in the uninsured plans. The Boston plan is larger, and the two together covered 36,400 MassHealth MCO enrollees as of June 2000.

Market consolidation and Medicaid withdrawals cut MCO participation to these 4 plans from 8 in 1997 and 13 in 1992. Almost all of MassHealth's capitated members are now in Medicaid-only MCOs. Recent commercial departures have been notable. In 1998, two leading private HMOs left the Medicaid business, Tufts Health Plan and the HMO wing of Blue Cross and Blue Shield. Their managements cited low MassHealth capitation rates, expensive enrollees, and administrative burdens. Harvard Pilgrim Health Care was the biggest loss, as it ceded its MassHealth membership to NHP.

MCO payments are made on an adjusted capitated basis, within three major rating categories representing different levels of anticipated risk. Rates are negotiated with each plan, subject to the federal ceiling of estimated fee-for-service costs, and plans are offered the option of buying stop-loss coverage to protect against unusually high-cost enrollees among the disabled and Basic populations. The two safety net plans receive higher payments through federal agreements. State officials describe MassHealth waiver funding as capitation with federal supplements that recognize the hospitals' higher cost populations served.

Competing MCOs, however, complain that the two hospitals' MCOs receive unfair subsidy, which the safety net plans use to win away referral physicians and community centers. The two hospital plans' catchment areas are mainly separate from each other, but each overlaps with the other two plans. Physician panels and participating centers of the plans also overlap, particularly with NHP. MCOs have also complained that state administrators are not cutting back PCCP enrollment and expanding MCOs as originally planned. Administrators seem satisfied with MCO performance, saying they provide good care.

The state's capitation rates are the second highest in the country even after adjusting for high Massachusetts health care costs and are also higher than average relative to Medicare levels. Nonetheless, MCOs and fee-for-service providers alike complain that MassHealth rates are too low, according to a MassHealth evaluation of the PCCP and MCO programs.

Medicaid DSH Program and Hospital Charity

The state's unusual Uncompensated Care Pool pays for medically necessary services at hospitals and community health centers for uninsured and underinsured residents of Massachusetts of low and moderate income.[39] The pool provides a statewide safety net of access to essential acute services for the uninsured not reached by the MassHealth expansions. Hospitals and CHCs screen applicants for MassHealth eligibility and if the applicant has no other funding, the pool will pay for free care for those with family incomes up to 200 percent of FPL, the same standard used under MassHealth. Beneficiaries up to 400

percent of FPL get partial free care; they must meet a per-family annual deductible. People with even higher incomes may qualify for "medical hardship" eligibility if they have very high medical expenses—much like Medicaid "spend down" eligibility. Persons with incomes below 100 percent of FPL generate most claims.[40] Free care constitutes three quarters of spending, emergency bad debt about 20 percent. Hospital inpatient services take over half of spending, hospital outpatient care gets over a third, and CHCs and demonstration projects account for less than 5 percent.

The pool was created in 1985 to spread the cost of uncompensated care more evenly across hospitals, but it has evolved over time. Funding traditionally relied on uniform hospital surcharges on private payers; hospitals with a surplus of surcharges relative to uncompensated care paid in, and hospitals in deficit received funds. After some years, the state brought the pool within Medicaid's DSH payment structure and hence began to receive federal matching payments for pool spending.

The most recent refinancing occurred in 1997, addressing a number of accumulated problems: The pool's traditional funding was fixed at somewhat above $300 million a year, which had become ever less adequate as medical costs rose. Given shortfalls, policymakers had sought to concentrate pool funds at the neediest hospitals—the public hospitals in Boston and Cambridge alone claimed over half of total pool spending. More and more hospitals were net contributors to the pool, fewer and fewer net recipients of funds. Hospitals facing price competition after 1991 were less able to pass through pool surcharges to payers, and hospitals lobbied for relief. Another issue was that the pool inherently favored acute hospital care over preventive, community-based care.

The state convened a Special Commission on Uncompensated Care, which in early 1997 made recommendations to enhance and stabilize pool funding, complementary to the planned Section 1115 waiver. The legislature quickly enacted the major recommendations: The law stabilized pool finances by increasing state funding by $15 million and by shifting the cost of $70 million in uncompensated care at Boston Medical Center (now privatized by merger) and Cambridge Hospital (still public) to the Medicaid program through the special MCOs described above. The statute also essentially shifted $100 million from hospital assessments to an assessment on health care payers.[41] Moreover, the Act provided for reviving a commission if revenues vary outside 75–125 percent of budget, thus addressing the issue of adjustments over time.[42]

The reforms also subtly changed the pool's mission, from supporting hospitals to supporting uninsured patients. Indeed, the pool has over time come to run somewhat more like a coverage program and less like a provider payment program. Applicants complete a detailed application; if qualified, they receive a year of eligibility, and many hospitals give them a free care card. The deductible for partial free care eligibles applies on an annual basis, not a per service basis. Moreover, state administrators are developing an electronic database for submitted claims; pool providers will use the UB92, the standard claim form developed by the National Uniform Billing Committee.

After reform, pool funds fully covered free care expenditures for the first time in many years. Surpluses did not last, however, as the costs of free care continued to increase despite the reduction in uninsurance. By 2001 the pool was over budget, spending its own carryforward of surplus plus additional appropriations shifted from other accounts in surplus. The 1997 reforms bought several years of stability and more equity in the distribution of pool funds, but with spending again outstripping dedicated pool funds, further changes seem likely.

Pharmaceutical Assistance

Massachusetts created ever more generous pharmaceutical programs in 1997, 1999, and 2001.[43] The Senior Pharmacy Program began first, on July 1, 1997, as a five-year pilot program of limited public benefits funded by the state's cigarette tax. It was administered by the Executive Office of Elder Affairs but with claims administered by MassHealth, on an

unmanaged, fee-for-service basis. Two-year enrollment fell well short of expectations, and critics cited inadequate outreach. The state extended enrollment periods, increased eligibility ceilings from 133 to 150 percent of FPL, and increased benefits from $500 to $750. The state's 27 home care corporations were funded to distribute applications and encourage eligible seniors in their locales to apply.

Pressures for further expansion increased in 1999, fed by escalating drug costs, consumer/voter perceptions of vulnerability, and legal developments. In October 1998, a federal court overturned as inconsistent with Medicare law the state's requirement that Medicare HMOs provide an unlimited drug option. Some 61,000 seniors therefore lost their unlimited HMO coverage on January 1, 1999, though a larger number gained limited coverage. The Cellucci-Swift administration, house, and senate all quickly offered competing plans to improve senior drug coverage.

As in earlier debates, the administration favored an insurance-style approach, with beneficiary premiums, a high deductible, and cost sharing subsidies for those with incomes under 150 percent of FPL. A house-senate legislative compromise wanted to expand Senior Pharmacy—eligibility from 150 to 188 percent of FPL and benefits from $750 to $1,250 per year. The legislature's approach targeted public assistance to low-income people, leaving higher costs uncovered. The governor sought to protect all seniors against very high annual costs, but required beneficiary premiums.

A hybrid first-dollar/catastrophic reform was passed. Under the newly renamed Pharmacy Program, senior eligibility was expanded to 188 percent of FPL and disabled beneficiaries were added, so long as they work fewer than 40 hours a month and meet CommonHealth guidelines. On top of this, a new unlimited benefit was added under the new Pharmacy Program Plus, funded for a one-year trial during calendar year 2000. Plus covered most elders as well as younger persons with disabilities who incur high prescription costs relative to their incomes.

The next law went further. Beginning in April 2001, "Prescription Advantage" permanently combined and replaced Pharmacy and Pharmacy Plus. Touted as the nation's first universally available drug coverage for the elderly and low-income disabled persons, Advantage offers unlimited benefits and imposes no income ceilings for senior enrollment, merely cost sharing: Enrollees pay premiums of up to $82 a month as well as deductibles and copayments up to an annual out-of-pocket ceiling of $2,000 or 10 percent of household income, whichever is less. Payments are graduated by income; members at or below 188 percent of FPL pay no premiums, and those with income under 200 percent of FPL pay lower copayments. Disabled persons qualify only if they work fewer than 40 hours a month. As of July 2001, about 41,000 people had enrolled, three quarters of them in the lowest income bracket, who face no premiums or deductibles.

The program faces two key problems, cost control and outreach to enrollees.[44] The initial budget was about $100 million a year, but the two legislative branches and the governor have all differed in projections, and some fear much higher costs. Moreover, knowledge of the relatively new programs has not been universal, and there are concerns that enrollment may lag, especially among upper-income, higher-premium people.

A simultaneous concern has been control of drug spending in general. Again, the legislature and the governor have differed. The FY 2000 budget authorized a state-overseen bulk-purchasing pool for prescription drugs for state employees, Medicaid and Medicare recipients, and those without prescription drug coverage—in all, an estimated 1.6 million people in the state. Former Governor Weld had agreed, but implementation was delayed by Governors Cellucci and Swift to study the idea and plan for the state-run Prescription Advantage plan to help the elderly, the prime users of pharmaceuticals. Today, the senate's 2002 budget would require prompt creation of a pool, and Acting Governor Swift announced readiness to proceed with bulk purchasing in summer 2001.[45]

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

Spending on long-term care services for elderly, mentally ill, and developmentally disabled persons is dominated by institutional costs, the largest single category of Medicaid spending. Policy-making attention, however, seems more drawn to continuing the shift from institutional to community-based care, encouraged to some extent by considerable pressure from advocates and lawsuits. The key concern has not been high spending, but rather the adequacy of payment rates. As of mid-2001, there appeared to be widespread acceptance that nursing home payment rates should be increased. Another high priority was implementing personal assistance services for persons age 18 to 65 with chronic physical disabilities. Nursing home quality has also drawn continuing attention; the most recent concern has been that not enough qualified nurses and aides are affordable at Medicaid rates.

Nursing Homes and Community-Based Care

Nursing Homes and Payment Rates. In the mid-1990s, Massachusetts was successful in constraining Medicaid payments to nursing homes.[46] National data show declines in its spending on homes and per person during 1995–1998, in contrast to national increases.[47] However, state data starting in FY 1996 show continuing increases in spending each year except 1997, despite nearly constantly dropping patient census during SFYs 1997–2001. MassHealth pays nursing homes prospectively, with the rate calculated by trending forward screened standard baseline costs, adjusted for case mix. The screens apply within three large groupings of costs—nursing costs, other operating costs, and capital. In SFYs 2000 and 2001, nursing homes received rate increases of about 5 percent, with some earmarking for wage support for certified nursing assistants. Currently, state officials are experiencing more-than-usual pressure to increase rates further because of fiscal problems in the industry.

Massachusetts is well endowed with nursing homes, having one-quarter more nursing home beds per 1,000 elderly persons than the national average and employing more workers per bed. Between 1995 and 1999, the number of nursing homes in the state remained fairly constant, around 590, and the number of beds rose from 56,325 to 57,983. According to nursing home representatives, 56 nursing facilities with 3,800 beds closed in 1999 and 2000, and another 50 expect to close by 2003. Occupancy rates are now about 93 percent. Almost all homes accept Medicaid patients.

According to nursing home industry figures, Massachusetts's nursing home margins are among the worst in the country, and the number of nursing homes running at a loss was expected to rise from about 50 percent in 1997 to about 75 percent in 2001. The more objective state Health Care Task Force agrees that there are problems. It reports that Massachusetts uses nursing homes more than the national average and that Massachusetts's nursing homes are generally in financial trouble, in part because of a change in payer mix. Private patients have declined, as many private-paying seniors choose alternative options such as assisted living and community-based services. Correspondingly, individuals currently entering nursing homes are sicker than earlier entrants. Nursing homes have become increasingly dependent on Medicare and Medicaid, for about 10 percent and 70 percent of revenues, respectively. Approximately one quarter of the state's nursing homes are in bankruptcy, all of them owned by national chains, and some facilities are likely to close. Concern was expressed that homes could not attract and retain qualified staff and that there is "potential" for quality deterioration.

The Task Force's working groups have recommended increasing Medicaid payment rates, but tying new resources to quality of care, better staffing, and improved planning and data collection, especially on access and quality. Another suggestion is for the state to try to increase in-state ownership of nursing homes. Pressures to improve payment rates

have become intense. There is concern that closures would leave the state without enough beds, especially in western areas where the bankrupt facilities are concentrated.

Community-Based Initiatives. Massachusetts funds a broad array of home- and community-based services for the elderly.[48] Many of the services that other states provide under home- and community-based waivers, such as personal care attendants, are covered as optional services under MassHealth, Massachusetts's regular Medicaid program. Still, Massachusetts's spending on home- and community-based services in 1998 was less than the national average,[49] and its growth rate was less than half the national average in 1995–1998 (see table 4). State data show that community spending has risen much faster than facility spending since at least SFY 1996. In SFY 2000, community spending growth outpaced facility spending growth by 16 to 2 percent. Just before that year began, in June 1999, the U.S. Supreme Court spelled out rights to such care for disabled Americans in its landmark *Olmstead* decision.[50] As a percentage of long-term-care spending, community services are projected to increase from 19 percent in SFY 1998 to 24 percent in 2002.

Community-based care of many types can be accessed through a variety of providers in Massachusetts. Except for home health, which serves over 26,000 enrollees, few beneficiaries are served by community-based care, compared with some 50,000 nursing home residents. Other community services, ranging from more intensive private duty nursing (about 500 served, mostly children) to personal care attendants for chronic conditions needing physical assistance, are physician prescribed, and are authorized in advance by the Massachusetts Division of Medical Assistance (about 5,800). Recent increases in the numbers of disabled enrollees have resulted in large increases in personal care services.

In 1990, Massachusetts contracted with its PACE provider (Program of All-Inclusive Care for the Elderly, a San Francisco model). The voluntary program combined Medicare and Medicaid funds to help frail elders eligible for both programs avoid having to live in a nursing home even though they qualify for admission. The state's newest initiative is the Senior Care Options program, PACE-like but broader, which encourages formation of senior care organizations (SCOs) to offer comprehensive and coordinated care through a single access point, day or night, and also to do seniors' Medicare paperwork. SCOs are to be capitated on a risk-adjusted basis and to have some flexibility to manage benefits. Seniors will have a choice of physicians and nursing facilities, geriatric support services coordinators, and the same complaint and appeal procedures as Medicare and Medicaid managed care. A memorandum of understanding with CMS has been signed, and the program awaits passage of enabling legislation.

Nursing Home Quality. Concerns about nursing home quality have been accentuated by the recent bankruptcy and closures of chain-operated homes.[51] Subsequently, the Health Care Task Force's working group on quality recommended that the bankruptcy of any nursing home should trigger immediate, regular state inspections. The finance working group recommended tying any payment increases to quality of care, as already noted. Health, safety, and other quality monitoring is the responsibility of the Department of Public Health (DPH), whose annual review found increased problems during 1997–1999. There is some evidence that poor financial performance may be associated with poor quality. In January 2001, advocates were discouraged by then-Governor Cellucci's decision to veto a legislative initiative to create a permanent Nursing Home Quality of Care Council.[52]

Persons with Serious Mental Illness

Since a comprehensive reform act in 1966, official state policy has been to move patients from inpatient to community residence and treatment.[53] Occasional disputes have still occurred about availability of care in the least restrictive treatment environment. The most recent hospital closures occurred in 1993, leaving only four state psychiatric facilities in 2001, with about 1,000 patients, most of whom stay less than a year.

Instead, the Department of Mental Health contracts with private providers, mainly through MassHealth's behavioral managed care vendor, and supports over 6,000 housing slots, about half in group homes, half in independent living. In an effort to supply a full range of coordinated support, DMH cooperates with numerous other state agencies, including medical assistance, youth services, public health, mental retardation, social services, vocational services, and housing and community development. Assistance goes to about 27,000 adults, adolescents, and children using a variety of inpatient and community-based services. Eligibility is not dependent upon income; it extends to all with serious conditions, although assistance is subject to resources availability and priority of an applicant's need.

Perhaps the most prominent current issue is children's access to mental health services. The state faces the threat of imminent litigation over availability of sufficient care at home, resulting in unnecessary hospital stays. The state has consistently increased funding for community-based alternatives for children, with new funding from tobacco settlement revenues. Recent news reports still highlight shortages of community care, resulting in unnecessary hospitalizations and increased waiting lists. Most recently, the state announced another initiative for home counseling and support. Another recent initiative was expansion of services and housing slots for the homeless in need of mental health services.

Persons with Developmental Disabilities

As for mental health, state policy for developmental disability is to reduce institutionalization and promote community services.[54] The lead agency is the Department of Mental Retardation (DMR), which split off from the Department of Mental Health in 1986. DMR runs 29 regional and area offices, as well as about 1,700 small community residences, serving almost 30,000 people in 1999, most living with their families. A flexible array of community services is available.

Residential clients still claim a disproportionate, though declining, share of the department's $870 million budget, and waiting lists have persisted for noninstitutional care, both for those in nursing homes and for those living in the community. State policymakers have worked with advocates and others to seek improvements. Advocates frequently litigate as well as negotiate for more services, adding to the considerable political motivation to improve community care. Again here, the state makes considerable effort to coordinate across agency lines, for example, to address the problem that children had been "graduating" out of eligibility for the Department of Education's special education program at age 22, then joining the disabilities waiting lists. The state responded in 1999 by fully funding for the first time a "Turning 22" program to provide a combination of day, family support, or transportation services to all the eligible 22-year-olds, hundreds of them per year.

Two state lawsuits were notable, loosely related to national developments. One class action, *Rolland v. Cellucci,* sought community placements on behalf of nursing home residents with developmental disabilities, under Medicaid law and the Disabilities Act; it was settled in March 1999 with new help for several hundred outplacements a year along with a new diversion plan to prevent avoidable nursing home admissions. The complementary *Boulet v. Cellucci* case was brought by claimants living at home while waiting for community residential placement, alleging Medicaid and constitutional violations.[55] *Olmstead* was decided during this lawsuit and facilitated its resolution with a five-year, $114 million plan for increased services to individuals with mental retardation.[56] According to interviewees, housing is the main bottleneck because people staying in the community pay so much more than residents of nursing homes.

Some administrators interviewed complained that, while *Olmstead* recognized the importance of affordability and of state control over its assistance program as a whole, the decision did not provide enough guidance. It was also suggested that, while the two settlements clarified the status of developmental disabilities, advocates for other disabilities

are not bound by their standards. One interviewee noted that the settlements explicitly and helpfully allow administrators to consider cost of placements in deciding exactly how many to provide per year.

Other Issues

Insurance Market Developments and State Regulation

Recent developments in insurance markets have drawn high-level attention and heavy media coverage. Insurance in Massachusetts is dominated by a small number of players—a few large health plans, a few large hospital networks. The state has the highest HMO penetration in the country, and Medicare and Medicaid HMO penetration is also above average.[57] Six HMOs were large in 1990, but by 1998, three HMOs—HMO Blue, Harvard Pilgrim, and Tufts—had 80 percent of the market. In 1996–1997, antitrust enforcement against HMOs was an active topic, and the state's Democratic Attorney General Scott Harshberger assertively intervened in health care, partly to boost his campaign for governor in 1998, but lost a close election to then Acting Governor Cellucci. Market structure as a policy concern seems to have had a lower profile in the late 1990s and early 2000s, seemingly overshadowed by fiscal concerns and patient protection.

Massachusetts HMOs manage care lightly. They have come to act more like preferred provider organizations (PPOs) than HMOs as a result of market and political-legal pressures. Many HMOs began the 1990s with restricted provider networks, often grounded in medical group practices. In 1996, however, the leading plan with a relatively "closed" panel of providers, Harvard Community Health Plan, merged with the largest, more "open," HMO, Pilgrim Health Plan, to become Harvard Pilgrim. By the end of the decade, most plans operated with open provider panels, and most providers contracted with most plans. In 1997, Harvard Pilgrim, in a highly politicized dispute, was unable to exclude New England Medical Center and affiliates from its HMO network.

Massachusetts residents and politicians seem quite devoted to maintaining access to the state's highly reputed, high-priced, and numerous academic medical centers. Many of the elite hospitals have merged and created networks of providers that remain "must-have" participants for HMOs. Efforts to shift patients to less expensive community hospitals have failed, and more care than ever occurs in the academic medical centers.

Insurers' Fiscal Problems and State Responses. High market share has not averted huge problems for health plans, and regulators have intervened. In 1997–1998, the problem was once-dominant Blue Cross Blue Shield of Massachusetts (BCBSM). The next year's near failure was Harvard Pilgrim, then the largest HMO.

Blue Cross. BCBSM insured well over half the privately insured in the mid-1980s but struggled in the transition to managed care.[58] Its market share fell as managed care grew, its efforts to enter HMO markets faced strong price competition, and it faced severe problems in upgrading its information systems. By mid-1997 its financial problems were acute enough that the insurance commissioner did the first audit of the company since the 1950s, then sought and received company acceptance of special regulatory oversight over day-to-day operations. Press accounts routinely referred to the "troubled" BCBS plan and detailed rumors of acquisition by an out-of-state plan. The company successfully restructured its operations, however, by selling assets, reducing staff, dropping out of loss-making Medicaid managed care, and improving its rate discipline. Regulators rejected BCBS's request to split into three companies by line of business, but within a year, the still-unified plan had improved its finances and was released from state oversight. Blue Cross has gained market share since the problems at Harvard Pilgrim.

Harvard Pilgrim Health Care. Harvard Pilgrim was formed in 1996 by a merger of the Harvard group model HMO with an individual practice association–style HMO, the latter formed by an earlier merger, and became the state's largest managed health plan.[59] The combined plan expanded rapidly but faced growing problems. In spring 1999, the company announced record losses for 1998, and its CEO abruptly resigned. Over the year, new

management discovered yet more losses and planned a shift in strategy away from growing market share to controlling costs, announcing a pullout from money-losing operations in Rhode Island, for example. By year's end, losses were again found to be larger than expected, and the HMO became technically insolvent. The plan entered state receivership on January 4, 2000, thereby gaining protection from hospitals and other creditors demanding overdue payments. Losses for 1999 eventually tallied $227 million, about one-tenth of annual revenue. Observers point to numerous shortcomings in its business strategies and operations; interviewees in Massachusetts emphasized primitive internal accounting systems and unrealistic pricing.

The receivership was only possible because of enabling legislation passed in November 1999. The insurance commissioner had wanted more insurance regulatory authority and to forestall use of bankruptcy law, perceived as less favorable to health system interests. The commissioner and the attorney general shared oversight under the receivership, the latter because the plan was nonprofit and a charity under state law. All members' coverage was maintained, and all providers were paid in full. The state overseers rejected sale to a for-profit buyer, electing to resuscitate the plan while retaining its nonprofit status and access to tax-exempt financing, but also rejected any direct public subsidy. The "turnaround plan" streamlined organizational structure, improved accounting, renegotiated payment rates with providers, and raised premiums. Finances soon improved, and the plan operated nearly in the black for the year, although losing about 400,000 members, many to Blue Cross's HMO Blue, as just noted. The receivership ended after about six months, replaced by administrative supervision, a lower level of oversight. According to the attorney general's office, of more than 20 health plans in the country placed into receivership, only Harvard Pilgrim emerged financially intact. Its competitors have also rebounded,[60] in part because of market-wide premium increases.

Effects on state health policy. These large insurers' problems required substantial policy attention, prompted a number of policy changes, and initiated wide-ranging discussion of future policy. Solvency concerns led directly to the 1999 receivership statute and indirectly to patient protection legislation in 2000 (see below). The Harvard Pilgrim crisis in particular was widely seen as a symptom of broader problems, and the governor created the influential task force already mentioned as a direct result. The new attorney general's handling of the crisis also greatly increased his political stature. His office has also spearheaded a new Health Benchmark Project to generate health system data—on finances, capacity, demand, and access—designed to improve policy-relevant information and provide early warning of future problems.[61]

Patient Protection Legislation

Provider-patient backlash against managed care has grown in Massachusetts since the mid-1990s, as elsewhere.[62] Unusually, especially given the strength of its provider and consumer lobbies, the state has lagged most others in taking action, seemingly because of executive-legislature disagreements. In 1996 Governor Weld signed minor legislation—banning "gag clauses"—and the next year created a managed care advisory commission, which advised some limited further changes. Large changes did not occur until after the insurer crises.

The advisory commission suggested some mild reforms, supported by Governor Cellucci, while legislative Democrats pushed for more. The governor by executive order instead created a new ombudsman's office within the public health department. This broke new ground by covering managed care complaints even in employer-based plans, whose regulation is normally thought preempted by federal law,[63] but many saw the program as inadequately funded. No agreement occurred in 1999, as even more bills were in

contention, including some from the medical society and the HMO industry. The Harvard Pilgrim crisis helped precipitate passage of a detailed bill in July 2000.

The law required managed care plans to allow enrollees direct access to providers of prenatal care and to care for chronic conditions. No financial incentives may encourage reduced access to care. DPH was directed to build on the early ombudsman program, assisting consumers in various ways, including managed care report cards, and overseeing a new system of external patient appeals of benefit denials. DPH was also to monitor plans' quality and issue report cards. The insurance department was charged with accrediting health plans, licensing utilization reviewers, and overseeing plan payments to providers. The law did not address managed care liability. The statute also called for a commission to explore approaches to universal coverage, restricted hospitals' ability to terminate services to patients, and further regulated the conversion or transfer of nonprofit hospital or HMO assets to for-profit entities.

The statute resulted in two key new Massachusetts offices—the Bureau of Managed Care within the Division of Insurance, and the Office of Patient Protection within the Department of Public Health. They finalized implementing regulations in April 2001, focusing especially on benefit denials; plans must respond to grievances within 30 days, and dissatisfied patients may appeal to an independent external review panel.

Other Insurance Regulatory Issues

During the study period, Massachusetts added mental health parity as a mandated health coverage benefit; the state has among the nation's largest number of mandated benefits.[64] By May 2000 legislation, health plans can no longer impose any annual, lifetime, dollar, or unit of service limitation for the treatment of biologically based mental illnesses that exceeds limits for physical conditions. HMOs, employer group plans, and nongroup individual plans had to comply by January 1, 2001, and smaller employers were given an additional year. The law provides partial parity for substance abuse when occurring in connection with a mental illness. State mental health authorities estimate that approximately 15 percent of adult residents have a diagnosable illness in any given year.

The state reformed individual and small group insurance markets in the early 1990s. These rules continued to be enforced and were slightly modified to conform with new federal requirements of 1996, allowing somewhat broader access to guaranteed-issue insurance.[65] Administration appears to have been noncontroversial, but fewer individuals now seem to buy coverage.

Health Care Market Developments and State Response

Hospitals. Fiscal pressure on hospitals has increased since the mid-1990s, and bottom lines are very weak, less from market developments than from public policies.[66] Whereas many hospitals have gained bargaining power relative to health plans in recent years, all believe that they are short-changed by Medicaid, and to a lesser extent by Medicare. The industry has become more vocal in seeking increased state funding, and the Task Force has been somewhat supportive. Some extra financial assistance has been provided already, and the pressure for more is great.

In the mid-1990s, hospitals faced very strong price pressure from newly powerful managed care.[67] Institutions had to economize, downsize, merge or affiliate with others, convert to nursing homes, or even close. After more than a dozen 1990s mergers, a handful of nonprofit hospital sales to for-profit systems, and the formation of about half a dozen large health systems, about three-quarters of the state's acute care hospitals were part of hospital networks by the late 1990s. Mergers seem to have abated since then, although the large networks formed by competing Boston academic medical centers have continued to expand slowly. Closures cut supply from 84 hospitals in 1995 to 71 in 1999, and with conversions cut beds by over 10 percent as well. A generation ago, the state was

seen as greatly over-bedded, but two decades of faster than average downsizing have shifted policy concern from excess hospital beds and undue consolidation to keeping hospitals open, by merger or acquisition where possible.[68]

Moreover, hospitalizations rose in 1996–1999, though not the number of days, whereas both had dropped in 1990–1996. Since then, demand seems to have risen further, and the media discuss ambulances' difficulties finding a hospital with room. Supply has thus shrunk and consolidated, demand is up, individual consumers want less managed care, and health plans are curbed by new patient protections. For all these reasons, hospitals in general have been strengthened vis-à-vis managed care.

One indication of increased hospital negotiating clout is that Partners HealthCare (the largest single network, whose seven hospitals serve one-sixth of all patients) reportedly won double-digit increases in 2001 rates from two of the state's largest health plans.[69] In December 2000, Partners had threatened to cease accepting Tufts patients. Partners obtained similarly higher rates from Harvard Pilgrim in 2001. There is certainly belief that higher hospital payments are being passed through by HMOs. One employer group has complained to the attorney general about Partners' market dominance, reportedly controlling about one-third of overnight patients in metropolitan Boston and one-fifth in eastern Massachusetts.[70] Perhaps antitrust concerns will revive.[71] Smaller community hospitals are worst off, and some Boston academic centers are struggling. Despite the stronger position of Partners and others, hospitals seem unlikely to fix their bottom lines solely based on private payments.[72]

Currently public payment policy is widely viewed as the key problem. Teaching hospitals provide much of the state's care, and their Medicare payments were particularly hard hit by the Medicare cuts of the Balanced Budget Act of 1997, even though part of the cuts were later restored. New requirements to automate administrative and financial transactions and enhance privacy protections are also raising costs for providers as well as for Medicaid—an under-appreciated recent federal mandate, noted a high-level state interviewee.[73] Medicaid has also continued to hold down hospital payments. Massachusetts hospitals have lower profit margins, weaker cash positions, and higher debt levels than hospitals nationwide, owing to low payment levels, according to a consulting firm study done in spring 2000 for the hospital association, whose conclusions were echoed in part by the Task Force.[74] The latter's working group in June 2000 recommended only "watchful waiting" by the state.[75]

The state legislature did not immediately raise funding but did hire the hospital association's consulting firm to conduct a more detailed analysis. Findings, first leaked in May 2001, echoed those of the year before, reporting that Medicaid underpays hospitals; initially, the analysis was vigorously disputed by state officials but largely accepted by the state Task Force, whose finance group in September 2001 called for some across-the-board Medicaid increases, along with targeted assistance to selected institutions.[76] News accounts add stories of severe distress at individual institutions.[77] Political consensus appears to be growing that higher funding is needed, but there is less consensus on whether funds need to be targeted or given across the board under Medicaid.

The state has already provided some additional funding. The 2001 budget called for additional funds for teaching hospitals to treat complex long-term patients and to train new pediatricians. Former Governor Cellucci had also proposed to increase the state's contribution to the uncompensated care pool by $100 million in order to eliminate pool shortfalls,[78] but final action was pending in mid-2001. There has also been modest assistance for distressed hospitals and other funding, but not yet broad Medicaid payment increases.

Spending on hospital care is already high, as discussed above, in good measure because of heavy reliance on the state's excellent and plentiful teaching hospitals for care. Policymakers may ultimately have to confront directly how much Medicaid and other payers want to pay for easy access to academic care. Managed care theory called for deliv-

ering care when medically appropriate in less expensive community hospitals, but as managed care rose in the 1990s, teaching hospitals' share of care in Massachusetts also rose, and suburban hospitals lost out.[79] A state-sponsored study of financially troubled community hospitals reported similar findings, and officials are concerned that the out-migration of patients makes the community hospitals more vulnerable as they become increasingly reliant on Medicare dollars. Explanations for the shift include new mergers between teaching hospitals and community hospitals, teaching hospitals' increasing affiliations with suburban doctors' groups, and the creation of primary care health centers sponsored by the teaching hospitals. The Task Force cochair has noted that teaching hospitals' increased market share appears to come from areas where community hospitals have closed or limited services. But the hospitals are very popular and powerful in Massachusetts. When one HMO recently announced that it would offer customers a policy with higher cost sharing for certain teaching hospital use, editorial reaction was prompt and negative.[80]

Community Health Centers. Community health centers play an important role as safety net providers.[81] In 1999, centers had nearly 3 million patient visits. CHC Medicaid funding has dropped over time, from 60 percent of revenues in 1992 to 45 percent in 1998, while uncompensated care increased. CHC finances worsened correspondingly. Between 1995 and 1998, more than half of all centers were losing money on operations.

CHCs in Boston have fared best, as CHCs there partnered with hospitals and health systems. Health systems got expanded networks, and CHCs got hospital investment in their capital infrastructure. Affiliations with centers became more attractive to hospitals as the earlier trend toward purchasing physician practices proved unsuccessful. One Boston-based researcher has found that hospitals that made the greatest investments in CHCs were also those that disproportionately served low-income populations. Reportedly, MassHealth expansions and full funding of the free care pool have also raised CHC negotiating power. Outside of Boston, inter-hospital competition is weaker, affiliations with CHCs seem less likely, and the centers have fared worse.

Conclusion

Massachusetts is almost uniquely supportive of health care, especially for low-income residents. Tradition, political ideology, the influential nonprofit hospital industry, ample state revenues, and a generous federal Section 1115 waiver all combined to create very strong support for expansions from the mid-1990s through the end of FY 2001 in June. Medicaid expansion for traditional categories of eligibles and their families extends to 200 percent of the poverty level and even above; there is an extensive free-care pool covering hospital and community health center care for uninsured people with incomes up to 400 percent of FPL, and seniors of any income can receive new pharmaceutical protection. The state has added new populations to its 1997 waiver, though rapid early growth has greatly slowed, and through June policymakers seemed willing to continue expanding.

Institutional providers have all won rate increases and are lobbying for more, with some support from the state's prestigious Health Care Task Force. Hospitals also want more state revenues for the free-care pool, now more than half funded by hospital assessments. Community-based care is expanding, but not fast enough to satisfy all advocates.

During January's start of the FY 2002 legislative budget cycle, the state's powerful speaker of the house predicted a "major smashup" between declining revenues and strong political demands for education, health care, and other social services. Legislative budget reports later warned of stormy times ahead. Indeed, there was enough contention to prevent agreement between the two houses and the governor before the start of FY 2002 in July, which is not very unusual in Massachusetts. FY 2001 ended in unexpected surplus, 10 percent of which the governor would use for hospital aid.[82]

The looming collision of priorities was postponed through summer 2001, only to find much deteriorated finances in September, which worsened after September 11. Given the

slowing economy, the large tax cut now being phased in, rising political demands from provider interests, and rising provider power relative to managed care plans, adjustment in priorities was inevitable. The final SFY 2002 budget of early December 2001 made numerous program cuts. However, Medicaid has thus far been a big "winner" in the new cutback era. No significant contractions were imposed through November, and past eligibility expansions all remained in place. Indeed, Acting Governor Swift added another expansion after September 11. At the same time that she dropped the waiting period for unemployment benefits, she expanded the MassHealth program that helps the uninsured, increasing the share of COBRA workplace insurance continuation payments that the state will contribute. The new senior pharmacy coverage has been continued with full funding, which has been quite adequate, as enrollment has slightly lagged projections. In short, Medicaid continued to operate as usual, though further realignments may occur later in 2002, as there could be difficulty funding the usual supplemental appropriation made to maintain current benefits. In any realignment of Massachusetts state spending, however, health care looks likely to hold its own.

Endnotes

1. The commissioner was quoted in Mishra, Raja. 2000. "Fewer in State Lack Health Insurance: Report Credits Booming Economy." *Boston Globe.* 25 August.

2. The previous site visits were in December 1996 and January 1997, and the report was broader. Holahan, John, Randall Bovbjerg, Alison Evans, Joshua Wiener, and Susan Flanagan. 1997. *Health Policy for Low-Income People in Massachusetts.* Washington, D.C.: The Urban Institute.

3. Twelve other states are also covered: Alabama, California, Colorado, Florida, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin, selected to present a balanced view of state activity and its impact on low-income families. Kondratas, Anna, Alan Weil, and Naomi Goldstein. 1998. "Assessing the New Federalism: An Introduction." *Health Affairs* 17(3): 17–24.

4. This report drew on far more sources than there is space to credit, especially in news media and Web sites.

5. Zuckerman, Stephen, Genevieve M. Kenney, Lisa Dubay, Jennifer Haley, and John Holahan. 2001. "Shifting Health Insurance Coverage, 1997–1999." *Health Affairs* 20(1): 169–177. Overall, the state uninsurance rate dropped from 8.2 to 5.9 percent, with a larger decrease among children, from 6.3 to 3.0 percent. Massachusetts Division of Health Care Finance and Policy. 2000. "Health Insurance Status of Massachusetts Residents," 2d ed. http://www.state.ma.us/dhcfp/pages/pdf/hism1200.pdf. [date accessed: May 2001].

6. Moore, Stephen, and Stephen Slivinski. 2001. "Fiscal Policy Report Card on America's Governors: 2000." Washington, D.C.: Cato Institute *Policy Analysis* No. 391.

7. Before the latest cuts, Massachusetts ranked fourth in total taxes per capita in 1999 ($13,011 versus national average of $10,298) according to American Legislative Exchange Council. 2001. "National Report on State Fiscal Policy: Recent Trends in Taxing & Spending." Washington, D.C.—but mainly because of progressive federal taxation of the state's high personal incomes. State spending as a share of personal income dropped by nearly 5 percent over 1995–2000, the 11th highest drop among states.

8. U.S. Bureau of Economic Analysis, Department of Commerce. 2001. "State Personal Income & State Per Capita Personal Income: 2000," Table 2. BEA News Release, April 24. http://www.bea.doc.gov/bea/newsrel/spi0401.htm#table2.

9. All Massachusetts executive and legislative budget messages for FY 2002 warned of slowdown, and innumerable news articles have warned of recession, including Pearlstein, Steven. 2001. "Global Recession Near, Some Economists Say." *Washington Post.* 26 September.

10. Health care accounts for 13 percent of current employment—and over one-quarter of job growth in 1980–1997, though growth has slowed. "The Massachusetts Health Care Industry: A Stalled Engine of Economic Growth." Report to Massachusetts Hospital Association by Standard & Poor's DRI. April 2000.

11. Massachusetts Division of Health Care Finance and Policy. 2000. "Massachusetts Health Care Expenditures." *Analysis in Brief* No. 1. http://www.state.ma.us/dhcfp/pages/pdf/aib_01.pdf; Health Care Financing Administration (HCFA), Office of the Actuary, National Health Statistics Group. 2000. "State Health Expenditures, 1980–1998." http://www.hcfa.gov/stats/nhe-oact/StateEstimates/Tables98/us50.htm; Massachusetts Division of Health Care Finance and Policy. 2000. *Massachusetts Health Care Trends: 1990–1999*. October. http://www.state.ma.us/dhcfp/pages/pdf/trends.pdf [date all accessed: April 2001].

12. The rainy day fund was about $1.6 billion in 2001, up from almost nothing in 1990, and near its legal cap of 7.5 percent of revenue. Commonwealth of Massachusetts. 2001. *Governor's Budget Recommendation, Fiscal Year 2002.* http://www.state.ma.us/bb/fy2002h1/default.htm. [date accessed: April 2001].

13. Leblanc, Steve. 2001. "Swift Unveils $150 Million Tax Cut Plan." *Boston Globe.* 27 June.

14. Syre, Steven, and Charles Stein. 2001. "Tax Cut's 'Difficult Reality." *Boston Globe*. September 9; Bailey, Steve. 2001. "Freeze the Tax Cut." *Boston Globe.* October 3. State revenues have slowed nationwide. National Association of State Budget Officers. 2001. "State Budget Shortfalls Mounting Substantially." Posting of October 4. http://www.nasbo.org/ [date accessed: October 9, 2001].

15. National Center for Tobacco-Free Kids. 2001. "State Tobacco Settlement: Massachusetts." January 11. http://tobaccofreekids.org/reports/settlements/StateSettlement.php3?StateID=MA. [date accessed: April 2001].

16. *Lorillard Tobacco v. Reilly* (Nos. 00-596 and 00-597 U.S. Supreme Court June 28, 2001) http://supct.law.cornell.edu/supct/html/00-596.ZS.html. [date accessed: July 2001].

17. Data in table 3 come from reports to the National Association of State Budget Officers. Different totals appear in the official cost reports to the federal government, used for Table 5. Yet other figures appear in internal state documents, e.g., Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April.

18. Spillman, Brenda C. 2000. "Adults without Health Insurance: Do State Policies Matter?" *Health Affairs* 19(4): 178–87.

19. Sources include Urban Institute compilations of Medicaid "2082" and "64" reports, explained in Bruen, Brian, and John Holahan. 2001. "Medicaid Spending Growth Remained Modest in 1998, But Likely Headed Upward." Menlo Park, California: Kaiser Family Foundation. http://www.kff.org/content/2001/2230/. [date accessed: May 2001]; Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April; National Association of State Budget Officers. 2000. "Fiscal Survey of the States." August. http://www.nasbo.org/Publications.html. [date accessed: May 2001]; Ellis, Eileen, and Vernon Smith. 2000. "Medicaid Enrollment in 50 States: June 1997 to December 1999." Menlo Park, California: Kaiser Commission on Medicaid and the Uninsured. October. http://www.kff.org/content/2000/2210/. [date accessed: June 2001].

20. Holahan, John, Randall Bovbjerg, Alison Evans, Joshua Wiener, and Susan Flanagan. 1997. *Health Policy for Low-Income People in Massachusetts.* Washington, D.C.: The Urban Institute.

21. Computations based on the same data as for table 4 but not presented in tables here.

22. Massachusetts Division of Health Care Finance and Policy. 1999. "What's Driving Prescription Drug Costs?" *Healthpoint* No. 13, April. http://www.state.ma.us/dhcfp/pages/pdf/hp_13.pdf. [date accessed: May 2001].

23. Pharmaceutical restrictions were implemented as this report was going to press.

24. Ch. 141 of the Acts of 2000.

25. The source for this and much other information in this section is Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April. According to consistently gathered national data, Medicaid participation in Massachusetts increased by 12.8 percent in SFY 1999 and 2.3 percent in SFY 2000, compared with national increases of 1.9 and 3.9 percent. National Association of State Budget Officers. 2000. "Fiscal Survey of the States." Washington, D.C. August. http://www.nasbo.org/Publications.html. [date accessed: May 2001].

26. The state manual for medical providers and outreach workers lists 75 health care programs, most not state-run. Massachusetts Division of Health Care Finance and Policy. 2000. *Access to Health Care in Massachusetts: A Catalog of Health Care Programs for Uninsured and Underinsured Individuals.* Boston. May. http://www.state.ma.us/dhcfp/pages/pdf/access.pdf. [date accessed: May 2001].

27. Chapter 23 of the Acts of 1988. Technically, the mandate allowed employers to pay a tax if they chose not to provide coverage; it was a "play or pay" mandate. See Sager, Alan, Peter Hiam, and Deborah Socolar. 1989. *Promise and Performance: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing*." Boston: Access and Affordability Monitoring Project, Boston University School of Public Health. April 9. http://dcc2.bumc.bu.edu/hs/sager/Promise%20and%20Performance%20reformatted%20Jan%2001.pdf. [date accessed: July 2001].

28. Holahan, John, Randall Bovbjerg, Alison Evans, Joshua Wiener, and Susan Flanagan. 1997. *Health Policy for Low-Income People in Massachusetts.* Washington, D.C.: The Urban Institute.

29. Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April.

30. A key source for this subsection is Center for MassHealth Evaluation and Research, University of Massachusetts. *Annual Report 2000: Commonwealth of Massachusetts 1115 Demonstration Project* (reviewed in draft May 2001).

31. Table 5 is based upon Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April; and Massachusetts Division of Health Care Finance and Policy. 2000. *Access to Health Care in Massachusetts: A Catalog of Health Care Programs for Uninsured and Underinsured Individuals.* Boston. May. http://www.state.ma.us/dhcfp/pages/pdf/access.pdf. [date accessed: April 2001].

32. Four key documents contributed to this section: Two were just cited as sources for Table 5. The third is Massachusetts Division of Health Care Finance and Policy. 2000. "Chapter 2: MassHealth." In *An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents.* Report to the Senate Committee on Ways and Means, House Committee on Ways and Means, and Joint Committee on Health Care. Boston. September. http://www.state.ma.us/dhcfp/pages/pdf/ch47mhlt.pdf. [date accessed: April 2001]. The fourth is Center for Health Policy and Research, UMass Medical School. 2000. *Health Care Resources for the Uninsured in Massachusetts: A Road Map to Coverage for Vulnerable Citizens of the Commonwealth.* Shrewsbury, Massachusetts. April. http://www.umassmed.edu/healthpolicy/roadmap/. [date accessed: November 2000].

33. Also covered are disabled persons with federal QDWI (qualified disabled and working individual) status and those who have lost their Medicare Part A benefits owing to their return to work. CommonHealth covers them up to 200 percent of FPL, with an asset test of double the limit for SSI eligibility.

34. Employers must have 50 or fewer full-time employees and meet other standards. The employer subsidy or Insurance Partnership program is sometimes listed as a separate program.

35. State officials perceive that the SCHIP requirements severely impair their ability to use premium subsidy. Almost all the children in subsidized ESI in Massachusetts qualify under the 1115 waiver, not under SCHIP. For more detail on premium subsidy under SCHIP, including survey response from Massachusetts, see Schofield, Linda. 2001. "Employer Buy-In Programs: How Four States Subsidize Employer-Sponsored Insurance." Washington, D.C.: Academy for Health Research and Health Policy. http://www.statecoverage.net/employer.pdf. [date accessed: May 2001].

36. Massachusetts Division of Medical Assistance. 2001. " MassHealth Begins Accepting Applications Under New HIV Waiver." Press Release, April 5. http://www.state.ma.us/dma/pressreleases/press_01_04-05.htm. [date accessed: June 2001].

37. Written sources for this subsection include Massachusetts Division of Health Care Finance and Policy. 2000. "Chapter 1: The Children's Medical Security Plan." In *An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents.* Report to the Senate Committee on Ways and Means, June. http://www.state.ma.us/dhcfp/pages/pdf/ch47cmsp.pdf. [date accessed: July 2001].

38. Sources for this subsection include Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April; Center for MassHealth Evaluation and Research, UMass. *Annual Report 2000: Commonwealth of Massachusetts 1115 Demonstration Project* (reviewed in draft May 2001); and Holahan, John, Suresh Rangarajan, and Matthew Schirmer. 1999. *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey.* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 26.

39. This subsection draws upon DeNucci, A. Joseph. 1999. *Independent State Auditor's Report on the Uncompensated Care Pool Administered by the Division of Health Care Finance and Policy*. No. 99-5069-3, November 3. http://www.state.ma.us/sao/uncomp.doc [date accessed: July 2001]; Massachusetts Division of Health Care Finance and Policy. 2000. "Chapter 3: The Uncompensated Care Pool." In *An Evaluation of Health Care Programs for Low Income Uninsured and Underinsured Massachusetts Residents.* Report to the Senate Committee on Ways and Means, November. http://www.state.ma.us/dhcfp/pages/pdf/ch47ucp.pdf. [date accessed: April 2001]; Bovbjerg, Randall R., Alison Evans Cuellar, and John Holahan. 2000. *Market Competition and Uncompensated Care Pools.* Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper No. 35.

40. Weissman, Joel S., Paul Dryfoos, and Katherine London. 1999. "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals." *Health Affairs* 18(4): 156–66.

41. The precise arrangement was more complex because of fears that a direct tax on employment benefit plans might be invalid under the Employee Retirement Income Security Act of 1974 (ERISA).

42. Other regulations equalized hospitals' application of eligibility rules, to reduce the disparities that had resulted from prior hospital discretion, and clarified the workings of partial free care eligibility. Reforms also increased grievance and appeals rights and required demonstration projects designed to shift free care to outpatient management.

43. Sources on program design include DeNucci, A. Joseph. 1999. *State Auditor's Report on Certain Activities of the Senior Pharmacy Program.* No. 98-4062-3, July 12. http://www.state.ma.us/sao/pharmacy.doc. [date accessed:

June 2001]; Massachusetts Executive Office for Administration and Finance. 1999. "Trends in Drug Expenditures and Utilization." *Policy Brief Series* No. 3, November 2. http://www.state.ma.us/eoaf/PolicyBriefs/SeniorsRx.pdf. [date accessed: May 2001]; Massachusetts Division of Health Care Finance and Policy. 2000. "The Pharmacy Program and The Pharmacy Program Plus." *Free Care Notes,* Winter. http://www.state.ma.us/dhcfp/pages/pdf/fcnotes4.pdf. [date accessed: May 2001]; Nixon, Victoria. 2001. "Massachusetts Elderly and Prescription Drug Coverage." *Access Update,* Number 1, Massachusetts Division of Health Care Finance and Policy, March. http://www.state.ma.us/dhcfp/pages/pdf/access1.pdf. [date accessed: June 2001]; and Massachusetts Department of Elder Affairs. 2001. "Elder Update, March 2001: The Massachusetts Prescription for Better Drug Coverage." http://www.state.ma.us/elder/PageWhatsNew.html. [date accessed: July 27, 2001].

44. Additional sources on program issues include *American Health Line.* 2000. "Access/Quality/Cost—Massachusetts: Rx Drug Plan Could Exceed Cost Estimates." 21 December; Massachusetts Taxpayers Foundation. 2001. " MTF Analysis: An Unbalanced Fiscal 2002 State Budget." *Bulletin.* 26 June. http://www.masstaxpayers.org/data/pdf/bulletins/01jun26.pdf. [date accessed: August 2001]; *American Health Line.* 2001. "Statelines—Rx Drug Benefit: Maine, Mass., Nev. Debate Proposals." 10 May; Lauerman, John F. 2001. "Bay State Seniors Pin Hopes on Prescription Drug Plan." *Springfield (Massachusetts) Union-News.* 23 July.

45. *American Health Line.* 2001. "Statelines—Massachusetts: Rx Bulk Buying Plan Lags Behind Neighbors." 26 July.

46. Written sources for this section include Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program: The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April; Massachusetts Division of Health Care Finance and Policy. 2000. *Massachusetts Health Care Trends: 1990–1999.* October. http://www.state.ma.us/dhcfp/pages/pdf/trends.pdf. [date accessed: April 2001]; Massachusetts Health Care Task Force. 2001. *Interim Report.* January. http://www.state.ma.us/healthcare/pages/pdf/int_rept.pdf. [date accessed: May 2001]; Massachusetts Health Care Task Force, Health Care Finance Working Group. 2000. "Costs and Premiums Proposed Findings on Nursing Homes—Preliminary Draft of 7/24/00." http://www.state.ma.us/healthcare/pages/pdf/nhfin724.pdf; Massachusetts Extended Care Federation. 2001. "Where Will Your Mother Go? A Special Report on the Crisis Engulfing Nursing Homes in Massachusetts and Its Implications for the Care of Our Frail and Disabled Citizens." Newton Lower Falls. April; Heldt Powell, Jennifer. 2001. "Nursing Home Crisis Predicted." *Boston Herald.* 13 April.

47. Computations based on same data as table 4 but not presented here.

48. The main written source for this subsection is Massachusetts Division of Medical Assistance. 2001. *The MassHealth Program—The Medicaid Program in Massachusetts: Program and Budget Issues for FY2002.* Boston. April.

49. Computations based on same data as table 4 but not presented here.

50. *Olmstead v. L.C. ex. rel. Zimring,* 119 S.Ct. 2187. http://laws.findlaw.com/us/000/98-536.html. See also Rosenbaum, Sara. 2000. "The Olmstead Decision: Implications for Medicaid." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/content/2000/2185/OlmsteadDecision.pdf. [date accessed: August 2001].

51. Written sources for this subsection include DeNucci, A. Joseph. 2000. *Independent State Auditor's Report on Certain Activities of the Department of Public Health's Licensing and Monitoring of the NewCare Health Corporation.* No. 2000-0290-3, November 16. http://www.state.ma.us/sao/00-0290-3.doc. [date accessed: July 2001]; Health Care Task Force, Working Group on Quality. 2001. *Final Report.* April 23. http://www.state.ma.us/healthcare/pages/pdf/quality.pdf. [date accessed: May 2001]; Massachusetts Extended Care Federation. 2001. "Where Will Your Mother Go? A Special Report on the Crisis Engulfing Nursing Homes in Massachusetts and Its Implications for the Care of Our Frail and Disabled Citizens." Newton Lower Falls. April.

52. *American Health* Line. 2001. "Statelines—Senior Care: Connecticut, Massachusetts Criticized." 19 January.

53. Written sources for this subsection include Executive Office of Health and Human Services, Department of Mental Health. 2001. "About the Department of Mental Health." http://www.state.ma.us/dmh/about_dmh.htm. [date accessed: August 2001]; Massachusetts Department of Housing and Community Development. 2001. *Housing and Community Development One Year Action Plan 2000.* http://www.state.ma.us/DHCD/ConPlan/09192k/2mst_pl.pdf. [date accessed: August 2001]; Tye, Larry. 2001. "Treatment Revolution." *Boston Globe.* 17 April; and Dembner, Alice. 2001. "State Plan Aims to Aid Mentally Ill Children: Program for the Poor Could Fend off Lawsuit." *Boston Globe.* 12 July.

54. Written sources for this subsection include Massachusetts Developmental Disabilities Council. n.d. "FY 1999 Annual Program Performance Report." http://www.state.ma.us/mddc/documents/99appr.pdf. [date accessed: June 2001]; Massachusetts Department of Mental Retardation. n.d. "Annual Report, July 1, 1999–June 30, 2000." http://www.dmr.state.ma.us/fy00.htm. [date accessed: June 2001]; Massachusetts Department of Mental

Retardation. 1999. “Report on the Use of Funds for Services to Individuals on the DMR Wait List.” Chapter 194 of General Appropriations Act of 1998 to The House and Senate Ways and Means Committees. January 1. http://www.dmr.state.ma.us/wait.htm. [date accessed: June 2001]; Massachusetts Department of Mental Retardation. n.d. *Annual Report, July 1, 1998–June 30, 1999.* http://www.dmr.state.ma.us/fy99.htm; and Massachusetts Department of Mental Retardation. 1999. “Cellucci/Swift Administration Unveils Plan to Care for Disabled.” DMR News Release 10/20/99. http://www.dmr.state.ma.us/dmrnews.nsf. [date accessed: August 2001].

55. Massachusetts Department of Mental Retardation. n.d. *Annual Report, July 1, 1998–June 30, 1999.* http://www.dmr.state.ma.us/fy99.htm. [date accessed: August 2001] (N.B. *Boulet* was filed as *Anderson v. Cellucci*).

56. Massachusetts Department of Mental Retardation. 2000. “Cellucci-Swift Administration, Reilly Announce Plans to Eliminate Wait List.” DMR News Release 12/20/00. http://www.dmr.state.ma.us/dmrnews.nsf/. [date accessed: August 2001].

57. Massachusetts Division of Health Care Finance and Policy. 2000. *Massachusetts Health Care Trends: 1990–1999.* October. http://www.state.ma.us/dhcfp/pages/pdf/trends.pdf. [date accessed: April 2001].

58. This account draws upon interviews and contemporaneous news accounts, including Pham, Alex. 1997. “State Seeks Oversight of Ailing Blue Cross.” *Boston Globe*. 22 May; *American Health Line.* 1997. “Inside the Industry—Massachusetts Blue Cross: To Detail Reorganization.” 18 December.

59. This account draws upon interviews; contemporaneous news accounts, including Griffith, Ted. 1999. “Baker Plans to Put a Brake on HMO’s Growth.” *Boston Business Journal*. 30 August; and Phillips, Frank. 2000. “Harvard Pilgrim in Receivership: Care, Coverage Will Continue.” *Boston Globe.* 5 January; receivership documents, notably those on the attorney general’s Harvard Pilgrim Web page, http://www.ago.state.ma.us/newhc.asp. [date accessed: July 2001]; and other materials, including Brewster, Linda R., and Paul B. Ginsburg. 2000. “At the Brink: How Harvard Pilgrim Got in Trouble.” Issue Brief Findings from HSC, No. 33, Center for Studying Health System Change, December.

60. Eckelbecker, Lisa. 2001. “HMOs Report Financial Gains.” *Worcester (Massachusetts) Telegram & Gazette.* 2 March.

61. Bureau of National Affairs. 2000. Online newsletter. 25 September.

62. This subsection draws upon BlueCross BlueShield Association. 2001. *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans* (including Massachusetts state profile). http://bcbshealthissues.com/proactive/newsroom/release.vtml?id=17640. [date accessed: September 2001]; Massachusetts Department of Public Health. 2001. “Office of Patient Protection” (includes history of office). http://www.state.ma.us/dph/opp/index.htm. [date accessed: July 24, 2001]; Bureau of Managed Care, Massachusetts Division of Insurance. 2000. “Certain New Requirements for the Oversight of Managed Care.” Bulletin 2000-12, September 8. http://www.state.ma.us/doi/bulletins/bulletins_00_12.html. [date accessed: July 24, 2001]; and Bureau of Managed Care, Massachusetts Division of Insurance. 2000. “Issues Related to Chapter 141 of the Acts of 2000.” Bulletin 2000-19, December 27. http://www.state.ma.us/doi/Bulletins/bulletins_00_19.pdf. [date accessed: July 24, 2001].

63. The Employee Retirement and Income Security Act of 1974, or ERISA.

64. Sources for this subsection include: BlueCross BlueShield Association. 2001. *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans* (including Massachusetts state profile). http://bcbshealthissues.com/proactive/newsroom/release.vtml?id=17640. [date accessed: September 2001]; Massachusetts Division of Insurance. 2000. “Mental Health Parity.” Bulletin 2000-06. July 20 http://www.state.ma.us/doi/bulletins/bulletins_00_06.html. [date accessed: June 2001]; Kennedy, Susan, Maria Schiff, and Heather Shannon, Massachusetts Division of Health Care Finance and Policy. 2000. “Mental Health Parity: What Will It Bring Massachusetts?” *Healthpoint* No. 19, October. http://www.state.ma.us/dhcfp/pages/pdf/hp_19.pdf. [date accessed: June 2001].

65. These are requirements of The Health Insurance Portability and Accountability Act of 1996, known as HIPAA.

66. Sources here include Massachusetts Hospital Association. 2001. Web Home Page (various documents). http://www.mhalink.org/. [dates accessed April–August 2001]; “Hospital Mergers, Acquisitions, Joint Ventures and Long-Term Leases.” *Modern HealthCare* (various issues, January 1998–2001); Connolly, Allison. 2000. “For Bay State Hospitals, the Coming Year Is Critical.” *Boston Business Journal.* 29 December. http://www.bizjournals.com/boston/stories/2001/01/01/story7.html. [date accessed: June 11, 2001]; Massachusetts Division of Health Care Finance and Policy. 1997. “Hospital Mergers and the Public Interest.” *Healthpoint* No. 2, March. http://www.state.ma.us/dhcfp/pages/pdf/hp_02_03.pdf. [date accessed: May 2001]; U.S. Department of Health and Human Services, Office of Inspector General, Hospital Closure Reports

1990–1999; Massachusetts Division of Health Care Finance and Policy. 2000. *Massachusetts Health Care Trends: 1990–1999.* October. http://www.state.ma.us/dhcfp/pages/pdf/trends.pdf. [date accessed: April 2001]; U.S. Health Resources and Services Administration. 2000. "State Health Workforce Profiles: Massachusetts." Bureau of Health Professions, National Center for Health Workforce Information & Analysis, HRSA, Rockville, Maryland, December 20.

67. Holahan, John, Randall Bovbjerg, Alison Evans, Joshua Wiener, and Susan Flanagan. 1997. *Health Policy for Low-Income People in Massachusetts.* Washington, D.C.: The Urban Institute.

68. Cole, Caroline Louise. 2001. "Hale Hospital Sale Backed." *Boston Globe.* 30 August.

69. Kowalczyk, Liz. 2001. "Hospitals Raising Rates for HMOs." *Boston Globe.* 18 March.

70. *Boston Globe.* 2001. 27 April.

71. A state reviewer of this report noted that the attorney general has just completed a significant antitrust market analysis in response to legislative request. Reilly, Tom, Massachusetts Attorney General. 2001. "Report to the Legislature on the Springfield Health Care Market." September 12. http://www.ago.state.ma.us/sphealth.pdf. [date accessed: October 9, 2001].

72. Massachusetts Health Care Task Force. 2001. *Interim Report from the Massachusetts Health Care Task Force.* January. http://www.state.ma.us/healthcare/pages/pdf/int_rept.pdf. [date accessed: May 2001].

73. These are requirements of The Health Insurance Portability and Accountability Act of 1996, known as HIPAA.

74. Coleman, Kevin, and Allen Dobson, The Lewin Group. 2000. "An Analysis of Massachusetts Hospitals' Efficiency and Costs." Prepared for the Massachusetts Hospital Association. http://www.mhalink.org/News/News/Newsdir/News00/4-6-00-B.HTM. [date accessed: June 2001]; Massachusetts Hospital Association. 2000. "Financial Stresses Mounting Due to Low Payments." MHA Press Release, April 6. http://www.mhalink.org/News/News/Newsdir/News00/4-6-00.HTM. [date accessed: June 2001].

75. Task Force Finance Working Group. 2000. "Initial Findings on Hospitals." Draft of June 12. http://www.state.ma.us/healthcare/pages/tf_04.htm#anchor180126. [date accessed: November 2001].

76. The Lewin Group. 2001. *Analysis of the Reimbursement Rates for Acute Hospitals, Nonacute Hospitals, and Community Health Centers.* June 25. http://www.mhalink.org/News/Newsdir/News01/Lewin_Contents.htm. [date accessed: July 2001]; Task Force Finance Working Group. 2000. "The Lewin Report, Medicaid Payments, and Massachusetts Health Care System." Presentation of September 17, 2001. http://www.state.ma.us/healthcare/pages/pdf/finslide.pdf. [date accessed: November 2001].

77. Kowalczyk, Liz. 2001. "Beth Israel Hires Turnaround Firm." *Boston Globe.* 21 September.

78. Massachusetts Hospital Association. 2001. "MHA Applauds Governor Cellucci's Proposed Hospital Relief Proposal." Press Release. January 22.

79. Kowalczyk, Liz. 2001. "Suburban Hospitals Lose Market Share." *Boston Globe.* 13 March.

80. Ibid.; Kowalczyk, Liz. 2001. "HMOs Eyeing Surcharge for High-End Care: Some '02 Plans Affect Visits to Medical Centers." *Boston Globe.* 28 August; *Boston Globe* [editorial]. 2001. "Health Care without Tiers." 29 August.

81. Sources here include reports from the Massachusetts League of Community Health Centers. http://www.massleague.org/press/articles/Statehouse_2000.htm. [dates accessed: May–July 2001]; Massachusetts Division of Health Care Finance and Policy. 2000. *Massachusetts Health Care Trends: 1990–1999.* October. http://www.state.ma.us/dhcfp/pages/pdf/trends.pdf. [date accessed: April 2001]; and Massachusetts Division of Health Care Finance and Policy. 1999. "Market Change Affects Community Health Centers." *Healthpoint* No. 14, July. http://www.state.ma.us/dhcfp/pages/pdf/hp_14.pdf. [date accessed: May 2001].

82. Cassidy, Tina, and Rick Klein. 2001. "Stage Set for Mass. Budget Battles: Groups Seek More in Tighter Times." *Boston Globe.* 16 January; Ranalli, Ralph. 2001. "Swift, Surplus Plan Get Harsh Reception." *Boston Globe.* 28 June.

Table 1 Notes

a. U.S. Census Bureau. 2001. *Profiles of General Demographic Characteristics 2000*. http://www.census.gov/PressRelease/www/2001/2khus.pdf.

b. Urban Institute calculations derived from the 1999 National Survey of America's Families. Note: All calculations only include residents under age 65.

c. U.S. Department of Commerce, Bureau of Economic Analysis. 2001. News Release: "State Personal Income and State Per Capita Personal Income: 2000. State Personal Income: Fourth Quarter 2000." April 24. http://www.bea.doc.gov/bea/newsrel/spi0401.htm.

d. U.S. Department of Commerce, Bureau of Economic Analysis. 2000. News Release: "1999 State Per Capita

Personal Income Revised." Table 1: Per Capita Personal Income, by State and Region, 1995–1999 (Dollars). September 12. http://www.bea.doc.gov/bea/newsrel/spi0900.htm. Note: Percent change calculated in inflation-adjusted dollars by The Urban Institute based upon the CPI-U as published in the *Economic Report of the President*. 2000. Table B-60. Washington, D.C.: U.S. Government Printing Office, February.

e. U.S. Department of Labor, Bureau of Labor Statistics. 2001. "Regional and State Employment and Unemployment: April 2001." Table 3. ftp://ftp.bls.gov/pub/news.release/History/laus.05182001.news.

f. Zedlewski, Sheila. 2000. "Family Economic Well-Being." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C: The Urban Institute. Notes: Percent change in poverty rates (1996–1998) calculated by the Labor and Social Policy Center, The Urban Institute. 1998 national and state adult and child poverty estimates show statistically significant decreases from the 1996 estimates at the 0.10 confidence level, calculated by the *Assessing the New Federalism* project, The Urban Institute.

g. The National Governors' Association. 2001. "The Governors, Political Affiliations, and Terms of Office, 2001." http://www.nga.org/cda/files/govlist2001.pdf.

h. The National Conference of State Legislatures. 2001. http://www.ncsl.org/ncsldb/elect98/partcomp.cfm?yearsel=2001. Note: D indicates Democrat, R indicates Republican, I indicates Independent, O indicates other, V indicates Vacant.

i. Two Urban Institute calculations: (1) Average monthly number of AFDC 1996 recipient children divided by number of children in poverty in 1996: U.S. Department of Health and Human Services. Administration for Children and Families. 1997. *Characteristics and Financial Circumstances of AFDC Recipients FY 1996*. Table 18. "Percent Distribution of AFDC Recipient Children by Age (October 1995–September 1996)"; (2) Average monthly number of TANF 1998 recipient children divided by number of children in poverty in 1998: U.S. Department of Health and Human Services. Administration for Children and Families. 1999. *Second Annual Report to Congress August 1999*. Table 9:22. "Percent Distribution of TANF Recipient Children by Age Group (October 1997–September 1998)." The numbers of children in poverty in 1996 and 1998 are Urban Institute calculations from the *National Survey of America's Families II*.

j. Based on three sources: (1) Urban Institute's TRIM [Transfer Income Model]; (2) Smith, Vernon K. 1999. "Enrollment Increases in State CHIP Programs: December 1998 to June 1999." Health Management Associates, July; (3) Urban Institute analysis of *1999 SCHIP [State Children's Health Insurance Program] Annual Report*. Rules for 1996 and 1998 are policies in place the majority of the year. Rules for 2000 represent plans approved as of January 1, 2000.

k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC-related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

About the Authors

Randall R. Bovbjerg is a principal research associate with the Urban Institute's Health Policy Center. His main research interests are health coverage and financing; regulation, competition, and the appropriate role for government action and the working of law in action, including the influence of legal culture on policy. Earlier work on changing state policy led him to coauthor one book on Medicaid and another on block grants, both from the Urban Institute Press.

Frank C. Ullman at the time of this research was a research associate with the Urban Institute's Health Policy Center, where he focused on implementation of the State Children's Health Insurance Program.

THE URBAN INSTITUTE
2100 M Street, N.W.
Washington, D.C. 20037

Nonprofit Org.
U.S. Postage
PAID
Permit No. 8098
Mt. Airy, MD

Address Service Requested

For more information,
call Public Affairs:
(202) 261-5709
or visit our Web site,
http://www.urban.org.
To order additional copies
of this publication, call
(202) 261-5687
or visit our online bookstore,
http://www.uipress.org.

This state update is a product of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

Recent Changes in Health Policy for Low-Income People received special funding from the Robert Wood Johnson Foundation as part of the Urban Institute's *Assessing the New Federalism* project. The project received additional financial support from The Annie E. Casey Foundation, the W. K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The David and Lucile Packard Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, the Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

THE URBAN INSTITUTE
2100 M Street, N.W.
Washington, D.C. 20037
Copyright © 2002
Phone: (202) 833-7200
Fax: (202) 728-0232
E-mail: pubs@ui.urban.org

This state update was prepared for the *Assessing the New Federalism* project. The views expressed are those of the authors and do not necessarily reflect those of the Urban Institute, its board, its sponsors, or other authors in the series.

The authors would like to thank the many state officials and representatives of consumer and provider organizations who participated in interviews and provided information.