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Health Policy for Low-Income People in Massachusetts

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Massachusetts has an extensive, high-cost health care system, with a tradition of excellence in health services delivery and medical education. The state also has a long history of progressive politics and support of government programs, including a strong public sector commitment to health services for the low-income population. The state has been a pioneer in health care reform. It enacted a universal coverage law in 1988, which included a pay-or-play mandate on most employers. Although the mandate gradually lost the support of key constituencies and was never implemented, the universal coverage law also included a number of other public programs to expand coverage to individuals outside the labor force, most of which are still in place. The state also has an uncompensated care pool to redistribute funds from those hospitals providing a lesser amount of free care to those providing a substantial amount.

Characteristics of the State

Massachusetts is a heavily urbanized state; of its 6 million residents, half live in the greater Boston area. Total state population grew

by less than 1 percent between 1990 and 1995, much more slowly than the rest of the nation (5.6 percent). The state's population is somewhat older than that of the average state, with a smaller proportion of children and a larger proportion of elderly. Massachusetts is more racially and ethnically homogeneous than the average state: The proportions of black and Hispanic residents are less than half those for the United States as a whole. The state does, however, have a slightly higher share of immigrants. Noncitizen immigrants compose 5.4 percent of the population compared with 6.4 percent at the national level. (table 1).*

Massachusetts is a relatively wealthy state, although its economy has struggled at various times. The state's economy was sluggish in the 1970s but boomed in the 1980s as information-based high-tech industries prospered. This "Massachusetts Miracle" helped fund expansion of public services and create support for mandatory universal health care. A recession hit late in the 1980s, reducing the number of jobs and tax revenues in the state. This forced cuts in state spending and aid to localities, as well as hikes in taxes. The drop in employment bottomed out in December 1991, and economic growth returned. Tax revenues were continuing to exceed policymakers' expectations as of late 1996.

The plans for coverage expansion under Mass-Health are among the most ambitious under way anywhere in the nation.

Table 1
State Characteristics

	<u>Massachusetts</u>	<u>U. S.</u>
Sociodemographic		
Population (1994–95) (in thousands)	6,002	260,202
Percent under 18 (1994–95)	24.2%	26.8%
Percent 65+ (1994–95)	12.3%	12.1%
Percent Hispanic (1994–95)	4.4%	10.7%
Percent Non-Hispanic Black (1994–95)	6.1%	12.5%
Percent Non-Hispanic White (1994–95)	86.6%	72.6%
Percent Non-Hispanic Other (1994–95)	2.9%	4.2%
Percent Noncitizen Immigrant (1996)*	5.4%	6.4%
Percent Nonmetropolitan (1994–95)	23.8%	21.8%
Population Growth (1990–95)	0.9%	5.6%
Economic		
Per Capita Income (1995)	\$ 28,021	\$ 23,208
Percent Change in Per Capita Personal Income (1990–95)	20.8%	21.2%
Unemployment Rate (1996)	4.3%	5.4%
Percent below Poverty (1994)	10.9%	14.3%
Percent Children below Poverty (1994)	17.2%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	12.6%	15.5%
Percent Medicaid—Nonelderly (1994–95)	8.9%	12.2%
Percent Employer-Sponsored—Nonelderly (1994–95)	73.7%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	4.8%	6.2%
Smokers among Adult Population (1993)	21.2%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	6.4%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	5.5	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	42.2	54.4
Violent Crimes per 100,000 (1995)	687.2	684.6
AIDS Cases Reported per 100,000 (1995)	23.8	27.8
<p><i>Source:</i> Complete list of sources is available in <i>Health Policy for Low-Income People in Massachusetts</i> (The Urban Institute, 1997).</p> <p>* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.</p>		

The 1990s economic expansion has raised incomes sharply, although at a slightly lower rate than in the nation at large. Massachusetts's annual per capita income of more than \$28,000 was 21 percent above the national average in 1995. The unemployment rate was about 20 percent below the national average in 1996, and the poverty population was 10.9 percent versus 14.3 percent for the United States in 1994. The poverty rate for children was 17.2 percent, a rate well below the national average of 21.7 percent (table 1).

Massachusetts has a comparatively high rate of health insurance coverage, particularly employer-

sponsored coverage (table 1). Only 12.6 percent of the nonelderly population was uninsured versus 15.5 percent for the nation in 1994–95; yet the uninsured population grew steadily in the late 1980s and early 1990s, after years of decline. This deterioration in coverage may have halted as of 1996, but the lack of insurance among some segments of the population remains a policy concern.

Massachusetts scores well on standard measures of health, often substantially better than the national average. Its infant mortality, low birth-weight, and premature death rates are much lower than those of the country as a whole (table 1).

Politics and Health Care Policy

In the absence of unusual health problems or insurance needs, Massachusetts gives health care high-profile policy attention largely because of a liberal political tradition of promoting health care and using public resources to aid the needy. The public sector, particularly state government, plays a large role in the state. In addition to creating a safety net for the poor, government has provided employment opportunities that have been a route to prosperity for successive waves of immigrants. The state remains heavily Democratic in voter registration, although the party has become more suburban and less based in old-time industrial unionism, ethnic associations, and big-city machines. Both houses of the legislature are heavily Democratic, although former governor Weld and acting governor Cellucci are Republican.

The Weld/Cellucci administrations and the legislature have pursued a number of objectives in health care. They repealed the employer mandate for universal coverage and ended the state's hospital rate-setting system. They have slowed Medicaid growth through cuts in provider payments, reductions in welfare caseloads, and managed care. In addition, they applied for and received approval for a Section 1115 waiver, which will result in a substantial increase in coverage through both Medicaid and employer-based coverage. Finally, they have managed the restructuring of the state's underfunded uncompensated care pool. The state has been very successful in obtaining federal matching funds to support these initiatives.

Medicaid Trends

Medicaid trails only K–12 education as the largest item in Massachusetts's general fund budget. The program accounted for 13 percent of state general revenue spending and 22 percent of the entire state budget including federal and other sources in 1995. From 1991 to 1995, state general-fund spending on Medicaid grew at an annual rate of 4.2 percent, which was slightly less than the growth in

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
Massachusetts and United States
 (Expenditures in Millions)

	Massachusetts			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990-92	1992-95	1995	1990-92	1992-95
Total	\$5,711.4	16.1%	9.4%	\$157,872.5	27.1%	9.9%
Benefits						
Benefits by Service	\$4,990.7	9.9%	9.4%	\$133,434.6	18.8%	11.0%
Acute Care	2,682.0	13.6%	10.8%	79,438.5	22.1%	13.0%
Long-Term Care	2,308.7	6.2%	7.8%	53,996.1	14.8%	8.3%
Benefits by Group	\$4,990.7	9.9%	9.4%	\$133,434.6	18.8%	11.0%
Elderly	\$1,639.3	2.7%	6.4%	\$40,087.4	16.7%	8.1%
Acute Care	336.9	-1.3%	7.1%	9,673.7	18.5%	11.9%
Long-Term Care	1,302.4	3.7%	6.2%	30,413.7	16.2%	7.0%
Blind and Disabled	\$2,097.6	11.8%	10.4%	\$51,379.4	17.7%	12.9%
Acute Care	1,134.8	14.6%	10.7%	29,760.7	22.8%	15.2%
Long-Term Care	962.8	8.7%	10.0%	21,618.7	12.3%	10.1%
Adults	\$414.0	17.5%	4.5%	\$16,556.9	20.4%	9.2%
Children	\$839.7	21.8%	16.8%	\$25,410.9	24.3%	13.3%
Disproportionate Share	\$609.6	3281.3%	10.1%	\$18,988.4	261.5%	2.7%
Hospital Administration	\$111.1	9.4%	5.1%	\$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

total general-fund spending. Taking into account federal spending as well, Massachusetts's Medicaid program grew by 9 percent per year during this same period, which was still less than growth in the total state budget (14.6 percent).

Despite recent moderate growth trends, the state's Medicaid program is large by national standards. On a per enrollee basis, the state spent more than any state (\$6,189) other than New York (\$6,194) in 1995. Moreover, the state's Medicaid spending per low-income person is \$4,254 versus \$2,041 for the nation. Although they constitute only one-third of Medicaid enrollees, the elderly and disabled accounted for 75 percent of Massachusetts's Medicaid expenditures in 1995, contrasted with 68 percent nationally. Consistent with this, 46 percent of Medicaid expenditures in the state were for long-term care versus an average of 41 percent for the nation (table 2).

The state enrolls a significant proportion of the low-income population into its Medicaid program—principally because its eligibility income standards are quite generous and because it has adopted most federal optional eligibili-

ty categories. The state covers 64 percent of the population below 150 percent of the federal poverty level (FPL) versus 51 percent for the United States overall.

With the exception of the blind and disabled population, Medicaid enrollment levels have remained relatively stable in recent years. There has been a decline in Temporary Assistance for Needy Families (TANF) enrollees because of an improved economy and the state's welfare reform efforts. Overall Medicaid enrollment growth averaged 1.8 percent between 1992 and 1995, versus the national rate of 5.2 percent. The below-average expenditure growth observed in Massachusetts's program is largely attributable to this flattening in enrollment (table 3).

Medicaid Initiatives

The most important development in the Massachusetts Medicaid program in 1997 is the planned expansion of coverage under a Section 1115 waiver program. The waiver program, termed MassHealth, will extend coverage to new population

groups and absorb two of the previously state-funded programs—the CommonHealth program for the disabled and the Medical Security program for the short-term unemployed. The plans for coverage expansion under MassHealth are among the most ambitious under way anywhere in the nation. In addition to retaining current coverage of pregnant women and infants up to 185 percent of the FPL, MassHealth will expand coverage to all children through the age of 18 to 133 percent of the FPL (and perhaps to 200 percent of the FPL). It will also establish a New State Benefit Plan that will extend coverage to long-term unemployed individuals and other adults whose gross incomes are no more than 133 percent of the FPL. The most important and most controversial component of the waiver program is the Insurance Reimbursement Program for low-income workers. This program will provide subsidies for private insurance to workers with incomes below 200 percent of the FPL and provide subsidies to small firms (fewer than 50 workers) that contribute at least 50 percent of the cost of premiums for plans that meet state standards.

Table 3
Medicaid Enrollment and Expenditures
per Enrollee: Contributions to Total Expenditure Growth

	Massachusetts			United States		
	1995	Average Annual Growth		1995	Average Annual Growth	
		1990-92	1992-95		1990-92	1992-95
Elderly						
Total expenditures on benefits (millions)	\$1,639.3	2.7%	6.4%	\$40,087.4	16.7%	8.1%
Enrollment (thousands)	101.7	0.4%	1.0%	4,116.6	5.1%	3.0%
Expenditures per enrollee	\$16,113	2.2%	5.3%	\$9,738	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	\$2,097.6	11.8%	10.4%	\$51,379.4	17.7%	12.9%
Enrollment (thousands)	168.7	12.7%	8.7%	6,405.2	9.8%	9.5%
Expenditures per enrollee	\$12,437	-0.8%	1.5%	\$8,022	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	\$414.0	17.5%	4.5%	\$16,556.9	20.4%	9.2%
Enrollment (thousands)	171.9	6.1%	-1.0%	9,584.2	11.5%	4.6%
Expenditures per enrollee	\$2,408	10.8%	5.6%	\$1,728	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	\$839.7	21.8%	16.8%	\$25,410.9	24.3%	13.3%
Enrollment (thousands)	364.1	4.0%	0.6%	21,566.0	13.1%	4.8%
Expenditures per enrollee	\$2,306	17.1%	16.1%	\$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

In addition to broadening eligibility criteria, Massachusetts's Medicaid program is attempting to rapidly expand managed care. Of 650,000 Medicaid enrollees, 378,000 are now in mandatory managed care for most services. About 75 percent of managed care enrollees are in the Primary Care Clinician (PCC) program, a fee-for-service gatekeeper model. Approximately one-fourth of the managed care enrollees are in health maintenance organizations (HMOs). The state wants to move toward greater reliance on HMOs and may phase out its PCC program. The primary issue is whether the HMOs in the state will be willing to take on substantially more Medicaid beneficiaries at rates the state would like to pay. HMOs are thought to better control utilization but to reimburse providers at higher rates than the state does under its PCC program. As a result, the state is reaping little savings with existing HMOs. HMOs offer the state the advantage of management expertise as well as the ability to exclude high-cost physicians

and hospitals. Thus, the state believes HMOs offer more promise for the future even though significant savings have not been realized to date.

The Uncompensated Care Pool

Massachusetts's support for the health care safety net includes a policy of subsidizing hospitals that provide disproportionate amounts of uncompensated care. The former hospital rate-setting system established an uncompensated care pool to distribute the burden of uncompensated care and to reduce the incentives to underserve the uninsured. The pool was later tapped to contribute to the state's large network of community health centers as well. Three issues related to the pool emerged. First, the amount of money in the pool was frozen at about \$315 million in 1988. As the cost of health care and the number of uninsured grew, the resources in the pool became increasingly inadequate. Second, the distribution of

the funds in the pool heavily favored the major public hospitals in the state, particularly Boston Medical Center and the Cambridge Hospital, such that many other hospitals treating the uninsured received minimal or no funds. Third, hospitals were finding it increasingly difficult to pass the cost of their pool assessments on to insurers in rate negotiations. A Special Commission on Uncompensated Care recently addressed these problems.

The solutions recommended by the commission and supported by the state's Section 1115 waiver application involved expansions of coverage through MassHealth and new supplemental payments (outside of the pool) to Boston Medical Center and the Cambridge Hospital. Eliminating disbursements to these two hospitals freed \$70 million of pool resources that could be distributed to other hospitals. Finally, the direct assessment on hospitals was reduced by \$100 million and replaced by a requirement of direct contributions by all third-party payers to the pool.

The Health Care Market

The health care marketplace in Massachusetts is undergoing dramatic changes. Hospital rates were deregulated in 1991, permitting insurers to negotiate directly with hospitals. Hospital competition is becoming more intense as a result of the deregulation and continuing growth of managed care. One result has been a considerable number of hospital mergers and consolidations. However, the aggressive cross-cutting competition seen elsewhere is absent in Massachusetts, perhaps because for-profit hospitals have only recently entered the metropolitan Boston marketplace. Consolidation among the strongest academic medical centers has further weakened competitive forces. Competition is impeded because insurers and managed care plans have essentially no alternative but to contract with these networks in order to offer attractive insurance products.

Long-Term Care

Because of high Medicaid expenditures for the elderly and disabled, Massachusetts has focused considerable energy on long-term care policy in recent years. The state's long-term care strategy includes attempts to substitute community-based long-term care services for institutional services whenever possible and appropriate. The state has reduced nursing home expenditures by restructuring admissions criteria, tightening nursing home reimbursement rates, and freezing nursing home bed supply. Massachusetts has developed ambitious plans to integrate acute and long-term care services through managed care. It has also made a concerted effort to have nursing home and home health agencies bill Medicare whenever possible. Finally, the state has moved large numbers of disabled patients out of state mental hospitals and large state intermediate care facilities for the mentally retarded.

Challenges for the Future

Despite the relatively high rate of insurance coverage, the strength of the safety net, and bipartisan consensus to retain government support of health services for the poor, Massachusetts faces some serious challenges regarding the accessibility and cost of its health care system. In particular, the state faces numerous potential obstacles in implementing the MassHealth program. The major issue is whether the program will be budget neutral as required under the Section 1115 waiver. The state has assumed that it can hold its expenditure growth to 4 percent per year. It will have to be very successful in implementing the expansion of managed care in order to achieve this low rate of growth.

In part, the state's success in controlling its own costs will depend on what happens in the broader health care market. A key question facing the state is whether the market will become more competitive. The health care system in Massachusetts is relatively high-cost because of the dominance of outstanding teaching hospitals and the large number of medical and surgical specialists. Will competition bring health care costs down or will the merger activity, particularly among the academic medical centers, exert such substantial market power that costs will not be altered significantly?

The current evidence suggests that it is unlikely that health care cost growth will decline significantly due to pressures to maintain the current high levels of quality and access. This could in turn affect the ability of the state to achieve savings through managed care. If the state cannot continue to manage cost growth because of market forces over which it has no control, the coverage expansion that it envisions could be threatened. In turn, if coverage does not expand, the rate of uninsurance may not decline as is now envisioned. The result would be to place more pressure on the uncompensated care pool and the hospitals that depend on it.

* Please note that these numbers have been corrected since the original printing of this report.

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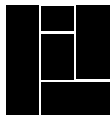
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