

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon
Chairman

Diane Rowland, Sc.D.
Executive Director

MASSACHUSETTS

Randall R. Bovbjerg

Background

Massachusetts is a high-income, moderately high-tax state that has faced severe fiscal pressure since SFY 2001. Voter registration is heavily Democratic, but since 1990, voters have elected fiscally conservative Republican governors balanced by nearly veto-proof, more liberal Democratic legislatures. New Republican Governor Mitt Romney won handily in November 2002, pledging not to increase taxes, but Democrats slightly increased their legislative dominance. Anti-tax sentiment is strong, yet co-exists with pro-expansionary attitudes on public services. Massachusetts ranks high on any measure of public generosity in health care,¹ reflecting its political philosophy, its large medical sector, and pride in its reputation for high-quality care.

In 1997, the state began a comprehensive expansion of public coverage, termed MassHealth, under a section 1115 Medicaid waiver whose fiscal assumptions proved very generous. The next year, SCHIP was integrated into MassHealth. MassHealth covered a very broad set of beneficiary categories and set income eligibility standards very high.² The state also ended asset tests for eligibility. Outreach has been strong, so a high proportion of eligibles actually enrolls. Beyond Medicaid, the state has also

¹ Spillman, Brenda C. "Adults without Health Insurance: Do State Policies Matter?" *Health Affairs* 19(4):178-187 (Jul-Aug 2000). Note that this report does not cite to its interviews; for case study methods see overview chapter.

² Children were covered to 150 percent of the federal poverty level, or FPL (and to 200 percent with payment of a premium), disabled children to 150 percent, parents to 133 percent, and childless adults if disabled or long-term unemployed (to 133 percent). Also, working families may be eligible for premium assistance (to 200 percent of FPL) for private coverage if the worker is in a small firm that pays at least 50 percent of premium. Even beyond these high coverage levels, disabled children or adults of any income are covered if they make sliding-scale premium contributions. Senior Medicare-Medicaid dual eligibles were covered up to 100 percent of FPL (one of 17 jurisdictions going so high). Also, all children through age 18 can participate in the separate Children's Medical Security Plan--with no limit on income. Premiums are required but up to 400% of FPL are moderate; only outpatient care is covered, and there are controls on utilization and provider payment, as well as cost sharing. MassHealth also covered aliens, with lesser benefits depending on their status. For a full explanation of the very broad expansions of eligibility, see Center for Health Policy and Research, UMass Medical School, *Health Care Resources for the Uninsured in Massachusetts: A Road Map to Coverage for Vulnerable Citizens of the Commonwealth*. Shrewsbury, Massachusetts (last updated in April 2000). <http://www.umassmed.edu/healthpolicy/roadmap>.

been one of the few to help pay for hospital charity, has run an unusually generous pharmacy program for the elderly, and is otherwise very generous in health care. Starting with a high rate of employer-sponsored insurance, the state by 2001 had added some 300,000 people to the MassHealth rolls. The state ranked among the nation's lowest in rate of uninsurance.³ Since 2001, however, private coverage has declined, and more recently MassHealth enrollment has also dropped.

General Budgetary Problems and Overall Responses

Growing budgetary stringency since SFY 2001

The main source of budget pressure has been shortfalls in revenue. Record state surpluses occurred through SFY 2001, despite over 40 tax cuts in the 1990s, culminating in a repeal of an income-tax surcharge in 2000. The repeal was worth \$1 billion a year--about a 5 percent reduction in revenue. Problems began in SFY 2002. Tax revenues fell by 14 percent, mainly from the recession but also from the drop in surcharge. Medicaid also overspent its appropriation by almost \$300 million. Since then, revenue trends have remained flat, while spending pressures have grown, especially for health care, debt service, and heavily formula-driven local aid. The SFY 2003 budget had to eliminate a projected deficit was some \$2 billion (almost 10 percent of appropriations).

During calendar 2003, an additional mid-year deficit of some \$650 million faced new Governor Romney in January. Revenue shortfalls were the primary problem; Medicaid did not overspend. The initial budget projections for SFY 2004 suggested a \$3 billion deficit, but fiscal pressure eased somewhat during budget deliberations, and the year ended with a small surplus.⁴ Short-term actions like a tax amnesty brought in more than expected and temporary federal fiscal relief was worth about \$550

³ Six percent of children are uninsured and 11 percent for adults aged 19-64, versus national averages of 12 percent and 19 percent. Data from 2000-2001 from Kaiser Family Foundation, *State Health Facts Online*. <http://www.statehealthfacts.kff.org>

million to the state, combining grant funds with enhanced medical assistance percentage (FMAP).⁵

Overall Budgetary Responses, SFYs 2003 and 2004

Through the SFY 2003 budget, Massachusetts maintained services by increasing revenues and drawing down reserves. About \$2 billion of the stabilization or “rainy day” fund was spent during SFYs 2002 and 2003, in addition to other trust-fund shifts.⁶ The state avoided securitizing future tobacco settlement funds, however. In SFY 2002, Medicaid, i.e., MassHealth, was cut, but very modestly. For SFY 2003, the \$2 billion budget gap was mainly filled through a \$1.2 billion increase in taxation and fees, including the nation’s only income tax increases in that year.⁷ Program cuts did occur, mainly in non-Medicaid programs. The administration proposed more cuts to MassHealth than the legislature accepted. Overall, the SFY 2003 budget grew by only 2.1 percent, half the 4.1 percent rise authorized the year before. Through calendar 2002, the state also shed some 7 percent of its workforce, largely through early retirement, which cut spending but raised pension obligations.

During the first half of SFY 2003, lame-duck Acting Governor Jane Swift made further cuts using her discretionary authority to maintain budget balance, including small ones in health care. In the second half of SFY 2003 new Governor Romney in January sought and received authority (although only for a year) to cut local aid and higher education, previously off limits to mid-year adjustments. The administration made additional cuts in Medicaid and elsewhere, including environmental programs and state operations.

⁴ FY03 Year End Review: Current conditions, future expectations, Eric Kriss, Secretary of Administration & Finance, July 7, 2003. http://mass.gov/agency/documents/eoaf/FY03_Year_End_Review_FINAL.ppt.

⁵ These funds come to states during FFYs 2003 and 2004, nationwide half as grant assistance and half as enhanced FMAP, under the Jobs and Growth Tax Relief Reconciliation Act of 2003, also called the stimulus bill, Public Law No. 108–27, 117 US Statutes at Large 752, May 28, 2003. Exactly how much FMAP a state gets depends of course upon how much it spends in state and local funds.

⁶ E. Matthew Quigley, “Preparing for the Storm: Rainy Day Funds in New England,” *New England Fiscal Facts*, Federal Reserve Bank of Boston, Summer 2003 No. 31. <http://www.bos.frb.org/economic/neff/neff31/storm.pdf>.

Faced with a larger gap for SFY 2004, some \$3 billion, the state cut spending by larger amounts, stopped spending down reserves, and relied less on revenue increases. New Governor Romney's adamant opposition to taxes seems to have been influential and was largely accepted by the legislature, even though some leading Democrats had called for significant tax increases. Some revenue increases were passed: over \$100 million in corporate tax "loophole closing," some \$400 million in higher fees, and about \$350 million in one-time shifts--plus new Medicaid maximizations. A smaller than usual amount of inter-fund transfers occurred; but there was no new borrowing, pension recapitalization, or securitizing of tobacco revenues--which the administration disdained as "fiscal gimmicks."

On the spending side, the budget sharply cut local aid and slowed Medicaid growth. Romney successfully argued that localities' finances were stronger than the state's and that Medicaid and other services had grown beyond "real need."⁸ Local aid was cut by \$230 million, almost 5 percent. Cuts to higher education were even greater, continuing its slide since 2001. Medicaid cutbacks totaled about \$500 million below the preexisting trend, but spending was still budgeted to rise about \$500 million (9 percent). Many cuts affected the much smaller public health programs, such as the tobacco control program. Other than Medicaid only K-12 education and debt service rose. Everything else was cut, so that the total SFY 2004 budget increase was only about 1 percent above adjusted SFY 2003 spending.

The SFY 2004 budget also accepted many of Governor Romney's proposals to reorganize health care administration to achieve administrative efficiencies. In the face of legislative resistance, a pension reform proposal was quickly withdrawn. In general, the legislature gave health care somewhat

⁷ Nicholas W. Jenny, *2002 Tax and Budget Review and 2003 Budget Preview* (Nelson A. Rockefeller Institute of Government, Fiscal Studies Program, March 2003, State Fiscal Brief No. 66). http://stateandlocalgateway.rockinst.org/fiscal_pub/state_fb/FB_66.pdf.

⁸ Governor's Message & Executive Summary, February 26, 2003, <http://www.mass.gov/budget/downloads/>. The Message continues "for every three taxpayers, there is one person getting free health care. This is not fair, and it's not right." The

higher priority than the governor; being able to tap some of the federal fiscal relief helped, although the governor succeeded in saving most of the funds (grant and temporarily enhanced-FMAP alike) in trust for the future. The governor vetoed about \$200 million of largely non-health-care spending, but three quarters of this was overridden. Since the budget was approved, there has been further sparring over supplemental revenue and spending bills, with mixed results.

Specific Impacts on Health Care

MassHealth

MassHealth (including traditional Medicaid and SCHIP) was largely protected from cutbacks through the SFY 2003 budget, and Medicaid appropriations grew about 8 percent that year, well above the 2.1 percent overall rise. Significant cuts began in mid-year SFY 2003. The final SFY 2004 budget made many more and much larger cuts. The immediate cuts were less than initially proposed by the incoming governor and feared by advocates; the broad sweep of MassHealth remains; and Medicaid spending still grew by 9 percent. However, a shift toward contraction has begun, which the governor has clearly articulated. The governor won legislative acceptance for almost all the cutbacks sought in spring 2003, fully 61 separate changes affecting most parts of Medicaid, saving \$553 million.⁹ In general, cuts targeted adults much more than children.

Provider payment had the biggest cuts in mid-SFY 2003, affecting hospitals, nursing homes, physicians, CHCs, druggists, and MCOs. The cuts averaged 3-5 percent, varying by provider and by service. Because they took toward the end of SFY 2003, the full cuts were felt only for SFY 2004 and beyond. For nursing homes, the initial cuts were more than offset by a complex bundle of rate in-

Executive Summary notes that local property taxes grew by 6.4 percent in 2002, while state tax collections declined by 14.6 percent.

⁹ MassHealth Overview, March 2003, Douglas Brown, Acting Commissioner, Division of Medical Assistance http://www.bcsmfoundation.org/foundationroot/en_US/documents/massHealthoverview.pdf. (PowerPoint presentation).

creases funded through a new assessment on homes, plus the additional federal matching amounts drawn down by the higher payment rate for homes. The administration sought to economize in 2004 by phasing in increases, but the legislature barred any administrative reallocation of such savings and also required that the administration pay out the full appropriated amount during the year, thus barring any mid-year administrative reductions. Pharmaceutical rates were initially set to decline from "wholesale acquisition cost" (WAC) plus 10 percent to WAC minus 2 percent. But at a legislatively required hearing, participating pharmacies all threatened to quit, and compromised at WAC +6 percent, along with changes in dispensing fees that favored generics.

Benefits cutbacks started with the dropping of adult dental services in SFY 2002. Five more optional services were cut in the first half of SFY 2003, including prosthetics, orthotics, and eyeglasses, but some were reinstated for SFY 2004. The state later somewhat raised drug co-payments, required some ancillary therapies to get prior authorization, expanded the state drug list to promote generics, enrolled some high cost members in care management, and made other small reductions, some of which arguably maintained or improved overall quality of care. One change believed to be an improvement is a Senior Care Options plan that coordinates care for dual eligibles, now being phased in almost on a demonstration basis.

Eligibility cutbacks took many forms. Two eligibility categories were cut. Long-term unemployed adults--a special Massachusetts category, about 50,000 people--were dropped in April 2003, though some re-enrolled as disabled. For SFY 2004, most of these were re-enrolled in a similar new program that began operations in October 2003, MassHealth Essential. However, Essential has a lower income eligibility ceiling and fewer benefits, its funding is capped, and it is authorized only for SFY 2004. Also cut in SFY 2004 were special status immigrant adults--legal residents not eligible for federal match after welfare reform, except for emergency services, which continued to be covered for

most of the prior reform enrollees. Caps on enrollment and new waiting lists have changed some parts of Medicaid to a non-entitlement program more like SCHIP. Caps have been promulgated so far to Essential (above) and to two smaller MassHealth programs, but implementation awaits federal approval.¹⁰ Cuts in eligibility standards of various magnitude were also passed for SFY 2004, including a reinstatement of eligibility asset tests for adults 19 to 65, changes to asset transfer rules; and a lower income eligibility level for HIV-waiver enrollees. Some of these changes are also pending federal waiver approval. Changes in processes of eligibility determination also occurred, premiums and cost sharing were sought to the extent allowed by federal law and outreach was reduced.

New revenues for MassHealth were sought from several sources other than traditional state taxes. One source was Medicaid maximization. The state sought to tap new sources of revenues to support MassHealth and thus draw down more federal support. Most notable was the new assessment on nursing home days for non-Medicare patients, noted above. The governor also proposed a new assessment on health insurers to help fund MassHealth in SFY 2004, but this was withdrawn during budget discussions. Starting in SFY 2003, a new “user fee” of \$1.30 was legislated on all pharmaceutical prescriptions, but was ultimately abandoned after very strong industry resistance and an adverse judicial ruling. Lesser revenue increases came from some rises in premiums and co-payments, as well as from expanded recoveries against the estates of Medicaid beneficiaries.

Prescription Advantage and the Uncompensated Care Pool

These programs are two of the ways in which Massachusetts stands out as more generous than other states. Governor Romney initially sought to de-fund Prescription Advantage, a very generous drug program mainly for elderly and for disabled persons; but the final budget maintained it, with trims. De-funding seems to have been requested more to pressure federal officials to approve a Phar-

¹⁰ Also affected are Family Assistance for HIV expansion members and working adults in small firms and CommonHealth for adults.

macy Plus waiver (unsuccessfully) than to pressure the legislature to stop spending. The program was maintained, but its enrollment period was limited to once a year. The final budget for SFY 2004 also boosted support for the Uncompensated Care Pool that provides free or reduced-fee charity care in hospitals and community clinics and also covers emergency bad debt. The Pool is not an entitlement program, and it has long been mainly funded by assessments on hospitals and health plans. The state's funds from traditional revenues are more than offset by the large annual federal DSH contribution drawn down by the Pool (payments for disproportionate share hospital programs). Because charity demand and costs rise over time while Pool budgets are fixed, financing had to be reformed in 1997 (with assistance from the MassHealth waiver), and another refinancing occurred for SFY 2004. The legislature was more generous than the initial administration proposal, partly because of the new availability of federal fiscal relief and new revenues from intergovernmental transfers from two localities where hospitals receive large amounts of Pool funding. The IGTs were used to raise hospital Medicaid rates and thus draw down open-ended federal match in addition to the capped DSH contribution. A new reform commission was also created and directed to find a more permanent solution. It is expected to control Pool payments to hospitals and to shift Community Health Centers' current payments from the Pool into higher MassHealth rates, so as to get open-ended federal match.

Employee Benefits and Reorganization of Health Care Administration

The SFY 2004 budget somewhat changed employee health benefits, but less than the governor's proposal to provide only level funding for employee health benefits and give group-benefit administrators new discretion over benefits. The final budget, however, merely increased the contribution that state employees make to their health care costs from the previous 15 percent to a sliding scale depending on the employee's salary. The legislature also largely accepted Governor Romney's reorganization of health agencies, which altered traditional stand-alone administration of what the Secretary terms "mission agencies" (like public health and mental health), merging provision of services

with the associated aspects of Medicaid. Four new offices were created involving 15 agencies, and the central Secretariat was strengthened. The reorganization plausibly will help streamline operations, assure that full FMAP support is sought for mission-agency services, and allow the administration to speak with one voice. In the 1990s a similar proposal would have brought the Department of Health within a Medicaid-oriented structure, and health advocates helped defeat it in part to maintain a separate voice for health.¹¹

The Future

The long Massachusetts expansion in public coverage may well be ending, given ongoing budgetary stringency and a shift in the political climate. The budget crisis is arguably the precipitating event, as it helped elect Governor Romney and constrained legislative preferences. MassHealth caseload declined about 7 percent during SFY 2003, even before significant change occurred in eligibility standards--whereas rises are expected in a recession. Enrollment still exceeds 900,000, well above the pre-expansion level.

Budgetary pressure will continue for the immediate future. Revenue collections during SFY 2004 are running slightly ahead of budgetary assumptions, but still well below prior trends, while health spending continues to grow.¹² Such divergence seems unsustainable, as health care already constitutes about a third of the budget, counting MassHealth, Prescription Advantage, the Uncompensated Care Pool, and employee health benefits. Early projections forecast a SFY 2005 deficit of about \$2 billion, driven by low revenue growth and high spending increases for health care,

¹¹ See John Holahan, Randall Bovbjerg, Allison Evans, Joshua Wiener, and Susan Flanagan, *Health Policy for Low-Income People in Massachusetts* (Washington, DC: Urban Institute/Assessing the New Federalism, November 1997). http://www.urban.org/UploadedPDF/Hp_mass.pdf.

¹² Massachusetts Department of Revenue, *Briefing Book*, FY2005 Consensus Revenue Estimate Hearing, December 8, 2003. http://www.mass.gov/eoaf/FY2005_ConsensusRevenueEstimateHearing.pdf.

pensions, and debt service (up some \$1.6 billion). Accumulated debt is very high, and the bond rating remains middling.

Many continue to support expansion of coverage. But support for contraction has grown substantially, on grounds of ideology as well as immediate budgetary stringency. The administration has articulated the need to limit the share of population that can expect public help and has called for more sharing of responsibility by individuals. For health coverage, this has meant capping some enrollments, higher premiums and co-payments, and executive reorganization to support fiscal restraint and more centralized control. The legislature for SFY 2004 accepted budgetary constraint; it also approved the reorganization--very unlike the mid-1990s rejection of then-Governor William Weld's similar proposal.

For these reasons, SFY 2005 looks like a difficult year for Medicaid in Massachusetts.