Prices of Equitable Access: The New Massachusetts Health Insurance Law

by Alan Sager

Massachusetts's new health insurance law has been shaped by much more than presidential politics. Ten years of evolving policy on health insurance and hospital finance have exerted powerful influences. Ironically, enacting universal access required paying hospitals much more money for their currently insured patients. This costly compromise may destabilize the law's implementation.

For decades, the United States has remained the only industrial democracy without universal entitlement to health care. On April 21, 1988, Governor Michael Dukakis signed a universal health insurance bill making Massachusetts the first state to promise health insurance to all citizens, and the second (after Hawaii) to require employers to offer insurance to workers.[1]

How did Massachusetts pass a law that has proven so elusive nationally? What are its main provisions? Will the new law be phased in successfully or will high costs ultimately block introduction of universal access? Will the Massachusetts legislation demonstrate to the nation the financial feasibility of equal access to care or instead convince others that such access provisions are unaffordable?

Answering these questions will require careful monitoring and evaluation over at least the next five years.[2] However, analyzing the direction and power of the forces that impelled the new bill into law can inform projections about its trajectory. These forces include Massachusetts politics, economics, and health care; the specific evolution of health policy in the Commonwealth over the last decade; and the perspectives and power of interested parties.

***Alan Sager** is associate professor (health services) at Boston University School of Public Health.*

Forces Shaping the Law

Economics, Politics and Health Services. Massachusetts currently spends much more money to provide health care to a slightly greater insured population than the national average. In 1986, the state ranked first in the nation in both hospital spending per capita and in physician-to-population ratio.[3] Massachusetts ranked thirteenth in proportion of its population with health insurance in 1985, with about 13.1 percent of the population under age 65 uninsured, a figure one-quarter below the national average. Yet despite health spending that is 20 to 25 percent per capita above the national average, Massachusetts currently devotes a lower-than-average share of gross state product to health care, as its per capita product is as high as 40 percent above the national average.[4]

A vigorous state economy has smoothed the path of those who would devote more money to public purposes. In recent years, Massachusetts's economy has grown much faster than that of the nation as a whole. For four years, the unemployment rate has been the lowest among industrial states. These factors have enabled Massachusetts to collect considerably more in state and local taxes per capita without exceeding the average national tax burden.[5]

In the fall of 1986, a nonbinding Massachusetts referendum calling for a comprehensive national health program was approved by two-thirds of the voters. The following spring, a survey indicated a willingness among 80 percent of the respondents to pay higher state taxes in order to finance universal access.[6] This declared support for improved health care access coexists with two Massachusetts laws passed by referenda in this decade to limit growth in both state and local taxes.

Although universal health insurance has enjoyed broad appeal in Massachusetts, this has not translated smoothly into political support in the legislature. Business, especially small business, has feared its costs; labor support has not been enthusiastic. Many legislators have worried about higher financial burdens on state government, especially if the economy were to enter a recession. Various individuals desiring universal access have feared that its costs, combined with higher spending for already insured patients, would be very expensive in the absence of reform in hospital payment mechanisms. However, hospital lobbying

has blocked consideration of any such reform.

Health Policy: Cost Control, Access, and Competition. Since the 1970s, increasing health costs, and high hospital costs in particular, have prompted a number of regulatory responses in Massachusetts. The state was among the first to implement certificate-of-need legislation and controls on hospital charges to commercial insurers. Perceptions of accelerating hospital cost increases led the state's Rate Setting Commission in 1981 to encourage Blue Cross and state hospitals to adopt a method of prospective payment. This program was expected to save money by giving hospitals an incentive to act more efficiently. Hospital revenues would depend on a base-year cost, increased to account for inflation, technology, and volume changes. A hospital would be allowed to keep any revenues received in excess of its costs of providing care, but was at risk should costs exceed revenues. Private insurers, business leaders, and state officials persuaded Massachusetts hospitals to accept a six-year implementation of this system in 1982 and these essentially private negotiations were subsequently ratified by the legislature in chapter 372 of the Acts of 1982.

However, a widespread concern was that cost control methods might endanger access to care for vulnerable patients. Advocates of equitable access feared that hospitals might respond to the incentives of the prospective payment system by reducing care to uninsured patients. Indeed, some hospitals mistakenly perceived the existence of such incentives and cut services used disproportionately by lower income patients.

The legislature had, perhaps in anticipation of such a response from hospitals, provided a guarantee of full payment for uncompensated care in the chapter 372 law. Subsequently, in 1985 a free care pool mechanism was established, funded by a surcharge on businesses and workers paying hospital bills, which has protected hospitals that provide above-average amounts of uncompensated care. As a result, uncompensated care as a share of hospital costs rose by 25 percent between 1984 and 1986, in contrast to a decline nationally. These provisions seem to be correlated with improved access for Massachusetts's uninsured citizens.[7]

By 1985, however, hospital, insurance and some business elements saw the chapter 372 system of regulating hospital payment and access as inferior to a more competitive approach to hospital payment and health care delivery. Yet the various parties articulated very different conceptions of competition. Hospitals, for example, sought increased freedom of action relative to health maintenance organizations and other ambulatory care providers; Blue Cross wanted to exercise its market power, while commercial insurers hoped to use preferred provider organizations to protect themselves against Blue Cross; and business sought opportunities to get hospitals to bid down their prices.

The complexity of hospital financing and the inability to reach easy agreements in 1985 led the legislature to postpone all but the most pressing changes until 1987. In chapter 574 of the Acts of 1985, the legislature scheduled all major provisions for paying hospitals to expire on September 30, 1987. In the interim, it was hoped that the various parties could formulate a comprehensive successor plan.

From Commission to Legislation

To negotiate this plan, chapter 574 called for the governor to appoint a Study Commission on Health Care Financing and Delivery Reform, whose members represented hospitals, insurers, business, labor, state government, consumer advocates, and others. The Commission's mandates were to design a new method of paying hospitals, to shape a more competitive delivery system, and to clarify relations between Blue Cross and commercial insurers. The commissioners reached agreement on only one important matter, and then only in principle: Substantial movement toward a more competitive health care system would shatter the method of pooling uncompensated care costs to buttress access. The Commission was unable to come to any important practical agreements.

First, while most members desired greater competition, its nature continued to be a source of disagreement. Second, while all agreed on the need to entitle uninsured citizens, no party was anxious to assume the bill. Representatives of the Dukakis administration were adamant that no new state money be allocated for insuring access. Representatives from big business believed it was already paying enough, both for its own workers (through health insurance) and for the workers of firms that did not offer insurance (through the free care surcharge). Small businesses feared the price tag that would accompany any mandate that they offer insurance. Third, there continued to be conflict between insurance industry representatives. Finally, hospitals demanded a substantial increase in revenue for serving currently insured patients, arguing that they had been squeezed too tightly by chapter 372 regulations and that Medicare reimbursement was increasingly inadequate.

The Commission was originally scheduled to issue a report in April of 1986, allowing legislators adequate time to review and debate its proposals before enacting a new law. It was not until February 1987, however, that the majority of the commission issued a set of consensus principles (hospitals dissented from even these). The recommendations signaled an inability to propose comprehensive reform, for which the commissioners were vigorously criticized in hearings two months later before the legislature's Joint Health Committee. The Committee promised to introduce a comprehensive bill, and in August it approved one whose access components were modeled closely after a proposal from Patricia McGovern, chair of the Senate Ways and Means Committee. McGovern's persistent advocacy of universal insurance was a powerful force for combining equal access provisions with hospital financing provisions in this bill.

The bill's access component called for a 5 percent payroll tax on all employers, up to 90 percent of which would be rebated to firms offering health insurance, and significant new state spending to subsidize insurance

to lower income workers and unemployed citizens. This measure was designed to circumvent the federal prohibition, in the 1974 Employee Retirement Income Security Act (ERISA), of state mandates that employers offer insurance. The hospital finance component of the Committee bill promised all facilities increased revenue for providing care for already insured patients. All received annual price increases equal to medical care inflation plus 1 percent, and a $100 million catch up payment was allocated for hospitals thought underfunded. The costs of this component were to be borne by business and workers.

In June, Governor Dukakis had promised to introduce his own legislation. He feared being excluded from a process that might succeed even without him. And he hoped his intervention could promote passage.

The governor's proposal, submitted in mid-September, relied much more heavily on raising money from business, through a 12 percent unemployment tax "surcharge" on the first $14,000 of each worker's income. Firms providing health insurance would receive a credit to offset some or all of this surcharge. The state would provide much less new money than requested by the Health Committee bill, but where state money was not involved, the Dukakis proposal was comprehensively ambitious. It sought to re-orient relations between Blue Cross and commercial insurers in order to encourage more price competition. It merged increased state financing and regulatory powers in a new superagency, and also proposed far-reaching access and quality protections. The state would be given authority to enforce all patients' rights to equal treatment, and to closely monitor health outcomes.

The Massachusetts House debated the Dukakis proposal shortly after the expiration of the existing law. The bill was vigorously opposed by the hospital association, despite a House concession to allow hospitals to increase their charges during the first year by 3 percent above medical inflation. Lobbyists for the hospitals claimed that quality of care would suffer, that workers would be underpaid, that vital jobs would go unfilled, and that Massachusetts would forfeit its medical leadership. Big business elements were upset at the prospect of higher payments to hospitals in the absence of effective cost controls, while small businesses feared the cost of mandated insurance. Labor leaders were also unenthusiastic about universal health insurance under a state mandate; most preferred to bargain for health benefits on behalf of their members. The Governor and his allies did little to build broad public support in favor of universal access, and early in October the House voted overwhelmingly to table the bill.[8]

Sen. McGovern then moved to pick up the pieces. A skilled politician committed to universal access, she drew several conclusions (accurately, as it turned out) from the defeat of the Dukakis proposal: No bill would pass without hospital support; it would take considerable new state spending to make universal access affordable to workers and acceptable to small business; big business did not command effective political influence on this issue; and access and hospital finance would have to be the two main concerns on which to focus.

McGovern reshaped the Dukakis bill to reflect her conclusions. She negotiated a compromise that passed the Massachusetts Senate late in 1987, but the legislative session ended before House action. The House debated its own version of McGovern's bill in February and passed it (by an 81-72 vote) in March. The House further reduced small business costs and further increased payments to hospitals. Senate passage (19-15) followed two weeks later. Disagreements between the two versions were resolved by a conference committee. The more vocal opponents to the final bill included on one side legislators who feared its cost, and on the other, those who felt that hospitals in their districts were still underfunded.

In the end, the bill passed mainly because its proponents accepted both higher business/worker payments to hospitals for patients already insured, and higher state payments on behalf of uninsured citizens. The final bill differed from most earlier versions in that it gave more money to hospitals, imposed higher financial burdens on state government (for example, by exempting businesses with five or fewer workers from the mandate to provide insurance or pay a surcharge to the state), deferred universal insurance longer, and was less specific about benefits and premiums for newly insured citizens.

Provisions and Implementation

The new bill, chapter 23 of the Acts of 1988, is entitled "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing." The bill thus has two distinct concerns, and while media accounts have focused almost entirely on access provisions, the law probably provides hospitals with payments for their currently insured patients that are almost double the amount of new spending to improve access.

Over the next four years, hospitals are expected to receive as much as $1.5 billion in additional Blue Cross, commercial insurance, and other private sector payments for serving their currently insured patients. Hospitals will even receive up to $50 million yearly in state funds, if Medicare payment increases fail to keep up with inflation—even if hospitals still profit on Medicare patients. Moreover, if hospitals admit more patients (and they have strong new incentives to do just that), their revenues will increase further. Almost all of these payments flow from private insurers directly to hospitals.

By contrast, while the law's access provisions are intended to provide an insurance entitlement to each Massachusetts citizen, they will be *phased in* over a period of four years. In addition, all state funds to improve access must be appropriated annually. New appropriations for access may be subject to the state's tax cap. If so, they must compete with local aid, public works, state worker salaries, and other worthy needs. The access provisions are estimated to cost between $600 and $800 million in new state money over the next four years.[9] Particularly in 1992 and the years following, new business payments and worker premium and out-

of-pocket payments will be required.

A first phase of implementation will make available supplemental Medicaid coverage to as many as 3,000 disabled adults and children beginning in July 1988. Two demonstration projects to test insurance/managed care for newly entitled citizens will be launched if funding is available.

In the second phase, a new state Department of Medical Security will begin managing the uncompensated care pool to buy insurance coverage for unemployed citizens. The state will *arrange* insurance, not provide it. Although a cap will be imposed on business contributions to the pool, higher annual state payments may permit this fund to insure large numbers of people who are unemployed. Managed care would be used to attempt to contain costs.

In a third phase, from July 1989 to September 1989, small businesses will become eligible for partial tax credits if they initiate health insurance coverage for workers. Students will be required to demonstrate insurance coverage when they register for college.

In April 1991, health insurance will be made available to workers already receiving unemployment insurance. The estimated cost of this program is $30 to $40 million yearly.

Finally, in April 1992, all firms with six or more workers will be required to pay $1,680/worker annually to a state fund (subsequent payments will be increased for medical care inflation). Health insurance payments made by employers will reduce or eliminate this obligation. The state fund will broker insurance for workers whose employers pay into the fund, as it will for employees of smaller firms, whose costs will be assumed by the state.

The provisions for insuring employed or unemployed citizens through the Department of Medical Security are somewhat vague. Coverage extends to those services "typically included in employer-sponsored health benefit plans." Citizens insured through the state will pay premiums on a scale directly related to income, but persons whose incomes "substantially exceed" the nonfarm poverty level will pay the full actuarial cost. Unspecified out-of-pocket payments are permitted.

The new law thus allows a great deal of administrative discretion. If costs of insurance are low, or if state appropriations are generous, the financial burdens on newly insured citizens are likely to be light.

Prospective Possibilities

Will the new law succeed in its aims of bolstering hospitals' finances and entitling all Massachusetts citizens to health insurance? Two polar views can be entertained. The reality will most likely fall somewhere in between.

An Optimistic View. Some of the legislation's cost control elements work as planned. Its sanctions against low-occupancy hospitals force some to close. Price competition among hospitals encourages more efficient service provision during routine admissions, and drives payment per admission below maximums allowed. Hospitals do not increase admissions even though they will receive full average cost for new admissions. Payments to hospitals prove adequate to meet institutions' operating and capital costs.

Physicians find it easy to work with insurers of newly entitled citizens; out-of-pocket payments are kept low; and access to care is expanded smoothly.

As a result, insurance premiums increase but remain affordable for businesses. Those with more than five employees find the costs of providing insurance bearable.

Higher hospital costs worry legislators but not enough to motivate a retreat from the promise of universal access. As it is implemented, managed care proves helpful in controlling costs without placing inappropriate limitations on services. During the transition to universal access, the uncompensated care pool is enlarged with state general revenues and proves adequate to finance needed services.

The Massachusetts economy continues to thrive. This helps employers afford higher hospital charges, and allows the state to finance new access-related spending without exceeding the tax cap.

A Pessimistic View. Hospitals receive higher revenues, but insist that even these are not adequate.[10] They deliver more care, which is enormously profitable because they now receive full average cost, not the more appropriate marginal cost, for increased admissions. With admissions and occupancy rates up, hospitals have little need to bid down their prices to attract patients. Hospital closings save little money because displaced patients are simply admitted to those institutions that remain open and that typically have higher average costs.[11]

Higher prices and higher volumes prove an explosive mix, driving insurance premiums up rapidly. Businesses respond to these increases by raising worker out-of-pocket costs and by closely scrutinizing service, all to little effect.

A combination of cumbersome insurance procedures and low payment rates (paralleling those of the Medicaid program) deter physicians from granting newly entitled patients effective access to primary care. Hospitals reduce uncompensated care, causing access to suffer. High out-of-pocket costs and restrictive managed care arrangements further compromise access.

Businesses soon to be required to offer insurance are so worried about costs that they appeal for a delay in discharging their 1992 obligation. The state similarly fears that it will be unable to pay its share of the costs of care for both unemployed citizens and for those working for small firms.

The Massachusetts economy enters a recession, but as the state is precluded by the tax cap from raising taxes to balance the budget, it is forced to cut its health spending. Businesses are obliged to raise workers' out-of-pocket payments still further because of high hospital costs. Hospital admissions consequently fall, and hospitals try to cut costs and prices to maintain occupancy rates. Revenues fall faster than expenses, however, and even large institutions face bankruptcy.

Lessons from the Process

Neither of these extreme views is likely. Much tinkering can be

expected. But for several reasons an outcome closer to the second is more probable. The financial viability of the legislation has been undermined by the very political compromises necessary to win its passage. The political power of hospitals is so great that they were able to hold universal access to health care hostage until they received assurances of more generous payments for current patients. Most advocates of broader access in the administration and legislature as well as outside of state government did not vigorously challenge hospital payment increases because they believed universal access could ride to enactment only on the back of those increases.

Consequently, almost all parties have pretended that hospital financing and universal access were separate and distinct. The reality that these provisions ultimately compete for the same scarce funds was ignored. This ignorance is sustainable so long as the Massachusetts economy is prosperous. When it slides into a recession, only the date of which is unknown, difficult trade-offs will be inevitable.

Given the demonstrated political influence of hospitals, they appear likely to win any subsequent struggle with access advocates over increasingly scarce funds. This result is especially likely if hospitals and their allies can persuasively point to provisions for universal access as the major cause of any future explosion in hospital costs.

In coming years, it will be important to distinguish the effects of the new law's two major components on access, cost, and quality of care in Massachusetts. Fortunately, in this respect, the timing of the implementation of each provision provides an opportunity to identify the consequences of each, for hospital charges will rise well before major improvements in insurance coverage are planned.

It may be that Massachusetts simply provides a difficult test of the affordability of universal health insurance. The enormous political and financial power of Massachusetts hospitals is a formidable obstacle to financing equal access. Mandated insurance may be affordable in Hawaii, but in 1986, hospital costs per capita in that state were exactly half those in Massachusetts.[12]

The Moral Burden of Hospitals

Few of the parties interested in improving health care access were unaware of these lurking difficulties. Most felt that the law that has been passed was the best compromise that could be achieved. Some thought that universal insurance, by bringing all patients (and thereby higher costs) into the system, would provide pressure for genuine cost control. Others were sanguine about the prospect of tremendous cost increases, assuming that higher spending for health care could be borne, that this direction was beneficial for the state's economy, and that in any case higher costs were a reasonable price to pay for universal access.

Neither of the alternatives—leaping to a comprehensive national health program or incrementally linking improved access with hospital cost control—has commanded much political support in Massachusetts (or anywhere else in the nation). That may change if the present law proves prohibitively costly either for business or to the state, and especially if it also destabilizes hospitals' own finances, as imagined in the pessimistic view.

It is to be hoped that hospitals will recognize their own stake in helping to shape a system of health care affordable to all. By international comparisons, the United States already spends enough on health to finance needed care for all its citizens. By interstate comparisons, Massachusetts's spending is certainly sufficient. One study has suggested that $475 million annually could be saved in Boston alone if the policies of that city's hospitals and the practices of their physicians were similar to those of their counterparts in New Haven.[13] If one-fifth of this rate of savings were extended statewide in Massachusetts, there would be funds adequate to finance all of the access provisions of the new law.

Massachusetts hospitals have found that demanding more money is the path of least resistance. More money solves their short-term problems. It also obviates thoughtful reform in medical resource allocation. If hospitals and physicians could be encouraged to spend our money more wisely, they could help make equitable access durably affordable.

Acknowledgements

Comments from Robert Master, Allan R. Meyers, Robert Restuccia, Susan Sherry, and Steven Tringale are greatly appreciated.

References

1 "Massachusetts Enacts Health Bill," *Boston Globe,* April 14, 1988.

2 Since October 1, 1982, perhaps $20 billion in payments to Massachusetts hospitals has been governed by the state's chapter 372 regulatory system. The consequences of this experiment for access, cost control, effectiveness of care, or the configuration of health services in the commonwealth have not been evaluated systematically. Nonetheless, the law is considered to have failed and is being abandoned.

3 American Medical Association, *Physician Characteristics and Distribution of Physicians in the United States, 1986* (Chicago: The American Medical Association, 1987).

4 Alan Sager, "Prospects for Universal Health Insurance," *Law, Medicine, and Health Care,* forthcoming, Table 3.

5 Cal-Tax Research Bureau, "California Taxing and Spending," February 1988, (developed from data in U.S. Bureau of the Census, *State Government Finances in 1985* and *Governmental Finances in 1984-85).*

6 "Dukakis Takes Reins of Health Care Bill," *Boston Globe,* June 29, 1987.

7 Alan Sager, "Changes in Financing Uncompensated Hospital Care in Massachusetts, 1982-1987: Motives, Mechanisms, and Meanings for Access," to appear in a forthcoming Pew Fellows book, Marion Ein Lewin, ed.

8 House bill 5310, chapter 23 of the Acts of 1988.

9 "Governor Sees $622 million Cost for Health Bill," *Boston Globe,* April 21, 1988.

10 For a preview, see Mitchell T. Rabkin, "Dear Doctor," (Boston: Beth Israel Hospital, April 19, 1988).

11 Donald S. Shepard, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs: A Preliminary Model and Applicaton," *Health Services Research* 18:4 (Winter 1983), 513-49; Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Services Research* 18:3 (Fall 1983), 451-75.

12 American Hospital Association, *Hospital Statistics, 1987* (Chicago: The American Hospital Association, 1987).

13 John E. Wennberg, Jean L. Freeman, and William J. Culp, "Are Hospital Services Rationed in New Haven or Over-utilized in Boston?" *The Lancet* (May 23, 1987), 1185-89.