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Mass. reform has nation's attention

HEALTH CARE REFORM | PART 1 OF 6

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BOSTON — Dr. Alasdair Conn examines a digital map of the Massachusetts General Hospital emergency room showing 49 beds color coded by status: ready to release, awaiting transfer, undergoing treatment. A click on his mouse uploads a patient's test results and vital signs. But it's the warning at the top of the screen that raises Conn's eyebrows: "Critical."

That's not the patient's status. It's the ER's status.

On this early December afternoon, 119 people crowd the hospital's emergency room in Boston's West End. They fill the lobby and lie atop gurneys crammed into nooks and lining hallways. The hospital's emergency room treats between 250 and 275 patients a day, about 90,000 annually, said Conn, Massachusetts General's chief of emergency medicine. The department, in the midst of a two-year expansion, is designed for 60,000 annual visits. Over time, as other hospitals closed or nursing homes opened nearby, the visits crept slowly higher. Then a spike in visits several years ago prompted closer examination.

"It was the newly insured," Conn said. "The biggest jump, 60 percent of our jump, was people between the ages of 20 and 45 who had no contact with the health care apparatus before, were newly insured and didn't have a primary care doctor."

When Massachusetts enacted its version of universal health care six years ago — the first state in the country to do so — state officials and hospital administrators expected emergency room visits to drop. They assumed the newly insured would seek treatment for flu, sprains and other non-life-threatening situations from primary care doctors. Instead, emergency rooms across Massachusetts are still packed with people seeking treatment for non-emergencies. Between fiscal years 2004 and 2008, ER visits swelled 9 percent to about 3 million per year, according to a state Division of Health Care Finance and Policy report from 2010. In 2008, the bulk of those patients — 82 percent — were treated and sent home. The report classified nearly half of those outpatient visits, which cost more than $500 million, as avoidable or preventable — meaning those patients should have sought treatment from a family doctor or clinic.

Another troubling fact for the health care reform law — sometimes called Chapter 58 for its place in the legislative statutes — was cost. Legislators raised taxes on cigarettes and dropped some legal immigrants' health benefits to close a budget gap, which some blamed on the health care law and others on the economy's collapse. (Massachusetts' highest court last month ordered the state to restore the immigrants' benefits.) Boston Medical Center, which treats a high percentage of patients covered by state programs, sued the state for cutting its reimbursement rates and, according to hospital administrators, threatening its livelihood. A judge later dismissed the case. After the plan's implementation, prices for treatment and insurance premiums continued to rise. Today, Massachusetts has the highest health

care expenditures in the U.S. If costs aren't contained, the federal Centers for Medicaid and Medicare Services expects health care costs to nearly double to $17,872 for every person in the state by 2020, up from $9,278 in 2009.

What worries many Massachusetts health officials is that despite the ever-escalating costs of providing universal health care, the number of people who can't afford insurance or care has increased, according to the Urban Institute, a nonpartisan research group. And mirroring the nation, the state has a shortage of primary care physicians. Among non-elderly adults, one in five reported having trouble finding a doctor who will see them, the Urban Institute found.

New patients waited an average 36 days see family physicians in 2011, according to the Massachusetts Medical Society, which called doctors' offices to determine appointment availability. The same study found that only 47 percent of primary care doctors were accepting new patients.

Some studies indicate that more of the state's insured residents are seeking preventive care, including dental treatment. An Urban Institute survey of Massachusetts residents found that 53 percent of the respondents reported their health status "very good" or "excellent," up from 46.7 percent in 2006. But no research has been done to determine whether the reform law has improved the overall health of Massachusetts health care recipients.

A precursor for the nation?

Many have looked at the Massachusetts experience as foreshadowing what could lie ahead for the rest of the country as the health care system undergoes sweeping changes.

Provisions of the national plan have already taken effect — preventive care benefits, changes to Medicare payments, elimination of lifetime maximum health insurance benefits — while countless others await implementation — mandates for health insurance coverage, expanded Medicaid eligibility, government-run health insurance shopping.

Massachusetts' law served as the blueprint for the Patient Protection and Affordable Care Act, the national health care reform law adopted in 2010. The Obama administration sought out key actors from the Massachusetts initiative to craft and promote its efforts, including an economist from the Massachusetts Institute of Technology and the former directors of the advocacy group Health Care for All and the Massachusetts Health Connector, the state agency overseeing subsidized insurance and helping individuals and small businesses shop for plans.

The Obama administration touts the federal law as a health care system cure-all: a cost-cutting, quality-enhancing, insurance-industry watchdog. Opponents deride it as a competition-crushing, freedom-imposing money pit.

Many components of the Massachusetts and federal laws overlap: the mandate that individuals carry health insurance, the requirement that many employers must offer plans, subsidies for the poor to buy insurance. It's not an exact predictor. Massachusetts did not require free preventive care. And its plan made no attempt to control costs — a key point in the national legislation and an issue that Massachusetts lawmakers have just begun to tackle. But as the nation stands poised to revolutionize the way it administers and consumes health care, Massachusetts is the closest thing to a crystal ball anyone has.

An Urban Institute study released in January points to the state's high insurance rate and surveys indicating improvements in health care access as signs of the Massachusetts law's success. But while the Bay State was ripe for reform, conditions likely will prove less fruitful

across the country, write the study's authors, including University of Minnesota professor Sharon Long, a public health economist who has studied the issue for several years for the Urban Institute.

"Massachusetts' 2006 reform effort was built on many years of incremental reforms, with bipartisan political support, strong commitment to reform across stakeholders and a strong economic environment. Few — if any — states, including Massachusetts, are starting to implement the Patient Protection and Affordable Care Act in such favorable conditions. … It is likely that the path to near-universal coverage nationally will be slower and bumpier than it was for Massachusetts in 2006," the study says.

Massachusetts has a long association with health care reform. The late Ted Kennedy, who represented the state in the Senate for nearly five decades, advocated for universal insurance coverage and other health reforms throughout his career. The state Legislature first passed a universal care law in 1988, though it was never implemented and was later repealed. In the 1990s, Medicaid was expanded and a drug program for seniors created. When health care reform plans emerged from both political parties in 2005, the idea earned high praise from the public.

When then-Gov. Mitt Romney proposed his plan, the Bay State faced two potential financial meltdowns related to health care: the loss of federal funds providing medical care to the working poor and the $1 million-and-growing price tag for treating the uninsured. Romney decided to redirect that money: Instead of paying to treat the poor, the state would pay to insure them. To compel "personal responsibility," the state would require those who could afford insurance to buy it.

Romney, now a Republican presidential candidate, staunchly defends the law. But impose that same program nationwide?

"It's a bad idea," he has said repeatedly.

Romney fashioned large portions of the 2006 law — titled "An Act Providing Access to Affordable, Quality, Accountable Health Care" — including the universal coverage requirement. (He did veto a penalty on employers who did not offer insurance to their workers, but the state's Democratic Legislature overrode him.) But Romney says he never intended that a solution designed for his state would apply to the other 49. During the 2008 presidential campaign, Democrats adopted the Massachusetts blueprint as their own.

The plan itself

In Massachusetts, the individual mandate works like this: Most adults age 18 and older must carry health insurance or pay a tax penalty equal to half the cost of the lowest-priced health plan — $1,212 a year for a single adult age 27 and older with an annual salary above $32,496. The fines decrease for those who earn less. Those with very low incomes and who meet certain eligibility requirements receive free care through MassHealth — the state's Medicaid program. Those making less than 300 percent of the federal poverty level — $67,056 for a family of four — may be eligible for a government subsidy to pay their premiums. If employers offer coverage, their workers are usually disqualified from subsidies even if they fall below the 300 percent poverty figure.

The federal rules differ in some respects, such as raising the poverty guideline to 400 percent and eliminating the employer plan subsidy disqualifier in some cases.

No one disputes that more Massachusetts residents are insured than before health reform. The state averaged an uninsured rate of 5 percent, the lowest in the country, between 2008 and 2010, according to the U.S. Census Bureau, and state agencies report that 99.8

percent of children have coverage. Texas averaged 24.8 percent uninsured during that period, the nation's highest, and the national rate was 16.4 percent in 2010, the census reported.

After the reform law's onset, 411,000 people have become insured, according to the Health Connector. An estimated 77,000 bought private insurance, about 41,000 through Health Connector's Web-based market Commonwealth Choice. Another 159,000 received subsidized or free coverage through Commonwealth Care. MassHealth, the state's Medicaid program, took on about 193,000 new members.

"For kids, 99.8 percent have health coverage in Massachusetts," said Brian Rosman, research director for the advocacy group Health Care for All. "It's a remarkable achievement."

Evidence suggests that the state's subsidized plan has not "crowded out" employer-provided programs. Insurance offerings by both large and small companies have increased, according to a Massachusetts Division of Health Care Finance and Policy survey. A July 2011 report said 77 percent of employers with more than two workers offered health plans in 2010, compared to 69 percent nationwide and 64.4 percent statewide in 2006.

Advocates of reform like to play up the law's success stories.

"People have had their lives literally saved," Rosman said.

The Health Connector promotes testimonials on its website and publications. The story of Jaclyn Michalos, diagnosed at age 27 with breast cancer shortly after buying insurance through the Connector, has been widely reported by national media outlets.

"If I didn't have health insurance, I might not be around to tell my story," she said in a promotional video. "They saved my life."

Lingering questions

The Massachusetts plan cannot claim to be a side-effect-free vaccine for the nation's health care affliction.

Gail Warner, 58, sips coffee inside a Dunkin' Donuts about 20 miles outside Boston. It sits in the shadow of the world headquarters for Staples, her former employer. Warner, a human resources benefits coordinator for 27 years, experienced the technicalities of implementing health care reform requirements on the corporate side and witnessed the benefits in her personal life. Her son, unable to find a full-time job after graduating college, bought a high-deductible, lean-benefits policy through the Connector for about $116 per month. His modest income from a few temporary jobs qualifies him for a subsidized premium. Warner and her husband, who both retired early with plans to travel in their RV, are covered by COBRA, a post-employment benefits plan, but expect to purchase through the Connector later this year when those benefits expire.

"It's going to cost me a lot of money, but at least I have access," she said. "Otherwise I would have had to work until I was 65."

The Warners, whose home is paid off, anticipate a monthly premium of about $1,000.

"It is a burden," she said. "It's going to be our No. 1 expense."

The median annual premium for employer-sponsored family plans jumped 48 percent to $14,606 between 2003 and 2010, according to the Commonwealth Fund, a private foundation promoting a high-performing health care system. An employee on that plan would pay $287 per month.

Massachusetts had the nation's highest premiums in 2008 and 2009 but slipped to ninth in 2010. Texas was 12th at $14,526. According to the Connector website, the cheapest plan for a family (a couple, both age 45, and their two children) who earns more than $67,056 and live in Lowell — a city about 30 miles outside Boston and about the same size as Denton — would cost $973 per month.

In 2009, 320,000 of Massachusetts' 5.2 million adults were uninsured for all or part of the year, according to state tax records. About 6,000 received waivers, and about 48,000 voluntarily opted out and paid the penalty. But 40,000 paid no penalty because affordable insurance was unavailable.

"Those are always the most upsetting calls, people who are over the income limits for subsidized programs that can't afford private health insurance," said Hannah Frigand, a helpline counselor at Health Care for All, an advocacy group that shepherded the Massachusetts law to fruition. "You can't really tell them very much."

Frigand and her five co-workers answer calls five days a week, about 36,000 calls annually. She expedites a call from a Colorado woman whose daughter plans to move to Massachusetts, answering questions about coverage options and eligibility from memory. An earlier call took much longer.

"I've been on hold for 45 minutes," she said after muting her headset's speaker.

Her client, Betty, is trapped in paperwork limbo waiting for the state to approve her enrollment in the subsidized Commonwealth Care program.

"She's kind of stuck and didn't know what to do," Frigand said. "She's been putting off care."

Betty suffers from lingering symptoms of a car accident not covered by auto insurance. After nearly an hour on hold: "Hi, Betty. So you heard that? On Friday you can call Commonwealth Care. They can look up your doctors, and you can enroll in a plan."

Most cases aren't as complicated as Betty's. Frigand can process an application for a state program and have it processed in a month — without the lengthy phone call. Applying at a hospital or one of Massachusetts' 280 community health centers shortens the process to 10 days.

The Massachusetts experience foretells much about what politicians, medical providers and patients can expect as the national law's provisions continue to unfold. Multiple stakeholders advocate aggressive public education for the uninsured populations moving into the system.

"Getting the card in people's hands is only the beginning," said Glen Shor, Connector's executive director.

Like the emergency room surprise, officials should brace for unexpected results.

Massachusetts' community health centers, which treated many uninsured patients before reform, expected to lose them when they join the insurance rolls. Instead, health centers gained 100,000 patients. The nation's first community health center, Geiger Gibson in suburban Boston, and other centers are framing themselves as medical homes for their patients — a single stop for primary care, dentistry, women's health, counseling, podiatry, pharmacy and, in some cases, day care and a food pantry.

"It's a great model of care," said Geiger Gibson executive director Nancy Bucken. "We wish we had room for more here."

They do have room for more patients. On a Friday morning in December, the Geiger Gibson waiting room was empty and the nearby Neponset Center had only a handful of patients.

Cost and responsibility

Massachusetts cannot answer the questions about cost. The Bay State and the rest of the country will face those challenges almost simultaneously.

Reform in Massachusetts added $353 million to the state budget, a “modest” 1 percent and well within expectations, said Gov. Deval Patrick and the nonpartisan Massachusetts Taxpayers Foundation.

“Health reform has not been a budget buster for Massachusetts,” Shor said. “That’s patently false.”

Opponents point out that a large chunk of the funding comes from the federal government, which portends disaster as 49 more states try to follow suit. Analysts at the libertarian Cato Institute argue that the state fails to account for added costs assumed by the private sector — $1 billion by their estimates.

Experts attribute rising costs of health care to waste — both administrative excess and unnecessary medical procedures. The sweeping actions necessary to correct the problem lack strong political support, says Alan Sager, a professor of health policy and management at Boston University. Massachusetts’ problem is exacerbated by the high number of teaching hospitals, all of which want the newest and best equipment.

“It’s an arms race,” said Conn from Massachusetts General, “and it drives up costs.”

Conn has some plans that may help. When non-emergent patients ask for treatment, staff members divert them to the hospital’s walk-in clinic during operating hours. At other times, they are fast-tracked through a screening program that sends 40 of 100 home without requiring full ER admission. A full-time employee helps locate primary care doctors for patients without them.

Conn envisions a time when people with pneumonia receive subsequent rounds of intravenous antibiotics from nurses making house calls. Keeping people out of the hospital is a key to cost control, he says, because 70 percent of the costs come from 10 percent of the patients.

“So we need to work on that 10 percent and get their costs down; it won’t be by giving better care to a healthy 25-year-old,” he said. “We can’t compete on the world stage spending twice as much as everyone else.”

BY THE NUMBERS

This is how the ranks of Massachusetts’ uninsured looked in 2009

2.7 — Total percent uninsured

1.9 — Percent of children

3.5 — Percent of adults, ages 19-64

0 — Percent of adults, age 65 and older

Source: Massachusetts Health Insurance Survey, the Urban Institute