



Health Care Reform and the Massachusetts Commonwealth Program: An Important Foundation to Build on for Children with Disabilities

Introduction

In April 2006, the Commonwealth of Massachusetts implemented its landmark reform plan which has resulted in almost universal health care coverage for its citizens. Through a combination of expanded public programs, robust employer-sponsored plans, and individual and employer mandates, Massachusetts now has the lowest rate of uninsurance in the nation — just 2.6 percent.

This success was built on a pre-existing foundation. Massachusetts has a history of expanding coverage options in a variety of ways. One of the earliest was the CommonHealth Medicaid buy-in program for adults and children with disabilities.

Twenty years ago, recognition grew that thousands of working-age adults with disabilities faced a difficult dilemma. They could choose to be unemployed and therefore eligible to receive the comprehensive health care benefits that the needs-based state Medicaid program offered. Or they could choose to take a job and lose their publically-funded health care benefits because the corresponding increase in income from work made them ineligible. This created a disincentive to employment and independent living. It also reinforced the link between poverty and disability. In the late 1980s, a coalition of advocates came together and partnered with legislators and Medicaid staff to create the CommonHealth program. The 1988 Massachusetts Health Security Act allowed working adults with disabilities (and also the families of children with disabilities) to ‘buy-in’ to the Medicaid program by paying a premium for coverage.

This brief describes the impact of the CommonHealth program and its relevance to the Massachusetts health care reform experience.

What is the CommonHealth program?

The CommonHealth program currently offers healthcare benefits through the state Medicaid program (known as MassHealth) to adults and children with disabilities whose income is too high to qualify for ‘traditional’ needs-based Medicaid. There

are three separate CommonHealth benefit plans: the CommonHealth Children's Plan, the CommonHealth Working Adults Plan and the CommonHealth Non-working Adult's Plan. Benefits under each of these are comprehensive and include:

- Inpatient and outpatient hospital services
- Doctor, nurse practitioner, nurse midwife, and clinic visits
- Well-child visits including immunizations
- Early intervention
- Pharmacy services
- Mental health and substance abuse services
- Audiologist services and hearing aids
- Vision care including eyeglasses and magnifying aids
- Chiropractor services
- Podiatrist services and orthotics
- Prosthetic services
- Abortion and family planning services
- Rehabilitation and therapy services (physical, occupational, speech)
- Renal dialysis
- Smoking cessation services
- Home health care
- Personal care and private duty nurse services
- Hospice services
- X-rays and laboratory work
- Medical equipment and supplies
- Oxygen and respiratory equipment
- Adult foster care, adult day health care, and day habilitation services
- Dental services for children and adults including checkups, cleanings, fillings, dentures, and other approved procedures
- Ambulance and transportation services

Premiums for the CommonHealth program are based on a sliding fee scale and there is no asset test or income limit. Those who are uninsured may buy-in to the full Medicaid benefit package. A person (either an adult or the family of a disabled child) with existing private health insurance may pay a lower premium for supplemental coverage for that individual. For the CommonHealth Benefit Plan for Working Adults, beneficiaries are required to demonstrate employment of 40 hours or more each month. For the children's benefit plan and the benefit plan for adults who do not meet the work requirement, a beneficiary's household income must exceed the financial eligibility for the MassHealth Standard program. Over 17,000 disabled adults and children are currently enrolled in the CommonHealth program, either as their primary source of health care coverage or as a supplement to private insurance.

How did the CommonHealth program come about?

For most people in the United States, health insurance coverage is obtained through an employer but the depth of the benefit package and its affordability can be quite variable. Prior to the implementation of the CommonHealth program, poverty and disability in Massachusetts were inextricably linked because of the need of many people with disabilities to access the comprehensive benefits offered through the Medicaid program. Since Medicaid is a needs-based program, a person's income must be limited in order to qualify. So why did some adults with disabilities and the families of disabled children turn to Medicaid, knowing it would prevent them from working? The structure of the private insurance market posed significant barriers, including but not limited to:

- Restrictions on access to coverage due to preexisting conditions;
- Expensive premiums for a relatively thin benefit package, leaving people with significant out-of-pocket expenses for such vital supports and services as durable medical equipment, prescription drug coverage and personal care assistance; and,
- Lifetime caps on benefits

In the late 1980s, a coalition of disability advocacy groups came together as part of Governor Michael Dukakis' early health care reform effort. Their vision of equal access to engagement in the workforce and the independence it represents helped create the CommonHealth program. It was the first Medicaid buy-in program in the nation.

What are some of the benefits of the CommonHealth Program to families of children with disabilities?

Families of children with disabilities benefit from the CommonHealth program in a variety of significant ways. Because they do not have to limit their income in order for their disabled children to qualify for Medicaid, parents can work, stay married and not have to fear being forced to relinquish custody of their children with disabilities. Medicaid is a particularly important source of health care coverage for children because of a provision called Early, Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT can be thought of as the 'children's benefit package' in Medicaid; it ensures that children under the age of 21 who qualify for Medicaid receive early screening and diagnosis of health problems and subsequent treatment for them. Through EPSDT, if a screening, diagnostic procedure or treatment is determined to be medically necessary for a child, the Medicaid program is required to cover it. Children who would otherwise be underinsured through gaps and limits in their private coverage can be covered through EPSDT for all of their health care needs.

Here is one family's story: *"In 1987, my daughter Sarah was born with a complex genetic disorder. At the time, we were covered by private insurance through my husband's employer. The benefit package was very generous; for example, there was no limit on the number of physical, speech and occupational therapy visits she could have. However, I*

needed to stay home to care for her and with only a single income our out-of-pocket expenses quickly became overwhelming. Sarah needed special therapies beyond the scope offered by our Early Intervention program. We had a co-pay for them of \$15 per visit. With four visits a week, that added up to almost \$3,200 a year out-of-pocket and that was for just one component of her care; she also had multiple doctor visits, hospitalizations, prescription medications and more – all with their own deductibles and co-pays. We were quickly sliding into significant medical debt; our savings were gone, our credit cards were maxed out and she was only two years old at the time. I was petrified that we would have to make a choice between Sarah’s health and losing our home. It was at this critical moment that I heard about the CommonHealth program through Early Intervention. For about \$40 a month (or \$480 a year), my family could ‘buy-in’ to the Medicaid program for Sarah’s uncovered co-pays, deductibles and additional uncovered services (like eyeglasses). As a result, we stopped our downward slide into debt and possible bankruptcy. I sincerely believe that Sarah is doing as well as she is medically because we’ve never had to make a choice between what she needs and what we could afford. My heart breaks for those families who have not had this kind of opportunity.”

In addition to individual working adults and families, society in general benefits as well. People who work pay taxes and participate in the local economy, buying products and services. They also depend less on tax payer-funded supports such as housing, food and fuel subsidies. It is a win-win for everyone.

How does CommonHealth serve as a model for other national healthcare expansion efforts?

Not only have the people in Massachusetts benefited from the CommonHealth Medicaid buy-in model. The success of the program in helping Massachusetts citizens with disabilities to engage in the workforce led in part to the creation in 1999 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA). This federal legislation allows Medicaid programs in other states to establish two new optional eligibility categories: for working people between the ages of 16 and 65 with disabilities who meet the Supplemental Security Income (SSI) eligibility guidelines and for those who are employed and had previously met the SSI disability guidelines but who have shown an improvement in their medical status. As of 2007, over 80,000 individuals in 32 states were covered under these new eligibility groups. Senator Edward Kennedy (D-MA), a long-time advocate for both people with disabilities and health care coverage expansion, sponsored the law. Senator Charles Grassley (R-IA) was his co-sponsor. The President’s New Freedom Initiative of 2001 enhanced TWWIIA with additional tools and funding in support of its goals. Grassley and Kennedy, building on the success of TWWIIA for adults, next turned their attention to families of children with disabilities. Together, they co-sponsored the Family Opportunity Act (FOA), one component of which gives states the option to allow families with income under 300 % of the Federal Poverty Level and whose children meet the SSI disability criteria to ‘buy-in’ to Medicaid for that

particular child. It passed in 2006. Five states have begun buy-in programs through the FOA for families of children with special health care needs, including North Dakota, Louisiana, Iowa, Illinois and Texas. At least three other states besides Massachusetts offer Medicaid buy-in programs for families of children with disabilities outside the FOA criteria, including Vermont, Pennsylvania and Ohio.

As Massachusetts gains knowledge and experience with its current health care reform plan, how might a Medicaid buy-in program like CommonHealth continue to play an important role in ensuring access to coverage for people with disabilities? Given the fiscal reality and the many competing demands for funding that we all live with, there will always be a limit to the resources that can be dedicated to any one problem. The ‘pot’ of money available to support the health care reform plan was and is finite – in order to achieve the goal of covering as many people as possible with affordable premiums, some compromises in the depth of the benefit package had to be made. CommonHealth provides an important safety net for those whose health care needs require a more comprehensive benefit package, given the shared funding of the Medicaid program between the Commonwealth and the federal government. With the federal match, the State’s dollars go farther and more people can be covered.

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