



Can Massachusetts Lead the Way in Health Care Reform?

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Our health care system is a mess. The number of uninsured Americans is approaching 50 million. The costs of health insurance are too high, and they are rising rapidly. Polls repeatedly

show that a majority of Democrats, Republicans, and Independents favor universal health care coverage. The trouble is that we can't agree on a solution. The left wants to scrap the current system and substitute a government-financed single-payer program. The right supports consumer-directed health savings accounts and tax credits. More moderate elements on the right, such as Governor Mitt Romney of Massachusetts, also favor requiring all persons to purchase health coverage if they can afford it. The center supports building on the existing system, including requiring all businesses to offer and help pay

for health coverage of their employees. Unfortunately, until now, everyone's second choice has appeared to be to do nothing. This ideological gridlock, combined with the war in Iraq and spiraling national debt, means that no national solution is likely to come out of Washington any time soon.

Hope for the dispirited, however, might be found in Massachusetts, where — by an overwhelming majority — the legislature recently passed health care reform legislation that is designed to cover 90 to 95 percent of the state's uninsured citizens over the next three years. Legislators achieved success by embracing ideas from

the right, the left, and the center and because of the active engagement of businesses, hospitals, insurers, and a sophisticated advocacy community.

The legislation is built on the concept of shared responsibility; it requires more of people who are uninsured, businesses that do not provide coverage to their employees, and the government. In addition, a portion of the funds in the "free care pool" that are now spent on care provided by hospitals to the uninsured will be used to help subsidize insurance for low-income persons. Massachusetts will require everyone who can afford health insurance to buy it — an individual mandate. To make this coverage affordable, it will essentially require persons who are less likely to need care and who are now uninsured to help support currently uninsured

persons who do need care. The justification is that if persons are permitted to wait until they need care to buy coverage, the concept of insurance will be destroyed. Similarly, businesses with more than 10 employees will be required to pay an assessment of \$295 per employee per year if they do not provide insurance for their workers. Although this section of the legislation was vetoed by Governor Romney, the legislators overrode his veto. To do otherwise would destabilize the delicate balance — in which business is required to contribute to the solution — that permitted consumer groups to support the individual mandate. It is estimated that this employer mandate would bring in about the same amount of money as the state now spends on health care for uninsured low-income workers.

The legislation includes a number of measures designed to make insurance more affordable. The state's Medicaid program will cover all children in families with incomes of up to 300 percent of the poverty level — about \$60,000 per year for a family of four. Adults with incomes up to 100 percent of the poverty level will also be covered. Subsidies will be available to help people with incomes between 100 percent and 300 percent of the poverty level to buy coverage. A new state marketplace will allow residents to purchase approved health insurance with pretax dollars.

The devil, as always, is in the details, and some aspects of the plan could well prove problematic. The first question is whether the current financing package will generate enough funds to sustain the program. Equally important

is whether the premiums will be too expensive for moderate-income persons, given that the legislation requires the fairly generous benefits usually found in most private health insurance plans but restricts the inclusion of high levels of patient cost sharing. The plan does, however, permit the use of high-deductible plans if they are part of a health savings account plan. The law also takes some, albeit very limited, steps to reduce the cost of privately provided health insurance. State Medicaid payments to hospitals and physicians will increase by \$90 million each year over the next three years, which will bring them more into line with private insurance payments. Currently, private payers are indirectly taxed to make up for the shortfall in Medicaid payments.

Many of the details of the Massachusetts plan still need to be worked out. We don't know exactly what the new insurance plans will look like, how much they will cost, and whether government subsidies will prove adequate. The cost of the reform will be contingent on the actual price of available plans and subsidy levels, which will not be known until regulations are drafted and insurers and health plans offer new products for this market. Although the new law represents a monumental change that will alter people's lives, it is not perfect, and refinements will have to be made — both in Massachusetts and in the many states that are studying similar options.

No state will copy Massachusetts's approach exactly, but many are already taking a serious look at its new plan. Some states may want to test the broader use of

lower-cost high-deductible plans, thereby stretching existing funds to cover more people. Others may move more aggressively to require employers to offer health insurance or pay a greater portion of the costs. This "play or pay" approach would create greater parity between companies that provide health insurance and those that do not.

Greater experimentation is needed to find realistic ways to control health care costs. States could, for example, provide reinsurance for high-cost cases, requiring better management of the care given to patients who need the most expensive interventions. This tactic would spread the cost of such cases broadly over the state's population, which is how insurance should function. It would make private insurance less expensive and could reduce overall health care spending.

Although we will no doubt continue to argue about the details of insurance reform, some lessons are already clear. Hospitals, physicians, and other health care providers need to be part of the discussion. They need to lead a broader political coalition that includes patients. The business community, as employers and purchasers of insurance, needs to be engaged actively in reform, or at least not opposed to it. In Massachusetts, consumers and strong grassroots organization put pressure on the political system to act directly. Just as important, advocates of expanded coverage need to focus on the goal and not be rigid about how to achieve it. Far too often, holding out for the best plan kills efforts to make real gains. No one thinks the Massachusetts plan is perfect, but all

agree that it represents considerable progress. Advocates were not happy with an individual mandate, and the business community was not happy with an employer mandate. All sides, however, believe they can live with the compromise, and the result will be increased coverage for the uninsured.

Progress on seemingly intractable problems must start somewhere. In 1991, Pennsylvania vot-

ers elected Harris Wofford to the Senate on a platform of universal health care, sending a message to politicians that the public supported action on health care. This message catalyzed action but ultimately ended with the failure of the perhaps overambitious Clinton health care plan. Massachusetts has now sent a new message to the rest of the country: providing health care to the uninsured is

possible. This move will embolden leaders in other states. One day, Washington may follow suit.

An interview with Dr. Altman can be heard at www.nejm.org.

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Health Care Reform in Massachusetts — A Work in Progress

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In April 2006, Massachusetts enacted far-reaching health care reforms (see box).^{1,2} Starting in July 2007, all state residents must carry a minimum level of health insurance, a requirement that will be enforced through the state tax return. Coverage may be through an employer, Medicaid, Medicare, or new programs that will facilitate the purchase of private coverage. In many instances, failure to comply with the new law will lead to financial penalties. By 2009, the proportion of state residents who are insured should markedly increase.

The reforms follow months of intense discussions and have bipartisan support (see the article by Altman and Doonan, above). Many of the measures are creative and novel. For example, assistance in the payment of premiums will be provided for low-income persons and families who are not eligible for other public insurance. This assistance will aid in the purchase of insurance by people with incomes under 300 percent of the federal poverty guidelines, which

in 2006 are \$29,400 for an individual and \$60,000 for a family of four living in the contiguous United States. For those who are ineligible for subsidies, the merger of the health insurance markets for small groups and individuals should reduce premiums, perhaps by 25 percent for individuals, according to state officials. A broader ability to purchase insurance on a pretax basis should reduce the net cost of insurance for those who cannot already do so.

Funding includes federal and state spending, as well as assessments on hospitals, insurers, and employers. Supplemental revenue to support the reforms is projected at \$201 million in fiscal year 2008 and \$173 million in fiscal year 2009, according to legislative analysts. This includes \$125 million each year from general state revenues; the rest is from employers. When fully implemented, the reforms should represent a meaningful advance against the problem of the medically uninsured, even though only Massachusetts residents will benefit.³

The overall effect is harder to predict. The requirement is for a minimum level of health insurance, not an optimal level. Improving access to medical care for previously uninsured persons may increase the demand for needed services, such as surgery, thus improving health but increasing costs. The reforms may make little difference in many factors that contribute to spending, including the costs of prescription drugs and health care administration. There will be new roles for the state and federal government, individuals, employers, and health insurers and some new cost-control measures. Nonetheless, the overall structure of private health insurance and the payment and delivery of medical care will remain intact, and costs will relentlessly increase.

In 2004, the health expenditure per capita in the United States was \$6,280, or more than \$500 a month, and accounted for 16 percent of the gross domestic product. Spending grew by 7.9 percent from the previous year. In 2005, the average monthly cost of cover-