

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](http://www.nejm.org).

Dr. Altman is dean of the Heller School for Social Policy and Management, and Dr. Doonan is the executive director of the Massachusetts Health Policy Forum — both at Brandeis University, Waltham, Mass.

## Health Care Reform in Massachusetts — A Work in Progress

Robert Steinbrook, M.D.

In April 2006, Massachusetts enacted far-reaching health care reforms (see box).<sup>1,2</sup> 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.<sup>3</sup>

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-

**Key Components of the Massachusetts Plan.**

**Individual health insurance mandate.** All state residents 18 years of age or older will be required to carry a minimum level of health insurance, which will be confirmed and enforced through the state tax return. Parents will be responsible for meeting the obligation for children. A database of insurance coverage for all persons will be established. The financial penalty for noncompliance will eventually be 50 percent of what a person would have paid toward an “affordable” insurance premium.

**Employer responsibilities.** There will be a \$295 annual charge per employee to businesses with 11 or more full-time employees that do not provide health insurance for workers or contribute to it. Such employers must offer “cafeteria plans,” which allow the purchase of insurance on a pretax basis. These employers will also be subject to a “free-rider surcharge” when their employees use more than a specified amount of care from a state “health safety-net fund.”

**Creation of the Commonwealth Health Insurance Connector.** This state authority will administer many of the insurance aspects of the reforms, including the new subsidized and affordable policies and the annual setting of a sliding scale for “affordable” coverage. The exchange will connect persons and businesses with 50 or fewer employees with insurance products. Policies cannot be sold through the connector unless they receive its seal of approval. Those who are eligible to purchase coverage will include people who are self-employed, not working, not eligible for coverage through work, or working at companies that do not offer insurance. Insurance can be purchased with pretax dollars. People can keep their policies even if they change jobs.

**Premium assistance for individuals and families with low incomes.** Persons who earn less than 300 percent of the federal poverty guidelines and who are ineligible for other public insurance will be eligible for subsidized policies through the Commonwealth Care Health Insurance Program. Premiums will be on a sliding scale based on household income, with no premiums for those who earn less than 100 percent of the federal poverty guidelines. No plans will have deductibles.

**New insurance products.** In July 2007, the individual and small-group insurance markets will be merged, reducing the cost of nongroup premiums. There will be new insurance products for people whose incomes make them ineligible for the subsidized plans. These plans may have deductibles, limited networks of physicians and hospitals, and substantial out-of-pocket costs. Young adults will be able to stay on their parents’ insurance plans until two years after the loss of their dependent status or until they turn 25 (whichever occurs first). Specially designed products with lower costs and limited coverage will be available for people between the ages of 19 and 26 years.

**Medicaid expansion.** Eligibility for MassHealth, as Medicaid is known in Massachusetts, will be expanded to include children of families who earn up to 300 percent of the federal poverty guidelines. Medicaid providers will receive rate increases.

**Cost and quality measures.** Cost and quality data for physicians, hospitals, and specific procedures will be collected and made public. Hospitals will be required to collect and report data on racial and ethnic health disparities. Medicaid rate increases will be tied to achievement of performance goals.

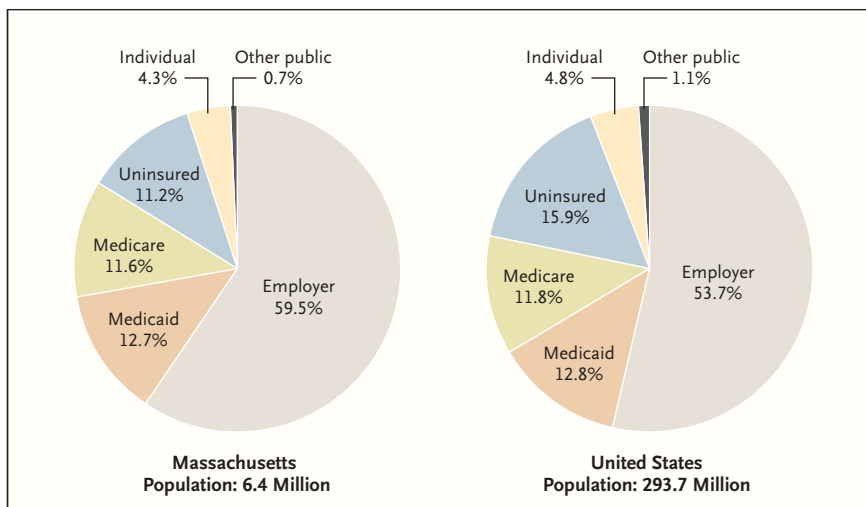
age through job-based health insurance was \$335 for an individual and \$907 for a family, according to the annual survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. In Massachusetts, the average cost of policies is higher.

Massachusetts has a long history of health care reform, including a controversial 1988 universal care law that was enacted but never implemented and that was eventually repealed. In the mid-1990s, the state expanded Medicaid and created a subsidized drug program for seniors.<sup>4</sup> As compared with the nation as a whole, Massachusetts has a higher percentage of residents who have health insurance through their employ-

ers and a lower percentage of people without insurance (see Figure 1). Massachusetts already spends a considerable sum each year to compensate community health centers and hospitals that treat the uninsured, using state and federal funds, as well as payments from insurers and employers who are self-insured. Some of these existing funds will be redirected to improve insurance coverage. Although such favorable conditions suggest that the reforms in Massachusetts than they would elsewhere, officials still have to implement the measures and address the diverse situations of the uninsured (see Figure 2).

When Mitt Romney, the state’s Republican governor, signed the

health insurance reform bill, he vetoed some provisions, including an annual charge of \$295 per employee to businesses with 11 or more full-time employees that do not provide health insurance or contribute to it. By early May, the legislature, which is overwhelmingly Democratic, had overridden this veto. The \$295 charge is dwarfed by the annual cost of health insurance, and the anticipated revenues are only about \$50 million a year. Although the so-called “fair share contribution” is not a substantial financial incentive for employers to provide insurance, it does symbolize the logic of the reforms — that employers and employees share responsibility for health insurance. Implementation depends on



**Figure 1. Health Insurance Coverage in Massachusetts and the United States.**

Data are from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured and are based on surveys conducted by the Census Bureau. Massachusetts data are for 2003–2004, and U.S. data are for 2004.

new regulations and insurance plans, as well as on the accuracy of many assumptions. One assumption is that the Centers for Medicare and Medicaid Services will approve the aspects that require its assent. These include the use of Medicaid funds to provide assistance to lower-income persons and families in the payment of premiums, expansion of Medicaid to include children of families whose income is up to 300 percent of the federal poverty guidelines, and continued support to Boston Medical Center and the Cambridge Health Alliance to care for people who remain uninsured. The waiver agreement under section 1115 of the Social Security Act allows the state to operate part of its Medicaid program under rules that are different from those that usually apply. Although approval is expected this summer, the federal government has not signaled its intentions. In any event, the waiver will expire in 2008 and will have to be renegotiated.

The estimated number of

people without health insurance in Massachusetts ranges from 550,000, which is based on an annual state survey, to 715,000, which is the number provided by the Census Bureau for 2003–2004; state officials consider the higher number less reliable. The Massachusetts plan assumes that about 515,000 residents would gain coverage, leaving perhaps 35,000 without insurance. However, there is no certainty about the number who will gain coverage. In addition, if the actual number is considerably higher, the funding will fall short.

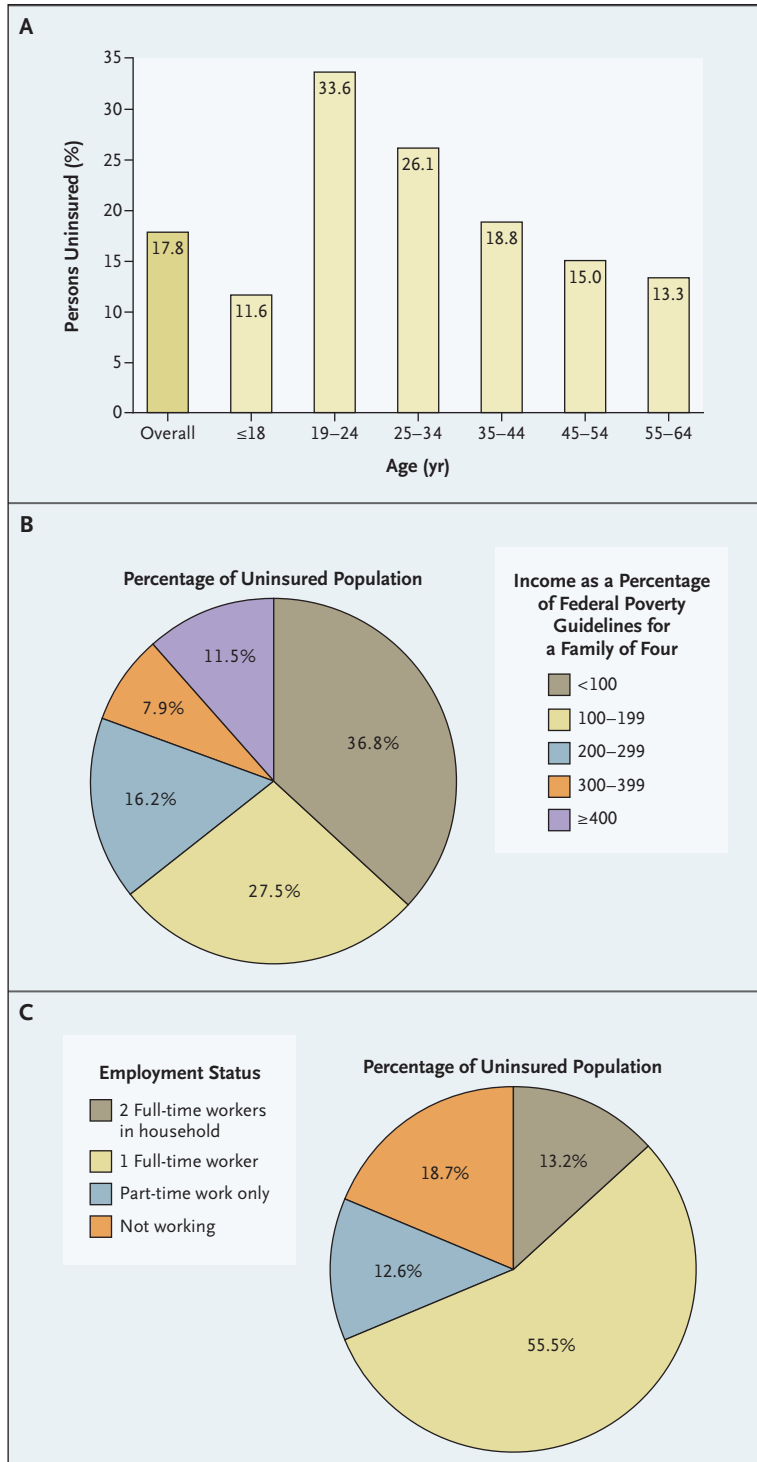
A new state authority, the Commonwealth Health Insurance Connector, will administer many of the insurance aspects of the reform and will have to approve the new policies before they can be sold. The target price of policies for low-income persons — before premium-payment assistance is applied — is \$300 a month, which would be paid mostly by the state. These policies will have Medicaid-like benefits. They will

not have deductibles, and there will be no premiums for persons who earn less than 100 percent of the federal poverty guidelines, or \$9,800 a year. Otherwise, such items as the actual cost of insurance, the premiums after assistance is applied, out-of-pocket payments, and the extent of coverage will not be known until policies become available later this year.

A related assumption involves the availability of “affordable” insurance for people with incomes that make them ineligible for subsidized premiums. The individual mandate to have insurance is contingent on the availability of affordable plans. Although the term has yet to be defined, an “affordability scale” is to be set annually, by the connector. It is uncertain, however, whether the policies will truly be “affordable.”

The insurance products are expected to offer coverage that is similar to the subsidized policies but may have important differences, such as deductibles, high-deductible plans tied to health savings accounts, substantial out-of-pocket payments, or more limited choices of doctors and hospitals. Although the Romney administration has set a target price of \$200 a month for “comprehensive insurance” for an individual, state legislative leaders contend that the actual price will be about \$320 a month. The features and prices will not be known until policies become available in 2007.

The Massachusetts health care reforms are ambitious and complex. State officials anticipate that adjustments will be needed along the way. Perhaps their most important assumption, however, is that the costs and economic burden will be acceptable in the long



**Figure 2. Characteristics of Uninsured Persons in the United States in 2004.**

Panel A shows the percentages of Americans younger than 65 years of age who were uninsured in 2004, according to age group; there were a total of 45.5 million such persons in that year. Panel B shows the income levels of the uninsured population; the 2004 federal poverty guidelines for a family of four were \$19,307. Panel C shows the employment status in the uninsured population. Data are from the Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*. January 2006, available at <http://www.kff.org/uninsured/7451.cfm>.

term. When the economy slows, state tax revenues decline. Simultaneously, Medicaid spending accelerates and the number of people who are either enrolled in Medicaid or uninsured increases.<sup>5</sup> For the reforms to succeed, Massachusetts will have to sustain them through the economic hard times, when they will be needed most.

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5. Kaiser Commission on Medicaid and the Uninsured. State fiscal conditions and Medicaid. November 16, 2005. (Accessed May 2, 2006, at <http://www.kff.org/medicaid/4087-04.cfm>.)