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HEALTH REFORM MASSACHUSETTS STYLE: INK BLOT TEST AND EXAMPLE FOR US ALL

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Everyone interested in solutions to our health system's problems (and who isn't) is looking to Massachusetts in the wake of its recent landmark legislation. Like the Rorschach ink blot test, many commentators see what they want to see, not what is actually there. Pessimists emphasize the uniqueness of Massachusetts and rush to proclaim that it can never happen anywhere else in America. Pragmatists see a bipartisan agreement to cover all people and celebrate, regardless of the type or coverage or the cost implications. Anti-tax zealots see the specter of a government promise to insure access for all and denounce it as socialism or worse. Single payer advocates see waste and greed in the reliance on private insurance and decry the focus on individual rather than employer responsibility. As the nation digests the facts and convenient fictions of the Massachusetts health care reform plan, this issue brief clarifies its key provisions and analyzes the implications for state-level and for national reform.

WHAT IT IS

First and foremost, the agreement *is* a triumph of bipartisan spirit over the frequently toxic politics of health reform. Governor Romney agreed to cover all citizens, and House Speaker Salvatore DiMasi and the Democrats agreed to keep the burden on employers and taxpayers to a minimum. Thus, both Romney and the Democratic leadership, with timely encouragement from Senator Ted Kennedy, agreed to stare down extremists in each party, *compromise*, and solve real problems. This is rare statesmanship all around, and deserves to be celebrated, for it is the only way to sustainable health reform.

The plan *is* built on the core of individual responsibility, perhaps the strongest American value. Individuals, not employers or governments, are required to obtain health insurance. At the same time and as in all times past, the community shares some responsibility for individuals' ability to help themselves. Most employers are expected

to continue offering workers health insurance on the job. Government also plays a crucial role, both creating a haven where insurance can be efficiently and fairly purchased, and subsidizing those who cannot afford it on their own. There are details to be worked out here, as discussed below, but there is a clear expectation and intent to make decent health insurance affordable for all.

HOW IT WILL WORK

First and arguably most importantly, most people will get insurance just like they do today, from their employers. Most offering firms have more than 50 workers. These workers will not receive new subsidies (but will continue to get those embedded in current tax law). One difference is that with the individual purchase requirement, workers must now accept their firms' offer, prove they are covered elsewhere, or pay a penalty at tax time. Massachusetts' Medicaid, or MassHealth (which includes their state children's health insurance program), is expanded to slightly higher income levels, and those eligible for it but not enrolled will have to sign up or prove coverage elsewhere as well.

A new purchasing pool—called the Commonwealth Health Insurance Connector—will combine the small group (firms with fewer than 50 workers) and non-group insurance markets under one set of regulations. These are the most problematic markets in our current system, and thus this is where the rubber meets the road along the drive to universal coverage using individual mandates and premium subsidies. The Connector is designed to enable workers in small firms, along with those without access to employer coverage and ineligible for MassHealth, to achieve the significant economies of scale in administration and risk pooling that the largest firms enjoy. Inside the Connector, those with incomes at or below 3 times poverty (\$49,800 for a family of three) can get premium subsidies on a sliding scale, with full subsidies available to those at or below poverty (\$16,600

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for the same family of 3). By way of comparison, a typical family policy in Massachusetts today costs more than \$12,000 per year, so subsidies are clearly needed for many people.¹

WHAT THE PLAN IS *NOT*

Despite key governmental responsibilities, the plan is *not* a new left-wing Trojan horse. Former Senator John Chafee (R-RI) had 16 Republican senator co-sponsors of his 1993 proposal for universal coverage with an individual mandate, including the 1996 presidential nominee Robert Dole (R-KA) and current Senate Finance Chair Charles Grassley (R-IA).² Many Clinton Administration insiders preferred this approach, but the fateful decision to keep an employer mandate, and thereby organized Labor's enthusiastic support, stifled the one real bi-partisan possibility at that time. Many who worked for compromise during 1994 remain haunted by this question: What if the Clintons had embraced Chafee's approach before William Kristol's infamous memo convinced Republicans they could gain power by refusing to deal on health care? The fate of many politicians and uninsured Americans, might have been quite different.

Placing the purchasing mandate on individuals is *not* a novel idea today. The New America Foundation embraced mandatory citizen-based health care at its founding in 1999.³ Before and since 2001, policy and political analysts across the spectrum, including academics (Mark Pauly and Patricia Danzon of the Wharton School at the University of Pennsylvania),⁴ analysts in think tanks (Urban Institute,⁵ Center for American Progress⁶), members of Congress (Sen. John Breaux (D-LA)⁷, Rep. James Langevin (D-RI)⁸), cabinet officials (former Bush Administration Treasury Secretary Paul O'Neill⁹), and pundits (Morton Kondracke of Roll Call and Fox News)¹⁰ have all written or stated that the only way for America to get from here to universal coverage is with individual mandates and appropriate public subsidies. Even Newt Gingrich recently said higher income Americans should be required to buy health insurance.¹¹ The intellectual ground for Romney and the Massachusetts legislature was well-plowed.

Nor is the plan a right-wing plot to enrich insurers or providers at the expense of the near poor. Limits are set on the state budget for premium subsidies, and restrictions on health plans' freedom to choose providers are reduced. Thus, the ability of providers and insureds to "charge what the market will bear" will be constrained in markets that are likely to be far more competitive than today's, not less. At the same time, the public commitment to make insurance more affordable is hard to retract. The near poor have the moral authority of a recent high-profile promise that was not present before.

The plan is *not* exportable to other states in a turn-key sense, or to the nation as a whole, at least not yet. Two structural features make the Massachusetts health system unique in America: a relatively low rate of uninsured (11% vs. 16% US average), and an existing revenue stream—

from governments and specific assessments on providers, insurers, and employers—that funds much of the cost of the currently uninsured. This stream will be converted into premium subsidies, meaning that—and this is crucial—the need for Massachusetts to raise new money to cover the uninsured is relatively small compared to other states or the nation as a whole.

UNRESOLVED ISSUES

Two key technical questions must be answered before implementation: Will guaranteed benefits be comprehensive enough for the newly insured and those who will treat them? And will the subsidies make the package affordable in the eyes of those who are required to buy it?

These are both more subtle questions than they may first appear. The budgeted subsidy amounts are appropriated, so there may not be enough money to guarantee everyone, for example, the most popular state employees' benefit package. Existing benefit mandates apply, save for insurance offered exclusively to young adults between the ages of 18 and 26. However, higher deductible plans that can be used in conjunction with Health Savings Accounts—i.e., plans with deductibles of at least \$1,050 for singles and \$2,100 for families and with out-of-pocket maximums of no more than \$5,250/\$10,500—also satisfy the insurance purchase requirement.

The to-be-appointed Connector Board is actually the key to making the program work. The Board must resolve the inherent tensions between program cost, affordability to families, and coverage expansion. For example, while maternity services must be covered by state law, it is also technically permissible to satisfy the insurance purchase requirement with a \$10,000 family deductible policy if that amount is also *the* out-of-pocket maximum. In essence, the Board must determine what kind of cost sharing requirements will be imposed on someone at or below poverty in conjunction with their mandated benefits. This combination of cost sharing and benefits will become the *de facto* minimum standard benefit package.

The Board must also determine the sliding subsidy schedule and has related responsibility for judging the "affordability" of the minimum package for all those getting less than full subsidies. The Board can adjust the subsidy schedule to make private insurance products sold inside the Connector affordable, subject to the overall subsidy financing budget limit. The Board can suspend the mandated purchase requirement if no affordable plans are offered in the Connector. The perception of affordability, perhaps especially for those without access to subsidies, but also in the court of public opinion, will be the ultimate equity test of the Massachusetts model. If the Board finds that there are no affordable plans, it will signal that the overall program is unraveling along with the political will to compromise on benefit package generosity or subsidy financing.

The legislation also has not resolved one of the thorniest issues in health system finance—what to do about employers that do not offer health insurance to their workers. Democrats insisted on some requirement, and an assessment of \$295 per worker per year was finally agreed upon. However, this will raise only a very small piece of the required financing, and Romney vetoed it with his line item authority, claiming it was not needed. To run for President in 2008 as a Republican, Romney feels that he needs to be able to say that his plan did not require, and that he did not sanction, taxing employers. The House overrode the veto almost immediately, and the Senate is expected to soon.

This veto-override dispute is more theatrical than real. Romney is right about the relative insignificance of this specific revenue stream but wants to pretend new revenues are generally not necessary for universal coverage, and Democrats know the amount in question would be small but felt compelled politically to ensure that all employers share the financing responsibility now placed squarely on individuals. Aside from the solidarity advantages of being able to say that all share in the gain and the pain, Democratic leaders feared that Labor would not accept the individual mandate model for coverage without this assessment on non-offering firms.

In truth, employer contribution requirements are one among many financing alternatives. Far from ideal, employer contributions generally reduce wages or jobs or both. Some Liberals deny this, but economists are convinced and convincing on this point. Progressive consumption taxes would be a far more growth-friendly way to finance universal coverage. Still, employment-based taxes may be better than implicitly subsidizing the ever-increasing uninsured. While neither essential nor wise, they remain a financing option for Massachusetts and the nation, whatever the ultimate fate of the Governor's showy veto and its impending override.

WHERE CAN WE GO FROM HERE?

Massachusetts does point to what is possible when opposing sides are willing to compromise. Universal coverage can be achieved if Democrats accept limits, and reasonable limits can be tolerated if Republicans make universal coverage a genuine commitment. Assuming successful resolution of the technical questions and short run financing tensions outlined above, the program in Massachusetts can get off to a healthy start.

Other states can build on this framework of compromise and individual plus shared responsibility by constructing their own preferred versions of financing burdens, the Connector pool and its Board. However, since no one else funds uncompensated care as generously as Massachusetts does at present, and since most states have a higher percentage of uninsured, other states' need for new funding will be greater. Thus they will have to have or build an even larger political commitment to the goal of universal coverage in order to get there without federal help.

For the long haul and for the nation as a whole, the looming question is, how can health care cost growth be contained so that universal access can be sustained? Massachusetts laid some foundation for cost containment by encouraging the use of electronic health records and pay-for-performance provider contracts, but these alone are not likely to reduce cost growth in the near term. The right kind of cost-growth containment, the kind that increases value per dollar spent, has three structural elements: an information system, including electronic records and decision-support tools for clinicians and patients that would facilitate quality care; re-tooled provider and patient incentives along with malpractice protections that would encourage timely and effective care and no more; and comparative technology evaluation before widespread use so that patients who can benefit most have the easiest access to new techniques, drugs, and devices.

All of these elements are possible to construct, but only with public and private collaboration at the national level. This will require time and statesmanship, and here Massachusetts' leaders have given us a shimmering example that could and should inspire others across the country and even, indeed especially, in Washington, DC.

¹ Massachusetts premiums taken from the Agency for HealthCare Research and Quality, Medical Expenditure Panel Survey, Insurance Component tables, 2003 data downloaded 5/2/06, <http://www.meeps.ahrq.gov/MEPSDATA/ic/2003/Index203.htm>, aged to 2006 dollars using assumption of 10% annual growth, an average consistent with recent experience according to the Kaiser Family Foundation/Health Research and Education Trust survey <http://www.kff.org/insurance/7315/index.cfm>.

² S. 1770, 103rd Congress, 1st session, November 23, 1993.

³ Ted Halstead and Michael Lind. *The Radical Center*. Anchor Books. New York: 2001.

⁴ Mark V. Pauly, Patricia Danzon, Paul Feldstein, and John Hoff, "A Plan for Responsible National Health Insurance," *Health Affairs* 10(1):5-25 (Spring 1991).

⁵ John Holahan, Len M. Nichols, and Linda Blumberg, "Expanding Health Insurance Coverage: A New Federal/State Approach," in *Covering America*, eds. Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute, Washington, DC. (2001).

⁶ Jeanne M. Lambrew, John D. Podesta, and Teresa L. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs* web exclusive, March 23, 2005.

⁷ Outlined in a speech to Academy Health Annual Policy Conference, January 21, 2004.

⁸ H.R. 4256, 109th Congress, 1st session, November 11, 2005.

⁹ Paul H. O'Neill, Invited Testimony, US Senate Committee on Finance, March 8, 2006.

¹⁰ Morton Kondracke, *Roll Call*, March 15, 2004.

¹¹ *Detroit Free Press*, April 4, 2006.