ESSAYS

The most ambitious effort in many years to reform the U.S. health insurance system was signed into law earlier this year in Massachusetts. In the essay below, a health economist who advised the state on the reform describes the plan and how it unfolded. Five commentaries weigh its odds of success and ask whether it can provide a model for the nation.

The Massachusetts Health Care Revolution: *A Local Start for Universal Access*

BY JONATHAN GRUBER

There is a standard health policy joke that goes like this. A health policy expert dies and goes to heaven. When there, he is greeted by God himself, and the Lord says that the health expert can ask one question of Him before entering heaven. The health expert chooses to ask God, "Will we ever have universal health insurance coverage in the United States?" To which God answers, "Yes, but not in my lifetime."

This joke summarizes the prospects that policy experts see for universal coverage in the United States. For senior policy-makers, this reflects the battle scars earned in past national conflicts over universal coverage. There has been no serious national attempt at universal coverage since the Clinton Health Security Act in 1994. Democratic presidential candidate John Kerry talked much more about lowering health insurance premiums than about broad expansions of coverage.

Over the past few years, however, significant coverage expansions have started to percolate up from the states. Maine's "Dirigo" program, enacted in 2003, gained national attention for its bold structure and large subsidies to individuals and employers. More recently, the state of Illinois announced plans to cover all uninsured children in the state. While these are dramatic expansions, they provide much less than universal coverage. In particular, they do not cover individuals who choose not to take up coverage even at highly subsidized rates, including the eight million children nationwide now eligible for public insurance but still uninsured.

A much bolder step was taken by the state of Massachusetts. Legislation enacted this April transforms the nature of the insurance market, subsidizes a large share of the low-income population so that they can afford health insurance, and mandates that all residents be covered by health insurance. This is truly a comprehensive reform that should bring the state closer to universal coverage than has been achieved anywhere else in the United States. But the legislation provides only a blueprint, with many details to be filled in. Its impact will depend on how state legislators and regulators resolve these outstanding issues.

In this article, I summarize the accomplishments, prospects, and pitfalls of the Massachusetts approach. I begin with a discussion of the major issues facing attempts at universal coverage, and the failings of approaches suggested by both the left and the right. I then turn to the specifics of the Massachusetts legislation, and how it cleaves a path down the center that addresses the shortcomings of either extreme. Finally, I discuss the remaining issues that are to be resolved in Massachusetts, and address the question of whether Massachusetts' approach can work in other states or in the nation as a whole.

Universal Coverage: What Are the Issues?

Any approach to universal insurance coverage in the United States must address three critical issues. First is the problem of pooling. Providing insurance efficiently requires large pools of participants created independently of the participants' health status. Absent such pools, insurers will be reluctant to offer insurance, or will do so only at very high prices, out of fear that their cus-

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tomers will be mainly people with serious health problem (a phenomenon known as adverse selection), who will then turn out to be very expensive. The majority of Americans can access insurance pools, either through large firms or publicly provided insurance, but most of the uninsured do not have access to any such pooling mechanism. Most of the uninsured do not work for an employer that offers insurance. Solving the problem of the uninsured thus requires developing a new pooling mechanism, either through government insurance or through private insurance pools such as that used by federal employees. The success of attempts to create a new pool will depend on its scale. Existing attempts to create state-level pools for small businesses have generally failed because they did not attract a sufficient number of enrollees to overcome concerns about adverse selection and to spread administrative costs. This is what recently caused the collapse of California's PacAdvantage plan, a voluntary pool for small businesses.

Second, there is the question of affordability. Health insurance is expensive. The average cost of family health insurance offered through large firms in Massachusetts is about $11,500, and it is even higher for small firms and yet again higher in the non-group market. For a family of four with an income of $40,000 (200 percent of the poverty line), family coverage would cost almost 30 percent of family income—a huge share of income to devote solely to health care. What is an "affordable" level of health insurance spending? There is no right answer, but these high costs highlight the fact that it is impossible for the government to substantially reduce the number of uninsured individuals without providing large subsidies to low-income groups to cover those costs.

Finally, attempts to extend insurance coverage must contend with the issue of mandates. Even large subsidies for health insurance coverage will not be sufficient to end the problem of uninsurance. As noted above, many of the uninsured are eligible for free public insurance or highly subsidized, employer-provided insurance, yet still do not take up either. To come close to full insurance in the United States would require an individual mandate—a requirement on individuals to obtain some type of insurance coverage. This mandate would be similar to auto insurance in most states, where individuals are required to have insurance if they want to drive a car.

The legislation transforms the nature of the insurance market, subsidizes a large share of the low-income population, and mandates that all residents be covered by health insurance.

Within the framework of these three issues, the left and the right ends of the political spectrum have favored contrasting approaches to achieve universal coverage.

The Left. The solution favored by the left is to expand public insurance entitlements. Eighteen percent of the nonelderly population and all of the elderly population are already covered by public insurance. Expanding public insurance would be by far the most efficient incremental expansion of insurance coverage, since it is tightly targeted to the low income groups most likely to lack insurance coverage otherwise. A natural extension of this approach would be national health insurance, such as in Canada, where one government insurer provides national coverage.

Such a system would have one clear advantage: savings in administrative costs. The administrative costs in private insurance average about 12 percent of premiums, while administrative costs in the Canadian National Health Insurance program are 1.3 percent. At the same time, there might be disadvantages from having the government set a national benefits package. The politicization of the benefits package selection might result in a package that would be wrong for most Americans. And government control could hinder innovation in how insurance is provided, resulting in missed opportunities for learning which approaches are best for benefits coverage and provider reimbursement.

Regardless of the pros and cons on policy grounds, however, the real problem with national health insurance is political. The private health insurance industry in the United States is a massive entity with more than $700 billion in claims paid. It is impossible to conceive of a world in which that industry could be legislated out of business. Health insurance reform that does not incorporate private health insurance seems unlikely in our lifetime, and maybe even in God's.

The Right. Those on the political right believe that the problems of pooling, affordability, and mandates are best addressed by expanding access to private health insurance. One strategy would be to give individuals tax credits to purchase health insurance from private vendors. Modest versions of this approach have been a staple of the Bush administration budget proposals in every year since 2001.

Such an approach has the advantage of directly addressing the affordability concern while maintaining the private health insurance market. But this approach explicitly does not address either of the other two issues. Currently, individuals who do not have access to either large employer pools or pub-

lic insurance, particularly those without any employer offer, face an insurance market that features high and variable premiums and often incomplete insurance coverage.[1] Providing individuals with more resources, but not giving them a place to take those resources to buy fairly priced insurance, is simply throwing good money after bad. Moreover, such an approach cannot provide anywhere near universal coverage. Even very generous subsidy policies cannot cover more than half of the uninsured on a voluntary basis.[2]

Massachusetts: Cleaving the Middle

The Commonwealth of Massachusetts is not typically regarded as a bastion of centrist thinking. Still, while the state does have a strongly partisan Democratic legislature, it has had a Republican governor for fifteen years. At the outset of his administration, the current governor, Mitt Romney, identified fundamental health care reform as one of his major goals (and perhaps even a signature legislative achievement that might promote a bid at the presidency). The political stars were therefore well aligned from the start.

Massachusetts has three other advantages that made universal coverage there more than just a wishful thought. First, the state has a relatively low uninsurance rate—about 9 percent of the non-elderly, compared to 18 percent nationally. This figure meant that fewer subsidies would be required to move to universal coverage. Massachusetts' lower uninsurance rate partly reflects its much higher rate of employer-offered insurance relative to the rest of the nation.

Second, a large amount of federal funding was at stake. As part of a Medicaid Section 1115 waiver—usually given in order to promote experimental or pilot health care programs—the state had since 1997 been receiving a large Intergovernmental Transfer (IGT) of the type used by many states to expand health care spending. The state was in essence using phantom state dollars to generate a federal match: it transferred the matched dollars to certain health care providers that then returned them to the state. Under the current waiver, renewed in 2002, the federal match amounted to $385 million by 2005. This money was directed toward the state's main safety net providers, Boston and Cambridge City Medical Centers, to run the state's largest Medicaid managed care plans. The rates paid these safety net providers were exceedingly generous, such that the federal government was essentially supplementing the expansion of these inner city hospitals.

In 2004 and 2005, the Center for Medicare and Medicaid Services (CMS) under the Bush administration was working to crack down on such schemes, and it threatened to eliminate the Massachusetts transfer. In response, the state took two actions. First, it found a large amount of state-only medical spending that could genuinely be relabeled as spending on the uninsured to justify the continued flow of the matching dollars. Second, it suggested to CMS that if the money continued to flow it would be reallocated: instead of being used to pay safety net providers, it would fund subsidies for individuals to buy insurance. CMS agreed to consider this alternative and gave the state a deadline of early 2006 to come up with a plan to use the funds to increase insurance coverage or lose them altogether. This was a real time bomb that importantly affected state deliberations.

Finally, Massachusetts had a ready-made funding source in place: the state uncompensated care pool. As part of an earlier attempt at health care reform in the late 1980s, the state set up a mechanism through which hospitals were able to bill to the state the costs of treating low-income patients, rather than absorbing those costs and passing them on to other payers. This pool had grown to over $500 million by 2005. Since universal coverage would reduce the ranks of the uninsured, it would obviate the need for a pool of this size. Some of these funds could then be rededicated to paying for a universal coverage system.

The Plan Unfolds

Initially, Governor Romney proposed a plan for universal coverage that had six central features. The first was the establishment of the "Exchange," a central purchasing pool through which insurance could be offered to individuals at lower rates than were available in the nongroup market. Second, all firms would be required to establish Section 125 accounts, which allow employees to pay their insurance premiums on a pre-tax basis, either for insurance provided by the firm or through the Exchange. Third, large subsidies would be made available to families living below 300 percent of the poverty line (roughly $60,000 for a family of four). Fourth, for those above 300 percent of the poverty level, a more limited insurance plan would be available at a cost of roughly $200 per month for individuals, so that insurance would be affordable even outside of the subsidized range. Fifth, all individuals would be mandated to have insurance coverage, as the state does for auto insurance. Finally, the plan would be financed by rededicating the federal funds going to safety net hospitals and by drawing on the funds in the uncompensated care pool.

Romney's proposal addressed the issues of pooling, affordability, and mandates in a bold and comprehensive way. Pooling would be achieved through the Exchange, which would essentially replace the unpredictable nongroup market with a more predictable group purchasing mechanism. Affordability would be addressed by subsidies to those below 300 percent of the poverty line and access to low-cost insurance for those above 300 percent of the poverty line. And universal coverage would be obtained through the individual mandate.

The proposal showed that the governor was serious about health care reform. Still, some of its features were problematic for the Democratic legislature. Most important, the legislature felt strongly that the plan should assign employers some responsibility. Some suggested that the governor's proposal be accompanied by "fair share" type provisions that would have levied assessments on firms from which the firms could then subtract their expenditures on health insurance. But such pro-

posals immediately met enormous opposition from both the business community and the governor. The legislature also wanted to cover more individuals through expansions of public insurance—another proposition strongly opposed by the governor.

Another important concern was the tremendous reduction in hospital reimbursement that would result from the rededication of current funding streams to insurance subsidies for low income individuals. The hospital sector is a vital component of the Massachusetts economy and a very powerful player in the local political scene. It was difficult to conceive that they could be forced to bear the brunt of financing this transformation.

Finally, there were also concerns about the type of coverage proposed above 300 percent of the poverty line and about the ability of individuals at that level to afford insurance under the individual mandate. In particular, Governor Romney's bill allowed that certain state-mandated benefits (such as infertility treatment) could, with the approval from the Exchange board, be excluded from the more affordable products; the legislature wanted to preserve all the mandates that they had previously written into law. There were also concerns that the $200 per month benefit package proposed by Romney would lead to excessively large patient cost-sharing burdens. Finally, there was strong opposition to mandating insurance for all citizens without ensuring that comprehensive insurance was affordable for them.

On the critical issue of the design of benefits, the legislation is largely silent. Little is specified except for the important issue of affordability.

Another advantage for Massachusetts was a Democratic legislature willing to look past its other disagreements with the governor and work together toward the goal of universal coverage. The final legislation followed the outline of Romney's plan while responding to some of the legislature's concerns. First, there is a very modest charge of $295 per employee for firms that do not offer health insurance to their employees. This small charge raises less than 5 percent of the total money spent in the legislation, and reflects more than anything a symbolic statement that employers should play some role. Governor Romney vetoed this provision in the legislation, but his veto was promptly overridden. Second, there is a very modest expansion in Medicaid, for children only, to 300 percent of the federal poverty line.

Third, the final legislation retains, at least initially, very large subsidies to hospitals in the state. The uncompensated care pool remains much larger than under the governor's proposal, and safety net hospitals retained much of the money they had been receiving under the federal matching grant whose revocation had been held over the legislature's head. These financing holes are filled, in a small part, by the employer assessment, and to a much larger extent by general revenues. And the subsidies are to be paid from essentially the same pot of money that funds subsidies to cover the uninsured, in order that as the system becomes more successful in covering the uninsured there will be fewer funds available to subsidize their hospital care.

On the critical issue of the design of benefits, particularly above 300 percent of the poverty line, the legislation is largely silent. The legislation requires only that there be very small patient copayments below the poverty line, and that there be no deductibles for plans offered to those below 300 percent of the poverty line. Plans must also continue to include state-mandated benefits such as infertility treatment. Beyond that, little is specified except for the important issue of affordability. The legislation contains a clause stating that the individual mandate is binding only for individuals for whom insurance is "affordable." This may prove to be a major loophole in the mandate.

Issues in Implementation

And there may be other problems, too. The legislation provides a blueprint for moving to universal coverage, but many of the critical details remain to be ironed out. By and large, the responsibility for addressing these details is left to the board of the new central purchasing mechanism, renamed the "Connector" in the final legislation, and to various state agencies, through their regulatory powers.

Minimum standards and affordability. The two major issues yet to be faced are related to each other. These issues are the standards for the benefits packages offered through the Connector and the structure of subsidies to low-income families. As the Connector moves forward to set up subsidy schedules and regulate available plans, it faces an "iron triangle" of competing pressures: the desire for affordability; the desire to minimize the public sector costs of subsidies; and the desire to ensure comprehensive insurance coverage for individuals. The problem is that the Commonwealth cannot move in all three directions at once. For example, if the state wants to increase affordability, it must either increase subsidies or make a less comprehensive insurance product available at a lower price. If it wants to minimize public sector costs, it must either make insurance less affordable through lower subsidies or decrease the cost of the insurance subsidies by making insurance less comprehensive. If it wants to make sure

that insurance is comprehensive, it must either make that insurance less affordable through higher premiums or raise the subsidies to offset those higher premiums.

Currently, Massachusetts has set aside $675 million for subsidies for those below 300 percent of the poverty level. As a consultant to the state in 2005-2006, I estimated that these funds were sufficient to make insurance affordable for that group. But there remain affordability concerns for those at 300 to 400 percent of the poverty level. For example, the typical large group family plan cost of about $11,500 per family amounts to almost 20 percent of family income for a family of four with an income at 300 percent of the poverty line. While "affordable" remains to be defined, a plan this expensive is clearly outside the range.

Clearly, unless a fairly low cost benefit package can be devised, insurance will be deemed "unaffordable" for a considerable share of the population, and those people will therefore be exempt from the mandate. Health economics research has shown, fortunately, that insurance can be more restrictive than the typical insurance package held today without impacting health in a negative way. There is no consistent evidence that the network restrictions put in place in the height of the managed care revolution of the 1990s negatively impacted health. And the famous RAND Health Insurance Experiment showed clearly that for the average person, the copayments for medical care could rise significantly without deteriorations in health.[3] At the same time, there were some subgroups of ill patients for whom higher copayments did deter needed care—primarily among low-income groups.

Employer erosion. Another major concern, particularly on the left, is the plan's lack of significant employer responsibility. Indeed, some have argued that placing responsibility for coverage on individuals and assessing employers that do not offer insurance only $295 per employee will actually lower rates of employer-provided insurance coverage, since $295 is less than employers would pay to have an employee insured. But this argument makes no economic sense. In principle, the plan could erode employer coverage. But the main force for erosion is the availability of subsidized non-employer based group coverage, not the individual mandate or the assessment. The Connector's subsidies for low income families could erode employer provision because individuals who wanted employer insurance only because there was no other good option now can turn elsewhere, and because individuals who want to get the low income subsidies *must* leave the employer pool.

The individual mandate would only increase pressure on employers to provide coverage, since employees would prefer employers who can help them meet the mandate. Employers may not respond to this pressure, but there is no reason why a mandate would decrease coverage. Now add the assessment on non-offering employers. Not offering has now been taxed relative to offering. The assessment is in essence a tax on not offering—it is simply additional pressure to offer coverage. Thus employers have no reason to respond to this tax by suddenly not offering.

There is a clear tension here, as our attempt to fix the holes in the employer system will put pressure on the very existence of the system. But this pressure does not come from the individual mandate or from the assessment. Quite the opposite: it comes from the fact that there is a new non-employer based pooling mechanism. This is a major accomplishment of the legislation, even if the byproduct is some erosion of employer-provided coverage. In other words, to ensure access for the many individuals who do not have employer offers, we put in place a system that might lead some employers to no longer provide insurance. It is not clear why this is a major problem. Ultimately, the goal of health reform should be to ensure that everyone has access to a pool to purchase affordable insurance. Whether that pool is inside or outside of the employer setting is not really relevant to achieving that goal.

The basic framework could be feasible in any other state or at the national level. The major advantage for Massachusetts was that the financing was easier.

Can It Work Elsewhere?

The major question that has been asked about the Massachusetts reform is whether it can work elsewhere. Clearly, the basic framework of a central purchasing mechanism, subsidies for low income groups, and an individual mandate could be feasible in any other state or at the national level. The major advantage for Massachusetts, however, was that the financing was easier because of the low number of uninsured, the incentive provided by the possible revocation of federal funds, and the uncompensated care pool.

A number of other states have low uninsurance rates, and they would be natural candidates for this type of approach. But the financing burden remains central. The key to making this work in other state contexts may be in making explicit the implicit tax on the insured (and on taxpayers who support public hospitals) from uncompensated care. Once citizens recognize, as they were forced to do in Massachusetts, that there are already implicit and explicit taxes being used to finance

uncompensated care, they may be more willing to rededicate those funds toward expanding coverage.

The major lesson from Massachusetts is that its approach cannot work elsewhere without all three parts of the proposal: a pool, subsidies, and an individual mandate. In particular, one common concern that has been voiced in the wake of the Massachusetts proposal is that other states will take parts of this proposal, such as the individual mandate, without other parts, such as sufficient subsidies to ensure affordability. This would obviously be very problematic. The insight of the Massachusetts approach was that a private sector-based universal coverage approach is a three-legged stool. Remove any leg and the stool falls.

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The New Massachusetts Health Reform: *Half a Step Forward and Three Steps Back*

BY STEFFIE WOOLHANDLER AND DAVID U. HIMMELSTEIN

Massachusetts runs in regular cycles. Every eighty-six years our Red Sox win the World Series. Once a decade Harvard hires a senior woman scientist. And every twenty years our legislature passes a universal health care bill that the governor hopes to use as a springboard to the White House.

Unfortunately, Governor Mitt Romney's stab at universal coverage looks set to repeat the flop of Michael Dukakis's bill two decades ago. Then as now, our governor crowed about "Health Care for All" in the statehouse rotunda. But Dukakis's plan imploded within two years, and today 250,000 more people are uninsured in Massachusetts than on the day it was signed.

The Structure of the New Bill

The new bill includes two provisions meant to expand coverage. First, it will modestly expand Medicaid eligibility. Second, it requires people with incomes above 100 percent of the poverty line to purchase a private insurance policy. The state will offer partial subsidies for the purchase of this private coverage to families with incomes below 300 percent of the poverty line (about $30,000 for a single person or $60,000 for a family of four). Those above three times the poverty line will have to pay the full cost of their own coverage.

To help make coverage more affordable, a new state agency called "the Connector" will connect people with the private insurance plans that sell the coverage. The Connector is also supposed to help design affordable plans. Massachusetts citi-

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