Massachusetts' Plan: A Failed Model for Health Care Reform

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Executive Summary

The Massachusetts Health Reform Law of 2006 expanded Medicaid coverage for the poor and made available subsidized, Medicaid-like coverage for additional poor and near-poor residents of the state. It also mandated that middle-income uninsured people either purchase private health insurance or pay a substantial fine ($1,068 in 2009). Smaller fines (up to $295 per employee) were also levied on employers who fail to offer insurance benefits.

The reform law has not achieved universal health insurance coverage, although half or more of the previously uninsured now have some type of insurance policy.

The reform has been more expensive than expected, costing $1.1 billion in fiscal 2008 and $1.3 billion in fiscal 2009. In the face of a state budget crisis in fall 2008, Gov. Deval Patrick announced that he will keep the reform afloat by draining money from safety-net providers such as public hospitals and community clinics.

While the number of people lacking health insurance in Massachusetts has been reduced, several recent surveys demonstrate that substantial problems in access to care remain in the state. While the new health insurance improved access to care for some residents, many low-income patients who previously received completely free care under the state's old free care program now face co-payments, premiums and deductibles that stop them from getting needed care.

In addition, cuts to safety-net providers have reduced health resources available to the state's remaining uninsured, as well as to others who rely on safety-net providers for services in short supply in the private sector. These safety-net services include emergency room care, chronic mental health care, and primary care. The net effect of this expensive reform on access to care is at best modest, and for some patients, negative.

By mandating that uninsured residents purchase private health insurance, the law reinforced the economic and political power of health insurance firms. Thus, the reform augments the already high administrative costs of health care. Moreover, the agency that administers the new law (the "Connector") adds an extra 4 to 5 percentage points to the already high overhead of private health insurance policies.

The reform failed to reduce overreliance on expensive, high-technology services. Indeed, some of its provisions such as changes in Medicaid rates and cuts to safety-net providers (who do more primary care) have further tilted health spending toward expensive, high-technology care.

A single-payer system of non-profit national health insurance could save about $8-$10 billion annually in the state through reduced administrative costs. This money could be used to cover all of the state's uninsured residents and to improve coverage for those who now have insurance, without any increase in total health care costs.

The Massachusetts reform law is not providing universal access to care, even in a state with highly favorable circumstances, including previously high levels of spending on health care for the poor, high personal incomes, and low rates of uninsurance. It is not a model for the nation.

Background

In 2006, under the leadership of then-Gov. Mitt Romney, Massachusetts set out to fundamentally change how it financed care for the poor, greatly increasing the availability of insurance while decreasing the use of free care by the uninsured. A major impetus for the reform came from the Bush Administration, which insisted that the state reduce block funding of indigent care through the state's free care pool, or forfeit $385 million in federal Medicaid funds. In addition, there had been considerable activism in the state by supporters of universal health insurance. For instance, in 2000, a universal health care initiative was placed on the ballot by a group of Massachusetts doctors and nurses. It was narrowly defeated after the state's health insurance industry, led by Massachusetts Blue Cross, spent a million dollars a week to oppose it in the final weeks before the election. The 2006 reform effort eventually garnered support from many of the state's politicians, as well as the insurance and hospital industries, and some consumer and business groups, although not the state's single-payer advocates.

At the time of passage of the Massachusetts Health Care Reform Act, the number of uninsured in the state was estimated by a University of Massachusetts survey at 550,000 and by the U.S. Census Bureau at 657,000. With no more than 10.4 % of its population lacking coverage (one-third lower than the 2006 national rate of 15.8%) the state's circumstances were believed to be favorable for health reform. In addition, the state had two other advantages: (1) it already spent substantial funds for care of the uninsured, primarily through block grants from a free care pool to safety-net providers such as public hospitals and community clinics to cover the costs of free care and medications; and (2) it was relatively wealthy with abundant health care resources, high personal incomes and a healthy tax base.

Under the reform, the state committed to providing subsidized medical coverage to an expanded set of eligible individuals through the Medicaid program (called MassHealth in Massachusetts) and through a new insurance program, Commonwealth Care. A unique feature of the reform is the statutory "individual mandate" that requires most non-poor adults to purchase private (unsubsidized) health insurance policies or pay a fine.

The Connector

The reform law authorized the development of an independent state agency, known as the Connector, to implement the reform. The Connector offers a menu of insurance options and serves as an intermediary to assist individuals in acquiring health coverage. It manages two similarly named but different health insurance programs, Commonwealth Care and Commonwealth Choice.

Commonwealth Care is a subsidized insurance program for Massachusetts adults earning less than 300% of the Federal Poverty Level. (Currently the FPL for a single individual is $10,404.) Commonwealth Care insurance is available only to people who do not have access to employer-sponsored insurance or Medicaid and who meet certain residency guidelines.

The Connector also manages the second program, Commonwealth Choice, which is a menu of

commercial, non-subsidized insurance policies available to individuals earning 300% of the FPL or more, and to small employers. The Commonwealth Choice program resembles the Federal Employees Health Benefits Program (FEHBP) in that it provides a menu of regulated, private plan options. However, it differs from FEHBP in that enrollees must pay the full insurance premium and they receive no subsidies.

In addition to managing these two programs, the Connector is charged with developing several policy and regulatory components of reform. Among its most important policy tasks are the establishment of the benefits packages and premium contribution schedules for the Commonwealth Care program, the development of regulations defining what constitutes coverage for purposes of the mandate, and the construction of affordability guidelines.

Mandatory Employer Contributions

Employers with 11 or more full-time equivalent employees are required to establish Section 125 plans, which enable employees to purchase health insurance on a pre-tax basis. In addition, these employers must make a "fair and reasonable contribution" to their employees' health insurance costs or pay the state an annual assessment of up to $295 per employee. These surcharges (which were predicted to yield $45 million annually but totaled only $5 million in the first year of the program) are to be used to help offset the costs of reform.

The Individual Mandate

The new law mandates that all uninsured adults with incomes greater than 300% of poverty must purchase private insurance or pay a fine. The fine was initially a few hundred dollars, but was $912 in 2008 and will rise to $1,068 in 2009. The fines are collected along with the state income tax, and are, essentially, a new tax on the uninsured. The law allows some taxpayers to avoid the fine if they can show that no affordable coverage is available.

Subsidized Care for the Poor and Near-poor

Commonwealth Care is publicly funded like Medicaid, but differs from traditional Medicaid by including enrollee-paid premiums and co-payments (from which enrollees earning less than 100% of the FPL are exempted) and benefit restrictions. Premiums and co-payments for the poor and near-poor (100% to 300% of FPL) are set using a sliding scale. Commonwealth Care plans are offered by four non-profit insurers, two of which are affiliated with the largest safety-net hospital systems in the state. Anyone offered employer-sponsored coverage, and many immigrants (including many legal immigrants) are ineligible for coverage under this program.

Unsubsidized Care for the Middle-income Uninsured

For the Commonwealth Choice program (the unsubsidized menu of plans for those earning more than 300% of the FPL) the Connector selected six large commercial insurers. The Connector classifies the available commercial plans into four levels: Gold, Silver, Bronze, and Young Adult. The first three levels are based on the comprehensiveness (i.e. actuarial value) of the plans. For instance, lower-priced Bronze plans include a $2,000 per person deductible,

restrictions on site of care, co-payments, etc. Gold plans resemble a traditional Blue Cross policy, but are very expensive. The fourth level (Young Adult Plans) offers a slimmer benefit level with caps on total benefits and is available only to adults younger than 27 years old.

Financing the Reform

On passage of the reform, then-Gov. Mitt Romney declared "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced."[1] However, the reform has not reduced health costs in the state, and the reform has proven far costlier than expected: $1.1 billion 2008, with costs of $1.3 billion forecast for 2009.

A small share of the financing for the program comes from assessments collected from employers who do not offer insurance and fines from individuals who do not purchase insurance as required by the mandate. A much larger share of the funding comes from funds diverted from the state's "free care pool." This pool had been financed through government appropriations and special assessments on private hospitals and insurers, and had funneled money to safety-net facilities such as public hospitals and community clinics. These safety-net providers not only care for uninsured and underinsured patients, but also provide disproportionate amounts of services that are in short supply in the private sector due to low reimbursement, including emergency room care, primary care, and care for persons with serious mental illnesses.

Outcomes of the Massachusetts Reform

How Many are Covered?

The number of uninsured people in Massachusetts has fallen since passage of the reform in 2006. However, the extent of the decline is unclear. Approximately 295,0000 are known to have obtained care through the state's Connector or Medicaid programs. State government officials estimate that an additional 147,000 people purchased health insurance without the state's help. According to these estimates, as of June 2008 about 440,000 Massachusetts residents had gained coverage. Estimates of the number of uninsured before the reform range from 550,000 to 657,000 (with most experts believing the more accurate estimate is the higher number, which comes from the U.S. Census Bureau). Thus a maximum of 67% to 80% of the state's uninsured now have insurance[2].

Insured Population by Type of Insurance (excludes Medicare enrollees)

	Number of members (rounded to nearest 1,000)			
Type of insurance	**6/30/06**	**6/30/07**	**6/30/08**	**Change since 6/30/06**
Private Group[a]	4,274,000	4,378,000	4,421,000	+147,000
Individual Purchase[b]	40,000	36,000	80,000	+40,000
Medicaid	705,000	732,000	785,000	+80,000
Commonwealth Care[c] **(subsidized)**	0	80,000	176,000	+176,000

[a] includes large group, small group and self-insured
[b] includes Commonwealth Choice and residual non-group market
[c] as of January 2009, enrollment in Commonwealth Care had fallen to 163,000

The above number of people with newly acquired private group insurance (147,000) may be an overestimate, as it is based on membership reported to the state by the health plans prior to the onset of the current economic downturn. Moreover, this membership may include some people who work in Massachusetts but live elsewhere (such as Boston's populous New Hampshire suburbs).

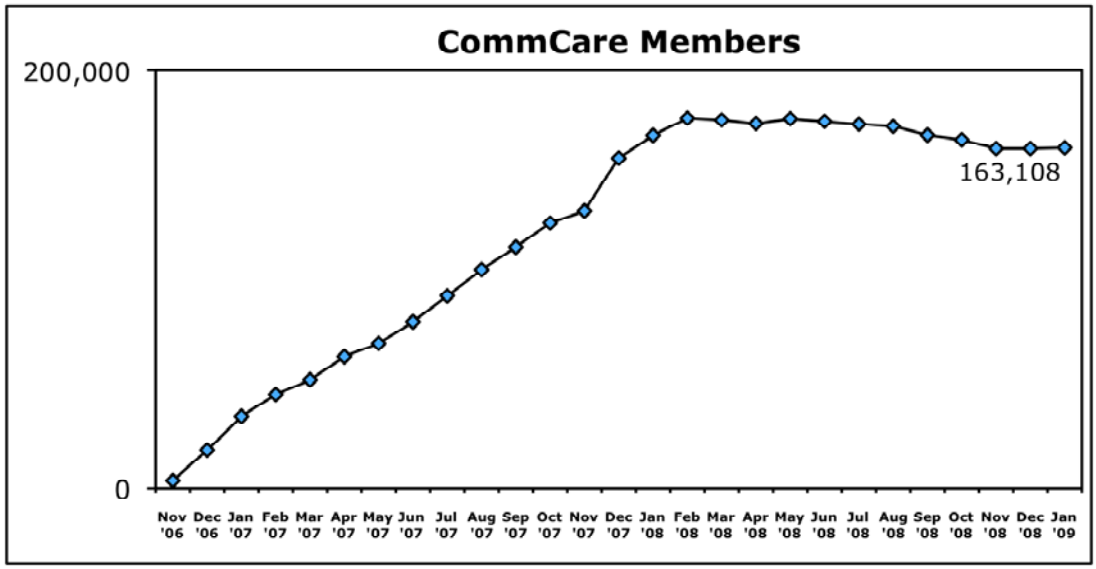
How many people in Massachusetts remain uninsured? Many state politicians are trumpeting the results of a recent phone survey by the Urban Institute (and available on the state's website at www.mass.gov), which found only 2.6% of respondents to be uninsured in mid-2008. However, despite considerable efforts, this survey reached few non-English speaking households and few households lacking landline phones---two demographic groups with high rates of un-insurance.

Surveys using more rigorous methods have yielded higher estimates of the number of state residents who remain uninsured. In March 2008, the U.S. Census Bureau conducted its annual door-to-door survey using a group of interviewers representing every major language group. Households were asked about their insurance coverage in the previous year --- 5.4% of people said they were uninsured.

Similarly, the Massachusetts Department of Revenue (DOR), which administers the tax penalties on those who fail to obtain the mandated coverage, reports that 5% of income tax filers were uninsured as of December 2007. However, persons who fail to file a tax return[1] are believed to be at high risk of being uninsured, so even these DOR figures may underestimate the number of uninsured residents.

Perhaps the most compelling evidence that the number of uninsured persons exceeds the 2.6% figure comes from the safety-net providers who continue to provide free care to the uninsured. According to the Massachusetts Department of Health Care Policy and Finance (which partially reimburses safety-net providers for such care), the number of patients receiving free care has fallen by just over a third (36%), not the 75% that would be expected if the state's uninsured had fallen from 10.4 % of the populations (its pre-reform level according to the Census Bureau) to the 2.6% rate that the reform's proponents claim.

Moreover, the coverage gains from the reform may have plateaued. It seems unlikely that gains in private, employer-based coverage (estimated by state officials to be 147,000 -- more than a third of the newly insured) will be sustained in the current economic downturn. Meanwhile, the state has begun dis-enrolling about 5,000 people per month from its subsidized Commonwealth Care insurance program following eligibility reviews resulting in a small drop in enrollment between mid-2008 and early 2009[3].



[1] Many persons who fail to file income tax returns do, in fact, have taxes deducted from their pay checks. Others may be paid under the table or have no income. However, the numbers of such "non-filers" is difficult to estimate.

Many Remain Uninsured Because Insurance is Not Affordable

The state has failed to ensure the availability of comprehensive plans at affordable prices. Despite the merging of the small group and individual insurance markets, which was expected to lower costs in the individual market, premiums continue to be unaffordable for even the least comprehensive (skimpiest) plans. For instance, the reform law specifically exempts uninsured families from fines if no affordable private plan is available. About 79,000 Massachusetts uninsured residents received this exemption in 2007, which excused them from fines, but left them uninsured.

The private insurance plans available through the Commonwealth Choice program can be extremely expensive. According to the Connector website (accessed December 29, 2008 at www.mahealthconnector.org) the cheapest plan available to a middle-income 56-year-old now costs $4,872 annually in premiums alone. However, if the policy holder becomes sick, (s)he must pay an additional $2,000 deductible before insurance kicks in. Thereafter the policy holder pays 20% co-insurance (i.e. 20% of all medical bills) up to a maximum of $3,000 annually ($9,872 in total annual costs including premium, deductible and co-insurance). A need for uncovered services (e.g. physical therapy visits beyond the number covered) would drive out-of-pocket costs even higher. It is not surprising that many of the state's uninsured have declined such coverage.

The Mandate Is Regressive

Both the mandated tax penalty and the insurance premiums paid through the Connector in order to avoid the tax penalty are highly regressive. Middle-income people pay a much higher percentage of their income than the affluent for fines or premiums, and older people pay more than younger people. For instance, for identical coverage a 57-year-old pays twice the premium charged to a 35-year-old.

Access to Insurance Does Not Guarantee Access to Care

Massachusetts health reform has had a salutory effect on access to insurance, having provided half or more of the state's previously uninsured residents with insurance policies. Yet, it has had a lesser effect on access to care. For some state residents, the reform has actually made access worse, even before the latest round of cuts to safety-net providers.

Many low-income residents had been eligible for completely free care (including medications) under the state's old free care system, including all residents earning less than 200% of poverty. Access to care was often excellent for low-income residents living near a safety-net provider such as a public hospital or community clinic, but less than adequate for those living further away.

The new insurance policies that replaced the free care system require co-payments for office visits and prescriptions, which are difficult for many low-income patients to pay. For instance, at Cambridge Health Alliance, doctors and nurses have cared for patients who were forced to interrupt care for HIV and even Hodgkins lymphoma, two serious but highly treatable conditions, because they were unable to afford the new co-payments. (Several of these cases

have also been reported to the state).

Moreover, the situation is likely to worsen. For fiscal year 2009 the Connector went through protracted negotiations with the four non-profit insurers participating in Commonwealth Care (the subsidized insurance program). In order to bring the state's cost increases down from 15.4% to 9.4%, the plans boosted co-payments and enrollee contributions, making services even less affordable for the near-poor families enrolled in Commonwealth Care. Several safety-net providers are now demanding (for the first time) that patients whose condition is not immediately life-threatening make up-front co-payments before seeing a doctor.

Many middle-income Massachusetts residents continue to have private policies with substantial gaps like co-payments, deductibles and uncovered services. The new law has put the state's imprimatur on high deductible, high co-insurance plans by offering them as "Bronze Plans" through the Connector.

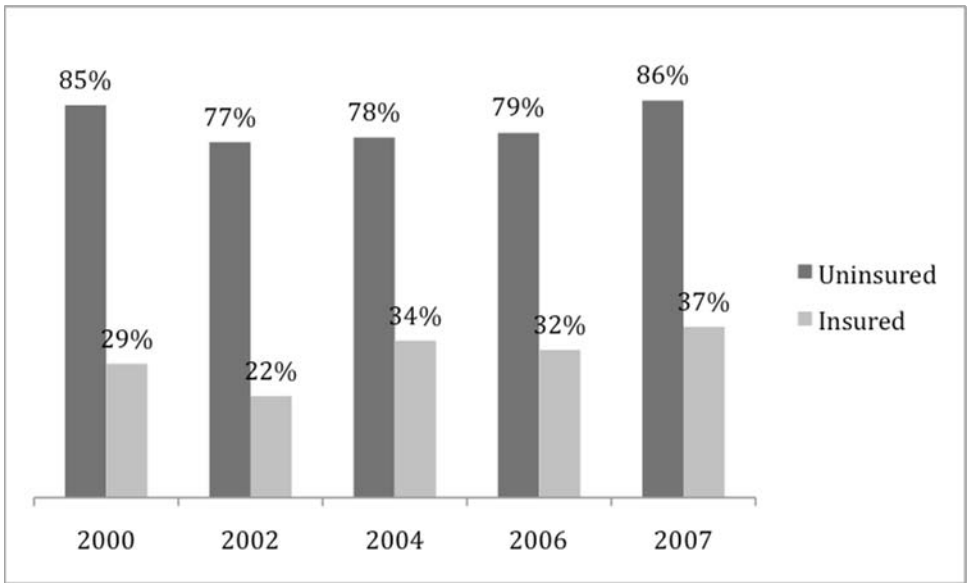
Such skimpy plans are known to decrease access to care, and provide little financial protection in the face of a prolonged and expensive illness. For instance, studies of medical bankruptcies have found that more than three-quarters of those bankrupted by illness or medical bills have health insurance at the onset of the illness that bankrupts them[4]. Bankruptcy sometimes occurs when a breadwinner loses employment, and with it health insurance, due to illness. In other cases, bankruptcy occurs in families who keep their private insurance throughout an illness, but are bankrupted by gaps in their coverage like co-payments, deductibles, and uncovered services. The Massachusetts reform failed to address the problems of these so-called underinsured.

The Evidence on Access to Care

What is known about the effects of the new law on actual access to care (as opposed to access to insurance)? A single 2007 survey done by the Urban Institute and partially financed by The Blue Cross Foundation found that the share of Massachusetts residents who went without needed care fell by 3.9% overall, and by 4.8% among low-income persons. An updated survey by the same researchers was done in mid-2008 (before the effects of the current economic downturn, increased co-payments, or safety net cuts are likely to have been felt), but has not yet been released. However a recent Boston Globe/Blue Cross Foundation survey found that one in three Massachusetts residents said the cost of care is their biggest health concern; 13% of insured individuals were unable to pay for some health services that they had received and 13% could not afford to fill necessary prescriptions.[5]

Data on the state's website (accessed December 30, 2008 and reproduced below) show no improvement in access to care between 2006 and 2007.

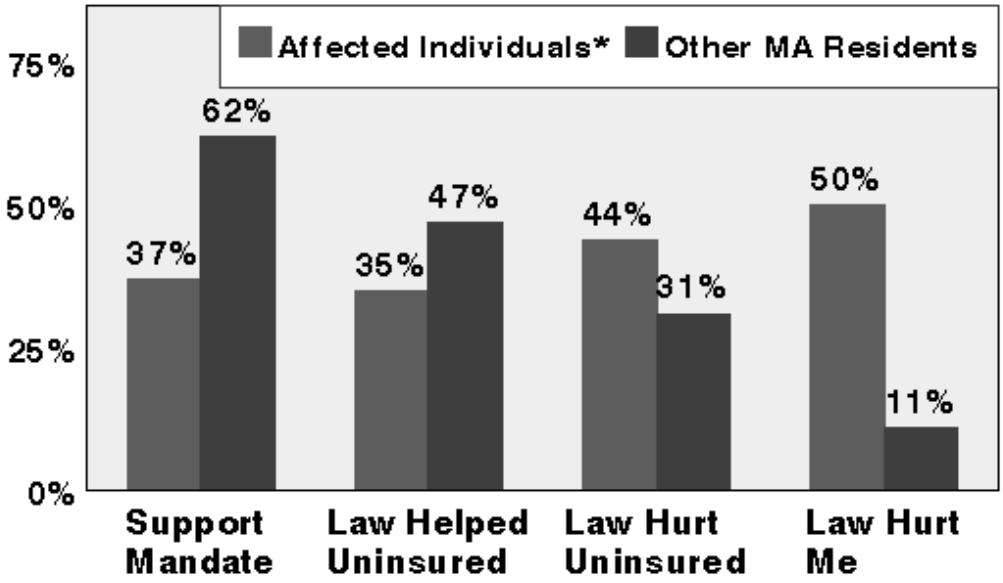
Percentage of adults ages 19-64 who needed care but cost was an obstacle[6]



As mentioned above, demand for care from safety-net providers remains substantial.

Finally, a recent Harvard School of Public Health/Blue Cross Foundation poll[7], suggests that many lower income residents were actually harmed by the reform. This survey of randomly selected Massachusetts residents included 176 persons directly affected by the new reform, either because they had been uninsured in the past year, or because the reform had forced them to change insurance. Among this group, more believed that the reform had hurt the uninsured than believed that the reform had helped (44% v. 35%). Fully half of those affected by the reform said that they had personally been hurt by it. Although unaffected Massachusetts residents had a favorable impression of the new reform, those directly affected did not; only 37% of them supported the new mandate.

Persons Affected by Health Reform Say They Have Been Hurt



***Those who were uninsured in the past year or changed coverage as result of the law.**
Source: Harvard School of Public Health/Blue Cross Foundation Poll, referenced above.

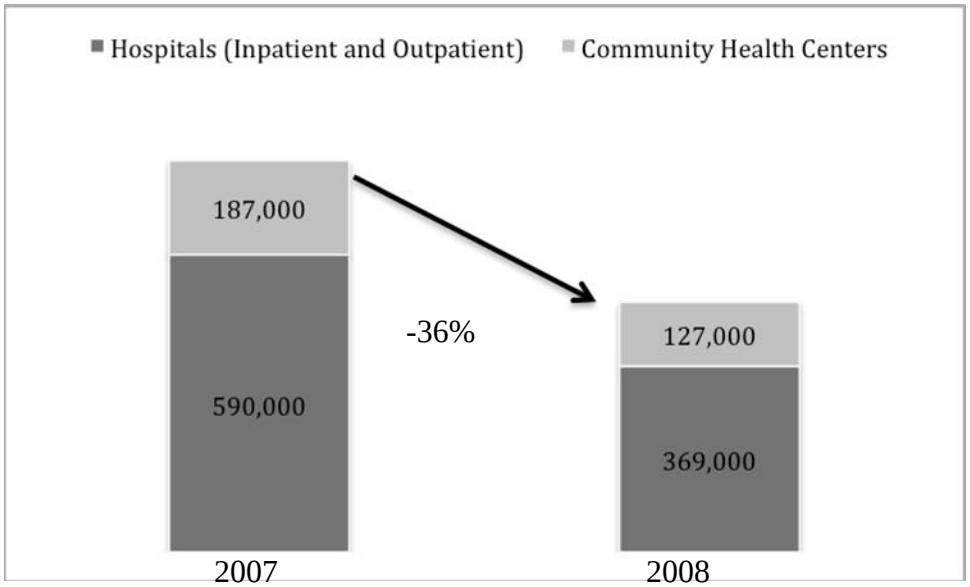
The reform has decimated the state's safety net

As detailed above, in 2006 the Bush administration refused to release $385 million in Medicaid funding unless the Massachusetts health reform reduced free care pool payments to safety-net hospitals. Hence, reduced funding to safety-net institutions is integral to the reform.

Although surveys suggest that between 50% and 75% of the uninsured now have insurance, the demand for free care has fallen much less. Free care patient visits have decreased by only about one-third statewide, and by only about one-fifth at one of the state's two major safety-net institutions, Cambridge Health Alliance. (Data from the other major safety-net provider are not publically available.) However, even prior to the most recent state budget crisis, funding for hospital free care had fallen faster than the demand for such services.

Decrease in Free Care Volume as a Result of Massachusetts' Health Reform[6]

(trend: First half of FY 2007 to first half of FY 2008)



In October 2008, Massachusetts Gov. Deval Patrick announced that the state was facing a $1.4 billion budget gap and intended to cut an additional $150 million from payments promised in the reform legislation to the states' two largest safety-net health institutions -- Boston Medical Center (formerly Boston City Hospital, now merged with Boston University Hospital) and Cambridge Health Alliance (CHA) , which runs 20 community health centers and the state's three remaining public general hospitals. As of February 6, 2009, these safety-net providers are planning substantial cuts in safety-net services. CHA will be forced to close Somerville Hospital and several neighborhood health centers, and to sharply reduce the provision of both inpatient and outpatient psychiatric care.

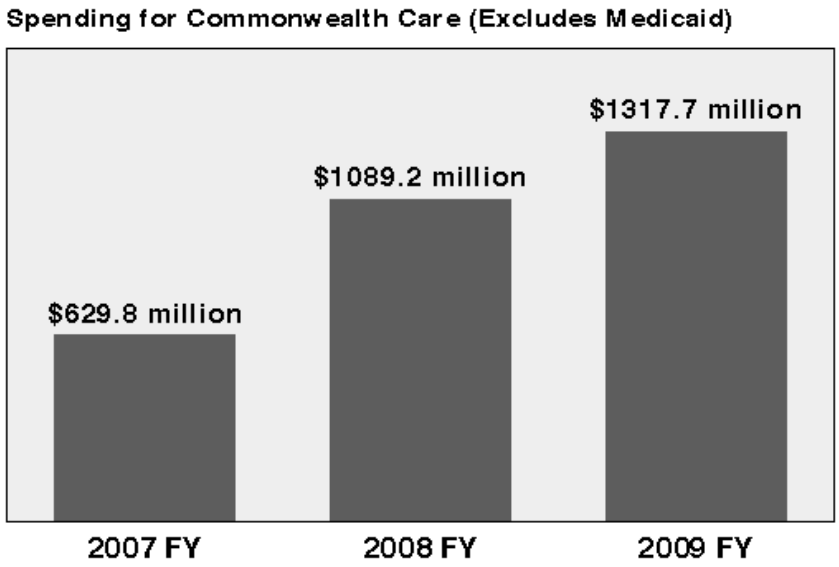
Budget cuts threaten the viability of these institutions, which have historically received special government payments to provide vital but money-losing services. These services include not only care for the state's uninsured, but also primary care, psychiatric care for the severely mentally ill, addiction services and emergency services that are in short supply because they generally lose money for private hospitals even when the patients have insurance. In essence, the Patrick administration has decided to pay for insurance for some needy patients by curtailing services for other needy patients, including not only the state's remaining uninsured, but also insured persons requiring care that private hospitals avoid. Such patients may literally find themselves with nowhere to go when sick.

Escalating Costs Make the Reform Unsustainable

The reform has been more expensive than expected (as shown below), costing $1.1 billion in fiscal 2008 and $1.3 billion in fiscal 2009. The plan does nothing to control skyrocketing health care costs. Even before the health reform, health costs in Massachusetts were among the highest in the world, approximately 25% higher than the U.S. average. Since the reform's passage, premiums have continued to escalate. The costs for the four (subsidized) Commonwealth Care plans rose 9.4 % in 2009, significantly higher than increases in inflation or wages.

The health reform has actually increased administrative costs and waste, already a major cause of high health care costs in the U.S. The Connector adds an additional 4.5% administrative cost to each policy it brokers. This is on top of the overhead of individual insurance plans, an average of at least 10%.

Finally, the reform does nothing about a major driver of high health care costs, the overuse of high-technology care such as CT scanners and surgeries, and the underdevelopment of primary care. Indeed, one little-known provision of the reform actually shifted resources away from primary care by lowering Medicaid payment rates for such services, while raising them for high-tech, tertiary care services.



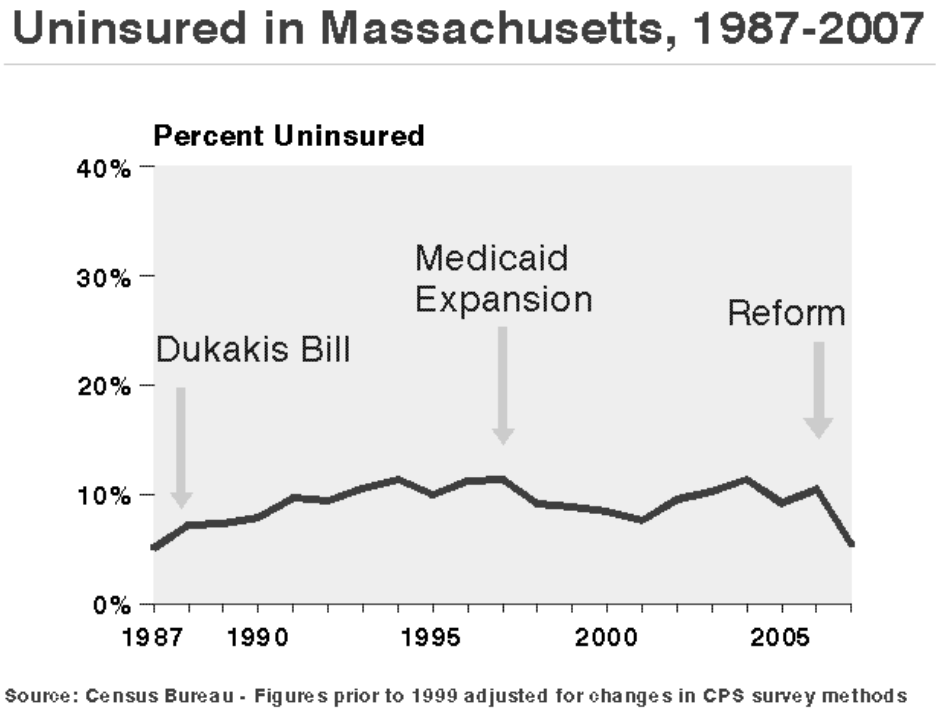
Source: Commonwealth of Massachusetts Information Statement for Bondholders, August 22, 2008

The Massachusetts Reform:
A Rerun of Past State Reforms That Have Failed

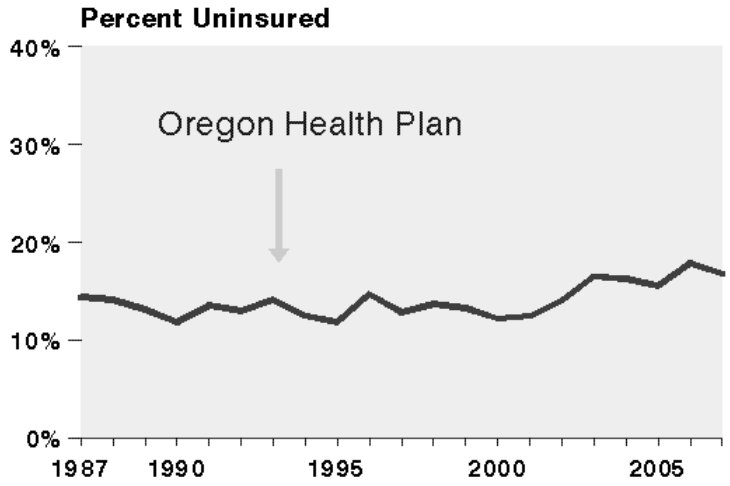
Back in 1988, Massachusetts passed a universal health care law very similar to the 2006 reform. Since 1988, many states—Oregon, Minnesota Tennessee, Vermont, Washington and Maine—have enacted reforms aimed at achieving universal coverage. All failed.

These reforms differed in detail, but shared common elements. All offered new public subsidies or expanded Medicaid for poor and near-poor people. All left the majority of private health insurance arrangements undisturbed, although many included new insurance regulations or state purchasing pools to help make affordable coverage available to individuals or small businesses. Some (Massachusetts 1988, Oregon 1992, Washington State 1993) contained mandates on employers or self-employed individuals.

None of these reforms made more than a temporary dent in the number of uninsured as shown in the series of state-by-state graphs on changes in rates of uninsurance below. These incremental reforms failed because they did not include effective cost-control measures. As health costs rose, legislatures backed off from forcing employers and the self-employed from paying ever-rising premiums and the mandates were repealed. Relying on Medicaid was fiscally problematic for states because tax revenues fall at the same time that unemployment pushes families out of private coverage. There is little reason to think that the current Massachusetts reform, or a national plan modeled on these state reforms, would have any better long-term success.

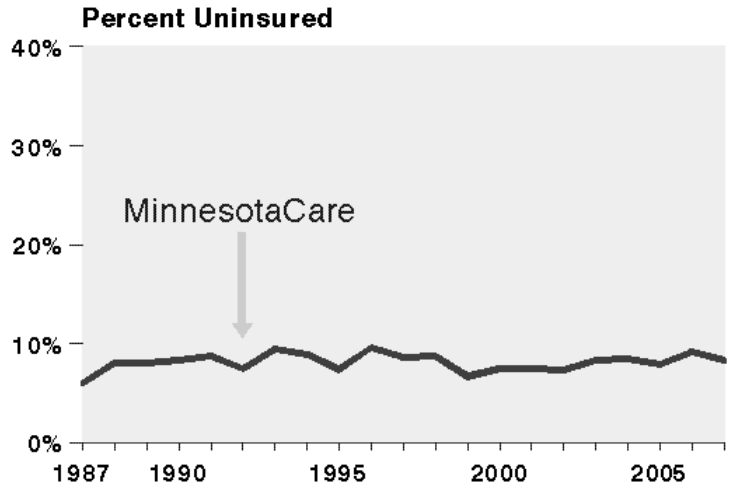


Uninsured in Oregon, 1987-2007



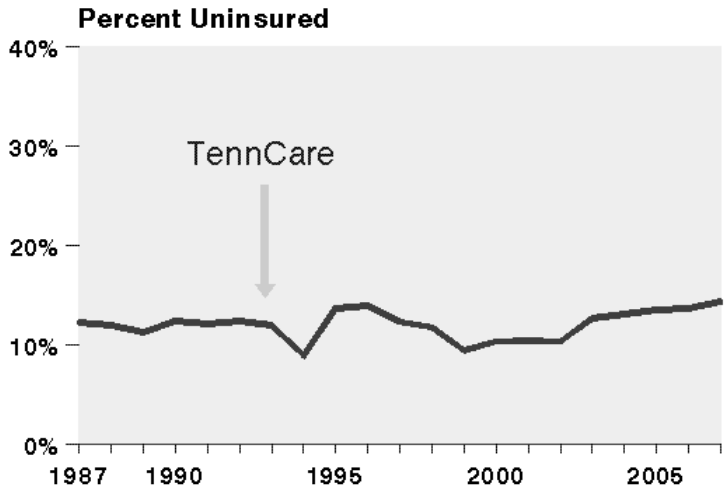
Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Uninsured in Minnesota, 1987-2007



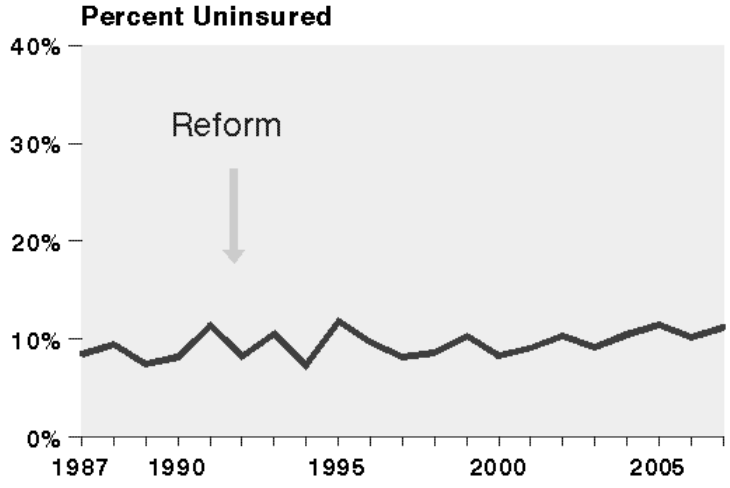
Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Uninsured in Tennessee, 1987-2007



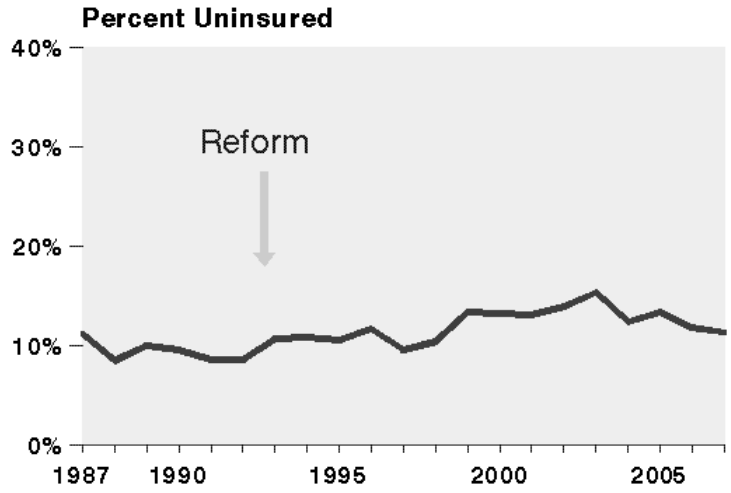
Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Uninsured in Vermont 1987-2007



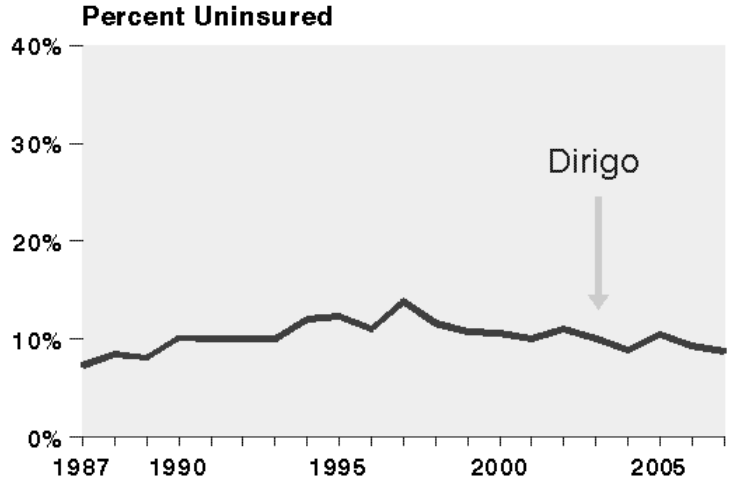
Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Uninsured in Washington 1987-2007



Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Uninsured in Maine, 1987-2007



Source: Census Bureau - Figures prior to 1999 adjusted for changes in CPS survey methods

Is there an alternative to this model?

Yes. A bill in Congress, **the United States National Health Care Act, H.R. 676** (also known as "The Expanded and Improved Medicare for All Act") would implement single-payer financing of health care while maintaining the private delivery system. A single-payer program would eliminate private insurers and use the administrative savings to provide comprehensive coverage for all. Features of the single-payer plan include:

- **Comprehensive coverage for all,** including doctor, hospital, long-term, mental health, dental and vision care as well as prescription drugs and medical supplies.

- **No premiums, co-payments, or deductibles** that inhibit access to care and unfairly burden the poor.

- **Free choice of doctor and hospital** and an end to insurance company and HMO dictates over patient care.

- **Pays for itself** by eliminating wasteful private insurance administration and profit. A progressive tax would replace what is currently paid out-of-pocket.

- **Controls costs so benefits are sustainable** through negotiated physician fees, global budgets for hospitals and bulk purchasing of prescription drugs and medical supplies. A single-payer system would facilitate health planning to reestablish the balance between preventive and primary care on one hand, and high-tech tertiary care on the other.

The nation must not look to Massachusetts' health reform as a model. If we truly want to provide comprehensive health care for all of us at a price we can afford, we must adopt a single-payer plan.

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