

Massachusetts Health Care Reform: A Look At The Issues

Independent analysts assess the Massachusetts reform and its potential for success and replication elsewhere.

by **John Holahan and Linda Blumberg**

ABSTRACT: Massachusetts recently enacted a major health reform that could move the state to close to universal health insurance coverage. We describe some of the politics behind the legislation and the law's key details. We discuss four major issues that the plan would face: (1) a definition of affordability—how much should be borne by individuals and how much by government; (2) issues the state will face in implementing the Insurance Connector; (3) whether employers will respond by dropping coverage; and (4) whether the financing would be adequate, both immediately and over time. Massachusetts will face challenges, but it offers a model that could be followed elsewhere. [*Health Affairs* 25 (2006): w432-w443; 10.1377/hlthaff.25.w432]

THE MASSACHUSETTS HEALTH CARE REFORM BILL was signed into law 12 April 2006. The legislation reflects a compromise reached by Gov. Mitt Romney (R) with leaders of the state Senate and House, Robert Travaglini and Salvatore DiMasi, respectively. The essence of the legislation is a mandate that everyone in the state have health insurance if affordable coverage is available (an individual mandate), an assessment on employers that do not provide coverage to their workers, a purchasing arrangement—the Commonwealth Health Insurance Connector—designed to make affordable insurance available to individuals and small businesses, and premium subsidies to make coverage affordable. No other state requires health insurance coverage for all of its residents, which makes this legislation and its pending implementation of intense interest to policymakers, employers, and individuals across the country. If its reform is implemented as designed, Massachusetts will be the first U.S. state to achieve universal or near-universal health insurance coverage.

Brief Background Summary

The health reform debate in Massachusetts was spurred in part by negotiations over extension of the state's Medicaid waiver. The waiver, granted in 1997, allowed the state to enact a major expansion of coverage and provided new federal match-

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ing funds on supplemental payments made to safety net–sponsored managed care organizations (MCOs). In the past few years, the federal government began to challenge the state’s financing of the waiver, in particular the MCO supplemental payments. Without restructuring the waiver, the state faced the loss of more than \$385 million in federal funds. The Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for approving or denying such waivers, desired to see these funds devoted directly to coverage for the uninsured through expansion of insurance and payment for unreimbursed Medicaid costs. These funds were critical to the financing of the state’s health care safety net.

Massachusetts has a relatively low uninsurance rate because of broad employer coverage and an extensive Medicaid program. Also, the state’s Uncompensated Care Pool provides funds to hospitals and community health centers (CHCs) that provide care to those without insurance coverage. This pool is funded by assessments on hospitals and a health insurance premium tax (essentially an assessment on those with insurance, including those in self-funded plans), as well as general revenues and federal matching funds. But the number of uninsured people had been rising in recent years, increasing pressure on those hospitals that provide the bulk of uncompensated care.¹ This in turn threatened to raise assessments on hospitals and insurers to support the pool. Since these assessments are passed on to purchasers in the form of higher insurance premiums, businesses that provide health insurance coverage to their employees were becoming increasingly concerned with the trend toward increased uncompensated care. At the same time, rising health care costs also contributed to the fragility of pool financing. These factors came together to spark an intense debate over health reform.

In June 2005 Governor Romney made a proposal that would move the state close to universal coverage. He eschewed any Medicaid expansion but instead offered income-related premium subsidies for those without an employer offer of coverage. The heart of his proposal was an insurance “Exchange” that offered low-cost products to individuals and firms with fifty or fewer workers, through which employees could purchase coverage with pretax dollars. Low-cost products would be offered through the Exchange by eliminating mandates that all insurance sold in the state include particular benefits and by allowing insurers to offer plans with high deductibles and limited provider networks. Governor Romney further proposed an individual mandate enforced by tax penalties.

The state Senate proposed Medicaid expansions for children and parents, provider rate increases, and strong support for safety-net providers, but it was unwilling to entertain any form of mandate or premium subsidies. Following Governor Romney, the Senate bill would establish an insurance Exchange offering low-cost products. The Senate did call for a “Free Rider Surcharge” in which firms that did not offer would have to pay the cost of any care their employees used in the Uncompensated Care Pool.

The state House proposed an employer mandate with a 5 percent payroll tax on

firms with fewer than 100 workers and a 7 percent payroll tax on those with more than 100 workers. Firms would get a credit offsetting their payroll tax liability in the amount of any contributions they made toward their workers' health insurance. Thus, in most cases, employers offering coverage to their workers would be able to avoid paying the payroll tax. The House also had an individual mandate subject to a provision that coverage would be affordable. They offered income-related subsidies up to 300 percent of the federal poverty level for individuals and families. For those below 300 percent of poverty, there would be no deductibles. The House bill also proposed a purchasing arrangement, called the Connector, in which low-cost products would be offered and subsidized premiums would be available. Finally, the House called for broad MassHealth (Massachusetts Medicaid State Children's Health Insurance Program, or SCHIP) expansions, expanding program eligibility up to 300 percent of poverty for children, 200 percent of poverty for parents, and 100 percent of poverty for childless adults, as well as sizable MassHealth provider rate increases.

The Compromise

The compromise legislation that was passed has several important features. First, it expands MassHealth for children to 300 percent of poverty and raises the current enrollment caps on Medicaid coverage for certain groups of disabled people, some childless adults, and people with HIV/AIDS—all covered as part of the MassHealth waiver. The broader Medicaid coverage proposals for adults in the House and Senate bills were not enacted. The compromise also calls for MassHealth provider rate increases reaching \$270 million after three years, along with the restoration of certain benefits for adults (dental, vision, chiropractic) that were cut in recent years.

Second, there is an individual mandate subject to an affordability provision. Income-related premium subsidies to help make coverage affordable are included, but neither the subsidy schedule nor the definition of *affordability* is set forth in the legislation. Individuals are also required to take up public coverage, if eligible (in principle, individuals and families could be exempted from the take-up requirement if the MassHealth premiums were deemed “unaffordable”). The individual mandate applies to people age eighteen and older and will be enforced via the tax system. The legislation did not include children in the mandate, although the MassHealth expansion and increased outreach efforts should result in close to full coverage. State income tax returns will require evidence of insurance coverage, and those not complying will face tax penalties.

Third, employers are, at a minimum, required to establish a Section 125 plan for their workers. Using the Section 125 plans, workers can pay their health insurance premiums with pretax dollars, even if their employers contribute nothing toward that coverage.

Fourth, if employers with more than ten employees do not make a “fair and rea-

sonable” contribution to their workers’ insurance coverage (with *fair and reasonable* yet to be defined), they are subject to a per worker per year assessment not to exceed \$295 (prorated for part-time and seasonal workers). Employers with more than ten employees that do not at least offer their workers a Section 125 plan are also potentially eligible for the Free Rider Surcharge. This surcharge requires employers to pay 10–100 percent of the cost of care provided to their workers and their dependents in the Uncompensated Care Pool. The Free Rider Surcharge will be triggered only when an employer’s workers incur \$50,000 or more in Uncompensated Care Pool costs.

Fifth, the compromise legislation includes a purchasing arrangement called the Commonwealth Health Insurance Connector. The intent of the Connector is to link individuals without access to employer-sponsored insurance and firms with fifty or fewer workers that offer health care benefits. Small businesses (fifty or fewer workers) will be able to purchase insurance either on their own or through the Connector. The board of the Connector is also charged with determining if coverage is affordable, given a family’s financial circumstances, and defining the minimum level of coverage required to meet the individual mandate.

Sixth, the Connector will operate the Commonwealth Care Health Insurance Plan (CCHIP), which will be available on a subsidized basis for those with household incomes up to 300 percent of poverty. Only those who (1) are not eligible for MassHealth or Medicare, (2) have resided in the state for the past six months, and (3) did not have access to employer-based insurance in the past six months with an employer contribution of at least 33 percent of premium for single coverage and 20 percent of premium for family coverage are eligible for CCHIP enrollment. The law allows for the Connector board to waive the exclusion of workers with employer offers, however. If it does so, the employer’s contribution would be paid to the Connector as an offset to the state’s CCHIP subsidy. If the employer’s contribution exceeds the amount of the state’s subsidy, the remainder would be used to reduce the worker’s premium requirement. Commonwealth Care will have no deductibles, and there will be limits on cost sharing for those with incomes below 100 percent of poverty. No premiums will be charged to those below 100 percent of poverty, and a sliding-scale premium will apply to those with incomes of 100–300 percent of poverty. The Connector will be responsible for setting this premium-subsidy schedule. Only those managed care plans now contracting with Massachusetts Medicaid may provide coverage through Commonwealth Care for the first three years.

Seventh, an unsubsidized component in the Connector will offer coverage to those with incomes above 300 percent of poverty. Plans in the Connector may have relatively high deductibles and limited provider networks, but they will be required to offer all state-mandated benefits. Employees without access to employer-sponsored insurance will be able to buy coverage through the Connector with pretax dollars through Section 125 plans, as noted earlier. There is no provi-

sion for nonworkers purchasing coverage independently through the Connector to do so on a pretax basis. The legislation also includes market reforms that will combine the individual and small-group markets. In this way, products offered to small employers will also be available to individual purchasers, and the relative health risks of small-group and individual buyers will be merged for purposes of determining premiums. In addition, insurers will be allowed to offer separate products for individual purchasers ages 19–26. These young-adult products will be available only for purchase through the Connector. Because young adults have a high rate of uninsurance, it is hoped that such regulatory flexibility will allow new products to be designed with this group’s particular needs and preferences in mind.

Eighth, the reform plan provides substantial protection for safety-net providers. These providers—particularly two major safety-net institutions in Boston and Cambridge—argued strongly that there was likely to be a residual pool of uninsured people to whom they would need to continue to provide care after the reform was implemented. The bill protects safety-net providers in two major ways. First, only plans that now serve Medicaid enrollees, which include plans operated by these two hospitals, are allowed to serve the CCHIP market. Second, these hospitals retain about \$900 million in direct funding in 2007 and \$480 million in 2009, at which time most Massachusetts residents are expected to have health insurance coverage.

Finally, the plan will be financed by maintaining the existing \$320 million in assessments on hospitals and covered lives, federal safety-net payments (a continuation of federal waiver payments) of \$610 million, federal matching payments on the MassHealth expansions, added benefits and rate increases (an estimated \$299 million for the third year), and \$125 million in new general revenues. The employer assessment (\$295 per worker) and the Free Rider Surcharge will also add modest new revenues.

The Big Issues

The Massachusetts health care reform is a bold initiative. It offers the potential to achieve close to universal coverage and offers a never-before-implemented mechanism, the individual mandate, as the centerpiece to achieving this goal. Government funding, through the Medicaid expansion and income-related subsidies for private plans, aim to help make coverage affordable. The approach retains some employer responsibility but keeps the employer burden low, thereby avoiding the serious business opposition that has afflicted reform efforts in the past.

Although there is much positive to be said for the strategy taken in Massachusetts, major challenges remain. Chief among them are the following.

■ **Affordability.** For an individual mandate to be fair and acceptable, it must make coverage affordable. The Massachusetts legislation does not define *affordability*, nor does it specify the subsidy schedule that will be offered to low-income residents.

The number of people covered under the reform will be a function of both of these. Ideally, the subsidy schedule would be directly linked to the affordability standard. In that way, each family would be subsidized to an extent that would allow them to purchase coverage within the standard of affordability. Nothing in the Massachusetts legislation requires such a linkage, however, and revenue constraints could make doing so difficult. In particular, the purchase of subsidized coverage is limited in the legislation to those with household incomes at or below 300 percent of poverty. This implies that a number of individuals and families with incomes higher than this benchmark might find appropriate coverage difficult to afford.² In addition, depending upon the level of demand for subsidized coverage and the premiums negotiated with subsidized plans, allocated subsidy funds might be insufficient to cover all of those who are eligible. The legislation suggests that in such an event, caps on enrollment in the subsidized CCHIP plans would be put in place.

The mandate will apply only to those who can obtain coverage within the definition of *affordability*. A high affordability standard (for example, individuals expected to spend up to 15 percent of income on medical care) would mean that the individual mandate could be applied to a larger number of individuals, thus increasing coverage. However, the financial burden on those with low and middle incomes would be great under a high standard; this might be considered unreasonable and could lead to decreased compliance. A high affordability standard could, however, reduce government subsidy costs if the subsidy levels were tied to the affordability standard. Conversely, a low affordability standard (for example, individuals expected to spend up to only 6 percent of income or less on medical care) would ease the individual/family financial burden of the mandate but would increase the per capita government subsidy required to ensure that individuals could meet such a standard. Very low affordability standards would most certainly require that enrollment in the subsidy program be capped, thereby excluding from the mandate some who would meet the income-eligibility standards for subsidization, or require that sizable new revenues be raised to finance subsidies for all eligible people.

■ **The Connector.** A second set of issues revolves around the Connector, its negotiating power, the benefits offered by its plans, and the premium savings its plans can provide.

Negotiating power. Enrollment in the Connector is limited to people working for firms that do not offer employer-sponsored coverage, nonworkers, workers who are not eligible for their employer's offer of coverage, the self-employed, and employers with fifty or fewer workers. Those working in firms with fifty-one or more workers whose employer makes a reasonable contribution to coverage are not eligible. The number of people enrolling in coverage through the Connector will be affected by the exclusion of those in firms of fifty-one or more workers as well as by the attractiveness of Connector plans to small employers relative to plans in the non-Connector market.

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The intent is that the Connector would hold down premiums by having plans with relatively high cost-sharing requirements and limited provider networks. High cost sharing is intended to make consumers more efficient purchasers of care and will shift some medical costs from the insurance policy to the person using the care. Limiting provider networks means that plans can exclude high-cost providers. Both of these approaches could help reduce premiums relative to those of other plans. But high-cost-sharing plans have not been popular in Massachusetts; they can be offered now in the commercial market, but they have only a small market share. This could change, however, by introducing higher cost sharing in health maintenance organizations (HMOs) and by linking high-deductible plans with health savings accounts (HSAs). Plans with limited provider networks are also possible today but have not been offered frequently. If the insurance market does not produce plans with high cost sharing and limited provider networks, their impact on costs is likely to be minimal. Without such cost-saving components, it will become important for the Connector to be an effective negotiator with plans. The consequence of a Connector with a smaller market share is that it will be in a weaker position to negotiate prices with participating insurers. In other words, the smaller the Connector’s enrollment, the higher premium prices in the Connector can be expected to be for a given set of benefits.

The Connector will also be responsible for negotiating premiums with the plans providing coverage through the subsidized CCHIP. In the first three years, only the four managed care plans providing government-funded services through MassHealth will be allowed to participate. Although the state already has experience negotiating with these plans, limiting competition by excluding all other potential bidders could adversely affect these plans’ incentives to bid efficiently or to negotiate with the state, or both. The level of premiums the state is able to negotiate for CCHIP plans will have direct implications for the level of subsidy required to make coverage affordable for low-income families, and hence the government costs of the program and its ability to expand coverage. Competition might increase with the entry of other plans after three years, but the first years’ experiences with the newly subsidized low-income population might be determinative.

Benefits. The fact that participating Connector plans are not required to offer a standardized package of benefits is also likely to impinge on its ability to create a competitive purchasing environment. The lack of standardization will make it more difficult for potential purchasers to compare plans by price. While benefit-package descriptions will, no doubt, be provided for each plan, variations in policies are notoriously difficult to compare for even the highly educated, which makes plan selection a much more complex undertaking and one more likely to re-

sult in consumer dissatisfaction or plans that do not deliver the best value for the money spent, or both.

Although the specific plans offered through the Connector may vary considerably, they may also be dominated by plans with high deductibles, other types of high cost-sharing requirements, or benefit limitations. These plans would have lower premiums than the more comprehensive policies typical of the current Massachusetts insurance market; however, they bring with them the potential of adverse consequences for middle-income residents and those with high health care needs. More-limited plans such as these are particularly attractive to those who do not expect to use much in the way of health care services.

For example, a large deductible is not a deterrent to someone who does not expect to go to the doctor during the year, and the lower premium that goes with that high deductible can be attractive. High-deductible plans might attract a sizable segment of the healthier portion of the Connector-eligible population, which would make it difficult for more comprehensive policies to survive either within the Connector or, over time, in the small-group/individual insurance market outside of it. This is because the premiums in comprehensive policies are driven up if they attract a population with relatively high average costs when the population with lower average costs is peeled off into limited plans. Limited-benefit or high-cost-sharing plans, or both, may result in shifting financing burdens away from the collective insured population and onto those who use health services the most. This dynamic would not be expected to occur within CCHIP because these plans do not have deductibles and would presumably be required to offer standardized benefit packages, as is true under MassHealth.

There are ways to counteract such a dynamic in the nonsubsidized portion of the Connector, short of defining a uniform and relatively comprehensive set of plan benefits. The state could provide additional subsidies beyond those now defined in the legislation for people with high health care needs and for those of modest incomes who just exceed the CCHIP income-eligibility limits. It will be critical to monitor the needs for such additional assistance as the reform is implemented. Ignoring such potential vulnerabilities would be akin to placing more importance on the number of people with some type of coverage than on the number of people who can effectively get access to needed medical care.

Potential premium savings. Directly related to the benefit-package discussion above is the issue of whether or not the unsubsidized Connector plans can be structured to achieve major savings, thereby making them attractive and affordable to the currently uninsured population. As noted, the designers' intent is that the Connector offer high-deductible plans with limited provider networks. Governor Romney's original proposal was to exempt these plans from mandated-benefits requirements, but the final legislation does not include this provision.³ Regardless, to greatly reduce premiums by reducing the types of services covered, the exclusions would have to go well beyond eliminating the mandated benefits (which by

themselves do not tend to be terribly costly) and would be so substantial as to make the remaining package of benefits unattractive to the vast majority of purchasers. Thus, the main way that premiums can be held down is through higher deductibles and other types of cost sharing and through offering coverage within limited provider networks only.

Limiting provider networks can achieve major cost savings only if the major academic medical centers and large numbers of specialists can be excluded. These kinds of policies can be offered now, but the evidence suggests that policies that excluded such providers might not do well in the marketplace. It remains to be seen whether such plans would be attractive to those without current coverage who are required to enroll in something under a mandate and might be looking for the lowest-price option to satisfy the law.

But the most likely approach for insurers to offer lower-cost plans is by constructing policies that require much higher out-of-pocket spending than is typical today. High-deductible plans can now be offered in the commercial market (although not by HMOs) but have had minimal take-up, which is probably an indicator of their limited appeal. As noted earlier, if such policies are attractive—say, because of the HSA feature—they will tend to increase segmentation in the insurance market by health care risk. If such high-cost-sharing policies do not prove attractive, it is difficult to see how plans in the Connector would be able to hold down premiums. As noted above, the Connector as envisioned does not seem equipped to use other mechanisms to control increases in health care spending.

■ **Employer response.** Ideally, the reform would not greatly disrupt existing insurance arrangements between employers and their workers. As the program is designed now, most employers—particularly large employers that already offer group insurance—are not likely to stop doing so. These employers are not required to provide insurance now, but they do so because the federal and state tax exclusion of their contributions to health insurance is a significant value to workers and helps employers recruit the best workers. Employer coverage also benefits from the advantages of risk pooling, control over benefit design, and low administrative costs. None of these would change under the reform. If a large employer dropped coverage, its workers could enroll in Connector-based coverage as individuals. Some workers in large firms might be better off if their employer established a Section 125 plan, stopped contributing to coverage, paid the fair-share contribution of \$295 per employee, and made commensurate increases in wages and salaries; workers could then enroll in the Connector and obtain the same tax benefits that are now available when an employer contributes. In general, however, the benefits of risk pooling, control over benefit design, and lower administrative costs associated with purchasing through a large employer are likely to trump the tax advantages of the Connector.

Employers with fifty or fewer workers are in a somewhat different position, however. Allowing workers to purchase coverage on a pretax basis using Section

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125 plans reduces the incentive for small employers to offer coverage to their workers independently. As noted above, an important catalyst for offering coverage under the current system is that it provides workers with a tax advantage that they cannot get when buying coverage on their own. The Connector would level that playing field. This is a more important issue among small employers than it would be among large employers: Small firms are already more likely to be on the cusp of offering and not offering coverage because the administrative costs of coverage are so much higher for them.

To the extent that sizable numbers of small employers that now offer coverage stop doing so under the reform, Connector enrollment will increase. Although increased enrollment might provide the Connector with some negotiating advantages, it might also increase the number of people enrolling in the subsidized plans, thereby increasing pressure on government costs and limiting the number of newly insured people. The lower incentives for small employers to offer coverage to their workers might be offset, however, if workers with current coverage do not find the Connector plans attractive.

There are many unknowns that make it impossible to predict the net change in the number of small employers that will offer coverage outside of the Connector, the types of plans that will be provided by offering employers, and other specifics of the future insurance marketplace in Massachusetts. These include the impact on premiums for different levels of coverage in the non-Connector market once its small-group and individual markets are merged; whether introducing more-limited plans in the Connector will make comprehensive plans too expensive to sustain as a result of risk segmentation; and whether negotiating power in the Connector will be sufficient to generate true premium savings relative to the non-Connector market. Much will depend upon the particular plan offerings in the Connector and their effects on the coverage decisions made by people with different health care risks.

■ **Revenues.** The final issue is whether revenues are adequate to meet the goals of the reform. By 2009 the legislation allows for about \$95 million to finance Mass-Health expansions and additional benefits. It further provides for \$725 million for income-related subsidies. Whether or not these revenues are adequate to bring the state to universal or near-universal coverage depends upon the number of people who want to enroll in subsidized coverage, their average health care risk, the power of the Connector to hold down CCHIP premiums, the subsidy schedule, and how the standard of *affordability* is defined. Taken together, these factors have joint implications for government costs, financial burdens placed on individuals and families, and the number of people covered by the mandate to obtain coverage (and hence the

number of people remaining uninsured).

Government costs can be contained either by requiring people to pay more of their incomes toward health care (in premiums or out-of-pocket payments or both) or by excluding more people from the mandate. The former raises obvious issues of fairness, and both have the potential to reduce the impact of the reform. Financial burdens on individuals can be lessened, and the mandate can be made most comprehensive if generous subsidies are provided to the low income and those with high health care needs. But doing so may push the program costs beyond currently budgeted levels, requiring additional sources of financing (such as increased sales, income, or excise taxes or some combination) or reductions in promised fund flows to existing safety-net providers.

Financing issues could also grow increasingly contentious over time. As noted above, premiums and subsidy costs are inextricably linked. We have argued here that the Massachusetts health reform does not contain strong cost containment measures. To the extent that health care premiums grow faster than state revenues, the need for subsidies will also grow to keep insurance affordable and maintain the reach of the mandate. These problems would be exacerbated with a recession, as the growth in state revenues declines.

Concluding Comments

The Massachusetts health reform plan is potentially of enormous consequence. If it is implemented successfully, Massachusetts will be the first U.S. state to achieve (close to) universal coverage, and many features of the plan will offer lessons for the country as a whole. The benefits of universal coverage come primarily from increases in economic well-being as a result of improved health. Using a methodology developed by the Institute of Medicine, we estimated the increase in economic well-being from improved health in Massachusetts to be about \$1.5 billion.⁴ This figure includes only the estimated value of healthy life years gained as a result of expanding insurance coverage to those who lack it, and it does not include other benefits associated with universal coverage that are much more difficult to quantify. These include the reduced risk of financial problems for individuals and families as a result of bankruptcies, reduced demands on emergency departments by the uninsured, greater workplace productivity, and higher tax payments from those whose health would be improved. Finally, universal coverage would reduce the financial burdens on many low-income families and small firms who now pay substantial amounts for coverage.

The numbers cited earlier indicate that there would be an additional \$299 million in new federal matching payments and approximately \$175 million in new state revenues (including the employer assessment, free-rider surcharge, and general revenues) generated under the reform. Even if the state finds that it needs additional funds to improve the subsidy structure, the cost of financing universal coverage in Massachusetts would be relatively small relative to the state's gross

domestic product (GDP). Elsewhere, we have calculated that if the total new cost were \$1.2 billion, this would be about 0.3 percent of the state GDP and about 2 percent of the state's current total health spending.⁵ Thus, even if new revenues are required, it should be affordable (although politically difficult) to raise what is needed, and the economic benefits that would be achieved would far outweigh the total new investment of state funds.

There has been much discussion nationally over whether the Massachusetts reform offers lessons for other states or perhaps even for the country as a whole. Massachusetts has advantages that most other states lack: It has a low uninsurance rate, an Uncompensated Care Pool that has provided ample support to the safety net, strong advocacy groups, and faced the need to restructure its use of MCO payments to maintain federal waiver funds. But if a state wants to push toward universal coverage, Massachusetts has much to offer. It is difficult indeed to imagine a major health reform that does not include an expansion of a state's Medicaid program, the use of income-related subsidies, a purchasing-pool arrangement, and a mandate. Achieving universal coverage anywhere will clearly require an individual mandate even if an employer mandate is also part of a state's reform. Combining all of these features is the strength of the Massachusetts reform.

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NOTES

1. According to the Current Population Survey, the number of uninsured people in Massachusetts increased from 637,131 in 2002 to 744,117 in 2004, a 16.8 percent increase in two years.
2. By "appropriate coverage," we mean coverage with premiums and cost-sharing requirements at reasonable levels relative to income. Plans with very high deductibles may, for example, have affordable premiums, but if the cost-sharing requirements of such a plan impede access to care when necessary, the coverage should be considered inappropriate for people at that income level.
3. Mandated benefits in Massachusetts include maternity care, mental health, infertility, and chiropractic services, among others.
4. J. Holahan, R. Bovbjerg, and J. Hadley, "Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays, and What Would Full Coverage Add to Spending?" (Boston: Blue Cross Blue Shield of Massachusetts Foundation, November 2004). This calculation requires estimation of the value of a year of healthy life and the effect of health insurance on health. We estimate \$2,635 to be the discounted present value of lost health over time as a result of being uninsured and conversely the gain to being insured. Multiplying this amount by approximately 550,000 uninsured people in the state yields economic benefits of about \$1.5 billion.
5. L.J. Blumberg et al., *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications*, June 2005, http://www.roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf (accessed 8 August 2006).