

P E R S P E C T I V E

Massachusetts: More Mirage Than Miracle

The state's reform measures amount to too little and too late of a challenge to the existing health care cost structure.

by **Tom Miller**

ABSTRACT: Enactment of the Massachusetts health reform plan stemmed primarily from several factors unique to the state. They were augmented by a questionable rationale that this latest version of health reform would forestall even greater threats ahead to the interests of the state's business community, private insurance policyholders, and taxpayers. The plan's foremost achievement involves development of a "Connector" mechanism to facilitate pooling and purchasing beyond the workplace. However, its successful implementation will be challenged by the complexities of enforcing an individual mandate and changing the long-standing course of an overregulated and high-cost health market. [*Health Affairs* 25 (2006): w450-w452; 10.1377/hlthaff.25.w450]

THE MASSACHUSETTS health reform plan has generated more favorable press plaudits and political projections than its shaky foundations merit. Achieving a sustainable balance of long-standing political tensions involving the affordability, comprehensiveness, and tax-subsidized cost of health insurance guarantees remains an elusive goal. Massachusetts policymakers need to consider other policy options that go well beyond the fiscal hydraulics of achieving a thin shell of universal coverage and address more serious shortcomings in the comparative value of health care services delivered to their constituents.

■ **What's the matter with Massachusetts?** No state until now has succeeded in requiring that all of its residents be covered by health insurance, let alone guaranteeing it.¹ If it's ever going to happen, it's most likely to occur in Massachusetts. A previous near-universal health care law for the state, relying on an employer mandate, was approved in 1988 but was ultimately repealed in the mid-1990s.

When Gov. Mitt Romney (R) signed bipartisan legislation in April 2006 aimed at moving the state much closer to this long-standing objective (through an individual mandate), oft-frustrated advocates of universal coverage in other states, or the country as a whole, were rejuvenated. Nevertheless, Massachusetts started out in a far better position than its would-be imitators, with a much lower rate of uninsurance; broader Medicaid participation levels; and a particularly generous, taxpayer-funded pool of money for uncompensated care. Moreover, the fortuitous timing of a soon-to-expire federal Medicaid waiver, placing more than \$300 million for uncompensated care funds at risk, provided the key leverage to seal the final legislative deal between Governor Romney and the predominantly Democratic state legislature. An equivalent harmonic convergence of the above factors remains far less likely in other states considering similar coverage expansion initiatives.

■ **Selling a bill of coverage goods.** Several superficially persuasive arguments used in

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the Massachusetts debate to secure support, or at least temper opposition, from business and taxpayer interests might have less staying power in the long run. First, many business groups, which saw an individual mandate for insurance coverage as a second-best political heat shield against either an employer coverage mandate or a single-payer ballot initiative, might need to reconsider their stance. Fiscal pressures during the next round of debate could lead state politicians to seek greater coverage contributions by employers, far beyond the legislation's initially modest, if not largely escapable, backup employer mandate.

Second, the "cost-shifting" rationale was repeatedly used to persuade taxpayers, employer plan sponsors, and private policyholders that they would pay significantly less if purported free riders were forced to purchase insurance and reduce their use of uncompensated care. Much of this argument is vastly overstated, if not illusory. At the national level, the best estimates of uncompensated care costs and financing suggest that less than one-third of the total medical costs of care for the full-year and part-year uninsured are "uncompensated"; that about 85 percent of funding for such uncompensated care is provided by government dollars; and that only about \$6 billion (in 2004 dollars)—less than 5 percent of the total medical care costs for the uninsured—remained as a possible source of cost shifting to private insurance premiums.² At a May 2004 forum, Urban Institute researcher Jack Hadley observed, "It's often very convenient if you're negotiating with an insurer to say, well, my costs are high because I treat so many uninsured people." However, the amount of private cost shifting that does go on is "relatively small."³ In Massachusetts, an even greater proportion of otherwise uncompensated care for the uninsured was already covered through public financing (state taxpayers picked up a little over half; federal taxpayers handled the rest). Public funding sources under the new plan are rearranged and transferred in part from uncompensated care payments to coverage subsidies, but there are no signs of any net reduction in taxpayer obligations. The in-

creased cost of health services consumed by the previously uninsured will exceed their new "private" contributions to coverage under an individual mandate.

■ **The Connector's reach exceeds its grasp.** The new pooling and purchasing mechanism, the Connector, could improve small businesses' ability to offer and at least partly fund coverage. It might reduce the "churning" and loss of coverage experienced during employment transitions and disruptions. However, its scope of choice and competition remains limited. It extends federal tax advantages for premium contributions by workers, but only by those in participating businesses with more than ten employees. Insurance buyers eligible for state subsidies through the Connector in the Commonwealth Care Health Insurance Program (CCHIP) (those with incomes below 300 percent of the federal poverty level) may only purchase plans, for at least the first three years, offered by the four incumbent operators of the state's Medicaid managed care plans. Plans purchased by state-subsidized consumers cannot include any deductibles, but every current state-mandated benefit must be included.

This constrained version of greater choice (slightly varied benefits offered by a handful of insurers), even if assisted by modest scale economies, isn't likely to deliver significant savings. The greater political temptation ahead will be to change the role of the Connector from a neutral clearinghouse into a more aggressive regulator and monopsony purchaser of plans sold to individuals and participating small-business employees.

■ **Will mandates be mandatory?** Proclaiming an individual mandate to purchase insurance and actually enforcing it are two different things. Current gaps in compliance with mandatory state auto insurance laws, involving a product that is more affordable and available than health insurance, suggest a threshold degree of difficulty. The first round of state-level tax penalties (loss of a personal exemption) in the Massachusetts plan lacks strength, and residents who don't file a tax return constitute another enforcement challenge. The

key test in year two will involve whether a proposed steeper penalty for people lacking insurance (half the cost of “affordable” health insurance) is politically enforceable or diluted by waivers.

■ **The high cost of care trumps coverage goals.** The Gordian knot of modern health policy stalemates links the cost of care inextricably to the comprehensiveness and level of insurance coverage, the sustainability of public subsidies, and the viability of insurance purchasing mandates. To be blunt, Massachusetts is a very high-cost state for health care, with a concentrated market of relatively inefficient providers already swimming in a sea of dysfunctional public subsidies and crippling overregulation. The Massachusetts plan attempts to squeeze down the future trajectory of the state’s insurance premiums with a series of cosmetic nips and tucks. It imposes a short-term moratorium on existing mandated benefits (without upsetting the installed base), allows health maintenance organizations (HMOs) to experiment with health savings account (HSA) options, drops “any-willing-provider” restrictions on health plan networks, parcels out tiny doses of cost sharing, redirects some (but not all) current subsidies for safety-net providers toward subsidized insurance coverage, and hopes to coerce enough relatively healthy uninsured residents into paying more for coverage than it is worth to them. These measures simply amount to too little and too late of a challenge to the existing cost structure. They will not achieve unrealistic projections of much lower premium levels.

■ **Wait till next year?** The temporary spring blossoms of shallow bipartisan compromise in the Bay State will fade away in the next few years amid inescapable fiscal conflicts, implementation shortcomings, and still-unreconciled political differences. Perhaps state policymakers will then, belatedly, flesh out more vigorously the new legislation’s initial skeleton of cost and quality disclosure measures, focused at the level of providers with whom consumers engage. Although relegated to the less ballyhooed sections of the state plan, their potentially innovative frame-

work for challenging those who deliver health care to actually do so more efficiently and effectively might eventually move the focus of policy away from trying to pour more money into the same leaky insurance coverage vessels and toward insisting that those who control most health care spending—primarily physicians—begin to deliver better outcomes that consume relatively fewer resources. Increasing the quantity of insurance coverage per se remains only one means, and often not the most important one, to the more important end of better health and overall well-being. The next few years of the Massachusetts experience should provide us an uncomfortable opportunity to relearn that lesson. It will also challenge other competing schools of health policy reformers, particularly those currently struggling to turn the rhetoric of consumerist approaches into the reality of measurable results, to pick up their own pace amid renewed enthusiasm in some quarters for strategies that are centered on more comprehensive coverage.

NOTES

1. J.E. McDonough et al., “The Third Wave of Massachusetts Health Care Access Reform,” *Health Affairs* 25 (2006): w420–w431 (published online 14 September 2006; 10.1377/hlthaff.25.w420); and J. Holahan and L. Blumberg, “Massachusetts Health Care Reform: A Look at the Issues,” *Health Affairs* 25 (2006): w432–w443 (published online 14 September 2006; 10.1377/hlthaff.25.w432).
2. J. Hadley and J. Holahan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?” (Washington: Kaiser Commission on Medicaid and the Uninsured, 10 May 2004).
3. Jack Hadley (the transcript mistakenly ascribes these remarks to John Holahan), Urban Institute, remarks at “Briefing: The Cost of Care for the Uninsured: What Do We Spend and Who Pays?,” Kaiser Commission on Medicaid and the Uninsured, 10 May 2004, p. 35, http://www.kaisernetwork.org/health_cast/uploaded_files/051004_kff_uninsured_transcript.pdf (accessed 28 July 2006). The transcript also mistakenly says “insured” instead of “insurer” in the quoted sentence.