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MASSACHUSETTS HEALTH CARE REFORM: THE VIEW FROM ONE YEAR OUT

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ABSTRACT

One of the most important developments in health policy in recent years was the health reform plan enacted by Massachusetts in April 2006. This sweeping bill reformed insurance markets, subsidized insurance coverage for a large swath of the population, introduced a new purchasing mechanism (the "Connector"), and mandated insurance coverage for almost all citizens. In this article, I review the history of health reform in Massachusetts, highlighting the unique features that came together to make reform a reality in this state. I then turn to a discussion of the major issues that have been faced in the first year of implementing this reform and the compromises made to maintain a broad consensus of support in the state. I also discuss the lessons learned and contrast the Massachusetts approach with alternatives, most notably plans that rely more strongly on the employer-based insurance system to expand insurance coverage in the United States.

There is a standard health policy joke that goes like this: Health policy expert X 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 have typically seen for universal coverage in the United States. For senior policymakers, this reflects the battle scars earned in past national battles over universal coverage, most recently, with the Clinton Health Security Act in 1994. There has been no serious national attempt at universal coverage since that time; for example, Democratic presidential candidate John Kerry focused much more on lowering health insurance premiums than on broad expansions of coverage.

All of this has changed over the past year. Perhaps the most vivid illustration of this sea change was the response of many to the bold proposal for health insurance expansion

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put out by presidential candidate Barack Obama.[1] This plan called for $65 billion per year in health care reform, with most of the spending devoted to expanding health insurance coverage. Obama proposes to provide access to new purchasing mechanisms for insurance, subsidize its purchase by low-income families, and even mandate that all children in the United States gain insurance. The reaction when this plan was revealed? Disappointment that he did not go further! Unfavorable comparisons were drawn in particular to the proposed plan of candidate John Edwards, who had proposed mandating insurance purchase for all, thereby guaranteeing close to universal coverage.

This reaction illustrates the influence of the fast-moving events of the past year. These events have mostly occurred at the state level, with a large number of states proposing dramatic new interventions to cover the uninsured. Most notable has been the health reform plan enacted by Massachusetts in April, 2006, which recently celebrated its first year anniversary. This sweeping bill reformed insurance markets, subsidized insurance coverage for a large swath of the population, introduced a new purchasing mechanism (the "Connector"), and mandated insurance coverage for almost all citizens. Once again, Massachusetts was responsible for a "shot heard round the world," or at least around the United States. The success to date of the effort in Massachusetts has led to similar proposals in a number of states, most notably by Governor Arnold Schwarzenegger in California.

In this article, I review the history of health reform in Massachusetts, highlighting the unique features that came together to make reform a reality in this state. I then turn to a discussion of the major issues that have been faced in the first year of implementing this reform, and the compromises made to maintain a broad consensus of support in the state. I then discuss the lessons learned and contrast the Massachusetts approach with alternatives, most notably plans that rely more strongly on the employer-based insurance system to expand insurance coverage in the United States.

UNIVERSAL COVERAGE: WHAT ARE THE ISSUES?

Any approach to universal insurance coverage in the United States must address three critical issues:

Pooling: The efficient provision of insurance requires large pools of participants that are created independently of (unobserved to the insurer) health status. Absent such pools, insurers will be reluctant to offer insurance, or will do so only at very high prices, for fear of adverse selection and high-cost exposure. The majority of Americans can access insurance through such pools, through either large firms or publicly provided insurance. But most of the uninsured do not have access to any such pooling mechanism (e.g., most uninsured do not work for an employer that offers insurance). Solving the problem of the uninsured requires developing some 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

[1] Details of the Obama plan are available at http://www.barackobama.com/pdf/HealthPlanFull.pdf.

they did not attract a sufficient number of enrollees to deal with concerns about adverse selection and to spread administrative costs.

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 nongroup market. For a family of four with income of $40,000 (200 percent of the poverty line), for example, 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.

Mandates: Even large subsidies to health insurance coverage will not be sufficient to end the problem of uninsurance. As noted above, many of the uninsured are today eligible for either free public insurance or highly subsidized employer-provided insurance and still do not take it up. 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.

Within the framework of these three issues, we can consider the alternative approaches to universal coverage favored by the left and the right of the political spectrum.

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. As discussed in Gruber (2005), expanding public insurance is 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 a clear advantage through 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. There would also be additional savings to providers from dealing with one national insurer rather than multiple private insurers. At the same time, there may be disadvantages from having the government set a national benefits package. The politicization of the benefits package selection may result in a package that is wrong for most Americans. A lack of innovation in insurance provision could also result 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 state of the world where that industry could be legislated out of business. It seems unlikely in our lifetime, or maybe even God's, to have health insurance reform in the United States that does not incorporate private health insurance.

The Right

For the right, these problems are best addressed through expanding access to private health insurance. For example, individuals could be given tax credits to purchase health insurance from private vendors. Modest versions of this approach have been a staple of the Bush administration budget proposals every year since 2001.

Such an approach has the advantage of addressing directly the affordability concern noted above, while maintaining the private health insurance market. But this approach explicitly does not address either of the other two issues that must be addressed to move to universal coverage. Currently, individuals who do not have access to either large employer pools or public insurance, particularly those without any employer offer, face an insurance market that features high and variable premiums and often incomplete insurance coverage. The Kaiser Family Foundation (2001) documents the unpredictable and incomplete nature of insurance contracts in the nongroup market in the United States. 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. In the type of modeling described below, I find that even very generous subsidy policies cannot cover more than half of the uninsured on a voluntary basis.

MASSACHUSETTS: CLEAVING THE MIDDLE

The Commonwealth of Massachusetts is not typically regarded as a bastion of centrist thinking. While the state does have a strongly partisan Democratic legislature, at the time of reform it had been led by a Republican governor for 15 years. Moreover, the particular Republican who was governor, Mitt Romney, laid out fundamental health care reform as one of the major goals for his administration (and perhaps even the signature legislative achievement that might promote him to the presidency). At the same time, there was a very sophisticated and experienced advocacy community in Massachusetts, which had been lobbying for universal coverage for years. This community was not ostracized but rather well integrated and respected by the policymaking community.

Why Massachusetts?

Massachusetts also has three other advantages that made universal coverage more than just a wishful thought. First, the state has a relatively low uninsurance rate of about 9 percent of the nonelderly, compared to 18 percent nationally. This implied that fewer subsidies would be required to move to universal coverage. This lower uninsurance rate partly reflects the much higher rate of employers offering insurance in Massachusetts relative to the rest of the nation.

Second, there was a large federal transfer to the state at stake. As part of a Section 1115 waiver in 1997, the state was receiving a large intergovernmental transfer (IGT) of the type used by many states to expand health care spending. Essentially, the state was using phantom state dollars to generate a federal match by transferring dollars to providers that were matched, and then returned to the state. Under the current waiver, renewed in 2002, this match amounted to $385 million by 2005. These IGT dollars were 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. But the rates paid to these safety

net providers were exceedingly generous, so that the federal government was essentially supplementing the expansion of these inner-city hospitals.

In 2004–2005, the Center for Medicare and Medicaid Services (CMS) under the Bush administration was working to crack down on such IGTs as a means of reducing federal spending. They threatened to remove the Massachusetts IGT as well. In response, the state took two actions. First, it found a large amount of state-only medical spending that could be genuinely 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 transitioned from payments to safety net providers toward subsidies to individuals to buy insurance. CMS agreed to consider this alternative, placing a deadline on the state in 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 already 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 (hospitals are forbidden from billing anyone who is pool eligible), rather than absorbing those costs and passing them on to other payers. This pool had risen to over $500 million by 2005. Since universal coverage would lower the ranks of the uninsured, it would obviate the need for a pool of this size. Thus, some of these funds could be rededicated to paying for a universal coverage system.

Romney's Plan

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 what was available in the nongroup market. Second, all firms would be required to establish Section 125 accounts, through which employees can pay their insurance premiums on a pretax basis, either for insurance provided by the firm or through the Exchange. Third, there would be large subsidies made available to families living below 300 percent of the poverty line (roughly $60,000 for a family of four) to make insurance affordable. Fourth, for those above 300 percent of the poverty line, a more limited insurance plan would be available at a cost of roughly $200/month for individuals, so that insurance was 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 funded by rededicating the federal funds now going to safety net hospitals and much of the funds in the uncompensated care pool.

This was a bold proposal that addressed in a comprehensive way the three issues raised earlier. Pooling would be achieved through the Exchange, essentially replacing the unpredictable nongroup market with a more predictable group purchasing mechanism. Affordability was addressed by providing subsidies to those below 300 percent of the poverty line, and access to low-cost insurance was achievable for those above 300 percent of the poverty line. And universal coverage was obtained through the individual mandate.

Legislative Concerns

This proposal showed the governor was serious about health care reform, but it had a number of features that were problematic for the Democratic legislature. Most importantly, the legislature felt strongly that the plan was missing an employer responsibility component. There were suggestions for accompanying this proposal with "fair share" type provisions that would have levied assessments on firms from which they could subtract their expenditures on health insurance. But such proposals were immediately met with enormous opposition by both the business community and the governor. The legislature also wanted to cover more individuals through expansion of public insurance, another proposition strongly opposed by the governor.

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

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

The Compromise

Another advantage for Massachusetts was a Democratic legislature that was willing to look past its other disagreements with the governor to work together toward the goal of universal coverage. The final legislation followed the outline of Romney's plan, while reflecting the concerns of the legislature to some extent. 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 this legislation and reflects more than anything a symbolic statement that employers should play some role. Despite this small level, Governor Romney vetoed this provision in the legislation—but his veto was 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 retained, at least initially, very large subsidies to hospitals in the state. The uncompensated care pool remained much larger than under the governor's proposal, and safety net hospitals retained much of the money they were getting under the federal grant in the initial years, partly through granting them monopoly rights for providing insurance to low-income residents. These financing holes were filled by the employer assessment, and, to a much larger extent, general revenues. But these subsidies are paid essentially from the same pot of money that funds subsidies to cover

the uninsured, so that as the system is more successful in covering the uninsured, there will be fewer funds available to subsidize their hospital care.

Thus, the final bill had several key features:

Privatized Public Insurance for Low-Income Residents. For adults below three times the poverty line, a new program was established ("Commonwealth Care") that provides insurance coverage at subsidized rates. The legislation specified that insurance be free below the poverty line, with minimal copayments, and that it be subsidized for those between 100 and 300 percent of the poverty line, with no deductibles, but the exact subsidy levels and benefits were not proscribed (other than mandating that all insurance continue to include state-mandated benefits). Individuals were to choose from one of four Medicaid Managed Care Organizations (MMCOs), the largest two of which were maintained by the large safety net hospitals.

New and Improved Insurance Market. While there were no subsidies available to those above 300 percent of the poverty line, there were major changes to improve the insurance market: a merger of the nongroup and small group markets, and the introduction of the Connector, a shopping forum for health insurance. In a sense, the Connector operates as the "anchor store" in the new "mall" that is the merged small group/nongroup market. The Connector has no monopoly power, and plans sold inside the Connector must be sold outside for the same price. But it does operate as somewhat of a market maker, specifying benefits packages that are likely to be emulated elsewhere.

The law specified that all adults in the state must be covered by health insurance, but only to the extent that such insurance was deemed "affordable" by the board of the Connector. Individuals who did not have coverage by December 31, 2007 would face the loss of their individual tax exemption (worth roughly $300), and those who did not have coverage in 2008 could be liable for a penalty of half of the premiums they would pay if insured. The law also mandated the charge of $295 per employee on all nonoffering employers with more than 10 employees, and mandated that all employers with more than 10 employees offer a Section 125 account so that their employees could pay health insurance contributions with pretax dollars.

IMPLEMENTATION: THE FIRST YEAR

While this legislation provides a blueprint for moving to universal coverage, many of the critical details remained 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," and to various state agencies through regulation.

Commonwealth Care Benefits and Premiums

The first set of decisions to be made by the Connector board was the premiums that individuals above 100 percent of the poverty line would pay for Commonwealth Care and the specification of benefits for that program. The board decided to impose premiums ranging from $18/month/adult for those at 100–150 percent of the poverty line to $105/month/adult for those at 250–300 percent of the poverty line. These premiums were set to rise from a minimum level for those near poverty to an amount comparable to the employee contributions for employer-provided insurance for those near 300 percent of the poverty line.

Benefits were set separately for three groups. For those below the poverty line, benefits were comparable to Medicaid, with minimal copayments, although neither dental nor vision care was covered. For those between 100 and 200 percent of the poverty line, there were higher but still small copayments of $5/$10 per office visit (to GP/specialist), $5/$10 for prescription drugs (generic/brand), and a $250 hospital copayment. Those between 200 and 300 percent of the poverty line were given a choice of paying their contribution amount and receiving somewhat less generous insurance than those between 100 and 200 percent of the poverty line ($10/$20 copayments for doctors/drugs, and a $500 hospital copayment), or paying more and receiving the same benefits as those in the lower income range.

These benefits were delivered by four competing MMCOs. To promote competition between these plans, individuals below the poverty line who were known to the system through their use of the Uncompensated Care pool were autoassigned to the lowest cost plan; in addition, contribution levels for those above 100 percent of the poverty line were tied to the cost of the lowest cost plan, with individuals paying the difference if they chose more expensive plans. This provided incentives for plans to be the lowest cost option in their area.

Structure of the Connector Marketplace

While the Connector is not a monopoly in selling to those above 300 percent of the poverty line, it plays an important leadership role in suggesting standards at which insurance may be sold to individuals and small groups. One major issue that the Connector board faced, however, was how much choice to allow through the Connector. One goal of the Connector was to allow individuals and employees to have a wide variety of choices in a context in which they previously had few. At the same time, some were concerned that excessive choice could overwhelm participants. The compromise was to design the Connector to have three levels, "bronze," "silver," and "gold," with six insurance plans offering options at each level. The "gold" level was set to a very generous HMO benefit (e.g., $5 office visit copayment). The silver level was set to approximately 80 percent as generous in terms of actuarial value, and the bronze level approximately 60 percent as generous.

Minimum Standards and Affordability

The two most important, and related, issues that were faced in implementation were the minimum standards that benefits packages would have to meet to qualify for the mandate (and avoid the penalty), and the definition of "affordable" for purposes of allowing some exemptions from the mandate. In its desire to obtain universal coverage but not to foment revolt by overburdening the citizens of the state, the Connector board faced an "iron triangle" of choices: to extend subsidies, thereby rendering insurance more affordable (although here the board was limited by the cap on subsidies for those at 300 percent of the poverty line); to mandate a minimal level of insurance coverage so that all could afford at least that level; and to allow some individuals to be exempted from the mandate.

These issues were highly controversial. In designing "minimum creditable coverage" (MCC), the board quickly agreed on restricting policies that provided only "indemnity coverage" (e.g., just a reimbursement of $500/day toward hospital costs) and those

with annual, and lifetime limits. The board also voted to set a maximum deductible of $2,000/individual, or $4,000/family, to have a maximum out of pocket limit of $5,000/individual, and $10,000/family, and to mandate at least three physician office visits be covered before the deductible. In addition, after much discussion, the board voted to mandate prescription drug coverage for plans to meet the MCC standards. These benefits are considerably less generous than what is available typically in the insurance market in Massachusetts, but the board was convinced that the inclusion of primary care and prescription drugs before the deductible provided real protection at an affordable premium.[2] These plans were provided for as low as 60 percent of the cost of insurance in the market today.

These decisions were immediately criticized by the business community as expensive and disruptive mandates. The argument was made strongly that the goal of this legislation was to provide insurance for the uninsured, not to restrict insurance options among the insured. Particularly informative was the fact that the prescription drug benefit contemplated by the board would result in 160,000 insured individuals not qualifying for MCC, and removing lifetime limits would result in 360,000 insured individuals not qualifying.

As a result, the board made three compromises in its final specifications. First, prescription drug benefits were mandated starting only in January 2009, so that firms had time to adjust their insurance offerings; in addition, the board is still working toward mandating a lower cost prescription drug coverage package than is typically offered. Second, the restriction on lifetime limits was removed. Finally, a number of existing insurance arrangements that met the principles of MCC in spirit, if not in letter, were exempted; most notable among these was federally qualified Health Savings Accounts.

No less controversial was the discussion of exemptions from the mandate. Advocates argued that insurance was not affordable, even at subsidized rates, for those below 300 percent of the poverty line, and was not affordable at unsubsidized rates to those between 300 and 500 percent of the poverty line (GBIO, 2007). I countered with an analysis suggesting that insurance was affordable for virtually all in the state (Gruber, 2007).

In the end, the board decided to pursue all three approaches. First, premiums were waived for those below 150 percent of the poverty line and lowered slightly for those up to 300 percent of the poverty line, so that they are now $35 from 150–200 percent of the poverty line, $70 from 200–250 percent of the poverty line, and $105 from 250–300 percent of the poverty line. Second, for those above three times the poverty level, the mandate only applied to MCC plans, which were available at $200, or less for those under the age

[2] It was important to convince the board that health economics research has clearly shown that insurance can be more restrictive than the typical insurance package held today, without impacting health in a negative way. The famous RAND Health Insurance Experiment (HIE), summarized in Gruber (2006), showed clearly that for the average person the copayments for medical care could rise significantly without health deteriorating. At the same time, there were some subgroups of ill (and particularly low-income and ill) patients for whom higher copayments did deter needed care, although primarily among low-income groups. Exempting prevention and maintenance from the deductible in this way met the needs of this group, although ultimately a better solution would be to move toward targeted copayments along the lines of Fendrick et al. (2001).

of 40 years. Finally, individuals were mandated to purchase insurance if they were below 300 percent of the poverty line (where it was subsidized) or above median income in the state (about $50,000 for an individual). In between, there were a series of exemptions in place that related premiums to income. The effect of these exemptions was essentially to mandate coverage for almost all young single persons in the state, while exempting many older individuals and families between 300 percent of the poverty line and median income.

Estimates suggest that in the end about 15 percent of the uninsured were exempted from the mandate. Many of these, however, were older individuals who may choose to buy the newly available insurance products on their own.

The Power of Consensus

As noted, a striking feature of this legislation was that it left many of the major decisions in the hands of the bipartisan Connector board. This board was composed of 10 members: three appointed by a Republican governor, three appointed by a Democratic attorney general, and four who were members of the administration. This was a dedicated but strong-willed set of individuals who came together with very different backgrounds and agendas. Yet, at every point in the process, the executive director of the Connector was able to maintain consensus. Every key vote except one was 10–0, and that one vote was 9–1.

This consensus has served to produce an amazingly uncontroversial first year of the program. Vital decisions that would likely have tied legislatures in knots were worked out in a harmonious fashion. Whether the center can hold throughout the life of this board remains to be seen, but so far it has operated strikingly well.

IMPLEMENTATION: THE CHALLENGES GOING FORWARD

While the Connector board has recently completed its difficult first year, many challenges lie ahead. In this section I review the major pitfalls facing the law going forward.

Integration With Employer-Provided Insurance

The first major issue is the integration of the Commonwealth Care program with existing employer-provided health insurance availability for low-income adults. The law specified that Commonwealth Care not be available to those with offers of ESI. This caused the problem, however, that low-income individuals who are charged high contributions for their ESI would have no way to afford them. In the short run, the board addressed this problem by exempting from the mandate anyone who is offered ESI but has contributions above the Commonwealth Care premium levels. This is responsible for about half of the 60,000 individuals exempted from the mandate.

Ideally, these individuals would not be exempted from the mandate (and from affordable insurance coverage). But making subsidies available to those with ESI could be very expensive. To see this, it is useful to contrast the three options available for treating employer-sponsored insurance (ESI) under this plan. The first is to have an ESI "firewall" under which those with offers of ESI in their workplace cannot access the subsidies (the approach used thus far). The second is to use premium assistance, whereby the state subsidizes ESI by paying the difference between (1) the contribution required of the employee by the ESI plan and (2) the contribution required under the state subsidized

plan (e. g., 1 percent of income at 100 percent of the poverty line; this is the approach proposed by the current legislative plan in California). The third is to use a "voucher"-style approach whereby the firewall is lifted and individuals with ESI can come to the Exchange, but only if they bring with them their employer contribution toward health insurance to offset state costs. This is actually an option that the Connector board can use in Massachusetts, and is also part of the governor's plan in California.

There are pros and cons to all three approaches. The "firewall" approach will save money by limiting the eligible population but will lead to the last two responses listed above (dropping and reduced employer contributions). It also raises equity concerns about low-income workers with ESI offers who cannot afford the ESI. The other approaches, however, can be quite expensive because the subsidies cannot realistically be restricted only to those who would otherwise be uninsured. For example, in Massachusetts, there are roughly 1 million workers with incomes below three times the poverty line, only 30,000 of which are both uninsured and have employer contributions above the Commonwealth Care premium level. Thus, by offering subsidies to any worker below 300 percent of the poverty line, the state could spend an enormous amount to ensure only a very small number of persons. This effect could be magnified by the fact that employers might respond to such a subsidy program by lowering their spending on insurance (and raising employee contributions) so that more employees qualify for these state subsidies.

Thus, there is a clear trade-off for the state: leave some uninsured and offered individuals out of the subsidy system, or spend state dollars to subsidize not only those individuals but also other low-income individuals who now are buying ESI on their own. This is a major issue that the state faces in moving toward truly universal coverage.

Public Responses on Affordability and Continued Premium Increases

The second major issue faced by the Connector is public responses to the new law as it moves toward maturity. The original bill budgeted sufficient funds for the law through fiscal year 2009, but at that point there will be two difficulties facing the state. First, the federal waiver will have run out, and it is far from certain that the federal government will continue to provide this large pool of money to the state; it is even less certain that it will be increased for premium inflation. Second, premiums will have increased in the Commonwealth Care program so that, even with constant enrollee shares of costs, the state will need more money to pay its share. Moreover, concerns over affordability make it far from certain that enrollee shares will stay constant and not fall.

At that point, the state will clearly need to find new and ongoing sources of financing for this program. Whether the state will be able to do so will depend critically on public opinion about the law. Two areas of public opinion in particular will be important. The first is the views of the individual mandate. Do citizens of the state feel that it is appropriately bringing all residents into the "social compact" of insurance? Or do they feel it is punishing individuals who would prefer to stay uninsured? The second is the general sense that universal coverage is a worthy goal for Massachusetts and deserves more taxpayer financing.

Financing and the Role of Employers

If more financing is required, a natural source of such financing is an increased assessment on employers that do not offer insurance. This was the last thing to go in the ultimate

legislative compromise and remains a top priority of many health advocates in the state who feel that the law let nonoffering employers off the hook.

In considering this source of financing, there are two important but underappreciated points. First, there is an enormous loss in revenues (and assessment impacts) from excluding small firms from the assessment. The majority of employees who are not offered insurance are in the smallest firms, so that excluding them dramatically reduces the impact of any assessment. My estimates suggest that an assessment that excludes firms of fewer than 10 employees, for example, raises only one-third to one-half as much as an assessment on all firms. Moreover, many small firms are actually high payroll—for example, small law firms or medical practices. A much more sensible and targeted protection for low-wage firms would be a payroll-based exemption, such as excluding the first $50,000 or $100,000 of payroll from taxation.

The second point is that some argue that placing responsibility for coverage on individuals, along with the $295 assessment on employers that do not offer insurance will actually *lower* employer-provided insurance coverage. It is important to recognize that this argument makes no economic sense. It is true in principle that this 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.

To see this point, consider the plan in three steps. The first is to introduce the Connector, with subsidies for low-income families. This could clearly erode employer provision, for two reasons: there is now another pooling option available to individuals who only wanted employer insurance because there was no other good option, and, to get the low-income subsidies, individuals have to leave the employer pool.

Now, consider adding the individual mandate on top of the subsidized Connector. The individual mandate will only *increase* pressure on employers to provide coverage, so that their employees can meet this mandate. They may not respond to this pressure, but there is no reason *per se* why a mandate would lower coverage. Furthermore, consider adding the assessment on nonoffering employers. Once again, this will only *increase* pressure on those employers to offer. Not offering has now been taxed relative to offering. There is no reason to respond to this tax by suddenly not offering!

That is, there is a clear tension here: this attempt to fix the holes in the employer system will also put pressure on the existence of the system. But this pressure does not come from the individual mandate or the assessment (quite the opposite); this pressure 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 employer erosion. 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 offer. 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.

CAN THIS WORK ELSEWHERE?

The major question that has been asked about the Massachusetts reform is: Can it work elsewhere? Clearly, the basic framework of a central purchasing mechanism, subsidies for low-income groups, and an individual mandate could work in any other state or

at the national level. The major advantage for Massachusetts, however, was financing, through the low number of uninsured, the existing IGTs, 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 existing (implicit and explicit) taxes being used to finance uncompensated care, they may be more willing to rededicate those funds toward expanding coverage.

The federal government could play an important role in promoting this type of approach to universal coverage. One means of doing so would be through national legislation of this type. Another would be to subsidize states to undertake these types of efforts, as was essentially done through the IGTs to Massachusetts. For example, federal matching grants to states could be used to promote experimentation with these types of approaches.

But the major lesson from Massachusetts is that this 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 stool that requires three legs. Remove any of the legs and the stool will fall.

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