

Point/Counterpoint

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Guest Editor Theodore J. Joyce organized the Point/Counterpoint in this issue. Ted is a Professor of Economics in Baruch College of the City University of New York, and a Research Associate of the NBER in the Health Economics Program. He also serves as the Academic Director of the Baruch/Mt. Sinai MBA Program in Health Care Administration and as a Research Associate of National Bureau of Economic Research. In addition to his regular duties as a co-editor of the *Journal of Policy Analysis and Management*, we thank Ted for organizing this exchange regarding implications of health care reform in Massachusetts on the likely impacts of the Patient Protection and Affordable Care Act.

WHAT CAN MASSACHUSETTS TEACH US ABOUT NATIONAL HEALTH INSURANCE REFORM?

Theodore J. Joyce, Guest Editor

The Patient Protection and Affordable Care Act (PPACA) is the most significant health policy legislation since Medicare in 1965. The need to address rising health care costs and the lack of health insurance coverage is widely accepted. Health care spending is approaching 17 percent of gross domestic product and yet 45 million Americans remain uninsured. But how to address these issues remains highly contentious.

The Massachusetts polity confronted the lack of universal health insurance coverage four years ago. Massachusetts now requires that all adult residents purchase affordable health insurance. The state set up a health insurance exchange for the purchase of non-group coverage and established a program to subsidize insurance for lower-income families. All three elements are part of the PPACA.

In this Point/Counterpoint, Jonathan Gruber and Douglas Hotz-Eakin use the Massachusetts experience to address the following question: “Does Massachusetts’s

Health Care Reform Point to Success with National Reform?” Each is uniquely qualified to respond. Jonathan Gruber is Professor of Economics at MIT and an inaugural member of the Massachusetts Health Connector Board. He was instrumental in designing the Massachusetts plan. Douglas Holtz-Eakin was former chair of the Department of Economics at Syracuse University’s Maxwell School. He served as Director of the Congressional Budget Office and was Chief Economist at the Council of Economic Advisors under George W. Bush. We also acknowledge the assistance of David Cutler, the Otto Eckstein Professor of Applied Economics at Harvard University, and Robert Kaestner, Professor of Economics at the University of Illinois–Chicago, who served as reviewers for the exchange.

DOES MASSACHUSETTS’S HEALTH CARE REFORM POINT TO SUCCESS WITH NATIONAL REFORM?

Douglas Holtz-Eakin

The Patient Protection and Affordable Care Act (PPACA) is now the law of the land, ending over a year of suspense over its fate. But the debate is far from resolved regarding its impact. Given their similarities, it is useful to look to Massachusetts’s experience to glean insights into the likely effectiveness of the PPACA legislation. Sadly, a review of the state’s experience bodes poorly for the future of national reform.

The most important feature that the Massachusetts reforms and the PPACA share is a “coverage first” strategy.¹ There are two major problems facing the U.S. health care sector. First, it costs too much. In 1970 national health expenditures were \$1,300 per person and consumed 7 cents out of every national dollar—7 percent of Gross Domestic Product (GDP) (Organization for Economic Co-operation and Development, 2009). For the past three decades, health care spending per person has grown roughly 2 percentage points faster every year than income per capita (Centers for Medicare & Medicaid [CMS], 2009). That is, in the horse race between costs and resources, costs have been winning. The result is that health care spending right now exceeds 17 cents of every national dollar—and will rise to 20 percent by the end of next decade (CMS, 2009). Within the federal budget, the rising cost of Medicare and Medicaid threatens a tsunami of red ink in the decades to come.

Second, because health care is getting more expensive, the cost of health insurance is skyrocketing. Over the last decade, insurance costs have increased by 120 percent—3 times the growth of inflation and 4 times the growth of wages. With higher costs has come reduced insurance coverage—more than 45 million are uninsured (U.S. Census Bureau, 2009).

It is important to solve both problems, but the order matters. A “cost first” approach employs strong delivery system reforms to permit quality care at lower costs, thereby freeing up resources to support coverage expansions. The coverage

¹ Some will dispute this characterization, as the PPACA has a number of initiatives intended to reform delivery systems and the cost of care. Unfortunately, most of them are demonstration projects that have no real guarantee of widespread implementation or politically tenuous reforms that Congress will likely override. For these reasons, the Congressional Budget Office has not reflected cost savings from these elements of the PPACA.

first approach commits to large-scale coverage expansions before undertaking delivery system reforms. Advocates argue that it is necessary to get everyone in the insurance pool, eliminate risk selection, and relieve providers of uncompensated care costs before delivery system reform will be possible. At the heart of this approach is the notion that covering everyone will eliminate the “free rider” problem and bring down health insurance costs for others who were paying the health care bills of the uninsured.

The Massachusetts experience suggests this is misguided. A coverage first approach did not eliminate problems with risk selection and free riding. Worse, because coverage increases utilization, providers are inundated with demand and access to care suffers. Finally, the experience shows that delivery system reforms do not occur, costs continue to skyrocket, and budgetary stresses result.

Put differently, the Massachusetts experience shows that expensive patients still have the opportunity to game the system by obtaining coverage and then dropping it after treatment. In combination with the incentives for others to overconsume when given coverage, the result was stretched resources, increased costs, and budgetary stresses.

As noted above, a basic premise shared by the reforms is that it will succeed in eliminating risk selection and cost shifting in health insurance markets. The state already had health insurance regulations, such as guaranteed issue and community rating, that were adopted in PPACA and imposed as well as an individual mandate.

But in Massachusetts, recent reporting indicates that consumers are purchasing insurance, undertaking expensive care episodes, and then dropping coverage (Lazar, 2010). According to these reports, Blue Cross and Blue Shield of Massachusetts reported that, in 2009, 936 people signed up for coverage for three months or less, undertook medical spending at 4 times the norm, and ran up a price tag of over \$1,000 per month. Because the average premium (roughly \$400) fell far short of monthly costs (over \$2,200), these effectively uninsured individuals continued to impose costs on the insured pool. Although comparable data are not available for other insurers, anecdotal evidence suggests that free riding remains a problem.

Is this quantitatively important? In 2009, roughly 86,000 individuals became newly insured. Blue Cross and Blue Shield have a roughly 50 percent market share and so insured perhaps 43,000 of those new enrollees.² If so, the 936 individuals constituted on the order of 2.2 percent of the enrollees and, clearly, a higher fraction of the costs.

This experience is also a mark against the use of the individual mandate. The original proposal by then-Governor Romney was that an individual had to either demonstrate the financial wherewithal to cover health care costs or purchase a catastrophic insurance plan. The legislative debate and implementation turned this into a mandate to purchase health insurance designed by the government. This is precisely the structure in the PPACA. Given the relatively modest penalties for non-compliance, it is reasonable to expect no more success at the federal level.

Thus, the regulatory environment envisioned in the PPACA did not automatically succeed in eliminating the uninsured or free riding. More importantly, it also did not lead directly to lower costs. Health care expenditures per capita in Massachusetts in 2004 were \$6,683, almost 27 percent higher than the national average (Blendon et al., 2008).

²The Census reports that Massachusetts's population rose from 6,497,967 to 6,593,587 between July 2008 and July 2009. See <http://www.google.com/publicdata?ds=uspopulation&met=population&idim=state:25000&dl=en&hl=en&q=population+massachusetts>. Long and Phadera (2009) estimate that the total population uninsurance rates were 2.7 and 2.6 percent, respectively, in 2009 and 2008. See http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/his_policy_brief_estimates_oct-2009.pdf. My estimate of the newly insured is computed from these data.

By 2009, health insurance costs in the state were an even greater 30 percent higher than the national average, according to Eileen McAnneny who testified before the U.S. Senate that “health care reform has done nothing to moderate premium trends to date” (Learning from the States, 2008). The average health insurance policy for a family of four costs \$16,897 compared to \$12,700 for the U.S. as a whole.³

The same pressures pushing up premiums have put a strain on the state budget as well. Massachusetts’s state health program costs have risen by 42 percent since 2006, with the result that spending that was projected to be \$725 million is now expected to be over 10 percent higher (National Health Preview, 2009; Commonwealth Connector, 2010).

This experience provides a caution to the budgetary impacts of the PPACA. The CBO estimates that the new entitlement for health insurance subsidies will grow at an 8 percent annual rate over the long term (CBO, 2009). Because the most important driver of long-run costs will be the underlying pace of health spending, this suggests little cessation in the pace of health care cost increases, which would be a recipe for budgetary duress.

The budgetary implications of the PPACA must be a central aspect of any evaluation because the reforms arrive at a time when the federal government ran a fiscal 2009 deficit of \$1.4 trillion—the highest since World War II—as spending reached nearly 25 percent of GDP and receipts fell below 15 percent of GDP (Office of Management and Budget, 2010). In each case, the results are unlike those experienced during the last 50 years.

Going forward, there is no relief in sight. Over the next 10 years, according to the CBO’s analysis of the President’s Budgetary Proposals for Fiscal Year 2011, the deficit will never fall below \$700 billion. In 2020, the deficit is projected to be 5.6 percent of GDP, roughly \$1.3 trillion, of which over \$900 billion will be devoted to servicing debt on previous borrowing (CBO, 2010).

Thus, it is of note that the CBO and the Joint Committee on Taxation estimate that the PPACA would lead to a net reduction in federal deficits of \$143 billion over 10 years, of which \$124 billion comes from health care reform and \$19 billion from education provisions (CBO & Joint Committee on Taxation, 2010).

Total subsidies in the PPACA exceed \$1 trillion over 10 years and include insurance exchange tax credits for individuals, small employer tax credits, the creation of reinsurance and high risk pools, and expansions to Medicaid and the Children’s Health Insurance Program. To finance the subsidies and reduce the deficit, total cost savings are projected to be nearly \$500 billion based on reductions in annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments (CBO & Joint Committee on Taxation, 2010). In addition to the cost saving measures, the Act raises more than \$700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions (CBO & Joint Committee on Taxation, 2010).

The prospect of these savings is important given the daunting fiscal outlook. But these savings rely on the PPACA evolving exactly as written. Is that realistic? A very different picture emerges when one acknowledges political reality. To begin, consider the history of the Medicare physician payment updates. Each year since 2002 the “sustainable growth rate” formula in current law has imposed cuts in payments to physicians under Medicare. And each year Congress has overridden these same cuts.

What, then, should one expect regarding the spending cuts through Medicare market basket updates, the Independent Payment Advisory Board, Medicare Advantage

³ See Agency for Healthcare Research and Quality (2006, Tables II.D.1, II.D.2, II.D.3) and the Kaiser Family Foundation (2008).

interactions, and the Part D premium subsidy for high-income beneficiaries? Although the specifics of each differ, when the time comes to implement these savings, Congress will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. As a result, it is reasonable to expect that the PPACA will *not* perform as written. Instead, the cuts will be politically infeasible and Congress is likely to regularly to override them.⁴

The Independent Payment Advisory Board (IPAB) is of particular importance. The IPAB will have 15 members, each appointed to six-year terms, and the majority of members are to be nonproviders. The IPAB's mission is to control Medicare costs. Specifically, if spending is projected to exceed preset targets, every other year the IPAB must develop proposals to reduce Medicare costs. Under the reform, the proposals will become law unless Congress acts to generate comparable savings in another manner. In the off years, IPAB will issue studies and recommendations.

Thus, in principle, the IPAB has more authority than the Massachusetts Special Commission on the Health Care Payment System, which is restricted to an advisory role. However, there are early signs that Congress will not cede that authority so easily. For example, while the IPAB starts work in 2015, proposals that affect hospitals and skilled nursing facilities are not permitted before 2020. Similarly, Congress specified that IPAB proposals should not ration health care, raise revenues, raise Medicare beneficiary premiums, increase beneficiary cost sharing, restrict benefits, or change eligibility. That is, IPAB should not do anything that might be politically unpopular. Finally, IPAB's jurisdiction is limited to the fee-for-service payment systems in Medicare; it will not control the pilots and demonstration projects that PPACA advocates point to as the most important element of delivery system reform.

Thus, it seems likely that Congress will continue to limit its authority and effective reach. Accordingly, it will join the Commission in producing payment recommendations, but like the Commission will not bend the cost curve on medical inflation, which is growing at a rate of 8 percent annually in Massachusetts (Kowalczyk, 2009).

Similar pressures will come to bear on the excise tax on high-premium, or "Cadillac," health plans. In the Senate version of the reform, this tax was supposed to be implemented immediately. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible ever to implement the tax, eliminating the associated tax revenue of \$78 billion over the next 10 years.

What is the bottom line? Removing the potentially unrealistic annual savings, reflecting the full costs of implementing the programs, acknowledging the unlikelihood of raising all of the promised revenues, and preserving premiums for the programs they are intended to finance produces a radically different bottom line. The Act generates additional deficits of \$562 billion in the first 10 years (Holtz-Eakin, 2010). And, as the nation would be on the hook for two more entitlement programs rapidly expanding as far as the eye can see, the deficit in the second 10 years would approach \$1.5 trillion (Holtz-Eakin & Ramlet, 2010).

Indeed it could be even worse. As noted above, when Massachusetts introduced its expanded insurance coverage, enrollment was much higher than had been projected. Immediately, costs were well above what had been projected and it was necessary to look for additional budgetary resources. Many more people signed up for the new heavily subsidized insurance than was originally predicted by budget officials. Almost immediately, costs far exceeded what had been budgeted, forcing state officials to scramble to find cuts elsewhere in government and other sources of revenue.

⁴ Some analysts point to the recently passed "PAYGO" (pay-as-you-go) rules as an impediment to Congress in this regard. PAYGO will not be a serious obstacle, as PAYGO rules can be waived by a vote, and, historically, frequently have been. In addition, the PAYGO rules were written to exclude paying for the costs of the annual payment update for physicians in Medicare, those revealing that Congress has little appetite for constraining these outlays.

The risk of costs exceeding projections is very real at the federal level. As analyst Jim Capretta (2008) points out, CBO projects that only 17 million individuals will take up subsidies through the state-based exchanges in 2016 compared to a population with incomes between 100 and 400 percent of the federal poverty line—roughly the eligible population—of roughly 130 million people. CBO is assuming that the bulk of low- to middle-income individuals will receive employer-sponsored health insurance. But will they? Perhaps employers will cease to offer insurance in large numbers, swelling the number of individuals in the exchanges and adding to a dangerous budgetary outlook.⁵

The final aspect of the coverage first approach is the impact on access to quality care. As more people are insured, utilization of services rises, raising the possibility that providers will be inundated by the demand. Here again, the Massachusetts experience is illuminating. At the start of the reform (2007), the Massachusetts Medical Society released a report describing the “critical shortage” of primary care physicians in the state (Massachusetts Medical Study, 2007). It indicated that almost 50 percent of internists were not accepting new patients. The typical waiting time for an appointment was 52 days.

The popular press suggests that after the reform the situation apparently worsened. In the fall of 2008, *The Boston Globe* reported that the waiting time for a primary care physician had risen to as long as 100 days. At the same time, the number of doctors accepting new patients had fallen and the newly insured were having difficulty finding care. One Massachusetts resident complained, “Before, I was uninsured and couldn’t see a doctor. Then I made the sacrifice to buy insurance, but I still can’t find a doctor who will see me. So I still don’t get to see a doctor, but it’s just costing me more now.”⁶

There is little comprehensive data regarding wait times. However, in 2009, Merritt Hawkins & Associates surveyed wait times in major metropolitan areas, including Boston.⁷ Compared to 2004, average wait times were up for dermatology (54 vs. 50 days), OB-GYN (70 vs. 45 days), and orthopedic surgery (40 vs. 24 days), and stood at 63 days (the highest in the survey) for family practice (no comparable date were available for 2004). Average waits declined from 37 to 21 days for cardiology visits. These data cannot directly link the experience of higher wait times to the reforms, but they are consistent with a rise in doctor utilization over that period.

A similar story appears to prevail in hospital utilization. *The Boston Globe* reports that “Thousands of newly insured Massachusetts residents are relying on emergency rooms for routine medical care, an expensive habit that drives up health care costs and thwarts a major goal of the state’s first-in-the-nation health insurance law” (Lazar, 2008). There is evidence that emergency utilization is tied to the provision of insurance. *The Boston Globe*’s research showed that low-income patients, who now receive state-subsidized insurance, utilize emergency rooms at a rate over 25 percent above the state average (Lazar, 2008).

Unfortunately, additional survey data are not available. However, to the extent that it is related to reform, it undercuts the objective of providing quality care at lower cost, as emergency room treatments cost considerably more than the alternative. The average cost of a non-emergency visit in the emergency room is \$976, compared to under \$164 in a primary care office setting (Turner & Persico, 2009).

The Massachusetts experience with a coverage first strategy is a cautionary tale for the PPACA. Starting from a setting that already included many of the insurance market rules that national reform will impose, Massachusetts continues to struggle with pooling all risks and eliminating free riding and cost shifting. The

⁵ To be fair, there is little evidence from the Massachusetts experience of employers dropping coverage.

⁶ Private conversation with Grace-Marie Turner following her participation on a panel on “Massachusetts Health Reform: Bragging Rights and Growing Pains,” sponsored by the Alliance for Health Reform on May 19, 2008.

⁷ <http://www.merrithawkins.com/pdf/mha2009waittimesurvey.pdf>.

approach did not control rising health care costs, with the result that insurance costs continue to spiral upward. These higher costs evidenced themselves as well as budgetary pressures, a particularly troubling prospect given the daunting federal fiscal outlook. Finally, the Massachusetts experience suggests that aggressive coverage expansions do not guarantee access to care. The increased utilization of providers' services will likely increase wait times for primary care physicians and, in Massachusetts, created increased utilization of emergency room care.

Another key aspect of the reforms is the role of the Connector—the Massachusetts version of the state-based exchanges in the PPACA. Exchanges offer the potential to increase the quality of competition in insurance markets, a change that is desperately needed. The Connector was originally envisioned as a place where individuals could shop for any acceptable private insurance policy using a defined employer contribution and state subsidies. The result would be to take the employer out of the health insurance business, empower individuals, and enhance competition.

In practice, the Connector quickly turned to social planning—for example, requiring that all plans have drug coverage when the market shows a strong demand for some that did not. It required that all employees be in the same tier of insurance coverage—thereby denying choice—and keeping employers in the health insurance decision-making process.

In the end, then, there is little difference between the practices of the Connector and a state Medicaid plan. It is an organ of the government that sets coverage and uses its power to negotiate subsidized reimbursements. It is a far cry from the pro-competition reform that was initially envisioned. National reforms appear to start much closer to where the Connector ended up, boding poorly for their ability to enhance genuine competition.

The United States is in genuine need of real health care reform that transforms delivery systems to provide quality care at lower cost, improves competition and choice in insurance markets, and reduces stresses on federal and state budgets. The experience of the Massachusetts reforms is one that witnesses continued poor functioning of insurance markets, failure to achieve health care cost control, explosive budget problems, and intrusive social engineering. It is also, unfortunately, the most likely predictor of the future of the Patient Protection and Affordable Care Act that is now the law of the land.

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MASSACHUSETTS POINTS THE WAY TO SUCCESSFUL HEALTH CARE REFORM

Jonathan Gruber

The Patient Protection and Affordable Care Act (PPACA) that President Obama signed into law on March 23, 2010, is intended, in part, to expand health insurance coverage and transform the operations of health insurance markets in the U.S. The PPACA is

also intended to improve the quality and cost-effectiveness of health care. The basic structure of the insurance-related aspects of this legislation follows the reform enacted by the Commonwealth of Massachusetts in April 2006. As in Massachusetts, the federal legislation relies on the principles of insurance market reform (for example, ending insurance discrimination based on health), individual mandates, and subsidies to make insurance more affordable for low-income families. As such, it is useful to assess whether the Massachusetts reform has been successful, and the lessons it provides for the prospects of national reform. I do so in this essay.

THE MASSACHUSETTS REFORM

It is important to note that Massachusetts differed in three very important ways from the U.S. as a whole before its reform in 2006. First, it had already reformed its non-group and small-group insurance markets to prohibit pricing based on health status (“community rating”), so that one of the key tenets of reform was already in place. As a result of this earlier reform in Massachusetts, the non-group and small-group insurance markets collapsed and prices rose enormously, so that by 2006 Massachusetts had a tiny non-group market and the highest non-group premiums in the nation (America’s Health Insurance Plans [AHIP], 2007).

Second, Massachusetts had a much lower uninsurance rate and a much higher rate of employer-sponsored insurance coverage than the nation as a whole, which implied that a smaller share of its budget was required to cover the uninsured than in most other states.

Finally, Massachusetts had existing sources of revenue to finance reform that the federal government does not have. In particular, Massachusetts had a tax on providers and insurers that financed care for the uninsured, and these funds could be naturally redirected instead to provide subsidies for health insurance coverage. In addition, it was receiving almost \$400 million per year in federal funds to support its safety net hospitals, money that was under threat of removal if Massachusetts did not use it to finance more fundamental reform.

The Massachusetts reform had several key features (with corresponding federal reform characteristics):

- Imposing an individual mandate that required all adult residents for whom insurance was “affordable” to purchase insurance; affordability was subsequently defined as an income-based threshold. The mandate was effective as of the end of 2007, and the initial penalty was \$219; in 2008, it ranged from zero for the lowest-income residents to \$912 for older and higher-income residents. By way of comparison, when fully phased in the PPACA will impose penalties that are a maximum of \$695 per year or 2.5 percent of family income, which is lower for middle-income families but higher for higher-income families than in Massachusetts.
- Establishing the Commonwealth Care program, which provides highly subsidized insurance to families with incomes below 3 times the poverty line (about \$66,000 in family income in 2010). Both the subsidy rate and the insurance package provided to low-income individuals are much more generous in Massachusetts than under the PPACA; on the other hand, the PPACA extends subsidies to 400 percent of the poverty line.
- Establishing the Commonwealth Choice program, which allowed individuals to purchase non-group insurance through the Connector, a new virtual marketplace that allows ready comparison of insurance options. The PPACA would establish similar exchanges in each state.
- Imposed a very small (\$300 per year per employee) charge on employers with more than ten employees that do not offer insurance coverage. The PPACA has a much larger employer charge of \$2,000 per employee for any employer

with more than 50 employees that does not offer insurance and has at least one employee receiving federal tax credits.

- Expansion of Massachusetts's Medicaid program, Mass Health, to all children below 3 times the poverty line (previously, coverage only extended up to 2 times the poverty line). The PPACA includes a much more sizable extension of Medicaid for all persons to up to 133 percent of the poverty line.

THE RESULTS IN MASSACHUSETTS

There has been only a short time to evaluate the impacts of this transformative change in insurance markets, but some lessons are clear. First, there has been a large proportional increase in insurance coverage in the state. The size of the estimated increase varies from survey to survey, but Figure 5 in Long and Phadera (2009) shows that the percentage decrease in the uninsured varies from almost 50 percent (from the Current Population Survey [CPS]) to 60 percent (from the Behavioral Risk Factor Survey and the National Health Interview Survey [NHIS]).⁸

Second, this expansion in insurance coverage has been associated with a rise in access to care. The share of the population with a usual source of care, the share with a doctor's visit in the last 12 months, the share receiving preventive care, and the share receiving dental care all rose significantly from the fall of 2006 to the fall of 2008 (Long & Masi, 2009).

Third, rather than a crowd-out of private insurance through the expansion of a publicly funded entitlement, there has been a "crowd-in" through a rapidly rising rate of employer-insured individuals. According to estimates from both the CPS and NHIS, total insurance coverage rose by about 300,000 persons in Massachusetts from 2006 to 2008. Both surveys find that this partly reflects rising private coverage; in the CPS, private coverage rose by about 200,000 persons, while in the NHIS the rise in private coverage was 100,000 persons.⁹ Either way, private insurance has risen, not fallen, with reform.

Some of this "crowd-in" is due to increased enrollment in employer-sponsored insurance by those endeavoring to meet the requirements of the mandate, but some has actually been through *higher* rates of employer insurance offering. The rate of employer-provided insurance offering in Massachusetts rose from 70 percent in 2005 to 76 percent in 2009, while it remained flat at 60 percent nationally (Massachusetts Division of Health Care Financing and Policy [MA DHCFP], 2010). There is no obvious explanation for this increase in employer offering, as the law introduces incentives for employers to drop insurance (by covering their low-income employees outside the employer setting) and does little to penalize those firms that do drop. The best explanation for this result is that there was a nonmarket impact of the mandate on employer behavior, with employees demanding coverage to meet the mandate and employers increasing coverage to meet the demand.

Fourth, the mandate implementation has been very smooth. Over 98 percent of tax filers required to file health insurance information with their tax returns have complied with the filing requirement. In 2008, 53,000 taxpayers out of at least 500,000 uninsured were assessed penalties for not having health insurance (Massachusetts Department of Revenue [MA DOR], 2009). Only 2,500 of those individuals filed and followed through on appeals of their penalty; the penalty was waived in about three-quarters of the cases.¹⁰

⁸ A recent study by Cannon and Yelowitz (2010) disputes some of these findings by raising technical issues about data collection in the CPS. But their conclusions are so effectively refuted by Long (2010) that there is no need to review them here. Moreover, none of the conclusions that I use here rely exclusively on the CPS data that they criticize.

⁹ Based on unpublished tabulations provided by Sharon Long at the Urban Institute.

¹⁰ Based on private communication with Connector staff.

Fifth, the costs of administering health reform have been quite low. The Connector was given only \$25 million in seed funding, and their net worth remains at \$20 million. The ongoing administrative costs are funded by an insurance charge of only 3 percent, which is very small compared to the typical loads found in the non-group and small-group markets.¹¹

Sixth, the reform has generally been popular. The Urban Institute found that in 2008, 74 percent of those surveyed supported reform, and only 15 percent opposed it; these findings did not change in 2009 (MA DHCFP, 2009).

Seventh, premiums have fallen dramatically in the non-group market. According to AHIP (2007, 2009), from 2006 to 2009 non-group premiums rose by 14 percent nationally; over that same period, they fell by 40 percent in Massachusetts. Some of that decline was due to a buy-down of non-group benefits; analysis by the Connector staff suggests that the decline for a given benefit structure was 20 percent.

Eighth, there has been essentially no impact on employer-sponsored insurance premiums. Massachusetts's employer-provided insurance premiums were higher than in the rest of the nation both before and after reform, but the rate of growth has been comparable. From 2005 to 2009, the typical cost of a single employer policy in Massachusetts rose from \$4,380/year to \$5,304/year, a 21 percent increase (MA DHCFP, 2010); the typical cost of a single employer policy nationally over this period rose from \$4,024/year to \$4,824/year, a 20 percent increase (Kaiser Family Foundation, 2009).

Finally, the costs of reform at full implementation have been very close to original projections. Legislative staff in 2006 projected that the Commonwealth Care program would cost \$750 million when fully implemented. In FY 2009, the first full year of implementation, costs were \$800 million; for FY 2010, costs are only \$735 million, below the original projections.

The Massachusetts Taxpayers Foundation (2009) undertook a comprehensive study of the net cost of reform, taking into account the costs of Commonwealth Care and Mass Health expansions, as well as savings through uncompensated care and supplemental payments to safety net hospitals. The study concluded that the net cost of reform in the state has been \$707 million, roughly half of which is borne by the federal government. Given that the state has newly insured about 300,000 individuals according to survey evidence, that is a cost of only \$2,350 per newly insured. This is a very low cost per newly insured compared to earlier estimates of the cost of alternative approaches to expanding insurance coverage (Gruber, 2008). This largely reflects the fact that one-third to two-thirds of the increase in insurance coverage has been through increased private coverage, which comes at no public sector cost.

WHERE CAN MASSACHUSETTS PROVIDE A GOOD PREDICTION FOR NATIONAL REFORM?

As was made clear earlier, Massachusetts differs in fundamental ways from the nation as a whole, which impacts the application of the state findings to the national stage. Nonetheless, a number of the results for the state should be broadly predictive for changes that result from a similar reform at the national level.

First, the impact on insurance coverage should be fairly similar at the national and state level. On the one hand, the national impacts might be smaller, because the law does not extend insurance coverage to undocumented aliens, who are a much larger share of the national uninsured than of the Massachusetts uninsured. On the other hand, the federal bill includes a number of additional features that should increase insurance coverage, such as stronger penalties on employers who do not offer insurance, subsidies that extend higher up the income scale, and tax credits

¹¹ Based on private communication with Connector staff.

for small employers to offer insurance. The Congressional Budget Office (CBO) estimated that the legislation would reduce the number of uninsured from 55 million to 23 million in 2019, a reduction of 58 percent. That estimate seems very reasonable. As a result, there should be a comparable or even larger rise in access to care than was seen in Massachusetts.

Second, there will be at most modest reductions in employer-sponsored insurance—or perhaps even the increase seen in Massachusetts. On the one hand, a much higher percentage of the population will be eligible for subsidies, which will increase incentives for employers or employees in employer-sponsored plans to drop insurance coverage. Moreover, insurance will be fairly available to all, reducing the risk to sick employees if a firm stops offering insurance. On the other hand, the subsidies under the national plan are much less generous overall than in Massachusetts, and the federal reform includes both penalties on employers who do not offer insurance and tax credits for small firms that do not. The CBO projects that employer-sponsored insurance will fall by only 4 million persons as a result of federal legislation, or 2.5 percent of ex-ante coverage levels. That conclusion is sensible, although there remains uncertainty over whether the rise in employer offering that was seen in Massachusetts will play out at the national level. Even absent that rise, however, a major erosion in employer-sponsored insurance is very unlikely.

Third, there should be little impact over the next decade on employer-provided insurance premiums. The nature of this reform, as in Massachusetts, was to largely leave the employer-provided insurance market alone. Small firms may benefit from shopping in the competitive exchange, and all firms may begin to benefit by the end of the decade from the cost controls embedded in the reform. But in general the negligible impacts on employer-provided insurance premiums found in Massachusetts should hold at the national level as well (a conclusion endorsed by CBO analysis).

Fourth, depending on how the crowd-out issue plays out, the cost per newly insured should not greatly exceed that in Massachusetts. The CBO projects that total spending on the coverage expansion in 2019 will be \$212 billion, with 32 million individuals gaining coverage, for a net cost of \$6,625 per newly insured. Expressed in 2009 dollars, that is roughly \$3,700, or about 57 percent more than Massachusetts's cost per newly insured. This likely reflects the fact that the nation as a whole has much lower incomes than does Massachusetts, and even though low-income subsidies are less generous, a much higher proportion of the newly insured will be using them. In particular, while in Massachusetts between one-third and two-thirds of the newly insured gain private coverage, at the federal level (unsubsidized) private coverage actually falls under the CBO estimates. Once again, however, this depends critically on how employer insurance offering responds to the law change; if it rises, as in Massachusetts, then the costs will fall toward the very low levels seen in that state, but if it falls more than projected by CBO, then costs per newly insured will rise more.

Finally, individuals will find the new exchanges a valuable outlet for insurance purchase. The Commonwealth Choice program has grown to 25,000 members, which accounts for roughly one-half of the growth in non-group insurance since reform. Moreover, there is at least suggestive evidence that this new competitive insurance marketplace has promoted the first major entry into Massachusetts insurance markets in decades: Centene Corporation has established the CelticCare insurance company for both the Commonwealth Care and Commonwealth Choice programs.

WHERE IS MASSACHUSETTS UNLIKELY TO PROVIDE A USEFUL PREDICTION?

Massachusetts can provide a useful guide in some areas, but it is less useful in others. For example, it is hard to use the experience of Massachusetts to predict what will happen to non-group insurance premiums under federal reform. The enormous reduction seen in Massachusetts was for several reasons, but primarily because

Massachusetts had (prior to reform) imposed insurance market restrictions without an accompanying individual mandate. Because this is not true in most states, there is unlikely to be the magnitude of reduction in non-group premiums as a result of federal reform. Yet other factors that drove non-group premiums down in Massachusetts are present in the federal legislation, most notably the mandate (which will improve the risk pool) and exchanges (which will provide for a more competitive shopping environment). Moreover, some of the cost controls may work to lower premiums in the non-group market over time.

For this reason, the CBO predicted that, for a fixed non-group policy, premiums would fall by about 10 percent after implementation, a reasonable estimate of the effect of taking out the preexisting distortion in Massachusetts. Overall, the CBO predicted non-group premiums would rise, which reflects the fact that individuals will be choosing more generous non-group products after reform. Of course, these findings ignore the substantial heterogeneity that will result from this change. Older and sicker individuals will clearly see a large reduction in their non-group premiums, while younger and healthier individuals may see an increase.

Moreover, the federal legislation goes much farther than did Massachusetts in taking on the issue of cost control and “bending the curve.” As with the Massachusetts reform, the legislation includes an exchange through which insurance will be competitively sold, hopefully increasing transparency and price competition in non-group insurance. However, the federal legislation also includes a variety of additional cost control tools, including the creation of a politically independent panel that will establish (and presumably lower) rates paid to Medicare providers; increased investment in comparative effectiveness research; a tax on high-cost insurance plans (“Cadillac tax”); and funding for pilot programs in a wide variety of areas intended to improve the quality and efficiency of medical care.

Neither the Massachusetts reform nor any past evidence can provide strong guidance as to the impact of the potpourri of cost control approaches attempted in this legislation. There is no compelling evidence that any of the cost controls in this legislation will “bend the cost curve.” At the same time, health policy experts can’t really say for sure how governments should best go about slowing cost growth. In such an environment of uncertainty, the best response is to try a number of approaches and see what works. This “spaghetti approach” (throwing a bunch of things against the wall and seeing what sticks) is exactly what is pursued in this legislation. Thus, although the bill is not guaranteed to lower cost growth, it incorporates virtually all of the leading-edge thinking about the types of reforms that might have that effect.

Third, the experience of Massachusetts may not tell us much about the key political issue going forward: the popularity, or lack thereof, of the individual mandate. There are a number of reasons to think that the mandate might be more popular in Massachusetts. First, it is binding on a much smaller share of the population than in the nation as a whole. Second, this law was passed with virtually universal support; there were only two dissenting votes in both houses of the legislature. As a result, public officials were able to engage in a massive social marketing campaign with no significant resources invested in “counter-advertising.” This social marketing may have been central to both the success and the acceptance of the mandate.

In other states the acceptance of the mandate will likely be much less widespread. If this requirement is not explained clearly and marketed appropriately, it may not be widely accepted by the public. Moreover, opponents of the legislation for many reasons may provide counter-advertising that will impede the success of the mandate.

Finally, unlike in Massachusetts, new revenues were required to fund the national reform. These revenues are raised partly through reductions in Medicare spending and partly through new taxes, primarily on high-income families. The Massachusetts experience therefore tells us little about the impacts of these revenue-raising actions.

In particular, one question that has gathered significant attention is whether the federal reform will actually reduce the deficit. According to CBO projections, the offsetting Medicare cuts and tax increases will exceed the new spending under this bill by \$119 billion over the first decade and by over \$1 trillion in the second decade. There are three important points to make about these projections. First, some have claimed that the numbers are “cooked” because some of the revenue raisers begin before 2014, while the majority of spending doesn’t start until after 2014. But this is completely disingenuous, as the trend in the bill is toward larger deficit reduction over time. Indeed, even if one just compares the 2014 to 2019 period, the bill reduces the deficit, and the deficit reduction is rising in 2018 and 2019 (and thereafter) (CBO, 2010). The cuts in revenue and increases in taxes are actually back-loaded, not front-loaded as these criticisms imply.

Second, some have raised the possibility that the cuts providing much of this financing will never take place. They point to the congressional experience with the physician payment cuts put in place by the Balanced Budget Act of 1997, which have been repeatedly delayed by Congress. But this amounts to cherry-picking a particular example. As highlighted by Van de Water and Horney (2010), this is one of many cuts in Medicare passed by Congress over the past 20 years—and the vast majority have taken effect. Indeed, three-quarters of the cuts in Medicare proposed in that 1997 bill have taken effect! As Van de Water and Horney (2010) conclude, “those who ignore all of the other Medicare savings provisions enacted over the past 20 years, single out the SGR [physician pay cuts] experience, and cite it as evidence that Congress does not allow intended Medicare savings to materialize have jumped to a faulty conclusion inconsistent with the record.”

Third, many have pointed out the fragile nature of these projections. The CBO does the best possible job predicting the long-run balance implied by legislation such as this, but it is by necessity a very uncertain projection. There is no reason, however, to think that CBO would systematically underpredict spending or overpredict revenues in this case; the government is as likely to exceed their deficit predictions as to fall short of them.

WHERE IS THE EVIDENCE STILL OUT?

A final category of topics are ones where, in principle, Massachusetts could provide useful lessons but for which there is not yet sufficient data to evaluate the Massachusetts experience. The most significant of these is the impact of reform on the health of citizens. Evidence presented above suggests that access increased, but ultimately what matters is the effect on health. Past evidence suggests that this increase in access should translate to improved health, but direct evidence from Massachusetts is not yet available.

Related is the question of whether an expanded supply of insured will reduce access for the existing insured, who face a limited supply of medical providers. Several surveys have been undertaken of physician wait times in Massachusetts. All show that wait times are quite high, but there is no consistent picture of how those wait times have changed since reform.¹² Clearly, adding 32 million newly insured patients to a static supply of health providers could exacerbate health care shortages.

¹² The Massachusetts Medical Society (2009) finds that average wait times for obstetrics/gynecology have gone up since 2005, but that wait times for internal medicine, gastroenterology, cardiology, and orthopedic surgery have all either stayed constant or fallen since 2005. Merritt Hawkins & Associates (2009) shows that wait times in cardiology fell in Boston by more than the national average from 2004 to 2009, but wait times for dermatology, obstetrics/gynecology, and orthopedic surgery rose by more than the national average over that period. Unfortunately, neither survey collects pre-reform data on family practice that would allow for a comparable calculation.

But it is unclear how significant these impacts will be, nor whether the supply of providers will respond to this rise in demand.

WHERE DOES THIS LEAVE US?

The recently enacted federal health insurance reform is one of the most transformative pieces of social policy legislation ever passed into law in the U.S. As a result, it is incredibly difficult to make strong predictions about the impact it will have on health insurance markets and health care.

That said, in this case policy analysts are fortunate to have a compelling “case study” to draw on in evaluating the likely effects of reform: similar reforms enacted in Massachusetts in 2006. These reforms clearly illustrate that the federal bill can substantially increase insurance coverage, can do so in an administratively feasible fashion, and can do so on budget. At the same time, the Massachusetts experience doesn’t tell us what will happen to health care costs or public acceptance of reform, which will be important indicators to watch going forward. The most important source of uncertainty about the federal legislation will be its ability to start the U.S. down the road toward health care cost control. Although those who viewed this bill as providing the comprehensive solution to our health care cost problems are undoubtedly disappointed, it is important to recognize that there was no consensus on what else should have been done to fundamentally control costs. This is clearly just the first step toward real cost control in the U.S., but it is impossible to cross the finish line without getting started.

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RIGHT ANALYSIS, WRONG CONCLUSIONS: RESPONSE TO JONATHAN GRUBER

Douglas Holtz-Eakin

I want to thank Jonathan Gruber for writing such a lucid analysis of the Massachusetts and U.S. reforms. First and foremost, it reveals a remarkable degree of agreement between us on the key issues.

Most importantly, the Patient Protection and Affordable Care Act (PPACA) is effectively insurance market reform and not a comprehensive health care reform that will address both cost and coverage. As he says, “As in Massachusetts, the federal legislation relies on the principles of insurance market reform (for example, ending insurance discrimination based on health), individual mandates, and subsidies to make insurance more affordable for low-income families.”

Gruber characterizes the cost control strategy as a “spaghetti” approach of throwing everything at the problem but acknowledges: “There is no compelling evidence that any of the cost controls in this legislation will ‘bend the cost curve.’” To be fair, I believe Gruber is more optimistic than I regarding the possibility that *if* one strand of the spaghetti does evolve as a potent cost control, then the political climate *will* permit it to be deployed quickly and broadly. But in the end our conclusions are not far apart.

Second, his essay highlights how Massachusetts *is* different than the United States as a whole. As Gruber points out, Massachusetts was able (at least initially) to finance its reforms using federal money. In contrast (and in rough terms), to provide \$1 trillion in benefits, the PPACA required \$500 billion in new revenues and \$500 billion in spending reductions elsewhere. This difference is crucial for the overall popularity of the reforms, its impacts on employer-provided insurance, and its budgetary impact. I discuss each in greater detail below.

Indeed, one way to think of the key difference is that in Massachusetts everything had already gone wrong. As noted in my essay, health care costs prior to the reform were already 27 percent higher than the national average. And, as Gruber points out, the insurance market was already in disarray: “the non-group and small-group insurance markets collapsed and prices rose enormously, so that by 2006 Massachusetts had a tiny non-group market and the highest non-group premiums in the nation.”

Most states have not put themselves in this catastrophic position of high costs and dysfunctional insurance, which may in part explain why the PPACA evolved as an extremely partisan and much more unpopular reform. Both stand in contrast to the bipartisan and more positively received Massachusetts reform.

These features will continue to influence the PPACA. Gruber argues that the “social marketing” that accompanied the introduction of an individual mandate may have been crucial to its acceptance, and the mandate was crucial to improving the non-group pool. Multiple lawsuits regarding the mandate were filed immediately after the passage of the PPACA, and 49 percent of Americans support these lawsuits (Rasmussen Reports, 2010). To the extent that there is broad noncompliance with the individual mandate, the combination of guaranteed issue and (modified)

community rating will lead to potentially severe adverse selection and the sharp premium hikes and deteriorating market that Massachusetts experienced prior to the introduction of its mandate.

Similarly, the Massachusetts business community evidently embraced its reform, which may explain the puzzling rise in employer-offered insurance that Gruber notes. In contrast, not only does the Congressional Budget Office project crowding out of employer-sponsored insurance, but elements of the national business community strongly oppose the PPACA, with the influential National Federation of Independent Businesses joining in a lawsuit against the bill (Reuters, 2010).

Thus, to a remarkable extent I find myself in agreement with Gruber's observations, but conclude that this does not bode well for the federal reform.

There are some areas, however, in which I come down differently than Gruber. As noted in my essay, I am skeptical that the proposed reductions in Medicare provider reimbursements will evolve as written in law. He makes his case for the plausibility of the cuts and the overall budgetary integrity of the PPACA. I will simply point out that the Centers for Medicare & Medicaid Services actuary Richard Foster (2009) concurs with my bottom line. We will have to agree to disagree and monitor future developments.¹³

Similarly, Gruber appears more optimistic regarding the impacts on access to health care, noting that for Massachusetts, "the share of the population with a usual source of care, the share with a doctor's visit in the last 12 months, the share receiving preventive care, and the share receiving dental care all rose significantly from the fall of 2006 to the fall of 2008." This suggests that the newly insured took advantage of their status and received services. However, it does not address the evidence of long wait times for services noted in my essay. This presumably affects the existing insured population as well as the newly insured. Gruber does acknowledge that "adding 32 million newly insured patients to a static supply of health providers could exacerbate health care shortages."

Finally, I am less sanguine than Gruber regarding the impacts of PPACA on existing employer-sponsored insurance. He concluded, "there should be little impact over the next decade on employer-provided insurance premiums." I think this is mistaken for two reasons. First, unlike Massachusetts, the PPACA raises substantial new revenues. Beginning in 2011, a new fee on pharmaceuticals will raise \$27 billion over the next ten years. Beginning in 2013, a 2.3 percent tax on medical devices will raise \$20 billion in the budget window. A new fee on health insurers will begin in 2104 and will raise over \$60 billion. Finally, in 2018 the 40 percent excise tax on so-called "Cadillac" insurance plans is slated to begin. (There is good reason not to count on this, as the unions' ability to squelch this initiative has been well displayed.) Each of these fees either raises the costs of medical services and thus, indirectly, health insurance, or raises the cost of health insurance directly. Employer-sponsored plans will not escape this upward premium pressure.

In addition, the PPACA relies heavily on Medicaid expansions, using Medicaid to cover 16 million of the 32 million newly insured individuals. As is well known, on average Medicaid reimburses at rates well below both Medicare and private payers. The incentives to shift costs will place additional upward pressure on employer-sponsored insurance premiums.

Jonathan Gruber has provided a clear and understandable exposition of the Massachusetts experience with reform. Unfortunately, it serves primarily to highlight the difficult road ahead for the PPACA.

¹³ In this light, it is interesting that the Congressional Budget Office (CBO) recently reanalyzed the discretionary spending in the PPACA and concluded that the \$115 billion is above what it had previously estimated (CBO, 2010).

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THE FACTS FROM MASSACHUSETTS SPEAK CLEARLY: RESPONSE TO DOUGLAS HOLTZ-EAKIN

Jonathan Gruber

Douglas Holtz-Eakin's article rightly highlights the enormous fiscal problems facing our nation, and he deserves credit for being one of the nation's leading voices on this critical topic. But, unfortunately, he relies on anecdote and assumption to conclude that federal health reform will worsen our nation's fiscal problems. An objective view of the evidence from Massachusetts shows the flaws in his arguments.

Holtz-Eakin's essay makes four main points. First, he argues that reform has raised health insurance costs in Massachusetts. This is clearly wrong. Holtz-Eakin highlights recent reports from insurance companies of free riding by those who come in and out of the non-group market in Massachusetts. But, as he notes, this is a tiny share of those who have gained coverage. He ignores the fact that overall non-group prices have fallen by over 50 percent relative to national trends through reform. And he ignores the fact that the federal reform bill has an annual open enrollment restriction, not present in Massachusetts, which should mitigate such free riding.

When it comes to data on group insurance costs, Holtz-Eakin doesn't rely on the facts, but rather testimony from a business group. The facts are clear: The Massachusetts reform did nothing to group insurance premiums, which grew at exactly the same rate as did national premiums. There is no reason to expect anything different from the Patient Protection and Affordable Care Act (PPACA), which is why the Congressional Budget Office (CBO) projects little impact of the PPACA on group insurance premiums. The bottom line is that Massachusetts was a high medical cost state before reform and remains one after reform, but there is no evidence reform has raised those costs.

Second, Holtz-Eakin argues that the Massachusetts program has gone over budget, and by extension so will the PPACA. Indeed, as Holtz-Eakin notes, in the first full year of implementation, spending on low-income subsidies in Massachusetts was about 10 percent higher than projected. But this is a fairly close prediction

given the bold new nature of this program; even if the costs of PPACA are 10 percent higher than predicted, the legislation would still lower the deficit in the first decade and beyond. Moreover, the most recent data for Massachusetts (which, to be fair, Holtz-Eakin is unlikely to have seen) shows estimated program costs that are virtually identical to the 2005 projection. So, after two years of full implementation, the program is exactly on budget.

The issue at hand here is not whether the U.S. is on a fiscally sustainable path, but rather what the PPACA does relative to that path. As I noted in my essay, this conclusion depends very much on what one assumes about Congress's political will in enforcing the cuts and tax increases that are required to finance this legislation. Here, Holtz-Eakin continues to focus on the one particular example that fits his case—physician fees—while ignoring the fact that the vast majority of other proposed Medicare cuts in the recent past have been enacted—including three-quarters of the cuts in that very same BBA 1997 legislation. Insisting that Congress is incapable of keeping its promises, in the face of the historical record to the opposite, is basically a recipe for legislative paralysis.

Third, Holtz-Eakin argues that the Massachusetts reform has led to restrictions on access to care. He refers to a particular study that shows wait times have risen in four out of five categories of patient care studied. But he does not reference another study at the same time (by the Massachusetts Medical Society) showing that wait times were flat or falling in four of five categories studied. As I highlight in my essay, it is simply too early to draw conclusions about the impact of the Massachusetts reform on wait times. But we do know from the survey evidence I cite that overall access to care has improved significantly; the portion of the population without a usual source of care fell by 40 percent.

Finally, Holtz-Eakin highlights that the Massachusetts reform did not control health care cost growth, and so by implication neither will the PPACA, which makes both reforms, by his reckoning, failures. There are two flaws in this argument. The first is that the Massachusetts law provides little guidance for PPACA in this area, as the Massachusetts law was explicitly *not* about cost control. By contrast, the PPACA includes a variety of mechanisms designed to control health care costs. Holtz-Eakin rightly highlights the uncertainty around whether these mechanisms will work—but it is clearly better to try uncertain approaches than to do nothing about cost control.

This last point highlights the second key flaw in Holtz-Eakin's argument: What is the alternative? Holtz-Eakin seems to have in mind some idealized cost control bill—but *no such bill exists*. There are a variety of nice-sounding ideas put out by both parties, but there is not yet any proposal that has been scored by a nonpartisan entity as “bending the cost curve.” Essentially, the choice facing Congress was to do a “coverage first, with some attempts at cost control” bill, or *no bill at all*.

So the bottom line comparison is not this bill versus some idealized alternative. The comparison is the PPACA versus no legislation. And on this count the evidence from Massachusetts and from nonpartisan entities such as CBO and the Center for Medicare and Medicaid Services Office of the Actuary (CMSOACT) support the value of the PPACA. CMSOACT recently projected that this legislation, by 2019, will raise national health care spending by 1 percent (less than one-sixth of one year's growth rate in health care costs) to expand insurance coverage of the non-elderly by 15 percent. Moreover, CMSOACT projects that the national health expenditures (NHE) implications of this legislation are falling over time, so that by the second decade the bill will lower, not raise the NHE.

In summary, we have legislation that (according to objective analysts such as CBO) covers almost 60 percent of the uninsured, reduces the deficit, and in the long run reduces national medical spending. The evidence from Massachusetts, where available, is fully consistent with all of these conclusions.