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National Journal

Test Case

Setting aside partisanship, Massachusetts enacted a law designed to provide health insurance for nearly every resident. Will the plan work?

■ By Marilyn Werber Serafini

Cover Story

Massachusetts' sweeping new law designed to ensure that nearly all residents have health insurance is a bipartisan approach that could become a model for other states and even the nation.



At the April 12 bill signing at Boston's Faneuil Hall, Massachusetts Gov. Mitt Romney shook hands with the state's health secretary, Timothy Murphy, as Sen. Edward Kennedy looked on.

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The Mass.-ter Plan

■ By Marilyn Werber Serafini

In 1994, when Sen. Edward Kennedy, D-Mass., and Republican businessman Mitt Romney were embroiled in an intense election battle for Kennedy's long-held Senate seat, few could have imagined that the two men would ever lock arms on, well, anything.

But that was 12 years ago. In April, Romney, now the governor of Massachusetts, and Kennedy became the proud parents of a revolutionary state health care law that's promising to ease the political deadlock over one of the nation's most troublesome and expensive problems.

Setting aside partisanship, the Republican governor partnered with Kennedy and the leaders of the state's heavily Democratic Legislature—as well as with business, consumer, and hospital officials—to author a law that positions Massachusetts to become the *first* state to have nearly universal health insurance coverage.

"We found a way to bridge the partisan divide, and to find a coincidence of interests among the various stakeholders in the health care community," Romney said during a recent interview with *National Journal*.

With health care costs still skyrocketing and the ranks of the nation's uninsured swelling to 46 million, frustrated states have taken matters into their own hands. Several states have approved sweeping efforts to try to cover many of their uninsured, but ultimately have fallen short of universal coverage. Congress, meanwhile, has done little, passing only Band-Aid fixes since President Clinton's botched effort in 1993 and 1994 to cover all Americans. That endeavor was so controversial that many political observers believe it was a key factor in the Democrats' loss of House and Senate control in the 1994 elections.

Now policy makers nationwide are scrambling to learn more about what Massachusetts has in mind. Romney is getting phone calls from governors of both parties, and health care experts who helped develop his state's reforms are being swamped with e-mails from state legislators, governors, members of Congress, and interest groups. They're all eager to hear about the details of the Massachusetts law and determine whether they can replicate it on the state or even the national level.

With implementation of the law in July 2007, Massachusetts will become the first state in the nation to impose a mandate on all individuals to have health insurance. Most of the state's uninsured residents will go through a new, quasi-governmental entity to purchase private insurance plans at more affordable group rates, with the poorest individuals receiving subsidies to help foot the bill. All but the smallest businesses will have to pay an assessment for each uninsured worker, to help subsidize coverage.

The plan fundamentally redirects government money—from propping up public, safety-net hospitals that provide free care to the poor to subsidizing the purchase of private insurance. All told, Massachusetts is expected to spend only a minimal amount of new money on the program.

The intriguing aspect of the Massachusetts plan is that it brings together ideas for health care reform from both the liberal and conservative camps, which have been badly polarized. It is an unlikely mix of seemingly incompatible concepts in a single package.

Universal coverage, for instance, has mostly been a liberal idea based on expanding government health insurance programs like Medicaid and Medicare. Conservatives have balked, contending that big government expansions would do nothing

to spur competition and lower prices. They've also opposed liberal proposals to require employers to offer health insurance or pay into an uninsured pool, the so-called "play-or-pay" approach. Conservatives have clung to the concept of subsidizing individuals to purchase insurance through the private marketplace, especially through tax-preferred health savings accounts. Liberals have complained that many individuals couldn't afford the added financial burden and would forgo coverage or care.

The Massachusetts plan's success may well ride on the fact that "it's a bipartisan agreement, it's a bipartisan agreement, and it's a bipartisan agreement," said Len Nichols, director of the health policy program at the New America Foundation, a Washington think tank. "This is a Republican governor running and shaking hands with a Legislature that's the bluest of blue. Here's a Democratic Legislature that's willing to accept limits."

How well the Massachusetts plan ultimately works not only has lasting implications for national health care policy. It could also make or break the political aspirations of Romney, who is widely expected to run for president in 2008. "This will be important to his future," Allan Hubbard, director of President Bush's National Economic Council, said during a recent interview with *National Journal*.

Robert Blendon, a professor of health policy and management at Harvard, predicted that the new law would give a significant political boost to Romney as he enters the presidential race. "It's not that he's going to talk about the plight of the uninsured," Blendon explained. "He'll use this to show he's a big governor who can reach across the aisle to get something done."

Romney's effort could give him an early edge over Senate Majority Leader Bill Frist, R-Tenn., a heart and lung transplant surgeon who might also stake a claim to running as the Republican White House candidate with the most to offer on health care. Other GOP presidential contenders could feel more pressure to propose major health care solutions. "This will raise the issue of whether Republicans should be doing something larger about this issue," Blendon said.

In turn, the Republicans' increased attention to health care will launch a "Democratic arms race," Blendon suggested. "Democrats cannot allow Republicans to have a bigger bill than they have." In particular, Sen. Hillary Rodham Clinton, D-N.Y., the early front-runner for the 2008 Democratic presidential nomination, could feel the heat. After playing a central role in her husband's

1993-94 health care debacle, she has shied away from proposing any major initiatives on the issue during her Senate tenure. But the Massachusetts reforms "will put Clinton in a difficult position," Blendon said. "People will expect her to come in with a significant bill."

Politicians of all stripes can learn something from the Massachusetts plan, in the view of the New America Foundation's



Nichols. “People running for president are reaching out for creative ideas,” he said. “I’ve been asked by candidates, two Democrats and two Republicans, to talk to them about this. They have questions that are very similar. How can you make universal coverage consistent with Republican principles? The answer is Massachusetts.”

How the Massachusetts Plan Will Work

Massachusetts officials agree that it’s early to declare total victory. They know all too well that passing a health care reform law doesn’t mean that it will work—or even that it will remain law. In 1988, then-Gov. Michael Dukakis, a Democrat, pushed through the Legislature a bill requiring employers to offer health insurance or pay into a system for the uninsured. Angry businesses forced a repeal before the law went into effect.

Today, proponents are optimistic about the new Massachusetts law because of its widespread support. It was approved 154-2 in the state House and 37-0 in the state Senate, and signed by Romney amid great fanfare at an April 12 ceremony at Boston’s Faneuil Hall. Kennedy, who was at Romney’s side for the bill signing, concedes that he’d rather have a Medicare-for-all national health care system. But, in an interview, Kennedy called the new law “workable,” adding, “It was well worth taking the chance.”

Proponents acknowledge that it will be two or three years before they know whether taking that chance pays off. “A lot of those things that get people upset are to be determined down the road,” said John McDonough, executive director of Health Care for All, a Massachusetts consumer group associated with the national group Families USA.

For the nearly 6 million people in Massachusetts who have health care coverage through an employer or through Medicare or Medicaid, nothing will change under the new law. Things will be radically different, though, for the state’s 460,000 uninsured residents.

Starting on July 1, 2007, everyone in Massachusetts must have health insurance. Residents must include their insurance-policy numbers on their state tax return, or pay a penalty—the loss of their state personal exemption. “Let’s say that the state tax rate is 10 percent, and the personal exemption is \$3,000. That’s \$300,” explained John Sheils, vice president of the Lewin Group, a health care consulting firm. In addition, for each month without insurance, an individual must pay a fine equal to half the cost of an “affordable” insurance product.

To cover the uninsured, the state’s first step will be to expand its Medicaid program to enroll the 106,000 eligible people who aren’t yet signed up. They have annual incomes below 100 percent of the federal poverty level (less than \$9,800 for an individual). An additional 150,000 uninsured residents with incomes between 100 percent and 300 percent of the poverty level (\$9,800 to \$29,400 for an individual) will receive a subsidy to help buy private insurance. The state’s remaining 204,000 uninsured people, who earn more than \$29,400, must buy private insurance without financial help.

Whether or not an uninsured individual gets a subsidy, he or she will go to the “Connector”—a quasi-governmental entity that is state-appointed but independently run—to be hooked up with a private plan. The idea is to make insurance more affordable to individuals by having them band together to get group rates. By allowing some flexibility in benefit design, and by placing a two-year moratorium on the creation of new state mandates that dictate what benefits insurance policies must

cover, Romney says he can reduce the average monthly premium for small-group insurance from \$350 to about \$200, with some premiums as low as \$154.

These plans won’t be as generous as standard small-group insurance plans elsewhere. The plans with low monthly premiums could have annual deductibles as high as \$1,000 and co-payments for medical services as high as \$40, and they are expected to offer more-limited networks of doctors and hospitals. (The national trend over the past decade has been to widen networks, to meet consumer demand for greater choice, and that has led to the popularity of more-expensive PPOs. The idea here is to return to more-restrictive HMO-style networks.) Plans for 19-to-26-year-olds, who are typically healthier, will likely have narrower benefits that won’t necessarily meet all of the state’s 40 mandates.

Employers also have new responsibilities. Whether or not they offer insurance to workers, all employers with 11 or more full-time employees must set up so-called cafeteria plans under Section 125 of the Internal Revenue Code. Doing so costs employers nothing, but allows workers who don’t get employer coverage to buy insurance through the Connector with pretax dollars. Employers who don’t offer insurance have to pay an annual assessment of as much as \$295 per employee to help subsidize coverage for low-income individuals and free care.

Although some details may need adjustment, proponents argue that the basic structure of the new program is solid. Without uninsured people filling emergency rooms with minor problems, there’s little need to prop up public hospitals with tax dollars, so that money can be redirected to help people buy insurance. Insurance will then allow people to receive medical care in a more appropriate and less expensive setting: the doctor’s office. Or so the theory goes.

Meanwhile, the Connector is intended to eliminate the problems inherent in the insurance market for individuals. When people buy insurance on their own, they don’t have the leverage that employers do to force competition and lower prices, and they can end up with policies that exclude the conditions for which they most need coverage.

Still, some liberals and conservatives at the far ends of the political spectrum forecast disaster under the new Massachusetts system. On the left, the AFL-CIO predicts that many low-income people won’t be able to afford good insurance, and will get skimpy plans. On the right, the Cato Institute and the Galen Institute contend that costs will exceed the state’s projections. They also argue that excessive government involvement and the new burden on employers, along with what they see as restrictive requirements about what insurance policies must look like, will hamper competition.

Is a public backlash possible? Adverse reactions to major health care reform proposals have typically resulted from new mandates on either employers or individuals. (An employer mandate killed the Dukakis health plan.)

This time, the \$295 per employee assessment on Massachusetts employers who don’t offer insurance has already proven somewhat controversial: Romney vetoed the provision in April, but the Legislature overrode it. There is also a possibility—although it seems unlikely at this point—that businesses might wage a legal challenge against the Massachusetts law, arguing that it runs afoul of the 1974 Employee Retirement Income Security Act, which pre-empts states from regulating employer health plans.

■ How Massachusetts Will Cover Its Uninsured



Nevertheless, many experts and businesses consider the assessment a small price to pay. "Two hundred and ninety-five dollars is a lot less than the cost of insurance," said Sheils of the Lewin consulting firm, who noted that the average annual cost of coverage for individuals nationwide in 2003 was \$3,500. If anything, the fee is so low that some experts fear that smaller businesses might choose to stop offering insurance and just pay the penalty.

Any backlash might start instead with individuals. Naomi Walker, director of the AFL-CIO's state legislative program, worries the most about the low-income Massachusetts residents who won't qualify for subsidies to buy insurance. "If you earn [\$29,400] a year, your monthly income would be about \$2,300 before taxes. You're in a high-cost state like Massachusetts, where housing costs are through the roof and gas is over \$3, and you're committed to pay \$250 to \$300 a month for health care. It's undoable for a lot of people," Walker said, adding that the cost of a family plan is between \$600 and \$700 a month.

Sheils predicted that eventually pressure will grow on Massachusetts politicians to increase subsidies—and thus government spending. "It's like *The Da Vinci Code*. It's a great story, but it's not real," he said of the new law. "I'm very concerned about the staying power for a bill where the costs are not well understood. The redirecting of uncompensated care to subsidize insurance is great, but it's not going to be enough to pay for the program."

Lessons for Other States

Could other states adopt the Massachusetts model? Would the effort under way in the tiny Northeast bastion of liberalism work in more-conservative and more-rural states like Alabama, or in far-more-populous states like California?

Admittedly, Massachusetts approached its health care problems with certain advantages: Compared with other states, it has fewer uninsured people, and they are better off financially. Only 13 percent of its residents under age 65 are uninsured, while the national average is 18 percent, according to the non-profit Institute for Health Policy Solutions. Just 6 percent of the state's nonelderly uninsured residents have incomes that are

less than 250 percent of the poverty level, while the national average is 11 percent, the institute reported. Those factors mean that other states would need more funding for subsidies to help their uninsured residents afford coverage.

Moreover, Massachusetts had an existing pot of money to work with, because it had requested and received two waivers from federal Medicaid rules in recent years. The first waiver, in 1998, granted the state \$600 million a year in federal funding to expand Medicaid and fund uncompensated care. The second waiver, in 2005, allowed Massachusetts to shift federal health care funds around while overhauling its program in ways that many other states couldn't.

In the view of House Ways and Means Committee Chairman Bill Thomas, R-Calif., it would be extremely difficult for his home state to afford the Massachusetts plan down to the last detail. California contributes less money per Medicaid beneficiary, giving it a longer, more expensive path to travel to provide insurance to everyone. In addition, he said, it's much harder to group individuals together for insurance purposes in rural areas, which California has more of than Massachusetts does.

But Thomas still believes that the Massachusetts plan creates a national vision that will help the federal government help the states. "For states that don't pay as much for the uninsured, for states that don't have this, for states that don't have that, you still have a vision, and you can begin to shape your insurance market," he said in an interview. "You can begin to direct government dollars going to providers. Before [the Massachusetts law], you had no vision, because it didn't exist anywhere."

"If government put its money someplace else, you have a different model," Thomas added. "In Massachusetts, they're putting their money someplace else for the first time. And that's kind of exciting." He said that the federal government has a role in eliminating insurance mandates and encouraging Massachusetts-style Connector arrangements to improve the insurance market for individuals. A Connector could work in every state, Thomas said.

The biggest challenge for any state is financing. Romney and Kennedy joined forces last year because the federal government



Former Secretary Tommy Thompson and current Secretary Mike Leavitt have been steering states toward subsidizing the purchase of private insurance.

them as big slush funds, giving dollars to big-city hospitals.... They didn't want it to be an uncompensated care thing. They wanted it to be a private insurance thing."

Ed Haislmaier, a research fellow at the Heritage Foundation, agreed that HHS—under previous Secretary Tommy Thompson and current Secretary Mike Leavitt—has been encouraging such approaches. In the past, "states have been in a box about what to do with Medicaid," he said. "Cut benefits or throw people off of the rolls. It's lose, lose, lose politically."

Leavitt "is very much cognizant of that," Haislmaier added, "and he's not going to force [states]. But he's saying, within certain parameters, we will be your partner.... If you're willing to do

was threatening to cancel the \$600 million in additional health care funding that the state was receiving from its 1998 waiver. The new Massachusetts program is expected to cost roughly \$1.6 billion a year, but it will be paid for mostly through existing federal and state funding streams; only \$125 million a year in additional state spending is needed.

Massachusetts responded to a clear message coming from the Bush administration's Health and Human Services Department that—as it considers a slew of requests from states for federal Medicaid waivers—it is highly interested in encouraging changes that involve redirecting funding from providing free care to the poor to subsidizing the purchase of private insurance.

"People in Washington, Republicans generally, hate these uncompensated care pools," said James Mongan, CEO of Partners HealthCare, a hospital network in Boston. "They view

stuff differently and creatively to transform from one of the worst systems to one of the best, they're willing to give whatever waiver help you need. But if you're just interested in rebuilding the current system, the answer is no."

Already, a handful of states are in a position to replicate the Massachusetts experiment, said Sheils, who listed Connecticut, Minnesota, New York, and Vermont as possibilities. "Connecticut is the richest state in the country, and it has one of the smallest percentages of uninsured. If they can't fix the problem, nobody can," he said.

And many states could find at least some money, said Martin Sellers, president and CEO of the Philadelphia-based Sellers Feinberg health care consulting firm, which Romney hired to help craft Massachusetts' new partnership with the federal government. Each state, for example, gets so-called "disproportionate-share payments" from the federal government to fund hos-

From Across the Ideological Spectrum

The Massachusetts plan brings together health care reform ideas from both the liberal and conservative camps. It is an unlikely mix of seemingly incompatible concepts in a single package.

LIBERAL IDEAS		IDEAS PROPOSED IN VARIOUS FORMS BY LIBERALS AND CONSERVATIVES			CONSERVATIVE IDEAS		
<p>Universal coverage Nearly everyone in the state would have health coverage, leaving little need for uncompensated care.</p>	<p>Employer mandate If employers don't offer insurance, they must pay up to \$295 per worker annually to help subsidize coverage.</p>	<p>Low-income subsidies Residents with incomes up to 300 percent of the federal poverty level would receive subsidies to help them buy insurance.</p>	<p>A "Connector" A quasi-governmental entity would be set up to serve as an insurance broker that would connect the uninsured with private health plans at more-affordable group rates.</p>	<p>Individual mandate Everyone in the state must buy health insurance or face a tax penalty.</p>	<p>Private health plans The law steers most of the state's uninsured toward purchasing private health plans.</p>	<p>Moratorium on mandates The state would be prohibited from creating new mandates that dictate what benefits insurance policies must cover.</p>	<p>Health plan flexibility Health plans could offer higher deductibles and more-restrictive physician and hospital networks.</p>

pitals that support the most uncompensated care. Moreover, he said, “states have these taxing districts that raise all this local money and pour it into their public hospitals.”

Sellers and Peggy Handrich—who handles state Medicaid waivers for the firm and was a Thompson staffer when he was Wisconsin governor—worked closely with Massachusetts, and they are now helping Michigan and Indiana to develop similar health insurance reform plans.

Michigan Gov. Jennifer Granholm, a Democrat, announced recently that she wants to cover half of her state’s uninsured population, or about 550,000 people. Granholm isn’t proposing an individual mandate, as in Massachusetts, but she wants to provide premium subsidies for people to buy private insurance through a Connector. She would cover people with incomes of as much as 200 percent of the poverty level, which is less than Massachusetts will cover. But the effort would cost more in Michigan because its Medicaid program covers people at a lower poverty level.

“What they have in Michigan is steeply increasing Medicaid caseloads and sharply declining employer-sponsored insurance,” Handrich said. “The situation that we are presenting to the federal government is, if you do nothing, they will keep paying, paying, paying for more and more people getting onto Medicaid. So they’re asking for a waiver for federal funding to match existing state spending to help support the cost of an expansion to 200 percent of poverty.”

Indiana officials, meanwhile, had been discussing health care reforms when the Massachusetts legislation became law, and “they were intrigued by what appeared to be some federal flexibility,” Sellers said. “So right now, we’re looking at what might be possible. But they have met with their stakeholders in Indiana to say they are thinking big.” Indiana is a relatively poor state with a lot of uninsured people; Republican Gov. Mitch Daniels’s party has a slim majority in both houses.

The District of Columbia is also a candidate. In 2004 and 2005, the District was working with Haislmaier, of the Heritage Foundation, on a Connector-style arrangement, but it went nowhere. He’s predicting that the Massachusetts law will reinvigorate the effort. Haislmaier eventually took his Connector model to Massachusetts, and now he’s getting as many as 20 phone calls and e-mails a day asking for information about the plan.

For its part, Congress could help support Massachusetts-style reforms by capping the tax deduction that employers get for offering benefits such as health insurance, in Thomas’s view. “We should redirect [the deduction money] to individuals,” he said. “So if people want more insurance, it’s out-of-pocket above a certain level. That would force insurance products to have more commonality, so that you begin to get a boilerplate price for the cheaper model. And then you redirect that money to the individual market, so that they can have the wherewithal to make decisions. This part can be done nationally.”

Sheils said he, like many economists, believes that capping the deduction “is absolutely the right thing to do.” Providing



the tax break encourages people to buy generous insurance and use more health care services. “It desensitizes people to the cost of health care,” Sheils said.

Thomas, however, won’t be the one to make such changes in Congress. He is retiring at year’s end, and concedes that he has run out of time. But he said that other Ways and Means Committee Republicans will carry these ideas forward. Rep. Jim McCrery, R-La., for example, has worked with Thomas to try to cap the tax deduction, and he is vying to replace Thomas as chairman. Rep. Paul Ryan, R-Wis., could also take the lead on the issue.

In the end, the bipartisanship behind the Massachusetts plan leaves some politicians and policy experts with hope for tearing down partisan barriers elsewhere. Back in January 2005, signing a Medicaid waiver for Massachusetts was the last thing that Thompson did before leaving HHS. Afterward, Romney and Kennedy accompanied Thompson to his going-away party, where Kennedy gave a rousing impromptu speech praising the lame-duck Republican secretary. “It was stunning,” Handrich recalled. “People in the back of the room, particularly the more political crowd in the back, were like, ‘Whoa, what happened here?’” ■

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