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Massachusetts' Health Reform Plan: Miracle or Muddle?

By Grace-Marie Turner and Tara Persico

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Executive Summary

Interest in the Massachusetts health reform plan remains high as observers at the federal and state levels monitor its progress toward achieving universal health insurance coverage and controlling rising health costs. Many of the features of the Massachusetts plan are contained in legislation under consideration in Congress, including a bill offered by Massachusetts Sen. Edward Kennedy's Health, Education, Labor, and Pensions Committee. Therefore, it is worth assessing the experience with the Bay State's reform initiative so far for lessons that may be useful for federal lawmakers.

When the state's reform plan was enacted in 2006, then-Massachusetts Gov. Mitt Romney was hailed for achieving what no other political leader has been able to accomplish: Developing a broad health reform plan with strong bipartisan support. By enacting sweeping health reform legislation, Massachusetts sought to be the first state in the nation to have all of its citizens covered by health insurance.

Since then, state officials, including Gov. Deval Patrick, as well as many others in the health sector and business community, continue to advance the reform experiment. But implementation continues to pose many challenges — both in access and costs — and observers are cautious about the outcome.

For example, more than half of those newly enrolled in health coverage in Massachusetts are in free or heavily subsidized plans, causing significant budget pressures for the state. Rising costs for health coverage and health care pose the biggest challenge to the success of the reform effort. And physician and medical workforce shortages have been exacerbated, with half of the state's internists and family physicians closing their practices to new patients.

Architects of the plan are confident it will succeed. Jon Kingsdale, head of the Commonwealth Health Insurance Connector Authority, and others implementing the plan say support remains strong among political leaders and the business community. Gov. Deval Patrick cites 439,000 newly insured residents in the state as evidence of its success.¹ But major problems remain, and duplicating the Massachusetts experiment would be a significant challenge for any other state, much less the federal government.

Massachusetts' reform initiatives that are being considered by Congress include an individual mandate, employer play-or-pay mandate, a national health insurance exchange, strict regulation of private health insurance, expansion of Medicaid, and establishing a government-mandated health benefits package. Before proceeding to implement this experiment on a nationwide scale, it would be wise to learn more about how the reform plan in this sophisticated, highly-motivated state is developing.

Overview of the Massachusetts Health Plan

Massachusetts' Health Care Reform Act was signed into law by former Gov. Romney, a Republican, on April 12, 2006, with support from the overwhelmingly Democratic legislature. Banner headlines throughout the country said that the Bay State was on track to be the first in the nation to achieve universal health coverage. This paper will offer an overview of the changes the state made and some of the results so far.

Key features of the Massachusetts health reform plan:²

- **Medicaid** was expanded to pay for coverage for children in families earning up to 300 percent of the federal poverty level (FPL) — \$32,508 a year for individuals and about \$66,150 for a family of four — as well as to subsidize coverage for other categories of individuals, including long-term unemployed workers and disabled working adults.³ Approximately 76,000 people have been added to the Medicaid rolls in the state as a result.
- The law created **Commonwealth Care** to provide taxpayer-subsidized health insurance to people with incomes above Medicaid eligibility but below 300 percent of FPL. No premiums owed by those earning less than 150 percent of FPL, or about \$16,500 a year, and who are on a sliding scale up to the income limit. About 177,000 people are receiving coverage through this program.⁴
- The legislation created **Commonwealth Choice** to provide a mechanism for those without job-based health insurance and who don't qualify for subsidies to purchase insurance. It also is a mechanism through which people can use tax-protected dollars to pay their premiums. So far, 22,000 people are enrolled in this program.
- The state requires all residents to have health insurance through an **individual mandate** and it imposes fines, which have increased every year, on those who don't comply or receive a waiver. The fines this year are up to \$1,068 for individuals. About 70,000 have been exempted from the mandate because they were deemed by the state unable to afford coverage and they don't qualify for subsidies.
- Employers are required to contribute to the cost of their employee's health coverage — a **play-or-pay mandate**. Employers with more than 11 workers must contribute at least 33 percent of the cost of premiums and cover at least 25 percent of their workers or pay a fine of \$295 per worker. About 72 percent of Massachusetts workers are enrolled in health insurance, significantly higher than the national average of 59 percent.

No Miracle Cure for High Costs

Massachusetts started its reform initiative with many things going for it — a Republican governor and Democratic legislature motivated to enact reform measures; business and health care communities willing to participate; and a relatively low rate of uninsured compared to the rest of the country.

But the biggest problem that Massachusetts had — and still has — is the high cost of health care and health insurance in the state.

Personal health care expenditures per capita in Massachusetts in 2004 were \$6,683, almost 27 percent higher than the national average.⁵ The promise of reform, advocates said, was that everyone could get insurance and that the system could be made more efficient and less costly by reorganizing the health sector. When the plan was enacted, the state argued that it was primarily moving money around — redirecting about \$1 billion in federal money and other fees to subsidize health insurance for residents under 300 percent of FPL. Officials argued that covering everyone would eliminate the “free rider” problem and bring down health insurance

costs for others who were paying the health care bills of the uninsured.

The state already had in place strict regulations governing the health insurance market — guaranteed issue, community rating, etc. — that now are being proposed in Washington with the hope of containing costs.

Through the new law, Massachusetts created a Connector to streamline the purchase of insurance — much like the National Health Insurance Exchange that Congress is considering.

Eileen McAnney of the Associated Industries of Massachusetts testified in April 2009 that health insurance costs in the state are 30 percent higher than the national average “and health care reform has done nothing to moderate premium trends to date.”⁶ On average, health insurance costs \$16,897 for a family of four in Massachusetts, compared to \$12,700 nationally.⁷

State officials are beginning to realize that one of the factors driving up costs is that the Health Care Reform Act did not relax the expensive mandates and insurance regulations that had made private coverage so expensive in the first place. A state study reviewing mandated health benefits, which was required under the 2006 Massachusetts health reform law, found that the most expensive mandates cost residents an additional \$1.07 billion between July 1, 2004, and June 30, 2005.⁸

Overall, one third of Massachusetts residents say that their health costs have gone up, not down, as a result of reform.⁹ Other studies show that the average premiums for Commonwealth Choice renewals — the unsubsidized plan — are expected to increase by nearly 10 percent this year, with the median-priced policy increasing seven percent.¹⁰ A survey conducted in the fall of 2008 said that many people still are struggling to pay for health care.^{11 12}

The Massachusetts health insurance market is dominated by three major health plans that

control most of the business, and all of them are heavily regulated by the state. As a result, there is no genuine competition and little consumer choice. Plans offered through the health insurance Connector have few, if any, of the tools that the private sector is using to engage consumers as partners in managing health costs and that are helping to hold down the costs of employment-based coverage in other parts of the country.¹³

Complaints about the high costs of the Massachusetts model cross political and ideological boundaries. Dr. Rachel Nardin, Dr. David Himmelstein, and Dr. Steffie Woolhandler described their views in a study for Physicians for a National Health Program and Public Citizen.¹⁴

They wrote that “the Massachusetts health care system, widely regarded as an example of how to provide universal coverage and keep costs low, is in fact faltering badly and should not be held up as a national model for reform.”¹⁵

Instead of reducing costs, the state’s 2006 reforms have been more expensive than expected, according to their study. “The budget overruns have forced the state to siphon about \$150 million from safety-net providers such as public hospitals and community clinics,” they wrote. (Drs. Nardin, Himmelstein, and Woolhandler don’t support private insurance and advocate instead a single-payer, government run health system.)

Plans offering coverage through the subsidized Commonwealth Care program received approval for a 12 percent rate increase in 2008,¹⁶ although offsets mean those eligible for the coverage will pay an average of 9.4 percent.¹⁷

The costs of the plan are straining the state budget as well as the pocketbooks of citizens. The state’s overall costs for health programs have increased by 42 percent since the reform legislation was enacted in 2006.¹⁸

Spending for 2009 was originally projected to be \$725 million.¹⁹ But it is now projected to be around \$800 million,²⁰ even though Commonwealth Care enrollment peaked at 176,000 members in mid-2008 and has declined slightly since. Gov. Patrick recently announced budget cuts that will reduce benefits and enrollment in the subsidized plans.

Officials may be able to buy some time with the state's share of the \$87 billion in additional Medicaid money approved earlier this year by Congress as part of the economic stimulus legislation, but without structural reforms, costs will continue to be a key concern.

As described above, in 2009, the "minimum creditable coverage" provision requires that all policies sold in the state must cover prescription drugs and have limited out-of-pocket spending, for example. This increases the cost of insurance and is putting additional financial stress on individuals and small businesses trying to comply with the mandate.

Jon Kingsdale, executive director of the Commonwealth Connector, is working to keep premiums low for those in the Connector plans. As a result, the full cost of the average monthly premium will fall \$1 in fiscal year 2010 to \$394 from \$395 this year. But analysts question whether the leveling is real and sustainable since it involves state decisions to freeze the base enrollee contributions and also to jawbone insurers to lower premium prices even as utilization and costs rise.

Massachusetts is relying heavily on the federal government for the funds to support its reform program. Gov. Patrick announced in September of 2008 that the federal government had agreed to renew its waiver request, which provides a significant amount of the funding through Medicaid.²¹ The \$21.2 billion three-year agreement is a \$4.3 billion increase over the current waiver and allows Massachusetts to continue providing Medicaid services to an expanded population of lower-income recipients

and to subsidize coverage for people earning up to \$66,150 for a family of four.

But the day of reckoning has arrived, as *The New York Times* reports.²²

"Threatened first by rapid early enrollment in its new subsidized insurance program and now by a withering economy, the state's pioneering overhaul has entered a second, more challenging phase. Thanks to new taxes and fees imposed last year, the health plan's jittery finances have stabilized for the moment. But government and industry officials agree that the plan will not be sustainable over the next five to 10 years if they do not take significant steps to arrest the growth of health spending," wrote correspondent Kevin Sack.

According to Jonathan Gruber, a health economist at the Massachusetts Institute of Technology, "Just as this may have been the easiest place to do coverage, it may be the most difficult place to do cost control."

The Times reports that Massachusetts promised providers their payments would not be cut or would even increase with the reform proposal. "Those who led the 2006 effort said it would not have been feasible to enact universal coverage if the legislation had required heavy cost controls," Sack reports. "The very stakeholders who were coaxed into the tent — doctors, hospitals, insurers and consumer groups — would probably have been driven into opposition by efforts to reduce their revenues and constrain their medical practices, they said."

Businesses supported the state's health care measure with the promise that their costs would go down or at least level off. A study last fall from the Center for Studying Health System Change found that "Many respondents were concerned that unless the state seriously addresses the underlying factors driving costs, that the current trajectory of the reform is financially unsustainable," according to lead author Debra Draper.²³

Washington is facing the question of whether it should expand coverage and focus on costs later, or start first with containing costs. Massachusetts' experience would suggest Washington would do well to begin by tackling the cost issue first before creating massive new health spending obligations. The Galen Institute has long recommended using market mechanisms, not the heavy hand of government price controls and rationing, to move toward a more efficient, cost-effective health sector.

According to James C. Capretta of the Ethics and Public Policy Center, "The Obama team is essentially pursuing the Massachusetts political strategy — cover everybody first with a massive new entitlement program and worry about imposing cost controls later," he writes. "But make no mistake: If President Obama succeeds, he and the Congress will be back in a year or two or three — when the coverage train has already left the station — to say the financial future of the country depends on agreeing to government-imposed cost constraints, just as Massachusetts officials are doing today."²⁴

Coverage

Massachusetts had a relatively low uninsured rate of less than 10 percent before the reform effort went into effect, compared to 16 percent nationally.

The state's reform effort expanded insurance coverage in several ways.²⁵ Medicaid enrollment was expanded to cover more low-income citizens. A new program also was created, called Commonwealth Care, to provide fully-subsidized coverage to adults whose incomes are under 150 percent of poverty. Residents earning up to 300 percent of poverty also can receive subsidized coverage through Commonwealth Care, but on a sliding payment scale. A new Health Insurance Connector was created to facilitate the purchase of insurance for those whose incomes are above subsidy levels. As noted earlier, fines are levied on

employers who don't participate and on individuals who don't obtain coverage in order to assure compliance.

When the reform plan was enacted, the state estimated that between 550,000 and 715,000 of its 6.4 million residents did not have health insurance.

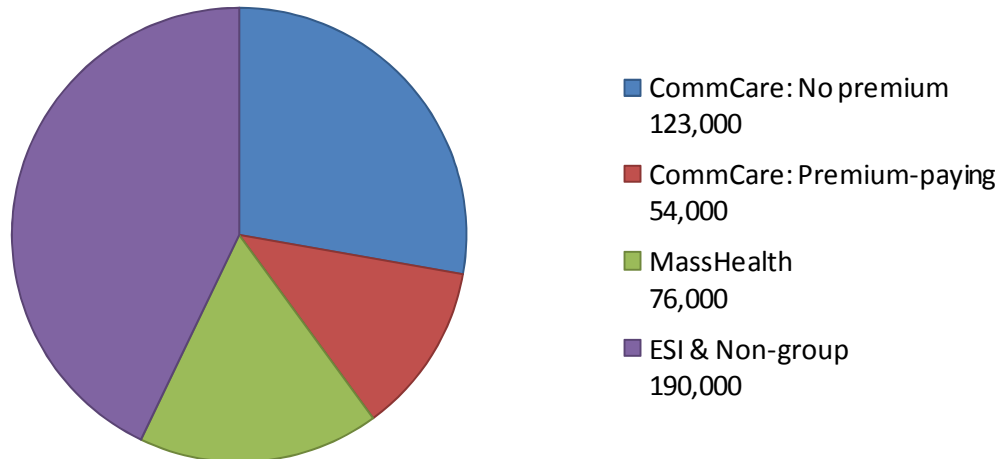
The state reports that since reform, its overall uninsured rate has dropped to 2.6 percent, or 167,300 according to a December 2008 survey by the Urban Institute.²⁶

Recent figures show that 57 percent of those newly-enrolled in health insurance receive subsidized coverage; 39 percent of these newly insured are receiving free or partially subsidized coverage through Commonwealth Care and an additional 18 percent are in an expanded Medicaid program. Just nine percent of the newly insured bought coverage on their own through the new Connector, and another 34 percent of the newly insured signed up through their jobs, incentivized by the requirement that both employers and individuals must comply with the mandate or face fines and tax penalties.²⁷

The great majority of those newly covered by insurance since passage of the legislation are in plans completely or heavily subsidized by the taxpayer. In terms of numbers, that means that of the 430,000²⁸ newly enrolled in insurance, more than 76,000 were added to the Medicaid rolls and another 177,000 are getting free or heavily subsidized coverage through the Commonwealth Care program,²⁹ paid primarily by a mixture of state funds and federal matching Medicaid dollars.

About 114,000 of those enrolled in Commonwealth Care, or 70 percent, pay nothing for coverage under Commonwealth Care. The remaining 55,000 pay between \$40 and \$140 a month for their coverage.

June 1, 2009 New Enrollment



Source: Massachusetts Health Connector.³⁰

Some experts question the state's ability to sustain the coverage numbers moving forward unless costs level off.³¹

To get to universal coverage, the state will need to convince people who don't get subsidies — and who face growing penalties for not enrolling — to buy insurance. Many of those who remain uninsured are people making less than 300 percent of the federal poverty level. The remainder don't qualify for subsidies and face rising health insurance costs, growing fines, or a complex waiver process. This presents a significant challenge to the state and will likely require additional action to bring them into compliance with the coverage mandate.

Mandates, Fines, and Enforcement

Play-or-pay mandate: Employers with 11 or more employees are required to provide a “fair and reasonable” contribution toward an employee's health insurance or pay an assessment of \$295 per employee per year.

A state report released recently noted that 72 percent of Massachusetts employers offer health insurance to employees, whereas nationwide, that figure is only 60 percent. The report also noted that many large retailers continue to rely

on state subsidy programs to provide health benefits to their workers.³²

Leaders at Health Care for All, a large consumer group that helped shape the state's 2006 law, are backing legislation that would require employers to contribute more to employee coverage. Congress also is considering a federal mandate that employers provide health coverage for their workers or pay for them to be covered through a new public health insurance program, which is viewed as a new tax on employment.

Benefit mandates. Massachusetts requires health insurance policies to comply with health benefit standards it sets. Washington is considering a similar requirement.

In Massachusetts, many small businesses now are being told that the coverage that they previously had no longer meets the state's minimum standards. They must either upgrade their insurance to cover prescription drugs, for example, likely increasing the cost, or face fines.

The inclusion of prescription drug coverage in the minimum creditable coverage requirements has particularly irritated employers and worries employees, according to a report by the Center for Studying Health System Change.³³

Effective Jan. 1, 2009, individuals are required to have prescription drug coverage to meet the individual mandate and avoid the tax penalty. Although employers are not directly affected by the requirements, respondents expected employers to be pressured to provide coverage that meets the requirements. Otherwise, employees will be required to obtain additional coverage or pay the tax penalty because their coverage does not meet the minimum standard. The Massachusetts Taxpayers Foundation has estimated that approximately 163,000 insured residents do not have prescription drug coverage, and of these, more than 80 percent have employer-sponsored coverage. According to the foundation, the additional cost to employers of adding prescription drug coverage is estimated at \$24 million.

Given the high costs of the reform, many respondents expressed dismay at what they perceived as the “richness” of the benefit requirements, believing the requirements fuel cost pressures and make affordable coverage even less attainable. As one respondent stated, “If the choice is between comprehensive and cost, comprehensive wins every time.”

The state also is looking to businesses to help fund the reform plan in other ways. When the health reform law was crafted in 2006, proponents estimated that the state would collect \$45 million in the first year in penalties from business that didn’t comply with the new law by providing coverage for their workers. Instead, businesses took action and offered insurance, and as a result, the state collected no fines in the first year and only \$7 million the next year. But, according to Jon B. Hurst, president of the Retailers Association of Massachusetts, “No good deed goes unpunished.”³⁴ Gov. Patrick is tightening the screws. Under a new rule he proposed in August, employers now are required to contribute 33 percent toward a full-time employee’s health premium AND have 25 percent of their employees enrolled in a health plan.³⁵ In addition, the 2006 law says that

employers are liable for a large portion of any health costs above \$50,000 in aggregate that any uninsured employees may incur in a year.

Many small employers have workforces composed of retirees and secondary wage earners who have other coverage. The new policy makes it almost impossible for them to meet the new test and avoid paying the penalty.

“I think there is going to be a revolt over this,” Hurst said. Employers calculate the reform measures already have cost them an additional \$500 million, and the tab is growing.

Employer frustration also appears to be growing as the state increases employer responsibilities and requires additional financial support from them. Businesses are fearful that as health costs continue to rise, the state will require them to pay an ever-larger share of employee health insurance premiums or that penalties for non-compliance will increase — or both. The mandates also have distorting effects on the state’s economy, such as discouraging companies from hiring more workers or encouraging them to hire part-time workers in order to escape taxes and penalties.

According to the Center for Studying Health System Change, employer support for reform is threatened by the costs of increased employee take up of employer-sponsored coverage (because of the mandate) and rising premiums. Improving access to health care coverage has been a clear emphasis of the reform, but little has been done to address escalating health care costs, the report says. Yet, both must be addressed, otherwise it concludes that the long-term viability of Massachusetts’ coverage initiative is in jeopardy.³⁶

There are other mandates, reporting requirements, penalties, and enforcement provisions in the new law which affect both individuals and businesses. For example, state agencies are required to verify individuals’ insurance status, monitor their income to see if they qualify for subsidies, and track individual

health habits (like smoking and wellness activities) to determine their health insurance premiums. Forty-five percent of large firms told pollsters that compliance with the paperwork requirements to track employee coverage and Section 125 benefits was very burdensome and another 29 percent said it was somewhat burdensome — 75 percent in all.³⁷

In addition, the reform plan created at least 10 new boards and commissions to run the new health system, such as the Health Care Quality and Cost Council, the Payment Policy Advisory Board, and the Health Access Bureau. To the state’s credit, most of these boards and agencies have been very transparent in their operations with regular reports on the Massachusetts state government website of their activities.³⁹

Oddly, the Health Care Quality and Cost Council is on the endangered list. The state was looking for places to cut spending to close a billion-dollar budget shortfall and the Cost Council was a prime target. It survived, but many observers are puzzled: Eliminating the agency charged with solving the largest problem in the Massachusetts health experiment — high costs — would be “penny wise and pound foolish,” said Charlie Baker, president and CEO of Harvard Pilgrim Health Care in a blog post on October 21, 2008.

Insurance and Affordability

Individuals who can prove that coverage is not affordable can get a waiver, exempting them from the mandate and fines for non-compliance. So far, about 70,000 people have received exemptions for financial reasons and another 9,000 have claimed a religious exemption.⁴⁰ As noted earlier, residents who don’t obtain coverage and do not request or receive a waiver are subject to a financial penalty of up to \$1,068 this year. In 2007, 86,000 Massachusetts residents were assessed a tax penalty.⁴¹ The penalty, which is imposed through an individual’s personal income tax return, will

increase each year until it equals 50 percent of the lowest-cost health plan.⁴²

The state has developed a schedule that tells residents what they can and cannot afford to pay for insurance. For example, if your family income is \$70,001, Massachusetts says you can afford to spend \$550 a month, or \$6,600 a year, for health insurance.⁴³ If you fit in the affordability categories and don’t buy coverage or get a waiver, you will be fined. Since 2007, the state has collected \$16 million in fines.⁴⁴

2008 Health Care Affordability Schedule

Annual Income	Affordable Monthly Premium		
	Individual	Couple	Family
\$			
0 to 15,612	\$0	\$0	\$0
15,613 to 20,808	\$39	\$0	\$0
20,809 to 21,012	\$77	\$0	\$0
21,013 to 26,016	\$77	\$78	\$0
26,017 to 26,412	\$116	\$78	\$0
26,413 to 28,008	\$116	\$78	\$78
28,009 to 31,212	\$116	\$154	\$78
31,213 to 35,016	\$165	\$154	\$78
35,017 to 35,208	\$165	\$232	\$78
35,209 to 37,500	\$165	\$232	\$154
37,501 to 42,012	\$220	\$232	\$154
42,013 to 42,500	\$220	\$297	\$154
42,501 to 44,016	\$330	\$297	\$154
44,017 to 52,500	\$330	\$297	\$232
52,501 to 52,812	affordable	\$396	\$232
52,813 to 62,500	affordable	\$396	\$352
62,501 to 70,000	affordable	\$550	\$352
70,001 to 82,500	affordable	\$550	\$550
82,501 to 90,000	affordable	affordable	\$550
90,001 to 110,000	affordable	affordable	\$792
110,001 or more	affordable	affordable	affordable

Source: Commonwealth Health Insurance Connector Authority.³⁸

Access and Workforce Issues

There are problems on the supply side as well. In 2007, the Massachusetts Medical Society released a report describing the “critical shortage” of primary care physicians in the state, posing a threat to the state’s health reform plan. It showed that nearly half of internists were not accepting new patients, and waiting time to get an appointment had increased dramatically to 52 days.⁴⁵

The shortage of primary care doctors is making it difficult in some parts of the state for people who are newly insured to find a doctor who will take new patients. *The Boston Globe* reported in the fall of 2008 that the wait to see primary care doctors in Massachusetts had grown to as long as 100 days, while the number of practices accepting new patients has dipped in the past four years, with care the scarcest in some rural areas.⁴⁶ The report said that many of the newly insured are struggling to find a doctor.

Physicians and patient advocates report growing stress for patients trying to get care and for doctors trying to squeeze them in. One doctor said he is working up to 60 hours a week to handle the increased patient load. Another began accepting new patients this year, but was so inundated by newly insured people that she had to shut her doors to new patients again six weeks later. One 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.”⁴⁷ *The New York Times* reported other examples of people newly covered who had difficulty finding doctors.⁴⁸ The Massachusetts legislature has approved an unprecedented set of financial incentives for young physicians and other programs to attract primary care doctors, but health care leaders fear the new measures will take years to ease the shortage.

Massachusetts has problems at the other end of the age scale as well: One-third of the state’s practicing doctors will enter retirement age in

the next decade. Also, 29 percent of the state’s practicing physicians are planning a career change. This does not bode well for the state in the future.⁴⁹

Nationwide, only two percent of medical students say they plan to enter primary care, forecasting a serious shortage in this important specialty area in the years to come. A growing shortage of doctors can be a significant impediment to achieving universal access to care. The challenges that Massachusetts is facing can be instructive for policymakers in Washington. The need for more doctors comes up at almost every congressional hearing and White House forum on health care, writes Robert Pear of *The New York Times*.⁵⁰ Obama administration officials, alarmed at doctor shortages, are looking for ways to increase the supply of physicians to meet the needs of an aging population and of millions of uninsured people who would gain coverage under legislation championed by the president.

Hospital use is increasing. *The Boston Globe* reported⁵¹ last fall 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.” A sizable number of patients who obtained state-subsidized insurance have continued to use the ER — at a rate 14 percent higher than Massachusetts residents overall, according to state data compiled at the *Globe’s* request. It found that patients with the lowest incomes, who formerly received free care in emergency rooms and now pay a nominal fee for state-subsidized care, are using ERs at a rate 27 percent higher than the state average.

Some physicians believe that a larger number of people with health insurance but with a limited pool of primary care providers is driving the overuse of emergency rooms. “Just because you have insurance doesn’t mean there is a [primary care] physician who can see you,” said Dr. Sandra Schneider, vice president of the American College of Emergency Physicians.

Routine care in ERs is considerably more expensive than at a doctor's office or community health center. The average charge for treating a non-emergency illness in the ER is \$976, while it costs between \$84 and \$164 to treat a typical ailment in a primary care doctor's office. Doctors and counselors working the front lines of emergency care say a major reason patients still flock to their doors for routine care is that there are too few primary care physicians in Massachusetts. The shortage of physicians to care for the newly insured is therefore driving up the costs of the reform effort.

Free-Rider Problem

A key argument proponents of Massachusetts health reform used to gain passage was to eliminate, or at least minimize, the “free-rider” problem and use of hospital emergency rooms by the uninsured. Reform advocates argued that mandating coverage for all would stop this cost shift to those who responsibly pay premiums from those who don't. Since the insured pay higher premiums to compensate for use of the system by the uninsured, they believed that insurance costs would go down if everyone were to have coverage.

The political promise of reduction in hospital use has not materialized. A recent study found that the cost of caring for emergency patients has risen 17 percent over two years. The increase is both in volume and cost. In an article, “ER visits, costs in Mass. climb,” *The Boston Globe* reported that visits to Massachusetts emergency rooms grew by seven percent from 2005-2007.⁵² The estimated cost of treating those patients jumped from \$826 million to \$973 million. Nearly half of the visits didn't require immediate treatment but could have been handled in a doctor's office.

Some safety net hospitals are threatening bankruptcy. They still are treating a large number of people without health insurance, but the payments they receive for uncompensated care have been cut under the reform deal.⁵³

As for lessons for the United States overall, Jack Hadley *et al* recently reported that the uninsured received \$56 billion in uncompensated care in 2008, representing 2.2 percent of all health spending.⁵⁴ More than 75 percent of this, or \$43 billion, was reimbursed through public funds directed to the costs of the uninsured. This means that the real cost-shift from uncompensated care is \$13 billion, out of a U.S. health care economy of more than \$2.2 trillion — about half of one percent. There are no cost breakdowns at the state level, but clearly the transfer costs for uncompensated care in Massachusetts, whose 6.5 million residents represent just two percent of the U.S. population,⁵⁵ would be small indeed.

The Congressional Budget Office in a June 16, 2009 letter to Senate Budget Chairman Kent Conrad said that “uncompensated care is less significant than many people assume... Broader insurance coverage might lead to less cost shifting in the health care system, but that effect would probably be relatively small and would not directly produce net savings in national or federal spending on health care.”⁵⁶

But there are other cost shifts that are documented and real. The much larger cost shift is from public plans that pay doctors and hospitals less than their cost of treatment, leaving private plans to make up the difference. The independent consulting firm Milliman Inc. estimates that the total annual cost shift in the United States from Medicaid and Medicare to commercial payers is approximately \$88.5 billion.⁵⁷ It found that annual health care spending for an average family of four is \$1,788 higher than it would be if Medicare, Medicaid, and private employers paid hospitals and physicians rates similar to those paid in the private sector.

Public Opinion: Universal Coverage Not Universally Appealing

A survey by Robert Blendon *et al* found that while support for reform remains favorable

overall, those who were directly affected by the law have the most negative views.⁵⁸

Surprisingly, those who were previously uninsured seem to be the most *unhappy* with the new law. One third of them say the law is hurting them, more than double the 15 percent who expected the law would hurt them when it passed in 2006. Among the poor and young adults, the percentage of people who said the law is hurting also spiked. Overall, only 22 percent of people directly affected said the law is helping them as opposed to 50 percent who say it is hurting. Half also said it has caused health costs to increase and only 14 percent said their costs had gone down.

These are sobering numbers for the White House and Congress. Even with huge subsidies, those who are most impacted seem to be most unhappy with Massachusetts' reform. That sets a high hurdle in trying to help the 46 million uninsured in the U.S. as a whole.

Challenges Ahead

Some argue that the Massachusetts plan is a good example of health care federalism — that is, of a state-level response to the larger problem of the uninsured.⁵⁹ Reform advocates, from Gov. Romney to Sen. Edward Kennedy to Democratic leaders in the Massachusetts legislature, had a vision of creating a competitive marketplace for affordable health insurance and reallocating subsidies to provide health insurance for uninsured citizens who use hospital emergency rooms for medical care at taxpayer expense. While officials say the problems the state is experiencing are only growing pains that can be overcome, the savings from reform have yet to materialize, and many difficult decisions remain to get costs under control.

Massachusetts had a head start on reform with a relatively low uninsured rate, a sophisticated medical system, and political leaders committed to reform. It forged ahead with its mandate and insurance overhaul, despite high costs of

coverage and insurance. Nothing in the reform measures seriously addressed the cost issue. Now, it is doing us the favor of revealing the problems and complexities of state attempts to achieve universal coverage. California, Wisconsin, Illinois, Pennsylvania, and other states have tried to launch similar universal coverage plans, but, so far, all have collapsed when legislators saw the price tag.

Many of Massachusetts' reform initiatives are contained in proposals now before Congress, including an individual mandate, employer play-or-pay mandate, a new health insurance exchange, strict regulation of private health insurance, expansion of Medicaid, and imposition of a government-mandated health benefits package. Before proceeding to implement this experiment on a nationwide scale, it would be wise to learn more about how the reform plan in this sophisticated, highly-motivated state develops.

The state is facing problems with rising health care and coverage costs, with opposition from businesses and individuals to expensive mandates, and with citizens frustrated that they are required to have expensive health insurance but have difficulty finding physicians who will see them. Further, the promise has not been fulfilled that hospital costs would go down as fewer uninsured people sought care in emergency rooms.

Controlling costs is the linchpin of success for the Massachusetts program. Other states and federal leaders should continue watching to see if Massachusetts can find the magic formula to achieve its goal of trying to get costs down by providing health coverage to everyone before proceeding down the same path.

Grace-Marie Turner is president of the Galen Institute, a non-profit research organization focusing on free-market ideas for health reform, and Tara Persico is director of research. They can be reached at PO Box 320010, Alexandria, VA, 22320 or galen@galen.org. Visit the website at www.galen.org.

Endnotes

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