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the Massachusetts experience: can it inform the national debate?

In what can only be described as a most unlikely achievement, Massachusetts—with a conservative Republican governor and a Democratic state legislature—was able to accomplish what no other state has been able to do to date: pass major healthcare reform legislation that provides essentially universal coverage.

As the country contemplates its next moves in healthcare reform, there is a natural interest in considering what we as a nation might learn from the “Massachusetts experience.”

Where Does Massachusetts Stand Today?

Three years after the passage of the Massachusetts reform law, the state has seen coverage expand to all but 3.5 percent of its population. Low-wage employees dominate the remaining uninsured. About 50,000 to 65,000 individuals will face a penalty for having “affordable” insurance available to them (defined as not exceeding a percentage of their income) and not buying it, while some 80,000 didn’t have “affordable” insurance available and will therefore not be subject to a tax penalty.

Massachusetts deliberately chose to expand access before taking on the much more difficult task of moderating spending. Not surprisingly, the state has had greater success in expanding coverage than it has in slowing spending—a fact that placed strong pressure on the governor and the legislature to begin steps that would address healthcare spending.

The federal stimulus bill has pumped enough additional funding into the state to spare it from any immediate adverse consequences from this strategy, but within the next couple of years, it will have to address the serious and difficult issues surrounding cost containment. To assist in this process, the state has convened a commission to advise it on changes to the reimbursement system and other strategies that will lower or slow spending. In a state where one out of five workers works in a healthcare-related activity, this effort not only will be politically difficult, but also could have adverse economic consequences for the state’s working population.

Major Decision Areas

There are three major areas of decision that Massachusetts and any other state contemplating reform need to resolve:

- > How to expand coverage
- > How to pay for the expansion
- > How to moderate spending

Massachusetts chose to expand coverage through a variety of mechanisms, ultimately relying on a combination of an individual mandate and subsidized insurance to provide nearly universal coverage for its citizens. Massachusetts expanded both eligibility and benefits under its Medicaid program. Children’s eligibility was expanded from 200 percent to 300 percent of the federal poverty line. Some optional benefits for adults were also restored. Enrollment growth among those previously eligible but not enrolled was

encouraged by the use of a single enrollment form for all programs along with an outreach program.

Subsidized insurance—that is, with income-based, sliding-scale premiums and copayments—was also made available to all uninsured adults with household incomes below 300 percent of the poverty line. The subsidized insurance was not made available to all who were uninsured and below 300 percent of the poverty line—only to those who lacked employer-sponsored insurance. The impact of these changes was reinforced with the introduction of an individual mandate.

The state used several strategies to pay for expanded coverage—strategies that may not be available for all states and certainly will not be available to the nation as it contemplates major expansions in coverage. First, Massachusetts had a relatively small number of uninsured—only about two-thirds of the national average. Second, Massachusetts was at risk for losing the benefits of its 1115 Medicaid waiver, which made supplemental payments to two safety-net programs and was due to end in 2005. The state persuaded the federal government to keep the federal dollars associated with these payments (\$385 million in 2005) in the Massachusetts systems for use in expanding coverage to low-income, previously uninsured people. Third, the state had substantial funding from what had been its uncompensated care pool, equal to \$232 million in FY06. Thus, the unusually small number of uninsured combined with two sources of substantial funding supported Massachusetts' desire to expand coverage to all or almost all of its citizens in ways that will be difficult for other states to replicate and obviously not available to the country as a whole.

Other Insights

The use of a public plan as a component of healthcare reform has already ignited substantial debate. It is worth noting that Massachusetts has chosen to achieve its close-to-universal coverage by using regulated private plans rather than relying on the availability of a public plan, as the Obama administration has been discussing. The

regulations combine guaranteed issue and renewability with adjusted community rating. The plans thus must offer coverage to all who seek it, and they are limited as to how much rates can vary as a result of preexisting conditions or other predictors of high cost, such as the patient's health status. These regulations were already in place in Massachusetts, which has had a history of activist regulation.

Massachusetts also makes use of an activist insurance exchange, referred to in the state as the Commonwealth Connector. Many of the details about how the insurance offerings would work, such as who can participate in the Connector or the minimum benefits that need to be included in an insurance plan, were not spelled out in legislation, but instead were delegated to the Connector.

Concluding Thoughts

Massachusetts has made clear that expanding coverage to almost all of its citizens was achievable in a relatively short time. Having had a relatively small percentage of uninsured compared with the national average was helpful. Even more helpful was the availability of substantial sums from a Medicaid waiver that would otherwise have disappeared and money from an uncompensated care pool. Keys to the state's success were using regulated private insurance (as in Germany and the Netherlands) rather than relying on a public plan, using an activist insurance connector, and most important, establishing a mandate on individuals to purchase insurance. The challenge is whether the state will have comparable success in moderating spending. It is just beginning its efforts in this area. Stay tuned. ●

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