Massachusetts Health Care Reform Is a Pioneer Effort, but Complications Remain

On 12 April 2006, Massachusetts introduced health care reform legislation "to provide access to affordable, quality, accountable health care" that became law in a bipartisan vote of 154 to 2 in the House of Representatives and 37 to 0 in the Senate. When then-governor Mitt Romney (R) signed the groundbreaking legislation, Chapter 58 of the Acts of 2006, he declared that "an achievement like this comes around once in a generation, and it proves that government can work when people of both parties reach across the aisle for the common good." Over the course of the next year, policymakers, stakeholders, and the newly formed Commonwealth Health Insurance Connector Authority addressed difficult issues pertinent to the law while new governor, Deval Patrick (D), who took office in January 2007, provided continued gubernatorial backing.

The state's new health care reform law aimed to extend affordable, high-quality coverage in a sustainable way to all residents and reduce the state's estimated 400 000 to 600 000 uninsured persons to nearly 0 over the course of the first 3 years (see **Appendix**, available at www.annals.org, for additional U.S. Census data). Policymakers planned to achieve near-universal health care by moving uninsured people from uncompensated care to insured care by expanding on employer-sponsored health insurance as the primary source of coverage for state residents; creating new, lower-cost plans for individuals and small businesses, with improved portability and flexibility for part-time and seasonal workers; and funding public programs for people without access to employer-sponsored health insurance. It also created standards of adequacy and affordability for new, state-endorsed insurance plans while encouraging pretax treatment of health insurance premiums for employees.

The law carried a first-ever individual mandate requiring residents to buy health insurance if they do not already have it and imposed financial penalties for nonparticipation. Meanwhile, it also maintained a modified health care safety net fund to cover the cost of care for people who remained uninsured because they could not afford or were ineligible for health insurance, such as undocumented immigrants.

The law was built on the concept of shared responsibility, relying on cooperation from citizens, businesses, insurers, hospitals, and advocacy groups. The effort, estimated to cost $1.3 billion in 2008, was financed mainly through a redistribution of existing monies spent on the uninsured and underinsured and through new funding streams, including a general fund appropriation of $125 million per year, employer fair-share and free-rider assessments, and federal matching funds on Medicaid spending. A key factor aiding the state's effort was its "free-care pool," initially set up to compensate community health clinics and hospitals that treat the uninsured. Legislators drew on these funds to help pay for the reform.

Massachusetts had other advantages that helped the state achieve its health care coverage goals. Compared with the nation as a whole, a higher percentage of residents had health insurance through their employers—nearly two thirds of employers already offered health insurance to their employees, compared with the national average of 56%. Massachusetts also had a lower percentage of people without insurance—approximately 10% compared with the national average of 16%.

This program was not the state's first attempt at health care reform. In 1988, it enacted a controversial universal health care law that was never implemented and was eventually repealed. That law was followed by a successful bid in the mid-1990s to expand Medicaid and to subsidize drugs for seniors.

This latest health care reform law took effect over the course of 1 year and was fully in place by 1 July 2007. As of 1 January 2008, approximately 300 000 people had already signed up for new coverage. So far, approximately 200 000 of those have enrolled for free or low-cost coverage in either MassHealth or Commonwealth Care. The remaining 100 000 are paying private insurance premiums, either through their workplaces, insurers, or the state. State officials expect that the number of newly insured residents will continue to increase as penalties for noncoverage become more significant in 2008. All residents older than 18 years of age are now required to carry minimum health insurance. Those who could not show proof of health insurance by 31 December 2007 lost their personal income tax exemption when they filed their 2007 income taxes, which is $219 for an individual. In 2008, failure to meet the requirement results in a fine equal to 50% of the least costly insurance premium that meets the standard for creditable coverage for each month the individual does not have coverage. The fine becomes a more sizeable penalty ranging from $672 to $912 for residents who earn an income of at least 3 times the federal poverty level. Residents younger than age 27 years who do not qualify for subsidized coverage (because they earn at least 3 times the federal poverty level) and are uninsured for all of 2008 pay $672. Residents age 27 years or older who do not qualify for subsidized coverage and are uninsured pay a fine of $912. Married residents who are un-

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Commonwealth Health Insurance Connector Authority

A key component of the plan was the creation of the Commonwealth Health Insurance Connector Authority (CHICA), an independent agency with a 10-member board, headed by former Tufts Associated Health Plans executive Jon Kingsdale, PhD. The CHICA assists qualified adult residents of the state with purchasing affordable health care coverage if they don't already have it.

The CHICA runs the Commonwealth Care program for low-income residents who do not qualify for MassHealth (the name used in the state for Medicaid and the State Children's Health Insurance Plan, which are combined into 1 program) and who are not working or are employed by a small business that uses the CHICA to offer health insurance. Commonwealth Care provides subsidized, no-deductible private insurance health plans for these individuals without health insurance who make below 300% of the federal poverty level—$30 636 for individuals and $61 956 for a family of 4. For individuals who earn less than $10 210 or families of 4 who earn less than $20 650, no premiums are charged. Those above that range and still under 300% are charged a reduced-rate premium on a sliding scale based on income. For example, premiums offered by Boston Medical Center Health Net range from about $20 per month for individuals earning between $10 210 and $15 315 to about $130 per month for individuals earning between $25 525 and $30 636.

Commonwealth Care has been available since 1 October 2006 for those below the poverty level. For those between 100% and 300% of the poverty level, plans have been available since 1 January 2007.

For those earning 300% or more above the poverty level, the CHICA administers the Commonwealth Choice health insurance program. The CHICA merged the individual and small-group insurance markets to reduce the cost of nongroup premiums, and now offers various private health insurance plans for individuals and small group employers.

Some plans have deductibles, limited networks of physicians and hospitals, and substantial co-payments. For people between 18 and 26 years of age, lower-cost, limited-coverage products are available. Young adults can also stay on a parental insurance plan until 2 years after the loss of dependent status or until they turn 25, whichever occurs first.

Residents can initially sign up for any plan, but by January 2009, everyone must have prescription drug coverage.

Insurance may also be purchased on a pretax basis, reducing the net cost. The CHICA allows employees to aggregate the contributions of multiple employers if they are part-time workers or work for multiple employers, and apply them to 1 insurance plan. It also promotes portability by allowing employees to keep the same plan even if they leave an employer.

insured must pay fines individually. For details, see the Mandated Coverage section below.

These penalties, which were only vaguely specified in the legislation, are central to effective health care reform, according to Jonathan Gruber, PhD, a professor of economics at the Massachusetts Institute of Technology. "Otherwise, the mandate has no teeth," he says.

Since Massachusetts officially took on the difficult job of health care reform, the rest of the nation has been watching to see whether it succeeds, and if so, just how the reform works. Many people have lauded the hard work and risk involved in tackling the complicated task—others have complained that the effort is misguided, inadequate, or doomed to failure. Leaders of the effort recognize the importance of keeping costs under control so that coverage remains affordable and the reform remains sustainable, while widespread cooperation on the health care mandate and maintenance of an adequate supply of primary care physicians to ensure accessible and high-quality health care are achieved.

Key Components of the Reform

Affordability

Massachusetts has financed health care reform by redistributing existing monies spent on the uninsured and approximately $400 million in additional new funding. Not everyone in Massachusetts likes the funding plan. In particular, 250 physicians in the state have signed a letter asserting that the plan seriously compromises the state's safety net by shifting money from previously funded free care for the poor to subsidized insurance companies that require co-payments the poor cannot afford and payment for medications that were once free.

"In effect, public funds for care of the poor that previously flowed directly to hospitals and clinics now flow through insurers with their higher administrative costs," according to a letter written by Rachel Nardin, MD, an assistant professor of neurology at Harvard Medical School and practicing neurologist at Beth Israel Deaconess Medical Center. Nardin says about a third of the signatories on the letter belong to the Massachusetts chapter of Physicians for a National Health Program, a single-payer advocacy group, of which she is chair.

In addition to these changes in subsidized health care, Nardin claims that premiums for even the lowest-cost nongroup plan available are unaffordable for many people who do not qualify for subsidies.

B. Dale Magee, MD, MS, president of the Massachusetts Medical Society (MMS), said that affordability is a matter of perspective and, "Certainly, not everyone values health care the same." He acknowledged that the difference between the cost of a policy and the median

amount that a person spends on health care in a year is substantial, noting that a health insurance policy may cost $4000 or more for an individual while most people spend under $1000 annually for health care. "So among people who are healthy, there is a pretty good chance that they may not find $4000 or more an affordable expense," he said.

Jon Kingsdale, PhD, executive director of the Commonwealth Health Insurance Connector Authority (CHICA), said that despite complaints, more people who need nongroup coverage are able to afford it now than in the past (for more information about the role of the CHICA in the reform, see Box). By pooling enrollees, the agency was able to negotiate rates that reduced the price of nongroup insurance by half while doubling the benefits. "That doesn't mean that everyone will consider it [the reduced price] affordable, but many people are benefiting," he said. He also noted that people who once relied on free-care clinics and who are newly enrolled in free and subsidized insurance plans are more likely to benefit from improved access to comprehensive and preventive care than in the past.

Without question, financial pressures are a considerable concern, and the ability to keep costs down is crucial to the future of the reform effort. The irony of this affordability issue, some people noted, is that insured persons are typically seen as the primary barrier to universal health care access because they do not consider health care coverage for others a priority—but in Massachusetts, policymakers are hearing the loudest objections from those who are uninsured and do not consider health insurance a priority for themselves.

Mandated Coverage

The state will continue to confirm and enforce coverage through the state tax return. The number of residents facing penalties for being uninsured in 2007 is not yet known; it will be determined once 2007 tax returns are filed, regulators say. The CHICA estimates that by 1 January 2008, between half and three quarters of the state's uninsured residents had enrolled in health coverage since the law took effect. Although universal coverage is the goal, a small percentage of residents are likely to remain uninsured, exempt from the insurance requirement mainly because they did not qualify for subsidies but were deemed unable to afford other coverage options, because of religious reasons, because they are illegal residents, or because they simply do not comply with the mandate despite the penalties. Only those in the last group would face penalties for noncoverage.

Most people in the state already received coverage through their employer at the time of the mandate and more are likely to do so now that the business mandate requires all Massachusetts employers with 11 or more full- or part-time employees to offer their employees a chance to buy insurance. These employers must provide "fair and reasonable" coverage, a requirement fulfilled if at least 25% of its full-time workers are enrolled in the company's health plan or if the company offers to pay at least 33% of the premium cost of an individual health plan for all persons employed full-time for more than 90 days. Companies that fail to do this are subject to the Fair Share Contribution of up to $295 per employee annually.

As part of a "free-rider surcharge," a company is also penalized if it fails to arrange for a pre-tax payroll deduction system for health insurance and has employees who receive care that is paid from the uncompensated care pool. If an employee or his or her dependent receives free care more than 3 times or all of an employer's employees and their dependents use free care 5 times or more overall, and if the total cost of such free care is $50 000 or more, then the employer must pay a portion of the health care costs. The free-rider surcharge regulations are not yet finalized.

Although the business mandate will mean additional costs for many Massachusetts employers, 75% of a randomly selected sample of 1056 employers surveyed in 2007 said that they felt a responsibility to help provide health benefits to their workers, and 70% said they supported the provisions of the health care reform legislation (1). The small employers surveyed also reported that they are not planning to restrict or end coverage in response to the recent reforms.

Primary Care Physician Supply

Growth in the number of newly covered individuals translates into an increased demand for primary care doctors in a state that was, even before health reform, facing a shortage. "That every citizen in the state should have access to health care from a primary care physician should be a basic right, but now the question is, 'Who will care for these people?' Are enough primary care doctors going to be available who will be willing to accept these patients?" said Barry Z. Izenstein, MD, a practicing endocrinologist and Governor of the ACP Massachusetts Chapter.

Primary care physician supply was not taken into account during the development of the health care reform. In 2007, the MMS released a report detailing a "critical shortage" of primary care physicians in the state that might threaten the success of the health reform, according to Magee, the MMS president. He noted that the workforce study showed that 49% of internists statewide were not accepting new patients, a jump of 13% from 2006, based on a telephone survey of physician offices. In addition, just 59% were accepting Medicaid, compared with 73% in 2006 and 79% in 2005. The average wait time for patients who wanted to schedule an appointment had also risen to 52 days compared with 33 days in 2006 and 47 days in 2005 (2).

So far, primary care physicians in the state have absorbed much of

the new patient load into their practices, said Kingsdale, the head of CHICA. Kingsdale reported that over the past few years, managed care organizations have added more than 1000 physicians who are accepting new patients to help care for newly insured patients, but there have still been some reported shortages in the western part of the state around the Berkshires and Cape Cod. He noted that residents might find immediate care for uncomplicated health problems from the growing numbers of limited service clinics, such as drop-in pharmacy clinics that provide care without an appointment. Massachusetts' Department of Public Health oversees these clinics, which are typically staffed by nurse practitioners.

Although such clinics can provide efficient care for minor medical problems, they do not allow for the delivery of comprehensive, coordinated care. Many primary care physicians worry that such piecemeal medical care may result in delayed treatment for major medical problems.

"The problem with a reform that focuses on insurance coverage is that it can succeed only if there are adequate numbers of well-trained primary care physicians available to care for such patients," said Allan Goroll, MD, professor of medicine at Harvard Medical School and a practicing general internist. The primary care shortage is not specific to Massachusetts. *Annals* and other journals have reported on low enthusiasm for careers in general internal medicine and a growing national shortage of doctors working in the field (3–5). "This is a state issue, but it is also a national issue. With all the debate in the political campaigns about health insurance, we also should be having the other discussion about what are we going to do in this country about strengthening and revitalizing primary care," Goroll said. Goroll and other physicians said that they hope the situation in Massachusetts will spur greater attention to the general internist workforce problem.

A National Model

The Massachusetts plan is being watched closely. Other states, including California, Illinois, Washington, and New Mexico, are already adopting the model, or at least some ideas from the model, in their efforts to reduce the number of uninsured people in their states. "A number of states are considering plans very much in our spirit. There is no reason the framework couldn't work. The number one concern is just the financing—that is, can other states come up with adequate funding?" said Gruber, who has provided guidance to Massachusetts and other states about economic decision making for health care reform, and who sits on the board of the CHICA.

The plan is not easily replicated, however. "Massachusetts is a lot easier place to tackle this than other places," said Bruce E. Landon, MD, MBA, MSc, associate professor of health care policy at Harvard University. Among Massachusetts' advantages is a smaller number of uninsured residents than other states—no more than about 600 000 in 2006 compared with, for instance, more than 6 million in California. In addition, the higher-than-average rate of employers who already offered health insurance to their employees also helped. Perhaps most important, the state was able to draw on a preexisting "free-care pool," valued at $610 million, to help pay for the reform. Health policymakers have noted that except in Maryland, New York, New Jersey, and West Virginia, where similar free-care pools exist, new taxes would need to be levied to make up for the lack of these funds. Clearly, raising taxes would make achieving reform more difficult.

Even in Massachusetts, funding and affordability remain big questions. Adequate funding for the next few years is basically guaranteed between state and federal subsidies, grants, and other monies, including money from penalties, according to Gruber. The CHICA is also working on ways to keep insurance premiums from rising significantly. "There is no doubt that the program will last at least through mid-2009. At that point we have to deal with some major trouble spot issues related to funding, but I'm fully confident we'll get through them," Gruber said.

In the end, whether the Massachusetts health care reform effort is ultimately sustainable may not be its most important legacy. Many health care experts view it primarily as an important experiment because it translates long-held theories about health care coverage, finally, into practice. At this early stage of implementation, how this reform affects patient care in the United States remains an intriguing question. "It is a crucial step forward in that it brought together people with diverse views and united them in a plan that has, amazingly, been implemented," said Ronald A. Arky, MD, a practicing endocrinologist and professor of medicine at Harvard Medical School. "It's a great test to solve a major problem."

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An Audio Summary is available online at www.annals.org.

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Appendix: State of Massachusetts

Resident Health Care Coverage in Massachusetts before Reform (data from March 2006 and 2007 Current Population Survey of the U.S. Census)

Number of residents: 6 328 346

Gender distribution: female: 52%; male: 48%

Age distribution: children 18y and under: 25%; adults 19-64y: 62%; 65-74y: 6%; 75+y: 7%

Median annual income: $56 236

Total uninsured: 620 128

Source: Kaiser Family Foundation, www.statehealthfacts.org.