

# The Third Wave Of Massachusetts Health Care Access Reform

A unique “political blueprint” that merges individual and employer responsibility for obtaining health insurance.

**by John E. McDonough, Brian Rosman, Fawn Phelps, and Melissa Shannon**

**ABSTRACT:** In April 2006, Massachusetts passed its third major health care access reform law since 1988. This law establishes new structures and requirements that have never been attempted by any state. Key features include a shift of federal Medicaid dollars from institutional support to individual insurance subsidies, establishment of an insurance “Connector,” individual and employer responsibility, a small-firm and individual insurance market merger, and provisions to address racial and ethnic health disparities. Massachusetts will engage in a multiyear implementation process. Only after this process is complete will the law’s significance be clear. [*Health Affairs* 25 (2006): w420–w431; 10.1377/hlthaff.25.w420]

FOR THE THIRD TIME SINCE 1988, Massachusetts has enacted an ambitious law to lower the number of its residents who do not have health insurance. As was true with two prior reform statutes, this new law contains novel elements that seal the commonwealth’s reputation as a breakthrough innovator, including provisions related to individual and employer responsibility, subsidized insurance for lower-income families, and insurance market reforms.<sup>1</sup>

We call this new statute (Chapter 58 of the Acts of 2006) and the policy formulation process leading to its enactment the “third wave” of Massachusetts health care access reform. Because the first two waves had influence in many other states and the federal government, the substance of the new law deserves attention. Because the statute contains novel elements that have never been attempted in any state, it bears analysis and watching. And because the process leading to Chapter 58’s creation had an unusually bipartisan and bi-ideological flavor, the process merits understanding.

This paper seeks, first, to describe major provisions of the new statute, and sec-

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ond, to describe the process leading to its passage. We begin with background on the Massachusetts health care system.

## The Massachusetts Context

Prior to enactment of Chapter 58, Massachusetts already boasted a health care safety net that provided expanded Medicaid coverage for certain low-income groups, along with robust financial support for hospitals and community health centers that provide care for the uninsured.<sup>2</sup> Two earlier statutes laid the foundation for the third wave.

■ **An employer mandate and its legacy.** In 1988, during the administration of Gov. Michael Dukakis (D), Massachusetts enacted a “universal health care law” intended to provide near-universal coverage by 1992, chiefly through implementation of a “play-or-pay” employer mandate that would have assessed firms with six or more employees \$1,680 per year per uninsured worker. The 1990 election of Gov. William Weld (R), along with a severe economic downturn and mobilized business opposition, eroded tepid legislative support and triggered a series of implementation postponements. The employer mandate was repealed in 1996 as part of an agreement with business leaders to support new tobacco taxes to help finance the second wave of health reform.<sup>3</sup>

Features of the 1988 law were implemented and stand today as durable components of the health care safety net: The CommonHealth program provides Medicaid coverage to disabled adults seeking to work and to certain disabled children (and served as the model for the “Ticket to Work” program enacted in 2005 in the federal Deficit Reduction Act); the Medical Security Plan, financed by a business assessment of \$16.80 per worker, provides coverage to workers who are collecting unemployment compensation (and served as the model for the 2002 federal Health Insurance Tax Credit for Eligible Trade Adjustment Assistance Recipients); the Healthy Start program provides coverage to lower-income pregnant women and new mothers; and the student health insurance mandate requires most college and university students to purchase health insurance.

■ **Medicaid expansion.** Integral to the second wave—a series of enactments in 1996 and 1997—Massachusetts obtained approval of a Section 1115 waiver from the U.S. Department of Health and Human Services (DHHS) to expand its Medicaid program (known as MassHealth) to previously ineligible populations. Because of these expansions, the number of people enrolled in MassHealth increased from 670,000 in 1995 to 1,038,000 today, out of a state population of 6.4 million. The commonwealth saw a compensating drop in the number of uninsured residents from 680,000 in 1995 to 365,000 in 2000, according to state surveys. The commonwealth also made a promise of near-universal coverage for children by expanding MassHealth eligibility for children to 200 percent of the federal poverty level and by expanding eligibility for the Children’s Medical Security Plan (a limited package of primary and preventive care services) to all uninsured children who are ineligible for

MassHealth.

A key element of the Massachusetts safety net is the Uncompensated Care Pool, which reimburses hospitals and community health centers (CHCs) for care provided to lower-income uninsured and underinsured people. The pool was established in 1985 as part of the state’s now-deregulated hospital rate-setting system and has survived numerous alterations since then. The pool is financed by a mix of federal, state, hospital, and third-party payer dollars. In fiscal year 2005 the pool paid \$538.4 million to hospitals and CHCs for uncompensated care.

### The New Massachusetts Health Reform Law

The new Massachusetts law, “An Act Providing Access to Affordable, Quality, Accountable Health Care,” is a complex mix of Medicaid changes, subsidized insurance offerings, insurance market reforms, safety-net alterations, individual and employer responsibility provisions, and more (Exhibit 1).<sup>4</sup> As was true with prior reforms in Massachusetts and other states, Chapter 58 will take years to imple-

#### EXHIBIT 1 Key Health Care Reform Implementation Deadlines In Massachusetts

Date	Requirement	Implementer
7-1-06 <sup>a</sup>	MassHealth children’s coverage expansion from 200% to 300% of poverty MassHealth adult benefits restoration MassHealth provider rates increase by \$90 million Connector Board appointed	Office of Medicaid Office of Medicaid Office of Medicaid Governor, attorney general
10-1-06	CCHIP (subsidized insurance plans) available to eligible people under 100% of poverty “Fair Share” contribution on employers who fail to offer “fair and reasonable” coverage, up to \$295 per worker, becomes effective	Connector Division of Health Care Finance and Policy
1-1-07	All employers must make Section 125 plans available to employees Family policies must maintain dependent children for 2 years past loss of dependency or to age 25 CCHIP plans available to eligible people at 100–300% of poverty	Department of Labor Division of Insurance Connector
4-1-07	Coverage through the Connector begins for small businesses and individuals over 300% of poverty	Connector
7-1-07	All adults 18+ required to purchase health insurance Nongroup and small-group insurance markets merge	Department of Revenue Division of Insurance
10-1-07	MassHealth pay-for-performance standards effective	Office of Medicaid
1-1-08	Full individual mandate penalty takes effect	Department of Revenue

**SOURCE:** Commonwealth of Massachusetts, Chapter 58 of the Acts of 2006.

**NOTES:** CCHIP is Commonwealth Care Health Insurance Program. Pending legislation may alter some of these implementation dates.

<sup>a</sup>All of these deadlines have been met.

*“To assist workers with multiple part-time jobs, the Connector will permit multiple employers to contribute to an employee’s premium.”*

ment and evaluate for its true impact. We avoid the term “universal” to describe it because some uninsured people will be ineligible for assistance or not be required to purchase coverage. How many uninsured people obtain coverage will be known only after implementation. The law will undergo amendments and revisions as implementation unfolds. It will face multiple challenges, including potential changes in federal Medicaid policies, rising medical and health insurance costs, an economic downturn, and a new governor’s inauguration in 2007.

Despite these uncertainties, Gov. Mitt Romney (R), House Speaker Salvatore DiMasi, and Senate President Robert Travaglini agree that the core purpose of Chapter 58 is to expand affordable health insurance coverage to 95 percent of Massachusetts’ estimated 530,000 uninsured residents within three years. Key elements of the law include the following.

■ **Subsidized insurance for the lower-income uninsured.** The law establishes the Commonwealth Care Health Insurance Program (CCHIP) to provide subsidized health insurance coverage for uninsured adults with incomes below 300 percent of poverty (\$29,400 for an individual and \$60,000 for a family of four annually). Eligible people with incomes below poverty will pay no premiums or deductibles and will be charged modest copayments. Those with incomes of 100–300 percent of poverty will pay premiums on a sliding-scale basis and face no deductibles. They will be charged copayments.

State officials estimate that CCHIP will reach 150,000–200,000 uninsured people by 2009. Some limitations exist. For example, uninsured people will not qualify for CCHIP if they have employer coverage available that covers more than 20 percent of the cost of individual coverage or 33 percent of the cost of family coverage—although the Insurance Connector may allow an employer to contribute its premium contribution to qualify the worker for CCHIP.

The state also is making a renewed commitment to identify and enroll 50,000–90,000 people who are now eligible for but not enrolled in MassHealth. Three million dollars has been appropriated for outreach and enrollment activities by hospitals, CHCs, and community-based organizations.

The Uncompensated Care Pool will continue with no changes in funding or regulations until October 2007, when it will become the Health Safety Net Fund. The pool will support hospitals and CHCs that provide care to the residual uninsured and underinsured population, and the level of this financial support is expected to greatly diminish over three years.

■ **Insurance Connector.** Chapter 58 establishes a new, innovative, quasi-public entity called the Commonwealth Health Insurance Connector Authority, governed by a ten-member board including public and private members. The Connector’s

purposes are to (1) reduce the health insurance administrative burden for small businesses; (2) make it easier for small businesses and individuals to find affordable policies; (3) allow individuals to buy insurance with pretax dollars; (4) allow part-time and seasonal employers to combine employer contributions; and (5) enable individuals to keep their coverage when they change jobs.

The Connector will facilitate the offering of private lower-cost health insurance plans to small businesses with fifty or fewer workers. It will make insurance products available to individuals and families who cannot obtain employer-sponsored coverage, enabling them to obtain coverage through pretax payroll deductions. To assist workers with multiple part-time jobs, the Connector will permit multiple employers to contribute to an employee's premium. It will offer special plans for people ages 19–26 that could include reduced benefits and higher cost sharing. Plans offered through the Connector will be developed by health insurance companies licensed to operate in the commonwealth.

All nonsubsidized policies offered through the Connector must cover benefits mandated by Massachusetts law. Deductibles and other cost sharing will require approval by the Connector board and the commissioner of insurance. Policies are anticipated to be more affordable through more-restrictive provider networks than are now the norm in Massachusetts.

The Connector will manage the CCHIP subsidized-coverage plans available to uninsured people with incomes below 300 percent of poverty. For the first three years (if enrollment targets are met), only four existing Medicaid managed care plans will participate (Health Net, operated by Boston Medical Center; Neighborhood Health Plan; Network Health, operated by the Cambridge Health Alliance; and Fallon Health Plan). All four are nonprofit and based in Massachusetts.

■ **Individual responsibility.** A controversial and unprecedented aspect of Chapter 58 is the establishment of “individual responsibility” or an “individual mandate.” The law requires all residents age eighteen and older to purchase health insurance and establishes state income tax penalties for those who cannot document coverage. In 2007 the penalty will be loss of the personal income tax exemption: about \$218 for an individual and \$437 for a family. In 2008 and thereafter, the tax penalty will be up to half the monthly cost of the lowest-cost acceptable health insurance plan within a person's region for each month without coverage. The Connector Board will determine target plans and premiums to calculate this penalty. Overlooked in most media descriptions is this fact: The penalty will be imposed on only those adults for whom the purchase of the lowest-cost plan is deemed “affordable.” The Connector Board will set the affordability definition and will determine what types of coverage are sufficient to meet the mandate's requirements.

■ **Employer responsibility.** Chapter 58 establishes three unprecedented new requirements on employers regarding their workers' health insurance. First, the law requires employers with eleven or more workers who do not make a “fair and reasonable” contribution to their employees' health insurance to pay an annual “Fair

Share Contribution” of no more than \$295 to the state for each full-time-equivalent (FTE) worker. This amount is the estimated private-sector share of the average per worker cost of free care provided to workers whose employers do not provide health insurance. A state agency determines what amount of contribution qualifies as “fair and reasonable.” If Uncompensated Care Pool costs drop in succeeding years as projected, the \$295 assessment will drop by a commensurate amount. Legislators estimated the assessment to generate \$45 million in fiscal year 2007, with lower amounts in succeeding years (Exhibit 2), and the Romney administration now projects \$31.5 million in FY 2007.

Second, the law requires all employers to establish Section 125 cafeteria plans through the Internal Revenue Service (IRS) to enable workers to obtain coverage through the Connector with pretax dollars. Section 125 plans do not require that employers make any premium contribution.

Third, the law establishes a “Free Rider Surcharge” on employers with eleven or more FTE employees whose uninsured workers are frequent users of the Uncompensated Care Pool, generating more than \$50,000 in costs in any given year. The penalty will be imposed on nonoffering employers that do not set up Section 125 plans. Thus, the surcharge acts as a stick on employers that fail to set up these plans. Legislators estimate that the surcharge will generate \$50 million in FY

**EXHIBIT 2  
Massachusetts Health Care Reform Financing (Millions Of Dollars), Fiscal Years  
2007–2009**

<b>Revenues</b>	<b>FY 2007</b>	<b>FY 2008</b>	<b>FY 2009</b>
Federal safety-net revenue	605.0	610.5	610.5
Federal Medicaid matching revenue	184.6	242.1	299.6
Hospital assessment	160.0	160.0	160.0
Third-party payer assessment	160.0	160.0	160.0
Free Rider Surcharge	50.0	40.0	25.0
“Fair Share” assessment	45.0	36.0	22.5
Commonwealth General Fund	125.0	125.0	125.0
<b>Total revenue</b>	<b>1,329.6</b>	<b>1,373.6</b>	<b>1,402.6</b>
<b>Spending</b>			
Supplemental funding to MassHealth managed care organizations	287.0	180.0	160.0
Uncompensated Care Pool/Health Safety Net Fund	610.0	500.0	320.0
MassHealth children to 300% of poverty	18.2	27.4	37.4
MassHealth benefit restoration	48.0	53.0	58.0
MassHealth rate increases	90.0	180.0	270.0
Commonwealth Care subsidies	160.0	400.0	725.0
<b>Total spending</b>	<b>1,213.2</b>	<b>1,340.4</b>	<b>1,570.0</b>
<b>Three-year balance (total revenue minus total spending)</b>	<b>116.4</b>	<b>33.2</b>	<b>-167.9</b>

**SOURCE:** Health Reform Conference Committee.

2007, with lower amounts in succeeding years.

■ **Insurance market changes.** Massachusetts administers an aggressively regulated small-group and nongroup insurance system, including guaranteed issue, modified community rating, and prohibitions on medical underwriting. Chapter 58 requires merging the small-group and nongroup markets in July 2007, with a study of its expected impact due by December 2006. Blue Cross Blue Shield (BCBS) of Massachusetts estimates that the merger will reduce nongroup premiums by as much as 25 percent, while estimates of increases on small-group premiums range from 2 percent to 8 percent. The law also permits smoking to be added as a rating factor and requires health plans to continue family coverage for young adults up to age twenty-five for at least two years beyond their loss of dependency status.

■ **Expansion and restoration of MassHealth coverage and benefits.** Chapter 58 expands children's MassHealth eligibility from 200 percent to 300 percent of poverty; by raising eligibility, the law leaves Commonwealth Care for adults, lowering the cost of those subsidies. The law lifts enrollment caps on special populations imposed during the 2002–03 fiscal crisis, including MassHealth Essential for low-income, long-term unemployed people; CommonHealth; and the HIV program. The law reinstates benefits that were eliminated in 2002, including adult dental services, dentures, and eyeglasses.

■ **Financing.** Nearly half of the law's financing is derived from existing federal dollars attached to the commonwealth's Section 1115 Medicaid waiver. This funding is combined with new federal matching dollars, existing private assessments tied to the Uncompensated Care Pool, and \$220 million (in FY 2007) in new state and employer dollars. Exhibit 2 shows projected sources and uses of dollars for FY 2007–FY 2009, as estimated by the legislative conference committee. While projections show a three-year balance between sources and uses, they also show that first- and second-year surpluses will be used up by year three, which points to growing shortfalls beginning in FY 2009.

■ **Reducing racial and ethnic health disparities.** Although reducing disparities was not an explicit policy focus, legislators used this opportunity to do so. First, new MassHealth pay-for-performance (P4P) standards must explicitly address disparities. Second, a Health Disparities Council has been established in cooperation with the Massachusetts HHS Executive Office. Finally, coverage expansions will disproportionately benefit racial and ethnic minorities, who are overrepresented among the uninsured.

■ **Other changes.** The law increases MassHealth payments to hospitals and physicians by authorizing an additional \$90 million per year over three years (\$540 million in total), seeking to increase payments from about 80 percent to 95 percent of costs. Beginning in year two, hospitals must meet improved quality benchmarks or P4P standards to obtain rate increases. Standards will be set by the state's Office of Medicaid.

The law establishes a Quality and Cost Council to set systemwide goals to im-

prove quality and lower costs and to produce Web-based quality and cost information for consumers. The law restores \$20 million in funding for public health and prevention programs and appropriates \$5 million to implement computerized physician order entry (CPOE) systems in hospitals.

## **The Massachusetts Health Reform Process**

How and why did this expansive package of reforms happen? We focus here on seven players and forces in loose chronological order.

■ **The Roadmap to Coverage initiative.** In 2001, BCBS of Massachusetts established a foundation to improve health care access in Massachusetts by providing grants to organizations serving the uninsured. In 2003, the BCBS of Massachusetts Foundation launched the Roadmap to Coverage initiative with the Urban Institute to conduct analysis and research on access in Massachusetts and to develop policy options to achieve near-universal coverage.<sup>5</sup> The Roadmap documented \$1.1 billion the commonwealth spends annually on its health care safety net, further projecting the incremental cost of universal coverage at \$900 million. The Roadmap first advanced the idea to combine employer and individual mandates in a coverage scheme, along with coverage subsidies, a purchasing pool, and MassHealth expansions.

At key points, the BCBS Foundation convened summits at the John F. Kennedy Library, which became focusing events for political leaders to advance their access agendas. The governor, Senate president, and House speaker all used summit gatherings to articulate their policy prescriptions to improve access.

■ **Gov. Mitt Romney.** Early in 2003, his first year in office, Governor Romney began articulating his intention to reengineer the commonwealth's health care system to achieve universal coverage. In 2002 his first HHS secretary, Ronald Preston, had begun conceptualizing how to shift federal Medicaid dollars from institutional to insurance subsidies. At Romney's direction, Preston began in 2003 developing a new structure, culminating in an unpublished "white paper" in May 2004.<sup>6</sup> Preston proposed an assessment of \$150 per worker per month on employers not offering insurance and a mandate on individuals to purchase health insurance. The employer assessment was discarded as Romney focused on redirecting federal dollars, an individual mandate, and insurance-market changes. The Heritage Foundation provided the idea for the Insurance Connector, called an "Exchange" in the governor's formulation.

In November 2004, Governor Romney announced his intention to submit legislation to achieve universal coverage, providing details in presentations and legislative filings in February and April 2005. His full legislative proposal was filed in July 2005. Hallmarks included creating a health insurance "Exchange," imposing an individual mandate, and shifting federal Medicaid revenues from institutional to individual coverage subsidies. Once his legislation was filed, the governor was largely an observer of the legislative process, issuing public statements, particularly supporting individual responsibility and opposing employer requirements.

■ **Affordable Care Today (ACT!).** In 2003 the advocacy community, led by Health Care For All, began developing proposals to place health care access expansion on the state's policy agenda in the 2005–06 legislative session. Advocates formed a coalition, Affordable Care Today (ACT!), comprising patient and consumer advocates, religious organizations, providers, business leaders, and labor unions. In December 2004 the coalition filed legislation that included MassHealth expansions and restorations, a “fair share assessment” on noncovering employers, insurance subsidies for low/moderate-income families, a small- and nongroup insurance market merger, and a quality and cost council.

In summer 2005, a subset of ACT! formed MassACT, a coalition to file a voter initiative petition for the November 2006 state election. The initiative was a modified version of the ACT! legislation and specified the assessment on noncovering employers at 7 percent of gross payroll on firms with more than 100 workers and 5 percent on firms with 100 or fewer workers, exempting the first \$50,000 of payroll. The assessment would have raised \$750 million and, with a new sixty-cents-per-pack tax on cigarettes, would have garnered the \$900 million necessary to implement the Roadmap. Organizers constructed the initiative as leverage to pressure legislators further than they might otherwise go, holding the option of a November 2006 ballot campaign as a last resort. In late 2005 volunteers collected 83,000 certified voter signatures to qualify the initiative.

■ **Senate President Robert Travaglini.** The Senate president, at a November 2004 Roadmap Summit, committed to passing legislation to reduce the number of uninsured people in Massachusetts by half within two years. In setting this goal, he established limits including no “single payer” Canadian-style plan, no new taxes, and no mandates on employers. In April 2005 Travaglini released his plan, which included increased MassHealth provider rates, public health investments, insurance-market changes, and the Free Rider Surcharge on employers whose workers were high users of the Uncompensated Care Pool, leaving out any coverage expansions to reduce the number of uninsured people. Throughout the subsequent twelve months of negotiations, he held to this stance. After the House approved an ambitious plan including employer and individual mandates in early November 2005, he released to the Senate his April proposal without access expansions, although senators added some Medicaid expansions during floor debate.

■ **House Speaker Salvatore DiMasi.** The House speaker assumed his job in October 2004 as the public phase of health reform began and was noncommittal until October 2005. In his first year as speaker, he adopted a conservative fiscal stance. Yet his Health Financing Committee chair, Rep. Patricia Walrath, worked with him to assemble a bill, released in October 2005, that surprised all observers by combining approaches from the Romney, Roadmap, and ACT!/MassACT plans, including employer and individual responsibility; the Insurance Connector; MassHealth expansions for children, parents, and poor childless adults, along with insurance subsidies; and the Quality and Cost Council.

DiMasi's plan, especially the 5/7 percent "fair share" employer payroll assessment, invoked images of the failed 1988 employer mandate, with a major difference: While the 1988 plan passed both chambers with slight majorities, DiMasi's plan passed the House with a comfortable two-thirds-plus majority, sufficient to override a gubernatorial veto. One week after House action, the Senate enacted its modest plan, and the stage was set for a nearly five-month legislative conference committee showdown.

■ **The business community.** Business found itself divided into four camps as conferees began: one group, including retailers and the National Federation of Independent Business, rejected any employer assessment; a group of construction industry associations and individual executives supported the ACT!/MassACT/House "fair share" assessment; leaders from the Greater Boston Chamber of Commerce, the Massachusetts Business Roundtable, Associated Industries of Massachusetts, and the Massachusetts Taxpayers Foundation opposed the assessment and negotiated for the opposition; and corporate leaders from BCBS of Massachusetts and Partners Healthcare supported the assessment and negotiated for some employer requirement. In early March 2005 the latter two groups reached agreement on the \$295 assessment on nonoffering employers, which was then embraced by DiMasi and Travaglini, opening the path for final negotiations leading to Chapter 58's enactment.

■ **The Centers for Medicare and Medicaid Services (CMS).** Since 1997, Massachusetts has operated its MassHealth program under a Section 1115 waiver, renewed intact in 2002 for three years. The original waiver, negotiated during the Clinton administration, included an unusual fund called "supplemental payments to managed care organizations" to ensure that safety-net systems at Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) would be unharmed in the new waiver program. These federal payments were used largely by the BMC and CHA to establish their own MassHealth managed care plans, Health Net and Network Health, and by 2005, "MCO supp payments" had grown to \$385 million.

In 2004, when state officials began negotiations with the CMS for a new waiver to begin on 1 July 2005, federal officials informed them that the supplemental payments would not be renewed. Intervention by Governor Romney and Sen. Edward Kennedy (D) led to a January 2005 agreement with outgoing DHHS secretary Tommy Thompson and CMS administrator Mark McClellan to permit Massachusetts to retain the funds, although only if shifted from institutional to individual subsidies no later than 1 July 2006. Subsequent letters and statements from Thompson's successor, Michael Leavitt; McClellan; and CMS Medicaid director Dennis Smith reiterated the requirement to redirect the \$385 million for FY 2007 and FY 2008 or face its loss.

■ **The conference.** A conference committee with three members from each branch was named in November 2004 to develop a compromise. It quickly became clear that the key negotiators were nonconferees, the president and speaker, who

*“Massachusetts is moving beyond legislative argument to real policy implementation.”*

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entered a fourteen-week stalemate over employer responsibility. Business leaders broke the logjam by agreeing to the \$295 assessment on employers with eleven or more workers who do not make a “fair and reasonable” contribution to their workers’ health coverage. Another disagreement involved state support for the BMC and CHA systems to replace lost federal dollars; the final law holds these systems financially harmless for three years, subject to state appropriations.

The Massachusetts House and Senate approved the conference agreement 4 April 2006 (House 155–2, Senate 37–0), and Governor Romney signed the new law in an elaborate ceremony in Boston’s Faneuil Hall April 12, although not before vetoing eight sections, including the employer assessment. All vetoes were subsequently overridden by the House and Senate.

### **Policy Significance And Lessons**

Chapter 58 has received much national attention. Many wonder if the plan represents a model for other states. In response, we offer some observations.

■ **Massachusetts differs in important ways from other states.** Massachusetts entered this process with an uninsurance rate lower than in most states—11 percent versus 16 percent nationally—and state surveys pin the Massachusetts rate at 8.3 percent. Massachusetts has tightly regulated small-group and nongroup insurance markets with guaranteed issue, modified community rating, and medical underwriting prohibitions that make an individual mandate more feasible than in states where medical underwriting, experience rating, and nonguaranteed issue are the norm.

The \$385 million “MCO supplemental payments” as a financing source exists in no other state. While other states have financing features, including disproportionate-share hospital (DSH) payments, that offer opportunities, the reform impulse alone in Massachusetts would have been insufficient to overcome resistance to these changes, absent federal financial pressure.

■ **Features of the Massachusetts plan are worthy of consideration.** The Roadmap to Coverage Initiative and Speaker DiMasi had the inspiration to merge individual and employer responsibility in a way that had never been considered federally or in any state. Individual responsibility is favored by the political right and disliked by the political left, and the reverse holds for employer responsibility. The default position for politicians is to do neither. Massachusetts’ willingness to attempt both is evidence of unusual political maturity. The courage to embrace mandates and not just politically safer voluntary approaches is additional evidence.

Transforming institutional subsidies into subsidies to help people buy coverage has been discussed for years by policy analysts. As with employer and individual

responsibility, this aspect deserves attention. It's an important experiment.

The Connector is a creative response to inefficiencies in small-group and non-group insurance markets and may develop approaches that can inform other states' experiments. Merging these markets has never been attempted in any state, and it demands attention. Also, although access was always the focus of this policy effort, experiments to address racial and ethnic health disparities and to establish the Quality and Cost Council might bear important fruit.

■ **Think of the Massachusetts experience more as a political blueprint and less as a policy blueprint.** Most unique about “third wave” Massachusetts reform is its merger of right and left, Republican and Democratic, conservative and progressive approaches to building a fairer, smarter health care system. Also important was the constructive, positive attitude maintained by all parties throughout the at times contentious process. Many have criticized and condemned Chapter 58, in whole or in part. What critics have been unable to do is develop an alternative plan that can engender genuine bipartisan support.

Massachusetts has done this, at least through legislative enactment and early implementation. The commonwealth is moving beyond legislative argument to real policy implementation. At a minimum, hundreds of thousands of uninsured people will obtain affordable, high-quality coverage over three years. Some aspects of the plan will fall short, and others will pleasantly surprise.

We do not call Chapter 58 “universal.” We prefer to advance predictions with modesty and pleasantly surprise, rather than boast big accomplishments and later disappoint. Give Massachusetts time to implement, and revisit what we have achieved by 2009. Then let's talk.

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**NOTES**

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