

Lessons for Other States

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

Admittedly, Massachusetts approached its health care problems with certain advantages: Compared with other states, it has fewer uninsured people, and they are better off financially. Only 13 percent of its residents under age 65 are uninsured, while the national average is 18 percent, according to the nonprofit Institute for Health Policy Solutions. Just 6 percent of the state’s nonelderly uninsured residents have incomes that are less than 250 percent of the poverty level, while the national average is 11 percent, the institute reported. Those factors mean that other states would need more funding for subsidies to help their uninsured residents afford coverage.

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

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

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

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

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

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

"People in Washington, Republicans generally, hate these uncompensated care pools," said James Mongan, CEO of Partners HealthCare, a hospital network in Boston. "They view them as big slush funds, giving dollars to big-city hospitals.... They didn't want it to be an uncompensated care thing. They wanted it to be a private insurance thing."

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

Leavitt "is very much cognizant of that," Haislmaier added, "and he's not going to force [states]. But he's saying, within certain parameters, we will be your partner.... If you're willing to do stuff differently and creatively to transform from one of the worst systems to one of the best, they're willing to give whatever waiver help you need. But if you're just interested in rebuilding the current system, the answer is no."

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

And many states could find at least some money, said Martin Sellers, president and CEO of the Philadelphia-based Sellers Feinberg health care consulting firm, which Romney hired to help craft Massachusetts' new partnership with the federal government. Each state, for example, gets so-called "disproportionate-share payments" from the federal government to fund hospitals that support the most uncompensated care. Moreover, he said, "states have these taxing districts that raise all this local money and pour it into their public hospitals."

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

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

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

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

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

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

Sheils said he, like many economists, believes that capping the deduction “is absolutely the right thing to do.” Providing the tax break encourages people to buy generous insurance and use more health care services. “It desensitizes people to the cost of health care,” Sheils said.

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

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