



Health Care Reform in Massachusetts — Expanding Coverage, Escalating Costs

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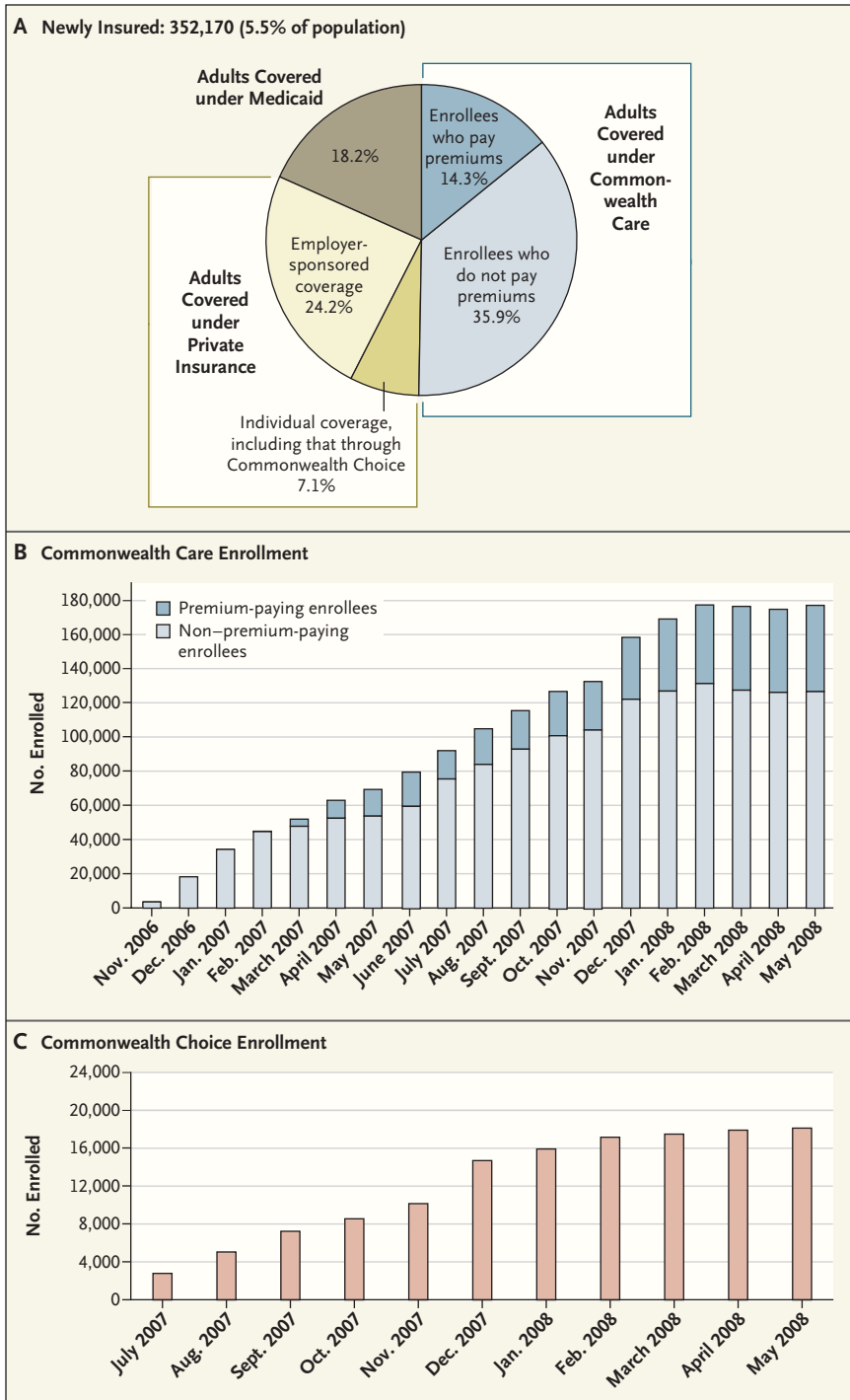
The far-reaching health care reforms that Massachusetts enacted in April 2006 are often cited as a model for other states.¹ After 2 years, the good news is that the new programs have ramped up

rapidly, the number of people without health insurance has been substantially reduced, and overall public and political support remains broad. Early data suggest that access to care has improved, especially among low-income adults; there have also been “reductions in out-of-pocket health care spending, problems paying medical bills, and medical debt.”² As of May 2008, about 350,000 residents — 5.5% of the state’s population — were newly insured (see figure). About half of them are enrolled in Commonwealth Care, a subsidized insurance program for adults who have no access to employer-sponsored insurance, Medicare, Medicaid, or veterans’ or student

insurance programs and who earn no more than 300% of the federal poverty guidelines. About a third have purchased private insurance or gained employer-sponsored coverage, and the rest have enrolled in Medicaid. About 72% of the approximately 25,000 people with new individual policies have purchased them through Commonwealth Choice, an unsubsidized offering of private health plans approved by the Commonwealth Health Insurance Connector Authority, which administers many aspects of the reforms. In addition, the individual and small-group insurance markets have been merged, markedly reducing the cost of individual premiums.

Not all the news is good, how-

ever. Perhaps 5% of the state’s population — the exact figure is a matter of conjecture and may be higher — is still uninsured, the financial burden of the reforms is increasing, and the challenges of sustaining the subsidized program have been exacerbated by the economic downturn. The features of plans that decrease the cost of premiums also increase out-of-pocket costs for those who obtain care. Although adults reported lower levels of health care needs that remained unmet because of cost in the fall of 2007 than in the previous year, those with low incomes reported increased difficulty in getting appointments or in finding a doctor or other provider who would see them.² And the state ultimately decided that not all residents must actually carry health insurance, as the legislation originally intended: exemptions are available for adults who make too much money to enroll



Growth in Health Insurance Coverage in Massachusetts after Health Care Reform.

Panel A shows the health insurance coverage among the 352,170 Massachusetts residents (5.5% of the 2007 state population of 6.4 million) who are newly insured. An estimated 550,000 to 715,000 residents (8.6 to 11.2%)¹ were without health insurance before reform. Data for Commonwealth Care enrollees are from the Commonwealth Connector as of May 1, 2008. Medicaid data are from MassHealth as of February 29, 2008. Data for private insurance are from the Massachusetts Association of Health Plans, representing the increase in the number of people enrolled in commercial insurance between January 1, 2007, and January 1, 2008. New private-insurance enrollment includes coverage through Commonwealth Choice, an unsubsidized offering of approved private health plans that has been available through the Commonwealth Connector since July 2007; as of May 1, 2008, a total of 18,122 people had purchased insurance through Commonwealth Choice. Panels B and C show the numbers of residents enrolled in Commonwealth Care and Commonwealth Choice, respectively.

state spending would be \$1.08 billion for fiscal year 2009 if 255,000 residents are enrolled, an increase of about 80,000 enrollees from the current number.³ If 225,000 residents enroll, as an earlier estimate suggested, spending would be \$869.4 million. By comparison, spending for Commonwealth Care was \$132.9 million in fiscal year 2007 and is projected to be \$647.4 million in fiscal year 2008. Moreover, as compared with the national average, the per-capita cost of medical care in Massachusetts is high.

“To maintain public and financial commitment to the new programs, controlling costs is 110% of the challenge for the next several years,” according to Jon Kingsdale, executive director of the Commonwealth Connector. The monthly cost per member in the subsidized insurance program is \$352.43, which is about what was budgeted and considerably less than

in the subsidized insurance program but are deemed unable to afford policies in the private market; others can be exempted on religious grounds or when unusual financial circumstances arise. If more residents were eligible for

subsidized insurance, fewer would qualify for hardship exemptions, but such an approach would further increase the cost of the new programs. Already, enrollment in Commonwealth Care is growing faster than was projected. Annual

the median cost of employer-sponsored coverage in the state. There are no monthly premiums for adults earning less than 150% of the federal poverty guidelines (in 2008, \$15,612 for an individual and \$31,812 for a family of four); premiums for those who earn 150 to 300% of the federal poverty guidelines are set according to a sliding scale, with a maximum premium for an individual of \$105 a month. About 70% of those who have signed up pay no premiums. People who are eligible for Commonwealth Care are deemed to have access to affordable coverage; Medicaid covers the children of adults enrolled in Commonwealth Care.

The requirement to carry insurance is enforced through the state income-tax return. In general, the Massachusetts Department of Revenue uses the affordability schedule adopted by the Commonwealth Connector and other financial and insurance information to verify the self-reported information on tax returns and to determine eligibility for hardship exemptions. In 2008, the maximum penalty for not having insurance is \$912. In 2007, it was \$219. Revenue from this penalty is expected to be \$8.5 million for fiscal year 2008.³

In June 2008, the Department of Revenue released preliminary data about the health insurance information reported on 2007 tax returns, covering 86% of the tax filings that are eventually expected. Of the taxpayers required to file insurance information, only 1.4% failed to comply. About 168,000 of 3.34 million adults (5.0%) reported that they did not have health insurance coverage at the end of the year. On the basis of the affordability schedule, about 97,000 were deemed “able to af-

ford” insurance — 86,000 who paid the penalty and 11,000 who have appealed it. About 62,000 were deemed “unable to afford insurance” and are thus eligible for an exemption. In addition, about 9,000 taxpayers claimed a religious exemption, and about 200 had already obtained a “certificate of exemption,” for financial reasons, from the Commonwealth Connector. About 10% of residents either do not file tax returns or are not accounted for as dependents on the returns of others, so the actual number without health insurance is probably higher.

As of January 1, 2009, people with health insurance must have plans that provide “minimum creditable coverage.” Among other requirements, such plans must cover at least three doctor visits for an individual or six for a family before charging any deductible, and they must offer prescription-drug coverage (with a limit on any separate deductible of \$250 for an individual and \$500 for a family). However, annual deductibles (capped at \$2,000 for an individual and \$4,000 for a family) and out-of-pocket spending (capped at \$5,000 for an individual and \$10,000 for a family) can be very high.

In 2008, health insurance in Massachusetts is considered affordable — regardless of the premium — for individuals with incomes above \$52,501, for couples with incomes above \$82,501, and for families of any size with incomes above \$110,001, according to the Commonwealth Connector. For people with lower incomes, the affordability schedule, which is revised annually, is used to determine whether residents can pay for health insurance, regardless of whether it is obtained through the Commonwealth Connector or directly from an insur-

er. According to the 2008 schedule, affordable policies typically require no more than 7.5% to 10.6% of income to be paid for premiums; the percentages vary according to income and type of household. People with preexisting medical conditions are not charged more for individual policies. However, because premiums increase with age, people with incomes below the affordability thresholds are considered to have no affordable private insurance options after a certain age — currently, 55 years for individual coverage, 50 years for couple coverage, and 30 years for family coverage. Income-based categorical exemptions apply mostly to adults who are not offered employer-sponsored insurance. Until a more detailed analysis of tax returns is completed, state officials will not know how many of the people deemed unable to afford health insurance fall into these categories. And, of course, people who use medical care have additional expenses for copayments, deductibles, prescription charges, and other out-of-pocket costs.

Premiums for the unsubsidized Commonwealth Choice program will increase by an average of 5% for fiscal 2009, which begins on July 1. Government payments for premiums in Commonwealth Care will increase by an average of 9.4%. The state's cost for Commonwealth Care is partially offset by federal reimbursement — projected to be at \$268.3 million in fiscal year 2008 and for \$360.6 million in fiscal year 2009³ — and a decrease in payments to community health centers and hospitals that treat the uninsured, which has caused difficulties for some centers and hospitals. Other revenues are limited. Revenue from the “fair share contribution,” an annual per-employee charge of \$295 paid by

businesses that have 11 or more full-time-equivalent employees but do not provide or contribute to health insurance, is projected to be \$6.7 million in fiscal 2008, as compared with the \$50 million per year that was estimated when the reform was enacted.^{1,3} The difference could reflect inaccurate or incomplete reporting or an inaccurate initial estimate of the number of employers that would be subject to the assessment. More people, including low-income adults, have employer-sponsored insurance than did before the reform.

Massachusetts has thus far avoided legal challenges to its reforms that might have been brought under the federal Employee Retirement Income Security Act, which prohibits states from setting plan standards for self-insured employers. Possible explanations are that the requirement for maintaining a minimum standard of coverage is placed on individuals rather than employers, that businesses largely support the reform,⁴ and that their obligations are modest. An employer's requirements are met if at least 25% of its workers enroll in the company health plan or if it offers to pay at least one third of the premium for individual coverage. Employers are

not required to provide health insurance to part-time employees. So far, employers have blocked efforts to make them pay more of the costs of the reform.

Health care reform in Massachusetts is not a panacea for the many shortcomings of the health care system.⁵ It is worth remembering that California, for example, has more people without health insurance (6.7 million) than Massachusetts has residents (6.4 million) and that the financing and delivery of medical care have not changed.¹ Having health insurance is not having health care.⁵ There are still many difficulties with access to primary care and other services. However, Massachusetts has made some strides, and given sufficient resources, more can be done. This includes identifying and reaching people who are still uninsured and helping them gain coverage, expanding employer-sponsored insurance, and improving the options for part-time employees, for low-paid workers who are offered insurance by their employers but who earn less than 300% of the federal poverty guideline and cannot afford it, and for others with hardship exemptions. The state legislature is considering new cost-control measures, and there is interest in

a plan from Blue Cross–Blue Shield of Massachusetts, the largest carrier in the state, which pays doctors and hospitals according to a combination of capitation and pay-for-performance approaches. As a practical matter, the improvements in health insurance coverage can continue indefinitely as long as public and political support remain strong and the state is willing — with the substantial help of the federal government through the renewal of a Medicaid waiver agreement — to keep paying the ever-increasing bill.

An interview with Jon Kingsdale can be heard at www.nejm.org.

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From Darwin's Finches to Canaries in the Coal Mine — Mining the Genome for New Biology

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The observations of finches that Charles Darwin made while in the Galapagos contributed to his theory of the origins of interspecies differences, ultimately leading to our understanding of mu-

tation and natural selection as drivers of phenotypic variation. Now, more than 150 years later, genomewide association studies have identified more than 100 new chromosomal regions at which

DNA variation influences risk of common human diseases and clinical phenotypes.¹ Since previous approaches to identifying genetic causes of common diseases have met with very limited