Health insurance protects against catastrophic loss and high medical costs associated with illness, accidents, or diseases. Health insurance is also paying for a larger share of preventive care and prescription drugs. Studies show that, all things being equal, people without health insurance are sicker and more likely to die earlier because of medical problems.1

In April 2006, Massachusetts passed a healthcare reform proposal with the goal of moving toward universal coverage. The plan is based on the principle of shared responsibility and asks more of government, business, and individuals. The most unique feature of the plan is a mandate that everyone who can afford it purchase health insurance. This plan builds off the base of the existing health financing system and earlier state reforms. It was a bipartisan proposal supported by a broad-based coalition. In the first year, more than 100,000 previously uninsured people obtained coverage as a result of these reforms.

This reform makes Massachusetts the first state since Hawaii in 1974 to enact a plan targeted at or near universal coverage. Massachusetts helped trigger a round of state healthcare reform initiatives across the United States and also holds potential lessons for future national reforms. Elements of the Massachusetts plan are being considered by a host of other states.

This chapter examines the goals and context behind this reform, including an examination of the history of healthcare reform in the state and the policy environment in Massachusetts. We then provide details of the plan and an initial assessment of the first year of implementation.

HISTORY

Massachusetts has a long history of innovation in the area of healthcare. The Boston Public Health Commission was the first in the newly founded nation and
headed by Paul Revere in 1799. The first permanent marine hospital was authorized to be built in Massachusetts in 1803. The first state board of health was created in Massachusetts in 1869. Massachusetts is home to some of the most advanced medical research in the world and boasts world-famous teaching hospitals. The state also has some of the highest-ranked health plans in the country. Three of the largest health plans in Massachusetts were ranked in the top 10 nationally for quality and enrollee satisfaction. Massachusetts also has some of the highest healthcare costs in the country. Healthcare is also a huge part of the state’s economy, responsible for the employment of more than 12 percent of the employment in the state.

Massachusetts has a history of innovation in the area of cost control and coverage expansion. Greater effort and success have been achieved in efforts to cover the uninsured than in controlling healthcare costs. In the 1970s, Massachusetts attempted to control healthcare costs by instituting government-regulated regional hospital rate setting. Toward this end, it also embraced managed care along with deregulation and competition between hospitals as rate regulation was repealed in the 1990s. Efforts to expand access to care can be seen in the development of the Uncompensated Care Pool, also known as the Free Care Pool, in 1985 and major healthcare coverage expansions and reforms in 1988, 1996, and 2006. These programs and policies demonstrate a commitment to innovation and experimentation and set in place program and political constituencies that could be built on over time. They are important to understanding the current reform.

In 1975, Massachusetts joined Maryland, New York, and New Jersey in establishing a hospital rate-setting program. This program set annual revenue caps for every acute care hospital in the state. Rate setting was precipitated by the rapid rise of healthcare costs in the 1970s driven by public coverage expansions (Medicare and Medicaid), increases in medical technology, and inflation. This initiative was supported by business and their concern about spiraling healthcare costs. It was successful in curbing medical costs, but only in the short term.

**UNCOMPENSATED CARE POOL**

In part to mitigate the impact of rate-setting regulations, the Uncompensated Care Pool was established in 1985. This pool pays hospitals for the care of low-income uninsured people and in effect made access to hospital and community health center services available to everyone in the state who meets residency and income criteria (less than 200 percent federal poverty level, or FPL, or $27,380 for a family of two in 2007). This program also made the cost of the uninsured explicit, and this helped shape and drive later reforms.

The Uncompensated Care Pool, funded at more than $800 million in fiscal year 2006, collects revenue through hospital assessments, surcharges on payers (insurers, health plans, and individuals), general state revenue, and federal Medicaid matching funds. Federal funds are secured through intergovernmental transfers that are part of an 1115 state waiver demonstration program with the federal government. The 1115 waivers allow states to disregard many of the rules of the
traditional Medicaid program in order to expand coverage and/or reduce costs in an innovative way. The structure of the Uncompensated Care Pool changed in the 1990s from one that paid only for hospital services to a program with registration providing a broad range of inpatient and outpatient services to the low-income uninsured not eligible for other state programs. It still does not pay for physician services, nonacute hospitals, or prescription drugs. The majority of pool funds are for hospital outpatient services (61 percent in fiscal year 2001), followed by inpatient services (34 percent) and community health centers (4 percent).

Although the program has had tremendous success in expanding access to care, there have been ongoing concerns about equity and accountability of pool funding at the state and national level. First, although the uninsured are more evenly distributed throughout the state, most of the people covered by this program are in the Boston area and distributed to two large safety net providers, Boston Medical Center and the Cambridge Health Alliance. Second, since 1990 the cost of uncompensated care in most years exceeded available funds, so hospitals still needed to cover some uncompensated care. Third, it has been difficult to track funding provided to these facilities and understand how the money is directly linked to services provided. Fourth, the federal government as part of the waiver renewal in July 2005 threatened to end this type of institutional funding. Federal officials wanted more of the money to go toward the direct purchase of insurance coverage for low-income individuals and families. As detailed in the following sections, this federal pressure helped ignite the latest round of reform.

EMPLOYER MANDATE AND DUKAKIS REFORMS IN 1988

The current round of reform builds on past efforts. In 1988, Massachusetts passed significant health reform including a so-called pay-or-play employer mandate requiring all employers with six or more employees to provide health insurance or pay into a fund. Employers with more than six employees would have to pay up to $1,680 per uninsured worker per year into a state fund. The legislation also included Medicaid expansions and new programs to cover children and pregnant women, children and adults with disabilities, and the long-term unemployed. It required that all full-time college and university students purchase health insurance. In addition, small businesses were offered tax incentives to help them offer coverage to employees. The law aimed to achieve universal coverage by April 1992.

Those still without employer-sponsored coverage would be able to buy insurance through a newly created Department of Medical Security. Premiums were to be on a sliding scale based on income, but the subsidies were not specifically defined in statute. The new department was required to use managed care products to reduce healthcare costs. The program relaxed hospital rate-setting standards and hoped that competition between hospitals would help reduce excess hospital bed capacity and ultimately lower costs.

This legislation passed with the strong support of the governor and presidential candidate Michael Dukakis. In contrast to the next two rounds of reform, however, there was significant opposition to this legislation in the state legislature, the
small-business community, and the Republican Party. One person close to the process characterized this as “the most controversial and heavily fought battle in the past 25 years in the Massachusetts State House.”

Dukakis lost the presidential election in 1988, and the economy in Massachusetts went into recession. A Republican, William Weld, was elected governor in 1990. The employer mandate was to take effect in 1992 but was delayed three times by the legislature and finally repealed as part of a reform package in 1996. The threat of retaining the mandate was used as leverage by the legislature with Governor Weld to help propel the 1996 reforms.

Some of the elements of the Dukakis reform that were retained include: Medicaid enrollment expansions, new programs for people with disabilities, assistance for the long-term unemployed, and coverage mandate for college students. Without these earlier coverage expansions, passage of the current reform, including the viability of an individual coverage mandate, would have been more difficult.

**MANAGED CARE GROWTH**

Hospital rate regulation ended altogether under the Weld administration in 1991 in a general trend toward competition and managed care. Managed care growth exploded in Massachusetts during this period and for a time was successful in keeping medical inflation under control. Health insurance premiums were held flat in the late 1990s but would experience double-digit growth from 2000 to 2007. Throughout the 1990s, consumer and provider backlash against managed care and the assertion of hospital systems substantially weakened the ability of managed care organizations to manage care and costs. Signs that managed care was weakening could be seen even as it was continuing to grow. The decline in managed care actually started in 1994 when the state passed an “any willing provider” law requiring all HMOs to contract with all pharmacies willing to take their price. Also in 1997, New England Medical Center won a battle with Harvard Pilgrim Health Care Plan to limit the health plan’s ability to exclude hospitals from coverage.

The development and success of integrated healthcare delivery systems helped push back against managed care. The largest integrated healthcare delivery system in Massachusetts is Partners HealthCare System. It was formed by the Brigham and Women’s Hospital and Massachusetts General Hospital in 1994. It has been joined by a number of hospitals in eastern Massachusetts and has 4,000 affiliated physicians. An example of their growing strength in the market can be seen in the showdown between Partners HealthCare System and Tufts Health Plan in 2001. In October 2001, Tufts and Partners terminated their contract. Partners wanted a 29.7 percent increase in payments over three years. Blue Cross Blue Shield of Massachusetts had previously agreed to double-digit increases in payments. Tufts, facing pressure from employers and enrollees about being excluded from the prestigious Partners HealthCare System, capitulated to the health system’s demands. Later, Partners received significant payment increases from Harvard Pilgrim. This example reflected a shift in the balance of power from the health plans
back to the providers, and this was reflected in sharp increases in private healthcare premiums.

**MASSACHUSETTS MASSHEALTH WAIVER AND COVERAGE EXPANSIONS IN 1996**

Another major round of reform was enacted in 1996. Massachusetts extended coverage to nearly all uninsured children through the creation of a waiver demonstration program and the adoption of the Children’s Medical Security Plan. In an innovative approach, legislators combined an increase in coverage for kids with a cigarette tax. It was pitched as a “good versus evil” story that proved politically powerful. This reform was seen as a blueprint for other states and national reform.\(^{15}\) It was a precursor to the 1997 federal State Children’s Health Insurance Program (SCHIP), which is a nationwide program designed to provide health insurance coverage to millions of children.

As part of the waiver demonstration program, the state created the MassHealth program and began implementation in 1997. The waiver and state legislation extended Medicaid coverage to children younger than 19 with family income below 133 percent of the federal poverty level. It made coverage available to all children younger than 12 with family income below 200 percent of the federal poverty level. It also created the Children’s Medical Security Plan, which would make primary and preventive care available to all children on a sliding fee scale based on family income. In addition, the law created a pharmacy assistance program for low-income seniors and maintained and extended coverage to disabled adults and the long-term unemployed. These coverage extensions, like the ones before, would build the foundation for the next round of reform in 2006. The program was funded through increased federal money, a 25 cent increase in the tobacco tax, and some general revenue.

The Weld administration had been working on a waiver since 1994.\(^{16}\) One crucial success in negotiating with federal officials was setting the baseline level for budget neutrality. States seeking Medicaid waivers must meet the condition of budget neutrality, which requires Medicaid programs not to exceed what they would be without the waiver. How fast the program would have grown absent a waiver and many other variables for calculating a baseline are critical, and the process is often as political as it is mathematical. Federal officials agreed with the Weld administration that expansions for children and pregnant women would not be counted against the state’s budget neutrality cap because states are allowed to increase coverage for these groups under federal law Section 1902a(r) (2). The bottom line is that the state could expand eligibility and capture significantly more federal funds.

These reforms were made possible in part by the governor’s efforts to obtain a waiver and by strong and persistent leadership in the legislature for expanded health insurance. Representative John McDonough and Senator Mark Montigny, chairs of the legislature’s Joint Committee on Health, brought together a broad coalition that was essential for passage. They developed the strategy of
linking coverage for children with a tobacco tax. Seniors were brought into the coalition with the new prescription drug program. Business supported the legislation’s repeal of the employer mandate. Providers and particularly pediatricians and children’s hospitals were strong proponents. Massachusetts also has a strong consumer organization, Health Care for All, that coordinated a powerful lobbying campaign. Legislation passed by wide margins in both chambers. In the end, Governor Weld vetoed the legislation because it increased the cigarette tax. The veto was easily overridden in the House of Representatives by a vote of 117 to 40 and in the Senate by a vote of 32 to 7.17

This success was achieved through a sophisticated political strategy, bipartisan support, and a broad-based coalition. Passage was achieved through a broad-based bipartisan coalition that included support from advocates, seniors, healthcare providers, hospitals, and business. Finally, the coverage expansions were financed through the tobacco tax and with federal money secured through an 1115 waiver demonstration program. With the exception of the tobacco tax, each of these strategies would be used to achieve the 2006 reforms.

1115 State Healthcare Reform Waiver Demonstration Projects

The number of uninsured in Massachusetts and in the nation rose in the early 1990s. President Bill Clinton’s healthcare reform plan in 1993 was designed to extend coverage and to protect people from the fear that they might lose the health insurance coverage they have when they most need it. With the defeat of the Clinton plan, attention turned toward the states. The Clinton administration was very supportive of 1115 state waiver demonstrations that could extend Medicaid coverage while keeping costs similar to what they would have been absent reform. Many states, including Massachusetts, took advantage of waivers to shift a substantial portion of their Medicaid populations from fee-for-service to managed care and used the savings to extend coverage to a greater portion of the uninsured. The Massachusetts waiver resulted in major coverage expansions. The number of uninsured in the state rose to 683,000 in 1995. At this time, Medicaid enrollment was 655,000. By 2004, the number of uninsured was down to 460,000. The 1115 waiver was responsible for the additional coverage of some 300,000 people in the state’s MassHealth Program. The number of total MassHealth enrollees grew to 972,000 by the late 1990s and today covers more than 1 million people of a total population of 6.4 million.18

MASSACHUSETTS HEALTHCARE ENVIRONMENT

This section provides background on the healthcare environment in Massachusetts. It examines the hospitals, health plans, healthcare costs, and the importance of healthcare to the local economy. It examines the problems and challenges that
help prompt reform. This is followed by a discussion of the details of this plan and how it has influenced other state efforts to expand healthcare coverage.

Massachusetts has some of the most advanced and expensive healthcare in the world. Healthcare and education drive much of the Massachusetts economy, and they are related. The educational facilities and teaching hospitals help develop the personnel and technology that drives healthcare advancements and costs. Massachusetts has four medical schools at Boston University, Harvard, Tufts, and the University of Massachusetts. Massachusetts General Hospital (MGH), Brigham and Women’s, and Beth Israel Deaconess Medical Center, all associated with Harvard Medical School, have international reputations and date back to the 1800s.19

In the greater Boston metropolitan region, 14 teaching hospitals generated an estimated $24.3 billion in economic activity in 2006. Teaching hospitals in the state are responsible for the direct and indirect employment of more than 200,000 people.20 The Milken Institute ranked the Boston metropolitan area as the leading healthcare center in the United States.

Healthcare premiums in Massachusetts, as in the rest of the nation, rose by double digits each year in the 2000s. In Massachusetts, health insurance premiums for families rose 69.2 percent between 2000 and 2006.21 Over the same period, median income rose just 10.7 percent. For the nation as a whole, the premium growth rate was 89 percent, with average wages growing at slightly less than 20 percent. In dollars, the average annual family premium in Massachusetts, including employer and employee share, rose during this period from $7,341 to $12,419. According to Mercer Health and Benefits, the average healthcare costs of an employee, including dental and dependent coverage, was $9,428 in 2006. Massachusetts is ranked fourth nationally behind Alaska, New Hampshire, and Wisconsin in healthcare costs.22

HEALTH PLANS

The Massachusetts healthcare system is dominated by not-for-profit hospitals and health plans. Compared to other states, the healthcare delivery system has traditionally had higher costs and lower provider margins. The state has higher than average income, traditionally higher rates of insurance coverage, disproportionately more specialists and physicians per capita than the nation, more and higher-cost teaching hospitals, and higher frequency of outpatient office visits and greater use of nursing homes.

Although the health plans in Massachusetts are routinely ranked among the best in the nation, they also suffered from the consumer backlash against managed care that developed in the mid-1990s. Thus the regional managed care organizations (MCOs) of today are less aggressive in their attempts to limit the growth in healthcare spending. It became difficult for managed care organizations to compel physicians to control costs by limiting access to specialists or being strong gatekeepers. In addition, MCOs no longer have the market clout to obtain deep discounts from physician groups, hospitals, and healthcare systems.
Currently, Massachusetts’s health plans have open access to a broad range of physicians and hospitals. Toward the end the 1990s and into 2000, employers were limiting options to one plan, so, in order to accommodate employees, plan networks were widened. Plans no longer controlled networks, and premiums grew at double-digit rates throughout the 2000s. The top four health insurers by membership in the state are Blue Cross Blue Shield of Massachusetts (3 million), Harvard Pilgrim Health Plan (1 million), Tufts Health Plan (600,000), and Fallon Community Health Plan (less than 200,000). All four plans have announced double-digit increases for 2007, for the seventh year in a row. Massachusetts health plans have consistently ranked among the best in the country by the National Committee on Quality Assurance annual assessment reported in *U.S. News and World Report*. For 2006, Harvard Pilgrim ranked number 1 nationally, Tufts number 2, Blue Cross Blue Shield number 4, and Fallon number 11. Plans were ranked based on access to care, member satisfaction, delivery of preventive services, and treatment (outcomes or protocols).

**IMPORTANCE OF HEALTHCARE TO THE ECONOMY**

Healthcare is a vital and growing portion of the Massachusetts economy and employed 12.2 percent of the population in 2003, which represented an increase of 26.6 percent since 1990. In 2004, Massachusetts received more funding for research ($2.3 billion) from the National Institutes of Health (NIH) than any other state but California ($3.6 billion). NIH funding accounted for 40 percent of total federal healthcare research funding in the state in 2004. Massachusetts is losing population as a percentage of total U.S. population. In 2004, per capita income in Massachusetts was $42,000, compared to the national average of $33,000. The state has less poverty and is more highly educated than the nation as a whole. The state has one of the highest HMO penetrations in the United States (37 percent compared to 23 percent nationally).

Massachusetts has 27.1 specialists per 10,000 people, compared to just 14.4 for the country. Drugs and nondurable medical expenditures soared through the 1990s. In 1994, they accounted for 7.8 percent of medical expenditures; in 2004, they accounted for 12.0 percent of healthcare expenditures in Massachusetts.

**IMPETUS FOR REFORM**

There was a confluence of political and economic factors that made 2006 an opportune time for healthcare reform in Massachusetts. The underlying problem was the number of uninsured and the likelihood that as healthcare costs continued to grow, this problem would worsen. Estimates of the number of uninsured in the state in 2004 were approximately 500,000, or close to 10 percent of the population.

The urgency behind reform in 2006 was the threat of losing significant federal money. The federal government 1115 waiver with the state was up for review and would not be renewed under the existing conditions. Specifically, the state
was in danger of losing $358 million annually in federal funds if they did not make significant changes to the intergovernmental transfer mechanism used to capture federal funds to help fund the Free Care Pool. The state spends more than $1 billion a year to provide services to the uninsured through the Uncompensated Care Pool, Medicaid disproportionate share hospital payments, and other safety net supports. Much of this money was federal, and it was in jeopardy. This existing safety net system was inefficient and unsustainable. The state was given a deadline of July 1, 2006, to modify its waiver and direct less of its money to large institutions providing uncompensated care and more money to provide or subsidize individual insurance.

A number of factors made healthcare reform easier in Massachusetts. First, the state has a strong safety net and an Uncompensated Care Pool. This pot of money could be drawn on to fund expansion. Second, it has a relatively low number of uninsured compared to other states (8 percent to 10 percent compared to 16 percent nationally). Third, it has one of the highest rates of employer-provided coverage. All firms with more than 50 employees in Massachusetts offer health insurance coverage, compared to 96 percent for the rest of the country. Furthermore, 52.4 percent of employers with fewer than 50 employees offer insurance, compared with only 41.9 percent for the rest of nation. Fourth, insurance in the individual and small-group market is regulated and more broadly available than in other states. The state requires insurance companies in the small-group market to use a modified community rating system, making it easier for older people with preexisting conditions to purchase care. Fifth, Massachusetts has a strong Medicaid program that provides coverage to more than 1 million residents. Strong public and private coverage keeps the rate of uninsured down, reducing the number that would have to be covered through reform. Sixth, the state has a history of healthcare reform, and coverage expansions enjoy strong public support. Finally, the state is more affluent than average and at the time of reform had a strong economy and a budget surplus. In 2007, however, the budget surplus turned into a $1 billion shortfall, and an economic downturn could jeopardize coverage expansion progress.

LEADERSHIP AND THE ROADMAP TO COVERAGE

Political leadership helped move insurance reform onto the political agenda. Strong leadership was essential from the governor, legislature, advocacy groups, business, and health plan and healthcare system communities. Political leadership was prodded and given a stage by the Blue Cross Blue Shield of Massachusetts Foundation in a series of three events called the Roadmap to Coverage. Events were held at the John F. Kennedy Library, and healthcare leaders from all sectors were invited. These events garnered considerable media attention on local television, radio, and newspapers. Each event had three important elements: new research and data, a top-ranking official keynote, and an audience that included the range of healthcare leaders in the state.

The first event on November 16, 2004, featured Senate President Robert Travaglini. He previously did not have a significant health insurance reform plan.
He used this opportunity to promise to cover half the uninsured in the state in two years. Governor Mitt Romney was working on a plan and Speaker of the House Sal DiMasi was interested in significant reform, so the engagement of the Senate president dramatically increased the chances of reform. This pronouncement convinced many that a real opportunity existed to pass reform in the current legislative session. The Senate president’s speech received considerable press attention, and Governor Romney, who had been working for some time behind the scenes, was quick to release his own plan in an Op-Ed in the Boston Globe shortly after this event.32

The first Roadmap event included a research piece from the Urban Institute, “Caring for the Uninsured in Massachusetts: What Does it Cost, Who Pays, and What Would Full Coverage Add to Medical Spending?”33 This report outlined the current state and federal resources that could be reconfigured to help pay for coverage expansions. The report concluded that more than $2 billion was spent on care for the uninsured in 2004, including $1.1 billion in uncompensated care. This breaks down to $800 million spent by hospitals, $155 million by community health centers, and $123 million by physicians. The report further estimated that between $374 million and $539 million in new funding would be required to cover the uninsured if existing funding could be reallocated. Total economic and social benefits of covering the uninsured were estimated at between $1.2 billion and $1.7 billion annually. The greatest value of the report was that it made the cost of the uninsured explicit. Uncompensated care is never free, and this report documented how these funds might be redirected toward more rational and appropriate care.

The second Roadmap event on June 21, 2005, featured the governor, who used the opportunity to fill in some additional details of his plan, but much remained undefined. The governor’s plan included an individual mandate with penalties of withholding tax refunds and garnering wages. He characterized this as a conservative proposal rooted in individual responsibility. It would provide low-cost limited benefit plans in a comprehensive, market-based approach to make insurance more available and affordable. He noted that 160,000 of the uninsured were currently eligible for Medicaid, many of the uninsured with incomes more than 300 percent of the federal poverty level could afford insurance, and a new program would be designed to help people with incomes less than 300 percent of the poverty level who cannot afford care. He believed this could be done with existing funds and without new revenue.

The Blue Cross Blue Shield of Massachusetts Foundation and the Urban Institute released its second report, which detailed a wide range of policy options for covering the uninsured. The report evaluated expanding access to MassHealth (the state Medicaid program), tax credits, individual mandates, employer mandates, voluntary purchasing pools, and government-funded reinsurance. The most significant finding was that voluntary programs even with significant subsidies would cover less than half the uninsured. They concluded that an individual mandate was necessary for substantial progress toward covering all the uninsured.
This report helped raise support for the individual mandate proposed by the governor.\textsuperscript{34} The keynote at the third event on October 7, 2005, was Speaker of the House Sal DiMasi. The speaker did not release details of the House plan. Details were released later in the month and then quickly passed by the House on November 8, 2005. Foreshadowing difficult negotiations between the branches of the legislature and the governor, the speaker warned against “fuzzy math” and to be realistic about the revenue that would be required to truly expand coverage. He emphasized the notion of shared responsibility of individuals, business, and government. The governor and the Senate president were reticent about new revenue and employer responsibility. These issues would stall progress until the legislation ultimately passed the legislature on April 4, 2006. At this meeting a report was also released on implementation issues.\textsuperscript{35}

Equally important to the process was pressure for change from a coalition of consumer groups. Massachusetts has a strong healthcare advocacy organization, Health Care for All. The executive director, John McDonough, is an expert on state healthcare issues and also has firsthand experience in the legislature. As the House chair of the Joint Committee on Health, McDonough took the lead in orchestrating the political strategy and coalition building necessary for the 1996 reforms. In 2005, Health Care for All organized a larger association of advocates known as MassACT (Affordable Health Care Today). This association includes the Greater Boston Interfaith Coalition, labor unions, community health centers, public health advocates, and a wide range of organizations focused on consumers and healthcare coverage expansion. This was the first time the faith-based community was directly and actively involved in healthcare reform, and they added significantly to the political dialogue pushing for passage and actively monitoring implementation.

Advocates had a three-pronged strategy. First, Health Care for All introduced its own comprehensive plan. The plan expanded Medicaid to all people in families with income less than 200 percent of the poverty level, provided sliding-scale subsidies for people between 200 percent and 400 percent of the poverty level to purchase care, and strengthened the affordability of coverage for small business. It was financed through a 60 cent increase in the cigarette tax and a payroll tax assessment that would fall on employers that do not provide health insurance. Further, in an effort to reduce premiums, the bill would provide state-sponsored reinsurance for all high-cost patients. Under the reinsurance plan, the state would cover high-cost cases. This would make healthcare costs lower and more predictable for insurers and reduce health insurance premiums for the public.

Second, the coalition pressured the legislature and helped organize a grassroots campaign through a ballot initiative. The ballot initiative would have mandated much of what was in their legislative proposal. The coalition organized more than 2,000 volunteers and collected more than 112,000 signatures. They had enough signatures to put the initiative on the ballot but withdrew it when they saw significant legislative progress. The threat of going forward with the initiative helped
spur legislative action. Third, the volunteers and network they created through the process of collecting signatures was used to lobby for coalition positions.

Massachusetts health reform was stalled for four months in a conference committee between the House and Senate as differences were ironed out. One major sticking point was employer responsibility. The House bill included a payroll tax of 5 percent for employers with 11 to 100 employees and 7 percent for employers with more than 100 employees. The tax would be refunded if the company provided health insurance. The Senate bill had limited employer responsibility. Employers with more than 50 employees would be required to contribute if their employees used the state’s Free Care Pool. Business leaders, including health plans and healthcare systems, helped broker a compromise that broke the stalemate. The compromise was a $295 annual fair-share surcharge for employers not providing insurance for each full-time employee. The details are described in the following section. Surprising little debate and opposition developed around the individual mandate.

**PLAN DETAILS**

The plan requires everyone who can afford insurance to purchase it. Government provides new programs, regulations, and a healthcare connector in order to make insurance more available and affordable. Businesses with 11 or more employees that do not provide insurance are subject to a fair-share assessment. Most businesses will also be required to establish cafeteria plans to enable pretax deductions of employee health insurance premiums. Many businesses will also be indirectly impacted by several provisions in this law. Employers that offer insurance that does not meet state standards may feel pressure to upgrade coverage. More employees will opt to sign up for employer-sponsored insurance, which could increase employer cost significantly.

**INDIVIDUAL RESPONSIBILITY**

The individual mandate for health insurance applies only to those who can afford it and begins July 1, 2007. This begs a number of questions. What type of insurance can satisfy the requirements of the mandate? Would a catastrophic bare-bones plan suffice? What is considered affordable and for whom? What are the penalties for noncoverage?

The Connector Board determined the minimal coverage required to meet the mandate, and it is fairly comprehensive. No bare-bones plans were allowed. Minimum coverage must include:

- Prescription drug coverage.
- Annual out-of-pocket cap of $5,000 for an individual, $10,000 for a family.
- Deductibles cannot exceed $2,000 per individual and $4,000 per family unless combined with a medical savings account.
• Coverage of preventive physician visits prior to any deductible.
• No limits on per year or per sickness.

Plans may have a lifetime cap. Currently, an estimated 360,000 people in Massachusetts, including a Connector Board member, have lifetime benefit caps. Still with these stipulations, an estimated 240,000 currently insured people will have to increase their coverage to meet the requirements of the mandate. These reforms may also pressure employers to change coverage to meet these standards.

The penalty for noncompliance with the mandate in the first year is loss of the individual state tax exemption, worth about $200 per person. The second year, however, the penalty is half the cost of an available low-cost plan, which could run into thousands of dollars. Health plans and other insurers will be required to send individuals and the State Department of Revenue proof of coverage. Similar to a W-2 form, the proof of coverage must be attached to tax returns.

One of the most difficult decisions the Connector Board made was on affordability and who would be exempt from the mandate. In a unanimous vote, resulting from a series of compromises, the Connector Board recommended an affordability schedule that applies the mandate to 80 percent of the uninsured and close to 99 percent of the public. At the same time, the board provided full premium subsidies to qualified uninsured people with family income up to 150 percent of the federal poverty level (up from 100 percent of the federal poverty level, or FPL). They also increased premium subsidies for people between 150 percent and 200 percent of the FPL. For people less than 300 percent of the federal poverty level who qualify for subsidized coverage through the Connector, care is considered affordable and therefore mandatory. For people with family income greater than 300 percent, a sliding-scale affordability schedule was recommended. For example, an individual making three times the poverty level, $34,341, will be required to purchase coverage if it is available for $210 dollars a month or less. If an employer offers coverage and the employee’s share is less than $210, the employee will be obligated to have insurance. If the employee’s obligation is more than $210, he or she will be exempt from the mandate. The affordability standard increases to $500 for an individual at six times the poverty level, or $60,001 annual income.

The Connector will also develop a case-by-case waiver and appeal process for individuals and families at any income level who believe that insurance is unaffordable for them. The Connector staff’s goal is for this process to be “lenient and efficient.” With this safety value and the increased low-income subsidies, the individual mandate will be applied broadly to nearly 99 percent of the total Massachusetts population.

GOVERNMENT RESPONSIBILITY

The state took on responsibilities for substantially increasing its Medicaid program, MassHealth, and for developing two new programs to be run by the Commonwealth Health Insurance Connector Authority. The law also created the Health Safety Net Trust Fund to replace the Uncompensated Care Pool. The
state expanded the Insurance Partnership Program, which provides subsidies and incentives for employers and employees to provide and enroll in employer-sponsored insurance. Further, it made significant reforms in the individual and small-group market. The law created a Cost and Quality Committee to implement sections of the law and make future recommendations.

MASSHEALTH REFORMS

A number of expansions to the MassHealth program were implemented shortly after reform passed on July 1, 2006. This resulted in new coverage for more than 40,000 uninsured and was an early success of the program. Further, the legislation restored MassHealth benefits that were cut in 2002 to help close a budget shortfall. This restored coverage for dental, vision, chiropractic, and prosthetics. Eligibility for children was raised from 200 percent to 300 percent FPL. The legislation also provided $3 million for MassHealth outreach funding targeted to community organizations. It increased the enrollment caps for several targeted programs that had been closed for enrollment. These changes will eliminate the waiting lists for these programs and will make all who applied and are currently eligible able to enroll.

- The MassHealth Essential cap, a program for the long-term unemployed, elderly, disabled, and special-status immigrants, was raised from 44,000 to 60,000.
- The CommonHealth cap, a program for children and adults with disabilities but with income too high to quality for MassHealth, was raised from 14,000 to 15,600. The program will be able to accommodate all people currently eligible.
- The HIV+ program enrollment caseload cap was raised from 1,050 to 1,300, and eligibility for this program was raised to 200 percent FPL.

Reform also included $3 million in new funding to reach out to uninsured people and enroll them in MassHealth or one of the new programs. Most of this money went to grassroots groups in the community, but some went to statewide advocacy groups to help organize and coordinate the message. These funds were rescinded by Governor Romney before leaving office and restored by incoming Governor Deval Patrick. This approach has shown early success. This is reflected in the better than expected enrollment of low-income uninsured people in the new Commonwealth Care program.

COMMONWEALTH HEALTH INSURANCE CONNECTOR

The Commonwealth Health Insurance Connector is an independent public authority with primary responsibility for implementing Chapter 25, Massachusetts Health Care Reform. The Connector is governed by a 10-member board that
includes state administrative officials and representatives of various interests appointed by the governor and attorney general.

The Connector has a broad set of statutory requirements. Major responsibilities include:

- Develop and run the Commonwealth Care Insurance Program, which will provide subsidized insurance options for uninsured people with family income less than 300 percent of the federal poverty level.
- Develop and run the Commonwealth Choice Program, which will provide health insurance options for small businesses and uninsured individuals with family income greater than 300 percent of the federal poverty level.
- Provide a Seal of Approval for health plans offered through the Connector.
- Establish a young-adult plan for people between 19 and 26 years of age.
- Define minimum health insurance coverage required to meet the mandate “Minimum Creditable Coverage.”
- Develop rules for implementing the individual mandate. The law requires everyone who can afford it to purchase health insurance.
- Support public outreach and awareness.
- Create a business strategy to be financially self-sustaining.
- Become a healthcare broker and purchasing agent.

The Connector has many faces. It acts much like a state agency when it is administering the subsidized Commonwealth Care program. Commonwealth Care makes subsidized insurance available to people with family income up to 300 percent of the poverty level. The Connector acts like a healthcare broker or purchasing agent when running Commonwealth Choice. This program will provide a range of plans through the Connector for the uninsured and small businesses with 50 or fewer employees, with enrollment to begin May 1, 2007, and coverage to start on July 1, 2007. This is also the date that the individual mandate takes effect. There are no subsidies, but the Connector has some leverage to negotiate lower premiums and has had some initial success.

The Connector has a staff of 45 with a mix of public- and private-sector experience reflecting the varied Connector responsibilities. It is overseen by Executive Director Jon Kingsdale and Chief Operating Officer (COO) Rosemarie Day. The organization is designed around staff and program functions. The COO, general counsel, planning and development officer, chief communications officer, and chief marketing officer report directly to the executive director. The director of human resources, chief financial officer, chief information officer, and directors of each of the major programs—Commonwealth Care and Commonwealth Choice—report to the COO. Contractors are used to determine eligibility, enroll people, and perform customer services for the Commonwealth Care program. The Connector also subcontracts with the Small Business Service Bureau in Worcester, Massachusetts, to assist with the implementation of Commonwealth Choice.
FINANCING THE CONNECTOR

The Connector is required to be self-funding and predicts that revenue will exceed costs by 2009. It received $25 million in initial funding from the legislature and will have spent $18 million over by the end of state fiscal year (SFY) 2007.37

Revenue will come primarily from administrative fees charged to health plans in both Commonwealth Care and Commonwealth Choice. Commonwealth Care administrative fees are equal to 5.0 percent, 4.5 percent, and 4.0 percent of premiums for SFYs 2007, 2008, and 2009, respectively. Commonwealth Choice administrative fees will be equal to 4.5 percent and 4.0 percent of premiums for SFYs 2008 and 2009, respectively. Projections are based on enrollment; staff run moderate and conservative estimates, but there is the possibility that estimates are inaccurate. In the event that the Connector experiences a temporary cash shortage, it has made arrangements with banks for short-term loans to fill any funding gaps. The Connector will be seeking an additional $1.5 million to $2 million from the legislature for providing new public information and responding to the appeals process.

COMMONWEALTH CARE

Commonwealth Care provides comprehensive coverage to people with incomes less than 300 percent of the FPL with no deductibles or coinsurance. In the first three years of the program, bidding to offer coverage to these people was restricted to the state’s four Medicaid Managed Care Organizations. Two of these plans, Boston Medical Center and Cambridge Health Alliance, will be able to enroll people they previously treated through the Free Care Pool. Type one plans, comprehensive coverage with no premiums, are available to people with family income less than 100 percent of the FPL. This type of coverage was extended to people with incomes up to 150 percent of the FPL on April 12, 2007. The first phase of the program began enrolling qualified people with incomes less than 100 percent of the FPL on October 1, 2006, less than four months after the first Connector meeting. They were already enrolled in the Free Care Pool that made them easier to reach. These people are also more likely to have chronic illnesses and have the most to gain from greater access to primary care. Commonwealth Care plans two through four, available for eligible people with family income between 100 percent and 300 percent of the FPL, became available on January 1, 2007.

The Connector negotiated capitation rates with the four Medicaid managed care organizations (MMCOs) eligible to bid on Commonwealth Care. Bids came in two stages with a 10-day window between rounds. The difference between initial and second bids resulted in $50 million in savings for the state. The Connector had negotiating leverage by guaranteeing the lowest-cost plan the automatic assignment of people who fail to select a plan. This was modified by the so-called spitting-distance rule that allows plans close to the lowest bid to receive a portion of automatic enrollment assignments. MMCOs will be paid different capitation rates based on age, sex, and geography, but the enrollees in plans two through
four will pay the same premium. If enrollees who have a choice of plans (types two through four) and chose a more expensive plan, however, they will pay the difference. This provides additional incentives to be the low-cost plan. Negotiations were so successful that there was concern that the plans bid too low. As a safeguard, the Connector instituted stop-loss and other protections to safeguard the health plans if they significantly underestimated costs in order to gain market share.

The issue of how much of the premium should be charged to people with family income between 100 percent and 300 percent of the FPL was the subject of considerable debate. A compromise was reached between stakeholders and is reflected in the premium schedule in the following list. The schedule was changed on April 12, 2007, when the board defined affordability for the mandate. People with incomes up to 150 percent of the FPL will pay no premiums, and premiums for people with incomes less than 200 percent of the FPL will have premiums reduced by $5. These new rates are considered affordable, and so the mandate for coverage and penalties will apply to people at these income levels.

### Commonwealth Care Monthly Premium Contribution Schedule, January 2007

<table>
<thead>
<tr>
<th>Percentage of the FPL</th>
<th>Adult Contribution</th>
<th>Two-adult Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>100.1%–150%</td>
<td>$18 or 1.76% of the FPL</td>
<td>$36 or 2.6% of the FPL</td>
</tr>
<tr>
<td>150.1%–200%</td>
<td>$40 or 2.8% of the FPL</td>
<td>$80 or 4.2% of the FPL</td>
</tr>
<tr>
<td>200.1%–250%</td>
<td>$70 or 3.8% of the FPL</td>
<td>$140 or 5.6% of the FPL</td>
</tr>
<tr>
<td>250.1%–300%</td>
<td>$106 or 4.7% of the FPL</td>
<td>$212 or 7.0% of the FPL</td>
</tr>
</tbody>
</table>

### COMMONWEALTH CHOICE

The Connector also faces the challenge of becoming a broker and purchasing agent while becoming financially self-sufficient. The vehicle for doing this is the Commonwealth Choice program, which will provide a range of health plan options to the uninsured and small businesses with 50 or fewer employees. The Connector may also serve larger companies by helping provide coverage for part-time or seasonal workers. The challenge is to find an advantage in a market already providing these services. Moreover, the statute requires that products available inside the Connector must be available outside the Connector at the same price, so they cannot compete on price. Legislators included this provision to protect the existing health insurance marketplace. The hope is that the Connector will provide value through administration and the range of plans it can offer to employers, employees, and the uninsured. People who have multiple employers or shift from one small business to another, may still be able to retain the same healthcare coverage through the Connector.
It is hoped that value will be created through choice of health plans and various options within particular health plans. In negotiations with the plans, the Connector staff encouraged health plans to develop options with selective provider and hospital networks in order to lower costs. Four plans came in with limited networks, and others are considering doing so as well. No real limited network plans are currently offered in the marketplace. In the current market, employers generally have reduced choices of health plans, and are often limited to one, and this requires health plans to have broad networks to meet the diverse needs of employees. This trend reduces the leverage of health plans and leads to higher costs and fewer choices of health plans for enrollees. The Connector can offer a choice of health plans, and employees can select limited network plans that include providers of their choice. The employer will contribute a set amount per employee (at least 50 percent of the cost of coverage), and employees will pay more for more expensive plans. This may push efficiency, broaden options, and possibly make lower-cost, limited network plans available outside the Connector. The value proposition remains untested.

There was a compressed schedule for receiving bids, evaluating submissions, and awarding the Connector Seal of Approval. This seal enables plans to offer products through the Connector. Interested bidders were required to submit five coverage options: one premier plan, two value plans, one basic plan, and one young-adult plan. All plans provide similar benefits (with the exception of the young-adult plan). Differences comprise monthly premiums, deductibles that need to be paid before coverage begins, coinsurance or a percentage of costs for which members are responsible, co-payments that are paid at the time of services, and how broad or narrow the provider and hospital networks are. The premier options have the highest monthly premiums but very limited cost sharing with no deductible. The value plans have midlevel premiums with deductibles between $500 and $1,000, possibly limited networks, and higher co-payments. These plans are similar to what most people with insurance have today. The basic plans will have the lowest premiums and the highest out-of-pocket costs. Unlike the other plans, the young-adult plan has limited benefits and will only be offered through the Connector.

Plans were evaluated based on costs and plan design, which included innovation, network, marketing, network coverage, and geographic coverage. The Connector Seal of Approval was provided to 7 of 10 plans that applied: Blue Cross and Blue Shield of Massachusetts, ConnectiCare, Fallon Community Health Plan, Harvard Pilgrim Health Care, New England Health, Neighborhood Health Plan, and Tufts Health Plan. The MEGA Life and Health Insurance Company, the Mid-West National Life Insurance Company, and United HealthCare received scores significantly below the top seven and did not receive approval at the time this chapter was published. The Connector conducted research on the market and held focus groups with target customers and found that people wanted choice but a limited set of high-quality plans. They also wanted individual attention and assistance with plan choice. At this point, seven plans each offer five options for a total of 35 possible
options. Not all options will be available in all regions, however, and the young adult plans are targeted to 19- to 26-year-olds, and it is not expected that there will be a high demand for premier plans. This will reduce the number of choices. The availability of help in plan section, experience, and enrollment patterns will be necessary to determine if this is the right amount of choice for consumers.

The Connector will also use a subconnector as well as brokers to make these plans more widely available. After bidding the project, the Connector selected the Small Business Service Bureau of Worcester, Massachusetts, as the subconnector. It has experience in servicing this community and was by far the lowest bidder. Responsibilities will include:

1. Customer service.
2. Eligibility determination/enrollment.
3. Web portal online enrollment.
4. Premium billing.
5. Collection remittance.
6. Helping businesses establish cafeteria plans that will enable the pretax premium contributions.
7. Liaison between brokers and the Connector.

The Connector will also work with individual brokers who will receive a $10 per member per month fee for the people they help enroll in insurance through the Connector. This rate is near the bottom of what brokers generally receive.

The law also calls for the Connector to make a young-adult-only plan available through the Connector for people between the ages of 19 and 26 who have no other source of health insurance. This will be the only place where such plans can be purchased. These plans may have more limited coverage and include caps on of $50,000 per illness or per calendar year. They must provide all mandatory state benefits, and insurers offering in this market must have one plan that offers prescription drugs. Bids submitted to the Connector show a range of prices for these plans between $100 per month without prescription drugs to more than $200 per month. The goal is to make insurance affordable for this group and make having insurance a habit. The downside is that there will be some people in this group who have expenses over the limits who will be underinsured.

EMPLOYER IMPACT AND UNDERSTANDING

Business in Massachusetts will be affected by reform in a number of direct and indirect ways. Direct requirements include: fair-share assessment contributions, efforts to extend tax deductibility to more employees, reporting requirements, and new antidiscrimination provisions.

Indirectly, as the individual mandate kicks in, employers may experience a jump in the number of employees enrolling in company-sponsored coverage. This may significantly increase costs and may have a far greater economic impact than the $295 assessment described in the following section. Further, reform sets
minimum coverage levels that all people will need to have to satisfy the mandate. Employers that currently do not provide insurance that meets this standard may want to adjust coverage to meet this standard.

Employer awareness and response will be critical to the future success of reform. To that end, the Connector partnered with Associated Industries of Massachusetts (AIM) to hold information sessions for small businesses throughout the state. These forums are expected to reach a minimum of 500 small employers. Other information is available through the Connector Web site, but the extent to which businesses are aware of and prepared for these changes is still uncertain.

**Fair-Share Assessment**

Companies with 11 or more employees that do not make a “fair and reasonable” contribution to their employees’ health insurance will be assessed a maximum fee of $295 per uninsured employee. The $295 amount was established to equal the per capita costs to the Uncompensated Care Pool of employees currently uninsured. This provision broke a major logjam over what employer responsibility should be.

The state Division of Health Care Finance defined **fair and reasonable** as having a minimum of 25 percent of a company’s full-time employees enrolled in their health plan or paying at least 33 percent of employees’ premiums. **Full time** was defined as 35 or more hours a week. Consumer groups, labor, and key legislators objected that these regulations were too narrowly configured. Legislative leaders believed legislative intent was to take into consideration part-time employees or full-time equivalents and that employers’ contribution should be more on the magnitude of 50 percent.

**Section 125 plans**

Reform legislation required businesses with more that 10 employees to establish Section 125 cafeteria plans. These plans would enable insurance premiums to be deducted from employee wages on a pretax basis. This money is not subject to federal, state, or Social Security taxes. It will result in significant savings for employees and also reduce the payroll taxes businesses have to pay. Failure to comply with this requirement may subject employers to a “free rider surcharge.” This charge will be calculated, in part, based on the money uninsured employees draw from the Free Care Pool, now known as the Health Safety Net Trust Fund.

**Health Insurance Responsibility Disclosure Forms**

The Division of Health Care Finance and Policy held hearings on draft regulations regarding the information that would be required from employers with respect to employee coverage. Regulations were subsequently withdrawn, in part, because of concern about the magnitude of information required. In technical corrections legislation, the reporting requirement date was postponed from
January 1, 2007, to July 1, 2007. This legislation also required employers to provide an annual written statement to employees with employer-sponsored coverage by January 31 each year. Employers must also report similar information to the Commission on Revenue. Falsification of this information could result in fines between $1,000 and $5,000.

**Nondiscrimination Rules**

Nondiscrimination rules will effectively require employers to provide the same benefits and make the same contribution to all full-time employees. Employers will not be able to pay more of the health insurance costs for employees making higher wages. Specifically, the legislation prohibits health plans from contracting with employers that do not make their products available to all full-time employees and that do not make a similar contribution to all company enrollees. The technical corrections legislation extended the compliance date to July 1, 2007, and further details are expected from the Department of Insurance.

**Insurance Partnership Program**

The Insurance Partnership program helps small businesses (50 or fewer employees) provide insurance to their uninsured employees. It also assists low-income self-employed people who are uninsured. Reform expanded eligibility for employees with family income up to 300 percent of the FPL. This brings subsidies in line with those offered through the Commonwealth Care program.

**INSURANCE REFORMS**

The new law merges the individual and small-group insurance markets but has created a commission to conduct a feasibility and impact study prior to implementation. A small group is defined as coverage of 50 or fewer employees. The commission hired an actuarial firm and released its findings in December 2006. The study found that rates in the individual or nongroup market would decrease by 15 percent as a result of moving individuals into a larger group, but rates in the small-group market would increase by 1 percent to 1.5 percent as more higher-risk individuals join this group. Nongroup reductions vary by carrier, and savings from certain health plans could be as high as 50 percent. On the other end, increase in some small-group insurance rates could increase as much as 4 percent. Because the findings did not predict major increases in the small-group market, the merger will go ahead as scheduled on July 1, 2007. At this date, the nongroup or individual market will be closed to all new enrollees.

The law also requires Massachusetts licensed carriers to allow young adults to remain covered on a parent’s insurance plan for up to two years after the loss of dependent status or until their 26th birthday, whichever comes first. This went into effect on January 1, 2007. Health plans may restrict coverage to young adults who remain in the plan’s service area.
QUALITY AND COST

The legislation created a number of councils and committees. The Quality and Cost Council is charged with setting cost and quality goals for the State of Massachusetts and developing strategies in these areas. It is chaired by the secretary of Health and Human Services and will report its recommendations by the end of 2007.

The law provides $1 million in new funding to the State Department of Public Health to create an infection prevention and control program. A task force was developed to recommend mechanisms for collecting and reporting data on infection rates and best-practice guidelines for prevention.

Healthcare reform also increases Medicaid payment to hospitals but makes these payments contingent on meeting quality standards. The Executive Office of Health and Human Services is charged with setting quality benchmarks and pay-for-performance measures. Statute requires that benchmarks include improvement in racial and ethnic disparities in healthcare services.

FUNDING AND SUSTAINABILITY ASSUMPTIONS

Financial sustainability will require a reduction in uncompensated care costs, enhanced federal and state funding, high enrollment in the new programs, and macroeconomic stability. It may also require stability in the rate of healthcare inflation. Reform is partially funded by transferring funds from the Uncompensated Care Pool, which was replaced by the Health Care Safety Net Trust fund. Successful funding will require uncompensated care spending to decrease to subsidize insurance coverage. Federal safety-net funds made possible through the 1115 waiver and additional federal matching for the increased Medicaid and State Children’s Health Insurance Program (SCHIP) funding are also essential to fund this program. The state 1115 waiver program needs to be renewed again by July 2008, the SCHIP program is up for renewal in 2007, and current levels of funding will need to remain at approximately the same level. In addition, $129 million per year for three years in new state general revenue was pledged for this program. This funding will need to be maintained at or around the same level, unless an alternative revenue source can be identified. Surveys show that many of the uninsured are unaware of the coverage requirement and that there is the possibility that a portion of the population will balk at the individual mandate. Finally, an economic downturn could increase the number of uninsured and reduce the availability of state funding.

CONCLUSION

Massachusetts has a long history of healthcare innovation. The current round of reform builds on a solid foundation of public and private health insurance. It also builds on a strong safety net, the costs of which were made explicit through the state’s Uncompensated Care Pool. The number of uninsured is low compared
to the nation. Many are still without health insurance, however, which entails social and economic costs and consequences. The healthcare sector in Massachusetts is a driver of the state’s economy. The state has a number of world-class medical schools and teaching hospitals. This educational system has advantages, but the state also has high healthcare costs. The dominant health plans in the state are not for profit and rank at the top in the United States in terms of quality and member satisfaction.

The latest round of reform was driven by political leadership, activist consumer organizations, and the threat of losing significant amounts of federal money. Legislative success was achieved through a broad-based coalition of consumers, providers, health plans, healthcare systems, and the business community. The strategy was shared responsibility, asking more of individuals, government, and business. The individual mandate is the most innovative piece and is essential to getting near-universal coverage. The coalition that made reform possible has held together through the first year of implementation. Compromise on key issues kept reform on track. These included setting subsidy levels, outlining benefits, and defining affordability and the required minimum level of insurance.

The current Massachusetts experiment is being closely followed by other states and may help spark the next round of national reforms. Although other states can learn from the particulars, more can be learned from the process. Because Massachusetts builds off the base of its existing system, it would be difficult to adopt wholesale. What can be replicated is the notion of shared responsibility, developing broad coalitions, and building on the success of existing programs. Mandates are difficult but essential to sustained progress. Massachusetts also separated coverage expansion from cost and quality reform. Many believed that they had to be addressed together, but it was not politically viable at the time. Dealing with access brings more people under the tent but does not hold the uninsured hostage to these more difficult issues. Ultimately, continued progress and sustainability at the state level are predicated on financing, which may drive necessary national reform.

NOTES

3. Ibid.


9. Ibid., 269.


11. Ibid., 60.


13. Ibid.


20. Ibid.


23. Ibid.


26. Ibid., 15.


29. Ibid., 58.


Chapter 2. Healthcare Insurance:
The Massachusetts Plan

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