Backgrounder

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The Massachusetts Health Plan: Lessons for the States

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State officials can dramatically improve the functioning of their state health insurance markets, establish portability and personal ownership in health insurance coverage, and make major improvements in how they finance health care for the uninsured. Massachusetts, a state with a conservative Republican governor and liberal Democratic legislature, has recently enacted comprehensive health care reform. Not surprisingly, many state officials from around the country are carefully examining the Massachusetts health plan, trying to discern what is applicable to or appropriate for their own states.

The Massachusetts plan, signed into law by Governor Mitt Romney, is a complex mixture of specific policy initiatives aimed at providing residents with "access to affordable, quality, accountable health care."[1] Most notably, the new law:

- **Creates** a single consumer-driven marketplace for health insurance for small businesses, their employees, and individuals;
- **Promotes** "defined contributions" rather than the defined benefit system in employer-based health insurance that does not disrupt the current tax treatment of health insurance;
- **Redirects** public health care subsidies from hospital systems that serve the uninsured to low-income individuals to assist them in purchasing private health coverage;
- **Expands** Medicaid eligibility for children;

Talking Points

- States should consider both establishing a statewide health insurance exchange for health insurance in which individuals can choose and own their health care coverage regardless of job change or status and without losing favorable tax treatment and replacing the current provider-based subsidy structure for the uninsured with premium assistance to individuals in need.
- States should avoid provisions found in the Massachusetts plan that impose a health insurance mandate on employers or that expand dependence on the already overburdened public health programs such as Medicaid.
- Moreover, states should be more aggressive than Massachusetts in preserving an individual's right to self-insure, in deregulating their state insurance markets, and in opening access to and choice of private health plans through a statewide health insurance exchange.

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- **Changes** the rules governing health insurance markets; and
- **Imposes** a mandate on individuals to buy coverage and penalties on employers who do not provide and subsidize coverage for their employees.

Several features of the Massachusetts health plan could revolutionize the traditional health care system by empowering individuals to buy and own their health insurance policies and keep these policies with them regardless of job or job status. However, officials in other states should shun the imposition of employer mandates and avoid public program expansions while making modifications and improvements to other significant components of the Massachusetts plan.

A Compromise

Given the partisan divide between the Romney Administration and the Democratic legislature, as well as the leftward political and regulatory climate in Massachusetts, the final language was not the ideal outcome for either the governor or the legislature. A key motivation for reaching an agreement was the expiration of an existing federal waiver. Massachusetts needed to restructure its waiver or risk losing federal funding for uncompensated care. Nonetheless, for the majority of the provisions, the final product was a genuine compromise on imperfect legislation.

The Achievements. There has been a great deal of media coverage of and commentary on the Massachusetts law. Regrettably, some of it has been inaccurate.[2] Regardless of ideological or partisan disagreements on specific provisions of the final bill, legislators in other states can learn a great deal from the Massachusetts legislation. Two of the new law's key achievements are:

1. Creation of a new market for health insurance in which individuals and families can buy private coverage of their choice, own it, and take it from job to job without losing the existing favorable tax treatment for employer-sponsored health insurance, and
2. Creation of a new system of premium assistance for lower-income individuals to purchase private coverage based on leveraging existing uncompensated care funds used to cover the cost of care for the uninsured.

These two components could revolutionize the traditional health care system by empowering individuals, including low-income persons, to buy and own their health care coverage, and they can be adapted to the unique conditions of other states.

The Shortfalls. At the same time, state legislators should avoid a number of troublesome provisions in the new Massachusetts law. These include the counterproductive employer mandate for providing health care coverage and the unnecessary Medicaid expansion. In reality, households, not employers, bear the burden of health care costs. Employer mandates constitute a regressive tax on workers and their families, usually in the form of reduced compensation or even job loss.

With regard to Medicaid, it is important to keep in mind that it is a welfare program. Ideally, the best Medicaid policy would "mainstream" individuals out of Medicaid and into the private health care coverage that is available to other Americans, just as the best welfare reform policy would mainstream

1. Acts of 2006, Chapter 58, Massachusetts Legislature, 2006 Session, April 12, 2006, at *www.mass.gov/legis/laws/seslaw06/sl060058.htm* (July 12, 2006).
2. For example, see Betsy McCaughey, "Romneycare's Fine Print," *The Wall Street Journal*, May 5, 2006, p. A16. McCaughey, former lieutenant governor of New York, states, "Moreover, under the new law, individuals purchasing their own insurance must buy HMO policies." In fact, any major medical plan of any type offered by any health insurance company, including a health savings account plan, may be offered through the Connector under the normal procedures of state approval for health insurance. For an accurate assessment of the Massachusetts legislation, see Edmund F. Haislmaier, "The Significance of the Massachusetts Health Plan," Heritage Foundation *WebMemo* No. 1035, April 11, 2006, at *www.heritage.org/research/healthcare/wm1035.cfm*. See also Robert E. Moffit, Ph.D., and Nina Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan," Heritage Foundation *WebMemo* No. 1045, April 20, 2006, at *www.heritage.org/research/healthcare/wm1045.cfm*.

welfare dependents into jobs in the private economy. In effect, simple Medicaid expansions are an obstacle to the achievement of the broader goals of comprehensive welfare reform.

The Massachusetts law includes several impressive structural changes in the insurance market and health care financing, but states should improve other elements of the Massachusetts law. In adopting an individual mandate for the purchase of health insurance, the legislature adopted final language that dropped a crucial provision that would have enabled individuals to demonstrate personal responsibility by allowing them to self-insure and demonstrate their willingness and ability to cover their own health care costs without enrolling in an insurance plan. This was a serious mistake.

The Massachusetts law also created a new health insurance market for small-business employees and individuals, but businesses of all sizes should be permitted to access the new consumer-driven market, and all consumers should have access to the broadest range of policies and carriers. The goal of state insurance reform should be to create a robust, wide, and open market. While the law provided some regulatory relief from state rules governing insurance plan designs and benefits, it should have pursued more aggressive deregulation of the health insurance market.

Key Components That States Should Adopt

The Massachusetts health plan is the product of a bipartisan compromise in a political and cultural environment that is peculiar to Massachusetts. It also reflects the peculiarities of that state's health care delivery system. Massachusetts is burdened with high health care costs, a high level of uncompensated care costs, and an overregulated health insurance market. Relative to other states, it also has a higher concentration of "branded" medical providers accustomed to leveraging their reputations for quality to charge high prices and dictate reimbursement rates to insurers. Consequently, the legislation includes provisions to allow insurers more flexibility in contracting selectively with providers and constructing "value-focused" networks. Massachusetts also has a high rate of employer-based coverage and a relatively low number of uninsured—a feature not found in all states.

The plan enacted by the Massachusetts legislature and signed by the governor is not a program that can simply be replicated in other states. The political, economic, and social conditions of the states vary greatly, as do their patterns of health care delivery, including the number of uninsured, the pattern of health care costs, the ratio of public–private health care coverage, and the level of regulation and government control over the system. The true genius of the Constitution's federal system of government is its capacity for adaptation to local circumstances and the promotion of competitive policy innovation, enabling Americans to learn the best practices and avoid the most common mistakes of their fellow citizens.

However, officials in other states should note that several features of the Massachusetts health plan could be adapted to the unique conditions of their states. Two features of conceptual importance merit close attention.

Component #1: Creation of a New Statewide Health Insurance Exchange

The Massachusetts plan creates a new consumer-driven marketplace (the Connector) where individuals and employees of small businesses can purchase health care coverage from a variety of competing health insurance plans. This is, in effect, a health insurance "exchange."[3] Conceptually, the Connector is like a stock exchange for health insurance—an administratively easy way for individuals to buy various health insurance products through an organized market, just as they would buy differ-

3. The idea of the health insurance exchange was developed by Alain C. Enthoven, professor of public and private management at the Graduate School of Business at Stanford University. See Alain C. Enthoven, "Employment Based Health Insurance Is Failing: Now What?" *Health Affairs Web Exclusive*, May 28, 2003, pp. W237–W248, and Alain C. Enthoven, "Open the Markets and Level the Playing Field," in Alain C. Enthoven and Laura A. Tollen, eds., *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice* (San Francisco: Jossey–Bass, 2004), pp. 227–245.

ent stocks, bonds, and mutual funds through an organized financial market.

In this specific case, the Massachusetts Connector is designed on The Heritage Foundation's version of a voluntary "health insurance exchange."[4] In this design, the health insurance exchange is not a regulatory agency. It does not supplant the authority of the state insurance department, nor does it impose a comprehensive standardized benefit package on health plan participation, such as Maine's Dirigo health care program.[5] It is not a purchasing entity like an association health plan or existing state-sponsored small-business purchasing groups. Moreover, this type of health insurance exchange is not intended to negotiate rates or benefits with health insurance carriers on behalf of its member employers, employees, or individuals. In this crucial respect, the health insurance exchange is not like the popular Federal Employees Health Benefits Program, which provides a broad range of health plan choice to federal workers and retirees.

Like a stock exchange for financial investments, a health exchange's primary role is to facilitate transactions among the government, employers, individuals, and health insurers, such as coordinating contributions and government assistance for premium payments to insurers and other related paperwork. In principle, of course, such operations do not have to be run exclusively through a government entity like the Massachusetts Connector. States could charter a nongovernmental agency to carry out such functions or contract with existing private-sector entities to administer the essential functions of a statewide health insurance exchange.

Correcting Market Deficiencies. The rationale for the Connector is rooted in the deficiencies and complexities of the current individual and small group health insurance markets and the layers of state insurance rules that govern them. These deficiencies are common in all states. They are evident from the difficulties that small businesses and individuals have in getting affordable health insurance and staying covered over time.

The Massachusetts Connector is a mechanism to overcome these deficiencies by combining the small group and individual markets.[6] It expands choice for employees of small businesses who typically have few, if any, choices of health plans or carriers. Moreover, the Connector expands access by facilitating coverage for individuals and families who currently do not have coverage through an employer by creating a new way of easing access to coverage for these persons and extending favorable tax treatment.

Establishing Portability. The empirical data on America's uninsured are voluminous. Nationally, more than 80 percent of the uninsured are in working families. While they are an economically diverse group, the largest portion of this population is composed of lower-income working families. Moreover, they are heavily concentrated in small businesses that commonly do not offer health

4. The Massachusetts Connector was designed largely on the basis of a Heritage Foundation proposal to compensate for the deficiencies of federal regulations and tax law and to create a consumer-driven market for health insurance: a statewide "health insurance exchange." The earliest version of the Heritage Foundation exchange proposal was embodied in a health insurance market reform bill developed by the Department of Insurance Securities and Banking of the District of Columbia. For a discussion of the key elements of the D.C. proposal, see Lawrence H. Mirel and Edmund F. Haislmaier, "Doing It Right: The District of Columbia Health Insurance Market Reform," Heritage Foundation *Lecture* No. 936, May 15, 2006, at *www.heritage.org/research/healthcare/hl936.cfm*.

5. For an account of Maine's Dirigo health care program, see Tarren Bragdon, "Command and Control: Maine's Dirigo Health Care Program," Heritage Foundation *Backgrounder* No. 1878, September 16, 2005, at *www.heritage.org/Research/HealthCare/bg1878.cfm*. In variants of "managed competition," the standardization of health insurance benefits across health plans is a central principle, and market competition is thus based on quality and price. In contrast, this version of the health insurance exchange provides for a lot of different health plans and a multiplicity of benefit offerings through a single market, similar to the CarMax business model for selling consumers a wide variety of makes and models of automobiles.

6. The existing individual market is collapsed into the Connector. The small group market still exists, but small businesses can voluntarily opt out and participate in the Connector. The legislation also sets up a commission to study possibly folding the small group market into the Connector at a later date.

insurance, and they are often found among part-time and contract employees that typically do not qualify for employer-based coverage.

The data also show that the uninsured population is constantly churning, with individuals and families going in and out of health insurance coverage, often because of changes in employment or employment status. In a detailed analysis of the empirical evidence over an extended period of time, Pamela Farley Short and Deborah R. Graefe of Pennsylvania State University found that the number of those who were "always uninsured" over the long term (defined as 48 months for the purposes of the study) amounted to no more than 12 percent of the uninsured population. The vast majority experienced gaps or frequent changes in coverage or were making the transition into and out of health insurance coverage.[7] Similarly, in a Commonwealth Fund study, Short, Graefe, and Cathy Schoen of the Commonwealth Fund observed: "To the extent that job turnover undermines coverage stability, designing ways for employers to contribute to the cost of coverage, without directly administering health insurance, could enhance continuity."[8]

The Massachusetts Connector makes coverage easier to purchase and to maintain. In other words, the Connector is intended to lessen the churning effect of the uninsured and general instability in coverage by providing an organized structure through which individuals and families can choose and purchase plans from competing insurers and maintain coverage regardless of job changes or employment status.

Preserving Tax Breaks. The federal tax code is a significant obstacle to achieving personal ownership and portability of health insurance. On one level, it is generous. It provides unlimited tax relief for the purchase of health insurance, but it largely confines that generosity to those who obtain health coverage through their places of work. Under current federal tax law, the total value of the employer-purchased health benefit is excluded from an employee's taxable income. On another level, it is stingy. Such lucrative tax preferences are not extended to workers who lack employer-based coverage. They must purchase coverage on their own with after-tax dollars.

This presents a dilemma: Buying a health plan in the individual market with after-tax dollars imposes a financial hardship, especially on individuals with lower incomes. The alternative—going without coverage—runs the risk of incurring high medical costs from serious or catastrophic illness. Without federal action to level the playing field, the policy challenge is to establish individual access to coverage in an inflexible federal tax system that almost exclusively privileges employer-based health insurance coverage.[9]

Through the Connector, the Massachusetts law resolves this dilemma and maintains the generous federal and state tax breaks for health insurance that are confined almost exclusively to coverage purchased by employers. In short, the new law establishes a defined contribution option for employers that they did not previously have. Specifically, an employer can designate the Connector as its employer-sponsored health insurance plan, allowing the employee to receive tax-free premium contributions from their employer. Thus, the Connector protects the current, favorable treatment of health insurance for employees and provides choice, ownership, and portability for them.

The Massachusetts reform also creates a new opportunity for employees to gain other tax advantages. The new law requires employers with 11 or

7. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 247–249.

8. Pamela Farley Short, Deborah R. Graefe, and Cathy Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," Commonwealth Fund *Issue Brief*, November 2003, p. 10, at *www.cmwf.org/usr_doc/Short_churn_688.pdf* (July 12, 2006).

9. See Grace-Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999).

more employees to set up a Section 125 plan so that their employees can pay their share of health insurance premiums with pre-tax dollars. This requirement will help all employees, but especially part-time and contract employees who may not receive any pre-tax contributions from their employers.

While critical of elements of the Massachusetts law, the editors of *National Review* nonetheless remarked:

> [T]he connector in the plan is genuinely innovative. The federal tax code encourages employers to provide health insurance rather than just giving people higher wages with which to buy their own insurance. The connector is a way of working around that problem. Employers would give workers a set amount of money, and they could use the connector to buy from one of several participating companies and the federal tax break would still apply.[10]

Component #2: Direct Assistance for Lower-Income Persons to Buy Private Coverage

The central issue in America's health care debate, aside from the rising cost of health care, revolves around the uninsured and helping them to get coverage. The correlative issue is how to finance additional assistance to help those who are without health insurance.

John C. Goodman, president of the National Center for Policy Analysis, notes that federal and state governments already spend tens of billions of dollars annually on a variety of programs for the uninsured, including Medicare and Medicaid funds for hospitals that serve a disproportionately large number of patients without health insurance coverage. Goodman has long argued that current government subsidies and tax incentives for the uninsured should be realigned and redirected to help the uninsured get coverage, primarily through health care tax credits.[11] The Massachusetts law puts this concept into practice by using existing government funding to help lower-income individuals purchase individually owned private coverage.

Governor Romney builds on Goodman's central insight. In Massachusetts, the costs of uncompensated care totaled $1.3 billion in 2005. In the traditional arrangement, hundreds of millions of government dollars, including federal funds,[12] were going to a few Massachusetts hospital systems to reimburse them for providing services to the uninsured—an arrangement that has often lacked accountability. With its uncompensated care waiver from the U.S. Department of Health and Human Services expiring, the Romney Administration proposed turning the massive uncompensated care subsidy structure upside down by using those funds to provide direct assistance to individuals and families rather than paying health care providers to provide services to the uninsured.

The direct subsidy will become a new premium assistance program, administered by the Connector and designed to help lower-income individuals and families buy private health insurance. Much like federal proposals for refundable health care tax credits or vouchers, the premium assistance program is designed as a sliding-scale system of financial help, based on the ability to pay, up to 300 percent of the federal poverty level ($30,480 for a single person and $60,432 for a family of four in 2005 dollars).

At the federal level, President George W. Bush has included a refundable tax credit for lower-income individuals and families in past budget proposals. While there are technical differences, the Romney income-based premium assistance program broadly covers the same uninsured populations that have been targeted by the Bush Administration's health care tax credit proposals.[13] The Bush Administration

10. "The Week," *National Review*, May 8, 2006, p. 4.

11. See John C. Goodman, "Solving the Problem of the Uninsured," *Thoracic Surgery Clinics*, Vol. 15, Issue 4 (November 2005), pp. 503–512.

12. State taxpayers provided 54 percent of Massachusetts' uncompensated care funds, and federal taxpayers provided the remaining 46 percent. Personal communication with Massachusetts Secretary of Health Timothy Murphy, May 31, 2006.

has consistently targeted its refundable health care tax credits on a sliding-scale basis to individuals earning up to $30,000 and families earning up to $60,000 per year.[14] Members of Congress have introduced similar proposals, but Congress has chosen not to enact these credits.

The adoption of this provision of the Massachusetts law amounts to a revolutionary change in health policy. It mainstreams low-income individuals and families into private health care coverage, and does this without new health care expenditures, by redirecting state health care spending from meeting the needs of providers to meeting the needs of patients and consumers. In sum, it converts the current *de facto* provider safety net into a consumer safety net.

Key Components for States to Avoid

To expand personal freedom and harness the power of competition through a more robust private market, states should resist certain features of the Massachusetts plan that obstruct this goal.

Imposing an Employer Mandate. The final language of the Massachusetts health law imposes new penalties on employers who do not provide health insurance to their workers, who do not make a "reasonable" contribution, or whose employees accumulate free care services.[15] However, employers in Massachusetts who provide coverage to their workers already pay a state health insurance premium tax. The existing premium tax is counterproductive, as are the new penalties. Governor Romney vetoed the new employer mandate provisions, but the Massachusetts legislature overrode his vetoes.

The underlying assumption behind an employer mandate—that employers pay for health insurance for their employees—is erroneous. In fact, households, not employers, pay 100 percent of health care costs. Health benefits, like wages, are part of the employees' compensation, and every increase in the payment for health benefits is routinely offset by decreases in workers' wages and other compensation.

Policymakers in other states should vigorously oppose employer mandates, regardless of how narrowly targeted or defined they may be.[16] Not only does an employer mandate provide an additional platform for further regulatory control over private health insurance contracts, but the additional

13. One of the major differences is that the Massachusetts subsidy program is based on a fixed pool of funds, whereas the Bush and congressional proposals are financed through general revenues. Federal officials have rarely proposed replacing the existing health care tax breaks—particularly the huge tax exclusion on employer-based health insurance—to fund a national health care tax credit system as many economists and conservative health policy analysts have recommended.
14. For the most comprehensive version, see U.S. Department of the Treasury, *General Explanation of the Administration's Fiscal Year 2006 Revenue Proposals*, February 2005, p. 20, at *www.treas.gov/offices/tax-policy/library/bluebk05.pdf* (July 12, 2006), and *General Explanation of the Administration's Fiscal Year 2007 Revenue Proposals*, February 6, 2006, pp. 25–26, at *www.treas.gov/offices/tax-policy/library/bluebk06.pdf* (July 12, 2006). The fiscal year 2007 version limits use of the tax credit to high-deductible health plans but maintains the same income eligibility standards.
15. The Massachusetts law levies a fee for uncompensated care on companies with 11 or more employees that do not offer health insurance coverage to employees. The fee is capped at $295 annually per employee and is calculated based on the use of free care by uncovered employees. A free rider surcharge is also applied to any firm with uncovered employees who together consume more than $50,000 in "free care" annually. However, the special fee would not be levied if the firm makes a Section 125 plan available to its employees. For a detailed description of the Massachusetts employer mandate, see Moffit and Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan."
16. Perhaps the most notable is the "Wal-Mart Bill," which the Maryland legislature enacted over Governor Robert Ehrlich's veto. The bill requires private employers in Maryland that have more than 10,000 employees to spend 8 percent of their payroll on health insurance for their employees or pay a tax to the state to help fund the state's share of the Medicaid program. The Maryland bill has spawned copycat legislation in numerous states. For a description of the Maryland employer mandate, see Edmund F. Haislmaier, "Covering the Uninsured in Maryland: Futile Gestures or Real Reforms?" Maryland Public Policy Institute, *Maryland Policy Report* No. 2006–2, January 17, 2006, at *www.mdpolicy.org/docLib/20060117_PolicyReport20062.pdf* (July 12, 2006).

costs of a mandate make it even more difficult for entrepreneurs to start and maintain a small business, and these higher costs are passed onto workers and their families through lower wages and even job loss.

Expanding Medicaid. The Massachusetts law expands Medicaid eligibility to children of working families up to 300 percent of the federal poverty level. As a general rule, expanding Medicaid or other public health programs, such as the State Children's Health Insurance Program (SCHIP), is not the best option for families or state policymakers. In surveys, the overwhelming majority of uninsured families expressed a preference for enrolling in private coverage, not public programs.[17] For state officials, Medicaid is consuming ever-greater portions of state budgets, crowding out other important services (e.g., education, transportation, and homeland security), and jeopardizing the quality of care for those whom the programs were intended to serve.

Instead of expanding eligibility for these struggling government-run public programs, states should pursue innovative alternatives for working families and protect the public program for the truly indigent. Building on new market mechanisms such as a health insurance exchange like the Massachusetts Connector and providing direct assistance to lower-income families so that they can afford private health coverage are far better alternatives than simply enrolling them in Medicaid or other public health programs. Moreover, states would do well to begin mainstreaming many of their working individuals and families out of public coverage and into affordable private health insurance options.

Key Components for States to Improve

As noted, the Massachusetts plan is the product of a bipartisan compromise in a political, cultural, and health system environment that is peculiar to Massachusetts. A number of provisions in the law need improvement, and states looking at the Massachusetts model should consider these modifications.

Removing the Legal Restriction on a Person's Right to Self-Insure. The Massachusetts health plan imposes a simple "pay or play" mandate on the individual by requiring an individual to purchase coverage or pay a state fine.[18] This simple mandate is not the ideal option for dealing with the "free rider" issue—the very real problem of individuals seeking and getting health care at hospital emergency rooms or other health care facilities and then leaving the taxpayer to pay the bill. These costs are incurred either directly through taxation or through higher private insurance premiums. In Maryland, for example, caring for the uninsured cost an estimated $713 million in 2005, raising family premiums by $948.[19] In Massachusetts, as noted, uncompensated health care costs reached a stunning $1.3 billion in 2005.

A far better option would be to adopt Governor Romney's original proposal, which would have protected an individual's right not to purchase health insurance coverage. His "personal responsibility" proposal would simply have required everyone who could afford health insurance either to purchase coverage or to self-insure by posting a $10,000 bond or

17. According to a 2002 Commonwealth Fund survey of uninsured adults, only 12 percent said that they would like to enroll in Medicare or Medicaid if they had the option, but a strong majority said they would prefer to enroll in private group or individual health insurance plans. See Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer Based Health Coverage and the Threat to Workers' Health Care: Findings of the Commonwealth Fund 2002 Workplace Health Insurance Survey," Commonwealth Fund *Issue Brief*, August 2002, p. 7, at *www.cmwf.org/usr_doc/edwards_erosion.pdf* (July 12, 2006).

18. Under the terms of the new Massachusetts law, beginning on July 1, 2007, all Massachusetts residents will be required to have health insurance and must indicate proof of purchase on their state tax returns. Anyone refusing to purchase a health insurance policy will lose his personal tax exemption in the first year. Continuing to refuse to purchase a health insurance policy will incur a monthly fine equal to 50 percent of the cost of an "affordable" health insurance product.

19. Regina E. Herzlinger, "Health Policy in Maryland and Massachusetts: A Study in Contrasts," Heritage Foundation *WebMemo* No. 1037, April 13, 2006, at *www.heritage.org/research/healthcare/wm1037.cfm*.

equivalent of a bond, which would demonstrate a willingness and ability to pay for any future hospital care. The $10,000 figure was taken from the Massachusetts auto insurance law, which also requires the posting of funds if one does not wish to purchase auto insurance. This is simply a tangible demonstration of a person's willingness to pay his own way and eliminates the option of obtaining expensive health care services and then skipping out, leaving the taxpayers to pay the medical bills.

The current debate over the individual mandate to purchase health insurance in Massachusetts must be understood against the backdrop of a simple fact: Federal law prohibits hospitals from turning away patients because of their financial inability to pay for care. In effect, the *status quo* imposes a mandate on taxpayers, and the burdens of that mandate are steadily increasing. These burdens are not relieved by resorting to new funding for public hospitals for the poor and the indigent, shifting bad debt elsewhere, or fruitlessly chasing down the unpaid bills of high-cost patients who are simply incapable of paying high health care bills. Governor Romney's original approach would protect individual taxpayers from paying the uncompensated care costs for free riders while preserving the individual's freedom to decide how best to pay for care.

Accelerating the Deregulation of the State Health Insurance Market. Massachusetts has a highly regulated health insurance market, especially for small businesses. Much of the recent criticism of the Massachusetts plan from conservatives is that the plan did not deregulate enough, and especially that it did not eliminate the guaranteed issue requirements for health insurance.[20]

In fairness, the Massachusetts law does make some important changes in health insurance regulation, including a two-year moratorium on new mandated benefits. It also introduces new flexibility for products in the Massachusetts health insurance market, such as tiered networks, expanded health savings account options, the factoring of tobacco use into health insurance ratings, and more affordable mandate "lite" health plans for younger populations between 19 and 26 years of age.

Projecting future health care costs or savings is extremely difficult. Nonetheless, the governor's staff estimates, based on the available insurance data, that these regulatory changes in the health insurance market will reduce average individual premium costs by 20 percent to 50 percent.[21] The governor's staff has also calculated that the new provisions giving consumers greater information, including transparency in pricing, will stimulate greater market competition in cost and quality among hospitals and other medical professionals, which will result in larger statewide health system savings.

Nonetheless, the critics' basic point is well-taken. The Massachusetts health insurance market is overregulated, as are the health care markets in many other states. Much of today's state health insurance regulation is counterproductive and outdated. With respect to benefit mandates, while many legislators believe that they are necessary and socially beneficial, it is also true that enactment of these mandates (which now exceed 1,800 nationwide[22]) is too often driven by anecdotes and "hard cases," narrow political considerations, or the special financial interests of providers who want legally required coverage and reimbursement for their specialties.

State legislators should rigorously review existing rules and repeal those that impose unnecessary

20. For example, see Council for Affordable Health Insurance, "Massachusetts' Health Care Reform Plan: Too Many Sticks; Not Enough Carrots," May 2006, at *www.cahi.org/cahi_contents/resources/pdf/massachusetts.pdf* (July 12, 2006).

21. Personal communication from Cindy Gillespie, counselor to Governor Romney, May 25, 2006. The key changes that are expected to yield savings in the insurance markets include allowing companies to use "value-driven" networks instead of complying with the older "any willing provider" rules, expanded use of health savings accounts and high-deductible health plans, introduction of co-payments, and greater pharmacy benefit management. Timothy Murphy, Secretary of Massachusetts Health and Human Services, "Massachusetts Health Care Reform," May 16, 2006, PowerPoint presentation, p. 7.

22. Victoria Craig Bunce, JP Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States, 2006," Council for Affordable Health Insurance, March 2006, at *www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf* (April 27, 2006).

costs on individuals and families. Specifically, states should provide greater flexibility as well as mandate and rating relief for carriers offering health insurance in the small group and individual markets. Better still, they should simply abolish the existing rules that govern these dysfunctional markets and start over with a clean slate: a single market and a common set of understandable rules focused on consumer information and protection.

Expanding Access to and Choice of a Statewide Health Insurance Exchange. The Massachusetts plan focuses primarily on providing relief to small businesses and their employees. Specifically, it creates an avenue for these individuals and families to take advantage of the generous federal tax breaks that accrue to employer-based health insurance while enabling them to own their own health insurance policies and keep them regardless of job change or status. The Massachusetts plan, however, restricts participation in the Connector to employees in businesses with 50 or fewer employees and individuals purchasing coverage on their own. Moreover, lower-income individuals receiving the new premium assistance subsidy are restricted in the types of products that are available to them through the Connector.[23]

Officials in other states who are interested in establishing statewide markets should consider expanding participation in a health insurance exchange to employers of all sizes, including state and local government employees. States should also fold public programs, such as certain enrollees in Medicaid and SCHIP, into the health exchange. In many instances, families involved with public health programs do not share the same coverage. Folding the public programs into an exchange would allow these families to maintain private coverage together under a single policy.

In establishing a health insurance exchange, state officials should also ensure that it does not and cannot become a barrier to entry for new and innovative insurance products or options. Therefore, consistent with consumer protection, it is equally important, that states should allow *any willing insurer* to participate in the health exchange arrangement and not restrict populations from choosing the product that best fits their needs, regardless of their income or level of financial help from the government. In the end, larger and more open participation in the statewide market will result in a more successful, competitive, and robust consumer-driven marketplace.

Conclusion

Massachusetts officials have made significant strides in reforming their health insurance market, and other states can learn from the Massachusetts experience. States should build on the solid features of the Connector: the establishment of a statewide health insurance exchange to allow individuals to buy and own health insurance without losing favorable tax treatment and direct assistance to low-income individuals and families for the purchase of private coverage using existing government funds. Likewise, states should reject certain problematic features of the final plan, such as the employer mandate and public program expansions, and improve other aspects of the plan.

Every state wrestles with the impact that rising health care costs and numbers of uninsured have on the economy and budget. Nonetheless, every state has its own health care delivery system that operates in a unique political, cultural, and legal, and regulatory climate. While the Massachusetts plan is clearly not perfect, it does make some crucial conceptual breakthroughs in health policy. Furthermore, the process itself illustrates that states, regardless of their differing characteristics, can tackle the difficult health care issues that thus far have stymied federal policymakers.

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23. Under the Massachusetts law, no deductibles are permitted for individuals getting premium assistance, which is available to uninsured people with incomes up to 300 percent of the federal poverty line. This is an unnecessary restriction on the market. Moreover, these individuals would be offered health plans exclusively through the Medicaid managed care organizations for the first three years of the program. This political compromise was included to ensure that the transition to the new system would not precipitate a financial crisis among the hospital systems that currently receive uncompensated care pool funding.