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The Massachusetts Health Reform: Assessing Its Significance and Progress

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Thank you for inviting me to the Cato Institute's forum to comment on Professor David Hyman's paper[1] and on the broader issue of the significance of the Massachusetts health reforms.

In the interest of dispelling any possible misimpression that I am owed more credit—or blame—than I am actually due, I must note that Cato's announcement for this event overstates in calling me "one of the chief architects of the Massachusetts health plan." In truth, my contribution was mainly to introduce the folks in Massachusetts to the concept and design of the Connector as the tool for organizing and administering their broader, consumer-choice reforms.

Credit for starting from a consumer-centered approach goes principally to former Governor Mitt Romney and his administration. Credit for the details of the end product goes principally to the Massachusetts legislature. In between, there were numerous stakeholders who also shaped the results.

Professor Hyman uses a tripartite convention in his analysis, and I shall do the same. His formulation, inspired by the late Italian film director Sergio Leone, is a horizontal assessment of "the good, the bad and the ugly." In contrast, I shall offer a vertical assessment and, more prosaically, label my categories "the significant, the noteworthy, and the tangential."

- What I consider "significant" are the basic policy concepts embodied in the reforms, the rationales for those concepts, and their applicability in other states.

Talking Points

- Massachusetts has committed to fundamentally restructuring its health system around the principle that individual consumers, and not employers or government, should be the key decision makers and owners of insurance in the health care system.
- That is a very significant shift in the health policy debate, and it is worth replicating elsewhere the core design elements that effectuate such a profound change.
- As for the details, their importance lies largely in the insights they offer for making further improvements in the next versions of the basic model. In other states, lawmakers and stakeholders will have to negotiate and compromise the details to suit their own unique circumstances.
- The ultimate test will be whether, over the next several years, such a consumer-choice model can begin to deliver a better-value health system.

This paper, in its entirety, can be found at: *www.heritage.org/Research/HealthCare/hl1044.cfm*

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- What I consider "noteworthy" are those provisions that are effectively prototypes of design features that could be improved upon by other states.
- What I consider "tangential" are those provisions that are largely Massachusetts-specific and thus of less relevance for other states.

The Basic Concepts of Reform

At its core, the Massachusetts legislation is a two-part approach to making consumer choice and ownership of health insurance the fundamental organizing principle of a state's health system.

The first part is a reorganization of the state's insurance market to provide small business with a simple and practical way to defined-contribution their workers into individual, portable coverage of the workers' choice without, in the process, losing any of the benefits of current federal standards and tax preferences for employer-group insurance.

The second part is an accompanying shift of taxpayer funding for the uninsured from a provider-centered, and largely opaque and unaccountable, reimbursement approach to a more transparent, consumer-centered system of premium support for the purchase of private health insurance.

However, it is not only this significant departure from the health policy status quo that has generated so much interest in the Massachusetts approach. It is also the fact that Massachusetts implements this fundamental policy shift using two new tools.

The first is the creation of a health insurance exchange, or Connector as they call it, to serve as the administrative mechanism for both the employer shift from defined benefit to defined contribution and the government shift of subsidies for the uninsured to hospitals and other health care facilities to a new system of premium support to individuals to get health insurance coverage.

The second is that lawmakers, having first made insurance more accessible and affordable, impose on residents a legal obligation to take responsibility for funding their own medical care.

But before exploring further the contentious issue of Massachusetts' individual mandate and the other reform details, it is important to examine the fundamental logic behind the reform design more closely. Why would Massachusetts or any other state want to reorganize its health system around the principle of consumer choice and ownership of health insurance? There are at least five very good reasons.

Better Value for the Money. The first reason is to get the system to deliver better value. Market-oriented health reformers have long argued for improving the health care value proposition by making consumers, as opposed to employers or government, the ultimate decision-makers in the system. It is only when the users and the payers are one and the same that the incentives in the health care system will be properly aligned to produce better value—that is, better results at better prices.

One method is through reforms that empower consumers to purchase more of their care directly. That is the rationale for expanding options like health savings accounts (HSAs) and health reimbursement arrangements (HRAs). But such reforms, while important, are not the whole answer.[2]

The key change that will bring the rest of the system into a rational alignment of economic incentives is to shift the basic organizing principle to one of individual decision-making—specifically, consumer choice and ownership of health insurance coverage. Then, depending on personal preferences, any given consumer's health insurance choice may or may not entail more direct purchase of care.

If the insurance carrier is made the agent of the consumer, as opposed to the agent of the employer

1. David Hyman, "The Massachusetts Health Plan: The Good, the Bad, and the Ugly," Cato Institute *Policy Analysis* No. 595, June 28, 2007, at *www.cato.org/pub_display.php?pub_id=8431*.
2. For a brief discussion of the role of consumer-driven products in health reform, see Nina Owcharenko, "Getting Health Savings Accounts Right," Heritage Foundation *WebMemo* No. 1127, June 14, 2006, at *www.heritage.org/Research/HealthCare/wm1127.cfm*, and Greg D'Angelo and Robert E. Moffit, Ph.D., "Building on the Successes of Health Savings Accounts," Heritage Foundation *WebMemo* No. 1239, October 20, 2006, at *www.heritage.org/Research/HealthCare/wm1239.cfm*.

or the government, it becomes much less important who writes the check to the doctor, the hospital, or any other medical professional.

In other words, in a consumer-choice market, whether any given consumer opts for an HMO, or a high-deductible plan with an HSA, or a preferred provider organization (PPO) plan, or an indemnity plan becomes simply a matter of personal preference and risk tolerance. Regardless of the plan choices of individual consumers, the whole market functions better because it is the consumers, and not their employers or government, making those choices. In a consumer-choice system, all plans, regardless of their scope or design, must serve the interests of consumers and must compete to provide consumers with good value for their dollars.

The issue of reforming public education offers a good analogy. Children certainly get a better education if their parents are more involved and engaged in their school and its curriculum. But to transform the system substantially and produce better results on a large scale, it is necessary that parents gain *direct* control over the funding of their children's education and the ability to choose which school they will fund. Truly transformative change will occur only if the educational system is reorganized around the principle of parental choice made possible through education vouchers.

In the same way that education vouchers make schools the agents of parents, consumer choice and ownership of health insurance makes health insurers the agents of patients. It is that fundamental change, above all others, that can truly transform the whole health care system.

Erosion of Employer-Sponsored Insurance. A second good reason a state would want to shift to a consumer-choice model is that the old employer-based model is steadily and irreversibly eroding. Today, only 60 percent of workers are covered by employer-sponsored insurance, and among those working in firms of 10 or fewer employees, the share has declined to 48 percent.[3]

Whatever advantage the arrangement may still hold for large employers, it obviously isn't working for small business. Absent the federal government requiring all employers to provide health insurance—a move that is as unlikely as it is ill-advised—the employment-based system will be replaced either by a continued expansion of government health insurance programs or by a reorganization of the private market to better meet the needs of workers and their families, especially those employed by small businesses.

Prevalence of Non-Traditional Employment. A third, and closely related, reason for shifting to a consumer-choice model is to better accommodate non-traditional employment patterns. The underlying premise of employer-sponsored health insurance is that the worker has one full-time job with an employer big enough to provide and administer job-based benefits. But that premise doesn't hold true for many individuals and families—those with part-time jobs, multiple jobs, seasonal employment, or temporary or contract work.[4]

Nor are these non-traditional employment patterns prevalent in only a few sectors. Rather, they occur among employers of all sizes, from the very small to the very large. They also occur among individuals and families with a wide range of incomes, and not just low-wage workers, and they occur among all sectors of the economy, including ones dominated by large employers such as manufacturing or government, and not just sectors such as retail, tourism, or agriculture.[5]

A system of individual and family ownership of health benefits does a better job of accommodating these economic realities, just as IRAs and 401(k) plans already do for retirement benefits.

Continuity of Coverage and Care. A fourth reason to shift to a consumer-choice model is to

3. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2006 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 298, October 2006, Figure 11, at *www.ebri.org/pdf/briefspdf/EBRI_IB_10a-20061.pdf*.
4. *Ibid.*, Figure 13.
5. U.S. Department of Labor, "America's Dynamic Workforce," Chapter 5, August 2006, at *www.dol.gov/asp/media/reports/workforce2006/ADW2006_Full_Text.pdf*.

reduce coverage disruptions. Far from being a static population, there is high turnover among the uninsured as individuals constantly lose and gain coverage.[6] Studies also show that the frequency and duration of coverage gaps vary widely. Initiatives designed to cover the uninsured will invariably be frustrated by the constantly changing target population if they don't start by first establishing a system of more stable and continuous coverage for the general population.

If the state's health care system is reformed so that health insurance attaches to individuals and not to jobs, a significant portion of the uninsured will be able to get and keep coverage without the need for additional public subsidies. Policymakers can then better target existing public spending through premium support to assist the remaining lower-income uninsured.

Greater continuity of coverage is also a precondition for greater continuity of care. It encourages longer-term relationships between consumers and insurers and doctors. Longer-term relationships create new incentives for insurers to invest in more preventive care and disease management and to engage in collaborative, rather than adversarial, initiatives with doctors and other medical professionals to redesign coverage and payment systems to produce better health outcomes for patients at reduced costs.

Real Competition. Finally, the fifth reason a state would want to shift to a consumer-choice model is that it is a precondition to removing obstacles to greater competition among medical professionals delivering health care services—competition to devise not only ways of reducing costs, but also ways of improving quality and outcomes. This is particularly true when it comes to the current system of financing uncompensated care largely through hospital emergency rooms. The creation of Medicaid and Medicare, combined with increases in the costs and complexity of care resulting from advances in medical science, and the imposition of a federal treatment mandate under EMTALA[7] have collectively produced the current situation wherein the vast majority of residual "charity care" in the U.S. health system is delivered in hospital emergency departments.

There are those who at least seem to be quite comfortable with the current situation. They argue, in one forum or another, that uncompensated care costs are small and manageable—around 5 percent of total health spending—and that given the availability of care, regardless of a patient's ability to pay, it is unnecessary or even undesirable to make covering all of the uninsured a legitimate policy goal. Indeed, some might even argue that the relatively less attractive circumstances associated with obtaining "free" care through an emergency room serve as an inducement to buy health insurance.

Yet while those points may have some validity, they overlook the negative collateral effects of continuing the current policy. One inescapable result of making hospital emergency rooms America's *de facto* health care safety net is that many hospitals are effectively deemed "too important to fail." For if society is counting on those hospitals to provide this essential public service, then they must be kept open—and since "free care" isn't really "free," it must be funded either through explicit public subsidies or cost-shifting to private payers, or a combination of both.

Therefore, hospitals need to be publicly subsidized and allowed to overcharge private patients to keep their doors open, regardless of their cost structures or the quality of care they provide. Furthermore, anything at all that might threaten those existing funding arrangements, and thus the survival of the hospital, must be avoided.

Ladies and gentlemen, as you wander down that logic path, you will find, one after another, virtually all of the justifications for numerous anti-competitive policies and arcane health care regulations from state "certificate of need" laws (designed to restrict the supply of medical services under the guise of cost control), to the government prohibitions on the building of specialty hospitals without ERs, to

6. Pamela Farley Short and Deborah. R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No.6 (2003), pp. 244–255.

7. Emergency Medical Treatment and Active Labor Act of 1986, 42 USC 1395dd *et seq*.

Medicare's hospital price-setting methodologies, to, for example, the state of Maryland's all-payer hospital rate-setting scheme that systematically overcharges every purchaser of every hospital service by 8 percent to cover the cost of uncompensated care.

It is also down this path that we find the justification for the tens of billions in federal and state tax money being shoveled out to hospitals to offset their uncompensated care costs, with virtually no transparency and no accountability. Today, that cost to America's citizens is in excess of $40 billion annually.[8]

But if our *de facto* health policy is that numerous "essential" hospitals need to be propped up with a complex web of direct subsidies, institutionalized cross subsidies, and all manner of complex regulation, why should we think that such arrangements will ever produce a high-value health system that delivers better quality at a better price? In short, how can we have robust competition based on value if numerous hospitals can't be allowed to fail in a competitive market?

Furthermore, because the EMTALA mandate applies only to hospital emergency departments, it also has the distorting effect of shifting more care to that venue and away from lower-cost, and often more appropriate, alternatives such as clinics and physician offices. In the case of individuals with chronic conditions, that shift often produces less continuity of care, resulting in poorer outcomes and higher system costs.

Thus, converting hospital uncompensated-care subsidies into a system of premium support to aid the low-income in buying coverage is a precondition for creating value-focused provider competition. Once nearly all residents have insurance coverage—and particularly if individuals choose and own their coverage—policymakers can insist that hospitals start earning their money the old-fashioned way, by competing to offer customers good value, and begin dismantling the regulatory edifice propping up some providers and shielding them from competition.

All of the forgoing five rationales are applicable to Massachusetts as well as any other state. What differs is the relative importance each state will attach to each rationale. For example, the high cost of care and lack of provider competition in Massachusetts, as noted by Professor Hyman, led its policymakers to put greater emphasis on provider competition and transparency in their reforms. Another state with, say, a greater share of its economy organized in very small businesses would likely place greater emphasis on features that provide continuity and portability of coverage for workers in small firms.

Learning from the Prototype

The next category of considerations is those elements of the Massachusetts reforms that constitute a prototype design on which other states can improve. There are at least three such areas: the insurance market rules, the functions of a health insurance exchange, and the personal responsibility provisions.

Shifting to a consumer-choice health insurance market in any state necessitates some degree of insurance market reform. The fundamental question, once again, is this: Who is to be the key decision-maker in the system? If a state wants to create a system in which the *customers* choose the health plan instead of the health plans choosing their customers or employers or government making decisions for people, it must first transform the current supplier-driven health insurance market into a buyer-driven market.

Indeed, a number of current problems can be traced to two features of the existing supplier-driven market. First, in a supplier-driven market, there are some customers the suppliers don't want because they are not as profitable, such as a person in poor health. Second, there are some customers who are quite desirable, but they are difficult and expensive for suppliers to reach, such as a young healthy individual with two part-time jobs.

A buyer-driven market makes it easier for desirable but marginal customers to participate. But it

8. Jack Hadley, Ph.D., and John Holahan, Ph.D., "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004, at *http://covertheuninsured.org/media/research/KaiserReport.pdf.*

also means that less desirable customers get to have a personal choice of health coverage as well. This is inevitable because one can't expect the healthy to buy coverage today without assurances that they will still have choice of coverage in the future should their health status decline.

Insurance Rules. Thus, in shifting to a consumer-choice health insurance market, policymakers need to first establish a set of coverage rules that are broadly considered "fair" to both consumers and health insurers.

First, the fairest way to rate the coverage should be on an age, geography and family status basis. Family status simply reflects the number of dependents of the primary policyholder, and geographic differences in premiums reflect differences in the underlying local cost of care. Broad age rating is also roughly "fair" inasmuch as people generally both consume more health services and earn more money as they age in the workforce.

Because Massachusetts' lawmakers were unwilling to move away from that state's narrow community rating rules, it will be more difficult for them to persuade younger, healthier individuals that coverage is a good value. However, most other states don't have Massachusetts' narrow community rating, so they will not need to change as much in their insurance rating rules.

Second, in a buyer-driven market, it will be necessary for coverage to be available on a limited guaranteed-issue basis. Again, it is a question of establishing rules that are broadly viewed as "fair." A reasonable set of rules is to specify that coverage is available on a guaranteed-issue basis at standard rates, but *only* in certain circumstances, such as during annual open season. Furthermore, it should be stipulated that individuals need to first "earn" their right to choose coverage at standard rates either by showing evidence of 18 months or more of prior creditable coverage or by being subject to rating surcharges and pre-existing condition exclusions for an initial period of several years.

Because Massachusetts' lawmakers opted not to modify their state's existing broader guaranteed-issue coverage rules in this way, they again made it far more difficult on themselves to persuade residents to buy coverage when they are healthy.

Third, the rating rules I suggest here raise understandable insurer concerns over possible selection effects once consumers can choose their preferred coverage during an annual open season. The problem of adverse selection in any health insurance market where diverse individuals of differing health status can choose health plans is very real.

The best way to address those concerns is for the state to work closely with carriers to design a risk transfer pool. Such a pool would work just like a state high-risk pool, but with the difference that the claims, but not the individuals, would be transferred to the pool and the excess costs redistributed proportionately among all policyholders. That way, any given insurer would be compensated if it got a disproportionate share of high-cost claims or individuals, but individuals would still retain the same choice of coverage, including those who later experience high claims or deterioration in their health status.

While the continuation of narrow community rating and broad guaranteed issue in Massachusetts makes it more difficult to persuade the young healthy to buy coverage, it also means that the state did not need to include such a risk transfer mechanism in its reform design, since plan selection effects are likely to be less. However, the better and safer option would be for other states looking to reform their health insurance markets to include a risk transfer pool in any similar reforms.

Functions of the Connector. The next area in which other states could improve on the Massachusetts prototype is with respect to the administrative mechanism—the "Connector" or health insurance exchange—for facilitating the major shift to a consumer choice market.

To start with, Massachusetts chartered its Connector as a quasi-public entity. While some other states might have reasons for doing the same, most state officials will likely prefer to charter it as an independent, private entity. In any event, many, if not most, of the functions of the Connector can be contracted out to private-sector vendors as the Massachusetts Connector has done in several instances.

However, regardless of corporate form, other states can avoid some of the unnecessary tensions and technical difficulties encountered by the Massa-

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chusetts Connector either by not delegating *any* governmental functions to an exchange or by separating the funding and supervision of any delegated governmental functions from the exchange's basic administrative function.

Examples of governmental functions include asking the exchange to design a payment scale for low-income subsidies or instructing the exchange to conduct eligibility verification for Medicaid or SCHIP[9] applicants. To be sure, state lawmakers may sometimes have very good reasons for wanting a health insurance exchange to take on a governmental function. For example, they may want the exchange to serve as a clearinghouse not only for private insurance plans, but also for government programs as a way to ensure more coordinated coverage for the population. Still, if lawmakers choose to assign an exchange any governmental functions, they should ensure that those functions are paid for separately out of the state's budget and not included in the administrative fee paid only by those purchasing private coverage through the exchange.

Indeed, one obvious flaw in the Massachusetts legislation is that the Connector is required to pay the state Medicaid department for the costs of determining premium support eligibility and administering payments for individuals receiving subsidies to buy coverage through the Connector. That is exactly the opposite of how a state should structure and fund such an arrangement.

Another lesson for other states from the Massachusetts prototype is to more clearly delineate regulatory responsibilities. Specifically, states should keep insurance regulation in their insurance departments, where it belongs. Having an exchange negotiate coverage with plans or otherwise set plan standards only invites confusion, delay, and opportunities for mischief. The better approach is for states to have the insurance department administer all rules and regulations established by the state that apply to coverage sold through an exchange. That way, it is clear to all that the exchange only offers for sale those insurance products approved by the state insurance department in accordance with state law—nothing more and nothing less.

Personal Responsibility. A final prototype issue is the contentious one of the Massachusetts individual mandate or similar "personal responsibility" provisions.[10] Clearly, as long as there is a federal mandate on hospitals to treat patients regardless of ability to pay, there will be an incentive for some to forgo purchasing health insurance and, if they need care, to try to stick others with the bill. Insurance reforms and premium support can never completely counter that incentive. Thus, state governments will inevitably have to consider some mechanism for enforcing personal responsibility if they are to escape would-be "free-riders" imposing not only their direct costs, but also the bigger, indirect costs—such as the cost of propping up uncompetitive providers—on the rest of us.

Here, too, the Massachusetts experience is instructive. Governor Romney did not propose a health insurance mandate.[11] What he proposed was that those who still insisted on going without coverage in a reformed system demonstrate proof of their willingness and ability to pay their own bills by posting a bond or establishing an escrow account. The Massachusetts legislature replaced those provisions with a requirement that individuals buy health insurance or be fined—essentially an individual "play or pay" requirement.[12]

I contend that the governor had the better idea, on both philosophical and economic grounds. Other states will likely improve on the Massachusetts prototype by developing still different approaches. However, regardless of the specific mechanisms and their relative merits, the larger issue is important.

9. State Children's Health Insurance Program.

10. For a brief discussion of mandates and the "personal responsibility" principle, see Robert E. Moffit, Ph.D., "Individual Taxpayers Already Under a Mandate," *Des Moines Register*, March 3, 2007.

11. An Act to Increase the Availability and Affordability of Private Health Insurance to the Residents of the Commonwealth, HD 4673, Massachusetts General Court, 2005.

12. An Act Providing Access to Affordable, Quality, Accountable Health Care, Acts of 2006, Chapter 58, Commonwealth of Massachusetts.

Put simply, one cannot expect the system to work well if individuals are allowed to *privatize* the benefits of their actions and *socialize* the costs.

The same issue is involved in Social Security reform, where reform advocates, such as those at Heritage and Cato, have argued for replacing the current tax-financed system with a system of mandatory private savings. I am obliged to note that in recent years, Cato has produced a number of papers advocating this concept of mandatory private retirement savings in lieu of Social Security and has deployed various sound arguments for such an approach, including the following:

> A system of personal retirement accounts would minimize problems of perverse incentives by virtue of the fact that a means-tested safety net would serve only as an adjunct to the main retirement system based on mandatory private savings. Absent a requirement to set aside money in personal accounts, a means-tested benefits program for retirees would create a "moral hazard" problem: workers would have an incentive to "game" the system and consume their incomes earlier rather than save sufficiently for retirement.[13]

Of course, this logic is even more applicable to the creation of a consumer-choice system of private health insurance within the context of the moral hazard created by a federal mandate on hospitals to treat patients regardless of their ability or willingness to pay for their own care—or even their legal status in the U.S.

Last, there are a number of considerations that are Massachusetts-specific. They either involve issues that may not be present in another state or issues for which each state must customize its own solutions. I include in this category most of the particulars of the premium support program, such as coverage benefits, income eligibility thresholds, and the rules and timetable for transitioning the uninsured into subsidized coverage.

I would also include in this category the "employer mandate" provisions, since they are almost entirely symbolic politics, are easy for employers to avoid, and would be thrown out as violating ERISA[14] if anyone ever went to the effort and expense of bringing a case against them in federal court.[15] The legislation also includes several boards and commissions that, while they involve health care, are completely incidental to its core reform elements.

The Massachusetts Record Thus Far

Barely one year later, the Massachusetts reforms are still in their start-up phase. Nonetheless, we do have some sense of how implementation is going.

1. After receiving bids from 10 carriers, for the first plan year, six different carriers are now offering 42 plan options through the Connector for the unsubsidized population, and enrollment in those plans began on May 1.[16] That's approximately 41 more options than most Americans have today. Nationally, 80 percent of companies offering health benefits provide workers a choice of one plan—take it or leave it. Outside of federal workers in the Federal Employees Health Benefits Program, Massachusetts citizens getting health insurance through the Connector are among the only group of Americans who can shop in a competitive health insurance market with such a broad range of health care choices.

   Pre-reform, the lowest premium for a typical uninsured 37-year-old in Boston was $335 per month with a $5,000 annual deductible. Now,

13. Will Wilkinson, "Noble Lies, Liberal Purposes, and Personal Retirement Accounts," Cato Institute *Social Security Choice Paper* No. 34, June 28, 2005. See also Michael Tanner, "The 6.2 Percent Solution: A Plan for Reforming Social Security," Cato Institute *Social Security Choice Paper* No. 32, February 17, 2004; David Altig and Jagadeesh Gokhale, "Social Security Privatization: One Proposal," Cato Institute *Social Security Choice Paper* No. 9, May 29, 1997; and Martin Feldstein, "Privatizing Social Security: The $10 Trillion Opportunity," Cato Institute *Social Security Choice Paper* No. 7, January 31, 1997.
14. Employee Retirement Income Security Act of 1974, Pub.L. 93-406, 88 Stat. 829, September 2, 1974.
15. William G. Schiffbauer, Esq., "Hiding in Plain View: ERISA Preempts Provisions of Massachusetts 'Play or Pay' Health Care Reform Law," Bureau of National Affairs *Health Care Policy Report*, Vol. 14, No. 37 (September 18, 2006).
16. *Ibid.*

through the Connector, the same individual can get health coverage for $184 per month ($118 pre-tax) with a $2,000 deductible—well below the $250 a month target set back when the legislation was being developed.[17] Indeed, most can get a health plan worth twice the value at half the price.

But had the state allowed health plans into the Connector on an "any willing plan" basis and not required the board's "seal of approval," certifying all plans already approved by the state's insurance commissioner, Massachusetts residents might have had even more choices and a more competitive marketplace. Moreover, had the legislature done more to revisit the inflexible regulatory regime in Massachusetts, including 43 benefits mandates,[18] health insurers could have offered residents still more variety and even more affordable products.

2. In the past year, the number of uninsured in Massachusetts has been reduced by 34 percent.[19] As of June 1, enrollment of the uninsured eligible for subsidized coverage through the Commonwealth Care program was 78,900—ahead of the target set of enrolling half the eligible population (70,000) by July 1, 2007—and as of July 1, enrollment was 92,046.[20]
3. For the year to date over the prior period (October 2006–May 2007), uncompensated care pool utilization has decreased by 12.8 percent, and the associated hospital costs are already down by 9.3 percent.[21]
4. After much debate, the Connector board established a "minimum creditable coverage" standard for determining whether individuals meet the individual mandate to obtain insurance. The standard is unnecessary but reflects the peculiar political and regulatory climate in Massachusetts. Because of its negative impact on a number of existing health plans, the board thus delayed imposition of these standards until 2009, which is a welcome development. Nonetheless, the comprehensiveness of the final regulations could, by 2009, lead the state to deem as many as 200,000 individuals currently covered by employer group insurance as having insufficient coverage to be in compliance with the mandate.[22] This includes an estimated 90 percent of employees in union-managed plans.[23]

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17. Commonwealth of Massachusetts Executive Department, "New Health Plan Will Be Available for Under $200," press release, March 3, 2007, at *www.mass.gov/?pageID=hicmodulechunk&L=1&L0=Home&sid=Qhic&b=terminalcontent&f=mcc_pr&csid=Qhic*, and Jon Kingsdale, "Massachusetts Health Reform," Commonwealth Connector, June 11, 2007.
18. Victoria Craig Bunce *et al.*, "Health Insurance Mandates in the States 2007," Council for Affordable Health Insurance, at *www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf*.
19. This represents an increase in covered individuals of about 125,000 relative to the findings of the prior year's state insurance coverage survey, which estimated 372,000 uninsured Massachusetts residents as of early 2006. See Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, "Section 1115 Demonstration Project Extension Request," June 29, 2007, at *www.mass.gov/Eeohhs2/docs/eohhs/cms_waiver_2007/ma-1115-extension.pdf*, and Massachusetts Division of Health Care Finance and Policy, "Health Insurance Status of Massachusetts Residents, Fifth Edition," December 2006, at *www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/res_06_report_5th.doc*.
20. Commonwealth Connector, "Commonwealth Care: Progress Report," June 5, 2007, at *www.mass.gov/Qhic/docs/CommCare%20Progress%20Report%206-5-07.doc*, and "Commonwealth Care: Progress Report," July 12, 2007, at *www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520board%2520meeting%2520July%252012%252C%25202007/CommCare%2520Progress%2520Report%25207-12-07.doc*.
21. "Section 1115 Demonstration Project Extension Request," June 29, 2007, and personal communications with Caroline W. Minkin, Policy Manager, Uncompensated Care Pool, Division of Health Care Finance and Policy, Massachusetts Department of Health and Human Services, August 22, 2007.
22. Alice Dembner, "State May Give Insured More Time to Upgrade; July Still Deadline to Have Coverage," *The Boston Globe*, March 16, 2007.
23. *Ibid.*

However, as the Massachusetts experience demonstrates, state officials should expand, not constrain, choice of health plans and at the very least allow individuals and employers to keep what they already have today. My colleagues[24] and I have suggested that other states could avoid this conundrum by applying a more basic existing standard for "creditable prior coverage" contained in the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA). Such a standard would apply broad parameters set in current law defining what constitutes a "major medical" plan without further restricting benefit design or increasing insurance costs on individuals.

5. Again, due to Massachusetts' peculiar political and regulatory climate and the governmental authority the state legislature gave the Connector, the Connector board, in addition to setting a comprehensive standard for minimal creditable coverage, also established an "affordability schedule" or threshold for what constitutes an "affordable" level of personal expenditure on health insurance and medical care.

   According to Jon Kingsdale, executive director of the Connector, defining an affordability scale was the "most difficult element" of the reform. It was contentious but ultimately resulted in a unanimous "compromise" by the board to increase subsidies for 52,000 low-income residents and then exempt approximately 60,000 unsubsidized residents from being penalized by the state if they fail to comply with the mandate on the grounds that the board deemed them unable to afford minimum coverage.[25]

   Even so, the mandate will continue to apply to 80 percent of the currently uninsured and 99 percent of all Massachusetts residents.[26] Moreover, although the state will exempt these residents from the penalties for failing to obtain coverage, nothing precludes them from actually obtaining insurance if they themselves consider it affordable.

   In fact, Jonathan Gruber, a Massachusetts Institute of Technology economist who sits on the board, was initially opposed to the compromise because he thought "people could afford health insurance at higher levels."[27] Gruber, in his own assessment of the earlier affordability definition before the compromise, produced research that shows that the subsidized could have afforded coverage and even spent more than they would have been required to, and the unsubsidized should also have been able to obtain minimum creditable coverage.[28] Additionally, Len Nichols, a health economist at the New America Foundation, considered the "compromise" affordability standard generous, noting that a sliding scale defining affordability as only having to spend 5 to 10 percent of income on health insurance premiums is well below the 17 percent of income the median household currently dedicates to total health care costs.[29]

Much more remains to be done as the reforms continue to be phased in over the next two years, but the political will to work through the difficult job of implementing the plan and to make the necessary revisions and compromises along the way remains strong. It appears for now that Massachusetts remains on track to put in place a reformed system tailored to that particular state.

The lesson for other states is that reform based on the principles of consumer choice and ownership of health insurance is feasible, though lawmakers and

24. Robert E. Moffit, Ph.D., "The Massachusetts Health Plan: An Update and Lessons for Other States," Heritage Foundation *WebMemo* No. 1414, April 4, 2007, at *www.heritage.org/Research/HealthCare/wm1414.cfm#_ftn12*.

25. Alice Dembner, "Health Plan May Exempt 20% of the Uninsured," *The Boston Globe*, April 12, 2007.

26. *Ibid.*

27. *Ibid.*

28. Jonathan Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance," March 2007, at *http://econ-www.mit.edu/files/128*.

29. Julie Appleby, "Mass. Health Plan Cost Rules Exempt 20%: Affordability Index Cuts Penalty for Lowest-Income Uninsured," *USA TODAY*, April 13, 2007, at *www.usatoday.com/printedition/money/20070413/4b_mass13.art.htm*.

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stakeholders will have to negotiate and compromise the details to suit their own unique circumstances. In the end, the ultimate test will be if, over the next several years, such a consumer-choice model can begin to deliver the better-value health system we all desire.

Conclusion

I generally agree with Professor Hyman's analysis of the Massachusetts reforms as containing a mixture of "the good, the bad and the ugly." My main quibble is that such an analysis, while technically correct, fails to provide the proper perspective.

As I have argued here today, I think it is terribly important that a state—and one of the most politically liberal in the nation at that—has now committed to fundamentally restructuring its health system around the principle that individual consumers, and not employers or government, should be the key decision makers and owners of insurance in the health care system.

To my thinking, that is a very significant shift in the health policy debate, and it is worth replicating elsewhere the core design elements that effectuate such a profound change. As for the details, their importance lies largely in what insights they may offer for making further improvements in the next versions of the basic model.

As I was thinking how to express this concept, an analogy occurred to me, which I shall close by sharing with you.

On December 17, 1903, Wilbur and Orville Wright made the first sustained, controlled flights in a powered aircraft. Their four flights that day ranged from at first only 120 feet to finally 852 feet. It is also true that their 1903 Flyer was underpowered and difficult to control. Indeed, there was a bit of the ugly about it as well, such as the elevators stuck out on spars in front of the wings.

But a century later, it is not those things that are remembered. Nor do we attach much significance today to the fact that the propellers were on the back, pushing the aircraft, or that they were driven using bicycle chains, or that the homemade, four-cylinder engine had no carburetor.

No, what is significant is that, having engineered over the previous two years solutions to the last big obstacles, a propeller design capable of generating enough thrust to keep their craft aloft and a system of rudders and elevators that enabled the pilot to maneuver it in any direction, one cold December day on a North Carolina beach, the brothers from Dayton Ohio, by turns, climbed into their contraption—and flew!

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