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The Massachusetts Health Plan: An Update and Lessons for Other States

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Massachusetts's experiment in health market reform is already showing progress. The average Massachusetts resident without health insurance will soon be able to obtain coverage for $175 per month through the state's Connector, a health insurance exchange for individuals and small businesses.[1] Because the Connector can accept pre-tax defined contributions, many will secure even lower premiums. A middle-class individual, for example, whose employer designates the Connector as its employer plan, could purchase that same health coverage for just $109 per month.[2] In addition, that individual would be able to choose from a variety of carriers and plans and maintain coverage from job to job—aspects of control that few Americans have today.[3] These early results demonstrate the dividends of state-level experimentation. Other states would do well to learn from Massachusetts's example, observing what works and what does not, and craft reform plans to meet the needs of their citizens, adjusted for their political culture and legal arrangements.

Lower Premiums. Massachusetts's latest premium estimates are dramatically lower than projected in a widely reported January 2007 memorandum that foresaw $380 per month individual premiums.[4] The current estimates are in line with the original projection of approximately $200 per month targeted by former Massachusetts Governor Mitt Romney in 2006, when he first advanced his health care reform proposal. In 2005, the average monthly premium for a single person in the Massachusetts small group market was $350.[5]

Seven insurance carriers thus far are set to compete for consumers' dollars in the new Connector, offering new plans, such as high deductible plans with premiums as low as $153 per month, and more health plans are expected. The competing plans will have a variety of co-payments, deductibles, and out-of-pocket payments.[6]

While Massachusetts has had a long tradition of heavy health care regulation, former Governor Romney was able to secure greater flexibility for the state's market. Five reforms were key:

1. Allowing insurers more flexibility to develop value-driven, tiered networks of health care providers;
2. Allowing insurers to offer products with higher annual deductibles and co-payments;
3. Allowing HMOs to offer health savings accounts (HSAs);
4. Creating a new class of more affordable health insurance products for persons ages 19 to 26 with dollar-limited annual benefits; and
5. Imposing a three-year moratorium on the imposition of new health benefit mandates.[7]

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The Massachusetts legislature also agreed to permit health insurers to factor participation in wellness programs and tobacco use into setting premiums. Altogether, these changes would hardly be considered revolutionary in many other states, but in Massachusetts they were significant. On the basis of these limited regulatory changes, plus revised estimates by Massachusetts's insurance carriers during the course of the 2006 state legislative debate, Romney projected a reduction in Massachusetts's health insurance costs.

The state's health care costs and insurance premiums could be reduced even further in future years as a result of provisions of the new law to establish greater transparency for consumers, including the publication of comparative data on price and quality. Those provisions were designed to address the fact that Massachusetts's cost of care is among the highest in the nation. The underlying cost of care is almost invariably the biggest factor determining the cost of health insurance in any given state.

The Problem of Government Benefit Setting. Notwithstanding the achievement of lower-than-expected health insurance premiums, Massachusetts is still burdened by excessive government control over benefit design. This inhibits flexibility in coverage and increases costs to individuals and families. Other states contemplating the adoption of a health insurance exchange like the Connector would be wise to review and repeal unnecessary insurance rules and outdated regulations as part of their efforts to expand private health insurance coverage and make it more affordable.[8]

As noted, the underlying cost of health care in Massachusetts is very expensive. This reflects the prevailing level of high wages in the state, the prevailing and expensive patterns of medical practice, and the relatively uncompetitive hospital market. These factors are aggravated by a level of government regulation over health care plans, such as 43 benefit and provider mandates, that is clearly excessive.[9]

The Massachusetts legislature also standardized benefit coverage for all citizens enrolled in the Commonwealth Care plan—that is, those who earn below 300 percent of the federal poverty level and are eligible for government assistance to purchase health coverage through the Connector.[10] The Commonwealth Care program is administered by the board of the Connector.

Outside of Commonwealth Care, insurers have more flexibility in structuring benefits for plans sold

1. The Commonwealth of Massachusetts, Executive Department, "New Health Insurance Plan Will Be Available for Under $200," *Press Release*, March 3, 2007.
2. *Ibid.,* p. 2. The Massachusetts premium estimate is based on the purchase of coverage for a 37-year-old person making $50,000 per year. Under the design of the Connector, an employer's defined contribution for private health insurance would be tax free, as it is today in conventional defined benefit health insurance plans. Moreover, individual employees can also take advantage of the general tax breaks under existing federal law by using an employer-based flexible spending account (a Section 125 account) from which individuals can make individual health insurance premium payments tax free to purchase a health plan through the Connector.
3. Only 23 percent of Americans have any choice of insurance carriers. See Alain Enthoven, "Employment Based Health Insurance Is failing: Now What?" *Health Affairs Web Exclusive*, May 28, 2003, p. W3-240.
4. The misleading $380 per month premium was leaked to the media and quickly seized upon by prominent critics of the Massachusetts reform, both liberal and conservative.
5. Hon. Timothy Murphy, Secretary of the Executive Office of Health and Human Services of Massachusetts, "Massachusetts Health Reform," presentation to The Heritage Foundation, April 10, 2006.
6. *Ibid.*, p. 3.
7. *Ibid.*
8. For a detailed discussion of what state officials should adopt and avoid in the Massachusetts health plan, see Nina Owcharenko and Robert E. Moffit, Ph.D., "The Massachusetts Health Plan: Lessons for the States," Heritage Foundation *Backgrounder* No. 1953, July 18, 2006, at *www.heritage.org/research/healthcare/bg1953.cfm*.
9. See Victoria Craig Bunce, J.P. Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in The States 2007," Council for Affordable health Insurance, 2007.

to non-subsidized individuals through the Connector. The Massachusetts Connector board, however, has two related responsibilities: granting a "seal of approval" for plans to market their coverage and determining "minimum creditable coverage" for persons in Massachusetts who will be required, as of July 2007, to buy private health insurance under the state's individual mandate.

The "seal of approval," or certification provision, adds another layer of regulatory approval for insurers seeking to offer coverage through the Connector on top of the provisions of state insurance law applied by the state's Department of Insurance. States considering similar reforms should avoid this duplicative feature in their reform designs. A simpler and fairer approach would be to allow plans to be offered through a state health insurance exchange on an "any willing plan" basis, meaning that a state's health insurance exchange would have to offer any plan that is certified by the state's insurance commissioner as meeting all the applicable requirements of state insurance law. At the same time, states should modify their basic health insurance laws as part of any broader health reform legislation that establishes a state health insurance exchange.[11] Blocking health plan entry, in any way, directly compromises the basic intent of a health insurance exchange and, thus, the efficiency of a market based on consumer choice and competition.

Regulatory Overreach. Likewise, the Massachusetts Connector board's authority to set a "minimum creditable coverage" standard for what constitutes acceptable coverage under the state's individual mandate is also problematic. Given the peculiar political culture of Massachusetts, this arrangement reflects the need to resolve the inherent conflict in the legislature's insistence that coverage be affordable *and* comprehensive. The result is that "affordable" coverage options are more expensive because they include more regulatory requirements for coverage. For example, the Connector board has recently started making decisions concerning the minimum level of drug coverage and lifetime caps on insurance, standards that are incompatible with plan offerings already marketed in the state. This new "minimum creditable coverage" standard could affect the existing insurance coverage of an estimated 200,000 Massachusetts residents, eventually making them pay *more* than they would otherwise. This number includes an estimated 90 percent of employees in union-managed plans.[12] In coping with this latest regulatory wrinkle, the Connector's board has recently agreed to grandfather in existing employer-based plans until 2009. Nonetheless, the latest set of rules includes nine provisions governing benefits, ranging from determinations of the acceptable level of preventive care to deductible levels for drug coverage.

As Massachusetts's experience demonstrates, health policy is riddled with unintended consequences. They can be costly, both economically and politically. In crafting any health care reform, state officials should make sure that they expand options, not contract them, and allow individuals and businesses that already have coverage to keep what they want.

Other states pursuing reform should avoid this type of problem by applying a more basic and less discretionary standard. A good alternative might be the standard for "creditable prior coverage" con-

10. For example, the law does not permit deductibles in health plans offered to persons receiving premium assistance. As Professor Mark Pauly, an economist at the Wharton School of the University of Pennsylvania, has remarked:

    > Getting decent coverage to almost everyone is a better initial goal than getting perfect coverage to fewer of the uninsured. Rather than focus on details of subsidized coverage—as Massachusetts seems to be doing because of its extensive list of coverage mandates—the initial focus should be on providing coverage of greater actual value than a given benchmark, leaving plan details to consumers, not special interests or public health experts.

    (Mark V. Pauly, "Is Massachusetts a Model at Last?" American Enterprise Institute, *Health Policy Outlook*, No. 1, January 2007, p. 3.)
11. For a discussion of this essential point within the context of a health insurance exchange, see Edmund F. Haislmaier, "Health Care reform in Maryland: Doing It Right," Heritage Foundation *Lecture* No. 1002, March 20, 2007, at *www.heritage.org/research/healthcare/hl1002.cfm*.
12. Alice Dembner, "State May Give Insured More Time to Upgrade; July Still Deadline to Have Coverage," *The Boston Globe*, March 16, 2007.

tained in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any health care coverage that meets the HIPAA standard would be automatically deemed to meet state standards. That would achieve the objective of ensuring that coverage is within the broad parameters of what is commonly considered a "major medical" plan (as opposed to a "limited benefit" plan), without unduly restricting benefit design or inadvertently increasing costs for individuals who already have coverage.

Lessons for Other States. Massachusetts achieved two major health policy breakthroughs: the creation of the Connector and the redirection, via a federal waiver, of existing government health care subsidies from institutions to individuals and families for private coverage.[13] The Connecter is a new market arrangement—a health insurance exchange—in which individuals and families can choose and own portable health insurance without the loss of the current generous federal tax benefits. The shift in focus to individuals and away from institutions, meanwhile, will progressively reduce reliance on uncompensated care. With modifications, both policy changes are exportable to other states, and imaginative state officials can use them to lay the groundwork for major expansions of private, personal, and portable health insurance coverage.[14]

With regard to the specific role of the health insurance exchange, state policymakers should take special care to avoid two specific problems:

1. **Do not create another regulatory hurdle on top of basic state insurance laws or create conflict with the authority of the state's existing insurance regulator.** The idea of the exchange is to serve as a mechanism for facilitating a consumer-driven health insurance system.[15] Any certification for plan participation in the new competitive market should be restricted to certification that health plans are licensed to do business in the state. This means, for all practical purposes, that the exchange should facilitate transactions for *any willing* health plan.
2. **Do not impose new comprehensive standard benefits on private plans.** A notable weakness of the Massachusetts Connector's design is its board's administrative determination of "minimum creditable coverage." This carries the potential to undermine the flexibility of plan offerings and increase costs, frustrating choice, competition, and affordability of coverage. A far better option is to leave with the state's insurance regulator the job of certifying that all plans meet basic state standards such as fiscal solvency, market conduct, coverage of basic benefit categories, and consumer protection against clearly unreasonable provisions such as excluding catastrophic expenses. Generally, states already have these laws on their books, and their insurance regulators already administer them. While many state lawmakers may have good reasons to modify their states' basic insurance rules as a part of reform, they should adhere to the principle that any changes should be clear, predictably administered, and uniformly applied. At the end of this process, there should be fewer rules, not more.

Conclusion. Massachusetts enacted a major reorganization of its health insurance market to allow, for the first time, small business employees the right to own personal and portable health insurance that they can take from job to job without a loss of tax benefits. While the recent premium estimates for health plans are in the range of those orig-

13. While this is the right direction for policy, implementation would be improved if the subsidy were a direct voucher for individuals and families that they could apply to their chosen plan rather than a subsidy embedded in the premium.
14. For a discussion of both policy breakthroughs, see Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way To Restructure State Health Insurance Markets and Public Programs," *Health Affairs*, Vol. 25, No. 6 (November/December 2006), pp. 1580–1590.
15. This means that the functions of the health insurance exchange would be limited to preparing descriptions of competing health plans for distribution to employers and employees; enrolling employers, employees, and their families; disseminating information and enrollment procedures; collecting and transmitting health insurance premiums; and administering any government subsidies or premium assistance for eligible enrollees.

inally targeted by former Governor Mitt Romney, current Massachusetts law still unduly limits the flexibility of health insurers in offering varied and even more affordable products.

The implementation phase of the Massachusetts Health Plan will continue for at least another three years. To their credit, Massachusetts officials and lawmakers recognize that they will need to make further adjustments to their reform design as it is implemented.

The major lessons for other states considering similar insurance market reforms are to pay particular attention to ensuring regulatory simplicity, clarity, and predictability and to permit insurers to offer consumers a wide range of alternative benefit designs. These policies enable individuals and families to obtain the coverage that best suits their personal preferences and circumstances.

In pursuing health care reform, other states can build on the policy breakthroughs achieved in Massachusetts but will have to adjust the details of their reform design to account for their own special circumstances, such as their demographic patterns, the way the health care delivery system is organized, and how existing uncompensated care is funded and delivered. These, in turn, are shaped by the state's social and political culture.

Americans are the heirs of constitutional genius. Federalism offers structural opportunities for public policy innovation greater than those found in any other constitutional arrangement. The states have the flexibility to address their divergent needs and circumstances, and their initiative provides other state lawmakers with the opportunity to evaluate and learn from these experiences.

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