# "Massachusetts' Experience with Health Care Reform Coverage Initiatives in the Context of National Reform"

Statement before the U.S. Senate

Committee on Health, Education, Labor & Pensions

by

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Thank you for this opportunity to share my state's experience with health reform, in the context of your effort to expand financial access to medical care for the nation. My name is Jon Kingsdale and I am the Executive Director of the Commonwealth's Health Connector. This is an independent state authority, established under the landmark health reform law, Massachusetts' Chapter 58 of the Acts of 2006, as one of several state agencies charged with expanding health insurance coverage. The Health Connector operates two new coverage programs, makes policy and regulatory decisions, and orchestrates public outreach and education efforts.

Perhaps the most important lesson from Massachusetts' effort to achieve near-universal health insurance is to demonstrate that it can be done, here in the United States. Two years after Chapter 58 took effect, the state's uninsurance rate had fallen to just 2.6%, by far the lowest in the country and about one-fourth of what it had been prior to reform.[i] This is not quite universal coverage, but it is only one percent or so above the uninsurance rates of some European countries commonly considered to have "universal" coverage. In the course of implementing Chapter 58, we have learned many lessons and we continue to evaluate and re-think our reforms. We do not have any "silver bullets" to offer, but I would suggest five lessons from the Connector's experience that might help inform national efforts.

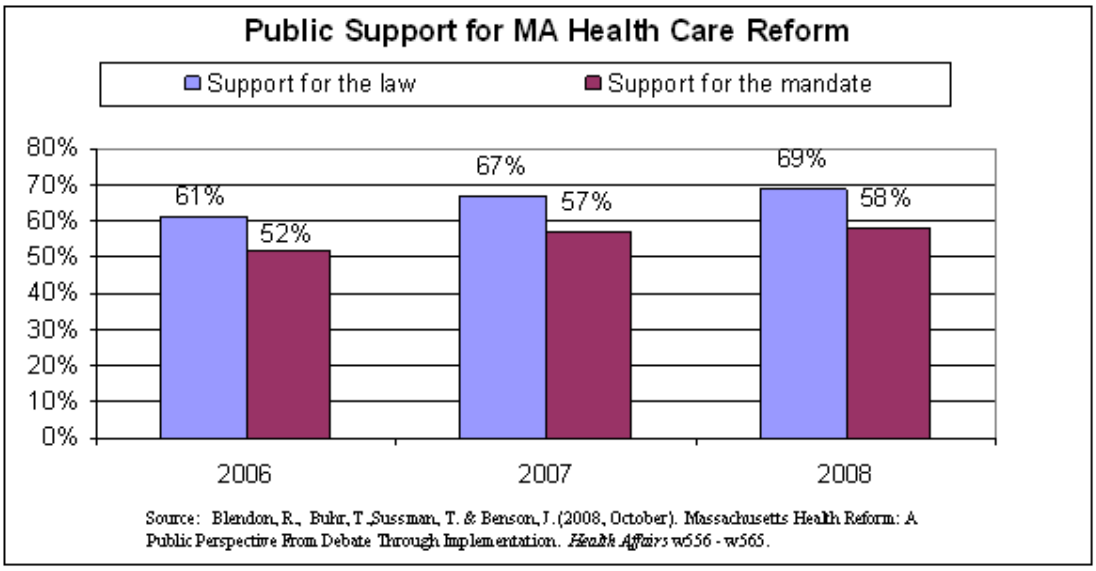
First, the individual mandate has proven essential to covering large portions of the uninsured. As evidence, I would cite the contrast with Hawaii, which enacted a mandate on employers and employees only. Yet, the rate of uninsurance there still fluctuates around 8%.[ii]

Not only does the individual mandate work to enroll those who might otherwise choose to remain uninsured—whether subsidized or not—it also works indirectly to lower the cost of insurance. The uninsured are disproportionately young, single male, and poor:[iii] some considerable numbers of them are quite healthy and prefer to take the chance of not being covered. As a result, these so-called "invincibles" do not contribute through insurance risk pools to subsidize those in poor health; moreover, when trauma or serious illness do strike the uninsured, they actually add to providers' bad debt and charity care, which is ultimately born by

premium-payers and taxpayers. Massachusetts has found ways to cover many the young "invincibles" at rates they can afford, and with coverage that helps lower premiums for others. Non-group enrollment in Massachusetts more than doubled in the year after the individual mandate took effect and, judging from the Connector's enrollment, some 55% of new, non-group enrollees were aged 17-35 and some 85% purchased single coverage.[iv]

The individual mandate is controversial. It polls less favorably than reform generally or than a mandate for children alone.[v] But it is the keystone of our reform. So, Massachusetts has taken special care to implement the requirement that adults have insurance, if affordable, in such a way as to build support for it over time. Importantly, it is enabled by complimentary initiatives, which exemplify our law's theme of "Shared Responsibility": (a) the commitment of employers with over 10 employees to make a "fair and reasonable" contribution toward group health insurance; (b) the commitment by government to subsidize insurance for low-income people without other access to coverage; and (c) the requirement that the larger health plans participate in the Connector and the non-group market, under regulations that guarantee issue and renewal of insurance policies using adjusted community rating.

The individual mandate is part of a broader commitment from various parties, including business and health insurers, to "Shared Responsibility." The second point I would make is that implementing health reform in Massachusetts is a campaign, built around this theme of "Shared Responsibility." Because individual responsibility is a critical element, which generates bi-partisan support and resistance, its acceptance cannot be taken for granted, but must be earned. Having done so, tax compliance is very high—98.6% in the first year—and the popularity of reform overall and even of the mandate have risen steadily.




As part of this campaign, Massachusetts phased in penalties for the mandate only after expanding new sources of coverage, and the Connector allows case-by-case exceptions to the individual mandate through a generous appeals process. We evaluate the results of our experiment, both to celebrate its victories and to identify and correct the problems. The state's

legislature follow reform's progress closely, even enacting follow-up reforms in 2008 (Chapter 305), and Governor Patrick has been has been steadfast in his support of Chapter 58 throughout this very challenging economic climate. The coalitions of interest groups that helped pass Chapter 58, on a bi-partisan basis and with nearly unanimous votes, continue to campaign for its implementation. These coalitions include liberal advocacy groups, employers and insurers. Third, because implementing this "experiment" is so challenging, Chapter 58 created new state entities to guide the reforms. Anything so ambitious as reforming one-sixth of our economy cannot be captured in a single piece of legislation, but involves some degree of trial and error, learning by doing. The Massachusetts legislature built a sturdy statutory framework for reform, but delegated many key policy determinations and provided the resources to oversee coverage expansions. It provided special funding for the first-year administrative activities of a half-dozen existing state agencies, capitalized the newly-established Health Connector, and authorized an ongoing source of administrative revenues for new programs.

Chapter 58 authorizes the Connector's semi-independent and broadly representative Board of Directors to make tough policy calls.[vi] The Connector conducts all its activities in public and very transparently, and it prides itself on being a "learning organization." For example, the Board defined "Minimum Creditable Coverage" and "Affordability" by unanimous votes in 2007, only to significantly revise these determinations in 2008 (also by unanimous votes). The Connector launched its small-group offering in early 2009 as a pilot, with a commitment to evaluate and revise it in light of preliminary experience.

By contrast, a statute is not a "learning organization" and Chapter 58 could not have anticipated the many twists and turns of implementing such complex change. Similarly, Senator Daschle has argued for delegating implementation of national health care reform to a new federal authority with expertise, independence and flexibility.[vii]

Fourth, properly constituted, resourced and empowered, an exchange can be a valuable component of a broader set of reforms. The Health Connector actually runs two different insurance exchanges, serving distinct functions and clients. Commonwealth *Choice* is a distribution channel for individuals in the non-group market to buy health insurance with their own money at premiums which are, by law, the same in or outside the Connector. "Commonwealth *Care*" offers a choice of plans, *purchased* by the Connector for uninsured adults earning 300% or less of the Federal Poverty Level (FPL)--to which some enrollees make a premium contribution, but those below 100% of the FPL do not. Commonwealth *Care* negotiates premiums and drives a hard bargain with its own dollars in a way that Commonwealth *Choice*, as a free-market exchange, simply cannot do.

Each program uses competitive solicitations and offers a choice of plans to enrollees at different price points. Both programs add value, but the two exchanges operate in very different ways, reflecting their different objectives, statutory rules, and target populations. If the Congress authorizes exchange(s) as part of broader reform, there are important decision points about how aggressive the exchange(s) should be in influencing premium rates, which populations an exchange should serve, whether the exchange(s) should try to stimulate change in the surrounding market, how best to promote coverage and inform the public about insurance, and whether there should be one national exchange or many state exchanges. These decisions must be coordinated with each other and the larger reform context. I have elsewhere supplied the Committee's staff with some thoughts on these questions.

The Commonwealth's Health Connector does enjoy considerable, though by no means total, independence from politics, and I would urge the Committee to consider the advantages of semi-independence for a public agency administering a market or exchange. On the one hand, an exchange's efficacy derives from its capacity, as a public agency operating in the context of larger reform, to exert market forces and prudent purchasing to improve the value of health insurance. On the other hand, its credibility and authority to improve competition and benefit consumers depends on its objectivity and independence from overt political influence. I would draw an (imperfect) analogy to the SEC, the Federal Reserve Board, and other such federal entities designed to improve the functioning of markets and cite, again, Senator Daschle's argument.[viii]

Fifth, as ambitious as Chapter 58 is, comprehensive reform was simply too much for Massachusetts to digest in one gulp. Rather, we are *trying* to sequence reform, starting with near-universal coverage and moving now to address costs. Massachusetts is very proud of having achieved 97.4% coverage, compared with a national average below 85%. Doing so has not exacerbated the underlying problems of run-away health care costs, shrinking supply of primary care clinicians, and fragmented, uncoordinated care which characterize American medicine. Neither has it solved these problems.

Having made the commitment to near-universal coverage, Massachusetts now confronts the challenge of controlling costs. This is the more difficult challenge. On the one hand, in enacting Chapter 58, the Commonwealth did not hold the uninsured hostage to first controlling medical costs. On the other hand, the Commonwealth will not be able to sustain near-universal coverage, if we cannot now control costs. So, we now confront costs from the moral high-ground of protecting near-universal coverage, but without any guarantee of success. The fifth lesson is that the nation must not hold the uninsured hostage to cost control, but that the nation will need a political strategy for progressing from the very difficult challenge of expanding coverage to the even greater challenge of controlling medical costs.

Comprehensive health reform is a marathon, not a sprint. Massachusetts has chosen to start with coverage and pace its reforms, but it also runs the risk of not finishing the race.

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[i] Long, S., Cook, A., & Stockley, K. (2009, March). *Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_access.doc

[ii] DeNavas-Walt, C., Proctor, B., & Smith, J. (2008, August). U.S. Census Bureau, Current Population Reports, P60-235, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Government Printing Office: Washington, DC.

[iii] Long, S., Cook, A., & Stockley, K. (2009, March). *Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2008 Massachusetts Health Insurance Survey*. Boston, MA: Division of Health Care Finance and Policy. Available online at, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_detailed_tabulations.pdf; and Massachusetts Department of Revenue (2008). *Massachusetts Department of Revenue, Data on the Individual Mandate and Uninsured Tax Filers*, Tax Year 2007. Boston, MA: Author. Available online at, http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/2007_Demographic_Data_Report_FINAL_(2).pdf

[iv] Commonwealth Health Insurance Connector Authority, Commonwealth Choice Enrollment Data.

[v] Sussman, T., Blendon, R.J., & Campbell, A.L. (2009, April 21). Will Americans Support the Individual Mandate? *Health Affairs* Web Exclusive w501 – w509.

[vi] By statute (M.G.L. c. 176Q § 2(b)), the Connector's 10-member Board of Directors is chaired by the Commonwealth's Secretary of Administration & Finance and also includes, *ex officio*, the Director of Medicaid;ex officio, the Commissioner of Insurance; ex officio, the Executive Director of the Group Insurance Commission; three members appointed by the Governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one of whom shall be a health economist, and one of whom shall represent the interests of small businesses; and three members appointed by the attorney general, 1 of whom shall be an employee

health benefits plan specialist, 1 of whom shall be a representative of a health consumer organization, and 1 of whom shall be a representative of organized labor.

[vii] Daschle, T, Lambrew, J. & Greenberger, S. (2008). *Critical: What We Can Do About the Health-Care Crisis*. St. Martin's Press: New York, NY.

[viii] Daschle, T, Lambrew, J. & Greenberger, S. (2008).