



Massachusetts Miracle or Massachusetts Miserable

What the Failure of the “Massachusetts Model” Tells Us about Health Care Reform

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Executive Summary

When Massachusetts passed its pioneering health care reforms in 2006, critics warned that they would result in a slow but steady spiral downward toward a government-run health care system. Three years later, those predictions appear to be coming true:

- Although the state has reduced the number of residents without health insurance, 200,000 people remain uninsured. Moreover, the increase in the number of insured is primarily due to the state’s generous subsidies, not the celebrated individual mandate.
- Health care costs continue to rise much faster than the national average. Since 2006, total state health care spending has increased by 28 percent. Insurance premiums have increased by 8–10 percent per year, nearly double the national average.
- New regulations and bureaucracy are limit-

ing consumer choice and adding to health care costs.

- Program costs have skyrocketed. Despite tax increases, the program faces huge deficits. The state is considering caps on insurance premiums, cuts in reimbursements to providers, and even the possibility of a “global budget” on health care spending—with its attendant rationing.
- A shortage of providers, combined with increased demand, is increasing waiting times to see a physician.

With the “Massachusetts model” frequently cited as a blueprint for health care reform, it is important to recognize that giving the government greater control over our health care system will have grave consequences for taxpayers, providers, and health care consumers. That is the lesson of the Massachusetts model.

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The key components of the Massachusetts plan form the core of proposals for national health care reform.

Introduction

On April 12, 2006, Massachusetts governor Mitt Romney signed into law one of the most far-reaching experiments in health care reform since President Bill Clinton's ill-fated attempt at national health care. The legislation took full effect on July 1, 2007, meaning that we now have had sufficient time to evaluate its successes and failures.

The Massachusetts reforms were pioneering in many respects. Among the key components of the bill were

- **An Individual Mandate.** Perhaps the most widely discussed aspect of the Massachusetts reform was its unprecedented "individual mandate," a requirement that every Massachusetts resident have a minimum amount of health insurance coverage, as defined by the state. Those who do not receive insurance through their employer or a government plan such as Medicare are required to purchase it on their own.¹ Initially, a failure to comply with this mandate resulted in the loss of the individual's personal exemption from the state income tax. That penalty increased to 50 percent of the cost of a standard insurance policy, or up to \$912 as of July 1, 2008.²
- **An Employer Mandate.** In addition to the individual mandate, the Massachusetts reform also imposed a mandate on employers with 10 or more workers. Employers who fail to provide health insurance to their workers are assessed a \$295 fee per employee,³ with additional penalties for employers whose workers repeatedly receive uncompensated care.⁴ And finally, all employers are required to offer their employees a Section 125 plan.⁵
- **Middle-Class Subsidies.** The reforms established a new program called Commonwealth Care to help families with incomes up to 300 percent of the poverty level (\$66,150 for a family of four) to pur-

chase insurance.⁶ The bill also expanded eligibility for Medicaid.

- **The Connector.** The Massachusetts reforms also established a new entity, called the Commonwealth Connector, to restructure the individual and small business insurance markets.⁷ Intended as a way to enable individuals to purchase personal and portable health insurance on a pre-tax basis, the Connector authority has evolved into a regulatory body with wide-ranging power over insurance in the state.

Health reform advocates on both the left and right have hailed Massachusetts as a model for reform. Numerous states have considered similar plans (although to date none have passed).⁸

More importantly, the key components of the Massachusetts plan form the core of proposals for national health care reform. In particular, both the Obama administration and congressional Democrats are leaning toward a plan that includes both an individual and employer mandate combined with middle-class subsidies.⁹ In addition, while he was still a presidential candidate, Obama called for the creation of a Connector-like national "exchange."¹⁰

But experience so far suggests that the "Massachusetts model" actually provides an object lesson in how not to reform health care. The program has failed even by its own goal criteria of achieving universal coverage. It has failed to restrain the growth in health care costs. And it has greatly exceeded its initial budget, placing new burdens on the state's taxpayers.

At the same time, the Massachusetts Plan has increased bureaucratic control over the state's health care system, limiting consumer choice. And it has set the stage for still more state intervention in the future, including price controls and explicit rationing.

Health care reformers in other states and at the federal level should look carefully at the failures of the Massachusetts model, and learn from them.

Expanding Coverage

There is no doubt that the Massachusetts reforms have reduced the number of people without health insurance in the state, but by how much is a matter of considerable dispute. According to official state statistics, the state's uninsurance rate declined from 10.4 percent in 2006 to just 2.6 percent today, leaving just 167,300 state residents without insurance.¹¹ However, there are several reasons for doubting this number.

The data show that roughly 80,000 more people have been added to the Medicaid rolls. In addition, approximately 176,000 people were receiving subsidized insurance coverage through the state's Commonwealth Care program.¹² That means 256,000 previously uninsured people were being covered through government programs. The more difficult question is how many uninsured residents obtained unsubsidized coverage. Here the state relied on a telephone survey conducted by the Urban Institute in mid 2008, which estimated an increase in coverage of 187,000 people.¹³ About 40,000 of these purchased individual insurance, either through the state's Connector or through the residual individual insurance market outside the Connector. The other 147,000 received coverage through their employer.

Such telephone surveys, however, are notoriously unreliable, particularly in the case of measuring health insurance coverage. For example, two groups that are much more likely to go without insurance are non-English-speaking immigrants (both legal and illegal) and young people. Yet, these groups are far less likely to be included on telephone surveys: immigrants because of the language barriers and young people because they lack traditional landline telephones.

More rigorous surveys have suggested that the number of uninsured remains far higher. For example, a door-to-door survey by the Census Bureau, conducted at roughly the same time as the Urban Institute's phone survey, estimated that 5.4 percent of state resi-

dents were uninsured.¹⁴ And an examination of state income tax returns (filers are required to certify their health insurance status on their returns) showed that roughly 5 percent of residents were uninsured as of January 1, 2008.¹⁵ And, since low-income residents, who are more likely to lack insurance, are not required to file state taxes, the actual percentage of uninsured is most likely a percentage point or two higher. Those estimates suggest that more than 200,000 Massachusetts residents remain uninsured.¹⁶

Furthermore, if the number of uninsured in the state had indeed been reduced by 74 percent, as suggested by the state, one might expect a comparable reduction in the amount of uncompensated care provided by the state's hospitals. In reality, the number of people receiving uncompensated care has declined by just 36 percent.¹⁷ In fact, one of the original selling points behind the Massachusetts reform was that it would shift subsidies for uncompensated care from hospitals to individuals. Uncompensated care subsidies were supposed to fade away, with the state using the savings to help low- and middle-income residents buy insurance instead. But hospitals now say that the rate of uncompensated care continues to be so high that they cannot dispense with their subsidies. The taxpayers end up paying twice.

There are also questions about the degree to which the reduction in the number of uninsured is sustainable going forward. For example, the increase in the number of people receiving employer-provided health insurance appears anomalous at a time when, nationwide, businesses are less likely to provide insurance for their employees. Also, the faltering economy and increase in unemployment will almost certainly cut into that number in the future. In addition, in the face of skyrocketing subsidy costs, the state is facing potential cutbacks to its Commonwealth Care program. It has already instituted eligibility reviews that have removed nearly 25,000 people from the program.¹⁸

When Massachusetts passed its reform plan, its supporters hailed it as a means to pro-

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vide universal health insurance coverage. “All Massachusetts citizens will have health insurance,” announced then-governor Mitt Romney.¹⁹ Thus, even by the standards of the program’s supporters, it has not met its goals.²⁰

It is also important to recognize that, whatever the increase in insurance coverage, most of the increase is due to subsidies, not the state’s individual mandate. Fully 58 percent of the newly insured are having that insurance paid for by the government, either through Medicaid or Commonwealth Care—proving that if you give something away for free, people are inclined to take it.²¹ Of the remaining 42 percent, more than three-quarters are receiving insurance through their employer.²² It is impossible to sort out the share of those who are receiving insurance as a result of the employer mandate versus the individual mandate, or who would have received insurance even in the absence of any mandate. We do know that relatively few previously uninsured individuals who had to purchase their own insurance did so. It seems clear, therefore, that the state’s generous subsidies have far more to do with the increase in insurance than does the individual mandate.

The evidence suggests a substantial degree of adverse selection taking place. Those signing up for subsidized coverage through the Commonwealth Care program were in poorer health than both the population at large and the previously uninsured population.²³ And younger residents, who composed the largest group of the uninsured before the mandate went into effect, continue to make up the largest group of the uninsured. Slightly more than 35 percent of the state’s remaining uninsured are between the ages of 18 and 25, and more than 60 percent are under the age of 35.²⁴ Before the mandate, those between the ages of 18 and 25 made up roughly 30 percent of the uninsured,²⁵ suggesting that the young (and presumably more healthy) are less likely to comply with the mandate.

One of the rationales for having the mandate was the belief that extending insurance to more young and healthy people would “strengthen and stabilize the functioning of

health insurance risk pools.”²⁶ However, the combination of subsidies and mandates may actually be making the pool older and sicker.

Thus, there seems to be little justification for an individual mandate.

Increased Insurance Regulation/Increased Cost

The proponents of the Massachusetts reforms also promised that those reforms would reduce health care costs. Governor Romney said that “the cost of health care would be reduced” and the plan would make health insurance “affordable” for every Massachusetts citizen.²⁷ Supporters suggested that the reforms would reduce the price of individual insurance policies by 25–40 percent.²⁸

In reality, insurance premiums rose by 7.4 percent in 2007, 8–12 percent in 2008, and are expected to rise 9 percent this year.²⁹ By comparison, nationwide insurance costs rose by 6.1 percent in 2007, just 4.7 percent in 2008, and are projected to increase 6.4 percent this year.³⁰ On average, health insurance costs \$16,897 for a family of four in Massachusetts, compared to \$12,700 nationally.³¹

The five insurance plans available through the Massachusetts Commonwealth Care program, which subsidized care for low- and middle-income individuals, are somewhat cheaper, roughly \$2,460–3,460 for an individual policy before application of the subsidy, but those costs, too, have been rising—up 11 percent since the program began for the lowest-cost plans.³² Moreover, the initial low cost for these plans was widely attributed to low bids from two insurers who were attempting to gain customer share through the program’s automatic assignment process. (Individuals participating in Commonwealth Care who do not choose an insurer are assigned to one. The lowest-bid plan receives the majority of assignees, with others receiving assignments based on how close their premiums are to the low bid.)³³ Having used their initial low bids as “loss leaders,” these insurers are now pressing for substantial premium increases.

Massachusetts has always been among the states with the highest-cost insurance. In part, this is due to the type of technology-intensive medicine practiced in the state and to the domination of the state's insurance market by a few large insurers. But, it is also partly due to the state's insurance regulations, including community rating and some 40 mandated benefits.³⁴

The reforms failed to deal with either of those issues. They failed to create the type of consumer incentives that would encourage consumers to become more cost conscious. Since the bill was signed, healthcare spending in the state increased by 23 percent.³⁵ And it generally retained the regulations and mandates that added to insurance costs.³⁶ In fact, the legislation established a new health care bureaucracy, the Connector, which has actually increased insurance regulation, and may have helped drive up costs.

The Massachusetts Health Care Connector was designed to combine the current small group and individual markets under a single unified set of regulations.³⁷ In addition to trying to unify and rationalize two admittedly dysfunctional regulatory schemes, the Connector was also meant as way to allow workers to purchase individual insurance while receiving the same tax break as for employer-provided insurance, thereby breaking the link between employment and insurance. This would give workers portable personal insurance that they could take with them from job to job, and which they would not lose when they lost their job. Unfortunately, the Connector has not lived up to its promise in the latter regard. In fact, as of May 2008, only 18,122 people had purchased insurance through the Connector.³⁸

On the other hand, as some critics feared, the Connector has become an aggressive new regulatory body. To qualify under the mandate, the Connector has decreed that insurance must now (1) include prescription drug coverage; (2) cover preventive care services; (3) have a deductible of no more than \$2,000 for individuals or \$4,000 for families, with drug deductibles of no more than \$250 for indi-

viduals and \$500 for families; (4) have an in-network out-of-pocket maximum (including deductibles, co-payments, and coinsurance) of no more than \$5,000 for individuals and \$10,000 for families; and (5) have no limit on annual or per sickness benefits.³⁹

These rules do not apply just to the previously uninsured. Individuals who already had health insurance, but whose insurance did not meet these requirements, were required to give up their current insurance and purchase insurance that conformed to the new rules. However, the state postponed the application of the requirements for those who currently have noncomplying insurance until January 1, 2009, meaning that we do not yet have information on how many Massachusetts residents were required to switch plans.

In addition, the Connector adds its own administrative costs, estimated at 4 percent of premium costs, for plans that are sold through it.⁴⁰

Massachusetts health reformers rejected proposals that would have reduced the rising cost of health insurance, such as eliminating regulations that drive up insurance premiums or those that limit competition in the insurance industry. Nor did they create incentives, such as increased cost-sharing, for consumers to become more value-conscious in their purchasing decisions. Instead, they increased regulatory costs and then simply threw money at the system through subsidies.

Not surprisingly, therefore, the cost of health care (and health insurance) in Massachusetts continues to rise.

Busting the Budget

When the Massachusetts reforms first became law, they were projected to cost about \$1.56 billion per year in total, with the largest component, the Commonwealth Care subsidies, costing roughly \$725 million per year. As it turns out, those estimates were not even close.

By mid 2008, the state was projecting that Commonwealth Care would cost \$869 million

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for FY2009, nearly a 20 percent increase, and more than \$880 million in 2010.⁴¹ However, the state secretary of administration and finance says that she expects actual costs to be far higher—perhaps even as much as \$100 million higher.⁴² The entire reform plan was projected to cost more than \$1.9 billion in 2009, some \$300 million above projections.⁴³ State government spending on all health care programs has increased by 42 percent (\$595 million) since 2006.⁴⁴

Part of the spending increase can be traced to greater than anticipated participation. That is, more people qualified for subsidies than was expected. Supporters of the program focus on this aspect, and excuse the growing cost as the price of extending coverage. But, beyond increased participation, the program's growing cost can also be traced to the failure of the program to reduce health care and insurance costs.

As Massachusetts State Senator Jamie Eldridge, one of the early supporters of the plan, recently told a congressional forum:

The assumption was that, as more people—and, in particular, more young and relatively healthy people—joined the system, premiums would go down across the board. There was also the assumption that as more people became insured, the number of people going to the emergency room would drop dramatically, saving the Commonwealth money. Neither of those things happened. . . . In fact, health reform has cost the Commonwealth much more than expected.⁴⁵

At the same time that spending for the reforms was skyrocketing, revenues for the plan were shrinking. For example, assessments under the “play or pay” mandate on businesses were expected to bring in \$45 million in its first year and \$36 million in 2008. In actuality, it failed to generate any revenue in 2007 and just \$7 million in 2008.⁴⁶ And as Senator Eldridge noted, expected savings from reductions in uncompensated care also failed to materialize.

With the health care program expected to contribute as much as one-third of the state's expected \$1.3 billion budget deficit in 2008, Governor Deval Patrick and the legislature imposed a \$1 per pack increase in the state's cigarette tax to help pay for the program. The regressive tax increase, which falls most heavily on the state's low-income residents, is projected to raise \$154 million annually. The state also imposed approximately \$89 million in fees and assessments on health care providers and insurers. On the cost-control side, the state imposed some modest cost-sharing increases on Commonwealth Care participants. And as mentioned, the state has begun a review of Commonwealth Care eligibility.

Despite these efforts, both cost increases and revenue shortfall are projected indefinitely into the future. Nearly all observers agree that without a concerted effort to control costs, the program is unsustainable.

Naturally there is talk of additional tax hikes. In particular, Patrick and Democratic leaders in the Massachusetts legislature are talking about an increase in the \$295 assessment for businesses that do not provide health insurance.⁴⁷ But the state's ability to raise additional revenue may be constrained, especially in the face of the economic downturn and an FY2009 state budget shortfall that could top \$2.4 billion.⁴⁸

Already, the rules for compliance with the business mandate have been subtly changed in a way that will raise costs for many small businesses. The legislation originally required businesses to either cover 33 percent of the cost of premiums for their employees or have at least 25 percent of their full-time employees enrolled in their company plan. However, last year the legislature changed the “or” to “and.” Small businesses are most likely to have difficulty in meeting both requirements. Many will find themselves facing either significant increases in the cost of employing workers or being required to pay the noncompliance assessment.⁴⁹

In addition, Patrick has threatened both insurers and health care providers with price

controls. Insurers participating in the Commonwealth Care program were ordered to cut reimbursements to providers by 3–5 percent.⁵⁰ There appears to have been little follow-through on that front, so Patrick has now chosen to attack the insurers directly. “Frankly, it’s very hard for the average consumer, or frankly the average governor, to understand how some of these companies can have the margins they do and the annual increases in premiums that they do,” Patrick mused to the media, shortly before announcing that he would explore whether the state had the power to regulate cap premiums.⁵¹

The state may even resort to explicit rationing. In 2008, the legislature established a special commission to investigate the health payment system in a search for ways to control costs.⁵² In March 2009, the commission released a list of options that it was considering, including “exclud[ing] coverage of services of low priority/low value” under insurance plans offered through Commonwealth Care. Along the same lines, it has also suggested that Commonwealth Care plans “limit coverage to services that produce the highest value when *considering both clinical effectiveness and cost.*”⁵³ And, while such moves would initially only impact those receiving subsidized coverage, the state is also considering “a limitation on the total amount of money available for health care services,” which is a global budget—the hallmark of government-run health care systems like that in Canada.

Shortages and Waiting Lists

Experience with national health care systems around the world has long shown that insurance coverage does not necessarily equate to access to care. Massachusetts is beginning to learn that lesson.

As we saw above, the Massachusetts reforms have expanded the number of people with health insurance in the state. Not surprisingly, increased coverage has led to increased utilization. But, at the same time, Massachusetts has done nothing to increase its supply of pro-

viders. Indeed, to the degree that it ratchets down on reimbursements, it may reduce that supply. Anecdotal reports suggest that a number of physicians are limiting their practice or refusing to accept new patients.⁵⁴

The inevitable result of an increased demand chasing a finite supply (in the absence of any form of price rationing) has always been shortages. The impact has been small so far. In 2007, 4.8 percent of state residents reported forgoing care because they could not find a doctor or get an appointment, an increase of 1.3 percentage points since the legislation was signed. For low-income residents, the problem was slightly worse: 6.9 percent couldn’t find a doctor or get an appointment—a 2.7 percentage point hike since 2006.⁵⁵ Waiting times were a somewhat bigger problem, with the wait for seeing an internist, for example, increasing from 33 days to 52 days during the program’s first year.⁵⁶

However, in the future, the problems are likely to grow worse, especially if the state follows through on threats to enact cuts in reimbursements and premium caps on insurance (which will almost inevitably be reflected in reimbursement cuts, and/or global budgeting). Such policies can only further reduce the supply of providers, leading to more shortages, more difficulty in finding a doctor, and a longer waiting time if you can find one.

Conclusion

When Massachusetts passed its pioneering health care reforms, this critic warned that it would result in “a slow but steady spiral downward toward a government-run health care system.”⁵⁷ Sadly, three years later, those predictions appear to be coming true.

At a time when other states are thinking of copying Massachusetts, and, perhaps more significantly, the “Massachusetts model” is being discussed as a possible blueprint for national reform, the failures in Massachusetts provide valuable lessons for reformers.

Notably, “universal coverage” should not be the primary goal of health care reform. The key

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issue in health-care reform is not coverage, but freedom—and secondarily, cost. But Massachusetts reformers made universal coverage the lynchpin of their efforts at the expense of any serious effort to control health care costs. As the *New York Times* noted, “Those who led the 2006 effort said it would not have been feasible to enact universal coverage if the legislation had required heavy cost controls.”⁵⁸ As a result, they pushed for universal coverage now, and put off “until another day any serious effort to control the state’s runaway health costs.”⁵⁹

This was a guaranteed recipe for exploding program costs, and is likely now to lead to price controls and other restrictions that will adversely affect the availability and quality of health care.

Yet Congress and the Obama administration seem determined to head down the same exact road. The focus of their health care efforts appears likely to be a series of mandates and subsidies in an elusive search for universal coverage.⁶⁰ There is even likely to be a new government-run (and taxpayer subsidized) program similar to Medicare that will operate in “competition” with private insurance.⁶¹ They would essentially create a new entitlement program, without taking any steps to control rising health care costs.

Already the administration’s reform plans are expected to cost more \$1.5 trillion over the next 10 years.⁶² It will therefore be necessary either to run up more national debt—at a time when massive future budget deficits threaten to bankrupt the country—or to break President Obama’s pledge not to raise taxes on the middle class.⁶³

And, without any other options, Congress will follow the Massachusetts model and turn to price controls and rationing. Thus, Americans will end up with the worst of all possible worlds: runaway costs and higher taxes followed by bureaucratic control over our health care choices.

Supreme Court Justice Louis Brandeis rightly called American state governments “the laboratories of democracy.”⁶⁴ Under our federalist system of government, states are able to experiment with policies on a small scale

before these policies are adopted by the whole nation. Of course, not all experiments are successful. And we can learn just as much from those that fail as from those that succeed.

When it comes to health care reform, Massachusetts has provided us with just such an experiment. Three years of experience shows that giving the government greater control over our health care system will have grave consequences for taxpayers, providers, and health care consumers. That is the true lesson of the Massachusetts model.

Notes

1. An Act Providing Access to Affordable, Quality, Accountable Health Care (April 12, 2006), Chapter 58 of the Acts of 2006, Section 12.

2. *Ibid.*, Section 13.

3. *Ibid.*, Section 47. Governor Romney vetoed this provision using his line-item veto authority, but the veto was overridden by the legislature.

4. *Ibid.*, Section 45(b). If a company’s employees incur at least \$50,000 in uncompensated care, the company may be charged a “free-rider fee” of up to 100 percent of the cost of the care in excess of \$50,000.

5. *Ibid.*, Section 48. These are cafeteria plans, authorized under Section 125 of the federal Internal Revenue Code, which allow employees to set aside pre-tax dollars toward payment of insurance premiums, medical care, and dependent care expenses.

6. *Ibid.*, Section 45.

7. *Ibid.*, Section 101.

8. Utah has passed legislation establishing a “portal,” which in many ways resembles the Connector. But the legislation has no mandates and is not nearly as comprehensive (nor as problematic) as that in Massachusetts. “2009 Utah Health Insurance Bills: What Passed?” Utah Insurance Blog, <http://insuranceinutah.com/2009/04/03/2009-utah-healthcare-bills-what-passed/>.

9. Robert Pear, “Democrats Agree on a Health Plan; Now Comes the Hard Part,” *New York Times*, April 1, 2009.

10. See <http://www.barackobama.com/issues/healthcare/>.

11. Sharon K. Long, Allison Cook, and Karen Stockley, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey," December 18, 2008, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_08.ppt.
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16. Suzanne King, "Massachusetts Health Care Reform Is Failing Us," *Boston Globe*, March 2, 2009.
17. Cedric K. Dark, "The Massachusetts Experience," Policy Prescriptions, March 15, 2009, <http://www.policyprescriptions.org/?p=275>.
18. "Connector Eligibility," Healthcare Financial, Inc., June 16, 2008, <http://www.hfi-mass.com/news/articles/061608.shtm>.
19. Mitt Romney, "Health Care for Everyone? We've Found a Way," *Wall Street Journal*, April 11, 2006.
20. This is not to say that *universal* coverage should be the goal of health care reform, and certainly not the primary goal. It has been amply demonstrated by national health care systems in other countries that universal insurance coverage does not necessarily translate into better access to care. See, for example, Michael Tanner, "The Grass Isn't Always Greener: A Look at National Health Care Systems Around the World," Cato Institute Policy Analysis no. 613, March 18, 2008. And while there is evidence that those without health insurance have somewhat worse health outcomes than insured Americans, the evidence of a direct link between health insurance and health is weak. Nor is it a given that expanding insurance coverage is the best or most efficient use of resources when it comes to improving health care. Helen Levy and David Meltzer, "What Do We Really Know About Whether Health Insurance Affects Health?" Economic Research Initiative on the Uninsured, Working Paper no. 6, December 2001. Moreover, in many cases, expanding insurance coverage will exacerbate the problems of third-party payment.
21. Kevin Sack, "Massachusetts Faces Costs of Big Health Plan," *New York Times*, March 15, 2009.
22. Peter B. Smulowitz, "A Model for Expanding Health Insurance? Lessons Learned from the Massachusetts Experiment," ACEP State Legislative/Regulatory Committee, <http://acep.org/WorkArea/DownloadAsset.aspx?id=45176>.
23. Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts," *Health Affairs* (July/August 2008): w270-84.
24. *Ibid.*, Exhibit 6.
25. Allison Cook and John Holahan, "Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on the 2005 Current Population Survey Data," Blue Cross Blue Shield of Massachusetts Foundation, 2006.
26. Health Care Access and Affordability Conference Committee Report, April 3, 2006, p. 3.
27. Romney.
28. "Massachusetts Healthcare Reform" (PowerPoint Presentation, Office of the Governor, April 10, 2006).
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32. Jon Kingsdale, "About Us: Executive Director's Message," March 12, 2009, http://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=executive%20director%20message&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/About%20Us/Executive%20Director%20Message/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken.

33. McDonough, p. w293.

34. At the time the Massachusetts reform was passed, those mandates included: treatment for alcoholism; blood lead poisoning; bone marrow transplants; breast reconstruction; cervical cancer/HPV screening; clinical trials; contraceptives; diabetic supplies; emergency services; hair prostheses; home health care; in vitro fertilization; mammograms; mastectomy; maternity care and maternity stays; mental health generally (in addition there is a requirement for mental health parity); newborn hearing screening; off label drug use; phenylketonuria (PKU) formula; prostate screening; rehabilitation services; and well child care. Services for the following providers must also be covered: chiropractors; dentists; nurse anesthetists; nurse midwives; optometrists; podiatrists; professional counselors; psychiatric nurses; psychologists; social workers; and speech or hearing therapists. Insurance policies must also provide coverage to adopted children, handicapped dependents, and newborns. Victoria Craig Bunce, J. P. Wieske, and Vlasta Prikazky, "Health Insurance Mandates in the States, 2006," Council for Affordable Health Insurance, March 2006.

35. Robert Seifert and Paul Swoboda, "Shared Responsibility," Blue Cross Blue Shield of Massachusetts Foundation, March 2009, http://www.bcbsmafoundation.org/foundationroot/en_US/documents/090406SharedResponsibilityFINAL.pdf.

36. The legislation did include a provision allowing workers ages 19–26 to purchase low-cost, specially designed products offered through the Connector that avoided many of the state's mandated benefits (although some of the most expensive mandates, including mental health benefits and prescription drug coverage, would still be required). It also repealed the state's "any willing provider" rule. Chapter 58 of the Acts of 2006, Section 90.

37. Chapter 58 of the Acts of 2006, Section 101. The law defines the Connector as "a body politic and corporate and a public instrumentality." It is designed to operate independent of any other government agency and has a corporate charter, but its board consists of the Massachusetts secretary of Administration and Finance, the state Medicaid director, the state commissioner of insurance, the executive director of the group insurance commission, three members appointed by the governor, and three members appointed by the attorney general. As an entity, it falls somewhere between a government agency and a private corporation. One useful analogy would be the Federal Reserve Board.

38. Robert Steinbrook, "Health Care Reform in Massachusetts—Expanding Coverage, Escalating Costs," *New England Journal of Medicine* 358, no. 26 (2008): 2757–60.

39. McDonough, p. w289.

40. Rachel Nardin, David Himmelstein, and Steffie Woolhandler, "Massachusetts' Plan: A Failed Model for Health Care Reform," Physicians for a National Health Program, February 18, 2008, http://www.pnhp.org/mass_report/mass_report_Final.pdf.

41. Alice Dembner, "Healthcare Cost Increases Dominate Mass. Budget Debate," *Boston Globe*, March 26, 2008; "National Health Preview," *Wall Street Journal*, March 27, 2009.

42. Dembner. Other sources have suggested that the cost of Commonwealth Care could exceed \$1.1 billion, but those projections were based on enrollment figures that appear higher than were actually seen in the first part of 2009. John Holahan and Linda Blumberg, "Massachusetts Health Reform: Solving the Long-Run Cost Problem," Robert Woods Johnson Foundation, January 2009.

43. Dembner.

44. Kevin Sack, "Massachusetts Faces Costs of Big Health Plan," *New York Times*, March 16, 2009.

45. Quoted in Trudy Lieberman, "Health Reform Lessons from Massachusetts, Part 1," *Columbia Journalism Review*, March 23, 2009, <http://www.cjr.org>.

cjr.org/campaign_desk/health_reform_lessons_from_mas.php?page=2.

46. John Hurst, "Small Businesses Pay for Plan's Shortcomings," *Boston Globe*, August 18, 2008.

47. "State Watch: Study Examines Spending under Massachusetts Health Insurance Law," Kaiser Daily Health Policy Report, April 8, 2009, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=57923.

48. Iris J. Lav and Elizabeth McNichol, "State Budget Troubles Worsen," Center on Budget and Policy Priorities, March 13, 2009, <http://www.cbpp.org/cms/?fa=view&id=711>.

49. Hurst.

50. Alice Dembner, "Mass. Panel Approves Changes to Subsidized Residents Health Plan," *Boston Globe*, December 14, 2007. Notably, Massachusetts's business mandate, as well as the state's general insurance regulatory environment, is cited by the Small Business and Entrepreneurship Council as a reason for ranking Massachusetts dead last among the 50 states for business-friendly health care policies. "Best and Worst for State Health Insurance Costs," *Wall Street Journal*, February 6, 2009.

51. Quoted in Sack, "Massachusetts Faces Costs of Big Health Plan."

52. An Act to Promote Cost Containment, Transparency, and efficiency in the Delivery of Quality Health Care (September 10, 2008), Chapter 305 of the Acts of 2008.

53. Report of the Special Commission on the Health Care Payment System, March 25, 2009 (emphasis added).

54. Kevin Sack, "In Massachusetts, Universal Care Strains Coverage," *New York Times*, April 5, 2008.

55. Sharon Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts," *Health Affairs* (July/August 2008): w270-84.

56. Sack, "In Massachusetts, Universal Care Strains Coverage."

57. Michael Tanner, "No Miracle in Massachusetts:

Why Governor Romney's Health Care Reform Won't Work," Cato Institute Briefing Paper no. 97, June 6, 2006.

58. Sack, "In Massachusetts, Universal Care Strains Coverage."

59. Ibid.

60. President Obama apparently does not intend to put forward a specific plan for reform. Rather, the Obama administration is offering general guidance and direction, while leaving the details up to Congress. Erica Warner, "White House Budget Director Grilled on Health Plan Details," Associated Press, March 10, 2009. However, it is possible to discern the outlines of what a health care reform proposal likely to emerge from Congress (and acceptable to the White House) will look like. See Pear.

61. Laura Litvan, "House Health Plan to Include Government-Run Option," *Bloomberg*, March 26, 2009.

62. Ricardo Alonso-Zaldivar, "Health Care Overhaul May Cost about \$1.5 Trillion," Associated Press, March 17, 2009. It is worth noting that cost estimates for government programs have been wildly optimistic over the years, especially for health care programs. For example, when Medicare was instituted in 1965, it was estimated that the cost of Medicare Part A would be \$9 billion by 1990. In actuality, it was seven times higher—\$67 billion. Similarly, in 1987, Medicaid's special hospitals subsidy was projected to cost \$100 million annually by 1992 (just five years later); however, it actually cost \$11 billion—more than 100 times as much. And in 1988, when Medicare's home care benefit was established, the projected cost for 1993 was \$4 billion, but the actual cost was \$10 billion. Stephen Dinan, "Entitlements Have a History of Cost Overruns," *Washington Times*, June 16, 2006.

63. Budget deficits are already projected to total more than \$9.3 trillion over the next 10 years, even without consideration of the full cost of health care reform. Lori Montgomery, "U.S. Budget Deficit to Swell Beyond Earlier Estimates," *Washington Post*, March 21, 2009.

64. *New State Ice Co. v. Liebman*, 285 U.S. 262 (1932).

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