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Routing

The Massachusetts Health Plan
The Good, the Bad, and the Ugly

by David A. Hyman

Executive Summary

In spring 2006, Massachusetts enacted legislation to ensure universal health insurance coverage to all residents. The legislation was a hybrid of ideas from across the political spectrum, promoted by a moderately conservative Republican governor with national political aspirations, and passed by a liberal Democratic state House and Senate. Groups from across the political spectrum supported the plan, from the Heritage Foundation on the right to Families USA on the left, although the plan had detractors from across the political spectrum as well.

This study briefly describes the basic structure of the Massachusetts plan and identifies the good, the bad, and the ugly. Although the legislation, as Stuart Altman put it, "is not a typical Massachusetts-Taxachusetts, oh-just-crazy-liberal plan," there is enough "bad" and "ugly" in the mix to raise serious concerns, particularly when the desire to overregulate the health insurance market appears to be hard-wired into Massachusetts policymakers' DNA.

If we want to make health insurance more affordable and avoid the "bad" and the "ugly" of the Massachusetts plan, Congress—or, barring that, individual states—should consider a "regulatory federalism" approach. Under such an approach, insurers and insurance purchasers would be required to subject themselves to the laws and regulations of a single state but allowed to select the state. As with corporate charters, this system would allow employers and insurers to select the regulatory regime that most efficiently and cost-effectively matches the needs of their risk pools. The ability of purchasers and insurers to exit from the state's regulatory oversight (taking their premium taxes with them) would temper opportunistic behavior by legislators and regulators, including the temptation to impose inefficient mandates and otherwise overregulate.

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Introduction

Massachusetts is notorious for its left-wing politicians and wacky social policies. It is "viewed by the rest of America as a sort of Marxist redoubt with great seafood."[1] Even its own residents call it "Taxachusetts." That said, the Massachusetts health plan enacted in 2006, as Stuart Altman neatly put it, "is not a typical Massachusetts-Taxachusetts, oh-just-crazy-liberal plan."[2] Instead, the plan represents a hybrid approach, incorporating ideas from across the political spectrum.[3] The plan was promoted by a moderately conservative Republican governor with national political aspirations and enacted by a liberal Democratic House and Senate. Groups from across the political spectrum, from the Heritage Foundation[4] on the right to Families USA[5] on the left, supported the plan. To be sure, the plan has detractors across the political spectrum as well.[6]

It is illuminating to view the Massachusetts health plan in light of the classic western *The Good, The Bad, and the Ugly*.[7] I begin by outlining the basic details of the Massachusetts health plan. Then I turn to the "good," the "bad," and the "ugly" of the plan. I conclude by discussing an approach to state-based health care reform more promising than what was wrought in Massachusetts.

What's It All About?

Depending on who's counting, between 7.2 percent and 10.7 percent of the Massachusetts population lacks health insurance.[8] To address this problem, the Massachusetts health plan incorporates an array of elements, the most critical of which are as follows:

1. An individual mandate;
2. An employer mandate ("pay-or-play"), and a requirement that employers create what is called a Section 125 cafeteria plan;
3. A "Connector" through which uninsured residents can purchase health insurance; and
4. Subsidies for those with incomes up to three times the federal poverty level.

A brief description of each provision follows.[9] Those wishing more detail can consult other sources, including the Commonwealth's official website for the Connector.[10]

The individual mandate requires all residents of Massachusetts who are 18 or older to purchase health insurance. The Commonwealth sanctions those who do not purchase such insurance via the state income tax. In 2007, the penalty is the loss of the personal income tax exemption—roughly $220 for an individual and $440 for a family. In 2008 and thereafter, the penalty (imposed on those for whom coverage is deemed "affordable") is set at half the monthly cost of the lowest-cost health insurance plan within a region for each month without coverage. The Connector Board is responsible for setting the definition of "affordable" and determining which policies meet coverage requirements.

The "pay-or-play" mandate requires that employers who have 11 or more employees and who do not make a "fair and reasonable" contribution to their employees' health insurance must pay an annual fee to the state. An employer makes a "fair and reasonable" contribution when it offers (A) a group health plan and is willing to pay at least a third of the cost of coverage under the plan, or (B) a group health plan in which at least 25 percent of full time employees are enrolled and the employer makes a contribution. If those conditions are not satisfied, the employer must pay a fee (the "fair share contribution"), currently capped at $295 per employee per year.[11]

The law also requires employers to create a "cafeteria plan," which enables employees to purchase health insurance on a pre-tax basis. Under current law, an individual who obtains health insurance through his employer can do so with pre-tax dollars. Those who obtain coverage in other ways must do so with after-tax dollars, even if they are unable to purchase coverage through their employer, and

even if they are unemployed.[12] This peculiar structure is the source of considerable horizontal and vertical inequity.[13] The Massachusetts plan attempts to level the playing field, since participation in a cafeteria plan allows participants to receive health insurance (and other qualified benefits) on a pre-tax basis. Employers that do not offer a cafeteria plan face a "free rider surcharge" that is triggered if the state pays more than $50,000 for care provided to a firm's employees in any given year.

Health insurance may be purchased through a "Connector," which is designed to replace and supplement the old individual and small group health insurance markets by creating a health insurance exchange. The merger of the individual and small group markets, and a temporary moratorium on additional mandates means that some Massachusetts residents will be able to obtain coverage at lower prices than was previously the case.[14] However, all the existing mandates were retained, and premiums for those already covered in the small group market are likely to increase by 2–8 percent.[15] The existence of the Connector is also likely to broaden the range of choices available to many individuals, pool the associated risk, and increase the portability of health insurance coverage.

The plan provides sliding scale subsidies to individuals with incomes of up to 300 percent of the federal poverty level (FPL), and individuals with incomes less than 100 percent of the FPL will not have to pay any premiums. In practice, that means that subsidies can be provided well up the income scale, as three times the FPL for a family of four is $60,000.

"The Good"

The Return of the States

The most important "good" of the Massachusetts plan is the reemergence of the states as significant policy-setting entities. After eight decades of treating the states as embarrassing impediments to the glorious sweep of federal power, the left has suddenly embraced federalism. (To be sure, they have only done so because they have been unable to enact their preferred policies for the nation as a whole, and they are likely to drop the state-based approach like a hot potato if they can get their way on the federal level—but better late than never, regardless.) Since many states have balanced-budget requirements, and none can print money, it will be interesting to see how these state-based reform strategies are modified when the fiscal reality of their plans slaps reformers in the face. Apart from the Medicaid program, which allows states to externalize at least 50 percent (and, depending on the state, as much as 80 percent) of the cost of Medicaid-based reforms,[16] states have limited ability to externalize their costs. Though the Medicaid costs internalized by each state are far less than the actual costs, they are still enough to sink the more ambitious plans and to push states to adopt other states' successes and avoid other states' failures. Perhaps the return of the states will mark the return of fiscal rectitude and small (state) government. Hope springs eternal.

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Spreading the Tax Preference

After years of languishing in political obscurity, fixing the tax preference for employer-provided health insurance has surfaced in the past few years as a policy initiative. That tax preference has provoked criticism from across the political spectrum, although there is considerable disagreement on the best way to fix the problem.[17] The President's Advisory Panel on Federal Tax Reform recently recommended that individuals be allowed to purchase health insurance with pre-tax dollars up to a specified amount,[18] and President Bush has proposed a standard deduction for health insurance that would both expand the tax break to all taxpayers and limit the size of the tax break for each taxpayer.[19] In the absence of a political constituency for eliminating the preference entirely,[20] expanding the pool of people receiving a tax break, as Massachusetts did, is an improvement.

Shifting the Focus

Past debates over the uninsured have emphasized the expansion of governmental programs and the funding of safety net institutions. By focusing instead on making it easier for the uninsured to obtain their own private health insurance, Massachusetts has broken free of that paradigm. Stated differently, Massachusetts is now effectively "subsidizing people, not providers."[21] The combination of broadened use of pre-tax dollars for those currently without employment-based insurance and subsidies for those least able to afford coverage has the potential to expand coverage while avoiding some of the public choice problems associated with the expansion of governmental programs to address the same problem.

"The Bad"

Pay-or-Play: Preempted or Just Counter-Productive?

The pay-or-play provision faces a significant legal risk of preemption.[22] The federal Employee Retirement Income Security Act, also known as ERISA, generally bars the states from regulating the health benefits offerings of employers who self-fund their health plans. States that want a "pay-or-play" provision without risk of ERISA preemption need to go to Congress and get an exemption. If that approach was good enough for Hawaii, which for many years has been the only state with an employer mandate, it is good enough for the rest of the states.

Unsatisfied with this approach, pay-or-play advocates have sought to amend ERISA to give the U.S. Department of Labor the authority to waive ERISA preemption and thereby allow states to experiment with additional regulations. Advocates of this approach emphasize that they merely seek to force employers not currently providing insurance either to do so, or to pay for the costs purportedly imposed on the state Medicaid program if they do not. Yet in their more candid moments they will admit their broader goals include direct regulation of the terms of coverage offered by self-funded employers, and the imposition of premium taxes on the amounts spent by these employers to provide coverage to their employees. But for the firewall created by ERISA, "pay-or-play" would soon degenerate into "pay or pay."

As if that wasn't bad enough, pay-or-play is based on the same theory as a minimum wage law. If employers aren't paying enough in wages (or providing health coverage for their employees), the government can just force them to increase those wages (or pay for coverage). Everyone will be made better off, and no one will be made worse off. We can vote ourselves rich!

Of course, it doesn't work that way. The predictable adaptive responses by employers will include laying off (or not hiring) employees, and shifting to part-time employees because the cost of the minimum compensation package of full-time employees (wages plus "pay-or-play") exceeds their value to the enterprise. Indeed, a "pay-or-play" mandate is likely to be much more harmful than an increase in the minimum wage, since the costs imposed on employers on the "play" side of the equation will be tied to the rate of health care inflation, instead of the rate of general inflation.

That said, the current Massachusetts "pay-or-play" structure isn't nearly as counter-productive as the one Massachusetts passed in 1985. That version, which was never implemented, would have required employers with six or more employees to provide health insurance and pay 80 percent of the premium, or be taxed $1,680 per employee—roughly $2,900 in 2007 dollars. The cost of the "pay" and "play" options in the current statute are much lower. Moreover, the "pay" option may be cheap enough that employers will simply take $5 per week out of the raises they were otherwise going to give workers, instead of relocating, firing their least productive employees, or switching to part-timers.

There is little or no evidence that pay-or-play will achieve universal coverage.

At the same time, it seems unlikely that employers currently offering coverage will drop coverage because they suddenly decide

they prefer the "pay" option. That's the good part of the bad news. The bad part of the bad news is that the "pay" option is so cheap, it is unlikely to induce employers to offer coverage that are not already doing so. The worst part of the bad news is that some legislators are now keen to increase the cost of the "play" option—by deeming an employer to be in compliance "only if 50 percent of its employees sign up for health coverage, or if the company contributes 50 percent toward an individual premium,"[23] which will suddenly make the "pay" option even more appealing.

Finally, there is little or no evidence that pay-or-play will achieve universal coverage. Consider Hawaii, the only state with such a mandate. Almost 30 years after the mandate was enacted, 10 percent of Hawaiians are uninsured—a percentage that is either higher than or comparable to that of Massachusetts.[24] The fact that Hawaii, with several thousand miles of ocean separating it from the nearest alternative location for businesses to relocate, couldn't get to universal coverage using an employer mandate suggests that pay-or-play isn't going to solve Massachusetts's problem.

Will an Individual Mandate Work?

Many health care reformers want everyone to be insured. An individual mandate certainly sounds like the most direct route to that goal. The sanctions for noncompliance, however, are far too low to encourage the purchase of coverage, even if one ignores the difficulties with enforcement.[25] The sanctions only apply to individuals who file tax returns, and even for those individuals, the sanction is far below the cost of obtaining health coverage. The most optimistic estimate for the cost of coverage through the Connector was $200 per month, meaning that the plan will threaten taxpayers with a fine of $200 (first year) or $1,200 (subsequent years) if they fail to incur a cost of $2,400. If more recent cost estimates are to be believed (more on this below), the plan will threaten taxpayers with a fine of $200 in the first year, or $1,500 in subsequent years, if they fail to incur a cost of $3,000 or more. Any bets on the likelihood of this set of penalties increasing the level of coverage in Massachusetts?

Even if the sanction is considerably higher, it is hard to believe an individual mandate will materially increase coverage. Consider automobile liability insurance, where virtually all states impose an individual mandate and back it up with stiff sanctions (e.g., suspension of license, significant fines, and jail time). Automobile insurance is cheaper than health insurance.[26] Yet 14.2 percent of motorists in the United States are uninsured, as are 6 percent of motorists in Massachusetts.[27] As Figure 1 demonstrates, the state-by-state patterns for those without auto insurance bear an uncomfortable similarity to the patterns for those without health insurance.[28] Indeed, the lack of auto insurance is so common that many drivers voluntarily buy coverage against a collision with an uninsured motorist, and more than a dozen states require such coverage.

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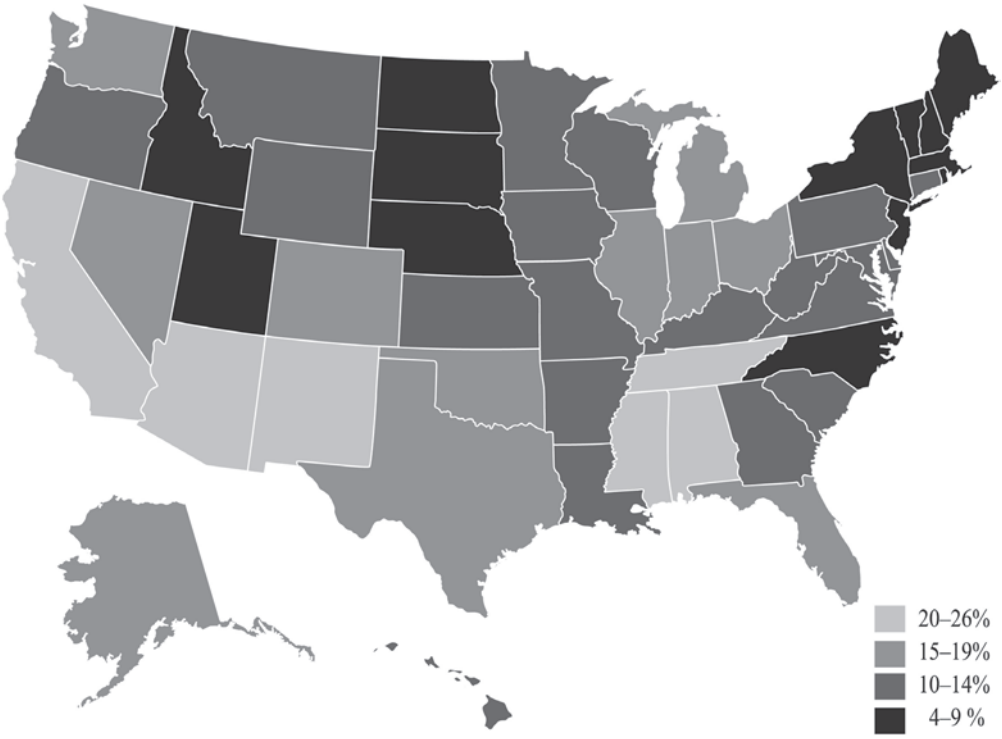
"The Ugly"

Out-year Costs? What Out-year Costs?

Massachusetts officials project the health plan will cost approximately $1.4 billion per year over three years and budgeted no amounts for the fourth year and beyond.[29] According to the Kaiser Commission on Medicaid and the Uninsured, "The state anticipates that no additional funding will be needed beyond three years."[30] Massachusetts plans to raise the $1.4 billion with a limited amount of new funding (derived from general revenue and employer contributions), but most of the money will come from diverting old funding (federal Medicaid payments previously earmarked for safety net providers and payments by employers to the state uncompensated care pool).[31] Have you ever heard of a government program that spent $1.4 billion per year for the first three years, and then delivered the same benefits in the fourth year with no addi-

Figure 1
Estimated Percentage of Uninsured Motorists by State, 2004



Source: Insurance Research Council.

tional funding? Particularly when spending will likely exceed revenue in the third year by almost $170 million?[32] Me neither.

Admittedly, though the out-year finances are ugly, they could be worse. The Massachusetts plan requires no special federal funding above and beyond the $385 million Massachusetts was already receiving each year in "excess" Medicaid payments to the state's uncompensated care pool.[33] Other states are seeking sizeable amounts of new federal funding to cover their coverage initiatives, and California is seeking to externalize a substantial majority of the costs of its reform proposal.[34]

Finally, the out-year costs are likely to be large because the Massachusetts plan does nothing to control the cost of health care—and health care in Massachusetts is already pricey because of the heavy reliance on teaching hospitals and academic medical centers.

Let's regulate!

A big part of the reason many people don't have health insurance is that it is too expensive.[35] A big part of the reason why health insurance is too expensive is because of regulation, whether benefit mandates, guaranteed issue, community rating, or restrictions on offering "last year's medicine at last year's prices."[36] Although Massachusetts eliminated some regulations that made the individual and small group markets more expensive than they needed to be, the Connector still retains much of the command-and-control approach to health insurance that helped cause the problem in the first place. Consider a small, but telling example. All policies offered through the Connector have to cover treatment for infertility, including expensive in-vitro fertilization services.[37] It is hard to conceive—pun intended—of the circumstances where that decision makes any sense whatsoever, apart from its appeal to the naked self-interest of those providing such services.[38]

When regulators internalize the costs of their decisions, they suddenly become more sensitive to the associated trade-offs. For example, South Carolina passed a law that prohibit-

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ed building on certain beachfront property on grounds that the prohibition was necessary for public safety. The Supreme Court held this law to constitute a taking.[39] After the Supreme Court's opinion, the bureaucracy charged with enforcing the law—the South Carolina Coastal Council, or SCCC—settled the case by purchasing the two lots in question for $425,000 per lot plus interest and legal fees. During the years of litigation, the SCCC had consistently claimed that there was a "threat to life and property" if the beachfront lots were built upon. Once it actually owned the lots, however, the bureaucracy underwent a "neck-snapping, intellectual about-face," and concluded that it was "reasonable and prudent" for houses to be built on the lots.[40] The SCCC ultimately sold both lots to a developer, even though a neighbor had offered $315,000 for one of the lots, along with a promise not to build on it. Thus, as an owner of the property, the SCCC was unwilling to take a loss to keep one lot unimproved. But as a regulator, it had been perfectly happy to impose a cost more than 10 times as great on the original owner to keep both lots vacant.[41]

In the health care setting, efforts to ban "drive-through deliveries" demonstrate a similar pattern. Prior to the passage of the federal Newborns' and Mothers' Protection Act, 28 states had prohibited insurers from requiring rapid post-partum discharges. Yet 18 of those states excluded Medicaid from the scope of these statutes, and 19 excluded state employees. The only thing these patient populations have in common is that states bear a significant percentage of the cost of providing health care coverage to both of them. Thus, "most state legislatures displayed concern for the plight of women and infants 'victimized' by drive-through deliveries only as long as state governments did not have to foot the bill to fix the problem."[42]

Even if regulators do not internalize their costs, concern about feasibility and public acceptability can force regulators to become more modest about both their means and ends. For example, the Connector board initially proposed to restrict policies with high deductibles and out-of-pocket limits. Requiring more comprehensive coverage had the predictable effect of increasing the expected cost of qualified coverage well beyond what Gov. Romney and other supporters had promised. According to the *Boston Globe*:

> The Connector's policy committee decided in November that the minimum plans should provide comprehensive coverage, including prescription drugs, and hired an actuary to model a minimal plan. It came back with a $260 average [monthly] premium and a fairly high deductible, which applied to hospital benefits. But when the board sought bids from insurers, many came in substantially higher. A summary prepared by board staff showed monthly premiums ranging from $250 for a 28-year-old to $500 for a 56-year-old, which one board member averaged to about $380.[43]

The *Globe* later reported:

> Advocates for the uninsured were stunned at the price, considerably higher than the $200 estimated by Mitt Romney when he was governor and first proposed universal coverage. A spokesmen for insurers said the requirements were too prescriptive and could undermine the goal of universal coverage.[44]

With the monthly premiums proposed by insurers much higher than expected—indeed higher than was politically feasible given the individual mandate—the Connector Board began reconsidering its requirements. Bowing to the fiscal and political realities, in April 2007 the Connector Board exempted 20 percent of the uninsured from the individual mandate and increased the subsidies to low-income residents who were not exempt.[45] Tellingly, the backers of the Massachusetts plan are no longer promising universal coverage.[46]

What can we learn from this sequence of events? Regulation may be necessary to deal

The backers of the Massachusetts plan are no longer promising universal coverage.

with some specific forms of market failure, but it should be enacted only after due consideration of comparative institutional imperfections and the "nirvana fallacy." What Harold Demsetz wrote over 30 years ago still applies to today's health care debates:

> The view that now pervades much public policy economics implicitly presents the relevant choice as between an ideal norm and an existing 'imperfect' institutional arrangement. This nirvana approach differs considerably from a comparative institution approach in which the relevant choice is between alternative real institutional arrangements.[47]

Massachusetts appears to be incapable of learning this lesson.

Conclusion

The Massachusetts health plan is a bipartisan success story, although as Sen. Ted Kennedy wryly noted at the signing ceremony, "when you come to a celebration of a signing and Mitt Romney and Ted Kennedy and the Heritage Foundation are all together, it's clear one of us didn't read the bill."[48]

Why did reform take the shape it did in Massachusetts? Massachusetts began with three important advantages in addressing the problems of the uninsured. Compared to the other 49 states, Massachusetts is richer, with a smaller percentage of its population uninsured, and it was already receiving $385 million per year in "extra" Medicaid funding.[49] Simultaneously, Massachusetts labors under the disadvantage that, compared to 48 of the other 49 states, the health care delivery system in its principal city is overwhelmingly based on an expensive infrastructure of teaching hospitals and academic medical centers. That is an important factor explaining why health care in Massachusetts is so expensive—and the fact that it is so expensive helps explain why a significant percentage of the population is uninsured. Thus, the delivery-side dynamics compound the regulatory inefficiencies noted previously. The Massachusetts health plan represents an attempt to reconcile these inconsistencies and provide affordable private-sector coverage to those currently without health insurance—an effort spurred by the presidential ambitions of its then-governor, and the imminent loss of its "extra" Medicaid funding.

Will the Massachusetts health plan work? Only time will tell, but there is enough "bad" and "ugly" in the mix to raise serious concerns—particularly when the desire to overregulate the health insurance market appears to be hard-wired into Massachusetts policymakers' DNA.

Where, then, should other states go from here? Regulatory federalism offers one intriguing possibility that turbo-charges the model of the states as laboratories of democracy.[50] Congress should sweep away the state-imposed trade barriers that forbid individuals and employers from purchasing health insurance from a state other than their own. Barring such federal action, individual states should unilaterally remove their own restrictions on residents purchasing coverage from other states. Doing so would require states to compete for premium tax revenue by providing the most desirable set of health insurance regulations.[51]

Barring federal action, individual states should unilaterally remove their own restrictions on residents purchasing coverage from other states.

Eliminating state-specific monopolies for the regulation of health insurance and moving toward a corporate law model would transform the market. It would also relieve the pressure on Congress to enact state-specific ERISA waivers or to regulate health insurance directly. Employers and insurers would be required to subject themselves to the laws and regulations of a single state, but allowed to select the state. As with corporate charters, this system would create a market for regulatory oversight, and would allow employers and insurers to select the regulatory regime that functions most efficiently and cost-effectively matches the needs and preferences of their risk pools. The ability of consumers, employers, and insurers to exit from the state's regulatory oversight (taking

their premium taxes with them) would temper opportunistic behavior by legislators and regulators. A race to the bottom would be unlikely because the state's residents would be the first to be affected.

In keeping with the cinematic framework of this paper, in the film *Groundhog Day* Bill Murray is forced to live the same day over and over again. The debate over the uninsured has had a similar feel for several decades, much as Elizabeth Perkins lamented in the film *Big*:

> All the same people having all the same discussion. It's like they cloned some party in 1983 and kept spinning it out again and again and again.[51]

If nothing else, Massachusetts has shaken up the monotony of debates over the uninsured, tempting one toward Bill Murray's conclusion at the very end of *Groundhog Day*: "Anything different is good."[53]

Notes

1. Noel C. Paul, "Massachusetts Conservatives," *New Republic*, July 20, 2004, online edition.

2. Quoted in Pam Belluck, "Massachusetts Sets Health Plan for Nearly All," *New York Times*, April 5, 2006.

3. Marilyn Werner Serafini, "The Mass.-ter Plan," *National Journal*, June 9, 2006, online edition. The legislative history for the plan is found at "Health Care Access and Affordability Conference Committee Report" (Affordability Report), April 3, 2006, www.mass.gov/legis/summary.pdf#search=percent22Massachusettspercent20Healthpercent20Carepercent20Billpercent22. Other useful sources on the plan include a series of web articles in *Health Affairs*. John E. McDonough et al., "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* 25 (2006): 420; John Holahan and Linda Blumberg, "Massachusetts Health Care Reform: A Look at the Issues," *Health Affairs* 25 (2006): 432; Elizabeth A. McGlynn and Jeffrey Wasserman, "Massachusetts Health Reform: Beauty is in the Eye of the Beholder," *Health Affairs* 25 (2006): 447; Tom Miller, "Massachusetts: More Mirage than Miracle," *Health Affairs* 25 (2006): 450; Nancy Turnbull, "The Massachusetts Model: An Artful Balance," *Health Affairs* 25 (2006): 453. Finally, the Policy Council held a panel discussion on health care reform in Massachusetts, keynoted by Gov. Mitt Romney on September 21, 2006. A transcript of "Health Care Reform: The Massachusetts Model" is available at http://policycouncil.nationaljournal.com/EN/ForumBriefs/200610/ed17dec0-a64d-42c7-8317-4c62af1357cc.htm.

4. Edmund F. Haislmaier, "The Significance of Massachusetts Health Reform," Heritage Foundation WebMemo no. 1035, April 11, 2006; Robert E. Moffit and Nina Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan," Heritage Foundation WebMemo no. 1045, April 20, 2006.

5. Families USA, "Massachusetts Becomes First State to Achieve Near-Universal Health Coverage," press release, April 18, 2006.

6. Arnold Kling, "Bill of Health," *Wall Street Journal*, April 7, 2006; Sally C. Pipes, "Massachusetts Will Fail," USA Today, April, 9, 2006; 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; J. P. Wieske, "Massachusetts' Health Care Reform Plan: Too Many Sticks; Not Enough Carrots," Council for Affordable Health Insurance's Great State Debate on Health Care Reform, May 2006. At the other end of the political spectrum, see Steffie Woolhandler and David Himmelstein, "Massachusetts Health Reform Bill: A False Promise of Universal Coverage," Physicians for a National Health Program, Resources, April 5, 2006. See also Serafini: "On the left, the AFL-CIO predicts that many low-income people won't be able to afford good insurance, and will get skimpy plans."

7. See also Michael D. Tanner, "Health Care Reform: The Good, The Bad, and the Ugly," Cato Institute Policy Analysis no. 184, November 24, 1992 (using a similar typology to consider the state of health reform proposals in 1992).

8. See Affordability Report (estimating that 550,000 people or 8.6 percent of the Massachusetts population is uninsured); U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States: 2005* (Washington: Government Printing Office, 2006), p. 27 (estimating that 10.7 percent of Massachusetts population is uninsured); Commonwealth Health Insurance Connector Authority Board of Director Meeting, June 7, 2006. ("In 2004, the Commonwealth's household insurance survey estimated that there were 460,000 people [7.2 percent] in Massachusetts without health insurance"), www.mass.gov/Qhic/docs/HCRnarrativefinal.doc.s

9. The Massachusetts health plan also includes other components. See Affordability Report.

10. The official website of the Commonwealth

Connector, www.mass.gov/?pageID=hichome page&L=1&L0=Home&sid=Qhic. See also Affordability Report.

11. Mass. Gen. Laws ch. 149, § 188(c)(1) (2007). This surcharge is expected to affect approximately 8 percent of the 35,000 Massachusetts companies with more than 10 employees and raise $26 million. "Massachusetts Proposes Minimum Standard for Employer-Based Care under New Law," *BNA Health Care Daily Report*, July 5, 2006.

12. David A. Hyman and Mark Hall, "Two Cheers for Employment-Based Health Insurance," *Yale Journal of Health Policy, Law, and Ethics* 2 (2001): 23–57. See also Federal Trade Commission and Department of Justice, "Improving Health Care: A Dose of Competition," 2004, chapter 5, pp. 5–6, 11–12; Paul Fronstin, "The Tax Treatment of Health Insurance and Employment-Based Health Benefits," EBRI Issue Brief no. 294, June 2006.

13. Hyman and Hall, pp. 23–57.

14. Affordability Report (projecting a 24 percent drop in non group premium costs). See also Haislmaier (noting insurers can offer innovative coverage options, including HSAs to those purchasing coverage through the Connector).

15. See Michael Tanner, "No Miracle in Massachusetts," pp. 5–6; McDonough et al., pp. 420, 426.

16. And that's before states try to bend the rules. For example, California Gov. Arnold Schwarzenegger proposes to expand Medicaid but have taxpayers in other states pay for more than their allotted 50 percent of the costs, because his reliance on Medicaid provider taxes allows him to pull down more federal dollars than California would put forward. See Michael F. Cannon, "Schwarzenegger's Health-Care Shakedown," *National Review*, online edition, January 22, 2007, www.cato.org/pub_display.php?pub_id=7169. The federal government has already taken some steps to restrict the use of provider taxes to further externalize the state's share of the costs of the Medicaid program to the federal fisc. It is likely that a naked grab for more funding by a single state trying to pay for coverage of non-Medicaid beneficiaries would trigger a more extreme response.

17. See David A. Hyman, "Getting the Haves to Come out Behind: Fixing the Distributive Injustices of American Health Care," *Law and Contemporary Problems* 69 (2006): 265 (cataloging different strategies for fixing the tax subsidy).

18. President's Advisory Panel on Federal Tax Reform, "Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System," 2005, p. 70.

19. See 2007 State of the Union, www.whitehouse.gov/news/releases/2007/01/20070123-2.html.

20. See Clark C. Havighurst, *Health Care Choices* (Washington: AEI Press, 1994), pp. 102–3 ("capping the tax subsidy is a notion that only a policy wonk could love, a meritorious policy idea with no natural political constituency").

21. Haislmaier.

22. *Retail Industry Leaders Association v. Fielder*, 2007 U.S. App. LEXIS 920 (4th Cir. 2007).

23. See Jeffrey Krasner, "Business Leader Suggests Health Law too Easy on Firms," *Boston Globe*, February 2, 2007.

24. Belluck.

25. For more on the predictable difficulties with enforcing the Massachusetts plan, see Michael Tanner, "No Miracle in Massachusetts," pp. 4–5.

26. This is true across the entire population, but age variation in pricing complicates matters. Health insurance for young adults is cheap (or would be in the absence of community rating), whereas auto insurance for the young is quite expensive.

27. Insurance Research Council, "IRC Estimates More than 14 Percent of Drivers Are Uninsured," news release, June 28, 2006.

28. Ibid.

29. See McDonough et al., p. 425.

30. See Kaiser Commission on Medicaid and the Uninsured, "Key Facts: Massachusetts Health Care Reform Plan," April 2006, p. 2.

31. Ibid., p. 2.

32. Ibid., p. 2.

33. See Haislmaier; and Belluck.

34. See Robert Pear and Raymond Hernandez, "States and U.S. at Odds on Aid for Uninsured," *New York Times*, February 12, 2007, p. A1; Ricardo Alonso-Zaldivar, "Schwarzenegger's Healthcare Reform Proposal Could Conflict with Bush's Aim to Balance Federal Budget," *Los Angeles Times*, January 30, 2007; Cannon.

35. Hyman, "Getting the Haves to Come out Behind," p. 265; Hyman and Hall, pp. 23–57.

36. Hyman, "Getting the Haves to Come out Behind," p. 265 ("government action generally favors the concentrated interests of incumbent

providers and hurts, rather than helps, consumers.")

37. "Health Care Reform: The Massachusetts Model."

38. This problem has repeatedly plagued the process of mandating benefits at the federal and state levels. See generally David A. Hyman, "Regulating Managed Care: What's Wrong with a Patient Bill of Rights," *Southern California Law Review* 73 (2000): 221; Hyman, "Getting the Haves to Come out Behind."

39. *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003 (1992).

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43. Alice Dembner, "Universal Plan Can Cost Under $300, Insurers Say," *Boston Globe*, February 5, 2007.

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49. *See* Christopher Rowland, "Mass. Health Plan Seems Unlikely to be U.S. Model: Demographics in State's Favor," *Boston Globe*, April 14, 2006; McDonough et al., p. 430.

50. *See New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932) ("it is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country").

51. *See* Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington: Cato Institute, 2005), pp. 115–16.

52. 20th Century Fox, *Big* (1988).

53. Columbia Pictures, *Groundhog Day* (1993).

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