Massachusetts Health Reform: Solving the Long-Run Cost Problem

Timely Analysis of Immediate Health Policy Issues

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Summary

Many of the features included in the Massachusetts health reform law, passed in early 2006, are being discussed as part of national reform. This paper is intended to inform the national debate and ongoing work in Massachusetts.

To date, the Massachusetts reform has had positive impacts on insurance coverage and access to medical care. The number of uninsured has fallen by more than half — with no evidence that subsidized coverage has "crowded out" private insurance. Unmet needs for a range of medical services have dropped, as have financial burdens associated with health care.

While the program has seen rapid enrollment, it has also seen higher than anticipated costs. Some of the cost problems are short term and should not be surprising for a major new initiative. But Massachusetts also faces a long-term cost problem.

Massachusetts' overall health care spending is higher than the national average and has grown more rapidly. We believe much of Massachusetts' high spending growth is due to problems in the hospital/physician market. The market is highly concentrated with several academic medical centers, most notably the Partners' Health System, being the dominant providers in local markets. While these academic medical centers typically have excellent reputations, they are also high-cost. Efforts by insurers to negotiate with the leading academic centers have proven difficult, if not impossible.

The problem of limited competition makes it extremely difficult for the state to address the growth in health care costs. If health care costs cannot be controlled, more and more people will become exempt from the individual mandate, and the cost of both Medicaid and low-income subsidies will increase. At stake ultimately is whether the Massachusetts reforms can survive.

We propose four options for addressing the long-term cost issues. The first option is to expand the managed competition model, and we suggest ways to do this. The second is to develop a public plan to compete with other insurers in the market and negotiate more effectively with providers. The third is to have the Connector negotiate on behalf of all CommCare and CommChoice plans over hospital and physician rates. The fourth is to develop an all-payer rate-setting system; all payers other than Medicare would use these rates, and they would apply to all providers.

Last, we suggest that Massachusetts take the final steps toward universal coverage by extending its mandate to children, restructuring subsidies to help more people, and addressing equity problems.

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In April 2006, the state of Massachusetts passed landmark health reform legislation.[1] Once fully implemented, the various components of the law are intended to bring the state close to universal coverage. This brief reviews the current status of the reform, summarizing significant accomplishments to date as well as the challenges faced in the near term and longer term.

The Massachusetts reform in many ways has become the model for the nation. The plans President-elect Obama and Senator Hillary Clinton espoused during the presidential primary campaign and the principles Senator Baucus announced are all derived to some degree from the Massachusetts experience.[2] The common features include an expansion of Medicaid, income-related subsidies, a purchasing arrangement, an employer assessment, and an individual mandate (in the Obama plan, only for children). It is reasonable to believe that any health reform enacted along these lines could achieve similar successes and would face similar problems as those experienced in Massachusetts. This paper is intended to contribute to the national health reform debate and continuing policy debates in Massachusetts.

The Reforms

The law, Chapter 58 of the Acts of 2006, titled "An Act Providing Access to Affordable, Quality, Accountable Health Care," expanded Medicaid (called MassHealth in Massachusetts) for children up to 300 percent of the federal poverty level (FPL) and restored coverage of certain adult groups where enrollment had been frozen. It established the Commonwealth Connector, a quasi-public entity, described more fully below, to organize the market and make affordable insurance products available.

The Connector provides insurance options on a subsidized basis for low-income adults and on an unsubsidized basis for small employers (not yet fully implemented) and higher income adults (through the new Commonwealth Choice or CommChoice program). The legislation placed a small assessment on employers with 10 or more employees who do not provide coverage or make a "fair and reasonable" contribution toward that coverage. It also requires those employers to offer a Section 125 or cafeteria plan. Finally, the law imposed a mandate on all adults to obtain coverage if there is an affordable product available to them. The law also merged the small employer and individual private insurance markets to bring down premiums in the latter with small increases in the former. The reforms have been phased in over the past two years, with nearly all components now in place.[3]

The Connector is a key component of the reforms. Its board has a major policymaking role in establishing the standards for affordable health coverage, the subsidy schedule for the CommCare program, and for the specific elements required for insurance coverage to satisfy the individual mandate provisions (termed "minimum creditable coverage"), as well as responsibility for operating the two new programs under health reform—CommCare and CommChoice.[4]

CommChoice is open to individuals and, in 2009, to firms with fewer than 50 workers. CommCare is available to adults with family incomes below 300 percent of the FPL who do not have access to employer-sponsored insurance (ESI). CommCare provides coverage through private managed care plans, which include comprehensive benefits, no deductibles, and limited cost sharing that increases with income. Premiums are free to those with income below 150 percent of the FPL, and are modest for those between 150 and 300 percent of the FPL, increasing with income. The premiums charged to CommCare enrollees are consistent with the affordability schedule established by the Connector board. All individuals eligible for CommCare are deemed to have affordable coverage available to them, and hence are subject to the individual mandate.

The affordability schedule is also used to determine whether an individual with income above 300 percent of FPL is subject to the mandate. If a policy that meets the affordability standard as well as the minimum creditable coverage provisions is not available, the individual is not required to enroll in an insurance plan. Unsubsidized coverage for all individuals seeking to purchase coverage directly is available through private plans. Those insurers participating in CommChoice must offer four different plans with actuarial values that are determined by the Connector Board.[5] The bronze plans have the lowest actuarial values of the three main plans, and those typically have deductibles of $2,000 for single coverage and $4,000 for family coverage. The silver and gold plans require less cost sharing; gold plans have no deductibles and small co-payments. The fourth actuarial level is available only to young adult purchasers. Since the plan levels (bronze, silver, gold, young adult) are set according to actuarial value standards as opposed to uniform benefit and cost-sharing designs, plans at the same level can have different benefits and cost-sharing requirements.

All of the Connector plans, including the bronze and young adult plans (YAP), satisfy the requirements of the individual mandate and if their premiums exceed the affordability standard for an individual's income, that person is not required to purchase coverage. Individuals can also purchase coverage through employers, if such an offer is available to them, or through the private nongroup insurance market that continues to operate outside of the Connector.

Massachusetts health reform has been praised by many observers and has been seen as a model for health reform in other states and nationally. It has received praise for the bipartisan support with which it was enacted and the speed of its implementation. Specifically, the work of the Connector board and staff have received high marks for establishing policies on affordability and the benefit package, negotiating rates with health plans, and the speed with which enrollment expanded. But it has also faced a barrage of criticism. It has been criticized by those who believe Massachusetts will fall short of universal coverage because the mandate will be ineffective, and that the reform structure is overregulated and overly prescriptive, particularly with respect to the benefit package.[6] Another criticism has been that the program's premiums are too high, leading to a significant number of people being exempt from the mandate.[7] Further it has been argued that there are no mechanisms in the program to control cost growth over time, thus the reform will prove unsustainable.[8] Criticism over the cost problems facing the state have been the frequent source of articles in the *Boston Globe*, the *Wall Street Journal* and the *New York Times*.[9]

Accomplishments to Date

The Massachusetts reforms have already had significant and positive effects on insurance coverage and access to medical care. The state reports that, as of August 2008, 439,000 people are newly insured.[10] Since April 2006, 72,000 people have been added to MassHealth and 176,000 to CommCare.[11] The remainder of the newly insured have new private coverage. There has been a reduction of 37 percent in the volume of care provided by the Free Care Pool and 41 percent in payments made by the Pool.[12] The four MassHealth managed care plans have actively competed for CommCare enrollees.

Six insurers offer bronze, silver, and gold, as well as young adult policies, to CommChoice enrollees.[13] CommChoice has been available since July 2007 but to date has only about 18,000 enrollees who purchase through the Connector;[14] this is expected to increase as the penalty for remaining uninsured is increased this year. Another roughly 14,000 are now buying coverage directly from carriers.[15] The individual mandate seems to be fairly effective thus far. Based on tax filings as of April 2008, only 97,000 uninsured adults had affordable coverage and were thus subject to the mandate in 2007 but chose to remain uninsured and

pay the penalty.[16] This number is likely to decline sharply as the penalties increase this year. A reported 69,000 individuals were deemed to be exempt from the mandate because they did not have access to an affordable health plan.[17]

In a recent study published in the journal *Health Affairs*, Urban Institute researcher Sharon Long reported extensive survey results showing the impacts of the new program.[18] Long conducted two surveys, the first in the fall of 2006, before most of the provisions were enacted, and the second in the fall of 2007. By the fall of 2007, the MassHealth expansion had occurred and CommCare and CommChoice were in place; however, the individual mandate had just been introduced and uninsured individuals had not yet been assessed the small 2007 tax penalty for failure to comply with the mandate.

Long reported that uninsurance among adults in Massachusetts dropped from 13 to 7 percent after reform. The uninsured rate fell from 24 to 13 percent among low-income adults (those with incomes below 300 percent of the FPL). The uninsured rate also fell for higher income adults, from 5 to 3 percent. The uninsured rate fell sharply among males from 18 to 9 percent and from 9 to 6 percent for females. The uninsured rate also fell dramatically for young adults, from 23 to 13 percent, while falling for other age groups as well.[19]

It is especially noteworthy that there was no evidence of subsidized insurance "crowding out" private insurance coverage.[20] The percentage of low-income people receiving coverage through their employers increased from 38 to 42 percent. While some had been concerned that private coverage could decline post-reform, the legislation did not create incentives for employers to stop offering insurance to their workers or for workers to stop taking it up. Employers offered coverage prior to the legislation without a mandate, thus there would be no reason to expect a decline when a small penalty was introduced for not providing coverage. In fact, as we predicted elsewhere, a properly designed individual mandate can increase the share of employers offering coverage, since workers would be seeking the most efficient avenues for satisfying the mandate.[21] The law also likely encourages employees to take up an offer of employer coverage. Additionally, there is no eligibility for CommCare if one is eligible for ESI and no eligibility for CommCare for six months if one's employer stops offering coverage, both provisions significantly decreasing the value of leaving employer-based insurance.

Long also found important improvements in access to care. There were post-reform increases in the percentages of people having a usual source of care, in the percent with preventive care visits, and in the percent with dental visits. There were lower levels of unmet need due to cost burdens, falling from 36 to 30 percent of low-income adults, with declines in unmet need due to cost for physicians, specialists, preventive care, tests, drugs, and dental care. The study did find that slightly more low-income people reported unmet need due to trouble finding a provider who would see them or trouble getting an appointment, increasing from 4 to 7 percent, a suggestion that provider supply may be insufficient to meet demand in certain geographic areas. Finally, Long found a substantial drop in out-of-pocket costs and a decline in the percentage of people reporting difficulty paying medical care expenses.

Further, the public support for Massachusetts health reform has stayed high; over 70 percent of the public continues to support health reform.[22] Moreover, the broad base coalition of Democrats and Republicans that voted to enact the legislation has remained supportive. This is critical in helping the state deal with difficult issues as they arise.

Costs—The Short-Term Problem

While the results on coverage and access are highly promising, the issue of the rising cost of the program is receiving increasing attention, typically negative, with some suggesting that spending is out of control and that the program is doomed to failure. There is considerable debate about the extent of this problem and its causes. Table 1 provides data from numerous sources that have been

Table 1. CommCare Enrollment and Expenditures

	Enrollment [c,d] (enrollees)	Conference Committee Projections[a] (in millions)	Funding or Requested Budget for Fiscal Year[b] (in millions)	Actual Costs or Current Projections[b] (in millions)	Commonwealth of Massachusetts Information Statement Projections[c] (millions, actual or projected)
FY2007	132,919[d]	$ 160		$ 133	$ 133
FY2008	175,617[c]	$ 400	$ 472	$ 625	$ 647
FY2009	255,000[c]	$ 725	$ 869		$1,082[e]

[a] http://www.aishealth.com/HealthReform/State_Massachusetts.html
[b] Health Connector Facts and Figures, May 2008
[c] Commonwealth of Massachusetts Information Statement, April 16, 2008, Linked from http://blog.hcfama.org/?p=1619
[d] "Revisiting Massachusetts Health Reform: 18 Months Later," December 2007, Community Catalyst
[e] This figure is an over-estimate as it was based on assumed enrollment increases in CommCare that are no longer expected to materialize.

repeatedly cited in the press to show the extent of the current spending problem. The original estimate when the legislation was enacted was that the program would cost $160 million in FY 2007, $400 million in FY 2008 and $725 million in FY 2009.[23] Actual costs seem to have been lower in FY 2007, $133 million, but have increased rapidly since then, substantially more than what had originally been projected.[24] The $625 million in FY 2008 was considerably in excess of the amount that had been requested in the budget for 2008.[25] The amount requested for fiscal 2009 is $869 million.[26] Another source projected that this could increase to as much as $1.1 billion,[27] but that was based on assumed enrollment increases in CommCare that are no longer expected to materialize.

There are several reasons for the higher than expected costs of the program. First, there has been much higher enrollment in subsidized programs than had been expected. Enrollment growth has increased tremendously over the period, from 132,900 enrollees in CommCare in FY 2007 to 175,600 in 2008.[28] It is estimated that there are now 250,000 new enrollees in MassHealth or in CommCare. In part, the surprisingly high number reflects the fact that early estimates relied on the state's household insurance survey, a telephone survey of households. It seems clear that the survey underestimated the size of the population below 300 percent FPL and the number of uninsured people. The state survey projected 370,000 uninsured people in 2006, compared to a projection of 530,000 uninsured based on analyses using the Current Population Survey conducted by the Urban Institute.[29] (Massachusetts has subsequently contracted with the Urban Institute to develop and implement a new survey, which has recently completed its first round.[30]) The underestimate of both the number of uninsured and the number of people in the income range eligible for subsidies based on the earlier survey has been a major factor in the unexpected size of enrollment in CommCare.

But there are other factors as well. The subsidy schedule that was eventually agreed upon by the Connector Board was more generous than had originally been anticipated. Full premium subsidies were made available to those below 150 percent of the FPL (as opposed to 100 percent) and the amount people were deemed able to pay for health insurance, i.e., the affordability schedule, increased relatively slowly as income increased, shifting more costs to the government than had originally been anticipated.

Next, there appears to have been some adverse selection into CommCare. Those uninsured who enrolled in the first year were less healthy than the overall uninsured population.[31] There has also been a disproportionate share of those who have signed up for CommCare who are eligible for full subsidies as opposed to a more even spreading of enrollment among those who are both fully and partially subsidized.[32] Cost data provided by the Connector support the view that increases in the cost of CommCare are a function of enrollment growth.[33] The Connector provides data that show that per member per month costs have been relatively flat between 2007 and 2008, and that projections for premium growth in 2009 are just under 4 percent. There are similar findings with regard to CommChoice where premium increases have averaged about 5 percent. These low rates of increase are consistent with the discussion above, e.g., the early enrollment of less healthy and lower income (CommCare) people followed by enrollment of those who are healthier.

All of these problems are likely to be short-term in nature and should not be surprising for a major new initiative. Enrollment will continue to increase, but the underlying numbers of uninsured and low-income people are now better understood.[34] While the initial enrollment resulted in some adverse selection, the next round of enrollment increases that will occur because of the mandate will likely be largely from healthier enrollees, slowing the increase in the average cost of CommCare plans. Government costs associated with new enrollees will be lower than the average for the initial enrollees because the new entrants will be higher income on average and thus required to pay some of the premiums. This would explain the modest increases in CommCare premiums.

Costs—The Long-Term Problem

The Massachusetts reform, however, also faces a long-term cost problem. Part of this stems from the fact that the Massachusetts plan was partially financed with (and depends on) federal funds through a Medicaid waiver. These funds came into the state in various ways, but their main objective was to support safety net providers. Under the waiver agreement in 2005, these funds were to be reallocated and used to finance the subsidies for the purchase of insurance in CommCare. In the original waiver agreement, the federal government provided $16.9 billion dollars over three years to the financing of reform. A major issue in Massachusetts has been whether this waiver would be renewed. Without renewal, the viability of the reform was in doubt. On September 30, 2008, the federal government agreed in principle to a renewal of the waiver, increasing the amount of waiver funds to $21.2 billion over three years retroactive to July 1, 2008. The money will allow the state to continue funding CommCare subsidies as well as to fund the residual safety net "free care" pool.

But the broader problem is that the state's overall health care spending on a per capita basis is substantially higher than the national average and has recently been growing more quickly. Data compiled by the Massachusetts Division of Health Care Finance and Policy and presented on February 6, 2008,[35] showed that:

- Massachusetts' health spending increased by 34.7 percent between 2000 and 2004, or 7.7 percent per year. Health spending more than doubled between 1991 and 2004.

Massachusetts' per capita income between 2000 and 2004 increased at an average rate of 1.0 percent per year.

- On a per capita basis, health spending is more than 26 percent higher in Massachusetts than in the United States as a whole and grew somewhat faster between 1991 and 2004. Spending in Massachusetts increased from $3,249 per capita in 1991 to $6,683 per capita in 2004. The comparable numbers for the United States as a whole were $2,654 in 1991 and $5,283 in 2004. A small share of the higher Massachusetts spending is due to medical research.
- Hospital expenditures accounted for half of the difference between Massachusetts and U.S. per capita health spending. Of the difference of $1,400 in per capita spending, $689 was attributable to differences in hospital spending per capita.
- Hospital care also accounted for a larger share of spending increases in Massachusetts than in the United States. Between 2000 and 2004, hospital spending accounted for 45 percent of health care expenditure increases in Massachusetts. In the United States, hospital spending accounted for 36 percent of the spending increase between 2000 and 2004.
- While health care spending increased by 33 percent between 2000 and 2004 in Massachusetts, health insurance premiums increased by 53 percent for individual policies and 44 percent for family policies.
- Health insurance premiums increased by 8.9 percent per year in Massachusetts between 2001 and 2007, faster than the U.S. average growth in premiums of 7.7 percent.

These data clearly show that health spending in Massachusetts is higher than the United States on average and is growing at a faster rate. Furthermore, health insurance premiums are growing even faster than health care costs in the state. Finally, hospitals account for a larger share of health spending in Massachusetts than in the rest of the United States. While these data are a bit old, some more recent data suggest these trends are continuing. For example, data from the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) indicate that individual and family premiums grew by 5.0 and 7.5 percent respectively in Massachusetts vs. 3.2 and 6.1 percent respectively in the United States between 2005 and 2006.[36] The underlying reasons for spending growth in Massachusetts are, in part, the same as those affecting the nation as a whole, e.g., increases in chronic illness, the growth in technology, the increasing costs of prescription drugs, and so on. However, the fact that costs are increasing faster in Massachusetts than in the rest of the country suggests that either utilization of existing services is increasing faster, new technologies are being adopted and dispersed quicker, or payments to providers are growing faster than is the case elsewhere.

Massachusetts is also faced with market imperfections that are likely contributing to high health spending growth. The hospital/physician market in Massachusetts is highly concentrated, with several academic medical centers that are the dominant provider systems in their local markets. In general, these medical centers provide state-of-the-art care, employ cutting-edge technologies, have outstanding physician leadership and are leaders in introducing electronic medical records and care coordination programs. But there seems to be little evidence of active competition on cost and prices between the dominant players and with the other hospitals in their local markets; thus, cost growth in the state is driven by the market power of the leading health care systems.

Efforts by insurers to develop plans that do not include the dominant systems seem unlikely to be successful. For example, Len Nichols and colleagues report that the Partners' system has successfully blocked efforts to develop tiered networks by "refusing to contract with any plans that would place them in a tier other than the preferred one."[37] There is widespread demand on the part of employers and individuals to have the leading academic medical centers in their provider networks. This strong preference on the part of the purchasers of insurance makes it difficult for insurers to offer products with more limited networks and constrains them in rate negotiations. For example, in 2000, when the Tufts Health Plan balked at the rate increase demanded by the Partners' system, Partners refused to contract with Tufts, leading the latter to accede to Partners' demands to avoid the loss of members.[38] Other hospitals appear to be unable or unwilling to compete aggressively with the dominant players on price. Though hard to prove, they appear to be content with shadow pricing.

The insurance market is also less than competitive. Blue Cross/Blue Shield has a dominant market share, accounting for over half the covered lives outside of MassHealth and the state employees' health plan.[39] Other insurers have a difficult time competing with Blue Cross because of its size, name recognition and ability to negotiate with multistate companies. As a result, they do not seem to compete over premiums to gain market share. The lack of serious competition in the insurance market reduces the incentive for the dominant insurer to use its market power in negotiations over rates with the major hospital systems.[40]

This problem is not unique in Massachusetts. Insurance markets in most states have become dominated by a small number of large insurers. For example, James C. Robinson found that in all but 14 states, three or fewer insurers accounted for 65 percent of the commercial market in 2003.[41] Robinson found that 34 states had highly concentrated insurance markets, using standards established by the Department of Justice (DOJ) and the Federal Trade Commission (FTC). He also found that medical costs grew considerably faster than inflation between 2000 and 2003 in the United States, but that private insurer revenue increased even faster. Thus the market power of insurers meant that they were not only able to pass on increasing health care costs to purchasers, but to increase their profitability at the same time.[42]

Dominant insurers do not seem to be able or willing to use their market power to effectively negotiate with consolidated hospital systems. Hospital consolidation has expanded rapidly since about 1990 in response to the growing power of insurers.[43] It is estimated that there has been a one-third reduction in the number of local hospital systems since 1990 and that 88 percent of large metropolitan areas now have highly concentrated hospital markets, based on measures used by the FTC and the DOJ.[44] The results from several studies on the impact of market concentration suggest that hospital prices are considerably higher in highly concentrated markets than in others.[45] This is particularly true in markets in which there are mergers among hospitals that are close to each other. One study estimated that such mergers increased prices by about 40 percent over the long term for both the merged hospitals and their rivals in those markets.[46] There is also evidence of shadow pricing in that rival hospitals have also increased prices in response to market consolidation.[47] The increased concentration of both insurers and hospital markets means that the nation is not reaping the benefits of competition.

These problems of concentrated market power, while not unique to Massachusetts, make it extremely difficult to address the growth in health care costs. The issues at stake in the control over health care costs are quite serious. With health care cost increases out-stripping growth in the state's tax base, taxes will have to be increased to support both MassHealth and the low-income subsidies under CommCare. If it is politically infeasible to increase taxes, then either coverage must be cut back or the subsidies will not keep pace with the increasing costs of insurance, and many low-income people could become exempt from the mandate. Similarly, for those above 300 percent of the FPL, those not eligible for subsidies, increasing health care costs relative to incomes would lead to many more people being exempted from the mandate. Gradually, the Massachusetts reform could unravel unless cost growth is controlled.

Options for Addressing the Long-Term Cost Problem

There are several policy options that the state could consider. These include steps to spur the adoption of electronic health records, expand prevention efforts particularly in the area of obesity, and invest in chronic care management. But the evidence on the effectiveness of these measures is somewhat mixed and suggests that savings are likely to be small.[48] More dramatic steps are likely to be necessary. In this section, we suggest four alternative proposals. We recognize that some of these proposals may not be politically feasible in the short term, but we believe that it is important that policymakers debate a range of options to assure the long-term viability of the reforms.

Managed Competition.
The first option to address long-term cost issues is a managed competition model. In fact, the CommChoice program operates under just such a model. Under CommChoice, the Connector has established a set of rules that insurers must follow. Each plan must offer three options (in addition to a young adult policy) with premiums that vary with out-of- pocket cost exposure; provider networks may also vary. The three options are priced to reflect the actuarial values of the plans, not the risks presented by those who enroll. That is, the difference in premiums between a comprehensive plan and a lower-actuarial-value plan reflects only the differences due to plan generosity, not differences in the risk of enrollees in the different plans.[49] But individuals choosing more comprehensive benefits or plans with more inclusive provider networks pay the full additional costs of those upgrades. Thus there is an incentive for individuals to choose plans with more tightly managed care, with higher out-of-pocket costs or with more restricted networks. The intent is to make individuals more cost conscious in their purchase of insurance and health services, thus putting pressure on providers to hold down costs.

There are two serious problems with this model, however. First, CommChoice is too small at this point to effectively drive the market, having only 18,000 covered lives. The Connector's market power is enhanced because insurers must price products offered outside the Connector at the same premiums, but it is still limited. Second, there is limited competition in the hospital markets. If insurers now do not have enough market power to control provider utilization and prices, it is difficult to see how individuals facing higher out-of-pocket costs could do so. That is, while individuals in principle can change insurers in response to higher premiums, it is not clear that this will mean that insurers will negotiate more effectively with providers.

There is one obvious solution to address the first of these problems. That would be to open up CommChoice and CommCare to all employers, not simply those with 50 or fewer workers. Any employer who can do better financially by purchasing through the Connector could do so. Ideally, the firewall between CommChoice and CommCare plans would be eliminated. All individuals could be allowed to choose among any of these plans, but with the subsidies for the low-income population tied to the more comprehensive CommCare plans. Low-income workers whose employers make health insurance contributions for them would apply those contributions to the CommCare plans, receiving government subsidies on the remaining premiums when appropriate. In this way, workers with incomes below 300 percent of the FPL working in offering firms would no longer be shut out of CommCare's comprehensive low-cost sharing plans at very affordable prices. Employers would be required to make the same premium contribution on behalf of each worker and would not be allowed to offer a plan both outside the Connector and inside the Connector. The largest employers presumably have the efficiencies of large group purchases and lower administrative costs and would not be attracted to the Connector in any event, but many other employers would be.

This approach would also mean that more lower-income individuals would be eligible for CommCare subsidies giving the state a one time bump in subsidy costs; however, the increase would be small. Since employers would have to make the same premium contribution to all workers, the income- related subsidies in the Connector would only apply to the employee's share.

While any increases in subsidies would be difficult in the current fiscal environment, over the long term it would give the Connector significantly more size and allow the managed competition model to fully evolve. The larger Connector plans could increase insurer negotiating power with providers, although, as discussed previously, that will not necessarily lead to insurers being more successful in such negotiations. But such a strategy could reveal the extent to which the fixed employer contribution approach would lead to individuals choosing more cost-effective plans, thus putting pressure on insurers to contain price and utilization of services.

A New Public Insurance Option. A second strategy to address long-term cost issues is for the state to develop a new public health insurance option open to the subsidized and unsubsidized populations that would operate similarly to the traditional Medicare program. The notion is like that espoused by President-elect Barack Obama and Senator Hillary Clinton in the recent Democratic primary.[50] The plan could adopt Medicare payment rules that would perhaps pay, at least initially, above Medicare levels. MassHealth payment rates could be aligned with those of the new state plan, though payment rates would at least initially be lower. Some providers may be unwilling to participate. But since most participate in MassHealth and Medicare, this seems unlikely since the new plan would pay higher rates. In principle, providers that participate in MassHealth could be required to participate in the new public plan or face penalties, but that will likely be unnecessary. The new state plan would be responsible for claims payment, utilization review, development of disease management and chronic care coordination programs, and so on. The basic intent is to use the power of a large strong buyer to bring down provider payment rates.[51] The new plan could be offered as the only plan in CommCare or as a plan that would compete with existing plans. It could also be offered as well as an option within CommChoice, to individuals and employers who purchase coverage through the Connector, and to state employees.

Because the state funded plan would be offered as a choice, employers and individuals would be free to choose a private insurance plan. It is likely that many employers and individuals would choose other insurance products, but the presence of the state plan would force insurers to compete with a plan with strong bargaining power and, as an arm of state government, a powerful financial interest in containing costs. Only those private plans with the ability to compete would survive. At the same time, a strong public plan cannot afford to seriously underpay providers because it will have responsibility for the viability and stability of the state's health system.

The Connector as Negotiator. The third alternative is to have the Connector negotiate on behalf of all CommCare and CommChoice plans over hospital and physician rates. The underlying assumption is that current insurers are unable or unwilling to exert market power and, thus, are not able to control health care spending in the state. The Connector might by joined by the Group Insurance Commission (the state employee plan) and MassHealth to jointly negotiate over rates. This alternative would be more effective if the Connector were opened up to larger firms or even to all residents to provide more leverage with providers. Again, individuals would not be required to choose a plan within the Connector; however, Connector plans would likely have the advantage of lower premiums due to its greater negotiating power.

The cost control under this approach would extend beyond the plans offered within the Connector because it would put competitive pressures on other plans to control health care spending. Failure to do so by those plans would mean that employers and individuals would increasingly migrate to the plans offered through the Connector. Efforts by hospitals to shift costs to plans outside the Connector would likely be in vain, since doing so would increase premiums in those plans and lead more people to enroll in Connector plans. This model could result in strong cost containment incentives without forcing all providers to live with the same rates for all payers.

All-Payer Rate-Setting
The fourth alternative, and one likely to engender the most controversy, is for the state to return to an all-payer rate-setting system that determines payments to hospitals, doctors, and other providers. The payment system would generally follow Medicare principles, paying some percentage above Medicare rates and controlling the rate of growth in prices over time. All payers would be required to use these rates, applying them to all providers and for the benefit of all individuals. MassHealth rates would be gradually improved, bringing their rates up to the same level as other insurers for all providers. Technical adjustments would be necessary to account for hospitals' teaching and uncompensated care responsibilities. This option is different than the third alternative as the rates would apply throughout the state health care system, instead of only to those plans providing coverage through the Connector (and, potentially, the state employees plan and MassHealth).

All-payer rate-setting systems have not always been successful (Maryland is the only surviving system from all those implemented in the 1980s), but the stakes are much greater now. While controversial, all-payer systems have the potential to effectively control hospital and physician payment rates and could be the difference between the failure of the Massachusetts reform effort and its success. A major disadvantage is the constant threat of providers lobbying the legislature, thus weakening rate-setting

pressures. This threat exists in the two previous models as well but would likely be greater in an all-payer system because there is no alternative for providers but to accept the system's rates.

While it has substantial cost-saving potential, regulatory approaches like all-payer rate-setting require the state to take on huge responsibilities, necessitating that the state balance the desire for cost control with the need to maintain the financial viability of the health care system.

Other Issues

Besides the cost issues, there are some remaining problems with the basic design of the Massachusetts approach. While these could be remedied, it would mean increased costs to the state. First, only adults are subject to the mandate. Extending the mandate to children would move toward universal coverage for that population. The remaining number of uninsured children is relatively small, but it is odd that they have not been subject to the mandate.

Second, the structure of the subsidy schedule results in people just above 300 percent of the FPL finding coverage unaffordable, and substantial numbers of this income group are exempt from the mandate. This number could grow in the future as health care costs increase relative to income. An alternative subsidization approach is for the state to pay the difference between the lowest cost premium in the CommChoice plan and the percentage of income dictated by the affordability schedule.For example, if the premiums for the benchmark plan were 10 percent of income and the affordability schedule dictated that the individual pay no more than 7 percent of income for premiums, the government would pay the difference. The amount that the state would have to pay to partially subsidize this population would be relatively small, and it would ensure that no one would be exempt from the mandate. With such a provision the state could truly achieve universal coverage. Of course, if cost growth is not brought under control, then the difference between premiums and the affordability schedule will grow over time; thus, once again, cost control is vital.

Third, under the current structure, low-income workers are disqualified from enrolling in CommCare's subsidized insurance plans if their employers make even relatively modest contributions toward a health insurance plan at the workplace. They are, however, only required to take up their employer's coverage if it is affordable. But this may leave low-income individuals uninsured who would otherwise be eligible for CommCare, simply as a consequence of their employers' offer decisions. Ideally, these individuals would be allowed to enroll in CommCare and bring their employer's health insurance contribution to the program. The employer's contribution could offset a portion of the government's cost of providing coverage, and the individual could be appropriately subsidized on the remainder of the CommCare premium.

While the Employee Retirement Income Security Act (ERISA) prohibits the state from requiring an employer to make such a contribution to CommCare, the employer should be indifferent between an individual worker using the contribution for the firm's plan or for CommCare. Consequently, it is likely to be almost as effective to merely provide the employer the option of doing so for its workers. If an employer chooses to do so, it could make its health insurance contribution to CommCare on behalf of its income-eligible workers instead of using it to enroll the worker in the firm's own plan. If the employer offered coverage to its workers but did not choose to make CommCare available to low-income employees, those employees would not be eligible for the subsidized program. This option could lead to substantially increased insurance affordability for low-income workers in offering firms, while keeping the employer health insurance dollars in the system.

Fourth, for those with modest incomes but who do not qualify for the CommCare program (i.e., those between 300 and 400 percent of the FPL), the bronze CommChoice plans carry potentially large out-of-pocket liabilities relative to their incomes. Most bronze plans have $4,000-$5,000 out-of-pocket maximums ($5,000 is 16 percent of income for a single adult just above 300 percent of the FPL, $4,000 is about 13 percent of income), and not all co-payment responsibilities count against those maximums. The cost-relative-to-income problem could be addressed by additional subsidization for high medical need, modest-income persons above 300 percent of the FPL, say by limiting the out-of-pocket liabilities in bronze plans for those between 300 and 500 percent of the FPL.

Conclusion

Massachusetts has successfully implemented major health reform legislation. It has established the Connector, which makes both subsidized and nonsubsidized products available, and has begun to enforce an individual mandate. The number of uninsured has fallen dramatically, and there is also evidence of improvement in access to health care across a wide variety of measures. Public support for the health reforms remains high.

At the same time, the state has been faced with unexpectedly high costs. These are related in part to higher than expected enrollment growth in CommCare, but are also due to other factors, such as adverse selection into the pool, underestimates of the low-income uninsured population, and a subsidy schedule that was more generous than originally anticipated. These short-term problems will fade as the program matures. But the state faces long-term problems related to the high cost of health care in the state. Massachusetts health care costs are high and have been growing at least as fast as those in the United States, with health insurance premiums increasing even more rapidly. A higher share of health care costs in the state compared to the United States as a whole occurs in hospitals.

The underlying reasons for general health care cost growth are the

growth in new technologies (including pharmaceuticals) and the increase in chronic illness; these are issues throughout the United States. The cost problems in Massachusetts are exacerbated by the market power of a number of academic medical centers and a lack of serious competition in both the insurance and hospital markets. These problems are not unique to Massachusetts; there has been growing concentration in both the insurance and hospital markets throughout the country. There is increasing evidence that growing concentration, particularly on the provider side, is a significant contributor to health care cost growth.

We discussed four options for controlling health care costs. The first is to expand the role of the Connector, opening it up to more businesses and individuals so that a managed competition model may be adequately tested. The market could reduce cost growth by making individuals more cost conscious. It is not clear, however, that individuals behaving more economically can offset the problems of market power and limited competition in the insurance and hospital markets.

The second alternative is for the state to develop a public health insurance plan that is open to the subsidized and unsubsidized populations and would compete with existing health plans in MassHealth, CommCare, CommChoice, and the state employees' health plan. The public plan would use its bargaining power to constrain provider rates, institute cost-effective treatment protocols, and, thus, introduce more effective competition in the market.

A third alternative is to have the Connector/state negotiate hospital rates and physician fees on behalf of plans participating in CommCare, CommChoice, and, perhaps, the state employees' plan, as well as MassHealth. The goal would be to amass significant bargaining power to allow the Connector to gain control relative to hospitals and physicians. Individuals and firms could still choose other insurance plans. The final alternative goes the farthest and would have the state return to an all-payer rate-setting system. The state would constrain rates paid by all payers (other than Medicare) to all providers on behalf of all individuals.

In addition to cost containment alternatives, we suggest that the state take the final steps in moving to universal coverage by extending the mandate to children, restructuring subsidies to provide some financial help to those above 300 percent of the FPL, and addressing the equity issue that exists when employees are required to take up their employer's coverage even when, given their incomes, they would be eligible for subsidies in CommCare.

Notes

[1] Blue Cross Blue Shield of Massachusetts Foundation, "Massachusetts Health Care Reform Bill Summary," 30 June 2006, http://www.bcbsmafoundation.org/foundationroot/en_US/documents/MassHCReformLaw Summary.pdf (accessed 19 October 2007); and J. Holahan and L. Blumberg, "Massachusetts Health Care Reform: A Look at the Issues," *Health Affairs,* 25, No. 6 (2006): w432-w443.

[2] Max Baucus, "Call to Action, Health Reform 2009," US Senate Finance Committee White Paper, November 12, 2008, http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf

[3] Two important exceptions are the expansion of CommChoice to small employers, now in a pilot phase, and establishment of the standard for minimum creditable coverage for the individual mandate, scheduled to go into effect in January 2009.

[4] http://www.mahealthconnector.org/portal/site/connector/

[5] http://www.mahealthconnector.org/portal/site/connector/

[6] K. Sach, "Massachusetts Faces a Test on Health Care," *The New York Times*, November 25, 2007; E. Haislmaier, "The Massachusetts Health Reform: Assessing Its Significance and Progress," Heritage Lectures, September 21, 2007; M. Tanner, "Lessons from the Fall of RomneyCare," Cato Institute, January/February 2008.

[7] S.C. Pipes, "At One Year, the Massachusetts Healthcare Plan Falls Short," *The Boston Globe,* May 15, 2007.

[8] "I Am Not a Health Reform," *The New York Times,* December 15, 2007; R. Kuttner, "A Health Law with Holes," *The Boston Globe,* January 28, 2008; M. Angell, "Health Reform You Shouldn't Believe In," *The American Prospect,* April 21, 2008.

[9] A. Dembner, "Healthcare Cost Increases Dominate Massachusetts Budget Debate: Controlling Them Said Key to Keeping Universal Coverage," *The Boston Globe*, March 26, 2008; "The New Big Dig," *The Wall Street Journal,* May 21, 2008; K. Sack, "Massachusetts Faces a Test on Health Care," *The New York Times*, November 25, 2007.

[10] Commonwealth of Massachusetts, Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," Quarterly Report, August 2008. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/key_indicators_0808.pdf

[11] Ibid.

[12] Ibid.

[13] Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, Tufts Health Plan. CommChoice website, linked from: http://www.mahealthconnector.org/portal/site/connector/

[14] The Massachusetts Health Insurance Connector Authority, "Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008," October 2, 2008.

[15] Ibid.

[16] Ibid.

[17] Community Catalyst, "Massachusetts Health Reform: What's the Real Story?" August 2008. http://www.communitycatalyst.org/doc_store/publications/mass_health_reform_august_2008.pdf

[18] Sharon K. Long, "On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs*, 27, No. 4 (2008): w270-w284.

[19] Sharon K. Long, "Who Gained the Most Under Health Reform in Massachusetts?" Massachusetts Health Reform Survey Policy Brief, October 2008, www.urban.org.

[20] Jon R. Gabel et al., "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs,* 27, No. 6 (2008) w566-w575; Sharon Long and Paul Masi, "How Have Employers Responded to Health Reform in Massachusetts? Employees' Views at the End of One Year," *Health Affairs,* 27, No. 6 (2008) w576-w583.

[21] Linda J. Blumberg, John Holahan et al., "Toward Universal Coverage in Massachusetts," *Inquiry*, 43, No. 2 (2006): 102-121.

[22] Robert J. Blendon et al., "Massachusetts Health Reform: A Public Perspective from the Debate through Implementation," *Health Affairs*, 27, No. 6 (2008) w556-w565.

[23] http://www.aishealth.com/healthreform/state_massachusetts.html

[24] The Massachusetts Health Insurance Connector Authority, "Facts and Figures," May 2008.

[25] Ibid.

[26] Ibid.

[27] Commonwealth of Massachusetts Information Statement, April 16, 2008, linked from http://blog.hcfama.org/?p=1619

[28] Community Catalyst, "Revisiting Massachusetts Health Reform: 18 Months Later," Issue Paper, December 2007, http://www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf

[29] Linda J. Blumberg, John Holahan et al., "Toward Universal Coverage in Massachusetts," *Inquiry*, 43, No. 2 (2006): 102-121.

[30] Sharon K. Long, Allison Cook, Karen Stockley, "Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey." Division of Health Care Finance and Policy, Executive Office of Health and Human Services, December 2008, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_08.ppt.

[31] Sharon K. Long. 2008. "On the Road To Universal Coverage: Impacts of Reform in Massachusetts at One Year," *Health Affairs* July/August. 27(4): w270-w284.

[32] Ibid.

[33] http://www.mahealthconnector.org

[34] A major uncertainty, however, is how the severe recession the U.S. is now experiencing will affect private coverage and the uninsured.

[35] Commonwealth of Massachusetts, Division of Health Care Finance and Policy, "Massachusetts Cost Trends:1991-2004"; February 6, 2008.

[36] Calculations using Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), Summary data tables, II.C.1 and II.D.1, 2005 and 2006. http://www.meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

[37] Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs,* 23, No. 2 (2004): 8–21.

[38] "A Handshake That Made History," The Boston Globe, December 28, 2008.

[39] Blue Cross Blue Shield of Massachusetts appears to cover 63 percent of the private insurance market in the state. Blue Cross Blue Shield, "About Us," http://www.bluecrossma.com/common/en_US/aboutUsIndex.jsp says the organization covers 3 million residents. Roughly 4,77,000 Massachusetts residents are covered by private insurance, including the elderly and those with multiple types of coverage, according to Urban Institute tabulations of the 2008 Annual Social and Economic Supplement to the Current Population Survey.

[40] "A Handshake that Made Healthcare History," Boston Globe, December 28, 2008.

[41] James C. Robinson, "Consolidation and Transformation of Competing in Health Insurance," *Health Affairs,* 23, No. 6 (2004): 11–24.

[42] Ibid.

[43] A. E. Cuellar, P. J. Gertler, "Trends in Hospital Consolidation: The Foundation of Local Systems," *Health Affairs* 24, No. 6, November/December 2003; D. Dranove, C. J. Simpson, and W. D. White, "Is Managed Care Leading to Consolidation in Health Care Markets?" *Health Services Research*, 37, No. 3 (2002): 573–94.

[44] W. B. Vogt and R. Town, "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" Robert Wood Johnson Foundation Research Synthesis Report 9, February 2006.

[45] A.E. Cuellar and P.J. Gertler, "How the Expansion of Hospital Systems Has Affected Consumers," *Health Affairs,* 24, No. 1 (2005): 213–19; C. Capps and D. Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs,* 23,

No. 2 (2004): 175–81; C. Capps and D. Dranove, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics,* 34, No. 4 (2003): 737-763; E.B. Keeler, G. Melnick, and J. Zwanziger, "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior," *Journal of Health Economics,* 18, No. 1 (1999): 69-86; R. Krishnan, "Marketing Restructuring and Pricing in the Hospital Industry," *Journal of Health Economics,* 20, No. 2 (2001): 213-237.

[46] L. Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," Mimeo, Northwestern University, 2005.

[47] M. Gaynor and W. B. Vogt, "Antitrust and Competition in Health Care Markets," in *Handbook of Health Economics*, edited by A. J. Culyer and J. P. Newhouse (New York: North-Holland, 2000); M. G. Vita and S. Sarber, "The Competitive Effects of Not for Profit Hospital Mergers: A Case Study," *Journal of Industrial Economics,* 49, No. 1 (2001): 63-84.

[48] The Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," December, 2008.

[49] The rates for those plans are identical whether purchased through the Connector or purchased directly from the insurers outside of the Connector.

[50] Jacob Hacker, "Health Care for America: A Proposal for Guaranteed, Affordable Health Care for All Americans Building on Medicare and Employment-Based Insurance," Economic Policy Institute Briefing Paper 180, Washington, D.C., January 11, 2007, http://www.sharedprosperity.org/bp180/bp180.pdf

[51] John Holahan and Linda J. Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Cost of Health Reform?" The Urban Institute, http://www.healthpolicycenter.org, October 23, 2008.

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