The New England Health-Care Experiment

by Brian P. Rosman, Health Care For All

New England *is* embarking on several ambitious health-care policy experiments. The goal is expanding affordable health coverage to the uninsured, and the mechanism is comprehensive legislation. Legislation was passed in Maine in 2003, and in Massachusetts and Vermont in 2006. All three plans are still in the process of being implemented, but collectively they provide models for national health-reform efforts.

The most far-reaching version is in Massachusetts. The legislation–known as Chapter 58–is premised on shared responsibility. Government, employers, insurers, providers, and patients all have obligations and benefits under the legislation. The final evaluation will take years, but implementation at this point should be judged a qualified success.

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Why Massachusetts?

The Bay State has a history of blazing health-care trails. In 1988, Governor Dukakis led a universal health coverage initiative based on the "pay-or-play" model, which would have imposed an assessment on employers that failed to provide coverage to their workers. That provision of the law was never realized, but other provisions, including expanded coverage for the disabled, students, and pregnant women, were successfully implemented and became national models.

In 1996, Governor Weld and the legislature overhauled the Commonwealth's Medicaid system into a streamlined program called "MassHealth," renamed to remove the welfare stigma usually associated with Medicaid. That program simplified the application process, expanded coverage to children and unemployed adults, and pioneered assisting low-income workers with premiums so they could sign up for coverage from their employers.

Commonwealth Care is subsidized insurance coverage for adults with incomes up to 300 percent of the federal poverty level – about $30,600 for an individual and $62,000 for a family of four.

The 2006 reform built on the legacy of the previous incarnations. Although the 1996 reform greatly reduced uninsurance among low-income residents, the uninsurance rate began to creep up again in 2002, particularly among low-wage workers. The numbers were still low (about 10 percent of the adult population), but the roughly 500,000 uninsured presented a major policy challenge. Their care was typically provided in expensive settings such as hospital emergency rooms, and their absence from the insurance pool increased costs for everyone else.

At the same time, the federal government, which had financed the MassHealth program under a waiver of Medicaid restrictions, insisted on changes that could restrict the use of federal funds. Providers also raised their voices as data showed consistent underpayment by state programs, which forced providers to charge private insurers more. The concerns led the Romney administration, legislative leaders, and a broad coalition of consumers, religious groups, labor, health-care providers, and others each to propose a comprehensive reform plan. The final product represented an amalgam of the approaches.

Implementation Progress Report

Chapter 58 consists of several major initiatives and dozens of minor provisions to be phased in over time. The following update roughly follows the chronological order of implementation.

MassHealth Expansion

The first step was to expand the MassHealth program. The eligibility expansion to children, the disabled, and unemployed adults—combined with an aggressive state-funded outreach campaign that utilized an online application process—resulted in some 50,000 new MassHealth enrollees as of summer 2007.

Commonwealth Care

Commonwealth Care is subsidized insurance coverage for adults with incomes up to 300 percent of the federal poverty level—about $30,600 for an individual and $62,000 for a family of four. The program is coordinated by a new state agency, the Commonwealth Health Insurance Connector Authority (the Connector). Four Medicaid managed-care organizations, all locally based and nonprofit, offer Commonwealth Care plans.[1]

The premiums and copayments for the plans, which have no deductibles, vary. Individuals with incomes up to 150 percent of the poverty line pay no premiums and nominal or low copayments. For those above the 150 percent threshold (around $15,300 for an individual), premiums start at $35 per month, rising on a sliding scale to at least $105 per month for those above 250 percent of the poverty line. Coverage is comprehensive, but not as complete as Medicaid coverage.

The plans started enrolling subscribers in February 2007, and as of July, over 90,000 individuals had signed up. The vast majority are in the no-premium or lower-premium plans. Between the MassHealth expansions and the new Commonwealth Care program, more than 140,000 uninsured Bay Staters are now receiving coverage and getting vital medical care that some have lacked for years.

Consider the case of Brian Calvey, 55, who had been suffering with gastrointestinal problems and seeing a physician only when he could afford to. For medications, he had to rely on his doctor's samples. His wife, 57, had not seen a doctor in 13 years. Both now have a primary care physician and are receiving preventive care.

Affordable Private Insurance

The legislation also reformed insurance laws to make affordable insurance more accessible. In July 2007, the individual health-insurance market merged with the market for small group coverage. With this change,

individuals could get lower group rates, a savings estimated at 15 percent. Also in July, the Connector offered a plan called Commonwealth Choice.

Commonwealth Choice is designed to simplify the process for individuals and companies with fewer than 50 employees and allow more choices for workers. To lower plan cost and achieve value, the Connector negotiated with insurers and gave its seal of approval only to plans that met its quality and price objectives. All Commonwealth Choice plans must cover several preventive care visits before any deductible is applied. As of July, around 2,500 individuals had signed up for Commonwealth Choice plans.

Additionally, the law sought to reduce the cost of coverage for many employees and employers by requiring firms with 11 or more workers to a create "Section 125" payroll deduction plan, a plan that allows employees to use pretax dollars to buy their health insurance. The effective cost of coverage goes down because employees do not pay income tax on the salary money used to buy coverage. And the employer saves on taxes, too. Major employers such as Boston College, Dunkin Donuts, and the Gap have already signed up with the Connector, allowing their part-time employees to purchase plans using pretax payroll deductions.

The law also creates two new insurance options for the group with the highest uninsurance rate—young adults. One provision requires family insurance plans to cover young adults aged 19 to 26 for up to two years after loss of dependency status. Another provision allows insurers to offer special reduced-benefit plans to young adults aged 19 to 26. These plans have caps on benefits, allowing them to be priced lower than standard coverage.

Employer Responsibility and Individual Responsibility

The law has two mandates that have received considerable attention. First, companies that have 11 or more workers but do not offer minimal coverage to their full-time workers must pay a "fair share assessment" to the state. The assessment is limited to $295 per worker annually. Second, individuals who fail to purchase available coverage must pay a penalty if that coverage is deemed affordable under standards promulgated by the Connector. The penalty for 2007 kicks in on December 31 and is limited to a loss of about $200 in the personal exemption that tax filers can take on their state income tax filing. In 2008, the penalty grows to half the cost of the least expensive plan on the market.

Maine and Vermont Plans

The health reform plans of Maine and Vermont have similarities to the Massachusetts plan. Maine's Dirigo Health Reform Act of 2003 relies on three interrelated approaches:

- DirigoChoice, a state-sponsored subsidized health plan for individuals and small businesses;
- initiatives to control health-care costs; and
- quality-of-care efforts.

The DirigoChoice plan covered some 14,700 Mainers as of July and is funded in part by an assessment meant to capture the savings produced when more people have coverage. In April, Governor Baldacci proposed a number of changes to reenergize the plan, including a state reinsurance plan, a "pay-or-play" employer mandate, and a requirement that individuals have coverage. The legislature did not enact these proposals, and in July, enrollment was capped.

The Vermont plan, Catamount Health, was enacted soon after the Massachusetts law was signed. It, too, has a subsidized coverage plan with sliding-scale premiums. Enrollment is scheduled to begin in fall 2007. As with the Massachusetts plan, employers face a modest assessment if they do not offer health coverage. There is no requirement, however, for individuals to get coverage. The statute focuses on improving chronic care and includes provisions to decrease costs by simplifying administration of health benefits.

National Implications

Taken together, the plans of Massachusetts, Maine, and Vermont provide a unique testing ground for ideas being explored by other states and by national policymakers. Both Republican Governor Arnold Schwarzenegger of California and Democratic Governor Edward Rendell of Pennsylvania have proposed plans that draw on the Massachusetts, Vermont, and Maine plans. Former Massachusetts Governor Romney has made the Massachusetts plan a part of his presidential campaign platform, and numerous national Democratic leaders are putting forth health plans based on ingredients found in the New England plans.

As the 2008 presidential election heats up, the goal of universal coverage will likely be on the front burner, and candidates will be looking closely at the New England experiments for ideas and insight.

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Endnote

[1]Individuals who want information on Commonwealth Care and other insurance options can obtain more information at 1-877-MA-ENROLL, or visit www.MAhealthconnector.org.