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Health Reform: Learning from Massachusetts

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“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.”

Supreme Court Justice Louis Brandeis, dissenting opinion in *New State Ice Co. v. Liebmann* 285 U.S. 262 (1932)

In 2006, Massachusetts enacted a comprehensive package of health insurance reforms intended to achieve universal coverage. The basic framework of these reforms – Medicaid expansions, a health insurance exchange, subsidies for lower-income households buying private coverage, an individual mandate, and an assessment on employers who do not provide insurance coverage—became the model for the coverage expansions in the Affordable Care Act (ACA) enacted in March 2010 and scheduled to take effect in each state in 2014.

As states proceed with the implementation of these reforms, they may look to Massachusetts for some indication of what to expect as the ACA coverage expansions take effect. One question that readers will likely have is how relevant the Massachusetts experience is for other states. This question has two components. The first is whether the Massachusetts reform was really the same as the ACA. The answer for the most part is yes, although there are some differences. Table 1 outlines key provisions of both reforms, which are the same, and notes where there are differences in, for example, income thresholds for subsidy eligibility or the size at which employers not offering insurance face penalties. In most cases, these differences are relatively minor—for example, the fact that there are four tiers of generosity for exchange plans in the ACA but only three in Massachusetts—and should have little effect on the generalizability of findings from Massachusetts to other state.

The second factor that affects the generalizability of the Massachusetts experience is whether Massachusetts is a typical state in other ways. Here, the answer is a bit different, because Massachusetts is clearly *not* a typical state. Its population is relatively well-off and well-educated, with the highest median household income and the highest fraction of adults with a bachelor's degree or more (Statistical abstract 2012). Its poverty rate is lower than any state except New Hampshire (Statistical abstract 2012). Prior to reform, the uninsurance rate in Massachusetts was already low—10.7% compared with 15.7% nationally—although six states (Hawaii, Iowa, Maine, Minnesota, New Hampshire, and Wisconsin) had lower rates

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(Census P60-231, August 2006, Table 10, p. 27). In addition, Massachusetts already had enacted significant insurance market regulations, such as guaranteed issue and community rating, so that establishing an exchange and imposing a mandate were the only missing pieces of the puzzle in the individual insurance market. One might argue that Massachusetts, with relatively more resources and fewer uninsured people than other states, was uniquely situated to address the problem.

Even if Massachusetts is not a typical state, its experience with reform provides useful lessons for other states. With the Affordable Care Act's infusion of federal assistance through premium tax credits and an enhanced Medicaid match, even states that have few resources of their own to devote to the uninsured are likely to realize substantial reductions in their uninsured populations, just as Massachusetts did, with attendant improvements in access and health. And for those states that are interested primarily in learning from the design and functioning of the exchange in Massachusetts, there is no reason to think that the fundamentals of consumer demand and insurer supply in the individual market are different there than they would be in another state's exchange. Lessons from Massachusetts about exchange design are therefore particularly valuable.

The goal of this special section in *Inquiry* is to provide a concise and accessible summary of some of the major lessons to date from the Massachusetts reform. The three articles in this volume examine different aspects of the reform. Sharon Long, Karen Stockley, and Kate Willrich Nordahl discuss how the reform affected insurance coverage, access to care, and affordability of care. They find that both private and public coverage increased significantly. Indeed, only 4% of Massachusetts residents are now uninsured, the lowest rate in the nation (Kaiser State Health Facts). They also find that several different measures of access improved: the fraction of adults reporting a doctor visit in the past year and the fraction of those who report having a usual source of care other than the emergency room (ER) increased, while the fraction who report needing but not getting medical care in the past year declined. Out-of-pocket health care spending declined. In short, the reforms largely achieved the goals of expanding coverage and improving access.

These results are complemented by the analysis presented by Sarah Miller, who finds that the reform increased total utilization and spending while reducing reliance on ER care. Miller also documents improvements in self-reported health. In other words, improvements in access to care translated into better health and more appropriate use of care. The reduced reliance on ER confirms the view that prior to the reforms, uninsured Massachusetts residents relied on the ER as a point of entry to the system. An additional benefit of reforms, therefore, is more efficient and appropriate use of health care services.

The papers by Long, Stockley, and Nordahl and by Miller confirm that reform yields benefits to health and economic well-being. These results should be of interest to policymakers debating whether reforms are worth implementing. Many states already have moved beyond considering whether to implement the reforms and are wondering instead *how* to implement them. For this audience, the paper by Keith Ericson and Amanda Starc analyzes the behavior of consumers and insurers in the Massachusetts exchange and discusses the implications for exchange design. For example, they analyze the consequences

of the Massachusetts exchange authority's decision to standardize plan design in 2010, which led consumers to choose more generous plans, and the imposition in 2011 of a specified enrollment period (rather than open enrollment every month) in response to insurer concerns about strategic behavior by consumers, as evidenced by higher claims among short-term enrollees.

Massachusetts' experiment with health reform has been a success by any measure, and its experience should light the way for other states embarking on the path to universal coverage.

Table 1

How does the Affordable Care Act compare to the Massachusetts reform?

	Massachusetts	Affordable Care Act
I. Medicaid expansion		
Children	Kids eligible up to 300% FPL in Medicaid and CHIP	Kids remain eligible up to higher levels, as before the ACA
Adults	Eligible up to 100% FPL	Everyone eligible up to 138% FPL
II. Health insurance exchange		
Exchange subsidy eligibility	<300% FPL (sliding scale)	100% – 400% FPL (sliding scale)
	Subsidized exchange is separate, with generosity assigned based on income	Both subsidized and unsubsidized consumers choose plans on a single exchange
Exchange plan offerings	Three tiers of generosity: Bronze, silver, gold	Four tiers of generosity: Bronze, silver, gold, and platinum
III. Individual responsibility requirement		
Penalty amount	Penalty is up to half the lowest-cost premium the person would have qualified for in the exchange (currently about \$1,200)	Penalty starting in 2016 is the larger of \$695 or 2.5% of income; penalty is smaller in 2014 and 2015
Exempt groups	Religious objection; income<150% FPL; premiums relative to income above specified levels from 300%-600% FPL; or "substantial financial hardship"	Religious objection; no income tax filing liability; premiums amount to more than 8% of income
IV. Employer responsibility requirement		
Which employers?	Applies to firms with more than 10 workers	Applies to firms with more than 50 workers
Penalty amount	Penalty is \$295/ per worker per year	Penalty is \$2,000 per worker per year if firm doesn't offer insurance and any worker receives a tax credit; OR if firm offers insurance that costs more than 9.5% of worker income and any worker gets a tax credit.
V. Other		
	Already had guaranteed issue and community rating; individual and small group markets were one risk pool	State regulation of non-group market varies from state to state

Note: FPL=federal poverty level; CHIP=Children's Health Insurance Program.