Opinion

Revisiting the Land of the Individual Mandate

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THE YEARS 2013 THROUGH 2016 WERE EXCRUCIATING FOR THE Massachusetts Health Connector. In 2013, the Connector was among the nation's most troubled federal/state health insurance exchanges, as it endured an epic collapse of its new website to help consumers purchase individual health insurance. Since then, it has taken a step-by-step and low-key "no news is good news" approach to rebuilding trust and credibility with its 252,000 clients.

Now the silent period is ending. In 2006, Massachusetts was the first and only state to enact an individual health insurance mandate, the essential model for the federal individual mandate included in the Affordable Care Act (ACA) in 2010 and implemented in 2014. In last December's Tax Cuts and Jobs Act, President Trump and Congress neutered the ACA mandate by reducing the financial penalty to 0. Despite widespread reports to the contrary, the mandate was not repealed, and the law, with its mandatory reporting requirements, remains on the books.

Thus, Massachusetts now returns to the spotlight as the nation prepares to examine the impact of the federal action, testing 1 state's experience against that of the other 49. In 2015, the last year for which tax data is publicly available, only 3% of adult tax filers in Massachusetts reported not having insurance meeting state standards, corroborating other data sources indicating that it has the lowest rate of uninsurance in any state (the most recent US Census data shows Massachusetts at 97.5 percent coverage). Depending on an uninsured person's household income, the monetary penalty ranges between \$21 and \$96 for each month without coverage. As of early February, at least 9 other Democratic-leaning states are considering adopting a similar mandate.

Massachusetts is 1 of 17 states that established and operate their own exchanges instead of relying on the US Department of Health and Human Services. State-run exchanges measurably outperform their federal

counterparts. According to the National Academy for State Health Policy, states running their own insurance marketplaces saw enrollment increases between 2016 and 2018 of 1.51%, while states using the federal system saw a 10.5% drop.¹ This is unsurprising because most of the 17 states are committed to ACA enrollment success while most of the 33 others are committed to failure. While other state exchanges—notably California’s—are strong performers, the Massachusetts Connector stands out because of its 12-year life span, the mandate, and other surprising factors.

The Connector’s successes are noteworthy. For example, premiums for its benchmark “silver” tier plans in 2017—and now 2018—were second lowest among the 50 states, even as premiums for employer-based coverage sold outside the Connector were the nation’s fourth highest. Unlike many states, where insurer participation is negligible, all major Massachusetts insurers sponsor Connector plans. Overall customer satisfaction in 2017 stood at 77%.² Also unlike other states, where many customers avoid the public exchange, nearly 80% of Massachusetts nongroup (individual) health insurance is sold via the Connector, including 45% of all nonsubsidized individual insurance. Meanwhile, the United Health Foundation’s 2017 *America’s Health Rankings* placed Massachusetts as the nation’s healthiest state, with its highest rate of health insurance coverage as one factor.³

The politics continue to surprise. In 2006, the nation noticed when the Massachusetts universal coverage law passed with strong support from Republicans (state legislators, Governor Mitt Romney, President George W. Bush) and Democrats (state legislators, Sen. Edward Kennedy). A colleague of mine observes that the acid test of any significant health reform occurs when the initiating chief executive leaves office and a new boss arrives. Nine months after the law’s passage, Romney was replaced as governor by Democrat Deval Patrick, who was replaced 8 years later by current Republican Charlie Baker. All 3 supported full and effective operation of the law and the Connector. Baker was one of the most recognized Republican governors in 2017 opposing congressional efforts to repeal the ACA. Within the Democratic-controlled state legislature, support has never wavered.

Peering inside the box of the Massachusetts Health Connector offers a view of some compelling policy features. For example, though much attention focuses on the need for a tough individual mandate to establish a broad insurance risk pool, the Massachusetts experience

demonstrates that affordability is much more important than mandates. In 2007, the state established a premium and cost-sharing affordability formula far more generous than the later ACA's standards. Leading up to implementation of the ACA in 2014, low- and middle-income Massachusetts consumers obtaining coverage through the Health Connector faced a potentially huge drop in affordability under the ACA subsidies.

To avoid such an affordability cliff, the state implemented its own "wrap," using state dollars to maintain prior affordability levels for the population below 300% of the federal poverty line. The difference is substantial. (Indeed, the monetary penalties collected from uninsured individuals through the individual mandate are used to help finance the state wrap.) In Massachusetts, a consumer buying Connector coverage with a household income at 300% of the federal poverty line (\$51,510 for a family of 3 in 2017) can access a plan for no more than 5% of income for health insurance with low copayments and zero deductibles, while a similar consumer buying ACA coverage in the other 49 states pays 9.56%. More than the mandate, this gap explains why Massachusetts' uninsurance rate dropped more than any other state's and has remained at this level. Massachusetts' success involves its affordability wrap, much more than the mandate. States committed to lowering their uninsured rates further should focus on affordability at least as much as an individual mandate.

Finally, it is worth noting Massachusetts' progress in moderating rising health costs, a priority for the state's policymakers since 2008. In July 2017, the Massachusetts Health Policy Commission released a report showing the state's annual rate of health spending growth was fourth lowest among the 50 states between 2009 and 2014, at 2.3%. Between 2004 and 2009, the state had the sixth-highest growth rate, at 6%. Per person spending in 2014 was still high, at \$10,559, second highest after Alaska and 31% higher than the national average.⁴ The state is now implementing an aggressive accountable care organization strategy in its MassHealth program. Concerted and determined state action can make a difference.

Concluding observations:

- For 12 years, Massachusetts has demonstrated strong bipartisan support for universal health insurance and its Health Insurance Connector Authority.

- Also, for 12 years, Massachusetts has enforced an individual health insurance mandate with public support and no discernible dissent.
- More important than the individual mandate to Massachusetts' success in covering more of its residents than any other state has been greater premium and cost-sharing affordability for eligible enrollees.
- Smart and determined state action can make a difference in achieving difficult and important state health policy goals involving access, costs, and quality.

References

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