The Accountable Health Care Act of Massachusetts: Mixed Results for an Experiment in Universal Health Care Coverage

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The affordable health care act of Massachusetts, signed into law in 2006, resulted in 98% of Massachusetts residents' having some form of insurance coverage by 2011, the highest coverage rate for residents of any state in the nation. With a strong economy, a low unemployment rate, a robust health care delivery system, an extremely low number of undocumented immigrants, and a low baseline uninsured rate, Massachusetts was well positioned for such an effort. Ingredients included mandates, the creation of separate insurance vehicles directed to both poverty-level and non–poverty-level residents, and the reallocation of the former free care pool. The mandates included consumer mandates and employer mandates; the consumer mandate applies to all Massachusetts residents at the risk of losing personal state tax exemptions, and the employer mandate applies to all Massachusetts businesses with 10 or more employees at the risk of per employee financial penalties. The insurance vehicles were created with premiums allocated on the basis of ability to pay by income classes. Unexpected effects included escalating taxpayer health care costs, with taxpayers shouldering the burden for the newly insured, continuing escalating health care costs at a rate greater than the national average, overburdening primary caregivers as newly insured sought new primary care gatekeepers in a system with primary caregiver shortages, and deprivation of support to the safety-net hospitals as a result of siphoned commonwealth free care pool funds. This exercise demonstrates specific benefits and shortfalls of the Massachusetts health care reform experiment, given the conditions and circumstances found in Massachusetts at the time of implementation.

Key Words: Romneycare, reform, health care, Massachusetts

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INTRODUCTION

In response to markedly escalating health care costs in the commonwealth of Massachusetts from 2004 to 2006, then governor Mitt Romney and the Massachusetts legislature implemented a unique health care insurance reform law. House Bill 4479, also known as the affordable health care act, was introduced as An Act Providing Access to Affordable, Quality, Accountable Health Care and was signed into law on April 12, 2006 [1]. Much of the impetus for this effort was the escalating cost of health care that had driven insurance premiums in Massachusetts to the highest rates in the country, and consequently, the perception of the irresponsibility this distinction implied threatened to jeopardize federal Medicare subsidies to the commonwealth.

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MANDATES, THE MASSACHUSETTS CONNECTOR, COMMONWEALTH CHOICE, AND COMMONWEALTH CARE

The central provisions of the law include two broad concepts designed to ensure health insurance coverage for all Massachusetts residents irrespective of their ability to pay. The concepts include novel mandates, in addition to creative vehicles for supplying inexpensive health care to residents.

At the time it was penned, a novel feature of the affordable health care act was the inclusion of coverage mandates for both employers and eligible residents. The employer mandate was included to increase employer-provided health coverage, with fines levied against employers that did not comply with providing employer-subsidized insurance to their employees. The consumer mandate consisted of an individual mandate for coverage to residents who, irrespective of their ability to secure coverage, may have chosen to remain uninsured as a result of financial choice or what had been a small number of health care coverage options.

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The affordable health care act also created a public authority known as the Massachusetts Connector. The responsibilities of the Massachusetts Connector included overseeing and establishing methods for supplying inexpensive health care. These charges included not only specifically providing free health care insurance to residents who are ineligible for Medicaid and who earn less than 150% of the federal poverty level but also formulating low-cost and affordable health insurance options for the broad range of residents now mandated to seek coverage.

The Connector created a set of two broad groups of products: subsidized products known as the Commonwealth Care products for individuals and families earning less than 300% of the federal poverty level and unsubsidized products known as Commonwealth Choice products for individuals and families earning more than 300% of the federal poverty level.

The Commonwealth Care products were modeled after existing Medicaid products available through MassHealth (Medicaid).

The Massachusetts Connector then created a set of unsubsidized products intended for the employer market known as the Commonwealth Choice products. The Commonwealth Choice products, provided by 6 insurance vendors, are intended for individuals and families earning more than 300% of the federal poverty level and are made available in a range of 4 product tiers with appropriately varying deductibles and copayment amounts. The target pricing range for the Commonwealth Choice products was approximately $250 per month [2].

CONDITIONS CONTRIBUTING TO SUCCESSFUL IMPLEMENTATION

Massachusetts was positioned to implement the accountable health care act because of a favorable blend of financial and health care variables. These favorable variables included both socioeconomic factors creating a strong economy and an existing health care system delivering high health care coverage rates for residents. It is possible that this environment may have been relatively unique to Massachusetts and perhaps to only a handful of other states, calling into question the ease of implementing similar legislation in a more widespread manner, particularly in states lacking these conditions.

Massachusetts is the seventh wealthiest state in the nation and possesses a relatively stable and small population of 6.4 million with very little net gain or loss in census [3]. Massachusetts shows an even overall distribution of wealth and possesses strong education and health care industries, with health care workers as the largest category of workers in Massachusetts. The health care environment within Massachusetts includes 6 major academic medical centers, two dominant Disproportionate Share Hospitals, and the most extensive federally subsidized community health center network in the country [2]. Given its geography, there is also an extremely small number of undocumented immigrants in Massachusetts, particularly when compared with border states such as Texas and California. Undocumented immigrants would be ineligible for most federal payment systems, thus creating an additional burden on proposed delivery systems [2].

Before its inception, the health care delivery system in Massachusetts had evolved into a system that likely favored the affordable health care act, namely, preexisting broad resident health care coverage through a combination of disposition, infrastructure, and systems development. In 2006, the year of signing, more than 70% of employers subsidized their employees' health care coverage, compared with the national average of 60%. Massachusetts also benefitted from a strong Medicaid system and an extensive State Children's Health Insurance Program. The net result of the financial stability of Massachusetts, combined with established health care delivery systems, resulted in greater than 92% resident health insurance coverage, among the highest rates in the nation.

FINANCING THE AFFORDABLE HEALTH CARE ACT

A significant portion of describing free and low-cost insurance options fell on the shoulders of a new 10-member public authority specifically created for the affordable health care act, the Massachusetts Connector. The Massachusetts Connector was charged with such detailed tasks as defining affordability, minimum benefits coverage, and the subsidy structure for low-income families. The affordable health care act is supported through increased net consumer payment, employer subsidization, and a redistribution of the funds in the Uncompensated Care Pool.

One fundamental part of implementing the affordable health care act consisted of outlining realistic health care expenditures relative to total personal and family income. The sliding-scale expense range was determined by the consumers' ability to pay and stretched from zero to 8% of total income in expected payments [2]. As of January 20, 2011, the federal poverty level was $10,600 for a single individual and $22,350 for a family of 4 [4]. There is no expected payment for families and individuals with income levels less than 150% of the federal poverty level; families above 150% of the federal poverty level experience stepwise expenditure health care coverage increases from 2% to approximately 8% of income. If residents choose to remain uncovered, they are penalized through the absence of a personal exemption on their state taxes. The amount of this penalty is intended to be approximately half the amount of the least expensive yearly insurance premium available for such an individual, up to approximately $1,212 per year in 2011 [5].