

# The New Massachusetts Health Reform: *Half a Step Forward and Three Steps Back*

---

BY STEFFIE WOOLHANDLER AND  
DAVID U. HIMMELSTEIN

**M**assachusetts runs in regular cycles. Every eighty-six years our Red Sox win the World Series. Once a decade Harvard hires a senior woman scientist. And every twenty years our legislature passes a universal health care bill that the governor hopes to use as a springboard to the White House.

Unfortunately, Governor Mitt Romney's stab at universal coverage looks set to repeat the flop of Michael Dukakis's bill two decades ago. Then as now, our governor crowed about "Health Care for All" in the statehouse rotunda. But Dukakis's plan imploded within two years, and today 250,000 more people are uninsured in Massachusetts than on the day it was signed.

## **The Structure of the New Bill**

**T**he new bill includes two provisions meant to expand coverage. First, it will modestly expand Medicaid eligibility. Second, it requires people with incomes above 100 percent of the poverty line to purchase a private insurance policy. The state will offer partial subsidies for the purchase of this private coverage to families with incomes below 300 percent of the poverty line (about \$30,000 for a single person or \$60,000 for a family of four). Those above three times the poverty line will have to pay the full cost of their own coverage.

To help make coverage more affordable, a new state agency called "the Connector" will connect people with the private insurance plans that sell the coverage. The Connector is also supposed to help design affordable plans. Massachusetts citi-

---

Steffie Woolhandler and David U. Himmelstein, "The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back," *Hastings Center Report* 36, no. 5 (2006): 19-21.

zens will be allowed to use pre-tax dollars to purchase coverage (although this tax break mostly helps affluent taxpayers in high tax brackets).

Businesses that employ more than ten people and fail to provide health insurance will be assessed a token fee (not more than \$295 annually—about fifteen cents per hour of labor) to help subsidize care. Additionally, hospitals won a rate hike assuring them better payments from state programs, and several provisions were included that are meant to attract additional federal funding to help pay for the Medicaid expansion.

The new plan is half a step forward for Massachusetts. One positive element in it is that all legal Massachusetts residents with incomes below 100 percent of the poverty line will now get publicly paid coverage. However, less than 17 percent of uninsured people in the state have incomes that low. Moreover, new federal Medicaid regulations that require proof of legal status will disenroll undocumented immigrants, as well as some African-Americans who lack birth certificates because they were born at home in the rural south. The bill also includes funds to help a few safety net hospitals keep their doors open. (Disclosure: We work at one such hospital.) However, it phases out the state's free-care pool, which has sustained safety net hospitals and covered many undocumented immigrants.

Unfortunately, the bill also takes three steps back. First, the contention that the bill will generate universal coverage is based on extremely fuzzy math. The politicians assumed that only about 500,000 people in Massachusetts are uninsured. The Census Bureau says that 748,000 are uninsured. Why the difference? The 500,000 figure came from a telephone survey conducted in English and Spanish. Anyone who did not have a telephone or who spoke another language (roughly one-third of immigrant families in Massachusetts) was, in effect, counted as insured—a dubious assumption since nationally 43.9 percent of phoneless adults are uninsured<sup>1</sup> and many non-English speaking immigrants lack coverage. The Census Bureau's 748,000 figure comes from a much more thorough survey, the Current Population Survey, which is carried out in person, door-to-door, with surveyors who speak multiple languages (including Portuguese and Haitian Creole, common in Massachusetts). In sum, the calculations behind the reform plan overlook everyone who lacks a phone or does not speak English or Spanish, nearly half of whom are likely to be uninsured. Hence, the level of funding in the bill for insurance subsidies and Medicaid expansion is grossly inadequate to cover the actual costs.

Second, 83 percent of the new coverage is of the “buy it yourself” variety. The linchpin of the bill is an individual mandate that forces near-poor and middle-income uninsured people to purchase coverage (or suffer tax penalties). Unfortunately, few of the uninsured can actually afford adequate coverage. Currently, a reasonably comprehensive health insurance policy in Massachusetts costs about \$6,000 annually for an individual or \$14,000 for a family. A wealthy uninsured person could afford that—but few of the uninsured are wealthy.

Only 23 percent of those without coverage make more than five times the poverty level.

Third, the legislation promises that the Connector will help the uninsured find comprehensive and affordable private health plans, but that's like promising delicious chocolate chip cookies with no fat, sugar, or calories. While officials have projected that the mandatory policy will cost only \$300 per month for an individual plan and \$600 for a family, the only way to get private plans that cheap is to strip down the coverage: boost copayments and deductibles and exclude important services from coverage altogether. Such stripped-down coverage may let politicians claim they've done something useful, but it provides neither adequate access to care nor real financial protection. In the RAND Health Insurance Experiment (the only randomized controlled trial comparing high-deductible plans to comprehensive coverage), high deductibles caused a 17 percent fall in toddler immunizations and swelled the number of children failing to see a doctor in the course of a year from 15 percent to 32 percent among school-aged children and from 5 percent to 18 percent among infants and toddlers.<sup>2</sup> While high deductibles reduced children's use of “rarely effective care” by 33 percent, they also reduced “highly effective care” by 28 percent. Adults in the RAND Experiment also used less preventive and primary care, and had higher blood pressure and higher risks of dying, when high deductibles were placed on their insurance coverage.

Stripped-down plans like those that the Massachusetts uninsured will be forced to buy also do little to protect people against financial catastrophe due to illness. In our own work on medical bankruptcy, 76 percent of those bankrupted by medical problems had insurance at the onset of the illness that bankrupted them; many were ruined by copayments, deductibles, and uncovered expenses such as physical therapy.

### **Covert, Regressive Taxes Rather than Cost Containment**

**T**he individual mandate will force working families to make bitter choices: pay premiums they cannot afford or buy stripped-down policies—or both. The vast majority of the new money in the bill comes from the mandated premium payments of low-to-middle-income families who are now uninsured. While families will pay these premiums to private insurance companies rather than to the government, they are in fact a highly regressive new tax: the wealthy contribute virtually no new money to the system, while the near-poor who were previously uninsured foot the bill.

Moreover, the legislation will do nothing at all to contain the skyrocketing costs of care in Massachusetts. With costs 30 percent above the national average, Massachusetts already has the highest per capita health care costs in the world. Predictably, rising costs will force more and more employers to drop coverage, while state coffers will be drained by the continuing cost increases in Medicaid and the private insurance subsidies for the near-poor. When the next recession hits, tax

revenues will fall just as newly unemployed people flood the Medicaid program or apply for the insurance subsidies promised in the reform legislation. The program is simply not sustainable over the long—or even medium—term.

### What Are the Alternatives?

In announcing the new bill, Governor Romney proclaimed that the bill marked the demise of the movement for single-payer national health insurance. Yet single-payer contains two elements lacking in the Massachusetts bill: universal coverage and cost control.

A simple single-payer plan would make coverage affordable by eliminating the multiple, competing insurers that generate our massive health administrative costs, currently at least 31 percent of total health spending.<sup>3</sup> For instance, Massachusetts Blue Cross spends only 86 percent of premiums paying for care. It spends the rest—more than \$700 million annually—on billing, marketing, and other administrative costs. Harvard Pilgrim and Tufts Health Plan—Massachusetts’s other largest insurers—are little better; each collected about \$300 million more in premiums than it paid out in benefits. That’s ten times as much overhead per enrollee as Canada’s national health insurance program. And our hospitals and doctors spent billions more fighting with insurers over payments for each bandaid and aspirin tablet. Overall, Massachusetts residents will spend \$13.3 billion on health care bureaucracy in 2006. If we cut bureaucracy to Canada’s levels we could save \$9.4 billion annually, enough to cover all of the 748,000 uninsured in Massachusetts and improve coverage for the millions more who are now under-insured.

A broad spectrum of researchers have concluded that single-payer is the only reform option that can expand coverage without increasing costs. Back in the 1980s, the Congressional Budget Office and the General Accounting Office estimated that universal coverage under single-payer was a break-even proposition because administrative savings would offset new clinical costs. More recently, a raft of studies by the Lewin Group—a fairly conservative consulting firm—evaluated proposed state single-payer plans and reached the same conclusion. Another consulting firm engaged by the Massachusetts Medical Society estimated that a single-payer plan could actually decrease spending while covering everyone in Massachusetts.

And despite millions spent by drug and insurance firms on “think tanks” and public relations denigrating the single-payer

option, and tens of millions of dollars lobbying politicians to keep single-payer off the table, it remains popular. Nearly two-thirds of Massachusetts physicians support it,<sup>4</sup> along with the Massachusetts Nurses Association and dozens of other labor and consumer groups and seniors organizations. Nationally, 62 percent of Americans favor “a universal health insurance program, in which everyone is covered under a program like Medicare that’s run by the government and financed by taxpayers.”<sup>5</sup>

The Massachusetts legislation raises ethical and policy issues that go far beyond health care. Has our democracy become incapable of enacting reforms, like single-payer, that benefit the vast majority of Americans but threaten the multi-million dollar paychecks of executives and the outrageous profits of private firms? Must every initiative to help the poor also further enrich the wealthy? Must we slash the estate tax if we hope to raise the minimum wage?

The Massachusetts legislature has answered: Yes. Their bill will generate huge new revenues for private insurers, vastly increase payments to already flush hospitals, excuse the wealthy from sharing the burden of covering the uninsured, and saddle working families with huge bills for

nearly useless coverage.

Our patients and our democracy deserve better.

1. S.J. Blumberg, J.V. Luke, and M.L. Cynamon, “Telephone Coverage and Health Survey Estimates: Evaluating the Need for Concern about Wireless Substitution,” *American Journal of Public Health* 96 (2006): 926-31.

2. J.P. Newhouse and the Insurance Experiment Group, *Free for all? Lessons from the Rand Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

3. S. Woolhandler, T. Campbell, and D.U. Himmelstein, “Health Care Administration Costs in the U.S. and Canada,” *New England Journal of Medicine* 349 (2003): 768-75.

4. D. McCromick et al., “Single-payer National Health Insurance: Physicians’ Views,” *Archives of Internal Medicine* 164 (2004): 300-304.

5. Washington Post-ABC News Poll: Health Care, October 20, 2003; available at: <http://www.washingtonpost.com/wp-srv/politics/polls/vault/stories/data102003.html>.

---

*Single-payer plans contain two elements lacking in the Massachusetts bill: universal coverage and cost control.*

---