

Massachusetts Health Reform Implementation: Major Progress And Future Challenges

The Massachusetts reform rolls on, meeting major milestones and confronting challenges, both anticipated and unanticipated.

by John E. McDonough, Brian Rosman, Mehreen Butt, Lindsey Tucker, and Lisa Kaplan Howe

ABSTRACT: Since its passage in April 2006, the Massachusetts health reform law (Chapter 58) has expanded affordable insurance coverage to 355,000 people. Major milestones have been achieved, including establishment of new coverage programs, merger of small-group and nongroup insurance markets, creation of an insurance “Connector,” determination of affordability and penalty standards for an individual mandate, and launch of employer responsibility requirements. Key challenges remain, including full implementation of the individual mandate, cost control, and securing of long-term financing. Massachusetts health reform is offering valuable and important lessons for the nation. [*Health Affairs* 27, no. 4 (2008): w285–w297 (published online 3 June 2008; 10.1377/hlthaff.27.4.w285)]

IN APRIL 2006 THE MASSACHUSETTS GENERAL COURT enacted comprehensive health reform legislation. The statute, “An Act Providing Access to Affordable, Quality, Accountable Health Care,” known as Chapter 58, offers an array of approaches to reduce the number of uninsured people in Massachusetts.¹ Passage has helped instigate a new wave of state health access activities and widespread commentary for and against the law.² Chapter 58 also triggered a robust implementation process involving government, providers, health plans, advocates, business, media, and the public. Success or failure holds serious consequences for the commonwealth, and results will influence consideration of reform elements in other states and in a possible 2009 national reform effort.

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In this paper we offer a status report covering activities during the first two years of implementation (between April 2006 and April 2008). Although detailed accounts could fill volumes, and much has been written extolling and castigating the law, we describe work to date, discussing critical milestones and drawing lessons for other states and the federal government.

The reform law’s organizing principle is shared responsibility. Consumers, government, employers, insurers, and providers all face new obligations and receive new benefits. The law’s passage was supported by broad stakeholder coalitions. A key challenge moving forward is maintaining this broad support.

Establishing The Connector

Chapter 58 assigns important implementation duties to a new state entity, the Commonwealth Health Insurance Connector Authority (known as the Connector).³ Facing an aggressive implementation schedule, the Connector board and staff had a short learning curve to establish an infrastructure and set policies.

The Connector Authority is governed by a ten-member board mixing content experts, constituency representatives, and public officials. Since its launch, the board has received intense scrutiny. Meetings are frequently attended by a hundred or more observers, including media. Most policy issues are decided after extensive debate. Early board decisions reflected the preferences of then Gov. Mitt Romney and now reflect Gov. Deval Patrick’s priorities.⁴ Board members strive to achieve consensus, requiring compromise on issues such as affordability, creditable coverage, and program structure.

Medicaid/MassHealth

Chapter 58 expanded eligibility and benefits in Massachusetts’ Medicaid program, MassHealth. The law expanded children’s eligibility from 200 percent to 300 percent of the federal poverty level. Optional benefits for adults cut during the 2002–03 recession, including dental care, dentures, and eyeglasses, were restored.

Chapter 58 increased MassHealth payment rates to physicians and hospitals, up to \$90 million per year in fiscal years 2007–2009. A portion of hospital increases in 2008 and 2009 are conditional on providers meeting “pay-for-performance” (P4P) standards. MassHealth developed the standards in consultation with the Payment Policy Advisory Board and the Quality and Cost Council.

Several factors triggered enrollment growth among those previously eligible and not enrolled. The use of a single application form for all programs, outreach grants to community groups, restrictions on the availability of hospital charity care reimbursement, and the individual mandate catalyzed a sharp upturn in

Medicaid enrollment of 110,740 by April 2008, resulting in total enrollment of 1,145,185.

Subsidized Insurance For The Lower-Income Uninsured

Chapter 58 required the Connector to establish the Commonwealth Care Health Insurance Program (CommCare) to provide subsidized insurance to uninsured adults with household incomes up to 300 percent of poverty who are ineligible for MassHealth or any other coverage. Eligible people with incomes below 150 percent of poverty are charged no premiums, no deductibles, and modest copayments. Those with incomes of 151–300 percent of poverty pay income-based, sliding-scale premiums and copayments, and no deductibles. CommCare plans cover inpatient, outpatient, and preventive services; behavioral health; and prescription drugs. Plans for those below 100 percent of poverty also cover dental services. Exhibit 1 shows the current list of CommCare premiums, copayments, and enrollment as of March 2008. The average current total monthly cost of a CommCare plan is \$355 (these costs are expected to rise approximately 10 percent beginning July 2008). The commonwealth funds CommCare through enrollee premiums and the Commonwealth Care Trust Fund. CommCare enrollment began 1 October 2006; as of March 2008, it covered about 177,000 people, surpassing expectations and creating unanticipated financial pressure.

CommCare is not available for every uninsured person with an income below 300 percent of poverty. Lower-income workers with access to employer-sponsored coverage are ineligible, even if the employer-offered insurance is unaffordable to them. Although Chapter 58 permits the Connector to allow employers to contribute to CommCare premiums to qualify these workers, the Connector has not implemented this option, fearing fiscal consequences and behavior changes by eligible workers and their employers.⁵

EXHIBIT 1
Commonwealth Care Premiums, Copayments, And Enrollment As Of 1 March 2008

Income level (as percent of poverty)	Lowest enrollee monthly premium (eff. July 2007)	Copayments (office visit/inpatient/generic drug)	Number enrolled as of 1 March 2008
0%–100%	\$0	\$0/\$0/\$1	81,969
100.1%–150%	\$0	\$5/\$50/\$5	45,368
150.1%–200%	\$35	\$5/\$50/\$5	28,342
200.1%–250% (low premium)	\$70	\$10/\$250/\$10	16,255
250.1%–300% (low premium)	\$105	\$10/\$250/\$10	
200.1%–250% (low copay)	\$92–\$96	\$5/\$50/\$5	4,364
250.1%–300% (low copay)	\$127–\$131	\$5/\$50/\$5	

SOURCE: Commonwealth Health Insurance Connector Authority.

Commonwealth Choice: “Seal Of Approval” Private Insurance

Unsubsidized plans were created for people who are ineligible for Commonwealth Care and who do not have access to employer-sponsored insurance. Commonwealth Choice (CommChoice) plans are administered by state-licensed private insurers; to be offered through the Connector and receive its “seal of approval,” these plans must meet Connector standards for quality and affordability.

CommChoice nongroup coverage became available 1 July 2007. Four levels of plans are offered by six carriers. The Connector set benefits for the most robust (Gold) plans, and it set ranges of lower actuarial values relative to the Gold plans for Silver, Bronze, and Young Adult plans (available to those ages 18–26). All CommChoice plans must meet the board’s “minimum creditable coverage” standards (described below) by providing “reasonably comprehensive” benefits, including inpatient, outpatient, mental health, and preventive services, and, as of February 2008, drug coverage.⁶ The principal variation among levels involves cost sharing, which increases sharply as premiums decrease. The Connector developed a ground-breaking, user-friendly Web site, <http://www.mahealthconnector.org>, allowing “apples to apples” comparisons among offerings.

The Connector predicted that at least 35,000 people would enroll in CommChoice in its first year. As of March 2008, 17,490 have enrolled. It is believed that a larger number have enrolled in parallel “non-Connector” plans, which are purchased directly from carriers and which mirror CommChoice benefits and costs.⁷ It is unknown how many CommChoice enrollees were uninsured previously or switched from more costly nongroup plans. So far, most of those purchasing CommChoice plans have obtained lower-premium (Bronze and Young Adult) plans with high cost sharing, including deductibles up to \$2,000 and coinsurance.⁸ Most Young Adult plans also have annual benefit caps.

The Connector intends to permit small employers (1–50 employees) to offer their employees a choice of plans within the Gold, Silver, or Bronze levels. Creating this system has proved complex and controversial and has been delayed several times. Small-group CommChoice plans are expected to be available as of July 2008.

Individual Mandate: Personal Responsibility For Creditable Health Coverage

The reform law requires every Massachusetts resident age eighteen and older to purchase creditable health insurance, provided there is an affordable plan available. The most difficult compromises in health reform’s first year involved the Connector’s struggle to define *affordable* and *creditable* for purposes of enforcing the individual mandate.

■ **Affordability.** Chapter 58 charged the Connector to define affordability: the

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maximum amount individuals and families must pay for health insurance. If no plan is available for that price, the mandate penalty is waived. In spring 2007, the Connector approved its first affordability schedule (to be examined yearly). The schedule is progressive—the percentage of income people are expected to pay for coverage rises from approximately 2 percent at 150 percent of poverty to more than 9 percent at 500 percent of poverty. For those with incomes under 150 percent of poverty, the affordability threshold is \$0, meaning that no premium is considered affordable. The schedule rises by increments of 50 percent of poverty, mirroring CommCare premiums up to 300 percent of poverty. Above that, the schedule rounds off these increments up to 500 percent of poverty, the median state income, at which point health insurance is deemed affordable, regardless of cost.

Simultaneously, the Connector released premium schedules, showing the lowest-cost available CommChoice plans, by age categories and regions. The affordability determination requires checking whether employer-provided coverage is available for the amount specified in the affordability schedule. If no employer coverage is available, the next step is to assess CommCare eligibility. If the person is ineligible for affordable employer coverage and CommCare, he or she must consult the premium schedules. If the lowest-price coverage available costs less than the affordability chart’s standard for that person, then the person is subject to the penalty.

The Connector administers an appeals system for those subject to penalties who believe that available insurance options are unaffordable. Waivers may be obtained prospectively or retrospectively based on financial hardship. The affordability schedules consider only premiums, not deductibles or other cost sharing.

■ **Creditability.** Enforcing the mandate necessitated defining a minimum level of coverage to satisfy the mandate—minimum creditable coverage (MCC). Individuals are not required to purchase a plan that does not meet MCC standards, and they will not satisfy the mandate by doing so. The Connector chose to phase in MCC standards, delaying full compliance until January 2009 to accommodate businesses with existing multiyear insurance contracts.⁹ Until then, all licensed and self-insured plans satisfy the mandate. Starting in January 2009, individuals must have insurance that (1) covers “comprehensive health benefits” defined by the Connector, including drugs; (2) contains no annual or per sickness benefit maximums or fee schedules for indemnity benefits; (3) limits deductibles to no more than \$2,000 for individuals and \$4,000 for families, and limits drug deductibles to no more than \$250 for individuals or \$500 for families; and (4) includes an in-network out-of-pocket maximum of \$5,000 for individuals or \$10,000 for families (if they have deductibles or coinsurance).¹⁰

The Connector debated each of these components. After hearing from employers that offer plans with lifetime benefit caps, the board voted to permit creditable plans with these caps.¹¹

■ **Penalties.** To enforce the mandate, Chapter 58 established state income tax penalties for adults who do not purchase affordable health insurance.¹² Penalties are assessed on tax forms based on the affordability and premium schedules. All residents are required on tax returns to document creditable insurance monthly, or an exemption on affordability or religious grounds. In 2007, the penalty was loss of the personal tax exemption, worth \$219 for an individual. For 2008, maximum penalties are \$76 per month, or \$912 per year, for those age twenty-seven and older with incomes at 300 percent of poverty or more (Exhibit 2). Penalties are lowest for those ages 18–26 and for anyone below 300 percent of poverty. The tax form, Schedule HC, was finalized in December 2007. Collected penalties are deposited into the Commonwealth Care Trust Fund.

Employer Responsibility

Employers share responsibility under Chapter 58 to expand health insurance access. The law created several explicit employer requirements.¹³ In addition, the MCC standard is inducing employers to alter plan benefits so that their employees’ coverage complies with the mandate. The mandate has also increased the take-up rate for employer-offered coverage. According to data released by the Massachusetts Association of Health Plans, an additional 85,000 people enrolled in employer-sponsored health insurance during 2007.¹⁴

■ **Fair-share contribution.** Employers with eleven or more full-time-equivalent (FTE) workers who do not make “fair and reasonable” contributions to employees’ health insurance costs must pay the Commonwealth a per worker “fair-share contribution” of \$295 annually. Defining *fair and reasonable* was assigned to the state’s Division of Health Care Finance and Policy (DHCFP), which promulgated regulations in 2006 assessing employers if they do not contribute at least 33 percent of premium

EXHIBIT 2
Massachusetts Health Reform (Chapter 58), Individual Penalty Schedule For 2008

Poverty/age status	Income	Penalty per month/per year
Under 150% of poverty	\$15,324	No penalty
150%–200% of poverty	\$15,325–\$20,424	\$17.50/\$210
200.1%–250% of poverty	\$20,425–\$25,536	\$35/\$420
250.1%–300% of poverty	\$25,537–\$30,636	\$52.50/\$630
Above 300% of poverty and		
Age 18–26	Over \$30,636	\$56/\$672
Age 27+	Over \$30,636	\$76/\$912

SOURCES: Commonwealth Health Insurance Connector Authority and Massachusetts Department of Revenue.

costs for full-time employees or do not cover at least 25 percent of eligible employees. This requirement is exceeded by prevailing Massachusetts insurance carrier standards in the small-group market, which generally require employers to pay at least 50 percent of premiums and cover at least 75 percent of eligible workers.¹⁵

In November 2007, Massachusetts released initial results of the fair-share assessment showing that 44,000 employers completed their Employer Fair Share/Health Insurance Responsibility Disclosure filing.¹⁶ Of the 19,056 employers with eleven or more FTEs, fair-share requirements were met by 18,538. By March 2008, approximately 650 firms that failed to meet fair-share contribution requirements paid \$6.6 million in assessments.

■ **Section 125 plans/Free-Rider Surcharge.** Chapter 58 requires employers with eleven or more FTE employees to establish Section 125 payroll deduction plans to facilitate pretax purchase of insurance for workers. These plans can greatly lower the cost of health insurance for workers, even if the employer makes no premium contribution. Employers benefit by avoiding FICA taxes on the employee's contribution. Most employers that offer group insurance do so using the Section 125 mechanism. Chapter 58 requires making these plans available to workers who are ineligible for group coverage.

Employers that do not make required Section 125 plans available to workers may be subject to a sizable monetary penalty if their employees or dependents receive care paid for by the commonwealth's Health Safety Net Trust Fund. As of April 2008, no penalties have been assessed against any employers because of this requirement.

■ **HIRD form.** To demonstrate compliance with the fair-share contribution and Section 125 requirements, employers with eleven or more FTE workers must submit a Health Insurance Responsibility Disclosure (HIRD) form annually to the Massachusetts DHCFFP.

Private Insurance Market Reforms

Chapter 58 enacted market reforms to promote access to coverage—the most important being the merger of the nongroup/individual and small-group health insurance markets on 1 July 2007. Building on parallel regulatory protections already existing in both markets—including guaranteed issue and renewal, medical underwriting prohibition, pre-existing condition limitations, and modified community rating—the merger allows individuals to choose any plan available to those working for small employers (1–50 workers). Those insured through a small employer can retain coverage after leaving their job.

Because individual coverage is now rated with small-group coverage, nongroup premiums have decreased dramatically. A 2006 commission to study the merger projected likely increases in small-group rates as a result of the merger of 1–1.5 percent, and no more than 4 percent.¹⁷ In fiscal year 2008, the lowest-cost Comm-Choice plan available to a thirty-seven-year-old cost \$184, on average. Before the

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market merger, the lowest-cost plan available to this same person cost approximately \$335 and had leaner coverage and benefits.¹⁸

Other reforms expanded access to group coverage. As of January 2007, fully insured plans covering dependent children must offer coverage for children for two years after loss of dependent status for tax purposes, or until they turn twenty-six, whichever comes first.¹⁹ Beginning 1 July 2007, employers buying health insurance must allow eligible full-time employees to join any health benefit plan the employer offers. The employer cannot pay a larger percentage of premiums for higher-paid employees than for other employees.

Public Education And Outreach

A broad public awareness effort has been critical to implementation. The Connector, the Massachusetts Health Care Reform Coalition (HCRC), and private insurers created distinct, statewide advertising campaigns. The Connector developed a partnership with the Boston Red Sox and focused on educating uninsured consumers about the mandate and CommChoice. Formed by hospitals, health plans, businesses, and others, the HCRC focused on building support for reform among insured voters. Insurers promoted brand recognition for their plans.

Locally, dozens of community, religious, and other nonprofit groups, plus hospitals and community health centers, have engaged in extensive outreach to educate communities and enroll people. Assisted by \$3.5 million in state outreach grants, their activities are culturally competent, multilingual, and geographically diverse. Business organizations coordinate outreach to business groups and small employers.

Other Key Provisions

Chapter 58 includes provisions to improve health care financing and delivery. Two initiatives merit special attention.

■ **Quality and cost.** Chapter 58 required establishment of a Quality and Cost Council to “develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care.” The council first convened in August 2006. In June 2007 it approved statewide annual goals.²⁰ The council has focused efforts on collecting data from insurers and hospitals on quality and cost measures to be made public via a Web site scheduled for launch in summer 2008 and on developing strategies and recommendations to achieve its goals. The council is partnering with the Department of Public Health (DPH) to post hospital serious reportable events (SREs) on the DPH Web site as part of an effort to eliminate SREs by 2012.

■ **Elimination of racial and ethnic health disparities.** Chapter 58 includes two initiatives to reduce racial and ethnic disparities in health and health care. First, new MassHealth P4P standards include measures to reduce disparities. No identified P4P system in the nation incorporates disparities reduction, so this effort is groundbreaking. A Policy Roundtable, consisting of public and private representatives, developed recommendations for MassHealth to consider in the P4P policy, which was implemented in October 2007.²¹

Chapter 58 also directed creation of a thirty-four-member Health Disparities Council to “make recommendations regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the commonwealth.”²² As of March 2008, this council had met only once.

Financing Chapter 58

State health reform spending includes MassHealth expansions and rate increases, Commonwealth Care subsidies, and payments to safety-net institutions. Funding comes from a mix of federal reimbursements under the state’s Section 1115 Medicaid waiver; assessments on insurers, hospitals, and employers; and state general funds. Spending and revenues for the first three years of implementation are shown in Exhibit 3. In coming years, paying for Chapter 58 looms as the largest challenge. Other state access programs, notably TennCare and the Oregon Health Plan, collapsed when funding ran short after years of enrollment success.

Projecting future costs for new health programs is frequently difficult, and disjunctions between forecast and actual costs have affected perceptions of the reform’s success. During spring 2008, public awareness of funding shortfalls grew as press reports indicated that more funds will be needed for the health reform program. Notably, enrollment in expanded MassHealth and CommCare has been much higher than anticipated, triggering higher-than-expected costs. Discrepancies arose as a result of the methodology used by the commonwealth to estimate the number of uninsured people, producing a lower number than other surveys. The methodology will be revised in future surveys.

Costs are also increasing as a result of growth in per capita charges for CommCare in the program’s second contract. During the first contract (October 2006 through June 2008), two of four participating insurers bid much lower than the other two. This was understood as an attempt to gain enrollees through the Connector’s automatic assignment process, which gave plans incentives to submit low bids to build enrollment. These two plans sought substantial increases for the program’s second contract period, commencing July 2008. The Connector has responded to the cost growth by raising enrollee premiums and copays in July 2008.

Projecting future costs remains problematic. Key unknown factors include the impact of continuing medical inflation and employer responses to reform. Although anecdotal evidence suggests that some employers are dropping coverage for some workers (particularly part-time workers) to qualify them for Comm-

EXHIBIT 3
Three-Year Projected Costs And Revenues Of Massachusetts Health Care Reform
(Chapter 58), Millions Of Dollars, Fiscal Years 2007–2009

Spending	FY 2007 (actual)	FY 2008 (projected)	FY 2009 (governor's budget submission)
1. MassHealth (Medicaid) benefits and eligibility expansions	\$ 136.4	\$ 227.7	\$ 309.0
2. MassHealth rate increases to hospitals and physicians	70.9	165.9	205.2
3. Commonwealth Care Program	132.9	618.5	869.4
4. Health Safety Net Trust Fund reimbursements to hospitals and community health centers	647.3	511.2	453
5. Other support payments to safety-net hospitals and health plans	338	444	518.8
Total spending	1,325.5	1,967.2	2,355.3
Revenue			
6. Federal Medicaid reimbursements	589.3	889.5	1,115.9
7. Employer Fair Share Assessment	0	6.7	5.0
8. Health Safety Net Trust Fund assessments on hospitals and insurers	320	320	320
9. State General Fund	416.2	751.0	914.4
Total revenue	1,325.5	1,967.2	2,355.3

SOURCE: Massachusetts Secretariat of Administration and Finance.

NOTES: Amounts for FY 2008 are projected as of March 2008. FY 2009 amounts are as filed by the governor in his budget submission (filed in January 2008). However, state officials now estimate that FY 2009 Commonwealth Care spending will exceed the amount initially budgeted by at least \$100 million. Spending categories 4 and 5 are not strictly attributable to health reform, because they existed prior to the passage of Chapter 58. Likewise, most of revenue category 6 and all of category 8 continue pre-existing revenue sources.

Care, there is no evidence yet of systematic crowd-out.

A key factor affecting finances will be the renewal terms for the commonwealth's Medicaid 1115 waiver agreement with the federal government. The current waiver expires 30 June 2008. The renewal of the waiver is a critical responsibility for the Massachusetts Executive Office of Health and Human Services. Negotiations are under way with the Centers for Medicare and Medicaid Services (CMS) for a fourth waiver. The CMS's willingness to ease existing caps and provide additional revenues to address medical inflation will be critical for Chapter 58's financial stability.

Observations And Conclusions

Massachusetts has made much progress in reducing its number of uninsured residents and in implementing Chapter 58 as designed. As of April 2008, more than 355,000 formerly uninsured people have obtained insurance coverage because of Chapter 58 (177,000 in CommCare, 55,000 in MassHealth, and 123,000 in private coverage).²³ Key milestones related to coverage expansion, benefit restorations, and market reforms have been achieved, including establishing CommCare

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and CommChoice, setting individual-mandate standards, and merging the small-group and nongroup insurance markets.

The diverse stakeholder coalition that supported Chapter 58’s passage remains united to achieve full, effective implementation. Chapter 58 passed with near-unanimous votes in the Massachusetts Senate and House of Representatives because of multiparty compromise including business, provider, insurer, and advocacy organizations. Since passage, all stakeholder groups have remained deeply engaged in implementation. Despite news reports of higher-than-expected costs, the governor, legislative leaders, and stakeholders have repeatedly reiterated support for full implementation. This consensus, crucial to enactment, has proved equally vital to implementation.

■ **Mission-critical challenges.** Chapter 58 left numerous details unspecified. Predictable and secure long-term financing is key, especially as CommCare enrollment continues to grow. Also vital is assessing the economic and political impact of the fully implemented individual mandate. The terms of the next Medicaid Section 1115 waiver, to begin July 2008, will define Chapter 58’s fiscal stability. The stakes for health reform’s success are substantial.

■ **Phase two: cost control.** An essential challenge is confronting rising premium inflation. Average increases of 8–12 percent have been implemented by major Massachusetts insurers for 2008. Continuing increases undermine affordability, expand the number of people who are exempt from the mandate, and undermine the law’s intent. At the same time, the intense public focus on Chapter 58 has helped trigger a public policy imperative in Massachusetts to devise an effective state response to rising costs. Key government and health industry leaders are engaged in devising a far-reaching cost control agenda.

■ **ERISA implications.** Implications related to the Employee Retirement Income Security Act (ERISA) remain unknown. As of May 2008, no legal challenge has been initiated on the basis that ERISA preempts Chapter 58’s provisions on employer and individual responsibility. Credible analysts have offered conflicting opinions on a court’s likely disposition of a challenge.²⁴ However, to date, this dog has not barked.

■ **National implications.** Already, Chapter 58 offers abundant experience to inform other state efforts to (1) expand subsidized coverage to lower-income uninsured people; (2) find and enroll large numbers of eligible people; (3) define meaningful measures of health insurance affordability for all income groups; (4) enhance insurance access and affordability for individuals by merging the small-group and individual insurance markets; and (5) create opportunities for consumers to compare competing insurance products on cost, benefits, and network restrictions.

■ **Process lessons.** The Massachusetts reform demonstrates the value of strong,

deep, and continuous stakeholder involvement in enactment and implementation. Chapter 58 shows value in legislating a clear and not overly prescriptive framework, while delegating tough implementation decisions to a politically credible, expert authority—while demanding an aggressive timetable to settle controversial, secondary policy decisions. And, like it or not, Chapter 58 may show the wisdom of separating the dual priorities of coverage expansion and cost control into distinct legislative enactments.

Since Massachusetts and Vermont passed comprehensive reforms in 2006, many states have studied details of both laws, and some have enacted discrete elements. Although some have tried, no other state has enacted comprehensive reforms; notably, California’s attempt failed in dramatic fashion in early 2008. After 2008, when key programmatic and financing elements have become clearer, summary judgments will be appropriate.

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NOTES

1. Commonwealth of Massachusetts, “Chapter 58 of the Acts of 2006,” <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm> (accessed 21 September 2007). See also J.E. McDonough et al., “The Third Wave of Massachusetts Health Care Access Reform,” *Health Affairs* 25 (2006): w420–w431 (published online 14 September 2006; 10.1377/hlthaff.25.w420).
2. J.E. McDonough, M. Miller, and C. Barber, “A Progress Report on State Health Access Reform,” *Health Affairs* 27, no. 2 (2008): w105–w115 (published online 29 January 2008; 10.1377/hlthaff.27.2.w105).
3. For more information, see the Connector’s home page, <http://www.mahealthconnector.org>.
4. L. Meckler, “How Ten People Reshaped Massachusetts Health Care,” *Wall Street Journal*, 30 May 2007.
5. A. Dembner, “Care Plan Gap Seen for Many Workers,” *Boston Globe* 19 May 2007.
6. Drug coverage will be required in all but Young Adult plans by February 2008 to reflect minimum creditable coverage (MCC) standards.
7. Insurers prefer direct enrollment to avoid paying the Connector’s administrative fee.
8. Under MCC standards, all plans with deductibles must cover at least three preventive care physician visits “pre-deductible.”
9. Employers are not required to offer MCC plans. Businesses argued that they would have to provide such plans because their employees are required to purchase them.
10. The alternative is expected to allow a higher deductible if generic and limited brand-name drugs are covered “pre-deductible.” Regarding the in-network deductible, deductibles, coinsurance, and nondrug copayments of greater than \$100 must count toward the out-of-pocket maximum.
11. Meckler, “How Ten People Reshaped Massachusetts Health Care.”
12. A lapse in coverage of up to sixty-three days is permitted.
13. For a detailed discussion of these requirements, see A.J. Bianchi, *Employee Benefits Advisory: An Employer’s Guide to the 2006 Massachusetts Health Care Reform Act*, 23 January 2008, http://www.mintz.com/newsletter/2008/Advisories/EBEC_EmpGuide/MHCRA-Emp-Guide.pdf (accessed 12 May 2008).
14. See Massachusetts Association of Health Plans, “New Numbers Show Significant Increase in Private Insurance Coverage,” Press Release, 20 March 2008, http://www.maahp.com/Insurance_Uptake3.20.08.pdf (accessed 12 May 2008)
15. See Bianchi, *Employee Benefits Advisory*.
16. For insurers, contribution requirements guarantee payment and participation requirements prevent adverse risk selection. For consumers, contribution requirements ensure affordability and participation requirements ensure that a quality plan is offered. See Executive Office of Health and Human Services, “Divi-

- sion of Health Care Finance and Policy and Division of Unemployment Assistance Announce Preliminary Fair Share Data,” Press Release, 21 November 2007, http://www.mass.gov/?pageID=pressreleases&agId=Ecohhs2&prModName=eohhspressrelease&prFile=071121_employer_fair_share.xml (accessed 12 May 2008).
17. Gorman Actuarial et al., *Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets*, 26 December 2006, http://www.mass.gov/Eocsa/docs/doi/Legal_Hearings/NonGrp_SmallGrp/Final_Report_12_26.pdf (accessed 2 October 2007).
 18. Commonwealth Health Insurance Connector Authority, “Massachusetts Begins to See Benefits of Health Care Reform in Moderating Premium Increases,” Press Release (Boston: Commonwealth of Massachusetts, 14 February 2008).
 19. Previously, insurance plans would cease covering dependents when they were no longer full-time students.
 20. The council’s goals include the following: (1) reduce the cost of health care, and reduce the annual rise in health care costs to no more than the unadjusted growth in gross domestic product (GDP) by 2012; (2) ensure patient safety and effectiveness of care; (3) improve screening for and management of chronic illnesses in the community; (4) develop and provide useful measurements of health care quality in areas of health care for which current data are inadequate; (5) eliminate racial and ethnic disparities in health and in access to and use of health care; health indicators will be consistent and consistently improving across all racial and ethnic groups; and (6) promote quality improvement through transparency. See Massachusetts Health Care Quality and Cost Council, “State Wide Quality and Cost Goals for 2008,” <http://www.mass.gov/?pageID=hqccmodulechunk&L=1&L0=Home&sid=1hqcc&b-terminalcontent&f=goals&csid=1hqcc> (accessed 15 February 2008).
 21. Massachusetts Medicaid Disparities Policy Roundtable, *Pay-for-Performance to Reduce Racial and Ethnic Disparities in Health Care in the Massachusetts Medicaid Program*, http://www.massmedicaid.org/pdfs/2007-7_disparities.pdf (accessed 21 September 2007).
 22. Members include legislative officials, administration officials, hospitals officials, and consumers.
 23. Massachusetts Division of Health Care Finance and Policy.
 24. Compare A. Monahan, “Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts,” *Kansas Law Review* 55 (2007): 1203. This article argues that Chapter 58 employer provisions are permitted under ERISA. Also compare W.G. Schiffbauer, “ERISA Preempts Provisions of Massachusetts ‘Pay or Play’ Health Care Law,” *BNA Pension and Benefits Reporter*, 26 September 2006; and H. Hollmer, “Experts Say Health Push May Violate Federal Law,” *Boston Business Journal*, 4 May 2007.