Mandatory Health Insurance: Lessons from Massachusetts

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What lessons can be learned from the implementation of mandatory health insurance? As the Obama administration contemplates enacting far-reaching health care reforms that increase the role of government, the case of Massachusetts is worth serious study. Massachusetts' three-year experiment with mandatory health insurance (known as Chapter 58 legislation) has been judged by some health economists to be a qualified success, since it reached a primary goal of lowering the number of uninsured in the state (Gruber 2009, Long and Masi 2008). On the other hand, Tanner (2008: 5) argues that previously uninsured citizens signed up for health insurance because it was free or heavily subsidized, not because of the mandate itself. Official state statistics claim the number of uninsured in the state dropped from 11 percent in 2005 to less than 3 percent in 2009 (Massachusetts Health Connector 2009). Tanner (2009) disputes this number and suggests the number is closer to 5 percent, using Urban Institute and Census surveys as evidence. What supporters and foes of mandatory health insurance both seem to agree on is that the number of uninsured has fallen in the state since Chapter 58, and yet there remain between 150,000 and 200,000 uninsured citizens.

Unlike a market-based solution, which would shrink the role of government while enhancing individual choices, Massachusetts

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mandates that individuals purchase health insurance, and it uses the "carrot and stick" approach. First, the state legislature created the Commonwealth Care Program in 2006, which allows lower-income residents to obtain health insurance subsidies, and second, it fines individuals (up to $912 per year in 2009) and qualifying firms ($295 per employee) if the individual is not insured.

There are reasons to be concerned about the rapidly growing expense of this program, which even advocates such as Gruber (2009) admit were put aside in the quest for universal coverage. The costs of Commonwealth Care have increased from $133 million in 2007 to an estimated $800 million by the end of 2009, as seen in Table 1, row (a), which is adapted from Raymond (2009). As is also seen in Table 1, row (b), this increase has been only partially offset by the corresponding $250 million drop in state expenditures for the uncompensated care pool, which Massachusetts pays to hospitals if individuals do not have health insurance. Note that since expenditures on uncompensated care dropped by only 34 percent, a substantial number of citizens are still uninsured, and perhaps are continuing to seek treatment through the emergency room rather than a primary care physician. Meanwhile, rows (d) and (e) represent changes in costs for state-provided medical insurance for the poor, or MassHealth, as it expanded coverage to previously uninsured individuals and simultaneously phased out supplemental Medicaid payments. Lastly, row (g) shows the increased payments to hospitals for low-income individuals who previously did not qualify for these government health programs.

The rapid growth in expenditures is not altogether surprising as Massachusetts only pays 50 cents for every $1 it spends on expanding its health care initiative. The federal government pays the other half in matching funds. From 2006 to 2009, Massachusetts' health care initiative, which includes supplemental payments to Medicaid and hospitals for unfunded care, increased from $1.04 billion to $1.86 billion, an increase of 78 percent, as seen in Table 1. Even if the federal government continues to pay half of the increase in these expenses, the growth rate in the state's spending on its health care initiative still averaged almost 26 percent from 2006 to 2009. The state now spends 33 percent more per person on health care than the national average, while in 1980 it was 23 percent more (Sack 2009). In total, annual expenditures on the state's health care initiative are

projected to be $409 million higher in 2010 than in 2006 (after receiving an additional $409 million in federal reimbursements), which is an average increase of $102 million per year, as seen in Table 1. However, federal reimbursements are not guaranteed, and must be negotiated by the state (Dembner 2008). This puts Massachusetts in a particularly vulnerable position if there are future federal budget cuts, since their health care expenses could potentially rise even more quickly.

A $409 million increase in state expenditures ordinarily might not cause much alarm during the budgetary process, since this was just a 2 percent increase in its $20 billion state budget, and a recent report by the nonpartisan Massachusetts Taxpayers Foundation (MTF) even states that the cost increase has been "marginal" (Raymond 2009: 7). The same report shows little concern about the underlying rapid rate of growth, since newly revised projections for 2010 show that enrollment and expenditures will plateau. However, these projections need to be taken with great caution, as past projections have been wide of the mark, as noted by MTF's most recent report (Raymond 2009). In any case, in the current fiscal crisis that Massachusetts and the nation faces, these higher health care costs take on greater significance. In 2009 the state collected $2 billion less tax revenue than in 2008, a drop of 10 percent. With only $500 to $800 million left in its "rainy day fund," the state is rapidly burning through its reserves (Massachusetts Taxpayers Foundation 2009). Thus, greater access to health care, a primary goal of the program, has been achieved, but the large increase in costs has put increased pressure on an already strapped state government.

As this article will explore, there is another, more hidden aspect of the Commonwealth Care program that may drive future costs far higher than originally projected. Embedded within the heavily subsidized program are several perverse incentives affecting firms and individuals. First, the program unintentionally gives incentives for smaller firms to discontinue health insurance so that their employees can sign up for cheaper state-subsidized care. Second, it gives incentives for employed individuals to earn less in order to qualify for higher benefits. Because subsidies immediately fall off as one crosses defined income brackets, instead of being slowly withdrawn, there are sudden and large implicit marginal tax rates that can exceed 100 percent in some cases. Enrollment in Commonwealth Care is

TABLE 1
Massachusetts: Health Care Reform Spending, FY06–FY09
($ Millions)

State Program	Actual FY06	Actual FY07	Actual FY08	Estimated FY09	Change FY06-FY09
(a) Commonwealth Care	$0	$133	$628	$800	$800
(b) Uncompensated care for hospitals	$656	$665	$416	$406	–$250
(c) Subtotal (a + b)	$656	$798	$1,044	$1,206	$550
(d) MassHealth coverage rate expansions	$0	$224	$355	$452	$452
(e) Supplemental payments to Medicaid MCOs (federal share)	$385	$0	$0	$0	–$385
(f) Subtotal (d + e)	$385	$224	$355	$452	$67
(g) Supplemental payments to safety net hospitals	$0	$287	$287	$200	$200
Grand total (c + f + g)	$1,041	$1,309	$1,686	$1,858	$817
State share of expenditures (50%)	$521	$655	$843	$929	$409
Annual increase		$134	$189	$86	
Average increase (FY06–09)					$102
Annual percentage change		25.7	28.8	10.2	78.5

Source: Adapted from Raymond (2009: 6, Table 2), which relied on data from Massachusetts state government.

expected to have "moderate" growth in 2010 according to state government projections, primarily due to the economic downturn (Governor's Budget 2009). Yet these incentives could cause enrollment to accelerate if more individuals and firms see and take advantage of the opportunities for government subsidies.

The outline of the rest of this article is as follows. First, it seeks to explain the mechanics of mandatory health insurance as it was enacted in Massachusetts, and the special difficulties of making health insurance a mandated purchase. Second, it explores in further detail the perverse incentives detailed above, with particular detail paid to the problems caused by the staggered health insurance subsidies for consumers. Finally, this article examines some alternatives to Massachusetts' current system that would somewhat ameliorate the perverse incentives embodied in the current system, as well as contain the state's growing medical costs.

The Massachusetts Experiment

In 2005 nearly a half million people in the state of Massachusetts—over 11 percent of the population—were without health insurance. As a result, Massachusetts' uninsured often sought primary medical care in emergency rooms, which is a highly inefficient and costly delivery mechanism for non-emergency care. Indeed, one in five U.S. adults (21 percent) reported they went to the emergency room for a condition that could have been treated by a regular doctor. In comparison, only 6 percent of patients in Germany report such unnecessary emergency room use (Commonwealth Fund 2008). In addition, in Massachusetts as well as the rest of the country, persons without health insurance may have no money to pay their bills after hospital stays. This problem creates a need for hospitals to seek additional revenue to cover these losses. Hospitals typically cover these losses by charging insurance companies higher rates, resulting in higher insurance premiums for the insured population. However, government reimburses 85 percent of uncompensated care, with over two-thirds borne at the federal level. Even so, uninsured individuals typically receive less care in a given year, wait longer to get treated, and have higher mortality rates (Hadley and Holahan 2004).

In 2006 the state, under then-governor Mitt Romney, led a drive to address the problem of its medically uninsured population. The legislature then passed a bill (known as Chapter 58) that created and enforced a mandatory health insurance program, the first of its kind in the country. The idea of the experiment was threefold. First, it sought to create better access for all state residents by making health insurance not only more available but more affordable. It does this through subsidizing the cost of private insurance to those who meet the affordability requirements but do not qualify for Medicaid. The goal is to shrink the number of people seeking primary medical care in the emergency rooms and improve overall health outcomes of the state's formerly uninsured citizens. Second, it aims to create more efficiency in the system by acting as a buying representative on behalf of thousands of small employers and individuals, which allows it to negotiate better rates with a number of private insurers. Third, it seeks to sharply increase the level of responsibility of Massachusetts' citizens by mandating that all people have health insurance coverage and requiring larger employers to play a role as well. Jonathan Gruber (2008), a health economist at MIT, was one of the primary architects of the plan, and argued that mandatory health insurance was a more cost-effective method than the government providing universal coverage.

New Health Care Choices

Mandating health insurance presents a dilemma that is vastly different from mandating, say, that an automobile owner pays for annual registration fees. With an automobile owner, the state can take a person's license away, denying him or her right to drive. The general public will find no problem with this tactic. However, if a person shows up at a hospital with a life-threatening condition and no health insurance or ability to pay, a hospital will not turn away the patient. This is not only federal law, it is also difficult to imagine doctors turning away these patients, or the general public agreeing to this type of policy. Thus, the state has far less leverage in enforcing and mandating payments in the area of health care. Unlike any other good, consumers of health care goods have in many instances an "effective demand" without having any money. This wrinkle presents particular challenges for policymakers, regardless of ideological stripe, in crafting an improved health care system for the United States.

The Chapter 58 legislation attempts to broach this problem, by offering Massachusetts residents three health insurance outcomes, depending upon their income level and employment status. Put simply, health insurance is either "free," paid for at the market rate, or state-subsidized, as seen in Table 2.

For those whose income falls below the federal poverty level (FPL), MassHealth provides "free" insurance. This is a Massachusetts health care program that is reimbursed through Medicaid, the federal aid program. MassHealth is also under financial pressure due to the sharp level of reimbursements it is requesting from Medicaid in recent years, but is not directly affected by the new mandatory health insurance program.

If residents' incomes are 300 percent or more above the FPL they will not qualify for any state aid, but may choose to elect to buy health insurance through Massachusetts' Commonwealth Choice

TABLE 2
Mandated Health Insurance in Massachusetts: Three Possibilities for Individuals

MassHealth	Commonwealth Care	Private Market or Commonwealth Choice
Income is less than 100% FPL	Income is between 100–300% FPL	Income is greater than 300% FPL
and	and	or
unemployed, or firm size is less than 11 employees.	firm size is less than 11 employees.	firm size is 11 employees or greater.
"Free"	Subsidized by government	Market rate (non-subsidized)

Note: FPL refers to the federal poverty level, which is indicated in Table 3

program, or purchase directly in the private market through employee-based plans. The advantage of the Commonwealth Choice program is that it allows the state to serve as a bargaining agent on an individual's behalf, which is particularly helpful if she or he is self-employed. It does this without providing subsidies to any party. The state negotiates for more inexpensive group rates, and gives individuals without health insurance a choice of policies from which to choose, at varying prices and amenities. Indeed, health premiums rose only 5 percent between 2007 and 2008 through the use of this program, indicating its relative success in holding down premiums (Massachusetts Health Connector 2009). In addition, since 2006 approximately 170,000 people used Commonwealth Choice who otherwise could have purchased private insurance through the traditional market. This outcome indicates some level of satisfaction (Raymond 2009: 2).

It is the middle range, for the individuals and families between 100 and 300 percent of the FPL thresholds, that is deserving of more attention, since this range provides very generous health insurance subsidies to qualifying individuals who sign up for Commonwealth Care. These subsidies do two things. First, they strongly discourage individuals from earning more (thus losing the benefits), and second, they encourage other individuals to earn less, so they too can qualify for Commonwealth Care. Over certain ranges, the subsidies are curtailed abruptly with a small earnings increase (and vice versa), leading to extraordinarily high implicit marginal tax rates, as will be discussed shortly.

Who exactly is eligible? Commonwealth Care is designed to assist adults who are not offered employer-sponsored insurance, do not qualify for Medicare, Medicaid, or certain other special insurance programs, and who earn no more than 300 percent of the FPL. In 2008, 300 percent of FPL was $31,200 for an individual and $63,600 for a family of four. In addition, if an adult worked in a firm with 11 or more employees, the firm is expected to contribute a set amount toward the health insurance costs and the individual is not eligible for Commonwealth Care. It is the hidden "devil in the details" that has created unintentional perverse incentives for both employers and employees. The state government is struggling to combat these incentives on the employer side, but has no plans to change them on the individual side. We now examine each group in turn.

Perverse Incentives for Employers

Massachusetts' legislation was designed to lessen the financial blow of mandatory health insurance to individuals by requiring all employers with 11 or more employees to make health insurance available for individual purchase, through Section 125 "cafeteria" plans. (Firms below this size are exempt from these requirements.) There are now three requirements for qualifying employers. First, they must satisfy certain requirements to avoid a "fair share assessment," which is a financial penalty from the state. Primarily, employers can avoid the assessment if they have at least 25 percent of their full-time employees (35 hours per week) enrolled in the company-offered health insurance plan. If employers do not meet this benchmark, they can still avoid the assessment by paying at least 33 percent of the premiums due on the full-time employees who are enrolled in the company-offered plan. Failing to meet at least one of these tests can result in an annual "fair share assessment" of $295 per employee per year, which is pro-rated for part-time employees. In addition, the firms must offer the same coverage to all employees. Third, employers must disclose to the state government how they are meeting these guidelines. The law was popular with many employees, as 166,000 signed up for health coverage since the law was enacted (Draper et al. 2008).

Yet there have been unintended consequences. Nationwide trends have led to employer health care premiums growing an average of 73 percent between 2000 and 2005, according to a Kaiser Family Foundation (2006) survey. As a result, employers have been forced in many cases to lower wage increases or health benefits (Sood, Ghosh, and Escarse 2007). With Massachusetts now offering heavily subsidized health insurance to workers making between 100 and 300 percent of the FPL, there are obvious incentives for those firms paying in that range to consider dropping health insurance benefits and to offer higher wages instead, in what is called "crowding out." Employers can then encourage employees to sign up for state subsidized care. A study by Long and Masi (2008) finds little evidence of crowding out, but other evidence by Draper et al. (2008) suggests otherwise—at least for small business owners.

Small group enrollment in private health insurance declined by 15,000 in 2007 (even as overall enrollment increased in Commonwealth Care), and a recent survey showed that some small

businesses are feeling the pinch from rising health care costs and expect to be "less committed" to offering health care coverage as the costs continue to rise. The same survey showed growing frustration from businesses about the increasing responsibilities that firms are expected to bear. In particular, since January 1, 2009, firms have had to offer health care plans with prescription drug coverage. They also must now provide quarterly (rather than annual) reports to the state on their employees' health care program (Draper et al. 2008).

Other perverse incentives have also arisen. For a firm that has 11 workers, it might be financially advantageous for the manager to fire one employee in order to take advantage of the Commonwealth Care program, and not pay any fair share assessments as well as eliminate all health insurance responsibilities. Likewise, other small firms might hesitate to hire more than 10 workers who were getting subsidized health care, because now they would be obligated to provide it or suffer the financial consequences. Thus, there are significant incentives that push small firms toward shrinking rather than growing. There is strong evidence that this has occurred in other, similar circumstances. A comprehensive Rand Institute report (Gates and Leuschner 2007: 78) found that small businesses that faced health care reforms across various states in the mid-1990s distorted their "firm-size decisions" in order to avoid costly regulations.

To date, Massachusetts has approximately 44,000 firms, and of those, 19,000 have 11 or more employees, thus subjecting them to the fair share assessment. As of March 2008, approximately 650 of the 19,000 did not pay their "fair share" and thus paid a total of $6.6 million in assessments. The employees working in the remaining 25,000 firms with fewer than 11 employees had to obtain health insurance either on their own or through the Connector program (Long and Masi 2008: 291). One would expect that the relative share of firms with fewer than 11 employees will grow in coming years, given the current incentives to do so. In addition, one would expect more employers to shoulder the fair share assessment rather than the cost of providing health insurance. Raymond (2009: 6) projects that fair share assessments will grow to $12 million in 2009 and $20 million in 2010, presumably as employers find ways to avoid paying for their employees' health insurance.

Perverse Incentives for Individuals

Like any government subsidy program that depends upon income levels, problems arise when the individual begins to earn more income. The subsidy is withdrawn, resulting in an implicit tax rate that may exceed the tax rate for the wealthiest income tax bracket. By way of example, suppose a person earned $20,000 and received a $5,000 government subsidy. Suppose also that for every additional $1,000 a person earned, $200 of the subsidy were removed. In this case, if a person received a raise to $25,000, then the $5,000 raise would mean a $1,000 decrease in the subsidy. Thus, the implicit tax rate would be 20 percent, which would not include the existing federal and state income taxes also paid.

This implicit tax, although high, is at least smooth and predictable in this example. However, the implicit tax rates of the Commonwealth program have sudden jarring transitions, leading to highly unusual and perverse incentives to earn less, not more, in order to qualify for government subsidies, as seen in Figure 1. They occur because the jumps in health care costs are immediate, rather than occurring at the margin. Thus, a $1,000 increase in income can throw an individual into a completely new and far more expensive category, resulting in an implicit marginal tax rate that can be exceed 100 percent for small changes in income. Richardson (1994) identified similar perverse incentives in the failed 1994 Clinton health care initiative, which sought to mandate that employers provide health care. In this case, small employers hiring one more worker might have suddenly paid thousands more dollars in health care costs for all their workers, as the firm moved to a higher bracket with less generous subsidies, and had to now cover all the workers at a higher rate.

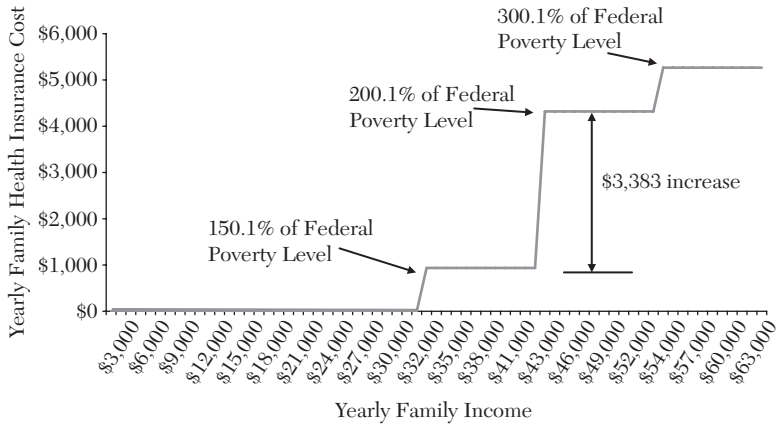
Take, for example, a couple with two children living in central Massachusetts. Let's also suppose the father works, earning $30,000 a year while the mother stays at home with the children. Assume the family signs up with the health insurance company BMC Healthnet, which offered the following state-subsidized rates below as seen in Table 3 in 2008. (This rate structure was typical of other health care providers' premiums, and information on multiple plans was obtained from a health care representative working for the Massachusetts Connector program.) Now at this point the family pays nothing for health insurance, as the family income is less than 150 percent of the FPL, as seen in Table 3. However, if the family

TABLE 3
Massachusetts: An Example of State Subsidized Health Insurance, by Federal Poverty Guidelines, 2008

	Single Person		Family	
Poverty Level	Income	Yearly Cost	Income	Yearly Cost
0%–150% FPL	$0–$15,600	$0	$0–$31,800	$0
150.1%–200% FPL	$15,601–$20,800	$468	$31,801–$42,400	$936
200.1%–250% FPL	$20,801–$26,000	$2,160	$42,401–$53,000	$4,320
250.1%–300 %FPL	$26,001–$31,200	$2,633	$53,001–$63,600	$5,266

Source: Massachusetts State Government Health Connector. These are rates quoted for individuals and families living in central Massachusetts in 2008, from the insurance company BMC Healthnet. Similar rates applied from other insurance carriers.

FIGURE 1
Massachusetts: An Example of the Changes in the Cost of Health Insurance for a Family of Four, at Various Income Levels



Note: The family is assumed to live in central Massachusetts and to sign up for the BMC Health Net.

earns another $10,000, then the family loses the free benefit but still qualifies for subsidized health insurance, since now it earns between 150 and 200 percent of the FPL. Since the net cost of health insurance has risen from $0 to $936 per year, the implicit marginal tax rate is 9.4 percent on the $10,000 raise, and does not include income and payroll taxes on top of that. The changes are also shown in Figure 1.

However, if the family's income rises from $40,000 to $50,000—because the spouse gets a part-time job—then the family moves into the next bracket, which is 200 to 250 percent of the FPL. Now, the health care premium increases from $936 to $4,320, a difference of $3,384, and a whopping 33.8 percent implicit tax rate. It's even worse for another family that earns $40,000, and gets a raise to $45,000. This creates a nearly 68 percent implicit tax rate on the raise. For a family close to the far edge of the FPL bracket, making say $42,000 and earning a small raise to $43,000, they will now see net losses. Their net income at $42,000 after paying for $936 in health insurance costs would be $41,064, while at $43,000 they would pay $4,320 for health insurance, and thus earn $39,680. The implicit tax rate on $1,000 worth of extra income is now 338 percent!

The perverse incentives built into this system are doubtless causing many families as well as individuals to think carefully about accepting pay raises. In some cases, it will benefit them to work less in order to qualify for cheaper health insurance from the state. These dynamics were ignored in the original cost projections for the state, and will probably drive enrollment to higher levels than have been originally predicted, as people who currently obtain health insurance through the marketplace switch to state-subsidized insurance plans.

For now, Massachusetts appears wedded to the idea of mandatory health insurance. One step toward smoothing those transitions out could be to have health insurance subsidies decline at a constant implicit tax rate. In one scenario, the subsidies could begin declining after earnings increased passed the 100 percent of FPL level, until one reached the market price for health insurance.

What should that implicit tax rate be? The double-edged sword here is that as one improves work incentives by reducing the implicit tax rate, it costs the state more money. Requiring a smaller share of each additional dollar earned to go toward health insurance premiums would improve work incentives, but would require greater government spending because more workers would qualify for subsidies. The reverse is also true. Suppose that for every $1,000 a person earned above the FPL, he would lose $80 of subsidy. If the market price of health insurance was $500 per month, or $6,000 per year, then a person would keep receiving subsidies until he or she earned $75,000 over the FPL, or about $85,000 per year. Although the implicit tax rate is fairly low (8 percent), one can see that this would be a very expensive program to subsidize, as most individuals would qualify. This means the state must raise taxes somewhere else to pay for it, again potentially destroying work incentives.

With regard to firms, the current rules in place have created an environment where firms will find it increasingly expensive to operate. If Massachusetts relieved firms of the responsibility to provide health insurance (and the federal government simultaneously eliminated the tax benefits), individuals would begin to shop for health insurance in much the same way as they do for car, flood, and fire insurance. Free-market forces would put downward pressure on health insurance premiums, as individuals would be better able to signal which types of benefits they were willing to pay for. It would also eliminate the perverse incentives that currently exist in Massachusetts' business environment toward hiring.

Conclusion

The success or failure of the Massachusetts mandatory health insurance program has been closely monitored as a harbinger of future outcomes for a nationwide move in this direction. To date, the results have been mixed, as has been demonstrated in this article. Mandatory health care reforms have resulted in fewer uninsured but have not contained soaring costs in the health care system. Instead, the reforms have created incentives for costs to rise even faster. Here is a summary of some of the reasons:

- Massachusetts' expenditures on its health care initiative have been discounted by 50 percent, thanks to matching funds from the federal government, which has encouraged a rapid increase in state expenditures.
- Growing burdens on businesses have meant that an increasing number are choosing to steer their employees into the state-subsidized system rather than provide health insurance themselves. In addition, some will hesitate to expand beyond 10 employees when faced with the cost of providing health insurance or state penalties.
- Consumers of health insurance over certain income ranges have strong incentives to earn less money in order to qualify for more generous subsidies.

Mandatory health insurance may improve access, but the nut has not yet been cracked to solve the second and now more pressing problem of efficiency and cost containment. An argument for making health insurance mandatory is that individuals get access to much medical care anyway, regardless whether they can afford it, by simply showing up at the emergency room or not paying their medical bills. But the case of Massachusetts also offers cautionary lessons for the United States as the Obama administration seeks wide-ranging health care reforms that move more in the direction of mandatory health insurance. Keen attention needs to be paid to the distortionary effect of regulations on individual and firm incentives, balancing out the costs versus the benefits to society of a subsidized program. The lesson learned is that it is difficult to create any subsidized program that does not encourage people to earn less—ironically, the programs get more expensive as the work incentives improve. In either case, the Massachusetts health reforms could cost far more

than projected, as individuals and firms change behavior in the face of new regulations.

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