First, federal financing arrangements need strengthening. Continued reliance on fragile state economies makes Medicaid a high-risk financial proposition for states.

Second, certain basic investments are essential. Payment rates for primary and specialty care need to be increased if greater provider participation is to be attained. Indeed, in many states payment rates are so low that even with a substantial increase, Medicaid would still be a bargain.

Finally, Medicaid needs to be able to work toward improving the underlying health care system and to integrate these efforts with those expected of exchange insurers. These efforts encompass investments in facilities, workforce, health information technology, and quality-improvement strategies. They also include the joint development of high-quality provider networks so that care remains stable even as slight income fluctuations expose millions of low-income persons to the risk of frequent shifts between Medicaid and exchange coverage.

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Massachusetts Health Care Reform — Near-Universal Coverage at What Cost?

Joel S. Weissman, Ph.D., and JudyAnn Bigby, M.D.

Massachusetts has long been known for its academic medical centers, biomedical research, high-quality health care, and perhaps not unrelatedly, high health care costs. In 2006, the state captured national attention when it passed a landmark health care reform bill, under which it has achieved near-universal coverage of state residents. Some observers, however, have questioned whether this reform has been too costly.

The Massachusetts reform law expanded Medicaid coverage; created state-subsidized insurance, called Commonwealth Care, for low-income persons who are not eligible for Medicaid; merged the individual and small-group insurance markets; instituted an employer "fair share assessment" and an individual mandate; and created the Commonwealth Connector, an insurance exchange that also sets standards for coverage and affordability. Under this reform, nearly universal coverage has been achieved, with 97.3% of all residents covered as of the spring of 2009 by health plans that meet a "minimum creditable coverage" standard. There is no evidence of private insurance "crowd-out,"[1] and access to care has increased, with fewer people encountering financial barriers to care.[2] Nevertheless, under the microscope of the national health care reform debate, questions have been raised about the appropriateness of the Massachusetts model for the country as a whole, given the costs of the program for individuals, employers, and the state; some have also questioned whether recent actions to reduce costs represent a retrenchment as compared with the law's original intent.

Spending in fiscal year 2008 was higher than expected and led to fears of rapid future growth and charges that the crafters of the reform had underestimated the size of the uninsured population and its needs. It is now recognized that Commonwealth Care's early spending growth was due to effective marketing and outreach campaigns, which made it easier than expected for people to enroll in public programs.[3] Commonwealth Care enrollment reached a peak of 176,000 in mid-2008, declined in early 2009, and has returned to its mid-2008 levels in recent months. Through fiscal year 2010, the increase in the annualized per-enrollee cost has been under 5%.

The Financing of Massachusetts Health Care Reform.*

Source	Financing before Reform	Financing after Reform			Additional Financing, Fiscal Years 2006–2009
	Fiscal Year 2006, Actual	Fiscal Year 2007, Actual	Fiscal Year 2008, Actual	Fiscal Year 2009, Estimated	
			millions of dollars		
Spending					
MassHealth	770	511	642	795	
Commonwealth Care	0	133	628	805	
UCP–HSNTF	656	665	416	417	
Total	1,426	1,309	1,686	2,017	
Additional, 2006–2009					591
Revenues					
UCP–HSNTF provider assessments and insurer surcharges	320	320	320	320	
Local contribution to MCO supplemental payments	385	0	0	0	
Federal financial participation	688	816	888	1,272	
Dedicated revenues	0	7	21	219	
Total	1,393	1,143	1,229	1,811	
Additional, 2006–2009					418
Difference					
General fund share	33	166	457	205	
General fund share of net new annual spending, 2006–2009					172

* Data are from the Massachusetts Executive Office of Health and Human Services. No enrollment increases besides those directly attributable to eligibility changes have been included in this analysis. Commonwealth Care spending is net of enrollee contributions. Dedicated revenues include new taxes and penalties dedicated to paying for health care reform. Some differences appear not to be exact, because of rounding. MCO denotes managed-care organization, and UCP–HSNTF uncompensated care pool–Health Safety Net Trust Fund (as the pool is called under health care reform).

The media have raised a more fundamental question about whether Massachusetts' experiment is too expensive — a "budget buster."[4] The only responsible way to address this question is to assess the new burden on state taxpayers by examining the net new costs to the state's general fund (see table). Before reform, the state provided about $1.4 billion annually in subsidies to institutions to cover services for the uninsured, about $33 million of which came out of the general fund. After reform, with revenues redirected to support Commonwealth Care subsidies and expansions of MassHealth (the Massachusetts Medicaid program), a decrease in spending on the uncompensated care pool, and a phasing out of subsidies for managed-care organizations associated with safety-net institutions, the net new spending was $591 million, of which $172 million — less than 1% of the state budget — came from the state's general fund. With all spending projected to decrease in fiscal year 2010 because of recessionary belt-tightening, the draw on the general fund will decrease substantially.

Moreover, a central premise of the formative political negotiations over the Massachusetts reform was "shared responsibility" — and indeed, a recent report showed that employers, government, and individuals pay approximately the same proportion of health coverage costs after reform as they did before reform.[5] In fact, only about half of the more than 400,000 residents who gained coverage by December 2008 were publicly subsidized. From this per-

spective, the individual mandate and employer incentives have provided good value for Massachusetts taxpayers, costing about $1,060 in net new state spending per newly covered state resident in 2008. The state succeeded in enacting a government program that stimulated private parties to use private dollars to help fulfill a public good.

Of course, the recession has created substantial challenges. Facing a deficit of more than $5 billion over 2 years, the Massachusetts legislature imposed major cuts in funding to subsidize coverage for about 30,000 legal immigrants who had qualified for Commonwealth Care but are not eligible for the federal Medicaid match. MassHealth has also had to eliminate certain planned increases in provider payment rates that were not part of the original reform legislation. Like other states facing economic difficulties, Massachusetts is raising new revenues, using reserves, and taking advantage of increased federal assistance. The state has also made cuts across the board, including reducing aid to cities and towns, reducing the number of state workers, and increasing cost sharing for state employees' health insurance. In this context, reductions in core funding for health care reform were not extraordinary and do not signal a retreat from the original commitment.

There is little doubt that the high cost of care in Massachusetts is causing major strains. From 2006 to 2008, the average price of a family insurance premium increased by more than 12%, and premiums increased by about 10% statewide this autumn. If insurance becomes less affordable, the number of people who are exempted from the individual mandate could increase. Some small businesses have reportedly suffered hardships in providing insurance for employees and say that rising premiums could threaten their continued participation. But costs were high before health care reform. In contrast to the state's approach to expanding coverage, its cost-control strategies have been incremental, and costs must now be seriously addressed.

Massachusetts was unusual in 2006 because it already had a low proportion of uninsured residents, a highly regulated insurance market, and an uncompensated care pool. Nevertheless, the national debate could be informed by our experience.

First, the philosophy of shared responsibility behind our reform provides a sense of fairness and allows government spending to be leveraged to accomplish societal goals. The individual mandate works hand in hand with employer incentives to expand private coverage, as long as government subsidies are available for low-income individuals. For example, initially, the greatest number of newly insured individuals obtained coverage through their employers rather than the individual market, suggesting that more employees decided to take up their employers' offer of insurance, quite possibly to avoid the mandate's tax penalty. At the same time, though the employer assessment did not increase the number of firms offering insurance, neither did the number decrease, as many had feared, perhaps because employers did not want to force their employees to buy insurance on the individual market at higher rates. How this plays out in national reform will depend on the design of the incentives. Massachusetts employers in 2006 were more likely than employers nationally to offer insurance. If national reform were to include policies that achieved rates of employer offers and employee take-up similar to those in Massachusetts, it could have a substantial effect on spreading the costs and reducing the government's burden.

Second, the cost of national health care reform should be framed in terms of new expenditures and predictable funding streams that can be redirected to other uses. These should include, at a minimum, projected savings, at all levels of government, from potential reductions in the costs of paying for public clinics and uncompensated care. Savings from the latter should also accrue to private entities.

Third, the changing roles and funding schemes for the safety net must be addressed head-on. Uninsured patients will not disappear and will have needs. Safety-net providers will find it challenging to continue functioning, given their dependence on Medicaid and Medicare, which pay lower rates than commercial insurance. One goal of reform should be to decrease cost shifting.

Finally, national reform must support the gains made in Massachusetts by supporting the building blocks that made change successful: expansion of Medicaid eligibility, subsidies for the poor, the individual mandate, and fair-share employer contributions.

In Massachusetts, achieving near-universal coverage was the right first step, providing thousands of residents with access to care and protection against financial uncertainty due to medical bills. Now, tackling costs has ris-

en to the top of the agenda. As we move toward national health care reform, we must balance individuals' needs for high-quality care with the obligation to be socially and fiscally responsible.

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Mandatory Vaccination of Health Care Workers

Alexandra M. Stewart, J.D.

Mandatory vaccination of health care workers raises important questions about the limits of a state's power to compel individuals to engage in particular activities in order to protect the public. In justifying New York State's regulations requiring health care workers who have direct contact with patients or who may expose patients to disease to be vaccinated against seasonal and H1N1 influenza, New York State Health Commissioner Richard Daines recently argued, "[O]ur overriding concern . . . as health care workers, should be the interests of our patients, not our own sensibilities about mandates. . . . [T]he welfare of patients is . . . best served by . . . very high rates of staff immunity that can only be achieved with mandatory influenza vaccination — not the 40-50% rates of staff immunization historically achieved with even the most vigorous of voluntary programs. Under voluntary standards, institutional outbreaks occur. . . . Medical literature convincingly demonstrates that high levels of staff immunity confer protection on those patients who cannot be or have not been effectively vaccinated . . . while also allowing the institution to remain more fully staffed."[1]

Workers at diagnostic and treatment centers, home health care agencies, and hospices are included in New York's requirement, although workers who can show that they have a recognized medical contraindication to vaccination are exempt. Each facility will have the discretion to determine the steps that unvaccinated health care workers must take to reduce the risk of transmitting disease to patients (see table).

Many health care workers believe that the mandate violates fundamental individual rights and public health policy, and some have filed court actions. In response, one judge ordered a delay in implementing the regulation, and New York's governor, David Paterson, suspended the requirement so that the limited supply of H1N1 vaccine currently available can be distributed to the populations most at risk for serious illness and death.

The workers argue, first, that compulsory vaccination violates the Fourteenth Amendment in depriving them of liberty without due process. But in 1905, in deciding the smallpox-vaccination case *Jacobson v. Commonwealth of Massachusetts*, the U.S. Supreme Court recognized that the "police powers" granted to states under the Tenth Amendment authorize them to require immunization. Police powers are government's inherent authority to impose restrictions on private rights for the sake of public welfare. Thus, health administrators may develop measures that compel individuals to accept vaccinations in order to protect the public's health.

Such measures include immunization requirements for school entry, which have been enacted by all states and the District of Columbia. These mandates have been