

# HEALTHY START: A POLICY AND LEGAL ANALYSIS OF HEALTH CARE REFORM IN MASSACHUSETTS

Matthew Kanter\*

*On April 12, 2006, Massachusetts enacted a comprehensive health care reform package designed to provide near-universal coverage for the state’s residents, including 550,000 who were previously uninsured. The first part of this paper describes and analyzes several features of the reform including the first-of-its-kind individual mandate, the employer mandates, and the “Connector.” It argues that while the legislation is not perfect—significant questions remain regarding whether it is adequately funded—the legislation goes a long way toward ensuring accessible, high-quality, and portable health care for Massachusetts residents. The second part of the paper analyzes a potential legal hurdle for the new legislation: whether the federal Employee Retirement Income Security Act (ERISA) pre-empts the employer play or pay mandate created by the State. Despite unclear and sometimes conflicting judicial precedent, the author contends that a federal court will likely uphold the employer mandate. The paper concludes by discussing policy implications for states considering similar health care reforms, as well as for federal politicians who want to adopt elements of the Massachusetts reforms into their national health care reform proposals.*

INTRODUCTION .....	66
I. THE LEGISLATION .....	66
A. The Connector .....	66
B. Insurance Market Reforms .....	67
C. Employer Responsibility .....	68
D. Personal Responsibility .....	69
E. Subsidies .....	69
II. POLICY ANALYSIS .....	70
A. The Benefits of the Legislation .....	70
1. <i>Substantial Increases in Insurance Coverage and a More Efficient Use       of Health Care Services</i> .....	70
2. <i>Portable Insurance</i> .....	72
3. <i>Lower Premiums in the Individual and Small-Group Markets</i> .....	72
4. <i>The Public Supports the Plan</i> .....	73
B. Legitimate Concerns with the Legislation .....	74
1. <i>The Legislation Contains No Cost-Containment Mechanisms</i> .....	74
2. <i>Minimum Creditable Coverage and the Definition of Affordability</i> .....	75
3. <i>Coverage in Name Only</i> .....	78
III. IS THE EMPLOYER MANDATE ILLEGAL? .....	79
A. <i>ERISA Pre-emption</i> .....	80
B. <i>Retail Industry Leaders Association v. Fielder</i> .....	81
C. <i>Applying ERISA and RILA v. Fielder to the Massachusetts Legislation</i> .....	82
IV. POLICY IMPLICATIONS FOR OTHER STATES .....	86
V. FEDERAL POLICY IMPLICATIONS .....	88
CONCLUSION .....	90
APPENDIX A: 2008 AFFORDABILITY SCHEDULE FOR INDIVIDUAL MANDATE .....	91

---

\* M.P.P., Georgetown University. B.C.L./LL.B., McGill University expected December 2008. The author wishes to thank the anonymous reviewers for their constructive comments. He is also grateful to Professor Angela Campbell, Jan Rugar, Ron Kanter, and Joanna Grosberg for their valuable insight on earlier drafts of this paper. Finally, he would like to thank the editors of the *McGill Journal of Law and Health* for their editorial assistance.

## INTRODUCTION

On April 12, 2006, Massachusetts enacted a comprehensive health care reform package designed to provide near-universal coverage for the state's residents, including 550,000 who were previously uninsured.<sup>1</sup> *An Act Providing Access to Affordable, Quality, Accountable Health Care*<sup>2</sup> (the "Act") is a complex mix of insurance market reforms, subsidized insurance offerings, and individual and employer responsibility provisions. If successful, the Act could serve as an example for health care reform throughout the United States.

The Massachusetts reforms are based on the premise of shared responsibility—that providing health insurance is the combined responsibility of government, individuals, employers, and health care providers. The bi-partisan legislation passed by staggering margins. It was approved 155-2 in the Massachusetts House of Representatives and 37-0 in the State Senate. Furthermore, the legislation has drawn widespread support from across the political spectrum, including from former Republican Governor Mitt Romney, Democratic Senator Ted Kennedy, the Heritage Foundation, and Families USA, a liberal health care advocacy initiative. It has also, of course, drawn widespread criticism from across the same spectrum.

This paper describes several key features of the legislation, including the individual mandate, the employer mandate, and the "Connector." It argues that, from a *policy* perspective, the legislation will go a long way toward ensuring accessible and quality health insurance for Massachusetts residents. The legislation is not perfect, however, and there are significant questions regarding whether health insurance will be affordable and whether the plan is adequately funded. The paper then examines a significant *legal* question surrounding the legislation, namely, whether the federal *Employee Retirement Income Security Act*<sup>3</sup> (ERISA) pre-empts the employer mandate to provide health insurance to employees or pay a penalty. While jurisprudence in this area is murky at best, it is argued that a federal court will likely uphold the employer mandate. Finally, the conclusion discusses policy implications of Massachusetts' health plan for other states and potential federal initiatives. During the Democratic primary campaigns, both Hillary Clinton and Barack Obama proposed sweeping health care reforms that drew heavily from the Massachusetts plan. Any significant federal health reforms must draw from the Massachusetts experience with reform and try to avoid the pitfalls learned two years after its implementation.

## I

## THE LEGISLATION

The ambitious Act has several significant provisions, many of which are creative, novel, and unprecedented. This paper describes the Connector, insurance market reforms, employer responsibility, personal responsibility, and state subsidies for insurance premiums.

## A. The Connector

Arguably the most revolutionary aspect of the legislation is the development of an innovative quasi-governmental entity known as the Commonwealth Health Insurance Connector (the "Connector").<sup>4</sup> The Connector is a state-chartered clearinghouse through which

---

<sup>1</sup> "Health Care Access and Affordability Conference Committee Report" (April 3, 2006), online: The 185th General Court of the Commonwealth of Massachusetts <<http://www.mass.gov/legis/summary.pdf>> at 1 [Conference Committee Report]. Officially, the Massachusetts Division of Health Care Finance and Policy estimated that there were only 372,000 uninsured Massachusetts residents in April 2006. See Alan G. Raymond, "The 2006 Massachusetts Health Care Reform Law: Progress and Challenges After One Year of Implementation" (May 2007), Blue Cross Blue Shield of Massachusetts Foundation.

<sup>2</sup> *An Act Providing Access to Affordable, Quality, Accountable Health Care*, c. 58, 2006 Mass. Acts.

<sup>3</sup> *Employee Retirement Income Security Act*, Pub. L. No. 93-406, 88 Stat. 829 (1974) [ERISA].

<sup>4</sup> Robert E. Moffit & Nina Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan" (18 July

individuals and employees in businesses with fifty or fewer employees who designate the Connector as their insurer will be able to purchase insurance from competing private companies, with pre-tax dollars. It will be run by an independent agency, the Commonwealth Health Insurance Connector Authority (the “Connector Authority”), whose eleven-member Connector Board will consist of individuals from both the public and private sectors. Jon Kingsdale, a senior executive at Tufts Health Plan, was appointed as the first Executive Director of the Connector Board in April 2006.

The Heritage Foundation, which developed the idea of a central health insurance exchange originally proposed by Alain Enthoven, refers to the Connector as providing a “Car Max” approach to health insurance:<sup>5</sup> different (private) health insurance plans are available through a large central dealership (the Connector). It is designed to work like a buying cooperative, generating lower premiums from the purchasing power which results from combining many individuals and smaller employers into a single, state-run insurance pool.<sup>6</sup> The Connector clearinghouse will pair buyers with sellers efficiently and facilitate the collection and transmission of payments, often from multiple sources. The Connector neither designs plans nor regulates the insurers offering the plans (which will continue to be regulated by the Department of Insurance), who are free to design plans subject to Massachusetts’ existing insurance laws. All plans offered through the Connector, however, must cover all forty-three mandated benefits under Massachusetts law, including mental health, maternity, and chiropractic benefits, and must meet the minimum creditable coverage requirements established by the Connector Board by January 2009.<sup>7</sup>

For individuals with annual incomes above 300 percent of the Federal Poverty Level (FPL), which is currently \$30,630 for an individual or \$61,950 for a family of four, there are no subsidies to purchase “Commonwealth Choice” plans through the Connector. Those individuals can, however, pool their purchasing power and risk to bargain for better rates than insurance companies would ordinarily offer to individuals and small groups. Policies offered through the Connector will be underwritten for a large risk pool (all individuals who obtain coverage through the Connector) rather than for each individual or small group that attempts to obtain insurance.<sup>8</sup> On average this should lead to larger risk pools, more risk spreading, and lower health insurance costs.

The Connector plans are also portable throughout the state, meaning that individuals can maintain coverage without interruption as they change jobs or experience gaps in employment. In addition, workers with multiple employers (such as seasonal, part-time, or temporary employees) can combine the employers’ contributions to their premiums.

## B. Insurance Market Reforms

The legislation also merged small group and non-group (individual and self-employed purchasers) insurance markets in July 2007. The merger was intended to stabilize the non-group market and generate risk-pooling and bargaining power advantages in order to reduce

---

2006), online: The Heritage Foundation, Web Memo #1045 <[www.heritage.org/Research/HealthCare/wm1045.cfm](http://www.heritage.org/Research/HealthCare/wm1045.cfm)>.

<sup>5</sup> Edmund F. Haislmaier, “The Significance of Massachusetts Health Reform” (11 April 2006), online: The Heritage Foundation, Web Memo #1035 <[www.heritage.org/Research/HealthCare/wm1045.cfm](http://www.heritage.org/Research/HealthCare/wm1045.cfm)>.

<sup>6</sup> Edward A. Zelinsky, “The New Massachusetts Health Law: Pre-emption and Experimentation” (2007) 1:49 Wm. & Mary L. Rev. 229 at 237-8.

<sup>7</sup> See Elizabeth A. Weeks, “Failure to Connect: The Massachusetts Plan for Individual Health Insurance” (2007) 55 Kan L. Rev 1283 at 1291.

<sup>8</sup> Zelinsky, *supra* note 6 at 237.

rates. Individual premiums are projected to decrease by 15 percent, while premiums for small employers are only expected to increase by 1 to 1.5 percent.<sup>9</sup>

### C. Employer Responsibility

The Massachusetts reform imposes three new requirements on employers. First, employers with more than ten employees must create “cafeteria” plans (under section 125 of the *Internal Revenue Code*) which allows employees to purchase insurance with pre-tax dollars.<sup>10</sup> Second, there will be a “free rider surcharge” levied on employers who do not provide health insurance and whose employees use a threshold amount of uncompensated care.<sup>11</sup> The final employer responsibility requirement is the imposition of a “play or pay” mandate. This provision was originally vetoed by Governor Romney, but the Democratic legislature overrode his veto. It requires employers with more than ten employees to provide a “fair and reasonable” contribution to their employees’ health insurance (play) or to pay an annual “fair share contribution” into the state’s Commonwealth Care Trust Fund of no more than \$295 per full-time employee per year.<sup>12</sup> The \$295 assessment represents the estimated private sector share of the average cost (per worker) of free care provided to workers whose employers do not provide health insurance.<sup>13</sup> If uncompensated care drops, the \$295 assessment will correspondingly decline.

Subsequent regulations from the Division of Health Care Finance and Policy provide that companies meet the “fair and reasonable” requirement if at least 25 percent of the firm’s full-time employees are enrolled in that firm’s health plan and the company is making a contribution towards it, or if the company has offered to pay at least 33 percent of its employees’ health insurance premiums.<sup>14</sup>

The assessment was originally expected to affect 8 percent of Massachusetts’ 35,000 companies with more than ten employees and was intended to generate between \$26 million and \$48 million.<sup>15</sup> Democratic Governor Deval Patrick later amended those figures, predicting the employer mandate to generate approximately \$24 million for 2007. However, as of late November 2007, only 518 companies had agreed to pay the penalty, which has generated about \$5 million.<sup>16</sup> Proponents of the health care reform take this low figure as an indication that employers are taking their portion of the shared responsibility seriously, and have begun and continue to provide adequate health insurance to their employees.<sup>17</sup>

---

<sup>9</sup> Kaiser Family Foundation, “Massachusetts Health Care Reform Plan: An Update” (June 2007), online: Kaiser Family Foundation <<http://www.kff.org/uninsured/upload/7494-02.pdf>> [Kaiser Family Foundation, “Update”].

<sup>10</sup> *An Act Providing Access to Affordable, Quality, Accountable Health Care*, *supra* note 2, §48(2). Cafeteria Plans are regulated by the *Internal Revenue Code*, 26 U.S.C. 125.

<sup>11</sup> *Ibid.* The surcharge will be imposed when an employee at a company receives free care more than three times in a year, or a company has five or more instances of employees receiving free care in one year. The free rider surcharge will range from 10 to 100 percent of the state’s costs of free care provided to the employees, with an exemption for the first \$50,000 of free care used.

<sup>12</sup> *Ibid.*, §47(c)(10).

<sup>13</sup> See John E. McDonough *et al.*, “The Third Wave of Massachusetts Health Care Access Reform” (2006) Health Affairs w420.

<sup>14</sup> For further explanation of these requirements see David A. Hyman, “The Massachusetts Health Plan: The Good, the Bad, and the Ugly” Policy Analysis No. 595 (28 June 2007) at 4, online: The Cato Institute <<http://www.cato.org/pubs/pas/pa-595.pdf>>.

<sup>15</sup> *Ibid.* at 10 note 11 suggests that the amount raised will be \$26 million annually. Weeks, *supra* note 7 at 1287 cites estimates that \$48 million will be raised annually.

<sup>16</sup> Alice Dembner, “Most Firms Complying with Health Law” *The Boston Globe* (22 November 2007), online: The Boston Globe Online <[http://www.boston.com/news/health/articles/2007/11/22/most\\_firms\\_comply\\_with\\_health\\_law/](http://www.boston.com/news/health/articles/2007/11/22/most_firms_comply_with_health_law/)>.

<sup>17</sup> *Ibid.* State Senate President Therese Murray argued that the \$5 million figure is “unequivocally good news” because “employers are obviously doing their part, and individuals are also taking their responsibility seriously.” Critics of the Massachusetts plan argue that this low figure is an example of how the plan is under-funded, and that a

#### D. Personal Responsibility

The most controversial and unprecedented aspect of the new legislation is the first-of-its-kind individual mandate. It is also the aspect that has garnered the most media attention. As of July 1, 2007, Massachusetts law *requires* all residents over age eighteen to “obtain and maintain creditable coverage so long as it is deemed affordable under the schedule set by the board of the Connector,” either through their employer, Medicaid, Medicare, or the Connector which facilitates the purchase of private health insurance.<sup>18</sup>

There are important exceptions to the individual mandate: those whose “sincerely held religious beliefs” prevent them from obtaining coverage and those for whom there is no coverage deemed “affordable,” are exempted from the mandate.<sup>19</sup> The Connector Authority is responsible for setting the affordability standards and it released an affordability schedule in July 2007. It is also responsible for determining which policies meet the requirements of adequate (*i.e.* creditable) coverage in order to satisfy the individual mandate.

Those who fail to comply with the individual mandate because they do not have documented, creditable coverage, face income tax penalties. In 2007, the penalty for not having health insurance was the loss of the personal income tax exemption (about \$219 for an individual or \$437 for a family).<sup>20</sup> In 2008 and thereafter, the penalty for each month without coverage will be half the cost of the cheapest available insurance premiums for creditable coverage within a person’s region. The cheapest plans cost approximately \$150 per month (\$1,800 per year) meaning that the penalty will be roughly \$900 annually, prorated monthly for each month the individual lacks insurance.<sup>21</sup>

#### E. Subsidies

The legislation also creates mechanisms to help people obtain coverage in order to satisfy the individual mandate. For individuals who cannot afford health insurance, the Massachusetts Plan includes government subsidies through Commonwealth Care. Subsidies are available for low-income uninsured adults below 300 percent of the FPL, allowing them to purchase insurance through the Connector. Eligible individuals below 150 percent of the FPL (an income of \$15,315 for an individual in 2008) will receive subsidized insurance through the Connector with *no premiums or deductibles* and only modest co-payments.<sup>22</sup> Individuals who earn between 150 and 300 percent of the FPL will also qualify for premium subsidies based on a sliding fee scale. There will be no deductibles for any Connector-subsidized plans, but the mandatory minimum creditable coverage requirements apply. All plans purchased through the Connector require a Connector Seal of Approval, indicating that they are of “high value and good quality.”<sup>23</sup>

---

tax increase will be required to fund the shortfall.

<sup>18</sup> *An Act Providing Access to Affordable, Quality, Accountable Health Care*, *supra* note 2, §2(a).

<sup>19</sup> *Ibid.*, §2.

<sup>20</sup> McDonough *et al.*, *supra* note 13 at w424.

<sup>21</sup> Commonwealth Health Insurance Connector Authority, Press Release, “Connector Board Endorses Plans from Seven Carriers” (8 March 2007), online: Commonwealth Health Insurance Connector Authority <<http://www.mahealthconnector.org/portal/site/connector/menuitem.4bab485e26865f535734db47e6468aoc/?fiShown=default>>.

<sup>22</sup> Originally, the legislation only called for individuals earning below 100 percent of the FPL to receive fully subsidized insurance (no premiums). However, on April 12, 2007, the Connector Board approved new premium subsidies, increasing the threshold for no-premium insurance to individuals who earn up to 150 percent of the FPL. See Raymond, *supra* note 1 at 12.

<sup>23</sup> Conference Committee Report, *supra* note 1 at 1.

## II POLICY ANALYSIS

Given the multi-step, multi-year implementation process of the legislation, it is difficult to fully analyze all of the legislation's (positive and negative) consequences. Indeed, it is only after the implementation process is complete that the law's full significance will become clear. That said, the legislation represents a clear step in the right direction for Massachusetts' health care, and has several significant policy benefits.

### A. The Benefits of the Legislation

#### 1. *Substantial Increases in Insurance Coverage and a More Efficient Use of Health Care Services*

The first, obvious, benefit of the legislation is that its comprehensive nature will lead to a significant increase in the number of Massachusetts residents with health insurance. According to the Kaiser Family Foundation, the Massachusetts plan will achieve nearly universal health coverage. The Foundation originally estimated that, eventually, of the roughly 550,000 uninsured Massachusetts residents, 92,500 would get coverage through Medicaid expansions, 215,000 would purchase private insurance through the Connector and 207,500 would obtain subsidized insurance.<sup>24</sup> That would leave 35,000 residents uninsured, meaning that 99.5 percent of Massachusetts residents will have insurance. This is a significant positive step. Indeed, as McDonough argues, while these predictions may not be completely accurate, "at a minimum, hundreds of thousands of uninsured people will obtain affordable, high quality coverage over the next three years."<sup>25</sup> As will be described below, this seems to have occurred in large measure so far, two years after implementation of the Massachusetts reforms.

While it is admittedly difficult to quantify these issues, John Holahan and Linda Blumberg (using methodology developed by the Institute of Medicine) argue that the increase in economic well being from improved health in Massachusetts will total \$1.5 billion.<sup>26</sup> This is the estimated value of healthy life years gained as a result of expanding insurance coverage to those who lack it. Holahan and Blumberg further argue that these economic benefits far outweigh any potential new investment of state funds.<sup>27</sup> Substantially increasing the percentage of Massachusetts residents with health insurance will have significant health and economic benefits for the state.

The most recent data, from the Connector Board meeting on November 16, 2007, indicate that 216,130 people have become newly insured in Massachusetts. The latest unofficial figures indicate that more than 342,000 people are newly insured, as of March 2008.<sup>28</sup> Of the newly

---

<sup>24</sup> Kaiser Family Foundation, "Massachusetts Health Care Reform" (April 2006), online: Kaiser Family Foundation <<http://www.kff.org/uninsured/upload/7494.pdf>>. Interestingly, this "fact sheet" is no longer on the Kaiser Family Foundation website. However, there are no updated estimates as to how many individuals will obtain insurance under the Massachusetts reforms.

<sup>25</sup> McDonough *et al.*, *supra* note 13 at w431.

<sup>26</sup> John Holahan & Linda Blumberg, "Massachusetts Health Care Reform: A Look at the Issues" (2006) 25 Health Affairs w432 at w442.

<sup>27</sup> *Ibid.*

<sup>28</sup> Alice Dembner, "Healthcare Cost Increases Dominate Mass. Budget Debate" *The Boston Globe* (26 March 2008), online: The Boston Globe Online <[www.boston.com/news/local/articles/2008/03/26/healthcare\\_cost-increases\\_dominates\\_mass\\_budget\\_debate/?page=2](http://www.boston.com/news/local/articles/2008/03/26/healthcare_cost-increases_dominates_mass_budget_debate/?page=2)> [Dembner, "Healthcare Cost Increases Dominate"]. The Connector Authority website indicates that of the roughly 340,000 newly insured, about one third (110,000) are enrolled in private, commercial insurance—85,000 through employer-sponsored insurance and 25,000 in individually purchased non-group insurance plans—and approximately 230,000 have signed up for subsidized or partially subsidized state programs. See Commonwealth Health Insurance Connector, "About Us: Executive Director's Message," (17 April 2008) online: Commonwealth Health Insurance Connector <<http://www.mahealthconnector.org/portal/site/connector/menuitem.dc4d8f38fdd4b4535734db47e6468a0c?fiShown=default>>.

insured, 132,919 people (61 percent) have enrolled in Commonwealth Care, the sliding scale subsidized insurance plans for individuals with incomes below 300 percent of the FPL. The majority of those people have enrolled in plans with fully subsidized premiums.<sup>29</sup> A further 73,012 individuals (34 percent) have signed up for MassHealth, the Massachusetts Medicaid program. Interestingly, however, although Commonwealth Choice plans—unsubsidized plans for people earning more than 300 percent of the FPL—have been on the market since July 1, 2007, enrolment has been “sluggish.”<sup>30</sup> As of November 2007, only 10,199 people (5 percent) had enrolled in these plans through the Connector.<sup>31</sup> Indeed, enrolment for individuals in the fully subsidized plans has exceeded estimates, while sign-up for higher income groups has not been as high as expected. Only a small percentage of individuals between 200 and 300 percent of the FPL have enrolled in Commonwealth Care plans, and a smaller percentage of individuals earning more than 300 percent of the FPL have enrolled in Commonwealth Choice. These figures have led some critics of the plan to argue that the premiums for these plans are simply unaffordable.

The enrolment boom of individuals earning below 300 percent of the FPL is an indicator that the health insurance reforms are working because significant numbers of previously uninsured individuals have now obtained health insurance.<sup>32</sup> However, since enrolment in the subsidized plans is growing at a higher-than-anticipated pace, the state may face a funding shortfall of as much as \$147 million by the end of the 2008 fiscal year in order to provide sufficient subsidies to low-income residents.<sup>33</sup> The subsidized plans may be a “victim of their own success” as high enrolment has created a budget challenge for the state.<sup>34</sup>

The significant increase in the number of Massachusetts residents, particularly low-income individuals, obtaining health insurance should lead to a more efficient use of overall health care services. Uninsured residents primarily use emergency rooms as a source of primary care, because American hospitals are required to provide care even if a patient cannot pay for it. This tendency towards emergency room treatment, rather than preventive, primary care is expensive. It represents an inefficient use of health care resources and leads to significantly worse health outcomes for the uninsured.<sup>35</sup> Moreover, hospitals are left with unpaid bills and increasing expenses for caring for the uninsured. In Massachusetts, this uncompensated care totaled \$1.3 billion in 2005, with the state picking up \$538.4 million through its Uncompensated Care Pool (UCP).<sup>36</sup> This fund, which is unique to Massachusetts, was established in 1985 and reimburses hospitals and community health centers (CHCs) for care provided to lower-income, uninsured and under-insured individuals. It is funded through an

---

<sup>29</sup> Christine Barber & Michael Miller, *Revisiting Massachusetts Health Reform: 18 Months Later* (December 2007) at 7, online: Community Catalyst <[www.communitycatalyst.org/doc\\_store/publications/revisiting\\_MA\\_health\\_reform\\_dec07.pdf](http://www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf)>.

<sup>30</sup> *Ibid.* See also Alice Dembner, “Success Could Put Health Plan in the Red” *The Boston Globe* (18 November 2007), online: The Boston Globe Online <[http://www.boston.com/news/local/articles/2007/11/18/success\\_could\\_put\\_health\\_plan\\_in\\_the\\_red/](http://www.boston.com/news/local/articles/2007/11/18/success_could_put_health_plan_in_the_red/)> [Dembner, “Success”].

<sup>31</sup> A further 8,000 to 30,000 people “... have enrolled in private insurance outside of the Connector, but this is difficult to track among insurers ...” Barber & Miller, *supra* note 29 at 7.

<sup>32</sup> It should be noted that there are still as many as 200,000 to 400,000 uninsured residents in Massachusetts. See Kevin Sack, “Massachusetts Faces a Test on Health Care” *The New York Times* (25 November 2007), online: The New York Times Online <[http://www.nytimes.com/2007/11/25/us/politics/25mass.html?\\_r=1&oref=slogin](http://www.nytimes.com/2007/11/25/us/politics/25mass.html?_r=1&oref=slogin)>.

<sup>33</sup> Dembner, “Success”, *supra* note 30.

<sup>34</sup> *Ibid.* Unlike the federal government, states are required to balance their annual budgets.

<sup>35</sup> The Ninth Circuit Court of Appeals in California took judicial notice of these facts. It held that it is “uncontested” that individuals without health insurance are significantly less likely to seek timely medical care than those with health coverage and that this lack of timely access is inefficient and poses serious health risks. See *Golden Gate Restaurant Association v. City and County of San Francisco*, 512 F.3d 1112 (9th Cir. 2008) [*Golden Gate Restaurant Association*, Ninth Circuit Court of Appeals].

<sup>36</sup> See Moffit & Owcharenko, *supra* note 4. The Uncompensated Care Pool has been renamed the “Health Care Safety Net Trust Fund.”

assessment of hospitals and a health insurance premium tax (essentially an assessment of those with insurance) and through general revenues and federal matching funds.

The Massachusetts plan leverages these public health care subsidies from institutions that treat the uninsured through the UCP to low-income individuals to assist them in purchasing health insurance. Moreover, according to an econometric model developed by MIT economist Jonathan Gruber, the roughly \$1 billion in the UCP should be able to fully cover the subsidies to the uninsured and allow people to purchase and use their health insurance with no new state spending.<sup>37</sup> Using this money to subsidize insurance, rather than pay for emergency room care after the fact, should lead to a greater focus on preventive and primary care, a more efficient use of health care resources, and generally improved health outcomes.

## 2. *Portable Insurance*

The second major benefit is that the Connector ameliorates one of the biggest problems in the American health insurance market today: people drift in and out of insurance coverage as their employment status changes, often exposing themselves to significant financial risk and impediments to accessing health care during periods without coverage.<sup>38</sup> The Connector allows individuals to keep their insurance (purchased with pre-tax dollars) regardless of employment or job status.

In a seminal study of the uninsured population in the United States, Short and Graefe note that there is considerable turnover in the uninsured population; it is not an unchanging group.<sup>39</sup> The vast majority of the uninsured experienced gaps and frequent changes in coverage, and between one-half and two-thirds of the uninsured population moved into and out of coverage over the course of a year.<sup>40</sup> These repeated gaps in health insurance coverage were caused mainly by changes in employment and instability in employer-sponsored health insurance. Short and Graefe argued, therefore, that “to the extent that job turnover undermines coverage stability, designing ways for employers to contribute to the cost of coverage, without directly administering health insurance, could enhance continuity of coverage”, which could improve continuity of care.<sup>41</sup> This is precisely what the Connector is designed to do. It creates stability in coverage because employers contribute financially towards health insurance, but the insurance is purchased through the Connector, rather than through the employer. The Connector empowers individuals to purchase and maintain their own health insurance policies and increases portability by allowing them to keep these policies when they change or lose their jobs.<sup>42</sup>

## 3. *Lower Premiums in the Individual and Small-Group Markets*

The third benefit comes from merging individual and small group markets, which took place in July 2007. Prior to the merging of the markets, it was extremely difficult and costly to purchase an individual policy in Massachusetts. Market inequalities, particularly adverse selection and asymmetric information, generally make individual and small group policies “prohibitively expensive.”<sup>43</sup> Merging the non-group into the small group market through the

---

<sup>37</sup> Mitt Romney, “Health Care for Everyone? We’ve Found a Way” *The Wall Street Journal* (11 April 2006), online: The Wall Street Journal Online <<http://www.opinionjournal.com/editorial/feature.html?id=110008213>>. <<http://www.opinionjournal.com/editorial/feature.html?id=110008213>>.

<sup>38</sup> Pamela Farley Short & Deborah R. Graefe, “Battery-Powered Health Insurance? Stability in Coverage of the Uninsured” (2003) 22 *Health Affairs* 244.

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.* at 253.

<sup>41</sup> *Ibid.*

<sup>42</sup> Moffit & Owcharenko, *supra* note 4.

<sup>43</sup> Weeks, *supra* note 7 at 1286. Adverse selection refers to the phenomenon whereby individuals who demand insurance are likely to use health care services at a higher than average rate. It results from asymmetric information,



Connector is expected to stabilize the market by increasing risk-pooling and bargaining power advantages, particularly for those who were previously priced out of the insurance market. Recent actuarial estimates indicate that individual insurance premiums will decrease by about 15 percent through the merging of the markets, although small group rates are expected to increase by 1 to 1.5 percent.<sup>44</sup> It should therefore be much more affordable for individuals to purchase insurance, while small groups should only see a minor increase in their premiums.

#### 4. *The Public Supports the Plan*

Public support of such comprehensive health care reform is critical to its success. While an early public survey (taken in September 2006, six months after the plan was announced) found that the public was largely supportive of the legislation, more recent surveys indicate that support is “widespread and has gone up” as more Massachusetts residents learn about and understand the reforms.<sup>45</sup> 67 percent of residents who had heard of the law in June 2007 approved of it, compared to only 16 percent who opposed it.<sup>46</sup> In general, Massachusetts residents acknowledge and support the partnership among the public, employers, and government required to meet the goal of substantially increasing health insurance coverage. Furthermore, those most likely to be affected by the individual mandate—the uninsured, younger adults, poorer residents, and minorities—are equally as supportive of the law as other Massachusetts residents.<sup>47</sup> Interestingly, while over 70 percent of Massachusetts residents were supportive of the parts of the law that require businesses to do more, support was more mixed regarding the individual mandate. Only 57 percent supported the individual mandate, which is a key aspect of the reform.<sup>48</sup> Indeed, without it, the quest for near-universal coverage may fall short. Moreover, in September 2006, support for the individual mandate varied by income: lower income individuals were least supportive of it (only 43 percent of Massachusetts residents who earned less than \$25,000 per year supported the mandate, even though they are eligible for insurance subsidies).<sup>49</sup>

Bandon *et al.* note that “[t]he public’s views on the individual mandate point to a need for both widespread education about the new requirement and for the new Commonwealth Health Insurance Connector Authority to exercise care when establishing the affordability standards for the individual mandate to ensure that those standards are viewed as fair by the public.”<sup>50</sup> Politicians, including Democratic Governor Deval Patrick, must fully explain the policy rationale behind the individual mandate—that a high rate of compliance will reduce the number of uninsured, stabilize risk pools by including healthy individuals, and allow the movement of funds from uncompensated care to subsidized insurance—as well as its centrality

---

the fact that individuals who purchase insurance know more about their health status and their projected demand for health care services than insurers do. The result, of course, is that insurers hedge against the potential for higher than average use of health care services by increasing premiums for individuals and small groups who purchase insurance on their own.

<sup>44</sup> Kaiser Family Foundation, “Update”, *supra* note 9.

<sup>45</sup> Kaiser Family Foundation, Press Release, “Poll Finds Most Mass. Residents Support New Health Reform Law, Including Individual Mandate, as Initial Deadline Nears,” (27 June 2007), online: Kaiser Family Foundation <<http://www.kff.org/kaiserpolls/kaiserpolls062707nr.cfm>>, quoting Drew E. Altman, President and CEO of the Kaiser Family Foundation.

<sup>46</sup> Kaiser Family Foundation, Harvard School of Public Health & Blue Cross Blue Shield of Massachusetts Foundation, “Massachusetts Health Reform Tracking Survey” (27 June 2007), online: Kaiser Family Foundation <<http://www.kff.org/kaiserpolls/upload/7657.pdf>>.

<sup>47</sup> Robert J. Bandon *et al.*, “The Massachusetts Health Reform Law: Public Opinion and Perception” (2006) at 1, online: Blue Cross/Blue Shield of Massachusetts Foundation <[http://bcbsmafoundation.org/foundationroot/en\\_US/documents/2006HealthReformPollingreport.pdf](http://bcbsmafoundation.org/foundationroot/en_US/documents/2006HealthReformPollingreport.pdf)>.

<sup>48</sup> Kaiser, Harvard School of Public Health & Blue Cross, *supra* note 46; only 52 percent supported the individual mandate in the September 2006 opinion survey.

<sup>49</sup> Bandon *et al.*, *supra* note 47 at 9.

<sup>50</sup> *Ibid.* at 1.

in achieving meaningful reform. Indeed, further outreach, education, and public understanding of the individual mandate are crucial to the program's success.<sup>51</sup> At the same time, however, the Massachusetts health care reform is significantly more popular than other recent health care reforms, including President Bill Clinton's reform package in 1994.<sup>52</sup> With continuing public education and a fair definition of "affordability," the legislation should continue to garner popular support as long as rising health care costs can be adequately contained.

## B. Legitimate Concerns with the Legislation

There are at least three legitimate concerns with the legislation. While these concerns are significant, they should not undermine the overall positive benefits and effects that the new legislation will have on Massachusetts residents or the significant progress that Massachusetts has made towards insuring a substantial number of previously uninsured residents. They should, however, be noted and addressed by other states and federal politicians who want to implement Massachusetts-style health care reform in other jurisdictions.

### 1. *The Legislation Contains No Cost-Containment Mechanisms*

The lack of significant cost-containment mechanisms may be the most critical concern with the legislation. While the start-up costs of the legislation were funded by re-directing Uncompensated Care Pool funds into private insurance subsidies, the legislation does nothing to contain the *future* skyrocketing costs of health care in Massachusetts, which are already the highest in the world.<sup>53</sup>

Nationally, health insurance costs increased by 73 percent between 2000 and 2005, compared to a 15 percent increase in wages over that same period,<sup>54</sup> yet the Massachusetts plan does not address any of the underlying factors that contribute to spending, including the cost of prescription drugs, health care administration, and the reliance on multiple private insurance companies to provide insurance. It has been argued that the overall structure of private health insurance and the payment of medical care will remain intact, leading costs to "relentlessly increase."<sup>55</sup>

Marcia Angell, Steffie Woolhandler and David Himmelstein, three critics of the legislation and supporters of single-payer health insurance, argue that even though the state covered the costs of implementing the reforms at the beginning of the program, at current growth rates the government subsidies will not be able to keep up with the soaring costs of health care.<sup>56</sup> As a result, Woolhandler and Himmelstein argue that "[t]he program is simply not sustainable over the long—or even medium—term."<sup>57</sup>

<sup>51</sup> Raymond, *supra* note 1 at 3.

<sup>52</sup> Blandon *et al.*, *supra* note 47 at 19.

<sup>53</sup> Holahan & Blumberg, *supra* note 26 at w436. See also Steffie Woolhandler & David Himmelstein, Press Release, "Massachusetts Health Reform Bill: A False Promise of Universal Coverage" (5 April 2006), online: Physicians for a National Health Program <[http://www.pnhp.org/news/2006/april/massachusetts\\_health.php](http://www.pnhp.org/news/2006/april/massachusetts_health.php)>.

<sup>54</sup> Weeks, *supra* note 7 at 1305.

<sup>55</sup> Robert Steinbrook, "Health Reform in Massachusetts—A Work in Progress" (2006) 354:20 *New Eng. J. Med.* 2095 at 2095.

<sup>56</sup> Marcia Angell, "Health Care Reform Needs Dose of Common Sense" *The Boston Globe* (17 April 2006), online: The Boston Globe Online <[http://www.boston.com/news/globe/editorial\\_opinion/oped/articles/2006/04/17/healthcare\\_plan\\_needs\\_dose\\_of\\_common\\_sense/](http://www.boston.com/news/globe/editorial_opinion/oped/articles/2006/04/17/healthcare_plan_needs_dose_of_common_sense/)>; Woolhandler & Himmelstein, *supra* note 53.

<sup>57</sup> Woolhandler & Himmelstein, *ibid.* The authors argue that the only way to contain costs and expand coverage is to change the system entirely and adopt a single-payer system (as in Canada). They point out that Massachusetts' high health care costs are the result of bloated administrative, marketing, and billing costs in private insurance companies. They argue that if Massachusetts cut bureaucracy to Canada's levels, the state would save \$9.4 billion annually, enough to cover every uninsured resident and improve coverage for the rest. However, while a single payer system may be more administratively efficient and be able to control costs, it is a political non-starter in any U.S.

To the extent that health insurance premiums continue to grow faster than state revenues (or if the number of very low-income uninsured was underestimated), the state may have to increase subsidies and government funding in order to keep health insurance “affordable” and maintain the reach of the mandate. Since substantial increases in government spending may not be politically feasible, if costs are not contained in the near future the state might have to exempt more people from the mandate, cut back on subsidies, or cap enrolment in Commonwealth Care subsidized insurance plans. Reduced subsidies could detrimentally affect the affordability of the individual mandate and could lead individuals to forego insurance if it became unaffordable. These financing issues could grow exponentially over time and could easily be exacerbated by the current recession. As Turnbull argues, “the long-term success and sustainability of the new law will depend on finding successful ways to control costs.”<sup>58</sup>

The lack of any significant cost-containment mechanisms in the legislation is troubling. While a significant percentage of Massachusetts residents now have health coverage, a funding crisis has been brought about by a failure to address costs while focusing exclusively on access.<sup>59</sup> Indeed, despite former Governor Romney’s assertion that the plan could be adequately funded from existing revenue sources, Massachusetts is already seriously considering a tax increase to pay for the plan, only two years after its implementation. A \$1 per pack cigarette tax is expected, which is projected to raise \$152 million annually to cover the shortfalls in the plan’s budget.<sup>60</sup>

Put simply, the next wave of health care reform in Massachusetts *must* contain cost-containment mechanisms if the legislation is to be viable. Two years of reform have demonstrated quite clearly that “broadening coverage without slowing costs is not a sustainable model” over the long-term.<sup>61</sup> However, the lack of cost containment mechanisms at launch should not overshadow the positive benefits and substantially increased access to health care that the legislation provides.

## 2. *Minimum Creditable Coverage and the Definition of Affordability*

While the Massachusetts legislation is broad, comprehensive, and detailed, it left a number of potentially contentious decisions to the implementation stage.<sup>62</sup> In particular, deciding what constitutes “minimum creditable coverage” and “affordable” coverage was left to the Connector Board.

In the legislation, “creditable” coverage must include all forty-three of Massachusetts’ state-mandated benefits, but the definition of “minimum creditable coverage” was left up to the Connector Board. Determining the requirements of minimum creditable coverage is an extremely difficult task. If the minimum coverage required to satisfy the mandate was too comprehensive (too many services had to be covered), then coverage may be too expensive and unaffordable, leaving many residents uninsured. On the other hand, if minimum benefits were set too low, this would create a class of underinsured people who would be forced to purchase

---

state, even Massachusetts.

<sup>58</sup> Weeks, *supra* note 7 at 1312 note 146, quoting Turnbull.

<sup>59</sup> Christopher R. Anderson, “Righting Healthcare Reform,” *The Boston Globe* (31 March 2008), online: The Boston Globe Online <[http://www.boston.com/bostonglobe/editorial\\_opinion/oped/articles/2008/03/31/righting\\_healthcare\\_reform](http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2008/03/31/righting_healthcare_reform)>.

<sup>60</sup> Alice Dembner, “Healthcare Cost Increases Dominate Mass. Budget,” *The Boston Globe* (26 March 2008), online: The Boston Globe Online <[http://www.boston.com/news/local/articles/2008/03/26/healthcare\\_cost\\_increases\\_dominates\\_mass\\_budget\\_debate/?page=2](http://www.boston.com/news/local/articles/2008/03/26/healthcare_cost_increases_dominates_mass_budget_debate/?page=2)> [Dembner, “Healthcare Cost Increases Dominate”]. One commentator even called Massachusetts’ health care reform the “Big Dig” of the next generation—an “ambitious and beneficial but deeply flawed public initiative with back-breaking costs to the taxpayer.” See Anderson, *ibid*.

<sup>61</sup> Steve Bailey, “Healthcare Reform II,” *The Boston Globe* (6 February 2008), online: The Boston Globe Online <[www.boston.com/business/healthcare/articles/2008/02/06/healthcare\\_reform\\_ii](http://www.boston.com/business/healthcare/articles/2008/02/06/healthcare_reform_ii)>.

<sup>62</sup> Raymond, *supra* note 1 at 13.

insurance that may not protect them in cases of medical need. The debate over health coverage illustrates the classic tension between access and comprehensiveness. There was also a significant debate over whether prescription drug coverage should be included in the definition of minimum creditable coverage. Health care advocates like Affordable Care Today! (ACT) argued that prescription drugs are an essential element of adequate coverage both because of their importance to modern medicine, and their ability to drive up consumers' out-of-pocket costs.<sup>63</sup> Other commentators argued, however, that the mandatory inclusion of prescription drugs in minimum creditable coverage would drive up costs substantially. Including prescription drugs in the minimum creditable coverage requirements could increase the costs of insurance premiums by 5 to 15 percent.<sup>64</sup> Moreover, roughly 200,000 individuals who already had health insurance but lacked prescription drug coverage would be forced to buy more costly coverage in order to comply with the mandate and avoid the fines.

In the end, the Connector Board decided on a set of fairly comprehensive standards for the minimum creditable coverage that an individual must have in order to satisfy the individual mandate. The Board defined "minimum creditable coverage" as "comprehensive health plans that include preventive and primary care, emergency services, hospitalization benefits, ambulatory patient services, mental health services *and prescription drugs*."<sup>65</sup> Creditable coverage must also cap annual deductibles, allow a minimum of three preventive care visits per individual before the deductible kicks in, and have maximum out-of-pocket spending limits of \$5,000 per year per individual or \$10,000 on a family plan.<sup>66</sup> Any insurance policy that does not contain all of these benefits is not considered adequate to satisfy the individual mandate. The Board has decided to delay the enforcement of the new minimum creditable coverage requirements, including prescription drug coverage, until January 2009 to give employers and consumers time to adjust their coverage in order to meet the minimum standards. Insurers are also trying to develop alternative minimum drug benefits that meet the minimum creditable coverage requirement without substantially increasing premiums.<sup>67</sup> Such comprehensive minimum benefits protect against individuals purchasing bare bones coverage, but it remains to be seen if the creditable coverage requirements will significantly drive up premium costs. It has been reported that insurers plan on increasing premiums 10 to 12 percent in 2008—more than twice the national average—in order to cover all of the mandated minimum benefits.<sup>68</sup> However, as Connector Board Executive Director Jon Kingsdale argues, if health insurance premiums continue with double digit inflation, Massachusetts' health care reform will not be sustainable.<sup>69</sup>

Another critical and related implementation decision that engendered significant debate was the Connector Board's definition of "affordability," since individuals only suffer tax penalties if they fail to obtain health insurance that is affordable. Indeed, as Holahan and Blumberg argue, "for an individual mandate to be fair and acceptable, it must make coverage affordable."<sup>70</sup> A higher affordability standard (such as 15 percent of income) would lead to more coverage (more coverage would be deemed "affordable"), but would produce a greater burden on middle-income individuals, particularly those earning just above 300 percent of the FPL who are unable to obtain government-subsidized policies. Such a high standard might be

---

<sup>63</sup> *Ibid.* at 19.

<sup>64</sup> Michael D. Tanner, "Whatever Became of RomneyCare?" *The Salt Lake Tribune* (29 January 2008), online: The CATO Institute <[http://www.cato.org/pub\\_display.php?pub\\_id=9127](http://www.cato.org/pub_display.php?pub_id=9127)>.

<sup>65</sup> Raymond, *supra* note 1 at 19 [emphasis added].

<sup>66</sup> *Ibid.* at 19-20. Minimum creditable coverage must also include a minimum of six preventive care visits prior to the deductible for family plans.

<sup>67</sup> *Ibid.* at 19.

<sup>68</sup> Sack, *supra* note 32.

<sup>69</sup> *Ibid.*

<sup>70</sup> Holahan & Blumberg, *supra* note 26 at w436.

considered unreasonable and lead to backlash and decreased compliance with the mandate, which would defeat the purpose of near-universal coverage. Indeed, if the premium levels are seen as imposing an undue hardship on individuals, public support for the legislation could erode, making it difficult to sustain an individual mandate.<sup>71</sup>

On the other hand, a low affordability standard (such as 5 percent of income) would ease the individual and family burden of the mandate, but it would also lead to broad exemptions from the mandate and could force more individuals into the subsidized Connector plans, which would increase government spending.<sup>72</sup> Choosing an appropriate affordability schedule is critical to the overall success and public approval of the legislation. Indeed, as Weeks argues, the “success or failure of the comprehensive state plan may turn in large part on the affordability scale.”<sup>73</sup>

In July 2007, the Connector Board unanimously approved an “affordability schedule” to determine whether minimum creditable coverage is affordable for most uninsured people in various income brackets (see Appendix A). It also created a waiver and appeals process that allows people to demonstrate that their individual circumstances should exempt them from the mandate even if the schedule says that they should not be exempt.<sup>74</sup> The affordability schedule deems that individuals who earn between 150 and 200 percent of the FPL can pay up to \$35 per month in insurance premiums, while individuals who make between 251 and 300 percent of the FPL can afford to pay \$105 per month. Individuals, couples, or families who earn more than 600 percent of the FPL (\$50,000 for an individual or \$110,000 for a family) are deemed to be able to afford health insurance at any cost and thus cannot be exempted from the requirement to purchase health insurance on affordability grounds.

The affordability schedule remains controversial. Opponents of the definition point out that some people could be forced to pay up to 9.6 percent of their income on insurance premiums, or pay a fine.<sup>75</sup> Moreover, out-of-pocket costs are not included in the affordability scale—so individuals or families with high out-of-pocket medical costs may be required to pay premiums and could have additional substantial health care costs that account for a significant portion of their budgets. Indeed, even after the affordability schedule was approved, “concerns remain about requiring people with moderate incomes to spend significant portions of their incomes on health insurance” and health care cost-sharing.<sup>76</sup> Other commentators argue that the affordability standard is too low, allowing too many individuals to get exemptions from the individual mandate because they will be unable to find “affordable” health insurance. This would defeat the purpose of a mandate—if individuals can easily escape its requirements—and would frustrate the legislation’s goal of achieving universal health insurance. The *New York Times* noted that as many as 60,000 people may not be able to afford premiums and could receive exemptions.<sup>77</sup> Ultimately, the jury is still out on the impact of the Board’s first affordability schedule.

The affordability schedule is to be updated by the Connector Board every year, so the definition of “affordability” could be a contentious issue each time it is revised. Whenever the Board releases a new schedule, it will have to keep in mind the balance between high

---

<sup>71</sup> Blandon *et al.*, *supra* note 47 at 19.

<sup>72</sup> Holahan & Blumberg, *supra* note 26.

<sup>73</sup> Weeks, *supra* note 7 at 1288.

<sup>74</sup> Raymond, *supra* note 1 at 20.

<sup>75</sup> Sally C. Pipes, “At One Year, Mass. Healthcare Plan Falls Short” *The Boston Globe* (15 May 2007), online: The Boston Globe Online <[http://www.boston.com/yourlife/health/other/articles/2007/05/15/at\\_one\\_year\\_mass\\_healthcare\\_plan\\_falls\\_short/](http://www.boston.com/yourlife/health/other/articles/2007/05/15/at_one_year_mass_healthcare_plan_falls_short/)>. For example, couples earning \$90,001 per year are deemed to be able to afford premiums up to \$720 per month (\$8,640 annually), which equals approximately 9.6 percent of their household income.

<sup>76</sup> Barber & Miller, *supra* note 29 at 6.

<sup>77</sup> Sack, *supra* note 32.

affordability standards, which force people to spend a significant amount of their money on health insurance, and low affordability standards which make it easy for individuals to exempt themselves from the requirements, hampering the ultimate goal of universal coverage. Indeed, as Raymond argues, “longer-term, the issue of individual affordability will have to be constantly revisited”.<sup>78</sup>

### 3. Coverage in Name Only

The final concern is that the legislation requires a “minimum level of health insurance, not an optimal level.”<sup>79</sup> The goal of the (particularly unsubsidized) Connector plans is to make health insurance affordable for individual and small group purchasers in order to facilitate compliance with the individual mandate.<sup>80</sup> But it is difficult to dictate to private market health insurers that they must provide affordable plans that are low-cost and effective. While the Connector plans could have reduced premiums and cost-sharing requirements by reducing the amount and types of services offered or covered, the Connector Board developed comprehensive requirements for minimum creditable coverage. As mentioned, these mandatory coverage requirements protect against bare bones insurance policies, but they also drive up costs to the insurers.

Since the plans offered through the Connector (with the exception of the Young Adult Plans for individuals between nineteen and twenty-six years of age) must include the minimum creditable coverage requirements, the only way for private insurers to provide affordable insurance and keep costs down is to offer plans that have low premiums (so that individuals can purchase them and satisfy the mandate) but high deductibles, high cost-sharing requirements, and limited provider networks.<sup>81</sup> Indeed, the majority of people who have signed up for unsubsidized plans have chosen to purchase Bronze or Young Adult Plans that have the lowest premiums, highest out-of-pocket costs, and, in the case of the Young Adult Plans, limited benefits.<sup>82</sup> Most of these Bronze plans have \$2,000 deductibles for individuals or \$4,000 for a family policy (the amount that must be spent by the insured before insurance kicks in) and steep co-payments.<sup>83</sup> But these low-premium, high deductible plans have not been very popular in Massachusetts, and individuals may simply prefer to pay the tax (half the cost of a low-premium plan), rather than purchase this type of health insurance.

Woolhandler and Himmelstein argue that the individual mandate requires individuals to spend money they do not have in order to buy “nearly worthless stripped down policies that represent coverage in name only.”<sup>84</sup> The Bronze plans may be considered “name only coverage” plans because the high deductibles and considerable cost-sharing may lead to insufficient or prohibitively expensive coverage for health care needs.<sup>85</sup> Indeed, under the mandate, if

---

<sup>78</sup> Raymond, *supra* note 1 at 26.

<sup>79</sup> Steinbrook, *supra* note 55 at 2095.

<sup>80</sup> For a full analysis see Weeks, *supra* note 7 at 1302.

<sup>81</sup> There are four types of Commonwealth Choice plans (unsubsidized plans purchased through the Connector): (1) Gold (Premium) Plans have the highest premiums, but also have comprehensive benefits, no deductibles and limited cost-sharing; (2) Silver (Value) Plans have mid-level premiums, no deductibles, and some cost-sharing; (3) Bronze (Basic) Plans have low premiums, but high deductibles and high cost-sharing; (4) Young Adult Plans (for individuals aged nineteen to twenty-six) have low premiums, high cost-sharing and limited benefits because they do not need to meet the standards of minimum creditable coverage. Of the 10,199 people who have enrolled in unsubsidized plans, the largest number (40 percent) have enrolled in Bronze Plans, and 28 percent have enrolled in Young Adult Plans. Only 23 percent have enrolled in Silver Plans, while 9 percent have purchased Gold Plans. See Barber & Miller, *supra* note 29 at 7.

<sup>82</sup> Woolhandler & Himmelstein, *supra* note 53.

<sup>83</sup> It should be noted that, as mentioned earlier, under the minimum creditable coverage requirements, plans will have to allow up to three primary care visits (six in a family plan) prior to the deductible.

<sup>84</sup> Woolhandler & Himmelstein, *supra* note 53.

<sup>85</sup> Barber & Miller, *supra* note 29 at 5.

individuals get sick, the Bronze plans contain significant gaps (for example, through limited provider networks) and large co-payments that could still lead to an individual's financial ruin. This leads to the worst of both worlds—individuals are forced to pay hundreds (or thousands) of dollars for health insurance, yet they will still not have adequate coverage if they get sick.

The problematic definition of affordability, the lack of cost containment mechanisms, and the potential to force individuals to purchase “name only coverage” are all serious problems that must be addressed by the Massachusetts legislature and the Connector Authority. They must also be acknowledged and addressed by other states and federal politicians considering health care reform initiatives. However, the potential benefits of the legislation—providing at least some health insurance coverage to a substantial number of previously uninsured Massachusetts residents, encouraging the more efficient use of health services, insurance market reforms that take advantage of bargaining power and risk-pooling, and the creation of legitimately portable health insurance all indicate that Massachusetts is going in the right direction. While the legislation may not be perfect, and subsequent health care reforms must address cost-containment issues, the Massachusetts legislation is definitely a step in the right policy direction.

### III

#### IS THE EMPLOYER MANDATE ILLEGAL?

While the amount of the assessment on employers who do not provide a “fair and reasonable” contribution to employees’ health insurance coverage is not financially substantial (up to \$295 per full-time worker per year), it symbolizes the logic of the reforms: both employers and employees should share responsibility for health insurance.<sup>86</sup> But a landmark ruling in a Federal District Court, which was later upheld in a two-to-one decision at the Fourth Circuit Court of Appeals, struck down a similar Maryland law on the basis that it was pre-empted by the federal *ERISA*.<sup>87</sup> Maryland had enacted the *Fair Share Health Care Fund Act* (the “*Fair Share Act*”) in January 2006.<sup>88</sup> That *Act* required for-profit employers with 10,000 or more employees to spend at least 8 percent of payroll on “health insurance costs” (play) or pay the difference between what they spent and 8 percent into a fund supporting the state Medicaid program (pay). In practice, this law only applied to Wal-Mart, because it was the only company that met the criteria (thus it is sometimes called the “Wal-Mart Law”).<sup>89</sup> This section of the paper will analyze whether Massachusetts’ play or pay employer assessment violates *ERISA*. It will argue that despite the ruling on Maryland’s *Fair Share Act*, the Massachusetts legislation is not likely to be pre-empted by *ERISA*. Ultimately, however, the law is unclear; cases have been decided on their specific facts and a judge may rule either way.<sup>90</sup>

<sup>86</sup> Steinbrook, *supra* note 55 at 2095.

<sup>87</sup> *Retail Industry Leaders Association v. Fielder*, 435 F. Supp 2d 481 [*Fielder*, Federal District Court] aff’d in *Retail Industry Leaders Association v. Fielder*, 2007 U.S. App. LEXIS 920 (4th Cir. Md., Jan 17, 2007), 475 3d. 180 [*Fielder*, Fourth Circuit Court of Appeals].

<sup>88</sup> *Fair Share Health Care Fund Act*, c. 3, 2006 Md. Laws (codified as amended at MD. Code Ann., Health-Gen. Section 15-42; MD. Code Ann., Lab. & Emp. §§ 8.5-101 to 107).

<sup>89</sup> See Julie Appelby, “Judge Overturns Wal-Mart Law” *USA Today* (19 July 2006), online: The USA Today <[http://www.usatoday.com/money/industries/retail/2006-07-19-walmart-healthcare\\_x.htm](http://www.usatoday.com/money/industries/retail/2006-07-19-walmart-healthcare_x.htm)>.

<sup>90</sup> For arguments that, legally, the Massachusetts play or pay mandate should be pre-empted, see *e.g.* Zelinsky, *supra* note 6; Julia Contreras & Orly Lobel, “Wal-Martization and the Fair Share Health Act” (2006) 19 St. Thomas L. Rev. 105; “Illegal Health Care,” Editorial, *The Wall Street Journal* (23 January 2007), online: The Wall Street Journal Online <<http://online.wsj.com/article/SB116951662631884439.html?mod=opinion&ojcontent=otep>>; William G. Schiffbauer, “Hiding in Plain View: *ERISA* Preempts Provisions of Massachusetts ‘Play or Pay’ Health Care Reform Law,” (2006) 14:37 *Health Care Policy Report* 1; *Retail Industry Leaders Association v. Suffolk County*, 497 F. Supp 2d 403 (E.D.N.Y. 2007). For arguments that the Massachusetts play or pay mandate should not be pre-empted, see *e.g.* Patricia A. Butler, “*ERISA* Implications for State Health Care Access Initiatives: Impact of the Maryland ‘Fair Share Act’ Court Decision” (November 2006) at 8, online: National Academy for State Health Policy

### A. ERISA Pre-emption

Federal legislation, *ERISA* “was enacted to remedy fraud and mismanagement in private-sector employer pension plans”.<sup>91</sup> It also applies to employee welfare benefit plans, which include any plan, fund or program which is established or maintained by an employer to the extent that such plan, fund or program provides certain welfare benefits, including medical, surgical or hospital care benefits.<sup>92</sup> In short, the vast majority of health care benefits that an employer extends to its employees qualify as “employee welfare benefit plans” under *ERISA*. Furthermore, §514(a) contains a broad and explicit pre-emption provision in which *ERISA* “supersedes any and all state laws insofar as they now or hereafter *relate to* any employee benefit plan”.<sup>93</sup> In order to define the scope of the pre-emption, the Supreme Court held in *Shaw v. Delta Air Lines Inc.* that a state law “relates to” an *ERISA* plan if the law has a “reference to” or a “connection with” such a plan.<sup>94</sup>

Following *Shaw*, the Supreme Court took an expansive approach to the pre-emption clause, which is “conspicuous in its breadth,” allowing it to pre-empt virtually any state law touching upon an employee benefit plan.<sup>95</sup> The Court held that several state employer-sponsored plans were pre-empted, such as Hawaii’s mandate that employers provide workers with health coverage.<sup>96</sup> However, the Supreme Court appeared to narrow the scope of the pre-emption in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*<sup>97</sup> That case concerned a state law that provided for hospital bill surcharges (24 percent of the bill) for patients whose insurance coverage was provided by a commercial insurer other than Blue Cross/Blue Shield. Its purpose was simply to encourage employers to contract with Blue Cross/Blue Shield plans. The Court emphasized that in an area of traditional state regulation, such as health care, federal law should not supersede state laws unless it was the clear and manifest purpose of Congress to do so.<sup>98</sup>

In *Travelers*, the Court held that while the New York law made Blue Cross/Blue Shield more attractive to *ERISA* (employer-sponsored) health plans, it only had an “indirect economic effect” on health insurance choices made by employers, and that such an indirect economic effect should not be pre-empted.<sup>99</sup> Such an economic incentive did not “bind plan administrators to any particular choice.”<sup>100</sup> More importantly, with respect to the Maryland statute, the Court held in *Travelers* that “there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice [a free choice with only one option available] would be treated as imposing a substantive mandate” which would clearly be pre-empted.<sup>101</sup> Although in that case the surcharges imposed by the New York law were not so prohibitive as to force all health insurance consumers to contract with Blue Cross/Blue Shield.

---

<<http://www.statecoverage.net/SCINASHP.pdf>>; Amy B. Monahan, “Pay or Play Laws, *ERISA* Preemption, and Potential Lessons from Massachusetts” (2007) 55 Kan. L. Rev. 1203; *Golden Gate Restaurant Association*, Ninth Circuit Court of Appeals, *supra* note 35; see also *Felder*, Federal District Court, *supra* note 87 at 496 note 15.

<sup>91</sup> Butler, *ibid.* at 4.

<sup>92</sup> *ERISA*, *supra* note 3, §§1002(1), (2)(a).

<sup>93</sup> *Ibid.*, §1144(a) [emphasis added].

<sup>94</sup> *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85 (1983).

<sup>95</sup> Butler, *supra* note 90 at 4. See also Zelinsky *supra* note 6 at 251.

<sup>96</sup> Congress later amended *ERISA* to provide an exemption for Hawaii’s employer health insurance mandate, since it was enacted prior to *ERISA*. See *ERISA*, *supra* note 3, §1144(b)(5)(A).

<sup>97</sup> 514 U.S. 645 (1999) [*Travelers*].

<sup>98</sup> *Ibid.*

<sup>99</sup> *Ibid.* at 659.

<sup>100</sup> *Ibid.*

<sup>101</sup> *Ibid.* at 664.



### B. *Retail Industry Leaders Association v. Fielder*

The Maryland law was challenged by the Retail Industry Leaders Association (RILA) on Wal-Mart's behalf. The case, *RILA v. Fielder*, represented the first time that a court has ruled on a state "play or pay" initiative.<sup>102</sup> After deciding that RILA had standing to pursue the case on Wal-Mart's behalf, Judge Motz examined whether the *Fair Share Act* had an impermissible "connection with" an *ERISA* plan. He held in a footnote that it had a direct and express "reference to" an *ERISA* plan and would have been pre-empted on those grounds as well.<sup>103</sup>

In order to determine whether the law had an impermissible connection with an *ERISA* plan, the court looked at (1) "the objectives of the *ERISA* statute as a guide to the scope of the state law that Congress understood would survive" and (2) "the nature of the effect of the state law on *ERISA* plans."<sup>104</sup> Judge Motz noted that the main objective of the *ERISA* pre-emption clause is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans" because national uniformity is impossible if employee benefit plans are subject to different legal obligations in different states or localities.<sup>105</sup> The *Fair Share Act* created spending obligations in one state that were not applicable in other jurisdictions: Wal-Mart had to spend at least 8 percent of its payroll on health care costs in Maryland, but not in other states.<sup>106</sup> Indeed, the *Act* required Wal-Mart to "segregate a separate pool of expenditures for its Maryland employees and structure its contributions (and employee deductibles and co-pays) with an eye to how it would affect the eight percent requirement."<sup>107</sup>

The judge then held that the *Fair Share Act* had a "connection with" an *ERISA* plan because it was intended to force Wal-Mart to increase its contributions to its health benefit plan, which was an *ERISA* plan, and that the actual effect would be to force Wal-Mart into doing so.<sup>108</sup> *ERISA* clearly prohibits state laws that directly regulate or mandate that private employers offer or pay for insurance.<sup>109</sup> Thus, the Maryland *Act* was pre-empted in accordance with the "long established Supreme Court law that state laws which impose employee health or welfare mandates on employers are invalid under *ERISA*."<sup>110</sup> Judge Motz held that the Maryland law was equivalent to a benefit-mandating law, because under the *Fair Share Act*, no rational employer would choose to pay the state rather than provide insurance.<sup>111</sup> Therefore, the effect of the law was to force Wal-Mart, a private employer, to provide a minimum level of health insurance benefits under an *ERISA* plan through a Hobson's choice, which was equivalent to imposing a substantive mandate.<sup>112</sup>

In a two-to-one decision, the Fourth Circuit Court of Appeals affirmed the lower court decision.<sup>113</sup> Judge Niemeyer, for the majority, agreed with Judge Motz's reasoning that the *Act* effectively required employers to restructure employee benefit plans, conflicting with *ERISA*'s goal of permitting uniform nationwide administration of these plans.<sup>114</sup> He concluded by noting that *ERISA* applied despite the "noble purpose" of Maryland's legislation because courts are

---

<sup>102</sup> Monahan, *supra* note 90 at 1211. See *Fielder*, *supra* note 87.

<sup>103</sup> *Fielder*, Federal District Court, *supra* note 87 at 493 note 12.

<sup>104</sup> *Ibid.* at 494.

<sup>105</sup> *Ibid.*

<sup>106</sup> *Ibid.*

<sup>107</sup> *Ibid.*

<sup>108</sup> *Ibid.* at 495.

<sup>109</sup> *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980).

<sup>110</sup> *Fielder*, Federal District Court, *supra* note 87 at 494.

<sup>111</sup> *Ibid.* at 497.

<sup>112</sup> *Ibid.*, quoting from *Travelers*, *supra* note 97.

<sup>113</sup> *Fielder*, Fourth Circuit Court of Appeals, *supra* note 87.

<sup>114</sup> *Ibid.* at 190.

not to “change the fundamental policy of *ERISA*” which they are “bound to enforce ... as the supreme law of the land.”<sup>115</sup>

### C. Applying *ERISA* and *RILA v. Fielder* to the Massachusetts Legislation

The Massachusetts fair share contribution does raise issues concerning the nationally uniform administration of employee benefit plans, because employers have to meet the coverage or contribution requirements imposed by the Division of Health Care Finance and Policy.<sup>116</sup> That is, employers must either cover 25 percent of full-time workers and contribute towards coverage or offer to pay one-third of the cost of coverage under the employer plan. For a national employer to be exempt from paying the assessment, it would potentially have to alter its benefit administration in Massachusetts, which would seem to contravene the Fourth Circuit’s holding in *RILA v. Fielder*. Indeed, several commentators, including Professor Zelinsky, argue that just as Maryland’s *Wal-Mart Act* is *ERISA* pre-empted, the Massachusetts fair share contribution is also pre-empted as “forbidden regulation of employer-provided health care.”<sup>117</sup>

Professor Zelinsky argues that, like the *Wal-Mart Act*, the fair share contribution is *ERISA* pre-empted under *Travelers* and its narrow interpretation of the “relate to” standard.<sup>118</sup> Under *Travelers*, state laws which “mandate ... employee benefit structures or their administration” relate to *ERISA*-regulated benefit plans and are pre-empted.<sup>119</sup> This, according to Professor Zelinsky, is precisely what the Massachusetts fair share contribution does: it mandates benefit levels by explicitly and directly requiring employers with eleven or more full-time employees to “offer” group health plans to which such employers must make “fair and reasonable premium contributions.”<sup>120</sup>

Professor Zelinsky cites *Egelhoff v. Egelhoff*<sup>121</sup> to further demonstrate his point. In *Egelhoff*, a Washington state statute provided that divorce revokes all beneficiary designations of a former spouse on a life insurance policy and pension plan provided by an employer. The United States Supreme Court held that this statute was *ERISA* pre-empted because it “instructs *ERISA*-regulated fringe benefit plans to disregard a pre-divorce beneficiary designation of a

<sup>115</sup> *Ibid.* at 197. The Federal District Court for the Eastern District of New York found that a similar Suffolk County law was pre-empted in *Retail Industry Leaders’ Association v. Suffolk County*, *supra* note 90. There, the law would have required large retail stores with more than a certain amount of grocery revenues, or floor area devoted to selling groceries, to make health care expenditures at a rate that approximated the cost to the county’s public health system of uninsured workers, or to pay the difference to the city. The Court held that while the objective of the law—protecting smaller retailers that offer health benefits from unfair competition from large retailers with no or limited employee health coverage—was appropriate, the law was “strikingly similar” to the Maryland law and was pre-empted by *ERISA*. See State Coverage Initiatives, “Update on *ERISA* Court Decisions,” Academy Health/Robert Wood Johnson Foundation (March 2008), online: State Coverage Initiatives <<http://www.statecoverage.net/SCI-Erisa-Update-0308.pdf>>.

<sup>116</sup> See Monahan, *supra* note 90 at 1215.

<sup>117</sup> Zelinsky, *supra* note 6 at 231. Some commentators, like Schiffbauer, argue that *ERISA* further pre-empt the section 125 “cafeteria” plans mandated by the Massachusetts *Act*. However, most commentators agree that *ERISA* “does not pre-empt the [Massachusetts] law’s requirement that employers maintain cafeteria plans qualifying under ... section 125” because the Department of Labor has held that such cafeteria plans are not considered “*ERISA*-regulated welfare plans.” See Zelinsky, *supra* note 6 at 265.

<sup>118</sup> Professor Zelinsky argues that §514(a) of *ERISA* pre-empt the employer contribution mandate of the new Massachusetts health law as “unacceptably ‘relat[ing] to’ employers’ medical plans for their employees.” See Zelinsky, *supra* note 6 at 260. He argues that the minimum creditable coverage standard would also be *ERISA* pre-empted insofar as having a mandatory minimum level of health benefits that must be provided is prohibited regulation of an *ERISA* plan. *Ibid.* at 232.

<sup>119</sup> *Travelers*, *supra* note 97 at 668. Note that such laws need not mandate employee benefit structures explicitly. A state law is pre-empted if it “produce(s) such acute, albeit indirect, economic effects [as to] force an *ERISA* plan to adopt a certain scheme of substantive coverage.” *Ibid.* at 668. See also Zelinsky, *supra* note 6 at 252.

<sup>120</sup> Zelinsky, *supra* note 6 at 259.

<sup>121</sup> 532 U.S. 141 (2001).

now former spouse.”<sup>122</sup> The Court held that the Washington law “governs” the administration of the plan by negating existing beneficiary designations on file with the *ERISA*-regulated plan.<sup>123</sup> Professor Zelinsky argues that the Massachusetts fair share contribution similarly governs *ERISA*-regulated health plans by requiring employers to sponsor health plans and make fair and reasonable contributions to them.<sup>124</sup> He concludes that in both factual situations (in *Egelhoff* and the Massachusetts fair share contribution), state law would “mandate ... employee benefit structures or their administration” in violation of the interpretation in *Travelers* of § 514(a) of *ERISA* and the standard for pre-emption.<sup>125</sup>

Despite Professor Zelinsky’s arguments, however, there are two major differences between Massachusetts’ play or pay provision and the one struck down in Maryland. These two differences should enable the Massachusetts law to avoid pre-emption. First, Massachusetts’ legislation is part of a wider package of comprehensive legislation aimed at regulating various aspects of health insurance provision. Maryland’s statute consisted only of a play or pay provision designed to affect Wal-Mart. In a suggestive footnote, Judge Motz, while striking down the Maryland legislation, stated:

I am expressing no opinion on whether legislative approaches taken by other States to the problems of health care delivery and its attendant costs would be pre-empted by *ERISA*. For example, the Commonwealth of Massachusetts has recently enacted legislation that addresses health care issues comprehensively and in a manner that arguably has only incidental effects on *ERISA* plans. In light of what is generally perceived as a national health care crisis, it would seem that to the extent *ERISA* allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling the costs and increasing the quality of health care for all citizens.<sup>126</sup>

It is unclear whether this is a “personal plea”<sup>127</sup> or an *obiter dictum* on the state of the law, but since the judge performed no reasoned analysis of the Massachusetts legislation, it is unlikely that this footnote has any legal value as a precedent. Butler, however, argues that the footnote’s suggestion that a comprehensive program with minimal impacts on *ERISA* plans could survive a pre-emption challenge would be helpful if Massachusetts ever has to defend the law in court.<sup>128</sup>

The second major difference is that the “pay” penalty is relatively weak in Massachusetts, compared to the one in Maryland. Some analysts like William Schiffbauer, a legal consultant to health insurers, argue that even a weak “pay” option sets a minimum contribution level of benefits for otherwise “voluntary” employer-sponsored health benefits and should still be pre-empted by *ERISA*.<sup>129</sup> The argument is that the Massachusetts law mandates that employers provide a benefit plan that includes health benefits, contrary to *ERISA*, because the employer assessment is earmarked into the Commonwealth Care Trust Fund, which is used to subsidize health insurance for Massachusetts residents. Employers are mandated to provide health insurance either directly or by supporting a publicly subsidized plan; there is no “none at all” choice.<sup>130</sup> Therefore, Schiffbauer argues, regardless of how low the employer assessment is,

<sup>122</sup> See Zelinsky, *supra* note 6 at 259.

<sup>123</sup> *Egelhoff*, *supra* note 121 at 148.

<sup>124</sup> Zelinsky, *supra* note 6 at 259.

<sup>125</sup> *Ibid.* It should be noted, however, that while Professor Zelinsky thinks that key parts of the Massachusetts health care reform are *ERISA* pre-empted (by the statute and case law), at 231 he nonetheless finds this result “regrettable since health care is an area in which states should be permitted, indeed encouraged, to explore novel approaches”. His paper calls for Congress to repeal §514 of *ERISA* and abolish the jurisprudence of *ERISA* pre-emption, in order to allow Massachusetts, and other states, to fulfil its potential as a laboratory of experiment in the health care arena.

<sup>126</sup> *Fielder*, Federal District Court, *supra* note 87 at 496 note 15.

<sup>127</sup> See Schiffbauer, *supra* note 90.

<sup>128</sup> Butler, *supra* note 90 at 9.

<sup>129</sup> Schiffbauer, *supra* note 90 at 2.

<sup>130</sup> *Ibid.* at 2.

having any assessment interferes with national benefit administration. Employers would have to provide different levels of health benefits to employees in Massachusetts compared to employees in other states. Professor Zelinsky agrees, arguing that play or pay provisions “directly intrude ... on *ERISA* plans by mandating the *minimum* level of coverage provided by their employers.<sup>131</sup> This is arguably the case in Massachusetts, where large employers must provide *at least* \$295 per full-time employee per year towards health insurance benefits.

To demonstrate this point Professor Zelinsky again cites *Egelhoff*, in which the Washington state law at issue allowed employers to elect out of the statute’s coverage, nullifying the retroactive effect of the participants’ divorce.<sup>132</sup> However, this ability to “opt out” did not save the Washington statute from *ERISA* pre-emption. The Supreme Court held that “the statute is not any less of a regulation of the terms of *ERISA* plans simply because there are two ways of complying with it.”<sup>133</sup>

By contrast, both Monahan and Butler argue that because the “pay” penalty is relatively insubstantial compared to the cost of providing insurance, the Massachusetts play or pay provision would likely survive an *ERISA* pre-emption challenge on the basis that it is a mere indirect economic incentive for a plan administrator to make certain choices with respect to its health care plan.<sup>134</sup> The argument is that this penalty is “so insubstantial” that it is not a *de facto* coverage mandate and therefore does not impact on the structure or benefits of the *ERISA* plans.<sup>135</sup>

Instead of forcing an employer to provide particular health insurance benefits to its employees, Monahan argues that the assessment penalty simply “provides a small financial incentive for employers to comply with the [fair and reasonable] standards.”<sup>136</sup> What contrasts this law from the Maryland law is that the Massachusetts plan makes it rational for an employer to choose the “pay” option, which should be considered as a tax to the state, rather than the provision of health insurance. Therefore, it is argued that the law does not require an employer to either adopt or amend an *ERISA* plan, as the Maryland law does, because employers could rationally choose to pay the \$295 assessment, which is not connected with an *ERISA* plan.<sup>137</sup>

The result, according to both Monahan and Butler, is that Massachusetts’ fair share contribution is more like an “indirect economic incentive” to create an *ERISA* plan (which was upheld in the *Travelers* decision) rather than a Hobson’s choice, requiring the employer to provide particular mandated benefits (which was struck down in *RILA*). Monahan argues that it is clear that “if Massachusetts required all employers to either cover 25 percent of their full-time employees or pay 33 percent of all employee health insurance premiums, such a law would be pre-empted.”<sup>138</sup> However, Massachusetts’ law does not require employers to cover their employees; it is simply a relatively modest financial disincentive associated with foregoing the provision of health insurance.<sup>139</sup>

This argument would be strengthened if the assessment were paid into Massachusetts’ “general revenue” fund, rather than earmarked for the Commonwealth Care Trust Fund. (Maryland’s assessment was also earmarked for the state Medicaid fund.) That way, employers

---

<sup>131</sup> See Contreras & Lobel, *supra* note 90 at 129, quoting Professor Zelinsky [emphasis added].

<sup>132</sup> See Zelinsky, *supra* note 6 at 261.

<sup>133</sup> *Egelhoff*, *supra* note 121 at 150. The two ways of complying with it included (1) treating divorce as revoking prior benefits or (2) giving notice that the employer had elected against the statutory rule.

<sup>134</sup> Monahan, *supra* note 90 at 1214. Butler, *supra* note 90 at 8.

<sup>135</sup> Butler, *ibid.* at 9.

<sup>136</sup> Monahan, *supra* note 90 at 1215.

<sup>137</sup> *Ibid.* at 1216.

<sup>138</sup> *Ibid.*

<sup>139</sup> *Ibid.*

would have a true choice between providing health insurance benefits and paying an assessment that could not be perceived as a mandate to provide any type of health insurance and would have no connection at all with an *ERISA* plan.<sup>140</sup> Since up to twenty other states have enacted or are considering play or pay provisions, they may want to consider a relatively low pay assessment (providing employers a true choice as to whether to “play” or “pay”), as well as putting the assessment money into general revenues, not an earmarked fund for health care provision. That way, these states will be sure to steer clear of *ERISA* pre-emption.

An emergency order issued by the Court of Appeals for the Ninth Circuit further indicates that providing employers with a legitimate choice between two acceptable alternatives (providing health care or paying money into a fund for health care) avoids *ERISA* pre-emption. The City of San Francisco passed an ordinance, designed to take effect January 1, 2008, that requires employers with twenty to ninety-nine employees (and non-profit employers with fifty or more employees) to spend \$1.17 per hour per employee on health coverage for any employee who has been employed for more than ninety days; for-profit companies with one hundred or more employees must spend \$1.76 per hour per worker on health coverage.<sup>141</sup> The ordinance also sets out several non-exhaustive qualifying health care expenditures which include contributions to Health Savings Accounts (HSAs), re-imbusement to employees for health care expenses, and direct costs incurred in the delivery of health care.<sup>142</sup> Businesses that do not meet the per hour health care spending requirements must pay the equivalent amount to a universal access fund for a primary and preventive care program called the Health Access Program. This program is available to uninsured San Francisco residents regardless of their employment status and delivers care to participants from a network of San Francisco General Hospital, Department of Health clinics, and participating non-profit and public providers.<sup>143</sup>

In late 2007, the Federal District Court for the Northern District of California, relying on the fourth circuit’s holding in *RILA v. Fielder*, held that *ERISA* pre-empts San Francisco’s ordinance because it is “connected with” and “refers to” *ERISA* plans.<sup>144</sup> However, in January 2008, the Court of Appeals for the Ninth Circuit granted a stay of the lower court’s order and an emergency order allowing the city’s ordinance to go ahead as planned. The court held that, as a preliminary matter, the city has a “strong likelihood of success” in its argument that the ordinance is *not* pre-empted by *ERISA*.<sup>145</sup>

The Ninth Circuit held that the ordinance requires that covered employers make certain levels of health care *payments* to an *ERISA* plan or some other entity, including the city; it does not require that employers provide certain health care *benefits* to its employees, through an *ERISA* plan or otherwise.<sup>146</sup> As a result, the ordinance does not mandate employee benefit structures or administration. In fact, the ordinance “does not force employers to provide any benefits or plans, to alter their existing plans, or to even provide *ERISA* plans or employee benefits at all,” and therefore it cannot be “connected with” an *ERISA* plan.<sup>147</sup> As in

---

<sup>140</sup> In striking down a local San Francisco “play or pay” ordinance designed to require San Francisco employers to provide health insurance to its employees or pay a rate per hour worked into a health access program, the Federal District Court for the Northern District of California suggested that future local and state government that want to implement “play or pay” provisions should craft assessments as general revenue measures and then give a tax credit to companies for health care spending, in order to avoid *ERISA* pre-emption. See *Golden Gate Restaurant Association v. City and County of San Francisco*, 535 F. Supp 2d 968 (N.D. Cal. 2007) at 980.

<sup>141</sup> *Ibid.* at 970.

<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.* at 971.

<sup>144</sup> *Ibid.* at 979.

<sup>145</sup> *Golden Gate Restaurant Association*, Ninth Circuit Court of Appeals, *supra* note 35 at 1119. Full oral arguments were heard on April 17, 2008 and the final ruling is expected in the summer of 2008. A decision in favour of upholding the ordinance could send the issue to the United States Supreme Court.

<sup>146</sup> *Ibid.* at 1119.

<sup>147</sup> *Ibid.* at 1122.

Massachusetts, a San Francisco employer may be influenced by the ordinance to choose to adopt (or alter) an *ERISA* plan to comply with the ordinance, in lieu of paying the city. However, according to *Travelers*, “such influence is entirely permissible.”<sup>148</sup> As a result, the ordinance went into effect in mid-January 2008 and is operational, pending the decision on the appeal of the merits.

Finally, from a practical perspective, the Massachusetts legislation was supported by much of the mainstream business community (likely because it was able to bargain for such a modest “pay” assessment), so it is unclear why any employer would now challenge it. It has been reported, however, that a number of “ideological” law firms from outside Massachusetts are looking for plaintiffs and preparing a lawsuit challenging the play or pay provision.<sup>149</sup> Even if the employer mandate were struck down (it had to be enacted overriding Governor Romney’s veto), it only represents a minor part of the legislation financially, and Massachusetts’ other health care reforms would continue to produce tangible benefits for Massachusetts residents.

#### IV

#### POLICY IMPLICATIONS FOR OTHER STATES

Several other states, notably California and Maine, have already tried to emulate some or all of the Massachusetts health care reform. In California, Republican Governor Schwarzenegger introduced the *Health Care Security and Cost Reduction Act*,<sup>150</sup> which was similar to the Massachusetts reform. The proposed California plan contained a “play or pay” provision for employers with more than ten employees which included a “pay” sanction (for employers not providing adequate health insurance) of 4 percent of the total employer payroll.<sup>151</sup> The plan also included an individual mandate—as in Massachusetts, Californians would be required to purchase insurance through their employer, individually or through the newly created “connector-type risk pooling mechanism.”<sup>152</sup> It would have also required health

<sup>148</sup> In addition, the Court held that the ordinance does not have a “reference to” an *ERISA* plan because it does not “act immediately and exclusively upon *ERISA* plans” and the existence of *ERISA* plans is not essential to the law’s operation: *ibid*.

<sup>149</sup> Celia Weislo, Malini Cadambi & Yvonne Liu, *Lessons Learned to Date from the Massachusetts Health Care Reform* (August 2007) at 14, online: 1199 SEIU United Health Care Workers East <<http://www.newamerica.net/files/MA%20HC%20Reform%20Lessons%20Learned%20to%20Date%20Aug%2007%20FINAL1.pdf>>.

<sup>150</sup> U.S., A.B. 1, *An act to amend Section 2069 of, to add Sections 4040.1, 4071.2, 4071.3, and 4071.4 to, and to add and repeal Section 2838 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 12803.25, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title 2 of, the Government Code, to amend Sections 1357.54, 1365, 124900, 124905, 124910, 124920, 128745, and 128748 of, to amend, repeal, and add Section 1399.56 of, to add Sections 1262.9, 1342.9, 1347, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 1399.58, 104376, 124905.1, 124946, and 130545 to, to add Chapter 1.6 (commencing with Section 155) to Part 1 of Division 1 of, to add Article 11.6 (commencing with Section 1399.820) to Chapter 2.2 of Division 2 of, to add Article 1 (commencing with Section 104250) to Chapter 4 of Part 1 of Division 103 of, to add Article 3 (commencing with Section 104705) to Chapter 2 of Part 3 of Division 103 of, and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.76 of, to amend, repeal, and add Section 796.02 of, to add Sections 796.05, 10113.10, 10113.11, 10123.56, 10176.15, 10273.6, 12693.56, 12693.57, 12693.58, 12693.59, 12693.766, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10919) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) and Part 6.7 (commencing with Section 12739.50) to Division 2 of, the Insurance Code, to add Section 96.8 to the Labor Code, to amend Sections 19167 and 19611 of, to add Sections 17052.31, 17052.32, 19528.5, and 19553.5 to, and to add and repeal Section 17052.30 of, the Revenue and Taxation Code, to add Sections 301.1 and 1120 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 12306.1, 14005.30, and 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.333, 14011.16.1, 14074.5, 14081.6, 14092.5, 14132.105, and 14137.10 to, and to add Article 5.215 (commencing with Section 14167.22) to, and to add and repeal Article 5.21 (commencing with Section 14167.1) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, 2007-2008, 1st Extra Sess., Cal., 2008.*

<sup>151</sup> See Weeks, *supra* note 7 at 1299.

<sup>152</sup> *Ibid*.

care providers to pay a tax of 2 percent of revenues for physicians and 4 percent for hospitals.<sup>153</sup> Similarly, Massachusetts already enacts a surcharge on providers and insurers to fund the UCP.

Ultimately, however, Governor Schwarzenegger's proposal failed to receive enough votes to pass out of the Senate Health Committee; it was voted down ten to one in January 2008. At present, although Governor Schwarzenegger and State Assembly Speaker Fabian Nunez have vowed to continue their fight for a comprehensive health care plan, future reform seems to be in jeopardy in that state.

As the failure to achieve comprehensive health care reform in California has shown, other states must be careful before attempting health care reforms similar to Massachusetts', because they may not be able to achieve similar results. Indeed, the Massachusetts health insurance market has several key features that enabled Governor Romney to propose, achieve, and implement meaningful health care reform. First, Massachusetts has a lower uninsurance rate than other states. Only about 11 percent of Massachusetts residents were uninsured in 2006, compared to about 16 percent nationally.<sup>154</sup> California, for example, has more uninsured residents than Massachusetts has people.

Second, Massachusetts has a history and tradition of regulating the health insurance market, including medical underwriting, guaranteed issue, and experience-rating provisions. Policy analysts argue that a viable individual mandate is much more feasible in a state with heavily regulated insurance markets.<sup>155</sup> Third, Massachusetts already had a large federal subsidy (a \$385 million Medicaid waiver) and a substantial taxpayer-funded UCP (which totaled about \$1 billion) to fund the start up costs of such a comprehensive program. It has been argued that "an equivalent harmonic convergence of [these] factors remains far less likely in other states considering similar coverage expansion initiatives."<sup>156</sup> Indeed, these features make the Massachusetts situation unique, and the costs and outcomes from a similar health care reform in another state, or federally, would likely be different.<sup>157</sup>

At the same time, key features of the Massachusetts plan should serve as examples for other states. First, it is important to note that bi-partisan collaboration is possible in order to achieve meaningful health reform. Indeed, the Massachusetts plan was a unique merger of the political right and left, Republicans and Democrats, conservative and progressive approaches to comprehensive reform.<sup>158</sup> It demonstrated the willingness of leaders from across the political spectrum to agree on a common goal (moving towards universal health insurance coverage) and to compromise in order to achieve that goal. Second, incremental reform will not produce substantial results. Any state initiative that seeks to implement meaningful reform will have to apply multiple policy mechanisms in order to achieve significant policy progress.<sup>159</sup> Finally, any state that proposes health care reform will likely attempt to reform or expand employer-sponsored insurance, which is currently the mechanism through which most Americans get their health insurance. However, any state considering reforms to employer-sponsored coverage will have to be aware of the *ERISA* pre-emption implications of any employer-related health care initiatives. Unfortunately, the *ERISA* pre-emption greatly inhibits states from

---

<sup>153</sup> *Ibid.* at 1300. There were also some key differences in Governor Schwarzenegger's proposal. The plan would have required insurers to spend at least 85 percent of premiums on patient care, limited insurance company spending on administrative overhead, and would have capped profits. There were also no caps on premiums or mandatory coverage provisions. Despite these restrictions, however, insurers generally approved of the plan, which is expected to generate four to five million new customers.

<sup>154</sup> Elizabeth A. McGlynn & Jeffrey Wasserman, "Massachusetts Health Reform: Beauty is in the Eye of the Beholder" (2006) 25 Health Affairs w447.

<sup>155</sup> See McDonough *et al.*, *supra* note 13.

<sup>156</sup> Tom Miller, "Massachusetts: More Mirage than Miracle" (2006) 25 Health Affairs w450 at 450.

<sup>157</sup> McGlynn & Wasserman, *supra* note 154 at w448.

<sup>158</sup> McDonough *et al.*, *supra* note 13 at w431.

<sup>159</sup> McGlynn & Wasserman, *supra* note 154 at w448.

experimenting with meaningful health care reforms, but until it is amended, states must draft and implement their reforms in accordance with the pre-emption.

## V

### FEDERAL POLICY IMPLICATIONS

The failure of California, a politically significant and trend-setting state, to achieve comprehensive health care reform means that advocates of overhauling the health care system have turned their focus back to Washington and the federal government.<sup>160</sup> Comprehensive reform has been a major national policy issue, particularly for the Democrats. Senator Barack Obama has advocated comprehensive reforms that, like Senator Hillary Clinton's proposals, have incorporated several aspects from the Massachusetts reform.<sup>161</sup> However, it is crucial that any federal health care initiative takes into account the successes and avoids the pitfalls of the Massachusetts reforms.<sup>162</sup>

Both Senator Obama's and Senator Clinton's proposed health care plans include significant play or pay employer mandates. Senator Clinton's "American Health Choices Plan" contains an employer play or pay mandate whereby large employers "will be expected to provide health insurance or contribute to the cost of coverage" and "small businesses will receive a tax credit to continue or begin to offer health insurance."<sup>163</sup> Similarly, Senator Obama's "Plan for a Healthy America" provides that employers who do not offer meaningful coverage or make a meaningful contribution to the cost of their employees' health insurance will be required to pay a percentage of payroll towards a national health care plan.<sup>164</sup> Of course, federal health care initiatives can implement an employer play or pay mandate without conflicting with *ERISA*, and they cannot be pre-empted. This point is crucial because federal play or pay provisions are legal, and the "pay" penalty can be set at a higher level than in Massachusetts without the risk of an employer bringing an *ERISA* lawsuit. Federal play or pay employer mandates may be an effective way to increase health coverage and fund significant health care reforms without the risk of pre-emption.<sup>165</sup>

Another similarity between the Democrats' plans is that they both propose an insurance exchange and pooling mechanism to help make insurance more affordable. Senator Obama's plan refers to it as a "National Health Insurance Exchange," which will contain income-based sliding-scale subsidies, like the Connector. It is interesting that both candidates have strongly advocated a Connector-type exchange, given that, as Professor Zelinsky argues, it is simply too soon to tell "if [the Connector] has in practice achieved its proponents' goals of a large scale health insurance marketplace which reduces health insurance premiums and increases the availability of health insurance coverage by pooling eligible individuals and employers while insurers compete for their business."<sup>166</sup> While in theory the Connector can potentially improve

---

<sup>160</sup> Christopher Lee, "Health-Care Reform to Shift Focus" *The Washington Post* (31 January 2008) A2.

<sup>161</sup> Although Senator Clinton has conceded the Democratic presidential nomination to Senator Obama, as an influential member of the United States Senate and the Democratic Party she still wields considerable power in federal politics and will still likely advocate her national health care proposals.

<sup>162</sup> On the other side of the political aisle, Republican presidential nominee John McCain has only advocated piecemeal health care reforms, including a direct refundable tax credit of \$2,500 for individuals or \$5,000 for families to offset the cost of insurance, and encouraging and expanding the benefits of Health Savings Accounts. See <[www.johnmccain.com/Informing/Issues/19ba2f1c\\_c03f\\_4ac2-8cd5-5cf2edb527cf.htm](http://www.johnmccain.com/Informing/Issues/19ba2f1c_c03f_4ac2-8cd5-5cf2edb527cf.htm)> for a discussion of his health care policies.

<sup>163</sup> Hillary for President, Press Release, HCPO725 "The American Health Choices Plan: Insuring Quality, Affordable Health Care for All Americans" at 2, online: Hilary Clinton for President <[www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf](http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf)> [Hillary for President].

<sup>164</sup> Obama '08, "Plan for a Healthy America" at 4-5, online: Obama '08 <<http://www.barackobama.com/issues/pdf/HealthCareFullPlan.pdf>> [Obama '08].

<sup>165</sup> Of course any significant "pay" option will likely face significant backlash from the business community.

<sup>166</sup> Zelinsky, *supra* note 6 at 239; for a discussion of the potential problems with the Connector, see Weeks, *supra*



competition, increase access to health care, and lower costs, it is still a relatively unproven commodity in practice. It should, however, definitely improve the portability of health insurance.

The key differences between Senator Clinton's and Senator Obama's plans involve the individual mandate and cost containment mechanisms. Senator Clinton's proposal contains a nationwide individual mandate in which all Americans "will be responsible for getting and keeping insurance in a system where insurance is affordable and accessible."<sup>167</sup> The plan will ensure affordability by limiting premium payments to a percentage of family income (to be determined by Congress and indexed over time) and by providing subsidies to lower income individuals. In short, according to MIT Economist Jonathan Gruber, who analyzed the budget implications of the Massachusetts reforms, Senator Clinton's proposal is "very, very similar" to the plan that Governor Mitt Romney proposed and negotiated through the Massachusetts legislature.<sup>168</sup> Indeed, she claims, much like Romney did in Massachusetts, that savings would come from modernization and reform, including the reduced need for uncompensated care payments.<sup>169</sup> Clinton's plan focuses primarily on access without adequately addressing cost containment issues. The lesson learned from Massachusetts, however, is that increasing access to coverage without adequately controlling skyrocketing health care costs is not a sustainable model, either in Massachusetts or federally. Any federal mandate must address cost containment issues in a direct and significant way, or it must include the potential for a substantial tax increase to keep the mandate affordable.

By contrast, Senator Obama's plan and campaign rhetoric have focused primarily on cost containment mechanisms, but his plan does not contain an individual mandate.<sup>170</sup> He has argued that Americans do not have health insurance because they cannot afford it, not because they do not want it or are not forced to purchase it.<sup>171</sup> His cost containment proposals include lowering costs through investment in electronic health information technology systems, and by increasing competition in the insurance and drug markets. In addition, a substantial section of his plan is devoted to promoting prevention and strengthening public health, which are also designed to contain costs in the long run.<sup>172</sup> While recognizing the vital importance of cost containment, it is unclear how successful his plan will be at signing up uninsured (particularly young and healthy) people for insurance without an individual mandate.

Health care reform in Massachusetts has two main implications for federal policy initiatives. First, if a federal politician wants to expand access to health care, the success of the Massachusetts model seems to indicate that an individual mandate is necessary to significantly increase the number and percentage of uninsured individuals who sign up for health insurance. Any proposal designed to achieve universal or near-universal coverage likely requires some type of individual mandate in order to increase the number of healthy individuals who enter into and stabilize risk pools, and bring down the average costs to the insurance companies. If young and healthy (and generally poorer) individuals are not mandated to purchase health

---

note 7.

<sup>167</sup> Hillary for President, *supra* note 163 at 2.

<sup>168</sup> Dan Balz, "Romney's Rush to Critique Clinton Missing the Facts" *The Washington Post* (18 September 2007), online: The Washington Post Online <[http://blog.washingtonpost.com/the-trail/2007/09/18/post\\_78.html](http://blog.washingtonpost.com/the-trail/2007/09/18/post_78.html)>. Interestingly, despite the overwhelming similarities between his reforms in Massachusetts and Senator Clinton's national health care proposal, during his brief presidential run, Governor Romney criticized Senator Clinton's plan as a "European-style socialized medicine plan" and "HillaryCare 2.0," evoking images from the Clintons' failed attempt at health care reform during President Clinton's first term in office.

<sup>169</sup> Hillary for President, *supra* note 163 at 7. She also advocates reversing President Bush's tax cuts in order to raise additional revenues for her health care plan.

<sup>170</sup> His plan contains mandatory coverage for children under the age of eighteen, but no individual mandate for adults. See Obama '08, *supra* note 164 at 5.

<sup>171</sup> See 2008 Democratic Debate at University of Texas in Austin: On Health Care <[www.ontheissues.org/](http://www.ontheissues.org/)>.

<sup>172</sup> Obama '08, *supra* note 164 at 11-13.

insurance, a substantial percentage of them are not likely to pay for it, even if costs are contained. This will lead to adverse selection in the risk pools as older and less healthy people are the only ones who purchase insurance (for example, in an insurance exchange like the Connector). This leads to higher average prices, in turn causing more individuals to forego insurance. In short, it seems as though the phenomenon that health economists refer to as the “adverse selection death spiral” will continue to exist in the absence of an individual mandate.<sup>173</sup>

Second, expanding access and broadening coverage without controlling costs is unsustainable. A federal initiative with a subsidized individual mandate will likely require significant cost containment mechanisms and/or a federal tax increase in order to remain economically viable over the long term. Of course, as Massachusetts has demonstrated, “expanding coverage is easy compared to controlling costs.”<sup>174</sup>

Any meaningful, comprehensive reform designed to ensure access to health care for a majority of the United States’ forty-seven million uninsured citizens will require both an individual mandate (or some mechanism for forcing everyone—including the healthy—into the appropriate risk pools) as well as significant, substantial, and long-term cost containment mechanisms. Massachusetts has gone part of the way; it is up to motivated and creative federal and state officials to develop health care strategies that build on Massachusetts’ successes in order to improve health care access while at the same time controlling costs.

#### CONCLUSION

This paper has examined both the policy and legal aspects of Massachusetts’ recently enacted health care policy reform. While the law is not perfect, it goes a long way towards ensuring that most Massachusetts residents have quality, portable health insurance and improved health outcomes. That said, the law has some areas for improvement, notably an appropriate definition of “affordability” and the pressing need for some cost-containment mechanisms.

Legally, the employer mandate (a largely symbolic but important part of the legislation) may violate federal law. While the legislation and jurisprudence is unclear regarding the *ERISA* pre-emption of “play or pay” statutes, it is argued that the Massachusetts legislation would likely be upheld and not pre-empted by *ERISA*. Nevertheless, other states considering reform must be aware of the *ERISA* pre-emption issue and its implications.

Finally, the passage of the legislation creates policy implications for other states and federal officials considering reform. While not all of the aspects of the Massachusetts plan will necessarily translate to other jurisdictions, it seems clear that political compromise from across the political spectrum, and comprehensive, rather than piecemeal, reform is necessary to achieve meaningful reductions in the number of uninsured Americans. Furthermore, in order to achieve a significant and substantial increase in access to health insurance (and therefore access to appropriate and efficient health care), a subsidized individual mandate is probably necessary. However, any such mandate *must* be accompanied with significant cost containment mechanisms if it is to remain viable and sustainable over the long term. It will be interesting to watch the implementation of the various parts of the Massachusetts legislation as parts of the *Act* come into effect over the next year, and to see whether the state is able to reign in costs effectively, or if they continue to relentlessly increase. Massachusetts’ success or failure could have a significant impact on the future of health care reform across the United States.

---

<sup>173</sup> Jonathan Cohn, “Mandate Overboard” *The New Republic* (7 December 2007), online: The New Republic Online <<http://tnr.com/politics/story.html?id=b5be7883-461b-453b-99b5-d1df748d242d>>. Cohn argues that Senator Obama’s lack of an individual mandate will lead to higher costs through the adverse selection death spiral.

<sup>174</sup> See Dembner, “Healthcare Cost Increases Dominate”, *supra* note 28, quoting Nancy Turnbull.

APPENDIX A: 2008 AFFORDABILITY SCHEDULE FOR INDIVIDUAL MANDATE  
 From the Commonwealth Health Insurance Connector  
 (<http://www.mahealthconnector.org/>)

## INDIVIDUALS

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
\$0	\$15,315 (150% FPL)	\$0			
\$15,316	\$20,420 (200% FPL)	\$35	2.4%	2.7%	2.1%
\$20,421	\$25,525 (250% FPL)	\$70	3.7%	4.1%	3.3%
\$25,526	\$30,630 (300% FPL)	\$105	4.5%	4.9%	4.1%
\$30,631	\$35,000 (341% FPL)	\$150	5.5%	5.9%	5.1%
\$35,001	\$40,000 (391% FPL)	\$200	6.4%	6.9%	6.0%
\$40,001	\$50,000 (489% FPL)	\$300	8.0%	9.0%	7.2%
\$50,001					

## MARRIED COUPLES WITHOUT DEPENDENTS

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
\$0	\$20,535 (150% FPL)	\$0			
\$20,536	\$27,380 (200% FPL)	\$70	3.5%	4.1%	3.1%
\$27,381	\$34,225 (250% FPL)	\$140	5.5%	6.1%	4.9%
\$34,226	\$41,070 (300% FPL)	\$210	6.7%	7.4%	6.1%
\$41,071	\$50,000 (365% FPL)	\$270	7.1%	7.9%	6.5%
\$50,001	\$60,000 (438% FPL)	\$360	7.9%	8.6%	7.2%
\$60,001	\$80,000 (584% FPL)	\$500	8.6%	10.0%	7.5%
\$80,001					

## FAMILIES

Annual Adjusted Gross Income Range		Monthly Premium	Percentage of Income		
Starting Point	End Point		Middle	Bottom	Top
\$0	\$25,755 (150% FPL)	\$0			
\$25,756	\$34,340 (200% FPL)	\$70	2.8%	3.3%	2.4%
\$34,341	\$42,925 (250% FPL)	\$140	4.3%	4.9%	3.9%
\$42,926	\$51,510 (300% FPL)	\$210	5.3%	5.9%	4.9%
\$51,511	\$70,000 (407% FPL)	\$320	6.3%	7.5%	5.5%
\$70,001	\$90,000 (524% FPL)	\$500	7.5%	8.6%	6.7%
\$90,001	\$110,000 (640% FPL)	\$720	8.6%	9.6%	7.9%
\$110,001					