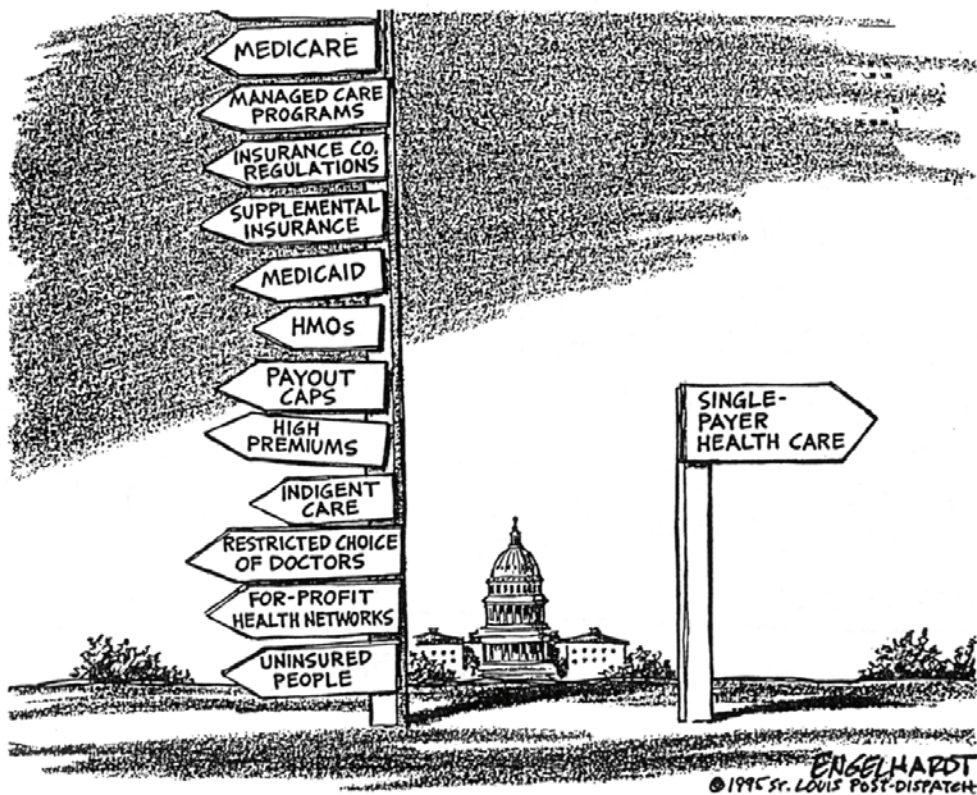


# Alternative reform proposals



## Talking Point 13

Alternative proposals for “universal coverage” do not work. State health reforms over the past two decades have failed to reduce the number of uninsured.



Simplicity, Anyone?



## OBSERVATIONS: U.S. HEALTH REFORM

## Obama's reform: no cure for what ails us

By David U. Himmelstein and Steffie Woolhandler

*As the applause fades for President Obama's health reform, David Himmelstein and Steffie Woolhandler fear that the new law will simply pump funds into a dysfunctional, market driven system*

It was a stirring scene: President Obama signing the new health reform law before a cheering crowd, and a beaming vice president whispering in his ear, "This is a big fucking deal." As doctors who have labored for universal health care we'd like to join the celebration, but we can't. Morphine has been dispensed for the treatment of cancer – the reform may offer a bit of temporary relief, but it is certainly no cure.

The new law will pump additional funds into the currently dysfunctional, market driven system, pushing up health costs that are already twice those in most other wealthy nations. The Medicaid public insurance program for poor people will expand to cover an additional 16 million poor Americans, while a similar number of uninsured people with higher incomes will be forced to buy private policies. For the "near poor" the government will pay part of these private premiums, channeling \$447 billion in taxpayer funds to private insurers over the next decade.

Unfortunately, private insurers win in the marketplace not through efficiency or quality but by maximizing revenues from premiums while minimizing outlays. They pursue this goal by avoiding the sick and forcing doctors and patients to navigate a byzantine payment bureaucracy that currently consumes 31 percent of total health spending. The health reform bill's requirement that uninsured people buy insurers' defective products will fortify these firms financially and politically.

Meanwhile insurers will exploit loopholes to dodge the law's restrictions on their misbehaviors.

For instance, the limit on administrative overheads will predictably elicit accounting gimmickry, for example by relabeling some insurance personnel as "clinical care managers." While insurers are prohibited from "cherry picking" – selectively enrolling healthy, profitable patients – they've circumvented similar prohibitions in the Medicare health maintenance organizations (HMOs). The ban on revoking policies after an individual falls ill similarly replicates existing but ineffective state bans.

Sadly, even if the reform works as planned, 23 million people will remain uninsured in 2019. Meanwhile the public and other safety net hospitals that uninsured people rely on will have to endure a \$36 billion cut in federal government funding.

Moreover, many Americans will be left with coverage so skimpy that a serious illness could lead to financial ruin. At present, illness and medical bills contribute to 62 percent of all bankruptcies, with three-quarters of the medically bankrupt being insured. The reform does little to upgrade this inadequate coverage; it mandates that private policies need cover only 70 percent of expected medical costs. The president has often promised that "if you like your current coverage you can keep it." Yet Americans who now get job based insurance will be required to keep it – whether they like it or not. And many who receive full coverage from an employer will face a steep tax on their health benefits from 2018.

Soaring costs and rising financial strains seem inevitable, despite claims that the reform will "bend the cost curve." Computer vendors have trumpeted imminent cost savings for half a century (see, for instance, a video made by IBM in the 1960s, available at <http://bit.ly/cckdtB>). Prevention, though laudable, does not generally reduce costs. Windfalls from prosecuting fraud and abuse have been promised before. The new Medicare advisory board merely

tweaks an existing panel. Without an enforcement mechanism, stepping up comparative effectiveness research cannot overcome drug and equipment makers' promotion of profligate care. Existing insurance exchanges where patients can compare and shop among private plans haven't slowed growth in costs for public workers nationally or in California. And the mandated experiments with capitated payment systems are warmed-over versions of President Nixon's pro-HMO policies and subsequent failed initiatives to fix America's health cost crisis through managed care.

Experience with reforms in Massachusetts in 2006 – the template for the national bill – is instructive. Our state's costs, already the highest of any state, grew by 15 percent in the first two years after reform, twice the national rate. Moreover, capitated physician groups had costs at least as high as those who were paid on a fee for service basis. Meanwhile, after initial improvements in the state, access to care has begun to deteriorate, and the state has begun to cut back coverage.

Overall, President Obama's is a conservative bill, drafted in close consultation with the drug and insurance industries. Its modest salutary provisions – such as an extra \$1 billion a year for community health centers and the expansion of Medicaid – mirror measures that have been passed even under Republican regimes. Its central tenet, that the gov-

ernment should force citizens to buy coverage from a for-profit firm, was first proposed by Richard Nixon when faced with the seeming inevitability of national health insurance in 1972. Similarly, Mitt Romney, a favorite of conservatives, embraced the Nixon approach as Massachusetts governor in 2006, a stance he has now abandoned. Democrats, having retreated from their traditional push for national health insurance, freed Republicans to move still further to the right.

Throughout the reform debate we, and the 17 000 others who've joined Physicians for a National Health Program, advocated for a far more thoroughgoing reform: a non-profit, single payer national health insurance program. We will continue to do so. Our health care system has not been cured or even stabilized. For now, we will continue to practice under a financing system that obstructs good patient care and squanders vast resources on profit and bureaucracy.

Passage of the health reform law was a major political event. But for most doctors and patients it's no "big fucking deal."

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# THE AMERICAN PROSPECT

## Health Reform You Shouldn't Believe In

What the Massachusetts experiment teaches us about incremental efforts to increase coverage by expanding private insurance.

**Marcia Angell** | April 21, 2008

**F**OR ALL THEIR PROMISE OF change, Democrats are remarkably timid about changing the health-care system. The system now costs twice as much per person as those of other advanced countries and delivers worse average outcomes. It prices tens of millions of people out of health coverage altogether and limits care for countless others. Yet leading Democrats are clinging to this system, proposing to cover more people but not changing the system itself except at the margins. The timidity extends to choice of words. No one is supposed to say “single-payer” or “national health insurance” anymore, because that is “politically unrealistic”; the most we are allowed is to talk of reforming the system incrementally so that someday it will morph into “Medicare for all.”

Thus, the proposals for reform taken most seriously by Democrats — including Barack Obama and Hillary Clinton — would retain the central role of the investor-owned private insurance industry as well as the thousands of for-profit businesses it pays to deliver medical services. This is the industry, mind you, that has brought us to the predicament we're in now, so let's take a quick look at it.

The U.S. health system is unique in treating health care as a commodity to be bought and sold in a marketplace. Care is distributed according to the ability to pay, not according to medical need. Private insurers compete by avoiding high-risk individuals, limiting services for those they do cover, and, whenever possible,

shifting costs to other payers or to patients in the form of high deductibles and co-payments. We have the only health system in the world based on avoiding sick people. It's a chaotic and fragmented system that requires mountains of paperwork, which is one reason premiums are so high. Employers who offer health benefits react by capping their contributions, so that workers pay more out of pocket and bear the full brunt of premium increases.

Insurers contract with hospitals, HMOs, and other health facilities to provide the care. They, too, are often for-profit businesses that promote lucrative services for well-insured patients (such as coronary catheterization for Medicare recipients), while giving short shrift to less profitable ones (such as psychiatric services for the indigent). To compete in a market environment, even not-for-profit facilities behave in much the same way as for-profit ones. Doctors often act as entrepreneurs, investing in health facilities to which they refer patients. And because they are usually paid on a fee-for-service basis, they have a strong incentive to overuse tests and procedures that have the greatest profit margins.

All of this drives up costs to the overall system, while yielding profits for the various players within it. In fact, there's a fundamental illogic to trying to contain costs in a market-based system. Markets are about expanding, not contracting. Like all businesses, hospitals want more, not fewer customers — but only as long as they can pay. Conventional wisdom holds that we need to retain this system because many Americans are satisfied with it. But except for industry spokespeople and

politicians whose campaigns they support, I've never met anyone who actually is. Many people like their doctors, but that is not the same as liking the system.

The reforms favored by leading Democrats vary somewhat, but all have at their heart expanding insurance coverage through public subsidies for those who can't afford the premiums or, alternatively, permitting those without access to good, affordable insurance to enroll in a new Medicare-type program that would be set up to provide them with coverage. Some reform proposals include a mandate requiring everyone to be insured.

Many proponents hope that a parallel Medicare-like system would eventually crowd out its less efficient private competitors, that under a play-or-pay requirement, employers would gradually decide to stop providing coverage and just pay into the common pool. However, this wishful thinking overlooks the power of the private health industry, through its huge lobby, to influence the rules so that it continues to profit while the public system is undermined.

All of these variations in the Democrats' plans run into this intractable dilemma: If the system stays essentially as it is and we try to expand coverage, costs will inevitably rise. On the other hand, attempts to control costs will inevitably reduce coverage. Without fundamental reform, coverage and costs have to move in the same direction. Yet, we don't have the option of expanding both coverage and costs. At 16 percent of gross domestic product, our health-care system is already unaffordable. In fact, costs are the central problem; universal health care would be easy if money were no object. Furthermore, none of the proposed reforms offers any workable mechanism for controlling the unsustainable inflation in health costs. Attempts to regulate private insurers to prevent the worst abuses would probably do little more than add to the complexi-

ty and administrative costs of the system.

The proposed reforms also make the fundamental mistake of confusing *insurance* with *health care*. As many Americans are learning, the two are not the same — not by a long shot. Health insurance can easily be too skimpy or too laden with exceptions and co-charges to be of much use. What people really want when they're sick is medical care, not medical insurance, just as they want education for their children, not the opportunity to buy education insurance.

Despite the Democrats' coalescence around the same approach for achieving universal care, only one such plan has been implemented — the Massachusetts health-reform plan. It is therefore worth looking at in some detail.

### **MASSACHUSETTS MIRACLE OR MIRAGE?**

This plan, which was enacted in April 2006 amid extraordinary hoopla, set out to cover the 500,000 to 750,000 uninsured residents of the state, and to see that the coverage for everyone else met a minimum standard. To that end, the state would purchase insurance for everyone with incomes beneath the federal poverty level, and partially subsidize it for those earning up to three times the poverty level (which now comes to \$31,200 per year for an individual). Everyone else — roughly 200,000 to 250,000 people — would have to purchase his or her own insurance or face stiff fines. The legislation established a new state agency, the Commonwealth Health Insurance Connector, which would try to make sure insurance was affordable and met the minimum standard and which would also determine the level of subsidies.

Financing the plan was iffy from the outset. When fully implemented, it was projected to cost the state only \$125 million in new money the first year — not very much in a state with a \$26 billion budget. Mostly it would be financed by diverting existing funds from two sources: Medicaid, under a two-year waiver that would permit federal money to be used for this purpose, and the state's generous "free care pool," which was established to provide direct services to uninsured patients in safety-net facilities and is supported by assessments on hospitals and insurers. There would also be a paltry fine on employers who didn't offer insurance, but

no one thought that would be an important source of funding. Success would depend crucially on the individual mandate requiring those with incomes more than three times the poverty level to pay for their own insurance.

What's happened since then? While those beneath the poverty level signed up for free insurance in even greater numbers than anticipated, very few people who were required to pay for their own insurance signed up. Even those eligible for partial subsidies were slow to enroll. The deadline to purchase insurance had to be extended, and 60,000 uninsured people were exempted from the mandate because — yes, that's right — they couldn't afford it (so much for universality). The state modified its requirement that all insurance meet a minimum standard. Jon Kingsdale, the executive director of the Commonwealth Health Insurance Connector, told me that was because the federal Employee Retirement Income Security Act prohibits states from setting standards when employers act as their own insurers (didn't the Massachusetts legislators know that when they crafted the law?), but he said that next year workers will be responsible for somehow upgrading their own policies, or (you guessed it) be fined.

Don't get me wrong. Massachusetts is to be congratulated for seeking to extend health care to everyone in the state. Every decent society should ensure health care, just as it does education, clean water, and police and fire protection. Massachusetts' plan is an ambitious and well-intentioned effort. But unfortunately, it's extremely unlikely to work for three main reasons.

First, the individual mandate is harsh, regressive, and probably unenforceable. It requires the near-poor to pay a much higher percentage of their income on health care than their more affluent neighbors. Although insurers are prohibited from charging more for people with medical conditions, older people have to pay more. The premiums for a 57-year-old are twice as much as for a 27-year-old. According to the Connector's Web site in March of this year, the least expensive plan for a 57-year-old had a premium of \$4,700 per year, a \$2,000 deductible, and substantial co-pays and co-insurance up to \$4,000 per year. (That cap did not include prescription drugs.) So a hypo-

thetical 57-year-old with a \$32,000 annual income (just over three times the poverty level) could pay as much as \$8,700 out of pocket — or over a quarter of his income. Family plans are, of course, different, but the effect is the same. Next year, those who haven't purchased insurance will be fined half the premium of the lowest-priced plan. Truly this is the Squeeze Blood from a Turnip Plan.

It also lets employers off the hook. They're supposed to pay a \$295 per employee fine if they don't provide health benefits, but they're now considered to have met their obligation if they offer benefits to just 25 percent of their employees or contribute 33 percent of the premiums — no matter whether employees accept the offer and no matter how skimpy the coverage. And a \$295 fine is no incentive to provide insurance that costs upward of \$5,000. So the growing problem of under-insurance will be left to workers themselves to solve.

Second, like all such plans, the Massachusetts strategy pretends that having insurance is the same as having health care. The Connector makes much of the fact that some 300,000 people who were previously uninsured now have insurance, but most of those already had access to health care, either through the free-care pool or Medicaid. So it's something of a shell game, with money that would have been spent directly on health care passed through insurance companies instead (which keep quite a lot of it).

The Connector offers a choice of insurance plans from four different companies for those eligible for state subsidies (called Commonwealth Care), and from six companies for those who have to purchase their own (Commonwealth Choice). There is a trade-off between premiums, on the one hand, and deductibles and other out-of-pocket costs, on the other. The plans with the lowest premiums have the highest deductibles and other costs. But those who select the cheapest plans are likely to be precisely those least able to afford high out-of-pocket costs. So they could end up with health insurance that they can't afford to use but have to pay for anyway. The speaker of the Massachusetts House of Representatives, Salvatore DiMasi, one of the prime movers behind the plan, wasn't worried. He told *The Boston Globe* last year, "We're moving to



universal insurance and then toward insurance that has substantial benefits. That's the key." Can he really believe that after people have signed up for stripped-down coverage, and costs have continued to climb, there will be the money and political will to add to the benefit package?

Third and most important, there is no effective mechanism for containing costs. Insurance companies can set premiums as high as they like. If they're much higher than the competition, of course, the Connector can choose not to offer those plans. But if all the companies raise their premiums at about the same rate, there's not much the agency can do. And sure enough, premiums have continued to rise faster than the background inflation rate (10 percent for Commonwealth Care next year). The only way to hold them in check is to cut benefits or increase deductibles and co-payments. (The Connector actually favors increasing co-payments to prevent Commonwealth Care from becoming so attractive that employers will drop coverage and send workers to the state plan.) Insurance will quickly become too expensive, as well as increasingly inadequate. The state, which now faces a \$1.2 billion budget shortfall and health costs of \$147 million more than projected, will not be able to contribute much more from general revenues. Funding depends utterly on the Medicaid waiver being renewed in July, by no means a sure thing.

### THE VERDICT: SINGLE-PAYER

Massachusetts is not the first state to come up with a plan to provide near-universal health insurance to its residents, although it is the first to rely on an individual mandate. Maine tried it in 2003, Minnesota and Tennessee in 1992, to name a few. And Massachusetts made an earlier attempt in 1988. All were greeted with great enthusiasm and fanfare in the media. And all failed and died with scarcely a whimper. More recently, California, inspired by Massachusetts, tried to pass similar legislation. Despite Gov. Schwarzenegger's support, it died in the state Senate in January. It didn't have resources anywhere near

comparable to those in Massachusetts, mainly the Medicaid funds and free-care pool, and had to rely more on employer contributions. What all the state efforts have had in common is that they left our current dysfunctional system essentially intact and simply tried to expand it around the edges.

The only workable solution is a single-payer system (there, I said it), in which everyone is provided with whatever care he or she needs regardless of age and medical condition. There would no longer be a private insurance industry, which adds little of value yet skims a substantial fraction of the health-care dollar right off the top. Employers, too, would no longer be involved in health care. Care would be provided in nonprofit facilities. The most progressive way to fund such a system would be through an earmarked income tax, which would be more than offset by eliminating premiums and out-of-pocket expenses.

This is not the same as Medicare for all. Medicare is embedded in our market-based entrepreneurial private system, and therefore experiences many of the same inflationary forces, including having to deal with profit-maximizing hospitals and physicians' groups. Doctors' fees are skewed to reward highly paid specialists for doing as many expensive tests and procedures as possible. As a result, Medicare inflation is almost as high as inflation in the private sector and similarly unsustainable.

In addition, Medicare is not what it once was. For the past eight years, it has been at the mercy of an administration intent on dismantling and privatizing it. The prescription-drug benefit enacted in 2003 is an example. It's a bonanza for the pharmaceutical industry because it forbids Medicare from using its purchasing power to get good prices. Medicare recipients have also been encouraged to enroll in private health plans, which are paid on average 12 percent more than it would cost traditional Medicare to care for the same people. Even as public funds are siphoned off to the private sector, premiums and co-payments have been

increased, and there are now proposals for means testing — a superficially attractive idea but ultimately a grave threat to any public program.

Over the years there have been many independent analyses of the costs of converting to a single-payer system, either within a state or nationally. They include studies by the General Accounting Office, the Congressional Budget Office, and consulting firms, such as the Lewin group, hired by state governments and, in Massachusetts, the state medical society. Most found that a single-payer system would initially cost roughly the same as the system it replaced, while providing universal coverage, and over time would be much cheaper.

Polls have shown that most people, and most Massachusetts doctors, favor a single-payer system. *The Boston Globe* called for a national single-payer system last May. In an editorial about the big three automakers' desire to transfer health costs to the autoworkers' union, the *Globe* said, "It would make more sense for the federal government to oversee a national health system financed from taxes. The cost could be spread across the entire population, rather than borne by Chrysler or other companies that no longer enjoy the assured profitability of their best years."

Nevertheless, the private insurance industry has managed to convince many political leaders, including progressives, that a single-payer system is unrealistic. But what is truly unrealistic is anything else. My greatest concern about the Massachusetts plan is that when it unravels, people will draw the wrong lesson. They will assume that universal care at a cost we can afford is impossible, and give up on it. It's not impossible; it's just unlikely to be achievable while leaving our dysfunctional system in place. Can we make it right? I'm tempted to say, "Yes, we can."

★ ★ ★ ★ ★ ★ ★ ★ ★ ★  
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*Report from the United States*

## STATE HEALTH REFORM FLATLINES

Steffie Woolhandler, Benjamin Day,  
and David U. Himmelstein

Massachusetts' recent health reform has generated laudatory headlines and a flurry of interest in state-based initiatives to achieve universal health insurance coverage. In 1988, a similar Massachusetts effort was also acclaimed and was imitated by several other states. Unfortunately, none of those efforts can be judged a success. The authors briefly review this earlier experience and caution against premature declaration of victory.

After seeming moribund for a decade, the drive for universal health care coverage shows signs of life. President Bush has proposed federal tax code changes to encourage the purchase of individual private health coverage and discourage very comprehensive, so-called gold-plated, plans. But most legislative activity has taken place at the state level.

Massachusetts' effort has attracted the most attention. Legislation passed in April 2006 promises near-universal coverage through an "individual mandate" requiring the uninsured to purchase their own coverage, with subsidies for poor and near-poor individuals. After the bill's passage, then-governor Mitt Romney declared: "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced" (1).

Six weeks later Vermont enacted a plan offering subsidized coverage to poor and near-poor individuals, commencing in October 2007. If more than 4 percent of Vermonters remain uninsured in 2010, the legislature promises to consider making coverage mandatory.

California's Governor Schwarzenegger, and officials in several other states, have proposed similar mandatory coverage programs. And President Bush lent his imprimatur to experimentation at the state level, proposing to allow states to

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shift funds from safety net hospitals to innovative state programs to subsidize private coverage.

Between the late 1980s and the collapse of President Clinton's plan in 1994, several states passed measures intended to dramatically expand coverage. In this commentary we review the impact of this earlier round of reform on the number of uninsured, using time trend data from the U.S. Census Bureau's Current Population Surveys. The Census Bureau changed its survey methods in 1999 and produced estimates for that year using both the old and new methods, which differed by 5.5 percent nationwide (2). Hence, to ensure comparability with the post-1999 Census Bureau figures, we adjusted the earlier state estimates by the percentage difference between the Census Bureau's two 1999 estimates.

#### ALTERED STATES

The last round of reform kicked off in 1988. Like the present one, it started with Massachusetts legislation shepherded by a governor planning a presidential run. On passage of the legislation, then-governor Michael Dukakis announced: "I am very proud of the fact that Massachusetts will be the first state in the country to enact universal health insurance for all its citizens" (3). The *New York Times* editorialized that "Massachusetts last week ventured where no state has gone before: it guaranteed health insurance for every resident" (4). In 1988, 494,000 people were uninsured in Massachusetts. The number of uninsured has remained higher than that ever since (Figure 1A).

A year later Oregon made headlines with "the most far-reaching health care reform plan in the nation" (5), combining universal coverage with explicit rationing of expensive care. When the plan gained the federal waiver needed for full implementation, the governor said: "Today our dreams of providing effective and affordable health care to all Oregonians has come true" (6). The number of uninsured Oregonians did not budge (Figure 1B).

The year 1992 was the high watermark for state health reform; bills passed in Minnesota, Tennessee, and Vermont. According to the *New York Times*, "Minnesota is enacting a program that will be the most sweeping effort yet to provide health insurance to people who lack it. . . . Joy Wilson of the National Conference of State Legislatures described the Minnesota plan as 'the first complete reform proposal in the United States'" (7). The plan called for universal coverage by July 1, 1997. Between 1992 and 1997 the number of uninsured in the state increased by 88,000 (Figure 1C).

Tennessee's governor unveiled "the most radical health care plan in America" (8) and declared that "Tennessee will cover at least 95% of its citizens with health insurance by the end of 1994" (9). The number of uninsured dipped for two years, then rose to levels higher than ever (Figure 1D).

Also in 1992, "Governor Howard Dean, the only Governor who is a doctor, signed a law here today that sets in motion a plan to give Vermont universal

healthcare by 1995.” “This is an incredibly exciting moment that should make all Vermonters proud,” Dean said (10). The number of uninsured in the state has grown modestly since then (Figure 1E).

The next year Washington State passed “one of the most aggressive health care experiments in the nation, a program that would extend medical benefits to all 5.1 million residents of the state” (11). The bill called for universal coverage by 1999. Between 1993 and 1999 the number of uninsured in the state rose from 661,000 to 898,000 (Figure 1F).

By 1995, the *New York Times* was lamenting that “ambitious state plans to extend health insurance to more people took on importance as possible models for the nation. But nearly a year later most of those plans are dead or stalled as the states turn their attention to cutting budget deficits. Meanwhile the number of uninsured people is growing fast” (12).

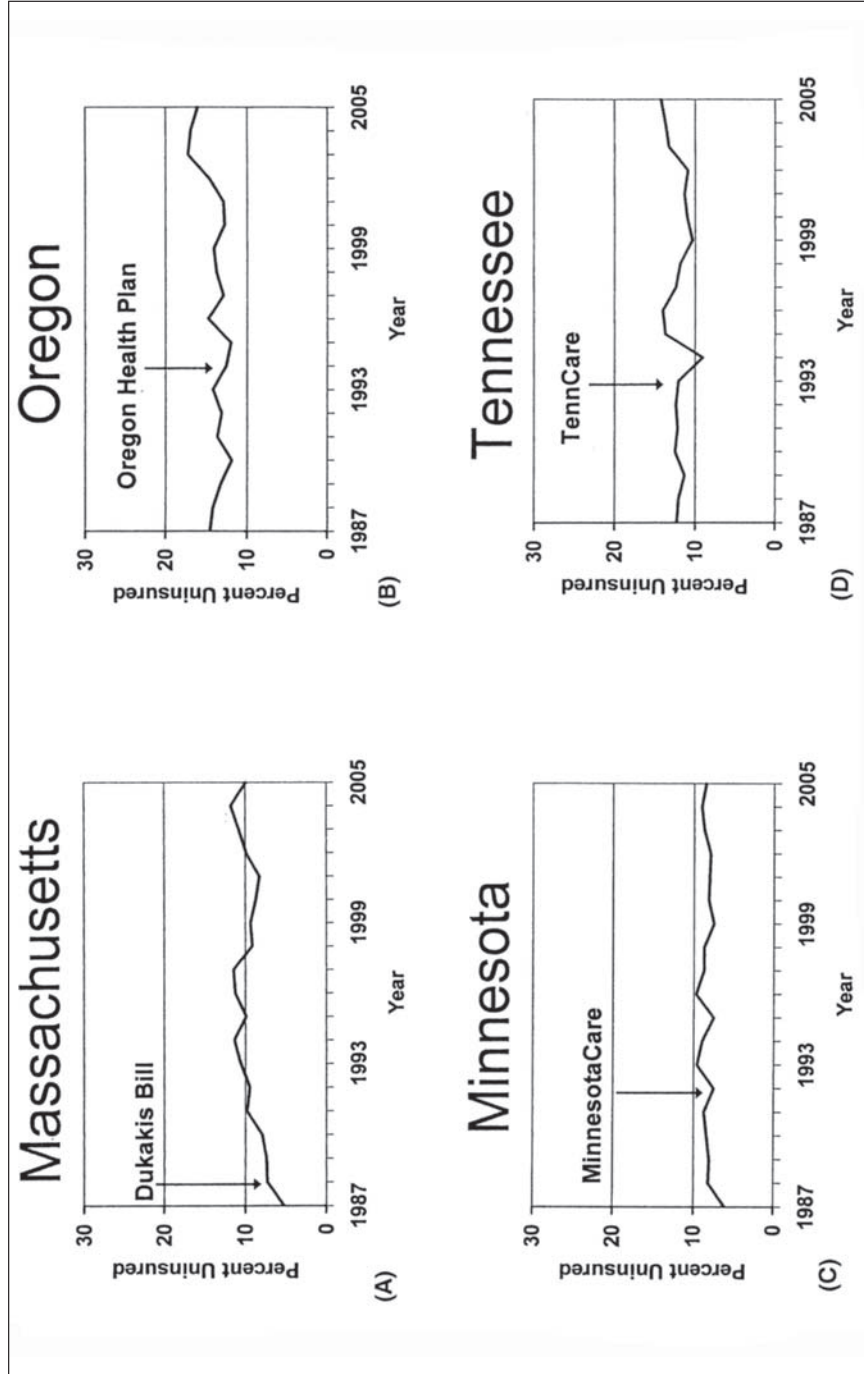
Heralding the new round of health reform, Maine passed its Dirigo Health Program in 2003. A *Boston Globe* columnist opined that “Maine has just become the first state in the union to approve a plan to provide universal access to affordable health insurance” (13). On signing the legislation, Governor Baldacci said: “It’s bold and comprehensive, and it is now the law of our state” (14). In 2006 the Associated Press reported that Dirigo “is now providing coverage to about 5,000 people who previously weren’t insured” (15)—about 4 percent of Maine’s uninsured (Figure 1G).

#### DOING THE SAME THING AND EXPECTING DIFFERENT RESULTS

The reforms enacted between 1988 and 2003 differed in detail but shared common elements. All offered new public subsidies or expanded Medicaid for poor and near-poor people. All left the bulk of existing private health insurance arrangements undisturbed, although many included new insurance regulations or state purchasing pools to help make affordable coverage available to individuals and small businesses. Dukakis’s Massachusetts legislation, as well as the reforms in Oregon and Washington State, included “employer mandates”—requirements that most employers cover their workers. The Massachusetts and Washington plans also mandated that self-employed individuals purchase coverage—prefiguring the individual mandates in the 2006 Massachusetts bill.

Why did these plans fail? While they made rhetorical swipes at cost containment, none included effective cost-control measures. As health costs soared, legislatures backed off from forcing employers and the self-employed to pay ever-rising premiums, and the mandates requiring employers and the self-employed to purchase coverage were repealed.

While Medicaid expansions incorporated in the state bills swelled Medicaid rolls, the erosion of private coverage continued, offsetting any gains. (Indeed,



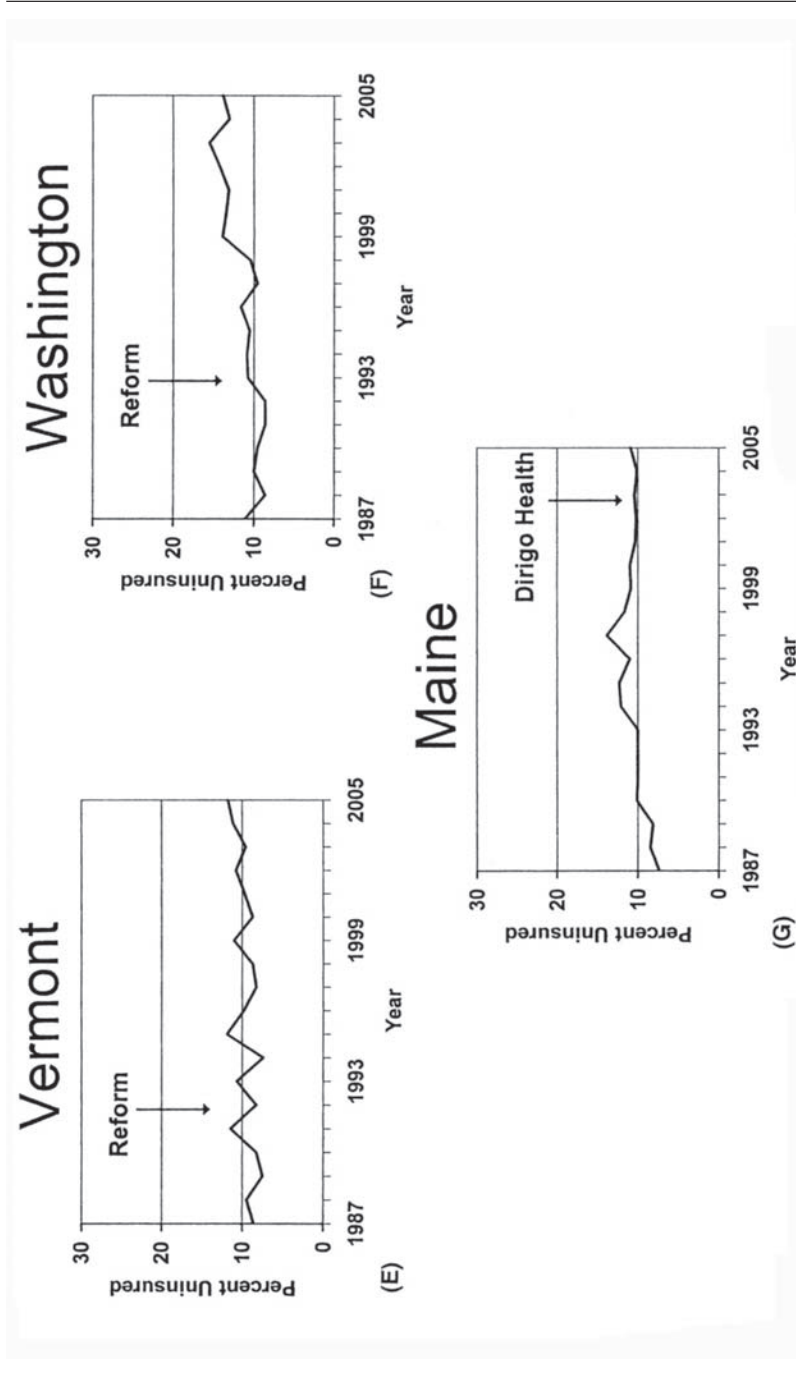


Figure 1. Percentage of uninsured in various U.S. states that have attempted state-level health care reforms, 1987–2005.

despite SCHIP—the State Children’s Health Insurance Program—which has added about 5 million children to Medicaid nationally since 1997, the number of uninsured children has fallen by only 2 million, while the number of uninsured adults has risen by nearly 7 million.) Moreover, relying on Medicaid has proved fiscally problematic for the states; when the economy cools, tax revenues fall just as unemployment pushes families out of private coverage.

Like earlier reforms, the recent Massachusetts reform, and those proposed in California, include expansions of Medicaid and requirements that most employers make at least token contributions toward health coverage. While some earlier bills required self-employed individuals to buy coverage, the new ones will impose this mandate on all uninsured people with incomes above poverty. As in several previous reforms, Massachusetts has organized a purchasing pool to help make coverage available to the previously uninsured, lower overhead costs in the individual insurance market, and spread the costs of high-risk individuals over a large risk pool. The new reforms rely on a new funding stream—the premiums (or fines) that the uninsured will be required to pay. But once again, effective cost controls are absent.

In Massachusetts, any savings from reducing the overhead on individual policies are being eaten up by the 4 to 5 percent surcharge that the new purchasing pool will add to premiums in order to fund its own operations (16). The legislature shifted responsibility for additional cost-control measures to a new council charged with setting goals, identifying quality improvement and efficiency measures, and setting up an Internet site to compare providers. Meanwhile, premiums for the new coverage will cost at least \$1 billion annually—probably much more. Funds diverted from the state’s existing free-care pool will cover only a fraction of this amount. And employer-provided coverage will predictably shrink as costs continue to rise, leaving the new program with an ever-larger responsibility for coverage.

Meanwhile, few of the near-poor uninsured seem able to afford even the newly subsidized policies (17), and the federal funds providing the bulk of the subsidies are set to expire in 2008. The unsubsidized coverage mandated for middle-income individuals (most of whom have incomes between \$30,000 and \$50,000) offers a bitter choice between unaffordable premiums (at least \$7,200 for comprehensive coverage for a single 56-year-old) or plans so skimpy (e.g., a \$2,000 per person deductible with 20% coinsurance for hospital care after that) that they hardly qualify as insurance. The religious coalition that was key to passage of the legislation has already called for a delay in enforcement of the individual mandate, fearing that it will place unbearable financial stress on many of the uninsured (18). In sum, neither government, nor employers, nor the uninsured themselves have pockets deep enough to sustain coverage expansion in the face of rising costs.

We remain convinced that more-radical reforms can simultaneously expand coverage and control costs (19). A shift from our complex and fragmented payment system to a simple single-payer approach could save about 14.3 percent

of total health spending—equivalent to \$323 billion in 2007—on reimbursement-driven bureaucracy (20). Such administrative savings are unattainable with lesser reforms. A nonprofit national health insurance system could also curtail wasteful over-investment in medical technology (e.g., the proliferation of new cardiac care hospitals located near existing ones) and attenuate incentives for unnecessary and even harmful care.

Powerful momentum for health reform is building. Previous reform efforts that built on existing but defective insurance arrangements have quickly succumbed to their faulty economic logic. Added coverage meant added expense, on top of already exorbitant costs. It would be shameful to squander the present opportunity on yet another round of reforms that are politically realistic but economically chimerical.

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# Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?

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## ABSTRACT

**BACKGROUND:** Massachusetts' recent health reform has decreased the number of uninsured, but no study has examined medical bankruptcy rates before and after the reform was implemented.

**METHODS:** In 2009, we surveyed 199 Massachusetts bankruptcy filers regarding medical antecedents of their financial collapse using the same questions as in a 2007 survey of 2314 debtors nationwide, including 44 in Massachusetts. We designated bankruptcies as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

**RESULTS:** In 2009, illness and medical bills contributed to 52.9% of Massachusetts bankruptcies, versus 59.3% of the bankruptcies in the state in 2007 ( $P = .44$ ) and 62.1% nationally in 2007 ( $P < .02$ ). Between 2007 and 2009, total bankruptcy filings in Massachusetts increased 51%, an increase that was somewhat less than the national norm. (The Massachusetts increase was lower than in 54 of the 93 other bankruptcy districts.) Overall, the total number of medical bankruptcies in Massachusetts increased by more than one third during that period. In 2009, 89% of debtors and all their dependents had health insurance at the time of filing, whereas one quarter of bankrupt families had experienced a recent lapse in coverage.

**CONCLUSION:** Massachusetts' health reform has not decreased the number of medical bankruptcies, although the medical bankruptcy rate in the state was lower than the national rate both before and after the reform.

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**KEYWORDS:** Health care financing; Health care reform; Health economics; Medical bankruptcy

**Table 2** Medical Causes of Bankruptcy in Massachusetts, 2007 and 2009

	Percent of All Bankruptcies, 2007 (N = 44)	No. of Debtors and Dependents in Affected Families, 2007*	Percent of All Bankruptcies, 2009 (N = 199)	No. of Debtors and Dependents in Affected Families, 2009*
Debtor cited medical illness/bills as a specific cause of bankruptcy or had large unpaid medical bills†	38.6%	12,700	45.6%§	26,709
Debtor or spouse lost ≤ \$ 2 wk of income because of illness or complete disability	34.1%	11,219	32.1%§	18,802
Debtor or spouse lost ≤ \$ 2 wk of income to care for ill family member	6.8%	2237	8.2%§	4803
Mortgaged home to pay medical bills‡	8.1%	2665	5.3%§	3104
Any of above	59.3%	19,510	52.9%§	30,985
Any personal bankruptcy	100%	32,268	100%	58,573

\*Extrapolation based on number of personal bankruptcy filings during that fiscal year (from reference 6) and household size of medical/non-medical debtors.

†Unpaid medical bills > \$5000 or > 10% of family income.

‡Percentage based on homeowners rather than all debtors.

§Difference between percentages in 2007 and 2009 nonsignificant,  $P > .40$  for all comparisons.