

Health

Covering the Uncovered

While Washington drags its collective feet on health reform, the states are moving ahead

By Michelle Andrews

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For Joe Rothfarb, 24, getting coverage for healthcare has been a real pain in the neck. Years of playing the drums in a rock band have damaged the nerves that run up his left arm into his shoulder and neck, causing numbness and tingling and a sharp pain in his hand. The high-deductible policy he bought after college didn't kick in to help with his search for a diagnosis. His next plan did cover the doctor visits and tests-but when he tried to renew it last year, the carrier canceled. "I think I had too many claims," he says. Today, after months of going naked, Rothfarb is set: For just \$40 a month plus copayments of \$5 or \$10, he's got a soup-to-nuts plan that should cover everything from CT scans to specialists to prescription drugs and physical therapy.



On the forefront of health reform

Rothfarb, who moved last September from California to Cambridge, Mass., is benefiting from his new state's effort to do right by its residents: health insurance for all. With the number of uninsured in the country now at 45 million and heading higher, and no real progress toward reform being made at the federal level, Massachusetts and a growing number of other states are finding ways to step into the breach. More than a dozen have proposed or enacted expanded coverage for children; Illinois, for example, provides comprehensive health and dental benefits for all kids up to age 18, regardless of income. New Jersey now allows parents to keep their kids on their health plans until age 30, as long as they have no dependents of their own. And at least a dozen states, including California, Pennsylvania, Maine, and Vermont, are working toward covering all or nearly all of their citizens.

Coverage for all. Massachusetts's plan, which launched a big enrollment push last week, is bolder and broader than anything on the books so far: It mandates that just about everybody have health insurance and subsidizes the costs for low-income residents. Policymakers and consumer advocates are watching closely. Such pacesetting efforts are "critical to what happens to the momentum for national health reform," says Drew Altman, president and CEO of the Kaiser Family Foundation, a nonpartisan research and education organization in Menlo Park, Calif. "They send a message that the paralysis we've seen in Washington is not necessarily inevitable."

Rothfarb, who's working part time for a health club and a crisis line while he applies to grad school, signed up for his plan through a new state agency that links individuals and small businesses with private plans whose benefits and rates are OK'd by the state. Since his income is less than 300 percent of the federal poverty level (\$30,630 for a single person or \$61,950 for a family of four), he qualifies for a partial subsidy from the state. By July 1, nearly all Massachusetts residents will be required to have health insurance or face a yearly financial penalty. This year, it's equal to their personal income tax exemption, or \$219. Next year, it will be 50 percent of the price of the cheapest insurance policy available to them. Businesses that don't offer insurance face a penalty of up to \$295 per worker.

Vermont and Maine are also making insurance available to everyone, but people without coverage can choose to participate or not. Will an "individual mandate" like Massachusetts's work? No one knows, but policymakers agree that without one, it will be difficult to achieve universal coverage. "That's the tectonic plate that's moved in the last year and a half," says Len Nichols, director of the health policy program at the New America Foundation, a Washington think tank. So-called young invincibles often go without, figuring the cost is too great and they won't get sick anyway. Many others forgo insurance because their employer doesn't offer it, or they can't afford it. But Massachusetts's program recognizes that people who have regular health insurance are less likely to use pricy emergency room services for primary care or put off regular checkups and preventive care that helps stave off illness. California, Pennsylvania, Oregon, and Maine are all considering proposals with some version of a requirement.

Playing the odds. In Massachusetts, Ben Healey will be a test of the mandate. The 25-year-old self-employed communications and research consultant from Brookline expects to make about \$55,000 this year, so he won't qualify for subsidized coverage. He'll consider managed-care plans from any of six insurance carriers, including Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, and Harvard Pilgrim Health Care. Deductibles for the various levels of coverage range from zero to \$2,000, while copayments for doctor visits run from zero to \$35. For a typical 25-year-old in the most expensive eastern part of the state, the monthly premiums for basic plans that include prescription drug coverage range from \$148 to \$255; at age 37, the numbers are \$175 to \$288. Healey would like to have the security of health insurance. On the other hand, if he decides the price is too high for what he gets, all bets are off. "I guess I'd keep hoping I won't get sick," he says. "The penalties aren't persuasive."

One reason many people don't have insurance, of course, is that their bout with cancer or a heart condition has made them a bad risk. So, while it mandates coverage, Massachusetts also guarantees that no one can be denied it. (Maine, Vermont, New York, and New Jersey have similar guaranteed issue provisions, as would the California and Pennsylvania plans, if enacted.) In Massachusetts and some other states, people like Rothfarb with existing conditions can't be charged higher rates, either.

Even when rates are equalized, a sizable chunk of the population won't be able to afford them.

Many state programs would provide substantial subsidies to lower-income people; Massachusetts, for example, is finalizing a plan to totally subsidize premiums for anyone whose income is 150 percent or less of the federal poverty level. It would also create an opt-out provision for a narrow group who may be too well off to qualify for subsidized coverage but are struggling too much to buy even the cheapest plan available. "We are cautiously celebratory," says Rabbi Jonah Pesner of the Greater Boston Interfaith Organization, a coalition of 50 religious institutions that has lobbied hard for affordable coverage. "For most people it's mostly affordable, with a decent exemption process so that people won't be punished if it's not."

Last year, when the Massachusetts law was signed, Peter Brook told reporters he was skeptical that the plan would work for everyone. The 46-year-old carpenter, who was diagnosed with diabetes at age 14 and needs insulin shots up to five times a day, had been uninsured for six years and used the emergency room when he needed to see a doctor. Under his new plan, his diabetes needles and test strips are all covered, and he's got a team of health professionals—an endocrinologist, a dietitian, a nurse practitioner—with whom he meets regularly. There's no deductible, no premium, and doctor visits are free. Now, Brook is skeptical for a different reason: "They're signing people up like gangbusters," he says. "How are we going to pay for all this?"

Indeed, long-term financing is a potential stumbling block in every state, given that healthcare costs continue to rise faster than income. "We anticipate there will be a wall that we hit," says John McDonough, executive director of Health Care for All, a Boston-based advocacy group. "We don't know how high it will be, but we do expect financial pressures and the need to identify revenue to sustain this long term." In Massachusetts, the plan relies primarily on federal Medicaid matching funds and on bringing costs down by moving people into managed, coordinated care. Since May began and new help lines went live, the service has been handling about 2,500 customer service calls a day. The push is on.

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