

Issue Brief:
**Japan and Massachusetts — A Comparison
of Universal Health Care Systems**

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Introduction

The number of uninsured in the United States continues to increase. The United States Census Bureau estimates that nearly 46 million Americans lacked coverage of any kind for all of 2004 (DeNayas-Walt, 2005, 16). Research also shows that millions more Americans went without health coverage for part of the year (Cohen, 2005, 2), and that 16 million Americans are currently underinsured (Schoen, 2005, W5-293). The consequences of uninsurance have been well documented. Compared to those with insurance, the uninsured:

- receive less screening and preventive care,
- lack needed medical care,
- receive less care for serious illnesses and chronic conditions,
- enter the health care system in poorer health, and
- have worse health outcomes (Hadley, 2006, 1-14).

The United States comprises just 4 percent of the world's population, yet has health expenditures that include about half of all the money spent on medical care in the world (Morone, 2005, 21). Despite this level of spending on health care, the United States remains the only industrialized nation in the world that does not have universal health care for all its citizens.

In April 2006, the Massachusetts legislature passed a bill, signed into law by Governor Mitt Romney, which establishes a universal health care system in the state by July 1, 2007. The new Massachusetts system expands private and public health insurance options, and implements individual and employer

mandates. This new plan for universal coverage operates within much of the existing health care structure, but also creates several new elements that are distinctive from any other state in the nation.

The Japanese health care system is predominantly a private one, and yet it is strictly regulated by the national government. The country's health care structure has many features in common with other health care systems both in North America and Europe, yet also contains aspects unique to Japan. The Japanese system achieves universal coverage through the use of a mandate on all residents, as well as a mandate on all employers (with five or more employees). Public health insurance options exist for groups such as the elderly, the self-employed, and the unemployed.

This study will introduce the general structure of both the Massachusetts and Japanese health care systems, and outline how each achieves universal access for its residents. The subsequent section will compare and contrast not only the health care systems, but the demographic and cultural differences that affect the implementation of the health care structure within these entities. Finally, this paper will conclude with an outlook on how universal coverage in Massachusetts might affect the health outcomes of the residents of that state.

Massachusetts's Universal Health Care Plan

Critical Factors — Massachusetts currently has approximately 550,000 residents who are uninsured, i.e., about 10 percent of the state’s population (Kaiser Commission on Medicaid and the Uninsured, 2006, 1). An important first step in examining the Massachusetts universal health care plan involves a discussion of the critical factors that contributed to and encouraged the reform. The first involves the reauthorization of Massachusetts’s 1115 Medicaid waiver. If Massachusetts did not pass a reform plan to redeploy funds to reduce the number of uninsured in the state, then the state stood to lose approximately \$770 million over the next two years. This potential loss of funds resulted from a requirement in Massachusetts’s 1115 waiver that the state reorganize funds currently used to support safety net hospitals to instead pay for insurance coverage for the uninsured (Helman, 2006).

A second factor was the existence of an initiative slated for the November 2006 ballot that would have required a substantial payroll-tax based contribution from employers. The ballot question was sponsored by a grassroots organizing effort that was spearheaded by the Mass ACT (Affordable Coverage Today) Coalition, which included groups such as Health Care For All, Greater Boston Interfaith Organization, and Neighbor to Neighbor Coalition for Social Justice. The consumer group, Health Care For All, has provided a strong voice in state health decision-making for the past 20 years. The group offered strategic guidance, health policy expertise, and credibility that assisted in the formation and longevity of the ACT Coalition. The legislature, as well as business groups, did not want to

see the payroll-tax initiative on the fall ballot. The Mass ACT Coalition announced that it would be willing to drop the initiative if a health bill passed that met their approval. (Massachusetts Health Reform, 2006, 3).

A third factor that contributed to the passage of the Massachusetts bill was the *Roadmap to Coverage* initiative sponsored by the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation. Through this initiative, the BCBSMA Foundation contracted with The Urban Institute to develop policy options that would assist Massachusetts in achieving universal coverage. The policy options that were introduced as part of this initiative became the building blocks for the universal care legislation. These options included a Medicaid expansion, subsidized insurance, purchasing pools, an employer mandate, and an individual mandate (Massachusetts Health Reform, 2006, 3).

An additional factor that played a role was a strong base of employer-sponsored insurance, i.e. 98 percent of employers with 100 or more employees and 65 percent of smaller employers contribute to health insurance for their employees. Furthermore, a large amount of existing funds, approximately \$600 million in the Uncompensated Care Pool, were already being spent on the uninsured in the state. Finally, political leadership and bipartisan efforts helped create an opportunity to move this legislation forward and compromise in order to reduce the number of uninsured in the state (Conference Committee Redraft, 2006, 1).

MassHealth — The Massachusetts plan has several different components that work together to create a universal health care system for the state. First, this legislation affects several different areas of MassHealth, the Massachusetts Medicaid program. The new law will increase the eligibility level of children from 200 percent of the federal poverty level (FPL) to 300 percent of FPL. Additionally, the law provides \$3 million for comprehensive community-based outreach programs to maximize the enrollment of eligible Massachusetts residents who are not currently enrolled in the MassHealth program. Furthermore, the plan raises enrollment caps on existing programs such as MassHealth Essential, CommonHealth, and MassHealth HIV (“Building Toward Full Coverage,” 2006, 1).

The reform measures also restore all MassHealth benefits that were cut during the 2002 legislative session, including dental and vision services. In addition, the new law creates a 2-year smoking cessation pilot program for enrollees in MassHealth. Finally, the new law includes \$90 million in rate relief for Medicaid providers for fiscal years 2007, 2008, and 2009. However, these rate increases will be tied to specific performance goals related to quality, efficiency, the reduction of racial and ethnic disparities, and improved outcomes for patients. It is estimated that these changes in the MassHealth program will provide Medicaid coverage to an additional 92,500 state residents (Conference Committee Redraft, 2006, 3).

The Connector — A second piece of the Massachusetts legislation establishes the Commonwealth Health Insurance Connector (the Connector), which will “connect” small businesses and individuals to affordable, quality insurance products. Operated as an authority under the Massachusetts Department of Administration and Finance, the Connector will be overseen by a separate, appointed Board of private and public representatives. Additionally, explicitly designed, lower-cost insurance products will be offered through the Connector targeted at 19 to 26 year-olds. Legislative estimates expect 215,000 residents to gain private insurance through this option. Insurance purchased through the Connector would also transfer easily from one job to another or could be supported by more than one part-time employer (Kaiser Commission on Medicaid and the Uninsured, 2006, 1).

Commonwealth Care Health Insurance Program — Another major component of the Massachusetts universal health care plan involves government-funded subsidies to low-income individuals to support the purchase of health insurance. This component is called the Commonwealth Care Health Insurance Program, and it allows low-income families to purchase health insurance with no annual deductible. Families or individuals with incomes below 100 percent of FPL would be able to receive comprehensive private insurance with no monthly premiums and extremely low co-payments. Individuals with incomes between 100 percent and 300 percent of FPL will receive sliding-scale subsidies towards the purchase of insurance.

This program will be operated through the Connector and the subsidized insurance products must be certified as being of high value and good quality. Estimates show that approximately 207,500 individuals will gain health insurance coverage through the subsidy program (Conference Committee Redraft, 2006, 2). Furthermore, the bill amends Massachusetts's Insurance Partnership Program, which provides subsidies both to employers with fewer than 50 workers and to their employees. Currently, the program provides subsidies to employers and employees when the employee's income is below 200 percent of FPL. Under the reformed guidelines, this income threshold would be raised to 300 percent of FPL (Widmer, 2006).

Market Reform — An additional piece of the Massachusetts universal health care legislation involves insurance market reform. One of these reforms involves the merging of the small-group and individual health insurance markets. This will allow for an estimated drop in non-group premiums of approximately 24 percent. Another insurance reform will allow young adults to remain on their parents' insurance plans until they turn 25 years-old, or for two years past the loss of their "dependent" status (whichever occurs first). Furthermore, HMOs will be allowed to offer coverage plans that are linked to Health Savings Accounts (HSA), which will reduce the cost of insurance through HMOs ("Building Toward Full Coverage," 2006, 1)

Employer Mandates — One of the more controversial parts of the new Massachusetts law involves the creation of an employer mandate. The first part of this mandate, termed the “Fair Share Contribution” goes into effect in October 2006 and requires employers with 11 or more employees to contribute to health coverage or pay a per-worker assessment of \$295 to the state’s free care pool. This assessment is based on actual free care costs and is designed to decline as more individuals gain health coverage (Widmer, 2006). Analysis indicates that this assessment may raise as much as \$48 million dollars (Belluck, 2006).

Another portion of the employer mandate involves employers (with 11 or more employees) setting up a Section 125 plan or “cafeteria plan” by January 2007. These plans allow an employer to offer health insurance and other programs (e.g., funds for day care services) to an employee on a pre-tax basis. However, the employer is not required to contribute to the plan, but the plan must meet the Internal Revenue Code guidelines for Section 125 plans. Workers that are not offered insurance through their employer will be able to use pre-tax dollars, through the cafeteria plan, to purchase insurance products through the Connector (Kaiser Commission on Medicaid and the Uninsured, 2006, 1).

The final feature of this mandate has been termed the “Free Rider Surcharge,” and will be effective as of October 2007. This surcharge will be imposed when employers do not offer health insurance and when their employees use free care. Obligation to pay the surcharge will be prompted when an employee receives

free care more than three times, or when a company has five or more instances of employees receiving free care in a year. The employer will face a surcharge between 10 and 100 percent of the state's cost of services provided to the employees in regard to the free care received. The first \$50,000 in free care costs will be exempted from the surcharge for each employer (Conference Committee Redraft, 2006, 4).

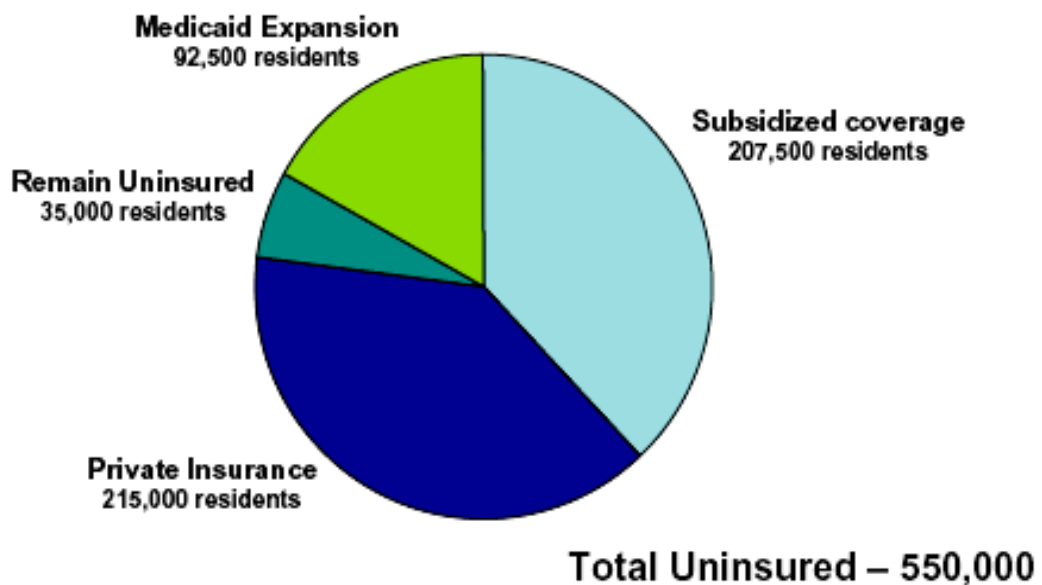
Individual Mandate — The Massachusetts universal health care law requires all state residents to acquire health insurance by July 1, 2007. Individuals and families will be required to provide details regarding their health insurance policy on their 2008 state income tax returns. If at that time, an individual has not obtained insurance the first consequence will be the loss of their personal exemption on their state taxes, worth around \$150. After that, residents could face penalties equal to half the cost of the cheapest policy they should have bought, which may equal around \$1,200. The individual mandate does state that residents must purchase “affordable” insurance coverage. A sliding “affordability scale” has yet to be determined, and will be set by the Board of the Connector. Legislators estimate affordability to range from \$200 to \$300 per month. If “affordable” health insurance is not available, residents may attain a waiver of the mandate (Fahrenheit, 2006).

Universal Care — By combining these components, the Massachusetts plan has created a near-universal health care system. Legislative estimates indicate that

by state fiscal year 2009 this health care plan will cover an additional 515,000 individuals. This would leave less than 1 percent of the state's residents uninsured. Figure 1 indicates the breakdown of how these programs work together to cover Massachusetts's uninsured population.

Figure 1.

How Uninsured Are Covered Under the Massachusetts Health Care Reform Plan



Source: Massachusetts Senate

Funding — The cost for the Massachusetts health care plan has been set at \$1.2 billion over three years. A large portion of these expenditures will be redistributed from existing funding including funds from Massachusetts' current Free Care Pool and the federal Medicaid dollars that the state risked losing if it

did not pass a reform package. New funding has been slated to come from the employer contribution and General Fund revenues (Kaiser Commission on Medicaid and the Uninsured, 2006, 2). The state has said that it does not anticipate the need for additional funding beyond the first three years; however, a legislative staff analysis estimates that the plan may start losing money in two to three years (Kowalczyk, 2006). Given the continuing rise in health care costs, an essential question is whether the plan has been financed sufficiently or whether new funds will be needed in future years.

Governor's Veto— On Wednesday April 12, 2006 Republican Governor Mitt Romney signed the Massachusetts universal health care bill into law. However, Governor Romney exercised his line-item veto to overturn eight parts of the health care bill. One of these was the Fair Share Contribution that charged employers with more than 10 employees \$295 per employee if they did not contribute to health insurance for their workers. Another portion of the bill that the Governor vetoed was the reinstatement of dental benefits to adult MassHealth recipients at a yearly cost of \$75 million. The heavily controlled Democratic Senate and House have vowed to override Governor Romney's vetoes (Mehren, 2006). On Tuesday April 25, the Massachusetts House of Representatives overrode all 8 of Governor Romney's vetoes; as of May 3, 2006 the Massachusetts Senate has still not acted to override the Governor's vetoes.

Japan's Universal Health Care System

Overview — Japan was the first country in Asia to provide its citizens with a comprehensive social insurance program. The country's health care system achieves universal coverage through the use of a mandate on all residents, as well as a mandate on all employers (with five or more employees) to contribute to their employees health plan. Therefore, the system is mostly financed through employer-employee contributions (based on income), as well as government subsidies for certain eligible groups. Additionally, the government mandates that all health plans operating in the country offer a comprehensive set of standardized benefits, and sets the fees for all covered services through a national, uniform fee schedule that directs all payments to all payers (Graig, 1999, 91).

Universal Health Insurance — Much like Canada, Japan does not permit any citizen to purchase private insurance coverage for benefits that are included under the country's mandated health insurance system. All Japanese citizens must join a health insurance plan either through their employer, local government, or trade association. There are three major groups that comprise more than 5,000 independent insurance plans:

- Employees' Health Insurance (EHI),
- National Health Insurance (NHI), and
- Health Services for the Elderly.

The method of funding for each of these groups varies, but all have co-payments between 10 and 30 percent (Blank, 2004, 67).

The EHI and NHI programs provide coverage for almost all citizens under age 70. Of those under age 70, about 65 percent are covered under the EHI system. This system covers workers in businesses with at least 5 employees through health plans that are managed by large corporations (known as societies), the government, or mutual aid associations. Under the EHI system there are three sub-groups of employees and their dependents. First, large corporations with more than 700 employees establish Society-Managed Health Insurance (SMHI). Second, Mutual Aid Associations (MAAs) provide health insurance for government and private school employees, seamen, and day laborers. Both the SMHI and MAAs are independent plans that are jointly managed by representatives of the employer and employees. Premiums in the SMHI and MAA plans range from 6 to 9.5 percent of an employees monthly income (up to a ceiling), and at least half of this premium is covered by the employer (Graig, 1999, 97).

The final group under EHI consists of small- and medium-sized businesses (i.e., employers that have between five and 700 employees) that access insurance through a single national pool, Government-Managed Health Insurance (GMHI). The GMHI is operated by the Ministry of Health and Welfare (MHW). Premiums are approximately 8.6 percent of the employee's income (also up to a ceiling)

and employers are responsible for half of this amount. The government uses tax revenues to subsidize approximately 14 percent of benefits under the GMHI. The SMHI and MAA plans do not receive any government subsidy because the enrollees in these groups tend to be higher income (Ikegami, 1999, 58). Co-payments for all EHI recipients are currently 20 percent for inpatient and outpatient services; dependents under EHI have co-payments of 20 percent for inpatient care and 30 percent for outpatient services (“Healthcare System,” 2005).

The rest of the under 70 population (the other 35 percent) includes the self-employed, unemployed, pensioners, and dependents who receive coverage through the NHI, also known as the Citizens’ Health Insurance (CHI). The NHI program is administered by municipal governments and NHI associations. It is funded through premiums that take the form of a local NHI tax, as well as subsidies from the national government. The premium is based on income, assets, and the number of people in a given household. It is collected directly by the local government, and while the amount varies, the maximum is around \$430 per household per month. Additionally, both individuals insured under the NHI and their dependents pay 30 percent of inpatient and outpatient costs with a maximum of roughly \$475 per month. The Japanese government subsidizes approximately 50 percent of the benefits under NHI (Blank, 2004, 68).

Finally, those citizens 70 and older (age 65 if bedridden) are covered by the Health Services System for the Elderly (HSSE), which is a system, administered by local governments and funded through the use of a pooling mechanism to which all other health insurance plans must contribute. The national government also funds part of the HSSE system. Until recently, the elderly paid a fixed fee for health services, but co-payments of 10 percent were implemented in 2001. Japan is facing one of the most rapidly aging populations in the world. In 2000, 17.2 percent of Japan's population was age 65 or older. By the year 2020, 26.9 percent of the population will be over age 65. Furthermore, until the 1980's Japan predominantly used hospitals as long-term care facilities. In 1986 the HSSE began covering care in intermediate nursing facilities with the aim of reducing the build-up of long-term patients in general hospitals. Nevertheless, the number of individuals needing long-term care is expected to double between 1997 and 2025 (Jeong, 2001, 16).

For this reason, Long-term Care Insurance (LTCI) was introduced in April 2000 with the goal of improved insurance for home care and new coverage for nursing home facilities. The elderly are required to contribute to the cost of the LTCI in the form of a deduction from their pension, which varies according to income level. Recipients also must pay a 10 percent co-payment and pay for their own meals (caps are set for low-income individuals). The rest of the expenditures for LTCI are collected from insurers and from the central and local governments in the form of taxes. Caring for the growing elderly population exists as one of the

greatest and most difficult strains on the Japanese health system (Jeong, 2001, 17). Together the EHI, NHI, and HSSE compose the three components of Japan's universal health care system.

Health Care Delivery — Japan's health care system is primarily private, with 81 percent of all hospitals and 94 percent of all physician offices (called clinics) under private ownership. One of the more unique aspects of this country's health care delivery system is that in many cases the only way to tell the difference between hospitals and clinics is by using the legal definition that states that clinics have less than 20 beds and hospitals have more than 20 beds. Japan has 16 hospital beds per 1,000 population, which is more than any other industrialized nation (Graig, 1999, 107).

Japanese physicians can be divided into private practitioners who are paid on a fee-for-service basis and make up 33 percent of doctors; and hospital-based physicians that are salaried and comprise 67 percent of physicians. Both Japanese hospitals and clinics treat outpatients, and individuals can choose where they want to receive treatment. Most clinics are solo practices that offer some specialty services but predominantly provide primary care. The hospitals provide much of the inpatient care in Japan, but rely on outpatient care for a large portion of their revenues. The reliance on outpatient services by hospitals results from private physicians and hospitals operating under the same fee schedule. Hospitals must use the fees they receive to pay both physicians'

salaries as well as capital and administrative costs. This leaves hospitals in a financial disadvantage in comparison to Japanese clinics. Additionally, routine outpatient care has a more generous fee under the national fee schedule than the fees for high-tech inpatient services. This is partially due to government cost-control measures and partially due to the dominance of the Japanese Medical Association (JMA) on the advisory board that sets the national fee schedule (discussed further in the following section). Finally, physicians and hospitals both dispense pharmaceuticals directly and profit by buying from wholesalers at a discount and then selling at the price set by the fee-schedule. This has resulted in the highest per capita consumption of pharmaceuticals in the world (Ikegami, 1999, 59-60).

Nationwide Fee Schedule — Payments for all health services are set according to the Medical Fee Schedule, which is revised every two years. Most health care services are reimbursed on a fee-for-service basis. However, due to rising health care costs, some services, mainly for chronic diseases of the elderly, have been “price bundled” into a set fee. In actuality two Medical Fee Schedules exist, one for the elderly and the other for the non-elderly population. The Medical Fee Schedules are established by an advisory body consisting of providers, payers, management, and labor. Due to the dominance of the JMA, hospital physicians have been excluded from this advisory board and therefore fees are set low for surgery and intensive care for both cost-control reasons and because of this exclusion of hospital personnel (Fukawa, 2004, 51-52).

In a given year, the overall health care budget is established through a two-step process. First a global budget is determined in consultation between the Ministry of Finance and the MHW. This creates a cap on the increase in overall health expenditures from one budget to the next. The Ministry of Finance must be involved in the process because the amount of government subsidies to the health plans exists as a fixed share of the plans' overall expenditures. After the size of the overall budget has been determined, the MHW determines how the budget is divided based on the recommendations of the advisory council. This division of the global health budget sets the fee schedule for the two year period. Over time the Medical Fee Schedule has become increasingly complex (Graig, 1999, 111).

Health Care Reform Package — For the first time in Japan's history, national health expenditures decreased in fiscal year 2002. This occurred not because of radical restructuring of the country's health care system, but because of reductions in prices in the Medical Fee Schedule for medical services and pharmaceuticals. Prices for the services that were cut dropped by an average 2.7 percent, which led to a decrease in overall health spending of 0.7 percent. Other reforms have been introduced, and some have been implemented in certain medical settings. One of these reforms involves new reimbursement methods such as the use of Diagnosis and Procedure Combinations (DPCs), which differ from diagnosis-related groups (DRGs) used in the United States in

that the fees for DPCs are per diem (although they do decline the longer the patient stay). This reform has been implemented in a limited way in 80 hospitals and two national health centers (Ikegami, 2004, 26, 29-30).

Another reform proposal called for an independent insurance plan for those individuals aged 75 and older, as well as cross-subsidization among the various plans to cover those aged 65 to 74 years-old. A third reform involves the concept of balanced billing, in which patients are charged the difference between what the insurance pays and what the health service actually cost. This reform has not currently been implemented and is opposed by both the MHW and JMA. The final set of reforms being considered involve changes to Japan's health system to address complaints related to long wait times, lack of health information given to patients, and the system feeling unresponsive and arrogant. These issues arise from a populace that has started to speak up for a more responsive and patient-oriented delivery system (Ikegami, 2004, 30-34).

Health Outcomes — Japan boasts some of the best health outcomes in the world for particular measures. The country currently has the highest life expectancy in the world at 78.4 years for men and 85.3 years for women (UN Statistics Division, "General Mortality," 2003, Table 22). Additionally, they have one of the lowest infant mortality rates in the world at 3.0 per 1,000 live births (UN Statistics Division, "Infant and Maternal Mortality," 2003, Table 15). However, it is difficult to always directly tie these positive health outcomes to the

country's health care system because a plethora of other factors (e.g., diet, nutrition, health prevention, income, education levels, etc.) strongly influence health outcomes for a nation. Furthermore, the Japanese have less ethnic, income, and educational disparities compared to a nation like the United States and therefore have fewer health disparities to be addressed. The Japanese health care system is not perfect, but it provides a model of universal coverage that includes features that should be carefully examined to determine their usefulness in improving the health care systems of countries such as the United States.

Comparing Health Systems

The Japanese and Massachusetts universal health care systems share many common features. Both utilize individual and employer mandates that compel persons and businesses to participate in the particular insurance schemes. Additionally, the Japanese and Massachusetts systems employ government subsidies to reduce the cost of health insurance for low-income individuals and their dependents. Both health systems operate within structures that are dominated by private practitioners and private health organizations such as hospitals and clinics. Furthermore, Japan and Massachusetts have many insurance plans administered by private companies or employer groups. However, in addition to privately operated insurance, the two systems both have health insurance programs operated by the public sector; whether national, state, or local government. Finally, the health care systems of Japan and

Massachusetts function under government regulation, to different degrees. The Massachusetts state government has regulated such things as health insurance market reforms and mandated benefits that must be covered by private insurance companies. Japan, on the other hand, has a much greater level of government regulation of its health care system.

While the Japanese and Massachusetts universal health care models have many comparable features, they also have striking differences that affect both health expenditures and health outcomes. The biggest difference between the two is Japan's Medical Fee Schedule. All sectors of the health care industry in Japan are regulated by this centralized fee schedule. This feature has been highly effective in controlling the total health expenditures of the country. It provides a financial incentive for the provision of selected services (i.e., primary care) in that the fee for these services is set higher than the actual costs. On the other hand, the fee schedule discourages the use of other health services by setting the fee much lower than the actual cost. The Medical Fee Schedule has been used as a powerful tool in the Japanese health care system to control costs and influence the distribution of health care resources (Blank, 2004, 104).

Another key difference between the two systems is that the government in Japan establishes the set of comprehensive benefits that are offered under the country's universal health care system. No Japanese citizen may purchase private insurance to cover any of the benefits that are covered under the national

plan. In contrast, the Massachusetts plan does not set a fixed benefits package for which all state residents are eligible. The level of benefits will differ according to the individual's insurance plan, as will the deductible, premium, and co-payment. This difference sets up tiered levels of insurance products that may reflect an individual's income or employment status.

Differences also exist between the two systems in a patient's ability to choose a health care provider. In Japan, an individual may choose any clinic or hospital that they want. Many Japanese citizens make these choices based on real or perceived differences in the quality of care provided at a given institution. In Massachusetts, however, most health insurance plans limit access to providers through the use of financial incentives and preferred providers. Additionally, providers have the choice of whether or not to accept different insurance plans, be they private or public (e.g., Medicaid). This limitation in choice of providers also creates differences in the quality of a given insurance plan.

From a social and demographic standpoint, Japan and Massachusetts have very different backgrounds. First, 99 percent of Japan's citizens are ethnically Japanese, which greatly reduces health disparities based on race. Additionally, Japan has a more equal income distribution that reduces the level of poverty (an indicator of poor health). Furthermore, Japan has much lower levels of crime, divorce, teenage births, drug use, automobile accidents, and incidence of HIV compared to the United States. The country also boasts better nutrition and

living habits that contribute to a healthier population (Ikegami, 1999, 61). Massachusetts on the other hand is 81 percent white, 6 percent African-American, 8 percent Hispanic, and 5 percent “Other” (Kaiser Statehealthfacts.org, “...by Race/Ethnicity...,” 2005). In addition, 30 percent of the state’s residents are low-income (i.e., income below 200 percent of FPL) (Kaiser Statehealthfacts.org, “...Federal Poverty Level...,” 2005). These ethnic and income differences create health disparities that a responsible health care system must be aware of and work to address. Massachusetts has higher levels of social phenomenon (i.e., crime, drug use, etc.) that negatively affect the health of its residents compared to Japan. These factors make it more difficult for Massachusetts to create a health care system that is equitable and addresses the wide range of health and non-health issues that exist in the state.

Potential Impact of Massachusetts’ Universal Health Plan

The main component of the Massachusetts plan relates to the concept of “affordable” health insurance coverage for all residents. Expanding the MassHealth program and providing subsidies to low-income individuals and families will greatly decrease the number of uninsured. Health insurance rates should decrease as more uninsured residents have coverage and receive primary health care in a doctor’s office as opposed to waiting until their health gets bad enough to use emergency room care (“Owning Up to the ‘M’ Word in Massachusetts,” 2006). However, the question remains of whether covering the uninsured will lower rates to the point of “affordability” for all residents of

Massachusetts. If rates do not drop significantly, the state's plan for universal coverage could be in jeopardy of failing to provide coverage for the majority of its residents.

Another strong concern tied to the Massachusetts plan links directly with Japan's Medical Fee Schedule. The Japanese government has used the fee schedule as an incredibly effective tool in controlling health care expenditures in their country. Massachusetts, however, has no cost control measure that holds the same weight or power as Japan's fee schedule. If health care costs continue to rise at the same rate that they have in recent years, then the Massachusetts plan may quickly become unsustainable. In fact, a legislative staff analysis estimated that the state's universal plan would start losing money in two to three years.

Lawmakers would then feel pressure to spend more tax money, increase the fee on businesses, or possibly even reduce the health coverage of this sweeping new law (Kowalczyk, 2006).

On a more positive note, reducing the number of uninsured in Massachusetts has the potential to produce better health outcomes for the state's residents, as well as greatly increasing access to timely and appropriate health care services. Increasing health insurance coverage for all Massachusetts's residents has the potential to reduce mortality rates for the uninsured by 10 to 15 percent. Furthermore, covering the uninsured leads to better health, which has the potential to improve annual earnings by about 10 to 30 percent and increase

educational attainment (Hadley, 2002, 93-97). Providing universal coverage for all persons in Massachusetts would result in lower costs of health insurance, improved access to care, more screening and preventive care, and ultimately better health outcomes.

Conclusion

The Japanese and Massachusetts systems offer two different models of how to achieve universal health care coverage. Both systems combine private and public entities in the provision of insurance and health care services.

Additionally, the systems both utilize employer and individual mandates, as well as government subsidies for lower-income persons. On the other hand, differences in the structure of these systems can offer lessons for policymakers, businesses, health advocates, insurance companies, health providers, and the general public. Variations in these systems can be used as learning opportunities that can ultimately be used to improve the efficiency and effectiveness of both the Japanese and Massachusetts universal health care systems.

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