The Patchwork Promise: How Two U.S. States and DC Are Approaching Universal Healthcare

By Jack Moorman and Deborah Siegle

I. The American Question: Right or Privilege?

In nearly every developed nation, the question of whether healthcare is a right has been answered with a confident "yes." Universal health coverage, while varying in form, has become a pillar of civic life — a baseline guarantee alongside education, infrastructure, and security. But in the United States, the debate rages on, its fault lines running through legislation, courtrooms, political campaigns, and dinner table conversations.

The Affordable Care Act (ACA), passed in 2010, was a milestone in closing gaps — 9 million people gained coverage by 2014. Yet, progress remains fragile. In 2025, the Congressional Budget Office warned that a proposed Senate bill could remove over 10 million people from Medicaid rolls. The deeper tension remains unresolved: Is healthcare a public right, or a private privilege?

In the U.S., the only legally mandated access point for the uninsured remains the emergency room — an ironic safety net for a nation that spends more per capita on healthcare than any other. A broken arm might mean a hospital bill of thousands. A life-saving drug, like insulin or epinephrine, might only be available through an ER visit and physician-prescribed script — if one can afford either.

Yet, amid national inconsistency, a few states and districts have built remarkable alternatives. Massachusetts, Washington, D.C., and Colorado have emerged as case studies in near-universal coverage, each with its own blueprint. This article tells their stories — not as utopias, but as grounded models of what is possible.

Note: "Universal Healthcare Coverage is typically defined as 95% or greater of the defined population having some form of health insurance. The defined population varies from State to State with some including non-citizens. In Massachusetts, for example, all residents include naturalized citizens, non-citizen legal residents, and undocumented immigrants.

II. Massachusetts: The Lab That Became the Standard

In 2023, just 2.6% of Massachusetts residents lacked health insurance — the lowest rate in the United States. This achievement was not accidental. The Commonwealth's multi-

decade experiment with healthcare reform made it the policy lab for the nation, launching frameworks later echoed in the ACA and continuing to push the boundary of what a state-level system can achieve.

Chapter 58 and the Romney Legacy

Long before "Obamacare," there was "Romneycare." In 2006, then-Governor Mitt Romney signed Chapter 58 into law, requiring all residents to obtain insurance, offering subsidized plans via the Health Connector exchange, and expanding Medicaid. By 2011, Massachusetts' uninsured rate fell below 4%.

The law's success was built on carrots and sticks: mandates for individuals and employers, subsidies for the poor, and enforcement through the tax system. It was also a rare bipartisan milestone, born of compromise and shared responsibility.

MassHealth: Serving One in Four

Massachusetts' Medicaid and CHIP program, MassHealth, now covers over 2 million residents — nearly one in four. Its scope includes low-income families, seniors, people with disabilities, and recently, postpartum mothers for up to 12 months post-birth.

The state uses Accountable Care Organizations (ACOs) to improve coordination, especially for behavioral health and chronic conditions. A 2024 Section 1115 federal waiver gave the state even more flexibility to tackle social determinants like housing, food access, and mental health.

The Health Connector & ConnectorCare

The Massachusetts Health Connector, established in 2006, predates the ACA's federal exchange. It offers subsidized and unsubsidized plans, and in 2023, nearly 300,000 people were enrolled. The ConnectorCare program, a state-supplemented subsidy, ensures that residents earning up to 300% of the federal poverty level pay low or no deductibles. Over 150,000 residents are covered under this tier.

Mandates & Accountability

The state maintains an **individual mandate** — repealed federally in 2019 — and requires employers with over 10 workers to either provide insurance or pay into the system.

This three-part design — individual, employer, and government — ensures shared investment. In contrast to national debates that swing with electoral tides, Massachusetts has maintained this architecture for nearly two decades.

Community Health and Equity

Massachusetts' 52 federally qualified health centers serve over 1 million people each year. Institutions like Boston Medical Center and Cambridge Health Alliance act as safety nets. The state also leads in equity-focused policy: the Health Equity Compact and the Birth Equity Initiative have targeted maternal mortality among women of color, and behavioral health reform is integrating mental care into primary systems through community behavioral health centers.

Cost vs. Coverage

In 2021, the state spent about **$13,300 per person** — among the highest in the nation. But this supports a system rich in specialty services, research hospitals, and intensive care.

Since 2012, the Health Care Cost Growth Benchmark, set by the Health Policy Commission, has capped spending growth at a target rate (3.1% in 2023). While not perfect, it has been cited as a model for aligning costs with outcomes.

III. Washington, D.C.: Coverage for All in the Capital City

If Massachusetts was the birthplace of state-level universal healthcare, then Washington, D.C. is its urban cousin — compact, diverse, and disproportionately affected by poverty, chronic illness, and political fragility. And yet, in 2023, the District managed to cover 97.3% of its residents.

D.C. has no counties, sprawling suburbs, or rural plains. Instead, it has Wards — small, politically potent zones defined by stark inequalities. Wards 2 and 3 are among the wealthiest enclaves in the country; Wards 7 and 8 suffer from the highest maternal mortality rates, unemployment levels, and food insecurity east of the Mississippi. This healthcare dichotomy defines the District's challenge — and its achievement.

DC Healthy Families & Medicaid Expansion

Washington, D.C. was one of the earliest adopters of the ACA's Medicaid expansion. Its local version, **DC Healthy Families**, is more generous than many state equivalents, providing free comprehensive coverage — including dental, vision, prescriptions, and transportation — to residents earning up to 210% of the federal poverty level.

By 2023, over 285,000 people were covered through Medicaid in the District, including 95,000 children and 28,000 seniors. The program is not just expansive — it's actively promoted through aggressive outreach, especially in underinsured neighborhoods.

DC Health Link: A Marketplace That Works

Launched in 2013, **DC Health Link** has become a quiet success story of the ACA. While federal enrollment faltered in some regions, the District maintained its own exchange, updating its technology, subsidies, and navigators year after year.

By 2018, D.C. had reduced its uninsured rate from 3.8% to 3.2%. In 2025, the marketplace rolled out new features in "Essential Plan" — zero-cost primary care, free labs and imaging, and generic medication for chronic illnesses like heart disease — further reducing barriers to entry.

Healthcare Alliance: Serving the Undocumented

Perhaps D.C.'s most radical departure from federal norms is its **Healthcare Alliance**, a program for low-income adults excluded from Medicaid due to immigration status. Originally launched in 2008, the Alliance now serves over 27,000 residents, including many undocumented individuals.

The program is under pressure. In 2025, proposed cuts from both the federal government ($715 million) and the D.C. budget ($457 million over four years) threatened the Alliance's sustainability. Even so, city leaders have committed to backfilling these gaps, recognizing the program's outsized role in maintaining near-universal coverage.

Safety Nets, Expanded

One in five D.C. residents receives care at a **Federally Qualified Health Center** (FQHC) — institutions like **Bread for the City**, **Whitman-Walker**, and **Mary's Center**. These clinics do more than deliver primary care. They offer food pantries, legal aid, and housing referrals, addressing the social determinants that undermine long-term health.

In 2025, the city opened **Cedar Hill Regional Medical Center** in underserved Southeast D.C. — the first new hospital in decades. With a $434 million price tag, it brings trauma, maternity, and oncology services to a region previously served by aging or shuttered facilities.

Pandemic Lessons and Continuous Enrollment – DC Stood Out by Doubling Down

The COVID-19 pandemic reshaped Medicaid nationwide, offering "continuous enrollment" protections that paused disenrollments and allowed for sustained coverage. When these

provisions ended in March 2023, many states saw massive coverage losses. D.C., however, doubled down on outreach and navigator programs, preserving its near-universal status.

The Price of Access

With its extraordinary coverage comes an extraordinary cost: D.C. has **the highest healthcare spending per capita** in the nation. In 2020, the figure was **$16,803 per person** — over $3,000 more than the national average.

High provider salaries, concentrated specialty care, and expensive infrastructure like FQHCs and academic hospitals all contribute. But for city officials, the tradeoff is justified — a test case for how far government can go to ensure health access within an urban microcosm.

The Storm Ahead

Despite these gains, the future is uncertain. Work requirements for Medicaid, biennial re-enrollment for the Alliance, and rising healthcare costs loom. But if Washington has proven anything, it's that a densely populated, economically diverse city can provide healthcare for nearly all — with enough political will and local funding.

IV. Colorado: High Elevation, Low Uninsured

If Massachusetts offers policy polish and D.C. urban scale, **Colorado** presents a third model: a rugged, decentralized, bipartisan strategy rooted in Medicaid expansion, community clinics, and practical inclusivity. In 2023, Colorado's uninsured rate was just **4.6%**, well below the national average.

Health First Colorado & CHP+: Dual Safety Nets

The state's Medicaid program, **Health First Colorado**, has grown to serve about **1.7 million residents** — nearly one in four Coloradans. It offers comprehensive coverage for low-income adults, children, and people with disabilities.

Complementing it is **Child Health Plan Plus (CHP+),** which provides low-cost insurance to children and pregnant women just above the Medicaid income threshold. Together, these programs form the foundation of Colorado's coverage success.

Connect for Health Colorado: Marketplace on a Mountain

Colorado was an early adopter of the ACA, launching **Connect for Health Colorado** in 2013. Its user-friendly interface and seamless linkages with Medicaid and subsidy systems have allowed residents to enroll or transition between programs without gaps.

In 2023, the marketplace expanded subsidies and extended enrollment periods, ensuring broader participation. Even those who shift jobs, incomes, or eligibility can find continuity — a cornerstone of universal care.

Extending Coverage to the Undocumented

In a bold step, Colorado began offering Medicaid coverage in 2023 to **undocumented seniors over 65**, provided they meet income criteria. While the numbers remain small, the symbolism is significant — rejecting exclusionary federal models in favor of local compassion.

Community health centers also act as frontlines for undocumented care. They offer no- or low-cost services regardless of immigration status, fear of deportation, or ability to pay.

FQHCs and the Rural Safety Net

Colorado's more than **20 Federally Qualified Health Centers** — including **Pueblo Community Health Center** and **Peak Vista** — are essential lifelines, especially in rural and underserved areas. These clinics manage everything from dental care to mental health, offering a sliding-scale fee structure and serving as de facto urgent care for the uninsured.

Cost and Efficiency

Despite broad coverage, Colorado manages relatively **low per capita spending**: in 2020, around **$10,028 per person**, compared to $13,000–$17,000 in higher-cost states. This frugality stems from negotiated provider rates, fewer specialty centers, and lower labor costs.

Still, disparities persist. Rural areas remain underserved. Communities of color experience higher burdens of chronic illness and premature mortality. In response, state officials are investing in culturally competent care and mobile health units.

The Rocky Road Ahead

Colorado's journey isn't complete. Health costs continue to rise. Federal funding remains uncertain. Yet the state's bipartisan, bottom-up model — emphasizing practicality over ideology — offers another viable blueprint for reaching near-universal healthcare in America.

V. Threads in the Tapestry: What These Models Reveal

The United States, often regarded as the land of innovation, still struggles to innovate a basic guarantee: healthcare for all. Yet, the stories of Massachusetts, Washington, D.C.,

and Colorado demonstrate that **universal or near-universal coverage is not just possible — it's already happening**, albeit in pockets.

These three places couldn't be more different:

- Massachusetts has elite hospitals, a high GDP per capita, and a longstanding social compact between government, employers, and citizens.
- Washington, D.C. is a politically insulated city-state with racial health inequities embedded in its geography.
- Colorado straddles rural, suburban, and urban realities, relying on decentralized pragmatism and community infrastructure.

Yet all three have converged on similar principles:

✔️ Medicare, VA, Public School Retirement systems, etc.

✔️ Encouraging or requiring employee healthcare plans

✔️ Medicaid expansion using Federal funds to the greatest extent possible

✔️ Robust insurance marketplaces with support and "friendly" interfaces

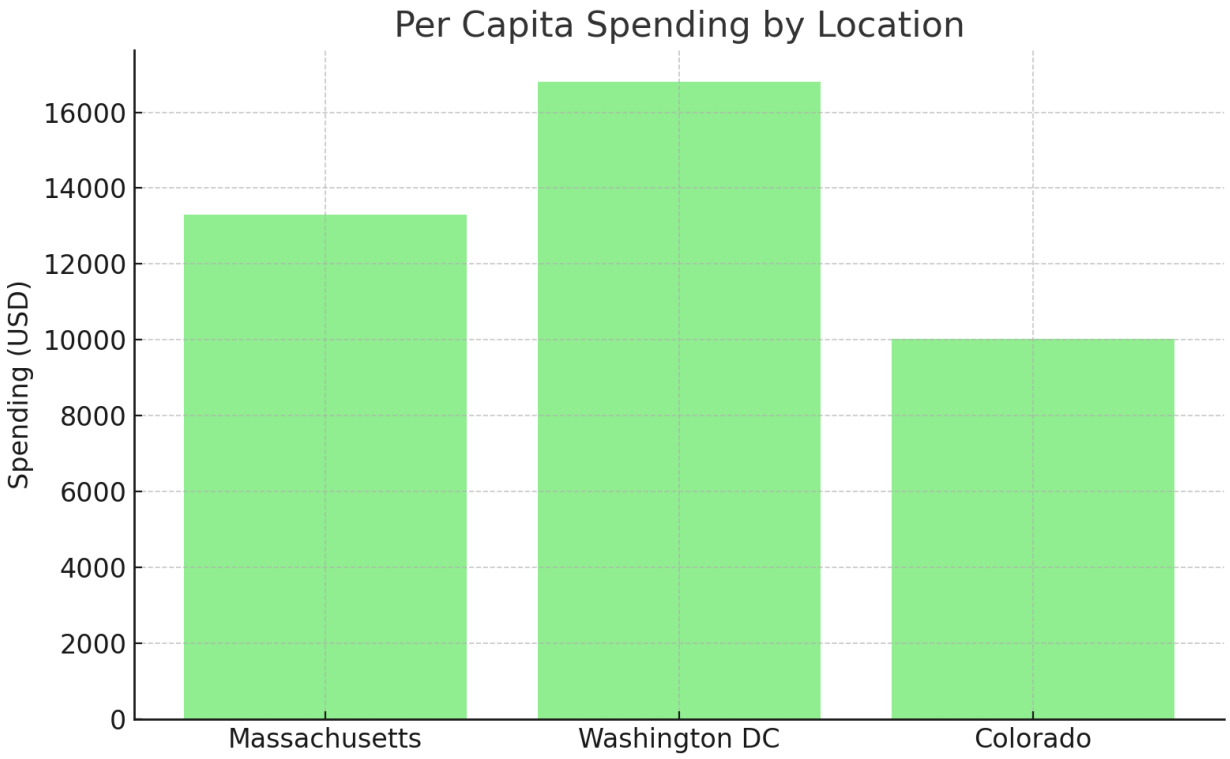
✔️ State-level innovation using Federal funding

✔️ Investments in Federally Qualified Health Centers to lower costs and improve access

✔️ Creative solutions for serving hard-to-reach residents

✔️ Negotiations with service providers and drug companies

They differ in methods — but not in intent. And that intent is critical in a national environment where universal coverage is not a federal guarantee, but a state-level decision.



Uninsured Rates			
Nation-wide	Massachusetts	Washington DC	Colorado
8.2%	2.6%	3.2%	4.6%

Texas	Wyoming
21%	28%

VI. Can the Rest of the Country Follow?

What's holding the rest of the country back? The answers are familiar: lack of bipartisan political support, unreliable Federal funding, and the projected increases in the cost of healthcare. But perhaps most important: voters who do not consider some level of universal healthcare a right for every citizen, regardless of their ability to pay for it.

The U.S. states and jurisdictions that have reached 90% or higher coverage show that high coverage levels don't require a single national plan to obtain that higher coverage.

State/Region	**Coverage Level**
Massachusetts	97.4%
Washington, D.C.	97.3%
Colorado	95.4%

It does require commitment by voters, action by the politicians, and financial support by the federal government.

But they also reveal vulnerabilities:

- In **Massachusetts**, costs remain dangerously high.
- In **Washington, D.C.**, programs like the Healthcare Alliance are threatened by budget cuts.
- In **Colorado**, geographic disparities test the limits of what can be done locally.

Universal coverage in the U.S. today remains a patchwork — elegant in places, threadbare in others.

The benefit of the dollars invested is significantly positive. And broader coverage will reduce the need for some healthcare costs by attending to health issues earlier. It is a plus for all the stakeholders.

We have the proof of principle that universal coverage can be achieved if each state uses the flexibility, innovation, and commitment demonstrated in these examples. Our hope is that the next decade will see these fabrics stitched into a cohesive quilt.

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