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Massachusetts Health Reform:
Near Universal Coverage, But
No Cost Controls or Guarantee of
Quality, Affordable Health Care for All

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Executive Summary

In April 2006, Massachusetts passed major health reform focused on expanding health insurance coverage to all state residents regardless of their income. In the process, Massachusetts established a model of shared responsibility among employers, individuals and government, and created a health insurance exchange “Connector” through which private insurers are required to offer coverage to people without access to other insurance, regardless of their age or health status. Today about 17 percent of Massachusetts residents are in the Connector,¹ through which they have a slate of private health plan options based on their income level, and the state now boasts the lowest uninsurance rate (2.6%) in the country, with 439,000 people newly insured.² Massachusetts helps ensure health plan coverage affordability with subsidies for people up to 300 percent of the Federal Poverty Level.

For these reasons alone, Massachusetts is an important building block for reform at the national level. But, Massachusetts has kept in place a system in which a handful of private insurers control most of the business and has not controlled costs in a meaningful way. Moreover, budgetary constraints in Massachusetts led to its inability to make health care coverage and costs affordable for many working families and individuals with incomes above the subsidy level. As a result, 167,000 people in the state are still uninsured. And, health insurance premiums and costs in the state have continued to increase well ahead of inflation, making it increasingly difficult for the Commonwealth to maintain subsidies for low-and-moderate income families.

As we look to enact national health reform, we can learn a lot from what Massachusetts has and has not been able to accomplish in its design and delivery of health insurance coverage. Of significant note, compared to other states, Massachusetts began with a lower uninsurance rate, a higher rate of employer provided coverage, stricter insurance regulations, and federal pressure to use federal dollars to provide insurance to more people, all of which shaped its model for reform. It appeased the provider stakeholders by raising its Medicaid provider rates and it achieved support of the private insurers by relying on them exclusively to deliver coverage through the Connector.

Many people mistakenly believe that health care reform proposals of President Barack Obama and Senate Finance Committee Chair Max Baucus mirror the Massachusetts model. While there are some similarities, there are also critical design differences. Both proposals include subsidies for low-and-moderate income families to purchase health coverage, some standardization of health care plans offered by private insurers and the establishment of a “connector” or “exchange” to facilitate the purchase of standardized health insurance.

But, unlike the Massachusetts plan that relies solely on private health insurance, the Obama and Baucus models provide individuals and businesses with a public health insurance plan option in addition to private health insurance. The need for a public health insurance option as, among other things, a countervailing force to insurer and provider oligopolies—which are driving up costs at an unsustainable rate—should not be underestimated. In “The Case for a Public Insurance Option in National Health Reform,” Jacob Hacker, Professor of Political Science at U.C. Berkeley and Co-Director of Center for Health, Economic & Family

Security, explains that “a public-private hybrid would build on the best elements of the present system: large group plans in the public and private sectors. At the same time, it would involve putting in place a new means of allowing Americans without access to secure workplace coverage to choose among insurance plans that provide strong guarantees of quality affordable coverage, including a guarantee of effective cost control—the central prerequisite of health security over the long run.”³

Also, in contrast to the Massachusetts plan, the Obama and Baucus plans require that employers either provide health coverage for employees or contribute a reasonable amount towards their employees’ coverage, with special provisions for small business. While the Massachusetts plan has a similar structure, the amount employers are required to pay is nominal (\$295 for each employee a year). As a result, the burden of paying for employees who do not have coverage at work falls on those employees and the Massachusetts and federal governments. Under the Obama and Baucus plans, a significant portion of that burden is carried by employers. The Obama and Baucus shared responsibility model therefore generates more revenue for subsidies to make health care more affordable to individuals.

Finally, the Obama and Baucus plans include numerous other measures aimed at controlling costs and focusing the health delivery system on value. The Massachusetts reforms were aimed at increasing coverage, not at controlling cost.

In sum, Massachusetts has done an impressive job of reducing the state’s uninsurance rate, but it would be very difficult for other states to achieve what Massachusetts has accomplished. That said, Massachusetts health reform has not achieved four critical objectives:

- **Overall Health Care Cost-Containment.** Massachusetts reform demonstrates the value of large risk pools for reducing costs. The combining of small group and individual pools in the State has resulted in as much as 45% lower health insurance premiums for individual policyholders. But Massachusetts reforms have not reined in spiraling overall health care costs; costs are still increasing more rapidly than in the rest of the nation. They demonstrate the limitations of a reform model that relies exclusively on private insurers, who then can set costs as they will. The lack of overall health-care-system cost controls mean savings for individuals are short-term. It also bodes poorly for the long-term sustainability of the Massachusetts reform plan. According to the June 2008 Web Exclusive *Health Affairs* report, “Massachusetts Health Reform Implementation,” in 2008 major Massachusetts insurers implemented average premium increases of 8–12 percent. The report concludes that, “Continuing increases undermine affordability, expand the number of people who are exempt from the [coverage] mandate, and undermine the law’s intent.”⁴
- **Guaranteed Access to Affordable Health Care.** Massachusetts has done a good job of ensuring that people with low incomes have affordable access to quality care. But, in 2008, the Access Project reported that more than one in ten adults ages 18 to 64 (11%) did not get needed care in the past year because of cost.⁵ This is borne out by a fall 2008 survey of Massachusetts residents on healthcare

conducted by the *Boston Globe* and the Blue Cross Blue Shield of Massachusetts Foundation that shows many people are still struggling to pay for healthcare despite more people having health insurance: 13 percent of insured residents said they couldn't pay for some health services in the past year; 13 percent of insured residents said they couldn't afford to fill a prescription in the past year because it cost too much or their copay was too high; and 33 percent of those surveyed ranked the cost of care their biggest health concern.⁶ In addition, of the 167,000 residents still uninsured in Massachusetts, nearly 100,000 chose to pay the low 2007 fine rather than purchase insurance they did not believe they could afford. (The fine increased to \$912 in 2008 and \$1,068 in 2009, forcing residents to choose between paying a substantial fine or paying for coverage they cannot afford.) In 2007, 69,000 got a waiver from having to buy insurance or paying a fine because the state agreed that their insurance options were not affordable for them.⁷ With the major reduction of the Massachusetts uncompensated care pool, a byproduct of reform, the uninsured remain vulnerable to the catastrophic costs of a sudden acute illness or accident.

- **Stability in Health Plan Membership and Continuity of Care.** While Massachusetts reform moves towards creating large risk pools through a state insurance Connector, it maintains a fragmented system that segregates people into three groups based on income, for whom different plans are available—Medicaid for the very poor, Commonwealth Care for people with low incomes who receive a subsidy, and Commonwealth Choice for people above 300 percent of federal poverty level (FPL). So, if the income of people in a subsidized plan goes up, they are forced to change plans. If their income then goes back down, to benefit from the subsidy, they have to change plans once again. Similarly, people who lose their jobs may lose their employer coverage. During the transition to new coverage, they may be forced to go uninsured.
- **Meaningful Competition Among Plans.** By relying exclusively on private insurers, Massachusetts has little leverage to drive competition in the insurance market and rein in costs. Private health plans, without competition from a public health insurance plan in the under-65 market, have allowed costs to rise much faster than inflation. In fact, in 2007, Massachusetts had the highest annual per capita health plan cost per employee in the country.⁸

In sharp contrast to Massachusetts, President Obama and Senator Baucus include a public health insurance plan option in their models for health care reform. It is an essential element for containing costs and guaranteeing access to quality, affordable health care. As the data show, a public health insurance plan choice in addition to private health plans—analogue to the public Medicare plan and private Medicare Advantage plans—drives competition, reins in costs and promotes accountability in the private insurance and provider markets. A public insurance option is also critical as a safety net—guaranteed backup coverage—for people who lose or otherwise lack private coverage.

Introduction

In April 2006, Massachusetts passed major health reform intended to provide all state residents access to health insurance regardless of their income. Massachusetts reform focused on expanding health insurance coverage, leaving cost containment for a later phase of reform. Almost three years later, it is clear that Massachusetts is helping its population, particularly people with low incomes who qualify for a subsidy and people with average health care needs who now have affordable coverage. We can learn from Massachusetts' achievements as well as from what it has failed to accomplish as we look to enact national health reform.

Massachusetts reform has successfully decreased, though not eliminated, uninsurance and underinsurance in the state. The reform did not, however, attempt to control mounting health care costs. Massachusetts reform also has continued to allow exclusive control of private insurance companies over the cost of health care coverage for people under 65; fragmented the population based on income; provided no guarantee of access to affordable health care to working families with incomes above 300% FPL; and failed to ensure that people losing coverage have guaranteed backup coverage.

Background

The history of the Massachusetts health care system and pressure from the federal government significantly shaped the design of the Massachusetts health reform law. As a result, Massachusetts was in a unique position as a state to focus on expanding coverage and not on overall cost-containment.

First, Massachusetts has a history of “shared responsibility” in health care that made it easier to bring employers to the table and put federal pressure on the state to provide more coverage. In 2006, Massachusetts ranked ninth among all states to offer employer-sponsored insurance (ESI), with 68 percent of working people under the age of 65 having access to health benefits from their employer.⁹ Massachusetts employers, therefore, were already taking more responsibility for the health care of their employees than in most other states. In addition, decades before the state had requested and received a Medicaid waiver that allowed it to use some of its Medicaid money to fund a “Free Care Pool” that paid providers for care given to people without insurance, mostly emergency care. The federal government pressured Massachusetts to redirect that money to subsidize health insurance coverage for people with low incomes instead of health care. But Massachusetts did not have far to go to ensure residents health insurance coverage; it already had the lowest rate of uninsurance in the country—less than 8 percent.¹⁰

Second, Massachusetts had already implemented some relatively strict regulations over the health insurance industry, which made covering the uninsured easier. Unlike in most other states insurers cannot refuse to cover people (guaranteed-issue) and can vary their premium for the same coverage only to a limited extent based on an individual's age or health status.

Third, advocates in Massachusetts pressured the state to expand coverage. They had a health care for all ballot initiative¹¹ ready for the November 2006 election, which business opposed because it imposed a strong employer mandate. The reform law that was passed instead contained a very small employer fine for not providing coverage. A bigger employer mandate is difficult for a state to pass because of federal laws governing employer insurance plans.

Lastly, the Massachusetts insurance market is dominated by community-focused non-profit insurance plans. These non-profits have focused their efforts on strengthening the health care safety net for vulnerable populations and improving the health and well-being of their communities. Non-profit plans have been found to provide better care¹² at lower administrative costs than for-profit insurance.

The health reform law enacted in 2006 expands the income-eligibility level for Medicaid, provides additional subsidized coverage for people with incomes below 300% of the federal poverty level (FPL) and establishes a health insurance exchange or Connector, somewhat reforming the private insurance market in the process. The law requires most adults with incomes above 300% FPL to buy health insurance from a private insurance company or face penalties—known as an “individual mandate.” Children are not subject to the mandate. The law also imposes a small penalty on employers with 11 or more employees who do not offer health benefits to their workers.

- **Expands Medicaid:** The law expanded children’s eligibility to 300% FPL and raised enrollment caps for a number of Medicaid programs. The law also increased payment rates to Medicaid providers.
- **Creates Commonwealth Care:** The law created a new program that provides subsidized health insurance coverage to low-income adults 19 years of age and older. Commonwealth Care offers a choice of four not-for-profit private health plans. People with incomes below 150% FPL pay no premiums, while those between 150% and 300% FPL pay on a sliding scale. People with incomes above 300% FPL are not eligible. There are no deductibles.
- **Requires that Most State Residents Have Health Insurance:** The law imposes an “individual mandate” that requires that all adults have insurance if affordable coverage is available or pay tax penalties.
- **Requires Employers Contribute Toward the Cost of Their Employees’ Health Coverage:** The law requires that employers with 11 or more workers who do not offer health benefits pay \$295 per worker each year.
- **Created Commonwealth Choice:** This program connects state residents without employer health benefits, and whose income is not low enough to qualify for Commonwealth Care, with the choice of several not-for-profit private insurers that have agreed to meet certain standards. People who buy a policy through Commonwealth Choice get no assistance with the cost of coverage. Commonwealth Choice, which

became available on July 1, 2007, has three levels of coverage—bronze, silver, and gold—and also offers plans for young adults ages 18 to 26 with lower premiums but a \$50,000 coverage cap. There are no mandated benefits, but plans must meet actuarial equivalence standards for each plan level. Small employers with fewer than 50 employees can offer Commonwealth Choice plans to their employees.

- Created the Health Care Quality and Cost Council:** The law created the Council to establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care; demonstrate progress toward achieving those goals; and disseminate, through a consumer-friendly website and other media, comparative quality and cost information.

Accomplishments

Reduction in Number of People Uninsured.

According to a report published by *Health Affairs* on June 3, 2008, “On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year,” (Fall 2006 to Fall 2007 in chart below)¹³ the number of uninsured dropped considerably between the fall of 2006 and the fall of 2007, particularly among those eligible for a subsidy. And, most people with average health care needs now have access to affordable health care. A December 2008 report by the Urban Institute, “Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey,” shows even greater improvement had been achieved by the summer of 2008 (Summer 2008 in chart below).¹⁴

	Fall 2006	Fall 2007	Summer 2008
Percent of All Adults Who Were Uninsured	13%	7.1%	3.7%
Percent of Adults with Incomes Above 300% FPL Who Were Uninsured	5.2%	2.9%	3.8%*
Percent of Adults with Incomes Below 300% FPL Who Were Uninsured	23.8%	12.9%	7.9%

* This number is only for adults with incomes between 300% and 499% FPL.

Reduction in Underinsurance.

An October 2008 study by the Urban Institute, “Impact of Health Reform on Underinsurance in Massachusetts: Do the Insured Have Adequate Protection?” found that the number of people who were underinsured has decreased slightly in Massachusetts. The report defined underinsurance as spending more than 10 percent of family income on out-of-pocket health care costs (5 percent for people with incomes below 200% FPL).¹⁵

	Fall 2006	Fall 2007
Percent Who Spent More Than 10% Out-of-Pocket	4%	3%
Percent with Low-Income Who Spent More Than 5% Out-of-Pocket	7%	6%

In addition, according to a 2009 report from the Urban Institute, “Massachusetts Health Reform: Solving the Long-Run Cost Problem: Timely Analysis of Immediate Health Policy Issues,” there were important improvements in access to care: “There were post-reform increases in the percentages of people having a usual source of care, in the percent with preventive care visits, and in the percent with dental visits. There were lower levels of unmet need due to cost burdens, falling from 36 to 30 percent of low-income adults, with declines in unmet need due to cost for physicians, specialists, preventive care, tests, drugs, and dental care.”¹⁶

Increase in Employer-Sponsored Insurance.

Many feared the Massachusetts reforms would lead employers to drop coverage. According to the June 2008 “On the Road to Universal Coverage” report in *Health Affairs*, however, employer coverage remained stable for adults overall and increased 5 percent for people with low incomes.¹⁷ So rather than reducing the number of people with private insurance through their employers, as some fear a government-run exchange would do, about 85,000 more people received employer-sponsored insurance in 2007.¹⁸

Reduction in Some Premiums by Creating Larger Risk Pools.

The Massachusetts health reform law enacted private health insurance market reforms to promote wider access to coverage. According to a June 2008 report published in *Health Affairs*, “Massachusetts Health Reform Implementation: Major Progress And Future Challenges,” the most important of these reforms was the merger of the nongroup/individual and small-group health insurance markets on July 1, 2007: “Building on parallel regulatory protections already existing in both markets—including guaranteed issue and renewal, medical underwriting prohibition, pre-existing condition limitations, and modified community rating—the merger allows individuals to choose any plan available to those working for small employers (1–50 workers). Those insured through a small employer can retain coverage after leaving their job. Because individual coverage is now rated with small-group coverage, nongroup premiums have decreased dramatically.”¹⁹

Small group premiums have not been affected much at all given that the small group market in Massachusetts was much larger (750,000 individuals) than the nongroup market (50,000 individuals) at the time of the merger.²⁰

What Still Needs to Be Accomplished

Overall Health Care Cost Containment.

While Massachusetts reform has lowered health insurance premiums in the individual market by combining individual and small risk pools, the lack of overall health care system cost controls mean those savings will be short-term. In 2008, major Massachusetts insurers implemented average premium increases of 8–12 percent, according to a June 2008 *Health Affairs* report, “Massachusetts Health Reform Implementation.” In addition, a 2006 commission that studied the merger of individual and small group insurance markets projected possible increases in small-group rates as a result of the merger of between 1 and 4 percent. The report concludes that, “Continuing increases undermine affordability, expand the number of people who are exempt from the mandate, and undermine the law’s intent.”²¹

An article in *The New York Times* (“Massachusetts Faces a Test on Health Care,” November 25, 2007) points out that the reluctance of so many to enroll in Commonwealth Choice and “the possible exemption of 60,000 residents who cannot afford premiums,”²² would undercut the goal of slowing the increase in health costs. On a panel discussion about Massachusetts health care reform sponsored by Kaiser Family Foundation on November 7, 2008, Jon Gabel, a senior fellow at the National Opinion Research Center, confirmed that cost containment remains a problem in Massachusetts: “Before the legislation was adopted, health insurance cost more in Massachusetts than it did in the rest of the nation. Costs were increasing more rapidly than in the rest of the nation. Now from our data, the same relationship still holds.”²³

A 2007 survey of employer health benefits by United Benefit Advisors, an independent employee benefits advisory organization, reiterates the problem. According to the survey, Massachusetts has the highest annual health plan cost per employee in the country, which rose from \$8,631 in 2006 to \$9,304 in 2007.²⁴

By the fall of 2008 there were reports that the cost of health insurance in Massachusetts would once again rise at almost twice the inflation rate, with the state’s major health plans predicting premium hikes in the neighborhood of 10 percent. Interviewed on Boston public radio, Jon Hurst, President of the Retailers Association of Massachusetts, found the news “very discouraging; the promise of health care reform clearly has not been felt by small businesses.” He said small businesses, which typically see the largest premium increases, cannot absorb another hike.²⁵

It’s not just employers who are having difficulty affording the increase in health care costs. *The Boston Globe* reported in February 2008 that the cost to the state for subsidized coverage will double in the next three years: “The subsidized insurance program at the heart of the state’s healthcare initiative is expected to roughly double in size and expense over the next three years—an unexpected level of growth that could cost state taxpayers hundreds of millions of dollars or force the state to scale back its ambitions.”²⁶ The article quotes Michael Widmer, president of the Massachusetts Taxpayers Foundation, a

business-funded budget watchdog group, who cautions that "The state alone cannot support that kind of spending increase."

Spiraling health care costs and the lack of predictable and secure long-term financing for the Massachusetts program undermine its long-term sustainability. A public insurance option that competes on a level playing field alongside the private plans in the Massachusetts Connector, would motivate private plans to streamline their inefficient and cost-inflating practices (see "Meaningful Competition Among Plans" section below) and help ensure provider rates are not excessive. All of the major insurers in Massachusetts continue to have administrative costs higher than a public health insurance plan like the public Medicare plan.²⁷ And, *The Boston Globe* reported in November 2007 that Blue Cross, the state's largest insurer, awarded its chairman a \$16.4 million retirement bonus even as he continues to draw a \$3 million a year salary.²⁸

In their report on "Solving the Long-Run Cost Problem" in Massachusetts, Holahan and Blumberg discuss the possibility that managed competition or rate setting could help control costs. For managed competition to have a chance of lowering costs, they propose that more people be brought into the Connector by opening up CommChoice and CommCare to all employers, not simply those with 50 or fewer workers.²⁹ However, they do not estimate how many people would be needed in the Connector to make managed competition a viable way to lower long-term costs. Even with thousands more people covered by the Connector, it would be very difficult for it to single-handedly overcome the problem of large, powerful providers unwilling to negotiate lower rates that has driven such high cost increases in the health care marketplace in the state.³⁰ Moreover, if these powerful providers were not in the mix, there is no evidence the insurers, without a competing public health insurance plan to set a benchmark with regard to the terms of coverage offered, would reduce their rates, disclose their claims, outcomes and provider rate data or their medical necessity protocols and compete on the value of the coverage they offer.

Similarly, in their discussion of rate setting, Holahan and Blumberg warn, "All-payer rate-setting systems have not always been successful (Maryland is the only surviving system from all those implemented in the 1980s)... A major disadvantage is the constant threat of providers lobbying the legislature, thus weakening rate-setting."³¹ With Massachusetts' powerful providers, it is hard to imagine such a measure even passing, much less being maintained.³²

In their report, Holahan and Blumberg also suggest that a public insurance option could "use the power of a large strong buyer to bring down provider payment rates."³³ In an earlier report, they explored the creation of a public health insurance plan option in depth, concluding that "The intent of the competing public plan is to use the administrative efficiencies of government-run health insurance plans, as well as the purchasing power of government to control costs. The underlying argument is that individual insurers do not have (or are unwilling to use) the market power to counter the pricing power of many hospital systems or physician specialties. This seems likely to remain true even if reforms lead to more aggressive competition in insurance/managed care markets. Thus, the power

of a larger purchaser motivated to contain costs is needed to control rising health care expenditures.”³⁴

Guaranteed Access to Affordable Health Care.

The Massachusetts reform helps ensure that private health insurance plans in the state’s Connector program offer a comprehensive benefit package to people below 300 percent of FPL in the Commonwealth Care plan. But, people above 300 percent of FPL in Commonwealth Choice plans are not assured a comprehensive, standard benefit package. Insurers need only offer them plans that meet a set actuarial level. Consequently reforms have not translated into affordable coverage or affordable care for many middle-income Massachusetts residents.

Moreover, Commonwealth Care, which provides subsidized coverage to people with low incomes, is not available to every uninsured person who meets the income qualifications. Lower-income workers with access to employer-sponsored coverage are ineligible, even if the employer-offered insurance is unaffordable to them.³⁵ In addition, people who lose access to employer-sponsored insurance are not eligible for Commonwealth Care for six months.³⁶

And, the combination of high premiums and limited benefits in the Commonwealth Choice program led fewer people than expected to buy such a policy in the first year. The Connector predicted that at least 35,000 people would enroll in CommChoice in its first year, but as of March 2008, only 17,490 had enrolled. And most of those purchasing CommChoice plans have bought lower-premium (Bronze and Young Adult) plans with high cost sharing,³⁷ including deductibles up to \$4,000 and coinsurance. Though insured, many of these people are still at financial and medical risk if they end up needing costly health care.

Indeed, the data showing a reduction in underinsurance looks only at people who had high health care costs in the previous year. Studies do not capture the incidence of insured individuals who are currently healthy even if their coverage is not adequate to protect them against financial hardship should they develop significant medical problems in the future. The authors of the underinsurance study published in *Health Affairs* make that clear: “High OOP [out-of-pocket] health care costs provide a conservative, lower-bound estimate of underinsurance as it only captures inadequate insurance coverage for those who had high health care costs in the last year. Consequently, this measure of underinsurance does not include any of the individuals with similar health insurance coverage who did not have high health care costs during the year.”³⁸

Furthermore, while an estimated 340,000 people had gained coverage as of April 2008—more than half of the estimated 650,000 people who were previously uninsured—most of these newly insured individuals (68%) are very poor people who enrolled in MassHealth (Massachusetts’ Medicaid program) or one of the Commonwealth Care subsidized plans.³⁹ People with incomes below 150% FPL pay no premiums, while those between

150% and 300% FPL pay on a sliding scale. People with incomes above 300% FPL are not eligible.

However, the Massachusetts Uncompensated Care Pool, created in 1985, paid for medically needed services provided by hospitals, community clinics and health facilities to uninsured and underinsured low-income residents up to 200 percent of the poverty line. It also provided partial uncompensated care to individuals between 200 and 400 percent of poverty, and aided individuals of any income level in cases of extreme medical hardship or debt.⁴⁰

The majority of the newly insured who were previously eligible for free care funded by the state through the Massachusetts Uncompensated Care Pool now face copayments under the new plan.⁴¹ In effect, public funds for care of the poor that previously flowed directly to hospitals and clinics now flow through private insurance companies, adding another layer of administrative costs.

Under reform, the Health Safety Net was created as a successor to the Uncompensated Care Pool. Like the Uncompensated Care Pool, the Health Safety Net covers medically needed services for those who are not eligible for health insurance and cannot afford to purchase it under the individual mandate. However, some people needing subsidized health care are no longer eligible for the Health Safety Net, or must contribute more fees to their healthcare, which can make needed services less affordable.⁴² These new cracks in the system mean more bad debt for providers. Bill Walczak, CEO of the Codman Square Health Center, reported in September 2008 that his health center, which serves a largely low-income and working-poor population, had seen an increase in bad debt (payments owed to it that it does not expect to collect) of more than 50% over the previous year:

“At a health center directors’ meeting recently, many directors said that their bad debt is up. The main reason for this is that the old free care pool covered patients who qualified for it for six months prior to the time they qualified for free care. So, if a patient came in for services without insurance, qualifying for free care meant that they would be covered for the visit that day. In today’s system, insurance kicks in 30 or more days after all the patient’s forms are submitted. And a certain number of patients also seem to allow their insurance to lapse, so that we have to re-qualify them when they show up for the appointments after their insurance lapses. As a result, a safety net provider has to make a decision on whether to see a patient without insurance and not get paid, or turn away the patient until they get insurance or come up with money to cover the service. Health Centers do not turn away patients in need of care, and so they see the patients and do not get paid, which typically turns into bad debt.”⁴³

In addition, disparities in health coverage persist in Massachusetts. In 2007, while 5.7 percent of all Massachusetts residents did not have health insurance, Hispanics and Black non-Hispanic residents had higher rates of uninsurance: 10.2 and 7.9 percent respectively.⁴⁴ This is despite the fact that 77 percent of all the uninsured in

Massachusetts are eligible for a subsidy.⁴⁵ Automatic enrollment in a designated plan for anyone who does not affirmatively enroll in a plan would address these disparities.

The Access Project, a non-profit organization that serves as a resource center for local communities working to improve health and healthcare access, states in its September 2008 report, “In Debt But Not Indifferent: Chapter 58 and The Access Project’s Medical Debt Resolution Program,” “while health reform has resulted in significant gains, the report showed that medical debt is not a thing of the past in Massachusetts. The Urban Institute found that almost one in five state residents (18%) were paying off medical bills in the fall of 2007. Also, despite important progress, health access problems remained. Though the percentage of people forgoing care because of cost dropped from 17 to 11 percent, more than one in ten adults ages 18 to 64 (11%) did not get needed care in the past year because of cost.”⁴⁶

A Fall 2008 survey of Massachusetts residents on healthcare conducted by the *Boston Globe* and the Blue Cross Blue Shield of Massachusetts Foundation confirms that many people are still struggling to pay for healthcare despite more people having health insurance. In some instances, they couldn't afford to use their health insurance because the deductible or copay was too high, putting them in the same position as people without health insurance. The survey found:⁴⁷

- 13 percent of insured residents said they couldn't pay for some health services in the past year;
- 13 percent of insured residents said they couldn't afford to fill a prescription in the past year because it cost too much or their copay was too high;
- 33 percent of those surveyed ranked the cost of care their biggest health concern;
- 39 percent of those surveyed said health care costs were among their top two concerns and no other worry came close to that.

Alison Bass and her family illustrate the problem of underinsurance. She wrote about her experience with high out-of-pocket health care costs in the *Boston Globe* on January 21, 2008:

“THE NEARLY 300,000 Massachusetts residents who signed up for health insurance under the state's new initiative are in for a rude awakening. They may now have some form of coverage, but many of them, even the very poor who used to get free care, are going to be socked with steep medical bills...

“By last fall, [my family] owed nearly \$3,000 in medical expenses. The bills had begun accumulating shortly after my husband, a social worker, switched jobs and we were forced to change health insurance from a local Blue Cross plan to a for-profit national plan. My husband was not offered a choice of health plans, and when we signed up it was not made clear that our deductible for the year would be \$3,000 (for in-network expenses; \$4,500 for out-of-network).

“Nor did we understand that once we met the deductible (i.e., spent \$3,000 to \$4,500 of our own money), we would then have to pay co-insurance: 15 percent of every in-

network expense we incurred and 45 percent of any out-of-network expenses...

“Instead of counting the full amount of our medical bills toward the deductible, the company only included a lower ‘discounted’ amount and excluded the cost of our co-insurance charges. According to the Access Project, such tactics are not that unusual. But they often go unnoticed because of the sheer complexity of the system. This experience has taught me that our system of private health insurance is badly broken and individual states cannot institute reform alone. We need universal healthcare on a federal level...”⁴⁸

The lack of price and quality transparency in the private insurance market leaves people unaware of their financial liability should they need costly health care services and precludes meaningful competition since people cannot compare plans based on the quality of care they deliver or the cost of that care. Moreover, to the extent they are considered business trade secrets, “innovations” in the private insurance marketplace permit plans to develop systems for denying and delaying coverage as well as for shifting costs that cannot be evaluated and do not allow for apples-to-apples comparisons among plans.

In sharp contrast to the private insurance market, a public health insurance option offers a transparent and predictable benchmark for good coverage and affordable costs. Of as great significance, as Jacob Hacker writes, “Acting alongside each other, with enrollees able to choose between them on a level playing field, public and private insurance can serve simultaneously as a safety valve and a spur for improvement for each other.”⁴⁹

Counterforce To Oligopolistic Insurance Market.

To be sure, Massachusetts has in place a series of important regulations designed to help ensure equitable access to coverage, including a merger of the nongroup and small group markets, guaranteed issue and renewal, prohibition against medical underwriting, and modified community rating.¹ But, Massachusetts has not created a truly competitive health care marketplace that enables people to make apples-to-apples comparisons among plans based on price and quality, reins in costs, promotes accountability and drives value or that delivers the financial and health security that people want and need.

Like 39 other states, the Massachusetts insurance market is dominated by three health insurers who control most of the business. Blue Cross Blue Shield alone controls 43 percent of the market share. Without a public insurance option as a benchmark and

¹ *Guaranteed issue and renewal* is a consumer protection that gives people the right to buy and keep health insurance coverage regardless of their age or health status. *Medical underwriting* is the insurance company practice that bases the premium and, sometimes the benefits, on an individual's own medical history; so the premium for people who are sick or who are likely to become sick (for example, people with diabetes) is higher than for people who are healthy. *Community rating* is a consumer protection that sets insurance premiums based on the claims experience of people in the community. With community rating, each policyholder's premium is based on the average cost of the entire pool—healthy and sick mixed together—not on each individual's age or health status. Massachusetts has ‘modified’ community rating because it allows insurance companies to charge higher premiums to older people.

countervailing force to these insurer oligopolies, insurers have driven up costs substantially. Health plans have not reduced their premiums or limited their cost-sharing to attract business. Moreover, they have shifted costs to residents through techniques such as exempting coinsurance from limits on total out-of-pocket costs.

Massachusetts, like every other state, also allows insurers to treat important information about their products and services as proprietary, preventing people from understanding key differences among plans in terms of scope of coverage and out-of-pocket costs. Insurance companies operate with little transparency, which greatly limits accountability and the ability of others to learn lessons about how best to contain costs and improve quality. For instance, *U.S. News and World Report* recently noted that 126 health care plans refused to provide data to a national accrediting agency that was needed for the magazine to rank plan performance.⁵⁰ Transparency in the public Medicare plan has helped identify huge variations in spending per capita across the country and to determine that areas with higher spending per person score no better on quality measures, and often score worse.⁵¹ Private insurers have few incentives to make such information public because keeping it secret gives them a leg up on the competition, and they can pass rising costs along to payers.

Researchers from the Urban Institute and others make a powerful case for the need to break insurer oligopolies, which are driving up health care costs, and demonstrate that a public health insurance option promotes value, can help reduce overall health care costs, and improves private insurance.

“Having a competing public plan will neither destroy the private insurance market nor lead to a government takeover. Private plans are attractive because of their ability to be responsive to consumer demands for choice and their innovations resulting from both the profit motive and desire to attract a larger enrollment base. Public plans are attractive because they can offer better access to necessary care for diverse populations, they have lower administrative costs, and they can be large-scale purchasers with a strong negotiating position with providers. The presence of both types of plans should allow the advantages of each to enhance a reformed insurance marketplace while protecting the markets from the potential negative consequences of each type acting alone.”⁵²

Data reflecting public Medicare plan growth over a recent 10-year period as compared with private health insurance confirms that public health insurance does far better than private insurance when it comes to reining in costs while preserving access. “Between 1997 and 2006, health spending per enrollee (for comparable benefits) grew at 4.6 percent a year under Medicare, compared with 7.3 percent a year under private health insurance,” according to Jacob Hacker.⁵³

For these reasons, both President Obama and Senator Baucus, in sharp contrast to Massachusetts, include a public health insurance plan option in their health reform proposals. Massachusetts, like every other state, is hard-pressed to implement a public health insurance plan option that eliminates the private insurer middleman and competes

on a level playing field with private plans. It is most effectively done at the federal level. In his analysis of how a hybrid public/private plan choice would improve the U.S. health care system, Jacob Hacker concludes that a national public health insurance plan option would allow for a much larger and broader risk pool and would be in a better position to contain overall health care costs by using its membership in negotiating for discounts. It can also test and, where appropriate, implement evidence-based protocols, which private plans may choose to shun because of cost concerns, for treatments and payment systems, rewarding value.⁵⁴

Stability in Health Plan Membership to Foster Continuity of Care.

One of the chief criticisms of the U.S. health insurance system today is its instability resulting from market volatility (insurance company mergers and plan changes) and lack of portability (people change jobs or employer contracts with new plans). Such changes can leave people without coverage and interfere with continuity of care, as each plan has different provider networks and coverage rules. They also provide a strong disincentive for private insurance companies to invest in care management and preventive care because individuals are likely to change plans, so they may not see savings from such investments.⁵⁵

Massachusetts reform undermines stability by segregating people with low incomes who receive a subsidy and do not qualify for Medicaid into one set of plans (Commonwealth Care) and those with higher incomes who do not get a subsidy into a different set of plans (Commonwealth Choice). That means if income rises for people who are in a subsidized plan, they are forced to change plans. If their income then goes back down, to benefit from the subsidy, they have to change plans once again. During the transition, they may be forced to go uninsured. In addition, since the state has dramatically reduced funding for uncompensated care, the safety net for people who are uninsured is extremely weak.

For people who want a guarantee of continuity of care, but have lost their private insurance, including a public health insurance plan option in a health insurance exchange provides backup until they enroll in a new private plan.

Conclusion

There is no question that Massachusetts health reform has meant that more people in the state have health care coverage than ever before and fewer people are underinsured. But, many people remain without affordable coverage and many more with inadequate coverage remain vulnerable to high health care costs. Moreover, there is also no question that the system in Massachusetts is unsustainable. The data show that health care costs continue to increase at double-digit rates.

The conditions in Massachusetts prior to reform—low uninsurance, high level of employer-sponsored coverage, stricter insurance regulations and federal pressure to allocate federal dollars to cover more people—offered the Commonwealth the opportunity to drive

uninsurance down to an extent that almost no other state could achieve. And, the dominance of community-focused, nonprofit insurance plans in Massachusetts likely has made strengthening the health care safety net easier than in other states. At the same time, the limited ability of Massachusetts (or any state) to mandate meaningful employer contributions towards the cost of health care or to drive competition and rein in costs through a national public insurance option means that Massachusetts is not likely to continue to have the money to subsidize coverage, and its achievements are destined to be short-lived.

The situation in most other states in the country are strikingly different—with much higher levels of uninsurance, lower levels of employer-sponsored coverage, the prominence of for-profit insurers and much more lax insurance regulations—which means it would be very difficult for most other states to accomplish on their own what Massachusetts has been able to achieve, and even Massachusetts had to sacrifice cost controls in order to achieve it. As Dr. Robert Steinbrook explains in *The New England Journal of Medicine*: “Health care reform in Massachusetts is not a panacea for the many shortcomings of the health care system. It is worth remembering that California, for example, has more people without health insurance (6.7 million) than Massachusetts has residents (6.4 million) and that the financing and delivery of medical care have not changed.”⁵⁶

Unlike the states, the federal government has the ability and the resources to ensure that private insurers and providers are charging reasonable rates and providing value. States could do provider rate-setting to rein in costs, but that would not drive value. A federal public health insurance plan option that competes on a level playing field with the private plans is best suited to address cost and quality issues. It can set a benchmark for coverage and costs against which private plans must compete and can serve as a safety net for people without private coverage.

For these reasons, among others, both President Obama and Senator Baucus have proposed a different framework for reform from Massachusetts, which includes a public health insurance option. The data suggests that such a model can bring down costs and promote quality, ensuring everyone in the U.S. access to good, affordable health care, in ways that a model that relies exclusively on private insurers simply cannot.

Necessary Elements of Meaningful Health Care Reform

Coverage for All

What Massachusetts Has Not Been Able to Accomplish

Massachusetts continues to have an exclusively private health insurance system, an oligopolistic insurance market, with the power effectively to set rates high. The state has no guaranteed backup plan in place that would ensure automatic coverage for people who do not enroll on their own. And the state does not mandate adequate employer contributions towards the cost of coverage to provide affordable coverage to tens of thousands of people above the subsidy level. The result is a system that leaves nearly 4% of the adult state residents uninsured:

- They may be unaware they qualify for a subsidy or lack the wherewithal to apply; 10.2 percent of Hispanics and 7.9 percent of African-Americans remain uninsured even though most of them qualify for a subsidy.
- They may have incomes above 300 percent of FPL making them ineligible for a subsidy, yet they still find available coverage unaffordable. As of March 2008, only 17,490 people with incomes above 300 percent of the poverty level had enrolled in unsubsidized plans through the state's health plan Connector (the state had predicted that at least 35,000 people would enroll in CommChoice in its first year). The state issued waivers to almost 70,000 residents because they could not afford coverage.
- They may be ineligible for a subsidy even though their incomes fall below 300% FPL because their employers offer them coverage, regardless of whether that coverage is affordable to them. And, they also may be ineligible for a subsidy, regardless of their income, during the six month period after their employers stop offering coverage.

The Uncompensated Care Pool that previously paid for care for the uninsured has been sharply reduced, making it harder for providers to help people who remain uninsured.

What National Health Reform with Hybrid Public-Private Insurance Could Accomplish

A hybrid system of competing public and private health insurers, a mandate to ensure employers contribute their fair share toward health care coverage and a system of automatic coverage can drive competition, rein in costs and ensure affordable coverage is available to everyone, even if they do not enroll in a plan or lose their private coverage.

Overall Cost Control

The Health Care Quality and Cost Council created by the reform law has been ineffective to date. And, the non-profit insurance industry, which dominates the market in Massachusetts, has not used its negotiating leverage to contain costs. Employers are struggling to continue to provide health benefits to their employees. According to a 2007 survey of employers by United Benefit Advisors, an independent employee benefits advisory organization, Massachusetts still has the highest annual health plan cost per employee in the country, rising from \$8,631 in 2006 to \$9,304 in 2007.

Massachusetts is also struggling to continue to provide subsidies for people with low incomes.^{lvii} *The Boston Globe* reports that the “subsidized insurance program at the heart of the state's healthcare initiative is expected to roughly double in size and expense over the next three years—an unexpected level of growth that could cost state taxpayers hundreds of millions of dollars or force the state to scale back its ambitions.”

A national public health insurance plan option would have low administrative costs and would bring down overall costs by driving competition in the private insurance market. Currently, private health insurers are oligopolies in most states, allowing them effectively to set rates and drive up costs. Finally, a public health insurance plan option would set a benchmark for care delivery, promoting value in the system, against which private insurers would need to compete, likely further reducing overall costs.

Access to Affordable, Quality Health Care

Although the state has seen a slight drop in the percentage of people who spent more than 10% of their income on out-of-pocket medical costs, from 4% in the Fall of 2006 to 3% in the Fall of 2007, a significant portion of people with insurance still report difficulty affording their health care. A Fall 2008 survey of state residents found that many people are still struggling to pay for healthcare. In some instances, they couldn't afford to use their health insurance because the deductible or copay was too high, putting them in the same position as people without health insurance. The survey found that: 13% of insured residents said they couldn't pay for some health services in the past year; 13% of insured residents said they couldn't afford to fill a prescription in the past year because it cost too much or their copay was too high; 30% of those surveyed ranked the cost of care their biggest health concern.

In addition, Massachusetts has not focused yet on driving

The public Medicare plan provides strong evidence that a national public health insurance plan option can drive competition in the health insurance market, rein in costs and provide people with the financial and health security they need. It can also set a benchmark for comprehensive coverage. For example, requiring an affordable out-of-pocket maximum that includes all premiums, deductibles, copayments and coinsurance, will ensure people do not continue to go into debt or bankrupt from medical expenses even when they have health insurance. Further, a public health insurance option can promote system-wide innovation that delivers value for our health care dollars in ways private insurers cannot, making health care more affordable.

Moreover, a national public health insurance plan option has greater potential to drive the quality revolution in a systemic way throughout the nation than do private plans.

quality.

Public plans operate in the open; private insurers operate in secret, which undermines competition and greatly limits accountability and the ability of others to learn lessons about how best to contain costs and improve quality. Participation in public health insurance plans is much more stable for enrollees as well as for providers. As a result, a public health insurance plan has much greater potential to reap the rewards of investments in prevention and general health improvement that require up-front spending but reduce long-range costs. Private insurance has little incentive to treat those with substantial health problems. A public health insurance plan option, which is required to cover anyone who is eligible regardless of risk, is best able to treat them and disseminate the lessons learned to the private sector.

Shared Responsibility

While individuals, employers and government all contribute to cost, their contributions are not equitable: Employers with 11 or more workers who do not offer health benefits must pay only \$295 per worker each year. Massachusetts was unable to impose any greater requirements on employers because federal law (ERISA) has jurisdiction over employer group plans. Therefore, the cost of subsidizing coverage for people with low incomes—who are more likely to work in jobs without employer-sponsored coverage—falls mostly to the taxpayer. In sharp contrast, individuals who do not buy insurance, and who do not secure a waiver based on affordability, must pay a penalty of \$1,068 in 2009.

National reform can help ensure equitable distribution of the cost of care among government, individuals and employers, based on ability to pay. Federal reforms can modify ERISA to allow a “play or pay” employer mandate, with higher minimum coverage standards for employer benefits than Massachusetts mandates, as well as higher per worker fees if coverage is not offered.

Strong and Fair Insurance Regulation

Massachusetts regulation still leaves private insurers, in the business of avoiding members with costly conditions, able to shift increasing costs to these members through high deductibles, coinsurance and copays, effectively punishing the sick and putting them at financial risk.

While Massachusetts has guaranteed-issue laws (insurers cannot turn anyone down for coverage based on age or health status) and modified community rating, Massachusetts allows age-rated banding. That means that an insurance company can charge a 62-year old twice as much as a 22-year old for the same policy. For example, the NHP Bronze family plan (lowest level of coverage) with a \$4,000 annual deductible costs \$6,972 for a 22-year-old head of household, and \$13,944 for a 62-year-old head of household.

In order to spread the risk equitably and widely, and thus lower costs, both private and public insurers should not be allowed to turn anyone away.

Insurers also should not be allowed to charge anyone more based on age, sex or their health status. Our health insurance system should not pit the young against the old, or the sick against the healthy.

A public health insurance plan option gives everyone the ability to enroll in a plan designed to assume risk and spread risk equitably among healthy and sick, effectively protecting the sick from financial risk.

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