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MASSACHUSETTS HEALTH CARE REFORM

Beth Waldman

ABSTRACT

The United States spends more per capita on health care than nearly every other country; yet despite this level of spending, quality outcomes in the United States are lower than in many developed countries. This poor quality is due in part to the fact that over 45 million Americans are uninsured. Health care in the US is provided mainly through employers as an employee benefit; those who work for employers that do not offer health insurance are left to purchase health insurance in the individual marketplace at great expense. Low-income individuals may receive coverage through Medicaid, a public health insurance program established in 1965 that is funded jointly by the federal government and each specific state. States have some flexibility in choosing which populations to cover through the Medicaid program. Massachusetts has long been a state that has provided relatively generous coverage to its residents. After taking steps over a number of years toward the implementation of state-wide universal coverage, Massachusetts, in April 2006, enacted landmark health care reform legislation aimed at providing all Massachusetts residents with health insurance coverage. Under the law, participation in the health coverage process was for the first time required by both individuals and employers. Since enactment, over 400,000 individuals who were previously uninsured have gained coverage in the state, either by accepting coverage through an employer where it had previously been declined, by purchasing in the individual market, or by enrolling in the state's expanded public coverage programs. As President Obama moves forward with his efforts at national health reform with health proposals contemplated in Washington, DC — proposals that build off of the success of the Massachusetts model — the nation watches Massachusetts to ensure that it can maintain its health reform during a time of deep fiscal crisis in the state.

INTRODUCTION

In April 2006, the Commonwealth of Massachusetts enacted health care reform legislation aimed at providing all Massachusetts residents with health insurance coverage. Under the law, participation in the health coverage process was for the first time required by both individuals and employers. This article provides a brief overview of health coverage in Massachusetts prior to the law's enactment and reports on progress to date in the law's implementation, including the treatment of immigrants. Furthermore, the article comments on the prospects of the Massachusetts Health Care Reform strategy to work for the United States as a whole.

BACKGROUND

Access to health insurance has been a major political and economic issue in the United States for nearly a century.[1] Unlike most of the industrialized world, the US does not provide universal health coverage to its citizens.[2] Health insurance coverage in the US is obtained in a number of different ways based on an individual's age, employment status, income, and state of residence. Health insurance coverage started gaining popu-

larity in the 1930s, and in the 1940s and 1950s insurance became a key part of employee benefit plans. During World War II, when employers had limited ability to provide wage increases to employees, they were able to attract workers by providing a comprehensive benefit package that included health coverage. Additionally, unions pushed for inclusion of strong health coverage in employee benefit packages. The federal government did not begin to actively provide health care coverage until the 1950s. The two main government programs that provide health coverage to Americans — Medicare and Medicaid — were established in 1965.

In 2008, 46.3 million Americans had no health insurance.[3] The majority of Americans continue to receive health insurance coverage as part of the employee benefit package from their employer or that of a family member.[4] Individuals aged 65 and older are eligible to receive health insurance coverage through Medicare, a program funded by the federal government.[5] Low-income individuals receive coverage through a combination of Medicaid and the State's Children Health Insurance Program, or SCHIP, known as CHIP since 2009, when President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), renewing and expanding coverage of the Children's Health Insurance Program from 7 million children to 11 million children.[6] The Medicaid and CHIP programs are jointly funded by the federal government and the individual state. States administer the programs, setting eligibility and coverage rules within guidelines provided in federal law. Because Medicaid and CHIP eligibility rules vary from state to state, there is disparity in coverage depending on where in the US an individual lives.[7] Additionally, because adults without dependent children are not eligible for either Medicaid or CHIP without a federal waiver, most of the low-income uninsured in the United States are non-elderly adults. Illegal immigrants, as well as legal immigrants who have been in the United States for five years or less (and who are known as "Aliens with Special Status," or AWSS), may only receive federally funded Medicaid or CHIP benefits covering emergency care.[8] States may choose to provide traditional Medicaid or CHIP benefits to these immigrants at full state cost. A handful of states have offered full benefits to the AWSS population. However, whenever state budgets are cut, these populations are often at the greatest risk for losing coverage because the funding is at full state cost.

The United States spends more per capita for health care than other countries.[9] In addition to spending the most, health care spending in the United States is also increasing at a higher rate than other high-income countries.[10] Health care spending in the United States is over 15% of the country's gross domestic product.[11] Yet most countries have seen health care spending grow faster than economic growth.[12] Despite spending more than other industrialized nations, the United States ranks poorly in terms of quality of and access to care as measured by life expectancy, infant mortality, preventable deaths, and percentage of population with health insurance.[13]

Massachusetts is a relatively small and wealthy state, with a population of just over 6.3 million residents and a number of world-renowned academic and medical institutions. It also is one of the most expensive states in the nation in which to receive health care.[14] The health care sector is the state's largest employer.[15] Historically, Massachusetts employers — both large and small — have been relatively generous in providing health coverage to their employees and dependents. The Massachusetts private health insurance market had been significantly reformed in the early 1990s to provide guaranteed coverage and to improve access to insurance through the small and non-group markets.[16] In addition to its strong employer base, Massachusetts also provided a strong safety net enabling individuals who needed assistance to obtain health insurance coverage. MassHealth, a combination of the state's Medicaid and CHIP programs, is one of the more expansive and generous public health care options in the nation.[17] In addition, the Commonwealth developed an Uncompensated Care Pool in the mid-1980s that provided a mechanism for safety net institutions to receive payment for giving free care to low-income individuals without access to coverage. Massachusetts also provided state-funded support for a number of health coverage and health related programs, including providing MassHealth benefits to legal immigrants who did not qualify for federally funded Medicaid benefits. Illegal immigrants, who would have been eligible for MassHealth but for their immigration status, received limited MassHealth coverage for emergency health care services. Prior to enactment of health

care reform, Massachusetts already boasted one of the lowest rates of uninsurance (that is, persons who are uninsured) in the country. Reported numbers of uninsured Massachusetts residents varied from between 370,000 to 620,000, depending on which survey was utilized.[18]

Massachusetts' generous, publicly funded programs utilize a combination of federal and state funding to support the state's Medicaid program and Uncompensated Care Pool. In part, the state's federal funding is authorized through an 1115 Demonstration Waiver (also called a 1115 Waiver or Waiver) that allows for funding not typically provided through the federal Medicaid program. As the state planned for its 1115 Waiver renewal for July 2005, the federal government sent clear signals that in order to successfully renew its Waiver the state would need to make significant changes to its program to retain federal funding aimed at the state's safety net providers.[19] The need to make changes provided the state and its political leaders with an immediate impetus to develop a health reform package that promoted coverage.[20]

Because of the differences between state Medicaid programs, it is difficult to objectively compare performance across states. However, the Massachusetts program is one of the most generous programs in terms of both populations covered and benefits offered. An April 2007 report from Public Citizen Health Research Group ranked Massachusetts first among Medicaid programs.[21] The report based its rankings on a review of four categories: eligibility, scope of services, quality of care, and reimbursement. Massachusetts was the top scorer in both eligibility and quality of care.

THE HEALTH CARE REFORM ACT OF 2006

With passage of its health reform legislation, Massachusetts became the first state in the nation to require its citizens to participate in health insurance by obtaining coverage either through an employer, the individual market, or with the assistance of a publicly funded program.[22] At the same time, the state substantially increased access by significantly expanding eligibility for publicly subsidized health coverage. With the implementation of its health reform law, Massachusetts now provides access to most individuals in the state who have incomes up to 300% of the federal poverty level (FPL), through a combination of programs funded through the renewed Massachusetts 1115 Demonstration Waiver.[23] Illegal immigrants remain eligible only for emergency coverage. Legal immigrants who do not qualify for federal funding were initially included as a covered group under health care reform. Because of the state's ongoing budget crisis, however, coverage for legal immigrants through the expanded publicly subsidized health coverage has been limited, as described in more detail below.

A significant piece of the health reform law was the creation of a health insurance exchange known as the Commonwealth Health Insurance Connector Authority ("the Connector"). In addition to administering the Commonwealth Care program, the Connector provides consumers who are ineligible for public assistance — but who cannot access health coverage through the traditional employer market — with a number of tools that provide information on differences in plans available in the non-group market. Furthermore, consumers can purchase health coverage through Commonwealth Choice.[24] Commonwealth Choice consists of a series of plans offered by private health insurers and designed specifically as part of health care reform to provide more affordable coverage to individuals and families who are not able to purchase coverage through an employer.[25] Small employers may also purchase coverage for their employees directly through the Connector's Contributory Plan.

By providing subsidized health coverage through Commonwealth Care, the Health Reform Act of 2006 gave an advantage to individuals with incomes at or below 300% of the FPL, employed or not, who did not have access to employer-sponsored health insurance, while individuals of the same income level who work for an employer offering health insurance are not eligible to participate. While recognizing that these criteria may burden some workers, the state was concerned that a plan that did not include this inherent inequity may lead to "crowd out" — that is, employers dropping their private offering of health insurance because of the existence of public coverage. If employers were to drop coverage, the health reform plan would quickly become unaffordable for the state. To make this more fair to those lower income individuals who could not afford the

employer-sponsored coverage they were offered, the health reform act included an affordability exception that exempted individuals without insurance from being penalized for not purchasing health insurance that they could not afford.

Under the health reform law, employers also bear responsibility to provide insurance to their employees. While the federal Employee Retirement Income Security Act (ERISA) law prevents states from levying an outright tax on employers that do not provide health coverage, Massachusetts — with support from the employer community — was able to develop an employer "fair share" requirement that to date has not been challenged.[26]

Also included in the health reform law were significant rate increases to certain providers of MassHealth services — particularly hospitals, physicians, and community health centers. By providing rate increases to these providers, the legislature allowed most stakeholders within the health care reform policy debate to have significant "wins."[27] In Massachusetts, as in most state Medicaid programs, health care providers have long argued that the state payment rates lagged significantly behind costs.[28] One major fear of health care reform was that by adding significant individuals to state coverage, health providers would feel the additional pinch of providing more care to individuals at below-cost rates, which would hurt their ability to remain viable and would put pressure on health insurance premiums paid by employers in the private market.

PROGRESS TO DATE

The health reform law has been hugely successful in providing access to health coverage in Massachusetts. Massachusetts now boasts the lowest rate of uninsurance in the United States.[29] The 2008 Massachusetts Health Insurance Survey found that nearly all Massachusetts residents had health insurance coverage in 2008; only 2.6% of state residents remain uninsured. Since the implementation of the law in 2006, more than 400,000 Massachusetts residents now have health insurance coverage.[30] Of those, approximately two thirds received coverage through a combination of MassHealth and Commonwealth Care, the state's publicly funded programs; and approximately one third received coverage through private insurance.[31]

The Connector successfully positioned itself as the epicenter of health care reform in Massachusetts. While numbers show that it has been quite successful in providing coverage through publicly subsidized insurance, it has been less successful in enrolling members into private insurance directly through the Commonwealth Choice program. This raises the question for the federal government and other states considering reform as to what role an exchange can successfully play in terms of enrolling individuals into the private marketplace. Because the health care products that Commonwealth Choice offers can be purchased directly through private insurers, there is no compelling reason for employers or employees to purchase coverage through Commonwealth Choice. The initial impetus behind the exchange concept — having an entity where employers could contribute toward the cost of insurance and employees could utilize partial contributions from multiple employers — has not yet been realized. This has been one of the more difficult responsibilities of the Connector. To date, given the other successes in Massachusetts, there has been relatively little focus on the lack of success in this area of the reform plan.

The year 2007 was the first year in which the state imposed significant individual mandate penalties for Massachusetts residents who could not provide proof of insurance. Of the 3.2 million taxpayers in Massachusetts, 5% reported being uninsured as of December 31, 2007. However, 40% of those who reported being uninsured were exempt from paying a penalty. In total, 3% of Massachusetts taxpayers were required to pay a penalty for not having purchased health insurance.[32] In 2008, the penalty for noncompliance with the individual mandate grew to half of the least expensive monthly premium for an individual. Based on a preliminary report released in December 2009, of the 3.4 million tax returns, 4% reported being uninsured for some or all of the calendar year 2008 and potentially subject to a penalty. Individuals with incomes below 150% of the federal poverty level or individuals who were uninsured for less than three months were exempt from paying a penalty. Just under 53,000 taxpayers were assessed a penalty in 2008, down from 60,000 in 2007.[33]

In addition to determining how many individuals in the state have access to coverage, it is also important to determine whether individuals with coverage are able to access care. Utilization of the Commonwealth's Health Safety Net Fund has decreased substantially since the implementation of Commonwealth Care.[34] This indicates that former users of the

state's Uncompensated Care Pool are accessing care through their publicly funded insurance coverage. While there has not been a definitive study on the ability of Massachusetts residents to access care, a recent survey found that 92% of Massachusetts residents reported having a primary care physician and only 5% of residents reported a time in the past year when they were not able to access necessary care.[35] However, the same survey found that 13% of residents with insurance were unable to pay for some health services in the same year. Thirteen percent also said that they were unable to fill at least one prescription because it was too expensive.[36]

Likewise, employers are required to pay US$295 per employee if they are deemed unable to meet the state's "fair share" requirements. These requirements have become stricter however; in 2008, of the 24,000 employers in Massachusetts required to comply with the requirements, only 855 failed to meet the requirements. Those firms paid a total of US$7.7 million to the state.[37] Based on the new regulations, the number of employers who fail to meet the revised requirements is expected to double, in which case the assessment would bring the state a total of US$30 million in revenue.[38] This assessment revenue is insignificant in relation to the overall cost of health coverage in the state. What is significant, however, is the policy commitment that the state has made to ensure that employers continue to serve as the main source of health coverage for Massachusetts residents by sharing responsibility for health coverage.

LOOKING FORWARD IN MASSACHUSETTS

In Massachusetts, as in the United States and in most developed countries, health spending is growing at a faster rate than personal income.[39] Health care cost growth has been an ongoing strain on personal budgets as well as on the state and federal budgets. A key goal of health reform was first to provide access for all, in order to better allow the state, insurers, and providers to improve quality and contain costs. From the start, however, a big question regarding health care reform legislation was the ability of the Commonwealth to sustain its commitment to coverage in the long term. The original health reform legislation included the creation of the Massachusetts Health Care Quality and Cost Council (the Council) to provide independent counsel to the state about how to improve the quality of health care and contain cost growth.

In its first three years, spending on health care reform was greater than expected; this was due both to faster-than-estimated enrollment into the Commonwealth Care program and a richer-than-initially-estimated coverage package. At the same time, the state Medicaid program implemented significant rate increases required by the health reform law. Likewise, health care costs as a whole have continued to grow at an unsustainable rate. With severe economic crisis throughout 2009, and the effect of the national economic crisis on the state, the need to develop cost containment strategies is of utmost importance in Massachusetts. For health care reform to be maintained, the state must find a way to contain costs so that health coverage can remain affordable for both families and government while ensuring that providers get fairly paid for their services. There are a number of efforts underway to develop long-term strategies to contain costs. In October 2009, the Council released a "Roadmap to Cost Containment," providing the state with a strategic plan to achieve cost containment in health spending in Massachusetts.[40] In addition, in 2009, the Commonwealth convened a Special Commission on the Health Care Payment System, which recommended that the state move toward global payments.[41]

The budget crisis in the state also requires cutbacks in spending in the state's Medicaid program. While the 2009 economic stimulus bill reduced pressure on state budgets through enhanced federal funding, states — including Massachusetts — still were required to make deep cuts in their health and human service budgets, including for health care programs. The Massachusetts budget for state fiscal year 2010, running from July 1, 2009, through June 30, 2010, made significant cuts to Medicaid and Commonwealth Care. First, under the budget, much of the gains to Medicaid provider rates were lost in the form of either rate cuts or freezes. In addition, since the economic downturn, investment in outreach and enrollment has been limited. In state fiscal year 2010, the Commonwealth Health Insurance Connector Authority made discretionary grants of US$2 million to community-based organizations. The Governor's state fiscal year 2011 proposal does not include any outreach and enrollment dollars, but anticipates that the Connector will again provide these outreach and enrollment grants. Without application and renewal support from community-based organizations, it is considerably more difficult for individuals to obtain or maintain public coverage.[42]

The final budget for fiscal year 2010 also eliminated Commonwealth Care eligibility for 28,000 legal immigrants who had been receiving benefits through state dollars. From a purely budgetary perspective, the cut was rational in that the US$70 million in savings to the state budget from such a cut were significant and assured. Ultimately, the state offered the Commonwealth Care Bridge program with limited funding (US$40 million) to provide coverage to these legal immigrants. In his proposed fiscal year 2011 budget, Massachusetts Governor Deval Patrick proposes to increase the funding to US$75 million with the goal of covering an additional 20,000 legal immigrants.[43]

Prospects for national health reform

In addition to Massachusetts, a handful of other states have attempted to implement health care reform strategies aimed at insuring all of their citizens.[44] Massachusetts' ability to implement a health care reform strategy to provide access to coverage for nearly all of its citizens stemmed from an already low rate of uninsurance, higher-than-average employer participation in health coverage, and an expansive Medicaid and CHIP program. In addition, the existence of the Uncompensated Care Pool meant that Massachusetts was already devoting significant dollars to caring for the uninsured. Health reform focused on converting those dollars to more affordable coverage options as opposed to dispersing them in urgent and emergent situations.

It will be difficult for other states to implement health care reform on their own, particularly given the difficult economic climate. Many experts believed, however, that the economic crisis provided an enormous opportunity to implement health care reform at the national level. Since the beginning of the Obama Administration, Congress and the President have been working towards national health reform.

A number of key elements of the Massachusetts Health Care Reform package have emerged in the final health reform bills developed by the House and the Senate. These common elements have included the use of an insurance exchange to provide information and potentially ease purchase of insurance, implementation of an individual mandate, and an employer pay-or-play provision. Two of the bigger issues in the national debate — whether to develop a public plan and whether to tax wealthier individuals to pay for universal coverage — were not part of the Massachusetts debate. Rather, Massachusetts funded its plan by shifting available federal and state dollars to pay for coverage instead of uncompensated care. On the issue of whether a public plan should be a component of a health care reform package, the state's newly subsidized program, Commonwealth Care, was developed to be separate from the Medicaid program and run as a quasi-independent state agency. It has not been viewed as a public plan, as it is administered through contracts with five managed care organizations. As a quasi-state entity, however, the Connector has been able to negotiate lower premium rates for Commonwealth Care plans than may be found in the private marketplace.

The national health care reform effort has been politically charged and public support for national reform is tepid.[45] The historic events surrounding the House vote on the bill of March 21, 2010 occurred as this article went to press and cannot be addressed here. Generally, Republicans opposed the bill, citing its impact on the federal budget and potential to substantially increase taxes, without concrete provisions to contain health care costs going forward. A number of conservative Democrats have also voiced concern. Whether the time has finally come for universal coverage in the United States, and how effectively coverage decisions will build on the Massachusetts health reform model, remain open questions.

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1. For an overview of previous attempts at universal health coverage in the United States, see Kaiser Family Foundation, *National health insurance — A brief history of reform efforts in the US* (March 2009). Available at http://www.kff.org/healthreform/upload/7871.pdf.

2. Universal health coverage can be achieved in a number of different ways through a number of different financing mechanisms. The term is used here to refer to any system in which all, or nearly all, citizens are guaranteed health coverage that provides

care to individuals for some level of basic services.

3. The United States Census Bureau, *Annual study of income, poverty and health insurance coverage for 2008* (September 10, 2009). Available at http://www.census.gov/prod/2009pubs/p60-236.pdf.

4. According to Census Bureau data (ibid.), 67.5 % of individuals were covered by private health insurance — a plan provided through an employer or a union or purchased by an individual through a private company, and nearly 60% of Americans receive coverage through employment-based health insurance.

5. Medicare provides coverage to individuals aged 65 and older, or younger individuals with disabilities who have met waiting period requirements. According to Census Bureau data (see note 3), nearly 14% of the population receives coverage through Medicare. Medicare provides coverage through three different avenues — Part A (inpatient hospital care and limited skilled nursing facility care), Part B (physician and outpatient services), and Part D (prescription drug coverage). Most individuals pay premiums toward their Part B and Part D coverage. Premiums vary by income. Additionally, individuals are required to make co-payments toward the cost of care received. General information on the Medicare program is available at www.cms.gov/MedicareGenInfo. Medicare provides limited coverage for long-term care services.

6. An overview of CHIP is available at http://www.cms.hhs.gov/LowCostHealthInsFamChild/. Just over 13% of the population receives coverage through a combination of Medicaid and CHIP (Ibid.).

7. Title XIX of the Social Security Act is the federal law governing Medicaid. Participation in Medicaid is voluntary; however, once a state agrees to participate in the program, it is obligated to follow minimum coverage requirements in terms of populations, incomes, and benefits. States may provide coverage at higher income levels or optional benefits. To provide coverage to individuals without children who are beyond the traditional population of parents, children, aged, blind, or disabled, a state must apply for and receive approval to operate their Medicaid program through an 1115 Demonstration Waiver. There is a wide variety in populations served through Medicaid and CHIP, typically based on a state's economic status. Poorer states, such as Mississippi and Texas, provide publicly funded coverage to residents at lower levels of incomes than richer states, such as Massachusetts, New York, and Minnesota. Most states provide coverage to children at higher levels of family income than to other beneficiaries.

8. This limitation was included as part of sweeping welfare reform legislation in 1996. See *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, P.L. 104–193, 110 Stat. 2105 (August 22, 1996).

9. The United States spends nearly US$6000 per capita on health care. Most countries spend between US$2100– $3000 per capita on health care. Kaiser Family Foundation, *Health care spending in the United States and OECD countries* (January 2007). Available at http://www.kff.org/insurance/snapshot/chcm010307oth.cfm.

10. Ibid.

11. Ibid.

12. Ibid.

13. K. Davis, C. Schoen, S. Schoenbaum, et al., *Mirror, mirror on the wall: An international update on the comparative performance of American health care* (New York: The Commonwealth Fund, 2007). Available at http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf.

14. A. Sager and D. Scholar, *The world's most expensive health care: Massachusetts health care costs, 1980–1998* (Boston: Access and Affordability Monitoring Project, 2000).

15. Commonwealth of Massachusetts, *Executive office of workforce development* (press release, March 5, 2009). Detailed labor market information is accessible at www.mass.gov/lmi. Health care was the largest industry in the United States in 2006. Source: United States Department of Labor, Bureau of Labor Statistics.

16. The non-group or individual market refers to individuals purchasing private insurance outside of employment; the small group market refers to the purchase of private insurance on behalf of employees by employers with 50 or fewer full-time equivalent employees.

17. Prior to health care reform, Massachusetts provided coverage through its Medicaid and SCHIP

program to 15% of the Massachusetts population. The program provided coverage for children and pregnant women with income to 200% of the federal poverty level (FPL); parents to 133% of the federal poverty level (FPL); long-term unemployed childless adults to 100% of the FPL; and children and adults with disabilities at any income level (with sliding scale cost sharing). In addition to providing individuals more coverage than is available through most other state Medicaid programs, Massachusetts also offered most optional benefits allowed under Title XIX.

18. A state-sponsored survey published in August 2006 found 372,000 uninsured. See Massachusetts Division of Health Care Finance and Policy, *Massachusetts survey of health insurance status* (August 2006). The Division of Health Care Policy and Finance then adjusted the numbers and concluded that 395,000 were uninsured in 2006. See Massachusetts Division of Health Care Finance and Policy, *Massachusetts household survey on health insurance status, 2007*. Available at www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/hh_survey_07.ppt. However, the United States Census Bureau's annual study published at the same time found 618,000 uninsured. See The United States Census Bureau, *Income, poverty & health insurance coverage in the United States: 2005* (August 2006). Available at http://www.census.gov/prod/2006pubs/p60-231.pdf. There are a number of methodological issues that resulted in surveys finding varying rates of uninsurance. The true number of uninsured at that time is not known; however, it likely lies between those numbers.

19. Since the beginning of the Massachusetts 1115 Demonstration Waiver in 1997, the federal government had been providing "temporary" support to safety net hospitals to assist those facilities with a transition from providing uncompensated care to the uninsured for which they received financial support from the state and federal government to organizations that received payment for services provided through an insurance-based system. In part, the federal government's insistence on ending supplemental payments to these safety net providers was driven by concern at the federal level of the growing Medicaid entitlement and increased emphasis by the Bush Administration on ensuring that states and public providers did not shift their financial responsibilities to the federal government. These supplemental payments were not common across state Medicaid programs, so few states face the same potential for federal pressure that Massachusetts felt during its waiver negotiations.

20. S. Anthony R. W. Seifert, and J. C. Sullivan, *The MassHealth waiver: 2009–2011. . . and beyond* (Boston: Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum, February 2009). Available at http://www.massmedicaid.org/~/media/MMPI/Files/MassHealth%20Waiver%202009%20to%202011%20and%20Beyond.pdf.

21. A. Raminerez de Arellano and S. M. Wolfe, *Unsettling scores: A ranking of state Medicaid programs* (Washington, DC: Public Citizen Health Research Group, April 2007). Available at http://www.citizen.org/documents/2007UnsettlingScores.pdf.

22. A key reason behind the individual mandate was to bring younger, healthier individuals into the insurance pool in order to spread the risk of higher expenses across a greater number of people. An individual who failed to obtain insurance during the first year of enactment was faced with the loss of US$219 through the state tax system. That penalty rose substantially to US$912 in 2008. The state has developed an exemption process that exempts individuals from paying a penalty for failure to obtain health coverage in specific circumstances, including if health insurance is not affordable.

23. Three hundred percent of the federal poverty level is US$32,490 for an individual and US$66,150 for a family of four. Federal poverty levels are updated annually in April.

24. All plans offered through Commonwealth Choice may also be purchased directly from the individual carriers offering the plan.

25. The health care reform legislation also reformed the non-group and small-group health insurance markets in Massachusetts with the goal of lowering prices and offering more choice for those purchasing outside of the employer marketplace.

26. The employer participation requirement applies to employers with 11 or more full-time equivalent employees located in Massachusetts. If the employer does not make a "fair and reasonable" contribution toward coverage, then the employer is required to pay a Fair Share Assessment. Additionally, employers with

11 or more full-time equivalents are required to offer all employees the ability to purchase health coverage (whether through the employer or with individual coverage) on a pre-tax basis.

27. This is in stark contrast to the current national debate where stakeholders have pledged to find significant cost containment in the system, and agreed to cuts in the rate of payment for Medicare and Medicaid in the out years of reform. See, for example, hospital industry agreement with the Obama Administration to take US$155 billion in cuts over a ten-year period. J. Reichard, "CQ HealthBeat Editor, Biden Announces Deal with Hospitals to Cute Medicare, Medicaid Payments by $155 Billion," *Washington health policy week in review* (New York: The Commonwealth Fund, July 13, 2009).

28. P. J. Cunningham and A. S. O'Malley, "Do reimbursement delays discourage Medicaid participation by physicians?" *Health Affairs* 28/1 (2009), pp. w17–w28. Available at http://content.healthaffairs.org/cgi/content/abstract/28/1/w17.

29. D. McCarthy, S. K. H. How, C. Schoen, et al., *Aiming higher results from a state scorecard on health system performance, 2009* (New York: The Commonwealth Fund, October 2009).

30. *Health Connector facts and figures* (March 2010). Available at www.mass.gov/connector. See also Massachusetts Division of Health Care Finance and Policy, *Health care in Massachusetts: Key indicators* (November 2009). Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pbus/09/key_indicators_nov_09.pdf.

31. Ibid. Between June 30, 2006, and June 30, 2009, Medicaid enrollment grew by 99,000 individuals; Commonwealth Care enrolled 177,000 individuals and 132,000 purchased coverage in the private market, either individually or through an employer. Of those purchasing in the private market, 24,000 purchased coverage through Commonwealth Choice. Between June 30, 2009, and March 2010, enrollment in Commonwealth Care dropped to 153,000 members.

32. Ibid.

33. *Massachusetts Department of Revenue, individual mandate, 2008 preliminary data analysis* (December 2009). Available at http://www.mass.gov/Ador/docs/dor/News/PressReleases/2009/2008_Health_Care_Report.pdf.

34. *Health Connector facts and figures* (see note 30). According to the state, visits by individuals eligible for health safety net funding decreased by 36% and payments from the health safety net to hospitals and community health centers similarly decreased by 38%. Individuals who remain uninsured with incomes at or below 400% of the federal poverty level may access full or partial free care through the Health Safety Net. The majority of individuals who utilize the Health Safety Net are undocumented immigrants who are not eligible for coverage through a publicly subsidized program.

35. *Health Connector facts and figures* (see note 30). These results are seemingly in contradiction with the nationwide primary care physician shortage. The Massachusetts Medical Society reports that internal medicine and family medicine are considered to be in critically short supply in their 2009 Physician Workforce Study. Massachusetts Medical Society, *Physician workforce study* (Waltham, MA: Massachusetts Medical Society, 2009). Available at http://www.massmed.org/AM/Template.cfm?Section=Research_Reports and_Studies2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=31511. However, the results are consistent with a recent study completed by Bailit Health Purchasing for the Blue Cross of Blue Shield of Massachusetts Foundation reviewing network adequacy within the Commonwealth Care program, which found that all Commonwealth Care members are enrolled with a primary care physician. Wait times for non-urgent care has been increasing since the implementation of health care reform. Study completed by the author, March 2009.

36. K. Lazar, "Medical costs still burden many despite insurance," *The Boston Globe* (October 23, 2008). Available at http://www.boston.com/news/health/articles/2008/10/23/medical_costs_still_burden_many_despite_insurance/.

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38. Ibid.

39. Kaiser Family Foundation (see note 9).

40. *Roadmap to cost containment: Massachusetts health*

care quality and cost council final report, October 21, 2009 (Boston: Health Care Quality and Cost Council, 2009). Available at http://www.mass.gov/Ihqcc/docs/roadmap_to_cost_containment_nov-2009.pdf.

41. *Recommendations of the Special Commission on the health care payment system, July 16, 2009* (Boston: Division of Health Care Finance and Policy, 2009). Available at http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

42. Because MassHealth and Commonwealth Care, like most other publicly subsidized health coverage programs in the United States, are income based, individuals must provide information proving eligibility at the time of initial enrollment and on a periodic basis. During times of economic crises, states often resort to shortening the time in which individuals have either to respond to redetermination requests or in the frequency of such reviews.

43. See "Governor Deval Patrick's budget recommendations, House 2 fiscal year 2011: Health Care." Available at http://www.mass.gov/bb/h1/fy11h1/exec_11/hbuddevhc.htm.

44. In addition to Massachusetts, two other states (Maine and Vermont) have enacted universal coverage legislation. An additional fourteen states have proposed legislation to enact universal coverage. See Kaiser Family Foundation/Kaiser Commission on Medicaid and the uninsured, *States moving toward comprehensive health care reform* (November 2008). Available at www.kff.org/uninsured/kcmu_state-healthreform.cfm.

45. In a February 2010 poll conducted by the Kaiser Family Foundation, 43% of those polled were in favor of reform, while 43% of those polled were opposed to reform. The poll also found that there was some bipartisan support on some pieces of the legislation. See Public Opinion and Survey Research Program/Kaiser Family Foundation, *Kaiser health tracking poll* (February 2010). Available at http://www.kff.org/kaiserpolls/8051.cfm.