UNICO Studies Series 7
Massachusetts Health Reform:
Approaching Universal Coverage

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All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the nuts and bolts protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

Daniel Cotlear
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The World Bank
Washington, DC
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<th>Description</th>
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<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
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<tr>
<td>AFDC</td>
<td>Aid to Families with Dependent Children</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Initiative Program</td>
</tr>
<tr>
<td>GSP</td>
<td>gross state product</td>
</tr>
<tr>
<td>EOHHS</td>
<td>Executive Office of Health and Human Services</td>
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<tr>
<td>FPL</td>
<td>Federal Poverty Limit</td>
</tr>
<tr>
<td>HCP</td>
<td>health coverage for the poor</td>
</tr>
<tr>
<td>HEDIS®</td>
<td>Healthcare Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>MCOs</td>
<td>managed care organizations</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
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<tr>
<td>SPAD</td>
<td>Single Payment at Discharge</td>
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<td>SSI</td>
<td>Supplemental Security Income</td>
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Executive Summary

The Commonwealth of Massachusetts, one of the 50 states in the United States of America, has achieved near universal health coverage of its 6.6 million residents after a landmark reform made health insurance mandatory for all residents in 2006. The reform was only the latest step in a sequence of national and state programs that successively enrolled more people in private and public health insurance programs over a period of four decades. Massachusetts passed Chapter 58 of the Acts of 2006, the Massachusetts Health Care Reform law, on April 12, 2006, and over a five-year period, more than 400,000 previously uninsured residents were provided with comprehensive health benefits. As of 2012, 98.2 percent of the population is covered, including 99.8 percent of children. Massachusetts has the highest rate of health insurance coverage of any state in the country. The program has widespread popular support, and it served as a model for the design of President Obama’s Affordable Care Act, which established a plan for mandatory coverage on a national basis for the first time in the United States.

There are three principle mechanisms through which coverage was expanded: (a) MassHealth: an expansion of public insurance programs for the poor and near poor, (b) private health insurance: an expansion and regulation of employer health benefits for workers and for the individual and small group insurance market, and (c) Commonwealth Care: the establishment of a new program that offers affordable credible coverage to residents who are not eligible for or cannot access either public insurance or employer-based health insurance.

The three regulatory components that led to successful reform were (a) a robust regulatory infrastructure that assures the insurance plans provide appropriate and affordable coverage, (b) a requirement that all eligible residents avail themselves of coverage or suffer financial penalties, and (c) that employers offer coverage for their workers in accordance with the law or face penalties. The private insurance market is constrained under the reform from refusing coverage for people with underlying illnesses or from charging unaffordable exorbitant premiums on the basis of age or health status. Universal coverage was achieved by expanding and reforming existing programs of private and public insurance, by crafting a new program to cover those individuals who fall through the gaps in coverage, and by strengthening the infrastructure through which eligibility for coverage, the operations of the public and private insurance market, and financing are monitored and regulated.

This report outlines the health care financing and delivery system in Massachusetts, details the structure and functions of the reform, describes the new quasi-governmental agency (The Connector) that serves as a regulator and a prototype health insurance exchange, and describes some of the political dimensions of reform. It also discusses the management and operations of the state and federally financed MassHealth program.

The pending agenda for health reform in Massachusetts includes new efforts to both control medical costs and to reform the primary care delivery model.
1. Introduction

The Commonwealth of Massachusetts, one of the 50 states in the United States of America, has achieved near universal health coverage of its 6.6 million residents after a landmark reform made health insurance mandatory for all residents in 2006. The reform was only the latest step in a sequence of national and state programs that successively enrolled more people in private and public health insurance programs over a period of four decades. Massachusetts passed Chapter 58 of the Acts of 2006, the Massachusetts Health Care Reform law, on April 12, 2006, and over a five-year period, more than 400,000 previously uninsured residents were provided with comprehensive health benefits. As of 2012, 98.2 percent of the population is covered, including 99.8 percent of children. Massachusetts has the highest rate of health insurance coverage of any state in the country. The program has widespread popular support, and it served as a model for the design of President Obama’s Affordable Care Act, which established a plan for mandatory coverage on a national basis for the first time in the United States.

Health reforms to expand coverage have been difficult in the United States generally, and Massachusetts, though it presented relatively more favorable conditions, still faced tremendous challenges. This level of health coverage could only be achieved by forging a political and economic consensus among government officials in the executive and legislative branches, business leaders, advocates for the poor, religious and community groups, and other key constituencies. The reform expanded coverage to individuals through a mandate that requires them to purchase health coverage as long as affordable coverage is available. Businesses with more than 10 employees are also required to offer health insurance with comprehensive benefits to employees and to pay a “fair share contribution” for the cost of the premium. The reform addressed issues in state and federal financing of expanded coverage for the poor and near poor through a combination of subsidies, appropriations, and redirection of funds that had been previously earmarked to reimburse providers for uncompensated care.

The mechanisms through which coverage\(^2\) was expanded has three principal components: (a) MassHealth: an expansion of public insurance programs for the poor and near poor, (b) private health insurance: an expansion and regulation of employer health benefits for workers and for the individual and small group insurance market, and (c) Commonwealth Care: the establishment of a new program that offers affordable credible coverage to residents who are not eligible for or cannot access either public insurance or employer-based health insurance.

Critically important to the success of the reform has been a robust regulatory infrastructure that assures the insurance plans provide appropriate and affordable coverage, that all eligible residents avail themselves of coverage or suffer financial penalties, and that employers offer coverage for their workers in accordance with the law or face penalties. The private insurance market is constrained under the reform from refusing coverage for people with underlying illnesses or from charging unaffordable exorbitant premiums on the basis of age or health status. Universal coverage was achieved by expanding and reforming existing programs of private and

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\(^2\) In this report coverage means that the person is enrolled in a health insurance scheme—either Medicare, another federal (such as the Veterans Administration) or state (such as the Fisherman’s Fund) health program, MassHealth, Commonwealth Care, or a private group or individual health plan.
public insurance, by crafting a new program to cover those individuals who fall through the gaps in coverage, and by strengthening the infrastructure through which eligibility for coverage, the operations of the public and private insurance market, and financing are monitored and regulated. This is the principle theme of the Massachusetts case study.

The path to universal health coverage in Massachusetts is not unusual when put in an international context. Countries like Chile, Germany, Japan, and Sweden all constructed their universal health coverage systems out of disparate and segmented insurance pools (Savedoff and Smith 2011; see also Carrin and James 2005). In each case, formal sector workers were the first to get mandatory insurance coverage, while public policy subsequently extended coverage to the elderly and poor. Universal coverage in Massachusetts was facilitated by national legislation creating Medicare (for the elderly) and Medicaid (for the poor) in 1965. Reaching universal coverage was also easier for Massachusetts because it had relatively few people engaged in farming and the informal sector. With the 2006 reform, Massachusetts effectively filled the gaps in coverage for its population, reaching a level of coverage comparable to that of Germany or Japan.

The political path to reform in Massachusetts is also familiar. Health reforms have been heavily contested in every country at one time or another. Expanding coverage was opposed and delayed out of concerns over public costs. Medical associations representing doctors regularly opposed health reforms in Chile, Japan, and Sweden, just as the American Medical Association has in the United States. A core feature of health care reform debates in all these countries—whether health care should be a personal or public responsibility—was also prominent in the Massachusetts political process. In each case, as in Massachusetts, politicians responsible for passing universal health coverage were able to do so through a combination of strategies, downplaying costs, mollifying or sidelining opponents, and shaping the reform to address public views regarding fairness and responsibility.

This report will briefly describe the reform and its context, but will focus for purposes of simplicity on the operational details of the MassHealth program of health insurance for the poor. A discussion of the administration and management of MassHealth can offer a glimpse into the inner workings of all other insurance plans in the Commonwealth. MassHealth, private insurance, and Commonwealth Care share similar tools, controls, and strategies. (See Annex 1 for a comparison of selected benefits of MassHealth, Commonwealth Care, and Commercial Insurance.)

2. General Health System Overview of Financing and Delivery

Population

Massachusetts has 6,613,100 residents 15 percent of whom have incomes that fall below the federally defined poverty level. It is a relatively wealthy state with a median annual income of $60,923 compared to a U.S. median of $50,022. Eighty four percent of the population lives in metropolitan areas. The gross state product in 2010 was $378,729 million. Total state government spending was $50,424 million ($7,701 per capita), of which 34.3 percent was spent

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3 All monetary units are in U.S. dollars.
on the MassHealth program. Total health spending in 2009 was $61.2 billion, or $9,278 per capita, making Massachusetts the most expensive state in terms of health care in the United States,⁴ or more than 15 percent above the national average even when accounting for higher wages and spending on research and health education.

Providers

Massachusetts has 79 hospitals: 1 public, 67 not-for-profit, and 11 for-profit. There are 36 federally qualified publicly funded health centers offering comprehensive outpatient care serving 588,000 patients with almost 3 million encounters per year. The state currently has 28,795 physicians of which 12,933 practice primary care, and the remaining 15,862 are specialists. The research infrastructure of Massachusetts’ medical schools garners the largest proportion of federal grants of any state. The health care sector is the largest employer in the Massachusetts economy, with 326,170 workers or 10.5 percent of the state’s workforce. The sector’s contribution to the local economy is also leveraged by the numerous other health-related industries that are drawn to the state because of the robust research and provider presence.

Financing and Agents

Health insurance coverage is provided by a variety of agencies and programs. Medicare, the federal program that covers the elderly 65+ and some of the disabled under age 65, covers approximately 16 percent of the Massachusetts population and accounted for $11.721 billion (19 percent of health spending) or $11,277 per capita in 2009. Medicaid and the Children’s Health Initiative Program (CHIP), under the program name MassHealth, covers a diverse population and finances a broad range of services including primary and acute care services for low-income individuals and families, and institutional and community-based long-term care for the elderly and other disabled adults and children. MassHealth covers 16.2 percent of Massachusetts residents, including nearly two-thirds of Massachusetts nursing home residents, approximately one-third of Massachusetts children, and more than one-quarter of nonelderly Massachusetts adults with disabilities. MassHealth spending ($11.8 billion in 2010) reflects both the high health care needs of the elderly and disabled populations that it serves and the broad range of services that it covers.

There are 13 private health plans that offer coverage in Massachusetts, 12 of which offer commercial insurance and 8 of which contract with the federal or state government to provide services to recipients of publicly financed programs such as Medicare and Medicaid. Commercial insurance purchased by employers, on behalf of their employees, or by individuals, accounts for the largest proportion of health spending in Massachusetts. As of March 2011, 79 percent of the state’s nonelderly population was covered by insurance obtained through the private group market (78.7 percent had private insurance purchased in a group, 1.3 percent purchased private insurance as individuals) (see figure 1).

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⁵ Massachusetts Division of Health Care Finance and Policy Publication Number: 12-38-HCF-01.
Private insurers and self-insured health plans collectively paid health care providers an estimated $15.9 billion or 43 percent of estimated total state health care spending in 2008. Commonwealth Care, a program developed under health reform to fill gaps left by existing public and private programs, covered 2.8 percent of the population, or approximately 160,000 individuals, in 2011. Commonwealth Care is available to nondisabled adults who earn up to 300 percent of the federal poverty level, who are not eligible for MassHealth, and who are not offered employer-sponsored health insurance. Commonwealth Choice is an unsubsidized program in which individuals may purchase highly regulated insurance offerings from a selected subset of commercial health plans certified to offer appropriate coverage and value by a quasi-governmental independent agency called The Connector (see details on page 21).

Commonwealth Choice covers 40,000 people, and it offers four tiers of coverage differentiated by price and by actuarial value of the insurance benefits. Small employers with fewer than 50 workers can subsidize their workers’ premiums through the Commonwealth Choice program and thereby receive credit for offering employer based insurance as required by law. An additional 1 percent of the population is covered by other public programs designed to support documented resident aliens and low-income individuals who receive unemployment benefits. A matrix comparing selected benefits and coverage limitations in MassHealth, Commonwealth Care, and commercial insurance is presented in Annex 2.

**Health Care Spending**

In 2009, health services spending (in millions) was distributed among the categories of care listed in table 1.

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6 Massachusetts Division of Health Care Finance and Policy Publication Number: 11-165-HCF-02.
<table>
<thead>
<tr>
<th>Category of Health Care Spending</th>
<th>Percent</th>
<th>In US$ (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>37.8</td>
<td>$23,108</td>
</tr>
<tr>
<td>Physician and Other Professional Services</td>
<td>25.2</td>
<td>$15,391</td>
</tr>
<tr>
<td>Prescription Drugs and Other Medical Nondurables</td>
<td>11.1</td>
<td>$6,808</td>
</tr>
<tr>
<td>Nursing Home Care</td>
<td>8.4</td>
<td>$5,121</td>
</tr>
<tr>
<td>Dental Services</td>
<td>4.8</td>
<td>$2,941</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>4.3</td>
<td>$2,601</td>
</tr>
<tr>
<td>Medical Durables</td>
<td>1.3</td>
<td>$784</td>
</tr>
<tr>
<td>Other Health, Residential, and Personal Care</td>
<td>7.2</td>
<td>$4,408</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
<td><strong>$61,162</strong></td>
</tr>
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3. **Brief Description of Public Health, Primary Care, and Key Supply-side Efforts**

Massachusetts is recognized for the strength of its health care providers, and the quality of care is considered to be among the best in the nation. With four medical schools, and a high concentration of care in academic tertiary care hospitals, it is not surprising that the cost and intensity of care is 15 percent higher than the national average. In 2006, 46 percent of the licensed beds were in academic medical centers compared with 19 percent nationally. The 79 acute care hospitals in the state have a capacity of 2.4 beds per 1,000. Massachusetts spends 18.5 percent more on hospital care compared to the U.S. average, with 60 percent higher utilization of outpatient hospital services and 23.1 percent higher utilization of emergency room visits. Hospitals serve all patients. Even “safety net” hospitals that serve a large number of poor people see a significant volume of privately insured patients, and all tertiary care hospitals are available to serve any patient in need of their services. It is illegal to turn away a patient.

The physician workforce is highly specialized, with more than 80 percent more nonfederal specialists per capita than the national average. Only 34 percent of physicians practice primary care. On a population basis, there is a variance in distribution from over 201 primary care physicians per 100,000 in greater Boston to 58 to 100 per 100,000 in some rural counties. Primary care services are delivered in private practices and in public health centers. These community health centers also serve as a “safety net” of access for the poor, and provide a disproportionate share of care to low-income residents.

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8 Ibid.
As of 2010, there were 36 centers providing care at 303 sites serving more than 588,000 people. The revenue for these centers is generated by a mix of grant support, payments for services from private and government insurers, and patient payments. Twenty-seven percent of revenue comes from MassHealth, 14 percent from federal grants, 9 percent from private insurance payments, 7 percent from Medicare, 2 percent from patient payments, and the rest from other sources. Over 6,000 full-time health workers are employed in Massachusetts community health centers. Patients insured by public programs are seen in community health centers and in private offices. Patients with private insurance are also seen by both private and public providers.

Health plans and physician organizations increasingly recognize the seminal role of primary care in the performance of local health systems. These organizations offer subsidies and incentive payments for practitioners of primary care in order to increase payments for primary care services, to offset the high cost of office overhead in the delivery of primary care, and to lessen the substantial wage gap between primary care physicians and specialists. Incentives are also available to help draw primary care physicians to rural areas and to urban community health centers. There are programs designed to repay medical school loans in exchange for service in these centers.

In 2008, the private health care sector, with some state contribution, developed a philanthropic loan repayment program for physicians and nurses who make a two- to three-year commitment to practice primary care in a Massachusetts community health center. Because of this incentive program, 118 primary care clinicians, able to care for more than 209,000 patients, have been recruited or retained. The University of Massachusetts, the state’s public medical school, forgives two-thirds the tuition costs for students who agree to work in primary care in underserved areas of the state. A program is also in place to facilitate the issuance of work visas and medical licensure for foreign medical graduates who agree to work in designated areas.

According to a 2011 report by the Executive Office of Health and Human Services primary care access in Massachusetts is improving. A survey conducted by the Boston Globe newspaper and a local research foundation noted that more than 90 percent of individuals reported having a primary care provider, and only 5 percent said that in the prior year they had difficulty accessing treatment, tests, or other care. In contrast, a national survey conducted in 2007 showed that about 20 percent of the U.S. population reported not getting or delaying needed medical care at some point in the previous 12 months.

There are a number of statewide programs of population and public health that target specific services, diseases, and populations. A statewide diabetes initiative is, for example, viewed as a strong program. Consensus treatment guidelines for managing the disease were developed with input from health plans, medical schools, specialty societies, the medical society, advocates for patients with diabetes, state government, and other stakeholders. These guidelines are widely deployed along with tools to assist in their implementation. Such tools include educational materials, templates for population registries, and other materials. Technical support for

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10 Primary Care Physician Recruitment Programs in Massachusetts, Massachusetts Department of Public Heath Primary Care Office, December 2008.
implementation of population-based diabetes services is available from the Department of Public Health and from health plans, from the philanthropy-funded Diabetes Association, and from the regional Centers for Medicare and Medicaid Services-funded quality improvement organization. Publicly reported quality measures of diabetes care are common, and most providers participate in some form of incentive payments to improve the delivery of care to patients with diabetes, from both private and public health plans.

4. Health Coverage for the Poor (HCP) Institutional Architecture and Interaction of HCP with the Rest of the Health System

This section will focus on the structure and function of MassHealth—the name that Massachusetts gives to its Medicaid program.

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America’s poorest people.

Medicaid, as a program, was an outgrowth of the Great Society legislation pioneered by President Lyndon B. Johnson in the wake of the assassination of President Kennedy. It was part of the Johnson administration’s “War on Poverty” and has been a contentious program generating tremendous political debate, but it has persisted despite the controversy.

Medicaid (when you sum up the costs of care provided in all the Medicaid programs in all states and territories) is the largest health care program in the United States, covering 62,594,979 people, or 20 percent of the population, at a total yearly cost of $389 billion.

As Medicaid budgets have grown since 1965, state spending on Medicaid has increased accordingly. Medicaid costs now represent the largest line item in state budgets, and further increases in health expenses of the poor strain state resources and cause political turmoil in most states. This remains true despite the fact that the federal government provides a minimum subsidy of 50 percent for the overall costs of the program. In every state, there is continuous and rancorous debate over the role of tax increases, reduction of benefits, and other efforts to control the rate of growth of Medicaid spending. State budget shortfalls are particularly acute during an economic downturn. Data from the Kaiser Family Foundation (Kaiser Commission 2011) show that under the current national health system in the United States, for every 1 percent increase in the national unemployment rate, state tax revenues decrease 3 to 4 percent, while Medicaid enrolment increases by 1 million people and the uninsured population increases by 1.1 million. At the same time, providers, especially hospitals, complain that Medicaid payments are too low and are less than the costs that they incur to provide care to the poor.

Safety-net providers, who shoulder a disproportionate share of care of the poor, often receive special subsidies to compensate for the extra expenses involved in the care of poor, disadvantaged, chronically ill, and ethnically diverse patients. As more states move toward a
managed care approach to control of Medicaid inflation, the safety-net providers are also suffering from shortfalls in reimbursement.

In Massachusetts, the governor is ultimately responsible for the financial and administrative integrity of the MassHealth program. The Massachusetts Medicaid Agency is a branch of the state Executive Office of Health and Human Services (EOHHS). The Secretary of EOHHS is a cabinet position in the governor’s office. At the federal level, the Medicaid program is similarly accountable to the president. The federal Center for Medicare and Medicaid Services, which regulates all state Medicaid programs, is an agency of the U.S. Department of Health and Human Services (HHS). The U.S. Secretary of HHS is a member of the cabinet of the President of the United States and is responsible for the integrity of the national Medicaid program. The federal Office of Management and Budget, reporting to the president, is charged with the responsibility to assure that funding of Medicaid is reasonable. Funding conflicts are constant because the Congress must annually allocate financing for the program in the budget cycle, and this is an overtly political process. The executive branch proposes the budget but only Congress has the authority to apportion the funds. Advocates for improved services for the poor are at odds with those who wish to constrain federal spending during funding debates. Similar political disputes regularly occur at the state level, since the governor’s office proposes the budget while only the legislature has the authority to allocate funds.

As noted, MassHealth is a key component in a series of interlocking health insurance schemes that has propelled the Commonwealth of Massachusetts to 1.8 percent uninsured compared to the nearly 16.3 percent rate in the United States as a whole. MassHealth offers health coverage to approximately 1.5 million people. Since it is a program that targets the poor, determination of eligibility for MassHealth requires means testing. The federal government establishes coverage criteria, a minimum benefits package, a series of optional benefits that may be offered with federal subsidy, and the operating rules of the program. The state provides financing and administrative management for the MassHealth program. In effect, the state operates the program under state laws within the parameters permitted by federal rules. MassHealth contracts with private and public providers. The vast majority of the care that is financed by MassHealth is delivered by the private sector.

As a first step on the path to universal coverage, Massachusetts undertook an effort to expand MassHealth benefits to a larger population. Under an experimental waiver of federal Medicaid operating regulations (termed a Section 1115 Medicaid Demonstration Waiver), MassHealth income eligibility standards were relaxed and additional categories of beneficiaries (such as long-term unemployed adult men) were invited to participate in the program. The costs of this expanded coverage were shared with the federal government, and some of the funds that were used to cover the cost of program expansion were gleaned from money that had been earmarked to compensate providers for care of the uninsured, anticipating that the future rate of uninsured would drop under the program’s new provisions. Additional funds were allocated with the expectation that future savings could be realized through expanded access to preventive services and with improved treatment of chronic illness, thereby avoiding secondary complications of diseases and costly emergency care (Blue Cross Blue Shield 2011).
An important feature of Medicaid expansion under the Section 1115 waiver was the transition from traditional fee-for-service care to a managed care model. Massachusetts requested bids from managed care organizations (MCOs) to enroll the majority of the MassHealth population in these plans. Four plans (Network Health, BMC Healthnet Plan, Neighborhood Health Plan, and Fallon Community Health Plan) were awarded contracts. They were paid by capitation to manage and coordinate the care of enrollees and were required to operate under stringent rules established by the MassHealth program. Requirements that the plans engage in extensive quality improvement activities, data reporting, and case management of the highest cost and most vulnerable segments of the population were key management strategies for the Commonwealth. These four private, not-for-profit subcontracting plans continue to compete for membership and enter competitive bidding for MassHealth contracts on a periodic basis. Accordingly, these private health plans then contracted with a provider network to assure that members could access services and receive appropriate care in order to improve outcomes while controlling medical expenses. The MassHealth program continues to manage approximately one-third of the enrolled population under its traditional fee-for-service arrangement, as well.

5. Targeting, Identification, and Enrollment of Beneficiaries

MassHealth, as a program that targets the poor, determines the eligibility of a beneficiary primarily by income. The federal government establishes an economic definition of poverty that is adjusted on an annual basis by income, financial resources, and family size. In addition, MassHealth eligibility is also established by other categorical factors such as gender, age, disability status, and pregnancy. MassHealth describes itself as a program for “Children, parents and caretakers of children, adults working for small employers, unemployed individuals, pregnant women, disabled individuals, Department of Mental Health clients, HIV-positive individuals, elderly people, and women with breast or cervical cancer.”

The following is a summary of the federally defined “categorically needy” groups for which the U.S. Medicaid program mandates that federal matching funds be provided in order to co-finance (with the states) the care of eligible beneficiaries:

- Limited-income families with children, as described in section 1931 of the Social Security Act, are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996.
- Children under age 6 whose family income is at or below 133 percent of the Federal Poverty Limit (FPL). (Since January 2010, the FPL has been set at $22,050 for a family of four in the continental United States. Alaska’s and Hawaii’s FPLs are substantially higher.)
- Pregnant women whose family income is below 133 percent of the FPL. (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions.
• Supplemental Security Income (SSI) recipients in most states (or aged, blind, and disabled individuals in states using more restrictive Medicaid eligibility requirements that predate SSI).
• Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act.
• Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI because of earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
• All children under age 19 in families with incomes at or below the FPL.
• Certain Medicare beneficiaries.

Other requirements for eligibility include citizenship or legal resident aliens (as well as an elaborate set of rules for exceptions including refugees, immigrants in special status from Iraq or Afghanistan, victims of domestic violence, and others). Undocumented aliens are generally not eligible for Medicaid.

States may also elect to expand coverage while continuing to receive federal subsidies. They may elect to increase the covered population by offering benefits to families with incomes at higher percentages of the Federal Poverty Level according to established regulations, as long as the state is able to pay for its share of the expanded coverage. Massachusetts has the most liberal Medicaid coverage criteria in the United States and has dramatically expanded its coverage, under the 1115 Waiver, both by raising the income ceiling for beneficiaries in certain categories and by offering coverage to other categories of individuals who would not normally be able to access Medicaid benefits.

Program enrolment is coordinated by the MassHealth agency. A variety of enrolment options exist. There is an online option called a “virtual gateway.” A potential beneficiary may apply in person or by mail at a MassHealth office, or may appoint someone else to apply for them (family member, friend, social worker, lawyer, advocate, and so forth). The application is filed by the head of the household. Eligibility of parents and children living at home under age 19 is considered a single application. Community agencies (community action programs, councils on aging, community development corporations) and state social service agencies (Department of Developmental Services, Department of Mental Health, Massachusetts Rehabilitation Commission, Department of Transitional Assistance, Department of Children and Families) are charged with seeking out and identifying potential beneficiaries, and funds are allocated for such outreach. Social workers, health care providers, hospitals, other social agencies can all serve as agents of potential beneficiaries and help them access benefits.

Verification of eligibility for MassHealth is a complex process, deemed necessary in order to reduce the risk of fraud in the program. Verification of income requires submission of tax returns, pay stubs, rent receipts, bank statements, and proof of eligible out-of-pocket health expenses, premium costs for private health insurance coverage (one can be eligible for both MassHealth and private insurance at the same time), and personal care expenses (which may be deducted from income to determine eligibility). Proof of citizenship is also required through the submission of a birth certificate, passport, or naturalization certificate. Disability status is established by a separate agency, the Disability Determination Service, using established medical
and vocational criteria to determine disability. Eligibility for MassHealth is granted for one year or until the beneficiary no longer meets categorical eligibility, and is re-determined on a yearly basis. Eligibility, once approved, is retroactive to three months prior to the enrolment date. This feature permits retroactive payments to the service providers if the person was deemed eligible, and offers an incentive to providers to assist individuals in the enrolment process.

The MassHealth application must be accompanied by the following documentation:

- Proof of identity
- Proof of citizenship for U.S. citizens and nationals
- Proof of immigration status for noncitizens (copy of green card or other official immigration papers)
- Birth dates for all family members
- Social Security number
- Proof of disability determination
- Proof of wages (two recent wage stubs, copy of tax return, or letter from your employer)
- Proof of self-employment, business, or rental income (copy of tax return)
- Proof of unearned income (Transitional Aid to Families with Dependent Children, SSI, child support, pensions, Social Security)
- Bank statements
- Copy of health insurance card for applicants with health insurance
- Proof of medical condition for people applying based on HIV/AIDS status
- Certificate of blindness for people applying based on blindness.

If an application is denied, there is an appeal option. There are advocacy agencies and private lawyers who specialize in appealing adverse coverage decisions. These appeals are heard by administrative law judge at the Massachusetts Board of Hearings, and adverse actions may be further appealed to the civil judicial system.

Once eligibility is determined, a beneficiary must choose a health plan—either the Primary Care Clinician Program operated by the MassHealth agency or one of the contracting private managed care plans that contract with MassHealth to service its eligible members. A MassHealth card (figure 2) is issued to each eligible member, and the contracting managed care plan also issues an identification card.

**Figure 2 Front and Back of the MassHealth Membership Card**

Source: MassHealth.
In addition to the identification card, an enrollee is also listed in an online eligibility database that can be queried by telephone, point-of-sale device, or computer at the time services are rendered in a physician’s office, hospital, or other provider site.

6. Special Topics Related to the Management of Public Funds in HCP

There are several factors that threaten the integrity of public financing of the Massachusetts health reform and of the MassHealth program in particular. The great recession of 2008 to 2010 resulted in an increase in the population of poor who are income eligible for Medicaid. At the same time, tax revenues have fallen, limiting available state resources to cover the costs of the additional enrolment. Health costs in Massachusetts continue to rise at an unsustainable rate. This increase is fueled by a combination of a concentration of high-cost providers (academic medical centers), excessive specialization, provider consolidation resulting in increased market power of hospital and physician groups to demand higher rates, an innovative health economy in which high technology is desired by the patients, the cost of medical education, the fact that the health sector is one of the largest employers in the state, and the reliance on a fee-for-service payment system that is believed by some to drive health care inflation.

A number of initiatives are in place to control the costs of the MassHealth program. There is an extensive medical management infrastructure in place designed to assess and control service utilization, some of which will be discussed below. In addition, the yearly process of redetermination of eligibility is an important cost-control measure. All states have used this technique to control overall program enrolment during periods of economic downturn. In 2009, a federal law called the American Recovery and Reinvestment Act, aimed at mitigating the impact of the economic recession, temporarily curtailed states’ ability to use this tactic and required them to engage in “maintenance of effort” to enroll eligible beneficiaries in Medicaid in order to qualify for federal matching Medicaid funds.

The redetermination process results in termination of eligibility for a significant number of MassHealth and Commonwealth Care enrollees each month. Terminations may result from either unavoidable or avoidable circumstances. An unavoidable termination occurs, for example, because an enrollee’s income has increased or he or she has gained access to employer-sponsored insurance. Some Commonwealth Care members disenroll because they do not want to or are unable to pay required premium contributions (Massachusetts Medicaid Policy Institute 2010).

The use of a redetermination process for coverage eligibility ironically results in an increase in the rates of the uninsured despite the fact that the intention of the program is to maximize coverage.

7. Management of the HCP’s Benefits Package

As noted, the federal government establishes a basic coverage package and states may add optional coverage categories within defined parameters, as long as the state is willing to shoulder up to 50 percent of the costs of these extra benefits, and the basic benefits package is established by federal rules accompanied by a federal subsidy. The decision to provide expanded coverage
for optional services is determined by the state’s ability to co-finance with the federal government the cost of those expanded services.

Medicaid benefits are comprehensive and cover primary health services, specialist care, and high-complexity services delivered at tertiary hospitals. Services are covered for ambulatory, outpatient, and inpatient care. Services are also covered in rehabilitation facilities and at long-term custodial care facilities (nursing homes) and by home care agencies (such as visiting nurse associations) and home hospice care.

According to the “Kaiser Family Foundation Primer on Medicaid 2010,”12 all Medicaid programs cover the following “mandatory services” as specified in federal law in order to receive federal matching funds:

- Physicians’ services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment services for individuals under 21
- Federally qualified health center and rural health clinic services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services
- Transportation services.

States are also permitted to cover many important services that federal law designates as “optional.” Many of these optional services are particularly vital for persons with chronic conditions or disabilities and the elderly. Prescription drugs (which all states cover), personal care services, and rehabilitation services are just three examples. The inclusion of many of these services in state Medicaid programs despite their “optional” designation in federal statute is evidence that, as a practical matter, they are often considered essential. Nonetheless, when states face funding shortfalls, these “optional” benefits are particularly vulnerable to cuts. Close to one-third of Medicaid spending is estimated to be attributable to optional services.

Commonly offered optional services include:

- Prescription drugs
- Clinic services
- Care furnished by other licensed practitioners
- Dental services and dentures
- Prosthetic devices, eyeglasses, and durable medical equipment
- Rehabilitation and other therapies
- Case management

• Nursing facility services for individuals under age 21
• Intermediate care facility for individuals with mental retardation services
• Home- and community-based services (by waiver)
• Inpatient psychiatric services for individuals under age 21
• Respiratory care services for ventilator-dependent individuals
• Personal care services.

MassHealth covers only services that are deemed to be medically necessary (see Box 1). Services that do not meet this definition are not covered. This rule excludes, for example, most cosmetic surgeries or procedures (except when necessary to treat functional defects), assisted reproduction, and other optional services. There are systems of prior authorization for elective surgeries, certain high-cost pharmaceuticals, and high-cost durable medical equipment. Other methods of cost control include small patient copayments for ambulatory services and for pharmaceuticals, including a higher copayment for certain brand name drugs. Annex 1 presents examples of medical management initiatives used by MassHealth, Commonwealth Care, and commercial insurance companies.

Beneficiaries must be treated by participating providers. All public providers and most private providers participate in the program. A beneficiary may choose to receive care in a private office or a public clinic. Under the subcontracting MassHealth managed care plans, beneficiaries must choose a primary care physician to coordinate care. If a primary care physician is not chosen, one is assigned to that member.
Physicians and outpatient services are reimbursed on a fee scale. Hospital care is paid on a case rate called Single Payment at Discharge (SPAD). Every hospital has a negotiated SPAD rate which is all-inclusive no matter how long the length of stay or diagnosis. Thus, simple cases are paid the same SPAD as complicated ones. The SPAD rate is negotiated to match the expected case mix of the hospital. Certain hospitals and clinics (public or private) that serve a disproportionate share of poor patients are paid at rates that can be significantly higher than other private providers. In the past, the SPAD rate was adjusted when patients required more than 20 consecutive days in a hospital. As a cost-control measure, this payment adjustment for catastrophic cases has been eliminated by MassHealth.

Recent enhanced medical management initiatives for MassHealth include freezing or reducing provider payment rates (including an increase in payments that are at risk based on performance on specific quality measures), enhancing member copayments for services and pharmaceuticals (generic and over-the-counter copayments increased from $2 to $3 per prescription), restrictions on optional benefits (including restorative dental services and dentures), prior authorization reviews for many drugs including the use of a preferred drug list [see box 2]) and certain medical procedures (including an initiative to better control certain drugs for behavioral health problems), postservice audits and fund recoveries for services that were not deemed to be medically necessary (using independent external auditors as Recovery Audit Contractors), fraud reduction through more frequent audits and investigations, and reform of policies regarding payment and

<table>
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<th>Box 1 MassHealth Definition of Medical Necessity</th>
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<td>130 CMR 450.204</td>
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<td>(A) A service is “medically necessary” if:</td>
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<td>(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.</td>
</tr>
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<td>(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)</td>
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<td>(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.</td>
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<td>(D) Additional requirements about the medical necessity of acute inpatient hospital admissions are contained in 130 CMR 415.414.</td>
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<td>(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).</td>
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Source: www.lawlib.state.ma.us/source/mass/cmr/cmrtext/130CMR450.pdf.
Note: CMR = Code of Massachusetts Regulations.
regulation of long-term care facilities (including a nursing home pay-for-performance scheme) (Kaiser Commission 2011).

The subcontracting managed care plans are paid a capitation by the MassHealth program and must offer comprehensive care to patients who are assigned to or selected by them. All contracting managed care organizations have extensive medical management and case management infrastructure in order to control medical expenses and coordinate the care of the small fraction of enrolled members who have the highest service utilization because of chronic illness, combined medical/mental illness, or social disruptions.

Box 2 “Moral Hazard” in the Context of Expanded Access to Benefits and Services

Since near universal coverage now provides access to services for a growing population of Massachusetts residents, there are increasing demands for the use of health care services by this population. Not all demands are appropriate, as illustrated in this case. Strong utilization controls are needed to avoid the overuse of services and to assure that the services delivered are appropriate and cost-effective.

Case: R.W.

R.W. is a 52-year-old man with diabetes, hypertension, and high cholesterol. His physician prescribed generic atorvastatin to control his cholesterol level. The patient saw an advertisement on TV for a brand name statin drug called Crestor. He asked his physician to prescribe it instead of the generic alternative. The physician submitted a request to MassHealth to cover Crestor. The accompanying clinical data did not support the use of the brand name drug. A physician reviewer, working on behalf of MassHealth, phoned the ordering physician to discuss the case. The ordering physician apologized and said that he only submitted the request for the nonpreferred drug because the patient demanded it. MassHealth declined to cover Crestor because generic atorvastatin is less expensive and equally effective.

For services paid for and managed by MassHealth, the Medicaid agency sets the fee scale and SPAD rates and negotiates them with providers. For services paid for and managed by subcontracting MCOs, there is a competitive bidding process and negotiation for capitation rates to be paid to those MCOs, and the subcontractor then negotiates payment rates and schemes directly with providers.

The MassHealth program is large and powerful enough to force providers to accept the program’s payment rates. As noted, providers perennially complain that the rates are too low.
8. The Information Environment of the HCP

The program has stringent requirements for data collection and reporting. Measures of service utilization and quality of care are publicly reported in a transparent manner and are used in the structuring of provider payment incentives. MassHealth participates in a national program of quality measurement, reporting, and performance improvement called the Healthcare Effectiveness Data and Information Set (HEDIS®). All Medicaid programs collect and report such data and are compared regionally and nationally. Moreover, comparisons abound regarding MassHealth HEDIS performance and the performance of commercial health plans and plans that participate in the Medicare and Commonwealth Care programs. National, state, and regional benchmarks on HEDIS metric performance are widely publicized. Because performance measures at the program, health plan, and provider level are openly reported, these data serve as a stimulus of competition among plans and providers to improve quality.

A sample of Medicaid HEDIS metrics\(^{13}\) include:

**Effectiveness of care:**
- Assessment of overweight and underweight individuals
- Immunizations for children, adolescents, and adults
- Women’s cancer screening
- Appropriate treatment of children with pharyngitis
- Use of appropriate medications in people with asthma
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive diabetes care
- Follow-up after hospitalization for mental illness

**Access/availability of care:**
- Adults’ and children’s access to preventive/ambulatory services
- Prenatal and postpartum care
- Call center abandonment rates

**Experience of care:**
- Consumer Assessment of Healthcare Providers and Systems (CAHPS\(^{®}\)) survey results for adults and children

**Utilization and relative resource use:**
- Guidelines for utilization measures
- Well child care in the first 15 months of life
- Inpatient hospital utilization
- Mental health utilization
- All-cause readmissions
- Antibiotic use rates
- Relative resource use for patients with chronic health conditions

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Health plan descriptive information:
- Board certification of providers
- Enrolment by plan category
- Language diversity of enrollees.

HEDIS measures are selected and defined through a process of scientific analysis and consensus development by the National Committee for Quality Assurance (NCQA). The NCQA is a coalition of health plans, government agencies, professional provider organizations, and hospital associations. While the details of the measures are frequently the subject of spirited debate, the rigorous process of choosing the metrics and defining the measurement methodology gives them great validity and legitimacy.

There are numerous incentives to improve performance on these measures. MassHealth and its subcontracted private plans have programs of performance payments for providers. Private plans that contract with the Commonwealth to service the MassHealth and Commonwealth Care populations also receive capitation rates that are linked to HEDIS performance. Members are preferentially assigned to plans with better HEDIS scores. Health plans use their good HEDIS results in marketing and advertising to tout the quality of the care that patients can expect to receive if they enroll with that plan, and providers highlight their HEDIS scores in advertising material designed to attract new patients.

Despite near universal coverage, disparities in health status persist among racial and ethnic groups and among patients who are insured by commercial health insurance and MassHealth. Data on selected measures of persistent racial and ethnic health disparities in Massachusetts are reviewed in Annex 3. The underlying causes of these persistent disparities transcend a person’s access to health insurance and are related to issues of poverty, social disruption, access to health care services, and other factors.

Table 2 compares 2011 HEDIS quality metrics among commercially insured and MassHealth beneficiaries.14

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<tr>
<th>HEDIS 2011 Indicator</th>
<th>Commercial Insurance (%)</th>
<th>MassHealth (%)</th>
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<tr>
<td>Breast cancer screening</td>
<td>78.9</td>
<td>67.2</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>55.2</td>
<td>76.2</td>
</tr>
<tr>
<td>Timeliness of prenatal care</td>
<td>91.8</td>
<td>89.7</td>
</tr>
<tr>
<td>Postpartum care</td>
<td>81.7</td>
<td>68.7</td>
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14 “MassHealth Managed Care HEDIS® 2011 Final Report,”

How did Massachusetts achieve health coverage for more than 98 percent of its residents? It was through a process of expansion of existing coverage models to include a large proportion of the population; increased regulation of the employer-based, small group, and individual private insurance market including a system of mandates and penalties for individuals or employers who do not comply with coverage requirements; and the introduction of a new program to fill in the remaining gaps. An expanded MassHealth, a tightly regulated expansion of private health plan coverage, and the addition of a new Commonwealth Care program, yielded the coverage outcomes of the Massachusetts reform.

Expansion of MassHealth, the principle step, brought individuals and population segments into government-funded coverage. The existing mechanisms of enrolment; provider contracting; provider payment and incentives; fraud control; and systems of utilization, quality, and financial management applied to the newly eligible population and thus did not have to be revised in any substantial way to accommodate the expanded coverage.

Regulation of the private insurance market required coordinated action by a number different state government agencies. The Secretary of Housing and Economic Development, through the Consumer Affairs Bureau’s Division of Insurance (which regulates private insurance companies) must certify that the coverage offered by insurers meets legal standards of “creditable coverage.” Individuals are required to purchase coverage if affordable coverage is offered to them. Corporations with more than 10 employees are required to offer coverage to their employees, and that coverage must meet minimal standards. The Secretary of Administration and Finance, through the Department of Revenue, must certify that individuals and employers are compliant with the law at the time that state income taxes are collected. A mechanism is then established to collect penalties from individuals or corporations who were found to be out of compliance with the law.

The Connector: A Prototype Health Insurance Exchange

The third piece of this universal coverage system, Commonwealth Care, relies on a new public organization, called The Connector. The Connector was established by Chapter 58 as a quasi-governmental independent agency. It was created to serve as a virtual marketplace for tightly regulated insurance products that are offered to two population groups: (a) Commonwealth Care for those who are income-eligible for the program, and (b) Commonwealth Choice for small businesses or for those individuals who are not income-eligible for subsidized insurance and are not offered insurance by their employer. The Connector offers a standardized menu of insurance plans, portability of coverage with change in employment status, and promotes administrative simplification for those who seek coverage. The Connector is legally separate from the state government and is able to contract with public and private entities. Its funding comes from a combination of state allocations and operational revenue (the agency charges fees of 4 to 5 percent of premium to health plans that contract to provide insurance coverage through its
programs.) The current operating budget, according to The Connector’s Annual Report, is approximately $30 million.

The Connector has a governing board consisting of 11 public and private individuals, including four ex-officio members (or designees):

“…the Secretary for Administration and Finance, the Director of Medicaid, the Commissioner of Insurance, and the Executive Director of the Group Insurance Commission. The governor appoints an actuary, a health economist, a representative of small business, and an underwriter. The Attorney General appoints an employee health benefits specialist, a representative of health consumers, and a representative of organized labor. Appointees cannot be employed by an insurance carrier licensed in Massachusetts.”

Meetings are public and the minutes are posted on the agency’s website.

The legislature wisely delegated important implementation, regulatory, and operational decisions about how the law would function to technical experts who serve administrative or governance roles in the new agency. It also concentrated a great deal of power into this agency, in order to negotiate favorable rate and terms with insurers, so that it could offer comprehensive benefits at the lowest possible cost.

The Connector serves a series of functions; it is a key regulator, policy maker, and implementer of health reform. It establishes standards for coverage and benefits packages, it determines eligibility for coverage and enrollee contributions, it solicits bids from insurers to provide insurance coverage to its enrollees, and it selects health plans that offer bids and are qualified to participate in its programs. The Connector fulfills its responsibilities for program integrity by monitoring and reporting on customer service needs of the enrollees and providing oversight of the use of public funds. As a policy maker, The Connector determines the standards for affordability of coverage and for defining “Minimum Creditable Coverage” to establish standards by which individuals’ and employers’ compliance with the provisions of the law can be measured.

The agency also has important outreach and marketing functions to inform the public of the availability of insurance and the new requirements to obtain coverage. It also offers customer service functions to the public through a toll-free phone number and through its website, where individuals can easily access information about the law’s requirements and coverage options that are available to them (Lischko, Bachman, and Vangeli 2009).

Health plans that wish to offer Commonwealth Care coverage must meet requirements of The Connector and must enter into competitive bidding with one another for the pricing of premiums. An individual who wishes to choose a Commonwealth Care plan through The Connector may do


so by phone, in person, or by accessing a single website that displays the competitive offerings of plans that meet minimum standards of coverage.

Commonwealth Care was created to fill in the gaps in coverage in order to offer coverage for individuals who work in the informal sector or for employers who are exempt from providing health coverage for their employees. The Commonwealth Care system is managed by The Connector, while the processes of enrolment and eligibility determination are managed by MassHealth. Plans that operate in Commonwealth Care are also required to comply with standards established by the Division of Insurance and by other state agencies.

The Politics of Health Care Reform in Massachusetts

To the outside observer, this coverage scheme may appear to be a patchwork of programs, with a variety of health plans, regulatory authorities, and an admixture of public and private resources and with each piece attempting to solve a particular type of coverage problem. The success of the program, though, lies in the fact that the various components of the system are stitched together in such a way as to provide for universal coverage, while avoiding the need to dismantle and rebuild the popular underlying insurance and delivery models that currently function adequately for a majority of enrollees. An important lesson from the Massachusetts experience is that multiple policy mechanisms were required to achieve the aims of meaningful change in coverage, reform of the private insurance market, and expansion of public programs.

Prior to the enactment of Chapter 58 of the Acts of 2006, conditions in the state were already favorable for health reform. Massachusetts had an uninsured rate that was one-third less than the national average, higher personal income relative to other states, and a healthy tax base. Massachusetts already provided block grant funding to safety-net health care providers to cover the costs of care for the uninsured. The Free Care Pool, the source of these block grants, was funded through a combination of tax revenues, federal subsidies, and surcharges on both private health insurance premiums and revenues of private hospitals. The Free Care Pool provided a generous level of support for the care of the uninsured compared to other states. This care was largely delivered in public hospitals, community health centers, and other public agencies.

A Republican governor, Mitt Romney, facing a Democratic majority in the legislature, articulated the business case for universal coverage and made it a centerpiece of his administration’s agenda. The speaker of the state House of Representatives and the president of the state Senate both embraced the initiative and actively promoted it. They led their legislative bodies to negotiate in a bipartisan manner over some of the more controversial provisions of the bill. The liberal-leaning legislature was incongruously convinced to include an individual insurance mandate in the law (a provision that was originally proposed by Stuart Butler of the conservative Heritage Foundation.) Conservative business constituencies, in exchange, were willing to accept a liberal-sponsored mandate for employer-sponsored coverage (a feature of the law that was also supported by religious groups, advocates for the rights of the poor, powerful provider groups, and by the state’s largest health insurer.) The negotiators merged individual and employer responsibilities in ways that had never been previously considered. Employer

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17 At the time that the law was passed, California, another progressive state, had an uninsured rate of 25 percent compared to just over 5 percent in Massachusetts.
responsibility is preferred by the political left and is unpopular with the political right, while the obverse is true for the issue of individual responsibility (McDonough et al. 2006).

There was great debate about equity and fairness of the Free Care Pool financing scheme, and there was widespread agreement that the changes in the program were necessary. Some business leaders, whose companies offered comprehensive health benefits to their employees, complained that other business sectors were taking advantage of the Free Care Pool funding mechanism by failing to provide coverage to their workers. Private hospitals quietly protested about a reallocation of their revenues to public providers, with insufficient accountability for the costs of care that was being delivered to the uninsured. The impetus to change was further spurred by the Bush administration, which threatened to withhold $385 million in federal Medicaid funds, allocated for indigent care in the Section 1115 waiver, unless Massachusetts reduced its program of block grant funding for the uninsured and replaced it with demand-side financing.¹⁸

Uninsured patients were shown to have avoidable high health expenses due to delayed care, to the use expensive emergency rooms instead of primary care, and because of a high rate of hospitalization for ambulatory sensitive conditions. A coalition of health care providers, private insurers, business leaders, and politicians from both political parties ultimately coalesced in a plan to expand coverage and to reduce the avoidable medical expenses that were attendant to the uninsured.

The 2006 reform was immensely popular with the public, and also with private health care providers (who received payment for their services, after the reform, from the newly insured patients who they had previously treated without reimbursement). But providers of safety net care in public hospitals and community health centers were rightfully concerned that the transfer of funding from the Free Care Pool to an insurance scheme would result in severe budget cuts. For years, state policy makers had discussed transforming supply-side subsidies into demand-side subsidies to help people buy insurance coverage.¹⁹ Safety net providers worried that insurance companies would not pay rates sufficiently high enough to offset the additional costs of caring for socially disenfranchised patients.

The 2006 reform addressed these concerns by adopting provisions to buffer public providers from anticipated financial shortfalls and to provide a glide path of three years in which a transition from block grant to insurance funding could be accommodated. Two public hospitals were awarded a total of $287 million dollars of supplemental funding for the first three years of the program, and additional supplemental payments have subsequently been granted to help reduce resultant budget deficits at these two key institutions, while both hospital systems have gone through extensive restructuring and painful reductions in staffing in efforts to reduce overhead costs.

The new scheme averted, in some respects, the inevitable political backlash that reformers would have faced from employers, providers, and beneficiaries if more radical change had been proposed. Simultaneously, the coverage scheme offered free or subsidized coverage to the poor and near poor, while at the same time offering affordable coverage to those who lacked insurance but who had income levels that disqualified them from free or subsidized programs. The

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¹⁸ Ibid.
¹⁹ Ibid.
individual mandate for coverage circumvented the problems of adverse selection, underwriting, and denial of coverage for reasons of health status, and thus alleviated a major concern of the insurance industry.

The strict regulation of plans and the requirements for basic standards of coverage and affordability assured the provider community that payment would be made for appropriate care and that the care of nearly all patients would be covered by the scheme. The employer community, the major purchaser of insurance coverage, was satisfied that all purchasers would be required to offer similar levels of coverage, assuring that less scrupulous employers could not skirt their responsibility to offer and contribute to credible coverage for employees. Other important political constituencies, such as advocates for the poor and religious groups, were mollified by the reform because the program was viewed as a great social good delivering on a promise of justice and equity in coverage and in access to services.

10. The Pending Agenda

Now that Massachusetts has effectively insured everyone, the remaining challenges are to (a) make sure all three arms of the program work together seamlessly, (b) control costs to keep it affordable, and (c) support an expansion and modernization of the primary care delivery model.

Architecture and Control of the Growth of Health Care Costs

The issue is one of cost management and control of service utilization. The overall health care coverage architecture has resulted in a finely balanced network of employer-sponsored health insurance, an individual mandate that requires individuals and families that have access to affordable coverage to purchase it, the expanded MassHealth program, the Commonwealth Care program that offers regulated and subsidized private insurance to those individuals who do not have access to affordable coverage, a health insurance exchange as a vehicle to regulate the subsidized and approved plans, and a residual Health Safety Net program to finance the care of the small subset of residents who remain uninsured despite the availability of the other noted coverage options.

Total per capita health spending in Massachusetts has been increasing and is growing faster than the national average, both in terms of per capita costs and in percent of gross state product (GSP) (Ayanian and Van der Wees 2012). From 2005 to 2009, Massachusetts total health spending per capita increased 24.7 percent, with an average annual increase in state health expenditures of 5.9 percent over a 10-year period. This compares with 19 percent growth for the United States as a whole from 2005 to 2009, with an average annual rate of growth in national health expenditures of 5.3 percent over the same 10-year period (Health Spending... 2011).

The impact of the reform on total health care costs is of ongoing concern and is the subject of new regulations and policy. Already the state with the highest per capita health care expenses in the nation, Massachusetts health care spending is projected to double by 2020 without further action. Did the reform itself produce a higher rate of health care inflation? The data on that question are unclear. Since 2006, private health insurance premiums in Massachusetts have grown at a rate that is lower than the national average (Blue Cross Blue Shield 2012b). Yet, in a
Box 3 Accountable Care Organizations

A new provider model called an Accountable Care Organization (ACO) has been under development in the United States.

An ACO is an aggregate of providers (physicians and hospitals) who are held responsible for the cost and quality of the care provided to a defined population. ACOs are positioned to accept global payments for care, and they set up the necessary management systems in order to bear financial risk. An ACO uses methods such as provider contracting, quality management, utilization management, data and reporting, and clinical guideline development.

Asserting that the fee-for-service payment model is a major driver of health cost inflation, the Massachusetts cost-control legislation encourages providers to aggregate into ACOs so that they can participate in global payment contracts.

In a report of the drivers of health care inflation in Massachusetts, the principle factors are high rates of service utilization, a disproportionate use of specialists and academic medical centers, a service mix that favors high-complexity procedures, and high prices (Blue Cross Blue Shield 2012b). The 2006 reform did increase the number of individuals with insurance, and their increased utilization of services has contributed to increased total health care spending; but it has not been the major source of spending increases (Blue Cross Blue Shield 2012b).

Some express serious doubts about the affordability of the reform, in terms of the effects on overall health care costs in the state and in terms of the actual cost to government and purchasers for the expanded coverage. Critics of the law termed it a “budget buster” when it was passed. The Massachusetts Taxpayers Foundation, an independent group that advocates for effective use of tax dollars and for improved operations of state and local governments, has noted that concerns about increased expenditures by the state government were unfounded (Massachusetts Taxpayers Foundation 2012). They concluded that incremental state spending on health reform activities amounted to 1.4 percent of the state’s budget, or $453 million. State spending on health reform averaged just under $91 million per year over a five-year period and this amount was well within the projected cost of the reform.

With growing recognition by both the public and providers that the current health financing scheme is unsustainable, there are now reinvigorated efforts to control cost. These challenges, coupled with the advent of universal coverage, helped trigger the political resolve to address health care payment reform in the Commonwealth. On the final day of the law-making session, the Massachusetts Legislature passed Chapter 244 of the Acts of 2012, which was immediately
signed by the governor. The explicit aims of payment reform legislation were to (a) establish annual state spending targets for all nonfederal health care programs, (b) encourage providers to aggregate into risk-bearing “accountable care organizations” (Box 3), (c) establish an independent Health Policy Commission to monitor health spending and encourage performance improvement for provider organizations, and (d) require Medicaid to expand its use of alternative (not fee-for-service-based) provider payment methodologies for the care of 80 percent of beneficiaries by 2015 (Mechanic, Altman, and McDonough 2012).

The most important feature of the cost-control legislation is the establishment of statewide health spending targets equal to the long-term average annual growth of the state’s economy. In 2013, this would amount to a target of 3.6 percent health care inflation compared to a projected national rate of 6.3 percent. For 2014 to 2017, benchmark health expenditures growth is set at the rate of growth of the GSP (Steinbrook 2012). Current projections are that GSP will increase at a rate of 4.4 percent per year over the next five years.20 The law further limits health expenditure inflation to 0.5 percent less than the rate of GSP growth during 2018 to 2022. These targets are to be achieved through a combination of regulation, transparency of payment rates and methods and reform of provider payment schemes.

Many observers in the United States believe that the fee-for-service payment system drives high costs, excess utilization, and gaps in quality (Fisher et al. 2009). This assertion is not without controversy. It is clear that fee-for-service payment is deeply entrenched in the U.S. health care economy. Even new “alternative payment models” continue to rely on the resource-based relative value scale fee-for-service payment scheme as the fundamental basis for reimbursing providers (Ginsburg 2012). Under the cost-control law, provider groups can expect to be held accountable for the cost, appropriateness, and quality of their services under new “alternative payment models,” coupled with steeper incentives to improve performance on quality metrics. These new models may include global payments, case rates, episode of treatment payments, pay-for-performance incentives, and other methodologies. The Health Policy Commission has the authority to gather and report data on provider performance and to publicize the data in a transparent manner. Provider organizations with costs that are deemed excessive can be required to engage in a corrective action plan, and provider groups that abuse their market power to demand excessively high rates may be referred to the state attorney general for prosecution.

In the near term, MassHealth and the entire state of Massachusetts will continue to grapple with reform of the provider payment model. Payment reforms, including a major shift away from fee-for-service payments, and selective contracting with high-performing providers, are the mainstays of this effort. The changes that will likely result will be smaller, more concentrated networks of preferred providers. These preferred providers will have enhanced capacities to manage the more complex, chronically ill, and socially disenfranchised segments of the MassHealth population in which a great deal of cost is concentrated. The new provider models, Accountable Care Organizations, are now forming and are being positioned to be able to receive and manage global payments for services. Innovative bundled payments and outcome-based payments to providers are also in advance states of planning. At the same time, reforms in payment for long-term care are in process. Provider payment reform and aggressive spending

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targets for nonfederal health programs are the mainstays of the first-in-the-nation cost-control measure signed into law in 2012.

**Beneficiaries, Targeting, and Enrollment**

A combination of publicity, penalties for noncompliance, and public support for expanded health coverage has contributed to the program’s success. The current policy agenda revolves around sustaining the viability of legacy safety-net providers that suffered revenue loss when large numbers of their traditional clients converted from a state subsidy financing scheme to an insurance scheme. Payment reductions to these critical access providers was an unintended consequence of health reform, and the loss of these providers would have impeded the newly insured population’s ability to obtain services from familiar providers who have the skills to engage with poor clients in convenient locations in low-income neighborhoods.

**Management of the Benefits Package**

The benefits package is relatively fixed. The major challenge is to incorporate appropriate payments for new technology, new pharmaceuticals, and novel therapies into the program. Because “all medically necessary” services are covered under most of the insurance programs, it is a continuing challenge to determine whether a particular service is medically necessary or is proposed for a particular patient based on marketing or lobbying.

**Public Financing of the Program**

Public support for health reform and its expanded coverage remains strong. Because of this strong public support, legislators are under pressure to at least maintain financing of the successful implementation of health reform. As noted above, the main policy agenda revolves around cost control and controlling the growth of the program’s expenses. This can and will be done by changing the way that health care is purchased in the Commonwealth, coupled with programs to increase provider accountability for quality, outcomes, and patient satisfaction.

**Information Environment, Monitoring, and Evaluation**

All of the planned reforms in provider payment and cost management depend on accurate and timely data. There is increasing pressure on providers to report on data that were, in the recent past, difficult for the MassHealth agency to obtain. The Attorney General and the Secretary for Health and Human Services have increased authority to gather and report data on provider performance, and these agencies are exercising that authority through the newly chartered Health Policy Commission. Simultaneously, private health insurance plans have joined in the evaluation and monitoring efforts. Provider contracts require data reporting as a condition of participation. New health insurance “products” are being marketed to employers at reduced cost, and are designed to offer incentives to patients to choose lower-cost providers who perform high on quality metrics.

Health information technology, at the analytic level and at the provider level, is a prominent component of reform. Federal subsidies are in place funded by the Affordable Care Act, for
providers who adopt electronic medical records and use them in a meaningful way. Provider payments in the federal Medicare program for the elderly and disabled will be reduced for providers who do not use electronic records. At the state level, medical licensure will be contingent on competency in using an electronic health record on January 1, 2015.

The Future of Primary Care

Massachusetts has one of the highest concentrations of physicians per capita in the United States, yet there is a relative shortage of primary care in some regions of the Commonwealth. A combination of factors continues to drive this mal-distribution of physician resources. Primary care providers are relatively underpaid compared to specialists. The popular conception in the state is that if you have a serious illness, it should be treated by a specialist. The difficulties in primary care access due to shortages of primary care providers exacerbates some of these trends, by impairing urgent-appointment availability, and by reducing the time that primary care doctors can devote to any one patient.

The fee-for-service payment scheme does not adequately support the delivery of comprehensive primary care, and it contributes to the relative shortage of primary care services in the Commonwealth. Modern models of primary care recognize the importance of care coordination, patient education, psychosocial support, family meetings, and other nonbiomedical activities. Such activities commonly occur outside of normal office hours, on the telephone, or over the Internet via an electronic patient gateway, and they are generally not reimbursed under a fee-for-service payment mechanism. Primary care physicians are dissuaded from going into a field in which the burden of unreimbursed services is high and funding for ancillary support services is limited.

In an effort to revitalize primary care as a specialty and as a service that is valued and desired by patients, there is a movement to abandon the traditional model of primary care in favor of a new model termed a Patient Centered Medical Home. Such a model involves the following elements (among others): team-based care, expanded support staff, case management staff embedded in the practice, health information technology to support population management and to reduce defects in care, improved health screening and chronic disease management, and enhanced access and availability with same-day, open-access scheduling. Financial support via subsidies for Patient Centered Medical Homes is part of the national and state health payment reforms that are in development. Moreover, a move away from fee-for-service payments to global payments will allow primary care practices to reinvest savings from reducing avoidable health expenditures in the primary care practice site. This will improve staff and provider salaries, upgrade facilities, and fund the additional staff necessary to implement the model.
# Annex 1 Selected Medical Management Initiatives Common to MassHealth, Commonwealth Care, and Commercial Insurance Companies

<table>
<thead>
<tr>
<th>Management Initiative</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization</strong></td>
<td></td>
</tr>
<tr>
<td>Elective surgery</td>
<td>Internal review of elective surgeries that are shown to have rates of overuse, such as hysterectomy and spine surgery.</td>
</tr>
<tr>
<td>High-cost drugs</td>
<td>High cost, those with similar action to generic, and drugs that have cosmetic indications.</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>Universally high cost, frequently unproven indications, or those tests that will not lead to medical interventions.</td>
</tr>
<tr>
<td>High-tech imaging</td>
<td>CT, MRI, nuclear imaging. High cost and frequently overused procedures. Emergencies are exempt from review.</td>
</tr>
<tr>
<td>Out-of-network care</td>
<td>Rare cases that cannot be managed by contracted providers. Need to distinguish patient/provider preference from medical necessity.</td>
</tr>
<tr>
<td><strong>Case management</strong></td>
<td></td>
</tr>
<tr>
<td>High-risk individuals</td>
<td>Patients with multiple co-morbidities. Care coordination. Individual care management planning.</td>
</tr>
<tr>
<td>Patients with chronic disease</td>
<td>Assurance appropriate medical management and improved patient adherence to treatment plan.</td>
</tr>
<tr>
<td>Severe mental illness</td>
<td>Helping maintain adherence to medications and therapies, detect exacerbations and crises for early intervention.</td>
</tr>
<tr>
<td>Socially disrupted patients</td>
<td>Assisting with social determinants of health, such as housing, transportation, and benefits. Coordination with families and providers.</td>
</tr>
<tr>
<td><strong>Utilization management</strong></td>
<td></td>
</tr>
<tr>
<td>Acute hospital admissions and length of stay</td>
<td>Concurrent review to assure that admission and length of stay are medically necessary and that care is given at the least expensive and restrictive venue (tertiary hospital, community hospital, skilled care facility, community).</td>
</tr>
<tr>
<td>Extended mental health treatment</td>
<td>Authorization of requests for additional therapy visits beyond the basic coverage limits when medically necessary.</td>
</tr>
<tr>
<td>Retroactive review of claims and denial of unnecessary charges</td>
<td>Computerized and manual review of provider claims against medical necessity criteria to detect fraud, up coding, and provision of services that are not medically necessary. Reclaim funds based on results of reviews.</td>
</tr>
<tr>
<td>Selective contracting with preferred providers</td>
<td>Providers who offer value proposition of higher quality and lower cost. Prior authorization or denial of access to providers outside of the preferred network.</td>
</tr>
<tr>
<td><strong>Technology review</strong></td>
<td></td>
</tr>
<tr>
<td>New pharmaceuticals</td>
<td>New products are constantly offered to patients and providers accompanied by aggressive marketing by the manufacturer. Explicit process of scientific review to determine if they are true advances in care.</td>
</tr>
<tr>
<td>New medical devices</td>
<td></td>
</tr>
<tr>
<td>New therapeutic interventions</td>
<td></td>
</tr>
<tr>
<td><strong>Care improvement</strong></td>
<td></td>
</tr>
<tr>
<td>Data and reporting</td>
<td>Health plan database is rich source of data for providers wishing to improve care, to detect variance from standards of care, and to develop population-based registries for disease management and screenings.</td>
</tr>
<tr>
<td>Technical support for quality improvement activities</td>
<td>Offer of consultation and technical advice for providers on care improvement initiatives. Link with case management.</td>
</tr>
</tbody>
</table>
## Annex 2 Comparison of Selected Benefits: MassHealth Standard, Commonwealth Care Plan I, and a Typical Commercial Insurance Plan

<table>
<thead>
<tr>
<th>Benefits</th>
<th>MassHealth Standard</th>
<th>Commonwealth Care Plan I</th>
<th>Typical Commercial Insurance Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Medical Care</td>
<td>Maximum benefit limit of 20 days for members ages ≥ 21.</td>
<td>Covered if medically necessary. Prior authorization required for elective hospital admissions. Maximum 100 days per calendar year benefit for rehabilitation care provided in an inpatient setting.</td>
<td>Covered for all medically necessary services. $600 copayment per hospital admission. Prior authorization required for elective hospital admissions. Services at noncontracted hospitals outside of service are covered only in emergencies.</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>Covered if medically necessary and when surgical procedure performed in contracted facility.</td>
<td>Covered if medically necessary and when performed at a contracted outpatient facility. Prior authorization required for out-of-network care.</td>
<td>Covered if medically necessary and when performed at contracted outpatient facility. $600 copayment per procedure. Some procedures require prior authorization.</td>
</tr>
<tr>
<td>Assessment of Children for Developmental Issues and Need for Special Services</td>
<td>Covered. Provides assessment services for children who may need special education and treatment in the context of the child’s current circumstances and physical, developmental, social, and educational history. Such assessments are furnished by authorized professionals (physicians, psychologists, social workers, nurses, or counselors). Prior authorization required for out-of-network care.</td>
<td>Commonwealth Care does not cover members under age 19.</td>
<td>Covered with prior authorization if not also covered by the child’s public school system.</td>
</tr>
<tr>
<td>Dental</td>
<td>Covered if medically necessary to treat a medical condition. Children covered for preventive and basic services for prevention of dental diseases and maintenance of oral health; adults covered for one cleaning per year and extractions.</td>
<td>Emergency care covered as a result of injury, accident, or other condition. Nonemergency care covered for medically necessary preventive and basic services to prevent and control dental disease and maintain oral health. Extensive prior authorization requirements for nonemergency care.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Institutional Care</td>
<td>Covered for all levels of care if provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, up</td>
<td>Not covered.</td>
<td>Not covered, except for short-term skilled rehabilitation, for a maximum of 100 days per benefit year.</td>
</tr>
<tr>
<td>Category</td>
<td>Coverage Information</td>
<td>Cost Information</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Copayments are $1 to $3.65 for covered generic drugs; $3.65 for covered brand name drugs. No copayment for members under age 19 or for members while pregnant and up to 60 days after giving birth. $0 copayment for birth control.</td>
<td>Copayments are $1 to $2.65 for generic drugs. Copayment of $3.65 for covered brand name drugs. No copayment for pregnant members and for 60 days after the end of a pregnancy and for family planning supplies. No copayment for prescription diabetes and asthma supplies or birth control.</td>
<td></td>
</tr>
<tr>
<td>Over-the-Counter Drugs</td>
<td>Covered if requested with a prescription written by a physician; must be obtained at a participating pharmacy; $1 copayment required.</td>
<td>Selected products are covered when dispensed at a participating pharmacy, with a $1–$3.65 copayment.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>Vision Care</td>
<td>Covered for routine eye examinations, eyeglasses/contact lenses, vision training, and other visual aids.</td>
<td>Routine eye exams covered every 24 months. Diabetes eye exams covered every 12 months. Service by participating providers. One pair of eyeglasses every 24 months with free frame from a selected list. Other frames and trifocals and bifocals up to plan cost of a maximum of $80. Contact lenses not covered. Prior authorization required for out-of-network services.</td>
<td>One visit every 24 months with $25 copayment. Glasses and contact lenses are not covered.</td>
</tr>
<tr>
<td>Mental Health Inpatient Care</td>
<td>Covered if medically necessary. Prior authorization required for in- or out-of-network services. Inpatient electroconvulsive therapy (ECT) requires additional authorization.</td>
<td>Covered if medically necessary. Prior authorization required for in- or out-of-network services. Electroconvulsive therapy requires additional authorization.</td>
<td>Limited to 60 days per benefit year at a designated facility. $600 copayment per admission. Prior authorization required. Some services are not subject to limitations.</td>
</tr>
<tr>
<td>Mental Health Outpatient Care</td>
<td>Covered if medically necessary. Prior authorization required for in-network services after 26 visits, or for all out-of-network services.</td>
<td>Covered if medically necessary. Prior authorization required for in-network services after 26 visits, or for all out-of-network services.</td>
<td>Limited to 24 visits per benefit year. $25 copayment per visit. Some services are not subject to limitation, with prior authorization.</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>Covered if medically necessary. Prior authorization required for all in- and out-of-network services.</td>
<td>Covered if medically necessary. Prior authorization required for all in- and out-of-network services.</td>
<td>Limited to 24 visits per benefit year. $25 copayment per visit. Prior authorization required for all services. Some services are not subject to limitation.</td>
</tr>
</tbody>
</table>
### Annex 3 Massachusetts Selected Leading Health Indicators by Racial/Ethnic Group

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Statewide Total</th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma deaths /100K</td>
<td>1.16</td>
<td>0.79</td>
<td>0.98</td>
<td>0.66</td>
</tr>
<tr>
<td>Asthma hospitalizations /100K</td>
<td>137.39</td>
<td>148.28</td>
<td>106.9</td>
<td>112.8</td>
</tr>
<tr>
<td><strong>Births / Natality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate /1,000 live births</td>
<td>4.92</td>
<td>4.88</td>
<td>4.04</td>
<td>4.03</td>
</tr>
<tr>
<td>Low birthweight (&lt;2,500 g or 5.5 lbs) %</td>
<td>7.52</td>
<td>7.86</td>
<td>6.91</td>
<td>7.23</td>
</tr>
<tr>
<td>Caesarean deliveries %</td>
<td>28.38</td>
<td>33.33</td>
<td>29.16</td>
<td>34.65</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancer deaths /100K</td>
<td>194.74</td>
<td>181.47</td>
<td>197.9</td>
<td>184.8</td>
</tr>
<tr>
<td>Cervical cancer deaths (female) /100K</td>
<td>1.53</td>
<td>1.33</td>
<td>1.46</td>
<td>1.27</td>
</tr>
<tr>
<td>Lung cancer deaths /100K</td>
<td>53.91</td>
<td>51.25</td>
<td>55.44</td>
<td>53.09</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease deaths /100K</td>
<td>260.07</td>
<td>216.99</td>
<td>261.7</td>
<td>219.3</td>
</tr>
<tr>
<td>Data Element</td>
<td>Statewide Total</td>
<td>White</td>
<td>Black</td>
<td>Hispanic</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
<td>-------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>All circulatory system disease deaths /100K</td>
<td>261.29 218.09</td>
<td>262.9 222.4</td>
<td>303.9 253.3</td>
<td>167.7 129.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>8.7 10.6</td>
<td>6.8 8.7</td>
</tr>
<tr>
<td>Had or have diabetes %</td>
<td>5.8 6.8</td>
<td>5.7 6.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health status and health care</td>
<td></td>
<td></td>
<td>12.7 17.6</td>
<td>26 25.9</td>
</tr>
<tr>
<td>Have fair or poor health %</td>
<td>12.5 12.6</td>
<td>11.4 11.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td></td>
<td>14.21 17.35</td>
<td>7.27 5.63</td>
</tr>
<tr>
<td>Homicide deaths /100K</td>
<td>2.88 2.76</td>
<td>1.08 1.14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Note: Racial and ethnic differences. Significance testing was done by comparing to the White rate. Pink shading (or the darker shading) shows that the difference is significantly “worse” than the White population. Depending on the variable, “worse” could be higher or lower than the White rate. Green shading (or the lighter shading) shows that the difference is significantly “better” than the White population. Again, depending on the variable, “better” could be either higher or lower than the White rate.
References


The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.