



Massachusetts Healthcare Reform: *A Framework for Evaluation*

by Michael Miltenberger and Steve Poftak

Executive Summary

Passed in 2006, the Massachusetts healthcare reform bill represents an innovative approach to healthcare reform in the United States. The bill (Chapter 58 of the Massachusetts Laws of 2006) has four main goals: to use an individual mandate to expand access to near universal levels; to establish guidelines for employers' 'fair share' contribution and involvement; to reorganize insurance markets and manage the distribution and subsidization of several insurance plans through the new Massachusetts "Connector"; and to establish transparency that will aid in understanding and assessing the bill's cost and quality of care.

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The reform is well into its third year. To learn from many of its creative designs, it is critical to establish, in the early stages of its adoption, a sound framework for evaluating the reform's effectiveness. Though we identify sources for the data that will need to be used to evaluate healthcare reform within the framework outlined in this brief, we do not provide the data here. Our goal is simply to outline the framework. State government and other researchers can subsequently work together to collect and analyze the data to determine the plan's effectiveness.

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Massachusetts Healthcare Reform

At least initially, the legislation should be evaluated based on the four aspects of the healthcare system that it sought to change. These four criteria incorporate the plan's performance with respect to access, financing, administration, and quality of care. The plan's opponents have argued that there are numerous pitfalls, particularly sustainability, related to each of these categories. To be considered successful, the reform must weather these criticisms and demonstrate success based on empirical measures in each of these four dimensions.

We have identified specific metrics that should be tracked within each of the categories, with a total of 17 data points on this performance scorecard. Of these categories, the cost and access metrics have received the most coverage in the press and in public debates, but it is more important to explore the legislation's effects in deeper ways. What changes in healthcare quality will result from improved access? How cost-effective are these improvements?

For some of these metrics, data already exist in the healthcare system and need merely be collected and evaluated. For other points, however, there are no existing data, and we stress the need for the state to collect this data proactively in order to track the reform performance. The most critical areas for evaluation will center on the plan's financing and the overall growth of healthcare costs in the Commonwealth.

The Massachusetts reforms employ a mix of several different approaches to fixing the healthcare system. The state, as well as the nation, has much to learn from the Massachusetts experience. Without skillful evaluation and the collection of appropriate data, however, health reformers across the country will be able to take little from this 'natural experiment'.

I. Introduction

Massachusetts has long held a reputation for innovation and creativity in healthcare policy. The Commonwealth has attempted sweeping health reform proposals many times, and the health care reform act passed in 2006 had its beginnings in elements of both failed and successful policy experiments of the 1980's and 1990's.¹

Recent history includes a bill enacted in 1988 during the last Dukakis administration; this bill sought to expand healthcare access and attempt to achieve near-universal coverage.² In addition to expanding access, the plan tried to control costs by slowing the construction of new provider facilities through 'determinations of need'.³

Cost and access metrics have received the most coverage, but it is more important to explore the legislation's effects in deeper ways. What changes in healthcare quality will result from improved access? How cost-effective are these improvements?

Facing opposition from business interests along with shrinking tax revenues due to a recession, the bill was first modified so that its individual and employer mandates were stripped out. The legislation lost much of its impact and appeal and two years later, it was repealed. In 1996 and 1997, the Commonwealth expanded and restructured the state Medicaid program MassHealth.⁴

The current reform, whose statutory name is "An Act Providing Access to Affordable, Quality, Accountable Health Care," arose out of negotiations among Governor Mitt Romney, then State Senate President Robert Travaglini and House Speaker Salvatore DiMasi. Each had a different approach.

Governor Romney came to office in 2003 favoring reforms that would significantly broaden coverage. His first HHS Secretary, Ronald Preston, made

several drafts of a plan. The basic elements of each of Preston's drafts included an individual mandate, a cost assessment on employers that did not offer insurance, and an insurance 'connector,' an idea borrowed from the Heritage Foundation. Senate President Travaglini offered a more modest approach. He set a goal of reducing the number of uninsured by half within two years. His starting position excluded the possibility of a single payor plan, and opposed new taxes and employer mandates. House Speaker DiMasi proposed a solution with elements from several plans, including employer and individual mandates, an insurance connector, low-income subsidies, and a quality and cost council. The Speaker's low-income subsidies and access expansions would be achieved through changes to the state Medicaid program—changes that would require the Romney administration to secure new flexibility from the federal government as part of the Medicaid waiver.

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The House and Senate enacted different versions of the plan, after which a conference committee lasting five months hammered out compromises on contentious points, mainly related to the employer mandate and assessment. Business leaders finally broke the stalemate by agreeing to a \$295 penalty for non-compliance. The final version of the bill was signed into law in April, 2006.⁵

II. Overview of the Plan

The Massachusetts Chapter 58 law contains several basic components³, each of which represents ideas from the original stakeholders and interest groups that were melded together in the compromise bill. The four components are as follows:

1. An individual purchase mandate and other mechanisms, including premium subsidies, to expand access;
2. A mandate for employers to contribute to premiums and/or enable employees to purchase insurance with pre-tax dollars;
3. Creation of a "Connector" to distribute insurance and manage subsidies;
4. A mandate to establish cost and quality transparency.

It is important to understand the primary goals that the legislators had in mind when crafting this reform, and the policy tools they used to achieve their ends.

Expand Access – The legislation employs four basic mechanisms to expand access.

- The individual mandate requires all individuals over 18 to carry health insurance, with some exemptions. Failure to purchase insurance will eventually result in a fine commensurate with half the cost of a 'reasonable' premium.
- The bill utilizes the MassHealth program to expand Medicaid eligibility to a modest degree, providing insurance for more low-income individuals; this expansion includes all children of families that earn below 300% FPL.
- The legislation provides for government subsidization of premiums for adults below 300% FPL who do not have access to employer-sponsored plans or MassHealth. This includes a full subsidy for individuals below 100% FPL and a sliding-scale subsidy for those between 100% and 300% FPL. None of the plans for these individuals include deductibles, only modest co-pays.
- The bill allows small business workers, including part-time and seasonal workers, to purchase their insurance with pre-tax dollars,

Massachusetts Healthcare Reform

giving them the same tax advantage as workers in larger firms.

Employer Participation – Most employers in the Commonwealth will share in the cost of healthcare. All businesses with 11 or more employees will be required to pay up to \$295 per employee per year if they do not provide health insurance coverage. Additionally, these employers must offer their workers at least a basic “cafeteria plan,” through which they can pay their share of health insurance premiums on a pre-tax basis.

New Insurance Market Structure and the Connector – The bill creates a new ‘Connector’ to plug employers and individuals into these markets, thereby changing the landscape of health insurance sales :

- The bill instructs the Department of Insurance to merge small group and individual markets. This compels insurers to treat these two groups as one risk pool with common “rate bands.”
- The bill creates the “Commonwealth Health Insurance Connector” to solicit bids from insurers for a menu of different plans to offer enrollees. The ‘Connector’ then aids employers and individuals with access to and purchase of these plans.
- Finally, the legislation creates a new “Commonwealth Care Health Insurance Program” (CCHIP). This program will be administered by the Connector to manage subsidies for adults below 300% FPL who do not have access to employer sponsored coverage and do not otherwise qualify for MassHealth.

Cost and Quality Transparency – This feature has three important provisions:

- The new mandate requires health insurers and providers to report cost and quality data. This information will be collected and examined by the new “Health Access Bureau” and “Healthcare Quality and Cost Council,”

and then made public for use by consumers, insurers, etc.

- The law ties MassHealth rate increases to improvement in certain performance measurements;
- The law tries to create a mechanism to identify and report health care delivery system inequalities through the new Health Disparities Council in the DHHS.

Containing the rapid growth in healthcare spending is an important health policy issue and must factor into any evaluation of the reform.

III. General Framework for Evaluating Health Systems

All four of the plan’s components provide innovative solutions that have not been tried or implemented elsewhere, at least not on the same scale.⁶ The plan creates several new mechanisms that will be difficult to implement and manage effectively. Ultimately, much of the success or failure of this proposal will rest on the execution of these newer elements. Thus, it is critical to develop a framework for assessing the performance of the reform; it is imperative to understand the questions that must be analyzed to gauge performance and the data sources that will be needed for answers.

When evaluating the performance of a health system, a myriad of factors can be used for analysis. Issues such as health status, health inequality, coverage, equitable financing, quality, consumer satisfaction, allocative efficiency, technical efficiency, cost containment, political acceptability and financial sustainability have all been listed as important goals of a health system, and thus of any reforms.

A framework by the WHO's Christopher Murray describes the explicit goals of a health system as three-fold: health, responsiveness, and fairness of financial contribution. These goals incorporate specific underlying issues, such as average level of population health, the distribution of inequalities with population health, respect for individual autonomy, the use of adequate financial risk pooling, and the payment of a "fair share" from different stakeholders.⁷ Although these are important goals and issues for the assessment of a nation's health system, only some may be applicable in the context of a statewide reform effort.

With such questions in mind, a number of sophisticated policy tools have been developed to evaluate health systems and reforms. Another WHO approach rates health reforms based on their improvement on roughly ten benchmark measurements and metrics.⁸ Of these ten metrics, four of them build on Murray's abstract goals with more concrete system goals:

- Reduction of barriers to access;
- Equitable financing, based on ability to pay;
- Administrative efficiency; and
- Efficacy, efficiency, and quality of care.

These four categories provide a strong theoretical grounding for the construction of a specific framework for Massachusetts. However, in addition to these topic lines of analysis, there are basic lessons to be drawn from these benchmarking frameworks. First, they must include measurable aspects of the system. Second, to allow for longitudinal comparisons, the data must be clearly articulated and retrievable on a periodic basis.

IV. Framework for Analyzing Massachusetts Reform

Any proposal or reform must be evaluated primarily on the basis of its initial stated goals; thus, we will

use the four basic 'components' of the legislation stated in the second section as the outline for our analysis. In this framework, the plan should be broadly evaluated on its four basic criteria:

- 1.** Will **access** to insurance and health services be expanded?
- 2.** Will the **financing** of the plan and benefits prove to be equitable and sustainable?
- 3.** Will the **administration** of new agencies and structures be efficient and/or effective?
- 4.** Will Massachusetts citizens receive greater **value** care in terms of cost and quality?

Each of these levels of evaluation represents an aspect of the healthcare system that was changed by the new legislation, and each change was implemented to achieve a stated objective. Additionally, each level of evaluation represents an area where the bill's critics have claimed that the reform is fundamentally flawed, or where potential problems could threaten sustainability. Finally, each of these areas represent major political considerations on the minds of average Americans, and thus also on the minds of the politicians considering reforms.

As we delve more deeply into the issues within each category of evaluation, we will discuss three issues. What potential problems may arise to threaten the legislation's success in this area? What primary questions should be asked to determine the effectiveness of the reform in this area?; What data points should be collected and examined to form some type of 'scorecard' on the legislation's effectiveness?

1. Access – According to the legislation's details, the plan employs several mechanisms to increase access. These mechanisms' effectiveness in achieving their objective should be framed around the change in the number of individuals without health insurance, and the change in the breadth of access for newly-insured individuals.

Massachusetts Healthcare Reform

As to the number of uninsured, several studies have revealed discrepancies in estimates of the size of the state's uninsured population. At the onset of the legislation in 2006, officials suggested that the state's insured population was around 500,000 individuals, while other studies suggest that the Census Bureau estimate of about 690,000 individuals was more accurate.⁹ This continues to be an important discrepancy, and much of the bill's success will be decided by the number of uninsured individuals who remain after the plan is fully implemented.

The Connector must define and maintain three interconnected measurements. These three measurements -- the 'affordability standard,' the 'minimum creditable coverage' (MCC) and the level of premium subsidy -- are all inextricably interwoven.

So far, the bill has claimed that enrollment has climbed by 439,000 previously-uninsured individuals, with 176,000 new enrollees in CommCare, 72,000 in MassHealth, and 191,000 enrollees in new private coverage.¹⁰ These figures are extremely important, but will become increasingly complex to collect and analyze. A recent study used survey data to quantify changes in insurance status and the effect of those changes on outcomes. This study cites a drop in the uninsurance rate from 13% to 7%, with an 11% drop in uninsurance among low-income adults.¹¹ Though these results are interesting and encouraging, survey data are often plagued with inaccuracies, and surveys may not be the most effective means to collect data on the reform's effectiveness.

With respect to enrollment in individual programs, through July 2008, the Commonwealth Care program has enrolled 176,000 adults under 300% FPL. Enrollment is projected to increase to 225,000 individuals in fiscal year 2009.¹⁰ It is unclear how quickly enrollment will change, or what percentage of the potentially eligible population this is servicing. In addition to the increase in

Commonwealth Care enrollment, the individual mandate and increased community outreach grants have spurred MassHealth to increase enrollment by 110,740.¹³

Second, the Commonwealth must monitor not only the increases in levels of insurance coverage, but also the increase in the utilization of actual medical services that should arise from greater insurance coverage. In order for the bill to improve access, the reform must succeed in increasing utilization rates for valuable health services. Relevant procedures include screenings such as mammograms or other tests, as well as regular primary care visits to monitor things such as blood pressure and cholesterol.

Accurately measuring changes in utilization rates for new marginal enrollees can be a complicated task. The survey study cited earlier provided preliminary results on this front, describing an increased utilization of preventive services and a decrease in the use of emergency departments for non-emergency conditions. However, these surveys provide an incomplete picture.

There are several sources that could potentially provide more accurate snapshots of utilization and behavioral patterns. The CDC's Behavioral Risk Factor Surveillance System can provide a baseline picture for utilization rates among Medicaid enrollees or uninsured individuals. Surveys like Mass Quality and HEDIS can provide aggregate data on preventive utilization rates for HMO, FFS, and Medicare beneficiaries.

Aggregate pictures of the changes in these rates can provide us with some answers to the access question, though they are not ideal. Ideally, the Connector should survey those who have identified themselves as new enrollees (either through the Connector distribution channels or through tax rolls) and audit their claims data to observe the behavior changes. The Connector and academic institutions such as the University of Massachusetts-Boston are currently conducting this research; but these analyses are vital to

evaluating the success of the reforms, and need to be conducted and discussed more broadly.

Proposed Scorecard Metrics:

- *Number of uninsured over time, and the rate of change in this figure.*
- *Size and growth of the Commonwealth Care program over time – percentage of the marginal enrollees that is crowding out private insurance versus percentage that is coming from the HSNTF or previously uninsured pool.*
- *Employer offer rates and employee uptake rates for health insurance coverage.*
- *Utilization rates of preventive care services – change in the percentage of citizens (ideally new Connector enrollees) receiving annual check-ups, mammograms, and annual blood pressure, cholesterol, or blood sugar readings.*

2. Financing – The reform plan is fundamentally based on a shared responsibility among individuals, employers, and government, with each contributing its ‘fair share’ to the cost of healthcare. The success of this plan rests largely on whether this cost-sharing arrangement will be sufficient to cover and sustain the expenses of the reform. Three questions drive the issues pertaining to the plan’s solvency:

- Will the three expected sources of revenue contribute in the ways that the plan anticipates?
- Will healthcare cost and utilization growth be effectively contained?
- Will the definitions of “affordability standard” and “minimum creditable coverage” allow for sustainable subsidy levels from the CCHIP?

With respect to government revenues, the plan draws on several sources of revenue to piece together funding, including: the uncompensated care (UCC) pool, now called the Health Safety Net Trust Fund (HSNTF); the free-rider surcharge and the fair share assessment. The HSNTF is the most

important revenue source for the reform plan, and it will be critical to see if the use of this pool drops as much as will be necessary for the plan to be sustainable.

The state originally estimated that the budget for the HSNTF would decrease from \$610 million in 2007 to \$320 million in 2009,¹⁴ but the actual decrease could differ substantially if the state’s assumptions are flawed. If the number of uninsured is closer to the 690,000 census figure, then the remaining number of uninsured to be taken care of by the UCC pool will be much higher. Also, if uptake into the connector program is not as large as expected or if more people are granted exemptions from the individual mandate, then the responsibilities of the HSNTF will be greater. Finally, if coverage from the new plans in the Connector is not broad enough, the HSNTF may have to fill some of the gaps in coverage and access for lower-income individuals.

The decrease in funding for the HSNTF is the most important financing issue related to the reform’s sustainability. Preliminary evidence suggests that the HSNTF’s use has decreased, although it is unclear whether this trend will continue in the future. Hospitals and community health centers received roughly \$475 million from the HSNTF in 2007, a marked decline from the previous year. But the projected demand for 2008 has increased slightly, with an anticipated total billing of \$497.6 million.¹⁵

In addition to overall use of the HSNTF, it will be important to monitor the extent to which HSNTF use involves undocumented aliens or U.S. residents from other states. Given the prominence of many provider networks in Massachusetts and their proximity to several other states, out-of-state utilization could be a significant barrier to the reform’s sustainability.

Finally, with respect to the issue of the fair share assessment, currently 650 firms have paid the Commonwealth \$6.6 million in fair share assessments.¹⁶ Although this would seem to be a substantial amount, it is unclear what impact

Massachusetts Healthcare Reform

these payments will have on the law's proposed objectives of increasing access and care. If firms find it more in their economic interest to simply pay the government assessment and then offer little or no coverage, then the bill will have diminished impact.

Containing the rapid growth in healthcare spending is an important health policy issue and must factor into any evaluation of the reform. Massachusetts already has per capita healthcare costs that are 30% above the national average.¹⁷ These costs are due, in part, to the presence of highly-consolidated and powerful provider groups, especially academic medical centers. These groups make lower reimbursement rates difficult to negotiate, and Massachusetts will need to address this issue in order to bring down costs.

For the second round of contracts with insurance carriers, we expect Commonwealth Care premium rates to increase. Many insurance carriers submitted low bids for their first year in order to gain market share and meet the bill's requirements, but these premiums look unsustainable in the long run, and almost all carriers are now applying to raise their rates.¹⁸

In addition to this problem, the proposal has granted funding to several programs, probably increasing costs in the short term. The bill arranges for provider reimbursement rate increases that will reach \$270 million after three years. Also, the bill has restored dental, vision, and chiropractic benefits for MassHealth enrollees.¹⁹ These commitments will be costly in the short run, and will encourage an increase in the Commonwealth's per capita health spending.

These problems are likely to increase premiums and fuel continued cost growth in the state, but it will be important to monitor the impact of the individual mandate on average insurance costs. One of the main principles of the individual mandate was that it would drive lower-cost young people into the pool of the insured, thus reducing average costs. In this light, it will be important to monitor the

impact of the individual mandate on both average premiums and per capita spending

The HSNTF also plays into the issue of cost control, because the state will have to look at utilization patterns for individuals who leave the uninsured pool.

Finally, the Connector must define and maintain three interconnected measurements. These three measurements -- the 'affordability standard,' the 'minimum creditable coverage' (MCC) and the level of premium subsidy -- are all inextricably interwoven. Setting any one of these three metrics effectively mandates the value of the other two. So, if the Connector sets its affordability threshold at a certain level, this level necessarily determines what the MCC will be, based on the coverage the affordable premium can buy. The affordability threshold will also determine the size of state subsidies in order for all eligible individuals to be able to purchase 'affordable' coverage. There are fundamental tradeoffs among these three levels; a change in any one of them will have to be counterbalanced by a change in one or both of the others.

Financing concerns have proved to be the undoing of previous reform efforts in Massachusetts and other states; it will be critical to watch how these issues unfold.

Although these measures are clearly linked, it is unclear that the Connector set the MCC or affordability levels with any consideration for the desired levels of the other two measurements. In the future, it will be important to monitor whether these three levels are adjusted in conjunction with one another. If they are not set together, the level of premium subsidy paid by the state is likely to be the factor that drives the choices made for the other two.

In addition to the problem of sustainability given the interrelationship of these three measurements,

there are administrative issues with some of the individual metrics. The definition of ‘minimum creditable coverage’ (MCC) is a vital aspect of determining the level of protection actually gained. Again, this decision represents a fundamental tradeoff between cost and risk protection.

Currently the MCC contains four requirements: “comprehensive benefits,” including prescription drugs; no annual or per-disease maximums; limits on deductibles; and the inclusion of an in-network OOP expenditures maximum.²⁰ A key metric that will help determine this policy’s effectiveness will be the number of medical bankruptcies. One study claimed that 76% of those who were bankrupted by medical problems had insurance at the onset of their condition.²¹ Other studies have subsequently challenged this figure, but the impact of healthcare costs on individuals’ finances is nonetheless an important metric.

As always, the devil is in the details, so the way that agencies execute the theories in the bill’s language is critical to the success of the reforms.

For the exact subsidy levels for individuals making less than 300% FPL, the fiscal year 2009 appropriation currently provides \$869 million for premium subsidies. It is unclear whether this level of funding will be enough to ensure that all of these individuals have access to ‘fair’ premiums based on the affordability definition. As program costs increase and insurers and their members are bound by MCC and the affordability definition, it appears that the subsidy will be the lowest common denominator that is used to offset the costs from the other two.

Together, these three issues will determine the program’s long-term financial sustainability, probably the biggest challenge facing the reform and the biggest criticism leveled by detractors. The financial underpinnings of the plan face several threats that must be adequately addressed if the program is to survive in the medium-to-long term.

Financing concerns have proved to be the undoing of previous reform efforts in Massachusetts and other states; it will be critical to watch how these issues unfold. Monitoring the HSNTF along with healthcare costs throughout the Commonwealth will likely become two critical efforts in evaluating the plan’s ultimate financial sustainability.

Proposed Scorecard Metrics:

- *Gross contributions to healthcare funding, and the percentage of total funding contributed by each revenue source: federal contributions, employer contributions and penalties, and private contributions (especially out-of-pocket.)*
- *Change in per-capita healthcare consumption and costs for the newly insured compared with expenditures from the HSNTF.*
- *Changes in overall healthcare spending as a percentage of state GDP, tax revenues, or per capita income.*
- *Changes in average premiums.*
- *Number of citizens exempt from the mandate due to the ‘affordability standard’.*
- *Changes in the rates of medical bankruptcy, compared to other states.*

3. Administration – The reform creates several new agencies tasked with executing the plan’s specifics. As always, the devil is in the details, so the way that these agencies execute the theories in the bill’s language is critical to the success of the reforms. There are two primary areas that need to be observed, the administration of the ‘Connector’, and the administration of ‘Commonwealth Care Health Insurance Program’ (CCHIP).

The administrative tasks of the Connector and the Department of Insurance will be focused on two primary issues: the efficiencies realized from the merging of the small group and the individual markets; and the competitive environment among plans in the Connector pool. Restricted networks

Massachusetts Healthcare Reform

will be critical to creating truly affordable plans for lower-income individuals. Officials have said that they will allow plans to make bids with narrow networks and negotiations with providers to drive prices down to a ‘reasonable’ level.²² Restricted networks may limit access for enrollees, but will be helpful in containing costs. The Connector’s ability to administer and balance this tradeoff will be vital to the future sustainability of the reform.

For the fusion of the small-group and individual markets, we must examine how much this joint pooling reduces insurance companies’ administrative costs and risk premiums. A study by Blue Cross Blue Shield of Massachusetts concluded that the merge would reduce non-group premiums by as much as 25% through reductions in administrative costs and better risk-pooling. This reduction in non-group premiums will certainly come at the cost of increased premiums for small-group enrollees. However, the increased rate estimate is expected to be only 1 to 4%.²³

It will be important to look at the aggregate changes in premiums for the small group and individual plans compared to historical data trends. If the cost gains for the non-group market were the same as the cost increases to the small group in a zero-sum fashion, then the merger will have achieved little, outside of redistribution. If the merger achieved more than redistribution, we should see a difference from these two groups in the non-medical costs of insurance or the loading costs of the premiums. Unfortunately, there are no other states that have merged these markets to serve as comparisons, and even if there have been gains from the merger, these are likely to be one-time effects.

Also, in the competitive environment established by the Connector, it will be critical to see if plans negotiating with the Connector compete meaningfully over price. The legislation does not require plans in the Connector to provide a uniform benefit package,²⁴ so we are likely to see a diversity of benefit packages. This could be problematic, depending on the difference between these benefit packages and the MCC. If the spectrum of benefit packages and their premium differences are large,

we may see problems of adverse selection, whereby sicker individuals opt for more generous plans, eventually driving these plans out of the pool. It will be imperative to monitor risk profiles of members in each plan to make sure that adverse selection is not occurring, or is at least compensated for on a risk-adjusted basis.

Finally, for the third category – the administration of the CCHIP – it will be important to monitor the distribution costs associated with this service. CCHIP will be marketing the plans in the Connector pool directly to consumers, so we would hope that the reform would be able to create cost efficiencies by streamlining the distribution channels. CCHIP administration costs should be compared to those of plans outside of CCHIP.

Scorecard Metrics:

- *Premiums in the new small and individual group market compared to the large group premiums in MA – additionally, it may be helpful to monitor these differential MLRs and the changes over time in premiums and MLRs.*
- *Plan survivorship and reasons for rate increases in the Connector as a proxy measure for the effects of adverse selection.*
- *Distribution costs as a percent of total costs in the CCHIP and in comparison to distribution costs and percentages in other plans outside of CCHIP.*

4. Cost-Effective Quality – Finally, the plan must be evaluated in part based on the quality of care that Massachusetts citizens receive. Although this was not one of the bill’s primary objectives, it is obviously a critical portion of a health system. To address quality of care concerns, the bill created several new agencies. These new agencies should be evaluated as follows:

- Will the Health Quality and Cost Council effectively transmit data to users?

- Will the Health Access Bureau improve quality and value through transparency?
- Will the Health Disparities Council identify and reduce disparities?

First, the new legislation requires insurers and providers to furnish cost and quality data in a transparent manner. The Health Quality and Cost Council will collect this information and transmit it to the public. The Council has already missed two deadlines in releasing its website information because of difficulty in selecting and auditing metrics from the hospitals.

In the eventual collection and dissemination of this information, it will be important to monitor two factors. The first factor is the volume of data that the state collects compared to private sector efforts to collect this data before the mandate, such as through the Massachusetts Health Quality Partners or MassPRO.

More importantly, it will be critical to see how much this data is used and how it influences behavior. Several sources could serve as baseline studies for the uptake and use of healthcare cost and quality information. In 2006, the Massachusetts Health Quality Partners, in conjunction with the Robert Wood Johnson Foundation, conducted a survey to measure the uptake of consumer information. This study could be used as a baseline against measurements such as unique web hits for the Council's website. But these measures do not accurately capture the effects of 'secondary dissemination,' whereby individuals use information through conversations and advice from those who have already used the site. Additionally, it will be important to see if individuals who use this data actually alter their behavior.

Second, transparency and public reporting are obviously important, but they are only important inasmuch as they create positive change in the cost and quality of healthcare. Thus, we must examine the impact of reporting programs on healthcare quality in the state. The reform dedicated \$5 million to the implementation of computerized physician

order entry systems (CPOE).²⁵ The state needs to monitor closely the changes in key quality metrics, such as error rates for incidents such as surgeries, hospitalizations, negative drug interactions, and other quality metrics. These changes should be compared with similar states that lack reporting mandates and the CPOE incentive.

Finally, the new Health Disparities Council should be evaluated for its effectiveness in identifying and reducing health quality disparities based on race, ethnicity, gender, language or other factors. Although the Council will be measuring and recording these disparities, the true effectiveness of the program will lie in generating public policy solutions to curb the identified disparities. This issue is complex, and empirical work from previous analyses does not yield a sufficient explanation for the existence and persistence of disparities. Theoretically, many of the disparities should be reduced with the expansion of access and other reforms from the legislation, but it will be difficult to disentangle these effects from other findings.

In addition to the research and work by the Council on Health Disparities, the bill also included outcome disparities as a new metric in the pay-for-performance framework of MassHealth reimbursements.²⁶ This is the first such metric of its kind in a P4P structure, and it will be closely watched by health policy and P4P experts to see its impact on patterns of care.

Scorecard Metrics:

- *Survey of the percentage of consumers that are aware of the reporting data (possibly through unique website hits) and the percentage that used it to make decisions, compared to similar surveys in the private sector.*
- *Change in accepted quality measurements, such as hospital infection rates, mortality rates, cardiac surgery error rates, compared to control states.*

Massachusetts Healthcare Reform

- *Cost effectiveness of quality gains, as measured by the changes in overall costs and quality from the reforms.*
- *Change in health disparities, compared to control states.*

V. Conclusion

Although we have tried to provide a framework for analyzing the effectiveness of the reform and its policies, the fact remains that concrete and clear answers to many questions will remain elusive. The data sources and analytical methods suggested in this paper describe best methods that we could use under the current circumstances to answer pressing questions about the reform. But in many ways, these sources and analyses will still provide only partial information on the implications of the reform and its changes.

Ultimately, the data suggested here will be insufficient to answer the two most pressing questions about the reform: How have health behaviors changed as a result of the reform? How have these changes impacted the Commonwealth's health outcomes? In order to answer these two seminal questions accurately, the state would need to collect detailed claims information from insurance carriers and match that data with extensive surveys conducted by the state. This approach does not appear to be politically feasible or desirable for the Commonwealth, and we will therefore continue to rely only on partial answers to the most pressing concerns about the reform.

On the cost front, all relevant data sources point to the fact that this fund will be supported by progressively less revenue and will become progressively more costly for the Commonwealth. Although there is not much to say about this from the standpoint of policy or evaluation, it is clear that the reform legislation will have to weather serious political and financial storms if it is to continue in the long term. Ultimately, it is likely that the bill will be amended in some serious ways to address

the growing funding shortages that most analysts project.

The Massachusetts reform plan is an innovative political and policy compromise that will provide important information on several critical health policy topics. Ultimately, the different facets of the plan need to be rigorously analyzed to ensure that we learn as much as possible from its successes and failures. Although difficulties lie ahead, many of the plan's central tenets have a promising future, and will likely be implemented elsewhere in the country.

Massachusetts Health Reform Scorecard Framework

Access

- 1.** Number of uninsured over time, and the rate of change in this figure.
- 2.** Size and growth of the Commonwealth Care program over time – percentage of the marginal enrollees that is crowding out private insurance versus percentage that is coming from the HSNTF or previously uninsured pool.
- 3.** Employer offer rates and employee uptake rates for health insurance coverage.
- 4.** Utilization rates of preventive care services – change in the percentage of citizens (ideally new Connector enrollees) receiving annual check-ups, mammograms, and annual blood pressure, cholesterol, or blood sugar readings.

Financing

- 5.** Gross contributions to healthcare funding, and the percentage of total funding contributed by each revenue source: federal contributions, employer contributions and penalties, and private contributions (especially out-of-pocket.)
- 6.** Change in per-capita healthcare consumption and costs for the newly insured compared with expenditures from the HSNTF.
- 7.** Changes in overall healthcare spending as a percentage of state GDP, tax revenues, or per capita income.
- 8.** Changes in average premiums.
- 9.** Number of citizens exempt from the mandate due to the ‘affordability standard’.
- 10.** Changes in the rates of medical bankruptcy, compared to other states.

Administration

- 11.** Premiums in the new small and individual group market compared to the large group premiums in MA – additionally, it may be helpful to monitor these differential MLRs and the changes over time in premiums and MLRs.
- 12.** Plan survivorship and reasons for rate increases in the Connector as a proxy measure for the effects of adverse selection.
- 13.** Distribution costs as a percent of total costs in the CCHIP and in comparison to distribution costs and percentages in other plans outside of CCHIP.

Cost-Effective Quality

- 14.** Survey of the percentage of consumers that are aware of the reporting data (possibly through unique website hits) and the percentage that used it to make decisions, compared to similar surveys in the private sector.
- 15.** Change in accepted quality measurements, such as hospital infection rates, mortality rates, cardiac surgery error rates, compared to control states.
- 16.** Cost effectiveness of quality gains, as measured by the changes in overall costs and quality from the reforms.
- 17.** Change in health disparities, compared to control states.

Endnotes

1. Woolhandler, S. and Himmelstein, D.U. The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back. *Hastings Center Report* 36, no. 5. September-October 2006.

2. McDonough, J.E. et. al. The Third Wave of Massachusetts Health Care Access Reform. *Health Affairs*. Web Exclusive; 14 September 2006; w420 – w431.

3. Grossman, Jerome. An Economic History of Health Care in Massachusetts 1990-2000. *Pioneer Institute for Public Policy Research*. White Paper No. 11; June, 2000.

4. McDonough, J.E. et. al. The Third Wave of Massachusetts Health Care Access Reform. *Health Affairs*. Web Exclusive; 14 September 2006; w420 – w431.

5. McDonough, J.E. et. al. The Third Wave of Massachusetts Health Care Access Reform. *Health Affairs*. Web Exclusive; 14 September 2006; w420 – w431.

6. Commonwealth of Massachusetts. Chapter 58 of the Acts of 2006.

7. Murray, C J.L. and Frenk, J. A Framework for Assessing the Performance of Health Systems. *Bulletin of the World Health Organization*. Vol. 78, Iss. 6; 2000.

8. Daniels, N. et. al. Benchmarks of Fairness for Health Care Reform: A Policy Tool for Developing Countries. *Bulletin of the World Health Organization*. Vol. 78, Iss. 6; 2000.

9. US Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States 2005. Issued August 2006.

10. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

11. Long, Sharon K. On the Road to Universal Coverage: Impacts off Reform in Massachusetts at One Year. *Health Affairs*. Web Exclusive, w271; 3 June 2008.

12. The Commonwealth of Massachusetts. Information Statement. August 14, 2008.

13. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

14. 2. McDonough, J.E. et. al. The Third Wave of Massachusetts Health Care Access Reform. *Health Affairs*. Web Exclusive; 14 September 2006; w420 – w431.

15. The Commonwealth of Massachusetts. Information Statement. August 14, 2008.

16. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

17. Woolhandler, S. and Himmelstein, D.U. The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back. *Hastings Center Report* 36, no. 5. September-October 2006.

18. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

19. Holahan, J. and Blumberg, L. Massachusetts Health Care Reform: A Look at the Issues. *Health Affairs*. Web Exclusive; 14 September 2006; w432 – w443

20. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

21. Woolhandler, S. and Himmelstein, D.U. The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back. *Hastings Center Report* 36, no. 5. September-October 2006.

22. Holahan, J. and Blumberg, L. Massachusetts Health Care Reform: A Look at the Issues. *Health Affairs*. Web Exclusive; 14 September 2006; w432 – w443

23. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

24. Holahan, J. and Blumberg, L. Massachusetts Health Care Reform: A Look at the Issues. *Health Affairs*. Web Exclusive; 14 September 2006; w432 – w443

25. McDonough, J.E. et. al. The Third Wave of Massachusetts Health Care Access Reform. *Health Affairs*. Web Exclusive; 14 September 2006; w420 – w431.

26. McDonough, John E., et. al. Massachusetts Health Reform Implementaion: Major Progress and Future Challenges. *Health Affairs*. Web Exclusive, w286; 3 June 2008.

