AIMING HIGHER FOR HEALTH SYSTEM PERFORMANCE

A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009 State Scorecard: **Massachusetts**

OCTOBER 2009

The Commonwealth Fund

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

Aiming Higher for Health System Performance: *A Profile of Seven States That Perform Well on the Commonwealth Fund's 2009* State Scorecard: Massachusetts

October 2009

To download the complete report containing all seven state profiles, click here.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1329.

Massachusetts: Sharing Responsibility to Achieve Near-Universal Access

Massachusetts has achieved the highest health insurance rates in the United States as a result of comprehensive health reform legislation in 2006. The reform law, known as Chapter 58, offers an array of approaches to reduce the number of uninsured in Massachusetts, including a Medicaid expansion (MassHealth), subsidized private insurance coverage (Commonwealth Care), a private insurance purchasing pool (Commonwealth Choice), and a new state entity to help residents find affordable, high-quality coverage (Health Connector). This hybrid approach reflects a basic philosophy of Massachusetts' reform that success is a shared responsibility: consumers, government, employers, insurers, and providers all have new obligations and receive new benefits under reform.

Three years into reform, Massachusetts is achieving very high levels of health system performance. The percent uninsured is at historically low levels, and there have been widespread improvements in access to health care for working adults. Those adults are more likely to have a usual source of care and to have had doctor visits, preventive care visits, and dental care visits under health reform than before. These gains reflect both increases in insurance coverage and improvements in the coverage that is available.[32] In addition to access gains, Massachusetts also outperforms most other states on measures of prevention and treatment and healthy lives, but ranks lower in terms of potentially avoidable hospital use and cost. Overall, Massachusetts outperforms all but six states on the *State Scorecard* (Table 8), and this level of performance does not yet reflect the full effects of reform. (There is a time lag for data collection in nationwide surveys and data sources.) Many of the key features of the Massachusetts reform were new ideas only three years ago—the Connector, for example—but now are familiar to policymakers and under consideration in federal reform.

Setting the Stage for High Performance

Massachusetts has a unique history when it comes to health system reform. Its residents have repeatedly been exposed to debate about universal coverage. Chapter 58 was a bold step forward in 2006, but within reach because of earlier reforms in 1985, 1988, 1991, 1996, and 1997.[33] Even prior to the 2006 coverage expansion, Massachusetts outperformed all but one state in covering children and all but eight states in covering adults on the 2007 *State Scorecard*. Health reform in Massachusetts has always been a process of "continuous policy improvement," says John McDonough, a legislative leader during the 1985 reforms and leading advocate for reform in 2006. (Mr. McDonough was senior advisor on national health reform to the late Massachusetts' Sen. Edward Kennedy.)

The core political values of the majority of Massachusetts residents resonate with universal coverage. Ninety-two percent of residents think that health care is a right.[34] Massachusetts has many more Democrats and Independents than Republicans, especially compared with the rest of the country, and there is generally greater support to provide health insurance for all uninsured people among Democrats (65 percent) and Independents (45 percent) compared with Republicans (28 percent).[35] Indeed, public opinion—and an initiative to put universal coverage on the November 2006 ballot—played a critical role in pressuring Massachusetts' leaders to enact health reform legislation.

Supporters of the ballot initiative, under the leadership of John McDonough and others, kept up the pressure for reform through Affordable Care Today

(ACT!!), a coalition of community and religious organizations, labor unions, doctors, hospitals, community health centers, public health advocates, and consumers. Individual organizations like Greater Boston Interfaith and the Blue Cross Blue Shield Foundation of Massachusetts created an early focus on coverage. And political leaders like Governor Mitt Romney (R), Senate President Robert Travaglini (D), Speaker of the House Salvatore DiMasi (D), and U.S. Senator Edward Kennedy (D) worked together to get the state and federal authority required to implement reform. Gov. Romney, in particular, set the terms of reform by insisting on an individual mandate and negotiating the terms of the Medicaid waiver that allowed the state to share the cost of reform 50/50 with the federal government.

The final contours of Massachusetts' coverage expansion reflected the history and influence of its health care industry, which is characterized by a few very large, nonprofit institutions. It is not unusual for these institutions to collaborate in Massachusetts, unlike public–private or insurer–provider skirmishes in other places that distract from system performance. Also, Massachusetts is geographically small and mostly urban—a city-state with one very large but well-defined health care marketplace—where policymakers know each other and are used to workable compromise. Finally, Massachusetts has the advantage of wealth—median household income is $58,286, higher than in all but six states—which has created the economic capacity required for the state to achieve near-universal coverage.

Coverage

Massachusetts ranks first among states on the State Scorecard's *indicators of insured children and adults. As a result of 2006 comprehensive health reform legislation, the state reports 97.4 percent of its residents now have health insurance coverage.*[36] *In 2007, the first full year of reform, Massachusetts' rates of residents deferring needed care because of financial barriers were one-half the national average.*[37]

Shared responsibility is the foundation of Massachusetts' coverage expansion. Adults are required to purchase health insurance, provided there is an affordable plan available. Employers with 11 or more employees must make a "fair and reasonable" contribution to employees' health insurance costs or pay a "fair share contribution" of $295 per worker annually.[38] Employers also must establish Section 125 payroll deduction plans to facilitate pretax purchase of insurance for workers. Insurers cannot refuse to cover people and can vary their premium for the same coverage only to a limited extent (these requirements were in place prior to reform). And taxpayers subsidize coverage for the poor who lack access to other insurance programs.

Chapter 58 also created the first private insurance market in the nation where an individual can buy health insurance coverage on the same terms and at the same prices as a small business, resulting in better coverage, better benefits, and prices that are significantly lower for individuals previously in the individual market. The combined market is subject to long-standing insurance protections, including guaranteed issue and renewal, a medical underwriting prohibition, preexisting condition limitations, and modified community rating.

As a result of the mandates and market reforms described above, the number of Massachusetts residents with health insurance increased by 428,000, giving the state by far the lowest rate of uninsured residents in the nation (Table 9). Enrollment in private insurance (private group and individual purchase) has grown by 190,000 since 2006, accounting for 45 percent of the total growth in coverage. In

Table 8. State Scorecard on Health System Performance: Massachusetts

	Overall and Dimension Rankings		Number of 2009 Indicators in:		Number of Indicators That Improved by 5% or More
	Revised 2007 Scorecard	2009 Scorecard	Top Quartile of States	Top 5 States	
OVERALL	6	7	14	11	14
Access	2	1	4	4	1
Prevention & Treatment	3	5	7	4	8
Avoidable Hospital Use & Costs of Care	36	33	0	0	1
Equity	1	7	*	*	*
Healthy Lives	8	6	3	3	4

Note: Data were available to rank Massachusetts on 37 of 38 *State Scorecard* indicators in 2009. Trend data were available for 34 indicators.
* The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators; thus, it is not included in indicator counts.
Source: The Commonwealth Fund, Oct. 2009.

addition to better take-up rates for employer-sponsored and individually purchased insurance, Chapter 58 also created new sources of coverage through a Medicaid expansion, a new program to subsidize private insurance coverage, and a private insurance purchasing pool, described below.

MassHealth

Chapter 58 expanded eligibility and benefits in Massachusetts' Medicaid program, called MassHealth. It expanded children's eligibility from 200 percent to 300 percent of the federal poverty level. Optional benefits for adults that were cut during the 2002–2003 recession, including dental care, dentures, and eyeglasses, were restored. Chapter 58 also increased MassHealth payment rates to physicians and hospitals, up to $90 million per year in fiscal years 2007–2009. A portion of hospital increases in 2008 and 2009 were contingent on providers meeting "pay-for-performance" (P4P) standards. The standards include measures to reduce health disparities, the first P4P system in the nation to do so.[39]

MassHealth enrollment also increased among those previously eligible and not enrolled. The use of a single application form for all programs, outreach grants to community groups, restrictions on the availability of hospital charity care reimbursement, and the individual mandate to purchase health insurance all combined to increase Medicaid enrollment. Overall, MassHealth enrollment has grown 10 percent since 2006, to 781,000 enrollees as of December 31, 2008 (Table 9).

Commonwealth Care

Chapter 58 created a new Commonwealth Care Health Insurance Program to provide subsidized insurance to uninsured adults with household incomes up to 300 percent of poverty who are ineligible for MassHealth or any other coverage.[40] Eligible people with incomes below 150 percent of poverty are charged no premiums, no deductibles, and modest copayments. Those with incomes of 151 percent to 300 percent of poverty pay income-based, sliding-scale premiums and copayments, and no deductibles. Commonwealth Care plans cover inpatient,

outpatient, and preventive services; behavioral health; prescription drugs; and dental services for those below 100 percent of poverty. The average current total monthly cost of a Commonwealth Care plan is $396.[41] Annual premium growth averages under 5 percent and (as of July 2009) government spending per enrollee and what enrollees contribute toward premiums *decreased* while, at the same time, choice of health plans and access to new primary care physicians *increased*. Commonwealth Care covered 163,000 people as of December 31, 2008 (Table 9).

Commonwealth Choice

Chapter 58 also created unsubsidized plans for people who are ineligible for Commonwealth Care and who do not have access to employer-sponsored insurance. Commonwealth Choice plans are administered by state-licensed private insurers. All Commonwealth Choice plans must meet the Connector's (described below) "minimum creditable coverage" standards by providing "reasonably comprehensive" benefits, including inpatient, outpatient, mental health, preventive services, and drug coverage.[42] The Connector sets four levels of benefits from which customers can choose. The principle variation among the four levels involves cost-sharing, which increases sharply as premiums decrease.

Commonwealth Choice enrollees pay from $1,500 to over $15,000 a year, depending on their age, family size, and plan preference. Premiums mirror Commonwealth Care up to 300 percent of poverty. Above that, the maximum amount individuals and families must pay for health insurance increases to 9 percent of income at 500 percent of poverty, the median state income, at which point health insurance is deemed affordable regardless of cost. Enrollees can shop for plans on the Connector's user-friendly Web site by entering just three pieces of information: the subscriber's age, household size, and zip code. Whichever plan the individual picks, enrollment is guaranteed, as is the next year's renewal, regardless of any change in the member's medical conditions.

The Connector

Chapter 58 assigned important implementation duties to a new state entity called the Commonwealth Health Insurance Connector Authority. The Connector sets standards for covered benefits in Commonwealth Care and Commonwealth Choice, evaluates the products

Table 9. Massachusetts' Insured Population Since the Implementation of Health Care Reform

Type of Insurance	June 30, 2006	June 30, 2007	Dec. 31, 2008	Change since June 30, 2006	Percentage of Total Change
Private Group*	4,292,000	4,396,000	4,441,000	+149,000	35%
Individual Purchase*	40,000	36,000	81,000	+41,000	10%
Commonwealth Care	0	80,000	163,000	+163,000	38%
Medicaid/MassHealth	705,000	732,000	781,000	+76,000	18%
Total Members	**5,037,000**	**5,244,000**	**5,469,000**	**+428,000**	**100%**
Est. Percentage Insured	93.6%	94.3%	97.4%		

* Private group and individual purchase counts include 19,000 people enrolled in Commonwealth Choice plans.
Source: Massachusetts Division of Health Care Finance and Policy, May 2009.

before offering them, and organizes the choices of plans so members can easily compare them. It is governed by a 10-member board, including content experts, constituency representatives, and public officials. The legislature intentionally delegated some of the most contentious policy questions to the Connector, which sets the standard that satisfies the individual mandate (called "minimum creditable coverage"), decides what premium is considered affordable, and determines whether or not a person should be penalized under the individual mandate. Addressing these questions in statute might have jeopardized the legislative consensus and would have precluded the process of experimentation, feedback, and refinement that has marked the Connector's approach to policymaking. "It isn't often in politics, especially in Massachusetts, that the stars align so an achievement of the magnitude of the Connector Authority not only works, but works efficiently and fulfills a real social need," says Dolores Mitchell, executive director of the Massachusetts Group Insurance Commission. "Kudos to all parties for a successful start," she says.

Access to Providers

Adults in Massachusetts, although more likely to have health care visits under health reform than before, reported difficulty finding providers who would see them.[43] *Internists accepting new patients and MassHealth patients dropped under health reform and wait times for appointments increased.*[44] *Some community health centers report longer waits for appointments after reform.*[45]

As coverage expanded, the demand for health services increased, particularly for primary care. Efforts are under way to enhance the supply of primary care practitioners and medical homes. One year after reform was enacted, private groups began to pilot incentives for recruiting and retaining young primary care clinicians, and the state approved retail clinics offering access to nurse practitioners in pharmacies. In 2008, the state authorized increased primary care training slots at the University of Massachusetts and special financial incentives for primary care clinicians. As a result, community health centers in Massachusetts have attracted 92 primary care clinicians to serve 100,000 newly insured people.[46]

Also in 2008, the legislature set a goal to transform all primary care practices into patient-centered medical homes (PCMH) by 2015, and provided $5 million to initiate a PCMH demonstration. That effort is being jump-started with an additional $500,000 grant to participate in the Safety Net Medical Home Initiative, launched by The Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation. Initially, 14 community health centers will be selected for PCMH implementation and, in parallel, the state will develop PCMH payment reforms to introduce in 50 to 100 high-volume Medicaid practices by January 2010. PCMH activities are the organizing framework for the state's increasing focus to improve quality and control costs—the objectives that many believe will drive the next wave of comprehensive health reform.

Prevention and Treatment

Massachusetts ranks high among states in terms of the quality of preventive care and treatment. The state's performance substantially improved on half of the State Scorecard *indicators in this dimension from 2007 to 2009. On a few measures related to care received in hospitals and nursing homes, Massachusetts ranks in the middle compared with other states.*

Massachusetts' health care marketplace is characterized by nonprofit, mission-driven medical centers,

and there are more academic medical centers per capita in Massachusetts than most states. These institutions take quality seriously, as reflected on the *State Scorecard,* but also are more expensive, which also is reflected. There are multiple organizations that for decades have been engaged in quality improvement, but there has not been a core set of priorities to guide a statewide quality agenda.

Chapter 58 established a new Quality and Cost Council to "develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care." The Council, which is driven by Massachusetts' Division of Health Care Financing and Policy, has focused efforts on collecting hospital-specific information on cost and quality, and making that information available to the public. Also, the Massachusetts Department of Public Health is working with hospitals to develop effective approaches to prevent medical errors prior to enforcing a new law that will prohibit hospitals from billing for preventable events. "The hope is that when providers are not paid for medical errors," says John Auerbach, Massachusetts' Commissioner of Public Health, "they will find ways to prevent them."[47]

Massachusetts is also one of nine states participating in a State Quality Improvement Institute (SQII) sponsored by AcademyHealth and The Commonwealth Fund.[48] Massachusetts' initiative builds on an ongoing project to reduce rehospitalizations (also sponsored by The Commonwealth Fund) and broadens the state's focus to coordinate multiple, simultaneous cost and quality reform efforts.

Potentially Avoidable Use of Hospitals and Costs of Care

Massachusetts ranks in the bottom half (33rd) among states in terms of potentially avoidable use of hospitals and costs of care. The state's Medicare 30-day readmission rate, for example, is 50 percent higher than the rate of the best-performing state. Employer-sponsored health insurance premiums are 10 percent higher for a single individual than the national median, and 25 percent higher than the best-performing state.

Massachusetts intentionally acted first to expand coverage, despite concerns about costs, reversing the typical argument that cost control is a prerequisite for expanding access. The result? "Only by controlling costs can Massachusetts sustain near-universal coverage," says Jon Kingsdale, executive director of the Health Connector, "giving moral weight to the dry, abstract argument for cost containment."[49] The strategy seems to be working; key government and

Table 10. Massachusetts' Health Care Reform Spending, Fiscal Years 2006–2010 (in millions)

Program	2006 Actual	2010 Projected	2006–2010 Change
Commonwealth Care	$0	$880	+$880
MassHealth Coverage Expansions, Rate Increases, and Benefit Expansions	$0	$487	+$487
Uncompensated Care Pool and Safety Net Trust Fund	$656	$381	–$275
Supplemental Payments to Medicaid MCOs (federal)	$385	$0	–$385
Total	**$1,041**	**$1,748**	**+$707**

Source: Massachusetts Taxpayers Foundation; projections as of May 2009.[51]

health industry leaders are now engaged in devising a far-reaching cost-control agenda.

Massachusetts' Chapter 305 of the Acts of 2008 enacted some modest reforms aimed at cost, including support for automating medical records. It also created a Special Commission on the Health Care Payment System that in July 2009 recommended a complete overhaul of health care reimbursement. The Commission concluded that moving away from fee-for-service to a "global payment" is the best strategy to reduce growth in per capita health care costs and promote safe, timely, effective, equitable, and patient-centered care. The Commission envisions these payments being made to "accountable care organizations" composed of hospitals, physicians and/or other clinician and nonclinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need.[50]

The Payment Commission's recommendations are controversial, but that is not a surprise to the advocates of the 2006 coverage reforms. "The current fee-for-service health care payment system is a primary contributor to the problem of escalating costs and pervasive problems of uneven quality," says Sarah Iselin, commissioner of the Massachusetts Division of Health Care Financing and Policy. "Through reform, Massachusetts is rethinking the link between how care is paid for and cost and quality, and how we can better motivate and reward effective, efficient, and patient-centered care," she says.

Since 2006, Massachusetts' health reform investments include MassHealth expansions and rate increases, Commonwealth Care subsidies, and payments to safety-net institutions. The Massachusetts Taxpayers Foundation estimates that health reform spending grew from a base of $1.041 billion in 2006 to a projected $1.748 billion in 2010 (Table 10). That is an increase of $707 million, or about $1,650 per newly insured person, half of which is supported by federal reimbursements. Federal funding is authorized under a Medicaid 1115 waiver, which was updated in December 2008 to allow growth in federal payments through June 2011—but only if the state spends additional federal funds on Commonwealth Care. Funding for the state share of health reform comes from state general revenue funds, tobacco taxes, and assessments on insurers, hospitals, and employers.

Healthy Lives

Since 2007, Massachusetts substantially improved on half of the State Scorecard *indicators related to healthy lives, including reductions in adult smoking and mortality amenable to health care. Childhood obesity, however, is moving in the wrong direction (as it is in the rest of the country), increasing slightly over the past decade: nearly one-third of Massachusetts' children are now overweight or obese.*

From the beginning of health reform, there was interest by some legislators and activists to ensure a strong connection between health insurance and public health. "As the coverage expansion was implemented and the focus on cost and quality intensified," says John Auerbach, "the link to prevention and wellness was clear."[52] Nine state agencies are working together to align public health policies and practices, and are currently developing statewide action plans for preventing and managing diabetes, and for preventing and controlling chronic disease.

The 2006 reform also reinvigorated traditional public health activities. For example, Massachusetts raised tobacco taxes as a strategy to pay for higher-than-expected enrollment in Commonwealth Care. The tax had an impact on the demand for tobacco products and boosted the number of calls received at

the Department of Public Health's smoking cessation hotline. Another set of initiatives promotes diet and exercise. The state partnered with television and radio stations to implement a high-profile public information campaign on healthy eating, and to promote "Mass in Motion," a Web site offering information about staying healthy.[53] The state also now requires fast food restaurants to post calories on menus, and public schools to calculate students' body mass index and relay the information along with explanatory materials to their parents.

Conclusion

Chapter 58 offers abundant experience to inform other state efforts to summon stakeholders to a common purpose, expand subsidized coverage to lower-income uninsured people, find and enroll large numbers of eligible people, define meaningful measures of health insurance affordability for all income groups, enhance insurance access and affordability for individuals by merging the small-group and individual insurance markets, and create opportunities for consumers to compare competing insurance products on cost, benefits, and network restrictions.[54] Massachusetts' early success suggests sequencing reforms, providing adequate resources and flexibility for a long implementation, and eventually forcing a confrontation on costs.[55]

Notes

[32] S. Long and P. Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web Exclusive, May 28, 2009, w578–w587.

[33] J. McDonough, "Massachusetts Health Reform: Bragging Rights and Growing Pains," Alliance for Health Reform and Kaiser Family Foundation transcript (May 19, 2008).

[34] Suffolk University, "Poll Reveals Disconnect on Mass. Health Reform," Press Release, poll results from June 4–7, 2007: http://www.suffolk.edu/20588.html (accessed June 2009).

[35] R. Blendon, T. Buhr, T. Sussman et al., "Massachusetts Health Reform: A Public Perspective from Debate Through Implementation," *Health Affairs* Web Exclusive, Oct. 28, 2008, w556–w565.

[36] Health Connector Authority, "Health Reform Facts and Figures" (June 2009): http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%25209%252C%25202008/Facts%2520and%2520Figures%25203%252008.doc.

[37] Commonwealth Fund *State Scorecard*: 7.3 percent of Massachusetts needed to see a doctor in the past year but could not because of cost, compared with 12.6 percent among all states on average.

[38] Defining "fair and reasonable" was assigned to the state's Division of Health Care Finance and Policy, which promulgated regulations in 2006 assessing employers if they do not contribute at least 33 percent of premium costs for employees or do not cover at least 25 percent of eligible employees. (This requirement is exceeded by prevailing Massachusetts insurance carrier standards in the small group market.)

[39] J. McDonough, B. Rosman, M. Butt et al., "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* Web Exclusive, June 3, 2008, w285–w297.

[40] Commonwealth Care is not available for every uninsured person with an income below 300 percent of poverty. Lower-income workers with access to employer-sponsored coverage are ineligible, even if the employer-offered insurance is unaffordable to them.

[41] Information about Commonwealth Care income eligibility levels, benefits, and costs are described on the Health Connector website: http://www.mahealthconnector.org.

[42] Individuals must have insurance that covers "comprehensive health benefits" defined by the Connector; contains no annual or per-sickness benefit maximums or fee schedules for indemnity benefits; limits deductibles to no more than $2,000 for individuals and $4,000 for families, limits drug deductibles to no more than $250 for individuals or $500 for families; and includes an in-network out-of-pocket maximum of $5,000 for individuals or $10,000 for families.

[43] Long and Masi, "Access and Affordability," 2009.

[44] Massachusetts Medical Society, "Physician Workforce Study, 2008."

[45] L. Ku, "How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform," published by the Kaiser Family Foundation (March 2009).

[46] J. Kingsdale, "Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned," *Health Affairs* Web Exclusive, May 28, 2009, w588–w594.

[47] The Commonwealth Fund, "Public Health in the State Reform Spotlight," *States In Action* Newsletter (New York: The Commonwealth Fund, June/July 2009).

[48] The AcademyHealth Web site has more information about the State Quality Improvement Institute: http://www.academyhealth.org/Programs/ProgramsDetail.cfm?ItemNumber=2501&&navItemNumber=2502.

[49] Kingsdale, "Implementing Reform in Massachusetts," 2009.

[50] Massachusetts Special Commission on Payment Reform, "Recommendations of the Special Commission on the Health Care Payment System" (July 2009).

[51] Massachusetts Taxpayers Foundation, "Massachusetts Health Reform: The Myth of Uncontrolled Costs" (May 2009).

[52] Commonwealth Fund, "Public Health in Spotlight," 2009.

[53] Mass in Motion: http://www.mass.gov/massinmotion/.

[54] McDonough, Rosman, Butt et al., "Massachusetts Health Reform Implementation," 2008.

[55] Kingsdale, "Implementing Reform in Massachusetts," 2009.

Sources

Massachusetts

HMA interviews with Jon Kingsdale, Ph.D., executive director of the Massachusetts Health Connector; Sarah Iselin, commissioner of the Division of Health Care Financing and Policy at the Executive Office of Health and Human Services; and Dolores Mitchell, executive director of the Group Insurance Commission (July 2009).

Robert Blendon et al., "Massachusetts Health Reform: A Public Perspective from Debate Through Implementation," *Health Affairs* Web Exclusive, Oct. 28, 2008, w556–w565; Jon Kingsdale, "Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned," *Health Affairs* Web Exclusive, May 28, 2009, w588–w594; Sharon Long and Paul Masi, "Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008," *Health Affairs* Web Exclusive, May 28, 2009, w578–w587; John McDonough et al., "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* Web Exclusive, Sept. 14, 2006, w420–w431; and John McDonough et al., "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* Web Exclusive, June 3, 2008, w285–w297.

Massachusetts Health Insurance Connector Authority, "Health Care Reform: Key Decisions" and "Health Reform Facts and Figures" (accessed via Web site June 20, 2009).