Massachusetts State Senate Research Internship Report:

The State of our Current Health Care System

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Introduction

In 2006, Massachusetts unveiled a landmark reform intended to provide health insurance for all state residents. Nearly six years later, the number of uninsured Massachusetts residents has decreased significantly and ethnic disparities in health care coverage have diminished. However, over the same period of time, health care costs have risen dramatically. In order to combat these rising costs, the Massachusetts legislature, first and foremost, needs to encourage a new payment system, eliminate inequalities in hospital payments, promote financial awareness for consumers, and strengthen disease prevention. This report will assess some of the benefits and drawbacks of the health care system as it currently stands and will offer several important policy recommendations.

Benefits of Massachusetts Health Care Reform

Better Health Insurance Coverage

By instituting an individual mandate, imposing tax penalties on both employers and employees that fail to obtain health insurance, and heavily subsidizing health insurance for individuals and families earning up to 300% of the Federal Poverty Level ($33,516 for an individual or $69,156 for a family of four in 2012), Chapter 58 of the Acts of 2006 has

considerably reduced the number of uninsured residents in Massachusetts.[1] For example, 98% of total state residents now have health insurance, as opposed to 94% when the health law was first enacted.[2] This means that about 439,000 residents are newly insured since the reform.[3] In addition, nearly all children (99.8%) and seniors (99.6%) now have health insurance.[4] Thus, Massachusetts today has by far the best health coverage in the country. To illustrate this point, the state with the second highest coverage rate is Hawaii with only about 92% of total residents insured.[5] Furthermore, only 84% of Americans nationwide currently have some form of health insurance, demonstrating the uniqueness of Massachusetts' health care feat.[6]

Moreover, since the health reform, more employers are offering their employees health insurance, going against the national trend. In 2010, 77% of Massachusetts employers offered health insurance, up from 69% in 2001.[7] In contrast, nationally, the trend has stagnated as only 69% of employers offered their workers health insurance in 2010, compared to a similarly low 68% in 2001.[8] Therefore, it is evident that the current health system has been largely successful in its efforts to provide health insurance for as many Massachusetts residents as possible.

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[1] "Health Reform Facts and Figures," The MA Health Connector, last modified Spring 2012, accessed May 4, 2012, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf

[2] "Estimate of Uninsured," The Official Website of the Commonwealth of Massachusetts, last modified 2011, accessed May 5, 2012, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/est_of_uninsur_rate.pdf.

[3] "The Top Ten Facts about Massachusetts Health Care Reform," Health Connector, last modified 2012, accessed April 20, 2012, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2011/Week%20Beginning%20March%2006/10%2520FACTS%2520POSTER.pdf

[4] "Top Ten Facts."

[5] Jerry Geisel, "Massachusetts' Insured Rate Hits 98.1%: Analysis," *Business Insurance,* December 14, 2010, accessed April 25, 2012, http://www.businessinsurance.com/article/20101214/BENEFITS03/101219966.

[6] "Massachusetts Facts at a Glance," The Henry J. Kaiser Family Foundation, last modified 2011, accessed May 3, 2012, http://www.statehealthfacts.org/profileglance.jsp?rgn=23#.

[7] "Top Ten Facts."

[8] Ibid.

Less Ethnic Disparities in Coverage

The health reform has also achieved a major reduction in ethnic inequalities regarding health coverage. For instance, prior to 2006, a disproportionate number of Hispanics were uninsured in Massachusetts, with nearly one in four lacking access to health care coverage.[9] As of 2010 though, 96% of Hispanics living in the state were insured.[10] Amazingly, the Hispanic population saw a 45% decrease in the number of uninsured individuals between 2008 and 2010.[11] Likewise, other races (non-Hispanics that include Asians and African Americans) also experienced a reduction in the rate of uninsured residents, dropping from 2.8% in 2008 to 1.5% in 2010.[12]

Improved Access to Care

According to a 2008 survey by the Blue Cross Blue Shield of Massachusetts Foundation and *The Boston Globe*, more than 90% of individuals reported having a primary care physician.[13] In addition, as of 2010, 81% of Hispanics have a personal health care provider, up from 75% in 2004.[14] Moreover, only 5% of Massachusetts residents said there was a time that they needed medical care, tests, or treatment and failed to receive it.[15] On the other hand, in 2007, 20% of Americans as a whole reported "not getting or delaying needed medical care."[16] Clearly, the health reform has also facilitated medical care and treatment for patients throughout the state.

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[9] "Chapter 58 Increases Coverage for Hispanics in Massachusetts," Health Care for All, accessed May 3, 2012, http://hcfama.org/.
[10] Ibid.
[11] "Health Care in Massachusetts: Key Indicators," Division of Health Care Finance and Policy, May 2011 Edition, accessed April 25, 2012, http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/2011-key-indicators-may.pdf.
[12] Ibid.
[13] "Top Ten Facts."
[14] "Key Indicators."
[15] "Top Ten Facts."
[16] Ibid.

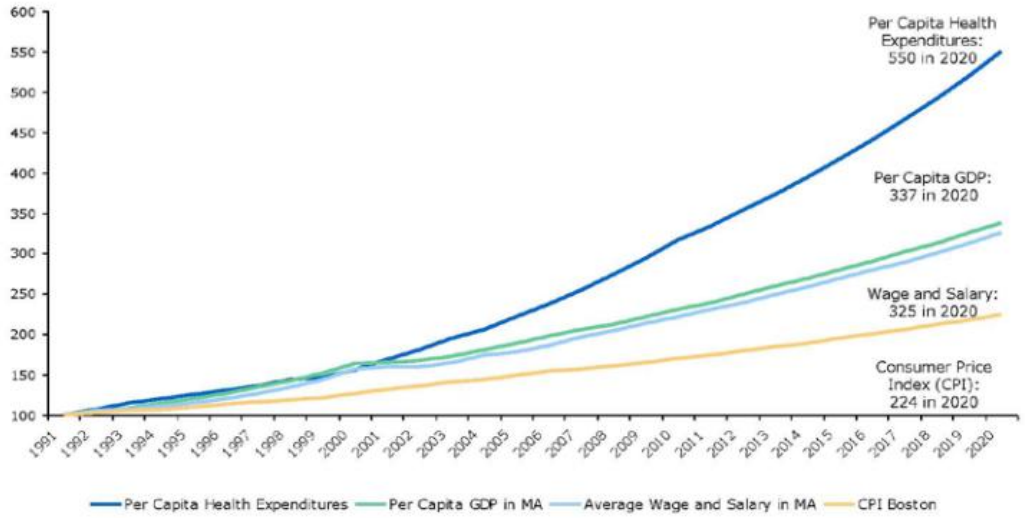
Drawbacks of Massachusetts Health Care Reform

Rapidly Increasing Health Care Costs

Although the 2006 health law has expanded insurance coverage for Massachusetts residents, rapidly rising costs and expenditures pose a major threat to the sustainability of the health care system. For example, in 2006, Massachusetts spent around $1 billion on Medicaid and other health care programs.[17] By 2009, this figure had soared to $1.75 billion.[18] Additionally, in 2009, Massachusetts spent $9,278 per capita on health care, the highest total for any state in the U.S.[19] These health expenditures, as illustrated below in Figure 1, have exceeded both the rates of economic growth and cost of living in Massachusetts. This is especially worrisome considering that health expenditures will consume 54% of the state budget in fiscal year 2012.[20]

Figure 1: Index of Per Capita Health Expenditures and Other Indicators in Massachusetts, 1991-2020 [21]

[17] Shawn Tully, "5 Health Care Lessons from Massachusetts," *CNN Money*, June 16, 2010, accessed April 4, 2012, http://money.cnn.com/2010/06/15/news/economy/massachusetts_healthcare_reform.fortune/index.htm.
[18] Ibid.
[19] "Massachusetts Facts."
[20] Zirui Song and Bruce Landon, "Controlling Health Care Spending – The Massachusetts Experiment," *The New England Journal of Medicine,* April 26, 2012, accessed April 28, 2012, http://www.nejm.org/doi/full/10.1056/NEJMp1201261#t=article.
[21] Amy Lischko and Kristin Manzolillo, "An Interim Report Card on Massachusetts Health Care Reform," *The Pioneer Institute*, no. 51 (2010): 9.



Rising health care spending has been accompanied by increasingly expensive premiums for individuals, families, and businesses. For example, between 2007 and 2009, the median annual premium for family plans jumped 10% to $14,300.[22] Since the reform was enacted, family premiums have increased by an average of $246.55 every year.[23] Likewise, over the same period of time, small businesses experienced a 12% increase in premiums.[24] Lastly, individual insurance plans have increased by $81.13 each year.[25] Even worse, for under-privileged individuals purchasing health insurance through the Commonwealth Choice Connector (established by the reform law of 2006), monthly premiums for the cheapest "bronze" plan rose 57% from about $175 in 2007 to $275 in 2012.[26]

As a result, both employers and employees have had to shoulder the mounting costs of these health care services. In 2010, Massachusetts companies spent a total of $18.1 billion on health insurance. Incredibly, according to a study by the Blue Cross Blue Shield of

[22] Tully, "5 Health Care Lessons."
[23] David Tuerck, Paul Bachman, and Michael Head, "The Economic Effects of Massachusetts Health Care Reform," *The Beacon Hill Institute,* September 2011, accessed May 5, 2012, http://www.beaconhill.org/BHIStudies/HCR-2011/BHIMassHealthCareEcon2011-0915.pdf.
[24] Ibid.
[25] Ibid.
[26] Song and Landon, "Controlling Health Care Spending."

Massachusetts Foundation, this figure is expected to reach $33.1 billion by 2019 if nothing is done to rein in costs.[27] This implies that if the system remains as it is today, local employers will spend $237 billion between 2011 and 2019. The study argues that as a result, employers will be forced to recoup at least $9 billion through layoffs in order to preserve profits.[28] Therefore, the spiraling health care costs could prove to be very damaging to businesses and their employees throughout the state.

Critics of the current health care system have also asserted that rising health care costs have wreaked havoc on the Massachusetts economy as a whole. For instance, in a September 2011 study, the Beacon Hill Institute estimated that total investment in Massachusetts was between $21.28 million and $29.32 million lower in 2010 than it would have been without the health care reform.[29] In addition, the study claims that the state's economy would have produced about 18,313 more jobs had the health reform not been in place.[30] Finally, the study concludes that with the passing of the 2006 law, the disposable income per capita in Massachusetts is $319 to $441 lower than it would have been otherwise.[31]

Although the precise effects of the health care reform on the state economy remain unclear, the current upward trend in health expenditures is not expected to change anytime soon unless the existing system is thoroughly reformed. This is evidenced by the fact that the state government, in the existing health care system, provides subsidies to a growing portion of society. For example, in 2011, MassHealth already had 1.3 million beneficiaries, and 60,000

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[27] Julie Donnelly, "Employers Will Spend $237 Billion on Health Care Between 2011-2019," *Boston Business Journal,* April 26, 2012, accessed April 29, 2012, http://www.bizjournals.com/boston/news/2012/04/26/blue-coss-study.html.
[28] Ibid.
[29] Tuerck, "Economic Effects."
[30] Ibid.
[31] Ibid.

more are expected in 2012.[32] These beneficiaries are very expensive for the government to support because the state heavily subsidizes health insurance under Commonwealth Care for those who are not covered by their employers. As a part of this program, families with an annual income of $69,156 have to contribute approximately $3,000 to health insurance whereas families making $44,000 only pay about $1,000 in premiums.[33] When considering that the actual annual cost of these premiums is almost $10,000, it is evident that the rising number of MassHealth beneficiaries greatly strains the resources at the disposal of the Massachusetts government.[34] This draining of resources is accentuated by the fact that a lot of the expenses of the health reform were supposed to be covered by the Uncompensated Care Pool (or "free care pool"), a government fund of approximately $700 million used to reimburse hospitals for treating uninsured residents.[35] It was believed that as more local citizens obtained insurance, the fund would become unnecessary and could be used to finance MassHealth as well as other government subsidized health care programs. However, although "free care" hospital visits decreased by 28% between 2007 and 2010,[36] overall visits to local emergency rooms rose by 9% between 2004 and 2008 to about 3 million visits a year.[37] According to a report by the Division of Health Care Finance and Policy in 2010, this increase in emergency room visits has had serious cost implications since private insurers and government programs pay "substantially

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[32] Suzanne Gore, "Innovations in Medicaid: Considerations for MassHealth," *Center for Health Care Strategies*, December 2011, accessed May 4, 2012, http://www.massmedicaid.org/~/media/MMPI/Files/Innovations%20in%20Medicaid_Dec11v2.pdf.
[33] Tully, "5 Health Care Lessons."
[34] Ibid.
[35] "Uncompensated Care Pool PFY05 Utilization Report," The Official Website of the Commonwealth of Massachusetts, December 6, 2005, accessed May 9, 2012.
[36] "Study: ER Visits By Poor Plummet in Mass," *CBS News*, March 24, 2010, accessed April 17, 2012, http://www.cbsnews.com/stories/2008/02/14/health/main3831107.shtml?source=related_story.
[37] Liz Kowalczyk, "Emergency Room Visits Grow in Mass," *The Boston Globe,* July 4, 2010, accessed April 17, 2012, http://www.boston.com/news/local/massachusetts/articles/2010/07/04/emergency_room_visits_grow_in_mass/.

more" for a visit to the emergency room than for a regular doctor's appointment.[38] Thus, it is clear that costs are rising in Massachusetts, posing a significant impediment to the overall sustainability of the current health care system.

Policy Recommendations

Reduction of the Disparity in Payments to Different Hospitals

One of the best ways of cutting health care costs is to eliminate the vast inequality in compensation to hospitals throughout Massachusetts. Currently, insurance companies raise their premiums in part because large, reputable hospital groups are unconstrained by the market and therefore can charge much more than small community hospitals. For example, on June 22, 2011, the office of Massachusetts Attorney General Martha Coakley released a report that acknowledged this considerable inequality. It noted, "The difference in prices each major health insurer pays to its lowest paid physician groups versus its highest paid physician groups exceeds 145%, and for two health insurers, exceeds 230%."[39] Similarly, the report found that "the difference in payments made to the lowest paid versus highest paid hospital in each major health insurer's network exceeds 170%, and for two health insurers, exceeds 300%."[40]

Although prices vary immensely throughout the state, studies have shown that they are not correlated with quality of treatment or care. For instance, Massachusetts General Hospital earns 15% more than Beth Israel Deaconess Medical Center for treating heart-failure patients, even though government figures demonstrate that Beth Israel consistently reports lower death

[38] Ibid.
[39] Martha Coakley, "Examination of Health Care Cost Trends and Cost Drivers," June 22, 2011, accessed April 17, 2012, http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf.
[40] Ibid.

rates.[41] Moreover, the average cost of a coronary bypass surgery at Mass General Hospital is $51,500, as opposed to $43,500 at Beth Israel, despite the fact that the latter has an overall lower mortality rate for its bypass surgery patients.[42]

Thus, this inequality in payments is not due to actual differences in care, but is rather a result of hospitals' market power. Currently, several of the hospitals in Boston, such as Mass General Hospital and Brigham and Women's Hospital receive a large inflow of patients because of their reputation and prestige. Accordingly, these hospitals ask for lofty payments from insurance companies. In turn, insurers, in an effort to preserve customers, are forced to accept the exorbitantly high prices. For example, Children's Hospital in Boston has negotiated the highest insurance payments in the state, arguing that its work with children is "uniquely expensive." [43] As a result, the hospital has reported profit rates three times the median for Massachusetts hospitals.[44] Nonetheless, insurers continue to pay because they know that parents won't buy their plans if they do not have access to one of the world's most prestigious pediatric institutions.

One of the most telling examples of hospitals exercising their market power in recent years has been the dominance displayed by Partners HealthCare, a company formed in 1994 that has brought together two of the top ten hospitals on US News and World Report's rankings: Mass General and Brigham and Women's Hospital. In 2000, the executives of Tufts Health Plan decided to stand up to this medical powerhouse and refused to accept Partners' substantial rate increase. Soon thereafter, thousands of Tufts customers threatened to switch insurance

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[41] Scott Allen and Marcella Bombardieri, "A Healthcare System Badly out of Balance," *The Boston Globe,* November 16, 2008, accessed April 17, 2012, http://www.boston.com/news/local/articles/2008/11/16/a_healthcare_system_badly_out_of_balance/?page=1.

[42] "Measuring Health Care Quality and Cost in Massachusetts," Division of Health Care Finance and Policy, November 2009, accessed May 4, 2012, http://www.mass.gov/hqcc/docs/measuring-hc-quality-cost-mass-nov-09.pdf.

[43] Allen and Bombardieri, "Badly Out of Balance."

[44] Ibid.

companies. The reaction was so severe that within days, Tufts was forced to give in to Partners' demands. Since then, Mass General and Brigham Women's Hospital are paid an average of 30% more than similar non-pediatric hospitals statewide for their procedures.[45]

Since the rise in costs is not associated with better treatment or quality of care, these hospitals must be limited on the increases that they can impose on insurance companies. Although large teaching hospitals argue that the money they receive is well-deserved because they provide innovation and medical training, their costs have spurred health care expenditures throughout Massachusetts. For example, Partners' higher rates amount to at least $800 million more for their hospitals and doctors than if they were paid at rates similar to their competitors.[46] This comes out to approximately $170 a year for every member of the three leading insurers: Blue Cross Blue Shield, Tufts, and Harvard Pilgrim.[47] Thus, it is crucial that regulations be put in place to prevent hospitals from using their market power to trap additional profits.

Increased Incentives for Consumers to Seek out Inexpensive Health Care

If consumers were more aware of the financial repercussions of the decisions they make regarding their health, demand for high-cost providers would shrink, thereby reducing expenditures. Currently, patients in Massachusetts are 2.5 times more likely to go to teaching hospitals than patients nationwide.[48] This results in about an extra $1.7 billion in health care expenditures annually.[49] Most of this cost is shouldered by insurance companies that are often accountable for their customers' treatment and care, regardless of the location. However, as was previously discussed, studies have proven that just because teaching hospitals are more expensive does not mean that they are more effective health care providers. Therefore, it is

[45] Ibid.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid.

imperative that patients have an incentive to go to lower-cost providers whenever possible. For example, the RAND Corporation found that encouraging insurers to limit reimbursement to community hospital rates and requiring their customers to pay the difference if they wish to obtain pricier health care would reduce cumulative expenditures by up to 1.3% or $800 million a year.[50] Thus, if patients became aware of discrepancies in health care costs throughout Massachusetts, through fluctuating premium or copayment rates (depending on the prices of different institutions) for example, unnecessary expenditures would definitely be circumvented.

A Shift from Fee-for-service Payments to Global Payments

By moving from a fee-for-service payment structure to a global payment structure, doctors will be encouraged to become more efficient and frugal with their treatment and care. Global payments differ from fee-for-service payments in that insurers offer providers a fixed monthly or yearly compensation for services depending on quality of care as opposed to a fixed amount for individual procedures, regardless of the outcome. Today, most health providers in Massachusetts are paid on a fee-for-service basis, which, according to a 2009 government report, is "inherently inflationary, rewards overuse of health services, does not reward primary care, preventative care, or care coordination, and contributes to administrative complexity." [51] Instead, the state should shift to global payments that "provide incentives for efficiency in the delivery of services… while potentially driving improvements in quality through better coordination of care."[52] The RAND Corporation found that encouraging "insurers to provide a single payment for all services related to a treatment or condition, including services delivered by multiple providers and in multiple settings" was the single most effective way of reducing costs in

[50] "Controlling Health Care Spending In Massachusetts: An Analysis of Options," *RAND Corporation*, 2009, accessed April 17, 2012, http://www.rand.org/pubs/research_briefs/RB9464-1/index1.html.
[51] "Roadmap to Cost Containment," Massachusetts Health Care Quality and Cost Council, October 21, 2009, http://www.mass.gov/hqcc/docs/roadmap-to-cost-containment-nov-2009.pdf
[52] Ibid.

Massachusetts with a possible reduction of up to $3.66 billion a year, or 6 percent of total health expenditures.[53]

One of the most promising global payment structures is the one that Blue Cross Blue Shield set up in 2009 called the Alternative Quality Contract, a payment plan that rewards providers for performance and cost-effectiveness. As a part of this plan, providers receive an annual budget depending on the historical costs for a patient's health care. All payments for medical care, whether the services are delivered by an Alternative Quality Contract group or an unaffiliated provider, count towards the budget. Then, at the end of the year, any money left over goes to the provider and any excessive spending must be paid to the insurer. However, providers must meet minimum overall quality scores in order to start receiving bonuses. As quality of care improves, providers receive more lucrative rewards. For example, if providers achieve optimal overall quality, they are eligible to receive up to 10% of their annual medical budget.[54] Thus, this payment structure is different from the failed capitation systems of the 1990s for two reasons: providers must meet 64 quality measures to receive bonuses and annual budgets are not the same for all patients. As a result, health care providers do not have an incentive to underuse health care services and they do not have to avoid sick patients.[55]

As Karen Davis, president of the Commonwealth Fund, has said, "It's not realistic to tell hospitals and doctors that they must improve quality if by doing so they are likely to lose money."[56] Therefore, Massachusetts must promote plans similar to The Alternative Quality Contract that reward cost-effectiveness *and* quality of care. Through the use of these fee-for-

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[53] "Controlling Health Spending," RAND.
[54] Robert Mechanic, Palmira Santos, Bruce Landon, and Michael Chernew, "Medical Group Responses to Global Payment: Early Lessons from the 'Alternative Quality Contract' in Massachusetts," *Health Affairs* 30, no. 9 (2011): 1734-1742.
[55] "The Alternative Quality Contract," Blue Cross Blue Shield of Massachusetts, May 2010, accessed April 17, 2012, http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf.
[56] Ibid.

performance programs, doctors will be highly encouraged to avoid "overprescribing," to share test results as opposed to ordering the same test several times, and to refer patients to lower cost, higher quality providers.[57]

Extra Emphasis on Disease Prevention

The Massachusetts health care system currently relies too heavily on disease treatment, rather than disease prevention. Many preventable diseases cost the state millions of dollars every year. If more illnesses were prevented, health care costs would decrease as the use of expensive procedures declined. For example, obesity incidence in Massachusetts almost doubled between 1995 and 2008, growing from 11.7 to 22.5 percent of the population.[58] Likewise, incidence of diabetes grew 29% in a recent four-year period.[59] Reversing these trends would greatly reduce health care expenditures since the cost of treating diabetes, for instance, is roughly $6,000 a year for every diabetic.[60] A 2011 study by the Urban Institute found that by reducing the prevalence of diabetes and hypertension by a mere 5%, Massachusetts would save $135 million within one to two years and $450 million within five years.[61] Thus, the state must improve its residents' access to primary care physicians, make healthy foods and beverages available for everyone, and encourage physical activity in order to reduce the costs of preventable diseases.

A Few Words on the Senate and House Bills for Cost Control

There are several important factors that must be considered in the forthcoming debates regarding the bills that the Massachusetts Senate and House have introduced to reduce the

[57] Coakley, "Trends and Cost Drivers."
[58] "Roadmap to Cost Containment."
[59] Ibid.
[60] Thomas Menino and Paula Johnson, "Health Care vs. Sick Care: Why Prevention is Essential to Payment Reform," *The Boston Globe,* April 03, 2012, accessed April 17, 2012, http://articles.boston.com/2012-04-03/opinion/31273529_1_health-care-diabetes-disparities.
[61] Ibid.

costs of health care throughout the state. First, even though both bills tackle rising expenditures, the House bill, in general, is a bit more stringent in its reduction of health care costs than the Senate bill. For example, the House bill would set the increase of health care spending at the annual growth rate of the state's gross product through 2015, and then reduce it to .05 percent below the state's growth rate starting in 2016.[62] The Senate bill, on the other hand, would peg the increase of health care spending at a half-percentage point above the gross state product's annual rate of increase through 2015, and then in 2016, the target would drop to equal the annual rise of the gross state product.[63] In addition, the House bill includes a provision for a 10% luxury tax on hospitals that charge more than 20% above the state median price for their services without justification.[64] Lastly, the House bill pushes all institutions to shift from fee-for-service payments to global payments, whereas the Senate bill would only require that state-run health plans make the move.[65]

While the unilateral and considerable reduction of health care expenditures proposed in the House bill is admirable, any bill's eventual effects on the state economy must first be taken into full consideration. Currently, the health care sector employs 326,170 people throughout Massachusetts, [66] and accounts for 20 percent of the state's economy.[67] Additionally, health care is the fastest growing sector in Massachusetts. Between 1990 and 2006, overall health care

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[62] Jennifer Levitz, "Massachusetts is Closer to Controlling Health Costs," *The Wall Street Journal,* May 9, 2012, accessed May 10, 2012, http://online.wsj.com/article/SB10001424052702304203604577394680378741636.html.
[63] Ibid.
[64] "Massachusetts Bill Aims To Help Control Rise in Health Care Spending," *California Health Line,* May 07, 2012, accessed May 10, 2012, http://www.californiahealthline.org/articles/2012/5/7/massachusetts-bill-aims-to-help-control-rise-in-health-care-spending.aspx.
[65] Levitz, "Close to Controlling Health Costs."
[66] "Massachusetts Facts."
[67] Richard Knox, "Health Care in Massachusetts: 'Abject Failure' or Work In Progress," *NPR*, February 13, 2012, accessed May 10, 2012, http://www.npr.org/blogs/health/2012/02/13/146701343/health-care-in-massachusetts-abject-failure-or-work-in-progress.

employment jumped by 32.6%.[68] Thus, the House bill might prove to hinder one of the state's most important industries. Furthermore, about 70 cents out of every hospital dollar is tied to labor, which means that significant government regulations of hospitals would probably lead to layoffs across the board.[69] As a result, any Senate or House bill must ensure that expenditures are being reduced in a way that preserves the competitiveness and innovation of the Massachusetts health care system.

Summary

Since 2006, Massachusetts has been a leader in health care coverage. The landmark reform improved access to care and minimized ethnic disparities in health coverage, among many other achievements. However, Massachusetts now spends more on health care (per capita) than any other state in the country. Premium rates have rapidly grown, straining the productivity of individuals, families, and businesses throughout the state. Therefore, a reform of the current system is necessary in order to rein in health costs. Specifically, the Massachusetts legislature should trim down the inequalities in hospital compensation, provide consumers with incentives to save, move from fee-for-service payments to global payments, and improve disease prevention. Nonetheless, as policy-makers debate the merits of cost control bills, they should pay heed to the effects of payment regulations on jobs and on the economy as a whole.

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[68] Rebekah Lashman, Jonathan Latner, and Navjeet Singh, "Trends in the Healthcare & Social Assistance Sector in Massachusetts," Commonwealth Corporation, March 12, 2008, accessed May 11, 2012, http://64.78.33.48/resources/documents/Healthcare.Presentation%20for%20CWC.pdf.

[69] Lynn Nicholas, "Hospitals Support Reducing Healthcare Costs, But Don't Endanger Jobs and the Economy," *Massachusetts Hospital Association,* April 27, 2012, accessed May 10, 2012, http://www.mhalink.org/blog/index.cfm/2012/4/27/Hospitals-Support-Reducing-Healthcare-Costs-But-Dont-Endanger-Jobs-and-the-Economy.

In the end, the success of the 2006 reform depends on the Massachusetts legislature's ability to reduce costs while enhancing quality of care and protecting the state economy.

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