

# The Massachusetts Health Insurance Law: Providing Health Insurance to All

Myra A. Kleinpeter, MD, MPH  
New Orleans, Louisiana

There have been increasing rates of uninsured patients in the United States over the past few decades. Despite this growing problem, little progress has been made to decrease the rate of growth of uninsured patients or to provide affordable insurance coverage to those who are unable to maintain insurance coverage throughout the year. The legislature in the Commonwealth of Massachusetts has enacted legislation that requires health insurance for all in the same manner that automobile insurance is required in many states. This bold comprehensive legislation augments current Medicaid and state child health insurance program coverage and expands coverage options for part-time workers, those employed by small companies or those employed at lower-income jobs.

This review provides a summary of the Massachusetts legislation as well as implications for uninsured patients, other stakeholders and safety net providers in other states. The health insurance mandate may have other unintended consequences to employees and employers in Massachusetts. While this plan of modified universal coverage will provide access to coverage, little is known currently if these new health insurance products will provide comprehensive insurance products.

**Key words:** health insurance ■ state child health insurance program (S-CHIP) ■ Medicaid

© 2006. From Tulane University Health Sciences Center, Department of Medicine, Section of Nephrology and Hypertension, New Orleans, LA. Send correspondence and reprint requests for *J Natl Med Assoc.* 2006;98:1867-1873 to: Dr. Myra A. Kleinpeter, Tulane University Health Sciences Center, Department of Medicine, Section of Nephrology and Hypertension, 1430 Tulane Ave., SL-45, New Orleans, LA 70112; phone: (504) 988-5346; fax: (504) 988-1909; e-mail: mkleinp@tulane.edu

## INTRODUCTION

The United States has the most technologically advanced health system, yet there are >45 million uninsured persons of all ages.<sup>1</sup> There are large numbers of uninsured patients among racial and ethnic minority populations.<sup>1</sup> Medicaid provides coverage for many uninsured patients; however, this option is often

limited to the poorest and most at-risk patients. State Child Health Insurance Programs (S-CHIP) expanded Medicaid coverage to more children to reduce the numbers of uninsured children in the United States.<sup>2</sup> These programs vary widely across the nation and have been limiting coverage as the cost of healthcare continues to increase as the states participating in these federal programs and as the federal government has limited the federal spending for these programs.<sup>2</sup>

At the same time, in an effort to remain competitive in business, organizations of all sizes, from small businesses to large corporations, state and local governments, schools and universities and other professional organizations have reduced health insurance coverage and options. These mechanisms include limiting insurance products, eliminating insurance coverage for part-time employees and retirees, raising employee contributions for health insurance premiums, reducing and/or eliminating employer contributions for health insurance premiums, restricting pharmacy benefits and raising employee deductibles. As a result of all of these strategies, many individuals have dropped health insurance coverage and have joined the increasing population of uninsured in the United States.<sup>1</sup> The American public reports much dissatisfaction with the current healthcare system, managed care companies and private health insurance.<sup>3</sup> Nevertheless, most Americans are satisfied with their current medical arrangements, support a national health plan, but do not trust the federal government to be fair and equitable in a single payer health plan.<sup>3</sup>

As the uninsured population in the United States has grown over the past three decades, much has been proposed, but little has been done to reverse the trend.<sup>4</sup> Increasing numbers of uninsured patients result in elevated healthcare costs to states, hospitals, governmental insurance programs and insurance companies by increasing the Medicaid and safety net spending for states, uncompensated care spending for states and indirectly for health insurance companies. The bold new legislation of Massachusetts requires individual health insurance coverage may be the blueprint to stem the rising tide of uninsured patients in the United States.<sup>4</sup>

## Prior Health Insurance Efforts

The debate over universal health insurance in the United States has been waged increasingly as the population of uninsured persons grows and as healthcare spending continues to increase faster than the rate of inflation.<sup>4-6</sup> The overall cost of universal coverage and the mechanisms to fund these programs have been at the center of debate for more than a decade.<sup>6</sup> As states struggle to balance their budgets, spending for healthcare has often decreased. State legislatures control and spend millions of dollars on healthcare through a variety of mechanisms, including legislative mandates, Medicaid program expenditures, public hospital and clinic funding, state support of medical and health professional schools and other health services programs.<sup>7</sup> There are many pressures such as socioeconomic, demographic and market factors that influence states' spending on healthcare.<sup>7</sup> The primary factors that influence state spending on healthcare are age distribution of the states' population, per-capita income, managed care penetration and the availability of physician specialists.<sup>7</sup>

Massachusetts is the home of some of the most acclaimed and prestigious medical institutions in the United States.<sup>8</sup> It has been referred to as a "medical mecca" due to the academic medical centers, scientific break-throughs, state-of-the-art clinical services and medical publications. Unfortunately, Massachusetts also holds the title as "The World's Most Expensive Hospitals."<sup>8</sup> In April 1988, the Massachusetts legislature enacted the Medical Security Act, which had the goal of providing affordable insurance to all residents of Massachusetts by 1992.<sup>9</sup> Unfortunately, economic factors in the state resulted in tightening of the budget, leading to a repeal of the tax responsible for financing of the legislation and ultimate failure of this legislative initiative.<sup>9</sup>

Legislative action in 1991 deregulated the state's hospital pricing system, thus enabling healthcare organizations and institutions to negotiate directly with health insurers.<sup>8</sup> This legislation resulted in market consolidation, aggressive competition and adjustment of hospital beds to the population with reduced inpatient utilization.<sup>8</sup> Over the next decade, utilization of inpatient services was reduced to the national average, but the outpatient utilization of services remained significantly higher than the national average.<sup>8</sup> Despite these improvements, healthcare costs at academic health centers and major teaching hospitals remained higher than costs at nonteaching community hospitals.<sup>10,11</sup> One factor that results in higher perceived cost but lower direct costs to patients and insurers, is the higher-than-average National Institutes of Health (NIH) funding in Massachusetts as well as grants from private organizations and foundations.<sup>8</sup> A random sample of physicians in Massachusetts indicated that single-payer financing of healthcare with universal coverage would provide the best care for most people, compared to the traditional managed

care and fee-for-service systems.<sup>12</sup>

Despite the failures of many of the national efforts to reform healthcare, Massachusetts has continued to enact legislation to expand insurance coverage.<sup>8</sup> Still, the number of uninsured Massachusetts' residents continued to increase.<sup>13</sup> Medicaid waivers were used to expand coverage; however, increasing costs of healthcare and increasing numbers of uninsured resulted in shortfalls of the budget, thus requiring legislative action and supplements to continue providing healthcare. Creative financing from federal matching funds, cigarette excise taxes and expansion of the S-CHIP coverage and funding led to decreasing numbers of uninsured children but stable levels of the working uninsured.<sup>13</sup> In April 2006, the legislature of the Commonwealth of Massachusetts enacted comprehensive healthcare reform mandating health insurance coverage for all state residents by July 2007.<sup>14</sup>

## Summary of Legislation

In an analysis of the Massachusetts plan for health policy concerns, individuals and employers have been provided a template for legislators in other areas of the country to develop a plan for their constituents to take personal responsibility for healthcare.<sup>14</sup> This legislation, a bridge between the principles of House and Senate bills H4479 and S2282, reallocates state funding for healthcare, provides businesses and other employers guidelines on how to provide access to health insurance while maintaining business and industry competitiveness.<sup>14</sup>

## Key Components of the Massachusetts Legislation<sup>14</sup>

1. Requires all individuals in Massachusetts to have health insurance coverage by July 1, 2007.
2. Reduces rate of growth of state spending for healthcare.
3. Expands Medicaid eligibility to all adults below the federal poverty level (FPL).
4. Expands Child Health Insurance Program (CHIP) coverage to children whose families earn below 300% FPL.
5. Penalizes individuals who can afford insurance for not purchasing coverage through legislative and fiscal sanctions including loss of individual exemptions for state income tax or fines.
6. Extends family coverage from age 23–25 to cover young adults.
7. Expands health savings accounts to cover healthcare costs.
8. Requires employers with >10 employees to contribute to employee healthcare costs.
9. Develops a Health Insurance Connector to help employers and individuals find affordable health insurance coverage.
10. Encourages private insurers to offer more low-

cost and individual options.

11. Provides an annual penalty of \$295 per employee to employers who do not provide health insurance coverage and progressive fines and penalties for those who refuse to provide coverage.
12. Creates a subsidized insurance program called the Commonwealth Care Health Insurance Program for individuals and households who earn <300% FPL. Premiums are on a sliding scale based on income.

## DISCUSSION

Historically, individual spending in Massachusetts for healthcare has been higher than the national average.<sup>7</sup> Many factors contribute to this elevated spending, including higher labor costs, higher cost of living, greater availability of physician specialists and increased availability of diagnostic medical testing equipment such as computed tomography (CT) and magnetic resonance imaging (MRI). In the past, Massachusetts has legislated improved access to mental health coverage for patients with insurance and managed Medicaid plans.<sup>15,16</sup> The earlier efforts were successful at expanding coverage and resulted in lower costs to insurance companies, employers and individuals through cost-shifting activities.<sup>15,16</sup> For example, managed behavioral healthcare resulted in utilization of less costly types of 24-hour care instead of inpatient hospital care with improved outcomes and lower costs for all segments of the population except adolescents.<sup>16</sup>

Legislative health insurance mandates in other states have met with indeterminate success, since they historically have been limited to Medicaid providers and managed care organizations. For example, mandates for mental health coverage across the nation were examined for their influence on adult suicide, which is strongly correlated with mental illness.<sup>17</sup> From 1981–2000, mental health mandates were not effective in reducing suicide rates.<sup>17</sup> Conversely, other employer and individual health insurance mandates have many desirable effects, including lower costs to government and improved distributed outcomes.<sup>5,18-20</sup> However, unintended consequences of these mandates, which negatively affect lower-income employees in particular, include lower wages, higher out-of-pocket costs and limited choice of health insurance options.<sup>18-20</sup>

Based upon these key components of the 2006 Massachusetts health insurance legislation, the primary stakeholders of health insurance (consumers, practitioners, employers, providers of healthcare goods and services and payers) have roles in the implementation of this legislative mandate.<sup>14</sup> While consumers will be required to take some personal responsibility for health insurance, access to health coverage will be expanded to many groups that have lacked it in the past.<sup>14</sup> One group that may be missed, though, is the undocumented work-

force, most commonly found in service industries. These individuals may be employed as day laborers or work for individuals rather than businesses. Persons employed by households who have traditionally lacked access to affordable health insurance may obtain coverage through the Mass Health Medicaid program or the new subsidized health insurance program called the Commonwealth Care Health Insurance Program.

The pricing of these health insurance policies may also include premiums based on risky health behaviors and health-promotion activities. For example, premium schedules for smokers versus nonsmokers may be significantly higher. Health plans may offer programs to promote smoking cessation. After a prescribed period of time, these former smokers will realize the cost savings of reduced premiums. Health screenings and cancer screenings will be covered at different rates through these health insurance products. Where early detection and treatment has proven to be associated with lower costs and decreased morbidity and mortality, these screenings should be covered with minimal costs to enrollees. However, where the evidence lacks risk-benefit measures, cost sharing between enrollees and health plans will continue. Those enrollees who complete early and timely screenings tend to have reduced morbidity and mortality associated with the conditions that are screened. These health-promoting behaviors may result in lower health insurance premiums for enrollees in a similar manner that risk-averting behavior results in reduced automobile insurance premiums. The overall costs to individuals, government or insurance companies are uncertain. These uncertainties may impact the implementation of the program.<sup>21</sup>

Health insurance coverage has become progressively limited over the past two decades, most drastically in the past five years, largely due to employers' and the government's need to reign in expenses.<sup>20</sup> The two corporations with the highest revenues in the United States, Exxon-Mobil and Wal-Mart, have attempted to limit their cost increases for healthcare and health insurance by a combination of limiting or reducing retiree health insurance coverage, increasing retiree and employee copayments and premiums, eliminating coverage or restricting coverage of part-time employees and requiring increased eligibility periods for health insurance enrollment.<sup>20</sup> States have attempted to decrease their expenditures for healthcare by restricting eligibility for Medicaid and other state-sponsored health plans.<sup>20</sup> The Massachusetts plan will require employers to offer health insurance to employees through a variety of mechanisms.<sup>14</sup> Most will find additional health insurance products available through the Insurance Partnership Program. Employers of  $\geq 11$  workers who do not provide health insurance will pay an estimated annual fee of \$295 per full-time employee, prorated for seasonal or part-time employees.<sup>14</sup> Employers who do not pro-

vide health insurance and whose employees use free care will be assessed a Free-Rider Surcharge.<sup>14</sup> This surcharge will range between 10% and 100% of the State of Massachusetts' costs of services provided by free care to the employee.<sup>14</sup> The first \$50,000 of this cost per employer will be exempted.<sup>14</sup> The surcharge will be paid to the Commonwealth Care Trust fund, which funds the subsidized health insurance program.<sup>14</sup>

Health insurance companies will be impacted in many ways through this legislation.<sup>22,23</sup> There will be an expansion of health savings accounts allowing pretax dollars for healthcare spending by the employee.<sup>14</sup> Consumers' costs are the same, but this will lower their income tax bracket and result in net tax savings. With an increasing number of Massachusetts' residents pursuing graduate degrees and having longer matriculation times in postsecondary education, young adults are full-time students for longer periods of time. This legislation will allow young adults to stay on their parents' health insurance for two years past their dependent status or age 25, which ever occurs first.<sup>14</sup> Through the Commonwealth Insurance Connector, 19–26-year-olds will be able to purchase lower-cost insurance products available.<sup>14</sup> Many of these individuals have previously not pur-

chased health insurance for a variety of reasons, including cost of health insurance premiums.

The Commonwealth Health Insurance Connector is created by this legislation to connect individuals, small businesses and individual employers with health insurance products.<sup>14</sup> The Connector certifies insurance products and allows for portability of insurance for individuals who move from job to job.<sup>14</sup> The Connector allows more than one employer to contribute to an employee's health insurance premium.<sup>14</sup> Employed individuals are able to purchase health insurance through the Connector using pretax dollars.<sup>14</sup> Eligibility for the Commonwealth Care Health Insurance Plan and the current Insurance Partnership Program will be expanded to 300% FPL.<sup>14</sup>

### Stakeholder Implications

The stakeholders in the Massachusetts health insurance legislation represent five primary groups: patients, payers (private and governmental), practitioners, health goods and services providers, and employers (Table 1).<sup>14,23</sup> The primary stakeholder is the uninsured patient. These patients will have access to health insurance through the private health insurance market, group purchase agreements, subsidized insurance products or

**Table 1. Stakeholders impacted by Massachusetts health insurance legislation**

Patients	<ul style="list-style-type: none"> <li>Uninsured</li> <li>Adult patients below federal poverty limit (FPL)</li> <li>Medicaid expansion to 300% FPL</li> <li>CHIP expansion to 300% FPL</li> <li>Patients who chose not to carry health insurance, but access through employers</li> <li>Families to expand coverage up to age 25 for young adults</li> <li>Subsidized for patients up to 300% FPL for adults</li> </ul>
Payers	<ul style="list-style-type: none"> <li>Commonwealth of Massachusetts</li> <li>Governmental programs (rural health clinics, federally qualified health centers, etc.)</li> <li>Health Insurance companies</li> <li>Pharmacy benefit managers</li> <li>Individuals (health savings accounts, out-of-pocket expenses, co-payments)</li> </ul>
Practitioners	<ul style="list-style-type: none"> <li>Primary care physicians</li> <li>Specialty physicians</li> <li>Other licensed allied health professionals</li> </ul>
Providers	<ul style="list-style-type: none"> <li>Hospitals</li> <li>Long-term care facilities</li> <li>Private physician offices</li> <li>Multispecialty group practices</li> <li>Durable medical equipment providers</li> <li>Pharmacies</li> <li>Community health centers</li> <li>Other medical services providers</li> </ul>
Employers	<ul style="list-style-type: none"> <li>Government agencies (federal, state, local)</li> <li>Corporations</li> <li>Small businesses (&gt;10 employees)</li> <li>Small businesses (≤10 employees)</li> <li>Other employers</li> </ul>

employer-sponsored insurance products.<sup>14,23</sup> Additionally, these patients will not be limited to traditional safety net providers. Unemployed patients, however, are not covered by this legislation unless they meet coverage guidelines for Medicaid or other subsidized products. Retirees who are not eligible for Medicare may not be covered by this legislation if they do not meet Medicaid guidelines and may only be able to participate through health savings accounts if they are not able to find coverage through the Health Insurance Connector. Undocumented employees, migrant workers, illegal aliens and other immigrants may not be covered by this legislation. Patients who do not enroll are penalized by loss of personal exemptions on state income tax except those not required to file state income taxes. These exclusions may result in continued costs from uncompensated care to the Commonwealth of Massachusetts.<sup>21</sup>

Patients with chronic illnesses will benefit from improved coordination of care through the availability of chronic care management programs through insurance providers.<sup>24</sup> Additionally, quality indicators will be collected and made public so patients may make informed decisions regarding provider selection and quality of care.<sup>14,23</sup> The American Public Health Association (APHA) has advocated the development and implementation of a system of universal health coverage system under a single-payer mechanism.<sup>25</sup> Although the Massachusetts plan is not a single-payer system, through the Commonwealth Health Insurance Connec-

tor, it may be able to provide complementary plans that will be best suited for individuals and families based on their personal insurance needs.<sup>14,23</sup>

Practitioners stand to benefit from the legislation with the prospect of nearly total insurance coverage and elimination of uninsured patients. This may increase the market demand for primary care practitioners or require their geographical redistribution to achieve the model of comprehensive community-oriented primary care in which a primary care home is established for all patients. The demand and distribution of specialists would depend on the primary care referral patterns and comorbidities in the population. Cost and quality data for physicians and specific procedures will be collected and made public.<sup>14,23</sup> Medicaid rate increases will be linked to achievement of performance goals.<sup>14,23</sup>

As a result of this legislation, healthcare provider organizations, such as multispecialty groups and hospitals, will have a different payer mix and fewer uninsured patients accessing healthcare services. This may result in reduced financial loss for these organizations since much of the current bad debt comes from uninsured patients. These providers may have additional capital for expansion of services or funds for other health-promotion activities or goals of the healthcare provider organization. Safety net providers could have additional revenue to maintain operations and not have to rely on funds from uncompensated care sources. Hospitals and provider organizations will be required to collect and

**Table 2. Massachusetts health insurance legislation coverage options**

Income	Individual or Family	Employment Status	Employer Insurance Available	Option	Health Insurance Connector Access
<300% FPL or >300% FPL	I	Full-time	Yes	Insurance through employer	Yes
<300% FPL	I	None or part-time	No	Medicaid	No
<300% FPL or >300% FPL	I	Student age <25	Yes	Through parents' insurance	Yes
<300% FPL	I	Student age >25	No	Commonwealth Insurance Care	No
<300% FPL	I	Disabled	Yes	Medicaid and/or Medicare	Yes (Medicare supplement)
<300% FPL	I	Retired age <65	Yes	Insurance through former employer or Medicaid if eligible	Yes
<300% FPL or >300% FPL	I	Retired age ≥65	Yes	Medicare	Yes (Medicare supplement)
<300% FPL	F	Full-time	Yes	Commonwealth Care Insurance	No
<300% FPL	F	Part-time	No	Medicaid and/or S-CHIP	No
>300% FPL	I	Student age >25	No	Private Insurance	Yes
>300% FPL	I	Disabled	No	Private Insurance	Yes
>300% FPL	F	Full-time	No	Private Insurance	Yes
>300% FPL	F	None or part-time	No	Private Insurance	Yes
>300% FPL	I or F	Retired age <65	Yes	Insurance through former employer	Yes

I: individual; F: family; FPL: Federal Poverty Limit; S-CHIP: State Child Health Insurance Program

report data on racial and ethnic health disparities.<sup>14,23</sup> Medicaid rate increases and reimbursements will be linked to the achievement of predetermined performance standards.<sup>14,23</sup> In the past, community health centers funded through the federal and state governments provided access to care to vulnerable populations. These centers should continue to have a role in providing healthcare, particularly culturally competent healthcare to vulnerable populations and in reducing barriers to care.<sup>26</sup> Health centers and health insurance should continue to thrive under the new Massachusetts plan if a comprehensive plan for inclusion of these centers as the focus of community-based primary care is developed.<sup>26,27</sup>

The stakeholders who may feel the most significant financial impact from the Massachusetts legislation are the health insurance providers, including the Commonwealth of Massachusetts.<sup>14</sup> The Commonwealth is responsible for funding and managing the public hospitals and clinics, the Medicaid program, and the SCHIP.<sup>14</sup> Due to expanding eligibility criteria for state-sponsored coverage for state as well as continuing coverage for family plans, many additional patients will obtain support from the state or parent's health insurance, respectively. These expansions may result in the inclusion of more relatively healthy persons in insurance plans; consequently, overall per-patient cost for insurance providers would be reduced.

Another stakeholder at the focus of the legislation is the employer. The Health Insurance Connector provides a forum and resource for information for employers to locate insurance products for employees.<sup>14</sup> There are financial consequences to employers whose employees require medical care and are not covered by insurance primarily in the form of fines that will be used to support the state insurance program. Prior legislative health insurance mandates have had unintended negative consequences on employment, including job loss and lower wages.<sup>18,28</sup> The plan does not provide coverage options for retired persons who previously received insurance through retirement benefits but are no longer covered as a result of changes in retirement insurance coverage. Future legislative efforts may address these individuals.

Despite a national debate on healthcare in the general public, the U.S. government has been slow to react that healthcare should be a right and not a privilege.<sup>29</sup> Much of the delay has been attributed to intense political opposition and the unwillingness of parties to compromise with one another.<sup>29</sup> The Massachusetts legislation represents a compromise to expand coverage to all, but at a cost that will be shared by all stakeholders. One of the next steps in the legislative review of the process may be to develop an academic program for health services research to understand every aspect of the development, enactment, implementation and modification of this legislative solution. One such program is the California Health Benefits Review Program that serves as a

source of information in state health policy-making for the state of California.<sup>30</sup> Through these efforts, other states may develop plans best suited to meet the needs of their diverse populations.

## CONCLUSION

This bold new legislation may serve as a model for legislative efforts to reduce the number of uninsured patients and control state spending for healthcare to uninsured patients. Personal responsibility is the cornerstone of the legislation coupled with assistance from employers and government-sponsored or -supplemented health insurance programs. The legislative mandate will provide the starting point perhaps for a national discussion for universal coverage, since the United States remains one of the few of the industrialized nations without a comprehensive plan for health insurance coverage for its citizens.

## REFERENCES

1. www.kff.org. Accessed 07/26/06 (Kaiser Family Foundation).
2. Brach C, Lewit EM, VanLandeghem K, et al. Who's enrolled in the State Children's Health Insurance Program (SCHIP)? An overview of findings from the Child Health Insurance Research Initiative (CHIRI). *Pediatrics*. 2003;112:499-507.
3. Blendon RJ, Benson JM. Americans' views on health policy: a 50-year historical perspective. *Health Aff*. 2001;20:33-46.
4. Davis K. Universal Coverage in the United States: Lessons from Experience of the 20th Century (Issue Brief). The Commonwealth Fund, 2001. www.cwmf.org. Accessed 07/26/06.
5. Holahan J, Winterbottom C, Zedlewski S. The distributional effects of employer and individual health insurance mandates. *Inquiry*. 1994;31:368-384.
6. Hadley J, Holahan J. Covering the uninsured. How much would it cost? *Health Aff*. 2003;W3:250-265.
7. Martin A, Whittle K, Levit K, et al. Health care spending during 1991-1998: A fifty-state review. *Health Aff*. 2002;21:112-126.
8. Mechanic RE. What will become of the medical mecca? Health care spending in Massachusetts. *Health Aff*. 2003;22:130-141.
9. Kronick R. Can Massachusetts pay for health care for all? *Health Aff*. 1991;10:26-44.
10. Mechanic R, Coleman K, Dobson A. Teaching hospital costs: implications for academic missions in a competitive market. *JAMA*. 1998;280:1015-1019.
11. Academic Health Centers: Leading Change in the 21st Century. Committee on the Roles of Academic Health Centers in the 21st Century, Linda T. Kohn, ed. Washington, DC: National Academies Press; 2004.
12. McCormick D, Himmelstein DU, Woolhandler, S et al. Single-payer national health insurance. *Arch Intern Med*. 2004;164:300-304.
13. McDonough JE, Hager CL, Rosman B. Health care reform stages a comeback in Massachusetts. *N Engl J Med*. 1997;336:148-151.
14. Health Care Access and Affordability Conference Committee Report. www.mass.gov/legisl/. Accessed 08/26/06 (Massachusetts Legislature).
15. Beinecke RH. Stakeholder perspectives on public managed care in Massachusetts. *Adm Policy Ment Health*. 2005;32:427-438.
16. Callahan JJ, Shephard DS, Beinecke RH, et al. Mental health/substance abuse treatment in managed care: the Massachusetts Medicaid experience. *Health Aff*. 1995;14:173-184.
17. Klick J, Markowitz S. Are mental health insurance mandates effective? Evidence from suicides. *Health Econ*. 2006;15:83-97.
18. Krueger AB, Reinhardt UE. The economics of employer versus individual mandates. *Health Aff*. 1994;13:34-53.
19. Thorpe KE. Cost and distributional impacts of employer insurance man-

dates and Medicaid expansion. *Inquiry*. 1989;26:335-344.

20. Holahan J, Cook A. Changes in economic conditions and health coverage, 2000–2004. *Health Aff*. 2005;W5:498-508.

21. Anonymous. Costs could derail Massachusetts health reforms. *Lancet*. 2006;367:1291.

22. Altman SH, Doonan M. Can Massachusetts lead the way in health care reform? *N Engl J Med*. 2006;354(20):2093-2095.

23. Steinbrook R. Health care reform in Massachusetts—a work in progress. *N Engl J Med*. 2006;354(20):2095-2098.

24. Master R, Simon L, Goldfield N. Commonwealth Care Alliance: a new approach to coordinated care for the chronically ill and frail elderly that organizationally integrates consumer involvement. *J Ambul Care Manage*. 2003;26:355-361.

25. Akhter MN. APHA policies on universal health care: health for a few or health for all? *Am J Public Health*. 2003;93:99-101.

26. Wilensky S, Roby DH. Health centers and health insurance: Complements, not alternatives. *J Ambul Care Manage*. 2005;28:348-356.

27. Mullan F, Epstein L. Community-Oriented Primary Care: New Relevance in a Changing World. *Am J Public Health*. 2002;92(11):1748-1755.

28. Klerman JA, Goldman DP. Job loss due to health insurance mandates. *JAMA*. 1994;272:552-556.

29. Bodenheimer T. The political divide in health care: a liberal perspective. *Health Aff*. 2005;24:1426-1435.

30. Oliver TR, Singer RF. Health services research as a source of legislative analysis and input: the role of the California Health Benefits Review Program. *Health Serv Res*. 2006;41:1124-1158. ■



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