

# The Massachusetts Approach: A New Way To Restructure State Health Insurance Markets And Public Programs

Massachusetts tackles the crucial issues of coverage continuity and portability.

by **Edmund F. Haislmaier and Nina Owcharenko**

**ABSTRACT:** In April 2006, Massachusetts enacted legislation to reorganize both its health insurance markets and a large portion of its health care subsidy system. In this paper we consider how the Massachusetts approach differs from most previous state health reform efforts, while also noting its antecedents. We examine the policy implications of the legislation's key elements and discuss how other states might consider altering the scope and specifics of those components. We conclude that both parts of the Massachusetts reform strategy merit consideration by other states and together hold promise for expanding coverage, particularly by addressing the problem of coverage discontinuity. [*Health Affairs* 25, no. 6 (2006): 1580–1590; 10.1377/hlthaff.25.6.1580]

WHEN MASSACHUSETTS ENACTED MAJOR HEALTH CARE legislation in April 2006, it sparked renewed national interest in state health reform efforts.<sup>1</sup> The attention is well deserved, as the Massachusetts legislation represents a distinct departure from the strategies underlying previous state reform initiatives. The challenge for policymakers is to better understand what is different about the Massachusetts approach and the insights it might offer other states.

What initially attracted the most attention were the legislation's requirement that Massachusetts residents obtain health insurance coverage and the imposition of assessments on employers not offering coverage. The "individual mandate" provision does indeed set a precedent for other states. However, it is best understood not as the conceptual starting point for the reform design, but rather as a supplement to the other key elements. If the situation is viewed from that perspective, the logic of other states' adopting some similar requirement will likely differ ac-

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ording to each state’s particular circumstances, as discussed later. Of lesser policy significance are the assessments the law imposes on “nonproviding” employers. As also discussed later, it is relatively easy for employers to comply with the law and thus avoid the penalties. Consequently, most Massachusetts businesses considered the provisions a tolerable political concession, and they should probably be viewed as tangential to the broader reforms.

Rather, it is two other core concepts embodied in the Massachusetts legislation that should principally interest policymakers. The first is the reorganization of a large part of the state’s private insurance system into a “single market” structure with uniform rules and a central “clearinghouse” for administering coverage. The second is the conversion of substantial public spending from a provider-subsidy system into a consumer-subsidy system for obtaining private coverage.

Massachusetts has embarked upon a new approach to state health insurance regulation combined with a new approach to delivering public subsidies. The two components offer a possible model for other states, either separately or in combination, and each is amenable to variation in scope and detail.

One can also make some general observations about their broad commonalities and how they differ from previous reform strategies. The first commonality is that both components fundamentally reorient the state’s health policy toward the objective of meeting the needs and interests of individuals as opposed to those of providers, employers, insurers, or government. The insurance provisions are designed to provide workers with personal and portable coverage while retaining the rating, underwriting, and tax advantages of employer-group insurance. The public-spending provisions redirect existing hospital subsidies for uncompensated care into premium-support payments to help low-income, uninsured workers and their dependents obtain the same private coverage. As such, the Massachusetts legislation might also be viewed as the next stage in the evolution of a consumer-focused approach to health system change.

The second commonality is that both elements represent a fundamental departure from the recent pattern of state health reform efforts. The Massachusetts legislation may be seen as a shift from a “product-focused” to a more “system-focused” approach to health reform and coverage expansion.

For more than a decade, states have largely focused on designing specific product solutions to address the perceived needs of discrete subpopulations, such as by standardizing private insurance benefit packages or crafting new Medicaid, State Children’s Health Insurance Program (SCHIP), or state-subsidized benefit plans for targeted coverage expansions. The same product-focused approach is also evident in state laws creating less expensive “light” insurance products with fewer

benefit mandates, federal legislation to create medical savings accounts (MSAs) and health savings accounts (HSAs) with high-deductible insurance products, and earlier federal and state legislation promoting managed care plans.

In contrast, Massachusetts took a more system-focused approach by restructuring how private insurance is purchased, sold, and administered; restructuring how public subsidies are delivered; and integrating those two sets of reforms into a unified design. The legislation does include some product-design provisions, such as permitting health maintenance organizations (HMOs) to offer HSA plans, permitting carriers to offer “mandate-light” plans to young adults, and limiting choices for subsidy recipients to “comprehensive” plans only. But those provisions are secondary to the basic reform design, which could function essentially the same without them. In contrast, past system-reform efforts have been largely limited to creating small-business pooling arrangements in some states and the introduction of Medicaid managed care plans.

But although Massachusetts was the first state to enact reforms combining both elements of this new model, the legislation’s insurance-market and public-program reforms each have antecedents in proposals advanced or adopted in other states.

### **State Health Insurance Exchange**

The heart of the Massachusetts approach is the creation of a novel, statewide health insurance “Connector” to serve as clearinghouse, or exchange, facilitating the buying, selling, and administration of private health insurance coverage. But Massachusetts borrowed the concept from legislation first developed and proposed by the District of Columbia insurance commissioner in 2004.<sup>2</sup>

The idea is that a state health insurance exchange acts as a “market organizer” and “payment aggregator” through which individuals and employer groups can obtain coverage. However, it differs in three essential respects from previous pooling arrangements adopted or proposed at either the state or federal level, such as health insurance purchasing cooperatives or association health plans.<sup>3</sup> First, a state health insurance exchange is deliberately designed to eliminate long-standing regulatory distinctions between separate individual and group, particularly small-group, insurance submarkets. Second, as part of a strategy for creating a “single market,” a state health insurance exchange operates according to a new regulatory design that blends selected features from the existing individual and group markets. Third, like a stock exchange or a farmers market, a state health insurance exchange serves only as a clearinghouse; it is neither a direct purchaser nor a product regulator.

■ **Key features.** The key features of a state health insurance exchange, and their implications, are as follows:

*Availability.* Any state resident may buy coverage through the exchange, as may any nonresident whose employer has designated the exchange as its employer-

group plan. One implication is that participating insurers and employers no longer need to provide continuation coverage. Continuation coverage consists simply of continued participation in the exchange, with state law allowing those who lose eligibility by reason of nonresidence to participate for a period consistent with federal law.

*Portability.* All of the insurance plans sold through the exchange are effectively state-regulated, individual products. Thus, coverage can become portable among employers within the state and retained during periods of unemployment, part-time employment, or self-employment. The funding arrangements, but not the coverage itself, would change during such transitions. Transitions between coverage through the exchange and coverage under separate employer-group plans would be governed by existing Health Insurance Portability and Accountability Act (HIPAA) regulations. Furthermore, since only plans approved by the state's insurance department may be sold through the exchange, the design also enables more reliable enforcement of consumer protection and antidiscrimination statutes.

*Standardization.* Coverage offered through the exchange is administered according to the principles of very large employer-group plans with multiple choices of carriers and products. Unlike some current markets in which buyers can drop coverage at any time, the purchase of coverage through an exchange is regularized and limited to an annual open-season period, with a few exceptions. This standardization makes it possible for participants to annually switch coverage on a guaranteed-issue basis, at standard rates, and without new underwriting.

*Compatibility with federal law.* The exchange is structured to be compatible with federal employer-group insurance law. State legislation is drafted in such a way that an employer may voluntarily designate the exchange as its "employer-group health benefit plan" for purposes of federal law, and the exchange agrees to be the employer's "plan administrator" under federal law. The firm's workers then choose coverage from among the insurance products offered through the exchange. For the employer, the exchange essentially functions like a giant third-party administrator (TPA), offering a standard menu of insurance products. This design has two important implications. First, it preserves the pretax status of employers' contributions toward coverage, enabling a firm's workers to buy portable coverage, in whole or in part, with tax-free dollars. Second, it transfers most of the administrative burden of plan sponsorship from employers to the exchange. For example, the "summary plan description" required by federal law can be standardized into a single document describing the menu of plans available through the exchange, to which each participating employer appends a description of who is eligible to participate in the employer's "plan" and the form and amounts of the employer's contribution. Thus, participating employers are relieved of most of the burdens associated with separately obtaining and administering group coverage for their workers.

*Uniform payroll withholding system.* The exchange acts as a “premium aggregator,” collecting and distributing to carriers premium payments made by employers, individuals, and, in the Massachusetts version, government premium subsidies. This reduces the employer’s role to participation in a single, uniform payroll withholding system, much like existing employee tax-withholding systems. It also effectively transfers the “payment risk” from insurers to the exchange. Insurers need no longer build into their premiums a factor to account for the probability that some portion of their customers will drop coverage before the end of the contract period.

■ **Comparisons with DC and Maryland proposals.** Comparing the Massachusetts law with similar proposals introduced in the District of Columbia in 2004 and in Maryland in 2006 reveals how states might differ on some of the specifics when applying this basic model to their own circumstances.<sup>4</sup>

*Number of plans offered.* For example, the original DC proposal limited the number of insurance products offered through the exchange. In contrast, the Massachusetts law and the Maryland proposal operate on what could be termed an “any willing plan” basis, meaning that the exchange must offer any plan wanting to participate that has received timely premarket approval from the state’s insurance regulator.

*Coverage requirements.* Another area of likely variation among states is the applicability of existing coverage requirements. The District of Columbia has very few insurance-benefit mandates, so the DC legislation simply required that they apply to any policy sold through the exchange. In contrast, Massachusetts and Maryland have enacted numerous benefit mandates over the years. The Maryland proposal would apply a new standard to policies sold through the exchange, requiring coverage for broad benefit categories such as hospital and physician services, prescription drugs, and mental health services but not further specifying the types of providers or services to be covered. In Massachusetts most existing coverage requirements would continue to apply to policies sold through the exchange. One exception is that for managed care plans sold through the Connector, the state’s insurance department is instructed to disregard existing statutes governing network adequacy and provider contracting and to instead apply alternative standards to be developed by the Connector. Another exception is that the Massachusetts law also authorizes the sale of so-called mandate-light policies to young adults (ages 19–26) who lack employer-sponsored coverage.

*Community and individual rating systems.* Similarly, the Massachusetts legislation incorporates, with only minor alterations, that state’s existing community-rating parameters. In contrast, the Maryland proposal would somewhat expand permissible rating variations based on age and geography, while the DC proposal permits age-adjusted premiums within a wide rate-banding system—geographic adjustments being irrelevant to the District of Columbia.

The DC and Maryland proposals apply different rating provisions to those join-

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ing the exchange as individuals, while Massachusetts leaves in place its existing community-rating and guaranteed-issue laws. Under the DC and Maryland proposals, issue of coverage through the exchange is guaranteed at standard rates to those joining as part of an employer group and to individual enrollees with eighteen months or more of creditable coverage. However, for individual enrollees with less than full creditable coverage, carriers are permitted to impose premium surcharges and preexisting condition exclusions, offset by the number of months of creditable coverage. The intention is to offer rewards and penalties that encourage individuals to obtain and maintain coverage. Carriers may waive those provisions for healthy uninsured enrollees on account of their desirable risk profile. For the less healthy uninsured, the underwriting provisions are time-limited and no more than they would otherwise face under a state high-risk pool program offering only one or two coverage options.

*Risk-transfer pools.* The DC and Maryland proposals would also establish separate insurer “risk-transfer” pools under the supervision of the state insurance regulator. The pools are designed to serve as “back-end risk adjustors.” All carriers doing business in the state are required to participate, and the pool would devise an assessment and payment system for adjusting among carriers for any substantial disparities in enrollment of high-risk individuals. The mechanisms are similar to those used in state high-risk pools, but with the advantage that high-risk individuals retain the same coverage choices as everyone else.

*Employer participation.* Under the DC and Maryland proposals, employers of any size could elect to make the exchange their group health benefit plan, and both proposals would make the state’s government the first employer to join the exchange. In contrast, Massachusetts limits employer participation to private firms with fifty or fewer employees, although larger private employers and state and local governments may enroll their part-time and contract workers. One advantage of including state government workers in an exchange is that by starting with a large pool of enrollees, insurers should be induced to offer attractive plans at competitive premiums and avoid some of the difficulties encountered by previous pooling arrangements. Also, all three proposals would have participating insurers pay standard commissions to brokers for bringing individual and group business to the exchange.

*Section 125 cafeteria plans.* Of particular interest to other states is that Massachusetts included a provision requiring employers joining the Connector to also establish Section 125 cafeteria plans. Under Section 125 of the federal tax code, workers may elect “voluntary salary reductions” to pay on a pretax basis for one or more benefits offered by the employer, including the worker’s share of premiums

for employer-sponsored health insurance. Thus, with a Section 125 plan also in place, 100 percent of the premiums paid by, or for, anyone participating in the exchange through an employer group becomes tax-free. The advantage to a state is it indirectly taps another source of federal subsidy for more of its residents. In addition, such a requirement essentially makes moot the question of whether or not employers participating in the exchange should be required to contribute some amount toward coverage. Since employers' coverage contributions are simply a subset of total compensation, as long as both employer and employee payments receive the same tax treatment, it becomes irrelevant how employers and their workers decide to divide those payments for accounting purposes. The state's interest in encouraging individuals to purchase coverage is satisfied by the fact that workers declining the offered coverage would forgo a substantial tax benefit.

*Retention of existing plans.* Another consideration for states considering this model is the question of whether to maintain their existing nongroup and small-group markets in parallel with the new exchange. The DC proposal would retain those existing markets, while the Massachusetts legislation folds the individual market into the exchange and creates a commission to study the feasibility of later doing the same with its small-group market. In contrast, the Maryland legislation proposes to simply make the exchange the only place in the state where individuals and small groups could buy insurance, thus limiting the sale of commercial group products to employer groups of more than fifty workers. The case for combining those submarkets is that such a move not only would reinforce and accelerate the creation of a single market, but, more importantly, would serve to eliminate potential residual selection effects.

## **A New Approach To Publicly Funded Health Coverage**

The second major element of the Massachusetts legislation was to redesign part of the state's system of public funding for health services. Indeed, that was the source of the original reform impetus. Massachusetts had been operating with a federal Medicaid demonstration waiver under which it had combined monies from a health insurance premium surcharge with state and federal Medicaid funds into a single uncompensated care pool and then used those funds to offset the costs incurred by health systems treating the uninsured. However, that waiver was set to expire in June 2006, and federal Medicaid officials had indicated their unwillingness to approve a waiver extension absent a better plan from the state. Thus, about \$385 million of the state's \$1 billion in uncompensated care pool funding was at risk.

Gov. Mitt Romney's proposed solution, which the legislature in large measure eventually adopted, was to convert funding for the uncompensated care pool into premium-support payments targeted to the low-income population below 300 percent of poverty, who were not otherwise eligible for Medicaid or SCHIP. This part of the Massachusetts design is similar in approach to other consumer-focused

Medicaid reforms.

For example, Florida is using a waiver to redistribute Medicaid dollars to individual enrollees.<sup>5</sup> Under Florida's plan, enrollees will be assigned a risk-adjusted dollar amount based on a variety of measures, including health status. Enrollees will then apply those funds to the coverage arrangement of their choice. Florida also establishes health care accounts for enrollees to earn bonus contributions, based on adopting a healthy lifestyle, which can be spent on other health-related services. Finally, Florida's plan integrates a premium-assistance option for enrollees, giving them the choice to enroll in private coverage.

The premium-assistance approach enables Medicaid or SCHIP enrollees to obtain private health care coverage, most likely through an employer. That is an increasingly relevant consideration, as states have expanded Medicaid and SCHIP eligibility to include more enrollees in working families. The approach also eliminates any stigma associated with enrollment in public programs, since service providers don't know the source of the funds used to purchase private coverage. The Health Insurance Flexibility and Accountability (HIFA) waiver stresses the importance of integrating a private coverage component into a state's waiver proposal, and premium assistance could be one way for states to meet that condition.<sup>6</sup>

In the same vein, Florida, as well as Arkansas and New Jersey, previously took a consumer-focused approach with the creation of "cash and counseling" demonstration projects for subsets of their disabled Medicaid populations. In those arrangements, enrollees are each given individual budgets to manage and direct payment for their personal care services, supplemented by assistance and guidance from family members and Medicaid case managers. Evaluations of those demonstrations recorded high rates of satisfaction among participants and indicate the potential for long-term cost savings, if the program is properly designed.<sup>7</sup> Because of its success, the "cash and counseling" model is now part of a standard waiver, called Independence Plus, offered to states by the federal Medicaid program.<sup>8</sup>

How far other states might be able to pursue this approach to public subsidy reform will depend heavily on the key variables of each state's demographics, the amounts and structures of its current subsidy arrangements, and numerous political considerations.

## **The Role Of Mandates**

Although the Massachusetts legislation imposes assessments on employers that do not offer coverage, it also gives them a much easier out than previous "play or pay" proposals. All an employer need do to avoid the penalties is enroll its workers in the Connector and offer them a Section 125 plan. As noted, the Connector relieves employers of the burden of obtaining and administering standalone group coverage, while the use of Section 125 plans reduces to a mere accounting exercise the division of premium payments between employers and workers. This suggests that another state enacting similar reforms, but without any employer

contribution requirements, would likely experience little difference in participation among employers and workers as a result.

In contrast, the individual-mandate provisions of the Massachusetts law have notable policy implications for other states. Those implications are twofold, with one major consideration for each basic part of the reform design.

■ **Obtaining and keeping coverage.** With respect to the insurance-market provisions, the Connector is designed to make coverage easier to obtain and keep. It also expands and makes more transparent the financial incentives for obtaining coverage, through increased tax sheltering of premium payments and the offer of premium support to low-income working families. Theoretically, the combined effect should be to induce more individuals to take up coverage, including those who are superior risks.

■ **Rate variations and selection effects.** Even so, an inherent trade-off still exists between rating rules and selection effects. The more a state permits carriers to price plans at rates that are attractive to younger, healthier people, such as by allowing substantial age-related variations in premiums, the more likely it should be that better-risk people will voluntarily obtain coverage. However, the wider the permitted rate variations, the more scope exists for selection effects among plans, and thus the greater the need for a compensatory risk-adjustment mechanism. Conversely, the more a state restricts permissible rate variations, such as through tight community rating, the less need there is for risk adjustment among plans but the greater the probability that better-risk people will forgo coverage entirely, despite the positive inducements of easier access and increased subsidies.

Thus, in making a political and policy decision to continue applying Massachusetts' existing community-rating provisions to coverage sold through the Connector, lawmakers were able to omit risk-adjustment provisions from their reform design but felt that they needed to include an individual mandate to buy coverage. States taking a different rating approach, such as the age-adjusted rating in the DC proposal, are likely to find an individual mandate to buy coverage less important, but the inclusion of an acceptable risk-adjustment mechanism more important, to the success of their reform design.

■ **Paying for uncompensated care.** The individual-mandate provisions are also relevant to the other main piece of the Massachusetts legislation: the conversion of uncompensated-care subsidies into premium-support payments. Indeed, Governor Romney's original proposal was to require that individuals demonstrate an ability to pay their hospital bills, either through insurance or directly.

Again, a trade-off is involved. State lawmakers operate within the constraints of federal law requiring hospitals to treat patients regardless of their ability to pay. Naturally, hospitals seek compensation for those costs, which is provided through various explicit and implicit arrangements involving federal and state funds and shifting costs to private payers. There are good health policy and economic arguments for shifting funding from provider subsidies to premium support. However,

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state lawmakers must also accommodate the political reality that acceptance of such a move will depend on the extent to which hospitals, and voters, believe that reforms will reduce demand for uncompensated care in roughly equal proportion to reductions in hospital subsidies. Hence, an individual mandate becomes a tool for securing acceptance of a larger funding shift than might otherwise be politically achievable. In other states, the extent of any funding shift, and the concomitant role for an individual mandate, will likely be the unique product of a complex calculus involving each state’s peculiar mix of political, economic, demographic, and existing hospital financing factors.

**Policy Implications Of Synergistic Reform**

Perhaps the most important insight behind the Massachusetts legislation was the realization that the whole was greater than the two parts. The two elements were combined into a single design based on the recognition that the administration of a premium-support system for the low-income uninsured would be greatly simplified if administered through a broader state health insurance exchange. The exchange offers not only a menu of private coverage options for subsidy recipients, but more importantly, a single place for matching subsidies with recipients and plans.

That combination also holds promise for addressing one of the most vexing features of the current market: coverage instability. Recent longitudinal research estimates that the long-term uninsured population constitutes only a small portion of the total uninsured population. A study of the total population experiencing one or more spells of uninsurance over a four-year period found that only 12 percent were consistently uninsured. In contrast, one-third cycled repeatedly in and out of coverage, and another 29 percent were covered for most of the four years but also experienced coverage gaps. The remaining 26 percent were uninsured for the majority of the four-year period but did have coverage for some interval during the four years. Those findings led the study’s authors to conclude that continuity of coverage should be made an explicit and principal policy goal for health reform.<sup>9</sup>

This design also offers other advantages for policymakers seeking to promote coverage continuity and expand coverage. For example, an exchange enables two-income couples to combine contributions from their respective employers to buy the plan they want, instead of being forced to choose one employer’s plan while forgoing the subsidy offered by the other employer. Similarly, a worker with two part-time jobs could combine contributions from each employer to purchase coverage. In the current system it is uneconomical for employers to offer full coverage to part-time workers. But an exchange creates the possibility of employers’ offer-

ing part-time workers prorated coverage contributions, with a realistic expectation that the rest of the premium can be paid out of other family earnings or a state premium-support program. Also, while Massachusetts limited its premium-support provisions to the low-income population not otherwise eligible for Medicaid or SCHIP, other states might consider a broader reform strategy that uses the exchange to cover some Medicaid or SCHIP enrollees, particularly those in working families.

**T**HE SIGNIFICANCE OF THE MASSACHUSETTS LEGISLATION lies not just in the novelty of its constituent parts, but also in the fact that the parts were combined into a unified design that seeks to meet the needs of the currently insured as well as the uninsured. Depending on a state's demographics, health system structure, and political environment, various combinations of similar insurance market reforms and public subsidy reforms might be adopted by other states. The key lesson for policymakers may be the realization that the problem of the uninsured can never be adequately and effectively addressed without first tackling the issues of coverage continuity and portability. Policymakers need to ensure that those who have or get health insurance today will be able to keep their coverage tomorrow.

#### NOTES

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