

**Missing The Mark:
A Human Rights Analysis Of
The Massachusetts Universal Healthcare Plan**

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Introduction

In April 2006, the State of Massachusetts adopted a universal healthcare plan available to all state residents. This paper evaluates the Massachusetts Plan according to international human rights law, which shares the Plan's goal of promoting population health by making quality healthcare accessible to all.¹

Should a healthcare system focus on promoting health for all of its citizens? International human rights law answers this question. It provides explicit criteria for evaluating proposed healthcare reforms, both broad policy agendas and specific measures. The key criteria are:

- *Availability* – there are sufficient medical personnel and facilities to treat prevailing health problems for all segments of the population;
- *Accessibility* – all people have physical, geographical, and financial access without discrimination based upon race, gender, religion, legal status, ethnicity, sexual orientation, level of education, or insurance status;
- *Quality* – healthcare meets state and federal regulations and other quantifiable measurements of care, but also includes the ability of healthcare providers to relate to and communicate with their patients; and
- *Appropriateness* – healthcare meets physical, educational, mental, ethical or cultural standards; in particular, the healthcare system should be simple and straightforward to guarantee full access.

Human rights law also includes the following procedural elements:

- *Participation* – healthcare proposals must give the targeted beneficiaries an opportunity to participate in its design and implementation;

¹ The Massachusetts Plan depends in large part on federal funding to implement its programming. It will receive these funds pursuant to the Bush Healthcare Proposal. The Proposal has two components. The first is the use of tax reform measures to make private health insurance more affordable. This provision is the subject of a separate report. The second concerns distributions to the States for use to expand healthcare services. It is by use of funds made available through this federal program that Massachusetts was able to fashion a new approach to providing healthcare services to state residents.

- *Information* – government must provide sufficient information about the nature and application of the new services so that members of the public can take advantage of them;
- *Non-discrimination* – health facilities, goods and services must be accessible, especially to the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the “prohibited grounds;”²
- *Remedies* – an appeals process must be in place, which provides for a redress of grievances if the above criteria are not met.

Applying these international criteria, it is clear that the Plan fails to comport with international human rights law; it will not effectively solve the current healthcare crisis facing Massachusetts, nor is it an appropriate reform model for other parts of the United States.

² The prohibited grounds include race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.

Summary of the Massachusetts Plan

The program is funded by a mix of federal Medicaid dollars, employer contributions, and a reallocation of existing state funding. It is expected to cost \$1.2 billion over three years. The principal component of the Massachusetts Plan is its “individual responsibility” requirement: All state residents must have or purchase health insurance by July 1, 2007, or be subject to financial penalties imposed by the Department of Revenue. To make compliance possible, the plan includes a number of changes to the current system:

- **Health Insurance Connector:** The Connector is a new state agency that assists individuals and small business find affordable, high quality insurance. The Connector can design insurance plans itself and then identify private insurers to administer them, or ask private insurers to propose programs for the Connector to promote to the public. It is also authorized to assist individuals who purchase non-Connector insurance plans.³ Its board is made up of private and public representatives.
- **Insurance Reforms:** Adults between the ages of 19-25 can remain on their parents’ insurance plans or are eligible for lower-cost products offered by the Connector. Non- and small-group markets are merged in order to reduce premium costs.
- **Subsidies:** Those individuals who cannot afford to purchase individual insurance, but earn too much to be eligible for Medicaid (households with incomes between 100%-300% of the federal poverty level - \$49,000 for a family of three), receive subsidies to purchase insurance through the Commonwealth Care Health Insurance Program, a program operated by the Connector. Initially, the only insurance available through this program will be managed care. The amount of subsidy varies depending on household income. None of the plans has deductibles. Individuals who earn less than 100% of the federal poverty level (\$9,800) are provided private insurance at no cost, while children in families that earn up to 300% of the federal poverty level are eligible for Medicaid (previously, the cut off was 200%).

³ The participating insurance companies have proposed plans that cost \$380 per month for individuals and which would limit individual deductibles and co-pays to \$5,000 per year. The Connector rejected these plans and asked the companies to propose plans that cost no more than \$280 per month. The average adult premium offered by employers nationally was \$335 per month in 2005.

- Medicaid Waiver: A key component of the plan is to divert federal funds from reimbursing and supporting hospitals to funding the purchase of health insurance. Medicaid reimbursement rates for doctors, whether they treat patients in an office or hospital setting, are standardized and tied to specific performance goals. These goals relate to quality, efficiency, the reduction of racial and ethnic disparities, and improved health outcomes. If providers do not meet these goals, their reimbursement rate remains stagnant.
- Employer Contributions: Employers with 11 or more employees who do not provide insurance will be required to pay \$295 per year per full time employee to the Commonwealth Care Trust Fund. The fee is prorated for employers with part-time and seasonal employees. Employers with more than 11 employees will also be required to offer pre-tax, health savings accounts.

***Availability:* Is there sufficient medical personnel and facilities to treat prevailing health problems for all segments of the population?**

Legal requirements: For healthcare to be available, a country must have sufficient quantities of functioning facilities, services, and programs.⁴ Reform proposals must address the question of whether there are sufficient facilities and services to treat health conditions for the majority of the population. This evaluation is particularly important in terms of availability of care for vulnerable and marginalized groups, and as with all the human rights requirements, the process of evaluation includes seeking the participation and input of those most affected by proposed reforms. If care is unavailable, reform proposals must provide for an increase in these services.

Analysis: The Massachusetts Plan does not include an evaluation of whether there are sufficient healthcare services and facilities for residents of Massachusetts. That analysis is particularly important for rural areas, poorer urban neighborhoods, and small towns. The Plan provides for managed care plans for people with lower-incomes, but those plans will mean little relevance for people who live in areas with insufficient services.⁵

There is no indication that the Plan’s drafters made an effort to determine the nature and extent of the health problems facing the most vulnerable groups in Massachusetts. That effort would have made it more likely that new insurance plans would address the needs of those groups and that the Plan would have provided preventive healthcare and education appropriate for the population to be served. Choosing to expand the current private insurance system without first obtaining data regarding what and where facilities and services are needed, and without a process for providing them, means the Massachusetts Plan does not address healthcare availability concerns.

⁴ Committee on Economic Social and Cultural Rights. General Comment Number 14 (2000): The right to the highest attainable standard of health. 11/08/2000 (UN Doc. E/C.12/2000/4) (hereinafter “General Comment 14”).

⁵ The Plan’s implementing legislation contains no indication that its provisions are based, at least in part, on a thorough review of the sufficiency of statewide medical facilities and personnel. It does provide for future research and public comment regarding ways to lessen racial health disparities. *See*, 2006 Mass. Acts Chp. 58, §1, *et. seq.* Section 16(O) establishes a health disparities council to conduct research and report its findings on an annual basis. Eight of the 34 members are to be representatives from communities suffering from health disparities. Other statutory provisions that establish research and data collection that concern health care quality include: Sections 16(K),(L)(b),(L)(e),(L)(j),(L)(l),(M)(b)(2).

As noted above, international law also requires that the individuals affected by health reform policies have an opportunity to engage in its design and development. Again, there is no indication that the drafters of the Plan sought and obtained comments from the people who are now required to purchase private health insurance. Such a process is essential for determining whether expansion of the existing system is the most efficient and effective way to increase healthcare services and improve population health.

Conclusion: The purpose of the Massachusetts Plan is to improve health outcomes for the uninsured. However, without a thorough review of how and where the current system has failed state residents, the Plan will not increase the availability of healthcare services and so will likely fail to meet its stated goals.

Accessibility: Do all persons have physical, geographical, and financial access to healthcare without discrimination based upon race, gender, religion, legal status, ethnicity, sexual orientation, level of education, or insurance status?

Legal requirements: Like all human rights, the right to health and healthcare prohibits discrimination on any basis. Individuals must also have the information necessary and the financial and physical means to take advantage of appropriate services and facilities.

Analysis: There are three ways in which the Massachusetts Plan does not meet international accessibility requirements: First, it does not address one of the primary barriers to access under the current system; second, it requires poor families to spend an unreasonable amount of their incomes on insurance plans; and third, it risks creating a new group of working poor without insurance coverage because of the “fair share” program.

In the U.S. there are two primary barriers to access – money and bureaucracy. The current health care system discriminates on the basis of income. Those with higher incomes have access to a high-quality system with sufficient doctors and hospitals, while the poor are relegated to a second-class system that is understaffed and under-supplied.⁶ The Massachusetts Plan responds to this problem not by expanding services or facilities for the poor but by expanding the private health insurance system.⁷ The Plan will increase access to certain insurance plans, but it remains unclear what type of coverage will be included under those plans, and, ultimately, whether the system will increase access to quality healthcare for those most in need, or instead continue to reflect current disparities between those with high incomes and those without.

The Massachusetts Plan requires families with low incomes – who are currently relegated to the second-class system – to purchase private health insurance. Since only 23% of the

⁶ According to the U.S. Census Bureau, approximately 31% of uninsured Americans make less than \$25,000 per year. Approximately two-thirds of the people in this country without health insurance earn less than \$50,000 per year. See, U.S. Census Table 8: “People With or Without Health Insurance Coverage by Selected Characteristics: 2004 and 2005.”

⁷ See, 2006 Mass. Acts Chp. 111M, §1, *et. seq.* which requires all uninsured individuals to purchase insurance.

uninsured population of Massachusetts makes more than \$49,000 per year (*i.e.*, more than five times the poverty level), the vast majority of the uninsured in Massachusetts (77%) are near poor (*i.e.*, with household incomes just over 300% of the federal poverty level) or middle-income.⁸ The Massachusetts Plan defines “affordable” insurance plans as those that cost \$250 or less per month. However, so far the lowest price insurance companies are willing to offer is \$380 per month (\$4,560 per year) not including deductibles or co-pays.⁹ For an individual earning \$28,800 (which is 300% of the federal poverty level), the premium payment would be 15% of his or her income, which represents a significant new mandatory expense and a barrier to accessing quality healthcare.

In addition to the expense for low-income Massachusetts residents, the Plan’s low cost insurance will likely be “stripped-down” coverage with high co-payments and deductibles that will exclude preventive services entirely. By definition, stripped-down plans discriminate on the basis of income and insurance status; they allow for lower quality care for the poor and near poor and violate the accessibility requirement of international law.¹⁰

There is also a risk that the “fair share” provision of the Plan will decrease access to care for the working poor. The “fair share” provision provides that employers who do not make insurance coverage available for their employees will be penalized \$295 per employee per year. However, that cost is significantly less than the cost of providing insurance benefits. Therefore, the provision risks encouraging employers who currently provide insurance to stop providing it and take the penalty instead. The Plan could therefore create a new class of working poor who will have to purchase individual insurance at great personal expense.

Conclusion: As noted above, the Plan will likely continue the current disparate access to care based upon income. To the extent to which the poor are disproportionately people of color, lack a secondary or advanced education, or are non-citizens, the Plan would also violate the other non-discrimination provisions of the accessibility element of human rights

⁸Woolhandler, Steffie and David U. Himmelstein. “The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back,” The Hastings Center Report. Vol. 36, No.5., pp. 19-21., Sept.-Oct., 2006.

⁹ See, Dembner, Alice. “State gives more time for bids on insurance,” The Boston Globe. February 2, 2007; *see also*, Pipes, Sally. “Intensive Care for RomneyCare,” The New York Times. February 24, 2007. These plans would have “a \$2,000 deductible and a total cost sharing of \$5,000.”

¹⁰ Stripped down plans also impact the quality of care which is discussed in more detail below.

law. Although it is unclear if the State asked for the input of people affected by this Plan when they formulated it, it is likely that effective participation by lower-income, uninsured Massachusetts residents and the working poor would have produced different results.

Quality: Does healthcare meet state and federal regulations and other quantifiable measurements of care; and do healthcare providers engage in intangible components of quality such as developing meaningful doctor/patient relationship, conveying health information; and do providers make healthcare recommendations without interference from non-medical, third parties?

Legal requirements: International human rights law requires that a health care system be of high quality. This means that services are scientifically and medically sound.¹¹

Analysis: The Massachusetts Plan creates a new agency – the Connector – that is charged with providing affordable, high quality insurance plans for purchase by the public.¹² As of February 2007, the Connector has been unable to provide affordable plans that meet minimum quality requirements.¹³ In order to satisfy its mandate, the Connector will likely have to settle for plans that provide fewer services or cost more.

Cheaper plans generally cover catastrophic care, but they typically do not cover preventive health services. Preventive healthcare is widely accepted as crucial for good health, and there is already an existing disparity in access to preventive care for minorities and low-income Americans.¹⁴ Therefore, mandating low-income families to purchase private health insurance that does not include preventive healthcare is extremely problematic. In addition to the problems this creates for people’s health, this approach is more expensive for the system as a whole because it results in people delaying care, only to seek it out when treatment is more expensive. It can also lead to increased bankruptcy filings from the healthcare costs still not covered by limited, low-cost plans.¹⁵ The likelihood of this result is

¹¹ General Comment 14, *supra.*, note 6.

¹² *See*, 2006 Mass. Acts Chp. 111M, §1, *et. seq.*

¹³ *See*, fn 3, pg. 3.

¹⁴ Disparities in Access to Preventive Health Screenings Exist for Minorities, Low-Income, Uninsured U.S. Residents, AHRQ Report Finds. Henry J. Kaiser Family Foundation Daily Health Policy Review. 12 January 2007. Available at: http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=42111.

¹⁵ “Seventy-six percent of those bankrupted by medical problems had insurance at the onset of the illness that bankrupted them; many were ruined by co-payments, deductibles, and uncovered expenses such as physical therapy.” *supra.*, Woolhandler, Steffie *et.al.*, Section 2 at 2.

increased because the individuals affected have not been consulted on these issues, as required by the participation element under international human rights law.

In addition to issues regarding coverage for preventive services, the Plan also falls short of human rights standards because medical providers and patients will not be the primary decision-makers in individual health situations. Instead, the private insurance industry will continue to determine which healthcare services are covered, the extent of coverage, whether new and experimental services are covered, and whether specific types of care or particular specialists are covered.¹⁶ This power enables the private insurance industry to interfere with both the practice of medicine and the confidential patient/doctor relationship. There is no indication that the Connector or any other healthcare agency in Massachusetts is authorized to limit this interference.

Conclusion: The Massachusetts Plan ensures that the poor and near-poor will have insurance, but only for the limited risks that insurance companies can profitably cover at Connector-set premium levels. Since private health insurance companies must remain profitable, the only coverage being offered is that which falls short of the health needs for the people of Massachusetts. The Plan does not ensure quality care is available for lower income individuals and so it does not meet international standards.

¹⁶ Massachusetts requires that private insurers provide coverage for certain “mandated” services, but it doesn’t specify the extent of the coverage or how those services are defined. Because a service is “covered” does not mean that it is done so properly or according to best medical practices. The Plan places a moratorium on new mandates until January 2008.

***Appropriateness:* Does healthcare meet physical, educational, mental, ethical or cultural standards? Is the healthcare system sufficiently simple and straightforward so as to guarantee full access?**

Legal requirements: Under international human rights law, appropriate care is that which respects medical ethics, is culturally appropriate, and is designed to be simple and straightforward so as to promote good health.

Analysis: The healthcare system in the United States fails the test of appropriateness. As noted above, money and bureaucracy pose the greatest barriers to healthcare services. Marked by massive bureaucratic complexity, the current healthcare system is so complicated that many people have no idea how to use it, much less a sense of how to ensure they get the care possible for a particular ailment. The Massachusetts Plan, relying as it does on the expansion of the existing system, simply continues this inappropriate complexity.¹⁷

The drafters of the Massachusetts Plan recognized that the system's complexity poses a significant problem. The Plan therefore requires a new agency – the Connector – to help

¹⁷ The Plan is inappropriate for other reasons as well. As currently structured, the Massachusetts Plan is highly dependent on federal funding because the State's commitment of extra funds is very limited. The Plan does not provide for secure, long-term funding of the Connector, of subsidies and of the costs of administration. Given rising health care costs, it is unlikely that there will be adequate funding for subsidies for the poor and near poor as the cost of private insurance increases unless the State obtains more funds from the federal government. However, the federal government has not committed to cover potential shortfalls in Massachusetts or any other state. If federal funding remains stagnant, or worse, is cut or redirected, the Plan will fail.

The Plan is also inappropriate because it can easily provide a disincentive for employers who currently offer health insurance to stop providing the benefit. The plan's basic requirements may result in a decrease of employer-provided benefits and an increase in costs for the taxpayer. One of the underlying assumptions of the Plan is that employers will continue to provide insurance to 68% of the state's non-elderly residents. The penalty on employers for not doing so is \$295 per employee per year – much less than the cost of providing insurance benefits. This penalty is probably too modest to encourage employers who don't provide insurance to do so, and it may encourage those employers who do provide insurance to eliminate the benefit. If a significant number of employers drop coverage because of this provision, more individuals will seek coverage through the Connector. Many of them could qualify for subsidies and the cost of the Massachusetts Plan would correspondingly increase.

individuals navigate their way through the newly created numerous plans and options. However, the fact that an entire new agency is necessary for this purpose speaks volumes about the nature of the plan itself. A new agency will only exacerbate preexisting complexities of the system by creating a new layer of bureaucracy.

The Plan expands the existing system with its multitude of claim forms, pre-approvals, co-pays and deductibles. The existence of the Connector does not cure the ills of the current system, and, as an agency, it has no power to make the new system any less complex. Healthcare access will remain inappropriately complex under the Massachusetts Plan, especially for those individuals who are entering the insurance market for the first time.

Conclusion: The Massachusetts Plan expands an existing, overly complex insurance system, and its long-term viability is at risk because of insufficient funding.

Conclusion

Human rights law does not dictate the financing method for implementing a particular right. If a government chooses to distribute healthcare through a privatized system, that is its prerogative, not a human rights violation. However, it becomes a human rights issue when the government's chosen financing method causes it to fail human rights standards. That is the case with the Massachusetts Plan. Although it is well-intentioned, the Plan depends upon a faulty financing methodology and faulty underlying assumptions. It assumes the profit-based insurance system can address the needs of unprofitable patients in need of healthcare. It will not improve the availability, accessibility, quality and appropriateness of healthcare for residents of Massachusetts and thus does not meet international human rights standards.

The Plan also fails to meet international procedural requirements. Nowhere in the implementing legislation are there remedies for the lack of availability, accessibility, quality or appropriateness; nor was the Plan's structure and implementation a result of a participatory process.¹⁸ The legislation does provide for future programs and expert panels to address the issue of disparities in care and for dissemination of information about the Plan; however, without the participation of and suggestions from the individuals it seeks to impact, the methods used may prove ineffective.

Although well intentioned, the Plan misses the mark. It does not meet international human rights standards and risks delaying efforts to find more comprehensive and more successful ways of addressing the health crisis for the residents of Massachusetts.

¹⁸ The only major remedy the Plan provides is the right of the individual to seek a waiver of his or her obligation to purchase private health insurance for financial or religious reasons.



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