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Health Letter

SIDNEY M. WOLFE, M.D., EDITOR

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Massachusetts' Plan: A Failed Model for Health Care Reform

Prepared by Dr. Rachel Nardin, Assistant Professor of Neurology, Harvard Medical School, with Drs. David Himmelstein and Steffie Woolhandler (both Associate Professors of Medicine, Harvard Medical School), and released on Feb. 19, 2009.

Dr. Nardin is a neurologist at Beth Israel Deaconess Medical Center in Boston. Drs. Woolhandler and Himmelstein are primary care physicians at Cambridge Health Alliance, Cambridge, Mass.

The Massachusetts Health Reform Law of 2006 expanded Medicaid coverage for the poor and made available subsidized, Medicaid-like coverage for additional poor and near-poor residents of the state. It also mandated that middle-income uninsured people either purchase private health insurance or pay a substantial fine ($1,068 in 2009). Smaller fines (up to $295 per employee) were also levied on employers who fail to offer insurance benefits.

The reform law has not achieved universal health insurance coverage, although half or more of the previously uninsured now have some type of insurance policy.

The reform has been more expensive than expected, costing $1.1 billion in fiscal 2008 and $1.3 billion in fiscal 2009.

While the number of people lacking health insurance in Massachusetts has been reduced, several recent surveys demonstrate that substantial problems in access to care remain in the state. Many low-income patients who previously received completely free care under the state's old free care program now face co-payments, premiums and deductibles that stop them from getting needed care.

In addition, cuts to safety-net providers have reduced health resources available to the state's remaining uninsured, as well as to others who rely on safety-net providers for services in short supply in the private sector. These safety-net services include emergency room care, chronic mental health care, and primary care.

By mandating that uninsured residents purchase private health insurance, the law reinforced the economic and political power of health insurance firms. Moreover, the agency that administers the new law (the "Connector") adds an extra 4 to 5 percentage points to the already high overhead of private health insurance policies.

The reform failed to reduce overreliance on expensive, high-technology services. Indeed, some of its provisions such as changes in Medicaid rates and cuts to safety-net providers (who do more primary care) have further tilted health spending toward expensive, high-technology care.

A single-payer system of non-profit national health insurance could save about $8-$10 billion annually in the state through reduced administrative costs. This money could be used to cover all of the state's uninsured residents and to improve coverage for those who now have insurance, without any increase in total health care costs.

The Massachusetts reform law is not providing universal access to care, even in a state with highly favorable circumstances, including previously high levels of spending on health care for the poor, high personal incomes, and low rates of uninsurance. It is not a model for the nation.

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Background

In 2006, under the leadership of then-Gov. Mitt Romney, Massachusetts set out to fundamentally change how it financed care for the poor, greatly increasing the availability of insurance while decreasing the use of free care by the uninsured. At the time of passage of the Massachusetts Health Care Reform Act, the number of uninsured in the state was estimated by a University of Massachusetts survey at 550,000 and by the U.S. Census Bureau at 657,000. With no more than 10.4 % of its population lacking coverage (one-third lower than the 2006 national rate of 15.8%) the state's circumstances were believed to be favorable for health reform. In addition, the state had two other advantages: (1) it already spent substantial funds for care of the uninsured, primarily through block grants from a free care pool to safety-net providers such as public hospitals and community clinics to cover the costs of free care and medications; and (2) it was relatively wealthy with abundant health care resources, high personal incomes and a healthy tax base.

Under the reform, the state committed to providing subsidized medical coverage to an expanded set of eligible individuals through the Medicaid program (called MassHealth in Massachusetts) and through a new insurance program, Commonwealth Care. A unique feature of the reform is the statutory "individual mandate" that requires most non-poor adults to purchase private (unsubsidized) health insurance policies or pay a fine.

The Connector

The reform law authorized the development of an independent state agency, known as the Connector, to implement the reform. The Connector offers a menu of insurance options and serves as an intermediary to assist individuals in acquiring health coverage. It manages two similarly named but different health insurance programs, Commonwealth Care and Commonwealth Choice.

Commonwealth Care is a subsidized insurance program for Massachusetts adults earning less than 300% of the Federal Poverty Level. (Currently the FPL for a single individual is $10,404.) Commonwealth Care insurance is available only to people who do not have access to employer-sponsored insurance or Medicaid and who meet certain residency guidelines.

The Connector also manages the second program, Commonwealth Choice, which is a menu of commercial, non-subsidized insurance policies available to individuals earning 300% of the FPL or more, and to small employers. The Commonwealth Choice program resembles the Federal Employees Health Benefits Program (FEHBP) in that it provides a menu of regulated, private plan options. However, it differs from FEHBP in that enrollees must pay the full insurance premium and they receive no subsidies.

In addition to managing these two programs, the Connector is charged with establishing the benefits packages and premium contribution schedules for the Commonwealth Care program; developing regulations defining what constitutes coverage for purposes of the mandate; and creating affordability guidelines.

Mandatory Employer Contributions

Employers with 11 or more full-time equivalent employees are required to establish Section 125 plans, which enable employees to purchase health insurance on a pre-tax basis. In addition, these employers must make a "fair and reasonable contribution" to their employees' health insurance costs or pay the state an annual assessment of up to $295 per employee. These surcharges (which were predicted to yield $45 million annually but totaled only $5 million in the first year of the program) are to be used to help offset the costs of reform.

The Individual Mandate

The new law mandates that all uninsured adults with incomes greater than 300% of poverty must purchase private insurance or pay a fine. The fine was initially a few hundred dollars, but was $912 in 2008 and will rise to $1,068 in 2009. The fines are collected along with the state income tax, and are, essentially, a new tax on the uninsured. The law allows some taxpayers to avoid the fine if they can show that no affordable coverage is available.

Subsidized Care for the Poor and Near-poor

Commonwealth Care is publicly funded like Medicaid, but differs from traditional Medicaid by including enrollee-paid premiums and co-payments (from which enrollees earning less than 100% of the FPL are exempted) and benefit restrictions. Premiums and co-payments for the poor and near-poor (100% to 300% of FPL) are set using a sliding scale. Commonwealth Care plans are offered by four non-profit insurers, two of which are affiliated with the largest safety-net hospital systems in the state. Anyone offered employer-sponsored coverage, and many immigrants (including many legal immigrants) are ineligible for coverage under this program.

Unsubsidized Care for the Middle-income Uninsured

For the Commonwealth Choice program (the unsubsidized menu of plans for those earning more than 300% of the FPL) the Connector selected six large commercial insurers. The Connector classifies the available commercial plans into four levels: Gold, Silver, Bronze, and Young Adult. The first three levels are based on the comprehensiveness (i.e. actuarial value) of the plans. For instance, lower-priced Bronze plans include a $2,000 per person deductible, restrictions on site of care, co-payments, etc. Gold plans resemble a traditional Blue Cross policy, but are very expensive. The fourth level (Young Adult Plans) offers a slimmer benefit level with caps on total benefits and is available only to adults younger than 27 years old.

Financing the Reform

On passage of the reform, then-Gov. Mitt Romney declared "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced." However, the reform has not reduced health costs in the state, and the reform has proven far costlier than expected: $1.1 billion 2008, with costs of $1.3 billion forecast for 2009.

A small share of the financing for the program comes from assessments collected from employers who do not offer insurance and fines from individuals who do not purchase insurance as required by the mandate. A much larger share of the funding comes from funds diverted from the state's "free care pool." This pool had been financed through government appropriations and special assessments on private hospitals and insurers, and had funneled money to safety-net facilities such as public hospitals and community clinics. These safety-net providers not only care for uninsured and underinsured patients, but also provide disproportionate amounts of services that are in short supply in the private sector due to low reimbursement, including emergency room care, primary care, and care for persons with serious mental illnesses.

Insured Population by Type of Insurance (excludes Medicare enrollees)

Number of members (rounded to nearest 1,000)				
Insurance type	**6/30/06**	**6/30/07**	**6/30/08**	**Change**
Private Group[a]	4,274,000	4,378,000	4,421,000	+147,000
Individual Purchase[b]	40,000	36,000	80,000	+40,000
Medicaid	705,000	732,000	785,000	+80,000
Commonwealth Care[c] (subsidized)	0	80,000	176,000	+176,000

a includes large group, small group and self-insured
b includes Commonwealth Choice and residual non-group market
c as of January 2009, enrollment in Commonwealth Care had fallen to 163,000

Outcomes of the Massachusetts Reform

How Many are Covered?

The number of uninsured people in Massachusetts has fallen since passage of the reform in 2006. However, the extent of the decline is unclear. Approximately 295,000 are known to have obtained care through the state's Connector or Medicaid programs. State government officials estimate that an additional 147,000 people purchased health insurance without the state's help. According to these estimates, as of June 2008 about 440,000 Massachusetts residents had gained coverage. Because the number of uninsured before the reform was estimated at 550,000 to 657,000, a maximum of 67% to 80% of the state's uninsured now have insurance.

The above number of people with newly acquired private group insurance (147,000) may be an overestimate, as it is based on membership reported to the state by the health plans prior to the onset of the current economic downturn. Moreover, this membership may include some people who work in Massachusetts but live elsewhere (such as Boston's populous New Hampshire suburbs).

How many people in Massachusetts remain uninsured? Many state politicians are trumpeting the results of a recent phone survey by the Urban Institute (and available on the state's website at www.mass.gov), which found only 2.6% of respondents to be uninsured in mid-2008. However, despite considerable efforts, this survey reached few non-English speaking households and few households lacking landline phones — two demographic groups with high rates of un-insurance.

Surveys using more rigorous methods have yielded higher estimates of the uninsured. In March 2008, the U.S. Census Bureau's annual survey found that the previous year 5.4% of people were uninsured.

This is similar to the figure reported by the Massachusetts Department of Revenue (DOR), which administers the tax penalties on those who fail to obtain the mandated coverage.

Perhaps the most compelling evidence that the number of uninsured persons exceeds the 2.6% figure comes from the safety-net providers who continue to provide free care to the uninsured. According to the Massachusetts Department of Health Care Policy and Finance (which partially reimburses safety-net providers for such care), the number of patients receiving free care has fallen by just over a third (36%), not the 75% that would be expected if the state's uninsured had fallen from 10.4 % of the populations (its pre-reform level according to the Census Bureau) to the 2.6% rate that the reform's proponents claim.

Moreover, the coverage gains from the reform may have plateaued. It seems unlikely that gains in private, employer-based coverage will be sustained in the current economic downturn. Meanwhile, the state has begun dis-enrolling about 5,000 people per month from its subsidized Commonwealth Care insurance program following eligibility reviews resulting in a small drop in enrollment between mid-2008 and early 2009 .

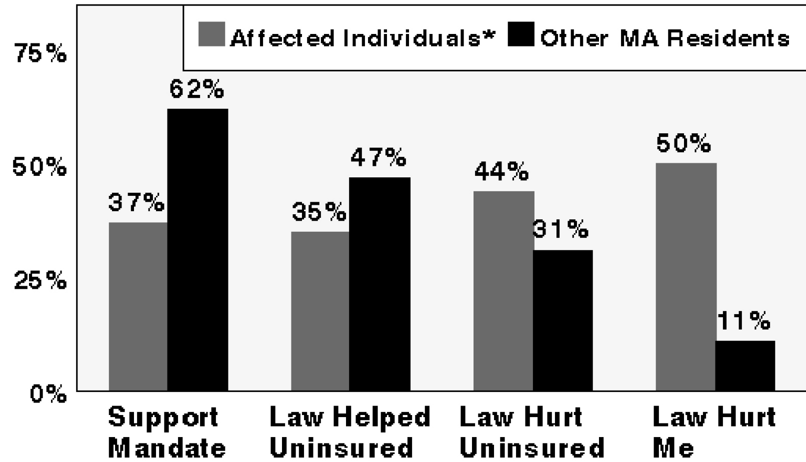
Many Remain Uninsured Because Insurance is Not Affordable

The state has failed to ensure the availability of comprehensive plans at affordable prices. Premiums continue to be unaffordable for even the least comprehensive (skimpiest) plans. For instance, the reform law specifically exempts uninsured families from fines if no affordable private plan is available. About 79,000 Massachusetts uninsured residents received this

exemption in 2007. This excused them from fines, but left them uninsured.

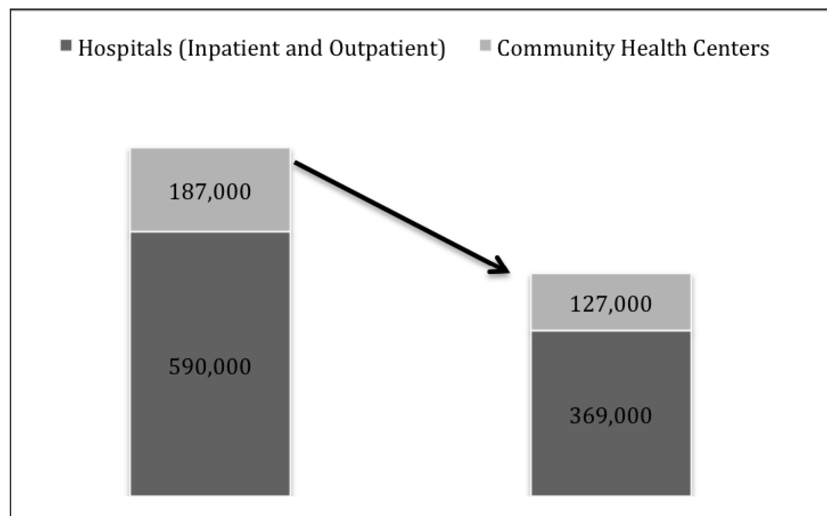
The private insurance plans available through the Commonwealth Choice program can be extremely expensive. The cheapest plan available to a middle-income 56-year-old now costs $4,872 annually in premiums alone. However, if the policy holder becomes sick, (s) he must pay an additional $2,000 deductible before insurance kicks in. Thereafter the policy holder pays 20% co-insurance (i.e. 20% of all medical bills) up to a maximum of $3,000 annually ($9,872 in total annual costs including premium, deductible and co-insurance). A need for uncovered services (e.g. physical therapy visits beyond the number covered) would drive out-of-pocket costs even higher. It is not surprising that many of the state's uninsured have declined such coverage.

Persons Affected by Health Reform Say They Have Been Hurt



*Those who were uninsured in the past year or changed coverage as result of the law.
Source: Harvard School of Public Health/Blue Cross Foundation Poll, referenced above.

Decrease in Free Care Volume as a Result of Massachusetts' Health Reform (trend: First half of FY 2007 to first half of FY 2008)



The Mandate Is Regressive

Both the mandated tax penalty and the insurance premiums paid through the Connector in order to avoid the tax penalty are highly regressive. Middle-income people pay a much higher percentage of their income than the affluent for fines or premiums, and older people pay more than younger people. For instance, for identical coverage a 57-year-old pays twice the premium charged to a 35-year-old.

Insurance Does Not Guarantee Access to Care

Massachusetts health reform has had a salutory effect on access to insurance, having provided half or more of the state's previously uninsured residents with insurance policies. Yet, it has had a lesser effect on access to care. For some state residents, the reform has actually made access worse, even before the latest round of cuts to safety-net providers.

Many low-income residents had been eligible for completely free care (including medications) under the state's old free care system, including all residents earning less than 200% of poverty. Access to care was often excellent for low-income residents living near a safety-net provider such as a public hospital or community clinic, but less than adequate for those living further away.

The new insurance policies that replaced the free care system require co-payments for office visits and prescriptions, which are difficult for many low-income patients to pay. For instance, at Cambridge Health Alliance, doctors and nurses have cared for patients who were forced to interrupt care for HIV and even Hodgkins lymphoma, two serious but highly treatable conditions, because they were unable to afford the new co-payments. (Several of these cases have also been reported to the state).

Moreover, the situation is likely to worsen. For fiscal year 2009 the Connector went through protracted negotiations with the four non-profit insurers participating in Commonwealth Care (the subsidized insurance program). In order to bring the state's cost increases down from 15.4% to 9.4%, the plans boosted co-payments and enrollee contributions, making services even less affordable for the near-poor families enrolled in Commonwealth Care. Several safety-net providers are now demanding (for the first time) that patients whose condition is not immediately life-threatening make up-front co-

payments before seeing a doctor.

Many middle-income Massachusetts residents continue to have private policies with substantial gaps like co-payments, deductibles and uncovered services. The new law has put the state's imprimatur on high deductible, high co-insurance plans by offering them as "Bronze Plans" through the Connector.

Such plans decrease access to care, and provide little financial protection in the face of a prolonged and expensive illness. For instance, studies of medical bankruptcies have found that more than three-quarters of those bankrupted by illness or medical bills have health insurance at the onset of the illness that bankrupts them. The Massachusetts reform failed to address the problems of the so-called underinsured.

In essence, the Patrick administration has decided to pay for insurance for some needy patients by curtailing services for other needy patients.

The Evidence on Access to Care

What is known about the effects of the new law on actual access to care (as opposed to access to insurance)? A single 2007 survey done by the Urban Institute and partially financed by The Blue Cross Foundation found that the share of Massachusetts residents who went without needed care fell by 3.9% overall, and by 4.8% among low-income persons. An updated survey by the same researchers was done in mid-2008 (before the effects of the current economic downturn, increased co-payments, or safety net cuts are likely to have been felt), but has not yet been released. However a recent Boston Globe/Blue Cross Foundation survey found that one in three Massachusetts residents said the cost of care is their biggest health concern; 13% of insured individuals were unable to pay for some health services that they had received and 13% could not afford to fill necessary prescriptions.

Finally, a recent Harvard School of Public Health/Blue Cross Foundation poll, suggests that many lower income residents were actually harmed by the reform. This survey of randomly selected Massachusetts residents included 176 persons directly affected by the new reform, either because they had been uninsured in the past year, or because the reform had forced them to change insurance. Among this group, more believed that the reform had hurt the uninsured than believed that the reform had helped (44% v. 35%). Fully half of those affected by the reform said that they had personally been hurt by it. Although unaffected Massachusetts residents had a favorable impression of the new reform, those directly affected did not; only 37% of them supported the new mandate.

In 2006 the Bush administration refused to release $385 million in Medicaid funding unless the Massachusetts health reform reduced free care pool payments to safety-net hospitals. Hence, reduced funding to safety-net institutions is integral to the reform.

Although surveys suggest that between 50% and 75% of the uninsured now have insurance, the demand for free care has fallen much less. Free care patient visits have decreased by only about one-third statewide, and by only about one-fifth at one of the state's two major safety-net institutions, Cambridge Health Alliance. (Data from the other major safety-net provider are not publically available.) However, even prior to the most recent state budget crisis, funding for hospital free care had fallen faster than the demand for such services.

In October 2008, Massachusetts Gov. Deval Patrick announced that the state was facing a $1.4 billion budget gap and intended to cut an additional $150 million from payments promised in the reform legislation to the states' two largest safety-net health institutions — Boston Medical Center (formerly Boston City Hospital, now merged with Boston University Hospital) and Cambridge Health Alliance (CHA) , which runs 20 community health centers and the state's three remaining public general hospitals. As of February 6, 2009, these safety-net providers are planning substantial cuts in safety-net services. CHA will be forced to close Somerville Hospital and several neighborhood health centers, and to sharply reduce the provision of both inpatient and outpatient psychiatric care.

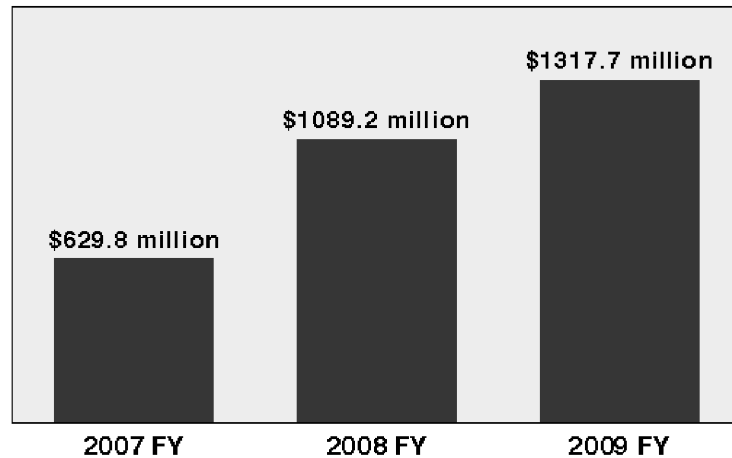
Budget cuts threaten the viability of these institutions, which have historically received special government payments to provide vital but money-losing services. These services include not only care for the state's uninsured, but also primary care, psychiatric care for the severely mentally ill, addiction services and emergency services that are in short supply because they generally lose money for private hospitals even when the patients have insurance. In essence, the Patrick administration has decided to pay for insurance for some needy patients by curtailing services for other needy patients, including not only the state's remaining uninsured, but also insured persons requiring care that private hospitals avoid. Such patients may literally find themselves with nowhere to go when sick.

Escalating Costs Make the Reform Unsustainable

The reform has been more expensive than expected, costing $1.1 billion in fiscal 2008 and $1.3 billion in fiscal 2009. The plan does nothing to control skyrocketing health care costs. Even before the health reform, health costs in Massachusetts were among the highest in the world, approximately 25% higher than the U.S. average. Since the reform's passage, premiums have continued to escalate. The costs for the four (subsidized) Commonwealth Care plans rose 9.4% in 2009, significantly higher than increases in inflation or wages.

The health reform has actually increased administrative costs and waste, already a major cause of high health care costs in the U.S. The Connector adds an additional 4.5% administrative cost to each policy it brokers. This is on top of the overhead of individual insurance plans, an average of at least 10%.

Finally, the reform does nothing about a major driver of high health care costs, the overuse of high-technology care such as CT scanners and surgeries, and the underdevelopment of primary care. Indeed, one little-known provision of the reform actually shifted resources away from primary care by lowering Medicaid payment rates for such services, while raising them for high-tech, tertiary care services.



Source: Commonwealth of Massachusetts Information Statement for Bondholders, August 22, 2008

The Massachusetts Reform: A Rerun Of Past State Reforms That Have Failed

Back in 1988, Massachusetts passed a universal health care law very similar to the 2006 reform. Since 1988, many states — Oregon, Minnesota Tennessee, Vermont, Washington and Maine — have enacted reforms aimed at achieving universal coverage. All failed.

These reforms differed in detail, but shared common elements. All offered new public subsidies or expanded Medicaid for poor and near-poor people. All left the majority of private health insurance arrangements undisturbed, although many included new insurance regulations or state purchasing pools to help make affordable coverage available to individuals or small businesses. Some (Massachusetts 1988, Oregon 1992, Washington State 1993) contained mandates on employers or self-employed individuals.

None of these reforms made more than a temporary dent in the number of uninsured. These incremental reforms failed because they did not include effective cost-control measures. As health costs rose, legislatures backed off from forcing employers and the self-employed from paying ever-rising premiums and the mandates were repealed. Relying on Medicaid was fiscally problematic for states because tax revenues fall at the same time that unemployment pushes families out of private coverage. There is little reason to think that the current Massachusetts reform, or a national plan modeled on these state reforms, would have any better long-term success.

Is there an alternative to this model?

Yes. A bill in Congress, the United States National Health Care Act, H.R. 676 (also known as "The Expanded and Improved Medicare for All Act") would implement single-payer financing of health care while maintaining the private delivery system. A single-payer program would eliminate private insurers and use the administrative savings to provide comprehensive coverage for all. Features of the single-payer plan include:

- Comprehensive coverage for all, including doctor, hospital, long-term, mental health, dental and vision care as well as prescription drugs and medical supplies.
- No premiums, co-payments, or deductibles that inhibit access to care and unfairly burden the poor.
- Choice of doctor and hospital and an end to insurance company and HMO dictates over patient care.
- Pays for itself by eliminating wasteful private insurance administration and profit. A progressive tax would replace what is currently paid out-of-pocket.
- Controls costs so benefits are sustainable through negotiated physician fees, global budgets for hospitals and bulk purchasing of prescription drugs and medical supplies. A single-payer system would facilitate health planning to reestablish the balance between preventive and primary care on one hand, and high-tech tertiary care on the other.

The nation must not look to Massachusetts' health reform as a model. If we truly want to provide comprehensive health care for all of us at a price we can afford, we must adopt a single-payer plan.

Product Recalls

January 16, 2008 –February 17, 2008

This chart includes recalls from the Food and Drug Administration (FDA) Enforcement Report for drugs and dietary supplements, and Consumer Product Safety Commission (CPSC) recalls of consumer products.

DRUGS AND DIETARY SUPPLEMENTS

The recalls noted here reflect actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request or by FDA order under statutory authority. If you have any of the drugs noted here, label them "Do Not Use" and put them in a secure place until you can return them to the place of purchase for a full refund. You can also contact the manufacturer. If you want to report an adverse drug reaction to the FDA, call (800) FDA-1088. The FDA Web site is www.fda.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Recalls and Field Corrections: Drugs – CLASS II

Indicates a problem that may cause temporary or reversible health effects; unlikely to cause serious injury or death

Name of Drug or Supplemenmt; Problem; Recall Information

Gabapentin Tablets, 600 mg, 100 Tablets, Rx Only, 369,464 units; Exceeds Impurity Specification (lactam). Lot #s: MK061367, MK061078, MK061079, MK061080, MK061081, MK061368, MK061082, MK061407, MK061408, MK061409, MK061410, MK061511, MK061512, MK061513, MK061514, MK061515, MK061642, MK070039, MK070040, MK070041, MK070042, MK070043, MK071311, MK071530, MK071531, MK071532, MK071633, MK071534, MK071535, MK071536, MK071537, MK071538, MK072721, MK072722, MK072723, MK072724, MK072725, MK072300, MK072301, MK072302, MK072303 and MK072304; Sandoz, Inc.

Gabapentin Tablets 800 mg, 100 Tablets, Rx Only, 369,464 units; Exceeds Impurity Specification (lactam). Lot #s: MK061424, MK061423, MK061083, MK061084, MK061516, MK061519, MK061520, MK061518, MK061517 and MK062068; Sandoz, Inc.

Propranolol Hydrochloride Extended Release Capsules, USP, 120 mg, 100 Capsules, Rx Only; 7,434 bottles; Potency; failed stability specification for fill weight of capsules (too much or too little active). Lot: 071A81, exp. Date: 12/2009; Actavis Elizabeth LLC.

Soma Compound Tablets USP, Carisoprodol 200 mg and aspirin 325 mg, Rx only, 100 tablets; 849 bottles; Superpotent: 12 month stability (by mfr Actavis, Totowa, NJ). Lot #: 61060A1, exp. Date: 11/2008;

Soma Compound with Codeine Tablets, USP, CIII, Carisoprodol 200 mg, aspirin 325 mg, and codeine, phosphate 16 mg, 100 tablets, Rx only, 2716 bottles; Superpotent: 12 month stability (by mfr Actavis, Totowa, NJ). Lot #: 5513A1, exp. date 07/2008; 60484A1, exp. Date 05/2008; 70257A1, exp. date 03/2009; Meda Pharmaceuticals Inc.

CONSUMER PRODUCTS

Contact the Consumer Product Safety Commission (CPSC) for specific instructions or return the item to the place of purchase for a refund. For additional information from the Consumer Product Safety Commission, call their hotline at (800) 638-2772. The CPSC web site is www.cpsc.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Name of Product; Problem; Recall Information

All-Terrain Vehicles (ATVs). The rear brake caliper support can crack and the front brake operation can experience a loss of pressure, posing a risk of the rider losing braking and steering control and suffering injuries or death. KTM North America Inc., (888) 985-6090 or www.ktmnorthamerica.com.

Arch Swing Sets. The metal around the weld at the top of the swing frame can fail, causing the top bar to fall, posing a fall and impact hazard to the user or by-standers. (800) 356-4727 or swingrecall@playland-inc.com.

Bicycle Forks. The suspension system on bikes with the recalled forks could become completely compressed and fail to return to its original position after a forceful landing. This can cause riders to lose control of the bicycle and crash. The forks can also expand forcefully if repair is attempted by the consumer, posing a risk of serious injury. Tenneco-Marzocchi s.r.l., (800) 227-5579 or www.marzocchi.com.

Bicycles with R-SYS Front Wheel Rims. The spokes on the bicycle's front wheel rim can break during use, posing a fall and crash hazard to riders. Mavic USA, (800) 664-9228 or www.mavic.com.

CONSUMER PRODUCTS

Construction Play Sets. Surface paint on the play sets can contain lead, violating the federal lead paint standard. DDI Inc., (800) 220-2390 or www.ddiretail.com.

Cottage Bunk Beds. When screws are missing from the upper bunk's guardrails, the vertical slats on the guardrails can detach and pose the risk of children falling when getting in or out of the upper bunk. The Land of Nod, (800) 933-9904.

Evenflo Activity Centers. When used as an activity table, the cap on one end of the product can loosen and fall off, posing a fall hazard to a young child. Evenflo Co. Inc., (800) 233-5921 or www.exersaucertriplefun.com.

"Field & Stream" Dual Burner Camp Stoves. Gas could flow at a rate that would produce higher than expected flames. Rainwater in the burners can also prevent proper ignition and allow gas to build-up and ignite unexpectedly. These conditions pose burn hazards to consumers. Dick's Sporting Goods, (888) 837-1380 or www.dickssportinggoods.com.

Glider Recliners. The base of the chair, if installed backwards, can allow the chair to tip-over backwards, posing a fall hazard to consumers. Lane Furniture Industries Inc., (877) 405-3745 or www.lanefurniture.com/customer.

Golfer's Billiard Games. Surface paints on the golf balls can contain excess levels of lead. Dick's Sporting Goods Inc., (866) 677-4771 or www.dickssportinggoods.com.

Halogen Clamp Lamps. The UV glass lens on the lamp can crack, exposing the halogen bulb, posing a fire hazard. Catalina Lighting Inc., (866) 949-8567 or www.catalinalighting.com.

High School Musical Manicure Kits. The lettering "HIGH SCHOOL MUSICAL" with glitter on the pouch used with the manicure kit contains excess levels of lead. Lead can be toxic if ingested by young children and cause adverse health effects. Fantas-Eyes Inc., (800) 352-7419 or www.Fantas-Eyes.com.

Home Sweet Playhome Canopies. A child's head could get entrapped in the canopy's window openings, posing entrapment and strangulation hazards. The Land of Nod, (800) 933-9904 or www.landofnod.com.

Intermatic DT17 Heavy Duty Digital Timers. The recalled timers can have a faulty ground connection, posing a hazard to consumers. Intermatic Inc., (800) 704-3595 or www.intermatic.com.

Jesus Fish Beads. Surface paint on the green fish can contain excessive levels of lead, violating the federal lead paint standard. Discount School Supply, (800) 606-3807 or www.discountschoolsupply.com/SafetyInformation.

LCD Television Wall Mounts. The wall mount can crack when used with televisions 26 inches and larger or with televisions that include a DVD player. The television can then fall from the wall mount and pose a serious risk of injury to consumers standing nearby. Milestone AV Technologies, (877) 277-3707 or www.milestone.com/initmount.

Lip Gloss Keychains. The metal clasp attached to the keychain contains high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Markwins Beauty Products, (800) 626-8878 or www.markwins.com.

Personal Cooking Systems and Group Cooking Systems. A tight valve attached to the stove's fuel source can allow gas to leak, posing a fire hazard to consumers. Jetboil Inc., (866) 611-9905 or customerservice@jetboil.com.

Playhouse Disney "Handy Manny" Toy Tool Sets. The tools contain eyes that can separate, posing a choking hazard to young children. Disney Store USA LLC, (866) 902-2798 or www.DisneyStore.com.

"Primovolta" and "Primavolta" Warming Gloves. The glove's electric heating pad can short circuit and overheat, posing a burn hazard to consumers. Outdoor Research Inc., (888) 467- 4327 or www.outdoorresearch.com.

Rheem, Ruud and United Refrigeration Oil-Fired Furnaces. If the furnace is not properly wired, the oil burner can continue to operate when the blower shuts off, posing a fire hazard to consumers. Air Conditioning Division of Rheem Manufacturing Co., (800) 577-3960 or www.rheemac.com.

Safety 1st SmartLight Stair Gates. The hinges that hold the stair gate in place can break, posing a fall hazard to children if the gate is placed at the top of the stairs. Dorel Juvenile Group USA, (866) 690-2540 or www.djgusa.com/safety_notice/.

CONSUMER PRODUCTS

Skull-and-Crossbones Necklaces. The skull and metal clasp of the necklace contain high levels of lead. Lead can be toxic if ingested by young children and can cause adverse health effects. Spencer Gifts LLC, (800) 321-2497 or www.spirithalloween.com.

Spa Factory™ Aromatherapy Fountain & Bath Benefits Kits. Pressure from the buildup of carbon dioxide in the jars of Bath Bombs/Balls or Bath Fizzies can cause the caps on the jars to blow off, posing explosion and projectile hazards. The mixtures also can contain citric acid, which can get into the eyes during an explosion, posing a risk of eye irritation. JAKKS Pacific Inc., (877) 875-2557 or www.myspafactory.com.

Stabilicer Lite Cleats. The elastic harness system attaching the cleats to footwear can detach, posing a fall hazard to consumers. L.L. Bean Inc., (800) 555-9717 or www.llbean.com.

Stationary Bicycle Trainers. A handle pin on the bicycle trainer can loosen during use, causing the machine to become disengaged, and pose a fall hazard to consumers. Saris Cycling Group, (800) 783-7257 or www.cycleops.com.

Tony Hawk Boy's Pajama Sets. This sleepwear fails to meet the federal children's sleepwear flammability standard, and poses a risk of burn injury to children. Mad Dog Concepts, (888) 623-3640.

XBi ALU Skis. The binding plates could crack or break, causing the skier to lose control or fall and suffer injuries. Nordica USA, (800) 892-2668 or www.nordicausa.com.

THE PUBLIC CITIZEN HEALTH RESEARCH GROUP
Health Letter

Editor.................................*Sidney M. Wolfe, MD*
Managing Editor.............................*Kate Resnevic*
Contributors.........................*Sidney M. Wolfe, MD*
Proofreader...................................... *Kate Resnevic*

Public Citizen President...........*Sidney M. Wolfe, MD*

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Having Health Insurance Does Not Mean Having Health Care

Statement of Rachel Nardin, M.D., President, Massachusetts Chapter of Physicians for a National Health Program.

My name is Dr. Rachel Nardin, a neurologist at Beth Israel Deaconess Medical Center in Boston, and assistant professor of neurology at Harvard.

In April 2006, Massachusetts enacted a health care reform law with the stated goal of providing near-universal coverage of the Massachusetts population. Nearly three years into the reform we know a lot about what has worked and what hasn't. Examining this data critically is vitally important as the Obama administration considers elements of the Massachusetts' plan as a model for national health care reform.

On Feb. 19 (see page 1), we released a new study on the Massachusetts reform. This study details many problems with the reform effort. We are also releasing a letter from nearly 500 Massachusetts physicians to Senator Kennedy asking him not to push for a Massachusetts-style reform nationally. My colleagues and I see the effects of the Massachusetts reform on patients every day and know that this is not a healthy model for the nation.

The Massachusetts reform is an example of an "incremental" reform. It tried to fill in gaps in coverage, while leaving undisturbed existing public and private health insurance programs. It did this by expanding Medicaid, and offering a new subsidized coverage program for the poor and near-poor. It also mandated that middle-income uninsured people either purchase private health insurance or pay a substantial fine ($1068 in 2009).

The reform has reduced the numbers of uninsured, although our report shows that the state's claim of near-universal coverage is untrue. This claim is based on a phone survey that reached few non-English speaking households and few who lacked landline phones—two groups with high rates of uninsurance. Other data also calls this claim into question. For instance, both the Massachusetts Department of Revenue and the March 2008 U.S. Census Bureau survey indicate that at least 5 percent of people in Massachusetts remain uninsured. Moreover, the use of free care services in Massachusetts has fallen by only a third, suggesting that the numbers of uninsured in the state may well be even higher than 5 percent.

Despite the reform, coverage remains unaffordable for many in our state. As a result, despite the threat of a fine, some residents remain uninsured. Others have bought the required insurance but are suffering financially. For a middle income, 56-year-old man, the cheapest policy available under the reform costs $4,872 annually in premiums alone. Moreover, it carries a $2,000 deductible and 20 percent copayments after that, up to a maximum of $3000 annually. Buying such coverage means laying out nearly $7000 before the insurance pays a single medical bill. It is not surprising that many of the state's uninsured have declined such coverage.

The study we released on Feb. 19 also reminds us that having health insurance is not the same thing as having health care. Despite having coverage, many Massachusetts residents cannot afford care. In some cases, patients are actually worse off under the reform than they were under the state's old system of free care because their new insurance has far higher co-pays for medications and care. According to a recent Boston Globe/Blue Cross Foundation survey, 13% of people with insurance in our state were unable to pay for some health services that they had received and 13% could not afford to fill necessary prescriptions. The reform does not appear to have reduced the numbers of people who were unable to get care that they needed because of the cost.

I will close with the story of one Massachusetts patient who has suffered as a result of the reform. Kathryn is a young diabetic who needs twelve prescriptions a month to stay healthy. She told us, "Under Free Care I saw doctors at Mass General and Brigham and Women's hospital. I had no co-payments for medications, appointments, lab tests or hospitalization …Under my Commonwealth Care Plan my routine monthly medical costs include the $110 premium, $200 for medications, a $10 appointment with my primary care doctor, and $20 for a specialist appointment. That's $340 per month, provided I stay well." Now that she's "insured," Kathryn's medical expenses consume almost one-quarter of her take home pay, and she wonders whether she'll be able to continue taking her life saving medications. ◆

Get Involved!

Do you want to get involved in the campaign to bring a single-payer health care system to the U.S.? Join us online at www.citizen.org/hrg to find out more about what you can do!

Public Hospitals, Community Clinics Suffering Under Massachusetts Health Care Reform

Statement of Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Research Group and Co-Founder, Physicians for a National Health Program

As Dr. Nardin pointed out (see page 10), many remain uninsured in Massachusetts and access to health care continues to be a problem statewide; for many residents it has actually worsened. This is particularly disgraceful given the surge in spending for the reform effort, which has run hundreds of millions of dollars over its original budget. The reform cost $1.1 billion in fiscal 2008 and $1.3 billion in fiscal 2009.

The Massachusetts reform law is not providing universal access to care, even in a wealthy state with the most favorable circumstances.

These high costs have already triggered a new crisis in our state. Last fall Gov. Deval Patrick announced massive cuts to safety-net providers including public hospitals and community clinics. As a result, these providers have reduced the care available to the state's remaining uninsured, as well as to others who rely on them for services in short supply in the private sector. These safety-net services, which often lose money for hospitals even when patients have good insurance, include emergency care, chronic mental health care and primary care. The public hospital where I work is busier than ever, but has just announced that it will close six community clinics, and about half of its inpatient psychiatry beds - despite critical shortages of primary care and psychiatric services. Most of our poor patients, who previously received completely free care, are now forced to pay upfront co-payments prior to receiving care.

Meanwhile, the reform further encouraged the overuse of expensive, high-technology care. Little known provisions in the bill increased payments for specialty care while cutting reimbursement for primary care. This has further tilted health spending toward expensive, high-tech care and away from the primary and preventive care that is the sine qua non of quality efficient health care.

By requiring that uninsured residents purchase private health insurance, the law reinforced the economic and political power of health insurance firms. Patients were forced to help foot the bill for private insurer's high overhead — three to four times higher than Medicare's administrative costs. Moreover, the agency that administers the new law (the "Connector") adds an extra 4 to 5 percentage points to the already high overhead of private health insurance policies. And for hospitals and doctors, the new reform has added new administrative burdens and costs.

In contrast, a single-payer system of non-profit national health insurance could save $8-$10 billion annually in the state through reduced administrative costs. This money could be used to cover all of the state's uninsured residents and to improve coverage for those who now have insurance with large copayments and deductibles, without any increase in total health care costs.

The Massachusetts reform law is not providing universal access to care, even in a wealthy state with the most favorable circumstances. We started out with high levels of medical spending and low rates of uninsurance. Yet even under these near-ideal conditions the reform is failing. It would be a grave mistake to use Massachusetts' reform as a model for the nation.◆

OUTRAGE from page 12

Canadian system and ours is the enormous cost savings in Canada of eliminating the private health insurance industry and all of the administrative waste it foists on doctors, hospitals and other health providers. Today's report estimates that a single-payer system of non-profit national health insurance could save $8-$10 billion annually in Massachusetts alone through reduced administrative costs. This is an amount far in excess of the rapidly-escalating annual cost ($1.3 billion in fiscal 2009) of the Massachusetts plan. Unlike the current plan, which robs Peter to pay Paul by taking money away from critical safety net programs in order to provide health insurance for others, money freed up because of a single payer plan could be used to cover all of the state's uninsured residents and to improve coverage for those who now have insurance with large copayment and deductibles, without any increase in total health care costs.

It is time to wake up from this insanity, not impose multiply-failed state health insurance programs on everyone in the country and enact single payer health insurance for all.◆

Ending the Insanity of Failed State Health Insurance Reforms

Albert Einstein once said, "The definition of insanity is doing the same thing over and over again and expecting different results."

In this case, the insanity of doing the same thing over and over again and expecting different results is the 20-year history of state health insurance reform legislation in the United States, detailed in the report included in this issue of *Health Letter*, involving nine different states. Although these reforms differed in detail, they shared common elements. All states offered new public subsidies or expanded Medicaid for poor and near-poor people. All left the majority of private health insurance arrangements undisturbed. As the state charts in the report document, all of these failed to have a lasting effect on the problems of uninsured people in those states.

State experiments are an important way of trying out programs which, if they succeed, can go national. In this country, Wisconsin programs for social security were an important predecessor to the Federal Social Security Act in 1935. But if they repeatedly fail, to keep experimenting on the people in those states by repeating the same set of mistakes, let alone using this private-public model for national health insurance, is nothing short of Einstein's definition of insanity.

It should not take a psychiatrist to diagnose or treat this insanity. Roll back the clock to 1962 when, in the Canadian province of Saskatchewan, there was a similar problem of many uninsured people, private health insurance companies for those wealthy enough to afford such insurance and the quandary of what to do. Saskatchewan enacted a single payer health insurance system in that year and, after nine years of very positive results; the system was instituted for all of Canada.

The major difference between the

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