

# Engaging Human Rights Norms to Realize Universal Health Care in Massachusetts, USA

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## Abstract

Massachusetts is a national leader in health care, consistently ranking in the top five states in the United States. In 2006, however, only 86% of adults aged 19–64 had health insurance. That year, Governor Romney signed into law An Act Providing Access to Affordable, Quality, Accountable Health Care. By 2017, more than 96% of these adults were insured. The 2006 Massachusetts health insurance reform later became the model for the 2010 federal Patient Protection and Affordable Care Act, also known as Obamacare. This article examines, through a human rights lens, the 2006 Massachusetts health insurance reform 10 years after its implementation (2007–2017) to shed light on the effectiveness of this approach in achieving universal health coverage. Drawing on documentary and interview data, and applying international human rights norms, we found that (1) the 2006 Massachusetts health reform replaced a crisis of uninsurance with a crisis of underinsurance; (2) state leaders in health reform propose widely diverging solutions to the increasing health care costs, the inability of many residents to afford needed health care, and the persistence of medical bankruptcies; and (3) health care is recognized as a human right in Massachusetts, but understanding of the substance or potential of the right is limited.

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## Introduction

In September 2015, the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development, which set forth 17 Sustainable Development Goals (SDGs) and 169 targets.<sup>1</sup> These include target 3.8, which aims to achieve universal health coverage, including financial risk protection and access to quality essential health care services, by 2030.<sup>2</sup> Every member of the United Nations, including the United States, has thus committed to achieving universal health coverage. Further, the 2030 Agenda is guided by the principles of the United Nations Charter and is grounded in international human rights law.<sup>3</sup> On this basis, this study uses a human rights lens to consider efforts to universalize health care in one US state, Massachusetts. The 2006 health care reform in Massachusetts is particularly important to understanding efforts to universalize health care in the United States because it was the model for the subsequent 2010 federal health care reform, known as the Patient Protection and Affordable Care Act (PPACA) or Obamacare.

Massachusetts is a national leader in health care, consistently ranking in the top five states on the Commonwealth Fund Scorecard on State Health System Performance.<sup>4</sup> In 2006, however, only 86% of adults aged 19–64 had health insurance.<sup>5</sup> That year, Governor Romney signed into law An Act Providing Access to Affordable, Quality, Accountable Health Care, also known as Chapter 58.<sup>6</sup> The law sought to increase health care insurance coverage for residents of Massachusetts by (1) mandating that all adults in the state have health care insurance unless an affordable option was not available; (2) expanding Medicaid, the publicly funded health care program for very low-income residents; (3) creating a new program of subsidized private insurance for low- and moderate-income residents; and (4) establishing a transparent health care insurance market exchange, the Health Connector.<sup>7</sup>

By 2017, Massachusetts had the highest rate of health insurance coverage of all US states, with less than 4% of the population uninsured.<sup>8</sup> Yet, with a population of 6.745 million people, more

than 200,000 people still lacked health insurance. Moreover, many people with health insurance could not afford health care due to high deductibles and co-payments. A 2016 study found that the 2006 law had not made health care more affordable for residents; indeed, 10 years after the reform, 43.1% of insured adults reported that the cost of health care was causing them financial problems.<sup>9</sup> Studies examining the impacts of Chapter 58 have found that (1) the reform has achieved greater health insurance coverage; (2) some health outcomes have improved for certain populations; (3) increased access to insurance has increased the utilization of health services for some low-income residents; (4) many residents—especially low-income residents, documented and undocumented immigrants, the working poor, and Latino, black, and middle-income individuals in poor health—still do not have health insurance; and (5) medical bankruptcies and high medical debt have persisted.<sup>10</sup>

Despite mixed results, the 2006 Massachusetts health insurance law had tremendous impact beyond state borders. In 2010, President Obama signed into law the PPACA, which was modeled on the Massachusetts law.<sup>11</sup> The PPACA mandated that all individuals maintain health insurance unless there was no affordable option; provided support for states to expand Medicaid; created new subsidized programs for low- and middle-income people; and required each state to maintain a health insurance exchange.<sup>12</sup> Not surprisingly, the PPACA has also had mixed results. Although the law has expanded insurance coverage to many people, recent research shows that a quarter of all adults with private insurance still cannot afford health care when premiums, deductibles, and out-of-pocket costs are taken into account.<sup>13</sup> Additionally, more than 27 million people remain uninsured.<sup>14</sup>

Most of the PPACA-mandated reforms have taken place at the state level, and each state has taken its own approach to implementation within the boundaries set by the federal law. As a result, there remain wide discrepancies in health insurance coverage and access to health care across states.<sup>15</sup> For this reason, research on state-level health insurance

coverage and access to health care is useful even after the PPACA. The Massachusetts case is particularly relevant, as Massachusetts has had a decade of experience with a system similar to those more recently implemented under the PPACA, which, although adopted in 2010, did not come fully into effect until 2014. This state-level research, particularly on Massachusetts, may provide insight into how best to move toward universal health insurance—and not slip backward—in the future.

Our study differs from previous studies on health law reform in Massachusetts in that it uses a human rights lens to assess the success of the 2006 law. In this way, it analyzes Massachusetts's progress in comparison to international legal and ethical norms rather than in comparison to the state's pre-2006 situation. In addition, this study examines the extent to which leaders in health law reform in Massachusetts believe that human rights frameworks generally, or the human right to health care in particular, could be useful in securing universal health care in the state. The right to health is widely recognized in international human rights law and in the majority of national constitutions around the world.<sup>16</sup> It therefore provides a legitimate legal and ethical framework for evaluating the success of health law reforms and may also be a useful foundation for moving toward universal health insurance and universal health care.

Following this introduction, the second part provides background on the 2006 Massachusetts health law. The third part presents our research questions, design, and methodology. Part four explains our findings, which are based on 19 interviews with leaders in health law reform in Massachusetts. Part five uses a human rights lens to analyze the findings from our document review and interviews. Finally, the conclusion offers our thoughts on the future of universal health insurance and universal health care in Massachusetts and the United States. Throughout the article, we distinguish between universal health insurance (the focus of the 2006 Massachusetts health law) and universal health care (the focus of international human rights law).

## Background on the Massachusetts health law reform of 2006

Massachusetts has been engaged in state-level health law reform efforts for decades. In 1988, for example, Governor Dukakis enacted legislation that would have provided almost universal health insurance by 1992.<sup>17</sup> Following the election of Governor Weld in 1990, most aspects of the legislation were repealed before they were implemented; however, provisions expanding Medicaid coverage to working adults and children with disabilities were left intact.<sup>18</sup> In 1997, Massachusetts used a Medicaid waiver to further expand health insurance coverage to hundreds of thousands of residents.<sup>19</sup> Medicaid is a federal program that works in partnership with states to provide health insurance to low-income American citizens and some legal residents.<sup>20</sup> States have broad discretion to design and administer their Medicaid programs, provided they meet federal standards.<sup>21</sup> Moreover, states can seek federal waivers allowing them to use federal Medicaid funding in ways that would typically not be allowed under federal rules.<sup>22</sup> The 1997 Medicaid waiver provided Massachusetts with additional federal dollars and allowed the state to expand insurance coverage beyond that required by the federal rules.<sup>23</sup>

As a result of these earlier efforts, by 2006, uninsured rates in Massachusetts were significantly lower than the national average.<sup>24</sup> Massachusetts also had a highly regulated health insurance market with extensive mandatory coverage requirements, prohibitions on exclusions for preexisting conditions and insurance premium variations based on gender, and a limit on premium variations based on age and geography.<sup>25</sup> Despite this progress, hundreds of thousands of residents still lacked coverage, and health insurance premiums and health costs continued to rise.<sup>26</sup> Moreover, the Medicaid waiver that Massachusetts had received in 1997—which provided US\$385 million in federal funding—was set to expire on July 1, 2007.<sup>27</sup> These issues created a political opening for health law reform in the early 2000s. In this light, in 2003, activists began organizing and advocating for the adoption of a constitutional amendment rec-

ognizing a right to health insurance.<sup>28</sup> The proposed amendment stated:

*Section 1: The People of the Commonwealth of Massachusetts hereby declare it necessary and expedient to alter the Constitution by the adoption of the following Article of Amendment:*

*Upon ratification of this amendment and thereafter, it shall be the obligation and duty of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval by the voters at a statewide election, as will ensure that no Massachusetts resident lacks comprehensive, affordable and equitably financed health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.<sup>29</sup>*

The proposed amendment would have created a legal duty on the part of the Massachusetts legislature and executive branch to ensure that every Massachusetts resident have comprehensive, affordable health insurance, but it did not mandate a specific form of health care system.<sup>30</sup> Massachusetts law provides that the Massachusetts Constitution may be amended through a ballot initiative process.<sup>31</sup> The process requires that petitioners collect certified signatures representing at least 3% of the total vote cast in the last gubernatorial election; that at least 25% of the legislature then vote in favor of the initiative in two consecutive constitutional conventions; and finally, that the initiative receive approval by a majority of voters.<sup>32</sup>

The concept of health care as a right was widely popular with Massachusetts residents, and a grassroots campaign was successful in collecting the required number of signatures for the petition initiative.<sup>33</sup> At the first constitutional convention in 2004, the Massachusetts legislature voted 153-41 in favor of the amendment.<sup>34</sup> At the same time, the Romney administration and legislators were drafting Chapter 58, which was enacted in April 2006.<sup>35</sup> At the second constitutional convention, held in July 2006, legislators voted 118-76 to send the amendment to a special committee for further study.<sup>36</sup> Two senators spoke against voting on the constitutional amendment, arguing that Chapter 58

should be implemented and evaluated before a vote was taken to amend the constitution.<sup>37</sup> In 2007, the legislature voted against discharging the amendment from that committee, effectively killing it.<sup>38</sup>

Supporters of the initiative then filed suit with the Supreme Judicial Court of Massachusetts in 2007 seeking a judicial remedy for the legislature's failure to vote on the amendment.<sup>39</sup> The court acknowledged that the legislature had a constitutional duty to vote on every initiative pending before it but ruled that there was no judicially enforceable remedy for such a violation.<sup>40</sup> As a result, the amendment was not placed on the statewide ballot in 2008. Although it failed, the constitutional amendment movement is widely credited with creating sufficient pressure on legislators and special interest groups to ensure the passage of Chapter 58 in 2006.<sup>41</sup> Although hospitals, health insurers, and other stakeholders might have opposed the proposed legislative reforms, the threat of the constitutional amendment appears to have made them more willing to support the legislation. In fact, many stakeholders conditioned their support for the legislation on the legislature blocking the constitutional amendment on universal health insurance.<sup>42</sup>

The 2006 Massachusetts health law reform is based on the concept of shared responsibility, meaning that individuals, employers, and the government each share part of the burden of health insurance coverage.<sup>43</sup> The reform featured individual and employer mandates and public subsidies to enable low- and moderate-income people to purchase private health insurance online in a marketplace known as the Health Connector.<sup>44</sup> Ten years after the passage of Chapter 58, Massachusetts has the highest rate of health insurance coverage in the United States, and the insurance gap among racial and ethnic groups has narrowed significantly.<sup>45</sup> The reform has also resulted in increased access to health care, general improvement in health outcomes, and an overall decline in mortality.<sup>46</sup> However, improvements have not been even across all groups in Massachusetts. One study showed no progress in reducing the unmet health needs of Latino, African American,

and middle-income individuals, and another report showed almost half of non-elderly adults reporting difficulty finding providers or getting appointments when needed.<sup>47</sup>

Despite the title of the act—An Act Providing Access to Affordable, Quality, Accountable Health—the legislation did not address cost containment or affordability.<sup>48</sup> In 2017, 25% of Massachusetts residents surveyed reported forgoing needed health care due to cost.<sup>49</sup> Further, 15% reported difficulty paying medical bills in the last 12 months, and of the people who had incurred medical debt, 78% had insurance at the time the debt was incurred.<sup>50</sup> These affordability challenges were often most acute for lower-income residents.<sup>51</sup> With this background, it is clear that there is a need for further health insurance reform to fully achieve universal health insurance and universal health care, to equalize health care benefits, and to address cost containment.

## Research questions, design, and methods

Focusing on the 10 years after the 2006 Massachusetts health insurance reform (2007–2017), our study uses a human rights lens—drawing specifically on the international human right to health care—to examine the reform’s successes, as well as remaining challenges, and the potential avenues for achieving universal health insurance and universal health care in the state. We employed multiple qualitative methods in our research. Step one involved a document review, including examination of the legislative history of the 2006 reform, and quantitative and qualitative studies of the impacts of the reform on universalizing health insurance and health care in Massachusetts. Additionally, a search of nongovernmental organizations’ websites provided information concerning past and current efforts to promote universal health care in Massachusetts. This document review provided the background explained above, prepared us for interviews with experts in the field, and established the context for the discussion in section five below.

In the second step, we conducted semi-structured interviews with 19 leaders in Massachusetts’s

health care reform efforts (past and present) between August 2016 and May 2017. These interviews sought answers to the following three research questions: (1) To what extent do leaders believe that the 2006 health law has been successful in achieving universal health care in Massachusetts? (2) What do leaders believe can be done to achieve universal health care in Massachusetts? and (3) Do leaders believe that human rights can be useful in achieving universal health care in Massachusetts? In addition to questions about the impact of Chapter 58, we asked interviewees about the impact of the constitutional ballot initiative, the potential impact of a constitutional right to health insurance in Massachusetts, and the role of the international right to health in advancing universal health care.

We recruited interviewees who have played a major role in health law reform, such as legislators, executive branch officials, leaders of nonprofit organizations, and policy analysts whose work has informed past or current debates on universalizing health insurance or health care in Massachusetts. We recorded, transcribed, and then coded the interviews, using data analysis software (NVivo 11) to draw out emerging themes. The data was then analyzed using a human rights framework, based on the right to health care (affordability and non-discrimination) and the human rights principles of universality, equality/equity, transparency, participation, and accountability. The study received ethics approval from the University of Massachusetts Boston Institutional Review Board (#2016123).

## Findings

### *The goals and process of the 2006 Massachusetts health reform*

All 19 leaders indicated that the focus of the 2006 health law reform was on expanding health insurance to achieve universal or “near universal” insurance coverage as a means to increase access to health care. Some interviewees used these terms—health insurance and health care— interchangeably. Julie Pinkham, executive director of the Massachusetts Nurses Association, pointed out this problem in Chapter 58:

*The way it's written would suggest that you actually get health care. But really the way the reform was written is you get insurance, and those are two different things.<sup>52</sup>*

Although most interviewees indicated that grassroots pressure—for health care as a human right, universal health care, a single-payer system, and health care access—played a significant role in generating political pressure on the legislature to address health care and pass the 2006 law, they noted that grassroots groups were not well represented during the discussions designing the reform and that their desires were not reflected in the final bill.

In contrast, a few interviewees described the legislative process that ultimately resulted in the reform law as collaborative, involving all stakeholders, and one where a diverse group of participants all sacrificed something to achieve their shared goal of expanding access to health insurance coverage. Jack Evjy, former chair of the Massachusetts Medical Society Task Force on Universal Access (2004–2006), thought the exercise of bringing a diverse group together to craft the reform allowed the group to pick the best aspects of each model, thus strengthening the end result.<sup>53</sup> While this process ensured political buy-in from powerful interests, other interviewees indicated that this buy-in came at great cost. State Senator Dan Wolf, for example, opined that health care reform has failed because insurance companies and other powerful actors have been able to co-opt the processes, preventing broad reforms.<sup>54</sup> In his view, these powerful interests narrowed what was politically possible:

*It is an insane system right now. It makes absolutely no sense. And the only reason we're not changing it is because there are wealthy interests in the State House that are preventing that from happening, in the insurance industry, in the pharmaceutical industry, and in the providers industry.<sup>55</sup>*

Ben Day, executive director of Healthcare-NOW!, suggested that the failure to include cost containment measures in the health law reform might have been a deliberate decision so as not to affect the revenue streams of some stakeholders.<sup>56</sup> In short, the

narrow universe of policy options under discussion in 2006 ensured that corporate and other private stakeholders did not have to give up much, if any, of their essential interests.

### *Success of the 2006 health reform in achieving universal health insurance*

Among the leaders interviewed, there was consensus that the resulting law was successful in achieving near universal insurance coverage. Jonathan Gruber, a professor of economics at the Massachusetts Institute of Technology and one of the chief architects of the reform, explained:

*[T]he bottom line is it was a law about making health insurance affordable for people and moving towards a market where everyone was guaranteed to have affordable and fairly priced health insurance. That's what the law is about, and it accomplished that goal.<sup>57</sup>*

However, other interviewees noted that the legislation did not address the rising costs of health insurance and health care. Gerald Friedman, a professor of economics at the University of Massachusetts Amherst, attributed this limitation to the fact that the reform never intended to address cost concerns:

*It failed utterly at things that it was never intended to do, which included improving coverage for people with insurance [by] controlling.<sup>58</sup>*

Because the law has not contained costs, people—even those with insurance—are not necessarily able to afford health care. Ben Day of Healthcare-NOW! argued that the “crisis of uninsurance” has been replaced by a much larger “crisis of underinsurance.” He explained:

*[T]he expansion of insurance was accompanied by ... a dramatic rise in high deductible plans, dramatic rise in out-of-pocket expenses, and ... insurance started covering less and less for a much larger share of the state. So it was like a halfway measure. I think it was relatively successful at addressing the crisis of uninsurance, [but] it created a new sort of larger crisis of underinsurance.<sup>59</sup>*

Similarly, Professor Friedman from the Univer-

sity of Massachusetts Amherst maintained that working people who earn too much to qualify for Medicaid might be worse off now because of rising prices, including more expensive premiums and co-payments.<sup>60</sup> Affordability is still seen as a barrier to access that keeps people from seeking health care when they need it, a reflection of the limited outcomes that resulted from the reform.

### *The next step(s) to achieving universal health insurance*

Interviewees viewed the continuing rise in health care costs as a problem that was not addressed by Chapter 58. However, they did not agree on the main cost drivers or on how the cost challenge might be addressed moving forward. They attributed the rising costs to a variety of sources: the overall complexity of the health care system; consumers wanting to go to expensive hospitals; providers billing by procedure and not taking cost into account when they treat patients; and the cost shift from public to private payers due to low Medicaid reimbursement rates. Others attribute it to the failure to adopt a single-payer health care system, which would reduce administrative costs and provide greater purchasing power due to the larger pool it would create. In this vein, interviewees disagreed on whether the expansion of public health insurance coverage—particularly Medicaid—is a positive outcome. Some viewed it as a failure of the 2006 health reform that now more than one-third of the Massachusetts population has public health insurance in the form of Medicaid or Medicare. Others viewed the expanded Massachusetts Medicaid program—though underfunded—as a great success worth fighting to keep in place.

Among myriad solutions offered as a next step in controlling costs, Amy Lischko, former assistant commissioner of health care finance and policy under Governor Romney, indicated that the focus must be on consumer education to change the perception that the most expensive health facilities offer the best quality.<sup>61</sup> Others proposed that effective solutions might stem from better measures, data, and analysis; reprioritized state revenues; and rate regulation. Some interviewees also acknowl-

edged the need to address the social determinants of health, as this would reduce the need for health care, thus reducing the overall costs of the system.

Jack Evjy, former chair of the Massachusetts Medical Society Taskforce on Universal Access, indicated that controlling health care costs could be done only incrementally:

*[N]o one plans to throw out everything having to do with Obamacare. It's not what's going to happen. On the other hand, folks are not going to put up with the problems that exist today ... But I suspect they'll go to the Senate, and then there'll be this change and then that change ... Compared to where things were ... a decade and a half ago, we've evolved to a much better place. In fact, we're scared to death we're going to lose all the good gains that we have made. That's increasing the anxiety that there is today. So I have great faith that what's going to happen is going to be the next step. And then a couple years from now, there'll be another step. And a few years after that, there'll be another step as we evolve to make things even better than they are today.<sup>62</sup>*

One incremental step, proposed by State Senator Dan Wolf, was to create a public plan for private employers to purchase health insurance for their employees.<sup>63</sup> However, he thought it would take a ballot initiative to get this done.<sup>64</sup>

Some interviewees, however, were skeptical about an incremental approach, noting that rising health care costs cannot effectively be addressed without moving to a single-payer system. For example, Ben Day of Healthcare-NOW! explained that tinkering around the edges simply would not work:

*[I]f you're not willing to do something like a single-payer plan, if you are not willing to ... cut out all these for-profit middlemen, and cut out the complexity of this system that drives up administrative wastes, and if you're not willing to negotiate as sort of a whole society, with drug manufacturers, and medical device manufacturers, if you're not willing to do any of those things, I think your options are really limited ... I think you really only have two options. You have the structural-change option, which changes the total cost structure dramatically, or you have the sort of moving-money-around-onto-different-shoulders approach.<sup>65</sup>*

However, not everyone agreed that a single-payer system would solve cost concerns. And there was a split among interviewees on whether states can move to such a system independently of the federal government.<sup>66</sup> Professor Friedman of the University of Massachusetts Amherst had some specific ideas for moving toward a single-payer system. One was to begin with greater regulation of hospital and provider pricing, thus reducing profits and the incentive to oppose a single-payer system. He also believed that if such a system were to come about through a referendum process, there would be significant challenges in getting an unwilling government to actually implement it. He likened it to the marijuana decriminalization referendums where state and local governments dragged their feet as long as possible after the measures passed. Thus, he thought there were limitations to people-driven referendums, as people still need government to implement them.<sup>67</sup>

### *The value of human rights in the struggle for universal health care*

According to interviewees, health care is or should be a right. They also believe that most Massachusetts residents consider health care to be a right. It was less clear to interviewees, however, how this right could be translated into concrete policy. Ture Turnbull, executive director of MassCare, noted that the concept of health care as a right “connects” with more people than confusing technical terms such as “single-payer.”<sup>68</sup> Ben Day of Healthcare-NOW! explained that rights-based language is “necessary but not sufficient” and therefore made the case for simultaneously addressing financing concerns.<sup>69</sup>

While most interviewees viewed the right to health care as inspirational and therefore useful in organizing grassroots campaigns, they did not see a practical role for human rights in addressing cost control or achieving universal health care. For example, Professor Wendy Parmet of Northeastern University Law School questioned whether human rights speak to specific aspects of health policy:

*“Health care as a human right.” Well, what does that actually mean? . . . What does that mean when we’re paying for insurance? I mean, details matter,*

*and how do we get this done?”<sup>70</sup>*

Despite the role played by the right to health care in building a grassroots movement that created pressure for the passage of Chapter 58, many interviewees did not see any benefit to enshrining the right in the state constitution. They noted that a constitutional right is unnecessary given that health care is already viewed as a right by Massachusetts residents. Former Romney administration official Amy Lischko stated:

*I also think everybody in their heart thinks that people who are sick should have access to care. I think where we maybe have some differences is around behavior and how to motivate good behavior . . . And who should, how much is your responsibility versus others’ responsibility. And as the cost gets more and more, those questions are really hard . . . But I don’t think anybody disagrees with it being kind of a right, and that people should have access to it.<sup>71</sup>*

On the other hand, John Goodson, former co-chair of the Health Care for Massachusetts Campaign, explained that the whole system is precarious because Chapter 58 is a mere law that could be repealed or defunded at any time.<sup>72</sup> For this reason, he argued that a constitutional amendment would be a better approach, as it could not be so easily undone by the legislature. Goodson stated:

*[W]e believe strongly that health care access should be part of the social contract. We concocted a strategy that would ensure a protected commitment for the indefinite future. What we have now in the Commonwealth really depends on the ongoing support of the Commonwealth to universal health care access. But the whole thing could come apart, could be taken apart, could be dismembered, it could be dismantled. So, we believe strongly, I believe strongly . . . that in order to really make this happen, we should go back to the Commonwealth, and we should get this amendment put in the constitution.<sup>73</sup>*

Although most interviewees believed that health care is a human right, Goodson was the only one who recognized a practical value to enshrining the right in the Massachusetts Constitution.



## Discussion

Drawing on our document review and interview data, and applying international human rights norms, we respond to our research questions as follows. First, to what extent do leaders believe that the 2006 health law reform has been successful in achieving universal health care in Massachusetts? Interviewees considered Chapter 58 successful in achieving its goal of lowering uninsured rates; however, the law was not intended to achieve and has not achieved universal health insurance coverage (much less universal health care) in Massachusetts. A little less than 4% of Massachusetts residents, approximately 240,000 people, remain uninsured.<sup>74</sup> In addition, Chapter 58 failed to address—and some interviewees believe exacerbated—the problem of underinsurance. According to a 2017 survey, one-quarter of Massachusetts residents report difficulty accessing needed medical care due to cost.<sup>75</sup> In short, although Chapter 58 reduced the underinsurance rate in Massachusetts, continuing problems of underinsurance and underinsurance demonstrate that the reform has not achieved universal health insurance or universal health care.

Second, what do leaders believe can be done to achieve universal health care in Massachusetts? All interviewees indicated that further reform is needed to address cost control and financial stability. There was no consensus, however, on the main cost drivers, and interviewees offered widely different ideas on how to address cost control, including educating patients and providers to use less expensive health care, reforming the way providers are reimbursed, and changing antitrust laws to address monopolies within the health care system. While all these approaches might control health care costs and thus ameliorate the problem of underinsurance, they would not ensure universal health insurance or universal health care. To achieve universal health care, some interviewees favored the creation of a single-payer health care system. Even among those who favored this approach, however, there was no agreement on whether it is possible, under federal law, to have a single-payer system at the state level.

Third, do leaders believe that human rights can be useful in achieving universal health care in

Massachusetts? Most interviewees viewed health care as a human right and believed that most Massachusetts residents held the same view. However, there seemed to be little understanding of the substance of the right to health care or how to implement it in practice. Interviewees viewed human rights rhetoric as useful for organizing grassroots movements but did not see how the right to health care could inform health care policy. Further, most saw no practical value to a constitutional right to health care. Some interviewees asserted that such a right is unnecessary because Massachusetts residents already view health care as right, and others were concerned that such a right would lead to costly litigation with very little benefit to the system or to residents. Only one interviewee saw practical value in constitutionalizing the right to health care; he maintained that it would make the right more permanent and less vulnerable to the whims of changing governments.

To our original three research questions, we add a fourth question. Do leaders in health law reform in Massachusetts understand the international human right to health and core human rights principles, such as universality, equality/equity, transparency, participation, and accountability? In short, the answer is—with few exceptions—no. There is now, however, a substantial literature on the content of the right to health, as well as methods of implementing the right. Moreover, 178 countries have ratified the International Covenant on Economic, Social and Cultural Rights, which enshrines the right to health, and the majority of countries include the right to health in their constitutions. Nonetheless, leaders in health reform in Massachusetts do not view the right to health as a practical guide to implementing and measuring progress in achieving universal health care. The lack of support for a constitutional right to health care among leaders—as opposed to a constitutional right to education, which is already recognized in Massachusetts—deserves further attention from researchers.

Additionally, while Massachusetts leaders have some understanding of the concepts of universality and equality/equity, many do not seem aware

that participation, transparency, and accountability are also components of the international human right to health. For example, some interviewees expressed the view that it was impossible to create a health care system that was truly universal and were content to achieve a system that covered most, but not all, residents. When asked to define accountability in the health care context, interviewees focused on providers' accountability to patients rather than the government's accountability to abide by and enforce human rights standards and to answer to the people for its decisions and actions. Similarly, when interviewees discussed transparency, they described efforts to make providers and insurers more transparent regarding costs rather than—or in addition to—the government's transparency regarding health policy decision making. Lawmakers' decision to jettison the constitutional amendment and adopt Chapter 58 instead is also an example of a failure to ensure transparency and participation in decision making—and neither the process nor the outcomes are understood as human rights issues.

Even interviewees who believed that human rights rhetoric was useful for movement building were unaware of the robustness of the international right to health or how it could be translated into concrete policy. With few exceptions, interviewees expressed little to no understanding of the importance of entrenching the right to health in law and policy, although this is well understood and accepted in much of the rest of the world. This lack of knowledge about the right to health reflects US attitudes toward economic and social rights more generally—that these are issues that arise in other countries and not in the United States—and suggests the need for education on international human rights norms and on the right to health specifically.

## Conclusion

Although Massachusetts has been a national leader on health insurance coverage, it has not achieved universal health insurance or universal health care. Further, while the consensus is that cost contain-

ment must be the next step, opinions of the experts on how to contain costs diverge widely, making imminent progress at the state level difficult. The situation is not without hope, however. Notably, in September 2017, Senator Bernie Sanders of Vermont and 17 co-sponsors, including Massachusetts Senator Elizabeth Warren, introduced a bill in the US Congress to establish "Medicare for All." Medicare is a public health care program that currently serves US residents who are at least 65 years old. This bill would automatically enroll all children under age 19 in the first year after the act's adoption and would lower the age of eligibility for Medicare (from 65 years) by 10 years each year until everyone had health insurance.<sup>76</sup> Importantly, Senator Sanders introduced a similar bill in 2013, but it had no co-sponsors.<sup>77</sup> Now that "Medicare for All" has 17 co-sponsors in the US Senate, it appears that universal health care may be gaining traction at the national level. In this light, the question arises whether Massachusetts will continue to be a leader among US states in achieving universal health insurance and health care. Adopting a constitutional right to health care is one step Massachusetts could take to ensure that it continues to be a pathbreaker in the field.

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