

~~Uninsured~~ insured

2006 Annual Report

Dear Community Partners:

2006 marked the fifth anniversary of the Blue Cross Blue Shield of Massachusetts Foundation. And what a five years they were! The list of major milestones in this report hardly begins to describe what has been accomplished since 2001 — by the Foundation’s staff and Board, by our supporters and partners in the community, by the organizations and programs we have funded, by the state’s political and community leaders, and by everyone who shares our commitment to expanding access to high-quality, affordable health care.

By creating the Foundation, Blue Cross Blue Shield of Massachusetts wanted to elevate the debate about health care reform and encourage leaders in Massachusetts to focus on the problems of people without health insurance. Through these efforts, the company hoped to help low-income and uninsured individuals and families gain access to health care and improve their health. The Foundation staff and Board members who were there at the outset could hardly have imagined that, within five years, Massachusetts would have in place a sweeping new law designed to dramatically expand health care coverage and access.

This report is largely about that law — Chapter 58 — and the people it affects. We start with an overview of what the Foundation has called the *Roadmap to Coverage*. It’s not a simple picture, and there is much uncharted territory ahead, but the journey is well underway. We then asked a few of the many individuals who have helped shape health care reform to share their perspectives on the Massachusetts experience — how we got here, the lessons learned, and the opportunities and challenges ahead. And we are also delighted to report on some early success stories.

At various stages of the law’s journey from vision to reality, the Foundation played an important, catalytic role, particularly in these areas:

- **Values:** During a time of great stress in our health care system, urging leaders and interest groups to focus on shared values and goals, rather than on what divides them.
- **Advocacy:** Making a significant commitment to funding statewide, health care advocacy organizations.
- **Data, Information and Policy Solutions:** Using research, studies, public forums and programs to promote better understanding of the dimensions and true costs of the problems of the uninsured, examine possible policy solutions, and promote better understanding of Medicaid and other public programs for low-income people.
- **Consensus-building:** Bringing stakeholders from every sector together, keeping expectations high, and helping to find workable approaches to health care reform.

The stakeholders in health care are never shy about making sure their points of view are heard, so we have no doubt that the discussion and debate over the unfinished business of reform will always be vigorous. But we also expect that they will be conducted in an environment that is informed by shared values, mutual respect, a belief in the value of information and data, and an understanding of the importance of community and grassroots organizations. To the extent that the Foundation has been able to contribute to that environment, we have accomplished an important part of our mission. Thank you for your support.

With best wishes,

Philip W. Johnston
Chairman

Nancy Turnbull
President

On the Road to Coverage

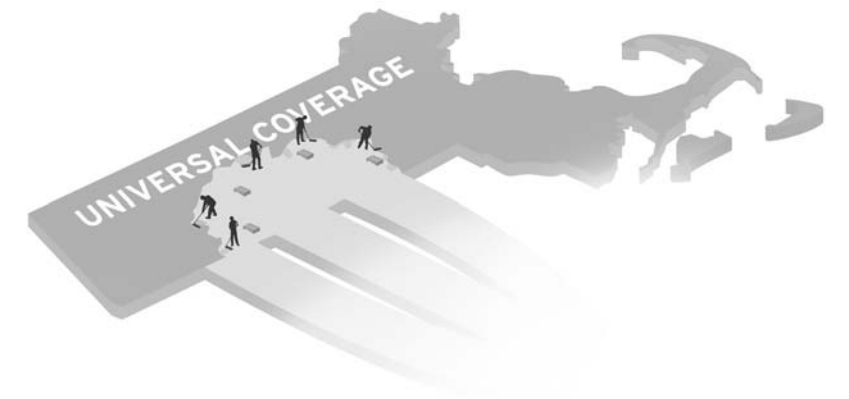
The Massachusetts health care reform law emerged from a landscape that included a high rate of employer coverage (83 percent of the insured), a long tradition of community activism on health care issues, a federal Medicaid waiver that allowed for creativity in the way federal matching funds could be spent, and a series of studies and “summits” sponsored by the BCBSMA Foundation to help chart a Roadmap to Coverage. Uninsured residents could get “safety net” care from the state’s Uncompensated Care Pool, funded with public and private dollars.

In 2006, an estimated six to eight percent of the state’s 6.35 million residents were uninsured.

Expanding access to health care coverage would require new sources of revenue, and many options were debated, such as taxing employers that failed to offer coverage, adding a surcharge to provider payments, taxing alcohol or tobacco products, or using general tax revenues to fund a government-run “single payer” system.

Stakeholders and political leaders converged around a variety of solutions that reflected the interests of their constituencies — expanding taxpayer funded public programs, obligating employers to make a “fair and reasonable” contribution to their employees’ coverage, requiring individuals to be insured, changing the rules of the insurance market, and giving employees the opportunity to pay for health insurance with pre-tax dollars. After months of debate, consensus emerged from the State House, based on the principle of shared responsibility. On April 12, 2006, the governor signed a landmark health care reform law to the cheers of onlookers from across the spectrum of health care interests.

The Connector, an independent public authority governed by a 10-member board, was created to implement the major provisions of the law and to develop policies that will support the three avenues of health reform — the expansion of public programs, new employer obligations, and the nation’s first-ever individual mandate, which requires residents to be insured if coverage that is both adequate and affordable is available to them. The Connector Board forged compromises on many of the contentious issues that could have divided supporters of the law, and one year after its enactment, a framework was in place that could bring health insurance coverage to 99 percent of the Massachusetts population.

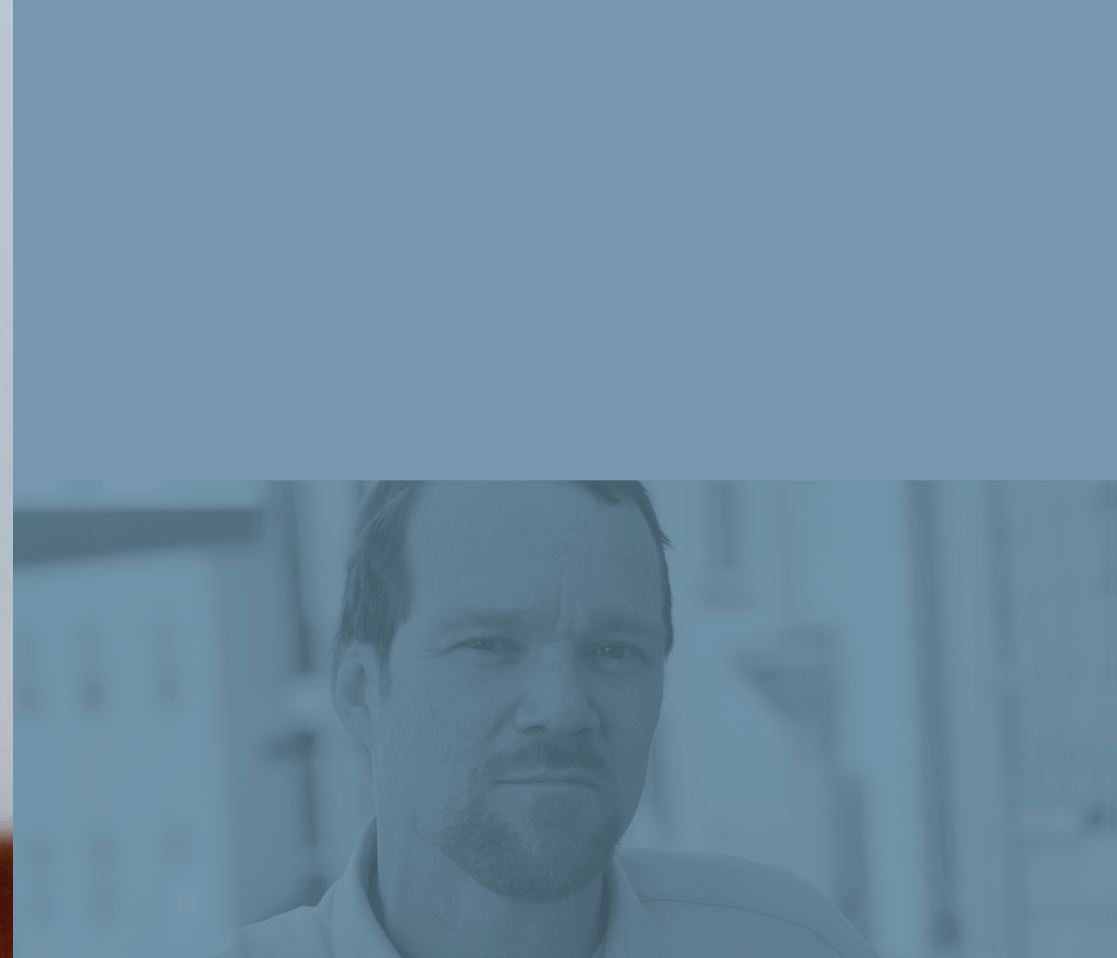


PRE-REFORM LANDSCAPE



TO HEALTH CARE REFORM





Peter Brook

I've been an insulin-dependent diabetic for 32 years, but I work as a handyman and health insurance was out of my reach. I put a lot of things off because I just couldn't afford to see specialists. In December of 2006, I got very sick and a case worker at the hospital came and helped me apply for coverage under the new law. I have to say, I'm pretty amazed at the plan I have. They're very proactive, they help me monitor and manage my diabetes, and they have nurses available 24/7. It's not like something you'd expect for people at the bottom of the totem pole.



Robert J. Blendon, Sc.D.

*Professor of Health Policy and Political Analysis,
Harvard School of Public Health and Kennedy School of Government*

Professor Blendon directs the Harvard Opinion Research Program and the Henry J. Kaiser National Program on the Public, Health, and Social Policy, which focuses on gaining a better understanding of public knowledge, attitudes and beliefs about major domestic public policy issues.

A Research Perspective

Pragmatism in a pro-health care state

When the discussion started in 2004, there was nothing close to consensus on what the right plan was, but Massachusetts is a very pro-health care state; the public likes health care coverage issues. Reform had been debated and tried many times over the years, and not much ever happened. So, everyone knew it was very hard to do.

The state's health care institutions wanted a solution for their own self interest because it meant increased funding, but they also had a longstanding interest in getting full coverage in Massachusetts. The hospital community, in particular, played a very important role.

In the end, all the interest groups were very pragmatic about being willing to consider compromise solutions that cross ideological lines. And with no unified vision of what would be the right thing to do, the legislature and the Governor took the right political course by mixing and matching ideas to find the middle ground. The bill contained policies that Republicans could really like and those that Democrats could embrace.

Challenges of implementation

In the next few years, we really have to worry about ease of implementation for small businesses, which are drivers of economic growth. When we surveyed residents in September 2006, 63 percent felt small employers would be worse off under the new law. They'll have to offer "cafeteria" benefits plans; they may have to collect for health insurance for the first time; and the new, "cost-sharing" products won't look familiar because Massachusetts is very much a first-dollar-coverage state. Their employees may complain that it's too expensive or too hard to do, and say they can't stay in their jobs or stay in the state. The program needs to seem fair and reasonable for workers who aren't covered now, and it needs to reduce the administrative complexity for their employers, as much as possible.

Lessons from the Massachusetts experience

The best advice for other states is to start a process for a federally funded initiative or waiver. In the absence of additional federal money, the number of uninsured people requiring a subsidy to buy insurance will be more than most states can handle. There's no one approach that will work for every state. Massachusetts was comfortable with a major expansion of public programs, but other states may not be. The keys are extraordinarily pragmatic political leadership and a hybrid approach that fits the state's culture.

Today, the states are less politically polarized than Congress, so it's likely the action will be in the states, within a framework of increased federal funding flexibility, at least until six, eight or a dozen states have something in place. Unfortunately, the history of health care reform, at both the state and federal levels, is not good. Failure and abandonment tend to come quickly, so there has to be a lot of attention paid to implementation, with an open process and a lot of patience. And, nothing can happen without strong civic and political leadership.



Reverend Hurmon Hamilton

Pastor, Roxbury Presbyterian Church, Boston

Rabbi Jonah Pesner

Director, Just Congregations, Union for Reform Judaism

Reverend Hamilton and Rabbi Pesner are leaders of the Greater Boston Interfaith Organization, a coalition of 70 congregations, labor unions, and community organizations dedicated to building civic participation, political leadership, and the capacity to act on issues of social justice.

A Grassroots Perspective

A need that crosses natural divisions

Hamilton: One of the most thrilling parts of working on this was seeing the faith community come together across all the natural lines that can separate us. We crossed denominational, class and racial lines and brought together people who are conservative, progressive and liberal in terms of their faith and who are conservative, progressive and liberal in terms of their ideologies, because we were united by common values.

Pesner: The Greater Boston Interfaith Organization was asked to become part of the grassroots effort on health care reform because we represent congregations in communities across the board, from some of the richest in the state to some of the least affluent. When we reached out to our communities, we found stories of suffering in all of them, rich and poor, when it came to health care. We trained people to tell their stories, at the pulpit, in public, to legislators, at the Governor’s town meetings. We made it clear we intended to hold politicians accountable. We called out plans that were clearly inadequate — we called them “Yugo plans” — where you’re covered, but if you ever use it you’ll go into debt. Our members became ground troops to organize and galvanize the citizenry.

Challenges of implementation

Pesner: The big unanswered question is around affordability. We were very torn about the individual mandate, with everyone required to have coverage, but could we live with it? Yes, if the coverage was affordable and if there were quality products. The mandate needs to be seen as an opportunity, not as punishment. We’ve held 70 “affordability workshops” with more than 630 attending, and we found that half can’t afford coverage. These are real people with real budgets, so that’s what we’ll continue to focus on.

Hamilton: If the law is adequately funded, and if we can get the affordability and adequate coverage standards right, and if we can calibrate the waiver from the individual mandate correctly, then, potentially, the savings that we get by capturing those folks between 100 and 500 percent of the federal poverty level, who don’t now have health care coverage and who are typically taken care of in emergency rooms — as we get them into coverage and preventive care, the savings will be there and that should strengthen community health. But it is a delicate balance for everyone concerned.

Lessons from the Massachusetts experience

Hamilton: My feeling is health-care reform ought to be done nationally, but it’s so important that, until it can be done correctly, it seems like it has to be done on a state-by-state basis. For other states, I would say, whatever solution you come up with should mirror, at least structurally, what we devised here, which is to say that there is a three-part responsibility — government, business and individual — and the right balance has to be found. Whatever solution you come up with must take into account, both in the process of shaping the policy and in the content of the policy, the voice and budgets of real people.

Pesner: It’s important to have a mobilized and galvanized citizenry. I hope local leaders elsewhere will understand the importance of grassroots organizing for support and for political cover. The power for real change comes from the bottom up; from people organized around civic institutions. Leaders need to think creatively about engaging the citizenry.



Olga Quinchia

I work in home health care six hours a day and don't get health benefits. I was on COBRA after my last job but I couldn't afford \$400 a month for insurance. I had to use free care for some ongoing problems. When Commonwealth Care started, I applied and my benefits started in March. Now I pay \$108 a month and five dollars for doctor visits and medications. I've had to change some of my doctors, but I have a primary care doctor who speaks Spanish and I've been able to see a cardiologist and get bone density and ultrasound tests. For me, it's working wonderfully.



Salvatore F. DiMasi

Speaker of the House, Massachusetts Legislature

Salvatore F. DiMasi has represented the Third Suffolk District of Boston in the Massachusetts House of Representatives since 1979 and became Speaker of the House in 2004.

A Political Perspective

Moving beyond patchwork reform

The financing of health care is a major issue for Massachusetts. It was a business inhibitor and a drain on our economy, with health care costs going up at double digits for almost 10 years in a row. By the same token, one in every six or seven jobs is related to health care and it's an economic engine for us as well. We have some of the greatest hospitals and the best health care in the country, but that's very expensive care, and we needed to strike a balance with quality and cost, and advance the notion of real reform. I had no preconceptions, no dog in the fight or favorite constituency, and I wanted to make sure it was fixed. My mantra was, "Quality health care that's accessible and affordable to everyone."

The Foundation's Roadmap to Coverage gave me a window into how the health care system worked and where things were interrelated. Sometimes with legislation you're forced to look at things in different boxes; you don't see the whole picture. But if you try to fix one part of health care without knowing how it relates to other aspects of the complicated system we have, you're not going to come up with a universal solution. I could see that there had been a lot of patchwork over the years in the health care system and we needed to pull all that together.

A breakthrough for shared responsibility

One weekend, I was thinking about the different proposals people were supporting, and I came in and said to Chris Hager, my Chief Health Counsel, "You know, some want an individual mandate and some want an employer mandate; one's a conservative idea and one's a liberal idea and different groups are pushing them. Why can't we do both? Why does it have to be one or the other?" And she agreed that it was worth trying.

The concept was shared responsibility; everyone had to sacrifice something in order to get something and if you thought you would get everything you wanted, then you weren't part of the solution, you were part of the problem. I think everyone's goal was really the same — universal coverage — because the benefits would be a healthier workforce and economy, and less anxiety and insecurity about being uninsured. Lo and behold, at the end, everyone felt they had a stake in this bill and supported it.

Challenges of implementation

Usually when we pass laws, 90 percent of the people don't know about it, unless and until it affects them directly. This law will affect everyone directly. The key is educating the public on the new system we've set up through the Connector and how that can be extremely helpful to them. And doing the outreach so that we make sure we help bring everybody into the insurance system in the coverage category where they belong. Individuals and businesses will have to understand what their responsibilities are, what the benefits of coverage will be, and what the penalties will be if they don't fulfill those obligations. We need to get people to think, first of all, "Where do I get my health insurance? Because I need to get it." I think that's the biggest challenge.

Lessons from the Massachusetts experience

A lot of states have unique problems. Massachusetts may be in a different place than most. What I say to them is, re-look at your entire health care system. How do you provide health care, who has access to it, what kind of quality do you have, are providers efficient? Look at how you can use your financial and your medical resources and make it work in a way that can expand coverage to as many people as possible in as efficient a way as possible, without taking away from quality or financially hurting the providers. And if you have to change the way you provide health care for people, go ahead and change it.



Stanley J. Lukowski

Chairman, Board of Trustees, Massachusetts Taxpayers Foundation

Stanley J. Lukowski is the recently retired Chairman and Chief Executive Officer of Eastern Bank. The Massachusetts Taxpayers Foundation is an independent, non-partisan organization that provides research and analysis on the state's spending, tax policies and economy.

A Business Perspective

A balanced approach to a growing problem

There was general agreement that we had to address escalating costs and reduce the number of people who were uninsured and who were using emergency rooms as their primary means of getting care. It's a very expensive and poor way of obtaining health care. That inspired all the factions to work together, and as they did, it came down to finding an appropriate balance between a government-provided approach and a more free enterprise system. People realized that if you went to one extreme or the other, nothing was going to get accomplished.

Challenges of implementation

Tough issues will come out of the implementation process, and we'll have to work our way through uncharted waters. For instance, it is going to be very difficult to develop products for the uninsured that find the right balance between having the coverage features we are used to in Massachusetts and having an affordable price. I suspect it won't be perfect at the outset; we will need to get some experience for a year or so. Another big issue is outreach. The general public is not aware of what the benefits are, what the requirements are, and what they need to do. Everyone needs to have some patience and continue to work together in a spirit of compromise. It's an important accomplishment and we have to make sure it works.

Individuals who own small businesses can't operate on a level where increased costs can just be passed on to the consumer. So any significant increases in their costs and obligations are going to have to be handled with a great deal of sensitivity. On the other hand, in general, businesses pay for the uninsured, either through taxation or through cost shifting to plans they offer their employees, so there is obviously a hidden cost of caring for the uninsured. The state has to work with the business community; they have to be careful about imposing obligations, but I think it's fair for any business with any meaningful number of employees to provide health care coverage.

Paying a premium for quality

In Massachusetts, our cost of living drives up the cost of health care and the cost of health care drives up the cost of living. It's a complex situation and I don't believe finding a way to cover the uninsured is going to have a significant impact on mitigating the total cost of health care in Massachusetts. We have some of the world's best providers and hospitals, we're accustomed to the highest quality and the latest technology and we want to attract the best physicians to practice here, all of which has a lot to do with the cost of care. So we pay a premium and that's not likely to change any time soon.

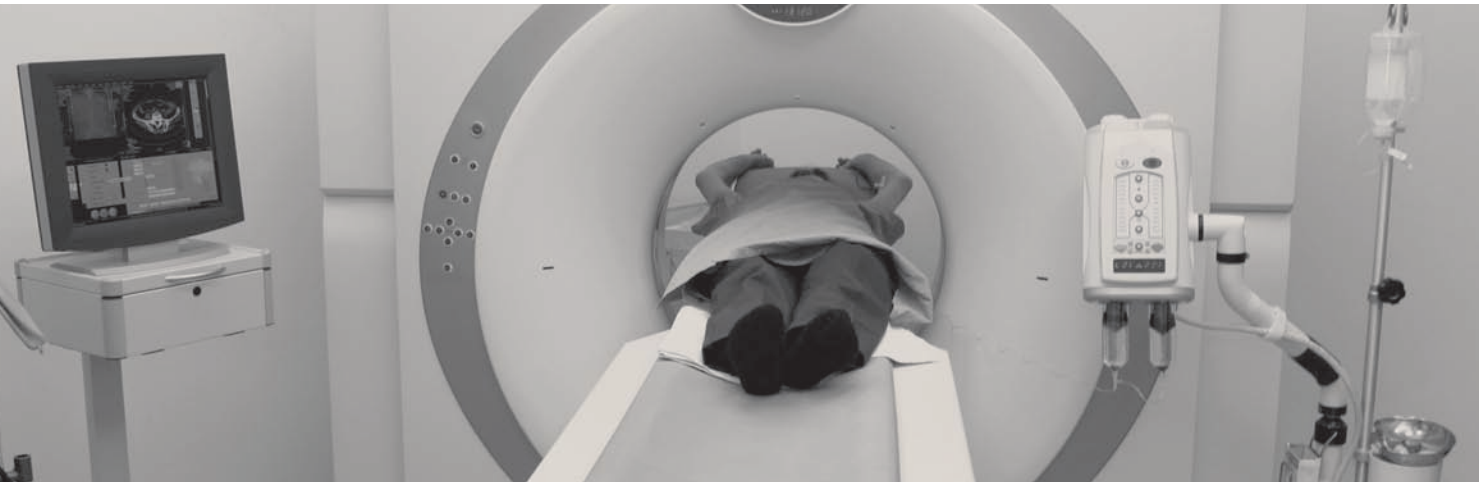
Lessons from the Massachusetts experience

I would say to business leaders in other states, first of all, this is inevitable. We have to find some method to provide health care to people, particularly the employed who aren't eligible for public programs. They need to have basic health care — a requirement of life, really — and we need to do it in a reasonable, efficient way. This has to happen, so find the best possible way, the most effective way for your state. There is no magic answer.



Bill DiCarlo

The worst thing you can do is have no health insurance. I became disabled and couldn't work — I was in bed for almost a year. My wife is a hair stylist with one other person and they don't have benefits, so I was paying \$1000 a month for COBRA, which was impossible. I went for six or eight months without insurance even though I needed major surgery and treatment for my diabetes. When you're really sick and all you can do is worry, it just makes it worse. Now, my wife and I can get coverage that's based on our income. And I have to tell you, my doctors are my friends; they really care about me.



James J. Mongan, M.D.

President and Chief Executive Officer, Partners HealthCare System, Inc.

James J. Mongan, M.D., leads Partners HealthCare System, a non-profit, integrated health care system founded by Brigham and Women's Hospital and Massachusetts General Hospital. The Partners system also includes, community and specialty hospitals, community health centers, a physician network, and home health and long-term care services.

A Provider Perspective

A confluence of interests

Broader coverage is good because it will lead to a more rational health care system with less cost shifting from the uninsured to those with coverage. The pay-for-performance and transparency provisions of the law will drive improvements in quality and efficiency across the board. Most importantly, hundreds of thousands of people without health insurance will finally be covered and have access to primary and preventive care.

There was a unique confluence of groups that came together to pass this bill, and for the first time in 30 years, we were able to break through the political gridlock. The Blue Cross Blue Shield of Massachusetts Foundation played a catalytic role, funding baseline studies by the Urban Institute and organizing summit discussions bringing all the parties together. People said, "We can continue to argue and get nothing done, or we can find a reasonable compromise."

Challenges of implementation

Affordability is key. If the plans are too expensive, the subsidy will have to be too large and the overall cost will be unsustainable. But if the policies are too thin, this approach will lose support. A tipping point may be whether the uninsured who are required to buy unsubsidized health plans will see this as a long-sought opportunity to obtain adequate yet affordable coverage, or as an invasion of their right to choose how to best use their own incomes.

In general, providers are more comfortable talking about quality than cost and efficiency, but that is an abdication of a very important responsibility, and I think efficiency questions inevitably loop around to quality issues. It's past time for provider organizations to step forward and take responsibility for making sure care is rationalized and that waste and over-utilization are reduced. The most important step in improving both quality and efficiency at this stage is the appropriate implementation of electronic medical records and the kinds of decision support that can be built into these records to guide clinicians to the best and most cost-effective care.

Lessons from the Massachusetts experience

You can see the hunger of other states that want to pick up on the Massachusetts experience. My advice — keep the dialogue going. My cautionary note is not to kid themselves into thinking this will be easy. Adequate health care coverage costs more than low-income people can afford, which means subsidies and additional revenue will be required. It always comes down to how you get the revenue, and you need to have an honest conversation about where it's going to come from, or you'll get nowhere.

Because of the real need for subsidies, I remain deeply skeptical regarding the ability of our country to deal with the uninsured in a satisfactory fashion on a state-by-state basis. My hope is that the Massachusetts law will be implemented successfully and that it will be not just a catalyst, but a real stimulus to action in three or four other states, and the first move toward breaking the logjam for what ultimately has to be done nationally.

A Health Plan Perspective

A strong start

As a health plan that includes members with Medicaid coverage, we had an opportunity to be part of the first wave of reform. Through a combination of Medicaid expansion, restoration of benefits, and the first phase of Commonwealth Care for people under 100 percent of the federal poverty level, there are tens of thousands of people who were uninsured six or eight months ago and who now have coverage. So that's real, tangible progress.

Health plans: Calibrating the risk

The health plans are the intermediaries, so the debate over adequate coverage and what is a reasonable price gets amplified when they submit bids; that's where theory meets reality. The challenge for the health plans is to be part of the solution and to be viewed as such. There are always opportunities for organizations to improve efficiencies, health plans included. But when 90 percent of the premium is paying for medical services, solutions and options for affordability must come from a collaborative effort by all the key parties involved including providers, purchasers and policy leaders.

Then there's the need to calibrate the unknown; that element of pure risk. Neighborhood Health Plan is thrilled to be part of the first phase of reform, but we had to make tough business decisions in terms of how much risk we felt we could take. What will it mean in terms of rates and membership; will the uninsured bring pent-up demand; how will it affect existing business? And you have to be pretty nimble. Implementation has moved very quickly and the list of things to do is very long — systems support, product development, marketing, customer service, and so on.

Providers: New patients, new complexity

For the "safety net" providers who take care of low-income, uninsured people now, no one will disagree that getting patients into an organized insurance plan and giving them access to coordinated primary care rather than fragmented emergency care is a good thing, but it's different. So there will be issues of capacity, resources and reimbursement. And there are populations the safety net providers care for now, like undocumented immigrants, that are not really included in health care reform. Providers who haven't participated in the Uncompensated Care Pool will be seeing a new group of patients and one of the biggest challenges will be the timely communication of pertinent information. Many providers have no idea what's coming. A lot of it is complex and becomes even more so when the new deductible products are rolled out under Commonwealth Choice.

Lessons from the Massachusetts experience

It was important to have a real sense of urgency — yes, we wanted to get it done because it was the right thing to do, but a significant factor that kept everyone focused was the prospect of losing nearly \$400 million under the federal waiver. Maybe other states will face a budget crisis or pressure on employer health care costs, but there has to be something pushing people because it's too easy to postpone tackling such a hard problem. I would also say, focus on the cost issue up front. We started with access, which is great, but I think it would have been beneficial if everyone had agreed on a framework for controlling costs at the same time. It's not easy, but we need real, substantive structural changes that will help reduce the trajectory of health care inflation or we risk going right back to where we started.



Deborah Enos

President and Chief Executive Officer, Neighborhood Health Plan

Deborah Enos has been President and Chief Executive Officer of Neighborhood Health Plan since 2005. NHP serves members with MassHealth, Commonwealth Care, employer-sponsored and individual coverage, and works in partnership with community health centers and other primary care and specialty providers across most of Massachusetts.



Faye Reed

I'm wheelchair dependent but I was out there collecting signatures for reform at bus stations. A lot of people are struggling financially or know someone who is, and health care is a big issue for them. I feel like it's one of the basics of social justice, like housing, food and education. I'm physically disabled, but it doesn't mean I'm helpless. My work on health care reform has helped me become self-actualized and the benefits that were restored — dental, eyeglasses, orthotics — have helped me deal with some of my own health problems much better.



Ali Noorani

Executive Director, Massachusetts Immigrant and Refugee Advocacy Coalition

Ali Noorani is Executive Director of the Massachusetts Immigrant and Refugee Advocacy Coalition, which, in partnership with its 100 member organizations, advances the rights and opportunities of immigrants and refugees through education, training, leadership development, organizing, policy analysis and advocacy.

An Advocacy Perspective

Stories of success

The new Massachusetts health reform law provides critical opportunities for the low-income immigrants of the Commonwealth. With the creation of subsidized coverage under Commonwealth Care, working parents such as Rosa, an immigrant from Honduras who was a janitor at the World Trade Center and who is now living in East Boston with her four-year-old son, will have access to regular health insurance.

Elderly immigrants such as Zina and Isaac from Russia, a medical translator and a physicist who came to join their daughter in the U.S., will now have their coverage protected. And disabled immigrants like Regassa, from Kenya, will be able to maintain their access to care.

But as with any new legislation, especially a ground-breaking law such as this, there are both opportunities and challenges that will play out through the implementation. For the constituency we represent, the biggest achievement in the law is the inclusion of legal immigrants in the eligibility rules for Commonwealth Care insurance. This was a clear indication that the legislature and the bill's architects understand the significance of the immigrant workforce in Massachusetts and the importance of keeping the workforce healthy.

Strengthening the safety net for all low-income immigrants

At the same time, there are a variety of challenges facing the immigrant communities affected directly and indirectly by this law. For example, a significant unknown within the law is the fate of the Uncompensated Care Pool, soon to be called the Safety Net Care Pool. This issue is at the crux of many of our concerns about the health care law. As more of the uninsured are able to sign up for coverage through the MassHealth and Commonwealth Care programs, undocumented immigrants who are not included in the law will increasingly become the primary users of uncompensated care. This will help to make the Pool a potential target for elimination, which would harm many of the state's immigrant workers who rely on "safety net" providers for access to care.

Another concern we have is that elderly and disabled immigrants will be unable to access the most appropriate care through the MassHealth Essential program, which was created for a long-term unemployed population and which does not provide benefits many elderly and disabled people need, such as adult day care, home health care and vision care. We do not expect that this challenge will be addressed in the short term, but it is an important opportunity for further improvements in health care delivery to the more than 3000 elderly immigrants in Massachusetts.

The MIRA Coalition is excited to be part of the process of monitoring the implementation of Chapter 58 and helping to improve health care access for our newcomer communities. While the law presents some significant challenges for the immigrant community, it represents a clear vision from the government of the Commonwealth that investing in the health care of all its residents is critical to the state's future.

A Quality Improvement Perspective

Cover the uninsured with quality

You can't have high quality health care if people are uninsured or can't get the care they need, so Massachusetts deserves tremendous credit for designing a plan for nearly-universal coverage. But now the political leaders and advocates of all types need to face the fact that, ultimately, health care for all under the current structure may be financially unsustainable. Increasing revenues — from taxpayers, employers or consumers — isn't going to make it affordable. I don't know how much more we need to properly cover the uninsured, but I firmly believe the largest amount of available money lies in improving quality of care.

For many dimensions of health care quality, when the quality gets better, the cost goes down. It's a bit of a balance; there are some forms of quality that are expensive, but health care has even more opportunities than most other industries to save money by improving quality. That's not widely believed by providers, patients and politicians, but it's true.

Set ambitious quality improvement goals

The initial agenda should include waste reduction. Stop doing things to patients that can't help them — the unnecessary, unwarranted, unscientific procedures, and drugs that drive up costs and often lead to worse outcomes. The leaders of health care in this state — the insurers, the hospitals, the medical society, nurses, advocates and the legislature and the governor — should set out for a three to four year period a list of improvements in care that we're going to measure and achieve for the purpose of making patients better off and making costs fall.

Here's a list of possible goals, for example: reduce hospital-acquired infections by 90 percent; reduce re-admission rates for chronic illnesses by one third; reduce complications of high hazard medications by 90 percent. These should be improvements that every patient in Massachusetts could count on. Experts can figure out how much money we would save and come up with a distribution formula, but I would tie the future of the stakeholders to achieving those gains. For hospitals, who might feel themselves at risk from reduced hospital use, we could say, "your revenues will go down but we will protect your profits. We'll protect your bottom line, but not your top line because the only way to provide coverage is to downsize the high end of the system."

We absolutely need more integration of care. I can't imagine another way to get the waste out if you don't have a responsible entity that's being paid to organize the care of a population. With integration, you can make rational choices and harvest plenty of savings from the system. Again, the biggest potential losers in the short term could be hospitals, because a properly run system should be oriented to making the hospital less and less necessary over time. My test of an integrated system is that hospitals seek to be empty instead of full and that hospitalization is thought of as a defect. That would be a good way to begin structuring affordable care.

Keep stirring the pot

At this point, Massachusetts health care reform is still feeding the beast. In order to get the law passed, you needed a social consensus, so most every interest got protected and no one had to put anything really important on the table. We can't get to what we need that way in my view; we'll have to have more people ante up more of their self interests. In the long run, I'm optimistic. Massachusetts has stirred the pot and unfrozen the system, at least temporarily, and the more dynamic it is, the more mixing up that's going on, the more chances there are for real solutions to precipitate out of it. With enough social will, we can do that.



Donald M. Berwick, M.D.

*President and Chief Executive Officer
Institute for Healthcare Improvement*

Donald M. Berwick, M.D. founded the Institute for Healthcare Improvement in 1991, to be a reliable source of energy, knowledge, and support for a never-ending campaign to improve health care worldwide by cultivating promising concepts for improving patient care and turning those ideas into action.



Joe Rothfarb

When I worked for temp agencies in other states, I'd get emergency policies. Here, I work for a non-profit that doesn't have benefits so I bought a non-group policy. I was so irritated about how much it costs that I took a long drive one day and I saw a billboard on Route 93 for Commonwealth Care. I found out I could get a policy for \$40 a month based on my income. I have chronic health problems and I was surprised that there were no pre-existing condition exclusions like other states. It's really remarkable, and I've been very impressed by the service and what they cover.



Karen Davis

President, The Commonwealth Fund

Karen Davis is a nationally recognized economist, with a distinguished career in public policy and research.

Since January 1995, she has led The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues, giving special attention to those groups with serious and neglected problems.

A National Foundation Perspective

Lessons from the Massachusetts experience

Massachusetts has stimulated a lot of interest in other states and demonstrated that there is a pragmatic way of reaching consensus, building on existing programs and putting together a mixed public-private strategy with shared responsibility for financing coverage. Massachusetts has had a lower rate of uninsured than most states, along with the Uncompensated Care Pool and the federal waiver; other states will have to design plans in different ways and they will need to have the federal government as an active participant in sharing the cost.

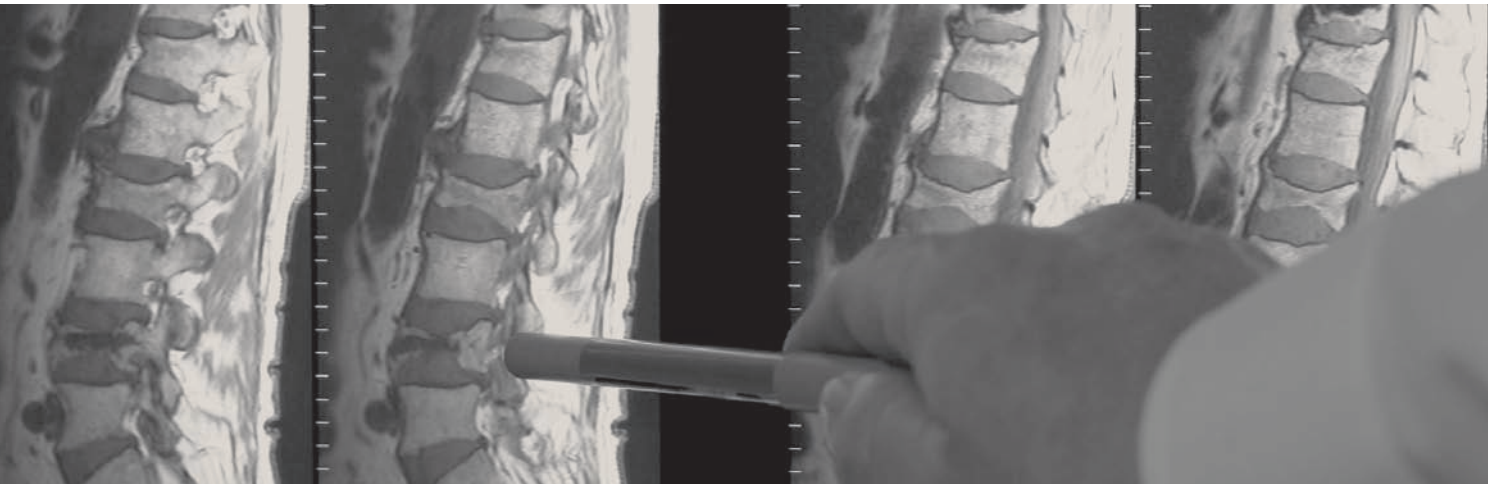
I would hope that health care foundations in other states could emulate the approach taken by the Blue Cross Blue Shield of Massachusetts Foundation and their Roadmap to Coverage. The Foundation's research played a very important role in giving all the stakeholders a shared understanding of the different options so people weren't quibbling over the numbers — what it would cost, who needed to be covered, and who would benefit.

Stimulating a national dialogue

The Commonwealth Fund is encouraging a national dialogue on access, efficiency and quality through our Commission on a High Performance Health System, which is chaired by Dr. Mongan and which includes [Blue Cross Blue Shield of Massachusetts CEO] Cleve Killingsworth. If you look at health care worldwide, other countries put much more emphasis on prevention and primary care, so problems are caught and dealt with much earlier. Patients have a medical home, with a primary care physician or nurse practitioner who takes on the coordination role and where all important medical information about the patient is available in one place.

A blueprint for system change

First and foremost, we have to extend health insurance to all if we are going to have a high performing health care system. With 47 million uninsured, not only does it mean they are not getting the care they need, it undermines the quality of care — people are not getting their diabetes and asthma controlled — and its efficiency — they are getting duplicate tests and fragmented care. Second, there needs to be transparency in reporting on performance, quality and cost. Third, reorganization of the health care delivery system must emphasize patient-centered primary care. And we need to change the payment system, not only redressing the imbalance between primary and specialty care, but moving toward an all-inclusive payment rate for acute and chronic care — paying for care from beginning to end. Studies show that the more doctors there are involved in care, the higher the cost and the lower the quality. Fourth, spread the practices that lead to higher quality and better patient safety. You can find examples all over the U.S. of success in reducing re-hospitalization rates and reducing conditions like hospital acquired pneumonia. Fifth, expand the use of information technology and electronic records and create a health information exchange so there is a repository for this information. Finally, get the public and private sectors to work together. Medicare, Medicaid and the private insurers each has a different set of rules, which means higher administrative costs and a diffusion of effort. Everyone should be working in concert.



Zoila Torres Feldman, R.N., M.S.
President and Chief Executive Officer
Great Brook Valley Health Center, Worcester

Zoila Torres Feldman is a long-time advocate for health care reform and the President and CEO of Great Brook Valley Health Center, a comprehensive, multicultural, community health center with medical, dental, and mental health services, available to families and individuals of all ages.

A Community Health Perspective

A revolutionary opportunity

Massachusetts has again begun a revolution. Courageously, leaders in government, health care, research, business, labor, religion, and advocacy organizations masterfully drafted, edited and compromised on a piece of legislation that will permanently change the way we understand health care access. By creating an insurance tool that can be priced and then fully or partially subsidized, we, in Massachusetts have created the opportunity to discuss, and to choose to agree, or not, on the substance of services that must be offered; the specifics of what deems someone eligible for some or all of those services; the affordability of the options; and finally, the division of responsibility among the individuals who need the services, the individuals and organizations that provide them, and those who fund them.

Measuring our success

The magnitude of this initiative is awesome, but the potential consequences for the health of individuals, the health of the public and the public health are of no less importance. The success of this initiative will be measured not only by the number of individuals that we successfully enroll, but by the number of individuals we find to be “undeserving” of coverage under the law, like undocumented immigrants, and by what we do with that knowledge.

As we care for many who until now had no access or limited access to care, our ability to measure disparities in health outcomes for identified populations will create the moral imperative to act to eliminate those gaps. The task is immense. We have long had the knowledge that these disparities exist. Now, with a thirst for solutions, and increased academic rigor to understand what contributes to the gaps, will we have the courage to act?

In the recent past, the capacity of our health care system to survey and respond to public health threats has been diminished. Our new system of individual health insurance will address issues of access to personal health care, but will not replace the need for attention to those conditions that affect all of the population. Will we reinvest in the brainpower, technology and skills needed at our first-in-the-nation Public Health Department to perform with the level of sophistication that the task requires?

New technology and electronic health records will enable us to identify not only what care we have delivered, but what have been the consequences of that delivery: Was the outcome expected and a result of the intervention? Was the care delivered responsibly and was it delivered at the right time and at the right place? Was it high quality? Was it cost effective? Success will be defined by what we then do with that knowledge.

A financial and moral imperative

While the successful implementation of the new legislation will require the cooperation of entities both within and outside government, it will require that the government remain fully engaged in restructuring and reinvesting in the current health care delivery system. The intertwined goals of reducing the cost of health care, increasing its availability, and striving for excellence in quality can only be achieved if we ensure that individual providers, community health centers and hospitals can recruit and retain academically, culturally, and linguistically competent staff, have adequate space for patient care, and can afford the technological infrastructure to measure and be accountable for the care delivered. Success will be measured by fiscal sustainability that will enable us to continue to care for all those who have been deemed deserving of coverage under the law, and also for those who were not. In the end, caring for all is the morally responsible thing to do.

Milestones:

2001

- Blue Cross Blue Shield of Massachusetts creates the Foundation with a four-year, \$55 million funding commitment.
- Andrew Dreyfus becomes the Foundation's first president.
- The Foundation's first Board of Directors is appointed, chaired by Philip W. Johnston.
- The Foundation issues its first report on the uninsured in Massachusetts, entitled *Life on the Edge of the Health Care System*.
- The Foundation's first "Access Grants" are awarded through the **Innovation Fund for the Uninsured**, **Connecting Consumers with Care**, and **Strengthening the Voice for Access** grant programs. Forty-seven organizations receive a total of \$1.6 million in support of three goals: coordinating care for the uninsured, increasing citizen participation in policy development and advocacy, and helping low-income consumers connect with health care services.

2002

- Ten medical journalists are chosen to participate in the Foundation's first Health Coverage Fellowship program, which provides reporters with an intensive immersion in medical and health care issues affecting low-income and uninsured people.
- The **Pathways to Culturally Competent Health Care** grant program is created to support planning and programs for health care delivery organizations.
- The **Building Bridges in Children's Mental Health** grant program is created to help fund community-based collaborations that reduce the fragmentation of services for children and their families.
- The **Catalyst Fund** grants program is created to help organizations that serve low-income and uninsured residents build capacity, with mini-grants funded exclusively by the associates of Blue Cross Blue Shield of Massachusetts, Inc.
- The 1st Summit on Access is held and a Foundation report entitled *Health Coverage in Massachusetts: Far to Go, Farther to Fall* is released.

2003

- The Massachusetts Medicaid Policy Institute is created to be a source for independent, non-partisan information and analysis of the state's Medicaid program.
- The 2nd Summit on Access is held and a Foundation report entitled *The Uninsured in Massachusetts: An Opportunity for Leadership* is released.

2004

- Policy Research and Analysis grants are awarded to two organizations for research on the success of a health plan for uninsured and low-income fishermen, and to develop policy recommendations that will address the causes of oral health disparities among communities.
- The 3rd Summit on Access is held and the Foundation's first *Roadmap to Coverage* report is released, in which the Urban Institute analyzes, for the first time, what is spent on medical care for uninsured patients in Massachusetts, who pays for it, and what full coverage would add to medical spending.
- The Boston Red Sox win the World Series!

2005

- Andrew Dreyfus leaves the Foundation to become Executive Vice President, Health Care Services at Blue Cross Blue Shield of Massachusetts.
- Nancy C. Turnbull is appointed President of the Foundation.
- The **Within Reach** grant program is created as part of a public-private partnership to help community-based programs and community health centers to reach and enroll low-income consumers eligible for MassHealth and other public coverage programs.
- The Massachusetts Institute for Community Health Leadership is created to train and develop emerging leaders who have demonstrated an unwavering commitment to health care for low-income people.
- The Foundation's largest grant making program to date, **Closing the Gap on Racial and Ethnic Health Care Disparities**, is created to support innovative and comprehensive approaches to reducing barriers and improving access for racial and ethnic minorities.
- An Urban Institute report entitled *Building the Roadmap to Coverage*, concludes that Massachusetts could achieve universal coverage with a relatively modest investment of new public funds.
- The 4th Summit on Access is held and a *Roadmap* report and "implementation papers" are issued, examining the elements of a phased-in approach for extending coverage to everyone in Massachusetts.
- Blue Cross Blue Shield of Massachusetts renews its ongoing funding commitment to the Foundation after donating more than \$60 million to the Foundation's endowment, the *Roadmap to Coverage* initiative and the Massachusetts Medicaid Policy Institute.

Milestones:

2006

- The landmark Massachusetts health care reform law, Chapter 58, is passed by the legislature and signed by the Governor, implementation begins, and tens of thousands of low-income, uninsured residents start receiving coverage through MassHealth and Commonwealth Care.
- The Foundation issues a report prepared by Dr. Robert J. Blendon and colleagues at the Harvard School of Public Health, in which they measure and analyze public support for the new law and perceptions of its impact, fairness and affordability, prior to implementation.
- Deval Patrick is elected the first African American Governor of Massachusetts, and pledges to support the implementation of Chapter 58.
- In the five years since its inception, the Foundation has committed grants totaling \$21.5 million to 199 organizations, and developed numerous policy initiatives to expand access to health care for the uninsured and low-income individuals and families in Massachusetts.

March 2007 — The Council on Foundations bestowed its most prestigious award for public policy, the Paul Ylvisaker Award for Public Policy Engagement, on the Foundation for its *Roadmap to Coverage* initiative.

“This award recognizes not only the importance of the Foundation’s efforts to support a dialogue on health reform, but is also a reflection of what the entire Massachusetts health care community has achieved through passage of the Commonwealth’s landmark health reform law,” said Philip W. Johnston, Chairman, BCBSMA Foundation.

Milestones:

BCBSMA Foundation Board and Staff



Chair
Philip W. Johnston
President
Philip W. Johnston Associates



Vice Chair
Robert Meenan, M.D., MPH, MBA
Dean, Boston University School
of Public Health



Jarrett Barrios
Senator
Commonwealth of Massachusetts



Helen Caulton-Harris
Chief of Springfield Dept. of
Health & Human Services



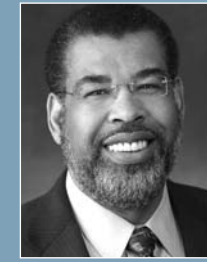
Matt Fishman
Vice President, Community Benefits,
Partners HealthCare System, Inc.



Milton Glass
Chairman Emeritus
Blue Cross Blue Shield
of Massachusetts



James W. Hunt, Jr.
President & CEO
Massachusetts League of
Community Health Centers



Cleve Killingsworth,
President & CEO,
Blue Cross Blue Shield
of Massachusetts



Howard Koh, M.D.
Associate Dean for Public
Health Practice
Harvard School of Public Health



Niek Littlefield
Partner
Foley Hoag LLP



Richard C. Lord
President & CEO
Associated Industries of
Massachusetts



John G. O'Brien
President & CEO
UMass Memorial Health Care



Rob Restuccia
Executive Director
Community Catalyst



William C. Van Faasen,
Chairman, Blue Cross Blue Shield
of Massachusetts



Regina Villa
President
Regina Villa Associates



BCBSMA Foundation staff (l. to r.): Kate Nordahl,
Nancy Nemicola, Tracy Aurigemma, Michael McCormack,
Phillip Gonzalez, Robert Seifert (MMPI), Elizabeth Cruz
(seated), Angela McCoy, Celeste Lee, Nancy Turnbull



Randy Wertheimer, M.D.,
Chief of Family Medicine,
Cambridge Health Alliance



Charlotte S. Yeh, M.D.
Regional Administrator
Centers for Medicare &
Medicaid Services, Region I

The Blue Cross Blue Shield of Massachusetts Foundation is pleased to support these organizations that are dedicated to finding innovative ways to expand access to health care for low-income, uninsured and vulnerable residents of Massachusetts. We are honored that from 2001 through 2006, these organizations have been building on the promise of our Foundation. As recipients of grants in the categories of **Innovation Fund for the Uninsured**, **Connecting Consumers with Care**, **Strengthening the Voice for Access**, **Pathways to Culturally Competent Care**, **Building Bridges in Children’s Mental Health**, **Closing the Gap on Racial and Ethnic Health Care Disparities**, **Within Reach** and **Catalyst Fund**, we applaud their commitment and creativity.

| | | |
|---|---|--|
| Abby Kelley Foster Charter Public School | Caring Health Center | Framingham Community Health Center |
| Abilities Unlimited of Western New England | Caritas Carney Hospital | Franciscan Hospital for Children |
| Access Project | Caritas Good Samaritan Medical Center | Franklin Community Action Corporation |
| Addiction Referral Center | Caritas Holy Family Hospital and Medical Center | Geiger Gibson Community Health Center |
| African Community Health Initiatives | Carson Center for Human Services | Georgetown University |
| AIDS Support Group of Cape Cod | Center for Community Health Education Research & Service | Gloucester High School/School-Based Health Center |
| Alliance for Inclusion and Prevention | Center for Health and Development | Granada House |
| Alliance for Multicultural Integration | Central MA Adolescent Substance Abuse Coalition | Great Brook Valley Health Center |
| Alliance to Defend Health Care | Child Care Resource Center | Greater Boston Guild for the Blind |
| Allies in Recovery | Children’s Friend and Family Services | Greater Boston Interfaith Organization |
| Baystate Medical Center | Children’s Healthcare and Nutritional Goals through Education | Greater Lawrence Community Action Council |
| Berkshire Medical Center | Codman Square Health Center | Greater Lawrence Family Health Center |
| Beth Israel Deaconess Medical Center | Community Action Committee of Cape Cod & Islands | Greater New Bedford Community Health Center |
| Boston Area Rape Crisis Center | Community Catalyst | Guidance Center |
| Boston Coalition for Adult Immunization | Community Health Center of Franklin County | Hallmark Health |
| Boston Health Care for the Homeless Program | Community Health Connections | Hampshire Community Action Commission |
| Boston Institute for Arts Therapy | Community Health Programs | Hampshire HealthConnect |
| Boston Institute for Psychotherapy | Community Healthlink | Harvard Medical School |
| Boston Medical Center | Community Partners | Harvard Street Neighborhood Health Center |
| Boston Public Health Commission | Community Research Initiative | Health & Education Services |
| Boston University Goldman School of Dental Medicine | Concilio Hispano | Health Access Collaborative of Southeast Massachusetts |
| Boston Urban Asthma Coalition | Cooley Dickinson Hospital | Health Care For All |
| Brandeis University | Crispus Attucks Children’s Center | Health Law Advocates |
| Bridge Over Troubled Waters | Diabetes Association | Health Quarters |
| Brigham & Women’s Hospital | Dimock Community Health Center | HealthCare Dimensions Hospice |
| Brighton-Allston Mental Health Association | Disability Policy Consortium | HealthFirst Family Care Center |
| Brightwood Health Center | Dorchester House Multi-Service Center | Healthy Malden |
| Brockton Hospital | DotWell | Helping Our Women |
| Brockton Neighborhood Health Center | Duffy Health Center | Heywood Hospital |
| Brookline Community Mental Health Center | East Boston Neighborhood Health Center | Hilltown Community Health Centers |
| Cambodian Mutual Assistance of Greater Lowell | Ecu-Health Care | Holyoke Health Center |
| Cambridge Health Alliance | Edinburg Center | Holyoke Medical Center |
| Cancer Connection | Family Health Center of Worcester | Home for Little Wanderers |
| Cape Cod Free Clinic and Community Health Center | Family Van | |
| | Fenway Community Health | |

Home Health VNA
Hospice of the North Shore
Island Health
Jeanne Jugan Residence/Little Sisters of the Poor
Jewish Family & Children’s Service
Jewish Memorial Hospital and Rehabilitation Center
John Snow Research and Training Institute
Joint Committee for Children’s Health Care in Everett
Jordan Hospital
Joseph M. Smith Community Health Center
Justice Resource Institute
Kit Clark Senior Services
Latham Centers
Latin American Health Institute
Lawrence General Hospital
Lowell Community Health Center
Lowell General Hospital
Lower/Outer Cape Community Coalition
Lynn Community Health Center
Lynn Health Task Force
Lynn Public Schools
Manet Community Health Center
Marlborough Hospital
Martha Eliot Health Center
Mary Immaculate Health/Care Services
Massachusetts Alliance of Portuguese Speakers
Massachusetts Alliance on Teen Pregnancy
Massachusetts Association of Community Health Workers
Massachusetts Coalition of School-Based Health Centers
Massachusetts Department of Mental Health
Massachusetts Health Care Education Fund
Massachusetts Health Policy Forum
Massachusetts Hospital Association
Massachusetts Housing and Shelter Alliance
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Law Reform Institute

Massachusetts League of Community Health Centers
Massachusetts Senior Action Council
Massachusetts Society for the Prevention of Cruelty to Children
Mattapan Community Health Center
McLean Hospital
Mercy Hospital
MetroWest Latin American Center
MGH Chelsea Health Care Center
MGH Revere Health Center
Mid-Upper Cape Community Health Center
Millbury Free Health Program
Morton Hospital and Medical Center
Mount Auburn Hospital
Multi-Service Center
National Alliance for the Mentally Ill of Massachusetts
Neighbor to Neighbor Massachusetts Education Fund
Neponset Health Center
New England Alliance for Children’s Health
New England Hemophilia Association
New England Rural Health RoundTable
North Quabbin Community Coalition
North Shore Community Health
North Shore Medical Center
Nueva Esperanza
Open Door Free Medical Program
Outer Cape Health Services
Paraprofessional Healthcare Institute
Parent/Professional Advocacy League
Parents Helping Parents
Partners for a Healthier Community
Partners in Health
Pathways to Wellness
People Acting in Community Endeavors
Planned Parenthood League of Massachusetts
Pregnant & Parenting Teen Program
Prevent Blindness Massachusetts
Public Policy Institute
Quincy Medical Center
Rape Crisis Services of Greater Lowell
RESPOND
Saint Anne’s Hospital

Saints Memorial Medical Center
Samaritans of Boston
Sisters of Providence Health System
South Cove Community Health Center
South End Community Health Center
South Middlesex Legal Services
South Middlesex Opportunity Council
South Shore Mental Health
Span
Springfield Partners for Community Action
Springfield Vietnamese American Civic Association
St. Francis House
Stanley Street Treatment & Resource
Stavros Center for Independent Living
Steppingstone
Talking Information Center
Tapestry Health
The Outreach Van Project
Tufts-New England Medical Center
UMass Memorial Children’s Medical Center
UMass Memorial Health Care
Union Hospital
United Way of Massachusetts Bay
Upham’s Corner Health Center
Urban Medical Group
Vietnamese-American Civic Association
Visiting Nurse Association & Hospice of Western New England
VNA Care Network
VNA of Cape Cod
VNA of Greater Lowell
VNA of Middlesex-East
Voice and Future Fund
Volunteers in Medicine Berkshires
Wayside Youth & Family Support Network
Whitman-Hanson Regional School District
Whittier Street Health Center
Windsor Street Dental Clinic
Women of Means
Women’s Educational and Industrial Union
Worcester Communities of Care
Youth Opportunities Upheld
YWCA of Central Massachusetts
YWCA of Lowell

Financials

From the Finance and Audit Committee

The Blue Cross Blue Shield of Massachusetts Foundation, Inc. For Expanding Healthcare Access (the Foundation) distributed grants totaling \$5.0 million in 2006. These grants were made possible by contributions from Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., including a \$13.2 million cash contribution to the Foundation's endowment and in-kind contributions totaling \$0.8 million. The Company's in-kind contributions represent a significant amount of the Foundation's operating costs, including investment expenses, facility costs and other operating expenses.

In addition, reflecting its continuing support of the Foundation, the Company has committed to a contribution of \$11.0 million in 2007 based on the Company's 2006 year-end results.

The year ended December 31, 2006, was a rewarding one for the Foundation which reached \$100 million in net assets. The Foundation investment portfolio experienced a \$10.1 million appreciation from investment income and gains from the unrealized/realized change in investments. For the one year ended December 31, 2006 the portfolio generated a total return of 13.1%. During the year, the Foundation invested approximately 60% in equities, 30% in fixed income and cash equivalents and 10% in alternative investments. We continue to believe that a well-diversified portfolio is appropriate for the Foundation's investments.

Our thanks to the hardworking members of the Finance and Audit Committee, Blue Cross Blue Shield of Massachusetts and its finance staff, and our investment consultants, New England Pension Consultants.

Submitted by,

Milton Glass
Chair
Finance and Audit Committee

Finance and Audit Committee: Milton Glass, Rick Lord, James Hunt

Report of Independent Auditors

The Board of Directors
Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

We have audited the accompanying combined statements of financial position of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access (the Foundation) as of December 31, 2006 and 2005, and the related statements of activities and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Foundation's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Foundation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access at December 31, 2006 and 2005, and its activities and changes in its net assets, and its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States.



Boston, Massachusetts
March 20, 2007

Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

Combined Statements of Financial Position

(Dollars in thousands)

| | December 31 | |
|---|------------------|-----------------|
| | 2006 | 2005 |
| Assets | | |
| Cash, cash equivalents and investments | \$92,350 | \$76,588 |
| Pledges and interest receivable | 70 | 195 |
| Due from Blue Cross and Blue Shield of Massachusetts, Inc. | 11,014 | 13,243 |
| Total assets | <u>\$103,434</u> | <u>\$90,026</u> |
| Liabilities and net assets | | |
| Grants and accounts payable | \$2,040 | \$2,203 |
| Due to Blue Cross and Blue Shield of Massachusetts, Inc. | 705 | 670 |
| Total liabilities | <u>2,745</u> | <u>2,873</u> |
| Net assets | | |
| Unrestricted | 100,556 | 87,003 |
| Temporarily restricted | 133 | 150 |
| Total net assets | <u>100,689</u> | <u>87,153</u> |
| Total liabilities and net assets | <u>\$103,434</u> | <u>\$90,026</u> |

See accompanying notes.

Combined Statements of Activities and Changes in Net Assets

(Dollars in thousands)

| | Years Ended December 31 | |
|--|-------------------------|-----------------|
| | 2006 | 2005 |
| Revenues and other support: | | |
| Contributions | \$11,396 | \$13,995 |
| Contributions in-kind | 777 | 917 |
| Investment income | 3,358 | 2,749 |
| Net unrealized and realized gains on investments | 6,779 | 775 |
| Total revenues and other support | <u>22,310</u> | <u>18,436</u> |
| Expenses: | | |
| Grants | 5,002 | 4,090 |
| External professional services | 1,768 | 1,621 |
| Salaries and benefits | 1,136 | 813 |
| Conferences, conventions, and meetings | 192 | 98 |
| Occupancy and equipment maintenance | 119 | 16 |
| Printing, stationery, and supplies | 46 | 200 |
| Postage and telephone | 17 | 22 |
| Other expenses | 494 | 8 |
| Total expenses | <u>8,774</u> | <u>6,868</u> |
| Excess of revenues and other support over expenses and change in net assets | 13,536 | 11,568 |
| Net assets at the beginning of year | <u>87,153</u> | <u>75,585</u> |
| Net assets at the end of year | <u>\$100,689</u> | <u>\$87,153</u> |

See accompanying notes.

Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

Combined Statements of Cash Flows

(Dollars in thousands)

| | December 31 | |
|--|-----------------|-----------------|
| | 2006 | 2005 |
| Operating activity | | |
| Excess of revenues and other support over expenses and change in net assets | \$ 13,536 | \$ 11,568 |
| Changes in net assets and liabilities: | | |
| Pledges and interest receivable | 125 | (195) |
| Due from Blue Cross and Blue Shield of Massachusetts, Inc. | 2,229 | (1,360) |
| Due to Blue Cross and Blue Shield of Massachusetts, Inc. | 35 | 379 |
| Grants and accounts payable | (163) | 2,203 |
| Net unrealized and realized gains on investments | (6,779) | (775) |
| Net cash provided by operating activities | <u>8,983</u> | <u>11,820</u> |
| Investing activities | | |
| Proceeds from sales and maturities of long-term investment securities | 7,823 | 2,325 |
| Purchases of long-term investment securities | (15,992) | (17,371) |
| Net cash used in investing activities | <u>(8,169)</u> | <u>(15,046)</u> |
| Net change in cash and cash equivalents | 814 | (3,226) |
| Cash and cash equivalents at the beginning of year | <u>2,934</u> | <u>6,160</u> |
| Cash and cash equivalents at the end of year | <u>\$ 3,748</u> | <u>\$ 2,934</u> |

See accompanying notes.

Notes to Combined Financial Statements

December 31, 2006

(Dollars in thousands)

1. Organization

The accompanying combined financial statements of Blue Cross Blue Shield of Massachusetts Foundation, Inc. for Expanding Healthcare Access (BCBSF) and Massachusetts Medicaid Policy Institute, Inc. (MMPI) present the combined financial position and results of activities and changes in net assets and cash flows of BCBSF and MMPI (collectively referred to as the Foundation).

BCBSF was incorporated in March 1992, and is a not-for-profit, charitable organization. BCBSF's mission is to provide and support education and research, foster health care innovation and reform, and develop, promote, and support programs to improve the quality of health care access.

Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA) is the sole member of BCBSF. Several members of BCBSMA are board members of BCBSF. BCBSF will achieve its goals through support for a combination of grants, social research, demonstration projects, and advocacy, rather than financing the direct purchase of coverage.

In July 2003, BCBSF formed MMPI to provide and support education and research, to promote programs to improve the quality of health care access and delivery, and to foster health care innovation reform and development including, but not limited to, research and distribution of information seeking to enhance the development of effective Medicaid policy approaches and solutions. BCBSF is the sole corporate member of MMPI, and as such, has a variety of powers, including appointment and approval of board members.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying combined financial statements, which are presented on the accrual basis of accounting, have been prepared consistent with the American Institute of Certified Public Accountants' Audit and Accounting Guide, Not-for-Profit Organizations, dated May, 2003 (Audit Guide). In accordance with the provisions of the Audit Guide, net assets and revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed stipulations, and are available for operations.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosures of contingent assets and liabilities, at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Investments

The Foundation considers all highly liquid debt instruments purchased with a maturity date of three months or less to be cash equivalents. Other invested assets are investments in partnerships, joint ventures, limited liability company interests and other equity investments. They are recorded using the equity method of accounting and are recorded on the statements of financial position within cash, cash equivalents and investments. Unrealized investment gains and losses are recognized in the statements of activities and changes in net assets.

2. Summary of Significant Accounting Policies (continued)

The amortized cost, gross unrealized gains (losses), and estimated fair value of cash and investments as of December 31, 2006 and 2005 are as follows:

| | December 31, 2006 | | | Fair Value |
|--|-------------------|------------------------|----------------|-----------------|
| | Amortized Cost | Gross Unrealized Gains | Losses | |
| Cash and cash equivalents | \$ 3,748 | \$ – | \$ – | \$ 3,748 |
| Other invested assets | 51,621 | 10,884 | (82) | 62,423 |
| Common stocks | 25,903 | 603 | (327) | 26,179 |
| Total cash, cash equivalents and investments | <u>\$81,272</u> | <u>\$11,487</u> | <u>\$(409)</u> | <u>\$92,350</u> |

| | December 31, 2005 | | | Fair Value |
|--|-------------------|------------------------|----------------|-----------------|
| | Amortized Cost | Gross Unrealized Gains | Losses | |
| Cash and cash equivalents | \$ 2,934 | \$ – | \$ – | \$ 2,934 |
| Other invested assets | 39,584 | 5,097 | (85) | 44,596 |
| Common stocks | 27,622 | 2,033 | (597) | 29,058 |
| Total cash, cash equivalents and investments | <u>\$70,140</u> | <u>\$7,130</u> | <u>\$(682)</u> | <u>\$76,588</u> |

Gross realized gains and losses included in net investment income for 2006 and 2005 are as follows:

| | 2006 | 2005 |
|-------------------------------|----------------|-------------|
| Gross gains | \$2,228 | \$75 |
| Gross losses | (79) | – |
| Net realized investment gains | <u>\$2,149</u> | <u>\$75</u> |

Income Taxes

BCBSF and MMPI are not-for-profit organizations established under Internal Revenue Code Section 501(c)(3) and are exempt on related income from both federal and state income taxes.

Contributions In-Kind

The Foundation recognizes contribution revenue and related expenses for certain services received at the fair value of those services.

Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

2. Summary of Significant Accounting Policies (continued)

Contributions

A contribution in the form of an unconditional promise to give is recognized as revenue by the Foundation in the period in which the promise is received. Contributions are comprised of cash received from various sources, including BCBSMA, individuals, businesses, and civic and service organizations. The Foundation reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of activities and changes in net assets as net assets released from restrictions.

The grants payable amount represents approved community grants which were awaiting final grant agreements from recipients.

3. Related-Party Transactions

BCBSMA provided BCBSF funding of \$11,787 and \$14,409, comprised of contributions in-cash and contributions in-kind, in 2006 and 2005, respectively. BCBSMA contributions in-kind represent a significant amount of the Foundation's operating costs, including salaries and benefits, facility costs, and other operating expenses. Salaries and benefits are related to financial support services provided by BCBSMA employees. Total operating costs charged by BCBSMA to the Foundation were \$2,322 and \$1,651 for the years ended December 31, 2006 and 2005, respectively. For the years ended December 31, 2006 and 2005, BCBSMA provided the Foundation with in-kind contributions of \$777 and \$917, respectively.

In May 2006, BCBSF donated \$150 in cash to MMPI.

At December 31, 2006 and 2005, the Foundation had receivables from BCBSMA of \$11,014 and \$13,243 respectively. At December 31, 2006 and 2005, the Foundation had amounts due to BCBSMA of \$705 and \$670, respectively.

4. Functional Expenses

Expenses were incurred for the following in the years ended December 31:

| | 2006 | 2005 |
|----------------------------|---------|---------|
| Program services | \$7,990 | \$5,947 |
| General and administrative | 784 | 921 |
| | \$8,774 | \$6,868 |

Report of Independent Auditors on Other Financial Information

The Board of Directors
Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

Our audit was conducted for the purpose of forming an opinion on the combined financial statements taken as a whole. The combining details appearing in conjunction with the combined financial statements are presented for purposes of additional analysis and are not a required part of the combined financial statements. Such information has been subjected to the auditing procedures applied in our audit of the financial statements and, in our opinion, is fairly stated in all material respects in relation to the combined financial statements taken as a whole.

Ernst + Young LLP

Boston, Massachusetts
March 20, 2007

Blue Cross Blue Shield of Massachusetts Foundation, Inc.
for Expanding Healthcare Access

Combining Statements of Financial Position

(Dollars in thousands)

| | December 31, 2006 | | |
|--|-------------------|--------------|------------------|
| | BCBSF | MMPI | Total |
| Assets | | | |
| Cash, cash equivalents and investments | \$ 91,757 | \$593 | \$ 92,350 |
| Pledges and interest receivable | 68 | 2 | 70 |
| Due from Blue Cross Blue Shield of Massachusetts, Inc. | 11,014 | – | 11,014 |
| Total assets | <u>\$102,839</u> | <u>\$595</u> | <u>\$103,434</u> |
| Liabilities and net assets | | | |
| Grants and accounts payable | \$ 2,040 | \$ – | \$ 2,040 |
| Due to Blue Cross Blue Shield of Massachusetts, Inc. | 624 | 81 | 705 |
| Total liabilities | <u>2,664</u> | <u>81</u> | <u>2,745</u> |
| Net assets | | | |
| Unrestricted | 100,042 | 514 | 100,556 |
| Temporarily restricted | 133 | – | 133 |
| Total net assets | <u>100,175</u> | <u>514</u> | <u>100,689</u> |
| Total liabilities and net assets | <u>\$102,839</u> | <u>\$595</u> | <u>\$103,434</u> |

Combining Statements of Activities and Changes in Net Assets

For the Period Ended December 31, 2006

(Dollars in thousands)

| | BCBSF | MMPI | Eliminations | Total |
|---|------------------|--------------|--------------|------------------|
| Revenues and other support | | | | |
| Contributions | \$ 11,321 | \$225 | \$(150) | \$ 11,396 |
| Contributions in-kind | 777 | – | – | 777 |
| Investment income | 3,352 | 6 | – | 3,358 |
| Net realized and unrealized gains on investments | 6,779 | – | – | 6,779 |
| Total revenues and other support | <u>22,229</u> | <u>231</u> | <u>(150)</u> | <u>22,310</u> |
| Expenses | | | | |
| Grants | 5,152 | – | (150) | 5,002 |
| External professional services | 1,679 | 89 | – | 1,768 |
| Salaries and benefits | 1,057 | 79 | – | 1,136 |
| Conferences, conventions, and meetings | 184 | 8 | – | 192 |
| Occupancy and equipment maintenance | 119 | – | – | 119 |
| Printing, stationary, and supplies | 41 | 5 | – | 46 |
| Postage and telephone | 16 | 1 | – | 17 |
| Other expenses | 493 | 1 | – | 494 |
| Total expenses | <u>8,741</u> | <u>183</u> | <u>(150)</u> | <u>8,774</u> |
| Excess of revenues and other support over expenses and change in net assets | 13,488 | 48 | – | 13,536 |
| Net assets at the beginning of year | <u>86,687</u> | <u>466</u> | <u>–</u> | <u>87,153</u> |
| Net assets at the end of year | <u>\$100,175</u> | <u>\$514</u> | <u>\$ –</u> | <u>\$100,689</u> |



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