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Massachusetts's Experience Suggests Coverage Alone Is Insufficient To Increase Addiction Disorders Treatment

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ABSTRACT **The Affordable Care Act is aimed at extending health insurance to more than thirty million Americans, including many with untreated substance use disorders. Will those who need addiction treatment receive it once they have insurance? To answer that question, we examined the experience of Massachusetts, which implemented its own universal insurance law in 2007. As did the Affordable Care Act, the Massachusetts reform incorporated substance abuse services into the essential benefits to be provided all residents. Prior to the law's enactment, the state estimated that a half-million residents needed substance abuse treatment. Our mixed-methods exploratory study thus asked whether expanded coverage in Massachusetts led to increased addiction treatment, as indicated by admissions, services, or revenues. In fact, we observed relatively stable use of treatment services two years before and two years after the state enacted its universal health care law. Among other factors, our study noted that the percentage of uninsured patients with substance abuse issues remains relatively high—and that when patients did become insured, requirements for copayments on their care deterred treatment. Our analysis suggests that expanded coverage alone is insufficient to increase treatment use. Changes in eligibility, services, financing, system design, and policy may also be required.**

In 2007 Massachusetts implemented An Act Providing Access to Affordable, Quality, Accountable Health Care, also known as Chapter 58 of the Acts of 2006, or simply Chapter 58. The well-documented legislation[1–3] established universal health insurance that covered an additional 400,000 state residents. The result was that 97 percent of residents had health insurance, including Medicaid.[4]

As does the Affordable Care Act of 2010, the Massachusetts law covered its residents through several mechanisms, including an individual and employer mandate, an expansion of Medicaid for people earning up to 150 percent of the federal poverty level, and subsidized insurance through an exchange for people earning 150–300 percent of the federal poverty level. What's more, Chapter 58, like the Affordable Care Act, requires coverage of addiction and mental health disorders in essential benefits that must be offered to all Massachusetts residents.

We examined the effect of the Massachusetts legislation on untreated addiction disorders. Did the law increase the use of treatment, as measured by admissions to treatment, volume of services delivered, and revenues and expenditures for services?

A focus on untreated addiction is important at the national and state levels. The prevalence of addiction disorders has historically outpaced resources, both private and public, available to pay

for treatment.[5] In 2010, 23.1 million people in the United States age twelve or older needed treatment for a substance use problem, and 2.6 million of these received treatment at a specialty facility.[6]

The story is similar at the state level. The 2006 Commonwealth of Massachusetts Substance Abuse Strategic Plan, using data from the 2002–03 National Survey on Drug Use and Health, estimated that 570,000 residents met the diagnostic criteria for substance use disorders treatment, and 117,000 sought but did not obtain treatment.[7,8] According to the 2010 National Survey on Drug Use and Health, the lack of insurance and inability to afford treatment is the primary reason why people who seek treatment do not receive it.[6]

Private and public health insurance plans have offered limited coverage for addiction disorders,[9] especially before passage of the Mental Health Parity and Addiction Equity Act of 2008. As a result, payment for treatment of these disorders has historically relied on annual federal block grants and state contracts that support safety-net treatment agencies.

For example, in fiscal year 2009 the Massachusetts Bureau of Substance Abuse Services spent more than $125 million for addiction treatment and prevention. That amount represents $35 million from the federal Substance Abuse Prevention and Treatment Block Grant and a state appropriation of $90 million for safety-net treatment for the uninsured and for addiction-related nonmedical services that are not covered in public and private insurance plans.[10] The $90 million state appropriation includes an increase of $60 million for new treatment services appropriated in 2006.

As noted, Chapter 58 required core health insurance benefits to include treatment for addiction disorders. This article focuses on changes in the three treatment services described below after the implementation of Chapter 58, as measured by admissions, service volume, and revenues or expenditures.

It is important to note that it is not easy to change these indicators when treatment capacity is tied to specific budgets. Capacity becomes malleable when services are paid by reimbursement attached to the patient, rather than by fixed program budgets defined by the terms of a contract or grant. Thus, capacity that might, for example, cover only 2,000 outpatient visits reimbursed at $50 per visit through a $100,000 grant or contract is not as prominent a concern when financial support is tied to demand—which might exceed 2,000 visits—and is reimbursed by insurance payments, as is the case under both Massachusetts and federal health reform.

Study Data And Methods

The study focused on outpatient, intensive outpatient, and detoxification services. These three services are the most sensitive indicators of changes in patient admissions, service volume, and associated reimbursement because they are covered by most private and public insurance plans, are offered by most treatment providers, and are commonly prescribed for patients who seek treatment for addiction.

We used a mixed-methods approach to investigate the qualitative and quantitative dimensions of the Massachusetts law's impact on addiction treatment service delivery during the period 2006–09, which represents two years before and two years after the law's implementation. Statewide and site-specific data came from structured interviews; the Massachusetts Medicaid program; Uniform Financial Reports, described below; and the Massachusetts Department of Public Health's Bureau of Substance Abuse Services, whose director facilitated our access to data and interviewees for the study.

INTERVIEWS In consultation with the director of the Bureau of Substance Abuse Services, we chose a convenience sample of five community-based treatment organizations. We conducted structured interviews with their chief executive officers.

All five organizations were not-for-profit providers of health services, with annual budgets of $19–$47 million in 2009. They included one federally qualified community health center; three agencies that focused on providing comprehensive addiction treatment but also provided other mental health services; and one agency that primarily provided mental health services but also provided addiction treatment services. Two of the organizations were formally affiliated with large hospital systems, and all five served both urban and suburban markets. Together, four of the five organizations accounted for approximately 30 percent of the total number of admissions reported to the Bureau of Substance Abuse Services during 2006–09.

Two of this study's authors conducted all interviews in person, with other authors participating periodically via teleconference. The interviews employed a structured discussion guide that focused on the number of people admitted to treatment for addiction disorders, number of units of services provided, revenues, payer sources, reasons for any observed change in those numbers, and opportunities to reach more of the untreated. We prepared summary notes from each interview and used them to extract the themes that are reported here.

DATA We used Uniform Financial Reports from 2005 to 2009. The Massachusetts Executive Of-

fice of Administration and Finance requires all not-for-profit organizations receiving state funds to complete these standardized public reports.[11] The report is generally prepared as an adjunct to and based on the organization's annual financial audit. The report details expenses, revenues, and the volume of services provided. We present Uniform Financial Report data for the five organizations we studied.

Medicaid data were extracted from standardized reports available only for 2007 to 2009 through Massachusetts Freedom of Information Act requests. These data represent statewide totals for the five managed care organizations and fee-for-service programs that pay for behavioral health services in the state. The Medicaid data included addiction treatment service codes and expenditures and units of service for each code. Separate Medicaid data were not available for each of the five treatment organizations that we studied.

Reports from the state Bureau of Substance Abuse Services information system contained the number of admissions, indicated by a new patient record; type and volume of services; and payer source for contracted services between 2006 and 2009. These data were available for all five organizations in our study and also provided statewide totals.

LIMITATIONS All data sources tracked the same phenomena: the volume of patients admitted, number of services delivered, and revenues or expenditures before and after the enactment of Chapter 58. However, this study has weaknesses.

Data from each source varied in reporting intervals, completeness, and compatibility between sources. The time periods for available data from each source varied, beginning in 2005 or 2006 and ending in 2009 or 2010. The Medicaid data had gaps in some years for some of the managed care organizations and included service definition codes not found in the other two sources.

In addition, revenue for services reported by providers on Uniform Financial Reports could be categorized differently from expenditures for services reported by either the Bureau of Substance Abuse Services or Medicaid. Specifically, the Uniform Financial Report might contain a category for outpatient admissions that includes medication-based counseling, non-medication-based counseling, group sessions, and individual sessions, while Medicaid and the Bureau of Substance Abuse Services use different codes and categories for each of those services.

Any follow-up study will require considerable financial support to fill such gaps and to aggregate and match categories to track comparable measures across different sources. We used macro-level directional trends in available financial data and congruity of interview data with those trends to offset the potential for error in the specific quantitative data limits.

Study Results

ADMISSIONS AND SERVICE VOLUMES FOR TREATMENT Except for a slight increase from 2006 to 2007, when the state appropriation increased by $60 million, annual statewide admissions to organizations that provided addiction treatment services under contracts with the Bureau of Substance Abuse Services were essentially flat. Admissions remained slightly above 100,000 from 2005 to 2009 (Exhibit 1). Admissions in the four organizations reporting these data remained roughly the same from 2006 to 2009, but they increased 19 percent between 2009 and 2010.

Statewide admissions to the three services we tracked that had been reimbursed by safety-net contracts but are now covered as an insurance benefit declined between 2007 and 2009. Specifically, admissions to detoxification services decreased from 39,000 to 37,000; outpatient services, from 22,000 to 19,000; and intensive outpatient services, from 7,500 to 6,000 (data not shown). Admissions data for the same three services at the four organizations we studied that reported this information also declined from 2007 to 2009. However, these declines were partially offset by new contracts to provide new services for adolescents with previously unmet needs and for patients needing a stable and therapeutic environment to begin recovery following medical detoxification.

REVENUE The Bureau of Substance Abuse Services data showed a statewide increase in the proportion of all admissions covered by private or public insurance, from 68 percent in 2005 to

EXHIBIT 1

Admissions For Addiction Treatment At Four Massachusetts Community-Based Treatment Organizations And Statewide, 2006–10

	Study organizations		All other organizations		
Fiscal year	No. of admissions	Percent of total	No. of admissions	Percent of total	Total no. of admissions
2006	28,219	27.2	75,322	72.8	103,541
2007	29,706	27.4	78,611	72.6	108,317
2008	28,744	26.9	78,128	73.1	106,872
2009	27,695	26.4	77,415	73.7	105,110
2010	32,911	31.1	72,944	68.9	105,855
All years	147,275	27.8	382,420	72.2	529,695

SOURCE Massachusetts Department of Public Health Bureau of Substance Abuse Services. **NOTE** Only four of the five organizations studied reported data to the Bureau of Substance Abuse Services during this period.

77 percent in 2009. In the organizations we studied, 74 percent were covered by insurance in 2005, and 82 percent were in 2009 (data not shown).

According to the Uniform Financial Reports, total annual operating revenues for the five organizations in the study were $51 million more in 2009 than in 2005, a 41 percent increase (Exhibit 2). This revenue increase was from both contract and third-party sources, such as Medicaid (data not shown). According to our interviewees, one exception for a specific organization between 2007 and 2009 was largely the result of losing specific state contracts. The remaining four experienced revenue growth (Exhibit 2).

The cumulative Uniform Financial Report data illustrate a shift in payer source across all five organizations after Chapter 58 was implemented (Exhibit 3). Although revenues from grants and contracts to provide safety-net services remained relatively constant, at 65 percent of total revenue from 2005 to 2007, they declined after that point. The inverse trend is seen for third-party reimbursement, which was 33 percent of total revenue in the early period and then increased to 39 percent after Chapter 58 was implemented.

MEDICAID EXPENDITURES AND SERVICE VOLUME We examined standardized Medicaid reports from 2007 to 2009 for changes in expenditures and volume for the three services of interest: detoxification, intensive outpatient, and outpatient treatment (Exhibit 4). The data show a 15 percent increase in statewide Medicaid expenditures for detoxification across all five managed care plans between 2007 and 2009. Volume of detoxification services tracked the expenditures. Total expenditures and volumes by the plans increased for intensive outpatient and outpatient services between 2007 and 2008 but decreased for both between 2008 and 2009. The decline was caused by a policy change: In 2008 the largest Medicaid managed care organization, followed by other payers, changed its utilization management policy, adding criteria to limit intensive outpatient and outpatient services.[12]

In contrast, both expenditures for and volumes of detoxification services increased throughout the study period (Exhibit 4). In fact, the largest increase occurred between 2008 and 2009.

QUALITATIVE FINDINGS Our qualitative data inform the quantitative results, introducing several possible explanations for some of the counterintuitive quantitative findings. Four themes emerged from a review of the structured interview data. These themes focus on the central question of reaching new people in need of services, as well as on the other contextual drivers and circumstances that affect patients' access to insurance and services.

Our interviewees reported that Chapter 58 has not generated an influx of new patients seeking services. Rather, the result of the law has been that many of the patients formerly treated through safety-net contract payments now have insurance. The growth experienced by the five organizations we studied was associated in one case with expansion to a new location and in all five cases with winning new safety-net contracts from the state for new services, including those for adolescents with previously unmet needs and for patients needing a stable and therapeutic environment to begin recovery following medical detoxification.

Despite the fact that 97 percent of Massachusetts residents are now insured, interviewees estimated that 23–30 percent of people being treated by their organizations did not have insurance at the time of service. This is a smaller percentage of uninsured patients than was the

EXHIBIT 2

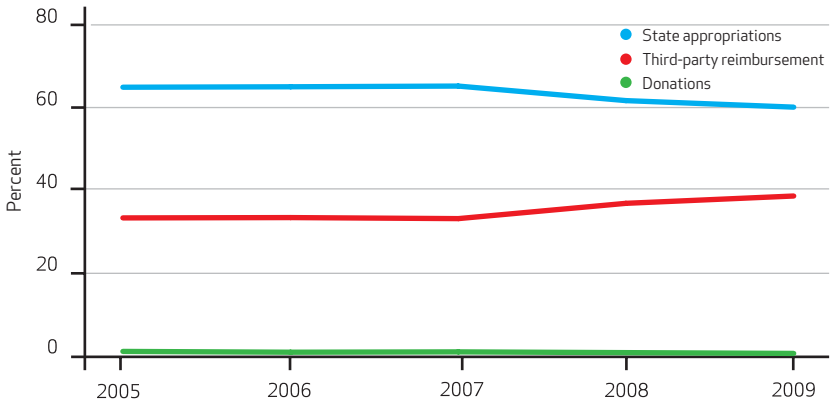
Annual Revenue At Five Massachusetts Community-Based Treatment Organizations, 2005–09

	Revenue ($ millions), by fiscal year					
	2005	2006	2007	2008	2009	Change, 2005–09 ($ millions)
Organization						
A	16.36	17.56	18.32	19.37	19.89	3.53
B	39.16	42.03	44.59	46.10	47.21	8.05
C	19.08	21.07	25.03	28.13	32.09	13.01
D	15.42	18.21	23.05	25.22	35.62	20.20
E	35.26	35.91	43.09	42.97	41.21	5.95
All five organizations	125.28	134.78	154.08	161.79	176.02	50.74
Increase from prior year	—[a]	7.58%	14.32%	5.00%	8.80%	40.50%

SOURCE Uniform Financial Reports, Massachusetts Executive Office of Administration and Finance. [a]Not applicable.

EXHIBIT 3

Sources Of Revenue At Five Massachusetts Community-Based Treatment Organizations, By Payer Type, 2005–09



SOURCE Uniform Financial Reports, Massachusetts Executive Office of Administration and Finance. **NOTES** State appropriations are grants; contracts; and "other," a category used by the Office of Administration and Finance. Donations are contributions and in-kind donations.

case before Chapter 58 was enacted. Interviewees gave the following explanations for the higher-than-expected rate of uninsurance among behavioral health patients: patients' noncompliance with the mandate; the lack of affordable insurance, even with subsidies; the complexity of the application process; and disenrollment because of administrative termination of coverage—that is, disenrollment for reasons such as failure to respond to notices, perhaps because of address changes—for otherwise eligible people.[13]

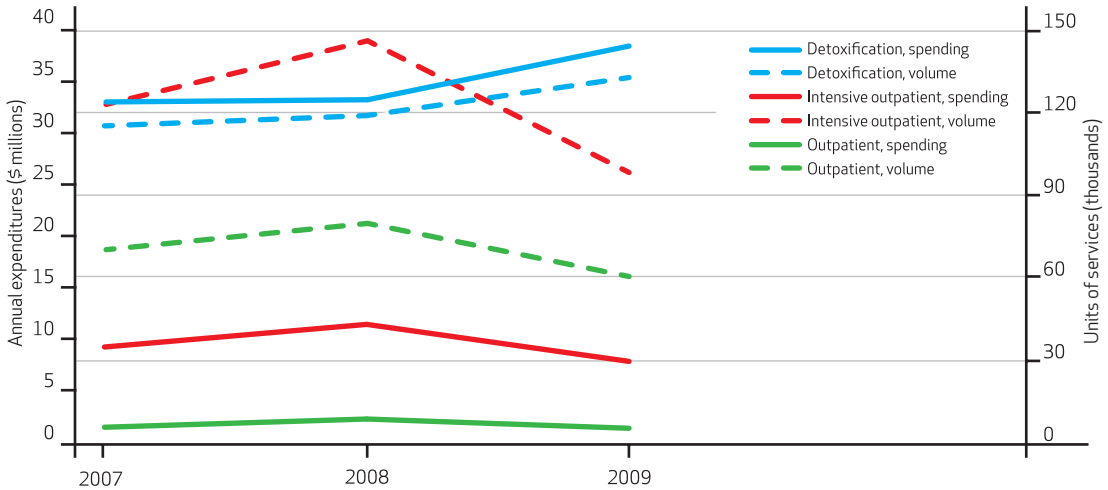
All five organizations in our study provided insurance enrollment support services, which included eligibility determination, at their own expense as part of their intake process. All five reported that patients experienced barriers to moving from eligible to enrolled status in the application process. The barriers our interviewees cited include the length of time required to process applications; the large number of people and decision points involved in the process, from initiating to approving an application; requirements for supplemental documentation of income and citizenship; and frequent changes of address for patients.

The interviewees explained that these barriers disproportionately disadvantaged patients with mental and substance use disorders. And they pointed to one other circumstance affecting eligible but unenrolled patients: Previously the Medicaid program had a policy of "presumptive eligibility," wherein Medicaid reimbursed a provider for an acute or emergency service delivered to an unenrolled patient. The policy is no longer in effect, and respondents noted its absence as a particular hardship in addiction treatment, which is sensitive to real-time demand.

Copayments can also be a major barrier. Copays ranging from $10 to $15 per visit for outpatient services and $50 to $250 per episode for inpatient mental health and addiction treatment are required by Commonwealth Care, the subsidized insurance exchange offering coverage for residents with incomes at 150–300 percent of the federal poverty level. Interviewees reported that

EXHIBIT 4

Changes In Medicaid Spending And Volume, By Treatment Service, 2007–09



SOURCE Massachusetts Medicaid program. **NOTES** "Intensive outpatient" includes what some data sources call "structured outpatient addiction program" or "day treatment." All three terms represent essentially the same service. Spending data are denoted by solid lines and relate to the left-hand *y* axis. Volume data are denoted by dashed lines and relate to the right-hand *y* axis.

serving low-income people is a core mission of their organizations. They said that they rarely collected on unpaid copays; instead, those unpaid fees contributed to the bad debt carried by each of the organizations. Several respondents described copays for subsidized insurance as essentially equivalent to rate discounts or reductions, which end up functioning as a disincentive for the organizations to expand services.

All of our interviewees were aware of Chapter 58 and its similarity to health reform at the national level. However, they had different reactions to the implications and importance of these policy shifts. One organization was forming close working relationships with primary care practices, while another was considering merging with a community mental health center and linking more closely to an acute care system. The community health center was fully engaged in taking advantage of the health center–related benefits of health information technology improvement provisions in the Affordable Care Act. The other two organizations gave no explicit indication of any plans for changes as a result of the act.

Discussion

In 2006, before the enactment of Chapter 58, the state estimated that a half-million Massachusetts residents needed substance use disorder treatment, and more than 100,000 were actively seeking treatment but unable to obtain it. What differences did we observe after Chapter 58 became law, when 97 percent of the state's population had insurance with an addiction treatment benefit? Data at the state and site levels revealed trends that varied according to the source of the data and what was measured.

All of the data sources—interviews, Uniform Financial Reports, Medicaid, and the Bureau of Substance Abuse Services—identified a shift in payer source, from state-administered safety-net contracts to Medicaid. The percentage of behavioral health patients with insurance coverage increased since the passage of Chapter 58, but not at the same rate as that for the state's population in general.

The data also indicated that revenues increased for the five organizations from 2006 to 2009 (Exhibit 2), while statewide expenditures for the three services tracked in Medicaid increased only slightly from 2007 to 2009 (Exhibit 4). New safety-net contracts approved by the state in 2006 provided dollars to expand services for adolescents and patients needing a stable and therapeutic environment to begin recovery following medical detoxification, and medication-assisted treatment for opiate dependence for patients at community health centers. These contracts account in part for the agencies' revenue growth. At the same time, Medicaid spending for detoxification rose, but that growth was nearly offset by the reduction in outpatient and intensive outpatient services caused by the payers' policy change described above.

Total admissions to treatment were essentially unchanged during the study period statewide, and there is no consistent pattern across the five organizations we studied that explains the volume of their patient admissions for the indicated services. For example, one organization increased admissions by opening a new location with a full range of services that were supported almost exclusively by Medicaid payments. Utilization or service volume at other organizations was more influenced by changes in payer policies.

No Increase In Admissions To Treatment

The admissions figures and the revenue figures seem to contradict each other. After the passage of Chapter 58, more of the patients admitted to publicly supported programs, especially for detoxification, were covered by Medicaid. Freed-up safety-net dollars not spent on previously uninsured people, as well as newly appropriated state dollars, enabled the state to add new services and contract with new vendors. The result was a fairly complete menu of services for addiction disorders for Massachusetts residents.

Yet neither the increased revenue nor the pent-up demand resulted in more admissions, which remained at roughly 100,000 a year both before and after enactment of Chapter 58. Why was this the case?

▶ **More people seeking treatment:** First, it is possible that the number of people treated has increased without detection. Many patients use services delivered by providers who have no obligation to report data to public agencies. These include licensed individual practitioners in private practice and primary care practices that bill third-party payers. This explanation assumes that private providers are now treating low-income patients who previously lacked insurance. A full analysis of all claims data would be required in order to detect such a trend.

▶ **Inconsistent clinical criteria:** Second, some policy analysts believe that the clinical criteria used to determine the number of people needing addiction treatment overstate the severity of their condition and therefore exaggerate their need for medical intervention in specialty settings. Countering this view is the fact that the National Survey on Drug Use and Health relies on self-reports of stigmatized behavior and, if anything, underreports the prevalence

of those who meet clinical criteria for treatment. Testing either view would require research well beyond the scope of this study.

▶ **NO CHANGE IN PRODUCTS OR DELIVERY SYSTEMS:** Third, it is possible that the majority of provider agencies across Massachusetts haven't changed their products or delivery systems and are subsequently producing the same results they always have, rather than attracting new patients. The exceptions from our sample are instructive.

One organization expanded its locations and, as a result, increased patient admissions and revenue. Another organization, the federally qualified community health center, engaged many previously uninsured people earlier in the development of their illnesses through its primary care service. A third agency at the time of the study was actively exploring connections with a mental health center and integrated hospital system. Analysts predict that, under the Affordable Care Act, future addiction treatment will include new organizations, services, and relationships between providers and the broader health care system, implying that shifts similar to those that took place in Massachusetts could eventually occur nationally as well.[14]

▶ **ECONOMIC DOWNTURN:** Fourth, the economic downturn strained state resources at exactly the same time as insurance coverage expanded. This explanation suggests that the downturn required cost savings for the state, which triggered more administrative disenrollment for otherwise eligible people and more stringent utilization management practices. The result was to discourage both utilization and program expansion. Although the lack of controls make it difficult to prove this explanation, the fiscal limitations placed on state budgets by the economic downturn are well documented and understood.

LESSONS FOR IMPLEMENTATION OF REFORM

Regardless of which explanation is correct, the experience in Massachusetts offers insights that can guide implementation of the Affordable Care Act. First, a system essentially built to serve 100,000 patients, absent modification, continued to serve approximately the same number of people before and after the addition of 400,000 state residents to health insurance rolls. Assuming that this conclusion is correct, it implies that reaching a greater number of previously uninsured and untreated patients will probably require redesigning patient recruitment and engagement practices, as well as service offerings. It may also require redesigning state policies to reward outreach, early intervention, and forming connections to primary care and emergency department providers.

When copays are a condition of service, patients often choose to defer the service, and providers limit its delivery.

Second, although many patient admissions to the five organizations we studied are now covered by insurance, the percentage of uninsured patients remains high. The nature of addiction disorders makes it likely that patients will resume substance use when they seek but do not immediately receive treatment. Presumptive eligibility policies—which maintain enrollment continuity—and streamlined electronic review processes for acute mental health and addiction disorder cases, when certified by financial eligibility specialists, would encourage the initiation of treatment and allow eligible patients to be enrolled. The marginal negative consequences of these policies, such as ineligibile patients' receiving services, might be offset by reductions in the costs associated with deferring or delaying treatment[15] and by more efficient use of state and block grant appropriations.

Third, copays were essentially equivalent to bad debt for the five organizations in our study. When copays are a condition of service, patients often choose to defer the service, and providers limit its delivery. A 2009 Massachusetts study indicated that 25 percent of people who were newly insured experienced gaps in their insurance coverage during the first year because of financial barriers.[16] These people could well be unable to afford copays.

Fourth, as revenue mix shifted for the five organizations, the state Bureau of Substance Abuse Services was strategic in its use of state appropriations and block grant resources. The bureau invested some of these resources in an initiative to create incentives, such as contracts that covered full costs, for federally qualified community health centers to provide medication-assisted treatment—for example, Buprenorphrine—to expand treatment access for the many Massachusetts residents with opiate dependence. A second strategy of the bureau was to invest resources in demonstrating new

services for adolescents and patients needing a stable and therapeutic environment to begin recovery following medical detoxification, and for medication-assisted treatment for opiate dependence for patients at community health centers. Finally, the bureau made sure that funds continued to be available to pay for services for residents who remained uninsured.

Conclusion

Many safety-net health providers and advocates for the uninsured have great expectations for the Affordable Care Act and its impact on access to health care. As the act's implementation unfolds, researchers and other stakeholders are working with communities, providers, and government entities to improve how the health care system operates and ways to evaluate it. In the context of these sweeping changes, specialty services such as addiction treatment might continue to fall under the radar and leave millions of people without the services they need.

Our analysis suggests that the absence of redesign in the Massachusetts addiction treatment system dampened the potential impact of universal coverage. A redesigned system might include more and diverse access points; patient-oriented interventions; streamlined enrollment processes for the eligible, and some form of reasonable presumptive eligibility for people with acute conditions; earlier engagement in treatment; and more incentives for people to enroll and stay in treatment.

There is a need to bring together families and providers to design better treatment systems; purchasers and payers to provide incentives for outreach and quality care; and researchers and policy makers to develop and implement outcomes-based best practices. Without input from each of these groups, it is questionable if the Affordable Care Act will reach its full potential for true health care reform in the current addiction treatment system. ■

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In this month's *Health Affairs*, Victor Capoccia and coauthors reflect on implications for the Affordable Care Act and its extension of substance abuse coverage to many previously uninsured people through the lens of Massachusetts's universal insurance law. Although that legislation also covered substance abuse services as an essential benefit, Capoccia and colleagues found that use of treatment services remained largely the same throughout a period from two years before the law was enacted to two years after. They conclude that expanded coverage alone is not enough to increase utilization unless accompanied by changes in eligibility, services, financing, system design, and policy.

Capoccia is a senior scientist at the Center for Health Enhancement Studies, University of Wisconsin–Madison, where he conducts research and support for NIATx (formerly the Network for the Improvement of Addiction Treatment). He was the program director of the Open Society Institute's National Initiative to Close the Addiction Treatment Gap, which seeks to increase resources for the twenty million Americans who need but cannot obtain addiction treatment.

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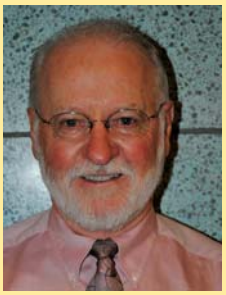

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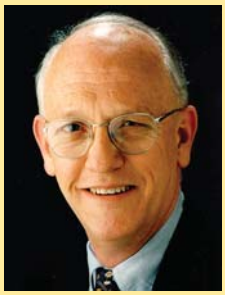
Christopher Toal is retired after a career in the private sector. He is a manager and consultant at Windspeed Venture Services Group. He was responsible for operations and finance for several firms in the high-tech sector. He holds a master's degree in English from New York University and a law degree from Georgetown University.

James H. Ford II is an assistant scientist at the University of Wisconsin.

James Ford has more than twenty-five years' experience as a health systems engineer, and he is currently working for the Center for Health Enhancement System Studies at the University of Wisconsin–Madison. Ford received a master's degree in industrial engineering from the University of Tennessee and a doctorate in industrial engineering from the University of Wisconsin–Madison.



David H. Gustafson is a research professor of industrial and systems engineering at the University of Wisconsin.

David Gustafson is a research professor of industrial and systems engineering at the University of Wisconsin–Madison and director of the Center for Health Enhancement Systems Studies, which includes one of the five National Cancer Institute–designated Centers of Excellence in Cancer Communications Research. He has both a master's degree and a doctorate in industrial engineering from the University of Michigan.