



**STRIVING FOR UNIVERSAL, AFFORDABLE HEALTH CARE:
LESSONS FROM MASSACHUSETTS**

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In the middle of the nineteenth century, Boston was home to a groundbreaking medical experiment. On October 16, 1846, in a small domed auditorium in the Massachusetts General Hospital, Dr. William Morton performed the first public demonstration of surgery under general anesthesia. After the patient inhaled the ether, another doctor, John Warren, removed a tumor in the patient's jaw – and thanks to the ether, the patient remained silent and in no pain. Following the operation, Warren announced to the large crowd of onlookers, “Gentlemen, this is no humbug!”¹

More than 150 years later, just a few blocks away from the Etherdome at Mass. General Hospital, we are in the middle of another experiment: a groundbreaking state effort to achieve universal health coverage.² In the months leading up to the law's enactment in 2006, and in the year-and-a-half since then, health care reform has brought together doctors, insurers, consumer and patient advocates, clergy leaders, and even Democrats and Republicans, to address the needs of Massachusetts' citizens. Government officials in other states and presidential candidates from both parties have embraced many different pieces of the Massachusetts health reform law. While no presidential candidate can yet take credit (or blame) for what we in Massachusetts continue to work to achieve, on the eve of a presidential election year, Massachusetts is in the national spotlight and may offer useful lessons for other states and the nation.

Today, I would like to discuss the major aspects of the Massachusetts law and the legal issues and challenges it raises. The central goal of the law is to ensure access to health care for everyone by achieving universal insurance coverage within the next few years. To promote

¹ Michael A.E. Ramsay, *Anesthesia and Pain Management at Baylor University Medical Center*, 13:2 BUMC Proceedings 151 (2000), http://www.baylorhealth.edu/proceedings/13_2/13_2_ramsay.html.

² See generally 2006 Mass. Acts Ch. 58.

universal coverage, the law relies on a variety of measures, including state-subsidized insurance, new rules affecting employers, and a controversial individual mandate requiring residents to obtain insurance. The law reflected careful policy and political analysis and compromise, yet the passage of the legislation was only the beginning. Many tricky political and legal challenges remain.

Of course, no state can achieve universal insurance coverage without addressing the constantly rising cost of health care. In the second part of my presentation, I will outline some of the ways that Massachusetts is attempting to address both the cost and quality of care in the state. Getting this balance right so that everyone will have access to quality care will be the measure of success of the Massachusetts experiment. Like the patient in Dr. Morton's ether experiment, so far we have not felt significant pain; but the operation is not yet complete.

1. Historical background on the Massachusetts health reform debate

Before I dive into the details of Massachusetts health reform, I'd like to share some history behind the comprehensive legislation, and the subsequent implementation of the law. This history reveals some of the legal, policy and political challenges and themes in any serious reform effort.

When Massachusetts government officials and private citizens began serious debate about health care reform in late 2004, the state started with two major advantages that made the goal of universal coverage seem possible, albeit difficult. First, Massachusetts already had the lowest percentage of uninsured residents of any state in the country – in early 2005, we had

618,000 people without health insurance, about 9.8% of the population.³ Second, like every other state in the nation, Massachusetts relied significantly on federal Medicaid funding to cover more than half of the cost of coverage for hundreds of thousands of low-income residents.

By early spring of 2005, the stars had already aligned to a significant degree. At the beginning of the legislative session, the Republican Governor, Mitt Romney, the Democratic leaders of both the Senate and the House, and leaders from key stakeholders including health care providers, consumer advocates, and clergy leaders all embraced universal health coverage as a goal. Their commitment was joined and supported by academic experts from Harvard and other institutions, and by non-profit involvement from an array of groups that could provide modeling and analysis of the complex financing issues. For some, such as ministers and rabbis of the Greater Boston Interfaith Alliance, this goal was a moral imperative. Others, such as business leaders and hospital and insurance executives, recognized the inefficiencies of the current system, in which everyone directly or indirectly paid the price in higher premiums and unreimbursed care for the uninsured.

This widespread movement toward reform was not a response to a major crisis. The vast majority of Massachusetts residents already had health coverage. Surveys showed overwhelming satisfaction with the quality of care – most patients in Massachusetts hold their doctors in very high esteem. Many were concerned about the escalating cost of health care, both due to rising premiums faced by individuals and rising costs borne by employers. But the push for health reform starting in late 2004 focused on universal coverage, not on health care costs.

³Massachusetts Budget and Policy Center, Facts at a Glance, *Four Years into Recovery, Uninsurance Still Higher than in 2001*, (Aug. 2006), http://www.massbudget.org/Facts_at_a_Glance_Census_2005_health_insurance_data.pdf.

Although health reform in Massachusetts was not driven by a major crisis, two factors put significant pressure on the Governor and Legislature to act. First, the state's Medicaid waiver was due to expire in June 2005. Federal officials sent early signals that favorable renewal of the waiver would depend on a serious effort by the state to fix its inefficient way of reimbursing hospitals for treating the uninsured. Unless the state adopted some type of legislation acceptable to the federal government, we risked losing roughly \$385 million in federal funding.⁴ This major threat prompted the state's congressional delegation to enter the picture. Senator Edward Kennedy, one of the most knowledgeable and committed members of Congress with respect to health care, played a major role in dealing with the federal administration and making the health reform achievable, at times calling the Governor and key legislators at home to help broker agreements.

A second incentive to act arose from the commitment of a large grassroots coalition to put an initiative petition for universal health care on the 2006 ballot in the absence of action by the state government. Led by the non-profit group aptly called "Health Care for All," this coalition had previously succeeded in pressing legislative measures to expand health care, and the Governor and legislators were acutely aware that an initiative petition would be warmly received by many voters.

Thus, by early 2005, a relatively loud chorus called for universal health care – this chorus was already starting to sing in harmony, though certainly not in unison. Beyond general

⁴ *The MassHealth Waiver*, Issue Brief (Massachusetts Medicaid Policy Institute) April 2005, <http://masshealthpolicyforum.brandeis.edu/publications/pdfs/26-Apr05/IssueBrief26.pdf>.

agreement on the fundamental goal – universal coverage – key leaders and organizations already had signaled broad agreement on several basic principles:

- First, most legislators and private stakeholders agreed that health reform should not be funded through increased income tax or sales tax hikes. The concept of an increase in the cigarette tax remained on the table, but most leaders were deterred by the threat of a gubernatorial veto.
- Second, in place of increased taxes, there was also initial agreement that expanded health coverage should be promoted primarily through private insurance, not insurance provided directly by the state, and certainly not through a single-payer system.
- Third, many of those involved, though not everyone, understood that the business community was a critical element of health reform, and that successful reform required substantial support from local business leaders. This rough consensus was partly the product of history. In 1988, Governor Dukakis had signed a major health reform effort into law, but opposition by the business community was so intense that the law was repealed by 1991.⁵

Despite these early signs of agreement, it still took more than a year to complete the health care reform legislation. The Massachusetts Legislature is a full-time legislature that stays in session throughout most of the year, and takes only relatively short recesses during the

⁵ Alan Sager, Deborah Socolar & Peter Hiam, BU School of Public Health, *Nine Lessons for National Health Reform from the Failure of the 1988 Massachusetts Universal Health Insurance Law* (1993), http://dcc2.bumc.bu.edu/hs/Nine_Lessons_from_the_Failure_of_the_1988_Massachusetts_U.pdf.

summer, the winter holidays, and the fall of election years. The legislature needed most of that time to work through this very complicated bill.

In part, this was because the devil is in the details, and many of the details involved controversial issues of great importance to particular stakeholders, who lobbied intensely in those areas. But the debate also featured a major ideological rift: while the governor and other conservatives pressed for solutions based on greater individual responsibility, liberal legislators and advocates favored greater shared responsibility, involving employers and government. In the end, the health reform bill represented a grand compromise that included major elements from both camps.

As we turn to the actual provisions of Massachusetts health reform, you will see one additional theme repeated over and over. In the effort to achieve consensus and complete a very detailed bill, the legislature deferred many critical policy and implementation questions. Some of those questions concern funding, and were simply left open for the legislature to wrestle with in the future. Other major implementation questions were left to agencies, which have spent the past year making hard decisions to bring health reform to life.

In fact, the health reform bill created two new state agencies to implement the most important parts of the new law: an entity called the “Health Care Connector,” which has a board of 10 members who are government officials or are appointed by the Governor or Attorney

General, and a separate “Health Care Quality & Cost Council,” which has 13 members representing government agencies and private stakeholders.⁶

The creation of these new entities may in part have reflected a checking and balancing among the legislative and executive leadership in the state, but it has also had an unexpected beneficial effect. Because both the Connector and the Quality and Cost Council include members who represent key government agencies as well as private stakeholders, they have helped to preserve and generate broad consensus in favor of important, difficult decisions, thus keeping intact the very coalition of interests that helped to win the reform law’s passage in the first place. Some of the consensus is due to culture and strong leadership; but some of it is built into the DNA of these new institutions, and there is an interesting lesson here. Independent government entities with multiple-member boards may seem inefficient and cumbersome. In the context of health care, however, they are probably more conducive to consensus-building and accomplishing results than arrangements that vest authority and power in a single agency or official, such as the Secretary of Health and Human Services.

In its wisdom, the legislature also included a very substantial role for the Attorney General in these new bodies. Three of the 10 Connector Board members are appointed by the Attorney General, and I also appoint a designee to the Quality and Cost Council.⁷ In addition, my office has broad jurisdiction to enforce consumer protection laws that apply to health insurers as well as providers.⁸ My office oversees and regulates non-profit “public charities,” including almost all hospitals and many health care providers in Massachusetts. When I took office last

⁶ M.G.L. c. 176Q § 2; M.G.L. c. 6A §16K.

⁷ M.G.L. c. 176Q § 2.

⁸ See M.G.L. c. 93 § 9; M.G.L. c. 93A § 4.

January, I brought many of the various health care responsibilities of the Attorney General together into a new Health Care Division to better focus our efforts in the health care area.

With this background discussion in mind, let's turn first to the measures created to expand access to health insurance, and some of the important policy and legal issues that these measures raise.

2. The challenges of providing universal coverage

After more than a year of intense public debate and legislative negotiations, the legislature and key stakeholders struggled to agree on ways to (1) increase access to health insurance for those who previously could not afford it; (2) fund this expanded access; and (3) encourage younger, healthier residents to sign up for insurance to ensure that the health insurance system was not just made up of the sickest portion of the population.

a. Measures to expand access to insurance

The first major challenge was to expand access to insurance to those who previously could not afford it. In part, this was done by expanding the state's Medicaid program by loosening various eligibility requirements. The reform law created a new type of subsidized insurance for people who make too much money to qualify for Medicaid, but who cannot afford to buy insurance on their own. This new "Commonwealth Care" insurance is offered to residents who earn up to 300% of the federal poverty level, or \$30,630 for a single person and \$61,950 for a family of four.⁹ Subsidies are available on a sliding scale for these policies – the size of the

⁹ M.G.L. c. 118E § 9A(2)(c). See also MassHealth, *2007 MassHealth Income Standards and Federal Poverty Guidelines*, http://www.mass.gov/Eeohhs2/docs/masshealth/deskguides/fpl_deskguide.pdf.

subsidy shrinks as one's income rises.¹⁰ But these Commonwealth Care policies are not offered by the government itself – rather, four private insurance carriers offer Commonwealth Care plans. The new Health Care Connector agency helps administer these plans.

The law also includes a modest expansion in a successful program that provides state subsidies for insurance for employees of small businesses.¹¹ With respect both to Commonwealth Care and this small-business program, the state provides subsidies, but the insurance policies themselves are issued by private carriers. Likewise, Massachusetts has a generous SCHIP program which provides access to health insurance not only for the poorest children, but also for the children of working class families as well.¹² This funding recently was put in jeopardy by President Bush's veto and CMS's regulatory changes to the program.

Two other parts of Massachusetts' expansion of access to health insurance do not involve any state subsidies, but instead, private insurance. First, the new law requires all private insurance carriers to cover young adults through age 25, an increase from the age of 23.¹³ As part of the overall reform package, health insurers agreed to this change, which allows college graduates to remain on their parents' policies while they look for work or work at small companies that may not offer health insurance, such as some start-up companies.

¹⁰ See Commonwealth Care, *Frequently Asked Questions*, http://www.mass.gov/?pageID=hicterminal&L=3&L0=Home&L1=Commonwealth+Care&L2=Basic+Information&sid=Qhic&b=terminalcontent&f=care_faq&csid=Qhic.

¹¹ See M.G.L. c. 118E § 2.

¹² See generally M.G.L. c. 118E §(a)(7).

¹³ See M.G.L. c. 175 § 108(2)(a)(3), M.G.L. c. 176A § 8Z, M.G.L. c. 176B § 4Z, and M.G.L. c. 176G § 4R.

Second, employers with more than 10 employees must offer a pre-tax benefit to employees.¹⁴ These pre-tax benefit plans, called Section 125 Plans or Cafeteria Plans, allow an employer to offer health insurance and other programs such as day care on a pre-tax basis to their employees. Employees designate how much of their wages they will contribute to the plan in the beginning of the year. Employees may then use those untaxed funds to pay for uncovered medical expenses.

b. Funding for expanded access

You have noticed, I am sure, that a number of these new programs require financial support and the hardest question with any new policy program is usually, “how do we pay for it?” This brings us to the second key challenge, the funding of this expanded access. For expanded Medicaid coverage, the federal government shares the cost. For both Medicaid and Commonwealth Care insurance, some of the cost will be covered through savings from a safety net program that previously reimbursed hospitals for caring for patients without insurance.¹⁵ This safety net was called the “Free Care Pool,” but that is a euphemism that only George Orwell could love – the Free Care Pool has cost state taxpayers roughly half a billion dollars a year. As more people obtain insurance coverage, the Free Care Pool will be phased out, and that money can be reallocated to pay for insurance subsidies.

But more funding – a lot more – is needed to pay for the new state subsidies that are a key part of the health reform law. For the first year, the legislature borrowed substantial funds

¹⁴ M.G.L. c. 151F.

¹⁵ See M.G.L. c. 29 § 2000.

from state reserves to cover the initial investment. However, many experts believe that increased legislative funding will be needed going forward to ensure adequate funding.

Aside from increased state budgetary funding, the reform package also includes funding measures based on concepts of employer responsibility. The law requires any employer with ten or more employees to pay a “fair share” assessment of up to \$295 per year unless it offers to provide health care for its employees.¹⁶ This mechanism is both an incentive for employers to provide health insurance and also a funding measure to help pay for expanded subsidies.

During the legislative debate, the House of Representatives initially included a much larger employer assessment. Through extensive negotiations, the legislature settled on the lower amount of \$295 per year for each employee; a small enough assessment that nearly all Massachusetts business leaders publicly supported the compromise. Nevertheless, despite this compromise, Governor Romney vetoed this provision, using his line-item veto power. The Legislature promptly overrode his veto.

Additionally, the statute imposes a free rider surcharge on employers who do not offer insurance or provide a section 125 plan. The surcharge is levied when an employee or dependant receives Free Care more than three times, or a company has five or more instances of employees or dependants receiving free care in a year, and these services exceed \$50,000 in a fiscal year. The surcharge ranges from about 10% to 100% of the state’s costs of services provided to the

¹⁶ M.G.L. c. 149 § 188(c)(10). See also M.G.L. c. 149 § 188(b)

employees. Revenue from the surcharge will be deposited in the Commonwealth Care Trust Fund.¹⁷

c. The individual mandate

In addition to employer responsibility, the health reform law also relies on individual responsibility to promote universal coverage. Massachusetts is now the first state in the nation to adopt an individual mandate that all residents obtain health insurance.¹⁸ Simplified, the individual mandate is somewhat like mandatory auto insurance, a common requirement in many states. Simplification has its limitations, of course: health insurance, even when universally available, is likely to cost significantly more than automobile insurance. And people can avoid auto insurance by choosing not to drive – the individual mandate in the health care context is not tied to a privilege, but to mere residency. This has led to opposition of the mandate both from libertarians and from some liberals.

The individual mandate is obviously an incentive for uninsured people to obtain insurance. But in reality, it is also a funding mechanism. By drawing more people into risk pools, many of whom are young and relatively healthy, in theory, the mandate brings additional funding into the system, in the form of premium payments. Without the individual mandate, the argument goes, the insurance pool will be disproportionately populated by older, sicker residents, making insurance premiums higher on average. Younger, healthier individuals are needed to cross-subsidize the risk. In practice, how much the individual mandate will actually help defray the cost of expanded insurance is still an open question.

¹⁷ See M.G.L. c. 118G § 18B.

¹⁸ See M.G.L. c. 111M § 2.

The sanction is a financial penalty paid in connection with the individual's income tax return. The mandate takes effect this year. Those who do not have health insurance by December 31 will not be allowed to take the personal exemption on their state income tax returns, which amounts to a penalty of about \$219.¹⁹ In future years, the penalty becomes much more significant – one-half of the average cost of purchasing health insurance, as determined by the Department of Revenue. That penalty could easily amount to \$2,000 or more.²⁰

Yet, it can't be that simple. If the individual mandate applied to every resident, it would raise obvious and serious questions of fairness. Is it fair or practical to require low-income people to buy insurance when they cannot afford it? To address these concerns, the legislature carved out an exemption: the mandate does not apply to individuals who are deemed unable to afford it.²¹ But what that means was the subject of one of the most difficult debates in the reform process. The legislature punted, and left the thorny question of what "affordability" means to be decided by the Health Care Connector.

The struggle to define "affordability" is one of the most interesting legal issues raised by the health reform law and it goes to the heart of legal definitions and legislative delegation to agencies. In order to define "affordability", the Connector recognized that all 10 members of the Connector Board would have to play an active role to ensure that the prices set were as fairly as

¹⁹ See M.G.L. c. 111M § 2(b). See also Department of Revenue, *Health Care Information*, http://www.mass.gov/?pageID=dorterminal&L=3&L0=Home&L1=Individuals+and+Families&L2=Personal+Income+Tax&sid=Ador&b=terminalcontent&f=dor_healthcare_healthcare&csid=Ador.

²⁰ Premiums range from \$122-\$800 per month, thus the annual penalty is between \$732- \$4,800. The lowest premiums are paid by young adults and the highest by those over 55. For those who qualify for subsidies, the cost of insurance is on a sliding scale from \$35- \$105 a month, therefore \$210-\$630 annually. See, e.g., Julie Appleby, 'Country is Watching' *Massachusetts Insurance Plan*, USA Today, July 1, 2007.

²¹ See M.G.L. c. 111M § 2(a).

possible. The first element of this decision was that the Connector had to keep the costs low enough to incentivize the young and healthy to buy into the plans. Additionally, they had to ensure that the cost of health care was not a burden unfairly carried by the young, healthy, and poor. Connector Members did not want to make the individual mandate so burdensome that people would choose to pay the tax penalty and go without. They also wanted to make sure that those individuals who could pay would indeed buy into the program. Finally, the Connector wanted to make sure that there was a way to address the needs that they were unable to anticipate at the time they developed this schedule. With that in mind, the Connector also created an appeals process for individuals who felt they could not pay for insurance even though their situation on paper demanded that they did.²²

By sometime next spring, we will have a fairly good idea of the effect of these new programs. In the meantime, the individual mandate exposes one of the basic tensions inherent in health care reform. On the one hand, Massachusetts is trying to achieve universal insurance coverage through a set of carrots and sticks. On the other hand, these insurance products are subject to an array of new and existing consumer protection measures to ensure that people are not misled into purchasing insurance that fails to meet minimally acceptable standards.

d. Expanded insurance coverage and consumer protection

In this new climate, we also have to worry about the quality of insurance offered and purchased by consumers who wish to comply with the mandate. To address the concern that low quality plans would flood the market, the Legislature once again left to the Connector the

²² See M.G.L. c. 111M § 4; M.G.L. c. 176Q §3(a)(7).

responsibility to set the floor for what would be considered adequate insurance.²³ If the floor of minimal creditable coverage was set too low, the individual mandate would force individuals to buy insurance coverage that did not cover enough of the costs of their health care – either because it required patients to pay too much out of pocket or because it excluded necessary medical care, drugs, and devices, forcing patients to pay not only for the insurance premiums but also for much of their health care. On the other hand, if the floor was too high, the insurance companies would charge so much for the insurance that no one would be able to afford to buy it.

To understand the dilemma the Connector faced, look at it from the perspective of an employer with 100 employees. Let's say, pre-reform, 70 of the company's employees got health insurance from the employer. Let's say another 10 got health insurance from some other source – maybe through their spouse or Medicare or through military insurance. And the final 20 were young and healthy and decided not to purchase insurance.

Along comes the individual mandate. Those 20 uninsured workers decide they need to get health insurance so they don't face a penalty. They compare their options and realize that the cheapest thing to do is to get health insurance through their employer. After all, the employer is subsidizing the insurance, so it's cheaper than going elsewhere. The company's healthcare costs just went up almost 20%. What does their HR director do? She looks to see where to cut costs and looks for other options in the insurance market to come up with some cost savings. If she finds that a bare-bones insurance plan that meets the requirements of "minimum creditable coverage" she may conclude that, heck, if the state says it's good enough, let's switch to that. Which is why the Board thought that in setting minimum creditable coverage, they weren't just

²³ See 956 CMR 5.03(2).

setting the floor for what insurance the previously uninsured would buy, they might well be setting the standard for what most health insurance in the state would look like going forward.

Therefore, defining this minimum became a high stakes proposition. We needed to make certain that Massachusetts consumers could remain or become insured and healthy without driving employers out of business.

In addition to the Connector's definition of minimum creditable coverage, we at the Attorney General's Office have been especially vigilant to protect consumers from unfair and deceptive trade conduct. We have been concerned that companies offering low cost but substandard health insurance products would take advantage of confusion and anxiety around the new rules to prey on consumers. For example, we have filed a consumer protection enforcement action against health insurers MEGA, Mid-West, and their parent company Health Markets. We have alleged that they engaged in a pattern of denying benefits required by Massachusetts law, misled customers through their advertising, marketing, and sales, and disclosed private health information to third parties. MEGA disputes the allegations and the case remains in litigation, but the case illustrates how issues of consumer protection are also issues of fair business competition so that those insurers who play by the rules are not at a competitive disadvantage.

e. Marketing and outreach to sell new insurance

As you can see, our health reform initiative creates a complicated set of new insurance options. For Massachusetts consumers, we are proud to say most of these options are offered by private insurers, supported by a backdrop of complex consumer protection regulations. These concepts are hard enough for expert health care lawyers who are members of the ABA Health

Law section; how do we communicate the complex requirements and protections of the law clearly and fairly to people who do not currently own, and in many cases have never owned, health insurance?

In Massachusetts, we have found an easy answer: the Red Sox. Yes, one of the primary marketing efforts for the new Commonwealth Care insurance lines has been a campaign of TV ads and related outreach focused in and around games at Fenway Park. While I will always insist that there are no more devoted fans than Red Sox fans, I'm sure in your state you can find similar marketing approaches that stand to reach, among others, a large number of young adult males, often the largest group of uninsured in a state's population.

To date, the effort to offer insurance coverage to the uninsured has been fairly successful. Since the law passed in April 2006, approximately 200,000 previously uninsured Massachusetts residents have enrolled in plans, bringing the percentage of uninsured down from 10 percent to 6.9 percent".²⁴ No one expected or promised universal coverage to happen overnight, and the progress to date is encouraging. But the next question we have to ask is whether it is sustainable?

²⁴ The Boston Globe reported in November 2007 that there have been 55,000 Mass Health enrollments and 133,000 Commonwealth Care enrollments. (Alice Debner, *Success Could Put Health Plan in the Red*, Boston Globe, Nov. 18, 2007). Using an uninsured number of 653,000 (Massachusetts Budget and Policy Center, *Facts at a Glance, Census Bureau Estimates One in Ten Residents of the Commonwealth without Health Insurance*, (Aug. 2007), <http://www.massbudget.org/FactsataGlance2006HealthInsurance.pdf>.) and a Massachusetts population of 6.5 million (U.S. Census Bureau, *State & County Quick Facts*, Massachusetts (2007)), <http://quickfacts.census.gov/qfd/states/25000.html>), the number of uninsured went down to 453,000 or 6.9 percent.

3. The next frontier: improving quality and constraining cost

So far, I have discussed a short history on the debate and passage of the health reform law and the first phase of the law's implementation, which has centered on many programs to expand access to health insurance. Implementation of these measures will continue in the months ahead, and these efforts will presumably continue for the foreseeable future unless we experience a major budget crisis or the adoption of major health care reform at the federal level. Government officials and private stakeholders realize, however, that the state's budget and its overall economy cannot support universal coverage unless we address rising health care costs. The struggle to constrain costs while also improving quality is the next, and probably the hardest, frontier that we face.

Of course, rising health care costs are a national problem. Health care costs have risen steeply. In 2005, the latest year for which data is available, total national health expenditures rose 6.9 percent -- two times the rate of inflation.²⁵ Rising costs put strains on state and federal budgets, on individual consumers who pay premiums and deductibles, and on employers who contribute to premiums.

I'd like to describe four major initiatives to curtail cost increases, and the various legal challenges associated with each of these.

²⁵ National Coalition for Health Care, *Health Insurance Facts; Facts on the Cost of Health Care* (2007), <http://www.nchc.org/facts/cost.shtml>.

a. Pay for performance

First, the new health reform law includes a pay-for-performance measure that ties increased Medicaid funding to hospitals' attainment of quality and performance benchmarks.²⁶ Many insurance carriers already include pay-for-performance provisions in contracts with providers, in an effort to increase incentives for hospitals to improve efficiency, reduce errors, and cut unnecessary spending. In our health reform law, the state joins this trend and uses its purchasing power to encourage quality and cost improvements.

In fact, Massachusetts goes further by expressly including the reduction of racial and ethnic disparities as a part of the pay-for-performance initiative.²⁷ To our knowledge, no other public entity has ever tied payments to the reduction of disparity along racial and ethnic lines. In fact, health care providers around the nation by and large do not even collect patients' racial and ethnic data on a regular basis. Yet, numerous studies have demonstrated that in many contexts, when the data is analyzed to control for income and socioeconomic status, persons of color receive recommended care less frequently than white patients.²⁸ Health care disparities sometimes occur along regional and gender lines too, and are often attributable to communication and cultural gaps. Addressing disparities is not only a moral issue; it is also a way to ensure that efforts to improve quality are promoted universally and aggressively.

Like many other parts of the health reform law, when it comes to pay for performance, the statute simply includes very broad language and leaves all of the details to be determined by

²⁶ 2006 Mass. Acts Ch. 58 § 116.

²⁷ M.G.L. c. 118E § 13B.

²⁸ See, e.g., Kevin Fiscella, Peter Franks, Marthe R. Gold & Carolyn M. Clancy, *Inequality in Quality Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA 2579-2584 (2000) and Robert Mayberry, Fatima Mili & Elizabeth Ofili, *Racial and Ethnic Differences in Access to Medical Care*, 57 Medical Care Research and Review, 108-145 (2000).

a state agency. Those details raise some tricky questions. One fundamental question is whether incentives should be based on a hospital's overall performance, or its improvement over time. If payments are based simply on a hospital's absolute ranking on quality and cost measures, then the best hospitals will be rewarded (and they are usually the ones with the most revenue to begin with), while a low-performing hospital would receive no reward for making substantial improvements. On the other hand, if incentives are paid only to hospitals with the largest improvements, then a hospital that consistently achieves excellence will in effect be penalized and will never receive incentive payments for maintaining excellence. Ultimately, the state agency in charge of implementing pay-for-performance has established a balanced formula to take into account both overall quality and efficiency ratings as well as improvement from prior years.²⁹

Another hard question is how to measure quality. The basic approach for measuring quality is to identify universally recognized standards of care, and then to measure compliance with those standards. For instance, all patients with diabetes should receive regular tests to monitor glucose control as well as yearly exams for eye disease. The state can attempt to measure performance of a hospital or physician group by measuring how frequently it meets these established benchmarks.

In practice, however, the measurement system must include the right benchmarks or else it does not provide accurate results. In addition, this system requires the collection of enormous amounts of raw data. To ensure reliable measures, the system must provide ways to review data

²⁹ See Mass. Medicaid Disparities Policy Roundtable, Mass. Medicaid Policy Institute, *Pay-for-Performance to Reduce Racial and Ethnic Disparities in Health Care in the Massachusetts Medicaid Program*, (July 2007), http://www.massmedicaid.org/pdfs/2007-7_disparities.pdf.

to account for gaps and incomplete data, which would skew results, and also provide mechanisms to allow hospitals and doctors to submit information to correct data errors.

Ultimately, a pay-for-performance model needs to be constructed very carefully to protect against unintended consequences. One risk is that hospitals would respond to pay-for-performance incentives by declining to treat high-risk patients in order to skew their performance measures and boost their results. If not properly designed, an initiative intended to remedy racial and ethnic disparities could actually exacerbate these disparities in care.

In Massachusetts, the total amount of state funding subject to pay-for-performance standards is relatively small, and it remains to be seen whether it is enough to make a major difference in how hospitals make decisions. Despite the various potential pitfalls, this pilot program offers the potential to improve both quality of care and efficiency if designed and implemented carefully.

b. Transparency: public reporting of cost and quality data

A second initiative designed to address both quality and cost is government creation of a website to display cost and quality data on health care providers in a transparent way.³⁰ The legislature sought to enable consumers to compare the costs and quality of receiving the same services from different hospitals or providers. This measure is part of a broader trend toward consumer responsibility in health care. Transparent reporting also allows providers and insurance carriers to see costs, and in a competitive market environment, this free flow of information theoretically will lead to more competition, better quality and lower prices.

³⁰ M.G.L. c. 6A § 16L.

Massachusetts is prepared to post both quality and cost information on its website starting this spring. Maine and New Hampshire already have similar websites, but their transparency programs are more limited – in particular, they only post cost data, and do not display corresponding quality data for providers. Other states have posted quality data without focusing on cost. We think the Massachusetts website will improve on these worthy efforts.

While many stakeholders and academic experts believe that public data reporting will yield beneficial results, this experiment raises some difficult questions and challenges remain. Perhaps most significantly, posting of data might lead some patients to choose the more expensive options, not the least expensive ones. If someone has robust insurance coverage that will pay for the vast share of a procedure's costs, then the person has almost no meaningful incentive to save money – indeed, there might be a risk that the patient would prefer the most expensive option, on the assumption that it is the best. Some call this the “Neiman Marcus effect.”

Additionally, making price information readily available to competitor providers in a concentrated marketplace may risk collusion on the part of providers. As economic models tell us, in oligopolies, there is an incentive on the part of providers to conspire to keep costs, and therefore profits, high. We are working to ensure that the way we post the data will help consumers make their best choice without threat of collusion and price increase.

Transparency measures such as our new website also face the same technical challenges raised by pay-for-performance measuring, such as the need to identify a relevant, complete set of quality benchmarks and the need to ensure that the data itself is accurate. In addition, data

collection systems should be designed to protect the privacy of individual patients. In Massachusetts, the Health Care Quality & Cost Council has developed rigorous, detailed rules to ensure that when the Council and its private contractor collects enormous amounts of insurance claims data, which will then be crunched to generate cost and quality information for the website, that claims data will be stripped of individual identifying information such as name, address and social security number, and other safeguards will be used to prevent any violations of privacy.³¹

Although most of the public discussion about our new website focuses on providing consumer information, perhaps the most significant value of this initiative in the long term is to promote evidence-based medicine. Many health care experts have studied medical practice throughout the nation and confirmed that different doctors and hospitals often treat the same patient symptoms and conditions in very different ways. Dr. Elliot Fisher, Principal Investigator at The Dartmouth Atlas Project has done a great deal of research uncovering differences in standards of care by geography and provider type. Where you go to get care can determine how much care you receive. Why is this and what does it mean for those who are getting less care? Surprisingly, this increase in care does not always mean an improvement in the quality of care. Elliot has found that for some types of treatment, including many very expensive procedures, when experts conduct a thorough statistical analysis of the evidence, it turns out that the intervention yields no patient benefit whatsoever. In fact, in some cases, his research has found that overutilization of some expensive interventions are harmful to our health. Information is a very powerful thing – as the Quality and Cost Council and other government and non-profit entities collect and analyze reams of data, a positive by-product may be a revolution in evidence-

³¹ See 129 CMR 2.00.

based medicine. Technology has played a large part in the rising costs of health care; information technology offers a major solution.

c. Electronic medical records

Closely related to pay-for-performance and transparency, the third major initiative related to cost and quality is to increase the use of electronic medical records. The collection of cost data is relatively easy because insurance claims are stored electronically by insurance carriers and third-party administrators. Collecting and analyzing data on health care quality is much more difficult because so many physician practices and hospitals still create and maintain paper folders, charts and doctors notes in barely legible handwriting. As a result, the use of electronic medical records offers improved patient care by letting a doctor in any hospital see a patient's full medical history and letting doctors track their patients more rigorously. Yet electronic medical records also hold the key to collecting, analyzing and using data to promote evidence-based medicine, provide information to consumers, and establish reliable pay-for-performance incentives.

With these benefits in mind, the comprehensive health reform law included a modest but important investment of \$5 million in a government-sponsored program to encourage the use of electronic medical records and computerized physician order entry systems for drug prescriptions and other physician orders.³² Various state entities have also been working closely with non-profit stakeholders to promote electronic medical records.

³² M.G.L. c. 6A § 16L(n).

Nevertheless, there are many obstacles to the successful creation of electronic medical record systems. The first is lack of available capital to invest in expensive IT systems. Many hospitals face serious capital needs simply to maintain and upgrade physical plant and expensive medical equipment, and may not be willing or able to make long-term investments in electronic medical record systems. The second is the human, cultural obstacle of persuading doctors and other medical staff to change their daily routines to use new computer systems. The newest generations of doctors and other health providers readily accept these systems. But try telling an expert oncologist who has been practicing for twenty years and has a packed schedule of clinical and research activity that she needs to change the way she has been keeping records for the last twenty years and you might meet some resistance.

The good news is that despite these challenges, many hospitals are successfully adopting electronic medical record systems. Arguably, there is also some bad news – these hospitals are each creating their own new system, and the format and content of each hospital’s system varies. In an ideal world, there would be a universally accepted electronic medical record for each type of practice (for instance, cancer specialists, diabetes specialists, general pediatrics, and so on). Over time, our systems may gradually evolve toward universal standards, particularly if government agencies and private insurers exert pressure in that direction.

As you know, the Health Insurance Portability and Accountability Act of 2003 set a federal standard for accessing and processing medical information.³³ These standards play a central role in how we must collect and post data. Thus, any time medical records are

³³ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 45 C.F.R. §§160, 164 (enacted Aug. 21, 1996; amended 2002).

centralized in order to maximize the amount of information a doctor has about a patient, there is always the risk of information getting into the wrong hands. Protection of consumer privacy is a major concern – and Attorneys General have a valuable role to play in protecting the privacy of confidential patient information.

d. Goal-setting: chronic disease management, EOL, preventable errors

A fourth major initiative under the new health reform law relating to quality and cost is a concerted effort by the new Quality and Cost Council to work with other state agencies and private entities to set goals and promote best practices and policies. Since last summer, the Council has identified detailed goals and proposals for each one: better chronic disease management; comprehensive measures by providers to prevent costly errors such as hospital-acquired infections; and more effective end-of-life care policies and practices.

e. Other ways for state Attorney General offices to address cost and quality

In addition to these new initiatives to address the cost and quality of health care, we intend to use the Attorney General's broad enforcement powers to promote more cost-effective health care and combat fraud and other practices. Like other states, we have a Medicaid Fraud division that uses both civil and criminal tools to combat fraud in provider billing, pharmaceutical marketing and sales, and other practices. This year, we estimate that we will recover more than \$32 million in Medicaid fraud cases. These cases not only recover funds, but should deter others from committing fraud that increases health care costs for taxpayers and the entire system.

Our new Health Care Division is using the broad authority under our state consumer protection law and other statutes to address unfair and deceptive practices by pharmaceutical companies, health insurers, and medical device manufacturers. Our Antitrust Division is promoting better quality and lower costs by enforcing laws requiring a competitive marketplace. Taken together, these measures offer some hope that we can rein in medical cost inflation without needing to take more drastic measures that place limits on choices for doctors and patients.

4. Conclusion – lessons learned

The Massachusetts health reform experiment has received a fair amount of national attention, and we hope that our experience helps provide useful guidance for national and state debates about health reform. I'd like to end with two lessons that are particularly relevant to this ABA summit.

The first is concerns federalism. Health care is an area that is particularly difficult to fix at the state level. The federal government plays an enormous role in health care finance through the Medicare and Medicaid programs, HIPAA and ERISA and other federal laws and regulations place significant restrictions on options for state regulation. State borders are porous, people move from state to state, and health care reform can have a direct impact on a state's economic competitiveness by affecting employers.

Yet while federal reforms would seem critical, the Massachusetts experience suggests that states can play an extremely valuable and central role in health care reform, as true laboratories of democracy. Governors, state legislatures, and state attorneys general are closer to

the various stakeholders and more familiar with the unique values and challenges of their state. States have unique assets and challenges, and may choose very different solutions – while some states might settle on tax increases to fund health care expansion, others might experiment with insurance reforms or other measures. So while federal reform is certainly needed to address many of the problems plaguing America’s health care system, at least in the absence of a comprehensive federal commitment to universal healthcare nationwide, federal efforts should promote and allow state reform efforts as much as possible.

The second lesson for today is the central role that lawyers have played in health reform in Massachusetts. Both government lawyers and private attorneys have worked to design the health reform plan, to deal with complex issues of insurance law, antitrust law, and privacy rights, and to help all sorts of clients adjust to a brand new regulatory regime and marketplace. As you well know, health care lawyers have the daunting but rewarding job of understanding very complicated rules, figuring out how best to change or deal with them, and then explaining them in plain English to clients or decision makers.

As in any other area, when it comes to health reform, a few lawyers and companies have skirted the law or tried to manipulate rules in a way that does not advance broader societal interests. Yet, I have been extremely impressed at how the overwhelming majority of lawyers and stakeholders involved in our ongoing health reform process have risen above self-interest and worked cooperatively to promote common interests. As you return to your home states to resume your practice, I would suggest that you will find that in most situations, you can find constructive, creative options for your clients that also serve the broader interests of promoting greater access to affordable, high-quality health care.

The ultimate lesson of health reform in Massachusetts is that cooperation and consensus can work. In the narrow short-term analysis, it might appear that an insurer can make a higher profit by denying certain claims or a provider by refusing to treat certain patients, all within the bounds of the letter of the law. But health reform was possible only because all of the stakeholders were willing to look beyond that very narrow approach to a broader vision. Employers have accepted the responsibility to provide health insurance or else pay a small assessment, knowing that in return they will no longer indirectly pay for the uninsured in the form of higher premiums. Insurance carriers agreed to extend coverage to young adults up to 25 years of age, knowing that health reform would broaden their risk pool and bring in additional capital through a set of new products and the individual mandate. The reform law is not perfect, and no stakeholder or participant came away with 100% of what it sought; but the cooperative coalition of interests has created a real possibility of major, meaningful change.

As leaders in your communities, you too can work toward health reform that is desirable and politically viable. In the last century, modern medicine has made unbelievable breakthroughs. Looking at the ultimate measure, the average life expectancy of Americans has risen from 47 years of age in 1900 to about 78 years of age today.³⁴ It's time for our laws and policies to catch up so that everyone can share in these amazing possibilities in an efficient, affordable way. And to update Dr. Warner's nineteenth century insight after the discovery of anesthesia, "Ladies and Gentlemen, this is no humbug!"

³⁴ National Center for Health Statistics, U.S. Dept. of Health and Human Services, *Health, U.S., 2006*, 193 (2006), <http://www.cdc.gov/nchs/data/hus/hus06.pdf#027>.