ISSUE BRIEF

The Massachusetts Health Policy Forum

An Analysis of Initiative Petition 99-4, "An Act to Protect the Rights of Patients and to Promote Access to Quality Health Care for All Residents of the Commonwealth"

A discussion moderated by Stuart Altman, Ph.D.
Thursday, April 6, 2000
9:00 to 9:30 – Registration and Breakfast
9:30 to 12:00 – Presentations and Discussion
Omni Parker House
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Introduction

"An act to protect the rights of patients and to promote access to quality health care for all residents of the commonwealth" was submitted as an Initiative Petition for a law under the provisions of Article 48 of the Massachusetts Constitution to appear on the November 2000 ballot. The sponsoring organization, the Ad Hoc Committee to Defend and Improve Health Care, received approval from the Attorney General in August 1999 and collected more than the required 57,100 signatures in the fall of 1999 to move the Petition forward in the lengthy initiative process. As required by Article 48, the secretary of state transmitted the Petition for consideration to the General Court in January. If the General Court fails to enact the Petition into law by Wednesday, May 3, the Petitioners will need to collect an additional 9,517 signatures by June 21 to secure placement on the November 7 ballot.

The original sponsoring organization, the Committee to Defend and Improve Health Care, describes itself as "clinicians, citizens and patients . . . committed to maintaining and improving the health of our patients." The Petition's first ten signers include prominent individuals from medicine and other fields including Nobel Prize winner Bernard Lown, MD, and John Kenneth Galbraith.

The Petition combines three complex and controversial areas of health care policy that most often have been considered separately:

I. Universal health insurance coverage

II. A bill of rights for managed care patients

III. Conversion of hospitals and health plans from non-profit to for-profit status

This policy report does not offer recommendations for or against the Petition, but instead provides analysis and background on each of the three policy areas. It is our hope that this policy report will inform both legislative deliberations and the public conversation that needs to take place regarding the Petition. Rather than supplying the final word, we hope to begin the public discussion of the Petition in an informed manner.

In preparing this policy report, the study team contacted Bernard Lown, MD, the first signer of the Petition and Chairman of the Committee to Defend and Improve Health Care. We agreed to submit questions to the Committee for their written responses and did so on February 11. Though the Committee was not able to answer our questions in time for the writing of this analysis, they provided a written statement in response on March 28. All questions and the Committee's response are included with this report as Appendix 3. Members of our study group also met with opponents of the Petition to understand their objections and concerns.

I. Universal Access and Cost Control Provisions

Provisions

SECTION 2 of the Petition inserts a new Section 1C into Chapter 111 of the General Laws stating: "There shall be established a patient-centered system of health care that will ensure comprehensive, high quality care and health coverage for all residents of the commonwealth, to be in effect no later than July first, 2002." The Petition further specifies the following "requirements" for the new system:

(a) access shall be provided to health care services for all Massachusetts residents and barriers eliminated to such services, medications, and supplies necessary for the prevention, diagnosis, treatment, rehabilitation, and palliation of physical and mental illness;

(b) patients shall be guaranteed the right to freely choose their health care providers, to have a second medical opinion and to appeal denials of care; and the clinical freedom of physicians, nurses and other health professionals to act solely in the best interests of their patients shall be assured;

(c) affordable health care coverage shall be ensured to all Massachusetts residents, with health care expenditures that rise no faster than those of the nation as a whole;

(d) the high quality of health care in Massachusetts shall be preserved and promoted; and the well-being of medical research, training, and innovation shall be protected and fostered;

(e) no less than ninety percent of all payments made for health care coverage shall be used for patient care, public health, or the furtherance of medical skill and knowledge, and no more than ten percent of such payments shall be used for administrative costs or any other purpose; and the paperwork and administrative tasks of patients, hospitals and health care professionals shall be simplified; and

(f) no financial incentives shall be permitted that limit patient access to health care services and medications that are appropriate or necessary, and incentives, direct or indirect, that promote the provision of inappropriate and potentially harmful care to patients shall be minimized.

The Petition does not specify the structure or financing requirements of a new system, but instead establishes two overlapping public bodies — a health care council and a special legislative committee — to make recommendations for the creation of a new system meeting the above listed requirements. With the exception of the ban on the conversion of hospitals and health plans to for-profit status (Section 1D – discussed in Part III of this report), there are no sanctions or penalties if either of the two public bodies or the General Court fail to meet the Act's specified deadlines or fail to act at all.

Health Care Council

SECTION 2 directs the Commissioner of Public Health to appoint a 17-member health care council to be composed of "moral, academic and community leaders, health care advocates, consumers, providers and third-party payors and shall include at least one member from each of the following organizations selected from nominations by such organizations":

- Ad Hoc Committee to Defend and Improve Health Care
- American Association of Retired Persons
- American Federation of Labor–Congress of Industrial Organizations
- Blue Cross and Blue Shield of Massachusetts
- Health Care for All
- Massachusetts Association of Health Maintenance Organizations
- Massachusetts Business Roundtable
- MassCARE
- Massachusetts Hospital Association
- Massachusetts League of Community Health Centers
- Massachusetts Medical Society
- Massachusetts Nurses Association
- Massachusetts Public Interest Research Group
- Massachusetts Senior Action

These 14 organizations can be classified as follows: advocacy, 6; provider, 4; insurers/HMOs, 2; business, 1; and labor, 1. Beyond these 14 groups, the Petition does not specify whether other organizations may submit nominations for the remaining 3 seats on the health care council. No provision guarantees the inclusion of either "moral" or "academic" leaders if all of the listed organizations fail to nominate individuals meeting that description. The Petition does not make provisions for or against the inclusion of executive branch officials. The Petition is silent on the authority of the commissioner to reject an organization's nominee, and on the election or appointment of a chairperson.

The Petition charges the health care council to hold at least four public hearings in different regions of the Commonwealth, to study various health care proposals, and to make recommendations to the commissioner and to the legislature for the establishment of "health care policies, laws, and other mechanisms" to ensure that the requirements listed in Section 1C (a through f) are met. The Petition does not specify a deadline for the formation of the health care council nor a deadline for submission of its recommendations to the commissioner or to the legislature.

Special Legislative Committee

SECTION 4 of the Petition directs the creation of a special legislative committee to study and recommend the establishment of a patient-centered system of health care conforming to the Section 1C requirements referenced above. The special committee would consist of 5 members of the House of Representatives to be named by the Speaker, 3 members of the Senate to be named by the President, and the 17 members of the health care council, for a total of 25 members. The Petition does not specify who will serve as chair or co-chairs of the committee. Section 4 directs that members of the special legislative committee be appointed no later than January 10, 2001, and that their report and recommended legislation be filed with the clerks of the House and Senate no later than September 30, 2001.

The Petition is silent on the overlapping responsibilities of the health care council and the special legislative committee to report recommendations to the state legislature, leaving open the possibility that both bodies could make different and conflicting sets of recommendations. There are no specific sanctions if the council or the special legislative committee cannot or do not forward plans to the General Court.

Discussion

The Petition's sponsors deserve credit for bringing the issue of universal health insurance coverage back onto the Commonwealth's policy agenda. This issue has appeared and reappeared sporadically since the mid-1980s. While access expansions have lowered the numbers of uninsured in recent years, those expansions have already been implemented. If no new expansions are enacted in the near future, the number of uninsured will begin to rise again, particularly if the recent growth in health insurance premiums continues to increase at current rates. In November 1999, the Legislature proposed the creation of a new special legislative committee to investigate ways to increase insurance coverage for the working uninsured. That proposal was vetoed by Governor Paul Cellucci and was not brought up for an override vote in the General Court.

However, specific details of the Petition framework regarding universal coverage raise issues and require discussion. According to "Frequently Asked Questions" on the sponsors' website (http://www.voteforhealth.org/FAQ.html), the Petition "requires that by July 1, 2002, Massachusetts have in place a system of health care that ensures comprehensive, high quality health coverage to every resident — and do it in a way that keeps costs reasonable and minimizes spending on bureaucracy." This assertion is not true. In reality, the Petition mandates the creation of two public bodies directed to make recommendations to the legislature for the establishment of a new health care system meeting the Petition's requirements. Assuming that one or both of these public bodies meets its charge to submit recommendations, legislative or otherwise, there is no constitutional way to compel the General Court to act on those recommendations.

Moreover, there is no way to require that the health care council or the special legislative committee even submit recommendations. Recent history in this regard is instructive. Since 1980, the Massachusetts legislature has established five special committees directed to submit legislative recommendations relative to health care finance and access reforms (1980, 1985, 1990, 1994, and 1996). Only one of these special legislative committees met its mandate to submit recommendations along with legislation for implementing the recommendations — the 1996 special legislative committee formed to recommend refinancing of the hospital uncompensated care pool. These recommendations were signed into law in July 1997. The other four special committees were given broader mandates to recommend wholesale improvements in health care financing and access. All four ended in stalemate, unable to agree on or submit legislative recommendations, which were part of their statutory charges. The broad directive to the health care council and the special legislative committee included in the Petition is more like the broad mandates to the four unsuccessful committees than the specific charge to the 1996 committee.

It is possible that approval by a substantial majority of voters in November 2000 will give this new legislative committee more momentum and legitimacy than that enjoyed by the four unsuccessful committees. However, in November 1986, Massachusetts voters approved a nonbinding ballot question memorializing the U.S. Congress to enact a national health program by a margin of 67.2% (1,045,975) to 32.8% (510,161). This vote did not avert the failure of the 1985 commission of the Massachusetts legislature to reach agreement before its unsuccessful dissolution in June 1987.

Finally, it is conceivable that even if a special legislative committee is unable to agree on statutory recommendations, the public discussion and attention generated by its work can encourage action by the General Court to expand health care access, universal or other-

wise, as occurred with prior unsuccessful committees. However, in those other instances, the expiration of key statutes was more instrumental in triggering action on hospital rate setting and mandated employer health coverage than the work of special legislative committees.

Cost Controls

Regarding cost controls, the Petition requires that "health care expenditures . . . rise no faster than those of the nation as a whole," but specifies neither a mechanism nor a target (providers or insurance plans) for cost controls. Massachusetts is one of several states with significant experience in attempts to control health care costs and to expand health insurance coverage to all residents. Understanding this experience may be helpful in evaluating the merits of this portion of the Petition.

Control of Providers. From 1975 until 1991, Massachusetts hospitals were subjected to mandatory cost controls under a series of complex hospital rate setting laws. Historically, hospital costs in Massachusetts have been the highest or among the highest in the nation. Prior to the emergence of managed care as an organizing framework, hospitals were regarded as the engine of the health care financing system and thus the principal target of regulation seeking to control overall health spending. Empirical evidence suggests that between 1975 and 1987, hospital rate setting controls reduced the rate of growth in Massachusetts inpatient hospital costs relative to the rest of the nation. Between 1988 and 1991, regulatory controls were relaxed under the provisions of Chapter 23 of the Acts of 1988 (also known as the "universal health care law"). State lawmakers relaxed the rate setting controls to address protests by hospitals and to gain political support for the universal coverage provisions. Dissatisfaction with the controls by numerous parties, including hospitals, insurers, employers, and state officials, led to deregulation of controls in 1991.

Control of Insurance. For several decades, Massachusetts also regulated premiums for Medicare supplemental (Medex) insurance policies issued by Blue Cross and Blue Shield. Regulatory review became a politically charged process that, among other factors, contributed to serious financial instability for this insurer in the late 1980s and early 1990s. Dissatisfaction with the rate review process led the state legislature in 1993 to largely deregulate Blue Cross Medex premiums as part of a larger reform of all Medicare supplemental products. Currently, the Division of Insurance does not review premium increases for any health insurance policies, though it establishes certain limits and "rate bands" that can trigger reviews.

Containing total health insurance premium costs at the state level would prove difficult, if not impossible, because approximately one half the Commonwealth's residents are insured through mechanisms beyond the reach of state regulation. First, any employer that self-insures for health insurance cannot be subject to state regulation because of the 1974 federal Employee Retirement Income Security Act (ERISA), which preempts such plans from state control. No study documents the proportion of Massachusetts workers enrolled in employer self-insured plans, though national estimates suggest that between 30% and 50% of all workers with employer-based coverage are insured through ERISA-protected plans. Second, 941,000 elderly and disabled residents (15.5%) receive coverage through the federal Medicare program, which is also beyond the scope of state regulation. Major portions of the provider community (hospitals, physicians, home health agencies, nursing homes) receive a substantial portion of their revenue from the Medicare program. In addition, nearly one million Massachusetts residents are covered by MassHealth, the Commonwealth's Medicaid program, which is subject to complex federal rules that may in part conflict with the Petition. If health costs for any of these populations rise beyond the rate of national health expenditures, the state would have to clamp down on all other sources of spending to meet the Petition's requirements for "health care expenditures that rise no faster than those of the nation as a whole."

In summary, Massachusetts' regulatory efforts at the provider and insurance levels to control health spending have been singularly unsuccessful. Complexity, rigidity, and political gaming were all in evidence in each attempt. Hospital rate deregulation was a deliberate policy choice made in response to regulatory failure. Moreover, major financing streams in the insurance sector are beyond the scope of state regulation, and Congress has shown no inclination to relax ERISA or other requirements. By failing to propose a mechanism by which expenditures will be controlled and by failing to specify the object of new controls, the Petition expresses a wish but offers no help in how to accomplish this goal.

Universal Coverage

The Petition is silent on how to establish universal coverage, leaving that challenge to the health care council, the special legislative committee, and the General

Court. This is unfortunate because although a large majority of the public supports the concept of universal coverage, this support always diminishes when concrete proposals to finance a new system are advanced. The Petition could have played an important role in identifying an acceptable method to reach universal coverage and in demonstrating public support for that approach. Instead, the Petition directs the council, the committee, and the General Court to guess which approach would meet public approval without the mandate that could have been provided by a vote for a more specific approach.

The cost to provide coverage to 623,000 uninsured in Massachusetts would be large. Assuming an individual cost of $2500, the total cost would be more than $1.5 billion annually. Subtracted from that would be about $300 million in hospital uncompensated care pool costs, and whatever amount could be drawn from new enrollees in premiums and cost sharing. For individuals with incomes below 200% of the federal poverty line ($33,396 for a family of four), federal matching funds could finance 50% of the cost, considerably lowering the overall cost to the state. Without an employer mandate, however, to compel continuing employee coverage, it would be difficult to confine this initiative to only the currently uninsured, particularly when subsidies would be available to individuals with income above 200% of the federal poverty line.

Generally, health policy specialists identify three potential (and disputed) options to universal coverage: (1) A mandate for individuals to purchase health insurance coverage linked to sizable and refundable tax credits; (2) A mandate for employers to cover their employees; or (3) Single payer/taxpayer financed coverage. Option 1 relies heavily on redesign of federal tax provisions, an option beyond the reach of state law. Thus, options 2 and 3 are the only mechanisms to reach universal coverage that potentially could be achieved through state action.

Concerning both options, recent history is instructive. Regarding employer mandates, in 1988, Governor Michael Dukakis signed Chapter 23, the universal health care law that would have required most employers to provide health insurance to workers beginning in 1992 or else pay a $1680-per-worker-tax that the state would use to buy coverage. In the years between enactment and implementation, political support for the mandate collapsed within the legislature as a severe economic recession gripped the Commonwealth. On three occasions (1991, 1994, and 1995) the legislature delayed the mandate rather than allow it to go into effect. In early 1996, the House leadership advanced a proposal to establish a less onerous mandate, called the "health care minimum wage." This proposal failed to garner sufficient support, and the mandate was repealed in July 1996 in Chapter 203 (which expanded insurance access to children and other disadvantaged groups, created the Senior Pharmacy Program, and raised the state tobacco tax by 25 cents). Since the 1996 repeal, no proposals for employer mandates have been filed.

Efforts in Massachusetts to promote universal coverage by means of tax financed (so-called "single-payer") mechanisms have been less successful. Bills to establish various forms of single-payer systems have been filed in nearly every legislative session since 1986. Each year, they have been referred to the legislature's joint committee on health care. Not once has the legislation attained sufficient support to receive a favorable committee vote, the first of many steps in the serpentine legislative process.

The failures of employer mandate and single-payer strategies do not mean that Massachusetts state government has been inactive in expanding insurance access for the uninsured. Access for uninsured children was improved through laws enacted in 1991, 1994, 1996, and 1997, so that health coverage is now available to every child in the Commonwealth; the remaining challenge is to identify and enroll every uninsured child. The state's Medicaid program was reinvented in Chapter 203 of 1996 through a federal regulatory waiver to expand eligibility to all children and some parents up to 200% of the federal poverty level. Massachusetts continues to be regarded as a leading state in efforts to expand coverage to affordable health insurance. This progress was verified in the 1999 Current Population Survey of the U.S. Census Bureau that documented a drop in the number of uninsured residents in Massachusetts from 753,000 in 1998 to 623,000 in 1999.

This heartening progress, though, reflects the implementation of access expansions enacted in 1996 and 1997. Currently, no significant access expansions are under consideration by the General Court. If none are enacted and implemented in the near future, the rise in health insurance premiums now underway suggests that the numbers of uninsured will begin to rise again shortly. Thus, the Petition presents an opportunity to begin a new round of discussions on appropriate and affordable mechanisms to increase health insurance coverage to any or all of the Commonwealth's 623,000 uninsured residents.

Conclusion

The Petition mandates the creation of two public bodies to develop recommendations for the Legislature to consider in establishing a new patient-centered health care system. But the history of such bodies in this state has been singularly unsuccessful. Because large parts of the state's health care system (chiefly, employer self-insured plans and the Medicare population) are beyond the scope of state regulatory control, it is unclear how the state could keep costs in line with national averages. Finally, efforts over many years to reach universal coverage through employer mandates and single-payer financing mechanisms have been unsuccessful. The only efforts that have survived legislative and implementation hurdles have been those that increased access to Medicaid for children and other disadvantaged groups. The Petition could help in restarting discussions concerning ways to expand coverage to the uninsured.

II. Patients' Bill of Rights and Other Managed Care Provisions

When Chapter 176G of the Massachusetts General Laws, the licensing statute for health maintenance organizations (HMOs) in the Commonwealth, was enacted in 1976, it affected a relatively small number of HMO plans, and likewise, a relatively small number of people enrolled in HMOs. In the intervening 24 years, managed care organizations have proliferated in Massachusetts, as they have across the United States, and now there are 17 licensed HMOs in the Commonwealth. More than 58% of the insured population in Massachusetts are enrolled in some form of managed care.

SECTION 3 of the Petition enacts a "Patients' Bill of Rights" for the Commonwealth. The broad package of reforms is aimed generally at members of managed care plans, but the proposed legislation makes the provisions applicable to all residents with any health insurance. Two major exceptions, noted above in our discussion of SECTION 1 and 2, would most likely also apply to these reforms. First, the federal ERISA statute restricts states from regulating health plans sponsored by employers who self-insure for their employees' medical expenses. This exemption would apply to between one third and one half of insured Massachusetts residents, predominately those covered under the policies of employees working for large firms. Second, Medicare managed care plans for those over 65 and the disabled are governed chiefly by federal regulation (which already includes some of the protections of the Petition). The effect of the proposed changes in state law on these plans is uncertain, particularly in light of the recent federal court decision that ruled that a provision of the federal Balanced Budget Act preempted state regulation of Medicare HMO benefits (*Massachusetts Association of Health Maintenance Organizations v. Linda Ruthardt, Commissioner of Insurance*, 194 F.3d 176 (1999)).

Many of the topics in SECTION 3 have been discussed in the legislature for the past few years. The first comprehensive managed care bill was introduced in early 1997. Both the House and Senate passed separate bills during 1998, but the joint conference committee was not able to produce a compromise for final approval. The process started over again in 1999, with each branch again passing separate bills. Another House–Senate conference committee was appointed in July 1999, and as of this writing no consensus legislation has been reported for approval. The sponsors of the Petition are certainly responding, in part, to their frustration over the slow pace of legislative consideration of managed care reform.

Overview

The provisions proposed in SECTION 3 of the Petition for the most part reflect the general categories of provisions contained in current pending legislation, but with important differences. The following represents an overview of major provisions of the Petition, along with a comparison highlighting the differences between the Petition and the current House and Senate bills. The individual provisions of SECTION 3, which would become effective on January 1, 2001, can be divided into three categories:

- Patients' rights to choose health care providers
- Standards for medical decisions by health plans
- Standards for contracting and financial arrangements between health plans and physicians

Patients' Rights to Choose Health Care Providers

A number of provisions in SECTION 3 focus on allowing insured patients the right to choose their health care professionals and facilities. These provisions would restrict the current policy of HMOs to limit coverage to providers affiliated with or approved by the HMO plan. Among these provisions is language that

- declares a general right of all patients to choose their health care professionals and facilities (Section 4(a) and 4(c)). This right is qualified by allowing a health plan to require the approval of a primary provider for a referral, and the payment of a reasonable additional fee to see a provider not in the plan's network.
- allows a patient to select an obstetrician or gynecologist as her primary care doctor, or to see an obstetrician or gynecologist without a referral from her primary care physician (Section 4(b)).
- allows a patient to remain with a provider who has been dropped from a health plan for up to 90 days (Section 6).
- allows a patient who needs treatment from a specialist to be treated by a specialist; and allows patients with chronic conditions to receive a standing referral that lasts for 6 months or a year (Section 7).
- allows a patient to use any emergency room when an ordinary person (called a "prudent layperson") would believe one's health is in serious jeopardy (Section 11).

Petition: All insured patients have the right to choose their health care professionals, health care facilities, and other health care providers, at reasonable additional fee to the patient if provider is not in plan network, subject to approval of primary health care provider. Obstetrician/gynecologist may be selected as primary care physician. Standing referral to specialists for insured patients with chronic conditions subject to renewal every 6 months or annually.

House: No provision for out-of-network services, except on a transitional basis for newly covered individuals. Obstetrician/gynecologist may be selected as primary care physician. Standing referrals for covered individuals with chronic illness.

Senate: Transitional out-of-network services for new members. Provides for a point-of-service pilot program, at reasonable additional cost to the insured. Obstetrician/gynecologist may be selected as primary care physician. Standing referrals for members who need ongoing care.

Standards for Medical Decisions by Health Plans

SECTION 3 of the Petition includes a number of provisions that regulate the standards used by health plans when deciding whether a particular medical treatment is covered under a plan. Section 5 declares that an "attending health care professional, in consultation with the insured patient, shall make all decisions, consistent with generally accepted principles of professional medical practice, regarding medical treatment, including provision of durable medical equipment, medications, and length of hospital stay. . . ." This provision could be interpreted as restricting the ability of health plans to impose a uniform standard of medical practice on the participating providers, such as restricted drug formularies, hospital stay limits, or treatment protocols. It appears to allow physicians to control all aspects of a patient's medical care, as long as the decision is supported by other doctors, and, arguably, the health plans could have to pay for anything that is medically defensible, whether or not it is medically appropriate or medically necessary.

Petition: All medical treatment decisions made by attending health care professional, in consultation with the insured patient, consistent with principles of professional medical practice.

House: Medical decisions made by attending physician, in consultation with the patient, consistent with evidence-based guidelines.

Senate: Medical decisions made by attending physician, in consultation with patient, consistent with generally accepted principles of medical practice.

These standards are reinforced by the utilization review provisions of Section 12. Utilization review is a process used by managed care plans to evaluate the necessity and appropriateness of health care services in order to determine whether to pay for the services. Under the provision, any patient who disagrees with the decision of a plan's utilization review procedure may seek a second opinion from a physician of the patient's choice. The plan is then required to reconsider its decision in light of the second opinion. If the patient is still dissatisfied, the patient can appeal the decision to the Commissioner of Public Health. The Commissioner can order the health plan to cover the disputed treatment if it meets the "reasonable medical needs" of the patient.

Petition: Sets minimum standards for utilization review organizations, including that they: conduct utilization review pursuant to a written plan, under the supervision of a physician; provide for a second opinion; and adopt consistently applied utilization review criteria. Patient may appeal to Commissioner of Public Health, who shall make a determination based on a standard of "reasonable medical needs."

House: Sets standards for managed care and utilization review organizations. Specifies issues eligible for expedited internal and expedited external review. Requires expedited external reviews for managed care and utilization review organizations, under specified conditions, with a waivable fee paid by the patient. Appeals decided by independent review team. "Appropriateness of requested health care" standard of review.

Senate: Sets standards for utilization review conducted by HMOs and preferred-provider organizations (PPOs). Specifies issues eligible for expedited internal and expedited external review. Requires expedited external reviews for HMOs, under specified conditions, with a waivable fee paid by the patient. Appeals decided by review agency. "Medically necessary covered benefit" standard of review.

Standards for contracting and financial arrangements

Section 13 of the Petition also prescribes certain standards for contracting and financial arrangements between health plans and physicians and within health plans. The "care share" provision requires that a health plan spend at least 90% of its revenues for health care. (The common insurance term for the "care share" is the "medical loss ratio." This is the amount of expenditures that are health-related, rather than administrative.) The Commissioner of Insurance is directed to determine the method for calculating the amounts spent for health and non-health purposes, and to publish the amounts for each health plan. If a plan spends more than 10 percent of its revenue for non-health purposes in any year, then it must refund the difference to its insured patients.

Petition: Non-health expenditures of Massachusetts insurance carriers may not exceed 10% of Mass.-associated revenues for each calendar year. The Commissioner of Insurance shall promulgate regulations that define what constitutes health and non-health expenditures. Every carrier shall report such figures to the Commissioner annually.

House: No provision.

Senate: Requires annual report of percentage of premium revenue expended for health services to members by the HMO.

Section 8 of the patients' bill of rights also prohibits health plans from using a compensation method for its providers that contains specific payments to induce the provider to "reduce, delay or limit specific, medically necessary services." The language states that "[c]arriers and health care providers shall not profit from denial or withholding of covered services that are medically necessary and appropriate." Plans are also required to disclose their financial incentive arrangements with health care providers, and plans may not terminate a provider for advocating on behalf of a patient.

Petition: Prohibits incentive plans that induce a health care provider to reduce, delay or limit specific, covered medically necessary services. Providers may not profit from withholding such services. All financial incentive arrangements must be fully disclosed and available for inspection.

House: No payments that induce a health care professional to reduce, delay or limit covered medically necessary services. Establishes a special commission to study and evaluate physician compensation arrangements. Makes available summary descriptions of types of provider compensation methodologies to covered individuals upon enrollment and to prospective enrollees upon request.

Senate: No payments that induce a health care professional to reduce, delay or limit covered medically necessary services. Does not prohibit capitation. Directs the Office of Managed Care Oversight to report annually on the impact of provider compensation methodologies on delivery of health services. Summary of compensation for each individual provider disclosed to plan members.

Analysis of Six Key Provisions

As outlined above, many of the Petition's provisions in SECTION 3 overlap considerably with the current House and Senate bills. Therefore, for the purpose of discussion, this analysis focuses on six areas in which the three versions differ significantly:

- Patients' choice of providers (Section 4)
- Medical decision making (Section 5)

- Utilization review and medical standards (Section 12)
- Care share (Section 13)
- Financial incentives and provider contracts (Section 8)
- Effect of provisions on existing contracts (SECTION 5)

Patients' Choice of Providers

There are several implications of the Petition's provision that patients are free to choose their health care professionals, facilities, and other providers, including implications for the provider networks maintained by managed care organizations and those involving the multitude of provider payment methodologies used by health plans. Analyzing these implications is problematic because of the range of potential interpretations of the Petition's language.

In spite of the qualification that the right may be exercised "in accordance with the terms of the health benefit plan," this section in its entirety may be read to permit insured patients to choose any health care professional. The Petition also provides that "patients may be required to pay a reasonable additional fee if they choose health care professionals . . . not within their carrier's network." The managed care industry would argue that this provision has the effect of undermining the core structure of managed care organizations; that is, their method of contracting with providers for the provision of services to their members, in exchange for a guaranteed number of the plan's subscribers in their patient populations. Implementing this provision would require answers to several key questions: On what basis would a "reasonable fee" be determined? Is "reasonable" that which is affordable to the patient, or that which covers the actuarial cost of the additional choice? Can the health plan still use a fee schedule for determining payment to non-network providers, even if it results in the patients having to pay a large balance bill?

Both cost and quality are at issue here. Health plans maintain, with some justification, that this provision could eradicate the most prevalent form of managed care, closed HMOs that do not cover visits outside of the panel of providers contracting with the HMO. By maintaining these closed panels, HMOs claim to be able to monitor quality and enforce compliance with plan standards. It is not clear whether health plans can impose their utilization review requirements on out-of-network providers. They also may not be able to assure a higher volume of patients to those providers in the plan, which is what gives the HMOs leverage to negotiate discounted rates. The sponsors of the Petition, however, maintain that their intent is not to preclude closed network arrangements (see Lown letter, Appendix 3B). This interpretation is possible given the ambiguity of the text, though other interpretations are also likely.

Medical Decision Making

The standards and criteria by which decisions are made regarding certain aspects of medical care, including diagnostic testing, course of treatment, and coverage for durable medical equipment, have long represented an area of great controversy in managed care reform legislation. Control over decisions regarding medical treatment is the subject of ongoing struggle between health care providers and health plans. Managed care organizations argue that utilization review is an important tool to control costs and ensure appropriate treatment for their enrollees. The Petition language may effectively eliminate plan-issued clinical practice guidelines, which health plans develop for the consistency of patient care. However, providers most often cite health plan–imposed preauthorization requirements for tests and equipment as interference with their professional autonomy. Providers further argue that their inability to make medical decisions holds great potential to compromise the standard of care to which they are held, ethically and legally, in their duty to their patients.

The Petition's provision that medical decisions be "made by an attending health care professional, in consultation with the insured patient" assures, in very simple language, the participation of the patient in treatment decisions, and excludes the utilization review function of the insurer from the equation. The House bill provides that such decisions be made in the same manner, with the qualification that the decision be "consistent with evidence-based guidelines." Similar to the Senate bill, the Petition requires that the decisions be "consistent with generally accepted principles of professional medical practice," a less narrow and specific standard. This qualification could be interpreted to be a more permissive standard than that in the House bill.

However, as noted below, the effect of this provision of the Petition may be weakened in practice due to the sentence at the end of Section 5. That sentence permits health plans to make contracts that supersede the

medical decision making standard set forth in the Petition's text.

Utilization Review and Medical Standards

Both the House and Senate bills contain detailed provisions governing utilization review and a patient's right to appeal an insurer's denial of a procedure or treatment in certain cases. The Petition's provisions are much sparer, but contain several requirements that would significantly impact on HMOs' operations. Two examples follow.

Second Opinions. One is an unconditional right of a patient to receive a second medical opinion from any physician chosen by the patient. The health plan is not required to accede to the opinion of the second doctor, but rather must reconsider its decision in light of the second opinion. Insurance plans might oppose this right, fearing that patients will shop around for a physician predisposed to approve a procedure that the plan feels is not medically necessary. This will put pressure on plans to defend any decisions they make in the face of an opposing opinion by a second doctor.

Appeals of Denials of Service. The other key requirement allows a patient to appeal any utilization review decision to the Commissioner of Public Health. In effect, this will make the Commissioner, an appointee of the Governor, the final arbiter of health plan standards for the Commonwealth. Advocates of this provision would support the public accountability this will bring to insurers' decisions, while opponents would see this as a dangerous politicization of medical decisions. The impact of this provision on medical care would depend on the stance taken by a Commissioner of Public Health at the time. In contrast, the House and Senate bills try to provide for an independent review system that is insulated to a degree from direct political pressure, through somewhat cumbersome organizational strategies. Under the House bill, appeals can be made to an independent review organization, which is certified by a board consisting mainly of health officials from the Governor's administration. In the Senate bill, reviews are heard by panels selected randomly from at least three "unrelated and objective review agencies" by a bidding process directed by the Department of Public Health.

This section, along with others, reflects the lack of consistency in the Petition with regard to the exact standard the insurers are to use in making medical coverage decisions. In the utilization review provision, medical decisions are required to be "scientifically derived and evidence-based," yet the Commissioner of Public Health is directed to assess the patient's "reasonable medical needs" when reviewing utilization review decisions. In the medical decision-making provision, however, coverage is required for treatments according to "generally accepted principles of medical practice." Each of these terms carries with it different shades of meaning, which may make a difference in the interpretation and enforcement of the Petition. The lack of consistency could lead to substantial confusion over the implementation of the statute.

Care Share

The Petition sets a minimum "care share" or medical loss ratio that must be met by Massachusetts health insurance carriers. As defined in the Petition, the care share refers to the percent of the health plan's Massachusetts-associated revenue that is spent on "health expenditures" for insured patients residing in Massachusetts. The Petition requires that the care share be no less then 90%, and, conversely, that the plan's "non-health expenditures" not exceed ten percent. If a plan spends more than 10% of its revenues on non-health expenditures, it must refund the difference to its insured patients. Currently, Massachusetts health plans file their medical loss ratios with the Division of Insurance. There is considerable variation in this ratio, both among plans and for the same plan from year to year. In Massachusetts, the medical loss ratio for most health plans has typically ranged from 85% to 95% in recent years. There is, however, wide variation in the methods used by health plans to estimate, categorize, and allocate certain expenses. As a result, it is difficult to compare medical loss ratios reported by different health plans because it is not clear if the differences are due to accounting and actuarial practices or are real differences in provider payments or administrative expenses.

There is considerable opportunity and discretion for health plans to influence their reported care shares solely through accounting and actuarial practices. For example, under current accounting rules, an HMO that wished to raise its care share could classify all of its medical management expenses as "health care expenditures" rather than administrative costs. Similarly, an HMO could adopt a conservative approach to estimating its incurred but not reported medical claims, which has the effect of raising its medical expenses and its care share. A health plan could also delegate certain administrative functions to a capitated provider group, and classify the entire capitation as a medical expenditure,

although the provider payment includes remuneration for a range of administrative activities. The Petition directs the Commissioner of Insurance to promulgate regulations that define "health" and "non-health" expenditures, but without consistent standards for categorizing and allocating costs, health plans could respond to a minimum care share requirement by adopting whatever accounting and actuarial practices result in favorable ratios for regulatory purposes.

Further clarification is also needed with regard to how the 90%–10% formula would be applied to provider systems that assume significant risk.

The Petition provides for a refund to insured patients in the event that a health carrier's non-health expenditures exceed 10% of revenues. However, it is not clear how the refunds are to be calculated and distributed. For example, would every health plan member be entitled to an equal refund, or would the refund be prorated by the amount of premium paid on behalf of each member? If the health plan had an overall care share of less than 90%, but exceeded the 90% requirement on certain lines of business (e.g., Medicare), would members in that line of business be entitled to a refund?

Financial Incentives and Provider Contracts

The Petition and the House and Senate bills all contain extensive language regulating terms of contracts between health plans and providers, including compensation methodologies for providers, termination of providers, and good faith communication between physicians and patients regarding the benefits available under the patient's health plan.

The Petition, like the House and Senate bills, prohibits contracts between a carrier and a provider or a carrier and a provider group from containing any incentive plan "that includes a specific payment made to a health care provider as an inducement to reduce, delay or limit specific, medically necessary services covered by the contract." This language appears to be modeled, at least in part, on the federal Physician Incentive Plan (PIP) rules, which apply to health plans that contract with Medicare or Medicaid. The federal government has developed detailed standards for assessing whether a particular payment method meets the PIP requirements, and any health plan in Massachusetts that contracts with Medicare or Medicaid is already subject to the PIP rules, at least for these lines of business. The federal rules might be a source of considerable guidance in determining how to implement the Petition, but it is not clear if this approach is consistent with the intentions of the sponsors of the Petition. While the federal rules already apply to the provider payment methods of all of the largest health plans in the Commonwealth, it is also not clear whether state regulation of provider payment arrangements for Medicare and Medicaid would be preempted by the PIP rules.

Among the issues that would need to be addressed in implementing this provision of the Petition are delineating what constitutes an inducement, including whether this term includes all capitation arrangements. On its face, the language does not appear to restrict the terms of contracts between provider groups and individual providers, so perhaps capitation within groups would not be captured within the proscription. The language in the Senate bill is clear that its prohibition on inducements does not include capitation arrangements. Given the lack of clarity in the language of the Petition, enforcement of the provision could be difficult, although arrangements that shield the individual provider from bearing financial risk are acceptable within the stated intent of the language (see Lown letter, Appendix 3B).

Section 8 of the patients' bill of rights further provides that neither carriers nor health care providers shall "*profit* from denial or withholding of covered services that are medically necessary *and appropriate*" [emphasis added]. It is unclear how the sponsors intend the term "profit" to be interpreted. Profit may refer to any amount by which payment to a provider exceeds the provider's actual cost of providing the service. Or, this provision may be interpreted as prohibiting providers from receiving any payment at all, or a discounted rate, for services that are not deemed both medically necessary and appropriate.

The Petition requires carriers to disclose all financial incentive arrangements with providers. It is not clear from the language of the provision if this disclosure must be made by the health care provider, the health plans, or both, or how specific such disclosure must be. For example, if a physician contracts with a health plan as part of a larger group, must there be disclosure only of the financial arrangement between the health plan and the group, or of the arrangement between the group and the physician as well? If a hospital has a contract with an HMO that pays for different services under different payment arrangements (e.g., per diem payment for medical surgical care, case rates for obstetrical care, and capitation for behavioral health

care), must the arrangement for each service be disclosed? Is this disclosure to be at the level of individual physicians? Or is it to be at the level of categories of financial arrangements, without identifying individual providers and their type of arrangement? It is not clear whether patients may have access to the financial arrangements that exist between the health plan and all providers, or only those between the health plan and the patient's own health care provider(s). If the goal of disclosure is to assist patients in understanding any potential financial incentives faced by their individual providers, and potentially to use this information as a basis for selecting a provider, it would appear that patients need information that is specific to individual providers and individual services.

The House and Senate bills include language requiring disclosure of provider reimbursement methodologies, with the House requiring it only in summary form, and the Senate requiring it with specificity to the individual physician level.

The Petition mirrors the House and Senate bills' extension of the "anti-gag" provisions contained in current Massachusetts law. In addition to the good faith communication from a provider regarding the provisions, terms, or requirements of the patient's health benefit plan that is currently protected, the protection granted the provider is extended to communications regarding the provider payment methodology of the carrier. The section does not, however, restrict carriers from "requiring a health care professional to withhold confidential specific compensation amounts."

Such provisions have been included in managed care reform legislation in the Commonwealth since the earliest versions were filed over three years ago, to protect providers from perceived retaliation from health plans for advocating on behalf of patients in the event of denial of services or for discussing or recommending services that may not be covered services for the patient. Termination without cause or non-renewal of contracts were feared by providers who engaged in such discussions with patients. The Petition prohibits termination of providers without cause and without a written statement to the health care provider of the reason for termination. The Senate bill, but not the House bill, contains a similar provision.

Effect of Provisions on Existing Contracts

The Petition also contains an exception to its provisions that may have unpredictable and discriminatory impact. The exception, legally termed a "savings clause," appears as SECTION 5 of the Petition and in the patients' bill of rights section. The provisions state that the Petition does not apply to any contracts in effect prior to the effective date of the Petition (January 1, 2001). In effect, a contract between a managed care plan and providers, or between a plan and an employer, can circumvent the rights granted to patients if the contract is completed before January 1, 2001. This could lead to substantial chaos during the few weeks between election day on November 7, 2000, and the new year. If the petition passes, health plans could scramble to alter contracts with their providers to evade the requirements of the law.

The potential for discrimination exists because of the imbalance of negotiating strength between large provider groups and smaller groups and individual providers who are dependent on managed care contracts. Whereas a large provider group might have the upper hand and insist on preserving those elements of the new law favorable to providers, a smaller group might have to accept a contract that contradicted the law's protections for their patients. If this happened, patients will be faced with a wide variety of legal protections depending on the details of the contracts signed between their employer or their provider and their health plan.

Conclusion

While many of the Petition's patients' bill of rights provisions mirror in large part the House and Senate managed care reform bills, significant differences exist. Regardless of any overlap, several of the Petition's provisions merit very close and careful consideration. For example, the HMO member's open choice of providers, medical decision making, requirements for health plan utilization review activities, the so-called "care share" requirement for medical loss ratios, proscription of certain provider payment methodologies, and the savings clause of SECTION 5 for contracts in effect at the time of enactment of the Petition all have drastic implications for current practices of managed care. While a critical reexamination of current managed care regulation may well be overdue (and this Petition is responsible for bringing such a discussion to the fore) the intent of the Petition's proponents must be explored to ensure that

the provisions achieve reasonable and implementable results.

III. Moratorium on the Conversion of Non-Profit Hospitals, Health Plans, and Insurance Companies to For-Profit Status

Provisions

SECTION 2 of the Petition adds a new Section 1D to Chapter 111 of the General Laws that states "…until such time as the health care council established pursuant to section one C determines that the requirements set out in said section one C have been met, there shall be a moratorium on the conversion of non-profit hospitals, non-profit health maintenance organizations, and non-profit health insurance firms to entities owned and operated for profit." Section 1C refers to the establishment of a universal health system as described in Part I of this policy report.

Discussion

Although the provisions of a moratorium on for-profit conversions are quite straightforward, the implications for a rapidly changing health system are complex. We identify the major implications of permitting or not permitting conversions to for-profit ownership. Some implications are more applicable to hospitals, others to health insurance plans, and some to both. Where appropriate, we identify the reasons health organizations seek to convert. Our list of the major implications is as follows:

- Reduced access to capital
- Limited ability to join a larger entity/system
- Potential loss of community benefits
- Incentive for undervaluation of charitable assets and private inurement
- Reduced ability to implement organizational change
- Opportunity to convert underutilized resources into a charitable foundation

Reasons to Seek Capital through a Conversion

The most common reason publicly acknowledged by health care organizations for conversion to for-profit ownership is the need for additional sources of outside capital. Hospitals that need capital in excess of what they can generate with tax-exempt debt, philanthropy, and retained earnings often consider sale to an investor-owned company. The capital needs range from property, plant, and equipment upgrades in an increasingly technologically driven and ambulatory-centered health care system, to purchasing physician practices or entering a price war due to competitive pressures in the local market area. Information technology and related "integrated delivery system" infrastructure also require major capital investment. A hospital's ability to generate capital internally or to borrow is limited by its ability to make a profit. Smaller hospitals must make higher profits than larger hospitals to qualify for borrowing tax-exempt debt and to generate the absolute sums of capital needed. It is not uncommon for capital requirements to outstrip the capital-generating capacity of hospitals, particularly when they are in a highly competitive environment.

To a much lesser extent, health plans may need an infusion of outside capital that they are not able to generate internally or through borrowing. Most health plans, particularly those that do not own hospitals or physician offices and clinics, do not have a great need for capital, other than to meet minimum solvency requirements. However, plans that aspire to expand geographically may outstrip their ability to generate adequate capital internally; one way to achieve geographic expansion is to convert to investor-owned status and use stock primarily as a means of acquiring other (for-profit) plans. This is not the only way to expand geographically, but it requires the least amount of cash at the outset. (The acquisition itself may ultimately require cash infusions, but those are generally not funded by the issue of stock). Internally funded expansions, either through acquisition or start-up, can take a substantial amount of cash, as happened with the $120 million investment of Tufts' Massachusetts HMO into its Tufts New England Plan (which ultimately closed its operations).

Health plans that are not adequately capitalized to meet solvency requirements, either due to large underwriting losses or a start-up situation, may choose to convert through being acquired by a for-profit insurer, and thereby enjoy the back-up capital infusion possibilities of a much larger company (e.g., Aetna, Cigna, Anthem).

Moratorium's Implications on Capital Needs

Those organizations most in need of capital have the most difficulty accessing capital through the debt market and also have to pay the highest interest rates. A potential consequence of the proposed moratorium is that those non-profit hospitals or health plans that need outside capital to survive may not be able to get it. Hence, non-profit hospitals or health plans that are struggling financially or facing an uncertain financial future may be forced to close. Such a consequence could mean the loss of a local hospital to a community or the interruption of health insurance coverage to policyholders.

As an alternative to closure, struggling organizations often consider mergers with regional or national players (most of which are for-profit) or with other competitors in the market. Mergers can be beneficial or detrimental to a community depending upon the individual case. A moratorium would limit choices, however, and force firms to seek competitors as merger partners. While such mergers can have positive outcomes and result in efficiency savings, they also necessarily result in more consolidated markets. In Worcester, Mass., for example, there were 14 independent acute-care hospitals serving the local area in the late 1980's; by 1998, there were only 2 hospital systems. One is a part of investor-owned Tenet Healthcare; the other system represents roughly 10 hospitals under the University of Massachusetts Medical Center. If recourse to outside capital is limited, local markets can become dominated by a few large systems. The result can be higher prices and reduced choices for consumers.

On the other hand, using the value of their stock, for-profit companies can take advantage of undercapitalized health care organizations and "cherry pick" non-profit community hospitals and health plans that have limited options for access to outside capital. As a result, charitable assets can be purchased at "bargain basement" prices. A moratorium would protect local non-profits from being cherry-picked, but it might also force them to close or to merge into a larger system that subsequently closes them.

A moratorium could also reduce the ability of non-struggling hospitals and health plans to meet the kinds of capital needs described above. Hospitals that cannot access sufficient capital may not be able to provide the clinical capabilities and services that patients expect. Health plans with limited access to capital might be prevented from achieving the growth necessary to remain competitive with large national insurance companies.

Reasons to Join a Larger Entity/System

Another very common reason that non-profits convert to for-profit ownership is the strategic need to operate within a larger entity or system. Hospitals join systems in order to achieve greater bargaining position in managed care contracts, to achieve economies of scale (not always or even often borne out, however), and sometimes to eliminate a competitor (preferring to join them rather than fight them). Stand-alone hospitals in a competitive marketplace may feel vulnerable to getting shut out of managed care contracts or to being too small to achieve managerial or other economies of scale.

Some teaching hospitals have been sold to investor-owned systems because of a concern by their medical school or university owners that they will become a cash drain in the future; these divestments from a university/educational system into an investor-owned system can offer both financial and strategic advantages to the university owner as well as to the teaching hospital.

Local or single-state health plans might seek to become part of a regional or national health insurer for strategic reasons such as to expand their access to larger employers and to enhance their own size vis-a-vis providers that they must contract with. The greater the local market share of a plan, the higher the discount it might be able to extract from its provider network.

Moratorium's Implications on the Need to Join Larger Entities/Systems

The proposed moratorium would limit the options that hospitals and health plans have in seeking strategic alignments in the marketplace. For hospitals, this could reduce their bargaining power with payers, diminish their ability to secure managed care contracts, and limit their potential for economies of scale. At the margins, this could result in weaker or financially unstable institutions that might be forced to reduce services and quality or exit the market. For plans, it might prevent them from achieving the size necessary to attract regional and national employers. It could also limit their potential economies of scale and reduce their ability to negotiate lower prices from providers. A potential result is that weak independent organizations would not be able to compete with large integrated plans and insurers. For both hospitals and health plans, the limits placed on

market changes could discourage new entrants and diminish potential innovation.

Restricting some strategic alignments could also be locally advantageous. National companies, which are mostly for-profit, can drain health care dollars from local sites to corporate headquarters (although the reverse can also occur). They may also move the locus of decision making for key resources from the local site to regional or national offices. Centralized management may not support services deemed important to a local community, particularly if those services are not profitable. The influence of the local board, which ordinarily might support such activities, may be reduced to only an advisory capacity. Hence, a moratorium on conversions might stifle market development and innovation, but it might also protect local interests.

Moratorium's Implications on Community Benefits

Opposition to for-profit conversions often focuses on the potential loss of community benefits provided by non-profit hospitals, health plans, and insurance companies. Experts disagree on the validity of these concerns, and an analysis is beyond the scope of this paper. But to the extent these concerns are valid they would be alleviated by a moratorium. We address concerns regarding hospitals and health plans separately.

Hospitals. Non-profit hospitals provide numerous community benefits, one of the most important of which is charity or uncompensated care. The data from studies of charity care are mixed. Some studies show for-profit conversions reduce levels of charity care, particularly when public hospitals or hospitals with large amounts of uncompensated care convert. Other studies indicate no reduction in charity care and, in fact, indicate an increase in community benefits from sources such as corporate investments, charitable foundations, and collection of taxes. The conversion of St. Vincent Hospital in Worcester illustrates the ongoing disagreement in this area. Opponents of conversion cite the loss of charitable assets and the small amount of funds left over for a charitable foundation. Proponents, however, argue that the new Worcester Medical Center could not have been built without for-profit investment. That center is now the cornerstone of a major urban renewal project in downtown Worcester. In sum, a moratorium on for-profit conversions would protect against the possible reduction in charity care, but it would also prevent those cases in which a net benefit is conferred.

Health Plans and Insurance Companies. There is a similar disagreement about community benefits provided by health plans. Opponents of conversion contend that non-profit plans are more willing to provide less profitable and even unprofitable lines of insurance, such as individual and prescription drug coverage. They also claim non-profits provide greater support for medical education and clinical trials. Proponents of conversion, however, point out that market forces have pressured all health plans to have similar underwriting practices. They argue that 85% of Americans insured by health plans are now enrolled in for-profit plans because the importance of the non-profit form in health insurance has declined. Even Congress determined, in 1986, that Blue Cross plans could no longer be distinguished from their commercial counterparts, and revoked their federal tax-exemption.

Both supporters and opponents have valid arguments, and it is likely that the benefit or detriment of any conversion varies considerably by the circumstances of the individual case. Here, again, a moratorium on conversions would protect some types of non-profit community benefits at the cost of eliminating some beneficial outcomes.

Moratorium's Implications on Undervaluation of Charitable Assets and Private Inurement

Since the increase in health care company conversions that began in the 1980s, billions of dollars in charitable assets have been lost because the assets of non-profit entities have been undervalued. Examples of well-known cases include the conversions of Foundation Health Plan, Inland Health, HealthNet, and HealthONE. These undervaluations may have occurred because of a lack of judgment and expertise or because of the potential for private inurement. In either case, a moratorium on conversions would prevent losses of this type.

The executive decision makers of plans and hospitals may have a personal agenda that can influence their judgment regarding a conversion strategy for their institution. Sometimes this has been blatant (and probably illegal), as when Columbia-HCA tried to acquire the Blue Cross Plan of Northern Ohio (Columbia-HCA offered generous "retirement" payments to the non-profit board, and hefty "consulting contracts" to the top management of the Plan). However, other times it has been more subtle. For instance, in some conversions, the CEO raised his salary considerably after the merger and

also gained the opportunity to be rewarded in stock options or stock.

Executives of non-profit hospitals may also be swayed by the possibility of higher salaries within a larger, investor-owned system, as well as the opportunity to join a larger corporation that offers a career path that goes beyond CEO of a single institution.

There is little question that both personal enrichment and a loss of charitable assets have occurred from some previous conversions of non-profit hospitals and health plans, particularly in other states. Regulation and previous experience have reduced the potential concerns in this area, but it is still a problem worthy of consideration. Although other states have enacted legislation monitoring conversions and protecting charitable assets, Massachusetts has failed to do so. However, Massachusetts has benefited from a very active Attorney General's office that has promulgated detailed guidelines regarding ownership conversions. A moratorium would provide protection in this area regardless of the extent of involvement of the particular Attorney General who holds office.

Reasons to Seek a For-Profit Partner to Implement Organizational Change

Particularly in the hospital sector, the need for radical organizational change in response to the competitive and managed care pressures of recent times can lead a non-profit board to acknowledge that the changes needed simply cannot be implemented by the existing management and board team. An organizational culture that fosters inefficiency or does not embrace the need to integrate with managed care or adopt new managerial techniques may be so difficult to alter that a major change in leadership and organizational culture is necessary. This can lead a non-profit board to seek an investor-owned partner, either through a management contract or a conversion.

A related problem can be an inability of the hospital to attract competent management, due to location, size, or other attributes. Although it may not always be the case that investor-owned companies have managerial depth and expertise to spare, they are sometimes marketed that way.

Moratorium's Implications on the Need to Implement Organizational Change

A moratorium on for-profit conversions would reduce the options facing hospitals and health plans seeking to implement organizational change. Although it is theoretically possible to alter the managerial culture of an organization from within, it is often most difficult to do so. This is particularly true because of the power and influence of the non-profit board. Opponents of conversions contend that the replacement of local non-profit managers and board members distances the organization from its community roots. They further argue that a change to a for-profit culture subordinates the needs of the community to those of making a profit. A moratorium would eliminate the kind of wholesale cultural change that often accompanies an ownership conversion. Proponents of conversion contend, however, that an efficiently managed organization, in tune with the challenges of competitive managed care, is necessary to succeed in today's marketplace, regardless of ownership status.

Opportunity to Convert Underutilized Resources into a Charitable Foundation

Another motivating factor for conversion (generally found in conjunction with other strategic or financial factors) is the desire by a community or a board (or a university owner) to "recover" the historical charitable investments made in a bricks-and-mortar hospital, in order to put them to potentially "better" charitable uses. Conversions of financially and strategically viable community and teaching hospitals have generated locally controlled foundations with hundreds of millions of dollars in their endowments. This can hold great appeal to a board or non-profit owner that faces the alternative of dealing with an increasingly competitive hospital marketplace that forces them to make distinctly uncharitable decisions in order to keep the hospital viable.

Conclusion

The Petition's proposal for a moratorium on for-profit conversions of hospitals, health plans, and insurance companies could have both beneficial and detrimental effects. The health care industry is complex and consequences of a moratorium are likely to be different in individual organizations and markets.

- A moratorium may restrict access to capital and the ability to join larger health networks, but it could also protect local institutions and ensure that decision making resides in the local community.

- A moratorium could protect charitable assets and community benefits delivered by non-profit providers, but it would also eliminate those con-

versions that result in a net benefit to the community.

- A moratorium would restrict the ability of health organizations to make strategic market changes and limit their ability to implement internal organizational change. At the same time, however, it would maintain the non-profit culture that has played such a prominent role in the state's health institutions.

All considered, a moratorium is a blunt instrument that provides protection but can stifle positive change. The proposed ballot initiative could exist with a complete restriction on ownership conversions or with no restrictions at all; but either represents an extreme case. The state could also consider a wide range of regulatory measures that have the potential to protect local institutions and values while allowing for necessary change. Many states regulate ownership conversions through legislation that protects charitable assets, prevents private inurement, guarantees maintenance of community benefits, and guards against monopolistic power. The problems of health care markets are dynamic and complex, and they are not readily amenable to simplistic solutions.

Appendix 1

Funding for this financial analysis was provided by the Massachusetts Health Policy Forum, through a grant received from the Coalition for Affordable Health Care Choices, an organization representing major insurers and business organizations in the Commonwealth. The selection of an analyst was through a Request for Proposals process administered solely by the Massachusetts Health Policy Forum. Likewise, the scope of work and analytical approach was defined solely by the Forum and Dr. Thorpe. The Coalition for Affordable Health Care Choices exercised no influence or control over any aspect of the financial analysis.

Potential Impacts of Certain Provisions of Massachusetts Initiative Petition 99-4

Kenneth E. Thorpe, PhD, Emory University[1]

Summary

Starting in January 2001, successful passage of Initiative Petition 99-4 would result in several important changes in the Massachusetts health care system. The financial impacts of these changes are difficult to predict. The financial implications concerning other aspects of the Petition, such as the proposed patients' bill of rights, may be estimated, but with substantial uncertainty.

Provisions of the proposed patients' bill of rights include the following:

- Patients have the right to choose their health care providers, subject to the approval of a freely chosen primary care physician. A primary care physician may include an obstetrician/gynecologist. Insured patients may be required to pay a reasonable additional fee if they choose health care professionals that are not within their carrier's network.
- Patients have the right to transitional insurance coverage when they are undergoing a course of treatment from a health care provider whose contract with a carrier is being terminated.
- Patients have the right to medically necessary referrals to specialists
- Patients have the right to receive emergency services, subject to authorization procedures, and be reimbursed when they pay cash for emergency services from providers not affiliated with their carrier.

The language contained within the Petition allows for us to generate some (but not all) estimates of the potential impact on the HMO industry. The Petition does not provide sufficient detail for a comprehensive estimate, nor does it allow for an estimate of the impact on other forms of managed care, notably point-of-service (POS) plans or preferred-provider organizations (PPOs).

All told, we estimate that the Petition, as written, could increase HMO premiums by 4 percent to nearly 10 percent. Additional detail could result in lower or higher estimates.

Overview

The successful passage of Initiative Petition 99-4 would result in several important changes in the Massachusetts health care system that would go into effect on January 1, 2001. The financial impacts of these changes are difficult to predict. The financial implications concerning other aspects of the Petition, such as the proposed patients' bill of rights, may be estimated, but with substantial uncertainty.

Provisions of the proposed patients' bill of rights include the following:

- Patients have the right to choose their health care providers, subject to the approval of a freely chosen primary care physician. A primary care physician may include an obstetrician/gynecologist. Insured patients may be required to pay a reasonable additional fee if they choose health care professionals that are not within their carrier's network.
- Patients have the right to transitional insurance coverage when they are undergoing a course of treatment from a health care provider whose contract with a carrier is being terminated.
- Patients have the right to medically necessary referrals to specialists.

[1] Estimates and opinions expressed in this paper are solely those of the author and do not reflect those of Emory University.

- Patients have the right to receive emergency services, subject to authorization procedures, and be reimbursed when they pay cash for emergency services from providers not affiliated with their carrier.

- At least 90 percent of a carrier's Massachusetts revenue must be spent on health care.

This financial analysis will provide an estimate of the financial implications that these provisions would have on the premiums currently charged by health maintenance organizations (HMOs) and point-of-service (POS) plans and preferred-provider organizations (PPOs). As there is great uncertainty underlying the actual impact of these provisions, a range of estimates is provided. I present a lower range and a higher range estimate.

Basis of Estimate

Broadly speaking, managed care plans (HMOs, PPOs, and POS) incur lower costs and premiums than fee-for-service plans.[2] I examine three types of managed care plans:

- *Closed-Panel HMO* — These plans limit payment for non-emergency care services to providers enrolled in their network. Relative to fee-for-service plans, HMOs generally have fewer hospital days per 1000 and pay providers lower fees.

- *PPOs* — These plans allow members to receive services out of network, but at a higher cost relative to in-network services.

- *POS Plans* — These plans are similar to PPOs, but in-network services closely resemble a closed-panel HMO. Out-of-network services are allowed, but at a higher cost to the member.

There is substantial research literature examining the cost savings traced to various managed care plans. Relative to fee-for-service plans, managed care plans may generate savings through a variety of activities including:

- utilization review and management activities

- provider discounting and risk-sharing arrangements

- network selection and negotiations

Most of the literature has focused on premiums charged to a similar group of enrollees. These premiums include both benefit payments to providers and administrative costs. In some cases, the research has attempted to identify the portion of the savings traced to reductions in utilization and reductions due to price discounts. Few, if any, studies have examined the financial importance of the "tools" commonly used by managed care plans to achieve these savings. As such, it is difficult to ascribe estimated savings to a particular approach or procedure used by a managed care plan to control overall expenditures. I start, therefore, with an aggregate estimate of the range of cost differences across managed care and fee-for-service plans (Table 1). The range of premium differences are derived from the sources outlined in the references. Moreover, they also include data from the Federal Employees Health Benefit Plan (FEHB). The FEHB estimates are based on age-adjusted premium differences between POS plans and HMOs offered in Massachusetts.

For the PPO/POS plan design, the lower estimate is based on utilization management activities (payment incentives, network selection) generating savings of between 2 to 3 percent and a provider discount generating a 5 percent savings relative to fee-for-service plans.

Table 1. Range of Savings in Premiums Traced to Various Forms of Managed Care.

Plan Design	Range of Savings Relative to Fee-for-Service*
PPO/POS	Lower Estimate 8% Higher Estimate 10%
HMO	Lower Estimate 13% Higher Estimate 25%

**Fee-for-service plan is assumed to have utilization review activities.*
Range based on empirical analyses from the sources listed in the References.

[2] A detailed set of empirical studies evaluating the savings traced to various forms of managed care is provided in the references.

HMOs are widely credited for generating substantial reductions in hospital admissions and days. Several studies have examined utilization and expenditures among managed indemnity plans (i.e., fee-for-service plans with utilization review), POS, PPOs, and HMOs. Perhaps the most widely cited set of studies are those completed by the Congressional Budget Office (see References 1 through 5). The CBO studies found that HMOs reduced utilization by 18 percent relative to managed indemnity plans. Any discounted fees relative to fee-for-service plans would result in even larger savings. The CBO-based studies provide the basis for the upper estimate of savings for HMOs in Table 1. (This estimate includes an estimated 7 percent discount relative to "managed" indemnity products.[3])

While many studies have examined differences in premiums among managed care and fee-for-service plans, many of these studies are outdated. Several use data from the early 1990s, a time when managed care enrollment started to grow rapidly. Arguably, the first enrollees into managed care plans at this time were younger and healthier. While some studies (notably the CBO studies) attempted to account for selection across plans, fully accounting for such differences statistically is difficult. Moreover, it is not clear that the extent of the difference in premiums found in these early studies persists today.

To get more recent data, I examined monthly premiums (in the Northeast) among workers enrolled in conventional fee-for-service plans, POS plans, PPOs, and HMOs.[4] After adjusting for age differences across health plans, the more recent data suggest that HMO premiums are approximately 13 to 20 percent lower than those for POS/PPOs. I use this as a lower estimate of the premium differences between HMOs and other forms of managed care.

In addition to the direct effect that the patients' bill of rights language may have on insurance premiums, some analysts have suggested an indirect effect as well.[5] For example, several studies have documented a spillover effect between higher HMO penetration in a market and lower fee-for-service costs. Presumably, the relative rise in HMO and managed care penetration result in a different practice style among physicians — one that spills over into their fee-for-service patients.

Though many have measured these indirect effects of HMO penetration on fee-for-service costs, the range of estimates varies widely. Perhaps the most persuasive work has been completed by the CBO. The CBO found a spillover effect, though its magnitude was very small (i.e., a 50% increase in HMO enrollment was associated with a 0.5 percent reduction in fee-for-service costs).[6] Though such interactions between the managed care and fee-for-service marketplace may exist, their importance is likely very small. As a result, the range of estimates concerning the patients' bill of rights considers only the potential direct effects of the Petition on premiums.

Employer Responses to Premium Increases

According to economic theory, increases in the cost of fringe benefits such as health insurance are borne by workers and not employers. Empirical work examining changes in wages associated with changes in fringe benefits are largely consistent with this theory. Employers could respond to higher health insurance premiums in several ways — they could drop insurance for all employees, increase employee cost sharing requirements, reduce their share of premium contributions, or reduce the scope of services available in the insurance package. Previous estimates, in particular those advanced by the CBO on various federal patients' bill of rights legislation have assumed that employers would offset approximately 60 percent of the higher costs of insurance through these approaches. The remaining additional costs of insurance (i.e., higher premiums) would be absorbed by workers through slower increases in cash wages over time. However, there is substantial uncertainty over employer responses to higher premiums. Thus, the estimates presented below will provide a range: at the higher end employers would pass 100 percent of the higher costs to workers through higher premiums and lower wages, and at the other end we assume that 40 percent is passed on to workers.

[3] The "price" savings are difficult to quantify since staff model HMOs generally rely on salaried physicians.

[4] These data are available from the Kaiser Family Foundation, Employer Health Benefits, 1999. Washington DC, 1999

[5] See, for example, CBO 1997, and Gaskin & Hadley 1997.

[6] CBO, 1997.

Specific Provisions

The analysis presented below examines seven provisions included in the Petition. Table 2 outlines these provisions and indicates the number of states that have adopted similar provisions.[7]

Patients' Right to Choose Their Health Care Providers

This provision would allow consumers to select any physician (subject to their primary care physician's approval) when receiving health care. If the physician were outside the health plan's network, the patient would pay a "reasonable" additional fee to see the provider.

As written, this provision would eliminate the current structure of closed-panel HMOs. Such plans generally limit payments to providers included within their network (other than for emergency care). This provision could open up these networks, making them operate more like PPOs or POS plans. The financial impact of these provisions would depend, in part, on the fee that would be charged to consumers going out of network for a physician. If the fee is low, there is little incentive for patients to stay in the network and, correspondingly, few incentives for plans to construct networks. At the extreme, this provision could result in premiums among closed-panel HMOs that resemble those charged by POS/PPO plans. However, more specific information concerning the charges to consumers receiving care outside the network is needed before a more definitive financial estimate could be made. A key issue concerning changes in cost will be the extent to which network-based physicians retain incentives to monitor utilization or are at financial risk for services provided.

There are other similar provisions in the proposal that would work in tandem with the right to choose providers. These include:

- Patients' right to medically necessary referrals to specialists
- Prohibition on physician financial incentives
- Health care professionals' right to make medical decisions in consultation with their patients

While the latter two provisions listed above complement the first, they likely would have a more modest financial impact on HMO premiums.

These three provisions together with the patient's right to choose providers may also impact POS/PPO premiums as well. The ultimate impact on these looser managed care networks would depend, in part, on additional information concerning the ability of patients to go out of network, as well as the "reasonable" fees they would pay. To the extent such fees differ from current practice in the industry, POS/PPO premiums would increase. However, as currently written, the Petition does not provide sufficient detail to estimate the impact of this provision on POS/PPO premiums.

Table 2. Patients' Bill of Rights Provisions in SECTION 3 of the Petition.

Provision	Number of States with Similar Provision
Emergency Room Services (Section 11)	37
Transitional Coverage When Physician Leaves Plan (Section 6)	22
Medically Necessary Referrals to Specialists (Section 7)	20
Prohibition on Physician Financial Incentives (Section 8)	23
90% of Premiums Reserved for Benefit Payments (Section 13)	--
Appeal Denials of Care (Section 12)	28
Choose health care providers (Section 4)	--

Source: Author's tabulation and Families USA

[7] These provisions apply to those employers that are not covered under the Employee Retirement Income Security Act (ERISA)

Premiums for Non–ERISA-covered Employees in HMOs

The estimate of the range of the potential impact on premiums for non–ERISA-covered employees currently enrolled in closed panel HMOs includes the following provisions:

- Patients' right to choose of their health care providers
- Patients' right to medically necessary referrals to specialists
- Prohibition on physician financial incentives
- Health care professionals' right to make medical decisions in consultation with their patients

The lower estimate of the effect on the HMO premium is a 2% increase. First, the lower savings attributed to HMOs relative to managed indemnity (13%) and PPO/POS plans (8%) is a 5% difference. The estimate then assumes that employers will offset 60 percent of these higher costs through changes in employee premium contributions and changes in the benefit package (i.e., copayments and service limits). The remaining 40 percent of the higher costs would result in higher premiums (40% times 5%), resulting in a 2 percent increase in premiums.

The higher estimate is a 7% increase in the HMO premium. This assumes the new network-based plans would retain some (about half) of the financial and utilization controls over and above what current POS/PPO plans have. Thus, the higher figure is based on half the current difference in HMO and PPO/POS premiums.

Transitional Coverage When Physician Leaves a Plan

Previous research conducted by the CBO indicates that health plans generally lose or gain approximately 10 percent of contracting physicians a year. The major costs associated with this provision are the systems and development costs to administer the transition between plans (i.e., health plans have to contract with the physician that moved outside the network, and consumers would receive notification as well). Some HMOs already make provisions for chronically or seriously ill patients to continue to receive care for up to 90 days. In other cases, women are often allowed to remain with their OB/GYN throughout their pregnancy. As these are relatively rare events, the premium impact is likely small, perhaps less than 0.2 percent for an HMO.

Appeals Process

The impact of an appeals procedure on health insurance premiums depends on several, unspecified design features (i.e., internal, external, ability to sue the plan, etc.). Many HMOs already have some appeals procedure. For instance, within the Federal Employees Health Benefit plan (FEHB), patients may appeal a denied claim or service to the plan and, ultimately, to the Office of Personnel Management (OPM). Depending on the OPM decision, federal employees may sue the OPM in federal court.

A simple appeals process would be one in which a plan establishes a grievance process, allows internal appeals, and, if not satisfied with the decision, allows appeals to an external board (which may or may not have binding authority). The impact on premiums in this case is relatively small, perhaps less than 0.5 percent of premium. More extensive appeals processes, which include broader rights to federal and/or state courts, would increase the number of appeals and the cost of insurance. The nature of any cost increase depends critically on the structure of this process.

Access to Emergency Services

Though this section needs additional clarification as well, similar federal and state proposals have estimated that approximately half of all emergency room visits that are not currently paid would be paid under a "prudent layperson" definition. If true, this would create incentives for hospitals to increase charges in their outpatient departments, emergency rooms, and clinics. Overall, others have estimated the costs of this component at 0.2 to 0.4 percent of premium.[8]

Limiting Non-Health Costs to 10 Percent of Revenues

The Petition would limit all non-health expenditures to 10 percent of revenues. Today, administrative costs in a "typical" managed care plan are approximately 15 to 16 percent of premium revenues. Such costs have approximately the following distribution by function (see Table 3).

At issue here are the functions affected by the 10% limit. Some of these functions could be reduced by the earlier provision of the Petition — notably network development. In the short run, however, most analysts believe that, on balance, most of the administrative investments undertaken by managed care plans through higher administration result in lower overall premiums.

[8] Congressional Budget Office, cost estimate of S. 6, February 24, 2000, and revision in letter to Senator Nickles on February 14, 2000.

Table 3. Estimated Administrative Costs by Function in a Managed Care Plan.

Function	Percent of Premium Revenue
Administration	5
Network Development	2
Claims	1 to 2
Systems	3
Network Services	0.2
Medical Management	3
Marketing	0.5 to 1
Total	**14.7 to 16.2**

That is, a 1 percent increase in medical management, utilization management, or medical management costs generates more than a 1 percent reduction in claims payments. Thus, in the near term, this limitation could result in higher overall premiums — perhaps by 1 to 2 percent — depending on how the costs are reduced.

In the longer term, however, the move toward electronic billing and Internet-based transactions could generate savings sufficient to meet this requirement. For instance, administrative, network development, claims, and management costs could be reduced with electronic billing by at least 5 percent.

Conclusions

The impact of the provisions outlined in Initiative Petition 99-4 on health insurance premiums cannot fully be estimated. Many of the key provisions are too vague to generate more specific estimates. Of particular note is the language that would impact closed-panel HMOs and their ability to develop networks. If, in essence, the proposal would allow consumers to choose any physician and go outside their network (with a small additional payment), the costs of the proposal could be at the high end of the estimates presented here. Though important, other components of the proposal are likely to have relatively small impacts on premiums. The only exception in the near term is the financial impact of the restriction on administrative costs. If phased in, however, even this limitation may have only a modest, if any, financial impact on insurance premiums.

Table 4 presents a summary of the estimated impact of the Petition on HMO premiums. As noted above, several of the provisions do not contain sufficient detail to develop an estimate. Further details on the proposal could result in higher or lower estimated impacts on HMO premiums. Moreover, the language concerning access to out-of-network physicians (in particular the "reasonable" fee language) could also result in higher POS/PPO premiums. As written, however, the language does not provide sufficient detail to develop an estimate of the impact on POS/PPO premiums.

The estimated HMO premium increases associated with the Petition would range from approximately 4 percent to nearly 10 percent. The ultimate impact of the Petition on the HMO industry in the Commonwealth will depend on further clarity regarding the key aspects of the financial "penalties" associated with out-of-network plan selection for consumers. These out-of-network rules will have a substantial impact on the negotiated price discounts and utilization management programs of managed care plans in the future, and with it, insurance premiums.

Table 4. Potential Impact of the Petition on HMO Premiums.

Provision	Higher Estimate	Lower Estimate
Choose health care providers Medically necessary referrals to specialists Prohibition on physician financial incentives Right to make medical decisions in consultation with patient	7%	2%
Transitional coverage when physician leaves plan	0.2%	0.1%
Appeals process	--	0.5%
Emergency room provisions	0.4%	0.2%
Limit administrative expenses to 10% (short-run impacts)	2%	1%
Total	**9.6%**	**3.7%**

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Appendix 2

AN ACT TO PROTECT THE RIGHTS OF PATIENTS AND TO PROMOTE ACCESS TO QUALITY HEALTH CARE FOR ALL RESIDENTS OF THE COMMONWEALTH

Be it enacted by the People, and by their authority, as follows:

SECTION 1.

Whereas, Massachusetts residents are entitled to and desire a system of health care that has the needs of patients as its central purpose and priority;

Whereas, the quality and availability of health care services and treatments is threatened by unreasonable restrictions on patient choice and interference with medical decision making;

Whereas, the affordability of heath care to residents is jeopardized by continued increases in health insurance costs and by reductions in health plan coverage, and many Massachusetts residents are uninsured or underinsured;

Therefore, it is the purpose of this act to ensure that there will be access to health care for all Massachusetts residents, including strong patient protections and a bill of patient's rights.

SECTION 2. Chapter 111 of the General Laws is hereby amended by inserting after section 1 the following new sections:

Section 1C. There shall be established a patient-centered system of health care that will ensure comprehensive, high quality care and health coverage for all residents of the commonwealth, to be in effect no later than July first, 2002. To establish such system, there is hereby created a health care council that shall consist of seventeen members to be appointed by the commissioner and shall serve without compensation. The members shall include moral, academic and community leaders, health care advocates, consumers, providers and third-party payors and shall include at least one member from each of the following organizations selected from nominations by such organizations: Ad Hoc Committee to Defend Health Care, American Association of Retired Persons, American Federation of Labor-Congress of Industrial Organizations, Blue Cross and Blue Shield of Massachusetts, Health Care for All, Massachusetts Association of Health Maintenance Organizations, Massachusetts Business Roundtable, MassCARE, Massachusetts Hospital Association, Massachusetts League of Community Health Centers, Massachusetts Medical Society, Massachusetts Nurses Association, Massachusetts Public Interest Research Group, and Massachusetts Senior Action. The council shall allow for public participation, including but not limited to the holding of at least four public hearings in different regions of the commonwealth. The council shall study various health care proposals, and make recommendations to the commissioner and the legislature on a plan for the establishment of health care policies, laws, and other mechanisms to ensure that the following requirements are met:

(a) access shall be provided to health care services for all Massachusetts residents and barriers eliminated to such services, medications, and supplies necessary for the prevention, diagnosis, treatment, rehabilitation, and palliation of physical and mental illness;

(b) patients shall be guaranteed the right to freely choose their health care providers, to have a second medical opinion and to appeal denials of care; and the clinical freedom of physicians, nurses and other health professionals to act solely in the best interests of their patients shall be assured;

(c) affordable health care coverage shall be ensured to all Massachusetts residents, with health care expenditures that rise no faster than those of the nation as a whole;

(d) the high quality of health care in Massachusetts shall be preserved and promoted; and the well-being of medical research, training, and innovation shall be protected and fostered;

(e) no less than ninety percent of all payments made for health care coverage shall be used for patient care, public health, or the furtherance of medical skill and knowledge, and no more than ten percent of such payments shall be used for administrative costs or any other purpose; and the paperwork and administrative tasks of patients, hospitals and health care professionals shall be simplified; and

(f) no financial incentives shall be permitted that limit patient access to health care services and medications that are appropriate or necessary, and incentives, direct or indirect, that promote the provision of inappropriate and potentially harmful care to patients shall be minimized.

The council shall review proposed and enacted health care legislation in the Commonwealth and make recommendations to the commissioner as to whether such legislation meets the requirements of this section.

Section 1D. Notwithstanding any general or special law to the contrary, until such time as the health care council established pursuant to section one C determines that the requirements set out in said section one C have been met, there shall be a moratorium on the conversion of non-profit hospitals, non-profit health maintenance organizations, and non-profit health insurance firms to entities owned and operated for profit.

Notwithstanding any general or special law to the contrary, until such time as determination is made, the commissioner and the commissioner of insurance, as appropriate, shall not grant, renew, convert or otherwise provide a license to any such entity that attempts to undergo such a conversion.

SECTION 3. The General Laws are hereby amended by inserting after chapter 176N the following chapter:

Chapter 176O: Patients' Bill of Rights

Section 1. The purpose of this chapter is to protect the rights of health care patients and to strengthen the relationship between patients and their physicians, nurses, and other health care professionals. To achieve these goals, this chapter, which applies to all health insurance carriers, including health insurance plans, blue cross and blue shield plans, health maintenance organizations, and preferred provider plans, establishes, as more specifically detailed in the following sections, the right of patients to choose their health care professionals, health care facilities, and other health care providers; the right of health care professionals to make all medical decisions in consultation with the patients; the right to continuity of care during the course of treatment; the right to a referral to a specialist if such a referral is a medical necessity; a limitation on and the requirement of open disclosure of financial incentives in contracts between carriers and health care professionals; protection of the right of health care professionals to discuss provisions of health benefit plans with insured patients; prohibition of termination of health care professionals by carriers without cause; the right to receive emergency services; the right to clear utilization review programs that include the right to a second opinion and the right to appeal a adverse determination to the commissioner of public health, and a requirement that at least ninety percent of the premiums of carriers be spent on patient care.

Section 2. Notwithstanding any provisions to the contrary of sections 108 to111, inclusive, of chapter 175 of the General Laws, of chapter 176A of the General Laws, of chapter 176B of the General Laws, of chapter 176G of the General Laws, and of chapter 176I of the General Laws, or of any other special or general law, the provisions of this chapter shall apply to all insurers licensed or otherwise authorized to transact accident or health insurance under said chapter175; a non-profit hospital service corporation organized under said chapter one 176A; a non-profit medical service corporation organized under said chapter 176B; all health maintenance organizations organized under said chapter 176G; and all organizations entering into a preferred provider arrangement under said chapter 176I; but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

The provisions of this chapter shall be administered by the division of insurance.

Section 3. As used in this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:

"Benefits", health care services to which an insured patient is entitled under the terms of the health benefits plan.

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I; but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer.

"Commissioner", the commissioner of the division of insurance.

"Emergency services" and "emergency care", services provided in or by a hospital emergency facility or a free standing emergency care facility after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the member's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

"Facility", an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

"Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care professional", a physician or other health care practitioner licensed, accredited or professionally certified to perform specified health services consistent with law.

"Health care provider" or "provider", a health care professional or a facility.

"Health care services", services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

"Insured Patient", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under other provisions of this chapter.

"Massachusetts care share", the percentage obtained by dividing Massachusetts-associated health care expenditures of a carrier by its Massachusetts-associated revenue for a calendar year.

"Medical necessity", medical care, which is consistent with generally accepted principles of professional medical practice.

"Network", a grouping of health care providers who contract with a carrier to provide services to insured patients covered by any or all of the carrier's plans, policies, contracts or other arrangements.

"Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or combination of the foregoing.

"Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

"Specialist", a health care provider that has adequate expertise through appropriate training, experience, and certification to provide high quality medical care for the treatment of a specific disease or condition.

"Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

"Utilization review organization", an entity that conducts utilization review, other than a carrier performing utilization review for its own health benefit plans.

Section 4. (a)All insured patients shall have the right to choose their health care professionals, health care facilities; and other health care providers; provided, however, that in accordance with the terms of the health benefit plan, such choice may be subject to the approval of a primary health care provider that has no financial incentives to deny care and that is freely chosen by the insured patient.

(b) An insured patient shall have the right to select an obstetrician or a gynecologist as her primary care physician and, whether or not an insured patient has so selected an obstetrician or a gynecologist as her primary care physician, such insured patient may visit an obstetrician or a gynecologist without the approval of her primary care physician

(c) Insured patients may be required to pay a reasonable additional fee if they choose health care professionals pursuant to this section that are not within their carrier's network.

Section 5. An attending health care professional, in consultation with the insured patient, shall make all decisions, consistent with generally accepted principles of professional medical practice, regarding medical treatment, including provision of durable medical equipment, medications, and lengths of hospital stay, to be provided to such insured patient under his supervision or control. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any carrier or the terms and conditions of any agreement between either the attending health care professional or the insured patient and any carrier.

Section 6. If an insured patient is undergoing a course of treatment from a health care provider at the time when a contract between a carrier and such health care provider is terminated for reasons other than fraud or failure to meet applicable quality standards, the carrier shall continue to provide coverage to such insured patient of health care services from such health care provider for a transitional period of 90 days following such termination; provided, however, that if the insured patient has been admitted to a facility, or has entered the second trimester of pregnancy, or has a terminal illness, such transitional period shall continue until the insured patient no longer has the medical necessity of remaining an inpatient, is no longer pregnant, or no longer needs treatment in conjunction with such terminal illness, respectively; provided, further, that nothing in this section shall be construed to require the coverage of health care services which would not have been covered if the contract between the carrier and the health care provider had not been terminated; and provided, further, that the health care provider shall agree to continue to accept reimbursement at the rates in effect prior to the start of the transitional period and shall adhere to the quality standards and other policies and procedures of the health benefit plan.

Section 7. All insured patients shall have the right to a referral to a specialist for the treatment of a disease or condition that as a medical necessity needs to be treated by a specialist; provided, however, that in accordance with the terms of the health benefit plan, such specialist may be required to develop a treatment plan subject to the approval of a primary health care provider and the utilization review procedures of the carrier; provided, further, that such specialist shall provide the primary care provider with all necessary medical information, including but not limited to regular updates on the specialty care provided; and provided further patients with chronic conditions may get a standing referral that needs to be renewed every six months or annually as may be agreed to by the primary care provider.

Section 8. (a) No contract between a carrier and a licensed health care provider or health care provider group shall contain any incentive plan that includes a specific payment made to a health care provider as an inducement to

reduce, delay or limit specific, medically necessary services covered by the contract. Health care professionals shall not profit from provision of covered services that are not medically necessary and appropriate. Carriers and health care providers shall not profit from denial or withholding of covered services that are medically necessary and appropriate.

(b) All financial incentive arrangements among health care providers and carriers other than basic salaries and fringe benefits shall be fully disclosed and available for inspection by the insured patients.

Section 9. No carrier shall refuse to contract with or compensate for covered services with an otherwise eligible health care professional or nonparticipating health care professional because such health care professional has in good faith communicated with or advocated on behalf of one or more of his current, former or prospective insured patients regarding the provisions, terms or requirements of the health benefit plans of the carrier, or the provider payment methodology of the carrier, as they relate to the needs of the insured patients of the health care professional. Nothing in this section shall be construed to preclude a carrier from requiring a health care professional to withhold confidential specific compensation amounts.

Section 10. No carrier shall make a contract with a health care provider that includes a provision permitting termination of the health care provider without cause. If a carrier terminates a contract with a health care provider, it shall provide a written statement to the health care provider of the reason for such termination.

Section 11. (a) A health benefit plan shall cover emergency services provided to insured patients; provided, however, that for treatment or diagnostic workup beyond stabilization for transfer, stabilization for discharge or admission, the carrier may require a hospital emergency department to call the physician on-call designated by the carrier for authorization, and provided, further, that such authorization shall be deemed granted if the carrier has not responded to said call within thirty minutes. Notwithstanding the foregoing provisions, in the event the emergency physician and the primary care physician or the physician designated by the carrier do not agree on what constitutes appropriate medical treatment, the opinion of the emergency physician shall prevail and such treatment shall be considered emergency care as defined herein; provided, however, that such treatment is consistent with generally accepted principles of professional medical practice. Consistent with the foregoing, carriers may enter into contracts with network hospitals or emergency physician groups or both for the provision of emergency services.

(b) Every carrier shall clearly state in its brochures, contracts, policy manuals and all printed materials distributed to members that such members have the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever an enrollee is confronted with a life or limb threatening emergency. No member shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use in a life or limb threatening emergency.

(c) Every carrier shall provide or arrange for the payment of cash benefits to an insured patient when the patient obtains emergency care from a provider not normally affiliated with the carrier; provided that amounts charged by the provider are reasonable; and provided further that the insured patient paid the provider himself.

Section 12. Utilization review conducted by a carrier or a utilization review organization shall meet, at a minimum, the following standards:

(a) any such entity shall conduct its utilization review program pursuant to a written plan;

(b) any such program shall be under the supervision of a physician and shall be staffed by appropriately trained and qualified licensed health careprofessionals;

(c) any such entity shall have a documented process to review and evaluate the effectiveness of its utilization review program;

(d) any such entity shall adopt utilization review criteria and conduct all utilization review activities pursuant to those criteria. Said criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based and shall be developed with the input of participating physicians;

(e) any such program shall allow an insured patient, if he disagrees with the conclusions of the utilization review, to have a second medical opinion with a physician selected by the insured patient, and to have the decision of the program reconsidered in light of such second medical opinion;

(f) any such entity shall have documented process to ensure that utilization review criteria are applied consistently;

(g) any such entity shall make utilization review determinations on a timely basis; and

(h) any such program shall allow an insured patient, if he disagrees with the final conclusions of the utilization review, to appeal the final conclusion to the commissioner of public health; and if said commissioner finds that the decision was contrary to the reasonable medical needs of the patient or was arbitrary or capricious, he shall order the carrier to provide the medical treatment in dispute to the insured patient.

Section 13. (a) The Massachusetts care share for a carrier in the commonwealth shall be no less than 90 percent, and non-health expenditures associated with insured patients residing in Massachusetts shall not exceed ten percent of Massachusetts-associated revenue for each calendar year. The commissioner shall promulgate regulations that make fair and equitable determinations about what constitutes health and non-health expenditures.

(b) Each carrier operating in the commonwealth shall report annually to the commissioner its total revenues, Massachusetts-associated revenue, total premiums, Massachusetts premiums, total health expenditures, Massachusetts-associated health expenditures, total non-health expenditures, care share, and Massachusetts care share. The commissioner shall issue regulations specifying the methods for calculating the information to be reported in accordance with this section. The commissioner shall publish annually the care share and the Massachusetts care share of each carrier doing business in the commonwealth. All written materials used for advertising and marketing health benefit plans to prospective insured patients or groups shall include a statement of the carrier's care share and its Massachusetts care share.

(c) Any carrier that fails to comply with the provisions of this section shall refund to its insured patients the amount by which such carrier's Massachusetts non-health expenditures exceeded ten percent. The refund payable for any calendar year shall be paid on or before June thirtieth of the next calendar year. A carrier that reports a Massachusetts care share below 90 percent may, upon written notice to the commissioner, pay the refund owed by reducing the total premiums payable by its insured patients for the calendar year in which the shortfall is reported by an amount equal to the refundable amount .

(d) Each calendar year, the commissioner shall audit the books and records of a random sample of no less than ten percent of carriers that have more than twenty-five thousand persons insured under blanket or group insurance policies. The commissioner may appoint an independent auditor to conduct the audit, subject to the control and supervision of the commissioner, and shall assess each insurer a fee to pay the reasonable costs of such audit.

SECTION 4. There is hereby created a special legislative committee to study and recommend the establishment of a patient-centered system of health care that ensures comprehensive, high quality care and health coverage for all residents, to be in effect no later than July first, 2002, consisting of five members of the house of representatives to be appointed by the speaker of the house of representatives, three members of the senate to be appointed by the president of the senate, and the members of the health care council established in section one C of chapter 111 of the General Laws. The members shall receive no compensation for the performance of their duties on the special committee. The special committee shall hold public hearings, study various health care proposals, and make recommendations for the establishment of a health care system conforming to the requirements of said section one C of said chapter 111. The members of the special committee shall be appointed no later than January tenth, 2001 and shall file their report,

together with recommended legislation, with the clerks of the senate and the house of representatives no later than September 30, 2001.

SECTION 5. No provision of this act shall be interpreted as applying to, affecting, amending, or otherwise impairing the provisions of any contract in effect prior to the effective date of this act or as applying to, affecting, amending, or otherwise impairing an automatic renewal provision, option clause, or other provision of such an existing contract that goes into effect on or after the effective date of this act.

SECTION 6. The provisions of this act are severable, and if any provision of this act is found to be unconstitutional, contrary to law, or otherwise invalid by a court of competent jurisdiction, then the other provisions of this act shall continue to be in effect.

SECTION 7. Unless provided otherwise herein, the provisions of this act shall take effect as of January first, 2001.

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Appendix 3A

QUESTIONS FOR INITIATIVE PETITION SPONSORS

Preliminary

1. Who were the principal drafters of the language in the Initiative Petition?

2. What was the process used by the sponsors in deciding what to include in the Petition?

3. If the General Court fails to enact all provisions of the Petition into law by May, are the sponsors interested in negotiating with the Legislature on a compromise measure prior to the final July deadline for ballot qualification?

I. QUESTIONS REGARDING A MORATORIUM ON FOR-PROFIT HOSPITAL, HEALTH PLAN AND INSURANCE COMPANY OWNERSHIP CONVERSIONS.

Because issues regarding ownership conversion of health insurance plans and insurance companies are different than those issues regarding conversions of hospitals, we have formulated two sets of questions that are similar, but that might yield substantially different answers.

A. Health Plans and Insurance Companies:

1. What are the advantages of freezing the current ownership mix of health plans and insurance companies? Why would the state be better off if this action were taken?

2. What are your primary concerns about the potential conversion of not-for-profit health plans and insurance companies to for-profit entities?

3. Do you have specific concerns with the for-profit health plans and insurance companies that are operating in the state at the present time?

4. What specific evidence can you cite that for-profit plans or insurance companies would be either detrimental or less beneficial than not-for-profit plans or insurance companies?

5. Are there any exceptions or conditions where you believe that an ownership conversion to a for-profit health plan or insurance company could be beneficial to the state?

6. If confronted with a choice between a take-over by a for-profit plan or insurance company or a not-for-profit entity that needed financial support from the state, what would you recommend and on what factors would your decision be based?

B. Hospitals:

1. What are the advantages of freezing the current ownership mix of hospitals? Why would the state be better off if this action were taken?

2. What are your primary concerns about the potential conversion of not-for-profit hospitals to for-profit entities?

3. What specific evidence can you cite that for-profit hospitals would be either detrimental or less beneficial than not-for-profit plans or insurance companies?

4. The Attorney General has actively reviewed and participated in previous hospital ownership conversions in Mass. Why would the state be better off substituting this moratorium for the process utilized in the past? In answering, please note if there were specific problems with the process in the past.

5. Are there any exceptions or conditions where you believe that an ownership conversion to a for-profit hospital could be beneficial to the state?

6. If confronted with a choice between a closure of a non-profit hospital that was needed by a community and a conversion to for-profit status, what would you recommend and on what factors would your decision be based?

II. QUESTIONS REGARDING THE PROPOSED PATIENTS' BILL OF RIGHTS

A. General:

1. ERISA

    a. How does the federal ERISA statute affect the application of the provisions of SECTION 3 of the Act?

    b. What is your intent regarding how the provisions would apply to the large number of individuals covered by self-insured employer plans?

    c. If the Act is enacted, and SECTION 3 becomes effective January 1, 2001, how many residents of the Commonwealth do you estimate will be exempted from the patient protection provisions due to ERISA's preemption of certain provisions of the Act?

2. Do you intend the provisions of SECTION 3 to affect the rights of Medicare and Medicaid patients?

3. In light of the findings of the IOM's study regarding medical errors in hospitals, unnecessary admissions and procedures, and poor prescribing practices, does the Petition offer any patient protections against overutilization and incentives for overutilization?

B. Specific:

1. For Sections 4-13 of SECTION 3 of the Act, please explain the basis for the inclusion of the provisions and the current deficiencies in health insurance practice that these provisions are intended to address.

2. Financial Incentives: In Sections 4 and 8, you refer to financial incentives that "deny care" or serve as an "inducement to reduce, delay or limit specific, medically necessary services covered by the contract."

    a. How would these provisions be enforced?

    b. How and by whom would the determination be made regarding what denies, reduces, delays or limits such services?

    c. What is the intent with respect to how broad this definition would be?

    d. Does this provision intend to prohibit any or all types of capitation arrangements?

    e. Might certain patient co-payments reasonably be included in such a determination? (i.e., A co-payment for a prescription drug may result in decreased access of a patient to a medically necessary treatment for a particular condition.)

3. In Section 4(c), does the "reasonable additional fee" that might be paid in the event that a patient seeks out of network care potentially qualify as a financial incentive to reduce care?

4. How would the provisions of Section 5 affect a) the implementation of drug formularies and b) plan practice guidelines? Does the second sentence effectively supersede the first sentence, since a plan could implement anything it wanted through a contract provision between patient or professional and insurer?

5. Treatment Decisions

a. What is the intent with respect to the interplay between treatment decisions made by a health care provider and preservation of the rights of the patient?

b. Are all treatment decisions made by a provider presumed to have the result of preserving the rights of the patient?

c. Who has final say as to what is within the definition of “medically necessary” or is a “medical necessity” as referred to throughout SECTION 3?

d. What implication does the additional criteria of “and appropriate,” as referred to in Section 8, have on the application of the definition of medically necessary?

e. How and by whom would the determination be made that something is medically necessary but NOT appropriate?

6. In Section 8, would health care professionals who provide such covered services be paid only enough to cover the wholesale cost of the service, or not at all? How would the “profit” that the section prohibits be avoided?

7. In Section 8(b), what is the intended limit on disclosures and at what level of specificity (e.g., by individual physician, by practice)? Would the information on all panel providers be available to all plan enrollees?

8. How would provider risk-bearing organizations (PHO's, physician groups taking insurance risk) be affected by these provisions? Current language says this chapter applies to all health insurance carriers, but does not mention how providers who are also taking insurance risk should be involved.

9. Care Share Provisions

a. Does the “care share” described in Section 13 prohibit any capital expenditures or infrastructure investments that extend beyond the 10% threshold?

b. The determination is delegated to the Commissioner of Insurance, but what would you intend to be included in such a definition of “non-health expenditures.”

c. Why do you set 10% as the limit on non-health expenditures?

d. Would you intend for there to be a mechanism for a waiver of this amount during any period of time?

e. What effect might the 90% care share have on newly licensed plans, whose health and non-health expenditures may be less stable during start-up?

f. How is this 90%/10% formula intended to apply to provider systems that assume significant financial risk?

g. Does this prohibit passing on financial risk as well? If not, how would other provisions of the Act apply to those systems that do assume risk?

III. QUESTIONS REGARDING THE ESTABLISHMENT OF A PATIENT-CENTERED SYSTEM OF HEALTH CARE AND THE PROPOSED HEALTH CARE COUNCIL

A. The Health Care Council and Special Legislative Committee

1. What was the process by which organizations listed in Section 1C were selected to submit nominations for membership on the Health Care Council?

2. Did all organizations listed agree to be included?

3. Was there any opportunity for other organizations not listed to request inclusion?

4. Why was the appointing authority provided to the commissioner of public health as opposed to the governor or the secretary of health and human services?

5. Why were no officials of the executive branch included in the makeup of the council or the special legislative committee?

6. What was your intention in locating the health care council within the department of public health while other equivalent or higher level state agencies (division of medical assistance, division of insurance, department of mental health, group insurance commission, division of health care finance and policy) have substantial responsibilities over which DPH has no authority or expertise?

7. How would the Council settle on its recommendations - by majority or unanimous agreement?

B. The Health Care Council and Special Legislative Committee's Mandates

1. Since 1980, there have been at least five special commissions formed to study issues related to health care finance and access reform. Four of those commissions failed to reach agreement and did not file legislation. The one commission that met its mandate had the narrowest and most clearly defined mission of the five. What gives you confidence that this commission, with a mandate broader than all previous five commissions, will be able to meet its mission? What happens if the Special Legislative Commission is unable to reach agreement on recommendations?

2. How can any potential council or special committee reconcile provisions 1C(a), 1C(b), 1C(d) and 1C(f) with the requirement of provision 1C(c)? In other words, how can "access … be provided to health care services for all Massachusetts residents and barriers eliminated", and "patients … guaranteed the right to freely choose their health care providers", and "medical research, training and innovation … protected and fostered", and "no financial incentives … permitted that limit patient access to health care services and medications", while ensuring that "health care expenditures … rise no faster than those of the nation as a whole"?

3. States have no legal authority to regulate or control Medicare and other federal payments or expenditures of self-insured employer based plans. Because these two sources alone represent far more than half of all health spending in the commonwealth, how can any structure meet the requirements of provision 1C(c)?

4. If there is a conflict between provision 1C(c) and the other provisions of 1C, which should take priority for the Council and the Special Legislative Committee?

5. Why did the sponsors not include any direction or recommendation regarding a mechanism to finance new patient centered system of health care?

6. To achieve universal coverage, either a single payer/tax financed system or an economy wide employer health insurance mandate are considered essential components. Can the sponsors identify any other financing option that could form the basis of a patient centered system that would ensure coverage for all Massachusetts residents?

Appendix 3B

Bernard Lown, M.D.

March 28, 2000

John E. McDonough
The Heller School
Brandeis University
Waltham, MA 02454

Dear Professor McDonough:

You pose a range of questions around the aims and consequences of the initiative petition sponsored by The Coalition for Health Care. I know that representatives of our organization and you have already discussed a number of key concerns at some length and in person, but I feel that a written response will prove helpful as well.

Let me begin by setting out for you the purpose of the measure, and describing the spirit that informs it. I understand the seriousness of your inquiry, but many of the points you raise around what you regard as possible consequences seem to arise from a misimpression of the measure's nature, and thus its true implications.

First and foremost, the ballot measure is presented not as an end in and of itself, but rather as a catalyst for dialog leading to change. It grows out of a belief that the arrangements underpinning the ways in which care and coverage is provided and financed in Massachusetts, and defining the ways in which health care organizations of every kind and clinicians and patients interact with one another, are no longer tenable -- considered either as human or economic propositions. In other words, whatever else may be the case, maintaining the present course is no longer a viable option, even were it desirable to do so.

This is our view, to be sure, but it is also an opinion that is heard with increasing frequency all over our state, and from some surprising quarters. Although we work day in and day out as clinicians, and so feel qualified to make such a judgment, we do not have all the answers. Nor, we believe, does any single individual, other group or expert.

We are confident that solutions do exist, but we are equally certain that such answers will be identified and implemented only as a result of a democratic process that brings together and draws upon the energies and efforts of our entire state, including the Legislature and Executive, the many entities and organizations with direct interests in health care, and — critically — the general public as well. Thus, the measure aims to:

- Foster a robust debate around the fundamentals of health care and what our state expects; a debate that engages the attention and understanding not only of "experts" but of the broadest possible public.
- Win endorsement of a set of simple, straightforward and common-sense values and principles that guide policymakers and engender the greatest possible public confidence.

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- Create a forum for discussion of ideas and resolution of differences around how best to achieve these objectives.
- Ensure action on whatever plans may ultimately be decided upon.

It is true, of course, that many who support this measure have strong and informed views, as individuals, about the particular changes that might best serve our state. We realize that you do also, as do so many others. We are convinced, however, that the place to begin this task is not with unilateral declarations or demands from ourselves or any other "expert," but with an open and wide ranging discussion of what qualities the people of Massachusetts expect and demand of health care in our state.

For these reasons, the ballot measure does not mandate or attempt to pre-ordain particular outcomes for the debate we seek to bring about, and it does not dictate to the people of Massachusetts how their health care arrangements must be structured. It is also the case that some elements of the measure allow for some breadth of possibility in their interpretation and implementation (although not necessarily the ones you allude to in your questions). These were deliberate and conscious decisions on our part, intended to address major areas of difficulty within present health care arrangements, and yet allow ample room for people and organizations acting in good faith to come together for discussion and resolution.

In adopting this approach, we recognize that some will fear extreme constructions of one provision or another, or wrongly assume an agenda that is not actually present in the measure. Many of your questions seem to probe into just these areas. We will address your concerns in detail, but the most truthful and telling answer we can give you, or anyone else who takes an interest in this measure, is a more general one: The nature of change in health care in Massachusetts will not be determined by us as drafters, nor by our coalition, but rather by the people of our state and their elected representatives, and by a body (the Health Care Council) that embraces all who have a stake in the outcome, whether as providers or insurers, employers or organized labor, clinicians or patients, elected officials or private citizens.

By express design, the measure and the process it sets in motion can and will result in nothing that does not command majority support among both those concerned most directly with health care in our state and among Massachusetts citizens themselves. This measure places the decision-making power in their hands, not ours.

Turning to the particular issues you raise:

- With respect to the principles and requirements guiding the work of the Health Care Council, you treat with skepticism the possibility that all can be satisfied, and cast the cost containment element in particular as inherently opposed to the others. We disagree. These provisions are not a blueprint for some Nirvana unobtainable in our imperfect world, nor expressions of naive idealism, but exist rather as concrete objectives to be construed by reasonable people acting in good faith. As clinicians, we recognize that by its very nature health care will always pose significant policy and ethical challenges to society, but we are convinced these hurdles will appear insurmountable only within the context of our state's set of health care arrangements, not its level of spending. Given health care spending that is already the highest in the nation, on a per-person basis, and double that of any foreign nation, we think it is eminently reasonable to see no contradiction between quality care and coverage for all residents and fiscal affordability and responsibility. Indeed, in our view, the two go hand in hand.

- You note the existence of ERISA and federally-controlled health programs. We recognize, of course, that federal statute rather than state law takes precedence in certain significant areas of health care. Our measure -- like any other action our state might undertake — does not change that nor attempt to, nor does it impinge upon such programs. We do not see any inherent conflict or impediment in the existence of a federal role, nor do we accept as adequate reason for the Commonwealth to do nothing the undeniable fact that Washington could take a lead in health care if it chose to. Despite the deep concern and hard work of many individuals in Washington, the federal government has abdicated its responsibility to help ensure Americans quality care at a cost our nation can afford. Given this reality, we as a state must do so ourselves.

- You seem to imply that the patient choice of physician provision could somehow end or preclude closed network arrangements. That is quite incorrect. The measure does nothing of the sort as written, nor is that its intention.

You may be assured that we oppose "any willing provider" arrangements as that concept has been implemented and understood, nor do we believe that there is any significant support for such a return to the past elsewhere in our state, so we regard this alleged difficulty, to be honest, as something of a red herring. The sole intention of these provisions is to ensure Massachusetts residents the right to select a physician in whom they can place their confidence, because — absent trust — caring is not possible, and because -- absent trust -- costs tend to rise as needlessly expensive procedures and treatments proliferate. Although choice is vital to all aspects of care, we would cite for you the situation faced by mental health patients and providers as particularly telling and troubling. The mental health community has been devastated by the absence of meaningful freedom of choice for patients in most plans. We regard this situation as unacceptable in and of itself, and also as a harbinger of likely developments across all areas of care. (And, similarly, we regard the use -- widespread with respect to mental health care and coverage — of the concept of medical necessity as a purely cost containment mechanism, rather than as accurate means of determining patient need for treatment, as precisely the sort of abuse our measure aims to prevent.)

- You ask us to attach additional specificity to the measure's bar against financial arrangements with certain effects. It would be difficult, to say the least, to attempt to "legislate" in detail in this area prospectively, when review of and changes to financing arrangements is one of the key roles the measure itself expressly delegates to the Health Care Council and the Legislature. However, the answer to your question about whether this provision would "prohibit any or all types of capitation arrangements" is an emphatic no. You may be interested to know, moreover, that the position many of us will advocate in the future forums created by the measure is that two-tiered capitation, where the insurer offers a capitation contract with an individual physician or with a very small group, creates a situation where the financial risk for the physician(s) conflicts too closely with clinical care. Three-tiered capitation, where the insurer offers a capitation contract with an intermediary physician organization or a provider organization, would be acceptable. In this arrangement, the provider group would bear financial risk, but the individual doctor-patient relationship would be buffered.

- You ask about the impact of the measure's ten percent limit on non-health spending. As you correctly point out, the ballot measure does not include a "one-size-fits-all" definition; deliberately so, because real and legitimate differences exist among the various kinds of entities covered by the provision and must be acknowledged. We remind you again that whatever methodology is adopted here will not be decided by us, but rather by all concerned and in the context of the appropriate regulatory process. We can assure you, however, that the purpose and intention of this limit is emphatically not to disable or disadvantage health care entities operating in Massachusetts, but simply to ensure that families, employers and government can be confident of receiving an acceptable return on their health care dollar — something that is increasingly not the case now. In understanding this provision, you may find it helpful to know that researchers whose work we respect greatly report, for example, that a number of Massachusetts HMOs already achieve or even exceed the required level of performance, while others are quite close.

- You raise several questions regarding the wisdom of promoting not-for-profit care and coverage, and of imposing a moratorium on for-profit conversions of hospitals and HMOs. We have included these elements because the transformation of health care into a business enterprise has had profoundly and demonstrably adverse effects — on care, on costs, on medicine's best Samaritan traditions — and yet it has proceeded apace, through a process largely hidden from public scrutiny or participation. We would be pleased to discuss this issue with you in greater detail than is practical here, but would point out by way of illustration: The clear preponderance of data showing that for-profit hospitals are more expensive than non-profits, while spending less on clinical personnel such as nurses, and avoiding charity care; Evidence of higher death rates, higher post-operative complication rates, and more preventable adverse events in for-profit hospitals; Data that for-profit HMOs have markedly lower HEDIS quality scores than their non-profit counterparts, with markedly lower patient satisfaction scores, and strikingly higher disenrollment rates; Indications that not-for-profit hospitals forced to compete directly with for-profits emulate the for-profits' misbehaviors in order to stay afloat financially; and, The literally billions of dollars in fines incurred in recent years by for-profit health care companies for unlawful and/or unethical practices. The measure pauses this rush toward for-profit care, pending a full and open public debate of its consequences.

- You suggest that the measure would have an adverse effect on costs. It is true that the measure explicitly forbids certain arrangements that purport to control costs (often, we might add, without apparent success) but which, in any event, have proven deeply harmful to the nature of care received by patients, including: the use of financial incentives to limit care or access to care; the creating of a conflict between the needs of the individual patient and individual physician income; and the denial of care. We believe, however, that there are efficient and valuable alternative tools available. Fundamentally, health care should be practiced in the best way possible, consistent with available clinical data that has been assessed for validity by the community of practitioners and experts. As clinicians, we believe in identifying "best practices" that are supported by the literature and using other methods of guideline development where there is not sufficient data. Reimbursement should incent these practices. Where there is reasonable variation in practice which is consistent with the scientific knowledge and supported by clinical experience, then reimbursement should not be used to force only a single or a limited set of clinical choices. Indeed, this concept is incorporated into the measure itself, and we are absolutely committed to the need for fair and effective mechanisms to control the costs of medical care, the precise nature of which will need to evolve as coverage becomes universal, health care choice is expanded, new therapeutic choices are developed and introduced, and appropriate levels of staffing for health care institutions are achieved.

- You ask what response we might have in the event of certain hypothetical developments that might or might not occur in the months ahead. We cannot speculate about things that remain both uncertain and ill-defined, but only say that we as individuals and as a coalition stand ready and willing to talk to anyone, and to any organization, about how best to achieve the objectives expressed in the ballot measure — objectives we believe to be shared by the great majority in this state.

- You have suggested that you believe this ballot measure stands substantial chance of winning voter approval: a cause for concern, you suggest, on grounds that the measure could somehow unleash forces detrimental to the state. Let us say again, we feel strongly that this notion of uncontrollable outcomes is unfounded. The measure, by design, is democratic in nature, and exists precisely because change in health care must happen in a way that is both rational and accountable to all the people of Massachusetts, and not simply evolve in the service of the narrowest and most parochial of interests, as is presently the case.

- You note the many previous attempts at change and how they had faltered, and seemingly caution against optimism that the sorts of fundamental change envisioned by the measure can be effected. We are, of course, well aware of this past history — and of the fact that many of those efforts, like this one, reflected the hard work of many people acting in good faith. But that does not alter the fact that the need for fundamental change remains.

Finally, let me note again something I hope has already come across in the meetings we've had: our measure is premised on the idea that constructive dialog amongst people of diverse backgrounds and interests is both needed and possible. In this context, we have found our meetings with both you and with Dr. Altman to be very useful and hope that you have as well. We say respectfully that a purported "critical analysis" of the measure conducted by those opposed to the measure would cause us great skepticism. But we recognize that your views are your own and informed by professional judgment and experience, and we would welcome your partnership in improving health care for all.

We look forward to continuing discussions with you and your colleagues on these issues of shared concern. We remain confident that common purpose can yet be found and trust that you do as well.

Sincerely,

Bernard Lown, MD