



The Center for Association Leadership

**First in Massachusetts:
What We Learned About
Healthcare Reform and Our
Members That Could Help You**

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1:00 p.m. – 2:15 p.m.**

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Baltimore, MD**



MMS Principles for Health Care Reform

1. Physician leadership. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2. One size will not fit all. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.

3. Deliberate and careful. Efforts must be undertaken to guard against the risk of negative unintended consequences in any introduction of a new payment system.

4. Fee-for-service payments still have a role. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments will likely should be a component of subset of any global payment system.

5. Infrastructure support. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.

6. Proper risk adjustment. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.

7. Transparency. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. Proper measurements and good data. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

(continued)

9. **Patient expectations.** Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. **Patient incentives.** Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

11. **Benefit design.** Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

12. **Professional liability reform.** Defensive medicine is not in the patient's best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.

13. **Antitrust reform.** As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

14. **Administrative simplification.** Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Physicians should be protected from undue administrative burden, or should be appropriately compensated for it.

15. **The incentives to transition.** In order to transition to a new model, incentives must be predominantly positive.

16. **Planning must be flexible.** Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

17. **Primary care physician.** All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

18. **Patient access.** Health care reform must enable patient choice in access to physicians, hospitals and other services, while recognizing economic realities.

Adopted by the Massachusetts Medical Society House of Delegates, May 21, 2011



Massachusetts Health Reform: Fact Sheet

Access to care

- The Massachusetts uninsurance rate is 1.9%¹
- 401,000 additional residents have insurance since the passage of the reform law in April 2006²
- 50.1% of new enrollees in state-sponsored insurance plans pay all, or a significant amount, of their monthly premium³
- Private sector employers are maintaining their employee coverage
 - 76% offer insurance to their employees, up from 70% in 2006, compared to the national average of 60%⁴
 - There is no evidence that employers are cancelling their private coverage and switching their employees to public plans⁵
- Commonwealth Fund says Massachusetts residents had best access to care in the nation⁶
 - 90% of patients had usual source of care, compared to 87% from before the law⁷
 - 86% of patients saw a doctor in the past year, compared to 81% before the law⁸
 - 78% of patients saw a doctor for preventive care in the past year, compared to 71% before the law⁹
- Premiums for state-sponsored insurance plans have risen only 5% annually¹⁰
- Tremendous improvement in health care benefits and premium costs for many residents¹¹
 - Single adults before health reform: \$335 premium, \$5,000 deductible, no drug coverage
 - Today: \$182 premium, \$2,000 deductible, drug coverage after \$100 deductible
 - Most health plans charge no-pay for pediatric preventive and wellness visits
- Emergency department visits rose only slightly (4%) since the implementation of health reform, but visits for non-urgent care fell by 2%¹²

Support for Massachusetts health reform

- 63% of households surveyed support the law, up from 51% from two years previously.¹³
- 70% of Massachusetts physicians support the state law; 13% oppose it¹⁴

Health care costs

- Per patient costs in state-sponsored plans were within market norms (\$423 pm/pm). FY10 increase was 3% to 7%, below the average market increase of 8% to 15%¹⁵
- Additional net state tax dollars spent on health reform in FY 2009 was only 1.3% (\$353 million) of the entire state budget¹⁶

Health care reform and primary care

- Primary care shortages continue in Massachusetts, but they predate health reform by many years, and mirror shortages in many other areas of the country. Notwithstanding these shortages, 47% of FPs and 49% of IMs are still accepting new patients; and 62% of FPs and 53% of IMs still accept Medicaid.¹⁷

Continuing Issues in Massachusetts

The initial health reform law in 2006 addressed access, and was not designed to address the overall cost of health care in a significant way. Subsequent legislative and regulatory activity has since focused on slowing rate of growth of health care costs.

- Health care costs, high in Massachusetts relative to the nation for decades, threaten to undermine these improvements in access and coverage. A legislative commission in 2009 recommended that the state move to alternative payment systems to address costs.¹⁸
- In February 2011, Gov. Deval Patrick introduced legislation to authorize the creation of ACOs throughout the state. Provider participation in these ACOs is voluntary. The legislation is currently being heard in the Legislature. Action is not considered likely until 2012.¹⁹
- The physician practice environment in Massachusetts remains challenging relative to practices nationwide, largely because higher office rents and labor costs and larger medical malpractice insurance increases²⁰

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VITAL SIGNS



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Every physician matters,
each patient counts.



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- 4 **THE PUBLIC'S HEALTH** Foundation's IHS Grant Awards • MA Responds Is Launched • Lessons Learned from Northern Ghana
- 5 **GOVERNMENT AFFAIRS** Upcoming Legislative Session • Post-Election Predictions
- 6 **PROFESSIONAL MATTERS** Processing Anger Constructively • *Women in Medicine Bulletin* • Workshop for Young Physicians
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- 8 **MMS EDUCATION PROGRAMS**

VOLUME 16, ISSUE 1, DECEMBER 2010/JANUARY 2011

Reforming Payment and Delivery Systems

BY LLOYD RESNICK

Payment and delivery-system reforms must complement one another. That was the main message from a payment reform conference cosponsored by the MMS and the Commonwealth Fund in October.



The first speaker, **Howard Grant, M.D.**, was former chief medical officer at Pennsylvania's Geisinger Health System. Geisinger's integrated and coordinated system is facilitated by homogeneous patient

populations, a large percentage of Geisinger-employed physicians, and most importantly by a Geisinger-owned local health plan. When asked whether such high levels of integration and care coordination could be replicated in Massachusetts, Dr. Grant said, "Call me in about six months, and I'll let you know." Dr. Grant became CEO at Burlington-based Lahey Clinic in November.

Medical home results at Geisinger include a 25 percent reduction in hospital admissions and a 53 percent reduction in readmission after discharge. In Geisinger's "value reimbursement program," fee-for-service payments and innovation-investment stipends are supplemented by incentive payments based on quality and efficiency.



Michael van Duren, M.D., chief medical officer at Sacramento-based Sutter Physician Services, explained how small groups of physicians uncover and resolve variability in care. The process employs

insurance claims data and an episode-based software tool that drills cost down to individual physicians. "When physicians explore variability without judgment in a safe, respectful environment, they make improvements to clinical practice," Dr. van Duren said.

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Medicare Reprieve Sought for 2011

In November, Congress passed a 31-day reprieve from the 23 percent Medicare physician payment cut that was scheduled to take effect on December 1. As this issue of *Vital Signs* went to press, bipartisan discussions were underway to identify funding offsets to pay for a full 12-month reprieve that would stabilize physician payments for all of 2011. That would theoretically buy time for Congress to devise a permanent solution to the Medicare payment dilemma, but congressional support for that very expensive "cure" is uncertain.

State Payment Reform on Front Burner after Election

BY TOM WALSH

Gov. Deval Patrick's reelection seems to ensure that payment reform efforts in Massachusetts will move forward in 2011.

JudyAnn Bigby, M.D., secretary of the state Executive Office of Health and Human Services, told *Vital Signs*, "We worked hard this past calendar year to see if we could work with the legislature on a piece of payment reform legislation. That did not happen, so once the formal session ended we did not want to lose the momentum we had achieved at the beginning of the year."

Dr. Bigby emphasized the importance of stakeholder input in the process. "Our goal is to enable as many people as possible to see where there is consensus on how to proceed and to make that obvious to the legislature," she said.

Agreeing that the election seemed to propel payment reform forward, Alice T. Coombs, M.D., MMS president, said, "We have to make sure this push for payment reform takes into consideration all stakeholders' concerns and allows us an opportunity to slow down and listen to what everyone has to say." The MMS has urged a deliberate pace toward payment reform because the state's physicians vary greatly in their readiness to change from the currently predominant fee-for-service system.

The Society has a seat on a state committee working to develop a blueprint for payment reform legislation. "The fact that they have given us an opportunity to contribute to this process is of paramount importance," Dr. Coombs said.

"Not Capitation Redux"

In a pre-election video campaign statement for the MMS website, Gov. Patrick was clear about his intentions. "I think the next frontier is cost control and containment," he said. He went on to address physician concerns about payment reform specifically: "I want to assure doctors that this is not capitation redux," he said. "It's [about] avoiding some of the hazards of capitation."

The governor's main election rival, Republican Charlie Baker, signaled his lack of enthusiasm for payment reform. "I've never thought that the whole thing was fundamentally about payment reform," Baker said using the same MMS web-video forum. "I don't know why we should turn payment... completely upside down for the entire system when there is no real evidence to me that the entire system is broken."

Shortly after Baker's loss on Election Day, Senate President Therese Murray told the *Boston Globe* that controlling health care costs and payment reform are top priorities for her. "It has to be done," she told the newspaper.

Committee Outlining Legislation

The job of developing payment reform legislation now rests with a panel known as the Committee on the Status of Payment Reform Legislation. The panel's job is to review a "draft outline" of possible legislation and to seek input from "interested stakeholders and experts," including the MMS. The committee must then make legislative recommendations to the Health Care Quality and Cost Council.

The committee began meeting on September 1 and its last formal session was scheduled for December 15. Dr. Bigby said she hoped to have draft legislation ready "shortly after that or near when the legislature reconvenes." On December 2, the committee held a public forum "to summarize what's come out of the meetings, so the public could see where we are," said Dr. Bigby.

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PRESIDENT'S MESSAGE



The Need to Change

A few weeks ago, I joined about 30 other physician leaders from across the country for a meeting with Don Berwick, administrator of the Centers for Medicare and Medicaid Services. The ultimate outcome of health care reform will be determined largely by how well key players lead the process, and I'm confident Dr. Berwick can establish effective reforms within these government health programs.

Much of the talk during the meeting centered on accountable care organizations (ACOs). In Dr. Berwick's vision, an ACO:

- Puts patients first and engages them in decision-making
- Closes gaps in communication among provider teams
- Sees patients and allocates resources at the right place and the right time
- Ensures smooth and effective "handoffs" between health care environments

Dr. Berwick also stressed the need for flexibility and heterogeneity in ACO development. Like our state's Secretary of Health and Human Services JudyAnn Bigby, M.D., Dr. Berwick understands that ACOs formed in rural areas will look different than those based around a tertiary-care urban hospital. Both models — and many more in between — need a chance to work.

I mentioned, again, the need for robust support as physicians adopt information technology. I also noted that there are approaches other than global payment, such as episode-based models, that we should consider.

The most important thing about the meeting was this: not a single person in the room said, "We don't need to change."

— Alice T. Coombs, M.D.

Payment Reform Conference

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Sara Rosenbaum, J.D., chair of the Department of Health Policy at George Washington University's School of Public Health and Health Services, cited "a strong tension" between antitrust law and policies that encourage integration of health care delivery. She predicted that "the antitrust imperative will in time give way to the integration imperative."



James Hester, Ph.D., director of the Vermont Health Care Reform Commission, explained Vermont's legislated balance between insuring more citizens, deploying health IT, and transforming health care delivery. Vermont's system of aligned incentives gives providers sliding-scale "management fees" linked to their performance on 10 medical home criteria from the National Committee for Quality Assurance.



JudyAnn Bigby, M.D., secretary of the Massachusetts Executive Office of Health and Human Services, reiterated comments she made in the November 2010 *Vital Signs*: "You can't move providers from one form of payment to another overnight," she said. "Diversity and flexibility is the theme I keep promoting."



Dana Safran, Sc.D., senior VP at Blue Cross Blue Shield of Massachusetts, explained how the health plan's Alternative Quality Contract (AQC) incentives are based on process, outcome, and patient experience measures.



Describing Atrius Health as "an ACO without hospital ownership," **Gene Lindsey, M.D.**, president and CEO of the 800-physician multispecialty group, emphasized the importance of eliminating waste and duplication in health care delivery. Atrius is also a pioneer of innovations such as shared medical appointments.



Barbara Spivak, M.D., president of the Mt. Auburn Cambridge Independent Practice Association, said that although Mt. Auburn Hospital and the IPA are separate entities, "We partner with Mt. Auburn in everything — even our approach to contracting with health plans." **VS**

For more coverage of the payment reform conference, including downloadable slides and video clips, go to www.massmed.org/paymentreformpresentations.

Post-Election Push for Payment Reform

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MMS Message Does Not Waver

Lynda M. Young, M.D., MMS president-elect, represents the Society on the payment reform committee. "Our basic message has remained the same — one size does not fit all," Dr. Young said. "We listen carefully to determine where there is room for compromise, while on other things — such as the need to move at a deliberate pace and make physician participation voluntary — we are tenacious."

Among other things, the MMS has urged the committee to test the value of accountable care organizations (ACOs) with pilots, and to require that providers occupy two-thirds of the seats on any oversight panels created by legislation. "We want physicians who actually care for patients on those boards," Dr. Coombs said. "Otherwise, the boards will not know the challenges that patient-care doctors face."

Dr. Bigby concurred with the MMS on ACO pilots. "We agree that there should be pilot projects, and we're working with the federal government to allow such projects to happen in Massachusetts," she said.

Two-Pronged Advocacy

The Society's advocacy approach has been two-pronged: listening to physician concerns during meetings of hospital staffs and specialty and district societies, and ensuring that those concerns are articulated to Dr. Bigby's committee in both written and oral testimony.

For example, the Society has strongly encouraged the consideration of payment methodologies in addition to global payment, including episode-based approaches and the retention of fee-for-service in certain settings. "We also continue to emphasize the need for scientifically valid quality measures and risk adjusters," said Dr. Coombs, "along with meaningful liability reforms that reduce defensive-medicine practices and an easing of self-referral and antitrust rules and enforcement."

Dr. Bigby said that physicians she has spoken with know the current system doesn't work well, and many are "eager to see some changes." But she was quick to add, "We want this to work for doctors and their patients, and we welcome their input."

Dr. Young concluded on a similar theme. "I am optimistic," she said, "but I know colleagues who are scared to death of this. We have to change, and nobody likes to do that. But in the end, our practices will be better because of things such as administrative simplification and the medical home model." **VS**

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VOLUME 14, ISSUE 7, SEPTEMBER 2009

PRESIDENT'S MESSAGE



Advocacy Is Not a Spectator Sport

This season of health care reform in Washington and Massachusetts is a defining moment for physicians and our Medical Society.

We always have two goals when we advocate: to help physicians provide the best care for their patients, and to help patients get the care they need.

We use the tools of legislation, regulation, health plan advocacy, the development of ethical standards, and more — often in a complex, volatile political environment.

Sometimes it's important to advocate visibly and vocally. At other times, it's more effective to be discreet and tactful. The art of advocacy lies in knowing which tactic to use and when. This year, we have done both.

The Society has a detailed protocol for policymaking, striking a balance between democratic decision making and the frequent need to act with just hours' notice. House of Delegates (HOD) policy guides our actions (such as the HOD's timeless principles for universal coverage found on page 5). Our Committee on Legislation can support, oppose, or initiate legislation.

We often seek the input and counsel of our members, our Board of Trustees, and others. This advice is supplemented by opinions spontaneously offered by our members. All of it is welcome, and all of it contributes to the final decisions.

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All Eyes on Legislature in Aftermath of Payment Reform Recommendations

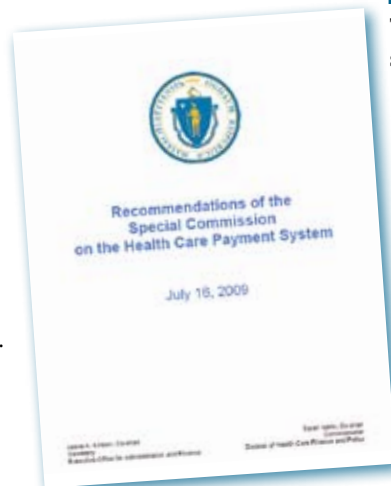
BY TOM WALSH

After seven months of research, outreach, and public hearings, the state payment reform commission recommended this summer that physicians and hospitals in Massachusetts be paid under a "global payment" model (see box on page 2) within five years. The commission's report also called upon government and insurers to provide ample support for physicians during the transition.

The commission's recommendations have shifted attention to the state Legislature, whose action will be needed to engineer any systemic payment change, and to the agencies and entities that will work to get physicians and hospitals ready for the major transformation.

The payment reform commission was created last year by the Legislature, which sought advice on how to develop a statewide payment model that would simultaneously moderate rising health care costs and improve the quality of care delivered in Massachusetts.

Alice A. Coombs, M.D., MMS president-elect, was the commission's only physician member. Others on the 10-member panel included representatives from hospitals, health plans, the Legislature, the state's largest purchaser of health insurance, and leading officials of the Patrick administration.



Physicians Need Tenacious Support

The Society supports the commission's recommendation to shift the focus to a more patient-centered model of medicine, with physicians and others providing coordinated, evidence-based, high-quality patient care.

Mario E. Motta, M.D., MMS president, said he was pleased the panel recognized that the move to global payments should be gradual and careful. He said the commission's initial sentiment was to move more quickly, but it acceded to the Society's concern that many of the state's physicians would need more time to change. "Most doctors will need some preliminary steps to get there," Dr. Motta said. "Very few physicians could succeed under this new system

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Society's Voice Heard amid Clamor of Health Care Reform in Washington

BY TOM WALSH

As the August congressional recess slowed the frenetic pace of health care reform in Washington, MMS leaders remained guardedly optimistic that the process would produce a final legislative approach to reform that is consistent with the Society's principles.

"To be successful, health care reform must support a diverse, pluralistic health care system," said Mario E. Motta, M.D., MMS president. "Reform must support and promote high quality care, and health care spending must be affordable and sustainable."

James F.X. Kenealy, M.D., chair of the MMS Committee on Legislation, said the Society was "continuing to provide frequent input" to reform developments in Washington. "Dr. Motta and I

both felt it was extremely important for MMS leadership to have clear-cut marching orders so we could respond knowing we are on firm ground with our colleagues in the Society."

As lawmakers' summer vacations began, three House committees and one Senate panel had approved sweeping reform measures, but "there's no one final bill out there to respond to," Dr. Kenealy said.

MMS Remains Strong but Flexible

Through its broadly stated reform principles (see box on page 5), the MMS has remained "at the table" throughout the health care reform debate. Amid some controversy, the American Medical

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President's Message

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Advocacy is not a spectator sport. At some risk, we participated in the work of the payment reform commission this year. Within days, our insights helped other commissioners appreciate the difficult challenges facing physicians and other health care providers. Alice Coombs, M.D., our representative on the commission, was tenacious in insisting that physicians be guaranteed ample time and support if our payment system changes. The final report provides such assurances.

We will be equally tenacious in the years ahead to ensure that physicians are able to succeed as our health care system evolves. We can't afford to lose any more physicians simply because other parties want to move too fast, too soon.

In Washington, the physical distances are greater, but our impact is just as powerful. During the heat of amendment-making and proposal-vetting this summer, congressional staff were on the phone with us at all hours, soliciting opinions and accepting suggestions. We argued for essential reforms in Medicare, defensive medicine, primary care, and more. Few state medical societies have this kind of impact in Washington.

Underlying this activity is the recognition that when we disagree with a proposal, we must offer an alternative and help create a solution. If we don't participate in this process, the debate will continue without us, and the end result will be intolerable and untenable. It's better to be inside the room than outside waiting for a decision on our fate.

You may not always agree with our decisions, and we may not always win all our battles. Uncertainty and ambiguity are the rule, and results are never assured. But we all share the same passion for our profession and commitment to our patients. That realization guides us daily.

Even if we disagree, your opinions, insights, and advice are always welcome.

Mario Motta, MD

— Mario E. Motta, M.D.

Payment Reform

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today, and their readiness to make such a transition is highly variable across the state."

It's estimated that about 20 percent of physicians in Massachusetts currently practice under some version of a global payment arrangement. Some are employed, while others are allied with a larger organization but not employed.

"The details — that's where the rubber meets the road in this process," Dr.

Coombs said. "We need to move ahead cautiously, and early adopters will have to be looked at and studied."

Dr. Coombs went on to caution that "without infrastructure support for providers by payers and the government, you cannot expect to have a successful transition to global payments. Without that support, it just won't happen."

Dr. Coombs also emphasized that the panel's recommendations to this point align with MMS payment reform policies and that physicians must stay engaged in the process.

Report Includes MMS Language

The MMS, Dr. Coombs said, was instrumental in laying out the commission's roadmap.

For example, she cited the following sentence from page 10 of the report: "The Special Commission recognizes that many providers will require infrastructure, legal and technical assistance and support, such as information technology adoption, training in use of registries, and managing risk before the transition to global payment can occur."

What Global Payment Is — And Isn't

The Special Commission on the Health Care Payment System studied the strengths and weaknesses of several payment models and concluded that global payment provides the best opportunity for addressing both cost and quality.

As envisioned by the commission, per-patient global payments would be risk-adjusted to reflect patients' health status and to ensure doctors are paid fairly and are not penalized for taking care of sicker patients.

Commission members stressed that the global payment model is "not a synonym for capitation," a payment experiment from the 1990s that has been broadly discredited because of its potential to unfairly deny care to patients and put providers at untenable financial risk.

The global payment recommendations would make providers responsible only for "performance risk" — cost, access, and quality benchmarks that are under their control. Health plans would be responsible for "insurance risk" outside provider control, such as the risk for covering unexpected or unusually costly cases.

Physicians, hospitals, and other providers would have to coordinate their care through new delivery entities called accountable care organizations (ACOs), which could be either formally incorporated or more loosely structured. Global payments would be funneled first to the ACO, then shared among the providers in the organization. The commission emphasized that "the market [should] determine global payment amounts."

Dr. Coombs said the term "legal" refers to the Society's message that medical liability reform and changes in antitrust laws will be needed before a global payment system can be widely adopted. The commission said it recognizes physician views on medical malpractice reforms and "recommends concerted efforts to resolve remaining issues and develop policy recommendations."

Dr. Coombs cited another MMS-inspired caveat in the report: "The Special Commission also recognizes

that certain narrow classifications of services or practitioners should continue to be paid outside of the global payment model for their services, such as very high cost drugs or providers of very limited and specialized services."

Next Steps

State legislative leaders were cautious about offering a specific timetable for action on the commission report, though initial hearings could begin this month. It seemed clear that final legislative consideration of payment reform remains months away at best, especially given the state's ongoing budget problems.

In the meantime, the MMS and other organizations are already planning for the financial, technical, and legal assistance physicians will need. **VS**

To download the commission's report, read the MMS payment reform principles and its statement in response to the commission's report, and

participate in the MMS blog on payment reform, go to www.massmed.org/paymentreform.

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VOLUME 14, ISSUE 8, OCTOBER 2009

Volunteer Physicians Rediscover the "Essence of Medicine"

Editor's Note: This is the first in a series of *Vital Signs* articles about physician volunteerism, focusing on programs facilitated by the MMS. Physician-author Lisa Gruenberg, M.D., will interview clinicians and patients at free health programs throughout the state.

In her inaugural article, Dr. Gruenberg examines what motivates physicians to volunteer.

How did I become a volunteer physician? The answer has a lot to do with the Massachusetts Medical Society.

In 2003, I left a busy gynecology practice because of burnout and family health issues. I started teaching anatomy and physiology at Harvard Medical School, but after a year, I had a hankering to see patients again, so I attended an MMS volunteer fair and found I could get malpractice insurance through the Society.

That prompted me to begin volunteering in free care programs around Boston. Inspired by my fellow volunteers, I rediscovered the essence of medicine. I relished seeing patients again in a setting that at times could be chaotic, but was also incredibly rewarding.

In the past year, I traveled to the Eastern Cape of South Africa through a program administered by the MMS and a Boston-based organization called South Africa Partners. I am now returning to a job in clinical medicine, but I will continue my commitment to teaching at Harvard and to volunteerism, both here and abroad.

What Makes Physicians Volunteer?

Laura Bookman, M.D., a board-certified Ob-Gyn, explained it this way: "I believe health care should be available to all as a right, but that is not the system

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Physician Empowerment a Likely Outcome of Payment Reform, Says Commissioner Iselin

BY TOM WALSH

If legislation moves Massachusetts to a "global" payment system for physician reimbursement, the transition from the current fee-for-service system should be "thoughtful," and doctors should be provided with necessary support before they are required to change to a new system, said Sarah Iselin, commissioner of the state Division of Health Care Finance and Policy (DHCFP). It's likely that the DHCFP will have oversight responsibilities during any such transition.

During a lengthy interview with *Vital Signs* in her downtown Boston office, Iselin was often animated in her endorsement of strategies intended to increase the quality of health care and address growing concerns about cost.

"To achieve our goal, we need to change the way we are organized in paying for and providing health care — having well-coordinated care of the highest quality that also conserves what are increasingly

scarce resources," the commissioner said. At the same time, Iselin noted that some people are mistakenly blaming the health care cost crunch on the state's three-year-old foray into near-universal coverage (see article below). "In fact,"

she said, "our spending as it's devoted to health reform is very much in line with what we expected."



Photo courtesy of DHCFP
Sarah Iselin, commissioner of the state Division of Health Care Finance and Policy

Supporting Physicians through Change

Iselin also co-chaired the Special Commission on the Health Care Payment System. In July, that commission recommended a move to global payments (see *Vital Signs*, September, page 1). Commissioner Iselin maintained that revamping the state's reimbursement system in that way would help improve the physician practice environment. "This vision of the future could really be empowering for physicians," she said.

"The commission was really about quality and care coordination," she

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State Health Reform — Three Years Later

BY TOM WALSH

After three years of health care reform in Massachusetts, the state's insured rate is at 97-plus percent, the highest in the nation. For the office-based physicians interviewed for this article, reform has not significantly altered their day-to-day working lives. But hospital officials said reform has increased the crowds waiting in many emergency rooms.

"It's good for patients to have coverage and not have to put off care until they are very ill," said MMS President Mario E. Motta, M.D., a North Shore cardiologist. "Health reform has enabled more patients to be seen in a timely way rather than waiting to a point where conditions are harder and more expensive to treat."

The historic nature of the accomplishment aside, for many physicians reform has not altered the status quo.

Little Impact on Volume, Some on Revenue

Devin McManus, M.D., a primary care physician in Falmouth on Cape Cod, said reform "has not affected my life or my practice very much." One reason, he said, is that family practices on the Cape tend to have a high percentage of older patients who have Medicare coverage. Secondly, Cape practices were already overburdened before reform. "We have such a shortage of primary care doctors here to begin with that even a potential influx of patients would not change the dynamics much," Dr. McManus said.

For some practices, though, reform has provided an economic boost. In Dr. Motta's 14-physician cardiology practice, about 10 percent of the care was provided without compensation prior to reform.

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PRESIDENT'S MESSAGE



Payment Reform: We Will Advocate and Support

I've heard from many of you who have deep-seated concerns about state payment reform. There's widespread fear that "global payment" is merely old-style capitation in sheep's clothing.

Let me be clear: the Medical Society will work tenaciously to ensure that any changes in payment methodologies honor and protect the sanctity of the patient-physician relationship, our professional code of ethics, and the Hippocratic Oath. Nothing less will suffice.

As the payment system evolves, the Society will do everything it can to make sure reform helps patients and their doctors. We will keep close tabs on the Legislature and comment clearly and forcefully on all payment reform proposals. We will implore lawmakers never to lose sight of the number one goal: better care for patients.

We will also work to ensure that the state provides doctors with the necessary infrastructural and logistical support during any transition. For example, many physicians will need help joining and functioning within the accountable care organizations (ACOs) that the payment reform commission recommended.

It's important to remember that none of the details have been determined, and much remains to be defined. Our advocacy and support will be ongoing throughout the process.

If payment reform maintains an unblinking focus on both excellent patient care and cost containment — and if government takes the role of facilitator rather than dictator — this effort can succeed for physicians and all other stakeholders.

Mario Motta, MD
— Mario E. Motta, M.D.

State Health Reform

continued from page 1

"We could not and would not send patients away because they couldn't pay us," Dr. Motta said, "but reform has substantially reduced the amount of uncompensated care provided in our practice. It makes a huge difference."

Eric P. Kaplan, M.D., a Lowell pediatrician in a nine-physician practice, said reform and the newly insured "haven't affected us a great deal." However, he said reform has helped a particular segment of his patients — those previously without insurance who've turned 19. "That means a 19-year-old who would otherwise go to a hospital or clinic can now see a primary care doctor," Dr. Kaplan said.

For Dennis Dimitri, M.D., and his two colleagues practicing family medicine in Worcester, the handful of 20-somethings who've come in as new patients since 2006 has made health care reform worthwhile. "Some had postponed seeking care and came to us with problems more advanced than they would have been if these people had been covered all along," said the 27-year practice veteran.

In one case he heard of — not his own patient — a young man who'd postponed doing something about lumps in his neck turned out have a lymphoma that was treatable. "At that age, many are playing medical roulette," Dr. Dimitri said.

Nevertheless, Dr. Dimitri said his practice — like many others closed to new patients or open only to members of families already with the practice — has not seen a cascade of new patients as a result of reform.

More Pressure on Emergency Departments

For Massachusetts hospitals, however, reform has kept already overburdened emergency departments either at or beyond capacity.

"We've seen more people using emergency departments than before because of patients who now have insurance," said Karen Nelson, senior vice president for clinical affairs at the Massachusetts Hospital Association (MHA). "For some who were formerly uninsured, we believe the habit [of relying on the ER] is just ingrained."

Nelson said other aspects of the health care delivery system must be improved to achieve overall reform. "Many more people have access, but the system has not changed yet," she said. For example, Nelson said, preventable readmissions will only diminish when there is better coordination of care between providers inside and outside hospitals. "Despite the improved access, the system is still not well connected," she said.

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Newly Insured in Last Three Years

Type of Coverage	No. of Individuals
Employer and other private group plans	96,000
Individual plans	46,000
MassHealth	99,000
Commonwealth Care	165,000
Total	406,000

Source: Mass. Department of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," August 2009.

Lynn Nicholas, MHA president and CEO, estimated that 30 percent of readmissions could be avoided if the delivery system were better connected.

Dr. Motta concluded that if reform improves preventive care and enables more coordinated disease management, then it may also, over time, succeed in containing overall health care costs. **VS**

LETTER TO THE EDITOR

Dentists and Primary Care

To the Editor:

The Joint Committee on Public Health of the Massachusetts Legislature is currently reconsidering a bill that would allow dentists to be designated as "oral physicians." I would encourage the MMS to reconsider its opposition to this legislation.

With the impending reorganization of health care, dentists can and should play a more significant role in health care. Dentists receive sufficient medical and surgical training to provide limited preventive primary care as oral physicians, including taking vital signs and recognizing oral manifestations of systemic diseases. Moreover, nondentists are now being trained to provide routine dental care, giving dentists an opportunity to perform limited primary care functions. Also, the Massachusetts DPH recently included dentists in the list of additional health care professionals who could be licensed to administer vaccines against pandemic influenza.

In the public interest, it is important for the MMS not to oppose legislation, similar to that already enacted for podiatrists and chiropractors, that would allow dentists to append "physician" to their title.

— Donald B. Giddon, D.M.D., Ph.D.
Cambridge, MA

Letters to the editor should be 200 words or fewer, and all are subject to editing. Send to the MMS Department of Communications, 860 Winter Street, Waltham, MA 02451-1411; vitalsigns@mms.org; or fax to (781) 642-0976.

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Physicians' Views of the Massachusetts Health Care Reform Law — A Poll

In 2006, Massachusetts enacted the country's first law mandating near-universal health care coverage,¹ and the state now has the lowest proportion of uninsured residents in the United States.

attention to the state's insurance gains and indicated that health care costs, though growing, have not exceeded early projections or expectations, others have argued that high costs and some reported problems with access to care should be taken as warnings of the problems the country might face if a similar reform were implemented nationally. For example, Michael Tanner of the Cato Institute has called the Massachusetts reform "unsustainable" because of its "failure to restrain the growth in health care costs" and the fact that it has "set the stage for . . . price controls and explicit rationing."³ Similarly, a June 24, 2009, post about the Massachusetts reform on the blog

of John Boehner of Ohio, the Republican leader in the U.S. House of Representatives, said that “out of control costs” and “rationing” have been consequences of universal coverage in Massachusetts.

We know from previous research that the Massachusetts public is favorable toward the state's legislation,⁴ but physicians can provide critical insight into how the law is actually functioning and how it has affected access to high-quality health care. In previous studies, Massachusetts physicians have been interviewed about their experiences with and impressions of other reform issues, such as managed care and a potential single-payer health care system, but only one poll to date has asked physicians about Massachusetts health care reform. That online poll, conducted by the American College of Emergency Physicians, focused on the views of 138 emergency doc-

Poll Methods

Study Design and Fielding

The poll was designed and analyzed by a team of researchers at the Harvard School of Public Health. The fielding process was coordinated by an independent survey research firm, Social Science Research Solutions.

Sources of Data

The data are from a randomized poll of 2135 Massachusetts physicians. Researchers obtained a random sample of physicians practicing in Massachusetts from the SK&A database, which is a comprehensive list of physicians based on published association and trade directories as well as federal and state license files. Information in the directory is updated and verified every 6 months.

Physicians were invited to participate in the study by means of a mailed letter and were offered an incentive ranging from \$50 to \$100 for completing the poll. The incentive amount was determined by the physician's specialty, as is standard practice in polls of physicians. All respondents were offered the opportunity to complete the poll by mail, Internet, or telephone; all chose mail or Internet.

Poll Questions

A complete list of questions asked as part of the poll is available in the Supplementary Appendix, available with the full text of this article at NEJM.org.

Data Collection and Statistical Analysis

The poll was conducted from August 11 to September 15, 2009. This period was chosen to help ensure the relevance of the data to the national debate on health care reform. Congress had originally been expected to vote on a health care reform bill in October 2009. The period was short to ensure that we captured views during a relatively uniform period that was less likely than a longer period to be interrupted by changes in the environment, such as media reports on the issue, that might affect physicians' views differentially over time. We issued a higher number of initial mailings and predicted a lower response rate than in longer-term surveys, and we used weighting techniques to ensure that the final responses reflect the views of the overall physician population. This approach is similar to standard techniques for polls of the public. It has been shown to be more accurate than surveys of the public with longer field times for issues that are sensitive to changes in media coverage, such as election campaigns. Independent studies have shown that statistically weighting the data for known population variables reduces the effects of a lower response rate.^{1,2}

More physicians wanted to participate in the poll than we had expected, so we allowed those who wanted to complete the poll after the deadline to submit their responses with the understanding that they would not be provided with an incentive. We compared the demographic profiles of those who responded within the window when incentives were offered to the profiles of the full sample and to the profiles of all physicians in Massachusetts. We found few differences in either comparison, although both of our samples include a smaller fraction of medical subspecialists than the population of Massachusetts physicians does. We also compared responses to a key substantive question (whether the respondent supports or opposes the legislation) between our two samples and did not find a significant difference in the level of support for the legislation.

To ensure that we used a representative sample, our analysis weighted the final sample to reflect the composition of Massachusetts physicians. Characteristics included in the weighting were specialty, regional location, and setting of practice (urban, suburban, or rural).

When interpreting our findings, it is important to recognize that all polls are subject to sampling error, and results may differ from what might have been found if all physicians in Massachusetts had been polled. The sampling error for this poll is ± 1.9 percentage points. Possible sources of nonsampling error also include nonresponse bias and effects of the wording and ordering of the questions. As calculated with the use of a standard of the American Association for Public Opinion Research, the response rate was 28%.

In comparing responses among subgroups of physicians, we used t-tests that accounted for the weighting of the data. All reported P values are based on two-sided tests.

1. Yeager DS, Krosnick JA, Chang LC, et al. Comparing the accuracy of RDD telephone surveys and Internet surveys conducted with probability and non-probability samples. August 2009. (Accessed October 21, 2009, at http://www.knowledgenetworks.com/insights/docs/Mode-04_2.pdf.)

2. Keeter S, Kennedy C, Dimock M, Best J, Craighill P. Gauging the impact of growing nonresponse on estimates from a national RDD telephone survey. Public Opin Q 2006;70:759-79.

tors. Its results suggest that reform in Massachusetts is putting pressure on emergency room capacity.⁵ In a poll we conducted with support from the Robert Wood Johnson Foundation and the Blue Cross Blue Shield of Massachusetts Foundation, we turned to physicians in Massachusetts more broadly to assess their per-

ceptions in three areas: their overall support for the legislation, their views of its effect on their own practice, and their views of its effect on health care throughout the state. (Methods are described in the box.)

Of 2135 practicing Massachusetts physicians who responded to the poll, 70% said they sup-

port the Massachusetts Health Care Reform Law, whereas 13% oppose it (see Table 1). The levels of support among primary care doctors and among specialists were similar. When asked about the law's future, 75% indicated that they want the law to remain in place — 46% with some changes, and 29% as is.

Table 1. Support for the Massachusetts Health Care Reform Law.*

Topic or Question	All Physicians (N=2135) [†]	Primary Care Physicians (N=786) <i>percentage</i>	Specialty Physicians (N=1338)
Support or oppose the Massachusetts Health Insurance Reform Law			
Support	70	72	70
Oppose	13	11‡	14
Don't know or refused to answer	16	18	16
The law should be . . .			
Repealed	7	6	7
Continued as it currently stands	29	30	30
Continued, but with some changes made	46	48	45
Don't know or refused to answer	18	17	17
Most important change physicians would like to see§			
Expand coverage	34	38‡	31
Include all/more people	11	15‡	10
Ensure better/more comprehensive coverage	12	11	12
Increase physicians/providers available	7	9‡	5
Introduce single-payer system	3	3	3
Ensure businesses cannot drop coverage	1	1	1
Address costs	23	24	23
Institute cost controls/spending limits	6	6	7
Utilize more/different funding	7	6	8
Implement malpractice reform/tort reform	2	2	3
Ensure affordability	7	10‡	6
Improve reimbursement	13	12	14
Reduce coverage	8	8	8
Restrict access	1	1	1
Increase patient contributions/ensure income eligibility	7	7	7
Other	10	10	10
Streamline administration	4	4	4
Eliminate mandate	2	2	2
Regulate insurance companies	1	2	1
Other	3	2	3
Don't know	7	4‡	9
Refused to answer	5	4	5

* Percentages may not sum to 100 because of rounding.

† Eleven physicians are categorized as neither primary nor specialty because they refused to answer the relevant question.

‡ This percentage among primary care physicians was significantly different ($P < 0.05$) from that among specialty physicians.

§ This question was asked only of the 995 physicians who answered the previous question with "Continued, but with some changes made." These included 382 primary care physicians, 606 specialty physicians, and 7 physicians who refused to answer the relevant question.

Table 2. Effect of the Massachusetts Health Care Reform Law on the 2135 Respondents' Practices and Their Patients.*

Area	Negative Impact	Not Much of an Impact	Positive Impact	Don't Know or Refused to Answer	Not Relevant to Practice
	<i>percentage</i>				
The administrative burden on your practice	35	43	3	13	6
The overall cost of health care for your patients	26	35	16	23	—
The financial situation of your practice as a whole	24	47	9	16	5
The amount of time patients wait to get an appointment to see you	24	60	2	6	9
Your ability to prescribe drugs your patients need	22	43	21	8	6
The costs that your patients pay out of pocket for needed care	21	33	21	25	—
The amount of time you can spend with a patient	21	66	2	5	7
Your ability to get needed referrals for your patients	20	51	11	9	9
Your personal financial situation	19	62	5	10	5
The hospital where you practice or send most of your patients	18	31	23	28	—
Your ability to order diagnostic tests or procedures for your patients	17	50	18	8	7
The amount of time patients wait in the waiting room before they can see you	17	70	1	5	8
Your insured patients' ability to pay for care	14	53	12	16	4
Your medical practice overall	13	57	22	8	—
The number of patients in your practice who receive uncompensated care — either because they are uninsured or because their insurance does not cover the care they need	13	33	33	15	7
Your ability to keep a patient in the hospital the length of time you feel is necessary	10	52	5	14	19
Your patients' continuity of care	10	49	26	9	7
Your uninsured patients' ability to pay for care	9	27	42	16	5
Your patients' adherence to the care regimen you've prescribed	8	54	21	9	8
The quality of care your patients receive	6	66	19	9	—
The number of patients in your practice who are uninsured	7	29	48	10	6
Your ability to have a patient admitted to a hospital	4	61	11	10	14

* Percentages may not sum to 100 because of rounding. For most questions, we used the phrase “helping, hurting, or not having much of an impact on,” except “the amount of time patients wait to get an appointment to see you,” “the amount of time patients wait in the waiting room before they can see you,” “the number of patients in your practice who receive uncompensated care,” and “the number of patients in your practice who are uninsured,” for which we used the phrase “increasing, decreasing, or not having much of an impact on.” Dashes indicate that “not relevant to your practice” was not a possible response to the question.

Table 3. Effect of the Massachusetts Health Insurance Reform Law on Health Care in Massachusetts, According to the 2135 Respondents.*

Topic or Question	Response				
	Excellent	Good	Fair <i>percentage</i>	Poor	Don't Know
Rating of the Massachusetts system for providing medical care to people in the state	10	53	30	6	1
Rating of the nation's system for providing medical care to Americans	5	28	43	23	1
Impact of the law on . . .	Hurting	Not Having Much Impact	Helping	Don't Know or Refused to Answer	
The overall cost of health care in Massachusetts	53	11	9	27	
Patients' ability to get to see a primary care provider	34	19	29	19	
The cost that patients in Massachusetts pay	31	21	16	32	
Primary care practices	25	16	31	29	
Hospitals	24	11	31	35	
Patients' ability to get to see a specialty physician	22	30	24	24	
Specialty practices	18	29	24	28	
People who did have health insurance before the law	16	67	7	10	
The quality of care in Massachusetts	12	34	37	17	
People who did not have health insurance before the law	3	10	79	8	

* Percentages may not sum to 100 because of rounding.

Seven percent favored repealing the legislation. Physicians who mentioned that some changes are needed were asked in an open-ended question what change they would most like to see. They most frequently mentioned issues related to expanding coverage (34%) and addressing the costs of the program (23%). Approximately three quarters of Massachusetts physicians (79%) reported being very or somewhat satisfied with their medical practice. Fifty percent reported that things at their practice had gotten worse over the past 3 years, and 23% said things had gotten better. Few said that

the Massachusetts health care reform law was a major reason for positive changes (13%) or negative ones (11%).

We also asked physicians about 22 aspects of their practices that might be affected by the law. Table 2 shows the responses in descending order of the number of negative responses. In 21 of these areas, a majority of physicians said that the law either did not have much of an effect or was having a positive effect on their practice. These include areas that have been important in the health care reform debate: the quality of care their

patients receive (85%), their medical practice overall (79%), the amount of time their patients wait to get an appointment (62%), and the financial situation of their practice as a whole (56%). Forty-eight percent of physicians said that the law was decreasing the number of patients in their practice who were uninsured, which was the highest percentage of positive responses regarding any practice area. Forty-two percent reported that it was positively affecting their uninsured patients' ability to pay for care. The aspect that elicited the most negative response was the law's

administrative burden on their practice; 35% of physicians said the law was negatively affecting this area. About one quarter of physicians reported negative effects in the overall cost of care for patients, their financial situation, and the amount of time patients wait for an appointment.

As for the broader effects on the state, 3 years after implementation of the law, Massachusetts physicians rate the state's health care system positively. Nearly twice as many physicians rate the Massachusetts system for providing medical care as excellent or good as rate the national system that highly (63% vs. 33%) (see Table 3).

In this section of the poll, we also asked physicians to assess the impact of the law on health care in the state as a whole. We queried them about 10 aspects of health care in Massachusetts that might be affected by the law. Table 3 shows the responses in descending order of the number of negative responses. In 9 of these 10 aspects, a majority or plurality said that the law either did not have much of an effect or was having a positive effect on the situation in the state. For example, more than three quarters of physicians (79%) believed the law was positively affecting people who had not had health insurance before the law went into effect. The second most positively affected aspect was the quality of care in Massachusetts (with 37% reporting that the law was helping). The one feature of the law's impact that received negative evaluations from a majority of physicians (53%) concerned the overall cost of care in the state. The next most negative-

ly affected aspect was patients' ability to see a primary care provider (with 34% reporting that the law was hurting that), although nearly as many physicians reported that the law was helping in this area (29%). More than 25% of physicians said they did not know what effect the law was having on each of five areas: the overall cost of care in Massachusetts, the cost that Massachusetts patients pay, primary care practices, hospitals, and specialty practices.

Massachusetts has the lowest proportion of uninsured residents in the United States. Our results show that there is widespread support among Bay State physicians for the law that led to this high level of coverage. At the same time, physicians believe that it has contributed to some problems with health care in the state.

Examination of physicians' views on care for their patients provides little evidence to support criticisms that the law is negatively affecting the quality of care that most physicians deliver. With regard to their own practices, a sizable minority of physicians indicate that the legislation has increased their administrative burden.

Physicians' views concerning the effect of the law on the state's health care environment are more mixed. Most believe it is helping the formerly uninsured, but that positive view is coupled with a majority belief that the program is driving up the cost of health care in the state. In addition, physicians are divided about whether it has imposed pressures on the state's primary care capacity.

Taken together, these findings

suggest that it is possible both to provide near-universal coverage of the population and to have a system that most physicians believe improves care for the uninsured without undermining their ability to provide care to their patients. At the same time, the Massachusetts experience provides evidence of trade-offs in other areas of the health care system, including rising health care costs and, for some patients, challenges in obtaining access to primary care.

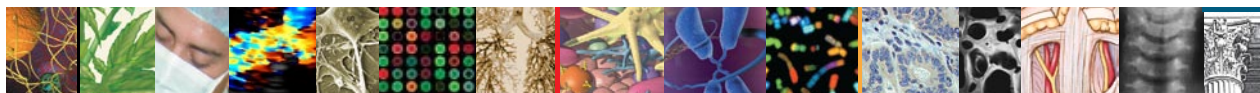
Dr. Blendon reports serving on the board of directors of, and holding stock in, Assurant. No other potential conflict of interest relevant to this article was reported.

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Perspective

Massachusetts Health Care Reform — Near-Universal Coverage at What Cost?

Joel S. Weissman, Ph.D., and JudyAnn Bigby, M.D.

Massachusetts has long been known for its academic medical centers, biomedical research, high-quality health care, and perhaps not unrelatedly, high health care costs. In 2006, the state captured

national attention when it passed a landmark health care reform bill, under which it has achieved near-universal coverage of state residents. Some observers, however, have questioned whether this reform has been too costly.

The Massachusetts reform law expanded Medicaid coverage; created state-subsidized insurance, called Commonwealth Care, for low-income persons who are not eligible for Medicaid; merged the individual and small-group insurance markets; instituted an employer “fair share assessment” and an individual mandate; and created the Commonwealth Connector, an insurance exchange that also sets standards for coverage and affordability. Under this re-

form, nearly universal coverage has been achieved, with 97.3% of all residents covered as of the spring of 2009 by health plans that meet a “minimum creditable coverage” standard. There is no evidence of private insurance “crowd-out,”¹ and access to care has increased, with fewer people encountering financial barriers to care.² Nevertheless, under the microscope of the national health care reform debate, questions have been raised about the appropriateness of the Massachusetts model for the country as a whole, given the costs of the program for individuals, employers, and the state; some have also questioned whether recent actions to reduce costs represent a retrenchment as

compared with the law’s original intent.

Spending in fiscal year 2008 was higher than expected and led to fears of rapid future growth and charges that the crafters of the reform had underestimated the size of the uninsured population and its needs. It is now recognized that Commonwealth Care’s early spending growth was due to effective marketing and outreach campaigns, which made it easier than expected for people to enroll in public programs.³ Commonwealth Care enrollment reached a peak of 176,000 in mid-2008, declined in early 2009, and has returned to its mid-2008 levels in recent months. Through fiscal year 2010, the increase in the annualized per-enrollee cost has been under 5%.

The media have raised a more fundamental question about whether Massachusetts’ experiment is too expensive — a “bud-

The Financing of Massachusetts Health Care Reform.*

Source	Financing before Reform	Financing after Reform			Additional Financing, Fiscal Years 2006–2009
	Fiscal Year 2006, Actual	Fiscal Year 2007, Actual	Fiscal Year 2008, Actual	Fiscal Year 2009, Estimated	
	millions of dollars				
Spending					
MassHealth	770	511	642	795	
Commonwealth Care	0	133	628	805	
UCP–HSNTF	656	665	416	417	
Total	1,426	1,309	1,686	2,017	
Additional, 2006–2009					591
Revenues					
UCP–HSNTF provider assessments and insurer surcharges	320	320	320	320	
Local contribution to MCO supplemental payments	385	0	0	0	
Federal financial participation	688	816	888	1,272	
Dedicated revenues	0	7	21	219	
Total	1,393	1,143	1,229	1,811	
Additional, 2006–2009					418
Difference					
General fund share	33	166	457	205	
General fund share of net new annual spending, 2006–2009					172

* Data are from the Massachusetts Executive Office of Health and Human Services. No enrollment increases besides those directly attributable to eligibility changes have been included in this analysis. Commonwealth Care spending is net of enrollee contributions. Dedicated revenues include new taxes and penalties dedicated to paying for health care reform. Some differences appear not to be exact, because of rounding. MCO denotes managed-care organization, and UCP–HSNTF uncompensated care pool–Health Safety Net Trust Fund (as the pool is called under health care reform).

get buster.”⁴ The only responsible way to address this question is to assess the new burden on state taxpayers by examining the net new costs to the state’s general fund (see table). Before reform, the state provided about \$1.4 billion annually in subsidies to institutions to cover services for the uninsured, about \$33 million of which came out of the general fund. After reform, with revenues redirected to support Commonwealth Care subsidies and expansions of MassHealth (the Massachusetts Medicaid program), a decrease in spending on the un-

compensated care pool, and a phasing out of subsidies for managed-care organizations associated with safety-net institutions, the net new spending was \$591 million, of which \$172 million — less than 1% of the state budget — came from the state’s general fund. With all spending projected to decrease in fiscal year 2010 because of recessionary belt-tightening, the draw on the general fund will decrease substantially.

Moreover, a central premise of the formative political negotiations over the Massachusetts reform was “shared responsibility” — and

indeed, a recent report showed that employers, government, and individuals pay approximately the same proportion of health coverage costs after reform as they did before reform.⁵ In fact, only about half of the more than 400,000 residents who gained coverage by December 2008 were publicly subsidized. From this perspective, the individual mandate and employer incentives have provided good value for Massachusetts taxpayers, costing about \$1,060 in net new state spending per newly covered state resident in 2008. The state succeeded in enacting a gov-

ernment program that stimulated private parties to use private dollars to help fulfill a public good.

Of course, the recession has created substantial challenges. Facing a deficit of more than \$5 billion over 2 years, the Massachusetts legislature imposed major cuts in funding to subsidize coverage for about 30,000 legal immigrants who had qualified for Commonwealth Care but are not eligible for the federal Medicaid match. MassHealth has also had to eliminate certain planned increases in provider payment rates that were not part of the original reform legislation. Like other states facing economic difficulties, Massachusetts is raising new revenues, using reserves, and taking advantage of increased federal assistance. The state has also made cuts across the board, including reducing aid to cities and towns, reducing the number of state workers, and increasing cost sharing for state employees' health insurance. In this context, reductions in core funding for health care reform were not extraordinary and do not signal a retreat from the original commitment.

There is little doubt that the high cost of care in Massachusetts is causing major strains. From 2006 to 2008, the average price of a family insurance premium increased by more than 12%, and premiums increased by about 10% statewide this autumn. If insurance becomes less affordable, the number of people who are exempted from the individual mandate could increase. Some small businesses have reportedly suffered hardships in providing insurance for employees and say that rising premiums could threaten their continued participation. But costs were high before health care reform. In contrast to the

state's approach to expanding coverage, its cost-control strategies have been incremental, and costs must now be seriously addressed.

Massachusetts was unusual in 2006 because it already had a low proportion of uninsured residents, a highly regulated insurance market, and an uncompensated care pool. Nevertheless, the national debate could be informed by our experience.

First, the philosophy of shared responsibility behind our reform provides a sense of fairness and allows government spending to be leveraged to accomplish societal goals. The individual mandate works hand in hand with employer incentives to expand private coverage, as long as government subsidies are available for low-income individuals. For example, initially, the greatest number of newly insured individuals obtained coverage through their employers rather than the individual market, suggesting that more employees decided to take up their employers' offer of insurance, quite possibly to avoid the mandate's tax penalty. At the same time, though the employer assessment did not increase the number of firms offering insurance, neither did the number decrease, as many had feared, perhaps because employers did not want to force their employees to buy insurance on the individual market at higher rates. How this plays out in national reform will depend on the design of the incentives. Massachusetts employers in 2006 were more likely than employers nationally to offer insurance. If national reform were to include policies that achieved rates of employer offers and employee take-up similar to those in Massachusetts, it could have a substantial effect on spreading the

costs and reducing the government's burden.

Second, the cost of national health care reform should be framed in terms of new expenditures and predictable funding streams that can be redirected to other uses. These should include, at a minimum, projected savings, at all levels of government, from potential reductions in the costs of paying for public clinics and uncompensated care. Savings from the latter should also accrue to private entities.

Third, the changing roles and funding schemes for the safety net must be addressed head-on. Uninsured patients will not disappear and will have needs. Safety-net providers will find it challenging to continue functioning, given their dependence on Medicaid and Medicare, which pay lower rates than commercial insurance. One goal of reform should be to decrease cost shifting.

Finally, national reform must support the gains made in Massachusetts by supporting the building blocks that made change successful: expansion of Medicaid eligibility, subsidies for the poor, the individual mandate, and fair-share employer contributions.

In Massachusetts, achieving near-universal coverage was the right first step, providing thousands of residents with access to care and protection against financial uncertainty due to medical bills. Now, tackling costs has risen to the top of the agenda. As we move toward national health care reform, we must balance individuals' needs for high-quality care with the obligation to be socially and fiscally responsible.

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Other Resources

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AMA White Paper: ACOs, CO-OPs and other Options: A "How-To" Manual for Physicians Navigating a Post-Health Reform World (Dec. 2010)

<http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/private-sector-advocacy/accountable-care-organizations.page>

Global Payments Video Series: How We Did It, and What Works (Jan. 2010)

http://www.massmed.org/AM/Template.cfm?Section=MMS_Advocacy&CONTENTID=33058&TEMPLATE=/CM/ContentDisplay.cfm

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http://www.massmed.org/AM/Template.cfm?Section=MMS_News_Releases&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=61514

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