Payment Reform After PPACA: Is Massachusetts Leading the Way Again?

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The Congressional debate leading to the enactment of federal health care reform legislation (the Patient Protection and Affordable Care Act or the “PPACA”¹) paid close attention to the structure and results of access reform legislation enacted in Massachusetts in 2006 in Chapter 58 of the Acts of 2006 (“Chapter 58”).² Many of the key access reform elements of the PPACA mirrored the most notable components of Massachusetts’s reform.³

In crafting the PPACA, the Administration and Congress had to consider the effect on the federal deficit of the coverage expansion and other benefits provided for under the legislation. Congressional Budget Office (CBO) scoring of each proposal during the legislative process became a focus of anticipation, debate, and controversy. Other, more political concerns became predominant,

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter PPACA]. The PPACA refers to the Senate version of the Act as adopted without change by the House. Amendments to the PPACA have been adopted by the subsequent Health Care and Education Affordability Reconciliation Act of 2010, a week after passage of the PPACA, and are included in the references throughout.


3. These include the individual mandate, Act of Mar. 23, 2010, ch. 58, sec. 12, § 2(b), 2006 Mass. Acts 94-95 (codified as amended at MASS. GEN. LAWS ch. 111M, § 2(b) (2010)); the concept of minimum creditable coverage that should be obtained and maintained by all qualifying individuals, sec. 12 § 1, 2006 Mass. Acts at 93 (codified as amended at MASS. GEN. LAWS ch. 111M, § 1 (2010)); the formation of state-level health care exchanges (the Commonwealth Health Insurance Connector in Massachusetts) to facilitate access to “affordable” health benefit policies, § 101, 2006 Mass. Acts at 134-45 (codified as amended at MASS. GEN. LAWS ch. 176Q (2010)); insurance reform, §§ 48-100, 2006 Mass. Acts at 117-35 (codified as amended in scattered sections of MASS. GEN. LAWS) (in Massachusetts, reform of insurance coverage had already proceeded substantially so was of less overall importance in the scheme of the Massachusetts reform); and government subsidies for low-income residents through the Commonwealth Care program to facilitate their obtaining affordable coverage, § 45, 2006 Mass. Acts at 113 (codified as amended at MASS. GEN. LAWS ch. 118H (2008)).
especially relating to increased federal spending on health care expected to accompany access expansion and subsidies so soon after the substantial deficit spending authorized in the American Restoration and Reinvestment Act of 2009. To obtain an acceptable CBO score, the PPACA contained certain quantifiable effects on the federal budget. These included tax increases, reductions in provider payments (especially Medicare inpatient hospital payments), and a significant decrease in payments for disproportionate share hospitals. These reductions assumed, presumably, that the affected hospitals would benefit from the anticipated increase in the number of previously uninsured patients who would access their services through non-Medicare benefit coverage. In addition the PPACA provided for other changes to Medicare payment policies that were intended to reduce costs while also improving quality, such as those relating to hospital-acquired conditions and readmissions.

The PPACA addressed efforts to achieve broader delivery and payment reform only in relatively limited ways, in part due to the political compromises.

7. PPACA § 3133, 124 Stat. at 432, modified by § 10316, amended by HCERA § 1104, 124 Stat. at 1047 (to be codified at 42 U.S.C. § 1395ww(r)).
10. These provisions include a national pilot program on bundled payments as an alternative to fee-for-service payment, PPACA § 3022, 124 Stat. at 395 (to be codified at 42 U.S.C. § 1395jjj); a "gainsharing" program encouraging the formation of accountable care organizations (ACOs), bringing together providers to accept payment based on various incentive models in order more effectively to coordinate the care of Medicare beneficiaries, id.; a "medical home" primary care and care coordination demonstration that would link primary care physicians and other primary care
needed to achieve enactment of such a broad and complex piece of legislation. But the PPACA also recognized that there are limits to seeking major changes in the overall structure of, and payment for, health services through using only Medicare.

By contrast, the political coalition that came together in 2005 and 2006 in Massachusetts to secure enactment of Chapter 58 made what seems to have been an intentional decision primarily to address access and to forego dealing with the necessarily concomitant issue of reducing cost increases likely generated by expanded access. Supporting this political consensus was the already high level of per capita state spending on health care in Massachusetts prior to enactment of Chapter 58, and the then federal Administration’s support for the reform’s philosophical underpinning: to move people from reliance on the limited benefits available through the Commonwealth’s uncompensated care pool to broader reliance on insurance coverage.

The challenge in Massachusetts was whether access reform would in fact be followed by broader efforts to contain health care costs, for both the Commonwealth budget and the private system, through delivery system and payment reform. Failure to undertake such efforts on a broad basis would increase costs because of enhanced demand for services but without simultaneous efforts to restrain those increases.

Federal health care reform, in its preliminary phases, focuses principally on coverage reform and access, not dissimilar to the initial focus in Massachusetts practitioners to promote coordinated care with payment based on an alternative to fee-for-service, PPACA § 3024, 124 Stat. at 404-05 (to be codified at 42 U.S.C. § 1395cc-5); creation of a Center for Medicare and Medicaid Innovation to develop innovative approaches to payment and delivery in the federal programs, PPACA § 3021(a), 124 Stat. at 389-92 (to be codified at 42 U.S.C. § 1311a); and authorization for the formation of a Patient-Centered Outcomes Research Institute as a private, non-profit entity, to undertake comparative clinical outcomes research associated with effective and efficient treatment options, PPACA § 6301(a), 124 Stat. at 728-29 (codified at 42 U.S.C. § 1320e).

11. Chapter 58 did, though, contain provisions in addition to those relating to access that foreshadowed the efforts at more broad-based system reform discussed later in this Essay, including provisions relating to increased spending for prevention and screening programs, an initial investment in health information technology to help fund a pilot program on computerized physician order entry, the launching of a State-wide infection prevention program, the creation of the Massachusetts Quality and Cost Council and the Health Disparities Council and inclusion of wellness programs under insurance policies. The author wishes to thank Senator Richard T. Moore, Senate Chairman of the Joint Committee on Health Care Financing of the Massachusetts Legislature, for his insights on the scope of Chapter 58.

12. The approval of the Centers for Medicare & Medicaid Services, within the federal Department of Health and Human Services, was needed for a Medicaid waiver that would allow federal financial participation in the proposed subsidized program. The approval of this waiver was crucial to the economics of the overall program.
under Chapter 58. The debate over health care reform at the federal level included expressions of the need for broader reform of the delivery system and for changes in payment mechanisms to encourage a more organized and efficient system for delivering care. There were similar expressions of intent enunciated in Massachusetts as the coalition that successfully secured the enactment of Chapter 58 indicated a desire to move on to seek system delivery and payment reform. Just as Massachusetts was a leader in securing access changes, can the history of post-Chapter 58 initiatives in Massachusetts serve as a model for likely changes at the national level that could be leveraged from enactment of the PPACA? This Essay addresses the efforts made in Massachusetts to seek further reforms, and then considers whether the steps taken there may serve as a further model for national efforts, in other states or through the federal government.

I. CHAPTER 305: A BLUEPRINT FOR REFORMS

What may be considered the second phase of Massachusetts’s efforts to establish health care reform occurred two years following the enactment of Chapter 58, with passage of Chapter 305 of the Acts of 2008.13 Chapter 305 is a blueprint for a broad array of reforms seeking improvements in the cost and quality of health care services.14

Of greatest significance for this Essay, Chapter 305 mandated studies and public hearings to promote a greater understanding of the factors that increase provider costs and insurance premiums, with the expectation that such an understanding could lead to recommendations to facilitate radical changes in the structure of, and payment for, health care services. This Essay examines three of these mandates and the response they have generated, to gain some insight into the potential outcome of similar efforts that might be undertaken either federally or in other States to address structural reforms to contain the cost of health care.

A. Payment Reform Commission

Chapter 305 mandated the formation of a Special Commission on the Health Care Payment System (the “Special Commission”), “to investigate reforming and

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restructuring the [delivery] system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care." The Commission was charged with examining alternatives to fee-for-service payment methodologies and recommending a common, all-payer payment methodology intended to promote a number of public values (coordination of care, rewarding primary care, reducing waste, decreasing unnecessary hospitalizations, etc.).

The Special Commission’s final report, released in July 2009, recommended a five-year transition to a global payment system based on risk-bearing accountable care organizations. The recommendations also included suggestions regarding an oversight agency to oversee implementation of the new payment system during the five-year period, to monitor increases in the cost of care, and perhaps to intervene in the event that cost increases exceeded certain pre-determined benchmarks.

The Special Commission’s recommendations require legislation in order to implement and have generated extensive discussion within Massachusetts regarding payment reform. The recommendations anticipated legislative

19. Id. at 10, 13.
20. Id. at 17-18.
21. Id. at 63.
proposals aimed at long-term system reform. They did not address interim legislative steps, although, as is discussed later in this Essay, this is the approach the Massachusetts legislature has chosen to use while the discussion on broader changes presumably continues.

B. Study of Insurer and Hospital Reserves

Public policy concerns about provider costs include consideration of the levels of reserves that providers maintain. Theoretically, the accumulation of “excessive” reserves by hospitals, and specifically non-profit hospitals with no obligation to make equity holder distributions, could generate investment in plant and equipment that, regardless of merit, could put pressure on the underlying medical loss ratio of insurance premiums. Chapter 305 sought to explore this issue by authorizing the Massachusetts Division of Health Care Finance and Policy (the “Division”), working with the Division of Insurance (“DOI”), to “examine options and alternatives available to the Commonwealth to provide regulation, oversight and disposition of the reserves, endowments, and surpluses of health insurers and hospitals.”

Health insurer reserves are generally subject to regulation to promote insurer solvency. There is, however, much less analytical material supporting an understanding about the appropriate levels of reserves for hospitals or health care systems and how they might be regulated.

With regard to hospitals, Chapter 305 mandated the Division to examine existing regulatory schemes, recent hospital fiscal practices, and financial reporting; and to review the methods by which hospitals fund community benefit programs, including how such funding may be regulated elsewhere.

In May 2010, the Division issued its “Study of the Reserves, Endowments, and Surpluses of Hospitals in Massachusetts.” The study describes a number of financial and accounting rules relating to hospital and health system reporting, and identifies the lack of clear standards for measuring the adequacy of hospital reserves. It did, however, suggest indirectly that there might be a standard to measure “excessive” reserves through a series of tests that determine whether a hospital has “considerable accumulated financial resources.” To date there has

http://www.mhalink.org/AM/Template.cfm?Section=Cost_Containment_Payment_Reform&Template=/CM/ContentDisplay.cfm&ContentID=9056.

23. See infra text accompanying notes 62-75.
27. Id. at 3-4. The Massachusetts Hospital Association has criticized the report for leading to possible “erroneous conclusions” and for leading to the “mistaken assumption that Massachusetts
been no regulatory or legislative action as a result of the Division’s report. But it
did focus on the differences in reserve levels among hospitals in the
Commonwealth, on the uses of unrestricted reserves, and on the potential for
drawing a correlation between levels of unrestricted cash and prices for health
care services.  

C. Hearings on the Drivers of Provider Costs and Payer Premiums

Chapter 305 expanded the existing authority of the Division to gather cost
information from hospitals in order to develop and implement regulations for
uniform reporting of information from public and private health care payers. The
data collected is intended to allow the Division to analyze changes over time—
and compare public and private payers—with regard to insurance premium
levels, benefit and cost-sharing designs, and plan cost and utilization. Among
the types of plan information the Division is authorized to gather is medical loss
ratio, level of reserves and surpluses, and provider payment methods and levels.

Chapter 305 requires the Division to hold annual public hearings based on
the provider and payer information it gathers. The hearings are to focus on
provider and payer cost trends, “with particular attention to factors that contribute
to cost growth” and “to the relationship between provider costs and payer
premium rates.” The statute also authorizes the attorney general to intervene in
such proceedings, and grants her independent authority to “review and analyze
any information” the Division derives from providers and payers. Based on the
information provided at the hearings, and other information the Division
considers necessary, as defined in regulations, the Division is to prepare “an
annual report concerning spending trends and underlying factors, along with any
recommendations for strategies to increase the efficiency of the health care
system.”

In March 2010, the Division held four days of hearings in accordance with

hospitals are awash in cash, when, in fact, the opposite is true.” See Press Release, Mass. Hosp.
Ass’n, Study Reveals Hospitals Hold Inadequate Surpluses and Reserves; State’s Narrow Focus
Paints Inaccurate Picture of Hospital Finances (June 25, 2010), http://www.mhalink.org/
AM/Template.cfm?Section=MHA_News1&template=/CM/ContentDisplay.cfm&ContentID=1136
2.

30. Id.
31. Id.
32. Id. § 6 ½ (a).
33. Id.
34. Id. § 6 ½ (b).
35. Id. § 6 ¾ (g).
the statute. In conjunction with these hearings, the attorney general issued a report regarding health care cost drivers. Her report emphasized the predominant role of market share over such other factors as case mix and quality, giving some providers leverage to secure preferential rates. The report’s stress on market share as the key factor in defining price differentials among providers generated significant controversy. The responses to the report highlight the complexities of seeking to establish one predominant factor to explain variations in payer rates, but the report contributed valuable data to the health care cost discussion by displaying the relative rates paid to specific hospital and physician groups by the major private payers.

II. EFFORTS AT SHORT-TERM FIXES: THE SMALL GROUP/NON-GROUP MARKET

While discussions commenced about seeking long-term systemic changes based on the studies and hearings that Chapter 305 initiated, more immediate political imperatives loomed in the Commonwealth. The financial burden posed by health insurance costs on small business has been a persistent bone of contention. While there are multiple causes for what seem like disproportionate increases in premiums for this class of insurance purchasers, with provider rates being only one factor, health care cost increases as reflected in insurance premiums is an issue of special sensitivity to small business. Recognizing this concern and also facing a re-election campaign in which his principal opponent was likely to be the former chief executive of one of the major health maintenance organizations (HMOs) in Massachusetts, Governor Deval Patrick decided to emphasize urgency in addressing health care costs, at least as reflected

36. The preliminary report, the schedule of witnesses, and its final report based on the hearings may be accessed on its web site at http://www.mass.gov/dhcfp/costtrends.


38. Id. at 3-4.

in health insurance premiums for small business, and to propose what were explicitly intended to be short-term interventions while debate continued about longer-term systemic change.

A. Emergency Regulations

On February 10, 2010, the Governor announced that DOI would adopt a set of emergency regulations under existing statutory authority, to address small business concerns about the cost of health care coverage. In announcing the emergency regulations, Governor Patrick explicitly related increases in small group premiums to underlying provider costs.\(^{40}\) The connection seemed to reflect an assumption that the private sector would use its contracting authority vis-à-vis providers to undertake cost containment measures that the government could not directly institute, absent new legislative authority. That is, the Administration seemed to promote a substitution of private regulation for public regulation, notwithstanding the former's lack of due process constraints.\(^{41}\)

Under existing authority at the time, HMOs were required to “submit proposed rates and benefits, or changes thereof, on or before their effective dates” and “are subject to the Commissioner's disapproval if the benefits and rates do not meet” statutory requirements.\(^{42}\) In practice, insurers filed proposed rates the day that they were to become effective. Following on Governor Patrick's direction, DOI promulgated emergency regulations relating to HMO rate filings specifically for changes to premiums and rating factors for small groups, to be effective on April 1, 2010.

On April 1, 2010, DOI rejected 235 of the 274 rate filings on the grounds that they failed to meet the statutory requirement that rates not be excessive or unreasonable in relation to the benefits provided, and thus effectively froze the rates at their April 2009 level.\(^{43}\) The Massachusetts Association of Health Plans and several HMOs brought suit and sought emergency injunctive relief to enjoin

\(^{40}\) Governor Deval L. Patrick, Remarks to the Greater Boston Chamber of Commerce Regarding Small Business Jobs Bill (Feb. 10, 2010) (transcript available at http://www.mass.gov/?pageID=gov3terminal&L=3&L0=Home&L1=Media+Center&L2=Speeches &sid=Agov3&b=terminalcontent&f=text_2010-02-10_jobs&csid=Agov3) (proposing "an oversight plan to screen provider rate increases").


\(^{42}\) 211 MASS. CODE REGS. 43.08 (2005) (emphasis added).

the Commissioner from prohibiting the plans from implementing their proposed rate increases. The suit contended that the Commissioner had impermissibly disapproved the proposed rate increases based on a predetermined, arbitrary and inadequate rate increase limit that was not actuarially sound. It also challenged the requirement that rates remain at the April 2009 level. The Superior Court denied the motion for injunctive relief on the grounds that the plaintiffs had not exhausted their administrative remedies and had not demonstrated entitlement to injunctive relief. It later ordered two of the plans to continue to use the April 2009 base rates (as modified by approved adjustments) during the pendency of administrative hearings and appeals.

One of the affected plans requested an administrative hearing. In order to prevail, it was obliged to demonstrate that each of the four independent bases for DOI’s rate disapprovals was incorrect. The administrative hearing was conducted by three DOI staff hearings officers, who, much to the surprise of most observers, unanimously overturned the Commissioner’s decision and found in favor of the plan on all four grounds.

The grounds and the rationale for the hearings officers’ rejection of them are instructive with respect both to the current state of confusion regarding what drives health care costs and attendant premium increases (making the development of coherent public policy difficult) and to any expectation that insurers would be able to exercise regulatory authority over provider rates (notwithstanding contractual obligations and market realities). The four bases for the initial decision and the rationale for the decision being overturned are as follows:

(1) The Commissioner found that the plan failed to demonstrate that it paid providers differing rates of reimbursement based solely on quality, patient mix, geographical location of care, and intensity of services, as


45. Id.

46. Id.

47. Massachusetts Ass’n of Health Plans v. Murphy, No. 10-1377-BLS2, (Mass. Sup. Ct. Apr. 23, 2010) (order granting preliminary injunction). The two plans enjoined from raising rates were Harvard Pilgrim Health Care, Inc. and Fallon Community Health Plan, Inc.


49. Id.
specified in the emergency regulations.\textsuperscript{50} Reflecting the principal thrust of the attorney general’s report cited above,\textsuperscript{51} the hearings officers found that the variations were “due primarily to the market power of certain providers, which derives from size, brand reputation or geographic location,” and determined that the plan had valid reasons to justify differential reimbursement beyond the four factors specified in the emergency regulation.\textsuperscript{52}

(2) The Commissioner found that the plan’s rates were unreasonable and excessive because it had failed to demonstrate that it had taken adequate steps to renegotiate rates with providers and had not demonstrated that it had decreased its provider costs by renegotiating those rates.\textsuperscript{53} The hearings officers ruled that the plan had established that there were legal, practical and market place barriers to reopening existing provider contracts, but that it had nonetheless made efforts to renegotiate rates within the short time allowed by DOI.\textsuperscript{54}

(3) The Commissioner had limited the plan’s overall assumed trend rate to a range of 100\% to 150\% of the New England Regional Medical CPI (“CPI-M”). The hearings officers ruled that using the increase of the CPI-M for New England as the sole criterion for deciding whether to disapprove the plan’s rates was incorrect.\textsuperscript{55}

(4) The Commissioner found that the plan had failed to demonstrate that it was adequately controlling utilization.\textsuperscript{56} The hearings officers found that the plan had “demonstrated its cost containment programs,” documented its realized cost savings, and proved that its cost

\textsuperscript{50} 211 MASS. CODE REGS. 43.08(10) (2010). The emergency regulations provided “If the HMO intends to pay similarly situated providers different rates of reimbursement, [it must include with its filing] a detailed description of the bases for the different rates including, but not limited to: (a) Quality of care delivered; (b) Mix of patients; (c) Geographic location at which care is provided; and (d) Intensity of services provided.”

\textsuperscript{51} See OFFICE OF ATTORNEY GEN. MARTHA COAKLEY, supra note 37.

\textsuperscript{52} The DOI noted, “[t]he Emergency Regulation does not characterize the four articulated Regulatory bases as the exclusive bases for justifying differential reimbursement.” Harvard Pilgrim Health Care, Inc. v. Div. of Ins., supra note 48, at 5 (emphasis added).

\textsuperscript{53} Id. at 6.

\textsuperscript{54} Id. at 10.

\textsuperscript{55} Id. at 10-15. The hearings officers cited several reasons for this conclusion: (1) it was purely backward-looking and did not measure costs comparable to the plan’s costs, (2) focusing on the rate of increase, to the exclusion of the actual premium number, would permit anomalous results, and (3) using a metric external to the plan as the sole factor to determine whether the plan’s proposed rates were excessive violated actuarial and regulatory principles and contravened the statutory requirement that rates be adequate. Id.

\textsuperscript{56} Id. at 15-16.
containment programs were adequate.\textsuperscript{57}

Following the hearings officers’ rulings, based on further submissions, DOI reviewed the rates for 200 plans for which HMOs had submitted updated rate information for the July-September, 2010, period.\textsuperscript{58} Taking a somewhat less aggressive approach, it approved single-digit rate increases for 63 plans, stating that the four insurers at issue had shown more restraint than other companies.\textsuperscript{59} It also required three insurers to supply more data to justify proposed double-digit rate hikes for 137 plans before it would make a decision. It did not reject outright any rate proposals.\textsuperscript{60} Further, it reached a settlement with the plan that had been the subject of the hearings officers’ decision, with an agreement on rate increases for April 1, 2010, remarkably close to the level sought by the Commissioner initially.\textsuperscript{61}

Traditional insurance regulation seeks to assure the fiscal solvency of the insurance industry in order to protect consumers. In the belief that underlying provider costs constituted the principal cause for increases in insurance premiums, the Patrick Administration sought to use existing standards focused on protecting solvency to address that concern. The brief history of the emergency regulations, the administrative appeal and the resolution of rate increase requests served to underscore the limitations of using existing statutory authority to restrain health care costs per se. It is no surprise, then, that, parallel to the regulatory efforts, the legislature itself moved to regulate health insurance premiums in its on-going effort to seek to restrain health care costs.

\textit{B. Legislative Developments: The Next Phase}

While the reports, hearings and analyses mandated by Chapter 305 pointed toward efforts for longer term systemic reform of the delivery and payment systems in Massachusetts, the political imperatives that resulted in the emergency regulations described above also led to further legislative action, intended to be of short-term effect while work continued on longer-term reforms. The next
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legislative phase of Massachusetts reform was enacted in August 2010 as Chapter 288 of the Acts of 2010 (Chapter 288). 62

While not taking concrete steps to implement the Special Commission’s recommendations, Chapter 288 establishes a new special commission on provider price reform, with a general charge to “investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers.” 63 The commission is specifically directed to examine “the variation in costs of providers for services of comparable acuity, quality and complexity . . . the correlation between price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider’s payor mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs; . . . the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and . . . policies to promote the use of providers with low health status adjusted total medical expenses.” 64 In developing its recommendations the commission is to consider the Special Commission’s recommendations, and the new commission’s recommendations must be consistent with those recommendations.

Also related to payment reform, Chapter 288 directs the Division to initiate activities to foster use by payers and providers of bundled payment arrangements in lieu of fee-for-service. 65 The legislation sets for the Division “as an objective, but not as a requirement, implementation of pilot bundled payment programs relating to payment for at least 2 acute conditions or procedures commencing by no later than January 1, 2011” and “for at least 2 chronic conditions commencing by no later than July 1, 2011.” 66

62. Act of Aug. 10, 2010, ch. 288 (Mass.). Chapter 288 was enacted toward the end of the 2010 legislative session, a session that formally concluded at the end of July. In the debates leading up to it, there was a serious question as to whether any legislative action would be taken in this arena that year. See Liz Kowalczyk, Health Payment Overhaul Shelved, BOSTON GLOBE, July 4, 2010, at A1. On July 4, the Boston Globe reported that legislative cost containment efforts in Massachusetts were on hold for the balance of the calendar year, “largely because of disagreements among key officials, legislators, and providers over how best to control health care spending.” Id. Senate President Therese Murray, an advocate of payment reform, said that she would not file legislation to change the system that year, as originally planned, “because of the logistical and political complexity of changing a system that has been in place for decades.” At the time she expressed the hope that stakeholders would be able to reach a consensus on legislation to be filed in 2011. Id.

64. Id. § 67(c).
65. Id. § 64.
66. Id.
Chapter 288’s most significant provisions expand existing insurance regulatory authority, but not explicitly with the intent of reining in underlying provider costs. The legislation empowers the Commissioner to require that, effective October 1, 2010, carriers offering small group insurance plans are to file for any changes in small group product base rates or rating factors at least ninety days in advance of the proposed change’s effective date.\(^6\) The Commissioner is directed to disapprove a base rate change if it is “excessive, inadequate or unreasonable in relation to the benefits charged,” and a rating factor change if the change is “discriminatory or not actuarially sound.”\(^6\)

While these standards are consistent with those of traditional insurance regulatory review, Chapter 288 establishes, temporarily, a novel approach to the Commissioner’s review. The key regulatory change is the requirement that the Commissioner is to “presumptively” disapprove a base rate change filing on specified grounds, relating to the insurer’s administrative expense and reserves and surplus.\(^6\) The grounds reflect a more nuanced approach to discerning the factors driving premium increases, and do not directly seek to control underlying provider costs through premium regulation.\(^7\)

With regard to payer contracting with providers, Chapter 288 does, however, promote one mechanism intended to provide better payer bargaining power: a mandate that any carrier offering a provider network and having five thousand or more enrollees in small group or individual plans must offer all small business and individuals in at least one geographic area at least one plan that contains either a limited network or a tiered network.\(^7\) A limited network is one in which the carrier selects the hospitals that it will include in its products’ networks; that is, it limits the access of its enrollees to only certain providers. A tiered network is one in which the cost share obligations of individuals accessing care are tiered

68. Id.
69. Id.
70. A filing will be “presumptively” disapproved as “excessive” if the administrative expense loading factor of the base rate, not including taxes and assessments, is projected to increase “by more than the most recent calendar year’s percentage increase in the New England medical CPI,” or if the aggregate medical loss ratio (“MLR”) for all products the carrier offers to small groups is less than 88% (that percentage rises to 90% effective October 1, 2011). Id. However, if a filing does not meet the 88% or 90% MLR standard, and therefore would otherwise be presumptively disapproved, it could nonetheless be approved by the Commissioner if the carrier’s aggregate MLR for all of its small group plans is at least 1% greater than it had been twelve months prior to the filing—an indication, presumably, that the carrier is making good faith progress to increase its overall MLR to the required minimum. Id. Further, a filing will also be “presumptively” disapproved as “excessive” if the carrier’s reported contribution to surplus exceeds 1.9% (2.5% if the carrier’s risk-based capital ratio falls below 300% for the most recently reported four quarters). Id.
based on the hospital he or she chooses to access, with tiering generally based on a correlation of the cost and quality of the hospital. In order to obtain savings from this benefit design mandate, Chapter 288 requires that the base premium for a limited or tiered network product must be at least 12% lower than the base premium for the carrier’s “most actuarially similar plan” that does not include such a network. This differential can be achieved by means that include, as examples, excluding providers with “similar or lower quality” (based on standard quality measures to be developed by the Massachusetts Department of Public Health) and with higher health status adjusted total medical expenses or relative price; or increasing cost share obligations for members who use providers for non-emergency services with “similar or lower quality” and with higher health status adjusted total medical expenses or relative prices.

III: LESSONS

In reflecting on the Massachusetts experience post-enactment of Chapter 305, certain observations come to the fore. First, health care is complex. There is no question that there are varying interests, that one person’s cost saving, or “greater efficiency,” is another’s “income loss” and that any approach to addressing the underlying costs of care must be cautious, incremental, and take cognizance of potential secondary effects of ideas that seem on the surface good.

72. Additional requirements applicable to limited or tiered network plans include the following: (a) variations among member cost-share obligations in a tiered plan must be “reasonable in relation to the premium charged as long as the carrier provides adequate access to covered services at lower patient cost share levels;” (b) the Commissioner is to determine “network adequacy” for each type of network “based on the availability of sufficient network providers” in the overall network; (c) in determining network adequacy, the Commissioner is to consider factors that include location of participating providers, the “employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.” Id.


74. Through what appears to be a drafting error, while the limited or tiered network requirements are slated to go into effect on January 1, 2011, these examples of how the 12% may be achieved are technically effective as of the date of enactment of the Chapter, a date earlier than the effective date of the imposition of the 12% differential requirement.

75. Act of Aug. 10, 2010, § 33. Other provisions of Chapter 288 require the Division to elaborate on the definitions of “health status adjusted total medical expenses” and “relative prices.” Id. §§ 11-12.


Second, regulation seems to be reemerging as a valid response to concerns about health care costs. Health care policy goes in cycles, and one may need to examine any lessons learned from efforts at provider rate regulation in the 1970s and 1980s to see whether there is any likelihood that such an approach can have salutary effects.

Third, insurers and providers need to be brought into a collaborative framework in which both can work together to achieve change in the system. Insurers were a little too quick to blame premium increases on providers. The experience with the highly publicized Anthem increases proposed in California in the midst of the national health reform debate indicates that provider rates are not the only, and may not always be, the principal driver of premium increases. Volume, price, underwriting, reserves, administrative expense and profit needs all have a role to play in varying degrees to produce proposed rates of increase that outstrip the CPI-M and provider price increases. The key to collaboration should be a recognition that neither group really wants to be, or should be, seen as responsible for solving the challenge of rising health care costs by itself. Providers cannot do so without the ability to control volume of service, something that may be more readily achieved by insurers in the current environment; and a willingness to take on more service-related risk. Insurers cannot do so without greater ability to control providers through contract, but that leverage will vary by market conditions, and the use of private regulation, absent due process constraints that attend public regulatory authority, could put them in untenable legal, political and market positions. For payers, shifting service-related risk to providers, as distinct from underwriting risk, may be attractive.

For example, when the DOI hearings officers’ decision described infra was announced, the president and CEO of the plan that brought the administrative appeal was quoted as stating, “It is time to focus on what is truly driving health care expense, and that is the cost of care. We must address the prices charged by hospitals and physicians.” Harvard Pilgrim Health Care, Inc., supra note 61. Further, in commenting on Chapter 288’s impact and recent data regarding continuing high premium increases for small business, the president of the Massachusetts Association of Health Plans is quoted as saying that the “rate cap” under Chapter 288 is “a short-term, one hit kind of gimmick...It did nothing to deal with the underlying medical costs.” Erin Ailworth, Small Firms’ Rates Soaring, BOSTON GLOBE, Sept. 23, 2010, available at http://www.boston.com/business/healthcare/articles/2010/09/23/small_firms_health_care_rates_soaring.


In discussing the continuing increase in base price for small business premiums notwithstanding Chapter 288’s enactment, the Boston Globe noted: “But the base price of a premium is frequently pushed higher by additional factors, including the size, age, and health of a company’s workforce, and the type of work performed. Smaller businesses are especially vulnerable to such variables. For instance, one or two employees with serious injuries or long-term illnesses such as cancer can dramatically add to insurance expenses.” Ailworth, supra note 78.
Rational cost control may very well lie in securing the political will to change both the payment system and the delivery system in a coordinated manner. That is, with a thoughtful implementation plan, the Special Commission may have gotten it more or less right. But the fact that Massachusetts has adopted only an interim step through Chapter 288 suggests the complexity of the task and the daunting political risks of undertaking such an effort without careful foresight.

Fourth, both Massachusetts and the federal experiences demonstrate what could be a truism about health care politics. Health policy and politics operate along a continuum, with access on one end and cost containment on the other. Each by itself is conceptually easy to achieve. Promoting access alone could be successful if no concern is given to the costs of care that will result. Improved access almost of necessity increases the overall costs of care even if it is possible to achieve efficiencies in one or more areas of the delivery system. Cost containment as the principal objective of health care policy can be advanced, at the other end of the continuum, by rationing care, an equally unlikely political outcome. Consequently policy is a continuous balancing, a shifting equilibrium between the poles of access and cost containment. Generally, when the two face off directly in the political commons, access wins and cost containment concerns are deferred. It is much easier to deal with access, both politically and conceptually, than to tackle the hard realities—conceptual, political, and economic—of health care cost control. The Massachusetts experience has demonstrated that access improvement may be achieved without simultaneously addressing costs, but eventually the piper must be paid. While at the federal level Congress and the Administration paid attention to this issue in enacting the PPACA, especially in light of the attention given to CBO scoring, the federal government has barely begun to make serious efforts on the cost containment front. Perhaps Massachusetts’s 2011 legislative session will provide more guidance based on the work done to date in the Commonwealth. Or perhaps we will continue to temporize around cost and hope that the piper never shows up.

81. See as an example the enactment of the so-called TRICARE for Life program. Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, § 712, 114 Stat. 1654, 1654A-176 (2000). TRICARE for Life, which was enacted in a Presidential election year, extended TRICARE eligibility to persons age 65 and over who would otherwise have lost their TRICARE eligibility by virtue of becoming eligible for Medicare. That is, TRICARE for Life provides a Defense Department-funded Medicare supplement program for persons who previously had been responsible for securing their own supplemental payment coverage from private sources.