A BETTER DEAL
FOR OUR HEALTH CARE DOLLARS

Testimony on H. 1208
An Act to Promote the Efficient Use of Health Care Revenues

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Honorable chairs and members of the Committee on Insurance, thank you for the chance to appear before you today.

An article in *Fortune* magazine last month discusses the profits and costs of an HMO that Wall Street is viewing as having a "magical touch" – largely because it finished the last quarter with (and I quote) "a mind-bogglingly attractive medical–loss ratio of 72.5%." [1]

Such a figure means that more than one of every four dollars that employers and workers paid to that HMO in premiums is being diverted from care. Yet its stock is soaring. That is perverse, clearly signaling a market that is not working in the public's interest. That perversity is also apparent in insurors' and investors' term "medical loss ratio" – more appropriately labeled the "care share."

The bill before you aims to help get a better deal for Massachusetts payors and patients. It would simply require HMOs and other health insurors here to spend at least 90 percent of their revenues on care. They could meet this standard by

- reducing their premiums,
- spending less on advertising, marketing, administration, and profit, or
- providing more care— paying for needed services that may now be denied.

Setting such a standard is a straightforward way to aid both

- employers and others who pay for care across this state, who now face a resurgence in health insurance premium increases, and
- people statewide who fear increasingly that HMOs may not put patients first.

And requiring insurors to devote 90 percent of revenue to health care makes them inherently more trustworthy. Once the 10 percent cap on non-health spending is reached, denying care to a patient will not yield more money for the insuror. Rather, any resulting savings must be spent on another patient's care or used to reduce premiums. This engenders much greater financial neutrality in decision-making about what care to provide. So this approach takes aim not at symptoms but at the major underlying problem which worries many patients about their health plans—the incentives that plans may face today to skimp on care.

As we reported to you two years ago, if a 90 percent care share standard had been used in Massachusetts for 1993-97, it would have made $1.2 billion more available for care (shifting it from non-care). Alternatively, it would have required cuts in premiums of $1.3 billion.

That could have increased health plans' resources for care by an average of 4.3 percent each year— without higher premiums or health spending. Roughly 30 percent of wasteful marketing and other non-care spending might have shifted to care. Alternatively, insurors could have cut their premiums while keeping constant the level of care provided.

Last year's passage of Chapter 141 did establish a requirement that insurors disclose the percentage of *premium* revenue used for health care. But even this simple disclosure provision is undermined in at least two ways:

-- It applies only to their premium revenues. Yet why should patients and payors not be equally concerned about how an HMO uses, for example, the income from its investment of previous years' surplus patient premiums?

-- There appear to be no detailed reporting standards designed to ensure appropriate and uniform categorization of expenses as medical care or administrative. The state should also specify uniform accounting standards for HMOs and health insurors. (The article in *Fortune* that I mentioned earlier offers good evidence of the need for such standards, as it questions the accuracy of the widely-cited data on Oxford Health Plans, the Connecticut / New York HMO that is currently a Wall Street darling.[2])

And, of course, disclosure alone cannot really protect most people. What, for example, can the worker do who sees a low medical loss ratio reported, but whose job offers no choice of plans?

Medicaid sets a similar minimum care share requirement for the HMOs it contracts with. <u>This proposal would help employers and the general public to get the same kind of deal that the state and low-income people already have</u>.

You can use these tools to get a better deal— to help make better use of health care dollars— for the patients, workers, and employers of Massachusetts.

Because health insurance premiums have been soaring for the past 2-3 years, and talk of continued increases abounds, now is the time to act. Let us lock in a solid care share through legislation.

Three years ago, we reported to you on the share of revenues devoted to care— and the share diverted from care— by the Commonwealth's HMOs and insurors. In 1999, we offered another year of data. The pattern that we found was dismaying.

In 1997, Massachusetts HMOs and Blue Cross, taken together, used just 85.0 percent of their revenues for care. That "care share" was the lowest level of the four years from 1994 to 1997, and was down from a high of 87.9 percent in 1996.

As just noted, if a 90 percent care share standard had been used in Massachusetts for 1993-97, it would have made $1.2 billion more available for care (shifting it from non-care). Or it would have required cuts in premiums of $1.3 billion.

Thus, such a minimum standard could have increased health plans' resources for care by an average of 4.3 percent each year— without higher premiums or health spending. Again, about 30 percent of marketing and other non-care spending might have shifted to care. Or insurors could have simply cut their premiums.

Some observers may say there is no reason to worry about care shares today, asserting that medical spending by HMOs and insurors has risen fast recently, so care shares have been rising. And they may say that premium increases are needed today. They may say that the care share problem has been solving itself.

Alternatively, some may simply say that periodic increases and declines in care shares reflect inevitable cycles in the insurance industry—and that patients and those who pay for care must simply suffer the consequences.

But even from year to year there is considerable fluctuation in the actual share of insurors' premiums spent on care. Our data on the mid-90s, however, showed average statewide care shares consistently below the desired 90 percent level.

There is another important reason for action, and action now. Very substantial HMO and insurance premium increases have occurred recently and are forecast the near future If premiums rise substantially, care shares are likely to drop. You can help protect Massachusetts employers as well as patients by locking in a reasonable care share now through legislation.

How would this standard work? The bill's 90 percent care share requirement could be met in any one of three specific ways. The following table describes the

three, at they would have taken effect had a 90 percent care share standard had been in place during 1994-97:

1) The amount of care paid for could rise by the number of dollars and percentage shown.
2) Administrative expenses could be cut by an equivalent sum, and by the percentage shown.
3) Total revenues (mainly premiums) could be cut by a slightly higher figure, which is also shown.

Any one would suffice. A blend of two or three is also possible.

Conservatively, the table's data reflect the assumption that all insurors operate at only a 90 percent care share. Yet some insurors now operate above the 90 percent care share level, so greater savings are conceivable. Most important, a 90 percent care share clearly is attainable.

(In various years, some plans may have high care shares and lose money; there appeared to be one large plan here in that situation in 1997. When plans' spending on care plus administrative and marketing costs together exceed revenues, they should seek to cut administrative costs rather than needed care.)

Table 1

What Would Have Happened Had a 90 Percent Care Share Requirement Been in Effect in Massachusetts during Calendar Years 1994 through 1997?

year	Mass. HMOs' actual care share	Rise in health care (and cut in non-care) if all HMOs were at 90% care share	% rise in care	% cut in non-care spending	Cut in premiums if care stays constant and all HMOs meet 90% care share
1994	85.1 %	$387,910,978	5.8 %	-44.3 %	$430,581,186
1995	87.0 %	$239,298,396	3.5 %	-25.9 %	$265,610,120
1996	87.9 %	$180,461,012	2.4 %	-16.2 %	$200,311,724
1997	85.0 %	$368,715,426	5.9 %	-36.8 %	$409,274,123
4-year total	**86.3 %**	**$1,176,375,813**	**4.3 %**	**-30.1 %**	$1,305,777,152

Source: Calculations from premium and other data reported by Weiss Ratings, Inc.
Note: Plans included in these totals (10 to 14 plans in each year) are those that operate substantially in Massachusetts and that are tracked by Weiss Ratings, Inc.

For 1997 alone, the estimated sum that would have been saved or reallocated to provide care is $369 million— twice the potential savings of 1996.
For the state's largest HMOs and insurors, 1997 care shares ranged

- as low as 79.0 percent, at Blue Cross, and
- as high as 94.5 percent, at Pilgrim.

Table 2 shows the four insurors that are by far the state's largest (six separate plans report). These insurors have 95 percent of the revenues of the ten plans included in Table 1's 1997 total.

Table 2
1997 Care Shares of the Largest Massachusetts Plans and Effect of a 90 Percent Care Share Requirement

	Total Medical Expenses	Total Revenue	CareShare: Medical Expenses/ Total Rev	If care shares were all = 90%: Rise in spending on care
Blue Cross & Blue Shield, MA	1,671,601,380	2,116,775,615	79.0%	$233,496,674
Harvard Pilgrim Health Care	1,089,136,583	1,238,152,432	88.0%	$25,200,606
HMO Blue	985,910,090	1,199,280,551	82.2%	$93,442,406
Tufts Associated HMO	1208,595,578	1,154,823,595	85.6%	$50,745,658
Pilgrim Health Care	820,239,074	867,684,570	94.5%	-$39,322,961
Fallon Community Health Plan	404,775,883	441,680,241	91.6%	-$7,263,666

WHY PASS THIS BILL?

This proposal is important for several reasons. We address one major reason here, and others below. For the last couple of years, many people in our state have been upset or angered by HMOs' decisions to end unlimited prescription drug coverage for senior citizens. Others have been frightened by reports of hospital closings or growing hospital deficits. What are the solutions to these and other health care problems?

One solution would be to increase spending on health care. Sometimes, that is a necessary stop-gap, even though it can mean painful votes to find new tax dollars— as with vital expansions of the state's senior pharmacy program.

But more money is not and cannot be a durable solution in the state that has the world's highest health care spending. Indeed, as we recently documented, health spending per person in our state, at about $6,400 per person, is roughly 30 percent above the U.S. average.[3]

So we should not have to increase health spending. We should be able to find the money we need to buy medications and sustain all needed hospitals within the huge sums we already spend.

A mother lode of rich ore is buried in existing health care spending. As legislators, you can choose to mine that ore. It is a fraction of the administrative waste—the excess spending—you've heard so much about over the years.

Had the 10 percent ceiling been imposed in 1997 on HMOs' and insurors' marketing, advertising, administration and profit (or surplus), those HMOs and insurors would still have had roughly $740 million to spend on these functions—down from the $1.1 billion that they actually spent. The $740 billion would have been enough. The ceiling means more money for nurses and medications, and less money for billboards and administrators.

A. What does this bill do?

1. It applies to health insurors, HMOs, PPOs, and other similar entities that pay for health care. In this testimony, we will call these "insurors."

2. It sets a simple standard. It would require insurors to spend at least 90 percent of their total revenue on providing health care.

3. No more than ten percent could be spent on advertising, marketing, administration, and profit.

4. Exceptions would be made for smaller insurors and for those just starting out.

5. Enforcement also would be simple. Insurors would complete a standard financial form used by the National Association of Insurance Commissioners and by the state of California in its required Knox-Keene Act reports, plus other information required by the Commissioner of the Division of Insurance.

B. Why this bill?

1. Mistrust of insurors is growing in health care. Many patients worry that they will not get the care that they need. Most of this mistrust stems from insurors' financial incentives to induce doctors and hospitals to give less care. Those incentives, in turn, stem from insurors' own desires to hold their costs down. Insurors hope to offer lower prices for health insurance to employers. And for-profit insurors aim to increase returns to shareholders.

2. Health care can and should be made more trustworthy again. This bill requires that at least 90 percent of revenues for most insurors must go to paying for health care. Such a requirement will increase patients' trust in health care by reassuring them that less money will be wasted and more money will go to financing care.

3. An insuror's stock will rise when its care share goes down in today's health care market, other things equal. As noted earlier, that is perverse, signaling a market that is not working in the public's interest. (And that perversity is apparent in insurors' and investors' term for the share of premiums spent on care, "medical loss ratio.")

4. In a genuine free market, competition among insurors would benefit the public. But a free market for health insurance is lacking. Not one of the four core requirements for a genuine free market is satisfied in health care.[4] So government needs to step in to protect the citizens of the Commonwealth.

5. The method proposed here is simple. It provides for strategic intervention by government where government can do the most good. It does not require costly or intrusive regulatory micromanagement. It does not use regulatory band-aids. Instead, it goes to the heart of the problem.

6. The General Court last year adopted several measures intended to help make health insurance more trustworthy, through the managed care patient protection law. But most of these approaches are attempts to cope with the symptoms or consequences of financial incentives to give less care. Setting limits on physicians' financial risk offers the potential (if carefully structured) to address the underlying cause of mistrust— the financial incentives to give less care. H. 1208 also deals with this underlying cause .

7. The method proposed in H. 1208 attempts to get to the heart of the matter. Requiring insurors to devote 90 percent of revenue to health care makes them inherently more trustworthy. Once the 10 percent cap on non-health spending is reached, denying care to a patient will not yield more money for the insuror. Any resulting savings must be spent on another patient's care or used to reduce premiums. This engenders much greater financial neutrality in decision-making about what care to provide.

C. Expected effects of the bill

1. Lower prices.

When premiums are needlessly high, the bill would encourage insurors and HMOs to reduce them. Insurors that do not make these changes up front will be required to repay their windfalls to purchasers/policy-holders.

What would the savings be in Massachusetts? The data in Table 1, as noted, are for Massachusetts HMOs and Massachusetts Blue Cross Blue Shield, for the calendar years 1994 through 1997. Spending by ERISA plans may be included for some insurors, but spending by preferred provider organizations is generally excluded.

If all Massachusetts plans had spent exactly 90 percent of their revenues on health care, $1.2 billion would have been transferred from non-care spending to health delivery during those four years.

In practice, the reductions in administration and other non-care spending required by this bill might be held down by the exclusion of ERISA plans. But perhaps not. It might be that the administrative spending above ten percent is concentrated heavily in the non-ERISA plans, since the ERISA plans sometimes pay only a contractually defined administrative fee to the carrier administering their benefits.

The data in the tables show that a 90 percent care share standard is a reasonable one for Massachusetts insurors today. It is important to enact such a standard soon, lest non-legitimate competitive forces drive down care shares. This seems to have happened in California, as discussed in section D, below.

What if an HMO's or insuror's financial reserves have become depleted below safe levels, so it must run a care share below 90 percent in order to replenish those reserves? That is a legitimate concern (both as a transition issue and continuing into the future). To meet it, the bill before you might be amended to permit waiving the 90 percent requirement for an insuror in a given year, to rebuild reserves.

But that would have to be offset in subsequent years once reserves reached a level specified in state legislation; such amendments might also permit an offset by prior year medical spending above 90 percent of revenues. Thus, the 90 percent care share requirement might be monitored as a cumulative or running average for three to four years. This would allow HMOs and insurors to make modulated responses to market forces, under-writing cycles, and unexpected financial crises or crunches.

Some may worry that a 90 percent standard would become the ceiling, not the floor. If this problem arises, it could be dealt with by gradually raising the care share standard above 90 percent level so all insurors would face a steady challenge to become more efficient. (But in the experience of New Jersey with a similar law, discussed shortly, this problem apparently has not occurred— the floor has not become the ceiling.)

As noted above, Table 1 describes either the percentage change in care or premiums OR the percentage cut in administrative expenses that would have taken place in 1994 through 1997 if all insurors had operated with a 90 percent care share. On balance, the estimates in Table 1 are probably conservative:

- First, as mentioned earlier, some insurors now exceed the 90 percent care share level. Abandoning Table 1's conservative assumption that all plans have a 90 percent care share would mean a greater improvement in care or greater reduction in premiums, along with more than a 30 percent cut in non-care spending. For example, if plans that exceeded a 90 percent care share during any year from 1994 through 1997 had retained those higher levels,

while other plans rose to the 90 percent threshold, spending on care would have risen an estimated 4.6 percent (rather than the 4.3 percent that Table 1 shows).

- As an estimate of benefits of H.1208, Table 1's figures are likely conservative in a second respect. The $1.2 billion 4-year total conservatively under-estimates the shift in spending under H.1208 because it reflects only data for HMOs and Blue Cross Blue Shield, omitting a number of sizable PPOs and other insurors that would have to meet care share standards.[5]

- These figures are, however, probably a slight over-estimate on another score. The bill requires an 85 percent care share for smaller insurors (and exempts the smallest ones and also the newest ones). So the transfer from non-care to care or to lower premiums would be slightly less than estimated for a few HMOs. But the great majority of privately-insured people in Massachusetts are in the larger plans that would face the 90 percent threshold.

- On balance, therefore, we think that the estimate that those four years would have seen a $1.2 billion cut from non-care spending is conservative.

<u>And as health insurance premiums rise, so will the benefits of the 90 percent care share standard.</u>

It might have been argued that the rising care shares between 1994 and 1996 shown in the table made it unnecessary to legislate a statewide care share standard. That is wrong. First, the drop in 1997 should give us pause. It suggests that perhaps care is increasingly being denied.

Second, unusual price restraint helped to raise care shares in general for several years. The insurance under-writing cycle has long meant periods of higher care shares followed by periods of lower care shares. But premiums now are soaring. So, again, this is the time to act, to protect ourselves— both as patients and as payors— before our premiums climb much further—and before our care is inappropriately cut.

<u>Care share legislation works.</u> Beyond these specific estimates for Massachusetts, there is solid evidence that existing care share requirements save money for people who buy health insurance.

a) <u>New Jersey has had minimum care share standards since 1994</u> for non-group and small employer policies. Carriers must "pay out 75 cents in benefits for every dollar received in premiums."[6] (A lower care share standard may be acceptable for non-group and small group policies, where administrative costs can be higher, but we think that 75 percent is too low even in these circumstances.)

Insurors and HMOs not complying with the standards have been required to pay substantial refunds to thousands of N.J. small employers:

- In 1999, 31 out of the 61 HMOs and other insurors serving small businesses had to refund a total of $18.9 million for excess premiums paid in 1996;

- insurors earlier had to refund over $13 million for 1995; and

- insurors had to refund over $5 million for 1994.[7]

To meet that fairly loose standard of 75 percent of premiums going for care for 1995, at least eight N.J. insurors and HMOs had to refund over 15 percent of the premiums paid for small employer plans, and *four refunded 35 percent or more*. Previously, in the law's first year, even more of the insurors had to pay such large refunds—including at least six insurors who sell (or have recently sold) small group policies in Massachusetts. For 1996, on the other hand, the number of plans refunding a high percentage of premiums declined.

This trend towards greater up-front compliance with the minimum care share suggests that the law has been effective. And the separate but similar standard set for New Jersey's individual coverage (non-group) market also appears to be effective. Insurors and HMOs have, on average, paid out "far more than $.75 on the dollar," the state has reported.[8]

b) A recent U.S. General Accounting Office analysis of federal loss ratio (care share) standards for medigap plans found that "The amount of premiums paid for policies with loss ratios below standards has declined substantially from 1993, the last year before the refund provision became effective," and concluded that the refund requirement "is working."[9] These standards are already benefiting Massachusetts seniors.

c) Massachusetts state government already sets high care share requirements in its contracts with Medicaid HMOs.

This bill would simply give other insured Massachusetts residents similar protection.

2. More care.

When insurors spend too much on administration, marketing, and profits, care share standards will discourage such diversions from care. We could discuss the waste involved in each of those, but will spare you all except— as an example— a few comments on marketing.

Ironically, competition has encouraged some extremely inefficient practices which a care share policy would rein in. HMO and insuror marketing often contains little useful information, and may be extraordinarily costly; for example, one estimate is that some Medicare HMOs spend over $1000 to recruit each senior.[10] Without this bill, such wasteful spending is likely to rise as HMOs grow and turn

increasingly to recruiting people from other HMOs, rather than from indemnity plans. This care share proposal would mean less of your premiums diverted to such wasteful non-care.

Capping unproductive spending at 10 percent would amount to forcing insurors to sign an advertising peace treaty. In newspapers and on television and radio in various parts of the state, you have seen the volume of advertising in recent years by insurors and HMOs. These ads don't save lives. Instead, they take money away from doctors, nurses, hospital care, and medications— money that could be used to save lives. How much does a full-page ad cost? How many nurses must be laid off to pay for one year's unproductive ads?

A radio report a few years ago featured the comments of an advertising executive. He was asked by Canadian tobacco companies to help overturn that nation's ban on tobacco advertising. He advised the companies not to undertake that fight because the prohibition on advertising was putting money into the companies' pockets. He contended that advertising was wasted expenditure. It raised the price of cigarettes. And it did not help companies gain market share because it was almost invariably defensive, helping companies retain the markets that they already had.

D. Possible complaints about the bill, and responses to those complaints

1. Burden on small insurors. Some may say this bill's 90 percent standard would be hard on smaller insurors, because they would have more difficulty estimating the costs of those they cover.

Responses: The requirement simply prevents insurors from benefiting from that difficulty by gaining windfall profits at the expense of purchasers. This would aid all buyers, and especially those purchasers— small businesses and individuals— who lack the market power to demand such ratios, as many larger employers are already doing.

The 90 percent care share may not apply formally to ERISA plans, but ERISA plans would be free to apply these standards or tighter ones, to the fees they pay for administering their benefits. By setting a more efficient standard, this policy would encourage all plans to move in that direction (for example, by reducing wasteful marketing expenses) and thus benefit all who pay for care in Massachusetts.

Moreover, the 90 percent care share would cut the amount of marketing and advertising spending that insurors undertake throughout the state. All such spending should be charged to the allowable ten percent, since it is an expenditure by the insuror, subject to state regulation, not an expenditure by a self-insured ERISA plan.

2. Excessive or costly state regulation and intrusion in a free health care market. Some might argue that Massachusetts has deregulated health care and prices came down in response. Spending a greater share of the health dollar on advertising, marketing, administration, and profits might make sense if that cut the dollars spent on health care overall.

Responses:

Health cost increases did slow in the mid-1990s in Massachusetts and nationally. But premiums are now climbing rapidly again. And there is no evidence that the earlier declines were attributable to higher spending on advertising, marketing, administration, and profits. Indeed, our state is still the costliest in the nation, even though we have had one of the greatest population shares enrolled in managed care. Current health care spending in Massachusetts is about $40 billion annually, or about $6,400 per person each year.

No genuine free market functions in health care. The conditions that must be satisfied by free markets are not close to satisfied. As HMOs merge and as hospitals merge, oligopoly market power grows and competition declines. Survivors can raise prices and cut care. This bill would reduce their power to do that. And this bill would do so pre-emptively.

Health care regulation in Massachusetts is not costly. Rather, health care itself is costly. If this bill helps to hold down premiums, it will make health care more affordable. This is vital to gaining coverage for the hundreds of thousands of Massachusetts residents who still lack health insurance. Spending more money to protect uninsured people may not be an affordable long-term strategy, and it is probably not necessary, given our state's high spending.

Further, this sort of regulation will be very *inexpensive to enforce*. It operates wholesale or strategically, on insurors. It does not burden individual patients, physicians, or hospitals.

3. Care shares are fairly high now, so why do we need this bill?

Responses: Care shares may have been relatively high in some recent years, in part owing to the ordinary working of the insurance underwriting cycle. But insurors have indicated their continued intentions to raise rates sharply. Care shares can be expected to fall, so this bill is needed.

It will be easier to introduce a robust care share requirement this year, while care shares are higher, than to try to enforce one in later years, while care shares are lower—just as it is easier to maintain a car's speed on a level highway than to accelerate while climbing a hill.

Sustaining high care shares legislatively will discourage predatory new HMO/ insuror competitors from entering Massachusetts– those who hope to make money by aggressively marketing and advertising. In some states, some managed care organizations enroll large numbers of patients but then experience very low care shares. They can do so in only a few ways: by under-serving patients, by enrolling younger and healthier patients who need less care, or by operating with greater-than-average efficiency. Neither the first nor the second should be rewarded. Therefore, care shares should be kept high in Massachusetts through legislative action.

There are useful lessons from California HMO data, reported to the state under the requirements of the Knox-Keene Act and compiled by the California Medical Association. It seems clear that for-profit HMOs' care shares are substantially lower than those of their non-profit counterparts. For example, the five largest for-profit California HMOs devoted only 79.0 percent of their incomes to health care in 1994-5, while the five largest non-profits devoted fully 92.7 percent of their incomes.[11]

Today, most Massachusetts HMOs— and all of the larger ones— operate not-for-profit. Imagine that one or more for-profit HMOs were to launch a heavy advertising and marketing campaign in this state. In response, one or more of our large non-profit HMOs might choose to convert to for-profit status, claiming that only in this way could they raise the capital they might desire to counter-advertise and counter-market.

Under the present conditions of wholesale market failure in the health sector, the entry of larger numbers of for-profit HMOs would divert still greater shares of health spending away from care and toward administration, advertising, marketing, and profit. That would result in higher spending on health care, less care, or both.

Entry of more for-profit HMOs would also tend to undermine the state's economy. Today, money raised in Massachusetts to pay for health care overwhelmingly remains in Massachusetts. Tomorrow, if for-profit HMOs operating in this state must repatriate their profits to stockholders elsewhere, less money is available to provide health care in Massachusetts. Moreover, diminished spending on health in Massachusetts has an unfortunate multiplier effect. The multiplier in health care is roughly 2.08. This means that every extra $100,000,000 that is sent to out-of-state shareholders yields a $208,000,000 reduction in economic activity in Massachusetts. (Less money spent on health care means less income for nurses, custodians, and others. That, in turn, means less money to spend to buy groceries or pay rent or even income taxes.)

Thus, protecting citizens of the Commonwealth with a requirement for higher care shares would have a multitude of benefits.

We thank you for the opportunity to present this evidence to you, and would be happy to take questions.

Notes

[1] David Stires, "Debunking Oxford," Fortune, 19 March 2001, accessed 30 March 2001 at http://www.fortune500.com/indext.jhtml?channel=print_article.jhtml&doc_id=200866

[2] David Stires, "Debunking Oxford," Fortune, 19 March 2001, http://www.fortune500.com/indext.jhtml?channel=print_article.jhtml&doc_id=200866

[3] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 – 1998*, 2 October 2000. This report is available on the internet at http://dcc2.bumc.bu.edu/hs/accessandaffordability.htm

[4] The four requirements:

- many small buyers and sellers
- no artificial restrictions on supply, demand, or price
- easy entry and exit
- good information about price and quality

Further, in a free market, mistrust is the watchword and "Let the buyer beware!" is the motto. Yet patients tend to get better faster when they trust their physician.

[5] See, for example, "The List: Preferred Provider Organizations," Boston Business Journal, 25 October 1996.

[6] "New Jersey's Health Insurance Reform Programs, Progress Report, 1993-1996," New Jersey Department of Banking and Insurance, http://www.naic.org/nj/ihc_seh.html

[7] "Health Insurance Reforms Mandate Refunds Of $18.9 Million To Small Businesses," press release, New Jersey Department of Banking and Insurance, 5 January1999; "Health Insurance Reforms Mandate Refunds Of $13 Million To New Jersey Small Employers," press release, New Jersey Department of Banking and Insurance, 14 August 1997.

[8] "New Jersey's Health Insurance Reform Programs, Progress Report, 1993-1996," New Jersey Department of Banking and Insurance, http://www.naic.org/nj/ihc_seh.html

[9] U.S. General Accounting Office, *Medigap Insurance: Compliance With Federal Standards Has Increased*, GAO/HEHS-98-66, March 1998, p. 11.

[10] John Rother, American Association of Retired Persons, as quoted in Nancy Ann Jeffrey, "Medicare-Education Campaign Is Hit With Vigorous Criticism," *The Wall Street Journal*, 31 December 1997.

[11] Access and Affordability Monitoring Project analyses of California Medical Association, Knox-Keene Health Plan Expenditure Summary, FY 1994-95, Sacramento: The Association, February 1996, presented in Alan Sager and Deborah Socolar, "Why Additional For-profit Hospitals and HMOs Should Be Outlawed in Massachusetts," testimony before the Joint Committee on Health Care, General Court, 3 April 1996.