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PROMISE AND PERFORMANCE

First Monitoring Report on

"An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing"

(Chapter 23 of the Acts of 1988)

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This document's format differs from that of the original 1989 report,
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SUMMARY

From great enthusiasm to unwarranted pessimism

1. The Massachusetts health law, Chapter 23 of the Acts of 1988, was passed and signed with excitement and optimism. Today, almost one year later, various parties disparage the law, fear it is in crisis, or call for its repeal. This speedy and wild swing from inflated hope to depressed fear or anger is not warranted.

2. Chapter 23 is a very complex law because it tackles difficult problems in a very complex field. We should appreciate its successes, identify specific problems, and investigate and remedy their specific causes.

3. Chapter 23 is really two laws in one. It begins the job of joining universal access and hospital finance. The perceived problems with the law reflect how much it attempts, and the serious dilemmas in health care finance and delivery that it exposes. The real problem is probably not that the law goes too far, but rather that it does not go far enough. Still, it is an important step forward. We should continue.

Hospital finance

1. Although Chapter 23 is usually referred to as a "universal health insurance" or "health care for all" law, most of the new money it authorizes goes to hospitals to pay for care of patients who are already insured. Hospitals get about five and one-half times as much new money as access improvements. At least during its early years, the law is misnamed.

2. Some $3.736 billion in new spending on hospital finance and access is called for under Chapter 23 during the four years before the requirement for universal insurance is scheduled to take effect, on 1 April 1992. Of this money, only about $585 million (16 percent) will go to improving access; the remaining $3.15 billion (84 percent) will finance hospital care for patients who are already insured.

3. Growing numbers of hospitals seem to be experiencing financial distress. This gives rise to most of today's anger and worry about Chapter 23, even though over 90 percent of the new money the law promises seems to be flowing smoothly through private insurance channels. This 90 percent is generated by the higher charges that Chapter 23 authorizes. The state has not made good on its promises to provide "Medicare shortfall" or certain uncompensated care funds. Estimates for fiscal years 1988 through 1990 indicate that, in the worst case, some $180-214 million in promised state funds will not be made available. This sum is about 1.2 percent of total estimated hospital expenses during these three years.

4. Our hospitals are (for complex reasons) more expensive than we can afford. This is the major reason for our hospitals' financial problems, and also the message of continuing federal Medicare squeezes on hospitals throughout the nation. The state's failure to carry out promises to hospitals mainly reflects the law's failure to solve those problems.

5. The state lacks the long-term ability to solve hospitals' long-term deficits. This is the real meaning of the state's apparent inability or unwillingness to keep its commitments to hospitals under Chapter 23. Just as the state enjoyed prosperous times recently, so did hospitals. Hospitals' accumulated surpluses from 1981 through 1987, in today's dollars, total $783 million. Today, the state is facing a five percent budget deficit, and is having trouble helping hospitals that may face, on average, one-to-two percent deficits. Just as the state is finding it difficult to balance its books by raising taxes, so are hospitals finding it difficult to balance their books by raising revenues in their usual manner.

6. If worries about a $500 million state budget deficit, in good economic times, can upset state commitments to hospitals, how would hospitals and universal access fare during a serious recession? We should heed the deficit's early warnings, and make the sorts of mid-course corrections that will leave both our hospitals and plans for universal access on sound financial footings.

7. Recent indications are that even appropriating all the funds promised by Chapter 23 to hospitals will not solve their financial problems. Hospitals may demand full deregulation of charges even if they receive the promised Medicare shortfall and uncompensated care money. But deregulation means shifting costs to employers and workers. This merely moves the problem. With health insurance premiums already rising 20-30 percent this year, how much additional increase can be tolerated? Deregulation will quickly return to haunt the cities and towns and the Group Insurance Commission with still higher premiums. If employers are unwilling or unable to increase their own insurance payments, workers will face either higher premiums or higher out-of-pocket costs of care-- or forego needed services. But if providing more money to hospitals is difficult, and if administrators lack the power to control costs of clinical services (doctors largely determine these), how will hospitals balance their budgets?

8. We are presented with two contradictory truths. Massachusetts already spends more per capita on hospital care than any other state, 35 percent above the U.S. average. And the United States spends more than any other industrial democracy. (These other nations have found ways to protect all their citizens, enjoy better health outcomes, and spend less.) Our teaching hospitals are substantially more costly than teaching hospitals elsewhere. Yet many Massachusetts hospitals are suffering financial distress. The first problem makes it hard to solve the second by providing more money. Neither state government, patients, nor business is willing to pay more.

9. Hospitals' current need for more money can't be satisfied by repealing Chapter 23's provisions to improve access. Chapter 23's universal access provisions cannot have caused hospitals' financial problems, because they have not yet been substantially implemented. Repeal would save very little money each year, up to 1992. And most of the money saved would either reduce

hospital revenues or be completely unavailable to hospitals. Since it is clearly in hospitals' interest to have more patients financially entitled to needed care, their motives in contemplating advocacy of repeal of the access provisions are difficult to decipher. The extent and causes of financial distress should be identified and then addressed-- in ways compatible with progress toward both universal access and genuine cost control.

10. Any state money made available for hospitals should be carefully targeted to relieving financial distress. Hospitals' financial circumstances vary-- and so do the needs of their communities. Some fare well while others are in trouble, often through no fault of their own. Some hospitals require short-term financial relief if they are to continue providing needed services. But substantial reforms are necessary for long-term viability of all our vital hospitals. These reforms should be accomplished gradually, so hospitals are not thrown through the windshield by any sudden deceleration in their revenues.

Access

1. The main access provision of the law, universal insurance, is deferred until 1992. Until then, a series of provisions to entitle special populations, to finance and manage uncompensated care, and to test methods for universal insurance are gradually phased in.

2. It seems that most of the law's early access provisions are being implemented fairly well, extending coverage to some new groups in special need of protection. With a small staff facing many demands, the new Department of Medical Security has gotten off to a good start, overall. But the provisions in the law and the plans of DMS to rely on traditional insurance methods should be re-examined. In what DMS itself describes as a marketplace of "high and rapidly increasing costs," a business-as-usual approach to improving access runs the risk of incurring unacceptably high expenses. There are other ways to provide affordable protection.

3. If DMS is not financed adequately, its ability to test methods of phasing in universal coverage will be undermined. Since insurors prefer to cover healthy people in large groups, DMS itself should experiment with non-traditional methods that have greater chances of providing universal access. If DMS cannot keep premiums and out-of-pocket costs low, many or most people who are uninsured today will not be able to afford the new coverage they will be offered. If the law is not given a fair and thorough test, critics will say it has failed even though it was never given a chance to succeed.

4. The risk that access to care could actually deteriorate under Chapter 23 has received too little attention. The law caps the business contribution to the hospital uncompensated care pool and promises that the state will pick up increases needed to keep pace with inflation. But the state has indicated it will not do so. This harms patients whose care should be financed from the pool, and also the hospitals that provide that care. Similarly, the state has refused funds to pay the uncompensated care costs of community health centers that are not affiliated with hospitals. Cuts in access to vital ambulatory care services have

already begun. Without adequate state (or other) financing, uninsured citizens' access to care could fall below levels available before Chapter 23 was passed.

5. During the four years before universal health insurance is scheduled to take effect, about 90 percent of the new money for access is public, and most of it is subject to annual state appropriation. But over 90 percent of the new money for hospitals' already insured patients is well-assured. Thus, if the current fiscal crisis or other forces continue to drive down state spending, access is likely to suffer more seriously than hospitals will.

Cost controls

1. Chapter 23 takes what was already the world's most costly health care system and promises still more money to satisfy simultaneously advocates of hospitals and of universal access. Thus, its hallmark is the add-on, not the trade-off. For example, the access and hospital finance provisions are separate. This makes it difficult or even impossible for a well-intentioned hospital to economize on care of its insured patients by reducing unnecessary admissions, and to use the savings to admit more uninsured patients.

2. The law seeks to contain hospital costs by reducing beds through hospital closings and conversions and through mothballing units; by managed care; and by competition. These cost controls are weak or worse. One major provision of the law, included to advance competition, is likely to raise spending because it provides a financial incentive to increase admissions. Hospital closings, ironically, are likely to proceed in a way that also raises spending. Smaller community hospitals in lower income areas may be forced to close even though they are efficient. Their patients are likely to be displaced to more expensive hospitals.

3. That the cost controls are weak is not surprising. The law's hospital finance and access provisions were joined under intense political pressure. The road to passing the combination was smoothed by the promise of large amounts of new state money for both hospitals and access.

4. For a number of reasons, there has been little political demand for effective hospital cost controls. Most businesses that provide health insurance seem to have been more anxious to save money by escaping or shifting costs of uncompensated care-- or by trying to manage their employees' use of care-- than by helping to tackle the tough job of controlling the rate of increase in all hospital costs. Hospital administrators have been accustomed to balancing their books by seeking higher revenues. This is the world they know, and the one in which they can have influence.

5. Real cost control, by contrast, requires changes that entail close cooperation of physicians, hospital by hospital, since physicians make the decisions that encumber the clinical resources-- and therefore the bulk of the money that hospitals spend. And physicians have not been involved in the design or implementation of the law's access and hospital finance provisions. Methods of providing and paying for hospital and physician care must be coordinated.

6. The law's cost control provisions do not require change in the mainstream behavior of most hospitals or doctors, most of the time. Some hospitals might close; some hospitals might bid down their prices (until occupancy rates rose high enough for the survivors to raise their prices and recoup earlier losses), and some patients' care might have to be managed, but most caregivers could enjoy business as usual.

7. Several hospitals have closed and others have sought help from the Acute Hospital Conversion Board to begin providing long-term care. But several other hospitals have sought and received from the Board permission to increase their rates in order to remain open. State policy and state money to relieve hospitals must be targeted and they must be guided by community need.

Conclusions and recommendations

1. Early problems surrounding Chapter 23 are attributable not to its twin goals of financial stability for hospitals and universal access to health care, but rather to the specific measures by which these goals are pursued, to the state's budget deficit, and to slowed rates of Medicare payments. The last two were not caused by Chapter 23. The access, hospital financing, and cost control provisions of the law deserve separate attention. Problems with each should be addressed appropriately.

2. By the best available evidence, Massachusetts already has the financial, human, and capital resources to realize Chapter 23's promises of health care for all and stable and adequate financing for hospitals. The goals should be retained but the means should be modified. Some methods are at hand in Massachusetts laws and regulations. To these should be added uniform hospital financial accounting and grouping of similar hospitals for fair payment.

3. Promising to pay for health care for all exposes many of the flaws in our long-standing methods of financing and providing health care. The law's access provisions require large amounts of new money from business, from state government, and even from many or most of those lower-income citizens who will be newly entitled.

4. Access for all is affordable, but Chapter 23's access provisions are very costly because they rely on extending traditional insurance mechanisms to cover all citizens. It is not likely that, even with the best intentions, this much money can be found. Private insurance is inefficient in health care, and it gets in the way of cost containment. The citizens of this state have declared their support for equal access in a referendum and their willingness to help pay for it in public opinion polls. But they cannot be expected to pay huge additional sums to reach this goal. It can be reached in other ways.

5. Carefully blending cost controls with hospital financing and access provisions would better satisfy the legitimate needs of patients, payors, and caregivers. This means real change, not just rhetorical change, in how services are financed and delivered. It requires active cooperation between hospitals and

physicians, and the building of trust between caregivers and payors. Massachusetts has the needed financial and human resources. The open question is whether it will require a crisis to marshal them.

6. This is an awkward time in Massachusetts health policy, one of fragility, a close observer said. Legislators and others are asking whether they made a mistake in voting for Chapter 23. Massachusetts has broken entirely new ground in health policy, and this is a little frightening. What have we gotten ourselves into? Time for calm reflection and analysis is needed. We do not need anger or spasms of irresponsible policy-making. Access and hospitals must both be protected, and so must those who pay for care.

7. Some say that health care is in crisis, and that comprehensive reform is required today. They say that incremental change cannot work, that it is impossible to jump across a wide chasm in two small steps. But if the chasm is too wide, we cannot leap safely across it either. Instead, we must build a bridge.

8. Fortunately, the tools and raw materials are at hand. This means reforming Chapter 23, not throwing it out. This law puts universal access together with hospital financing, though not yet in a way we can afford. With our state's enormous resources, we can shape the health care system we want and need.

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I. INTRODUCTION

Last April 21st, amidst hope and excitement, Gov. Michael Dukakis signed the nation's first law promising universal health insurance. Chapter 23 of the Acts of 1988 declared that access to health care "is a natural, essential, and unalienable right". But today, misunderstanding and anger seem largely to have replaced hope and excitement.

We have been analyzing the law's design and monitoring its implementation. This report presents the results of our work to-date. Our first aim is to provide accurate, objective information about what has happened-- the design of the law, the steps taken to implement it, the successes, and the problems. Our second aim is to analyze why these things have happened. Not surprisingly, there is some disagreement about both what has happened, and why. We try to present the range of views, and then offer our own conclusions. Our third aim, less central, is to offer suggestions for reforming the law in the interest of durably affordable and effective health care for all citizens of the Commonwealth.

We believe that this work is important to Massachusetts health care today. Chapter 23 is so complicated and ambitious that it is subject to misunderstanding. Some groups, for example, have concluded-- prematurely-- that the law has failed, and call for its repeal. They do not specify either the ways in which they believe the law has failed, or how their own proposals will advance the public interest.

Any treatment must rest on accurate diagnosis. We therefore pay special attention to the law's problems: what are they; how serious are they; and to what extent are they attributable to the design of the law, to the manner of its implementation, to problems that antedated the law, or to such outside forces as federal Medicare payment policies or the rate of growth in state revenues?

This is the first in what we expect will be a series of progress reports on the implementation of the law. Each report will strive to cover topics of interest to a wide variety of groups, and to present them in an interesting and readable manner. Even though this report is lengthy, it does not pretend to be fully comprehensive. Its topic is too complex to permit that. Central subjects of subsequent reports include: the design and implementation of the four CommonHealth initiatives, reliance on insurance to finance universal access, changes in hospital and health center provision of uncompensated care, the sources of hospital financial distress, the role of the physician in linking finance with delivery of affordable care, the structure of relations between physicians and hospitals, the meanings of competition in health care, and the need for integration and direction in state health policy.

The authors of this report are Alan Sager, an associate professor (health services) at Boston University School of Public Health; Peter Hiam, a former chair of the Massachusetts Rate Setting Commission and former Commissioner of Insurance; and Deborah Socolar, a researcher at Boston University School of Public Health. Deborah Socolar drafted sections on implementing CommonHealth, other access programs, and community health centers. Peter Hiam drafted sections on implementing the universal health insurance initiatives. Alan Sager drafted the bulk of the remaining sections. This report is the product of cooperation. Each section reflects discussion among the authors, and advice and information from a number of individuals closely involved in formulating, implementing, and observing health policy in Massachusetts. We are grateful to all who took the time to help us. Nothing in this document necessarily represents the views of Boston University School of Public Health.

Most analysts who have acquired enough familiarity to write about a subject form general conclusions about the nature of problems and solutions in the field. We are no exceptions. First, we share the conviction of the framers of Chapter 23 that health care for all is a right. (Their powerful statement on this subject is reprinted shortly.) Second, we have concluded that this right is affordable in Massachusetts today, without increasing spending. Third, there are serious barriers to making real this right, as the early implementation of the law demonstrates. Fourth, having declared the right to health care, the next step is to analyze the nature and causes of those barriers, and to suggest methods of removing them. A worthy goal should be pursued, even if the means have to change.

II. OVERVIEW OF THE LAW'S PROVISIONS

Chapter 23's three main sets of provisions concern access, hospital financing, and cost control. This section describes the provisions, discusses their origins, and indicates why they are joined together in one law.

A. Access

The law's provisions to protect Massachusetts's 600,000 citizens lacking health insurance have received by far the most public attention. Variously called the "Health Care for All," "Universal Health Insurance," or "Medical Security" law, Chapter 23's language on access is clear and powerful. Like all small print, it is worth reading:

> It is hereby found and declared:
>
> That, the access of residents of the commonwealth to basic health care services is a natural, essential, and unalienable right which is protected by Article I of Part the First of the Constitution.
>
> That there live within the commonwealth many thousands of persons who lack access to basic health care services because they are not able to purchase health care insurance at a reasonable price or because they are restricted from purchasing such insurance by the practices of the insurance industry.
>
> That, such lack of access to health care negatively affects the health status of the uninsured in the commonwealth by the delay or lack of medical treatments, thereby increasing the incidence of disease and illness in the commonwealth.
>
> That, the cost of providing hospital care to the uninsured is a burden on the taxpayers and certain businesses in the commonwealth.
>
> That, most businesses in the commonwealth assist their employees in the purchase of health care insurance and that many other businesses are precluded from providing such insurance because of economic and cost concerns.
>
> That, the inability of certain businesses to offer health insurance benefits to their employees is a hindrance to their ability to compete for capable employees in the labor market and therefore has a negative economic impact on the commonwealth.
>
> Therefore, it is found that it is in the public interest of the commonwealth to promote the accessibility of health care services for all its citizens, a public purpose for which public money may be expended.[1]

This is the first clear legislative declaration in the United States that health care for all is a basic right.[2]

But despite this strong language, Chapter 23 builds access to care slowly. It schedules three kinds of initial attacks on access problems: a set of programs to provide insurance protection to special populations; state initiatives to better finance and manage the vital efforts of hospitals and health centers to protect access by providing uncompensated care; and a series of "phase-in demonstrations" to test methods of insuring all who are now uncovered.

Health care for all. The law promises to make insurance coverage available to each resident of the Commonwealth by 1 April 1992. Then, all residents, employed or unemployed, who lack a minimum level of insurance will be able to purchase it through a new state agency, the Department of Medical Security (DMS).

What services are to be covered? The law calls for those "which typically are included in employer-sponsored health benefit plans...."[3] Equally vague are enrollees' share of insurance premiums and out-of-pocket payments. The law says only that DMS must set premiums and out-of-pocket costs to rise on a sliding scale as family income rises. Enrollees would pay the entire premium if their incomes "substantially exceed" the poverty level.[4] Benefits and affordability vitally affect citizens' willingness and ability to elect newly offered insurance. This is central: Chapter 23 only requires that insurance be offered, not that it be accepted.

DMS will not insure; rather, it will broker competing private insurance plans. The new coverage is to be financed through a combination of state general revenues, premiums and out-of-pocket payments from newly insured citizens, and a new unemployment tax surcharge of 12 percent on the first $14,000 of income per worker for firms with more than five full-time employees. Costs of covering both uninsured workers at smaller firms and long-term unemployed citizens would be borne mainly by the state.

This surcharge, up to $1680 per worker, could be partly or fully offset by employer payments for health insurance. Employers would thus provide the insurance or pay the surcharge. This "play or pay" approach was framed as an exercise of the state's taxing power. It was hoped in this way to avoid the 1974 federal Employee Income Retirement Income Security Act's (ERISA) prohibition against state requirements that businesses provide health insurance. Prospects for doing so are considered uncertain by some.[5]

If Chapter 23 is successfully challenged on ERISA grounds, its universal insurance provisions will have to be re-written or an ERISA exemption sought from Congress.

Special populations. A series of provisions are gradually extending insurance coverage to special populations. The first are four programs begun 1 July 1988, collectively called "CommonHealth", and run by the Department of Public Welfare. The first two, for disabled working adults and for disabled children, allow purchase of comprehensive Medicaid-like coverage when incomes exceed Medicaid eligibility levels. Wrap-around benefits can supplement private health insurance coverage that is often not adequate to the needs of disabled men, women, and children. The plans also assist persons who have been unable to change jobs because their new employer's insurance policies would exclude coverage of pre-existing conditions. These programs are wholly state-financed.

A third program nearly doubles the income eligibility level for pregnant women and infants under age one, to 185 percent of the federal poverty level. Because it relies on a new federal authorization, half of this program's costs are borne by the federal government.

A fourth program provides up to two years of Medicaid coverage to welfare recipients who begin working, if their income remains below 185 percent of the poverty level.[6]

Even though these efforts are being managed by the Medicaid program, they may set important precedents for the main universal insurance initiative. Will outreach be vigorous and effective? Will benefits, income-tempered premium schedules, and possible out-of-pocket payments be set to encourage widespread enrollment and appropriate service use?

Another of Chapter 23's efforts to advance insurance coverage is its requirement that students attending college at least three-quarters time obtain or demonstrate health insurance coverage by September 1989.

In April 1990, an important new program to provide health insurance to workers and families receiving unemployment compensation will begin. It will be financed by a surcharge of up to $16.80 per worker per year on unemployment insurance premiums paid by employers.

State management and financing initiatives. An important early Department of Medical Security responsibility is to manage the hospital uncompensated care pool. Established in 1985, this pool has paid hospitals the costs of their free care and bad debt write-offs (for both inpatient and ambulatory care) at Blue Cross rates of payment. Hospitals devoting less than the state-wide average percentage of costs to uncompensated care pay into the pool. Hospitals providing more free care or writing off more bad debt draw money from the pool. This provision makes it possible for hospitals to serve more uninsured patients without suffering the financial penalty of raising their charges to insured patients to great-- and possibly uncompetitive-- heights in order to recover their costs.

For citizens without insurance, the pool has been the main bulwark of access to acute care, and an important financial resource for ambulatory care. Hospitals are not obliged to serve uninsured patients, except in emergencies, but they will be paid in full if they choose to provide care. The pool will remain vital to protecting access until the goal of universal protection against health costs is reached.

Before Chapter 23 was passed, the pool was financed mainly by an uncapped surcharge on non-Medicare, non-Medicaid hospital bills. This was paid by businesses that provided health insurance, and by their workers. Just before Chapter 23 was passed, the surcharge was close to 13 percent of bills (up from around ten percent just a few years earlier). Many business groups were worried by the increase in the surcharge rate. In addition, they were upset at paying for their own employees' health costs and also, they believed, for costs of uninsured workers whose care was financed through the pool. In response to business demands, the health law capped the private sector's responsibility to pay for uncompensated care.

The law gradually but markedly reduces real (constant dollar) private sector payments into the state's uncompensated hospital care pool from $325 million in 1988 to about $225 million in 1991 (assuming 8 percent price inflation). This reduction in surcharge obligations was Chapter 23's major attraction to the business community.

To protect access, the law promised that state government would pay future increases in pool payments for free care and bad debt. DMS is now charged with managing the pool. This requires balancing access with cost control, and will reveal much about state commitment to access.

In January of 1990, the state will resume paying hospital bills for persons receiving General Relief income supports (cash payments from the state only, without federal participation) that were discontinued some fifteen years earlier. In the interim, these costs have been the responsibility of the private sector, and are now included in the free care pool.

Preparing for Health Care for All. Beginning in the fall of 1988, the new Department of Medical Security began studying and testing methods of insuring those who lack health coverage. Its main tool is to broker and subsidize private insurance. In effect, an insurance policy must be purchased for each group member or individual covered. Additional money must therefore be found to cover each newly insured person.

Demonstration projects to test design of insurance policies for uninsured citizens, and for managing their care, were also to begin in 1988; these have been delayed to 1989. In July of 1989, DMS is called on to begin operating an insurance purchasing pool to aid businesses with fewer than six employees to initiate health insurance coverage. Also, for two years beginning in July 1989, businesses with 50 or fewer employees that initiate health insurance coverage will be partly subsidized through small state tax credits.

B. Costs of Access

Before universal insurance. During the four years between passage of the law and implementation of its universal insurance provision, cumulative new spending by all parties to improve access is projected at $585 million. The projected increase in payments to hospitals, for their patients already insured, is almost five and one-half times as much (Table 1). This indicates that, at least until 1992, Chapter 23 is mainly a hospital finance law. Importantly, almost all of the hospital money is derived from increased private sector payments, while the great bulk of the improvement in access must be financed through annual state appropriations.

Health Care for All. The access provisions will become substantially more costly after 1 April 1992. Relying on Senate Ways and Means Committee estimates,[7] it appears that the net increase (over spending expected under provisions of current law) in total annual spending by all parties on health care for citizens currently uninsured will be over $400 million in state fiscal year 1993, the first full year of implementation.

In state fiscal year 1988, total spending on uninsured citizens was estimated at $618 million; this was projected to rise to slightly over $1 billion by 1993 without new legislation. According to Senate Ways and Means Committee estimates, the law is expected to raise the 1993 spending on persons who would formerly have been uninsured by about 40 percent, to $1.4 billion (Table 2). The state, businesses not formerly providing insurance, and individuals would bear substantial increases; the obligations of firms that had been providing insurance would drop.

Table 1

Projected New Spending by Object and Source April 1988 - March 1992 [8]

	new spending on ($ millions)		
	hospitals	access	total
new spending by			
private sector	$2,951	$63	$3,014
public sector	$200	$522	$722
total	$3,151	$585	$3,736

	row percentages		
	hospitals	access	total
new spending by			
private sector	97.9%	2.1%	100.0%
public sector	27.7%	72.3%	100.0%
total	84.3%	15.7%	100.0%

	column percentages		
	hospitals	access	total
new spending by			
private sector	93.7%	10.8%	80.7%
public sector	6.3%	89.2%	19.3%
total	100.0%	100.0%	100.0%

Table 2

Projected Spending to Serve Citizens Uninsured Absent Passage of C. 23 (state fiscal year 1993, $ millions) [9]

Payor	Pre-C. 23	Post-C. 23	Change	Pct.Change
State	$143	$291	$148	103.5%
Firms previously providing insurance	549	434	-115	-20.9%
Firms previously not providing insurance	0	208	208	---
Premiums and out-of-pocket	317	486	169	53.3%
Total	$1,009	$1,419	$410	40.6%

C. Hospital Payments

According to state administration estimates, the law calls for annual private payments to hospitals-- from Blue Cross, commercial insurors, and self-payors-- to rise by $941 million (about 40 percent) over the first four years. In addition, the Commonwealth pledged to appropriate $200 million over these four years to compensate hospitals for Medicare payments that fail to keep up with hospitals' own costs of providing care. (The state thereby promised to shoulder costs that the federal government is unwilling or unable to bear. In total, the state administration projects increased hospital revenues of about $1.14 billion through hospital fiscal year 1992.[10] This figure badly under-estimates true costs.

Discussions of the cost of the law's hospital finance provisions have tended to focus on the sum of the annual increases, rather than on the more appropriate measure, the cumulative increase. Necessarily, the cumulative increase will be substantially larger. (The first year's increase becomes part of the second year's base, and so on. It is therefore paid not once but four times over four years.)

The accumulated increase in payments to hospitals provided by Chapter 23 would be about $3.15 billion between April 1988 and March 1992. Over nine-tenths would be borne by employers and workers through higher insurance premiums. This money is assured to hospitals. Only the remaining $200 million is subject to state appropriation (Table 1), and is therefore in doubt.

D. Cost Controls

Realizing that the law would be costly, its authors included several provisions designed to constrain spending increases. First are policies expected to result in the closing or conversion to non-acute services of some hospitals, and for the delicensing of beds in others. It was argued that empty beds were very expensive. When the first debate over universal health insurance legislation was raging, in mid-September 1987, state Secretary of Human Services Philip Johnston asserted that "`hospitals' need for more money is being driven by the cost of supporting 6,000 to 9,000 empty hospital beds.'"[11]

The law created an Acute Hospital Conversion Board charged mainly with smoothing the way for hospitals that wished to change from acute to rehabilitation, long-term, psychiatric, substance abuse, or other types of care. The Board could grant financial relief (the right to raise charges) or regulatory relief (from determination of need, for example).

Second, it was hoped that price competition among hospitals would lead them to reduce their charges per unit of service from the maximums allowed under the law, thereby reducing total spending. To spur competition for patients, a substantial increase in payments was promised hospitals whose admissions rose. This reversed the financial incentive to limit admissions that had been in effect since 1982. Earlier versions of the law also included provisions for greater competition among Blue Cross and other insurors; most of these were dropped before passage because they would have torn apart the complex subsidies for non-group policies and supplementary Medicare coverage (Medex) that are woven into existing insurance laws.

Third, the law exhorts DMS to rely heavily on managed care arrangements to lower costs.[12] Many health services professionals have long argued that up-front insurance entitlement of individuals could in itself save money by removing financial barriers to seeking appropriate care early in an illness, before costly hospital care would become necessary. Similarly, well-insured patients could develop long-term relations with family physicians, who could get to know them and manage their care. But Chapter 23 does not mention the potential benefits of coordination and continuity that managed care can bring to patients. Rather, managed care is apparently viewed in the law as a necessary cost-reducing counter-balance to entitlement through insurance.

E. Why Did Massachusetts Pass This Law?

A number of reasons can be offered to explain why Massachusetts became the first state in the nation to promise universal health insurance. First, economic growth in the second half of the 1980's increased state revenues even while it reduced the cost of a universal health insurance plan. The percentage of the population without health insurance fell to a rate one-quarter below the U.S. average.[13]

Second, economic progress made it easier for the state to realize politically its increasingly egalitarian values about health care. The state's voters had supported a national health program in a non-binding referendum. A series of studies called attention to the plight of citizens without health insurance, and noted that most were workers or the dependents of workers.

Third, through the early and mid-1980's, cost control efforts further increased the visibility of access problems, and made many groups more aware of the need to protect access. In 1982, the legislature had sought to slow the rate of increase in Massachusetts hospital care (which was the most expensive in the nation) through regulation. In the mid-1980's interest grew in competition as a means of cost control. It was feared that either regulation or competition could, in its way, harm access of uninsured citizens or other vulnerable groups. Increasingly, state officials, businesses, and others who desired to control hospital costs appreciated the need to do so in ways that protected or even enhanced access.

It became clear to many that more competition would undermine the complex cross-subsidies that protected access in Massachusetts. Insurance for all citizens was therefore needed, it was believed, to make the world safe for competition. At the same time, it was believed, insurance would provide with dignified entitlement, which would encourage them to seek care appropriately and promptly. Insurance entitlement was distinguished in most people's minds from compensating hospitals for their uncompensated care costs. The latter left the decision to provide care in the hospital's hands, and concentrated payment in what was viewed as the most costly site of service.

Fourth, the scheduled formal expiration of the rate setting structure governing hospital payment, without any agreement on its successor, left all parties with great feelings of uncertainty. A substitute was needed.

Fifth, two politicians and the fortunate confluence of events contributed to Chapter 23's passage. Sen. Patricia McGovern, chair of the Senate Ways and Means Committee, advanced a proposal for health insurance for the "working poor" late in the winter of 1987. This was about six months before the state's law governing hospital finance was to expire, and about thirteen months before Gov. Dukakis won the New Hampshire Democratic primary.

As Sen. McGovern and members of the legislature's Health Committee advocated broad health insurance provisions and married them to a new hospital finance law, and as the governor's campaign flourished, his refusal to take a position on universal health insurance was criticized. He finally agreed to draft his own proposal. It relied little on increased state funding. It sought to placate business by limiting the rate of increase in hospital revenues. It sought universal access by requiring employers to cover their workers or pay a tax.

In sum, the proposal gave hospitals less than they believed they needed, and asked many businesses without insurance to spend more than they wanted or thought they could afford. Through the fall and winter of 1987-1988, Sen. McGovern negotiated with hospitals, businesses large and small, the administration, and access advocates. She put together a package that could squeak through both House and Senate, with the support of a leadership anxious to help the governor's presidential campaign.

Sixth, because no party was willing and able to fight for effective cost control, an issue that could have jeopardized consensus was taken off the table.

As a result of all this, hospitals got more money, some of it promised by the state; costs of smaller businesses' workers' coverage were borne entirely by the state; and implementation of the universal access requirement was deferred until 1992. The promise of more state money for hospitals and access was the glue that bound the law together. Even then, some worried that the law's access or hospital finance provisions were too costly to various parties, while others feared that hospitals were not getting enough money to cover their costs.

III. ACCOMPLISHMENTS AND PROBLEMS

Introduction

The law's access provisions are widely believed to be in trouble. Some observers in other states consider the entire law to be "moribund." This is surprising, since the access provisions have not yet been implemented to any substantial degree.

The state's inability or unwillingness to appropriate promised funds, in combination with hospitals' growing financial distress, is the main source of the perception that the Chapter 23 compromises are becoming unglued. Hospitals are angry at the state's apparent unwillingness; they are deeply worried about the financial consequences. Promised money includes $50 million yearly in "Medicare shortfall" funds, to make up for the asserted failure of the federal Medicare program to increase its payments to hospitals rapidly enough to keep pace with inflation. Some of this money was in the state's 1989 budget, but the governor has refused to release it.

Both hospitals and access advocates are similarly upset about the possibility that no state funds will be appropriated for fiscal years 1989 and 1990 to meet the state's obligation to the uncompensated care pool.

In March of 1989, hospitals responded to the governor's failure to request these funds in his 1990 budget by seeking the money directly from the legislature. An amendment to this effect to the House budget for state fiscal year 1990 lost overwhelmingly, largely because it would have raised the state deficit. Hospitals then argued that, since the state was failing to meet its obligations under Chapter 23, hospitals should not be bound by it either. They sought the right to charge their private (non- Medicare, non-Medicaid) patients whatever they wished, and to uncap the private sector's obligations to the free care pool. This amendment lost only by a tie vote.

Are the law's problems associated with its design, with the mechanics or politics of its implementation, or with forces external but relevant to it? Probably, all are at work. The most serious immediate problem is the state's budget deficit, the causes and duration of which are difficult to determine, and which seems hard to remedy through increased taxes (in part because it was an increasingly unpopular governor who requested those taxes). Moreover, when the governor called for higher taxes, he did not request the money needed to implement the promises made to hospitals, or for access, in Chapter 23.

But it seems premature to declare so complex and ambitious a law moribund, especially well before any of its central access provisions have been implemented. If it is feared that the means adopted by the law are not likely to be affordable, we must choose between abandoning the goal and changing the means.

Similarly, the law was written as if there were no need to make trade-offs. The reverse is true. Money spent to finance hospitals' services to their already-insured patients is not available to improve access for citizens lacking coverage.

If we are far sighted, the law's early difficulties (whatever the causes of the budget deficit that highlighted those difficulties) will inspire us to examine its provisions and seek methods of satisfying at once the legitimate claims of uninsured citizens, payors, hospitals, physicians, and other caregivers.

A. Access

The early implementation of Chapter 23's access programs calls attention to many of the issues that will be faced in 1992, when all citizens of the Commonwealth are entitled to health insurance. These issues include the adequacy of private insurance benefits, the resistance of various groups to spend the money needed to purchase appropriate benefits, the very different needs of different sub-groups within each population, the appropriate design of out-of-pocket payments and insurance premiums (to promote access to appropriate care), problems of adverse selection of costly patients into programs willing to insure them, and whether traditional insurance is a workable mechanism for financing universal access.

Special populations. The CommonHealth programs (CH), run by the Department of Public Welfare (DPW), are the major new insurance coverages offered in Chapter 23's first year. DPW succeeded in designing policies and procedures for four new programs in 10 weeks, from the signing of the law to the start of state fiscal year 1989, when enrollment began. This was a major achievement; it should not be overlooked.

DPW set itself a goal for first-year CH enrollment of 25,000, with specific targets for each program; in March, CH had 13,000 enrollees. These enrollment targets were formulated early, with little information. Staff are now developing 1990 targets, attempting to determine more accurately the size of the potential populations that are eligible and in need.[14]

With a goal of enrolling 2,000 disabled adults and over 1,000 disabled children in fiscal 1989, DPW has, through February, enrolled just 366 and 200, respectively --20 percent or less of the annual targets.[15]

Outreach has been somewhat limited, with planned massive mailings slowed by inadequate administrative resources. Department staff and advocates believe that lack of information is a key reason potentially eligible citizens have not enrolled, and stress the need for expanded marketing efforts.

The state should not take sole responsibility for outreach problems. While the state has legal responsibility, Chapter 23 has been described as a public-private partnership, and hospitals have refused requests to inform their employees and associated physicians about the CommonHealth programs through an organized campaign. The Massachusetts Hospital Association has, for example, declined an offer from the Health Care for All Coalition, a consumer advocacy group, to prepare informational materials.

To learn more about these problems, CommonHealth staff are conducting a survey and marketing effort, re-contacting a sample of those who sought information but did not enroll in the program for disabled adults. DPW has also planned a client satisfaction survey, but it has been delayed by budgetary constraints.

One early reform, in December of 1988, has been to reduce premiums for the two disabled programs, and to eliminate them for enrollees below 200 percent of poverty. The impact of these changes is just beginning to be seen in increasing enrollments.

People involved with CH are also exploring the appropriateness of the definition of "disabled" being used. Does the federal Title XVI definition exclude some of the intended population-- those who are unable to obtain adequate insurance coverage and are held back from working because of need to retain Medicaid?

One important policy decision recognized the burden of pre-existing condition exclusions; under regulations adopted in December, when employer-sponsored insurance has pre-existing condition exclusions, disabled adults are no longer required to purchase that insurance before buying CH coverage.

But advocates for the disabled note a key outstanding scope-of-benefits issue, the need to cover transportation to medical appointments. The Health Care for All Coalition and other consumer advocates are also very concerned about plans to begin requiring co-payments in the two disabled programs. Lower income persons facing co-payments tend to defer care; it seems highly inappropriate to raise such barriers for a population with recognized, serious, and continuous health care needs.

Persons eligible for CommonHealth now include an estimated 4,000 to 4,500 of the women delivering babies annually in the past under DPH's Healthy Start program. That should translate into an average of more than 300 new enrollees monthly, but analysis of preliminary data from CH indicates that in the best month for new enrollment since July 1988, CH enrolled at most 200 pregnant women.[16] It seems possible that up to 40 percent of the population in need of service-- and that had previously been served by the state's Healthy Start program-- is being lost to the state's maternity care programs. Agency staff observed, however, that some of these women, once referred to DPW, may find that they are eligible for cash assistance (AFDC) and thus for Medicaid. In that case, they would not be counted in the CH case load.

Chapter 23's extension of Medicaid to pregnant women up to 185 percent of poverty (at this writing, 185 percent of poverty is $14,292 for a family of two) was important for access, because Medicaid benefits are more comprehensive than those of the solely state-funded Healthy Start program. But any diminished enrollments of pregnant women could undercut this gain. Seeking to prevent this backsliding, the Massachusetts Healthy Start Coalition has noted that DPH's client assistance policies for Healthy Start were superior to those at DPW. Prenatal care advocates have identified DPW policies and procedures which serve to delay enrollments. Recognizing the importance of timely coverage, DPW has now begun measures to revise some of these policies.

The first year's reasonable goal of enrolling a total of 4,000 infants under age one in CommonHealth also implies a need to enroll over 300 per month, on average. Preliminary DPW data show that only about half that number enrolled in December, the best month so far. More attention clearly must be paid to outreach to this vulnerable population, as well.

The welfare-to-work group is the largest within CommonHealth, with over 6,800 individuals enrolled at the end of February. It expands on a previous DPW program that rolled over 2,800 individuals in July of 1988. DPW's goal was to cover 12,000 individuals or 4,000 families by 1 July 1989. A subsidiary program, called "CommonHealth Assist," was created through an amendment to Chapter 23, passed with the fiscal 1989 budget. It recognized that those citizens returning to work from welfare whose employers offer unaffordable insurance are as deserving of DPW subsidy as those whose employers do not offer any insurance. (The Department of Medical Security, on the other hand, has not yet acknowledged this problem, which may be a widespread one, in its own programs.) While CH Assist is potentially important for access, consumer advocates are concerned that even the DPW-subsidized sliding premiums are too high, especially for those whose employers contribute nothing.

Welfare-to-work enrollees who sign up for HMO's get more comprehensive coverage, including medications, than those who use fee-for-service insurance. This emphasis on managed care has problems. For one, it leaves at a disadvantage those clients who live in parts of the state where managed care is not available.

Consumer advocates have found CH planning staff fairly receptive to the needs of these special populations. On the other hand, welfare office staff around the state are apparently still confused by this admittedly complex and unfamiliar patchwork of new programs. Many of CH's inclusive policies run counter to those of the past; a new type of effort may be needed. One perhaps ironic advantage of CH's presence in DPW is that, because many standard Medicaid procedures have presented barriers to access, developing more "user-friendly" policies for the CH programs may set precedents helping to improve access for Medicaid as a whole.

Some have considered reorganizing all access-related programs or moving them into DMS. For now, it seems to make sense to retain CommonHealth in DPW, because that agency has the financial and managerial capacity to run it. It also appears desirable, for now, to retain the residual Healthy Start program in an agency, the Department of Public Health, where it is working well.

Despite its limitations, CommonHealth is already helping people who had no health insurance before, or who had not been able to work and retain adequate medical coverage. The CommonHealth programs for disabled children and working adults, in particular, represent important first steps in expanding access to new groups. Although their numbers are small so far, the complexities of launching ambitious new programs are at least partly to blame. As outreach expands, more enrollees will doubtless find these programs valuable.

All possible sources of enrollments lower than expected should be examined. These could have included overly optimistic goals; stringent application and eligibility certification processes; premiums that are too high; confusion and lack of adequate promotion from local welfare staff; inadequate financing for marketing; state government's relative inexperience with marketing combined with hospitals' refusal to cooperate; and the inherent difficulty of decisions to return to work, or change insurance status. Other possible issues are reluctance to participate in DPW programs, and the adequacy of services for those with specialized needs. Advocates are also becoming concerned about the rigor of disability determinations, especially for children.

Measures must be taken to address enrollment shortfalls in all the programs, but the program for pregnant women is of particular concern, because any shortfall there represents a worsening of access for pregnant women since Ch. 23's passage.

Students. The Department of Medical Security is charged with ensuring that students enrolled at least three-fourths time in Massachusetts universities and colleges have health insurance by September 1989. In several respects, the approach DMS has taken to this program is comparable to that used for the broader phase-ins of insurance coverage for all, and is suggestive of the agency's overall outlook.

Working with the state Board of Regents of Higher Education, the Association of Independent Colleges and Universities, and insurors, DMS developed "Basic Guidelines." These were released in February, 1989, and set out anticipated minimum benefit standards in time for schools to pursue contracts with insurors. By late spring, the Department plans to issue formal regulations, which will define what level of coverage in a parental policy, for example, is sufficient to permit waiving coverage through the school plan. DMS recognizes that obtaining comments on the regulations from students will be important.[17]

Preliminary Board of Regents data indicate that 36 percent of public college students sign up for school insurance now. Some students, though, are probably over-insured through overlapping parental coverage, while others lack any coverage. Private college students may be more likely to have parental coverage.

Of colleges offering health insurance now, many have very skimpy policies. Some of these schools urged DMS to grandparent in existing policies, merely mandating an undefined level of insurance.

DMS defined a low floor for the minimum benefit package for the 1989-1990 school year, but has announced its intent to raise the minimum in the future.[18] The anticipated cost of the minimum package is $200-450 per student. (A school that runs a good health service can keep insurance costs down, but this may merely shift costs from "insurance" to tuition or fees, since the latter pay for the college health services.) Even at that level, DMS staff realize, affordability will be an issue for many students.

The minimum benefit package allows 20 percent co-insurance for most services, with added deductibles or co-payments for outpatient care -- though just $10 for physician visits. A school with a reasonably comprehensive student health service may manage care, provide referrals, and have higher co-payments or exclude unauthorized outside care, except emergencies. Policies may cap benefits at $25,000 per illness or accident and $1,500 for any pre-existing condition (one present within the six months preceding enrollment).

In setting the minimum standards, DMS staff say, they were reluctant to create access barriers by allowing even this level of co-payments, but also were very concerned to keep premiums down. They also had hoped to mandate more generous coverage of pre-existing conditions, but that would have substantially raised premium costs. Requiring higher maximums per illness or injury is a DMS priority for the expanded benefit package for the following year; this would be important both to aid students most needing insurance -- those facing catastrophic costs -- and to reduce the burden such costs will otherwise doubtless put on the hospital uncompensated care pool.

In this program, as elsewhere, DMS staff emphasize the need to learn more about utilization patterns and the market for this insurance, and thus express reluctance to set hard-and-fast policies too soon. DMS aimed to build on what is offered now in student plans, staff say, and to avoid asking insurors to do too much that is unfamiliar.

As in the design of the health care for all phase-ins, DMS plans to employ traditional insurance industry products and policies, including allowing pre-existing condition exclusions. Within this framework, DMS staff understandably see a need to balance access and affordability for policies students must purchase on their own. But in attempting to design an insurance package affordable for students and to assure ready access to primary care, DMS may serve least well some of those students most in need of insurance coverage -- those with pre-existing conditions or whose costs become catastrophically expensive. These efforts to lower premium costs will necessarily result in either failure to guarantee needed access or in placing additional demands on the free care pool.

B. State management and financing initiatives

Progress in this area is mixed. The language in the law and in several regulations supports protection or even improvement in access to care. But these written statements do not seem to be complemented adequately with money. This theme is illustrated in two areas, in financing and managing the hospital uncompensated care pool, and in financing uncompensated care for community health centers.

The uncompensated care pool. As noted earlier, Chapter 23 caps private sector uncompensated care obligations and promises that state government will appropriate funds needed to pay free care and bad debt costs. The governor has refused to ask the legislature for the money to meet the state's obligation to the uncompensated care pool for 1989 or 1990, saying that hospitals' bad debt write-offs can be curtailed through better management. This seems to mean spurring hospitals to collect more money from patients deemed able to pay. If such management efforts fail, and if the state refuses to make good on its promise to pay for pool increases, and if hospitals cut down on care that the pool has financed in the past (because they fear under-payment), levels of care for citizens vulnerable to access deprivation may actually be lower under the law than before it was passed.

According to state estimates, some $30 million in state funds would be needed to pay for uncompensated care that has been or will be provided in fiscal years 1988 and 1989. Only $1 million has been approved by the governor, although the legislature appropriated $8.5 million. Hospitals estimate that some $77 million will be required for fiscal years 1988 through 1990. Money for uncompensated care finances improved access. If the state cuts back, and hospitals respond by reducing uncompensated care, access suffers. If hospitals maintain their effort, they are hurt financially.

DMS administration of the pool shows the same mixture of some provisions tending to improve access and others tending to harm it. Under earlier uncompensated care regulations,[19] a hospital that chose to serve a low-income citizen was obliged to consider that service "free care" if the patient's income was at or below 100 percent of the federal poverty line. Between 100 and 200 percent of poverty, the hospital had the choice of considering the service as partly free care and partly bad debt, with the bad debt share rising with patient income. Above 200 percent of poverty, the hospital could consider the service as free care in the event of "medical hardship."

DMS has now promulgated new regulations governing uncompensated care.[20] These liberalize the definition of free care by reducing hospital discretion about the income that qualifies a patient for free care. (Hospitals are still not obliged to serve anyone except in an emergency.) Now, all uncompensated care provided to patients with incomes at or below 200 percent of poverty is free care, not subject to collections efforts. The regulations fail to further specify how medical hardship is to be determined, but only require that hospitals include those procedures in their credit and collections policies.

If uninsured patients in need of care who fall below the 200 percent of poverty income ceiling know this rule, this change should make it easier for them to seek service. They would know in advance that they could be served without charge if a hospital agrees to treat them. It is not clear that many patients will be able to take advantage of this provision.

In other respects, the regulations seem to provide fairly good formal protections to lower-income uninsured citizens who seek needed health care from hospitals. For example, if a hospital wishes to refuse to serve patients "solely due to financial considerations, its Credit and Collections Policy shall specify the policies and reasons for deferral or rejection, and the clinical approval or acknowledgment of such deferral or rejection shall be documented."[21] If hospitals prepare and follow such policies, with DMS encouragement and supervision, they and their associated physicians would be asked to indicate general guidelines and specific reasons for refusing to treat people who could not pay. This visibility and scrutiny could make it more difficult for needed care to be refused.

We believe that access would be even better protected if DMS were to promulgate regulations clearly governing both determination of medical hardship and circumstances under which hospitals could refuse to provide needed care. Patients and their advocates need to know their rights. It is hard to learn an individual hospital's policies in advance of seeking care, when 100 hospitals make their own judgments. Confusion results when policies are not clear, publicized, or even known by hospital administrators, front-line staff, and physicians.

Medical hardship could appropriately be offered at incomes as high as 300 or 400 percent of poverty, for example to patients denied health insurance because of medical underwriting-- because they were likely to need costly health care.

Access to appropriate care would be improved further if hospitals were assured that the pool would finance the care that was given. Unfortunately, it is just in this area that the administration's unwillingness or inability to request funds to meet the state's uncompensated care obligation could prove to be self-fulfilling. The administration has said that management of the pool will obviate a state appropriation for state fiscal years 1989 or 1990.

DMS has been told to manage the pool by setting goals for hospital collection of bad debts. Hospitals that fail to collect on bad debts up to the state's expectations will bear the loss. Hopes of saving pool money by pressing hospitals to collect bad debts rests on several premises. One is that most uncompensated care-- 60 percent, by some estimates [22]-- is bad debt, much of which could be paid by patients if they only wished. Some of the 60 percent will be reclassified as free care when the free care ceiling is raised to 200 percent of poverty. There is no evidence on the distribution of the remainder of the bad debt by patient ability to pay. Collection efforts could have an unintended effect of deterring lower income patients in need of care from seeking service. In practice, the real line between free care and bad debt is very difficult to draw, and even harder to administer in ways that are fair and protect access.

A second premise is that hospitals had often not worked very hard to collect these sums because they could more easily and at lower cost collect the same money from the pool.

What hospitals fear is that the state will set the standard for collecting bad debt to a level sufficient to remove the need for any state funds to pay for uncompensated care. And DMS has declared its expectation that "the total estimated liability of the pool to hospitals shall not exceed $318.5 million" for hospital fiscal year 1989.[23]

Perhaps not by coincidence, this sum is nearly identical to the capped private sector obligation to the pool, so hospitals may fear that DMS could use its regulatory power to make its expectation come true. Hospitals could feel it necessary to reduce the amounts of free care or bad debt they provide. This tendency could be reinforced by general fears that the state will simply refuse to meet its financial commitments under Chapter 23, already signaled by non-payment of the Medicare shortfall funds.

The governor has also signaled state policy in this area by declining to ask for state funds to pay-- as an employer-- its share of the private money flowing into the uncompensated care pool. This would have amounted to about five percent of the private sector obligation; consequently, this decision raises by about five percent the costs of the pool to all other employers providing health care coverage. By shifting state costs to business, this action reduces the benefit to business of Chapter 23's cap on private sector pool obligation. It exposes the weakness of the earlier business strategy artificially to cap their own uncompensated care obligations (by shifting costs to the state) without attending to the underlying sources of hospital cost increases.

The case of the health centers: where the dollars aren't. Massachusetts community health centers provide about 1,200,000 ambulatory visits yearly. This makes them a key resource for low-income and uninsured residents. Many have begun cutting staff, rationing or eliminating services, refusing new patients, and fearing for their survival. Vital parts of this long-standing safety net of 56 health centers-- 29 licensed independently and 27 operating under hospital licenses-- are now in jeopardy.

The central problem is the state's failure to contribute promised free care funds for the independent centers. State budget decisions made in fiscal 1988 and 1989 will likely leave health centers worse off than in recent years, before the passage of Chapter 23, despite the relatively small cost of these vital guarantors of access.

On the surface, Chapter 23 appears to offer equitable treatment of independent health centers, on one hand, and hospitals and health centers operating under hospital license, on the other hand. The law states that, for independent health centers, "assistance for uninsured individuals ... shall be the amount provided in uncompensated care by the community health centers for the preceding fiscal year." However, the entire amount is subject to appropriation. By contrast, hospitals' and their affiliated health centers' uncompensated care costs are largely covered by private sector pool surcharges (and would be fully covered if the state met its commitment under Chapter 23).

For free care at independent health centers, the state had appropriated $2.9 million in fiscal 1987 and $1 million in fiscal 1988-- sums that fell well short of prior years' actual free care levels. But the situation is now far worse. Despite providing about $6 million in free care in FY 88 and the same sum in FY 89, independent health centers received no retrospective free care reimbursement in the state's fiscal 1989 budget. The fiscal 1990 budgets proposed by the governor and House eliminate such funds again. Shortly after the governor's fiscal 1989 budget veto of $1 million in health center free care funds last summer, the administration said it was looking "quickly and thoroughly at other funding sources," but these have never materialized.[24]

A package of human service "survival amendments," offered to the 1990 House budget, aimed to earmark $6 million in phase-in DMS funds for health center free care. It was defeated overwhelmingly. The Department of Medical Security has been discussing a managed care project for uninsured patients enrolled at community health centers, which depends on state appropriations. DMS originally requested $3 million in fiscal 1990 for the effort; funding is now uncertain.

Community health centers have also suffered cuts in a Department of Public Health grant program and in state funding for technical assistance. Rising salaries required to recruit and retain physicians and nurses have further squeezed their budgets.

The $6 million free care funding shortfall represents roughly 20 percent of the cost of services provided by independent centers in fiscal 1988. If not funded, this will mean 150,000 visits that these sites will be unable to provide in the coming year-- 13 percent of all community health center visits in the state.[25]

Since the fiscal 1989 veto, seven centers have had to lay off translators, social workers, outreach, and other staff who are essential to their mission, but whose costs are not directly reimbursable. A recent telephone survey by the Massachusetts League of Community Health Centers found that, in the first seven months of fiscal 1989, over one-third of the independent centers have cut sessions, or limited or closed enrollment for some services (particularly obstetrics, AIDS, mental health, and alcohol services). Intake of new patients has been slowed at many centers, and closed altogether at one. Patients must wait weeks longer than formerly for appointments at many sites. More than half have implemented hiring freezes; all have salary freezes; and all are planning future lay-offs.[26]

Jackie Jenkins-Scott, then president of the League, reported in June 1988 on a survey of Massachusetts health centers that found one-third of the internal medicine positions vacant, along with one-fourth of the obstetrics posts and one-fifth of those in pediatrics.[27] The League notes that lack of funds makes centers even less able to attract physicians today.

Among the 29 independent health centers, eight are actively pursuing hospital licensure, because of their need for free care funding. Seventeen say that, unless free care funds are approved, they will have to close, obtain hospital licenses, or make major service cuts within the next three years.[28]

On another front, hospital-licensed health centers are concerned because the House accepted the governor's budget proposal to reduce Medicaid rates for out-patient departments (by which those health centers are paid) to the apparently inadequate community physician provider levels. Survival of some of these centers could also be threatened, especially if such cuts occur abruptly.

The state is contemplating reducing these rates out of a belief that Medicaid patients should be receiving care in lower-cost settings. In the abstract, this is appropriate. But it is by no means clear that adequate non-health center, non-outpatient department physician care is available in practice to many Medicaid patients. Cities like Lynn and Lawrence, for example, seem to face serious shortages of private practice primary care physicians, especially in lower-income neighborhoods. When health centers and outpatient departments are lower income citizens' only real sources of physician care, it is wrong to under-pay them just because a hypothetical alternative is cheaper.

The combination of Medicaid fee reductions and threatened state failure to finance the uncompensated care pool adequately may lead some hospitals to refuse requests of currently unaffiliated health centers to come under their licenses. The hospitals may fear that they will be unable to absorb any associated losses.

While saving state dollars, the reductions in health center funding are short-sighted for the health care system overall, as they will raise system costs, even in the immediate future, in several ways. They force community health centers desperate for free care funds to seek hospital licensure, which will require payment for health centers at the higher hospital rates. They reduce the capacity of low-cost providers, which will encourage or oblige use of costlier sites. And they limit physical and financial access to care for high-risk populations, thus aggravating illnesses, which could become more expensive when and if eventually treated.

In contemplating reduced financing and service levels of health centers, it is important to recall that the admonition, "first, do no harm," applies to more than individual treatment decisions in medicine. It applies also to the delivery of care.

Should health center free care levels decline in fiscal years 1989 and 1990, this could give the impression that the books have been balanced, and that health centers don't need special free care appropriations. Such an impression would probably be false, as the books would have been balanced by reducing service levels.

C. Preparing for Health Care for All

DMS has the primary responsibility for creating universal access to health care. The new agency had a delayed start, because the Commissioner, James Hooley, was not designated until August 1988. And because the Legislature chose not to exempt DMS from any of the state's personnel or budget rules, it has experienced delays in obtaining approvals for and filling new positions.

It is all the more impressive, therefore, that by February of 1989 the agency was able to issue a detailed and thoughtful request for proposals (RFP) for the mandated phase-in initiatives.[29] (The RFP includes both an appendix information relating to the uninsured and a bibliography.)

The RFP is an important document. It sets forth the department's view of the trends in small group health insurance and contains a number of basic decisions that are likely to be precedents for any permanent system of universal coverage that may evolve from DMS's work. It is commendable that DMS has spelled out its policy position and has issued a Request for Information, but the best course would have been for the department to have put its policies into regulations and held a public hearing before issuing the RFP. For example, such decisions as to set sliding scale premiums in relation to a non-group enrollee's income, without regard to assets, or to require as a condition of eligibility that small businesses must contribute 70 percent of the purchase price of insurance are matters of agency judgment which will have broad effect. Only by following the regulatory process could DMS have assured that all those affected by its policies could have made their views known.

DMS sees the small group insurance business as being in an "underwriting death spiral," as only the poorer risks remain in community rated groups, and insurers grow ever more selective about what community rated business they will write. DMS sees individual ("non-group") products as being in much the same position, with a limited market, use of medical underwriting to screen out poor risks and, in the case of Blue Cross/Blue Shield, lengthy waiting periods and a three year exclusion of coverage for pre-existing conditions. DMS's analysis parallels the thoughts of those in the insurance community who assert that the markets for non-group, small group, and even many medium-size groups are becoming "dysfunctional."

The remedy proposed by DMS is to replicate as much as possible existing insurance practices, but by the use of subsidies, to make health insurance more affordable and also more attractive to low risk enrollees, thereby reducing costs. The RFP does say that the department has a preference for lower cost plans, but its reliance on subsidies and spending contrasts with the emphasis that Chapter 23's language places on actual cost containment. Insurors are not challenged to design and market innovative plans that offer promise of strong cost reductions or containment. The department's emphasis upon the tried-and-true is certainly understandable, but in what the RFP describes as a marketplace of "high and rapidly increasing costs," a business-as-usual approach runs the risk of incurring unacceptably high costs.

DMS plans to offer several types of subsidies, including one enabling individuals to pay a premium based on income and family size. The administrative costs of groups of fewer than 25 employees will be subsidized down to the level of larger groups. DMS will also enter into risk sharing agreements with companies insuring under-25 groups, including provision of stop loss coverage for pre-identified individuals whose health conditions would generally make them uninsurable.

Because of its offer to pay the costs of most who are otherwise uninsurable, DMS can claim that its phase-in initiatives meet most of the universal access requirements of Chapter 23. But the RFP permits companies to continue to use underwriting practices which will still bar assured access to those in need of medical care. Pre-existing condition exclusions and waiting periods are permitted. The RFP states that the department will evaluate such underwriting restrictions in part on "whether on the whole such restrictions can be viewed as a reasonable balance between affordability to the state and subscribers and greater access to coverage." This approach will be a familiar one to the insurors. By permitting them to reduce risk by the use of traditional underwriting practices, it will increase the likelihood that they will submit proposals. But this policy is not in accord with the purpose of Chapter 23. That act charges DMS with the task of achieving the goal of universal access to health care. Chapter 23 specifically recognizes that affordability and industry practices are the bars to access to health care. By continuing to rely on these restrictive industry practices and by continuing to use "affordability" as a justification for denying health insurance coverage, DMS is assuring that the goal of universal access to health care proclaimed by Chapter 23 will remain unattainable.

Similarly, DMS's intentions will be measured by its policies on premiums, co-payments, and deductibles. If these are set too high, they will discourage uninsured citizens from buying policies that are ostensibly available to them.

One of the distinguishing features of the RFP is that it will require all enrollees, both group and non-group, to fill out health statement questionnaires. This information will undoubtedly be useful to DMS and will be necessary if the department is to subsidize the health risks of individual enrollees. However, it also raises concerns about confidentiality, which are not addressed in the RFP. The RFP is silent about the industry's authority to require blood tests. If such tests are allowed, DMS should adhere to the policy of the Dukakis administration that HIV blood tests are not to be used.

Although the RFP was a major task of DMS, the next step in the process is likely to be even more challenging. The subsidies provided for in the RFP will need to be negotiated separately for each proposal. The ultimate premium level and cost to DMS will rely on agreements on specific medical conditions and claims projections; it is likely to be a repetitive, difficult and time-consuming process. And until it has been completed, DMS will not know with certainty how many enrollees it will be able to include in the phase-in program.

Certain issues raised by the law's structure will benefit from continuous monitoring in the future. First, will benefits be generous enough, and premiums and out-of-pocket payments affordable enough, to encourage lower-income uninsured citizens to elect insurance coverage once it is offered by their employer or by the state? Data cited by DMS in its request for proposals for the phase-in demonstration projects indicated the seriousness of this problem. A 1987 study by the Service Employees International Union found that almost half of uninsured workers earning below $10,000 per year had rejected health insurance coverage their employers had offered.[30] It is to be hoped that DMS will consider the problems of low-income workers who are unable (because of high premiums, low incomes, or both) to purchase insurance from employers who already offer it.

As noted earlier, similar issues have been encountered in CommonHealth initiatives. Moreover, affordability is far from the only barrier to taking advantage of benefits. Witness the substantial number of lower income citizens eligible for Supplementary Security Income (SSI) who fail to enroll for this important benefit-- one that is more than free: it provides cash.

Second, Chapter 23 permits continued experience rating by health insurors, including exclusion of coverage for pre-existing conditions. This and other means of creaming better risks make it likely that the state will be obliged to finance health insurance coverage for the most costly patients. The "underwriting death spiral" just mentioned suggests this problem will only grow. (One recent example is Blue Cross's recent request for a 45.6 percent increase in rates for non-group subscribers.[31])

Should this problem grow, it will raise questions about the adequacy and fairness of benefits and financing when public and private health insurance are mixed.

Third, the second problem could compound the first. That is, if more costly patients become the state's obligation, the state could respond by cutting benefits or raising out-of-pocket payments and premiums-- to lower state obligations to all patients, drive away costly patients, and raise revenue. If DMS did this, fewer lower-income patients could afford insurance and fewer would elect it, unless they expected they were especially likely to use the benefits.

We believe that DMS is unwise is excluding those with incomes higher than 300 percent of poverty from its phase-in demonstrations. Apparently, this stems from a fear that high-risk (high-cost) individuals would then seek coverage under a phase-in. This policy fails to respond to the very underwriting death spiral that DMS identifies, and it prevents DMS from learning the costs of insuring one of the populations most in need of coverage.

These issues lead to further and more basic questions about the role of insurance as a mechanism in providing and financing universal access to affordable care. On the delivery side, insurance entitles individuals; it does not itself compel cost control or clinical trade-offs. Such provisions must be added on, at additional administrative expense-- added, that is, to the high initial costs of basic administration of insurance benefits in health care.

On the financing side, insurance raises money by grouping similar individuals. This act, experience rating, means that those more likely to need and use more costly care must pay more. The response must be manifest subsidization from public funds, subject to the uncertainties of annual appropriation, if care is to be affordable by people who cost more to serve. This contrasts with the less visible but equally necessary cross-subsidization under community-rated insurance or tax financed care. If people who are costly are to get care, someone must pay.

A more immediate and basic concern is DMS's financial and human capacity to do its many demanding jobs. DMS has accomplished much with extremely limited resources. But if it is to be successful in implementing the RFP and all facets of the phase-in initiatives, creating an information system, and responding to uninsured citizens' questions, it must have a substantial increase in its budget. Governor Dukakis requested $3.2 million for DMS administrative funding for fiscal 1990, to permit hiring 23 more staff. But the House budget allowed only $1.3 million for administration, insufficient even to annualize the agency's fiscal 1989 staff, which is authorized to reach 20 positions.

Yet the diverse tasks facing DMS will expand rapidly in the coming year, to include: 1) implementing the phase-in programs for small businesses and individuals who lack insurance, and expanding them as funding permits; 2) monitoring compliance and managing utilization of the uncompensated care pool; 3) implementing the mandate on colleges to have students insured in September; 4) conducting on-going studies of the uninsured and of the effectiveness of DMS initiatives; 5) working with the Department of Employment and Training (DET) to begin coverage for people receiving unemployment compensation in April; and 6) administering a fund (also with DET) to help relieve hospital labor shortages (a fund which may presently be on hold because it depends on an assessment on hospital revenues that state officials are apparently reluctant to make).

Without additional staff and funds for outside contracts, the agency will find it very difficult-- perhaps impossible-- to discharge even minimum responsibilities in these areas. And little can be sacrificed without seriously harming current access or chances of expanding it in the future. Study of the phase-in efforts, for example, is essential to provide data for imminent planning tasks. It would be a shame if Chapter 23's access provisions were perceived to have failed when the real problem was that they had not been given a full chance to succeed.

D. Hospital Finance Provisions

Conflicting truths. There are two conflicting truths about Massachusetts hospital financing in general. The first is that increasing numbers of our hospitals are experiencing financial distress. The second is that our hospitals are the most costly in the world. The second truth makes it more difficult to address the first by providing more money.

The United States spends more money to provide health care to fewer citizens than any other industrial democracy. We also suffer inferior health outcomes.[32] In 1988, this cost about $540 billion, or about $1.5 billion daily.

By contrast, even after the military spending increases of the past eight years, we spend almost 60 percent more on health than on defense (both sectors are as defined somewhat narrowly in federal budgets and national accounts).

How do other nations do better with less? Do they prevent illness? Probably not. Smoking and drinking seem more common in Europe than here. Intense industrialization there probably means more serious environmental threats to health.

Do they save money by keeping people out of the hospital? No, patient-days per capita are much higher in Western Europe and Canada.

The answers lie mainly in more intelligent use of resources. Because hospitals elsewhere typically have constrained budgets (or something similar) but unconstrained obligations to serve all citizens, they and their physicians must make clinical trade-offs-- making care available according to need and clinical efficacy, not ability to pay.

The hospitals' view. At this writing, it seems that the major source of hospital discontent with Chapter 23 lies in the inability or unwillingness of the state legislature or administration to appropriate or spend funds promised under the law.

The first problem facing hospitals concerns the Medicare shortfall funds. Chapter 23 promised hospitals $50 million annually for four years to offset failures of Medicare payments to keep pace with hospitals' own costs. The governor approved but has not yet released $37 million of $50 million that the legislature voted for this purpose for state fiscal year 1988. Hospitals were to be paid $50 million in both 1989 and 1990, but the governor did not request this money and the 1990 House budget does not include it.

The second problem concerns the state's obligation to the uncompensated care pool. About $77 million is estimated by hospitals to be needed for this purpose for fiscal years 1988 - 1990. The legislature voted $8.5 million for 1989; all but $1.0 million was vetoed by the governor. The governor has sought nothing for 1990; the House added nothing.

(A third problem, separate from Chapter 23, concerns disputes between hospitals and the state about Medicaid payments from past years.)

Although the Medicare payments can be categorized as new money for hospitals' already insured patients and the uncompensated care payments as new money to improve access, as we have used these terms in this report, both affect hospital bottom lines. This is clearly true in the first instance, and will be true in the second if hospitals incur uncompensated care expense which is not paid by the state.

The Massachusetts Hospital Association (MHA) has argued reasonably that Chapter 23 embodied a political deal, and that the Commonwealth should keep up its end. In total, some $180-214 million in Medicare shortfall and uncompensated care funds will apparently be owed hospitals for fiscal years 1988 through 1990. Assuming total hospital expenses of $15,700,000,000 for these three years, the under-payment would amount to 1.1 to 1.3 percent of expenses.

Hospitals have asserted that they need the money because their finances are deteriorating. The MHA is said to be about to launch a dramatic state-wide television campaign for more money.

Hospitals have been demanding full funding of Chapter 23's commitments or, failing that, deregulation of charges, to allow them to raise the money they believe they need from private sector (business and employee) sources. It has been said that hospitals are now considering demanding deregulation of charges even if the Chapter 23 promises are fully financed by the state. If so, this would mark a new and somewhat extreme hospital position, that even the level of increased revenues offered in Chapter 23 is not adequate.

The MHA offers several points in support of its positions that hospitals are suffering financially, and that they have been controlling their costs.[33] First, hospitals' overall operating revenue fell from a surplus of 1.2 percent in 1986 to a deficit of 1.4 percent in 1988.[34] In 1988, 64 percent of hospitals suffered operating losses. When philanthropic and endowment revenues are included, hospitals fell from a surplus of 2.8 percent in 1986 to break-even in 1988 (no surplus or deficit). Half of the hospitals in the state suffered overall losses in 1988.

Second, the rate of increase in hospital costs in Massachusetts has been second-lowest in the nation for the past five years.

Third, MHA asserts that hospital employment declined by 2.7 percent in Massachusetts over the past five years while it increased by 3.0 percent nationally.

In summary, Massachusetts hospitals do seem to be suffering financial distress, even though they have been working hard to hold down the rate of increase in their costs. This seems to argue for higher revenues.

An alternative view. There is another view of this matter. First, hospitals throughout the nation face financial problems. In the eight-county Philadelphia area, for example, 25 of 57 hospitals (43.8 percent) are suffering overall losses.[35] In Massachusetts itself, although some hospitals are hurting, others are enjoying positive bottom lines. There is no agreement on whether some hospitals enjoy financial success is a consequence of tighter management, leaner physician practice patterns, accidents of reimbursement formulas, or other factors. Those who do well point to their own competitive virtues while those who do not do well point fingers.

Second, although Massachusetts hospitals apparently made no money overall in 1988, they did enjoy surpluses for at least the preceding seven years. Between 1981 and 1986, total hospital net income in Massachusetts was $601 million, in 1986 dollars.[36] Using the MHA's total surplus of 1.6 percent of revenue for 1987, and hospital revenues of $4.944 billion,[37] the 1987 surplus is about $79 million. Inflating both figures at 5 percent annually up to 1989 yields a total surplus of $783 million (in 1989 dollars) accumulated by Massachusetts hospitals during fiscal years 1981 through 1987.[38]

Where is that money?

Most likely, it has been spent for a variety of good purposes. But why was more of it not saved to buffer our hospitals from today's financial problems?

Third, there is the question of the level of revenue to which hospitals are entitled. When the Commonwealth is facing a deficit of perhaps five percent, and when many businesses are paring costs, how can they be expected to increase payments to hospitals-- when the latter are suffering deficits of perhaps one-to-two percent, on average? Medicare, which is responsible for so much of hospitals' slowed revenue growth, reduced its own price increases in response to past hospital profits and the continuing federal budget deficit.

Fourth, although the rate of increase in Massachusetts hospital costs has been very low for the past five years, there are at least two good reasons. One is the state's own regulatory structure of prospective payment controls, which has governed the rate of increase in revenues hospitals could enjoy. This spending-constraining system seems to have been partly successful. Though it does seem to have worked fairly well, hospitals should not take much credit for putting it into place. Had the state not instituted tighter controls on hospital revenues in the past, hospitals would be even more nakedly exposed than they are today to reduced rates of revenue increases.

Another reason for our hospitals' lower-than-average rate of increase in spending is that Massachusetts began the period with costs very substantially above the national average. In 1975, Massachusetts hospital costs per citizen were 49.9 percent above the U.S. average; in 1980, 40.7 percent above; in 1982, 37.8 percent above; and in 1987, 34.5 percent above.[39]

This raises the question of why so many in the state are contemplating abandonment of the present regulatory methods. Advocates of a more competitive method of hospital financing might well scrutinize the record and ask who is likely to benefit from deregulation. It is worth reiterating that hospitals enjoyed operating surpluses through 1987 and overall surpluses through 1988 under this regulatory structure, even though it allowed cost increases well below the national average, and even while it improved access to health care.

Deregulation may seem like a "quick legislative fix," because it quiets hospitals' public appeals for funds, at least temporarily. But business and worker outrage at higher health insurance premiums are just a step away.

So, arguably, is extreme hospital financial distress at the bottom of the next recession, if they are allowed now to raise their revenues to heights that are unsustainable in the long run. Friends of hospitals do them no favor by deregulating their charges.

Some hospitals will argue that they want only the right to raise their charges, that they will not take advantage of this right, because of competitive pressure. Those who make such arguments need to offer supporting evidence. It is hard to imagine why hospitals would fight to have their private sector revenues uncapped unless they planned or hoped thereby to raise revenues. It is unrealistic to assert that hospitals claiming financial distress seek only a hypothetical solution, one of which they could not use because of "competitive pressures" to offer discounts below posted prices. Hospitals must think that someone will pay the higher prices.

It is to be wondered how common price discounting actually is in Massachusetts today, with HMO's-- the main group seeking price discounts from hospitals-- accounting for fewer than ten percent of all hospital admissions in hospital fiscal year 1987.[40] It has been said that some hospitals have already sought from some HMO's prices higher than Chapter 23 allows.

Some say that our state's high hospital costs can be explained statistically and therefore justified. They cite, for example, a recent study by Robinson and Luft, who calculate that adjusted cost per admission in Massachusetts in 1986 was only 9 percent above the average of 43 states that have not pursued cost reduction through regulation or competition.[41] But this controls for "hospital-specific differences in local market structure, third party payor mix, patient mix, utilization levels, wage levels, teaching role, ownership status, and county-specific differences in physician density, patient density, and median family income." This analysis was designed specifically to remove the influence of many of the forces that statistically "explain" costs of hospital care per adjusted admission in order to isolate the role of prospective payment regulations or competition in different states. But most of these very forces must be retained and considered if we are to understand why, before and despite regulation, our hospital costs are so high.

Massachusetts was 51.7 percent above the national average in hospital outpatient visits per capita in 1987.[42] So some of the high cost of hospital care per citizen is attributable to a higher commitment to ambulatory care. (This may partly reflect deliberate state incentives to shift patients to outpatient settings.)

Some other factors that are often mentioned do not seem very important in explaining our high costs. Massachusetts is very slightly above the national average in beds per capita (2.8 percent above) and admissions per capita (4.1 percent above). Our average length-of-stay is substantially higher (11.5 percent above the national average), but longer stays do not usually add all that much to the real cost of care, other things equal, because patients receive few expensive services as they recuperate toward the ends of their stays.

More important, our rate of surgery is one-seventh above the national average (13.6 percent). Our citizens seem overall to receive more health services from more workers at greater cost than do patients in the nation as a whole. Our hospitals employ substantially more workers per citizen (35.7 percent above the national average) and also substantially more workers per patient admitted to the hospital (30.3 percent above the national average). By contrast, our hospital workers earn, on average, little more than the national average for hospital workers (5.2 percent above). With personal income in Massachusetts averaging about one-eighth above the national average,[43] and with high costs of living here, our hospital workers are relatively disadvantaged (assuming a job mix similar to the national average). Moreover, although hospitals claim that during one recent period, hospital employment in Massachusetts declined when it rose in the nation as a whole, other data show that between 1979 and 1987, hospital workers per capita rose by five percent nationally and by fully nine percent in Massachusetts.[44] It is important to make per capita comparisons, because the national population (and thus the need for hospital workers) is growing far faster than the Massachusetts population.

Fifth, it is the pattern of care in Massachusetts hospitals-- more than the needs of patients, teaching, or research-- that seems to explain the greater part of the cost difference. Wennberg and his colleagues[45] have found per capita hospital costs in Boston to be double those in New Haven, though both cities rely very heavily on teaching hospitals, and are similar demographically. Boston physicians admit more surgical patients with relatively minor problems, and more medical patients with diagnoses about which physicians tend to disagree regarding appropriate admission rates. Boston hospitals also employ substantially more workers per patient-day. It therefore seems that Boston's high spending is explained not so much by research, teaching, and tertiary care, but rather by an expensive style of clinical practice.[46]

It should therefore be possible to reduce Boston's level of service without cutting effectiveness of care. Even a modest narrowing of the differential between Boston's and New Haven's rates of hospital spending, extended statewide in Massachusetts, would be sufficient to finance Chapter 23's access provisions.

Support for Wennberg's findings comes from a crude comparison of the cost per admission and the number of workers per admission at Boston teaching hospitals and comparable hospitals in other cities. Four Boston teaching hospitals (Massachusetts General, Beth Israel, Brigham and Womens, and New England Medical Center) were compared with five major teaching hospitals in other cities (Yale-New Haven, Hospital of the University of Pennsylvania in Philadelphia, Columbia-Presbyterian in New York, Johns Hopkins in Baltimore, and Northwestern in Chicago).

In 1987, the Boston hospitals averaged $9,730 per admission and 19.2 workers per 100 admissions. The five non-Boston hospitals averaged $7,644 per admission and 14.4 workers per 100 admissions. Boston's cost per admission was 27 percent greater, and its workers per admission, 34 percent greater. All hospitals were tertiary teaching hospitals. If anything, those outside Boston were more tertiary and specialized, averaging almost 45 special facilities listed by the American Hospital Association. The Boston hospitals averaged almost 38 special facilities. A less crude comparison would control for case mix and severity differences, but this was not attempted here. Such work should be pursued, to provide better information on the sources of our state's high hospital costs.

In recent decades, Massachusetts has provided generous support for hospital expansion. No one is contemplating abandoning hospitals now. But we must find a way to continue the work begun under Chapter 372, the 1982 cost containment law. We need to decelerate our cost increases, so our hospitals don't fly through the windshield when their revenues crash into the next recession. Hospitals must be helped to respond positively to the diminished rate of increase in revenues they will inevitably suffer in coming years. This will make universal access more affordable. It will also help hospitals, and society, accommodate the costs of serving growing numbers of older citizens and patients with AIDS. Our hospitals' financial resources are great; they must and can be stretched wisely to provide the care our patients require.

E. Controlling Costs

The law's methods of controlling costs are not likely to be effective. Even if they were, the failure to integrate the cost controls with the access provisions means that any savings that are won are not readily available to be mobilized on behalf of universal access.

There is little reason to hope that closing beds-- or even entire hospitals-- will reduce costs. Empty beds cost very little when hospitals do not staff them.[47] Hospitals that have lost patients in Massachusetts appear to be smaller and to provide less costly patterns of care. If this holds true when controlling for case mix, total costs will rise when patients are relocated. Shepard has found that closing hospitals tends to harm access and increase costs.[48] McClure, an early advocate of bed closings and hospital closings, was aware of this practical danger. He observed in a follow-up to his original study (which endorsed closings) that "the most likely candidates for hospital closure" appear to be the very hospitals that "contribute relatively little to rising national hospital expenditures."[49] There is the added risk that Massachusetts, like New York City, will close too many beds, leaving us with a dangerous shortage. We should move cautiously and deliberately.

Closing beds or hospitals might save money, if overall use of hospitals is reduced, but there is no pressure or provision for this in Chapter 23. Rather, hospitals now have a large incentive to raise admissions: they are paid 100 percent of average cost for new admissions, a sum almost always in excess of the actual cost of new admissions, and they lose the same sum if they reduce admissions.

Even the hypothesized advantages of bed closings are difficult to realize if beds are not closed. The Acute Hospital Conversion Board, thus far, may be serving more to keep hospitals open by allowing them to raise their charges to private payors, than to grease the skids to an economical closing or conversion to non-acute care. Five of seven hospitals appealing to the Board have done so to seek higher charges to continue providing acute care. These increases have been granted, sometimes up to 15 percent.

Does the Board's action reflect a policy decision that closings are not a good way to save money, a recognition that closings can harm access, or the political power of hospitals and their communities to secure more money? Or have its actions been merely ad hoc responses, in the absence of policy? The Board faces a difficult-- if not impossible-- task in responding to hospital appeals, because of its lack of funding. Without a permanent and adequate staff, it is hard to imagine how the Board can function as the legislature intended. If the Board's actions reflect hospitals' political power, we may be witnessing an example of competition for winners and regulatory protection for losers. Hospitals have different needs and can appeal for more money on different grounds. Without a state-wide limit on hospital spending, each can make its case through competition (we are attracting patients), vital community service, a history of underpayment in the past, or any of a number of arguments. What is lacking is a sense of trade-offs, of limits, of goals. The state needs to act cogently and comprehensively on cost control and hospital financing. It is not yet doing so.

Chapter 23 proposes to rely heavily on managed care to limit the costs of universal insurance without harming access or effectiveness. The law's language on managed care appears to focus on the cost control aspect. DMS seems to be taking a different view of managed care, seeing it as a vehicle for promoting more continuous and appropriate services.[50] This is important, since application of managed care principles even by an established and well-regarded health maintenance organization may be harmful to the health of lower-income citizens.[51] Managed care may seek to control costs by raising barriers to access; this can seem easier or quicker than investing in the longer term hope of cost reduction through appropriate service. Early information, some of it anecdotal, about initial experiences in managing care for lower income patients in Boston suggests more reliance on paper compliance and regulatory barriers to care seeking than actual care management by responsible primary care physicians or other caregivers who know the patient. Managed care also plagues caregivers with irritating paperwork.

The central point here is that several motives merge in managed care. These include promoting entitlement to appropriate, early, continuous, and coordinated care; and saving money. The experience in recent decades shows that when different motives merge to support one policy, as they did among the promoters of deinstitutionalization from state mental hospitals, the advocates of more appropriate services do not always win out. Managed care is only one potential instrument for blending access, effectiveness, and cost control.

Competition is the greatest anodyne of cost control. Even if more competition could be achieved in health care, it may well not be price competition.[52] Competition among health maintenance organizations seems not to have slowed the rate of increases in health costs in Massachusetts, although the state enjoys the fourth-highest rate of HMO penetration in the nation-- about 60 percent above the U.S. average.[53] If we do have more price competition among hospitals, it will inevitably be short-lived. Once some hospitals are squeezed out of business, and occupancy rates rise again, surviving hospitals will raise their prices to recoup their costs of competing.

Nationally, the growth in all forms of competition, managed care, utilization review, and other policies seems to have had little effect on the rate of increase in health spending.[54] Whatever the merits of bed closings, managed care, and competition, it appears that effective cost control will require more far reaching reforms. Failure to undertake these will inevitably make the costs of financing both universal access and hospitals' real needs seem higher than they need to be. The problem is not a shortage of money.

Rather, it is failure to control costs responsibly and effectively that jeopardizes both universal access and our great system of health care.

F. Overall Assessment

Is Chapter 23 a durable prescription for financing universal access and hospital care, a miserable failure, or a set of steps roughly in the right direction? Does it require wholehearted implementation, outright repeal, or mid-course corrections?

The major questions about Chapter 23 are whether it will finance universal access at an affordable price, and whether it will pay hospitals enough to satisfy them-- again at a price Massachusetts can pay. These questions can be framed more concretely: 1) How well are the law's access provisions designed and implemented? 2) How well are the law's hospital financing provisions designed and implemented? 3) If law is suffering problems, what are their causes, and what should be done about them? 4) On balance, does the law help or hurt? Is it a durable arrangement, or just a step forward (or backward)?

In one view, about 90 percent of the Massachusetts population already has some sort of health insurance, so it should not cost too much to cover the rest. Many of those lacking insurance are still served today, though often at unnecessarily high cost, because they may be seen late in their illnesses, when expensive interventions are necessary, and because they are served mainly in the most expensive settings, acute care hospitals. While some new money is necessary, redistributing existing spending will go far in covering those who are today uninsured.

Related to this is the view that even Chapter 23 does not, by Senate Ways and Means Committee estimates, require greatly increased spending on uninsured citizens, in state fiscal year 1993, to finance universal entitlement. In this view, the state budget shortfall of 1988-1990 is only transient. The state's financial condition will not be a persisting barrier to universalizing access. Once overcome through normal revenue growth resting on an economy that continues to boom, or through other means, the legislature could easily appropriate the funds needed to implement the law's access provisions.

Similarly, in one view, while the hospital financing provisions are not profligate, they are basically as sound and generous as could be expected in any state. They require only full funding, which will soon be possible. Any hospital financing problems are either short-term or are not caused by Chapter 23 (though failure to implement the provisions for Medicare shortfall and uncompensated care funds means that the law does less than intended to ameliorate hospital financing problems).

A somewhat different view is that relatively little money is now spent on uninsured patients, and most of what is spent cannot easily be saved without compromising needed services. It is not easy to prevent many of the health problems of citizens who are uninsured today, or to detect them early enough to treat them at markedly lower cost. Moreover, Massachusetts already has the world's most costly health care system, and Chapter 23 is likely actually to increase costs for insured citizens. This means that when we do cover those who now lack protection, the price tag will be high. For all these reasons, adequate financing for universal access will require that substantially more money be spent on men, women, and children now lacking insurance. From where could this money come?

There are two choices: we could decide to spend more money on health care, or we could reduce the cost of serving those who are well insured. New money cannot be expected. Despite the recent growth of our state's economy, it seems-- by the best available data-- that our health care costs consume an above-average share of the Massachusetts economy. Increases in this proportion will drive jobs from the state. The task is to cover all who live in Massachusetts, with the money we now spend. It is enough. Even if it were not, hospitals and doctors must realize that the days of rapid revenue increases are past. Our state's hospitals, for example, cannot expect the state's taxpayers to replace Medicare payments that the federal government, with its vastly greater resources, is reducing. As Chapter 23's provisions make it impossible to reallocate existing spending, they would need to be amended to link hospital financing and access provisions. This could allow us to economize on care of well-insured patients and to use the savings to universalize access without spending more money overall.

While the law was the best bargain politically possible at the time, its compromises were costly. This was a traditional political marriage, cemented with money for both hospitals and universal access. By promising more money for access and more money for hospitals, it prepared a bill too great to be paid. In this view, the state's budget crisis may be temporary for the state, but only the first of many signals that Chapter 23's provisions are not durably affordable. The main strain seems to be in the hospital financing provisions. These seem too costly to afford, but they are also inadequate to sustain current arrangements for hospital care, even for patients who are well insured. Yet financial strains on the hospitals are likely to grow as Medicare payments decline, leading hospitals to seek more money from the state, from business, and from patients in coming years. What will happen during a recession?

A compromise position might be to hold fast to the goals of universal access and of stable and adequate financing for the state's hospitals-- but at affordable costs. In this view, the cost of universal access is not treated as an independent phenomenon, requiring so much money to insure so many hundreds of thousands of citizens. Similarly, hospitals are not seen as needing so many billions of dollars annually; health care costs are not seen as natural events, but as consequences of human decisions about how much care to provide, in what way, to which people. Marshaling our current finances to cover all citizens requires involving physicians in making clinical trade-offs, providing the care that works to the patients who need it.

Possible sources of reform, in this view, include growing business understanding that only substantial changes in health care financing and delivery will slow the rate of increase in their health insurance premiums; growing hospital appreciation that they cannot persuade government or business to provide ever more money; growing physician realization that hospital financing reforms are part of the solution to their own financial problems;[55] and growing popular awareness that business-as-usual is unaffordable. A further source of reform could be a group-- perhaps in a state administration or a legislative committee-- that offers a diagnosis of problems and a vision of reform that payors and caregivers and patients find persuasive. Strong leadership will be required to overcome physicians' alienation and costly practice patterns, and hospitals' mistrust of payors and dedication to competition. Complementary reforms in medical malpractice, physician payment methods, and other areas will be helpful.

Perhaps Chapter 23 marks not the end of the road to affordable health care for all citizens, but rather its beginning. For all its costly promises-- and perhaps because of them-- the law is revealing the impossibility of continuing business as usual in Massachusetts health care.

It is not the strain of universal access that is threatening many hospitals' bottom lines today. It is the pressure of federal spending reductions coincident with a state budget crunch on a health care system too costly to sustain. Neither of these new elements is likely to disappear; each is likely to persist or recur. Our hospitals must come to live with these realities, and so must advocates of universal insurance. This means turning away from the road smoothed by billions of dollars in new money, and toward the as-yet poorly mapped road of budgets, clinical trade-offs, and careful coordination among payors, hospitals, and physicians. These changes will not be easy for so many parties accustomed to a fierce independence, even one that has been financed by a generous public. But it is possible. We have the human resources and the money to provide and pay for the care that works to the people who need it.

REFERENCES

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[1] Chapter 118F, Section 1 of the General Laws of the Commonwealth, inserted by Chapter 23 of the Acts of 1988, Section 45.

[2] William J. Curran, "The Constitutional Right to Health Care," *New England Journal of Medicine*, Vol. 320, No. 12 (23 March 1989), pp. 788-789. Curiously, Curran mentions Chapter 23 only in passing, and fails to note its clear endorsement of the right to health services.

[3] Massachusetts General Laws, Chapter 118F, section 6(i).

[4] Massachusetts General Laws, Chapter 118F, section 9.

[5] Roble DT, Nicholson, ST, Legal issues raised by subcommittee proposals, Memorandum to the Subcommittee on Access for the Uninsured/Underinsured, Study Commission on Health Care Financing and Delivery Reform, Commonwealth of Massachusetts, 26 September 1986.

[6] First phase of universal health plan is hailed, Boston Globe, 30 August 1988; CommonHealth, Department of Public Welfare, Commonwealth of Massachusetts, CommonHealth training manual, Boston: The Department, June 1988.

[7] Note: Firms previously not providing insurance includes self-employed; it is estimated that $68 million will be required to insure fully this group.

Source: Adapted from Senate Ways and Means Committee staff analysis of cost of predecessor legislation, 10 March 1988.

[8] Notes: Assumes HFY 1992 private sector hospital spending increase at $195 million, equal to that estimated for HFY 1991; private access spending reflects a decrease of $68 million in cumulative uncompensated care pool payments and an increase of $131 million for college students' insurance; the public access spending includes $100 million for insurance for unemployed workers receiving unemployment insurance.

Sources: Office of the Governor, The Massachusetts Health Security Act of 1988, Fact Sheet #3: How much will the Health Security Act cost the Commonwealth? April 1992; Senate Committee on Ways and Means, Staff analysis of cost of predecessor legislation, 10 March 1988.

[9] Senate Ways and Means Committee, "Estimated Health Care Bill Costs," worksheet, 10 March 1988. This worksheet appears to have addressed provisions slightly different from those legislated in Chapter 23; some of its estimates have been modified accordingly.

[10] Office of the Governor, The Massachusetts Health Security Act of 1988, fact sheet #2: Hospital financing and cost-containment provisions, April 1988. Hospital fiscal years

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begin on 1 October; state fiscal years begin on 1 July. State fiscal year 1990, for example, begins on 1 July 1989.

[11] Hospital workers rally against health proposal, *Boston Globe*, 17 September 1987.

[12] Massachusetts General Laws, Chapter 118F, section 9.

[13] Chollet, D, Uninsured in the United States: *The nonelderly population without health Insurance*, Washington: Employee Benefit Research Institute, 1987.

[14] Interview with Department of Public Welfare staff, 22 March 1989.

[15] Massachusetts Department of Public Welfare, "CommonHealth Enrollment Numbers," Boston: The Department, 9 March 1989.

[16] For the pregnant women's, infants, and one-to-five-year-olds' programs, DPW has difficulty in counting enrollees who came into Medicaid because of Chapter 23's expansions, as they can only be distinguished from other Medicaid clients by income data, which are not readily available in DPW's computer system. Estimates of these enrollments can be obtained by subtracting FY 88 enrollments from FY 89 levels.

[17] Conversation with Department of Medical Security staff, 15 February and 30 March 1989.

[18] James A. Hooley, cover letter to Department of Medical Security, "Basic Guidelines for Mandatory Student Health Insurance for 1989-90," Boston: The Department, 24 February 1989.

[19] "Criteria for Credit and Collections Policies of Acute Care Hospitals," 114.1 *CMR* 30.00.

[20] "Administration of Acute Hospital Uncompensated Care Pool and Criteria for Credit and Collection Policies," 117 *CMR* 2.00.

[21] 117 *CMR* 2.06 (3)(b).

[22] And supported by 1987 data in Massachusetts Rate Setting Commission, "Acute Care Hospitals Bad Debts and Free Care Costs for Fiscal Years 1986 and 1987," Boston: The Commission, 21 February 1989.

[23] 117 *CMR* 2.04(2).

[24] "Budget Cuts May Threaten Well-Being of Local Health Centers," *Dorchester Argus-Citizen,* 18 August 1988.

[25] Ellen Hafer, Governmental Affairs Committee Chair, Massachusetts League of Community Health Centers, testimony on FY 1990 state budget, 11 February 1989.

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[26] Ellen Hafer, Governmental Affairs Committee Chair, Massachusetts League of Community Health Centers, testimony on FY 1990 state budget, 11 February 1989; and Patricia Edraos, personal conversation.

[27] Presentation at Statewide Health Coordinating Council meeting, 24 June 1988.

[28] Ellen Hafer, Governmental Affairs Committee Chair, Massachusetts League of Community Health Centers, testimony on FY 1990 state budget, 11 February 1989.

[29] Department of Medical Security, *Toward Universal Health Care*, 21 February 1989.

[30] Cited in Department of Medical Security, *Toward Universal Health Care*, Request for Proposals for Phase-in Initiatives, 21 February 1989, Appendix A, p. 29.

[31] "Blue Cross Requests Premium Increase," *Boston Globe*, 30 March 1989.

[32] Organisation for Economic Cooperation and Development, *Measuring Health Care, 1960-1983: Expenditures, Costs, and Performance*, Paris: OECD, 1985.

[33] Massachusetts Hospital Association, *Massachusetts Hospitals: Issues and Concerns*, February 1989, p. 2.

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[35] Gilbert M. Gaul, "A Grim Prognosis for Region's Hospitals," *Philadelphia Inquirer*, 5 March 1989.

[36] Rate Setting Commission, Commonwealth of Massachusetts, *Key Trends in Massachusetts Acute Care Hospitals, 1981 - 1986*, Boston: The Commission, May 1987.

[37] American Hospital Association, *Hospital Statistics, 1988*, Chicago: The Association, 1988.

[38] This is a conservative figure, since it inflates each year's surplus only by overall Boston area consumer price index increases, and not by the higher interest rates hospitals could have earned if they had banked their surpluses.

[39] American Hospital Association, *Hospital Statistics*, 1976, 1981, 1983, and 1988.

[40] Massachusetts Health Data Consortium, unpublished data.

[41] James C. Robinson and Harold S. Luft, "Competition, Regulation, and Hospital Costs, 1982 to 1986, *Journal of the American Medical Association,* Vol. 260, No. 18 (11 November 1988), pp. 2676-2681.

[42] This and succeeding Massachusetts - U.S. comparisons are for hospital fiscal year 1987 and are calculated from American Hospital Association, *Hospital Statistics, 1988*, Chicago: The Association, 1988; population data are taken from U.S. Bureau of the Census estimates for 1 July 1986 and 1987, weighted to the mid-point of the fiscal year.

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