Background
In the 11 ½ months since Governor Romney signed Chapter 58 of the Acts of 2006 (“an act providing access to affordable, quality, accountable health care”) on April 12, 2006 the Massachusetts Health Care Reform process has been moving rapidly and receiving intense national attention.¹

As a psychiatrist, the Massachusetts Health Care Reform process reminded me of a Rorschach inkblot – people see very different things in it depending on where they are coming from. Governor Romney saw it as a vehicle for allowing market forces to stimulate innovative approaches to the problem of broadening access to insurance in an affordable way. Advocacy groups like Health Care for All see it as a vehicle for allowing social/political forces to define the health benefit package and control pricing.

This policy debate is playing out under a public spotlight. In this way Massachusetts is providing a service to the nation. Instead of the generally vague proposals put forward in campaigns at election time the Massachusetts Health Care Reform process involves real debates and real decisions occurring in real time. Because the process has been so public I chose to flesh out the background for the April 5 EAG meeting by copying three recent public statements into this case rather than to do a summary of my own:

#1: From Bruce Bullen, Chief Operating Officer at HPHC: “Connector Vote An Important Step, But Key Decisions Lie Ahead.” Posted by CommonHealth [the WBUR-sponsored Health Care Reform blog], Tuesday, March 13th, 2007.

Last Thursday, the Connector Board took a major step forward in implementing the health reform law. The Board unanimously endorsed a broad range of product choices from seven carriers, including Harvard Pilgrim. These products will be available on May 1st, with coverage effective July 1st. Consumers will be able to choose from a range of plans - comprehensive to basic - and many individuals will be able to buy on a pre-tax basis, significantly reducing their cost of coverage. Given the high cost of health care in Massachusetts, the fact that consumers will have more affordable options is very good news.

But the really hard work is just beginning. In a few weeks the Connector Board will define the minimum level of coverage a person must have to comply with the individual mandate. The board will also determine who, if anyone should be exempt from the individual mandate. Individuals who do not have coverage that meets the

¹ A Google search for “Massachusetts Health Care Reform” on March 21 yielded 11,500 citations.
minimum standard and who are not exempt from the mandate will be required to pay a tax penalty. I urge the Connector Board to proceed cautiously with these decisions.

For health reform to succeed, we need to persuade those without coverage to buy it and those with coverage to keep it. If we set the minimum standard too high we defeat the purpose of the law by making it difficult for those without coverage to buy. If we also require those who are currently insured to “buy up”, we risk an unintended backlash.

By setting a minimum coverage standard, Massachusetts will be the only state in the nation to define a floor for adequate coverage. As one of the only states in the nation to lose population in recent years, we need to create a climate where people want to live and bring up their families and where employers can create and grow jobs. Setting the minimum coverage standard too high could impede our ability to remain economically competitive.

Setting the affordability standard is a problem that may be even thornier. An individual mandate is critical to the financial viability of the health reform law. Through universal participation we reduce our reliance on the uncompensated care pool, allowing us to use these funds to provide people with coverage. We also create a broader insurance risk pool, which ensures that the merger of the small group and nongroup markets does not precipitously raise costs for our state’s small businesses. Some individuals with unique financial circumstances may need exemptions, but we will jeopardize the financial foundation of health reform if we weaken the mandate substantially.

Universal participation, consumer choice, and building on the realities of the current marketplace are key to successful implementation of the next phase of the law. [Available at: http://blogs.wbur.org/commonhealth/?p=27#comments]

#2. From John Kingsdale, executive director of the Commonwealth Health Insurance Connector Authority: New health plans: better than what's out there

A Boston Globe Editorial by Jon Kingsdale, 3/19/07

IN THE DISCUSSION of the new health plans that will be available to uninsured people in Massachusetts starting May 1, one important detail has been missed: These plans are far better and more affordable than any plan uninsured individuals can purchase right now.

Under the plans announced last week, the typical individual who is uninsured -- a 37-year-old living in Greater Boston -- will be able to buy health insurance from the Connector for as little as $175 per month. That's about half of the $335 premium individuals would pay now if they tried to buy insurance on their own.

Currently, people don't have a lot of choice if their employers don't offer them insurance and if they earn too much to qualify for state-subsidized insurance. All of their options are expensive, as is the alternative of forgoing coverage and paying all medical expenses out of pocket. So let's do some comparison shopping.
Right now, an individual in Massachusetts can buy insurance for $335 a month. That plan doesn't cover prescription drugs, so consumers have to foot the bill for all medications. It includes a $5,000 deductible, meaning that until that amount is reached, consumers have to pay out of pocket for every medical expense, from doctors' appointments to emergency room visits.

Compare that with the $175-a-month plan the Connector will soon offer. This plan covers prescription drugs. The deductible is $2,000 -- no small amount, but less than half of the $5,000 the same consumer pays under a plan now offered. Even more important, the Connector's plan, unlike current plans, allows patients to see primary-care physicians and specialists for just a small co-payment before the deductible is met. (Truth in advertising: Premiums generally rise over time, so the plans may cost 1-2 percent more by July 1.)

All told, then, the Connector has successfully cut the monthly premium consumers pay today by half, and slashed the deductible by almost two-thirds. The result is not cheap -- healthcare never is -- but it's far more affordable than anything available today. And the Connector is looking to make it even more so, by working with employers to allow employees to pay for insurance with pretax dollars. This would further reduce the $175 premium to a net cost of about $109.

Also, these new plans include important protections. They help protect against medical bankruptcy by capping out-of-pocket expenses at $5,000. Even if an enrollee needs major surgery or contracts a chronic illness, no one will ever have to pay more than $5,000 for hospital and medical services in a given year.

Massachusetts also guarantees access to coverage, meaning that health insurance companies cannot refuse to sell an individual insurance because he or she is sick, nor can they raise premiums if an enrollee falls ill. Whichever policy a consumer chooses, the insurer has to provide it and has to renew it.

So how is Massachusetts delivering more insurance for lower premiums? Because of two reforms. First, Massachusetts is changing the current system, which penalizes those who have insurance by forcing them to subsidize services for people who don't buy insurance. By expanding the pool of people with insurance, Massachusetts is helping drive down everyone's costs.

Second, the Connector is increasing competition among health plans. Ten health plans bid to receive the Connector's seal of approval. Everyone who shops for health plans at the Connector can now compare the seven "winners" who were approved to offer health insurance starting May 1. That's creating choices that didn't exist before.

Massachusetts is leading the way on healthcare reform. It is the first state to make high-quality, affordable healthcare available to every resident. It is the first to require that people with insurance have access to preventive-care office visits before having to
pay a deductible. It is the first to cap annual deductibles and out-of-pocket medical spending. And, when the board meets on Tuesday, Massachusetts is expected to become the first state to phase in a requirement that all health plans offer prescription drug coverage -- an extraordinary benefit that not even Medicare requires. Once Massachusetts takes this step, it will have guaranteed a level of health security unprecedented in the United States.

#3. From the New York Times (the day after the Connector Board meeting John Kingsdale referred to in the next to last sentence of his Op-Ed piece.) Massachusetts Sets Benefits in Universal Health Care Plan Pam Belluck, New York Times, 3/21/07

BOSTON — Massachusetts took a major step toward enacting its near-universal health care overhaul, with the board that oversees the plan voting on Tuesday to require insurers to provide certain minimum benefits, including coverage of prescription drugs.

The decision, subject to final approval in June, would make Massachusetts the first state to establish standards that apply to every resident and every health insurer.

“It’s setting the definition of what is acceptable health care coverage, which is really unique in America,” said Stuart H. Altman, a professor of health economics at Brandeis University. “What you’re doing is not only affecting what the uninsured can get. You indirectly are affecting what is considered to be acceptable coverage for everybody.”

The requirements were worked out over several months and include several compromises, balancing the interests of businesses, insurers and health care advocates.

For example, the board, called the Commonwealth Health Insurance Connector Authority, agreed to phase in some of its requirements, giving residents and employers an extra 18 months to buy health plans that meet all the new criteria. While residents will still need to have some form of insurance starting in July, they will have until January 2009 to get all the required coverage.

“This is another giant step forward,” Jon Kingsdale, the executive director of the authority, said at the meeting. Later, he said, “basically we have to be thinking about January ’09. It’s not a perfect solution, but it’s an acceptable solution.”

The goal of the health insurance law, passed in April 2006, was to make sure that most of the state’s uninsured residents, about 515,000 people, would be covered. Those who fail to get insurance would face penalties that could include the loss of a personal income tax deduction.

About 47,000 of those people fall below the federal poverty line and are eligible for Medicaid. An estimated 150,000 with incomes at 100 percent to 300 percent of the
poverty line will get a state-subsidized rate but will still have to pay something, typically $18 to $170 a month.

The rest will be required to buy insurance that meets standards set by the authority, and the challenge has been to make those plans affordable while ensuring enough coverage.

Earlier this month, the authority approved plans from seven insurers with premiums ranging from $175 to $288 a month and deductibles ranging from nothing to $2,000 a year.

Among the compromises the board made Tuesday was allowing insurance plans to continue to place caps on lifetime coverage, something that advocates for universal coverage had been pushing to eliminate.

The authority also voted to set a maximum deductible for basic health plans of $2,000 per individual per year, and a maximum out-of-pocket cost of $5,000 if providers within an insurer’s network are used.

Prescription drugs generated some of the most impassioned discussion Tuesday.

Richard Lord, a member of the authority board and president of Associated Industries of Massachusetts, which represents 7,500 employers, appealed to the board not to require drug coverage.

“No other state does this,” Mr. Lord said. “To prescribe it as a requirement I just think is going beyond what the law intended.”

But Dolores Mitchell, the executive director of an agency that provides health insurance to 265,000 state employees, said that for some residents, drug coverage was “not just optional, it’s maybe life and death, to say nothing of the preventive, since those people who can’t afford it often end up in the hospital.”

Ultimately, insurers, business interests and advocates said they found something to like in the plan.

“There are people who are satisfied with insurance that covers less than these requirements, and there are advocates who believe that all insurance should cover more than these requirements,” said James Roosevelt Jr., the chief executive of the Tufts Health Plan and chairman of the Massachusetts Association of Health Plans. The authority, he said, “struck a balance.”

Brian Rosman, the research director for the advocacy group Health Care for All, said he was “disappointed that the board did not eliminate lifetime maximums,” but called the drug requirement “a terrific step.”
He said his group’s next priority was pressing the authority to delay imposing penalties on lower-income people who may struggle to afford the minimum required insurance.

That could include people like Ali Shriberg, 33, of Brookline, who is afraid she will not be able to afford a $2,000 deductible on a $40,000 salary as a freelance corporate trainer.

And Maria Alves, 39, a dental assistant from the Dorchester area of Boston, who has two children, ages 9 and 14, and a husband on disability.

“I save a lot to give my kids food to go to school and pay the rent for them to live,” Ms. Alves said. “Now they will penalize me if I don’t have insurance. I cannot afford it. I wish I can, but I can’t.”

Customer: Dave Segal, Senior Vice President of Customer Service and Market Performance.

Questions for the Ethics Advisory Group
As a process deeply embedded in the political sphere, Massachusetts Health Care Reform is certain to have multiple twists and turns as political and economic factors change over time. Harvard Pilgrim Health Care will have to respond to changing demands, often quite rapidly, and under intense public scrutiny. Being clear about our framework of values for dealing with the Health Care Reform process is a key component of being prepared. The broad question for the April 5th Ethics Advisory Group was:

Please advise about a framework of values for HPHC in its dealing with the Massachusetts Health Care Reform process. What HPHC values can be advanced through Health Care Reform? What values could be impeded or threatened?

Some of the more specific questions the group was asked to address on April 5th were:

- What values are most relevant to helping HPHC consider how to balance the need to provide affordable products for the uninsured against the desire of many for comprehensive coverage that may not be affordable? (re this question, see the attached article from the 3/25 Boston Globe)
- The rules of the new merged small group/nongroup marketplace require HPHC to price products sold inside and outside of the Connector similarly. What values are most relevant to helping HPHC decide whether to raise prices for small businesses in an effort to make Connector products more affordable?
- If the majority of the currently uninsured are young, healthy and extremely price-sensitive, what values are most relevant to helping health plans decide whether (and how) to focus their product development efforts on this population in an attempt to insure as many of the uninsured as possible?

Relevant precedents
On June 21, 2001 the EAG discussed “Working in a Fishbowl: Ethical Issues of Consistency, Confidentiality and Publicity.” With reference to a clinical situation (thoroughly disguised ) that could have become very public the EAG was asked “how much weight (if any) should be given to the potential for bad publicity? What ethical considerations are relevant to deciding how much weight to give publicity concerns?”

HPHC staff commented that the issues raised by [the case] are common – as when members threaten to go to the media or when influential persons contact HPHC on behalf of a member’s concern. Public attention puts a spotlight onto HPHC’s decisions, thereby raising the stakes if those decisions turn out to be wrong.

A very consistent values framework emerged from the discussion. Employers commented that they prefer to partner with organizations whose decision making processes they can count on. They respect a health plan partner that thinks carefully and does what it believes is right more than one that gives in to threats. Similarly, HPHC staff commented that if the threat of adverse publicity changes the content of decisions “we can’t maintain any standards for ourselves.” Within this broad perspective the EAG made a series of specific suggestions:

• While there was a unanimous perspective that HPHC should not change its standards or values because of pressures or threats, the EAG felt that accelerating the process of evaluating the situation and taking special care to be as sure about the proposed course of action as the unavoidable uncertainties of clinical practice allow was appropriate. EAG members commented that the fear and sense of being overwhelmed that [the] parents showed in [the case] is characteristic of many incidents in which threats and pressures occur. Just as a clinician may (reasonably) give a highly anxious patient an earlier appointment, a health plan may (reasonably) accelerate whatever kind of review of the patient’s request that is clinically appropriate. In spotlight situations it is especially important for HPHC to be very clear about the position it is proposing and the rationale for that position. The EAG saw this process of accelerated assessment, clarity about rationale and careful documentation as a justifiable way of “giving weight” to the threat [to go to the media]. But the group felt that once that accelerated review was completed, the decision itself should only be swayed by new information, not by threats. (emphasis added)

By using the April 5th EAG meeting to deliberate about a framework of values for another “spotlight situation” HPHC was acting in accord with the 2001 recommendation for being as clear as possible about its guiding values before public spotlight pressure descends.

EAG DISCUSSION/RECOMMENDATIONS
Jim Sabin opened the meeting by welcoming Nancy Turnbull back to the Ethics Advisory Group. After leaving the Blue Cross Blue Shield Foundation where she had been president since 2005 Nancy returned to the Harvard School of Public Health as Associate Dean for educational programs and Senior Lecturer in Health Policy.
Before turning to the specific issues that Massachusetts Health Care Reform poses for Harvard Pilgrim, the discussion focused on the Health Care Reform program itself. There was unanimous agreement that the goals of program – increased access to health insurance and health care – represent a vital public good, and there was recognition of how important the Massachusetts experiment is as a pilot for other states. Within a context of (a) strong endorsement of the aims of Health Care Reform and (b) strong commitment to helping the program succeed, the EAG nevertheless (c) identified a number of concerns, which I have summarized in bullet form:

- When the Connector was created it was initially envisioned as a distribution channel for new products that insurers would design – in other words, seeking to use market forces to address the problem of the uninsured. It has developed, however, more like a regulatory body, setting content for the insurance package and seeking to manage pricing. This has resulted in an expectation that expanded benefits will be offered at reduced premium rates. It is not clear whether and how these objectives can be achieved.
- Individuals will be required to have “creditable” health insurance but will have limited choice as to what kind of coverage counts as “creditable.” There was concern as to whether the mandated products will truly be affordable to low income persons. Since health costs are rising faster than income the affordability problem will get worse over time.
- From the perspective of equity participants were concerned that low income persons will be required to spend a larger portion of their income for benefits that will often be less useful to them than what many wealthier employees receive.
- The standards set for “creditable” coverage will require some persons who are currently insured to “buy up” to more comprehensive benefits than they wish to purchase.
- Insurers are being pressured to create “affordable” products but thus far there has been little public focus on the 80+% of premium costs created by the prices charged by providers. With hospitals running at capacity and physician office practices largely filled there is little provider incentive to reduce charges.

After discussing the overall structure of the reform process the group turned to deliberating about the components of a values framework for HPHC to use in the context of a volatile political environment. The EAG recommended six values for the framework:

1. **Always tell the truth.** Several participants felt that health plans were being placed in an “impossible” situation of being (a) asked to offer comprehensive benefits at (b) premiums significantly lower than current marketplace rates in (c) an environment predisposed to blame insurers for any failures of the program. The EAG felt that if it is not possible to offer a comprehensive level of coverage at the premium rates being sought HPHC should make this dilemma clear.

2. **Be a responsible corporate citizen.** Despite the difficulties Massachusetts Health Care Reform poses, the EAG felt that because of (a) its mission to “improve the health of the people we serve, and the health of society” and (b) its status as a not for profit
corporation (c) Harvard Pilgrim should do all that it reasonably can to ensure the success of the reform effort.

3. **Risk being unpopular.** While the unanimous perspective was that HPHC should support the aims of the Massachusetts program, telling the truth about problems with the program may not win popularity in the public arena. Jim Sabin reinforced this concern by quoting an April 4 entry in the WBUR Commonhealth blog (www wbur org/weblogs/commonhealth/?p=55#more-55):

   *[The proposed premiums] can hardly be considered “affordable” health coverage. It can, however, be considered “affordable”…for insurance companies so they don’t lose their profit margins…There is no way health care can be profitable to a private insurance industry without bilking the customer of every last dime…”*

4. **Remain financially sound.** The pressure to achieve insurance affordability for low income persons and the public spotlight on health plans could lead to pricing the new products below a point of actuarial soundness. The EAG saw remaining financially sound as a significant value, as reflected in the aphorism “no margin, no mission.”

5. **Encourage fair distribution of responsibility.** Everyone wants Massachusetts Health Care Reform to succeed but no one wants to bear disproportionate financial burden. Making the premium affordable by shifting costs to employers would create a new (but hidden) tax on business. Making the premium affordable by creating unrealistically high deductibles for low income persons would harm those who reform is intended to help.

6. **Educate constituents.** Over the years the EAG has frequently defined education of constituents and the public as a key value for HPHC. Health Care Reform is complicated and politics does not necessarily promote transparency and education. The EAG felt that HPHC should not whisper the truth but should actively seek to educate itself and others re the Health Care Reform process.

A long time participant in EAG discussions commented that “I can’t remember a discussion that was so not admitting of a solution…solving the problem of the uninsured is beyond what any particular company can do… Health plans may be in an impossible situation!” Others commented that since no state has found a way of providing affordable care to all its citizens it is not surprising that Massachusetts’s bold and original approach to the problem has put health plans into the middle of a very messy situation. Health plans are being asked to accomplish things that the political process – locally and nationally – has avoided. With regard to the “impossible situation” some EAG members felt that Massachusetts Health Care Reform poses for health plans the group recalled the aphorism a former EAG member often quoted – “If you do the best you can angels can do no better!”

**Summary**
1. The EAG saw Massachusetts Health Care Reform as an inevitably imperfect effort to solve what has been an intractable policy problem for all 50 states.

2. Despite the difficult demands the reform process places on health plans, the EAG felt that HPHC’s mission and its status as a not for profit entity require it to do all it reasonably can to help the reform program to succeed.

3. The EAG identified six values it saw as most relevant for guiding Harvard Pilgrim’s response to Massachusetts Health Care Reform: always tell the truth; be a responsible corporate citizen; risk voicing unpopular truths; ensure continuing financial stability for the organization; ensure that HPHC treats all its constituents fairly; and, act as an educator.

4. The EAG thanked Dave Segal and his colleagues for allowing it to contribute to an area so important to the health plan and to the state.

Jim Sabin