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As key congressional committees prepare within a matter of days to begin unveiling legislation to overhaul the American health care system, Ropes & Gray releases its second issue of *Health Reform Matters*, our quarterly newsletter on the policy, politics and process of health reform. This issue includes articles exploring recent Washington developments in depth, along with a feature article examining Massachusetts' experience with health reform and an interview with Christina Severin, President, and Leanne Berge, Vice President, Strategic Planning and Business Development, of Network Health in Massachusetts. Network Health has enrolled a substantial number of the newly insured in Massachusetts, and is part of the Cambridge Health Alliance, a safety net health system that has experienced funding difficulties under reform. Ms. Severin and Ms. Berge offer insight into some of the lessons Massachusetts has to offer, for plans, providers and employers.

In this and future issues, *Health Reform Matters* will offer analyses of key aspects of health reform, including tracking legislative and political developments, examining the impact of key policy issues, and closely monitoring the implementation of reforms. Through cross-office and cross-department collaboration, we will continue to leverage Ropes & Gray's extensive experience and knowledge in health care and related practice areas. For more immediate updates on health reform developments, Ropes & Gray also regularly issues Health Reform Matters Alerts. Our continuously updated [Health Reform Resource Center](#) provides a compendium of our newsletters and alerts, along with major policy proposals, legislation, analyses and other key documents in the reform debate.

We welcome your feedback on all of these resources and solicit your suggestions for future newsletter features. We encourage you not only to use our materials but also to contact us directly to help you assess what health reform means for you and your organizations. ■

Recent Developments

Since Ropes & Gray launched *Health Reform Matters* with its first issue in February, Washington has shifted into high gear in pursuing passage of comprehensive health reform. With major health-related legislative victories under their belt and comprehensive reform measures in development, President Obama and the Congress have put their once-in-a-generation goal of remaking the U.S. health care system within reach in this calendar year.

Already much has been accomplished. Thanks to the American Recovery and Reinvestment Act signed in February, health care dollars have begun to flow for research initiatives, Medicaid programs,

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community health centers and various capital infrastructure projects. Billions more are in the pipeline for such high priority investments as health information technology. (Ropes & Gray has been tracking the allocation of these dollars, and has made available a [chart](#) to assist clients in assessing available funding opportunities.) The budget resolution that both houses of Congress passed in late April for fiscal year 2010 paves the way for health reform. At the same time, the Administration has made progress (albeit slow) in filling out its health reform team, with the appointments of Kathleen Sebelius as Secretary of Health and Human Services (HHS), Nancy-Ann DeParle as Director of the White House Office of Health Reform, Dr. Margaret Hamburg as Commissioner of the Food and Drug Administration, Dr. Thomas Frieden as Director of the Centers for Disease Control and Prevention, and Jeanne Lambrew as Director of the new HHS Office of Health Reform.

But the heavy lifting on health reform still lies ahead. Despite the bipartisan commitment to achieving health care reform announced at the White House summit in March, the usual divisions are beginning to surface. Among other disputes, the two parties are actively debating: (1) whether Congress will use a controversial budget reconciliation mechanism to adopt health reform (allowing legislation to pass the Senate with only 50 votes); and (2) whether reform legislation will create a "public plan." Difficult decisions on how to pay for reform, just now coming to the fore, will surely fuel the political fires.

Despite the daunting task, the five congressional committees with jurisdiction over health reform (the Senate Committees on Finance and on Health, Education, Labor and Pensions (HELP), and the

House Committees on Ways and Means, on Energy and Commerce, and on Education and Labor) have each begun work in earnest on reform legislation. They envision a schedule in which each committee will “mark up” (*i.e.*, amend and approve) bills in June or July, followed by floor consideration of a consolidated bill in each house before the August recess. That would leave the fall to work out differences between the House and Senate versions, with an eye toward final passage before the 2009 session adjourns. The schedule is ambitious, but one that Congressional leadership believes is critical to ensure action before the pressures of another election take hold next year.

The most public of this work has been undertaken by the Senate Finance Committee, which has held a series of roundtable discussions and released a range of policy proposals in each of three major areas of reform: delivery system reform, coverage and financing. (Ropes & Gray’s analysis of each of these policy papers, as well as the papers themselves, are available in the [Comprehensive Health Reform](#) section within our [Health Reform Resource Center](#).) Committee members met to discuss the proposals in closed-door sessions and plan to mark up a consolidated bill in early June. The HELP Committee recently released a [12-page briefing paper](#) outlining its goals and broad approach to reform to guide Committee discussions. In an attempt to quell reports that Finance Committee Chairman Max Baucus (D-MT) and HELP Committee Chairman Ted Kennedy (D-MA) are working at cross purposes, the two key leaders issued a [joint statement](#) on May 30 reiterating their commitment to working together to find common ground on reform.

Fewer official details have been released on the House side, although an unofficial summary of the Energy and Commerce Committee’s [plan](#) has been circulating. At this point, the work of the House has been largely confined to Democratic committee members. Republican members of both the House and Senate have released their own set of policy proposals that are more modest in scope than those under consideration by the committees.

Based on the options, summaries and papers that have been released to date, a clearer picture of the likely elements of a reform bill is starting to emerge. All of the committees appear to favor an individual mandate, coupled with tax subsidies for low income individuals and families and an expansion of Medicaid. There is broad bipartisan consensus on the need for a Massachusetts-style health insurance exchange to facilitate enrollment, set standards and spread risk. Insurance regulations would be tightened, and the delivery system reformed primarily through changes to Medicare payment policies to focus on paying for quality rather than quantity. The employer system would remain in place, although there remains debate over whether some form of an employer mandate or “pay or play” system would be

adopted. New investments will likely be made in prevention and wellness and in the health care workforce. The elephant in the room, of course, is whether lawmakers will adopt a public plan option. ■

The American Recovery And Reinvestment Act: Funding Opportunities and New Privacy Rules

The federal government has been busy implementing the American Recovery and Reinvestment Act (ARRA), and has begun to dispense the nearly \$100 billion allocated for health care investment. To assist clients in tapping into these opportunities, Ropes & Gray has prepared a user-friendly [chart](#) summarizing the available funding sources and providing links to applicable federal guidance and other information. Although the government has not yet released details on how to access all of the funding, look to the [Economic Recovery Legislation and Implementation](#) section within our [Health Reform Resource Center](#) for continual updates to this chart as those details become available.

In addition to ARRA’s major investments in health care infrastructure, ARRA also enacted sweeping new changes to the privacy protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes will affect all health care organizations that possess protected health information (PHI) and, in particular, impose broad new notification requirements in the case of a breach of unsecured PHI. While interim final regulations on the breach notification requirements are not due until August 16, 2009, HHS issued guidance on April 17 regarding the types of technologies and methodologies that may be used to secure PHI in order that it not be subject to the breach notification requirements. Click [here](#) for a detailed section-by-section analysis of the new privacy provisions in ARRA.

Highlights of the implementation of health-related funding opportunities to date include:

- **Health Information Technology (HIT).** ARRA provides an estimated \$17 billion in Medicare and Medicaid incentive payments and \$2 billion in funding to the Office of the National Coordinator for Health Information Technology to invest in HIT architecture through various grant programs. The Medicare and Medicaid payments will not be available until 2011, and the extent to which they can be drawn upon will depend on HHS’s definition of a “meaningful user” of electronic health records, which it must issue by December 31, 2009. Likewise, the National Coordinator has started releasing preliminary details on how the \$2 billion in HIT grant funding will be awarded.

- **Medicaid Support.** HHS has made \$15.2 billion in Medicaid funding available to states for the first two quarters for which ARRA's enhanced Medicaid matching rates apply (i.e., October 2008 - March 2009). This funding has proved critical to states as they struggle to balance budgets in a year of sharply shrinking revenues and rising deficits. More will be released in future quarters, and HHS has provided guidance on state eligibility for, and certification of, those funds. HHS also announced increased Medicaid Disproportionate Share Hospital (DSH) allotments for FY2009. Links to state-by-state grant amounts for these enhanced Medicaid funds are available in the [Ropes & Gray chart](#).
- **Community Health Centers (CHCs).** HHS took quick action to release \$155 million for 126 new CHCs, \$338 million for programs to expand CHC services, and \$850 million for capital improvements. Additional funds are available for facility investments and HIT systems.
- **Comparative Effectiveness.** ARRA provides \$1.1 billion to study the comparative effectiveness of different health care treatments and strategies. NIH has released several grant opportunities related to comparative effectiveness research, and additional HHS agencies should announce funding opportunities in the near future.
- **Research and Capital Grants available through the National Institutes of Health (NIH).** ARRA provides \$10.4 billion to NIH for research and capital funding. NIH has begun distributing these funds, and has announced grants for the purchase of instruments, to support and expand the scope of existing research, to support new research focusing on areas such as health disparities, bioethics, genomics and stem cells, and specifically to support autism research and hiring of faculty at research centers. New grants continue to become available and deadlines are passing quickly.
- **Prevention and Wellness.** The Centers for Disease Control and Prevention (CDC) has distributed \$200 million to states to support purchasing of vaccines, and will be awarding additional funds for innovative programs to improve vaccination rates, to reduce rates of chronic disease, and to support local efforts to reduce health care acquired infections. ARRA provided a total of \$1 billion for a prevention and wellness fund.
- **Other Funding Opportunities.** ARRA also provides significant opportunities for capital funding and broadband technology outside of HHS that could be available to health care organizations. For example:

- State stabilization funds have been distributed to states for use in capital projects in educational facilities,
- The Department of Energy is allocating \$2.7 billion in funding to states to support energy efficiency infrastructure projects,
- Enhanced Community Development Block Grant funding is supporting a variety of development projects,
- Funding is available for the expansion of broadband technology including telemedicine and distance learning,
- New roads are being financed with highway infrastructure funding, and
- The Build America Bond program is providing financing assistance for projects funded through state or local government bonds.

Ropes & Gray can assist you in navigating these varied funding opportunities. Contact your regular Ropes & Gray attorneys for more information and assistance. For more details on these opportunities, refer to our reference [chart](#) on ARRA implementation and our [summary](#) of the health funding available under ARRA. ■

Congressional Budget May Pave the Way for Health Reform

The April passage of Congress's Fiscal Year (FY) 2010 budget resolution may prove decisive to Democrats' efforts to legislate comprehensive health reform this year. Buried within the discussion of outlays, projections and deficits are arcane procedural rules that may ultimately determine whether a reform bill can survive a floor debate in the Senate or whether it will be stalemated by a filibuster. "Budget reconciliation" has become a provocative term in Washington, perennially viewed by the majority party as a critical legislative tool for carrying out key budgetary priorities and simultaneously by the minority as an egregious power grab. The prospect of Democrats using it to pass health reform has Republicans seething, and many conservative Democrats concerned.

Bills considered under reconciliation in the Senate are protected from a filibuster, which requires 60 votes to overcome. When both houses of Congress and the Presidency are controlled by a single party, the Senate filibuster becomes the primary vehicle through which the minority party retains its legislative influence. Reconciliation takes that tool away, as reconciliation bills need only 50 votes to pass (with the Vice-President serving as the tiebreaker).

The budget resolution passed by Congress authorizes, but does not require, the use of reconciliation for health reform legislation prior to October 15. If the committees of jurisdiction have not passed a bill by

that time, they may not do so through reconciliation. October 15 has therefore become a “drop dead” date – if bipartisan negotiations do not produce a bill capable of surviving the normal legislative process (including any filibusters) by that time, it appears almost certain that the Democratic leadership will move forward to adopt health reform legislation under reconciliation. The Democratic leadership has emphasized its desire to approach health reform in a bipartisan fashion, without reconciliation, but hopes that the threat of reconciliation will keep Republicans at the negotiating table. For now, Democrats and Republicans have been working together closely to draft legislation, at least in the Senate. But keep an eye on that October date as the legislative process unfurls.

The substance of the budget resolution, despite scant detail, provides an important blueprint for congressional reform efforts. In particular, the resolution establishes “deficit neutral” reserve funds in the House and Senate that authorize comprehensive health reform legislation as long as the reforms are fully paid for. The resolution does not identify funding sources. The reserve funds generally require the committees to develop legislation that is consistent with the President’s eight health reform principles, including reducing costs, providing universal coverage and improving quality.

In contrast to the congressional budget, which does not specify a price tag for health reform, the President’s budget calls for a \$634 billion down payment on health reform. (Click [here](#) for Ropes & Gray’s summary of the President’s budget proposal). This reserve fund will be used to finance health reform, and identifies savings to pay for it. Approximately half of the reserve fund would be financed by reducing federal Medicare and Medicaid spending over the next ten years, while the other half would be funded by new tax revenues generated by limiting tax deductions for high-income wage earners. Legislators in both parties have voiced strong opposition to the President’s proposed tax changes, while signaling their support for the Medicare and Medicaid payment reform proposals, many of which are likely to find their way into upcoming reform legislation. The President’s budget is not self-implementing; that is, its provisions will become law only if Congress opts to enact his proposals into legislation. ■

The “Public Plan” Puzzle: What Will It Mean for Your Organization?

In the debate over how to provide affordable coverage to all, no issue has proven more contentious than the question of whether Congress should create a public health insurance plan. The “public plan,” as it is known, could take one of a number of forms and roles in a reformed health care system, depending on the outcome of the feverish political debate on the subject. In general, a public plan, as proposed by supporters, would serve as a public source of

insurance coverage for those who do not desire or cannot obtain a private insurance plan. Democrats generally support the concept of a public plan, arguing that it would increase choice and lower costs, thereby introducing healthy competition to the health plan marketplace. Most Republicans oppose a public plan, expressing concern that it would not compete on a “level playing field” with private plans and ultimately drive private plans out of business through cost-shifting and other predicted effects. Some fear a public plan is a back door to a single payer system.

Beyond the rhetoric and competing claims, a full understanding of what a public plan might mean for a reformed system—and for your organization’s role in a reformed system—requires a closer look at the various elements of a public plan:

- **Administration.** A single, national public plan could be administered through a “Medicare-like” entity within HHS; or, alternatively, multiple public plans could be created that would be administered by states or regional third-party administrators. Greater centralization in administration could yield greater administrative efficiencies, but would also invite concern that a single national public plan would have an unfair advantage in the health plan market. Proposals to level the playing field include introducing government firewalls, such as requiring that the public plan be run by a different entity than the entity that will administer the proposed new national insurance exchange; or creating multiple decentralized public plans.
- **Provider participation and reimbursement rates.** Under a “Medicare-like” option, the public plan would likely be set up so that Medicare participating providers would be required to participate in the public option, and they would be paid rates set by the public plan. Payments could be set at the Medicare rates, or higher. Under other, more decentralized public plan models, provider participation in the public plan could be voluntary, and the public plans could be required to assemble provider networks and separately negotiate payment rates with participating providers. Concern is high among providers and suppliers that a public plan could drive down rates, with employers and insurers on guard against a structure that could force them to cross-subsidize public plan rates that are set below cost.
- **Rating rules and risk adjustment.** To ensure a level playing field, most policy proposals would subject the public plan to the same rating rules that would apply to private plans. Rating rules, such as community rating and guaranteed issue rules, restrict efforts to vary the price of insurance according to the risk of the person or group seeking coverage. Payments to the

public plan would also be subject to the same risk adjustment as payments to other non-group and small group plans offered through the national insurance exchange.

- **Solvency and reserve requirements and other federal subsidies.** A “Medicare-like” public plan option has been criticized as reaping an unfair advantage for the government if it is exempted from the capitalization and reserve fund requirements that apply to private plans participating in the same market. Alternative proposals for decentralized public plans generally would apply solvency and reserve requirements to the plans. However, critics have noted that it is unrealistic to expect that the government would actually permit a public plan to fail, and the government advantage thus could never fully be overcome. Moreover, to the extent that a public plan receives government subsidies—i.e., its revenues do not fully cover its costs—the objection is that it would be even more difficult for private plans to compete effectively.
- **Eligibility rules, enrollment and minimum benefit requirements.** Most public plan proposals would subject the public plan to the same eligibility rules, beneficiary enrollment and minimum benefit requirements as would apply to private plans. Critics have opposed the idea of a default enrollment mechanism—through which those who do not affirmatively select an insurance plan would be automatically enrolled in the public plan—as providing an unfair advantage to the public plan. It is also possible that adverse selection could undermine the stability of the public plan—while relieving the burden on the private market—if individuals with greater health problems were disproportionately enrolled in it.

The debate over a public plan is slippery not only because it implicates core political principles such as the respective roles of government and private industry, but also because the potential public plan options span a wide range of possibilities. Indeed, some public plan proposals currently on the table resemble existing state employee insurance coverage programs, which often have significant private sector involvement, and thus might serve as a potential basis for compromise. Other potential compromises include providing a public plan option during a transition period only and having a public plan option as a backstop for regions where there are fewer private plan options. As the legislative proposals start emerging in the next few weeks and months, Ropes & Gray is here to help you look beyond the grandstanding on this issue to see how any public plan option might affect your organization’s strategy and operations. ■

Preparing for Health Reform by Understanding the Massachusetts Experience

In 2006, Massachusetts enacted health reform legislation seeking to extend health insurance to nearly all Massachusetts residents. With the eyes of the nation on the Massachusetts experiment, this groundbreaking legislation has achieved that goal—in December 2008, the state estimated that over 97 percent of Massachusetts residents had health insurance coverage. Yet Massachusetts health reform is still a work in progress. Critics point out that health care costs in Massachusetts are rising faster than the national average and that, due to high copayments and deductibles under certain health plan options, some insured residents still find it difficult to afford the care they need. Given current budget pressures, there also continues to be concern about the ability of the Commonwealth to sustain the public funding that has been provided to support the goals of the initiative.

As federal health reform begins to take shape, many are looking to Massachusetts as a model—albeit an imperfect one—for the national effort. While the extent to which federal reform will be modeled after the Massachusetts experiment is not yet clear, it is likely to incorporate at least a few of the program’s most widely supported features, including (1) an individual mandate, (2) “creditable coverage” standards, (3) subsidization of insurance premiums for low and moderate income individuals, (4) a “health insurance exchange” and (5) a “fair share” contribution from employers. These five features are explored in more depth below.

- **Individual Mandate.** The Massachusetts law provides for an individual mandate, which requires residents of the Commonwealth over age 18 to have health insurance benefits that meet at least a minimum standard. Residents can file for an exemption from the requirement based on their sincerely held religious beliefs, and any resident who can demonstrate that coverage is unaffordable is also entitled to an exemption. The Commonwealth offers subsidized health insurance for low income residents to assist in satisfying their obligations under the mandate. Penalties are imposed on those subject to the mandate who fail to obtain coverage. The current penalty, assessed by the Massachusetts Department of Revenue through annual tax filings, is a fine of up to 50% of the monthly premium that the individual would have to pay for the minimum amount of coverage for each month that the individual is without coverage. For 2009, penalties could be as high as \$1,068 a year.
- **Creditable Coverage.** Creditable coverage is the minimum amount of health insurance a Massachusetts resident must have in order to satisfy the individual mandate. The minimum requirements for creditable coverage were phased

in over time to provide residents with the opportunity to comply. Currently, in order to satisfy the requirements of the individual mandate, residents must have a health benefit plan that provides core services (including physician services, inpatient care, day surgery and diagnostic procedures), as well as a broad range of medical benefits (including preventive and primary care, emergency services, hospitalization, prescription coverage and mental health and substance abuse services). Beginning in 2010, creditable coverage must also provide x-rays, maternity and newborn care, radiation therapy and chemotherapy. In addition to these coverage requirements, the creditable coverage standards also address annual limits on deductibles and other out-of-pocket expenses.

- **Subsidization of Insurance Premiums.** To help ensure that Massachusetts residents can afford insurance coverage, Massachusetts developed the Commonwealth Care Health Insurance Program. Commonwealth Care provides health insurance subsidies and no-deductible plans to low and middle income Massachusetts residents who are not eligible for employer coverage or government-sponsored coverage. Commonwealth Care provides sliding-scale insurance premium subsidies for individuals with incomes of up to 300 percent of the federal poverty level. Individuals with incomes of less than 150 percent of the federal poverty level pay no insurance premiums. Commonwealth Care is not a “public plan” of the type that has provoked such controversy in the federal debate; instead, it provides public subsidies for individuals to enroll in independently operated plans.
- **Health Insurance Exchange.** Massachusetts has created a health insurance exchange called the Commonwealth Health Insurance Connector Authority, known to most simply as the Connector. Through the Connector’s web-based interface, individuals and small businesses can compare different private insurance plans and choose the plan most suitable for their needs. To facilitate plan comparisons, the Connector categorizes insurance plans into three levels: “bronze,” “silver” and “gold.” Bronze level plans generally have lower premiums but higher copayments and deductibles, whereas gold level plans have higher premiums but lower copayments and no deductibles. The only plans offered through the Connector are those that have received the Connector Seal of Approval from the Connector Board. Such plans adhere both to the minimum creditable coverage standards and any other requirements established by the Connector.
- **Fair Share Contribution.** Massachusetts health reform has implications for employers as well. Employers with 11 or more full-time equivalent (FTE) employees must comply with

a fair share contribution requirement as follows. Employers with 50 or fewer FTE employees are deemed to be making a fair share contribution if at least 25% of their employees participate in their group health plan (the Percentage Test) or the employer offers to pay at least 33% of the cost of individual coverage for full-time employees after 90 days of employment (the Premium Contribution Standard). Employers with more than 50 full-time employees must comply with both the Percentage Test and the Premium Contribution Standard unless 75% of such employer’s full-time employees are enrolled in the group health plan during the quarter in which the fair share contribution is measured, in which case the Premium Contribution Standard does not apply. Employers who do not satisfy the fair share contribution requirement are required to contribute to the state health insurance pool an annual amount not to exceed \$295 per full-time employee.

Although federal reform is likely to differ in significant details from the Massachusetts model—and it is not yet clear how the Massachusetts program would be affected by nationwide reform—the program offers important insights into how a reformed system might work. ■

Interview with Christina Severin and Leanne Berg of Network Health

This month *Health Reform Matters* interviewed Christina Severin, President, and Leanne Berge, Vice President, Strategic Planning and Business Development, of Network Health. Cambridge Health Alliance, a safety net system, originally formed Network Health as a Medicaid managed care plan in 1996. With the onset of Massachusetts health reform, Network Health also began offering one of the four subsidized plans available through the Commonwealth Connector – Massachusetts’ regulated health insurance exchange. Through these two products, Network Health provides comprehensive, high-quality care to over 160,000 low-income enrollees.

Health Reform Matters (HRM): The Senate Finance Committee recently released a report outlining various policy options for expanding coverage under comprehensive health reform at the federal level. This report appears to adopt many elements of the Massachusetts model, such as the proposed health insurance exchange, non-group and small group market reforms, and the possibility of private market reforms in lieu of a comprehensive public plan. What lessons learned and challenges faced during the implementation of health reform in Massachusetts do you believe should guide the federal effort to establish universal coverage?

CS and LB: Massachusetts has unique characteristics that may make expanding our model nationwide difficult. The distrust of health

insurers held by many Americans is not as pervasive in Massachusetts. The major Massachusetts insurers are all non-profit and locally-based and have long-standing relationships with the communities they serve; they are not viewed as impersonal, faceless national corporations. Given Massachusetts's small size, the key health industry stakeholders also tend to know and trust each other.

Massachusetts could help to inform the debate over a public plan. Although most of our health reform has occurred through the private marketplace, the State continues to directly operate a Medicaid so-called managed care plan, called the Primary Care Clinician Program, or the "PCC." The PCC plan is largely fee-for-service without the benefits of managed care tools. Our experience has been that this relatively unmanaged "public plan" increases, rather than restrains, overall health care costs when it is offered as a side-by-side option for all Massachusetts Medicaid enrollees. We have found that providers are less willing to contract with managed Medicaid organizations, including Network Health, unless they can obtain a higher level of reimbursement. To counter this effect, private plans have been forced to pay higher rates to health care providers as part of the contracting process. So having a competing public plan has inadvertently driven up private plans' contracting costs. So, although Medicaid managed care plans are proven time and time again to be more cost effective than state-run PCC plans due to their care management programs and their administrative efficiencies, these plans could offer an even greater level of savings if they were not competing against a public plan.

Given private managed care plans' success at covering the uninsured in Massachusetts, we do not think the federal government should establish a single, national public plan. Instead, it should allow each state to develop its own version of a public plan. States could choose whether to administer this plan directly or to contract with a local not-for-profit managed care organization to serve as the administrator. A safety net health plan (i.e., a plan that is not-for-profit and primarily serves Medicaid and other publicly funded enrollees) would have the infrastructure and experience to successfully balance cost containment with a community focus.

Safety net plans, like Network Health, enabled the quick roll-out of Massachusetts health reform. Health reform was signed in April 2006 and became operational that fall. With many new low-income enrollees suddenly eligible for coverage, the safety net plans were able to leverage their longstanding provider relationships and ensure that these new enrollees continued to have access to their existing provider networks and other providers in their communities.

HRM: How has Network Health's business model changed post-health reform? Do you think that Network Health and other plans in Massachusetts

will have an advantage within Massachusetts and in efforts to expand to other states if comprehensive health reform is passed based on the Massachusetts model?

CS and LB: Our business model has generally remained the same, while our business has virtually doubled. We went from having one contract with State government (for Medicaid) to two (Medicaid and the Commonwealth Health Insurance Connector). Yet despite the increase in volume, we have not had to develop a new business model, because the two contracts are quite similar, as are these two membership populations; and for the most part we were able to build on the infrastructure already established. As we have discussed, Massachusetts is a very local health care market, and that for the most part is not welcoming to national for-profit players. We would expect our experience with Commonwealth Care to be an advantage in other states assuming health reform passes in a model similar to Massachusetts.

HRM: One major point of contention has been whether comprehensive health reform should include a public plan option. One of this plan's purposes would be to cover low-income individuals who are unable to afford private plan premiums. As a plan specifically designed to serve the low-income population, what are your thoughts on a public plan?

CS: As we discussed earlier, a publicly-run plan will not necessarily be effective at controlling overall health care costs if it is directly managed by the government. I also think it will be tough for any agency to wear two hats, both administering its own plan and regulating all plans. For example, the Commonwealth Connector does a very good job at regulating plans through its contracted relationships with the Managed Care Organizations, in addition to the myriad of other functions it performs, like enrolling Commonwealth Care members, setting standards for Minimal Credible Coverage (MCC), setting the annual affordability scale and managing the Commonwealth Choice program (the unsubsidized insurance program for small groups and individuals). All of these functions are complex and technical; running a plan would be a large expansion of the State's role, would create another layer of government bureaucracy and would put the State in a position of competing with the health plans that they are charged with regulating without adding perceptible value.

LB: A public plan does not necessarily have to be publicly administered. It seems that the definition of a public plan also should include public contracts with private plans, particularly not-for-profit plans, since some public concern rightfully seems to rest with the larger profit margins in shareholder backed plans. So why not leverage existing resources and networks by purchasing these services?

***HRM:** Another point of contention has been whether or not to include an individual mandate. Based on your experiences under Massachusetts health reform, which includes an individual mandate, what is your opinion of such a mandate?*

CS: This is a tricky question. Individual mandates can ensure near-universal enrollment if there are affordable options along the income scale, and we make sure that nobody slips through the cracks. For example, residents with access to employer-based coverage are not eligible for Massachusetts's subsidized plans. Yet often times, the employer's plan offers less comprehensive coverage and is relatively expensive, leaving employees with greater out-of-pocket health care costs. We need affordable price points for "creditable" coverage for all people in order to have an individual mandate that is fair and effective.

***HRM:** President Obama, Secretary Sebelius, Governor Patrick, and many others have consistently talked about the need for cost containment as a major initiative within health reform. What are your views on cost containment and how can it be most effectively implemented?*

CS: Ultimately, I think we will see a greater use of global payments, such as those being proposed for Accountable Care Organizations (ACO), which will align the financial interests of different providers. For example, in the current fee-for-service system, overworked and undercompensated primary care physicians are not incentivized to effectively manage their patients' access to care outside of the primary care setting. Doctors do not have the time or incentive to change the behavior of patients who use the emergency room for non-emergency care needs. And, under the current fee-for-service system, the hospital is incentivized to provide this non-emergency care in these expensive settings. If properly integrated, all providers within the system would be encouraged to deliver the most efficient care at the right time in the right setting.

This being the case, there is no one-size-fits-all solution, and certain providers will not find it feasible to be part of such a large, integrated system. For example, many community health centers thrive independently, and currently have relationships with multiple hospitals that may be in distinct ACOs in the future. We will need to think of ways to implement the benefits of global payments with providers who do not fit into a fully integrated system.

***HRM:** Prevention and wellness programs have featured prominently in many health reform proposals, and are often described as cost containment programs. Network Health offers wellness programs to enrollees and uses a comprehensive interdisciplinary approach to managed care. How significant do you believe these programs will be to the success of comprehensive health reform?*

CS: To-date, Network Health, and insurers generally, have been unable to prove an unqualified return on investment in prevention and wellness programs. Because our members typically stay with us for less than a year, we are not afforded enough time to see results from longitudinal programs such as BMI (body mass index) reductions, smoking cessation or even diabetes management, for example. We continue to invest in these programs because they are the right thing to do, are part of our mission, and are embedded in our contracts with the State.

LB: The return on prevention and wellness programs is societal, not one that necessarily will benefit individual plans, particularly Medicaid health plans which experience so much churn. Nevertheless, we ensure that these programs are implemented in a robust manner for the good of individual members and for the good of the health care system overall. ■

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