

# Massachusetts Tries to Rein In Its Health Costs

By [ABBY GOODNOUGH](#) and [KEVIN SACK](#)

BOSTON — On the Republican campaign trail, the health care debate has focused on the mandatory coverage that [Mitt Romney](#) signed into law as governor in 2006. But back in Massachusetts the conversation has moved on, and lawmakers are now confronting the problem that Mr. Romney left unaddressed: the state’s spiraling health care costs.

After three years of study, the state’s legislative leaders appear close to producing bills that would make Massachusetts the first state — again — to radically revamp the way doctors, hospitals and other health providers are paid.

Although important details remain to be negotiated, the legislative leaders and Gov. [Deval Patrick](#), all Democrats, are working toward a plan that would encourage flat “global payments” to networks of providers for keeping patients well, replacing the fee-for-service system that creates incentives for excessive care by paying for each visit and procedure.

“We have shown the nation how to extend care to everybody,” Mr. Patrick said in an interview, “and we’ll be the place to crack the code on costs.”

Those who led the 2006 effort to expand coverage readily acknowledge that they deferred the more daunting task of cost control for another day. It was assumed then that the politics would pit doctors, hospitals, insurers, employers and consumers against one another, and obliterate the fragile coalition behind the groundbreaking coverage law.

Predictably, the plan did little to slow the growth of health costs that already were among the highest in the nation. A state [report](#) last year found that per capita health spending in Massachusetts was 15 percent above the national average. And from 2007 to 2009, private health insurance premiums rose between 5 and 10 percent annually, according to [another state study](#).

Yet the plan, which generated fresh attacks on Mr. Romney in a recent New Hampshire debate and a blistering Internet ad by Gov. Rick Perry of Texas, has largely succeeded in providing nearly universal coverage. Only 2 percent of residents and a fraction of 1 percent of children in Massachusetts are uninsured. The law’s popularity has given state leaders added incentive to make it financially sustainable.

But the process has been painstakingly slow. It started in 2008, when the Legislature appointed a commission to study changes in the medical payment system. A year later, the commission

recommended the broad outlines of a global payment plan that essentially calls for teams of providers to be put on a budget for each patient's care.

The networks would receive an annual fee for the care of each patient, with higher payments for patients deemed to be greater health risks and with bonuses for high-quality care. In theory, the healthier these so-called accountable care organizations can keep their patients, the more reimbursement they can pocket as profit. Insurers are already required to accept all applicants in Massachusetts, as will be the case nationally, in 2014, if the new [federal health care law](#) survives its legal and political challenges.

In February, three months after Mr. Patrick's re-election, he submitted a bill that would impose a global payment system for most state employees, [Medicaid](#) recipients and others with state-subsidized health insurance — roughly one in four residents.

His plan would set parameters to help private insurers and providers follow suit, in the hope that they would gradually gravitate to global payments, without coercive legislation. And it would give the state's insurance commissioner broader authority to reject premium increases deemed excessive, with an added goal of holding down hospital costs.

Lawmakers in each chamber have struggled to draft their own proposals, which they hope to bring to a vote by early next year. In the House, one idea is to move health care providers to a global payment system within three years, with a goal of keeping health care spending increases to about 3.9 percent a year after that — roughly the typical growth in the state's gross domestic product.

But State Representative Steven Walsh, House chairman of the Joint Committee on Health Care Financing, said it would be crucial to move slowly, adding that it could take 15 years "to squeeze all the inequities out of the system."

Because medical spending is driven not just by volume but also by pricing, a major question has been whether global payments alone will have much effect. It may be equally important, Mr. Patrick and others argue, to rein in the ability of the state's most prestigious teaching hospitals and physicians' groups to negotiate high rates of reimbursement.

A series of news media and government investigations have revealed that large, high-status providers, like Partners HealthCare System, which owns the Harvard-affiliated Massachusetts General and Brigham & Women's hospitals, command substantially higher reimbursement from insurers than other entities.

In [reports](#) the last two years, Attorney General Martha Coakley, a Democrat, has concluded that differences in payments to hospitals cannot be explained by variations in their quality, the mix of their patients or the costs of academic medicine. Last month, the House majority leader, Representative Ronald Mariano, introduced a bill that would force insurers to narrow the inequities in payments.

Mr. Patrick said the state needed to help struggling hospitals by raising Medicaid reimbursement rates. But he also cited his insurance commissioner's recent denials of premium increases as the kind of pressure needed to keep prices down. "I think having the authority that we have in respect to the insurers has been a very, very important tool," Mr. Patrick said, "and we need similar authority with the hospitals."

Massachusetts has had a model for global payments since 2009, when Blue Cross Blue Shield of Massachusetts, the state's biggest health insurer, began experimenting with an "alternative quality contract" that pays groups of doctors and hospitals a set fee to work as a team in caring for patients. The plans cover about 613,000 people, or roughly two-thirds of Blue Cross members in health maintenance organizations, but none of those in preferred provider organizations.

This month, in an important advance, Partners HealthCare joined the program, with incentives to keep cost growth below the Blue Cross average.

"It's a big deal," said Stuart Altman, a health economist at Brandeis, "because they're the biggest player in town and it sort of solidifies that this will be one of the major changes in the system and that it's likely to be around for a while."

Under market and political pressure, Partners also agreed to renegotiate its contract with Blue Cross Blue Shield and accept lower reimbursements, which is expected to save \$240 million over three years. Andrew Dreyfus, president of Blue Cross Blue Shield of Massachusetts, said payments to Partners would increase at about 2 percent a year rather than the previously anticipated 5 percent to 6 percent.

The politically powerful hospitals clearly hope to persuade lawmakers that price controls are not needed. "This contract is evidence that at Partners, we think the market is working to address affordability," said a company spokesman, Rich Copp.

Mr. Patrick said such experiments were important, but did not go far enough. "We still need a bill because we've got to have scale," he said. "It can't be one-offs."

Initial resistance is also expected from doctors. The most recent annual [work force study](#) by the Massachusetts Medical Society found that nearly 60 percent of physicians — and higher rates of specialists — said they were not likely to join a voluntary global payment system.

But Mr. Walsh said that doctors and other stakeholders were becoming more comfortable with the idea. "It's not seen as a foreign approach anymore," he said.

Abby Goodnough reported from Boston, and Kevin Sack from Atlanta.