**TESTIMONY RELATIVE TO H.1239/S.744**
**AN ACT ESTABLISHING MEDICARE FOR ALL IN THE COMMONWEALTH**
**BEFORE THE JOINT COMMITTEE ON HEALTH CARE FINANCING**
**NOVEMBER 14, 2023**

The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, for a better health care system, and on behalf of physicians, to help them provide the best care possible.

As an organization, we believe health care is a human right and we advocate for policies that we believe can successfully and effectively promote universal access to equitable, comprehensive, affordable, high-quality, administratively streamlined health care. To that end, we have reviewed H.1239/S.744, *An Act establishing Medicare for all in the commonwealth*, to assess and evaluate whether and how this proposed payment structure may be able to achieve these goals. While the stated goals and objectives of this proposal align with our policies and goals around universal access, we do not believe this legislation as written can achieve those goals and we have significant concerns about both a lack of detail, as well as many legal and practical barriers to implementation. As such, we believe this proposal requires further study. In addition to identifying our concerns with this legislative proposal, the MMS wishes to share related policies below adopted by our House of Delegates, to provide the physician perspective on a range or relevant approach and issues relating to health care access, payment reform, and quality assurance.

We support the explicit stated goals of the legislation as outlined in Section 2, including the aspiration to provide equitable access to quality, affordable health services for all residents as a right. However, we are doubtful of the ability of the proposed legislation to reach those goals for the following reasons. A foundational concern regarding H.1239/S.744 is that it proposes to eliminate other forms of insurance and replace it with a single payor system in Massachusetts, but does not acknowledge the lack of legal authority to do so. For example, there is currently no legal pathway to divert Medicare funds to a

Massachusetts trust as the legislation proposes – this would require a federal legislative change, which seems an insurmountable barrier at present. Moreover, while Massachusetts could in theory pursue an 1115 Demonstration Waiver in the Medicaid program seeking to divert all Medicaid funds into the Trust, however without significant and comprehensive details about the program, which is lacking in this proposal, it is doubtful such a waiver would be approved; lastly, Massachusetts does not have the authority to eliminate federally-regulated, self-insured health plans (this legislation proposes to prohibit insurers from collecting premiums for health services covered by the Trust), which accounts for approximately 60% of the commercial market in Massachusetts.

Beyond these significant legal concerns, we have other practical concerns regarding how this proposal can be implemented and operationalized. As a practical matter, the proposed structure of the Trust and its various responsibilities is not designed to work in our current agency structure. For example, the new Board has many overlapping responsibilities with the Health Policy Commission and the Center for Health Information Analysis, including, for example, evaluating performance of the health care system. Additionally, the Board is given oversight responsibility for evaluating requests by health facilities for capital investments, a process current sitting within our Department of Public Health through our extensive statutorily derived Determination of Needs process. There is no consideration of whether or how the responsibilities and oversight currently carried out by our Division of Insurance would be handled moving forward. How are these responsibilities of the Board to be reconciled with our current agency responsibilities and statutory processes? The bill also proposed to create a re-envisioned health care information technology structure, which would be extremely costly and cumbersome, but does not contemplate how a new system would be integrated or work with existing electronic health record platforms, which were extremely costly and time-consuming for practices and health systems to implement. Additionally, it is not clear whether and how all the patient protections established in Chapter 176O would apply should the commercial market cease to exist in Massachusetts. On a very practical level, this proposal does not take into consideration the serious amount of capital infusion that would be required from the commonwealth at the outset to stand up the trust and attempt to implement and operationalize.

Additionally, we are concerned about the tremendous amount of responsibility allocated to the Board of the newly created Massachusetts Health Care Trust, absent material and satisfactory parameters or statutory guidelines for implementation. For example, the legislation essentially establishes government rate setting through the Board without any guidance as to how reimbursement rates would be set, what

factors would be considered, and whether and how they would address current challenges with government funded health services including a lack of inflationary updates and a fee schedule that is reflective of real-world practice costs. There is also no high-level guidelines as to whether reimbursement would be effectuated vis-à-vis a fee-for-service mechanism versus a global or capitated program. The Board is entrusted with an overwhelming amount of responsibilities with minimal parameters or oversight.

The MMS thanks the Committee on Health Care Financing for your consideration of these comments and our related policies in its deliberations. For the reasons above, we believe H.1239/S.744 requires further study.

## Related MMS Organizational Policies

### Health Care Is a Basic Human Right

The Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right. (HP)
The provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. (HP)

*MMS House of Delegates, 5/4/19*
*Reaffirmed MMS House of Delegates, 12/10/22*

### Universal Access

The MMS supports and will advocate for universal access to equitable, comprehensive, affordable, high-quality, administratively streamlined health care through a national health program, as well as through legislation at the state level and will continue to explore and evaluate payment structures that may be able to achieve these goals. (HP/D)

*MMS House of Delegates, 5/13/23*

The Massachusetts Medical Society supports comprehensive health coverage that provides universal access to equitable, high-quality, continuous, affordable health care, and is open to supporting any proposal that achieves this fundamental universal coverage goal. (HP)
The Massachusetts Medical Society will take a leadership role in advocating for comprehensive health coverage that provides universal access to equitable, high-quality, continuous, affordable health care, and oppose proposals that undermine these principles. (D)

*MMS House of Delegates, 12/5/20*

The Massachusetts Medical Society supports a system for health insurance coverage that allows for universal access to quality, equitable, affordable coverage. (HP)

The Massachusetts Medical Society take a leadership role in advocating for health insurance coverage that allows for universal access to quality, equitable, affordable coverage. (D)

*MMS House of Delegates, 12/7/19*
*(Item 3 of Original: Sunset, Time-Limited Directive Completed, MMS House of Delegates, 12/5/20)*

**Ideal Payer System**

The Massachusetts Medical Society (MMS) defines an ideal payer system and the definition encompasses goals that include:

- universal coverage of population;
- coverage of preexisting conditions;
- accessibility to everyone regardless of location or background;
- portability for all medically necessary services; and

The MMS definition of an ideal payer system encompasses comprehensive services that include:

- acute and chronic illness care;
- prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablements;
- rehabilitation of disabled persons: to improve their function for work and living;
- immunization;
- counseling and other behavior health support;
- unimpeded access to appropriate specialty and subspecialty care; and

The MMS definition of an ideal payer system encompasses qualities, that include:

- efficiency/cost-effectiveness;
- equity/fairness, convenience and satisfying;
- maximal patient and physician involvement and engagement, including, choice, mutual decision-making, and respect;
- use of appropriate technologies, scientifically assessed for the needs of patients;

- continuous improvement efforts for better health care;
- outcomes through: practitioner education, at the undergraduate, graduate, and continuing medical education levels;
- research; • reorganization of processes of care;
- professional self-management, internal to the practice;
- voluntary participation of physicians and patients; • maintain freedom of physicians to contract directly with their patients;
- individuals retain right to establish medical saving accounts and to purchase catastrophic health insurance from insurer's of their choice
- maintain freedom of entry into the health insurance market and attention given and care delivery changes made based on outcome measurement and patient and physician experience surveys; and

The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- simplicity uniform administrative criteria for eligibility and billing, single forms, single open formulary;
- accountability;
- consistency in benefit coverage limitations related to scientific evidence and expert opinion;
- timeliness;
- responsiveness: correction of defects; and
- appropriate funding (HP)

*MMS House of Delegates, 5/2/03*
*Reaffirmed MMS House of Delegates, 5/14/10*
*Amended and Reaffirmed MMS House of Delegates, 4/29/17*

**Principles for Health Care Reform**

The Massachusetts Medical Society adopts as amended the Principles for Health System Reform policy adopted at A-11 to reads as follows:

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1) *Physician leadership*. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment

reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2) *One size will not fit all.* One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.
3) *Deliberate and careful.* Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.
4) *Fee-for-service payments have a role.* While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.
5) *Infrastructure support.* Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.
6) *Proper risk adjustment.* In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.
7) *Transparency.* There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.
8) *Proper measurements and good data.* Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.
9) *Patient expectations.* Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering

new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10) *Patient incentives*. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.
11) *Benefit design*. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.
12) *Professional liability reform*. Defensive medicine is not in the patient's best interest and increases the cost of healthcare. A payment model where physicians have the incentive to do less, but combined with an environment where patients request more, may lead to increased litigation as an inevitable outcome unless there is effective professional liability reform.
13) *Antitrust reform*. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state and federal legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
14) *Administrative simplification*. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.
15) *The incentives to transition*. In order to transition to a new model, incentives must be predominantly positive.
16) *Planning must be flexible*. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.
17) *Primary care physician*. All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.
18) *Patient access*. Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities. (HP)

*MMS House of Delegates, 5/21/11*
*Amended and Reaffirmed MMS House of Delegates, 5/4/19*