Beyond Harvard Pilgrim

Managed Care and the Health Care Markets in Massachusetts: Where Do We Go from Here?

Harvard Pilgrim Health Care's financial woes may be off page one, but the implications of its receivership continue to ripple across the state. For public policy makers and health industry leaders alike, the challenge is to better understand what led to the problems, not just at Harvard Pilgrim, but across the state's health care system. And the opportunity is to consider steps to forestall the next round of crisis headlines.

Easily said; not easily accomplished. But as this Mass Insight report reveals, 15 experts from disparate corners of the Massachusetts health care world share a fair amount of consensus on the diagnosis of the problems—and, surprisingly, on the state's role in the cure.

continued on page 3...

Top experts discuss:

- Lessons Learned
- Next Steps
- Consensus on Roles for the State

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(continued from page 1)

A COMPLEX NETWORK MAKES up what we call the health care system in Massachusetts. Different interests can offer varying explanations for the same problem. Even when parties agree on a diagnosis, they may dispute the remedy. But a look back at the problems leading up to the Harvard Pilgrim crisis can provide lessons and opportunities for the state. Several areas of consensus among experts should provide guidance as policy makers and health industry leaders move forward:

- **Managed care *has* been successful in some ways.** For all the serious problems that exist now, the state's move to a deregulated system emphasizing managed care and market-driven incentives was successful in some important ways. Managed care did result in significant cost savings that helped keep insurance premium rate increases below what they might otherwise have been.

- **External factors have driven costs to rise.** Many of the financial and other problems that now face providers, payers, employers and consumers are driven by external forces, such as soaring pharmaceutical costs and federal actions such as the Balanced Budget Act. At best, the state can deal only marginally with such factors.

- **The health care system too often has not helped itself.** Many problems facing important pieces of the state's health care system have been self-inflicted. Unrealistic premium rate underpricing by HMOs, done to secure market share, is a glaring example.

- **The state can play a more useful role—without taking over.** Few favor steps back—or toward—major new state regulation. But the state can at least play a better and more coordinated role as watchdog, analyst, information source and even neutral arbiter of health care market issues.

If such agreement exists at 50,000 feet, consensus about overall causes and solutions is less clear at ground level. In part, that reflects a health care sector made up of individual constituencies with priorities and interests that often conflict.

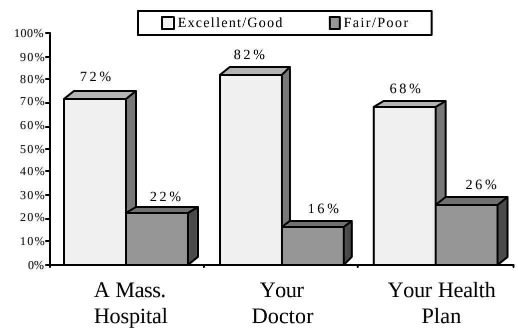
No single paper can completely identify and explain—let alone resolve—such differences. Our hope is to offer a general road map that begins with how the state arrived at its current point, looks in overview terms at where we are now and then suggests directions that might help avoid the next big health care pothole.

Where appropriate, the story is told—and told best—in the actual words of 15 Massachusetts health care experts interviewed by Mass Insight for this report (see inside front cover). We acknowledge their support and appreciate their time and cooperation.

The Mass. Perspective

This report should be viewed within the context of high public satisfaction with health care quality in Massachusetts. A January 2000 Mass Insight/Opinion Dynamics survey showed that the vast majority of Massachusetts residents continue to give hospitals, their doctors, and their health plans ratings of "good" or "excellent." (See pg. 5 for more data).

Rate your most recent experience with:



January, 2000; tel. survey of 500 Mass. residents

Table of Contents

Background .... pg. 4
Cost Pressures Build .... pg. 5
HMO Growth Strategies Contributed to the Problem.. pg. 6
Massachusetts Has Its Own Issues .... pg. 8
Where the State Can Make a Difference .... pg. 9

I. Background: The Shift to Market-Driven health care

GOING INTO THE 1980S, health care in Massachusetts generally fit a national pattern. Hospitals and other important players worked within a regulated environment. Fee for service was the norm, with payers sending large infusions of cash into the system. Because hospitals were paid on a cost-plus basis, incentives to control health care costs were few. And when the state did seek to contain costs—by regulating the supply of hospital beds, for example—affected parties would turn to the political arena and often undo such cost-containment efforts.

WITH NO FEDERAL SOLUTION at hand, states were left to craft their own ways to maintain health care quality while reducing system costs.

In 1991, Massachusetts acted. Through Chapter 495, it replaced regulation with market-driven competition. The premise and promise were simple: Market-driven incentives and an expansion of managed care would bring costs under control. Employers, faced with steep annual premium rate increases and heavy bottom-line costs for health care, began to turn increasingly to HMOs, which had been largely left out of state regulation. State policy had already fostered the rapid growth of such plans.

> The premise and promise were simple: Market-driven incentives and an expansion of managed care would bring costs under control.

"The reason we deregulated was because the benefits of regulation became outweighed by the disadvantages," said one Mass Insight interviewee. "By 1991, a variety of dynamics were converging: The hospital system had become so expensive that the business community was rebelling. And HMOs, which in the early years of state rate setting were the little engine that could, were by 1990 becoming major players." (All quotes are from interviews with the experts listed on page two of this report).

HMOs and managed care were supposed to tame premium and other health care cost inflation through their gatekeeper role and by putting together networks of efficient providers. By controlling doctors—who generate much of the system's expenses—managed care would control costs, the theory went.

COMBINED WITH STATE POLICY actions, the market-driven model, which had managed care as its leading element, did deliver early successes.

During the early 1990s, inefficiencies were squeezed out of the system, resulting in cost savings that in turn helped keep insurance premium rate increases below what they might otherwise have been (as will be discussed later, other factors also contributed to these lower premiums). And consumer satisfaction with the quality of care remained high.

"Competition definitely did take capacity out of the hospital system that 15 years of state planning could not do. A lot of hospitals have closed, which would not have happened if left within the regulated system. But it does raise the question: Did we take the right hospitals out?"

One other health care system barometer stands out: The number of people in Massachusetts lacking health insurance remains well below the national average. But this is not necessarily due to the market-driven model. To the contrary, the number of uninsured people grew in Massachusetts during some of the years after deregulation. The recent drop from 1997 to 1998 was prompted mainly by legislative actions, not by the notion that the market would lower prices in ways that would lead to greater access.

II. Cost Pressures Build: But Find No Release

EVEN AS EMPLOYERS AND policy makers issued a collective sigh of relief over these early premium rate and other system improvements, seeds were already being planted for the financial pressures that would fully bloom in the late 1990s.

SOME OF MASSACHUSETTS' high health care costs reflect unique factors, including:

- Capacity levels in teaching hospitals—and their use by consumers—that are far above national averages.
- A higher ratio of physicians to population.
- Massachusetts' high overall cost structure.
- Extensive state mandates to cover specific, and often expensive, treatments.
- Demographic factors, including an older-than-average population.

OTHER UNDERLYING COST PRESSURES are due to health care system trends that will likely continue:

- Prescription drug costs and consumer demand for heavily-marketed new and expensive drugs are soaring.
- Technology creates more and more sophisticated medical devices that are expensive for providers to buy and patients to use.
- Ambulatory surgery, intended in part to save on costly hospital stays, is increasing in both cost and volume.
- Costs of maternity, chronic care and end-of-life care are rising, partly reflecting changing demographics.

According to teaching hospital officials and others, Massachusetts has also been hit hard by the Balanced Budget Act of 1997 (BBA), which was aimed at slowing the growth in Medicare spending. BBA's impact has hit Massachusetts providers, especially its teaching hospitals, far harder than anticipated.

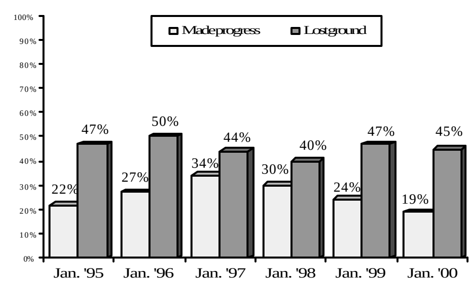
At the same time, Medicare's national rate system especially hurts high-cost states such as Massachusetts. Because of inadequate Medicare reimbursement, providers pass costs on to employers, who may pass them on to employees, resulting in higher health care costs for them. Medicare problems cannot be fixed at the state level, but the Massachusetts congressional delegation has been urged to keep working on this reimbursement issue.

"For much of the 1990s, Medicare spending by the federal government enabled plans and hospitals to all compete by shifting costs. With the BBA, the feds were basically saying, You've been dumping costs on us so you can low-ball costs to HMOs and employers. That's now going to stop."

The Mass. Perspective

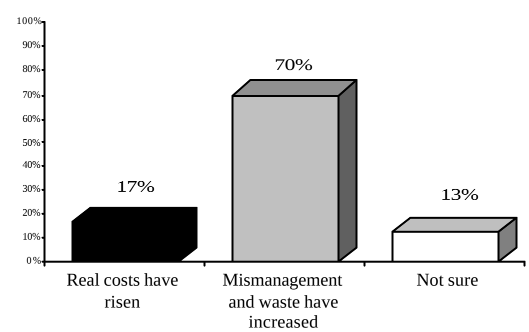
While very satisfied with their own health care, most Massachusetts residents believe the system overall needs changes. Although most say they have seen progress in the economy, crime and the environment, the January 2000 Mass Insight/Opinion Dynamics survey shows that the public believes the state has made little progress in containing health care costs.

Little Progress Seen in Controlling Health Care Costs



In the midst of an industry debate over why costs have increased, the public believes that "mismanagement and waste," are not real factors. The state's HMOs and hospitals need to more effectively communicate the size and nature of their financial situation to counter this notion.

Public Sees Mismanagement as Cause of High Costs



For a copy of the complete report, "Public Attitudes on Health Care and Managed Care in Massachusetts," call Mass Insight at 617-722-4160 x18.

III. HMO Growth Strategies Contributed to the Problem

WHILE THESE EXTERNAL drivers are significant, many of today's financial problems are the result of questionable business decisions by HMOs themselves—and the state's failure to detect and prevent them.

Unlike other states, HMOs were deliberately left out of the rate setting structure that was in place in Massachusetts before deregulation. As a result, Blue Cross—which at the time was the giant among health insurers—Medicaid and commercial insurers all had to reimburse hospitals according to rate setting rules, leaving the HMOs free to underprice Blue Cross and pay hospitals less. In essence, despite its huge size, Blue Cross was left unable to bargain for favorable rates.

This policy—along with such other factors as internal administrative problems and the attempt to absorb Bay State health care—helped trigger the earlier Blue Cross financial crisis that in some ways was a precursor of Harvard Pilgrim a few years later. But at the same time, this policy helped enable HMOs to quickly solidify their base in Massachusetts. A higher percentage of people under 65 belong to managed care plans in Massachusetts than in any other state.

In this unregulated environment, price wars broke out among HMOs, some of which offered unrealistically low premium rates to win over employers. For employers, the payoff was lower rates (also due in part to one-time savings that usually follows a shift from fee-for-service to managed care). For the plans, covered lives became Job One.

"The marketing departments of Harvard Pilgrim and some of the other plans ended up having much more say in premium rate setting than the underwriting departments," said one interviewee. "Employers were getting rates under best-case assumptions. Which turned out to be wrong."

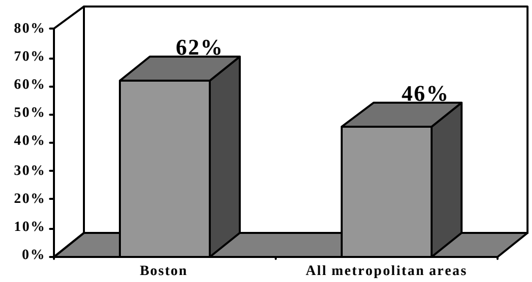
This success in signing up members initially helped the plans build up large cash reserves, some of which were used to acquire additional holdings and properties in Massachusetts and New England. Many of the out-of-state experiments failed. Combined with premi-

Note: Source for first three data charts: 1997 Center for Studying Health System Change, Community Tracking Study; source for fourth chart: American Medical Association and American Osteopathic Association.

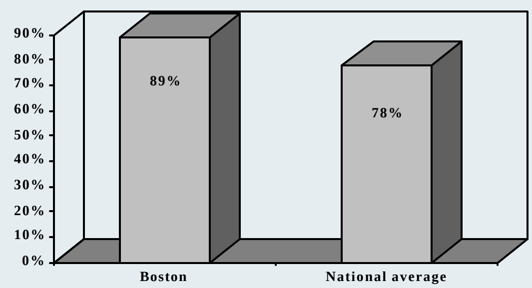
* non-federal, patient care physicians, excluding certain specialties

Facts and Figures

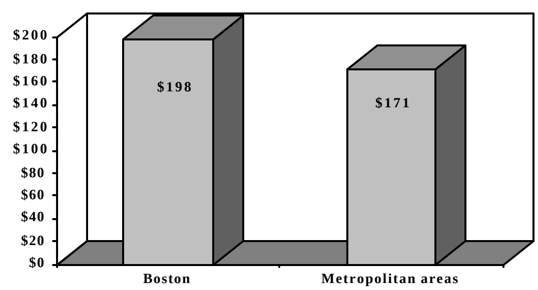
Insured Persons Covered Under Gatekeeping Arrangements



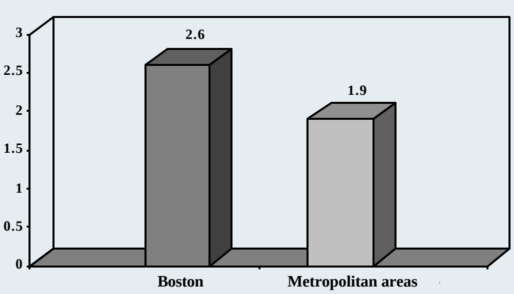
Consumer Satisfaction with Managed Care



Average Monthly Premium for Employer-Sponsored Insurance



Physicians* per 1000 Population, 1997



um under-pricing, the administrative and financial burdens alone that came with such expansion would be the second domino in a financial tumble.

"The plans saw a strategic value in taking short-term losses by making toeholds in other geographies, transferring dollars from core markets to new markets. In all cases, they did it with such a total lack of regulation that they put their fundamental mission of paying claims and providing care at risk. And in just about every case, they were bad decisions."

WITH THEIR MAJOR FOCUS on gaining market share, the plans' primary mission—acting as gatekeeper to improve health care system efficiencies while retaining quality—was often neglected.

While some organized employer associations tried, without much success, to warn that a bubble was being created that would inevitably burst, most purchasers "were perfectly happy to just keep taking advantage of the plans all spending each other to death" through expansion and acquisition.

> In this unregulated environment, price wars broke out among HMOs, some of which offered unrealistically low premium rates to win over employers.

Plans felt pressured to become larger because of the insistence by major purchasers for wide networks and choices. The Harvard-Pilgrim merger is an example of plans increasing their size not so much to increase efficiencies but to satisfy purchasers who demanded wide and relatively unlimited access to providers. Harvard Pilgrim ended up handling about 1800 different contracts, a complexity that adds tremendous administrative and other burdens for both provider and plan.

"As employers, we're schizophrenic," said an employer interviewee. "On the one hand, we want quality care and we want (our insurers and plans) to manage care. But then if they do manage care, our employees complain to us. So we continue to demand wide access, which of course serves to offset the whole cost-saving notion of managed care." As another interviewee more tersely put it, "This was the miracle of the marketplace run amuck."

Rather than integrated elements within a health care system, the managed care plans have increasingly acted more like insurance companies, albeit in a special category.

Should State Government Have Played a Stronger Role?

By virtually all accounts, state government was either unaware of or did not fully understand the implications of premium underpricing, acquisitions and other business moves by the plans. One important reason was that in fact, HMOs were undergoing a fundamental role transformation from being largely providers to being basically insurers. Other factors that were cited included:

- Insufficient financial requirements on the plans;
- Inadequate data coming in from health plans, providers and others;
- Insufficient staffing and expertise within state agencies to analyze data, even if it was available. Beginning with deregulation in 1991, many people with the most experience in health care issues began leaving state government.

Whatever the causes, "state government has been significantly asleep at the wheel. They didn't see what was going on and they should have been able to. A more alert public sector health leadership could have identified problems earlier and forced corrective changes."

The problem is that the state went from a regulated model to an unregulated model without setting up a system for mid-course corrections. While few are suggesting major new regulatory bodies, most analysts call for a beefing up of both financial information requirements and the capacity of existing state agencies to review such data.

As one top state official put it, "What is the most effective role for the state? Is it regulation, law or leadership?"

IV. Massachusetts Has Its Own Issues

GIVEN THE HIGH LEVEL of managed care's penetration in Massachusetts, more success would be expected in driving down costs. Why hasn't that happened? To paraphrase Senator John McCain, our own health care iron triangle—plans, consumers and providers individually and collectively—bears responsibility.

- As described above, plans were reluctant to limit provider access for fear of alienating employers and other purchasers, who in turn feared alienating consumers and employees;
- Massachusetts has too many hospitals, some claim. And an oversupply of doctors—nationally and especially here—works against effective gatekeeping. “When 75 percent of the doctors are specialists, the notion that (consumers) have to go through a gatekeeper to see a specialist is clearly bound to fail. We're not talking about good medical care here—we're talking about income.”
- Consumers want to see health care better controlled—but not their health care. “That is the rock and hard place. The rights of the individual are preeminent in this country. When I want my bypass surgery at age 83, I expect to get it. And I expect to get it Monday.”
- Consumers don't pay enough in direct co-payments to encourage them to accept cost-saving measures that don't undermine quality care.
- The collective health care system—plans, payers, providers and government—has failed to properly educate consumers about the need for restraint. Polls show great public worry about health care rationing. But in fact, high costs run up by an insured population in essence creates de facto rationing of health care for the uninsured.
- While endorsing gatekeeping and managed care as a general principle, elected officials or others in government often undermine such efforts by responding to public fears about managed care and mandating coverage for certain costly procedures. In-vitro fertilization was an example cited by several interviewees.

DOUBLE DIGIT PREMIUM RATE increases are returning. No unanimity exists among interviewees about the extent of the financial problem. Indeed, some interviewees disputed the claims of financial crisis altogether: “The (providers) continue to beat the drum that somehow, our health care system is underfunded, and not overpriced,” said one. “Show me verifiable, standardized data to prove it.”

Hospitals claim to be in particular distress, especially community hospitals.

“You simply can't keep asking this industry to cut back and cut back and still expect quality. This system now has absolutely no excess revenue to grow, to create or come up to the levels where we should be in this technological era,” said one hospital industry official.

Countered a health care policy expert: “The hospitals claim they're going down the tubes, but that's just not true.”

But there is a consensus that the plans and other health care components are to some extent undercapitalized, in large part because the plans have so deeply cut into their reserves. The machinations over Harvard Pilgrim demonstrated that Massachusetts' political leadership appears determined to retain the state's unique, largely non-profit health care system. And because non-profits cannot raise capital in equity markets, revenue-raising options are limited.

As already discussed, consumers and providers remain unwilling to limit their provider options and accept limits that would mean real cost savings. Which leaves only one short-term option: Higher premiums.

In the wake of Harvard Pilgrim's receivership, large employers are facing premium hikes averaging about 15 percent. For smaller employers, premium hikes have been far higher, with reports of 40 percent or higher annual spikes. So far, employers—who know that they had been paying rates lower than they might have been without HMO underpricing and other policies—have been willing to pay the extra costs, some of which they in turn pass to employees.

But if the economy cools, will employers be able to endure double-digit rate inflation over the course of several years? And if they pass those costs on, do they run the risk of losing workers in an already tight labor market? Might large employers in Massachusetts turn to the "directed benefit" option—offering 401K-style health coverage, for instance? Such high-stakes questions have prompted the creation of several task forces and other efforts in Massachusetts to consider health care system options.

Executives' Recommendations:

Where the State Can Make a Difference

MASS INSIGHT ADVOCATES NO particular solutions or positions. But based on our interviews with experts from all sectors of the health care industry, we have come up with a range of issues and potential roles for the state that can help advance further discussion.

The State as Financial Monitor

In the wake of Harvard Pilgrim, it is likely that HMOs and other parts of the health care system will soon be legislatively or otherwise required to maintain financial reserves and file more extensive financial data.

Who will analyze that data? And who will enforce the new requirements?

In the 1980s, state policy served to nurture HMO growth. "Rather than debate what form of (price) regulation, there was no regulation. Certain issues such as merger and acquisition activity, minimum capitalization and perhaps most importantly, premium rate adequacy are all areas where people would like to see better, mandated reporting."

But reporting regulations will mean little without a sufficient number of carefully trained auditors and others to review carrier data. "Given the size of this business, regulators in place today are underfunded and underskilled."

Some feel a new, high-level apparatus is needed within state government to serve as a planning and coordinating function, perhaps along the lines of the Health Care Coordinating Council that existed until the early 1990s. Recognizing this problem, Health and Human Services Secretary William O'Leary is now looking into better ways of coordinating agencies and their flow of information.

Some interviewees maintain that existing structures, such as the Division of Insurance and the Division of Health Care Finance and Policy, already have sufficient authority and standing to deal with problems. Others suggested a quasi-public, independent authority that would have both information-gathering responsibilities and sufficient enforcement powers.

The State as Honest Broker

Beyond a regulatory role, health care experts want the state to serve as a neutral forum within which warring health sector parties can help identify and resolve issues, with a more aggressive role in producing credible information for executives and the public.

"Instead of Tufts doing this and Lahey doing that, I would love to have the state bring a group of experts together to identify the four or five most pressing problems that are addressable at the state level and then target one or two of those a year," one interviewee said. "The lack of any coherent state health policy leaves us all just flailing about."

In essence, major health care issues today are defined on a somewhat ad hoc basis, often driven by which particular sector is facing the biggest crisis at the moment.

The state could serve to better define issues in ways that could help lead to agreement and resolution. Credible data and information are central to many of these initiatives:

- **Establish agreed-to facts:** For example, hospitals claim they are losing substantial money, while others contend they are in fact profitable. Might the state commission a credible, third party team of auditors to resolve such baseline disputes and educate the public about the real facts?

- **Verify prompt payment:** Another issue in dispute is over whether providers are being paid both fully and promptly. "This billing and reimbursement business is a disaster," one interviewee said. "In no other business do you submit an appropriate, well-documented bill only to be told months later that it isn't." The state could play a role in determining the extent of the payment problem and help identify causes and solutions.

- **Streamline administrative and information systems:** The lack of uniform billing codes and forms is a problem cited by a wide range of experts. While some interviewees said this is an area ripe for state leadership, others countered that federal uniform coding standards already exist and issues such as coding must be settled federally.

  But all noted that agreement should be achieved at least on the nature of the coding and billing problem. "We have a wonderful opportunity here to get the parties around a table and work out ways to increase the accuracy of information between payer and provider by sharing information, such as current codes. Look at the banking industry: It is able to instantly move huge sums of money around world. State government is in a position to play a role in bringing the different sides together to settle an issue such as this."

- **Simplify contracting:** Right now, thousands of different plans serve thousands of employers. Could the state simplify the contract process by suggesting—though probably not mandating—a limited number of contract models? This would simplify life for both plans and purchasers—while educating consumers about health care costs and options.

- **Encourage outcome-based medicine and consumer education:** Managed care has been given a bad name—and in some cases with good reason—because it is viewed as just an effort to manage costs. Doctors and other providers need to restore its original promise of offering a full range of quality care in cost-efficient ways. Providers should be rewarded for pursuing evidence-based medicine. Consumers must be better informed about the need to restrain costs and that such restraint is in fact essential to the health care system's ability to sustain long-term access and quality. Some employers said they would like to see the state provide an objectively drawn list that ranks providers based on quality outcomes.

- **Independently assess the costs and benefits of proposed mandates:** Twenty years ago, efforts to control the supply of hospital beds were often thwarted by political pressures. Today, well-intended legislative actions often place financially burdensome—and medically unproven—mandates on providers and plans. Example: Mandated coverage of bone marrow transplantation for certain breast cancers which medical literature has now found ineffective.

- **Support the gatekeeper role:** All parties agree that the HMO managed care role is in jeopardy. Massachusetts' system has historically been more open than those of other states, such as California. Efforts by plans to assert their gatekeeper role have recently been undermined by both consumers and providers, though many approaches have been successful. For example, the Group Insurance Commission, the state's largest insurance buyer, offers lower premiums to people willing to stay within selective networks of doctors and other providers. The state's challenge is to support similar gatekeeping efforts by other purchasers and plans.

- **More than 600,000 Bay Staters remain uninsured:** Any policy initiatives must deal not only with this reality, but with the likelihood that that number is likely to rise unless appropriate steps are taken.

In short, all parties have a stake—and a role to play—in making our health care system more effective and efficient while maintaining the high level of quality. But as William Schwartz, a health economist and physician titled his prescient book about such issues nearly 20 years ago, getting to that point will indeed require some "painful prescription."

News Update...

Since these interviews were conducted, the state has taken steps to begin addressing some of the issues highlighted by the experts quoted here. Secretary of Health and Human Services William O'Leary has created two task forces, responsible for examining the issues of finance and access. Heading the Finance Task Force will be Stuart H. Altman, Sol C. Chaikin Professor of National Health Policy at Brandeis University; the Access Task Force will be led by John A. Libertino, Chair of Urology at the Lahey Clinic. Both groups will receive copies of this report to help inform their discussions.

This report is being distributed to the more than 300 experts and leaders, in both the public and private domains, who shape healthcare policy in Massachusetts. Its findings will be taken up by a roundtable of selected leaders, whose recommendations will then provide a basis for action by state policymakers (including the two task forces referred to above), leading healthcare organizations, and employers. For additional copies, please call 617-722-4160 x18 or visit www.massinsight.com.

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This project is based in part on Mass Insight's February 2000 briefing for corporate clients and state leaders and is a product of our work on behalf of our clients.

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Since 1989, Mass Insight has organized leadership groups and facilitated public-private initiatives to improve state performance on issues that have a significant economic impact on Massachusetts.

Mass Insight provides public policy services to businesses, institutions, associations and government focused on strategic Massachusetts issues. We identify ways to improve government performance and work with groups of public and private sector leaders to put ideas into action. We provide organization and communications support, synthesize complex policy information into short, easy-to-read issue reports, sponsor the longest-running public opinion surveys in the state, and offer unique credibility as a public-private facilitator.

Mass Insight organizes its own public-private leadership initiatives when four criteria are met:

- A major competitive priority exists
- There is no current effort underway
- Our initiative will have the support and participation of major business groups, public and private sector leaders
- We can add value.

This report and the facilitated discussions it will generate are part of a series of initiatives on health care-related issues, produced by Mass Insight since 1993, that have helped clarify the policy agenda for the state and major employers and health care organizations in Massachusetts.

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