The Boston Health Law Reporter

A PUBLICATION OF THE BOSTON BAR ASSOCIATION HEALTH LAW SECTION

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We are pleased to present to you the Spring 2012 Edition of the Health Law Section’s Health Law Reporter. Our Health Law Reporter provides BBA members with cutting-edge and unique perspectives on the fast-changing field of health law.

For the past several years, Massachusetts has played a leading role in national health reform, with our models for mandated individual insurance coverage, health insurance exchanges and other concepts winning acceptance and adoption at the national level. This edition of the Health Law Reporter addresses several of these important aspects of health reform.

We are pleased and honored to begin this issue with a contribution from Governor Deval Patrick. This is followed by discussion of the extension of health insurance to legal immigrants in Massachusetts, and a discussion of some of the unique impacts of national health reform on Massachusetts. We also profile one of the key individuals involved in implementing health reform in our state, Aron Boros, the Commissioner of the Massachusetts Division of Health Care Finance and Policy.

We also have a contribution discussing the pending lawsuits in the U.S. Supreme Court regarding the federal Affordable Care Act. This is just a preview of what is to come, as we will address the outcome of those Supreme Court lawsuits in our next edition of the Health Law Reporter, so stay tuned! One of the best ways to keep abreast of these issues is through the BBA Health Law Section. We invite the involvement of anyone who wishes to join our section, and welcome the addition of your time, talents and ideas. The Health Law Section has several committees to choose from (CLE, Communications, Membership, Legislative Update, Social Action); or you can volunteer as a participant at one of our CLE programs or Brown Bag lunches. Your ideas for new programs, events or new approaches to making our Section better are welcome.

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This month, we celebrate the sixth anniversary of Massachusetts health care reform. Our reforms are an expression of values, a codifying of our belief that health is a public good and that everyone deserves access to affordable, high-quality care.

Like President Obama’s Affordable Care Act, we took a hybrid approach, relying mainly on private insurance provided through the workplace, with varying degrees of public subsidy, depending on a person’s ability to afford private insurance.

It’s working. Today, more than 98% of Massachusetts residents have health care coverage, including 99.8% of children. No other state in America can touch that. More companies offer their employees insurance today than before the bill was passed. More than 90% of our residents have a primary care physician and four out of five have seen their primary care doctor in the last year. Emergency room visits for primary care are down and spending on the uninsured and underinsured has dropped by nearly half.

We’re healthier, too. For example, because of access to screenings, we’ve seen a 36% decrease in cervical cancer in women.

All of this while adding about 1% to state spending on health care.

Those are the numbers; but policy matters most when it touches people. And this policy touches people. I remember meeting a young woman named Jaclyn Michalos, a cancer survivor who got the care she needed through the Commonwealth Connector, our version of the Exchange. She had no affordable way to receive the care she needed before Massachusetts’ health care reform – it saved her life. People no longer have to fear having their insurance cancelled when they get very sick and need it most, or that a serious illness will leave them bankrupt. Health care reform in Massachusetts is helping people in profound ways.

Our next challenge is slowing the growth in health care premiums. This is a national problem, one neither caused by our reform nor unique to Massachusetts. Spending on health care makes up 18% of all spending in the United States and is projected to reach 34% by 2040 if costs continue to grow at historic rates. In recent years, growth in health care costs has outstripped growth in GDP even as the share of Americans with health insurance has fallen. In many ways, this will be harder to solve than universal access. But we need to solve it.

As spending on health care programs and emergency care grows, it weakens our ability to compete and slows job growth. In budgets everywhere – families, businesses and governments alike – spending on health care comes at the expense of spending on education and other basic needs. Left unchecked, health care costs threaten our fiscal integrity and our ability to provide future generations with the services we have enjoyed.

Just as we in Massachusetts have provided the national model for universal access, I believe we are on track to crack the code on cost control.

We have already seen significant progress. Two years ago, I directed the state’s Commissioner of Insurance to disapprove excessive premium hikes. While an admittedly blunt tactic and not in and of itself a long-term solution, it was a necessary step to galvanize the market to act. Massachusetts is home to an innovative, world-class health care community and they have responded with real solutions.

Hospitals and insurance carriers have reopened their contracts and cut rate increases, in some cases by more than half. We’ve created limited network health plans to give consumers opportunities to get great care in neighborhood settings at lower cost. There are new plans coming out tailored for small businesses that promise to be as much as 20% cheaper than current rates. Our new Wellness Track program offers a 15% rebate for certain small business owners who take part in the wellness program. We are also ending administrative duplication by requiring common codes and forms from insurers and providers. And with the help of the Affordable Care Act, more and more providers are piloting medical home or accountable care models that manage well-
ness for the whole person, and deliver both better care and more cost-effective care.

All of this is making a difference. In the last two years, average premium increases have since dropped from over 16% to less than 2% today. Our focus now is on making these gains last.

There are a number of strategies we are pursuing, including putting an end to the “fee-for-service” model wherever practicable, to stop paying for the amount of care and start paying instead for the quality of care. We need to empower doctors to coordinate patient care and to focus on wellness rather than sickness.

We are working with our health care community to accelerate this transition to innovative models for delivering health care, in which incentives are realigned to reward integrated care that emphasizes wellness and lowers costs for everyone. For example, Blue Cross Blue Shield has persuaded some of the state’s biggest hospitals and thousands of doctors to accept a fixed amount each month per patient rather than receive payment for each individual procedure.

In state government, by using these new tools and new approaches to how we pay for care, we will avoid nearly a billion dollars in cost increases in this fiscal year and another several hundred million more next year. Our goal is for integrated, cost-efficient caregiving to predominate throughout Massachusetts by 2015.

This is a complex challenge but we are making great progress and will be successful in the end. We have no choice. For us, and for this country, solving the health care challenge has everything to do with fulfilling our generational responsibility – that old-fashioned idea that each of us in our time must do all we can to leave things better for those who come behind us. This challenge belongs to all of us, from whatever party or no party. We owe it to our future to get this right.
“In light of their particularly vulnerable status, it thus remains necessary to exercise heightened vigilance to ensure that the full panoply of constitutional protections are afforded to the Commonwealth’s resident aliens.”

Introduction

Last January in *Finch v. Commonwealth Health Insurance Connector Authority* (“*Finch II*”), the Massachusetts Supreme Judicial Court held that section 31(a) of chapter 65 of the Acts of 2009 (“§ 31(a)”), violated the state Constitution. The decision in *Finch II*, which followed the Court’s earlier *Finch I* decision determining that § 31(a) discriminated on the basis of alienage or national origin and was subject to strict scrutiny, paved the way for approximately 40,000 low-income legal immigrants to receive state-subsidized health insurance. By so ruling, the Court effectively reaffirmed the state’s commitment to near universal health insurance. The two decisions also clarified that legal immigrants are a protected class under the state Constitution and that in Massachusetts, strict scrutiny is indeed strict.

This Article presents our unique perspective as plaintiffs’ counsel. We focus on the pragmatic issues affecting the cases rather than the constitutional questions that were before the Court.

Section 31(a) - The Fiscally Motivated Law

In 2006 the legislature passed and Governor Romney signed landmark health care reform requiring nearly every state resident to have comprehensive health insurance so long as it is affordable. To support that requirement, the state established the Commonwealth Care Health Insurance Program (“Commonwealth Care”) which provides sliding scale premium subsidies for low and moderate income residents who otherwise lack access to insurance. When Commonwealth Care was established, legal immigrants were eligible to participate on the same basis as other residents.

In 2009 the state faced a severe budget shortfall. Looking to save money, the legislature enacted § 31(a), which was expected to save over $80 million by eliminating Commonwealth Care for legal immigrants who were ineligible for federal means-tested public benefits under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”). This class was comprised of individuals with a variety of immigration statuses, including individuals who had green cards for less than five years. Under PRWORA the state did not receive partial federal reimbursement for enrolling this class in Commonwealth Care, although it did receive federal support under a Medicaid waiver for enrolling U.S. citizens and other federally-eligible aliens. The legislature therefore felt that this class was “more expensive for the state to insure” than other members of Commonwealth Care. And, of course, immigrants could not vote to voice their displeasure with their expulsion from Commonwealth Care.

In order to mitigate the hardship caused by § 31(a), the legislature appropriated $40 million to create the Commonwealth Care Bridge Program (“Bridge”). Bridge provided less comprehensive coverage, with higher cost sharing to legal immigrants who had been on Commonwealth Care prior to July 2009, but were excluded due to § 31(a). Bridge, however, was never available to those who would have otherwise become eligible for Commonwealth Care after July 31, 2009, had § 31(a) not been enacted. For example, legal immigrants who lost access to employer-sponsored insurance after July 2009 could not join Bridge and were left uninsured.

Health Law Advocate’s Role

We work on behalf of Health Law Advocates (“HLA”), a not-for-profit law firm affiliated with Health Care For All (“HCFA”). HLA provides legal services to low-income, vulnerable individuals and families that have difficulty accessing or paying for health care. After legal immigrants were excluded from Commonwealth Care, HLA was inundated with calls presenting similar scenarios: “I’m afraid I won’t be able to pay for...”
specialty care services,” or “I was denied state insurance and am now uninsured.” Hearing these concerns, we became convinced we needed to do something. We also believed that § 31(a) undermined the promise of universal access to care made by the state’s health insurance reform. If legal immigrants could be denied health care when times got tough, so could other politically vulnerable groups. In this way, the fundamental commitment that the state made in 2006 was broken but not irretrievably lost.

Litigation was not our first choice. We knew it would be time-consuming and expensive. Constitutional challenges to state laws are never easy; courts are reluctant to second-guess the legislature’s fiscal decisions. Our clients also preferred less adversarial methods. Thus in the fall of 2009, along with HCFA, HLA contacted other organizations committed to health reform, local health care providers, and community organizations. In addition, HCFA met with legislators. Although some expressed concern for the well-being of the excluded class, it soon became apparent that the legislature would not revisit its decision. We therefore began to focus on litigation.

As a small not-for-profit, HLA has very limited financial resources. But it does have a dedicated staff and a rich network of committed volunteers. Chief among the latter was HLA’s Volunteer Legal Advisor, Stephen Rosenfeld. Invaluable support was also provided by Lauren Barnes of Hagens Berman Sobel Shapiro LLP, and Jack Cushman, who was initially practicing solo but later joined Stern Shapiro Weissberg & Garin LLP. Northeastern University School of Law also provided law students and a legal fellow. With their help, we researched the viability of a constitutional claim against § 31(a). As our research progressed, we became convinced that § 31(a) was unconstitutional.

During this period we also spoke with immigrant advocates around the country. Some believed that § 31(a) would withstand judicial scrutiny on the basis of Doe v. Commissioner of Transitional Assistance.17 In Doe, the Supreme Judicial Court appeared to affirm a state law excluding the same class affected by § 31(a) from the state’s federally-created transitional assistance program and establishing a separate cash program for that class which contained a six month durational residency requirement.18 However, as we studied Doe, we realized it supported our position. The durational residency requirement was upheld precisely because the program to which it was attached did not discriminate against legal immigrants; it benefitted them. The immigrants’ exclusion from the transitional assistance program, however, was not actually before the Court. In dicta the Court suggested that legal immigrants were a protected class in Massachusetts and that their exclusion from the cash assistance program was constitutional only because as a federal means-tested public benefit, the state was obligated to follow PRWORA. Comparing Doe with § 31(a), we believed that Commonwealth Care was not a federal public benefit and the state was not required to adhere to PRWORA’s eligibility requirements. Thus, the very factors that led the Court to find for the state in Doe would lead the Court to find for our clients. As a result, we decided to rely on Doe in challenging § 31(a) as violating the state Constitution’s protections against discrimination.

Eventually, four clients20 who were harmed by § 31(a) agreed to be class representatives. Dorothy Ann Finch is a permanent resident who had to stop working due to a medical condition. Although initially approved for Commonwealth Care, she was denied coverage because of § 31(a). Lacking insurance, she incurred medical debt and faced a collection action. Roxanne S. Prince is a single parent with a family-based visa. Her employer did not offer health insurance. She had been enrolled in Commonwealth Care before being placed in Bridge. As a result, she lost the continuity of care with her providers. Another plaintiff, a domestic violence victim, is a political asylum applicant and mother of two U.S. citizen children. In 2006, she started receiving Commonwealth Care. When § 31(a) struck, she was placed in Bridge where she was unable to access culturally and linguistically appropriate care. A fourth class representative had been living and working in the U.S. for more than eight years under a visa based on her employer’s petition for an alien worker. She later became a law-
ful permanent resident but held her green card for less than five years. Because her employer did not offer insurance, she was enrolled in Commonwealth Care before being transferred to Bridge. When she was diagnosed with cancer, she had difficulty accessing oncologists and related providers in her area. The latter two class representatives insisted on anonymity because they feared retaliatory harm to themselves or their children.\(^{21}\)

As in any litigation, we also had to consider who to sue, the specific claims we would raise, and where we would seek relief. We determined the appropriate defendants were the Commonwealth Health Insurance Connector Authority ("Connector Authority"), which administers Commonwealth Care, and its then Executive Director, Jon Kingsdale. Deciding upon the specific claims required more analysis. As noted above, because we believed that the case concerned a program unique to Massachusetts and that *Doe* supported our clients’ claims, we focused on the state Constitution’s commitment to equal protection. However, we believed that § 31(a) also violated the federal Constitution and knew that federal law allows for reasonable attorneys’ fees to the prevailing party.\(^{22}\) We therefore added a federal civil rights claim.

The choice of forum and relief sought proved to be challenging. We considered filing in a superior court, asking for a temporary restraining order and preliminary injunction. Doing so might have provided our clients relatively swift relief, but courts are generally reluctant to issue preliminary injunctions against public entities. We also knew that any order issued by a trial court was likely to be appealed, and possibly stayed, pending appeal. After consultation with our clients, we therefore decided that initial review by the full Supreme Judicial Court offered the best chance of speedy relief. On February 25, 2010, we filed a declaratory judgment action before the Single Justice (Cordy, J.) asking him to report the case to the Full Court.\(^{23}\) In addition, because we challenged the constitutionality of a legislative appropriation, we served the Attorney General,\(^{24}\) who had the right to intervene.

**Finch I – On and Off the Path to the Massachusetts Supreme Judicial Court**

As we probably should have anticipated, our path to the Supreme Judicial Court was not swift. After filing its answer, the Connector Authority removed the case to federal court. Although we could have remained in federal court, we believed that federal litigation would be delayed by a likely certification of questions to the Supreme Judicial Court and eventual appeal to the First Circuit. On the other hand, if we dropped our federal claims, thereby forfeiting attorneys’ fees, the federal court would have been able to exercise judicial discretion to return the case to state court. Concluding the latter was in our clients’ best interests, we exercised our right to delete the federal claims\(^{25}\) and asked Judge Young to remand the case to Justice Cordy.\(^{26}\) In June 2010, he agreed.

Once the case returned to Justice Cordy, we requested a reservation and report to the Full Court. In response, the Connector Authority argued that there were unresolved factual issues so that the case should be sent to Superior Court. On July 21, 2010, Justice Cordy reported four questions of law to the Full Court but also required the parties to agree upon a statement of material facts about the funding and operation of Commonwealth Care pre- and post-§ 31(a). During the summer of 2010, we developed that statement of material facts with the Connector Authority through its legal counsel, Carl Valvo, Cosgrove, Eisenberg & Kiley, P.C., and Ken Salinger, the Massachusetts Attorney General’s Office, which had intervened.

The four questions reported focused on the appropriate standard of review for judging the constitutionality of § 31(a). Two issues were critical: (1) are legal aliens a protected class under the state Constitution?; and (2) even if they are, should the less stringent rational basis test be applied because § 31(a) borrowed its classification from PRWORA? We began working on our brief. HLA’s arguments were quite simple. First, the Massachusetts Constitution either under Article 106’s explicit protection against discrimination on the basis of national origin,\(^{27}\) or under general principles of equal protection, recognizes legal immigrants as a discrete and insular, suspect class. Second, PRWORA does not require the state to discriminate in the provision of Commonwealth Care. As a result, under *Doe*, the discrimination effected by § 31(a) could not be saved by PRWORA; it had to be subject to strict scrutiny.

In making these arguments, we were generously supported by several amicus briefs\(^{28}\) that expanded upon our arguments and...
offered valuable background information to the Court.

Although we had hoped for a speedy ruling, that was not to be. However, on May 6, 2011, in a 3-2 decision, the Supreme Judicial Court held that § 31(a) discriminated on the basis of alienage or national origin and was subject to strict scrutiny. Writing for the Court, Justice Spina rejected our argument that legal immigrants were protected by the national origin provision in Article 106. He agreed, however, that legal immigrants were a suspect class under the state Constitution. He also found that Commonwealth Care is a state public benefit and that Congress was indifferent about whether it included or excluded legal immigrants. As a result, the state’s actions would be subjected to strict judicial scrutiny. The Court ordered the case be remanded to the Single Justice to determine whether § 31(a) could survive strict scrutiny.

**Finch I - The Restoration of Coverage Nears**

After receiving the Court’s decision in Finch I, our clients were grateful. In its opinion, the Court recited the well-settled rule that a statute cannot survive strict scrutiny unless it is “narrowly tailored to further a legitimate and compelling governmental interest and [is] the least restrictive means available to vindicate that interest.” Because saving money is not a compelling state interest and the state had always justified § 31(a) as a fiscal measure, we assumed that Justice Cordy would find § 31(a) unconstitutional. On May 23, 2011, we filed a motion for partial summary judgment. We were surprised by what happened next. The defendants argued that § 31(a) was designed to further a compelling state interest in advancing federal immigration policies. Specifically, the defendants relied on PRWORA’s preamble which identifies federal policy as promoting the self-sufficiency of aliens, and the denial of public benefits so that they do not serve as an incentive to immigration. Defendants also argued that the merits of this defense should be decided by the Full Court. Justice Cordy agreed that the case should be reported to the Full Court. So in the fall of 2011, more than two years after our clients had lost Commonwealth Care, we were back before the Supreme Judicial Court. Once again, we were supported by powerful amicus curiae briefs.

Our arguments were straightforward. First, if strict scrutiny was to be strict, the Court had to consider the actual, not a hypothetical motive for § 31(a). If it did so, the answer would be clear: the appropriation was designed simply to save money. Second, furthering national immigration policy is not a compelling state interest. Finally, even if furthering national immigration policy were an actual purpose for § 31(a), and even if it were a compelling state interest, the appropriations bill was not narrowly tailored to further that interest.

On January 5, 2012, in a unanimous opinion written by Justice Cordy, the Supreme Judicial Court ruled that § 31(a) was unconstitutional. The Court noted that the state’s articulated purpose for its discrimination against our class of legal immigrants was fiscal; indeed, the record contained no evidence that the legislature thought about national immigration policy, nor had the legislature considered whether § 31(a) was narrowly tailored to further the self-sufficiency of legal aliens in the Commonwealth. The mere fact that § 31(a) referenced PRWORA did not justify the discrimination against plaintiff class members. According to the Court, “the conclusory method does not satisfy strict scrutiny.”

**Conclusion**

In March 2012, the Connector Authority began restoring state-subsidized Commonwealth Care coverage to our plaintiff class. Complete restoration is expected as of May 1, 2012. Because of the Massachusetts Constitution and strict judicial scrutiny, our clients are now able to receive the state health insurance they were wrongfully denied. Once again Massachusetts has lived up to the commitment of equality in its Constitution and the promise of universal health insurance made in 2006.
appropriate, references to these subsequent appropriations.

4 Finch I, 459 Mass. at 655.
6 Id.
7 Id.
8 Commonwealth Care was created distinct from MassHealth, which is defined as a welfare program pursuant to federal law. See M.G.L. ch. 118E, § 9 and § 9A (2007). In fact, in order to be eligible for Commonwealth Care, a resident must not be eligible for MassHealth. M.G.L. ch. 118H, § 3(a).
9 For example, a ‘[r]esident’ eligible for Commonwealth Care was defined under the law as “a person living in the commonwealth, . . . including a qualified alien, as defined by section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 . . . or a person who is not a citizen of the United States but who is otherwise permanently residing in the United States under color of law; provided, however, that the person has not moved into the commonwealth for the sole purpose of securing health insurance under this chapter . . . .” M.G.L. ch. 118H, § 1. See also M.G.L. ch. 118H, § 3; 956 C.M.R. 3.04 (2008); 956 C.M.R. 3.09 (2008).
14 461 Mass. at 239-40 (quoting Senator Steven Panagiotakos).
16 459 Mass. at 660 n.5 (noting that legal immigrants whose household income declined after August 31, 2009 to at or below 300% of the Federal Poverty Level were left without state coverage.)
17 Doe v. Commissioner of Transitional Assistance, 437 Mass. 521, 533-34 (2002) (concluding that the appropriate standard of review “depends on the nature of the classification that creates the distinction between subgroups of aliens. If that classification were a suspect one such as race, gender, or national origin, we would apply a strict scrutiny analysis.”)
18 Id.
19 The Arizona law, S.B. 1070, 49th Leg., 2d Reg. Sess. (Ariz. 2010), modified by H.B. 2162 (Ariz. 2010), has been the subject of federal challenges, with the most recent decision issued by the Ninth Circuit in U.S. v. Arizona, 641 F.3d 9 (9th Cir. 2011), which has subsequently been appealed and is scheduled to be heard before the U.S. Supreme Court on April 25, 2012. See Arizona v. U.S. no. 11-182. 20 After filing the complaint, HLA was contacted by other legal immigrants who offered to provide further testimonies or affidavits in support of class action certification. See Chelsea Conaboy and Martin Finucane, SJCR Orders State to Cover Legal Immigrants, BOSTON GLOBE, Jan. 6, 2012, at 1 (interviewing the parents of legal immigrant Samuel Goncalves). 21 HLA succeeded in obtaining a Court Order allowing two class representatives to proceed under the pseudonyms Jane Doe 1 and Jane Doe 2. 22 42 U.S.C. § 1988. 23 This process is permitted pursuant to M.G.L. ch. 214, § 1 and M.G.L. ch. 231A, § 1.
24 Plaintiffs gave notice to the Attorney General initially pursuant to M.G.L. ch. 231A, § 8 and subsequently under Fed. R. Civ. P. 51. 25 Fed. R. Civ. P. 15(a)(1). See Carnegie Mellon Univ. v. Cohll, 484 U.S. 343 (1988)(a remand is within the discretion of the judge and is the preferred course of action when no federal claims remain and the federal court not invested substantial resources on the dispute.) 26 In hindsight it is quite plausible that we would have succeeded on the federal claim; however, our clients’ needs directed us to a more expedient process in state court.
28 The following organizations submitted amici curiae briefs on behalf of the plaintiffs in Finch II: the Asian Pacific American Legal Center et al. (represented by Doreena Wong, Justin Ma, Daniel S. Floyd, Minae Yu, Jordan Bekier, Christopher Punongbayan, and Kimberly Lewis, Andrew Kang, Miriam Yeung, Erin E. Oshiro, Jessica S. Chia, and Priscilla Huang, and Jacinta S. Ma); the Massachusetts Law Reform Institute, Health Care For All and the Massachusetts Immigrant and Refugee Advocacy Coalition (represented by Victoria Pulos); the American Civil Liberties Union of Massachusetts (represented by Anthony D. Mirenda, Ara B. Gershengorn, Thomas Ayres, Katie Marie Perry, and John Reinstein).
29 459 Mass. at 675.
30 Id. at 663. Justice Duffy disagreed with this conclusion. Id. at 690 (Duffy, J., concurring in part and dissenting in part).
31 Id. at 675-77. 32 Id.
33 Id. at 677-78. Not all the justices agreed. Concurring in part and dissenting in part, Justice Gants, joined by Justice Cordy, argued that § 31(a) was consistent with Congress policy in PRWORA and that as a result, the rational basis test should be applied. Id. at 684-86.
34 Id. at 669.
36 See 8 U.S.C. § 1601. PRWORA, however, does permit states to exercise independent decision-making with respect to alien eligibility for state public benefits which may be provided at the state’s cost. 8 U.S.C. §§ 1621-1624.
37 The following organizations submitted amici curiae briefs on behalf of the plaintiffs in Finch II: the Asian Pacific American Legal Center et al. (represented by Doreena Wong, Justin Ma, Daniel S. Floyd, Minae Yu, Jordan Bekier, Christopher Punongbayan, and Kimberly Lewis, Andrew Kang, Miriam Yeung, Erin E. Oshiro, Jessica S. Chia, and Priscilla Huang, and Jacinta S. Ma); the Massachusetts Law Reform Institute, Health Care For All and the Massachusetts Immigrant and Refugee Advocacy Coalition (represented by Victoria Pulos); the American Civil Liberties Union of Massachusetts (represented by Ara B. Gershengorn, Katie Marie Perry, John Reinstein, and Laura Rotolo); and the Chinese Progressive Association et al. (represented by Sarah F. Anderson, Nancy J. Lorenz, and Jan M. Stiefel).
38 461 Mass. at 238-42.
39 Id. at 244.
40 In addition, under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1312(f), 1411, 124 Stat. 119, 183-84, 224-26 (2010), in 2014, lawfully residing individuals, such as our plaintiff class, will be eligible for federal subsidies to support the purchase of health insurance under the state exchanges, regardless of PRWORA.
National Health Care Reform Comes Home: Massachusetts’ Implementation of the Affordable Care Act

by Michael T. Caljouw and Sarah G. Gordon

Introduction
On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (hereinafter the “ACA”). The law has been characterized as the most sweeping reform act since the implementation of Medicare and Medicaid. ACA goes beyond these historical areas of federal involvement in health care and impacts how insurance products are sold to employers and consumers.

At a very basic level, ACA increases access to health insurance coverage through broadened Medicaid eligibility, the Children’s Health Insurance Program (“CHIP”), and subsidized premium assistance for certain lower-income individuals. These costs are intended to be met by increased insurer, employer, and pharmaceutical taxes; reduced Medicare and Medicaid spending; and other revenues. The law also includes important measures designed to enhance the delivery and quality of health care. While some provisions of ACA became effective shortly after passage in 2010, most provisions do not take effect until 2014, and others will be phased in over the next few years.

Four years earlier, in the Spring of 2006, Massachusetts enacted its own version of health care reform when then-Governor Mitt Romney signed Chapter 58 of the Acts of 2006 (“Chapter 58”). Chapter 58 increased health insurance coverage through a combination of Medicaid expansions, subsidized private insurance programs, and insurance market reforms. This expansion of coverage was financed through an individual mandate to purchase health coverage, redirected Uncompensated Care Pool and Disproportionate Share Hospital funds, and requirements that employers either make a “fair share contribution” to their employees’ health insurance or pay a “free rider surcharge.” Since enactment of Massachusetts health care reform, over 98% of the Commonwealth’s residents have health insurance coverage, including 99.8% of children.

ACA follows the Massachusetts model in many important ways. While many have noted that both pieces of legislation include individual mandates to purchase health insurance, there are many other similarities, ranging from insurance exchange structures to new rules for insurers and employers. Despite these thematic parallels, Massachusetts policymakers have much work to do implementing the thousands of pages of federal laws and regulations within an existing state framework. Harmonizing the two laws will be a painstaking, multi-year process involving every major health care stakeholder: Massachusetts and federal governments, employers, insurers, consumers and health care providers. While some states have chosen to challenge ACA provisions, Massachusetts policymakers and stakeholders have instead already commenced the implementation process. Accordingly, the following article examines five key features of ACA that must be addressed during Massachusetts implementation:

1. The Individual Mandate to Purchase Health Insurance Coverage;
2. Employer Responsibilities;
3. Individual and Employer Subsidies;
4. Essential Health Benefits and Minimum Credible Coverage Requirements; and
5. Medicaid Expansions and Basic Health Plan Coverage Options.

1. The Individual Mandate
The major expansion and reform provisions under ACA occur in 2014. Beginning that year, ACA mandates that individuals must purchase insurance coverage if they can afford it – meaning that there are affordability exemptions from ACA’s individual mandate based on limitations in income. Otherwise, a qualifying individual must demonstrate that coverage exists (through either private or public insurance programs), or face a federal penalty. This penalty gradually increases over a three-year period, from a maximum of $285 per family (or 1% of family income, whichever is greater) in 2014 to a maximum of $2,085 per family (or 2.5% of family income, whichever is greater) in 2016. The penalty will be prorated by the number of months without coverage, and post-2016 penalty amounts will increase annually by the cost of living.
Chapter 58 includes a conceptually similar mandate. Massachusetts residents are required to obtain health insurance coverage only if affordable coverage is available. The Massachusetts Health Connector (the “Health Connector”) annually sets a schedule of affordability based on income levels and defines the minimum level of required or creditable coverage. The affordability schedule is progressive, with the percentages of income people are expected to pay for coverage rising over time. Individuals with incomes under 150% of the federal poverty level (“FPL”) and those with valid religious exemptions are exempt from the Massachusetts individual mandate. Otherwise, Chapter 58 establishes fiscal penalties for qualifying adults who do not purchase health insurance that meets the standards of minimum creditable coverage. Penalties are assessed through the Massachusetts Department of Revenue tax filing process and are based on the affordability and premium schedules. As a general matter, penalties are lowest for those ages 18–26 and for anyone with income below 300% of FPL. While the penalty was phased in over time, the penalty for non-compliance can now reach up to half the cost of the lowest available yearly premium.

In light of the operational differences between the Massachusetts and federal mandates, Massachusetts policymakers must resolve certain key issues. First, different income exemption standards mean that there are different standards of who is subject to being penalized. There is also conflict in the amount of the penalty and how it is phased in over time. Because the federal individual mandate has somewhat different provisions and does not appear to preempt the state mandate, Massachusetts legislative action is likely required to prevent uninsured Massachusetts residents from facing both state and federal penalties. To illustrate the real conflict between the laws, in 2016 and beyond, uninsured people who earn less than 250% of FPL are subject to higher penalties under ACA than under Chapter 58. Meanwhile, individuals with more moderate income levels are penalized less under ACA than under Chapter 58. Indeed, unless reconciled, uninsured individuals may face both state and federal mandate penalties for the same period of time.

2. Employer Responsibilities

ACA, like Chapter 58, relies on the central premise that the majority of individuals will obtain their insurance through employer-based coverage. Accordingly, employer responsibilities are central to the success of both statutes.

Under ACA, businesses with fifty or more employees must offer coverage that meets minimum standards beginning in 2014, or face two types of penalties. First, businesses that do not offer coverage are fined $2,000 per full-time employee (after the first thirty employees). Second, businesses that offer coverage to employees who receive a public subsidy based on affordability are fined the lesser of $3,000 per employee receiving the subsidy or $2,000 multiplied by the total number of employees.

Chapter 58 establishes a separate set of standards, requiring that businesses with more than ten full-time-equivalent employees bear a “fair and reasonable” contribution to the insurance premiums of their employees. The annual assessment is $295 per employee (verified by prorated quarterly filings). Compliance with the so-called “fair share contribution” is determined through two tests:

- Percent of Full-Time Employees Enrolled: Are at least 25% of “full-time” employees enrolled in a qualifying employer-sponsored health plan?
- Premium Contribution Levels: Does the business pay at least 33% of the cost of individual coverage for its “full-time” employees who have been employed for at least ninety days?

As of 2009, Massachusetts businesses with fifty or fewer employees needed to meet only one of these two prongs. Larger employers (those with at least fifty-one employees) automatically comply if 75% of their “full-time” employees are enrolled in a qualifying employer-sponsored health plan. Larger employers with less than 75% enrollment must meet both prongs of the test to be exempt from the assessment. Chapter 58 also establishes a Free Rider Surcharge on businesses. This surcharge is different from the state’s fair share contribution. The surcharge is applied when a qualifying employer (with eleven or more employees) does not arrange for a pre-tax payroll deduction system for health insurance and has employees who receive care paid for by the Health Safety Net.

Massachusetts officials are currently working to reconcile many differences between the state and federal health care reform laws relating to employer obligations. At a basic level, ACA imposes significantly higher penalties but also exempts more businesses. ACA exempts all small employers (with fifty and fewer employees) while the state law applies to businesses with eleven or more full-time employees. The state and the federal laws also use different definitions of “full-time” employment. Another key difference between the state and federal rules is that under ACA, full-time equivalent
employees (FTEs) are used only to determine if the employer has a sufficient number of employees to be subject to the coverage requirements while Chapter 58 uses employee thresholds to calculate the assessment as well. Since the federal law becomes effective in 2014, Massachusetts legislative action is needed in 2012 or early 2013 to allow adequate time for administrative agency and business operational compliance.

3. Essential Health Benefits and Massachusetts Minimum Creditable Coverage

ACA, like Chapter 58, sets baseline requirements in order to ensure that individuals receive access to (and health insurers offer) a comprehensive set of benefits and services. The federal baseline coverage requirements are called Essential Health Benefits (“EHB”), while the state baseline coverage requirements are called Minimum Creditable Coverage (“MCC”).

While both laws set forth basic requirements for coverage of benefits and services as well as cost sharing, the laws differ in both scope and applicability.

A. Federal Essential Health Benefits (“EHB”)

The federal EHB requirement applies to all individual and small group coverage offered in a state’s commercial health insurance market. Fully insured large group health plans, grandfathered health plans, and certain self-insured health plans are exempt from the requirements to provide EHB.

Health plans subject to the federal EHB requirement must provide an “Essential Benefit Package” (which must include EHB as defined by the Secretary of Health and Human Services (“HHS”)), annual limitations on cost sharing, and offer coverage in one of the “tiers” – Bronze, Silver, Gold, or Platinum — available through the exchange.

While ACA grants the Secretary of HHS broad authority to define the EHB requirements, ACA establishes ten categories of benefits that must be included within any final EHB rule. These include emergency services, maternity care, prescription drugs, preventive care and pediatric services. ACA also caps total annual out-of-pocket costs for these plans (equal to the out-of-pocket limit in Health Savings Account qualified plans), and sets annual limits on deductibles for employer-sponsored health plans.

B. Benchmark Plans and State Implementation of EHB

In order to provide the states with flexibility to implement ACA EHB provisions, HHS issued a bulletin on December 16, 2011. ACA requires that the scope of EHB benefits be equal to the scope of benefits covered under a typical small group employer plan available in the state. Rather than set forth a prescriptive regulatory scheme for the initial years of implementation (2014 and 2015), HHS offers states broad flexibility in selecting a “benchmark” plan, which will define the benefits (but not the cost-sharing requirements) that each individual and small group health plan must provide. The bulletin provides four alternative benchmark plan options:

- The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employee Health Benefits Plan (“FEHBP”) options by enrollment; and
- The largest insured commercial non-Medicaid HMO operating in the state.

HHS intends to assess the benchmark plan selection process and is expected to issue subsequent guidance for EHB for years 2016 and beyond. This later approach may ultimately exclude some state mandated benefits from inclusion in the EHB package.

The interplay between state and federal mandated benefits and the state selection of a benchmark plan will be key implementation issues. Currently, Massachusetts has 58 mandated benefit laws on the books, none of which are preempted by ACA, and ACA requires states to defray the costs associated with coverage of any state-mandated benefit that is in excess of the EHB for individuals enrolled in a qualified health plan (“QHP”).

At the same time, of the plans that could potentially be selected as the “benchmark” plan in Massachusetts, only the health plans offered in the small group market and by HMOs are required to cover all of the state mandated benefits. This is important because, if the state selects one of the State Employee Health Benefit plans or the FEHBP, only those mandated benefits that are included as part of that “benchmark” plan become part of the EHB package. The state would then become responsible for funding coverage associated with the remaining benefits mandated by state law. Finally, the guidance further clarifies that if a state enacts additional mandated benefit legislation after December 31, 2011, and those new mandated benefits are not included as a covered benefit within the benchmark plan, the state is responsible for the cost of covering those benefits as well.

As part of the state implementation activities in Massachusetts, the Division of Insurance and the
Health Connector are examining the implications of each potential benchmark plan on the state’s commercial market. The Division of Insurance is collecting data on the benefits and services provided by health plans within each category. While meaningful similarities exist between the health benefit plans offered in the small group and the largest HMO plan, there are important differences between these offerings and the state employee health benefit plans in terms of covered benefits.26 The most striking differences however are between the FEHBP and the state plans. The FEHBP does not cover some of the state’s mandated health benefits, including those mandates that are the most expensive.27 The federal guidance recommends that states select a benchmark plan by the third quarter of 2012, and Massachusetts is expected to make its decision by this fall.

C. EHB and Minimum Creditable Coverage (“MCC”)

Finally, many questions have been raised regarding the intersection between the federal EHB requirements and Chapter 58’s requirement that individuals purchase coverage meeting MCC requirements - and whether Massachusetts will eliminate or modify Chapter 58’s MCC rule. The Board of the Health Connector has promulgated regulations requiring that an MCC-compliant health plan cover a broad range of medical services, include limits on the out-of-pocket costs for individuals and families, and not include limits or caps on certain benefits.28 Unlike EHB, the Massachusetts rules govern out-of-pocket spending such as deductibles and co-payments, and set a basic actuarial value as a floor for minimum coverage. While the requirements for obtaining MCC-compliant health care coverage apply to individuals, health plans writing coverage in Massachusetts provide coverage that is consistent with these requirements.

By contrast, EHBs apply to non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs.29 Large group (both fully- and self-insured), and grandfathered health plans in existence as of the effective date of the federal law, are exempted from the EHB requirements. While Massachusetts law does not reach those employers subject to ERISA, most Massachusetts employers nevertheless offer coverage that enables their employees to comply with the requirements of the Massachusetts mandate. There is some concern that if Massachusetts eliminates its own requirements for comprehensive coverage, individuals employed by large employers will lose access to MCC-compliant coverage.

Massachusetts individual mandate and MCC requirements are not preempted by ACA. Massachusetts is therefore permitted to continue to enforce its own individual mandate and baseline requirements for coverage. This will continue to be an important discussion during the forthcoming year as the state considers legislation designed to bring the state into compliance with ACA.

4. Individual and Employer Subsidies

ACA expands access to health insurance coverage through the establishment of premium credits, available to both individuals and to small employers purchasing coverage through the exchange. Massachusetts health care reform took a similar approach through subsidies for individuals below a set income threshold who purchase coverage through the Health Connector; however, Massachusetts did not provide corresponding subsidies for small employers. The upcoming sections discuss the intersection between the Federal assistance provided to individuals and employers and the subsidies provided through Massachusetts health care reform.

A. Individual Premium Credits

ACA provides individuals without access to Medicare, Medicaid, or affordable employer-sponsored insurance the opportunity to purchase coverage through the Exchange with premium and cost sharing assistance, provided that certain income criteria are met.30 The ACA premium credit program provides refundable and advanceable premium credits to eligible individuals and families with household incomes between 100% and 400% of FPL. Individuals seeking premium credits are restricted to purchasing a QHP through the state’s exchange. At the time an individual seeking assistance enrolls in coverage through the state exchange, the exchange is required to determine the individual’s eligibility for advanced tax credit.31 The expected individual premium contribution will be set on a sliding scale, ranging from 2% of income for individuals earning up to 122% FPL and 9.5% of income for individuals earning between 300%-400% FPL.

ACA makes the premium credit advanceable and paid directly to the health plan in which the individual enrolls. However, the state exchange is required to annually reconcile these advanced payments against the actual credit for the taxable year. Unlike the structure of the Massachusetts premium assistance models, individuals obtaining ACA premium credits could receive additional credits over the course of the year should their income status change (through a loss of employment or wages); conversely, such a scheme could potentially result in individuals owing additional income tax li-
ability should their income status improve mid-year.\textsuperscript{32} In addition to premium credits, ACA provides cost-sharing subsidies to eligible individuals and families to assist in payment of an individual or family’s out-of-pocket costs, including co-payments and deductibles.

In Massachusetts, the most significant aspect of Chapter 58 was arguably the eligibility expansion of the publicly-subsidized MassHealth and the establishment of the publicly-subsidized Commonwealth Care program. Commonwealth Care provides individuals earning up to 300\% FPL with access to comprehensive and affordable coverage. Unlike the federal premium tax credits, however, individuals enrolling in Commonwealth Care enroll in one of the four “Plan Types” and pay a discounted monthly premium on a sliding scale that is based on income. There is no reconciliation at the end of the year, thus no opportunity to either receive additional subsidies or be responsible for tax liability. However, the Health Connector does conduct regular reconciliations to redetermine eligibility.

By 2014, federal premium tax credits will become available and could replace state subsidies for current Commonwealth Care members who earn between 133\% and 300\% FPL.\textsuperscript{33} These federal subsidies will provide less assistance to individuals than is currently provided by Commonwealth Care. Critical decisions still need to be made by Massachusetts officials as to how to address this overlap and whether to continue to provide state assistance to individuals who are now enrolled in this program at the amount currently available. A discussion of current options for providing continued assistance for Commonwealth Care enrollees is contained in subsequent sections.

State fiscal considerations may resolve many of the questions concerning restructuring state programs, and the Commonwealth is in the process of conducting an analysis of different options for restructuring the programs and the impact on the state budget going forward. However, if the Health Connector does not provide for additional “wrap” subsidies, Commonwealth Care enrollees could have to pay higher premiums and out-of-pocket expenses than they do now.

\section*{B. Employer Subsidies}

ACA created a new premium tax credit to enable small businesses to purchase health insurance coverage for their employees.\textsuperscript{34} This credit, unlike the individual premium credit, became effective immediately upon enactment of ACA in 2010. For years 2010 through 2013, the tax credit is worth up to 35\% of a taxable eligible small employer’s premium payments. During those years for eligible small employers, the maximum amount is 25\% of the employer’s premium payments. That amount increases to 50\% in 2014. In order to qualify for the credit, an employer is required to meet three qualifications. The first is to have fewer than twenty-five FTEs during the taxable year. Second, the annual average wage for all employees during the taxable year must be less than $50,000. Finally, the employer must have in place a “qualifying arrangement.”\textsuperscript{35}

Currently, Massachusetts offers an assistance program for eligible small employers and self-employed individuals to provide health insurance coverage for employees. Similar to ACA’s small employer tax credits, the Massachusetts Insurance Partnership Program provides premium subsidies for small employers with between two and fifty FTEs, provided that the employer offers comprehensive coverage to employees and contributes at least 50\% of the costs of the premiums.\textsuperscript{36} MassHealth is authorized to provide as much as $1,000 per year for each qualified employee.\textsuperscript{37}

An open question remains as to the fate of the Insurance Partnership Program, given the new insurance tax credits made available by ACA for small businesses that are in effect today. Much will be contingent upon the status of the Massachusetts Section 1115 federal Medicaid waiver and availability of state and federal dollars as the current public insurance programs are reorganized to satisfy the new coverage requirements contained within ACA and maximize new federal matching funds.

\section*{5. Medicaid Expansion and the Basic Health Plan}

One of the centerpieces to Chapter 58 was its expansion of Medicaid eligibility and the creation of subsidized coverage through the Commonwealth Care program – and these will be impacted by the mandatory Medicaid expansion included within ACA. In particular, Massachusetts will likely need to reorganize several existing public programs due to changes in eligibility criteria created by ACA. Although by no means an exhaustive list, the analysis below illustrates just a few ways in which the Massachusetts landscape may change in the coming year.

First, ACA expands mandatory coverage of Medicaid eligibility to individuals who earn up to 133\% FPL.\textsuperscript{38} This change will allow most legal residents with incomes up to 133\% FPL to qualify for MassHealth. One of the key features of ACA is that it simplified Medicaid eligibility by removing
categorical eligibility requirements. Coverage provided to expansion population is not required to comply with the Medicaid benefit requirements that are required for other mandatory populations; however coverage must at least equal benchmark or benchmark equivalent coverage.39 ACA allows states the option of developing a Basic Health Plan, which covers eligible individuals with incomes between 133% and 200% FPL and allows legal immigrants with incomes up to 133% FPL to receive coverage through this plan.40

In Massachusetts many of these individuals within the mandatory expansion population may already be covered through the MassHealth Basic, MassHealth Essential or Commonwealth Care programs.41 Members enrolled in either the Commonwealth Care program or MassHealth experience significant churn between programs as their individual eligibility status changes. Moving these individuals into MassHealth will simplify the program and reduce churn. However, as with all of the new federal rules, ACA’s Medicaid expansion provisions bring about new and important policy considerations that the state will have to address. During the coming months, Massachusetts will need to sort through the existing state coverage programs and determine how to incorporate the new classification of eligible individuals and how to fully take advantage of opportunities to receive enhanced federal matching dollars. The Patrick Administration has announced its recommendation to establish a Basic Health Plan within MassHealth for this population.42 Many of the individuals who will become eligible for the Basic Health Plan are currently enrolled in Commonwealth Care today, including legal immigrants.

Finally, Massachusetts must determine how to cover those individuals who currently receive insurance or subsidies through Commonwealth Care and earn 200% -300% FPL along with those earning up to 400% FPL. The Patrick Administration has announced recommendations to provide individuals with incomes between 200% and 300% FPL who receive a premium tax credit with additional state subsidies.43 This population will be transitioned to the ACA-mandated exchange and receive premium tax credits. However, premium tax credits and cost sharing subsidies will not provide the same level subsidies that individuals within this population receive through Commonwealth Care today. The Patrick Administration further announced its recommendation to provide additional assistance to those between 200% and 300% FPL with “wrap” coverage. The amount is currently estimated to cost the Commonwealth $187 million.44 Both ACA and Massachusetts health care reform contain provisions that expand affordable health care options for the state’s most vulnerable populations. Important decisions need to be made at the state level as to how best to transition this population in a manner that maintains coverage for this population and ensures that Massachusetts is in full compliance with the new federal rules.

**Conclusion**

Much of the public’s attention on national health care reform, including much legal analysis, has been focused on Washington, D.C. With a United States Supreme Court challenge and a national election in which health reform is center stage, that is quite understandable. However, there are very significant challenges related to federal health reform facing Massachusetts today. Policymakers are confronting the hard task of reconciling a federal law which – in many important ways – differs from its older sister in Massachusetts.

Massachusetts has convened a dedicated workgroup to address these and the many other issues presented by ACA. The group has met several times since September 2010, and consists of state officials from the Executive Office of Health and Human Services, the Massachusetts Health Connector, the Massachusetts Division of Insurance, the Massachusetts Department of Public Health, MassHealth, other relevant state agencies, health plans, providers, employer groups, consumer groups and other interested parties.45 In addition, smaller state-led workgroups have commenced more focused discussions with stakeholders.46 Led by the Massachusetts Division of Insurance and the Massachusetts Health Connector, these groups have included the so-called “Three R’s” Workgroup addressing implementation issues centering on reinsurance, risk adjustment and risk corridors. The separate Insurance Market Reform Workgroup has focused on essential health benefits, catastrophic health plans, child-only health plans, group market size and rating issues and enrollment matters. As of April 2012, no workgroup sessions have begun to address the many issues presented by the individual mandate or employer responsibility issues.

This article illustrates that there are difficult legal, policy and operational issues to face from ACA’s implementation in Massachusetts. Much of the work has already begun in earnest. However, with many of the major provisions effective in 2014, state lawmakers and agency officials will need to continue with careful deliberation and timely legislative and regulatory actions.
Introduction

On January 15, 2009, Massachusetts joined 18 other states in adopting the Uniform Probate Code ("UPC"). Article V of the UPC went into effect on July 1, 2009, making sweeping substantive and procedural changes to guardianship law, aiming to grant greater protections to the civil rights of incapacitated persons. Further changes to the UPC were adopted in April of 2012, mostly relative to intestate succession and estate administration.

In theory, Article V of the UPC was designed to streamline procedural requirements for appointing surrogate decision makers while protecting the civil rights of the incapacitated by crafting decrees and orders specifically tailored to address particular areas of incompetency. In practice, however, so far the UPC has led to a significant increase in petitions, motions and return appearances being filed by health care facilities for incompetent patients at a time of diminished Probate Court system resources. Under the UPC, health care facilities are more frequently securing the appointment of guardians and seeking specific and modified court orders for admission to skilled nursing facilities, treatment plans for patients unable to give informed consent, non-routine medical decisions and end-of-life decisions. They are doing so for a broader scope of medical conditions and transfer situations, and finding that Probate Court judges, in applying the UPC, are often limiting the authority of guardians to give consent for treatments unless further court review and approval are secured.

The UPC instructs Probate Court judges not to confer more authority over a person than is necessary. The balance between an incapacitated patient’s civil rights and the altruistic discretion of hospitals and other treating facilities has been fundamentally altered by the UPC as Probate Court judges are now clearly required to make orders only to the extent necessitated by the protected person’s limitations and other conditions.

Furthermore, the variability of the Massachusetts Probate Courts in applying the UPC often adds delay and unnecessary cost for health care institutions and consequently their ability to efficiently and effectively treat the very individuals that the UPC was intended to protect. For example, the cost-effective health care system is designed to move patients out of an acute care setting as quickly as possible when sub-acute level care is more appropriate and a bed placement has opened up for the patient. In order to authorize the transfer of an incompetent patient, who has no involved family members and never appointed a health care agent before becoming incompetent, Massachusetts acute care hospitals are often forced to keep such a patient in the acute care setting pending the appointment of a guardian or the modification of the existing guardianship to authorize transfer to a skilled nursing facility, which is specifically required under the new law. This new aspect of the law results in extended stays in acute settings for extra weeks or months, exposing patients to greater risk of infection and relapse, often without access to needed rehabilitation and long term care services. This occurs while the hospital counsel or family attorney navigates the various courts’ processes, subject to the courts’ overburdened schedules and lack of personnel.

Additionally, health care institutions pursuing guardianships will often encounter the challenge of being in the middle of a dispute with or among the incapacitated individual’s family members about whether a guardian is needed, who will serve as guardian, and decisions as to treatment or treatment discontinuation. More often than not, a facility facing adversarial family members especially needs to petition for guardianship to secure a court order approving the recommended treatment plan. The facility is forced to bear the financial burden of pursuing a guardianship that is significantly delayed by the objecting family members.

Venue limitations under the UPC and inconsistent guardianship proceedings among Massachusetts Probate Courts also challenge health care facility petitioners who must obtain guardians and court orders for treatment and transfers for the growing number of incapacitated
patients lacking duly appointed surrogate decision makers and/or any involved family members. Clearly, the demographic trends of people in the U.S. living longer are impacting the number of patients in Massachusetts who need a legal surrogate to make health care decisions. The current backlog of cases pending in the underfunded and overburdened Probate Courts across the Commonwealth further delays guardianship proceedings and can lead to great variation of process among the Probate Courts.

**General Overview Of Guardianship Law and Procedure Under The UPC**

**A. Understanding Guardianship Substantive Requirements:**

Under the UPC, a guardian may be granted an array of general powers that effectuate the guardian’s ability to act as a medical decision maker on behalf of an incapacitated person. The guardian’s powers fall into three general categories, and each category necessitates distinct procedural and substantive requirements under the Code. Generally, the first category is known to practitioners as “ordinary medical decision making,” the second is “placement authority,” and the third is commonly referred to as “extraordinary medical decision making” or “substituted judgment” proceedings, which necessitate the appointment of a public defender paid by the Committee for Public Counsel Services who is specifically trained to advocate for the patient in these types of cases.

With regard to the first category, a guardian appointed without any additional authority is generally authorized to make decisions about routine, non-invasive medical procedures. Once appointed by the court, such a guardian may have the authority to “make decisions regarding the incapacitated person’s support, care, education, health and welfare . . . and the guardian shall act in the incapacitated person’s best interest and exercise reasonable care, diligence, and prudence.” Such “ordinary decision making” authority generally gives consent to treatment and arranging appropriate medical inpatient or outpatient care that does not involve any antipsychotic medications. A guardian need not seek explicit orders for each “ordinary care” decision, so long as the guardian is appointed by the court and is acting in the incapacitated individual’s best interest. Also, guardians are the duly appointed legal surrogates who have authority over the use and disclosure of the health information for the “person in need of services.”

The second category, placement authority, requires an explicit court order allowing the guardian to consent to placement in a skilled nursing facility or other health care facility. The court, rather than the guardian, after a hearing on the matter, will apply the “best interest” standard in determining whether such authority, and thereby placement, is appropriate. This authority is required for admission of any person under guardianship to any facility licensed as a skilled nursing facility, whether for long term care or any short term rehabilitation, even if only for several days. The requirement also applies regardless of who the guardian is, including those who are spouses, children or other family members as opposed to professional or institutional guardians. Issues also arise regarding persons from out of state and whether the foreign decrees authorize admissions to skilled nursing facilities in the Commonwealth.

Finally, a guardian can only make “extraordinary medical decisions” upon an explicit court order authorizing the specific treatment in question. Extraordinary medical procedures generally fall into two categories: (1) administration of antipsychotic medication, known as “Rogers authority”; and, (2) all other invasive treatments. For both types of extraordinary medical procedures, probate courts apply the “substituted judgment” standard, whereby the Court weighs various factors in order to determine the decision that the incapacitated individual would have made if competent. The drafters of the UPC did not specify an exhaustive list of such extraordinary authorities, accounting for and leaving flexibility to adapt to evolving medical techniques and standards. The UPC has, however, codified the following common examples of extraordinary treatment: “[treatment with antipsychotic medication, sterilization, abortion, electroconvulsive therapy, psychosurgery and removal of artificial maintenance of nutrition or hydration.” The UPC is not clear as to whether a guardian may consent to a “Do Not Resuscitate”, “Do Not Intubate” or “Do Not Hospitalize” order without specific court authority. Prior to the adoption of the UPC, Massachusetts courts suggested that a substituted judgment finding is required for the guardian to enter a DNR/DNI order. An exception to this requirement may exist when the patient is in acute medical distress, the guardian/family/physician all agree that there is no choice to be made, and avoiding resuscitation or lifesaving measures will not hasten death.

**B. Understanding Guardianship Procedural Requirements**

Any person “interested in the welfare of the incapacitated” may petition for a determination of incapacity and/or the appointment of a guardian over the incapacitated person (hereinafter “Respondent”).
UPC contains venue rules that require the petitioner to file in the Probate Court of the county where the Respondent resides at the time the proceeding is commenced. Pre-UPC guardianship procedure was more lenient in permitting Massachusetts health care facilities to file petitions of permanent appointment and motions for temporary appointment in the Probate Court located in the County where the facility was located.

Upon receiving a petition for guardianship, the Probate Court issues a citation, which is to be served in hand upon the Respondent as well as the heirs at law at least two weeks prior to the return date listed on the citation. Where there are no heirs at law or the interested parties do not receive notice, a publication must occur in the County where the proceeding is pending at least seven days prior to the return date. G.L. c. 190B §1-401(3). The “return date” is, in effect, a deadline by which interested persons to the case may file an objection. This date is usually about 4-6 weeks from the date of filing of the petition with the Court. A permanent guardianship cannot be completed until this date passes and proof of service upon all interested parties and/or publication is filed with the Court.

While the permanent petition is pending, a petitioner may file a verified motion for the appointment of a temporary guardian if “an incapacitated person has no guardian, and the court finds that waiting during the longer time frame to secure a permanent appointment under UPC procedures will likely result in immediate and substantial harm to the health, safety or welfare of the person alleged to be incapacitated occurring prior to the return date, and no other person appears to have authority to act in the circumstances.” A temporary guardian appointment is effective for 90 days, at which time it will be reviewed and new medical documentation will be required. On a temporary motion, the Petitioner must give seven days in-hand notice to the Respondent and the same by mail to any heirs at law. If the Court finds that an immediate emergency exists requiring the appointment of a guardian, it may waive or shorten the notice requirements, provided that the Respondent is notified of the proceeding as directed by the Court, and the Respondent and heirs at law receive notice after the proceeding instructing them that they may vacate the order.

If a petitioner requests ordinary authority or skilled nursing home authority, the court must determine whether such placement is in the best interest of the Respondent. The Court may appoint counsel to represent the interests of the incapacitated person, or a guardian ad litem (GAL) to investigate and provide a report to the Court. If a petitioner seeks extraordinary authority or authority to consent to administration of antipsychotic medication (“Rogers authority”), the courts will always appoint counsel for the Respondent.

Variability of Guardianship Proceedings Among Massachusetts Probate Courts

After a new guardianship petition and motion for temporary guardian is filed it can take two weeks to several months to have the first hearing date depending on which Probate Court the guardianship petition is filed. This length of time, particularly for petitions filed by acute care hospitals, is extremely problematic, costly, and can pose imminent harm to Respondents. The lack of sufficient funding for the Massachusetts Probate Courts has caused cuts to staff and most recently, a limitation on the hours that the Courts are open to consider petitions and motions. This contraction of service is happening at the same time that the UPC is requiring the Probate Courts to adapt to entirely new rules and process on estate administration while still handling the normal work load. The increasing amount of incapacitated patients is also resulting in significantly more demands on the Probate Courts with more guardianship case filings.

A. Venue Requirements

The UPC provides that a guardianship petition shall be filed where the Respondent resided prior to hospitalization. This venue requirement seems warranted if the patient has family or friends residing in the same County who are involved with the patient’s care and can provide information about the patient’s preferences prior to his incapacity. However, a growing number of patients are homeless or have resided alone without any known heirs or acquaintances prior to hospitalization. Requiring health care facility petitioners to file in a Court that may be a long distance from the facility, causes undue delay, burdens the facility, the guardian, the court appointed counsel, and testifying physicians. Further, an incapacitated individual has the right to attend any hearing, and in Rogers cases, must attend a hearing absent extraordinary circumstances. As written, the UPC does not acknowledge exceptions to the venue rule where the patient has no ties to his previous residence.

For example, a Boston tertiary care hospital that must seek a guardianship appointment to secure an order to approve a discharge plan to a sub-acute facility for a patient found homeless in Barnstable County is expected to file the matter in Barn-
Like most guardianship proceedings, the temporary guardianship motion requires the petitioner to overcome the venue obstacle, the petitioner must use the resources of an already over-burdened health care system.

There is great variation among the Probate Courts on the strict adherence to this venue rule. As applied, courts vary as to permitting filing in the venue where the health care facility is located. More troubling, it seems that a Probate Court’s financial constraints and perceptions about other Counties’ practices drive judicial decisions to reject filings. Anecdotally, it has been reported among regular guardianship petitioners to Judge is available, and then attempt to contact the Probate Court to obtain a court date. A date obtained in this manner is often times weeks out, at best.

In other cases, the court will not assign a case a court date. Instead, the petitioner must determine which Judge will hear the matter and when that Judge is available, and then attempt to contact the Probate Court to obtain a court date. A date obtained in this manner is often times weeks out, at best.

C. Appointment of Counsel

Even if a petitioner is successful in docketing within a few days of filing, most of the Probate Courts will not mark-up a hearing date until approximately seven to ten days from filing, which is consistent with proper notice under Mass. G.L. c. 190B §1-401(3). Although judges hold weekly motion days, clerks in many of the busiest Probate Courts are unable or unwilling to schedule new cases less than a few weeks after the docketing of the case, if at all.

When an expeditious hearing date can be obtained, inconsistencies among the Probate Courts in counsel appointment can further delay the process and lead to vast differences in the time it takes to secure the requisite legal authority to implement a discharge and/or treatment plan. Patients needing rehabilitation or long term care services and treatment can remain unnecessarily in acute care settings.

As previously mentioned, all Probate Court judges will appoint Rogers counsel or counsel for the Respondent when consent to treat with antipsychotics or extraordinary authority is sought. Counsel must be notified of their appointment, accept the court appointment and have the opportunity to visit with the Respondent prior to the hearing on a proposed treatment plan. There is a limited list of Committee for Public Counsel Services ("CPCS") attorneys who can accept Rogers appointments. Again, due to the courts’ backlog, counsels are often not appointed until days or even weeks after the filing of the petition. Often the appointed counsel for the patient does not receive notice of appointment in time for a hearing, cannot visit the patient in time, or cannot accept the appointment at all. In such instances, the initial hearing date on a motion for a temporary guardian and immediate approval of a treatment plan is continued.

Additionally complicating matters are the inconsistencies among judges in appointing counsels and GALs in non-Rogers cases. Where a guardian is needed to authorize the transfer out of an acute care hospital to a home care or non-acute facility setting, currently there are huge and unpredictable variances in the process among the Probate Courts and even the judges within each County. Because the UPC calls for judicial discretion for counsel appointment, some judges routinely choose to appoint counsel, or even a GAL, while others do not. Without knowing judicial preference beforehand,
clerks may fail to appoint counsel, and the petitioners may prepare for a hearing date only to receive an order requiring a counsel appointment on the day of the hearing.

D. Shortage of Guardians

In guardianship cases involving patients who have no living or involved family members and never appointed a health care agent while competent, petitioning health care facilities need to identify and secure the services of some suitable person to serve as guardian. Overburdened Probate Court clerks and judges are unlikely to find a willing attorney or social worker to serve as a guardian in patient care cases filed by hospitals and nursing homes. The involvement of the Courts in helping secure guardians varies greatly from County to County. By separating the guardianship function over health care decisions from the conservator functions over financial affairs into two separate legal proceedings, the UPC makes it difficult to find willing volunteers to serve as guardians in cases involving incompetent patients with no involved family or friends who are willing to serve as guardian. For hospitals and other facilities that regularly seek guardianship appointments it has become a constant challenge to secure the services of guardians for incompetent patients. The shrinking pool of guardians is in part attributable to the increasingly complex annual reporting required under the UPC, coupled with the convoluted manner in which professional guardians are compensated for indigent patients. Under the current scheme, a professional guardian can only seek payment for serving a MassHealth patient by seeking approval from the Court to order MassHealth to adjust the amount of the patient’s contribution for her care from external income sources (social security or pension). This adjustment must be authorized by the Court on an annual basis, and it is a mechanism that precious few attorneys will tolerate to serve as guardians. This is a situation that will get worse and warrants a systematic fix.

E. Process to Affirm Health Care Agents

As currently written, the UPC provides that a properly designated health care agent’s authority under M.G.L. c. 201D takes priority over the authority of a guardian, and cannot be revoked absent court order. Further, the comments to M. G.L. c. 190B §5308, state that the language of the revised UPC “should aid in preventing the mere institution of a guardianship proceeding from upsetting an arrangement for care under a health care proxy.” Accordingly, it is clear that the drafters of the UPC intended to prioritize designated health care agents and respect an individual’s right to prepare an advance directive.

Under M. G.L. c. 201D §5, a health care agent has broader decision making authority than a court appointed guardian. “The agent has authority to make any and all health care decisions on the principal’s behalf that the principal could make, including decisions about life-sustaining treatment, subject, however, to any express limitations in the health care proxy.” An agent’s powers are not limited to non-antipsychotic treatment plans or consenting to non-extraordinary authority, as are the guardians. Further, an agent may admit an incapacitated individual to a locked psychiatric facility, whereas the under G.L. c. 190B §§5-309, a guardian explicitly lacks such authority.

Despite the UPC’s clear intent to uphold the broad authority of health care agents without the need for court intervention, M. G.L. c. 201D §7 makes it easier for the patient who executed a proxy when competent to render it unreliable for the health care provider by refusing treatment or to undergo a procedure authorized by the agent. M. G.L. c. 201D §7 states that “[a] principal may revoke a health care proxy by notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the proxy.” In such circumstances, this section of the Massachusetts Health Care Proxy Law requires a physician who is informed of or provided with a revocation of a health care proxy to immediately record the revocation in the principal’s medical record and to notify orally, and in writing, the agent and any health care providers known by the physician to be involved in the principal’s care of the revocation.

Thus, hospitals encountering patients who refuse treatment over the authority of their agents often have no choice but to file a guardianship petition or seek a court order affirming the authority of the agent in order to secure the requisite legal authority over treatment decisions. The UPC does not provide for any process to resolve such cases. The Health Care Proxy Law does provide a process through which a petitioner, including a hospital or health care facility, may “commence a special proceeding in a court of competent jurisdiction, with respect to any dispute arising under [M. G.L. c. 201D].” This language suggests that a petitioner may seek to affirm the powers of the agent, but neither M. G.L. c. 201D nor the UPC provide any further guidance on when affirmation of a proxy is appropriate or any procedural guidelines regarding affirming an agent’s continuing authority under a proxy despite a pa-
tient’s refusal to voluntarily submit to treatment.

Some hospitals have been successful in petitioning Probate Court judges to affirm an agent’s authority on the basis of the Probate Court’s general authority. Other hospitals have adopted the practice of seeking a guardianship appointment of the agent in such cases. Currently, there is a lack of uniformity on how to most expeditiously secure the minimum necessary judicial intervention while protecting the patient’s rights. Arguably the patient’s rights would be best served by honoring the prior broad agency appointment. But if there is evidence of unfitness of the agent or a question of sufficient competency by the patient to have the informed capacity to refuse the treatment, then some level of an evidentiary hearing may be required in many of these cases to sufficiently adjudicate the matter.

**F. Short Order on Notice**

One mechanism that can be attempted by health care facility petitioners, and should be more widely accepted by all Massachusetts Probate Court clerks and judges, is to file motions for short orders of notice due to an exigent medical situation and the necessity of expediting the proceedings. A short order of notice allows the moving party to be heard on its motion within a period of time shorter than the required 7 days notice. Further, it allows a motion to be heard on a day that may otherwise be blacked out by those who schedule motions for the Judge due to the number of already marked up matters. There is a great variance currently among the Probate Courts as to their willingness to permit short orders of notice. In all venues, Court staff and case managers alike are understandably resistant toward any cases filed on emergency status, as it burdens an already strained system. Emergency motions are now almost always met with scrutiny and some push back.

Moreover, each County differs on its procedure to expedite appointment of counsel for matters that may be marked up more quickly. Some judges permit petitioner’s counsel to propose CPCS counsel who is available on short notice. Other judges forbid proposing counsel in a motion and instruct that counsel is appointed “off the list” where too often counsel is not appointed in time for the scheduled hearing. In some Counties, depending on the nature of the circumstances, temporary guardianship appointment may be made without appointment of counsel, and subsequent appointment is made with a short review date in order to reassess the emergency order. A broader adoption of this approach among more Counties would be helpful.

**G. Out-of-State Patients/Jurisdictional Questions**

Another major challenge many Massachusetts health care facilities face now under the UPC is with out-of-state incompetent patients. Facilities located near the border of neighboring states, as well as Massachusetts teaching hospitals and centers of excellence, regularly treat out-of-state patients and inevitably many of them are not competent to make informed health care decisions. Many Massachusetts hospitals and sub-acute facilities have service areas that include large portions of Rhode Island, Connecticut, New York, New Hampshire and Maine.

Many out-of-state incompetent patients present without having made out an advance directive recognized by their state of residence. This leaves a major question of jurisdiction and applicable law. Clearly, a Massachusetts hospital cannot treat and discharge such a patient on a non-emergency basis without seeking the appointment of a guardian and would need to do so by filing a petition in a Massachusetts Probate Court. Many Probate Courts, however, will not accept such petitions and instruct Massachusetts health facility counsels to seek an appointment in the state court of the patient’s residence.

In other situations, a patient does have a surrogate in place from another state but additional questions come up as to that out-of-state surrogate’s authority to consent to antipsychotic treatment and other invasive treatments being rendered in Massachusetts.

The American Bar Association has proposed adoption by the states of the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act (“UAGPPJA”). This Act would address jurisdictional issues such as transfer, out of state jurisdiction, and multi-jurisdictional guardianships. Massachusetts could resolve many of these jurisdictional issues by joining the 30 other states that adopted the Act.

**H. Consequences of the Variability in Procedure Among Probate Courts**

The increasing length of time under current UPC Probate Court practice before a temporary or permanent guardianship is heard is problematic and does not serve the interests of the incapacitated individuals that the UPC was drafted to protect. It is important to understand that most cases initiated by health care facilities are, by their very nature, urgent situations. For patients who do not have a surrogate decision-maker but
are medically stable and ready for discharge, the current Probate Court system is causing acute care hospitals longer than is medically advisable to discharge. These patients are often at greater risk of acquiring healthcare-associated infections, also referred to as nosocomial, hospital-acquired or hospital-onset infections. These patients also remain unable to obtain appropriate rehabilitation or post-acute care, facing the likelihood that his or her condition will deteriorate. Further, proper placements cannot be held indefinitely and are often lost by the time a temporary guardian appointment with the discharge approved by the Court can be secured. Patients who must wait one month for a guardianship order often will not be accepted by the originally available post-acute care facility or program as the bed or placement has been filled. Moreover, the patient in a locked psychiatric facility awaiting a guardianship appointment and an order approving a treatment plan must remain in the most restrictive setting, suffering the symptoms of a psychiatric illness without the ability to commence an antipsychotic treatment plan.

Conclusion

The variability of Massachusetts Probate Courts in applying UPC requirements is currently causing unnecessary financial costs to the Massachusetts health care system, inconvenience and uncertainty to litigants and their counsel, and most importantly, is not serving the interests of the incapacitated. Some of the current challenges stem from the financial shortfalls and lack of resources in the system. Many, however, could be easily rectified by UPC amendments and/or more consistent application of procedural steps by all of the Massachusetts Probate Courts in handling guardianship petitions and motions filed by health care facilities. A re-examination of the UPC as applied by the Probate Courts and the handling of all health care intervention matters is due and should be undertaken by the Chief Administrative Justice of the Massachusetts Probate Courts. Such a process could hopefully result in more efficient, fair standardized procedural rules to ensure that the UPC’s intent to create uniformity of procedure and greater rights for the incapacitated is effectively carried out in practice.

(Endnotes)
2 The UPC defines an “incapacitated person” as “an individual who for reasons other than advanced age or minority, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self care, even with appropriate technological assistance.” Mass. G.L. c. 190B §5-101(9).
3 Mass. G.L. c. 190B, § 5-306. Under the UPC guardians no longer have any authority over the funds or estate of a person, but rather no have authority only over the person’s personal/health care decisions. Court appointed surrogate authority over the financial affairs of an incapacitated person is limited to a conservator, who must be appointed through a separate legal process from a guardianship under the UPC.
4 Mass. G.L. c. 190B, § 5-407 (a), (d).
5 Mass. G.L. c. 190B § 5-309 (g). “No guardian shall have the authority admit an incapacitated person to a nursing facility except upon a specific finding by the court that such admission is in the incapacitated person’s best interest.” According to the note for § 5-309(g), the requirement of specific authority for admission to a nursing facility is an important new protection for the elderly.
7 45 C.F.R. §164.502 (g)(1) and (2); Mass. G.L. C 111, §70; Mass. G.L. C 112, §12C
8 The UPC replaces the reference of “ward” to “person in need of services” for adult incapacitated individuals.
9 Mass. G.L. c. 190B § 5309 (g).
10 The Court in Rogers et al v. Commissioner of the Department of Mental Health et al., 390 Mass. 489 (1983) held that specific court authority must be sought to administer antipsychotic medication, whereby the court applies a "substituted judgment" standard in order to determine whether an incapacitated individual would have refused treatment if he were not incapacitated.
11 Brophy v. New England Sinai Hospital, 398 Mass. 417, 427 (1986) (At least six factors are weighed in making substituted judgment: the individual’s express preferences regarding treatment; the strength of the individual’s convictions in relation to their refusal of treatment; the impact of the decision on the individual’s family; the probability of adverse side effects; the prognosis with and without treatment; and any other relevant factors); Mass. G.L. c. 190B § 5306A.
12 The Massachusetts Comment to Mass. G.L. c. 190B §5-306A states that: “The types of treatment for which a substituted judgment procedure may be required are not listed as they may vary depending on the invasiveness of the particular proposed procedure or because of advancements which reduce side effects, etc., see In Matter of Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).”
13 Massachusetts Comment to Mass. G.L. c. 190B §5-303.
20 Id.
21 Mass. G.L. c. 190B § 5308 (c).
22 Mass. G.L. c. 190 § 5308 (d).
23 Often urgent and potentially life-threatening circumstances call for even more immediate court intervention which can be availed through the Emergency Judicial Response System.
24 Mass. G.L. c. 190B 521 §§ 5-309 (g).
26 The current hours for Massachusetts Probate Courts are 8:30am – 3:30pm.
29 See 130 C.M.R. 520.026 (E)(3).
30 Mass. G.L. c. 190B §5-309 (e).
31 Mass. G.L. c. 201D §10
33 Mass. G.L. c. 201D §7 (emphasis added).
34 Mass. G.L. c. 201D § 17.
35 The National Guardianship Association describes UAGPPJA on their website, http://www.guardianship.org/uagppja.htm
20. Limitations on annual cost sharing are capped at Section 223(e)(2)(A)(ii) of the Internal Revenue Code of 1986 (Currently $6,050 for an individual and $12,100 for a family). Section 1302(c)(1)(A). Annual limits on deductibles are capped at $2,000 for an individual and $4,000 for a family. Section 1302(c)(2)(A). ACA contains provisions for indexing of annual limits.


23. Should a state not select a benchmark plan, the default benchmark plan for the state will be the small group plan with the largest enrollment in the state.


25. ACA, § 1311(d)(3)(B).

26. See DOI presentation on results of survey of potential benchmark plans presented to ACA Stakeholder Working Group. March 12, 2012. Examples of differences between the small group plans include routine eye care exams, dental services, physical and occupational therapy, coverage, and speech generating devices. Differences between the small group coverage and the state employees’ Group Insurance Commission (GIC) include: skilled nursing and rehabilitation therapy, private duty nursing, assisted reproductive technology, early intervention, hearing aids, chiropractic therapy, and physical and occupational therapy. Most differences relate to number of visit limits.

27. See id. Massachusetts’s mandates on Autism Coverage and Infertility not part of FEHBP.

28. 956 CMR 5.00: Minimum Creditable Coverage


30. Subtitle E – Affordable Coverage Choices for All Americans; Part I – Premium Tax Credits and Cost Sharing Reductions; Section 1401 – Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan. Amends Subpart C of IV of Subchapter A of Chapter 1 of the Internal Revenue Code of 1986 by adding a new Section 36B.

31. See Department of the Treasury, Proposed Rule on Health Insurance Premium Tax Credit. 26 CFR Part 1, 76 Fed. Reg. 50931 (Aug. 17, 2011). The monthly credit amount is equal to the lesser of either the premium for the month for one or more QHPs covering the individual or family, or the excess of the adjusted monthly premium for the “benchmark” plan offered through the exchange. See Proposed 26 CFR 1.36B-1.

32. 76 Fed. Reg. 50933 (August 17, 2011). Provided of course that the state does not implement a Basic Health Program, which provides coverage to individuals earning between 133% and 200% FPL.

33. ACA §1421- Small Business Tax Credit. Credit for Employee Health Insurance Expenses of Small Businesses. Amending Subpart D of Part IV of Subchapter A of Chapter 1 of the Internal Revenue Code of 1986 by adding a new Section 45R.
Introduction

On March 23, 2010, following nearly a year of congressional debate, President Obama signed the Patient Protection and Affordable Care Act (the “ACA” or “Act”) into law.1 The Act is the most significant piece of social welfare legislation since the Great Society, redefining the boundaries between the federal government and the states in the regulation and finance of health insurance.2 Congress relied on the Commerce Clause, the Taxing and Spending Clause, and the Necessary and Proper Clause to enact various pieces of this comprehensive solution to the nation’s health care crisis.

The ensuing litigation over this landmark law may redefine the reach of Congress’s regulatory powers. On March 26-28, 2012, the Supreme Court heard six hours of oral arguments on four issues briefed by the parties and amici. First, the Court considered the threshold question whether the minimum essential coverage provision in Section 1501 (the so-called “individual mandate”) was a tax for the purposes of the Anti-Injunction Act. If so, federal jurisdiction over the individual mandate will be deferred until at least 2015, when individuals who have paid the penalty may sue for a refund. The Respondents and the Government both argued against this result; however, the Court appointed an amicus to brief and argue that the Anti-Injunction Act bars jurisdiction.3 Second, assuming the Anti-Injunction Act does not apply, the Court heard argument on whether the individual mandate exceeded congressional power under Article I of the Constitution. Third, the Court considered severability: if the Court were to hold that the individual mandate is unconstitutional, should any part of the ACA be left standing?4 Finally, the Court considered whether the Act’s Medicaid expansion unconstitutionally coerces the states.5

This high-profile litigation has sparked public interest across the nation, including at Boston University School of Law, where Professors Kevin Outterson and Abigail Moncrieff created a special class, Constitutional Health Care Litigation. Law students from both Boston University and Boston College participated and submitted several amicus curiae briefs to the Court.6 Outterson and Moncrieff were joined by professors from other law schools in Boston and across the nation.

This Article examines the nearly yearlong effort in this class to craft arguments to aid the Court in adjudicating a wide-ranging dispute about the proper role of the federal government in health care. In Part I, this Article sketches the basic structure of the ACA. Part II provides a brief procedural history of ACA-related litigation. Part III and IV then examine the law students’ efforts to craft arguments before the Court to place them within the broader context of the ACA litigation and the recent oral arguments.

I. Structure of the Act

The ACA’s primary focus is expanding access to health care coverage. The Act achieves this objective through several mechanisms. First, the Act reforms the small-group health insurance market by greatly restricting medical underwriting.7 In its place, the Act establishes a system of adjusted community rating coupled with guaranteed issue and renewability reforms.8 To compensate for the influx of riskier individuals into private health insurance markets, the Act mandates that qualifying individuals maintain “minimum essential coverage” or pay a so-called “penalty.”9 In addition, the Act eliminates certain health insurance industry practices identified as unfriendly to consumers, including rescissions and caps on coverage.10 Second, the Act provides tax incentives to encourage small businesses to provide coverage to their employees and mandates that certain large employers provide coverage.11 Thus, the Act builds upon the existing system of employer-sponsored health insurance. Third, the Act expands eligibility for Medicaid, thereby creating a uniform health care entitlement for more of the poor.12 Congress provided that the federal government would shoulder all expansion costs initially, requiring the states to grad-
ually assume a maximum of ten percent of the costs associated with the newly eligible population by 2020.\textsuperscript{13}

The balance of the ACA contains an assortment of health care policy provisions, including public reporting of company payments to physicians, longer data exclusivity for large molecular weight drugs, and many attempts to control the increasing costs of health care. Although these provisions were not directly challenged in the litigation, their fate will nonetheless hang in the balance as the Court considers whether, in light of any constitutional infirmities, the bulk of the Act can be salvaged under the doctrine of severability.

\textbf{II. Taking the Battle to the Courts}

On March 24, 2010, only a day after President Obama signed the Act, fourteen states filed a lawsuit in federal district court in Florida. Among other things, the states alleged that the minimum essential coverage provision exceeded the Article I powers of Congress and that the Medicaid expansions were coercively unconstitutional. Numerous lawsuits followed in various federal district courts, challenging everything from the constitutionality of Medicaid itself to whether President Obama was a citizen born in the United States. Constitutional challenges to the minimum essential coverage provision have garnered the most attention, as opponents of the Act have attacked this “pay or play” provision as a mandate that invades personal liberty.\textsuperscript{14} While these cases were litigated across the country, the case that ultimately made it to the Supreme Court originated in Florida and was heard on appeal at the Eleventh Circuit Court of Appeals.

The Eleventh Circuit held that the individual mandate impermissibly regulates individuals by forcing market entry.\textsuperscript{15} Accordingly, the court concluded that the mandate is an exercise of the general police power, which is expressly reserved to the states by the Constitution.\textsuperscript{16} The court further held that the mandate was not essential (i.e., necessary and proper) to implementation of Congress’s broader regulatory scheme.\textsuperscript{17} Rather, the Eleventh Circuit reasoned that the numerous exemptions and exceptions to the individual mandate and the associated penalty would, in fact, frustrate Congress’s objective of growing the insurance risk pool.\textsuperscript{18} Thus, the court opined that Congress included the mandate merely to compensate insurance companies for their compliance with the new federal regulatory scheme.\textsuperscript{19}

As to the Medicaid expansion, the Eleventh Circuit held that although the Supreme Court has yet to formulate an administrable test for coercion, the ACA’s expansion of Medicaid fails short of the point where “pressure turns into compulsion.”\textsuperscript{20} In reaching its holding, the Eleventh Circuit found several factors particularly compelling. First, the court reasoned that the states impliedly waived such challenges because, prior to joining the optional Medicaid program, the states were placed on notice that Congress reserved the right to alter, amend, or repeal the Medicaid Act.\textsuperscript{21} Second, the court found that the states’ coercion claims were belied by the federal government’s decision to shoulder nearly all costs associated with the ACA’s Medicaid expansion.\textsuperscript{22} Third, the court noted that Congress had provided the states with reasonable notice to adjust their budgets and, if required, to raise additional revenue to support the expansion.\textsuperscript{23} The court took pains to note that the states would not be required to provide \textit{any} funding for the expansion until nearly seven years after enactment, in 2017.\textsuperscript{24} Further, the court reasoned that the states were left with ample time to arrange for an orderly exit from the federal-state Medicaid partnership by devising alternative healthcare programs.\textsuperscript{25} Finally, the court observed that the Medicaid Act provides the Secretary with discretion regarding funding decisions related to non-compliance, and thus deeply discounted petitioners’ claim that all Medicaid funding would automatically be lost for failure to comply with the expansion.\textsuperscript{26} Therefore, consistent with all prior court challenges to Medicaid amendments, the Eleventh Circuit found the states’ claim that the ACA’s Medicaid expansion would leave the states without a real choice unpersuasive.\textsuperscript{27}

\textbf{III. Briefing the Issues}

The goal of making an original contribution drove the search for \textit{amicus} brief topics in our class. Over 150 briefs were filed with the Supreme Court in this case, many reiterating similar points on the issues. In such a crowded field, we wanted to avoid repeating arguments made by the parties or other \textit{amicis}. The topic that garnered the most attention in the media and in the quantity of \textit{amicus} briefs filed below was the individual mandate. The Supreme Court surprised most observers when it also granted \textit{certiorari} on the challenge to the Medicaid expansion because there had been no circuit split on this issue. Accordingly, fewer \textit{amicus} briefs ad-
dressed this topic. The granting of certiorari on the Medicaid expansion also raised concerns for many Medicaid scholars, as there would be no reason for the Court to accept the challenge unless it was seriously considering invalidating the expansion.

When the Supreme Court set the briefing schedule for the challenge to the ACA, it set the deadline for Petitioners to brief the challenge to the individual mandate in early January, followed by severability in early February, and the Medicaid expansion in mid February. Three teams from our class wrote individual mandate briefs; our team settled on Medicaid. Professor Outterson reached out to several Medicaid scholars and formed a group of professors who wanted to work with us on the brief. They were eager to provide an amicus brief on this issue because Medicaid has a long history of being expanded by Congress and upheld by the courts without any constitutional controversy at all, which is precisely the point that we chose to make in the brief.

All of the Medicaid briefs filed on behalf of the Petitioner states focused on the financial burdens of Medicaid and general complaints about the program. Few offered any substantive legal argument or direct attack on any particular section of the ACA. In writing an appellate brief, one is inherently torn between writing to advance the argument one wants to make, and responding to the arguments made by the other side. Because our brief was in support of the Government as Respondents, we had the advantage of filing after the Petitioner states’ Merits Brief and their amici. After reading what we considered to be gross factual distortions of the program, a major focus of our brief became a factual statement of the history of the Medicaid program, together with the legal precedents for Medicaid expansion. We decided not to respond to some of the more provocative and extreme amici, as this could only give more traction to some of their more audacious claims.

Because many other ideas were floating around, the approach we took was to have various teams write up short 2,000 to 3,000 word sections on various ideas as to what should be in the brief, and then to decide which ones were the most important points to get across and then tie them together. With a strict word limit of 9,000 words, many excellent pages were cut.

One section that survived the editing process looked carefully at the text of the Medicaid expansions in the ACA. This section focused on the structure of the amendments, looking at the way the law was written to try to parse out exactly what part of the statute the states objected to. Because the states did not identify which precise part of the Title II expansion was coercive, part of the brief walks through the elements of the expansion they do mention and explains why each provision is not coercive.

Throughout assembling the brief, the group informally consulted with other groups who were writing amicus briefs in support of Respondents, as well as attorneys at the Department of Justice. While we were solely responsible for writing our brief, coordinating with other groups was essential to make sure that we were not repeating arguments that they would make. We also wanted to avoid unknowingly undermining arguments made by the Respondents, who had to file their brief only a week before ours. By the time their Merits Brief was filed, it was too late to make any changes to our brief, except for small changes at the margin.

After many drafts, our nearly final brief was circulated to health policy scholars across the country in the first week of February. More than 50 signed on to the brief, which was filed on February 17, 2012. At oral arguments on March 28, 2012, several questions seemed directly taken from our brief, although the Justices did not mention it by name.

IV. Oral Argument

The provision of the Social Security Act which gives the Secretary of Health and Human Services the discretion to withdraw some or all of a state’s Medicaid funding if the state does not comply with the program requirements received a lot of attention from the Justices. Justice Breyer questioned the Petitioners on how the provision could be an issue when it had been in the Social Security Act since 1965, while Chief Justice Roberts and Justice Kagan questioned the Respondents on how the Secretary had exercised that discretion in the past and how the Secretary might use it in the future. Justice Ginsburg asked the Petitioners whether it mattered that some states liked the Medicaid expansion and wanted to keep it, an argument that we made in our brief. Some of the material from our brief also appeared in a question by Justice Breyer, when he asked how the current expansion could be found unconstitutionally coercive without jeopardizing the past
expansions.\textsuperscript{33} Justice Kennedy questioned the Respondents on the Maintenance of Effort provision, which we had discussed at some length.\textsuperscript{34}

**V. Conclusion**

From the months of heated debate leading up to its passage, to the challenges to the ACA filed immediately after the legislation was passed, to the extraordinary volume of \textit{amicici} the case has attracted at every stage of litigation, the story of healthcare reform is replete with voices from every part of the ideological spectrum. Our brief is one voice in a discussion that will continue long after the Supreme Court hands down its opinion in June and will hopefully inspire others to engage in a conversation that affects every resident of the United States. We are grateful that Boston University School of Law offered this unique class this year.

(Endnotes)


3 For a thoughtful critique of the Court’s practice of appointing \textit{amicici} to defend orphaned arguments, see Brian P. Goldman, Note, \textit{Should the Supreme Court Stop Inviting Amici Curiae to Defend Abandoned Lower Court Decisions?}, 63 Stan. L. Rev. 907 (2011).

4 Severability is often described as a doctrine of judicial restraint. See Adrian Vermeule, \textit{Saving Constructions}, 85 Geo. L.J. 1943, 1946 (1997) (describing severability as “a norm of legislative supremacy positing that statutes should take effect to the full extent the Constitution permits”). When a court finds that part of a statute is unconstitutional, it seeks to preserve the legislative bargain so long as (1) Congress would have passed the statute but for the constitutional defect and (2) the statute is capable of functioning without the severed provision. See Tom Campbell, \textit{Severability of Statutes}, 62 Hastings L.J. 1495, 1505-06 & n.51 (2011).

5 Although the Court has paid lip service to the concept of coercion, it has never invalidated a federal law on this ground. See, e.g., South Dakota v. Dole, 483 U.S. 203, 211-12 (1987); Steward Mach. Co. v. Davis, 301 U.S. 548, 590 (1937).


7 See 42 U.S.C.A. § 18091.

8 See id §§ 300gg-1(a), 300gg-3, 300gg-4(a).

9 26 U.S.C.A. § 5000A (West 2011) (effective Jan. 1, 2014). The individual mandate ensures that the cost of covering higher-risk individuals (e.g., the elderly and chronically ill) is subsidized by lower-risk individuals (e.g., the young). See Roger L. Pupp, \textit{Community Rating and Cross Subsidies in Health Insurance}, 48 J. Risk & Ins. 610, 610–11 (1981).

10 See, e.g., 42 U.S.C.A. § 300gg-12 (ban on rescissions); id § 300gg-11 (no lifetime or annual limits).


12 See 42 U.S.C.A. § 1396a(a)(10)(A)(i) (VIH) (West 2003 & Supp. 2011); Sara Rosenbaum, \textit{Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System}, 7 J. Health & Biomedical L. 1, 16–17 (2011), 13 See 42 U.S.C. § 1396d(y)(1). To permit the states adequate time to plan for shouldering their relatively modest share of implementation costs, the federal government will pay all expansion costs between 2014 and 2016. \textit{Id}. Thereafter, the states’ share will gradually increase before reaching a capped contribution of 10 percent in 2020 and subsequent years. \textit{Id}.


14 Florida v. U.S. Dep’t of Health & Human Servs., 648 F.3d 1235, 1311-13 (11th Cir. 2011).

15 See id. at 1309-11.

16 See id. at 1265-68 (quoting \textit{Steward Mach. Co.}, 301 U.S. at 590).

17 See id. at 1267 (citing 42 U.S.C. § 1304); see also \textit{Harris v. McRae}, 448 U.S. 297, 301 (1980).

18 Florida,648 F.3d at 1267-68.

19 Id. at 1268.

20 See id. at 25 Id.

21 Id. (citing 42 U.S.C. § 1396c).

22 \textit{Florida},648 F.3d at 1267-68.

23 Id at 1268.

24 See id.

25 Id.

26 Id. (citing 42 U.S.C. § 1396c).

27 See id. (“These factors convince us that the Medicaid-participating states have a real choice—not just in theory but in fact—to participate in the Act’s Medicaid expansion.”); see also \textit{Wilder v. Virginia Hosp. Ass’n}, 496 U.S. 498, 502 (1990) (noting that participation in Medicaid is voluntary but subject to conditions).


29 E.g., Brief of Indiana State Legislators, the James Madison Institute, and Christopher Conover, No. 11-400 (U.S. Jan. 17, 2012), available at http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/11-400_petitioner_amcu_islandcheckdam.pdf

30 42 USC §1396(e), see generally Transcript of Oral Argument, \textit{Florida} v. U.S. Dep’t of Health and Human Services (No. 11-400).

31 Transcript of Oral Argument at 12, 49, \textit{Florida} v. U.S. Dep’t of Health and Human Services (No. 11-400).

32 Id. at 20.

33 Id. at 24.

34 Id. at 52.
Obtaining an OIG Advisory Opinion: The General Counsel’s Perspective - Interview of Daniel Orenstein, General Counsel, athenahealth, Inc.

By Julia R. Hesse

As many of you may know, athenahealth, Inc. recently received a favorable Advisory Opinion from the Office of Inspector General (Advis. Op. 11-18, December 7, 2011). Athenahealth is best known for its Internet based practice and revenue cycle management, and electronic health record services. Athenahealth also offers patient communications, and care coordination services on the same integrated technology platform. The favorable Advisory Opinion relates to athenahealth’s care coordination service. The Advisory Opinion itself has been discussed in the press and also by trade associations like the American Health Lawyers Association, and is interesting in its own right.

The purpose of this interview is not to discuss the substance of the Advisory Opinion, though. Instead, I recently sat down with Daniel Orenstein, the General Counsel of athenahealth, Inc., to discuss the process of obtaining the Advisory Opinion. The questions are all mine; Daniel provided all answers.

Is this the first Advisory Opinion your company had sought?

Yes.

Who within the organization started the conversation with regard to getting an advisory opinion?

It’s a “chicken and egg” question. I was called into a meeting with the CEO and our head of Business Development, who were discussing this business idea. They knew that it raised some potential anti-kickback issues and they raised the issue of a potential advisory opinion with me because we had already discussed seeking advisory opinions in other situations. The anti-kickback analysis was often part of the initial conversation on a major initiative.

What was different about this project that made you decide to go forward with the Advisory Opinion process?

This was a new planned service offering in the “drawing board” stage and where we had the strategic opportunity to get the security of the opinion. It wasn’t a “must-have” because it is a complimentary service offering – while it was a highly strategic initiative, if we got some negative feedback we could work with it ... and the prospect of getting positive feedback outweighed the negative. Also, because it is a new service offering – essentially creating a new market for information exchange outside of the usual paradigms – getting an advisory opinion could give us a competitive advantage.

Did you have the opportunity to discuss the idea informally with the OIG before the formal request was made?

No. The OIG has a set process where they wanted the written request and then they take some time and ask for more information. That’s when you kind of get into more of a dialogue. But the OIG is clear; they wanted the initial request in writing. We did explore with outside counsel, though, whether it was possible to withdraw the advisory opinion request if the OIG reacted very negatively to the concept.

Did you have any ability to direct your advisory opinion request to a particular person...
within OIG (i.e., someone who may have been known in the community as being more focused on Health IT issues)?

No. We were assigned an attorney who turned out to be very engaged and very good and easy to work with and responsive. We were very concerned, though, when we got the OIG’s initial request for additional information, because the tone of the request seemed to indicate that maybe there were some things about the model that they didn’t understand, or we didn’t communicate adequately enough. But when we started engaging with the OIG about their questions, we got through that and the OIG felt that we were able to respond adequately.

Did you send all of your information to the OIG only in writing? Or did you have an opportunity to present the vision of the project to them, either in person or over the phone?

We didn’t do any communications directly. All of the communications were through our outside counsel. We suggested meeting in person as a possibility and we would have done that. The OIG wanted our first response in writing; we offered to do a “demo” of the product but the OIG decided they did not need a demo. We did provide some charts and graphical representations of what we were doing as exhibits that I think were very helpful. In one of the rounds of responses we tried to make it simpler and easier to understand than some of the narrative that we had given previously.

How many rounds of back-and-forth did you have with the OIG?

We received two requests for additional information, and there were a couple of questions which we answered verbally. We also had to submit a factual certification at the end prior to issuance of the opinion, and there was a round of back-and-forth on the factual certification.

Did some of their requests for information make it clear that perhaps they didn’t understand the model in the way that you would want to present it? Were you surprised at all by the content or the depth of their requests for information?

The OIG’s requests were pretty much what we anticipated. We knew we would get some questions and we would probably have a little work to do to respond. The OIG had a lot of questions around the economic model. I think they were correct to push us on that, because we hadn’t articulated it as clearly as we should have and it forced us to go back and spend some significant time internally. We revised the pricing model to make it simpler. I, personally, was on a crusade to make the model simpler. We needed to make the pricing model simpler – not only for the OIG, but we needed to make it simpler for the market to understand this. If we can’t communicate it adequately to a sophisticated government agency, just think about communicating it to a two or three doctor practice that doesn’t have a lot of time. I think that was probably the most salutary part of the process. We actually got to a simpler economic model out of the process.

How long did the advisory opinion process take? And how long did you think it was going to take?

We submitted it in May or June (of 2011) and we had the opinion in December. I was pleased that we had it within the year. The OIG responded very quickly, as compared to a number of other agencies that we work with. Also, some of that time was spent on our side, with internal processing of responses back and forth. The OIG responded efficiently – which is great because pressure started mounting towards the end of the year to roll the service offering in general availability at the beginning of 2012. I was a little surprised that the OIG was so responsive. I had the “Plan B” starting to formulate just in case we didn’t have the Advisory Opinion in hand before that sales meeting in February.

When you think about it from the OIG’s perspective, though, they must love getting the advisory opinion requests because that’s where they get to do the big policy-level thinking, right?

Yes. When we received the work product back from the law firm, we felt it needed more of the policy argument in it because we wanted to appeal to that bigger picture thinking. We think there are some really strong public policy arguments in favor of this model because it facilitates care coordination. There are a lot of folks in the government who are interested in that now because of the challenges with making health exchange work properly. So, we worked to include the public policy argument and I think, at the end of the day, that was an important factor in the decision making.

I can see why you would want to put the request in context.
and explain not only why it matters for the business, but also who it benefits and why?

That actually took a little while to communicate to our law firm.

The challenge from the outside lawyers’ perspective is always that we never know your business as well as you do and therefore we can’t divine the public policy piece as well as the business can.

That’s right. There were a couple of points in time where I think it was appropriate that we took over a bunch of the drafting and a bunch of the processing. For example, we were really best positioned to work on the economic model internally, and we were probably best positioned to craft the policy arguments.

Were there any unanticipated “hiccups” along the way that, in hindsight, you would think might be part of any advisory opinion process?

The OIG’s initial response back to us was a little bit of a shock. In some ways it was encouraging; but in some ways it took you aback to see how much they were getting into everything and questioning some of what you were doing. On the other hand, we were pleasantly surprised about the OIG’s responsiveness.
Policymaker Profile: Interview of Áron Boros, Commissioner, Massachusetts Division of Health Care Finance & Policy

by Phillip Rakhunov

Introduction

On August 22, 2011, the Patrick-Murray Administration announced the appointment of Áron Boros as Commissioner of the Division of Health Care Finance and Policy. Since 2008, Mr. Boros has served as Director of Federal Finance for state’s Office of Federal Finance.

In his capacity as Director of Federal Finance at MassHealth, Mr. Boros has been engaged in key initiatives, including MassHealth and federal expenditures. Over the last several years, he has been deeply involved in a variety of health care payment initiatives, including the MassHealth Section 1115 Medicaid waiver and Health Safety Net programs.

Mr. Boros is also an attorney and received his J.D. and Masters in Public Policy from the University of Michigan. Prior to joining the Office of Medicaid, Mr. Boros worked as an Associate in Foley Hoag’s Boston Office, where he researched and implemented strategic initiatives for health care industry clients. His work included initiatives related to chronic disease management, health information technology, and evidence-based medicine. In this role, Boros became an expert on Medicaid and Medicare regulatory issues, including national coverage decisions, coding and payment concerns. Mr. Boros also has experience in a hospital setting, having served as a Law Clerk at Trinity Health’s Saint Joseph Mercy Hospital in Michigan.

Interview

Mr. Boros, please tell me about how you became interested in public health?

My dad is a doctor. He is an oncologist, and oncology plays a particularly important role in our society. It’s exciting medicine, it’s challenging medicine, and for many reasons: not just the science of it, but also the human aspect of it. I always knew, however, that I did not want to spend fifteen years in [medical] school after high school, so ultimately I did not think that medicine was the direction I wanted to go in.

What really inspired me to go back to graduate school was – and this will date me a little bit – it was the Supreme Court election case of Bush v. Gore. Yes, Bush v. Gore drove me to law school. Even then, I knew I didn’t really want to be a lawyer in the long term, but I also knew I wanted more tools than a policy degree would give. So, I went to the University of Michigan for a joint program in Law and Public Policy, hoping to develop a career in healthcare policy and policy making. So fast forward, and this is a dream job for me. The Division of Health Care Finance & Policy really straddles both those worlds. It’s deep in the weeds on data analysis, data collection, and ultimately in really drawing a story out of the data at the lowest level. At the same time we are involved in helping shape Massachusetts state policy and the interactions between federal and state policy at the systematic level.

I want to ask you a few questions about your background, going back to your years at Amherst College. During your time at Amherst, were you already considering going into public service?

I was. I always knew that there was an underlying social mission for me that was going to be more than, for example, investment banking. But, back then, I certainly didn’t know what that was going to be. My first job out of college was at a graphic design firm, but I always had that sense that giving back is important. I’ve been given a lot of opportunities and I’ve been blessed with certain advantages in life, and I felt that there was a responsibility that came along with that. I can’t say that I knew, when I was graduating from Amherst, exactly how that would play out - but it’s no surprise to me that I ended up in this kind of role.

Tell me how your legal education at the University of Michigan impacted your career.

While I was in law school, I did two really meaningful things that influenced my career path. First, I worked for the General Counsel’s office at the Trinity Health’s Saint Joseph Mercy Hospital in Michigan. It was a really interesting look into what healthcare law really is. I think that a lot of law students don’t understand how much
of healthcare law is transactional, as opposed to things like end of life decisions, or policy about minimum credible coverage. When you look at what hospitals are actually doing day-to-day and what they need legal advice about, you realize that most health law is transactional.

Take a big, integrated health care system: hospitals, physician groups, and other sites of care like community health centers. Because they are big employer, they have a lot of labor and employment issues. They are land-owners, so they have real estate and capital assets issues. Of course mergers and acquisitions and contracting have unique health law concerns, such as compliance with self-referral and antitrust laws. Contracting also involves increasingly complicated relationships between hospitals, physician groups, and other kinds of ambulatory care providers and long term care providers, not to mention health plans. Other industries aren’t regulated to the same extent as health care. Here we have special rules surrounding health care arrangements because of Medicare and Medicaid, for example. So, every merger, every contract, has another layer of complexity. The legal clerkship that I did at the Mercy Hospital was the first time I heard about Stark laws; first time I heard about anti-kickback laws.

The other really important thing that I did when I was in law school is that I worked for the graduate employees union. I was on the bargaining team that represented graduate employees in a couple different roles. And that was also a really an important part of my career development.

**After law school, you spent some time in the private sector at the law firm of Foley Hoag?**

Yes. For several years after law school I worked at Foley Hoag LLP, in their government strategies group. There, I got my education from Nick Littlefield and his team about how the world really works with respect to policy making and the way things get done in Washington. I also did a lot of pricing work, working with payers. For example, some of our clients had medical products of one kind or another, and we worked with Medicare and Medicaid about how those products would get paid for. After Foley, I left to go work for the Patrick Administration in the Medicaid office.

**Tell me about your work with the Medicaid Office.**

At the Medicaid Office, I worked on the financial aspects of the federal/state relationship.

**And, is that the program known as the MassHealth?**

So, you can decide how much you want to get into the weeds on this, but it’s probably good for people to understand that MassHealth is a specific state program that provides health care services. Medicaid is the state/federal partnership that overlaps most, but not all of what MassHealth does. For example, Commonwealth Care it is also part of the Medicaid Office. So is the Health Safety Net that we run here at the Division of Health Care Finance & Policy and the Medical Security Program run by Division of Unemployment Assistance. The Office of Medicaid is bigger than just MassHealth.

**It is clear that you have had quite a diverse education and professional experiences; please tell me how these experiences have come together for you.**

It all comes together as kind of building blocks: in law school, I learned textbook law; in policy school, I learned textbook economics and statistics; at the Hospital, I learned what health law really was; and with the union, I started my education in politics and learned about power of negotiation and bargaining; then, I went to work for Nick [Littlefield at Foley] and learned how policy making and politics happen in the real world at the State and Federal level; and then went to work for the State and really got to understand how the sausage gets made.

**What led you to begin your public service with the State Medicaid Office?**

Primarily, it was that Massachusetts continues to be a leader in taking a hard look at the health care system and making it better. Governor Patrick is upholding a long tradition of leadership on health care issues that stretches back for at least 20 years. Lots of people deserve credit for laying the foundation that the Governor is building on, including Governor Dukakis, Senator Kennedy, and Mitt Romney (whether he acknowledges it or not).

I want to ask you about a couple of the initiatives that I understand you worked on while you were at the Medicaid Office and which I believe are now a part of your areas of responsibility. One that you mentioned earlier is the Health Safety Net.

The Health Safety Net is a program run by my office that pays hospitals and community health centers for care that otherwise would be uncompensated. This covers people who either are uninsured or under-insured for the services provided by the hospital.

Federal Health Reform (the Affordable Care Act) will have a significant
impact on the Health Safety Net because of the way it changes the coverage market. Over the next couple of years, until those federal rules come into effect, we will be taking a hard look at how the Safety Net fits into everything else that is going on with the implementation of the ACA in Massachusetts.

Is the Safety Net program unique to Massachusetts?

Yes. It’s a claims-based system for paying for uncompensated care, which I believe is unique among states.

What is your take on the recent conversations about cost containment and payment reform?

The Patrick administration, from the Governor and the Secretary [of Health and Human Services], down to agencies like ours, has proposed an approach that achieves cost containment by promoting integration of the delivery system and improvement of the experience of care and the delivery of care. Instead of a hospital and a physician never speaking to each other and having their own isolated connections to the patient, we want to build those connections. That way, the physician knows when a patient goes to the hospital and manages some of their care in the hospital; for its part, the hospital communicates about discharge back to the physician and helps coordinate follow-up care to ensure the patient doesn’t end up back in the hospital.

The goal is to use the transformation of the delivery system to drive higher-value care – better quality, and lower cost – by taking advantage of the improvements that you can get by breaking down some of these walls. The idea is appealing, and it’s easy to string together some sentences about it – but it’s hard to do in practice.

If you know nothing else about the big picture of health care policy, take this: the [Centers for Medicare & Medicaid Services] just released data showing that in Massachusetts, per capita healthcare expenditures for every man, women and child are $9,278 per year. That means that, on average, my family of three is paying almost $30,000 a year for health care expenditures.

This figure includes Medicare, Medicaid, out of pocket, and insured costs that either you or your employer are paying in premiums, distributed among the population. This is the highest per capita cost of all of the states, in the highest per capita cost country in the world. We can reduce those costs. It will be hard, it will really take change to accomplish this, but it is possible and there is no reason for us to be the most expensive health care system in the world.

You’ve been in this job now for six months or so. What has surprised you the most coming into this particular position of the Commonwealth?

There are a lot of hard choices to be made about lowering costs and improving quality, and there are lots of complex interactions between various stakeholders inside and outside of government. What has surprised me the most is the high level of collegiality in the face of those hard choices and difficult tradeoffs. I expected there to be more contentiousness between the parties. When push comes to shove with the cost containment legislation, that may change. But I have been really impressed by the level of discourse inside and outside the Statehouse, and how everybody really is taking this problem seriously.

That said, the choices and challenges will only get harder and I encourage people who are thinking about this to continue to be bold while maintaining civil discourse, in order to push the envelope of what we can accomplish.

As you know, we are coming into what is anticipated to be a very heated election year, and I’m wondering whether the political climate impairs your ability to do your job of analyzing the data and trying to make decisions based on the numbers and economics, as opposed to politics.

The Division has, and deserves, a strong reputation for providing objective analysis. I don’t see that changing. We can’t control what different people try do with our analysis, but our reputation speaks for itself: we stick to our best understanding of what the data tells us.

Is there one issue that you would like to bring to the forefront of the readers’ minds?

No matter what happens, there is going to be a lot of change in the health care system in the next few years. Your clients are going to need to invest in understanding value. What I mean by that is that they are going to be asked more and more to prove that their piece of the heath system provides high-quality care that actually makes people healthier and happier at a reasonable price. Attorneys who understand that communicating about value is going to drive a successful business model will be positioned to best support their health care clients. To be a little bit more concrete, right now we are talking about cost and payment systems, integrated care. The conversation of tomorrow will be quality measurement, outcome measurement, and really proving that the money spent is delivering results. I anticipate that at—
In December of 2011, the Superior Court of Massachusetts enforced an investigative subpoena issued by the Massachusetts Board of Registration in Medicine (“Board”) to Sturdy Memorial Hospital, Inc. (“Sturdy”), compelling the disclosure of materials claimed by Sturdy to be privileged core materials of medical peer review committee. The subpoena at issue sought to compel the production of certain handwritten notes (“Notes”) created by Sturdy’s Medical Director concerning a physician, Dr. Doe, about whom complaints had been lodged. The Board sought all documents pertaining to Dr. Doe, including documents relating to incident reports referencing the physician and the investigation thereof, such as the Notes. Sturdy objected to producing the Notes, claiming they were protected by the medical peer review privilege under G.L. c. 111, § 204(a). The Board asserted that the Notes are protected under G.L. c. 111, § 205(b), which would allow for the production of such materials prior to the commencement of formal adjudicatory proceedings.

In finding that the Notes at issue constituted raw materials, the Sturdy court relied heavily on the analysis of the Supreme Judicial Court (“SJC”) in its 2009 case, Hallmark, in which the SJC distinguished peer review core materials protected under Section 204(a) from Section 205(b) raw materials. In Hallmark, the SJC recounted the statutory history of the peer review privilege, noting that, in 1987, it had held that Section 204(a) did not protect “raw materials” relied on by a peer review committee if they were obtained from other sources. In response to that decision, the Massachusetts Legislature enacted Section 205(b) to extend the medical peer review privilege to documents that might otherwise fall outside the scope of Section 204(a), but that are nonetheless necessary to risk management and quality assurance programs. The Hallmark court pointed out that while both sections shield information from the general public and other third parties, Section 204(a) shields information from the Board only until the Board com-
This case takes a very narrow view of the materials protected by Section 204(a) from disclosure to the Board during the investigatory stage. While Hallmark and Beth Israel both held that raw materials obtained from other sources were subject to production to the Board during this stage, neither required the production of the work product of the hospital’s Medical Director in the course of his duties as the coordinator and chairman of the hospital’s designated peer review committees. In analyzing contested materials regarding privilege, the Sturdy court seemed to emphasize form over substance in a way that favors Board access. The Court gave little credence to the Medical Director’s affidavit explaining the purpose for which the Notes were created. Instead, it focused on timing and the fact that a peer review committee had not yet convened. Indeed, the court observed that the “Notes may, at some point be necessary work product of a medical peer review committee” and presumably then would be protected from Board review.7

This ruling, if followed by other courts, could have practical implications for health care providers. The Notes were not specifically designated as privileged peer medical review materials and the Medical Director was not careful about specifying in what capacity he was creating the Notes. Attorneys should consider advising healthcare clients to be mindful of the timing and process for protecting materials under the medical peer review privilege. Furthermore, early on, clients may want to consider convening a formal review committee meeting to preserve the confidentiality of materials made in connection with incident reports or investigations of professional misconduct. Finally, there is a concern that a more restrictive definition of the core peer review protection of Section 204(a) and the heightened possibility of early-stage disclosure of materials to the Board of Registration disciplinary unit, particularly notes created by the Medical Director or another physician peer review committee, could undermine the candor and openness that is necessary for an effective peer review process.

(Endnotes)
3 G.L. c. 111, §§204(a), 205(b).
5 Sturdy, 2011 WL at *2, citing Hallmark, 454 Mass. at 509.
6 See Beth Israel Hospital Association v. Board of Registration in Medicine, 401 Mass. 172, 183 (1987) (“Section 204 does not protect information generated by other components of the QPCAP system or the ‘raw materials’ relied on by a [peer review committee] if obtained from other sources.”); Carr v. Howard, 426 Mass. 514, 522 n.7 (1998) (holding that protection under Section 204(a) only applies to documents which are themselves a product of the proceedings, reports, and records of a peer review committee, and not merely materials made to be presented to such a committee).
7 Sturdy Memorial Hospital, 2011 WL at *4.

by Matthew S. Buehler

The Massachusetts Medicaid plan, MassHealth, pays for nursing home care received by individuals who have less than $2,000 in assets and meet certain other criteria. This creates an incentive, however, for individuals to give away their assets to friends and families in order to qualify for nursing home benefits. To minimize this incentive, MassHealth reviews asset transfers made by an applicant. The Appeals Court in Gauthier v. Director of the Office of Medicaid, 80 Mass. App. Ct. 777 (2011), reviewed such an asset transfer in the form of a care agreement.

Specifically, the plaintiff in Gauthier entered into a care agreement with her son whereby she transferred all of her assets to him. The plaintiff applied to MassHealth roughly two years later for nursing home benefits. MassHealth, however, found that the care agreement was a disqualifying asset transfer.

MassHealth reviews all asset transfers made an applicant for nursing home benefits within the five years preceding the application. If MassHealth determines that an applicant has made a “disqualifying transfer” of assets during that period, it imposes a period of ineligibility before the applicant can receive benefits. A contract for future care (such as the agreement between the plaintiff and her son) is “a disqualifying transfer of assets to the extent that the transaction does not have an ascertainable fair-market value or if the transaction is not embodied in a valid contract that is legally and reasonably enforceable by the applicant.” However, even if a disqualifying transfer has occurred, no ineligibility period will be imposed if the applicant “demonstrates to the MassHealth agency’s satisfaction that (1) the resources were transferred exclusively for a purpose other than to qualify for MassHealth; or (2) the [applicant] intended to dispose of the resource at either fair-market value or for other valuable consideration. Valuable consideration is a tangible benefit equal to at least the fair-market value of the transferred resource.”

The ineligibility period (in months) imposed for a disqualifying transfer of assets is “equal to the total, cumulative, uncompensated value ... of all resources transferred ... divided by the average monthly cost to a private patient receiving nursing-facility services in ... Massachusetts at the time of application, as determined by the MassHealth agency.” The “uncompensated value” of a resource is defined as “the difference between the fair-market value of the resource ,, at the time of transfer ... and the actual amount the individual received.” Fair market value is “an estimate of the value of a resource if sold at the prevailing price.” The plaintiff suffered from Alzheimer’s disease. By September 2004, when the plaintiff was 79 years old, her condition had reached the point where she could no longer live alone and she moved in with her son and his wife (the plaintiff’s daughter-in-law). The son and daughter-in-law subsequently renovated their home and built a living area for the plaintiff. In March 2006, the plaintiff entered into a Care Agreement (“the Agreement”) with her son. Under the Agreement, the son agreed to provide the plaintiff with lodging, 3 meals a day and weekly housecleaning and laundry services. In return, the plaintiff agreed to pay $225,000 up-front to her son.

After 90 days, the son had the right to terminate the Agreement for “good and sufficient cause” and keep any payments. “Good and sufficient cause” was defined to include if the plaintiff could no longer care for her personal needs, including bathing or dressing herself. The Agreement remained in effect over 2 years until the son terminated it in May 2008 after he had back surgery and could no longer lift the plaintiff. At that time, the plaintiff had paid $182,000 to her son and did not have any further assets.

Upon termination of the Agreement, the plaintiff moved into a nursing home and applied for MassHealth benefits. MassHealth though denied her application on
the ground that the Agreement was a disqualifying transfer. The plaintiff appealed the denial of MassHealth benefits with the Office of Medicaid Board of Hearings. After a hearing, the agency Hearing Officer upheld the denial of benefits.

In particular, the Hearing Officer found that the plaintiff’s payment of $182,000 to her son was a disqualifying transfer as the Agreement had no fair-market value. The Hearing Officer further found the payment was made at least in part to qualify for MassHealth. As a result, the plaintiff was ineligible for nursing home benefits for 682 days ($182,000 divided by a $267 average daily cost of a private nursing home in Massachusetts).

In reviewing the Hearing Officer’s decision, the Appeals Court first upheld the finding that the Agreement was a disqualifying transfer. Fair-market value is determined by reviewing the value of what the applicant received at the time of transfer. At the time of its execution, however, the Agreement was ambiguous as to how long the son would care for the plaintiff and what care she would receive. The Agreement did not have a set duration and lacked benchmarks for care provided. The Agreement instead only required the son to care for the plaintiff as much he could for as long as he could.

Moreover, the plaintiff was already in failing health in March 2006 due to Alzheimer’s and needed one-on-one supervision. As a result, the son literally could cancel the Agreement if and when she executed the Agreement was to enable the plaintiff to qualify for MassHealth without having to make a refund. These factors provided substantial evidence to support the Hearing Officer’s finding that the Agreement did not, at the time of its execution, have an ascertainable fair market and hence was a disqualifying transfer.

The Appeals Court next reviewed the Hearing Officer’s finding that the plaintiff entered into the Agreement at least in part in order to qualify for MassHealth. MassHealth provides an exception for transfers made solely for another purpose than qualifying for benefits. To qualify for this exception, an applicant must provide more than verbal assurances as to his or her intent. An applicant must instead prove his or her intent through convincing evidence. The Appeals Court found that substantial evidence supported the finding that the plaintiff did not meet this burden.

The plaintiff was already in failing health when she executed the Agreement. The Agreement thus contemplated a possible future where the plaintiff would need more care than the son and his wife could provide. At that time, the plaintiff would have no alternative but to go to a nursing home, and would have to apply for MassHealth. This supported the conclusion that one purpose of the Agreement was to enable the plaintiff to qualify for MassHealth if and when her son could no longer care for her.

The Appeals Court found, however, that these facts were insufficient to end the inquiry into the intent of the Agreement. MassHealth regulations also provide an exception for transfers where the applicant intended to receive valuable consideration. The Appeals Court noted that it was possible that the son intended to give the plaintiff fair consideration, even if he believed that she would ultimately have to receive nursing home care. In fact, the son did build a living area for the plaintiff and cared for her under the Agreement for nearly two years. The Appeals Court stated that these facts could support a finding that the plaintiff did intend to receive fair consideration, although the Hearing Officer did not make any separate findings on this issue. The Appeals Court thus remanded the case for further findings.

In addition, the Appeals Court addressed the calculation of the plaintiff’s ineligibility period. The Hearing Officer based the ineligibility period on the entire $182,000 transfer by the plaintiff. This period is supposed to be based on uncompensated value, i.e., the difference between what the plaintiff paid under the Agreement and what it was worth. The plaintiff paid $182,000 under the Agreement, although, as discussed above, it is difficult to determine the fair market value for what the plaintiff received. The Hearing Officer appears to have treated the Agreement as worthless based on its lack of value when executed. The Hearing Officer also noted, though, that the plaintiff received 22 months of care under the Agreement — and that the average monthly cost of nursing home care was $8,010. The plaintiff thus likely would have paid nearly $182,000 if she spent those 22 months in a nursing home instead.
The Appeals Court noted that MassHealth regulations are unclear whether uncompensated value is measured at the time of execution or by the services subsequently provided under a contract. The Court indicated that it preferred calculating the value of the contract based on the value of services actually provided but it declined to make a definitive ruling without more guidance from the agency. Instead, the case was remanded for further findings as to the intent and uncompensated value of the Agreement. Until then, the value of future care contracts will remain uncertain.

(Endnotes)
1 130 C.M.R. § 519.006.
2 130 C.M.R. §§ 520.018 & 520.019.
3 130 C.M.R. § 520.019.
4 130 C.M.R. § 520.007(J)(4).
5 130 C.M.R. § 520.019(F).
6 130 C.M.R. § 520.019(G)(1).
7 130 C.M.R. § 515.001.
8 130 C.M.R. § 515.001.
9 The plaintiff initially sought judicial review under G.L. c. 30A, § 14(7) of MassHealth’s decision. The Superior Court (Donovan, J.) upheld the denial of benefits and the plaintiff appealed this decision to the state Appeals Court.
13 130 C.M.R. § 520.019(F)(1).
16 130 C.M.R. § 520.019(F)(2).
18 130 C.M.R. § 520.019(G)(1).

by Margaretta Homsey Kroeger

In January 2012, the Massachusetts Appeals Court reviewed an order of the Probate and Family Court appointing the parents of a mentally ill pregnant woman as her guardians for the purpose of consenting to an abortion and to a sterilization procedure. The Appeals Court determined that the order violated the woman’s right to due process and did not comply with the requirements of the state’s substituted judgment statute. Accordingly, the Appeals Court reversed in part, vacated in part, and remanded the matter for further proceedings.

At the time of the appeal, Mary Moe was a 32-year-old pregnant woman diagnosed with schizophrenia and/or schizoaffective disorder and bipolar disorder. She had suffered a psychotic break when she was in college and had been hospitalized numerous times due to her mental illness. Moe had also been pregnant on two previous occasions. The first time she became pregnant she had an abortion, and the second time she gave birth to a son who was placed in the custody of her parents. Moe’s psychotic break occurred at some point after she had the abortion and before the birth of her son.

In October 2011, Moe had visited a hospital emergency room where it was determined that she was two or three months pregnant. The Department of Mental Health then filed a petition requesting that Moe’s parents be appointed as her guardians for the purpose of consenting to an abortion. A hearing on the petition was held before a judge of the Probate and Family Court in December 2011. At the hearing, Moe stated that she would not have an abortion. She also made several inaccurate assertions, including that she was not pregnant, that she had met the judge before, and that she had previously given birth to a girl named Nancy, when she had in fact given birth to a boy. Based on these “substantial delusional beliefs,” the judge found that Moe was incompetent to decide whether to have an abortion.

The judge appointed a guardian ad litem (“GAL”) to investigate whether, under a substituted judgment analysis, Moe would consent to an abortion if she were competent. In Massachusetts, court authorization is required before a guardian may consent to certain extraordinary medical procedures on behalf of a person who has been found incompetent. In determining whether to authorize a procedure, the court will apply the doctrine of substituted judgment, whereby it “substitutes itself as nearly as possible for the individual in the decision making process.” In doing so, the court “seeks to maintain the integrity of the incompetent person” by providing an opportunity to exercise his or her fundamental right to decide whether to consent to such a procedure. The court must determine not “what is necessarily the best decision but rather what decision would be made by the incompetent person if he or she were competent.”

The GAL submitted a report concluding that Moe would not choose to have an abortion if she were competent. The record revealed that Moe became “agitated and emotional” discussing her first pregnancy that ended in an abortion. Moe had also stated that she was “very Catholic” and would never have an abortion. However, her parents stated that Moe was not an “active” Catholic and they believed it was in her best interest to have an abortion.

After considering the facts contained in the GAL report, the judge reached the opposite conclusion than the GAL. Without holding a hearing, the judge found that Moe would choose to have an abortion if she were competent and ordered that Moe’s parents be appointed as guardians to consent to the abortion. The judge further ordered, sua sponte, that Moe be sterilized by the medical facility that performed the abortion procedure. Moe then appealed the order.

In reviewing the order, the Appeals Court first observed that the decision to bear or beget a child is a fundamental right of all people, including those who are incompetent. As a result, the court will
apply the doctrine of substituted judgment when determining whether a guardian can consent to an abortion or sterilization on behalf of an incompetent person.

Turning to the portion of the order requiring sterilization, the court stated that, “[b]ecause sterilization is the deprivation of the right to procreate, it is axiomatic that an incompetent person must be given adequate notice of the proceedings,” along with an opportunity to be heard on the issue of the ability to give informed consent and, if unable to consent, a substituted judgment determination. The court noted that none of these procedural requirements were met when the judge ordered Moe’s sterilization sua sponte and without notice. It held that the required level of due process had not been provided, and it reversed that part of the order.

The Appeals Court then considered the portion of the order requiring an abortion. It first determined that the judge’s decision that Moe was incompetent to decide whether to have an abortion was supported by evidence in the record, namely that Moe denied that she was pregnant. However, the court noted that the other evidence on which the judge relied, that Moe believed that she had met the judge before and had given birth to a girl, did not support a determination that she was incompetent with respect to the abortion issue, given that “[a] person may be adjudicated legally incompetent to make some decisions but competent to make other decisions.”

The court next determined that the order requiring Moe to have an abortion did not comply with the state’s substituted judgment law. The court stated that, after Moe was found incompetent, the judge was legally required to hold an evidentiary hearing to determine whether she would have an abortion if she were competent, unless the judge found “extraordinary circumstances” that required her to be absent from the hearing. Alternatively, the judge could have based the substituted judgment determination exclusively on affidavits and documentary evidence if the judge had made “an additional finding, based on representation of counsel,” that there were no contested issues of fact. Because the judge did not hold a hearing or make the required additional findings, the court vacated the portion of the order requiring the abortion, and remanded the case for “a proper evidentiary inquiry and decision on the issue of substituted judgment.” Finally, the court vacated the portion of the order appointing Moe’s parents as her guardians to the extent that it was conditioned on the need for them to consent to the abortion, and the court directed that the order be modified to appoint her parents as guardians for general purposes related to routine medical care.

(Endnotes)
2 “Mary Moe” is a pseudonym used to maintain the confidentiality of the lower court proceedings. See G.L. c. 112 § 12S.
4 See G.L. c. 190B, § 5-306A.
5 See id.; see also Matter of Moe, 385 Mass. 555, 559 (1982).
7 Id.
8 Id.
10 Id.
11 Id.
12 Id. at 139.

by Meghan M. Cosgrove

On March 6th, the District Court in Massachusetts denied a motion by Fresenius Medical Care Holdings, Inc. d/b/a Fresenius Medical Care North America (“Fresenius”) to dismiss a qui tam complaint under the False Claims Act, 31 U.S.C. §3730, filed by former employee Christopher Drennen (“Drennen”). In reaching its decision, the Court not only found that Drennen’s allegations of fraud were specific enough to meet the pleading requirements under Rule 9(b) of the Federal Rules of Civil Procedure (“Rule 9(b)”), but also held that the public disclosure bar did not preclude Drennen from filing his action as the Court found him to be an “original source” of the information alleged.

Drennen, a former area manager of Fresenius, the nation’s largest dialysis provider, alleged that the company billed Medicare over a ten (10) year period for certain hepatitis B and ferritin tests that were not medically necessary. Specifically, he claimed that Fresenius billed hepatitis B tests more frequently than Medicare’s National Coverage Decision allowed and without the required supporting documentation, including the physician orders. Drennen made similar claims regarding Fresenius’ billing for ferritin tests although provided less detail with respect to these tests.

The False Claims Act (“FCA”) prohibits the submission of false or fraudulent claims to the federal government and allows private individuals to sue on behalf of the federal government under its “qui tam” provisions. It is well-settled case law that qui tam fraud actions brought under the False Claims Act are subject to the heightened pleading requirements of Rule 9(b). This rule requires that a relator plead claims of fraud with sufficient particularity such as “the dates of the claims, the content of the forms or bills submitted, their identification numbers, the amount of money charged to the government, the particular goods or services for which the government was billed, the individuals involved in the billing, and the length of time between the alleged fraudulent practices and the submission of claims based on those practices . . .” While the “time, place, and content” factors are not used as a checklist, a relator must plead specific information with respect to the claims for payment that are submitted to the government in order to meet the Rule 9(b) pleading requirements.

In this case, Fresenius argued that the information provided by Drennen did not meet the specificity requirement of Rule 9(b) because he did not identify the names of the Fresenius employees who submitted the claims for the tests, the physicians who ordered the tests, or the details about when the tests were billed to Medicare. In rejecting Fresenius’ argument, the Court noted that Drennen identified the location where the unnecessary tests were performed, the type of test performed, the time period during which the tests were performed, and the cost billed. In addition, Drennen provided the initials of six (6) patients who received sixty-four (64) unnecessary hepatitis B or ferritin tests. The Court found the information provided by Drennen sufficient to meet the Rule 9(b) pleading requirements.

Beyond the heightened pleading requirement of Rule 9(b), qui tam actions under the False Claims Act are also subject to a dismissal if the activity alleged has already been publicly disclosed (the “public disclosure bar”). A relator can still overcome the public disclosure bar, however, if the relator is considered an “original source” of the information. To be considered an original source, the relator either must have voluntarily disclosed the information on which the claims are based to the government prior to public disclosure, or have direct and independent knowledge of the publicly disclosed claims and voluntarily provide this information to the government prior to filing an action. With respect to the latter category, a relator’s knowledge is considered direct and independent if it has been acquired through the relator’s own efforts and is not dependent upon the public disclosure. If the information in the relator’s possession is not considered direct and independent, the relator is not considered an “original source” and the public disclosure bar prevents the relator’s action from going forward.

The Court found that all of the elements of the public disclosure bar
were met but that Drennen was an “original source” of the information he alleged in his complaint. In reaching its decision, the Court rejected Fresenius’ argument that Drennen needed to have direct and independent knowledge of the billing practices of every Fresenius clinic, the medical history of all patients, and every hepatitis B and ferritin test given from 2001 to the present. Even though Drennen’s personal knowledge of Fresenius’ alleged false and improper billings was limited to just the ten dialysis clinics that Drennen supervised, the Court found the information that Drennen provided with respect to these ten clinics in addition to his knowledge of Fresenius’ nationwide computer system and Medicare billing system was sufficient to establish Drennen’s direct and independent knowledge for all of the alleged medically unnecessary tests done on a nationwide level, including those occurring in clinics that Drennen did not supervise.

This case serves as a reminder to practitioners that the time, place, and content factors used to establish specificity under Rule 9(b) are not a rigid checklist. A relator may still meet the pleading requirements of Rule 9(b) as long as the information alleged is sufficiently specific with respect to the submission of fraudulent claims to the government. In addition, this case suggests that a relator’s personal knowledge of a limited number of improper billings can be extrapolated in certain circumstances such that the relator can be considered the “original source” for allegations of FCA violations on a nationwide level.

(Endnotes)

1 31 U.S.C. §3729 et seq.; These private individuals are often referred to as “whistleblowers” or “relators.”
3 Id at 233.
4 Id at 226.
5 31 U.S.C. §3730(e)(4)(A); The First Circuit has applied the following analysis in determining whether the public disclosure serves as a bar: (1) whether there has been public disclosure of the allegations or transactions in the relator’s complaint; (2) if so, whether the public disclosure occurred in the manner specified in the statute; (3) if so, whether the relator’s suit is “based upon” those publicly disclosed allegations or transactions; and (4) if the answers to these questions are in the affirmative, whether the relator falls within the “original source” exception as defined in 31 U.S.C. §3730(e)(4)(B). U.S. ex rel. Rost v. Pfizer, Inc., 507 F.3d 720, 728 (1st Cir. 2007).

It is important to note that the Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010) (“PPACA”) significantly narrowed the use of the public disclosure bar as a defense in FCA cases. First, the bar is no longer jurisdictional in nature, rather it provides that a court “shall dismiss an action or claim under this section, unless opposed by the Government . . . ” In addition, the categories of public disclosures have been significantly narrowed post-PPACA as reflected in the italicized terms below. Information is considered “publicly disclosed” and thus a qui tam action is barred if the allegations or transactions are contained in (i) a federal criminal, civil, or administrative hearing in which the government or its agents a party; (ii) a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation; or (iii) in the news media.

7 31 U.S.C. §3730(e)(4)(B); PPACA also amended the definition of “original source” to remove the requirement that a relator have “direct” knowledge of the allegations or transactions and instead allows a relator who simply has knowledge, whether direct or indirect, that “is independent of and materially adds to the publicly disclosed allegations or transactions” to be considered an “original source.”
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