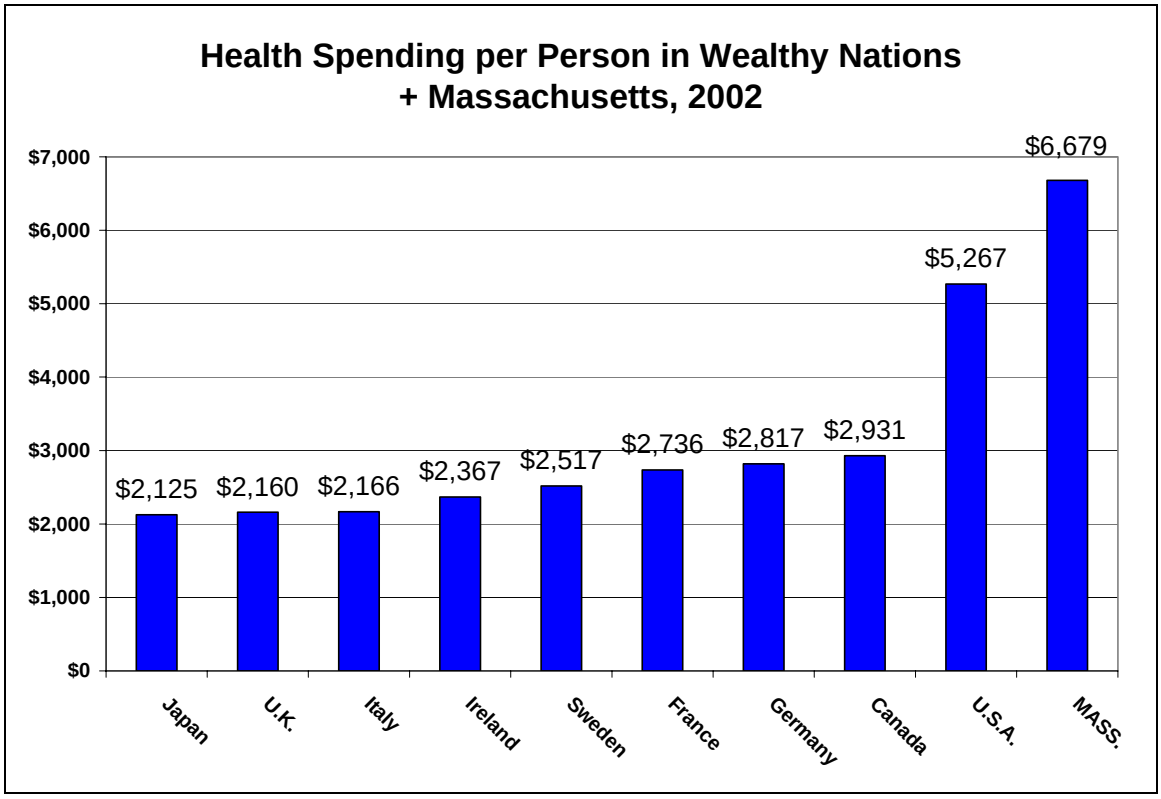
SUMMARY AND EXHIBITS

$1 BILLION PER WEEK IS ENOUGH

RECYCLING THE HALF OF HEALTH SPENDING NOW WASTED —NOT CUTTING BENEFITS OR RATIONING BY ABILITY TO PAY— IS KEY TO FINANCING HIGH-QUALITY HEALTH CARE FOR ALL



A Report Submitted as Testimony on
S. 755, An Act to Establish the Massachusetts Health Care Trust

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Joint Committee on Health Care Financing,
Massachusetts General Court
Room A - 2, State House
20 July 2005

***Disclaimer**: As always, we write and speak only for ourselves, not on behalf of Boston University or any of its components.*

Massachusetts has the costliest health care in the world.

It is reckless to pretend
that more money to finance business-as-usual
will continue to flow indefinitely.

Contingency planning for
an unpredictable future
is vital.

Please consider these three expert predictions—

"Stocks have reached what looks like a permanently high plateau."
—Irving Fisher, Professor of Economics, Yale University, 1929

"64K ought to be enough memory for anybody."
—Bill Gates, 1981

"Massachusetts health care rests on a solid foundation. Everyone complains that costs are high, but we're getting our money's worth. That's why payers and patients will continue to find money that Massachusetts health care requires."
—Anonymous Massachusetts health economists, 1975 - ?

Massachusetts already has the resources to take care of us all

		State Rank	***% Above U.S. Avg.***
Estimated health spending/ week in Mass.	$1 billion	--	***--***
Estimated health spending/person, 2005	$8,213	1	***+ 27%***
Hospital spending/ person, 2003	$2,176	1	***+ 41%***
Share of patients served in teaching hospitals	--	1	***--***
Patient care MDs/ 1,000 people, 2002	3.92	1	***+ 54%***
Specialist share of physicians, 2002	71.3%	--	***+12%***
Registered nurses/ 1,000 people, 2002	11.2	1	***+ 44%***
Share of people in HMOs, 2003	38.4%	2	***+62%***

SUMMARY

As health care spending in Massachusetts has soared to $1 billion per week, 18.5 percent of personal income, the numbers of people uninsured and under-insured have grown. The challenge is to use today's vast resources to cover us all well. But proposals that enjoy good political currency would fail to do so.

The governor talks about expanding health insurance coverage while controlling cost, but his proposal seems likely to hike spending and to provide only partial benefits (and high out-of-pocket costs) for many. This might be called a recipe for O-Mitted Care.

This failure should not discredit the aim of making health care affordable for all in Massachusetts without increasing spending. Indeed, the Commonwealth already has the dollars and the doctors—and the competence and compassion—to finance the care that works for all the patients who need it.

Consolidated financing is the best foundation on which to begin to build durable and sustainable medical security for all who live in this state. It offers a framework in which we can squeeze out and recycle much of the half of health spending now wasted.

In past years, experts debated whether health care reform should emphasize universal coverage, or cost control, or both at the same time. Many experts long thought that it was reasonable to pursue universal coverage first. Political support for cost control—either alone or married to coverage expansions—seemed too weak. After covering everyone, cost controls could follow.

The 1988 Massachusetts universal health care law, signed by then-Governor Dukakis, was an example of that approach. Unfortunately, the 1988 law could not be implemented, largely because it did not contain costs. Indeed, it immediately increased them by giving hospitals very large payment hikes.

Massachusetts may now be in danger of again passing a law that promises coverage to all but that cannot be affordably implemented. Even worse, while the 1988 law at least promised full benefits to almost everyone, the governor's current proposal does not. It would offer only partial benefits to many of those it would newly cover, accompanied by both high out-of-pocket costs and increased total spending. (And it would likely catalyze further de-insurance, setting an example that private payers and the existing Medicaid program could imitate.)

Without cost controls, expanding coverage requires some combination of higher spending and watered-down benefits. <u>But weak benefits and high out-of-pocket costs are a formula for cruelly and unfairly rationing health care by ability to pay.</u> Therefore, we believe it is no longer responsible to propose universal health care coverage in Massachusetts without also proposing fair, effective cost controls.

Owing to high health care costs in our state, there seems today to be no overlap between what is politically achievable and what is financially workable. It seems that the bills that have the most political support because they promise some coverage for all can't work because they don't contain cost, and the bills that could work because they offer universal coverage and cost control can't pass.

Workable cost controls would challenge the way money is spent in health care today because they would capture dollars that are now wasted. All money now spent on health care—even the one-half that is wasted—is income to some party. Workable cost controls are therefore opposed politically by those who fear the loss of this money.

It is unrealistic to continue to talk only about coverage and about money. It is essential to work also to contain cost and to reform the actual delivery of care. Winning durable health insurance coverage for everyone in Massachusetts requires addressing cost control. Because much money is wasted today on unnecessary care for insured patients, even as many others are under-served, financing that coverage requires addressing the actual delivery of care. This report describes ways to do so.

It is both tragic and totally unnecessary that any person in Massachusetts should suffer avoidable pain, disability, or premature death for lack of needed health care. With the highest health spending per person in the world, we in Massachusetts can find ways to squeeze out waste, empower physicians to spend money much more carefully, and pool financing in order to cut administrative waste and cover everyone.

This report makes ten main points—

1. Massachusetts health care is the costliest of any state's, so the costliest on earth—triple the spending per person in Britain, Italy, and Japan. This year's health spending in Massachusetts is about $52.7 billion (about double the total state budget). That is $1 billion each week. It should be enough to provide good coverage for all who live here. Yet some 7-10 percent of this state's residents are uninsured and growing numbers are under-insured.

2. The governor's proposal only pays lip service to the idea of covering us all well without higher spending. It would actually raise spending while leaving most newly-insured people without adequate protection. It skates lightly over the cost problems we face, lacking provisions to address sources of high costs and waste. It sets a dangerous precedent of accommodating our high costs by adopting skimpy coverage. This might win a short-term political numbers game by counting people presumably insured, but it would worsen the trend toward widespread under-insurance and rationing care by ability to pay. Our governor, like many failed generals, is calling his proposal an advance, but it is really yet another retreat from the fight to contain costs.

3. Here and nationally, health care consumes a growing share of the economy. Assuring full, durable coverage for all requires tackling this unsustainable burden. Family insurance premiums here doubled in 6 years. Health costs grew from 15.6 percent of personal income here in 2000 to 18.5 percent in 2003-04. Massachusetts Senate Bill 755 is the only bill offering serious cost controls.

4. Contingency planning is essential—now. Massachusetts health care is addicted to more money each year to finance business as usual. Yet that pays for less care for fewer people, while caregivers complain they are underpaid. It is unrealistic to assume there will continue to be more public and private money for health care. But health care here is badly prepared to cope with the effects of an economic downturn. A financial crisis would be the worst time to design affordable health care for all and protect all needed caregivers. Health care finances may be squeezed sharply—or gradually. Patients, payers, and caregivers all deserve a plan to put our care on a stable footing.

5. That can be done. About half of health spending nationally is wasted—on unproductive paperwork generated by the way we pay for care, on fraud, on unnecessary services, and on excessively high prices. Reallocating the wasted sums is vital to providing needed care to all and stabilizing caregivers. In Massachusetts, wasting half of health spending means wasting about $26 billion this year, roughly equal to the state budget. Cutting waste from about 50 percent of health spending to 20 percent ($10 billion this year) would free nearly one-third of current spending to expand care for people now uninsured and under-served.

6. A major cause of this state's high costs is our use of extremely specialized caregivers. We rely heavily on teaching hospitals and specialist physicians.

7. The aim of health care cannot be immortality—but medical security is achievable. Consolidating the many streams that now finance care provides the best foundation on which to build medical security. This is partly because it quickly wins huge administrative savings, which can be used to finance expanded coverage. Spending to administer health care financing would fall about 45 percent. This would permit a large rise in spending on actual care—about 9 percent overall and about 25 percent for physician care, we have estimated. Pooling the money also makes it much easier to lower drug prices, reduce fraud, and, most important, encourage and enable doctors to spend money carefully to provide the care that works to all who need it.

8. Eliminating unnecessary care—and using those resources instead to serve patients now under-served—is vital to keep care affordable. Doctors must play the central role in eliminating wasted services. Shifting costs to patients cannot contain total costs, promote appropriate care, or protect caregivers. Doctors' decisions control some 87 percent of the health dollar. Engaging doctors is therefore essential to containing cost and covering all people.

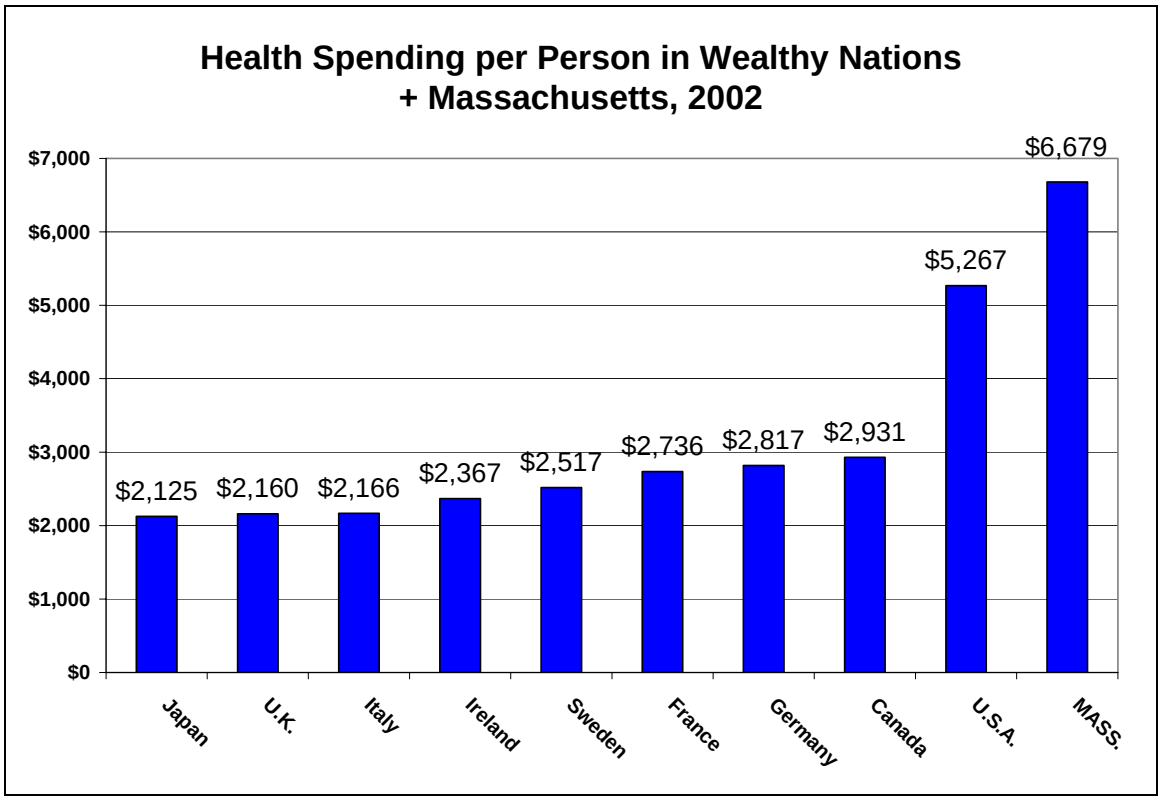
9. Legislators and state health care officials must start and sustain a mature political, financial, and clinical conversation about how to contain cost, make coverage for all who live here durably affordable, and sustain all needed hospitals, doctors, nurses, long-term care providers, and other caregivers. It is both vital and feasible to address these issues at the state level. It is vital because Congress is not going to act soon in useful ways. And as health care melts down, more and more parties will demand state action. It is feasible because state government has important financial and political influence on health care, and because it can persuade all stakeholders to come to the table.

10. The aim of providing coverage to all in Massachusetts has again won political visibility. But the universal coverage horse has many riders. These include hospitals, doctors, and nursing homes that seek higher Medicaid payments, and employers and insurers that want to cut their payments to the Uncompensated Care Pool. Most proposals combine increased coverage with increased payments to caregivers and increased cost. They reflect a contrived appearance of consensus that won't endure. Fulfilling any promise of much new money seems unlikely. A similar combination shaped the 1988 Massachusetts law that promised universal health care but never delivered.

- The 1988 law failed politically because its coverage expansions were to begin years later, but higher hospital payments began immediately, letting hospitals withdraw support for implementing the access provisions.
- It failed financially because its coverage expansions relied on implausible new spending—instead of squeezing out and recycling waste in what was even then the costliest state.

We must not re-draw that fatally flawed design.

Exhibit 1



Source: OECD, and Health Reform Program calculations from CMS data.

Exhibit 2

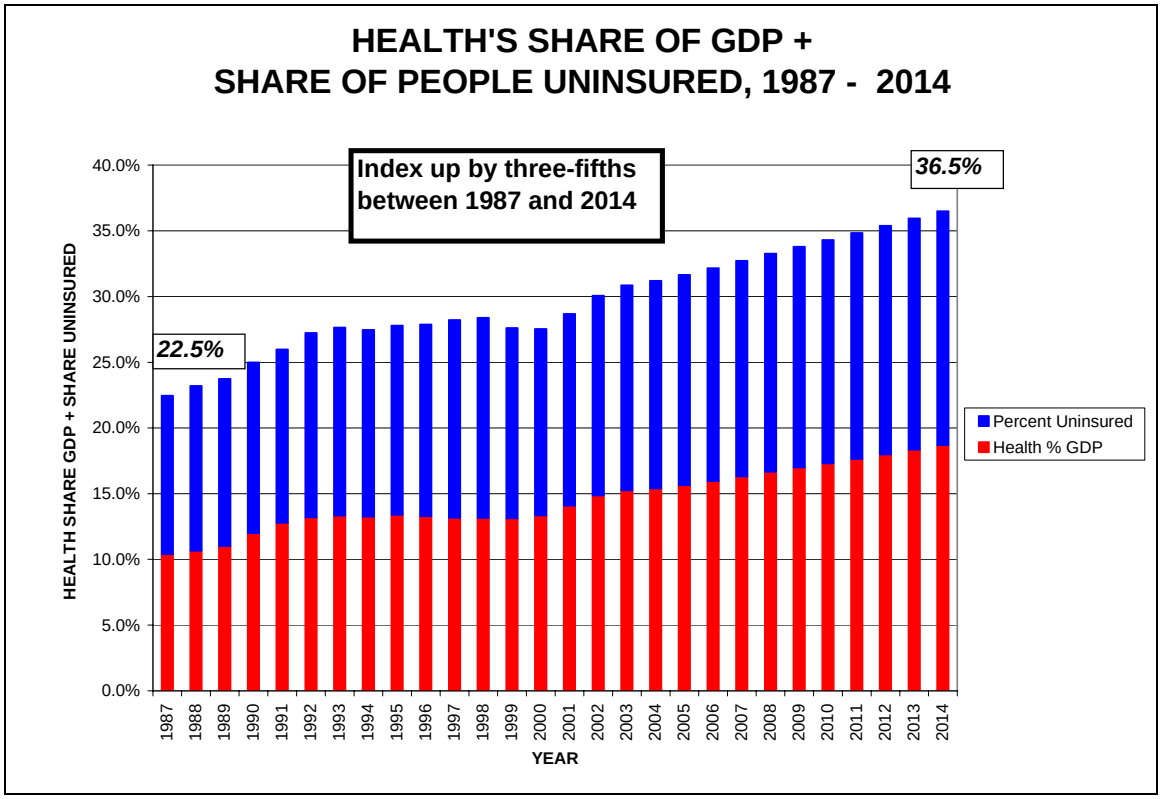
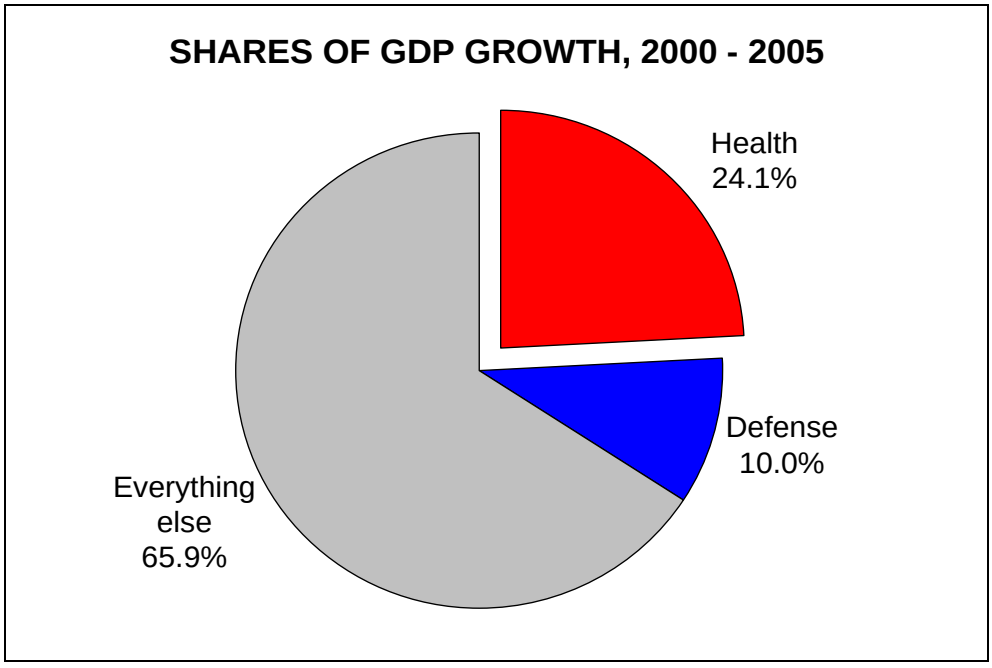
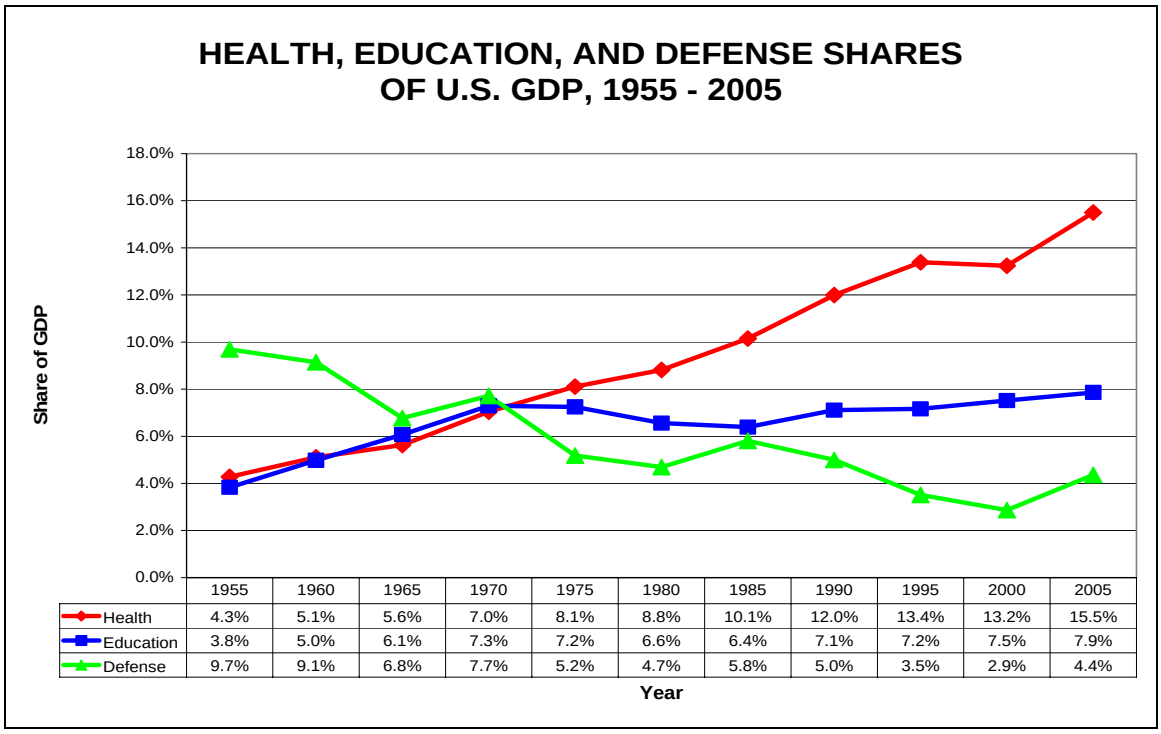


Exhibit 3



A. Sager, D. Socolar, *$1 Billion Per Week is Enough*, 20 July 2005, www.healthreformprogram.org

Exhibit 4



	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	2005
Health	4.3%	5.1%	5.6%	7.0%	8.1%	8.8%	10.1%	12.0%	13.4%	13.2%	15.5%
Education	3.8%	5.0%	6.1%	7.3%	7.2%	6.6%	6.4%	7.1%	7.2%	7.5%	7.9%
Defense	9.7%	9.1%	6.8%	7.7%	5.2%	4.7%	5.8%	5.0%	3.5%	2.9%	4.4%

Exhibit 5

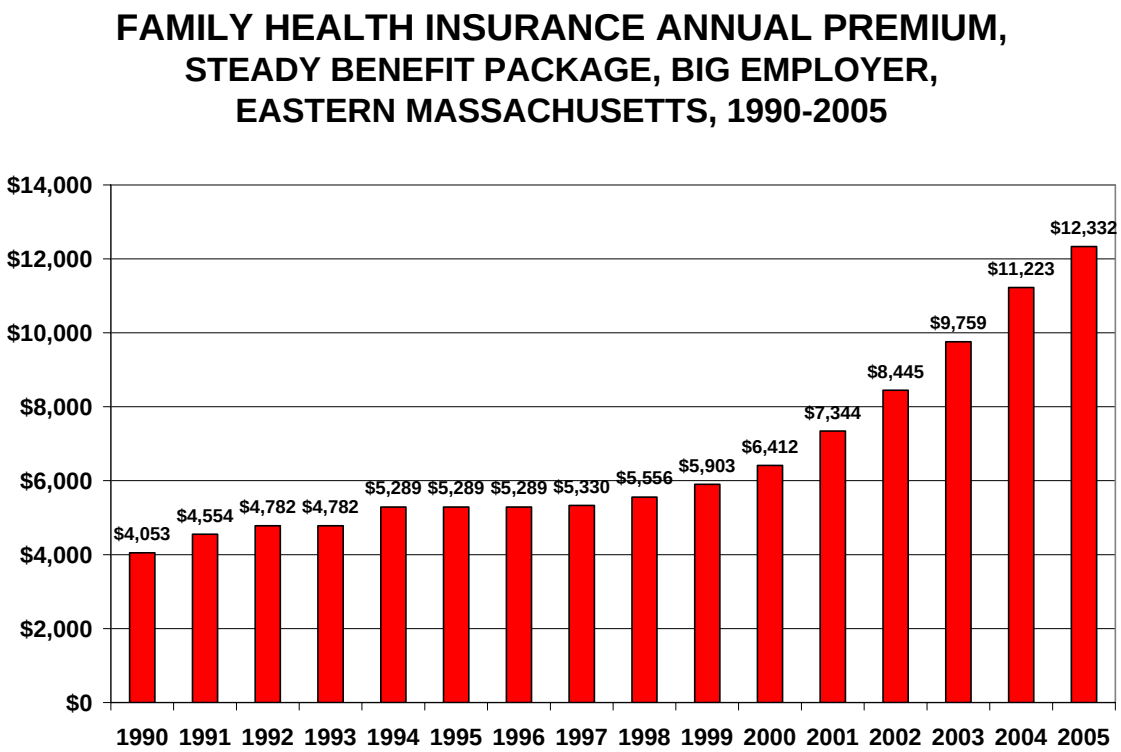


Exhibit 6

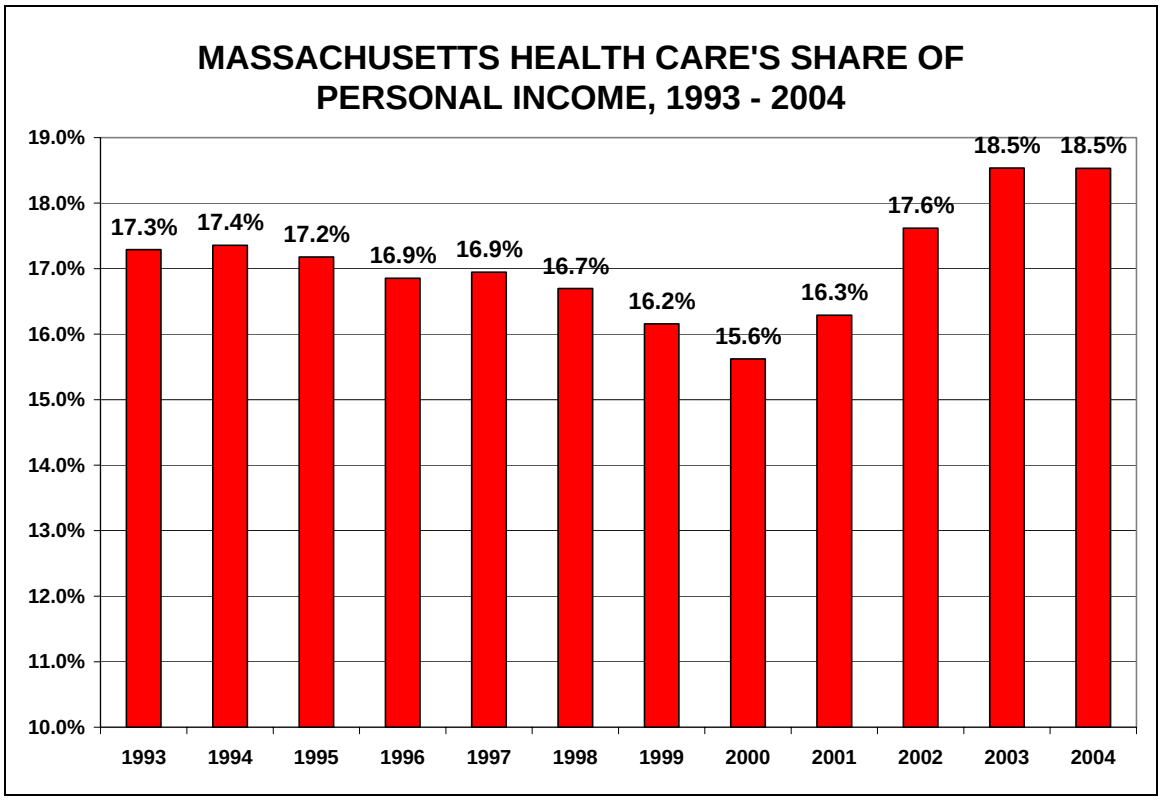
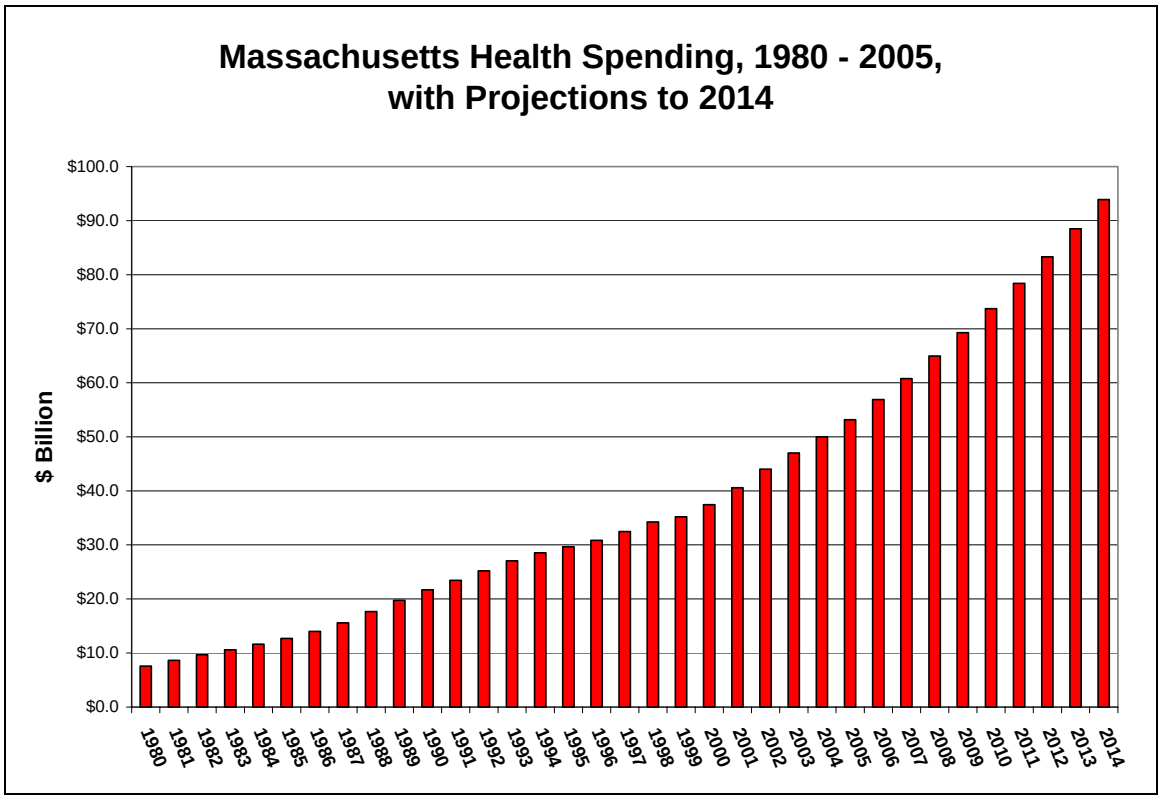


Exhibit 7



The following exhibits present rough estimates of the share of spending now absorbed by each type of health care waste in the U.S. The table also shows the shares that we suggest may constitute an irreducible minimum of waste.

Exhibit 8

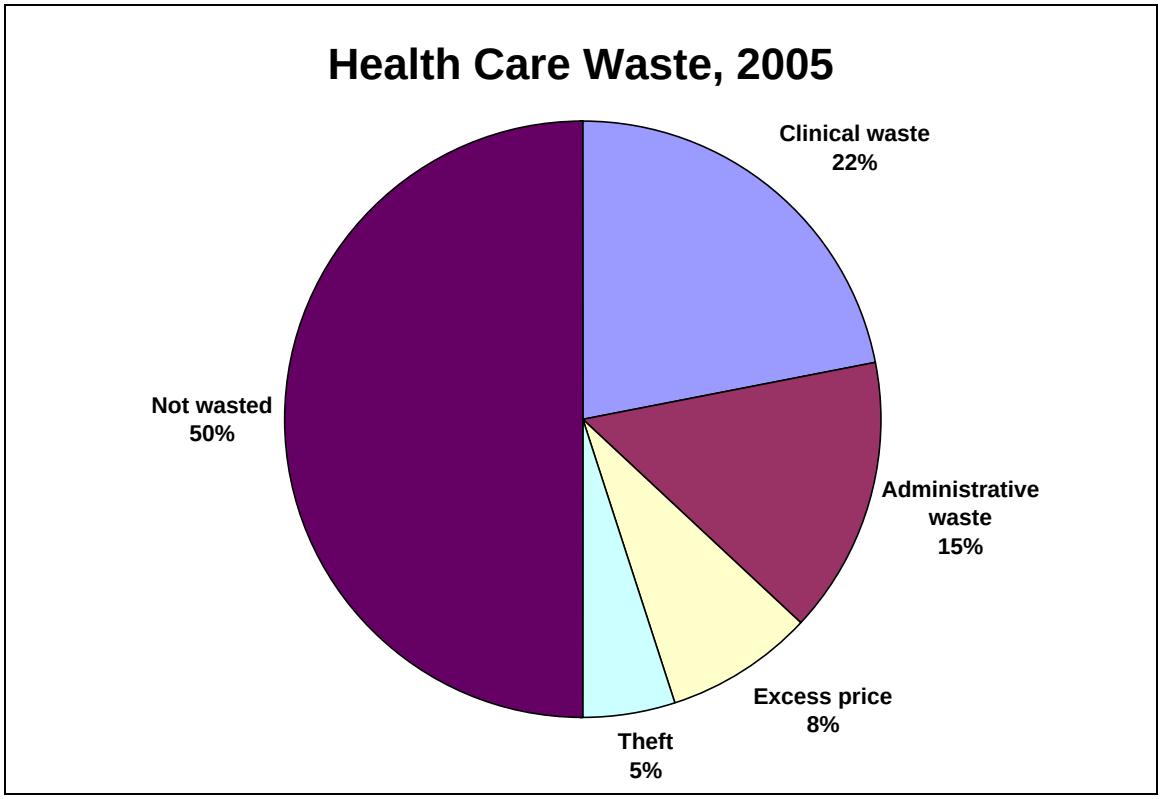


Exhibit 9

Four Types of Waste in U.S. Health Care Today
with Estimates of
Their Current and Irreducible Shares of Health Spending

Type of waste	Share of health $ today	Irreducible share of $
Clinical waste	22 %	10 %
Administrative waste	15 %	5 %
Excess prices	8 %	3 %
Theft and fraud	5 %	2 %
Total	50 %	20 %

Exhibit 10

Massachusetts has the resources to take care of us all

	Massachusetts	% Above U.S. Avg	State Rank
Estimated health spending, 2005	**$52.7 billion**	**--**	**--**
Estimated health spending per week, 2005	**$1.0 billion**	**--**	**--**
Estimated health spending/person, 2005	**$8,213**	**+ 27%**	**1**
Medicaid % personal health spending, 1998	**19.3%**	**+ 23%**	**4**
State Medicaid $ as % of state-funded budget, 2004	**12.2%**	**- 4%**	**31**
Hospital spending/ person, 2003	**$2,176**	**+ 41%**	**1**
Hospital beds/ 1,000 people, 2003	**2.5**	**- 11%**	**36**
Hospital operating margin, 2002	**0.2%**	**--**	**35**
Patient care doctors/ 1,000 people, 2002	**3.92**	**+ 54%**	**1**
Registered nurses/ 1,000 people, 2002	**11.2**	**+ 44%**	**1**
Share of people in HMOs, 2003	**38.4%**	**+ 62%**	**2**
Share of people uninsured, 2002-03	**10.3%**	**- 33%**	**45**

Sources: See endnotes.[1]

Exhibit 11

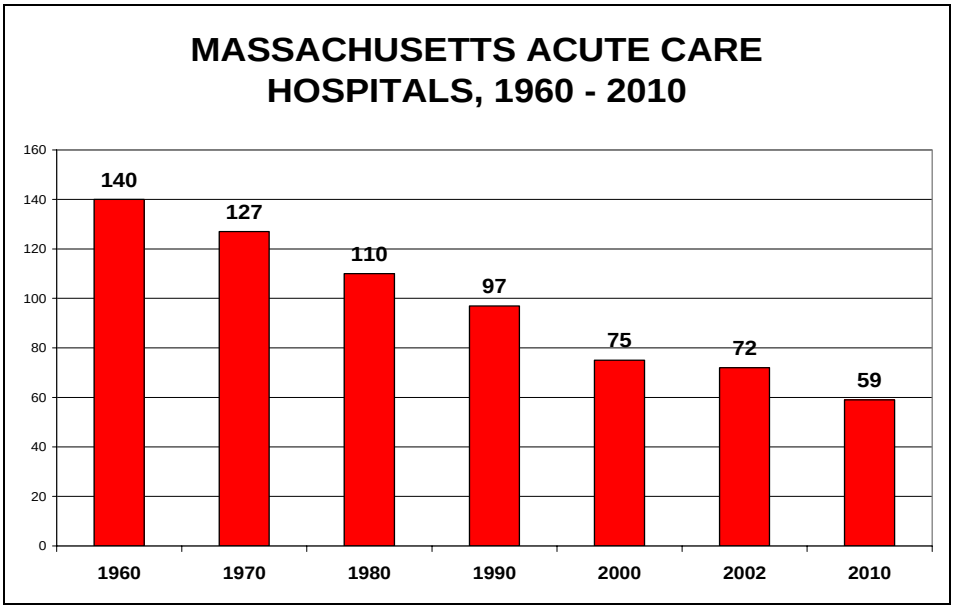


Exhibit 12

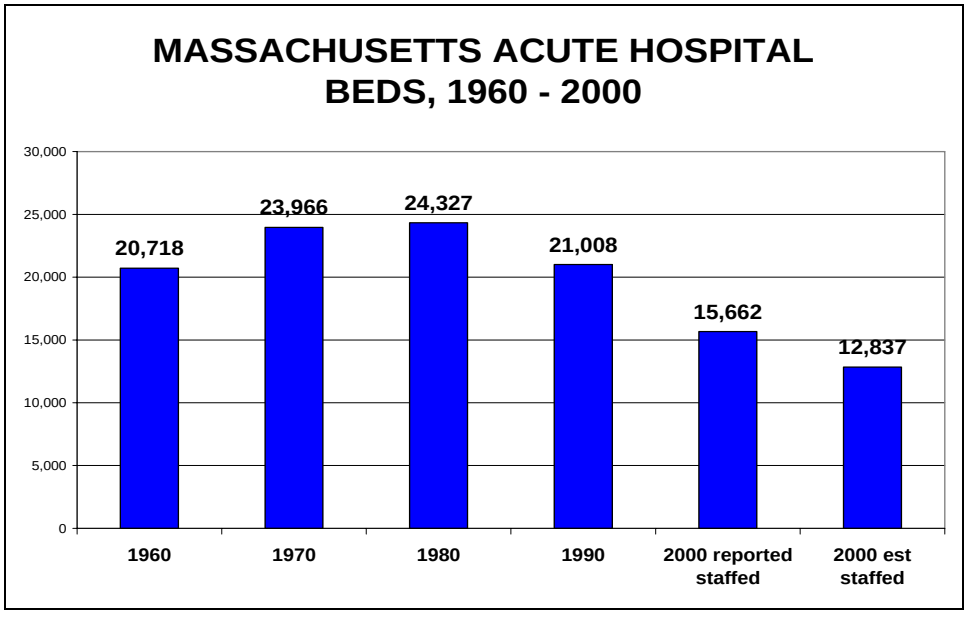


Exhibit 13

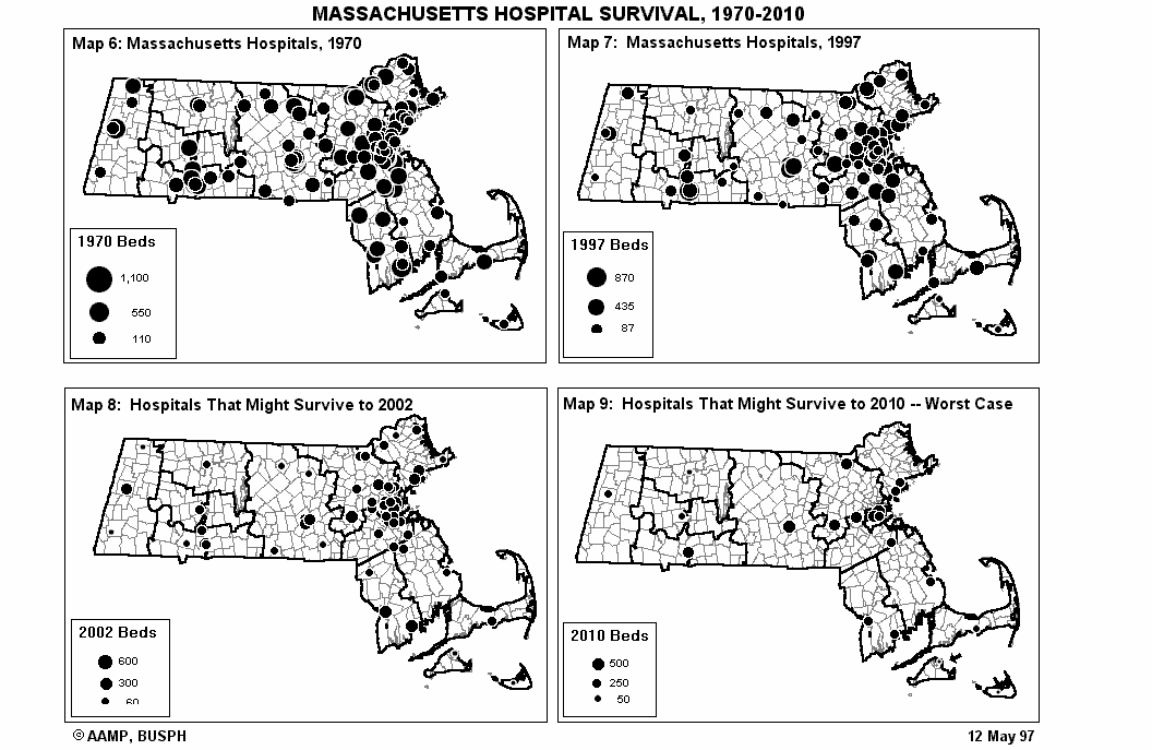


Exhibit 13 shows the number, size, and distribution of hospitals across the state in 1970 and then in 1997, when the maps were prepared. If use of hospitals had been reduced to the rates that many managed care proponents were advocating then, the number of hospitals surviving to 2002 and 2010 would have been approximately as shown on the other two maps. Closings since 1997 have been just slightly slower than that, so many large regions of the state now indeed are struggling with sharply reduced hospital capacity.

Exhibit 14

MASSACHUSETTS AND U.S. ACTIVE NON-FEDERAL PHYSICIANS PER 100,000 RESIDENTS, 1970 - 2002

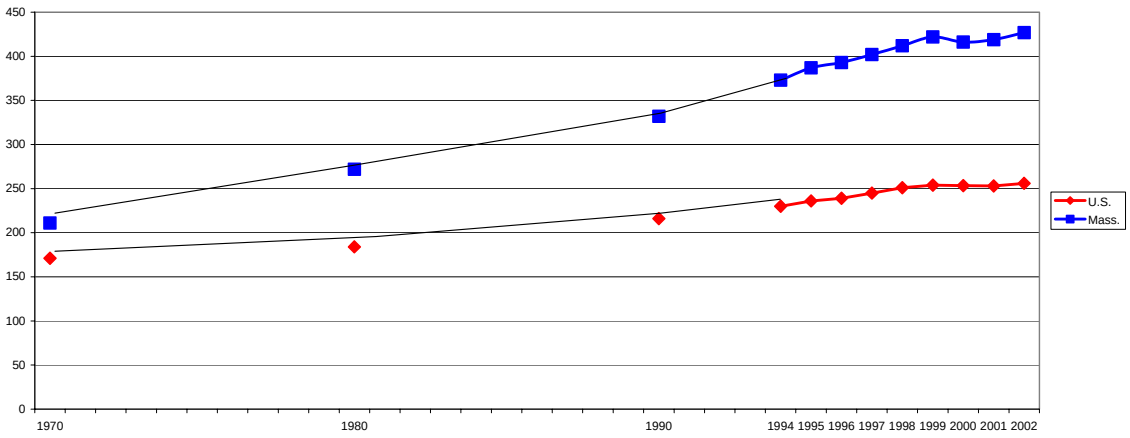


Exhibit 15

Physician Supply and Health Spending by State

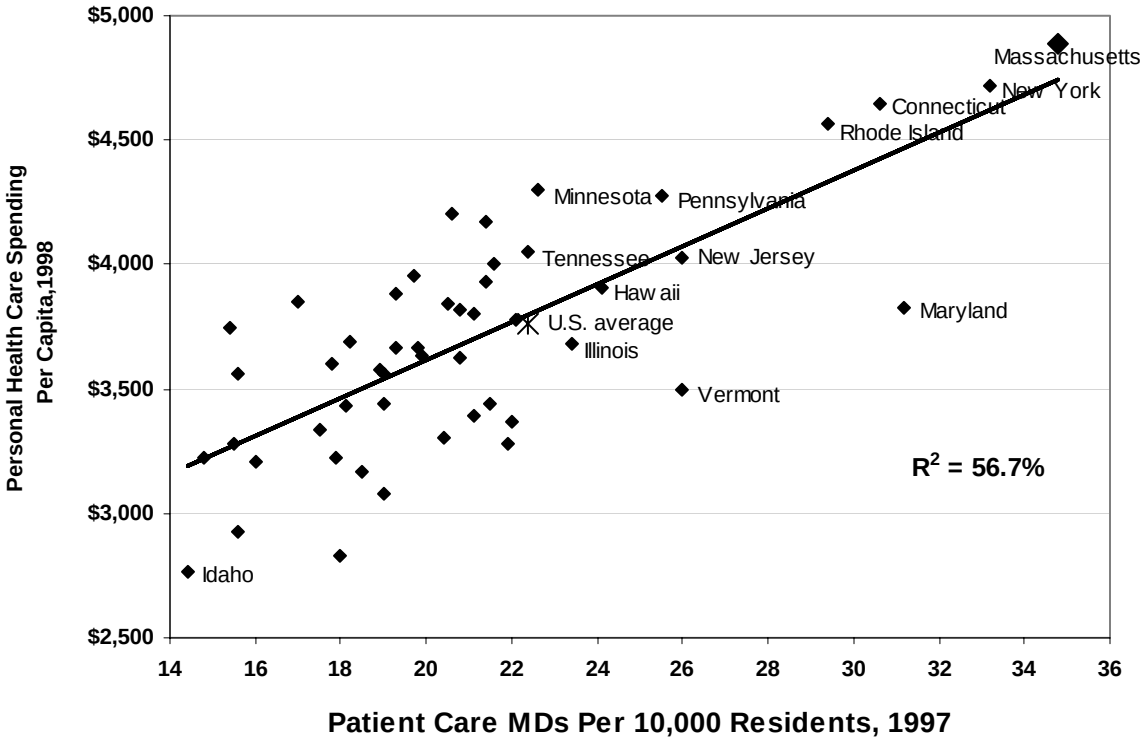


Exhibit 16 **PROJECTED 2005 MASSACHUSETTS HEALTH CARE COSTS, WITHOUT AND WITH REFORMS including coverage for all and consolidated financing** **assuming that proportions from 1999 analysis persist [2]**	**Costs and savings ($ billion)**
BASELINE: 2005 cost of care for Massachusetts, without reform	**$52.7**
ADDED COSTS: $5.8 billion in new costs with reform	
Bring uninsured people to the average level of coverage	+ $5.8
Address under-insurance with comprehensive benefits for all Data; care coordination; new services for people with disability	$58.5
SUBTRACTED SAVINGS: $7.5 billion in new savings with reform	
Savings in administration of coverage and financing	- $7.5
Savings in caregivers' administration of financing	
More appropriate use of hospital and other clinical care	
Negotiating drug prices; budgeting construction and equipment	- $51.0
Total cost of care for Mass. residents with reform, 2005	**$51.0**
Change from baseline costs – net saving from reform, 2005 (~3%)	**-$1.7**

Note: Numbers may not exactly equal totals because of rounding.

Exhibit 17

SPENDING ON PATIENT CARE AND ADMINISTRATION, WITHOUT AND WITH REFORM, MASSACHUSETTS, 1999

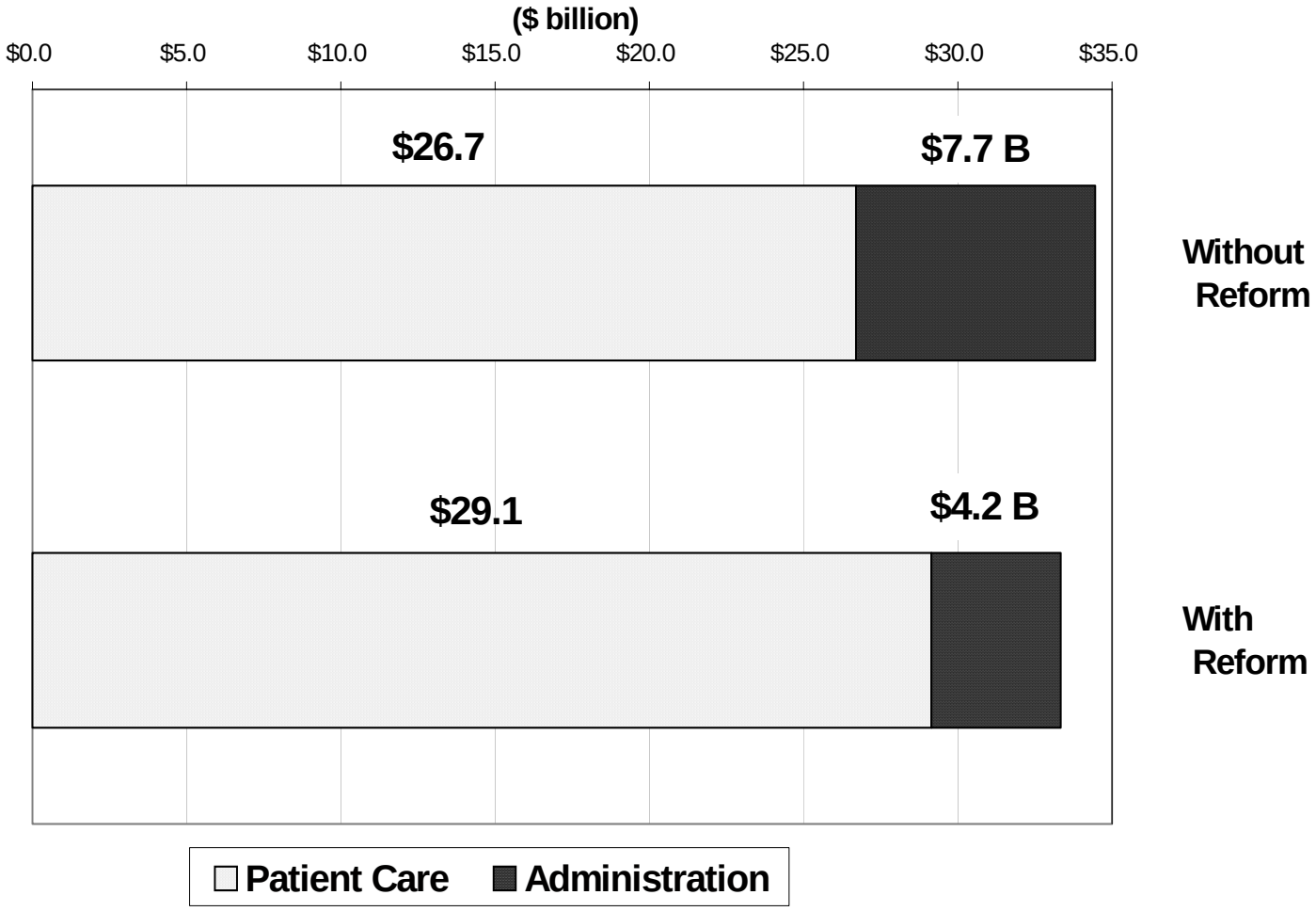


EXHIBIT 18

EXPENSES FOR ADMINISTRATION AND FOR CARE, NOW AND WITH REFORM: Mass. Physicians, Nursing Homes, and Hospitals, 1999

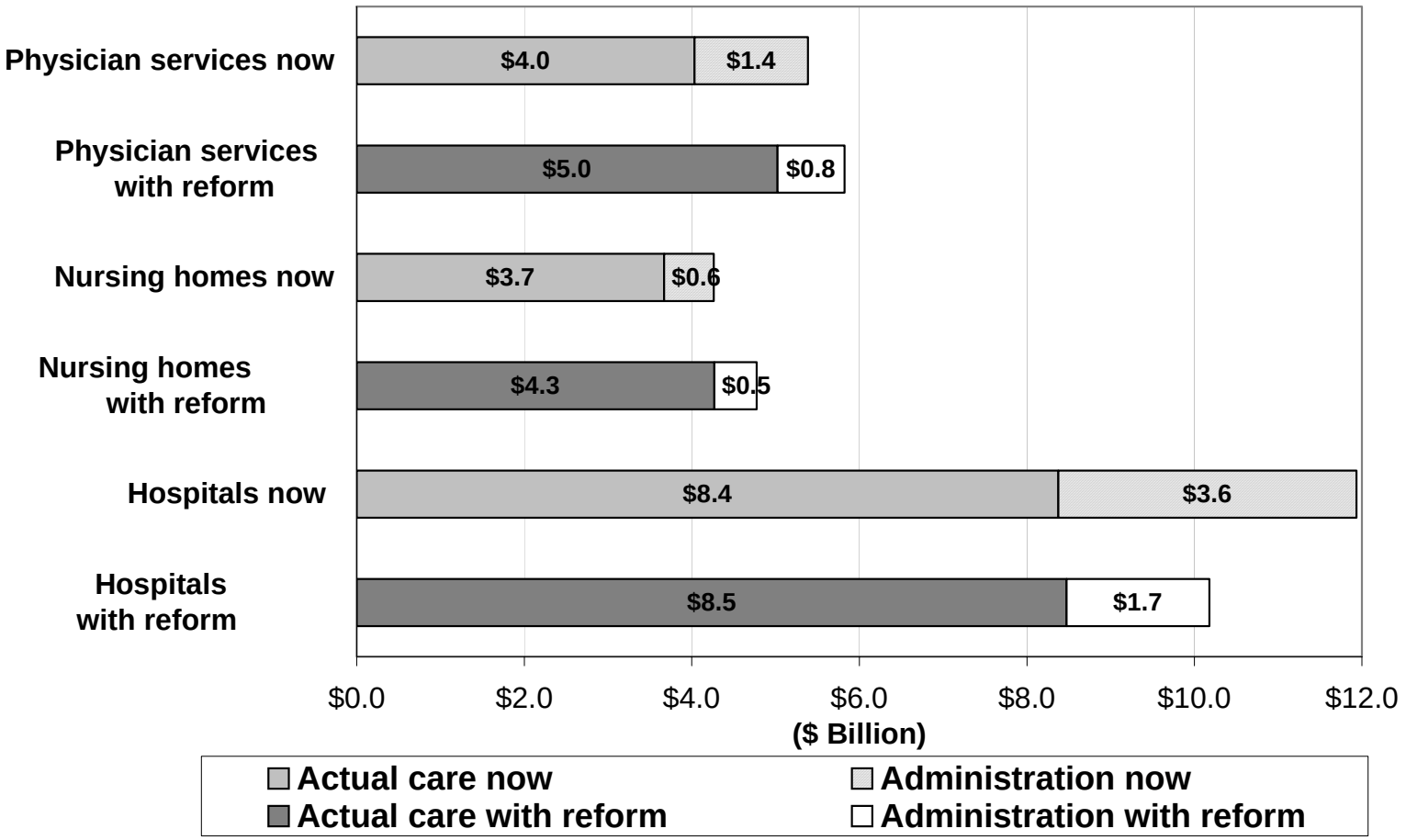


Exhibit 19 [3]

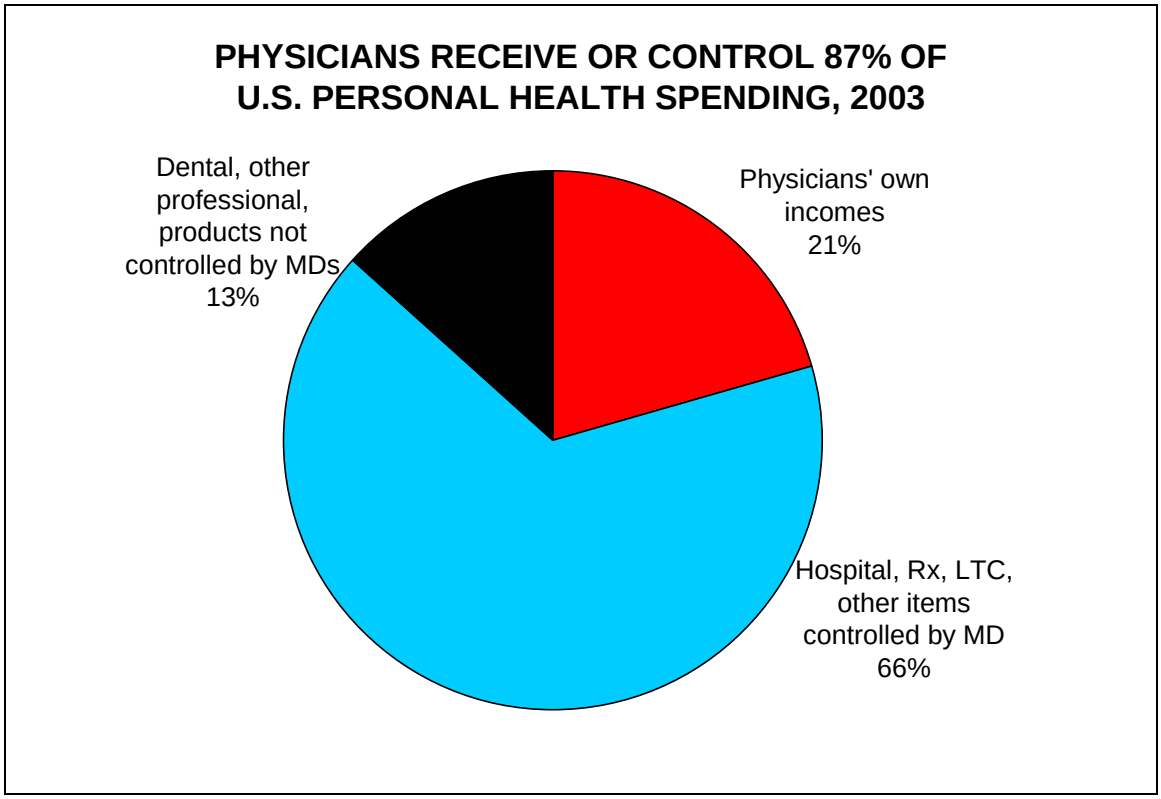


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Exhibit 20

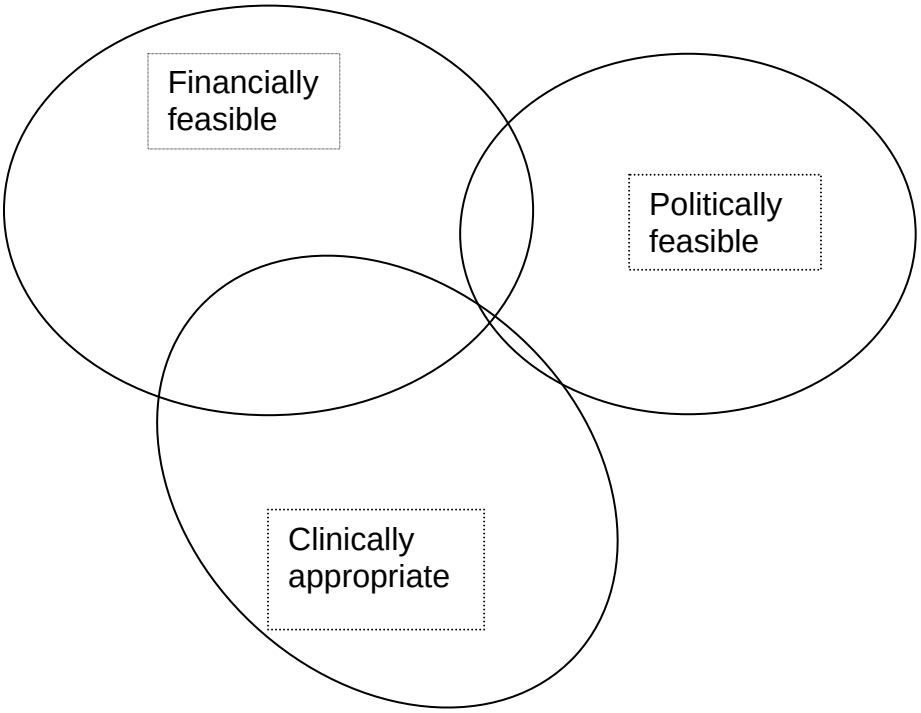

Exhibit 21

NOTES

[1] Sources for table: Estimated health spending in Massachusetts, 2005—calculated from 2005 U.S. personal health spending per person and Massachusetts excess over U.S. in 2000 (latest available year), plus additions for research, construction, government public health activities, administration of public programs, and net cost of private health insurance. The latter are added in proportion to their share of the nation's health spending in 2005.

Estimated health spending in Massachusetts per person, 2005—we used 1 July 2005 population estimates, calculated by projecting forward the rate of population increase from 2003 to 2004.

Medicaid percent of personal health spending, 1998—obtained from CMS state health spending data; this will shortly be updated to 2000.

State Medicaid spending as a share of states' own contributions to budget—Congressional Research Service, Memorandum to Sen. Jeff Bingaman from Christine Scott, "Medicaid in State Budgets," 13 June 2005.

Hospital spending per person, and beds/1,000 people, 2003—American Hospital Association, *Hospital Statistics, 2005 edition*, Chicago: The Association, 2005.

Hospital operating margin, 2002—net patient revenue plus other operating revenue, less expenses, divided by net patient revenue plus other operating revenue—American Hospital Association, *Hospital Statistics, 2004 edition,* Chicago: The Association, 2004.

Patient care doctors/1,000 people, 2002—data provided by the American Medical Association.

Registered nurses/1,000 people, 2001—Kaiser Family Foundation, "Registered Nurses per 10,000 Population, 2002," www.statehealthfacts.org.

Share of people in HMOs, 2003—Kaiser Family Foundation, "HMO Penetration Rate, 2003, " State Health Facts, www.statehealthfacts.org.

Share of people lacking health insurance, 2002-2003—This is a two-year average, from U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2003,* P60-226, August 2004.

[2] These figures roughly update Table 1 from Alan Sager and Deborah Socolar, "Testimony on Universal Health Care" to the Joint Committee on Health Care, Massachusetts General Court, April 1999. The numbers build on our current best estimate of $52.7 billion in total Massachusetts health spending for 2005. These figures assume that the proportions for each category in the 1999 analysis persist. (This updated table was developed in discussions with Dr. Patricia Downs.)

[3] Health Reform Program analysis of CMS 2003 health spending data.