How Can We Fix Harvard Pilgrim's Problems without Making Ours Worse?

Alan Sager, Ph.D. and Deborah Socolar, M.P.H.

2nd Report on Medical Meltdown in Massachusetts

Access and Affordability Monitoring Project

Boston University School of Public Health
715 Albany Street
Boston, Massachusetts 02118

phone (617) 638-5042
fax (617) 638-5374
asager@bu.edu, dsocolar@bu.edu

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Since our state has the world's highest health care spending, we cannot to afford to solve Harvard Pilgrim's problems by paying substantially higher premiums indefinitely. Massachusetts health care has to just say no its addiction to more money for business as usual, without end. To do so, it will need state government encouragement.

1. What are Harvard Pilgrim Health Care's problems?

- ***High costs and low revenues***

- While Harvard Pilgrim (HP) seems to be covering its current costs of care each week, it suffers from:

    - lack of working capital
    - lack of reserves
    - inability to pay off accumulated obligations to hospitals, doctors, and probably others

How much does HP really owe?

No one knows. The accounting systems really are a mess. Worse, HP seems to have denied many arguably legitimate claims, which means they don't yet show up on HP's books as financial obligations.

The hospitals claim they are owed $265 million. But that was $310 million a few weeks ago. And are the claims valued at charges or the lower rates contained in HP's contracts with hospitals?

How much are doctors and other caregivers owed? Probably lots, but no one has yet pulled those numbers together, and no one may even be trying—or able—to do so. If the hospitals are owed $265 million, it may well be that the doctors, therapists, labs, pharmacies, diagnostic facilities, and other caregivers are owed $200 million or more. (The share of the premium dollar going to non-hospital caregivers commonly is just a little lower than the hospital share.)[1]

Say that HP needs to borrow $175 million to rebuild its working capital and financial reserves, and to make a start on repaying its accumulated obligations.[2]

This should not be a lot of money for an HMO with annual revenues of about $2.75 billion last year. An average 12 percent premium increase this year raises revenues by $330 million, assuming no net leakage of patients. Repeating this in 2001 raises revenues by another $370 million—through what bankers used to call the magic of compounding. And total revenues would rise to $3.45 billion.

How long would it take to repay the accumulated obligations? Not too many years—perhaps five, or ten at most.

So HP has a short-term cash problem to rebuild reserves, and a middle-term problem to pay caregivers what they are owed.

And it certainly has a middle-term management problem. A fair number of people associated with Harvard Pilgrim in various ways have told us over the past four years that HP is, simply: "a mess. Nothing works. No one listens. No one would believe how bad things are here." If these things were true, why didn't HP's management know about them and respond? And this has been one of the top-rated HMOs in the nation.

2. What caused those problems?

a. high costs:

- spending to expand to win a greater market share in more states—to win more power over employers, hospitals, and doctors

- bad management / self-sanctification / a measure of arrogance

- the Harvard Community Health Plan – Pilgrim merger and earlier acquisitions diverted human and financial resources—and management attention—away from designing more efficient care; the merger forced many potentially productive people to spend five years in meetings to try to make the merger a reality; they have been punished enough!

- possibly, Harvard Pilgrim has attracted a somewhat older and sicker mix of patients, particularly older patients in its Medicare HMO

- (not prescription drugs—that's a problem everywhere, not a cause of HP's problems)

b. low revenues

- keep prices down to grow market share to gain power over employers, hospitals, and doctors

- pressure from Massachusetts Health Purchasors' Group (the state's Group Insurance Commission, big businesses), demanding lower prices

The drive to grow bigger to win more power stemmed in large part from the original merger between MGH and Brigham (arguably illegal since no public hearing was held first). The two hospitals announced their own merger (mainly to win bargaining power against payors) in December of 1993.[3] The HP merger was announced only seven months later in July of 1994.

All merging HMOs and hospitals promised lower costs through economies of scale. They have not yet visibly delivered. They have not documented any savings.

3. What are *our* problems and how could they be worsened by mistaken solutions to HP's problems?

Here are four problems we face:

- The world's highest health care costs
- The world's highest hospital costs
- A substantial number of people lacking insurance
- New assertions that only half of the health dollar filters down to pay for appropriate care, with the remainder eaten up by clinical waste, administrative waste, and "adverse drug costs." [4]

HP and other HMOs/insurors can be expected to raise premiums by 25-40 percent over the next few years. That will stabilize them if they get past their current cash crunches. In time, it should make more money available for hospitals and doctors and drug makers.

But it will cost us a great deal. As a result, the number of people lacking health insurance will rise sharply.

And more money will not cure hospitals' and drug makers' addictions to more money for business as usual.

And it will not address any of the underlying causes of high costs and medical insecurity in Massachusetts.

And it will inflate our costs to unnaturally higher and unsustainable heights, so that when Massachusetts health care fails, it will fall farther, faster, and more destructively.

So—we must avoid solutions that paper over HP's problems with dollar bills.

4. Possible private and public approaches to help Harvard Pilgrim.

a. default

ARGUMENTS FOR:

- Default is the proper judgment of a free market, if only we had anything close to one.

- As Charlie Baker often said, when he was in state government, if they make mistakes, let them go broke.

BUT:

- Patients would then have to seek new coverage, which will entail profound disruption; many patients would not be able to retain all of their caregivers; and there would be no respite—no chance to wait until the next open enrollment period.

- Hospitals, doctors, and others would have to eat substantial losses, causing some of them to go broke, and leading—and enabling—the survivors to raise prices on their remaining patients.

- Wall Street would raise interest rates (the prices it charges for lending money) on everyone in Massachusetts with remote ties to health care. [5]

- Many of the remaining shreds of competition in health care would disappear.

b. sale to a for-profit

FOR:

- A sale would be a cheap source of money to recapitalize HP and pay off its debts.
- For-profits are said to be more efficient.
- A sale could be seen as a last resort, the only alternative to default.

BUT:

- For-profits are not more efficient in health care.[6]

- For-profits have lower medical loss ratios (we call them "care shares"), meaning that a greater share of their money goes to administration, advertising, marketing, and rewards to stockholders.

- For-profits' stocks are not high, so they lack cheap ways to raise capital for HP.

- A for-profit that took over HP will demand a generous return on its investment, roughly 20-25-30 percent return on equity each year; other things equal, that means less care or higher premiums, or some combination of the two. At 25 percent, a for-profit would effectively charge fully 614 percent as much in interest on its money as a state-backed loan. (Costs of state-backed loan and non-profit loan are discussed shortly; see Table 1.)

- Some unknown share of patients will leave a for-profit HP; that may make it hard for it to stay in business.

- A for-profit might well refuse to keep HP in business, and might buy it merely to try to shift HP's members over to Aetna US Health, Cigna, or elsewhere—that would be little more than a disguised default—a for-profit purchase of HP's membership list and mailing list.

- A for-profit would probably refuse to pay off old HP debts to caregivers or Wall Street, again leading to higher prices and interest rates; if it did repay those old debts, it would demand a substantial profit on the money it sent to caregivers.

- A for-profit is likely to be deterred by the state's unfriendly climate.

- A state-backed loan is a much better alternative to default than a sale to a for-profit.

c. gift

FOR:

- Gov. Cellucci has seemed, on occasion, to suggest that some $30-50 million in tobacco settlement money is available to help HP.

- The hospital association seems to have said that if HP can't pay hospitals what it owes them, the state should step in and pay.

BUT:

- The governor seems to forget that the tobacco windfall money is just like tax money—since it can be spent on the same things.

- The governor's hint of a one-time gift does not seem to be accompanied by any requirements that HP reform itself, or that state government monitor HP for a long time. This approach therefore appears to amount to be little different from throwing money at a problem.

d. private loan to recapitalize: HP borrows privately

FOR:

- HP simply goes into the market to borrow what it needs to rebuild reserves and pay off old debt

- HP raises premiums to pay off the loan and happily emerges from receivership

BUT:

- Who's anxious to lend them money? If they do, how high an interest rate will they demand in exchange for the loan?

- Is HP too risky a business to lend to? For months—maybe several years—they were unduly optimistic about their financial position. How can we trust them now?

- The private borrowing may not raise enough money—or it may raise money at very high interest rates. Some employers and patients may not be confident that HP will survive. They may depart, draining revenue out of HP.

e. Hospitals and others extend a private loan: Hospitals delay asking for their money, or somehow lend HP money by deferring their demand to be paid for past care.

An HP in receivership doesn't have to pay off obligations that pre-date receivership. An HP sold to a for-profit does not have to pay off those obligations. An HP that goes broke does not have to pay off those obligations. So what are the hospitals getting for their forbearance—a greater hope that they will be paid, and with substantial interest. This proposal might amount to little more than a public relations acknowledgement by the hospitals that they will not see their money soon.

This means that hospitals would basically be lending to themselves. And it makes them worse off by moving their claim to be paid (for care already given) to the end of the line.

This approach by itself does nothing to ease HP's immediate cash crunch, since it does not make available money to rebuild HP's financial reserves or provide working capital.

It does not help the doctors and other caregivers owed money by Harvard Pilgrim.

If this proposal amounts to more than a public relations announcement by the hospitals that they will not soon see their money, it could be dangerous. This arrangement could put the hospitals and HP into a curious near-partnership.

If some (but not all) hospitals that are owed money by Harvard Pilgrim—and no other caregivers—participate in a loan to HP, this raises issues of fairness. Would HP feel pressure to channel patients to the forbearing hospitals? Would the hospitals that loan HP the money ask for higher prices from HP on current care? Would the hospitals suggest that HP negotiate lower payments to hospitals that don't agree to delayed payments from HP? Formal assurances may not suffice to assuage fears like these.

Further, would HP be emboldened by the hospitals' forbearance to squeeze them further? (It is sometimes said that when you owe a bank $100K, they own you; when you owe a bank $100 million, you own them.)

In any sort of implicit partnership between hospitals and HP, more money for either means less for the other. An HMO wants to use hospitals less and pay them less. Hospitals want higher use and higher payments. The old Humana was blown apart when the explosive mix of its HMO and hospital businesses finally detonated.

It was recently suggested that this approach might be married to a formal backing by Harvard University,[7] as discussed next. Harvard might lend its name and hospitals might lend money. Perot Systems and other private investors might lend additional money; private investors would not be accorded voting rights on Harvard Pilgrim's board.

It appears that part of this arrangement would entail Harvard Pilgrim exchanging the money it now owes hospitals for "surplus notes," which would pay high interest, and which would only be paid off when HP shows a surplus. That option still looks a great deal like the hospitals lending money to themselves. The arrangement would also entail HP borrowing money from private investors who would demand high rates of interest.

This approach is complicated because many parties' actions must be coordinated. And it is expensive, since the surplus notes would have to be paid off at high interest rates.

It would be valuable to calculate the total cost of this approach, versus the cost of other approaches, such as a state-backed loan.

State regulators have estimated that Harvard Pilgrim needs an infusion of some $225 million if it is to remain in business as a non-profit insuror. Of this, $50 million could be raised by selling land or buildings of centers used by Harvard Vanguard.

We have estimated the cost of privately or publicly borrowing the remaining $175 million at various rates of interest, repayable over ten years.[8]

We have calculated the interest costs of private borrowings at two rates, 10 and 15 percent, as shown in Table 1. We recognize that some private lenders and investors might demand higher rates than these, while Harvard University might be willing to accept lower rates if it participated. So these rates might be viewed as a conservative range of private rates.

Harvard Pilgrim would have to repay between $102.5 million and $163.8 million in interest alone over the 10 years. And these calculations are also conservative, in that they assume steady and level payments, beginning right after the money is borrowed. Actual interest payments could easily be higher, in that private loans would probably be structured to allow HP to repay loans "if it resolves its management problems and retains its members." [9]

By contrast, ten-year level payment state general obligation bonds now command interest rates of only 5.15 percent, resulting in total interest payments of $49.3 million over ten years, yielding total savings ranging between $53.2 million and $114.5 million.

In practice, this means that a state loan would cost Harvard Pilgrim $4.9 million a year in interest payments, while a private loan would cost between $10.3 and $16.4 million a year, and a for-profit investment would cost $30.3 million a year.

State-backed borrowings would therefore save between 51.0 and 69.9 percent of the interest Harvard Pilgrim would have to pay if it borrowed privately. Similarly, the private interest cost would range between 208.0 percent and 332.4 percent of the state cost. The money saved translates into smaller premium increases for employers and workers or smaller cuts in care. The savings would make it easier for HP to survive.

(The following table also shows the effects of the return that a for-profit owner would demand if taking over HP, as discussed earlier. A 25 percent return would effectively mean the for-profit charging fully 614 percent as much for interest/profit as a state-backed loan.)

Table 1

Interest Costs of Borrowing $175 Million to Buttress Harvard Pilgrim: Private Loans versus State General Obligation Bonds

	Private loan at		For-profit investment at	State general obligation bonds
interest rate	10.00%	15.00%	25.00%	5.15%
Total payment over 10 yrs. ($ million)	$ 277.5	$ 338.8	$ 477.7	$ 224.3
Total interest ($ million)	$ 102.5	$ 163.8	$ 302.7	$ 49.3
Annual interest payment ($ million)	$10.3	$16.4	$30.3	$4.9
Excess cost over state loan	$ 53.2	$ 114.5	$253.5	- - -
Savings from state loan as % of private cost	52%	70%	84%	- - -
Private interest cost as % of state loan cost	208%	332%	614%	- - -

Notes for Table 1:

All loans or investments are considered to be level payment, self-amortizing loans for the purpose of comparative analysis.

The private loans at 10.0 and 15.0 percent are illustrative private rates. One editorial mentioned in passing that hospitals considered a rate of ten percent to be too low for them. ("A Role in HPHC," *Boston Globe*, 9 February 2000.)

The for-profit investment return is in the middle of the target range of 20-30 percent we have heard mentioned and consider credible. Some observers may consider a lower rate of return. Because the figures included here assume a level payment, self-amortizing loan, they may well understate the actual return on investment that a for-profit might seek. That is because the return (called interest here) declines annually as more of the principal is repaid. If the for-profit investor kept its equity in a Harvard Pilgrim entity, it would expect an annual return on the entire equity, which would be 25.0 percent of $175 million each year, in this example, or $43.75 million annually and $437.5 million over ten years.

The 5.15 percent rate for the state general obligation bonds was the rate available to the state for ten-year level payment, self-amortizing bonds in early February 2000, according to the State Treasurer's Office.

Sources for Table 1: See note.[10]

f. a securely-backed loan to recapitalize HP

We have said that a state-backed loan to HP might be the best way to buy it time—time to raise rates, cut costs, put itself back on its feet, and pay off its debts.

David Warsh recently urged that Harvard University use some of its $14 billion endowment to guarantee a loan to HP.[11]

These approaches share two main advantages.

They would help HP secure the lowest possible interest rate, minimizing its need to raise rates, and minimizing the chance of default.

They would instill confidence in employers and patients that HP will be around to serve them. This would prevent a bleeding of revenue that could kill HP. It would also instill confidence in doctors and hospitals that HP will honor its debts.

Warsh urges Harvard to act because it has the money and the historical ties to HP, and because its name is on the door.

But why send Harvard to do state government's job?

It is much more important that state government get involved and stay involved.

5. What possible solutions would work best-- financially, politically, legally, and medically?

The possibility of state government backing of a loan to rebuild Harvard Pilgrim's reserves has received very little public attention. A loan to Harvard Pilgrim could be backed or co-signed by the Commonwealth. (Such a state general obligation borrowing would have to satisfy a genuine government purpose. Stabilizing the state's largest HMO at the lowest reasonable cost should qualify.) The state's costs would be covered by regular payments from Harvard Pilgrim. We have urged state backing for such a loan even though many major politicians have opposed state help.

Opponents offer at least three reasonable objections:

- HP dug itself into a hole. Why should state government reward its mismanagement and arrogance with a state bail-out?

- State aid to HP would set the worst precedent to other HMOs—and to hospitals, nursing homes, and groups of doctors—that could demand special state aid to prevent bankruptcy. The prospect of state aid might even induce HMOs or caregivers to act recklessly, anticipating that the state will engineer a soft landing for them.

- Many fear that guaranteeing a loan would expose the state to paying off the $175 million note if HP defaulted despite the loan.

Let's take the objections one at a time.

First, HP—a little more than most HMOs—has engaged in self-important self-sanctification, but it did not dig itself into a hole all by itself. It had help.

State government helped by trusting HMOs and refraining from supervising them. State government cheerleading led to the public choice not to require HP to set aside financial reserves. State government recklessly and ideologically checked its brain at the door to the free market health care saloon. The market gave HMOs many wrong-headed incentives and encouraged dangerous behaviors—to low-ball prices, to take greater shares of bigger multi-state markets, in order to— to— to do what, exactly?

And the HMOs chose many ineffective, costly, or offensive mechanisms to try to contain cost.

Moreover, state government's own Group Insurance Commission was one of the leaders of the pack demanding unnaturally low HMO premium rises during the mid-1990s.

Since state government inactions and actions helped to create the problem, state government has a financial responsibility to be part of the solution.

Second, many other HMOs, hospitals, nursing homes, and groups of doctors will go broke regardless of what happens to HP. That is because their costs are too high relative to their revenues. State backing for a loan to Harvard Pilgrim will not encourage caregivers and HMOs to be more reckless. Rather, state backing for a loan to HP—when accompanied by the right package of public interventions (please see section 7 for

some of these)—will prevent bankruptcies. Ironically, state government will better appreciate the need for these interventions after it commits itself to backing loans like Harvard Pilgrim's. Financial exposure concentrates the mind and cuts through the market competition rhetoric that has helped to bring Massachusetts health care near to the point of melting down.

Waiting for the phone to ring again is not an adequate state policy. Hypothetically: "Hello, HospitalNetwork calling. Have you got $400 million for us?" State backing of a loan to bridge HP's financial chasm would help set the right precedents, not the wrong ones:

- State government could get practice dealing with mismanaged HMOs/insurors and caregivers—or those victimized by un-free markets and competitive environments that were not of their own making.
- State government could build its capacity to discriminate between fatally ill insurors/caregivers and those that can be revived.
- State government could learn to take responsibility for identifying and stabilizing all needed caregivers, and for finding ways to pay them enough to sustain them, as long as they are operated efficiently.
- State government could learn first-hand that an insuror/caregiver policy of more money for business as usual is not necessary, smart, or sustainable.
- State government could begin to re-learn the need to remain continuously engaged in a partnership with Massachusetts health care, and not to sit in the stands at a health care demolition derby.

Third, the state's potential financial exposure, while real, is greatly exaggerated. After all, if private parties would make the loan at a higher rate of interest, they would expect to get their money back. The state would pay nothing unless Harvard Pilgrim defaulted. The state-backed loan would have a greater chance of being repaid since its backing would translate into a lower interest rate, which would lower HP's cost of staying in business. The state backing would also help to reassure employer groups and patients, and thereby to help stabilize HP's revenues.

What would happen in the worst case, if the state backs a loan to HP and it goes sour?

- The state would be partly compensated by the secure collateral of the remaining Harvard Pilgrim health centers used by Harvard Vanguard.

- Most of the remaining money—the unsecured part of the state-backed loan—would have been used to pay for health care, including the shouldering of some of HP's debt. This money would have gone mainly to pay hospitals and doctors, thereby reducing their needs and desires to raise prices to offset HP non-payment of its obligations.

- If Harvard Pilgrim does not pay some of its bills, doctors are particularly likely to suffer income loss. Their losses are more diffuse than the hospitals, because there are so many of them, and they often have weak handles on their finances. This problem has probably received much less attention than it deserves.

6. What lessons can we draw?

The market hasn't worked. Managed care hasn't worked in its present form. Even the low price increases of the mid-1990s have now been revealed as politically driven and financially unsound because they were achieved artificially by deferring costs, not by real savings. Lower prices can only be justified by lower costs—not just the mirage of lower costs. Competition hasn't work to lower cost. We need to try something else. But what? The warehouse of ideas is surprisingly empty, and just-in-time inventory management might not work.

We will all pay more for HP's half-decade debacle.[12] How do we minimize the price of fixing HP? And how do we minimize the risk of bigger HP-like catastrophes, year after year, as Massachusetts medicine melts down?

Paying more money for business as usual means blowing up the Massachusetts health care financing balloon until its fabric stretches dangerously thin, dangerously close to bursting.

There's no free lunch. Paying more for health care means less money for everything else—both outside health care and inside health care—including covering the 600,000-plus people who are still uninsured. And higher prices mean still more uninsured people.

The politically acceptable solutions to Harvard Pilgrim's problems—the ones that don't require steady state government involvement in health care finance and delivery—may be the least likely to work well medically or financially. That is, they may disrupt care more, and cost more.

We have to stabilize HP in a way that re-engages state government with the main elements of Massachusetts health care—covering everyone, containing costs, paying caregivers fairly and adequately, and identifying and stabilizing all needed caregivers. This means a sustained public – private partnership. It means a summit, such as Cardinal Law called for last week. Probably a year of weekly summits, until we hammer out something that works for all of us. We may all have to settle for our second choices, but we will have to agree on a second choice that works for all of us.

7. How did Massachusetts health care get into this mess?

The HMO, hospital, nursing home, and prescription drug industries insist that their problems have been caused primarily by inadequate funding. Many also blame higher drug spending, and bad management at HMOs and hospitals. Anti-hospital zealots blame excess hospitals and beds. Some economists blame patients for their unwillingness to accept higher cost-sharing or HMOs' restrictions on referrals and on choice of caregiver. Anti-government fanatics blame regulation.

These explanations are largely untrue. The main problem is *high cost*, not inadequate revenue. As the table shows, our per capita health care spending is 30 percent above the national average.

Why is Massachusetts health spending so high? Partly for legitimate reasons associated with research, training doctors, serving a slightly older population and people

from other states, higher quality, and the like. But mainly because our style of health care is more elaborate and expensive than is typical elsewhere. This reflects both teaching hospitals' dominance and the huge number of doctors working here—64 percent more than the average state.

No villains or conspiracies created these high costs. They were not intended, but they are a reality. If we don't address them, we will never find the money to improve health care quality or cover uninsured people—or pay for job training, special education, housing homeless people, and al the other things we care about.

Hospital costs here skyrocketed to 42 percent above the national average in 1998 while hospitals suffered financially, and while nurses were being cut—and while more clerks were being hired to harvest the money hospitals believed they were owed.

Health spending in this state, this year, will total about $38 billion. That is almost double the state budget. It equals $4,337,899.10 each minute.

One main cause of high costs and quality problems has been the mistaken reliance on price competition, managed care, and hospital closings to contain costs during the 1990s. Why did these fail?

When state law intensified price competition in the early 1990s, hospitals and doctors did not respond by becoming more efficient as market proponents had said they would. Price competition always works well in the economics textbooks, but usually less well in practice. Competition means sleepless nights, as most owners of small businesses can testify.

With only a few HMOs or hospitals competing in each region of the state, many merged or low-balled prices in hopes of dominating their markets. Regional monopolies have emerged. Competition rhetoric has been a smokescreen behind which powerful hospitals have tried to engineer their survival—often at the expense of smaller institutions.

Nothing close to a free market exists in health care. The unfree market has protected wealthier hospitals, not more efficient or more needed ones. Hospital closings therefore have tended to increase costs. Closed hospitals were more likely to be located in lower-income communities, so their loss has undermined access to care.

Further, managed care multiplied private bureaucrats and strange new layers of private administration far faster than it could contain clinical cost. Even though our state's share of people enrolled in HMOs is 79 percent greater than the nation's, Massachusetts health care costs (as noted earlier) exceed the national average by 30 percent—or $9 billion this year.

And HMOs increasingly relied on bribing ("incenting!") hospitals and doctors to withhold care—thus angering and frightening patients. Rewarding doctors who give less care is no substitute for paying doctors fairly and helping them spend inevitably finite money carefully. And the $6,100 spent per person this year in Massachusetts, while finite, should suffice to finance the care that works for the people who need it.

Table 2

A few realities of Massachusetts health care

	Mass.	U.S. average	Mass. % above (+) or below (-) U.S.	Mass. rank among states
Estimated health spending, 2000	$ 38 billion	$1.3 trillion		
Est. health spending per person, 2000	$ 6,100	$4,690	+ 30.7 %	1
Hospital spending per person, 1998	$ 1,678	$1,180	+ 42.3 %	1
Rise in hospital $ per person, 1997-98	7.6 %	3.2 %	+ 137.5%	N/A
Hospital beds per 1,000 people, 1998	2.7	3.1	- 13.7 %	34
Hospital total financial margin, statewide	- 0.19%	5.75%	- - -	N/A
Physicians per 1,000 people, Dec. 1997	4.05	2.45	+ 64.1 %	1
Share of people in HMOs, 1997	55.9 %	31.2 %	+ 79.2 %	2
Share of people uninsured, 1998	10.3 %	16.3 %	- 36.8 %	8

Sources for Table 2: HCFA, AMA, AHA, Census, and Hoechst-Marion-Roussel data, and authors' calculations from those data.[13]

8. Elements of durable reform

Careful state action can help the Commonwealth avoid the medical meltdown that looms before us.

HMOs, hospitals, nursing homes, and drug companies continue to insist that their problem is low revenue—not high costs or prices. They therefore continue to demand more money for business as usual. That might solve their immediate problem. But it worsens our problem of paying for health care. And it should not be necessary in the state with the world's costliest health care.

Instead, it is possible to cover everyone, contain cost, and raise quality at the same time, by more carefully using the huge sums we already spend. Key to that is liberating doctors from financial incentives so that they can think clinically and make the trade-offs that best use today's generous resources.

Although publicly-financed care for all under a global budget might best control cost equitably,[14] that seems unlikely to pass soon. Several other measures would be helpful near term. Some tackle individual problems; others are broader.

First, in exchange for financial security, HMOs and hospitals must accept careful and sustained public oversight— including substantial reserve requirements for all HMOs, hospitals, doctor groups, and others that bear risk. Oversight must also include uniform industry-wide accounting, caps on administrative spending, and limits on revenue growth. HMOs and all others that bear risk must completely and accurately report monthly on reserves, revenues, and accrued costs. HMOs have relied on mergers and price increases to protect themselves. Instead, HMOs should test new ways to work with their physicians to spend finite dollars better—to protect all of us.

Second, state government must identify the hospitals, beds, and emergency rooms required to protect the public's health—for now and as baby boomers age. Let's not close facilities that will surely be needed tomorrow, as we did with public schools.

Third, state government must also identify which hospitals face financial distress. Needed but distressed hospitals would qualify for aid from a new security fund financed by a 0.25 percent assessment on all hospitals' revenue. The state should also help endangered hospitals secure debt refinancing at lower interest rates, and seek receivership authority to stabilize failing but vital hospitals.

Fourth, the state must guarantee adequate (but capped) revenue for all needed hospitals—as long as they are operated efficiently. In exchange, hospitals would be publicly accountable, like all other public utilities.

On another front, HMOs vowed to win low prices from drug manufacturers but now say that drug costs are out of control. So, fifth, HMOs should support government negotiations with drug makers for statewide discounts. Government should also press drug makers to contribute, in cash or in capsules, prescription drugs for people who cannot afford even discounted prices. Drug makers' scare tactics notwithstanding, they can afford it. Even after financing research, their profit margins are the highest of all U.S. industries—more than two and one-quarter times those of the average industry. [15]

Sixth, the role of government and the role of competition in health care should be reversed. It is futile to continue trying to use market competition to contain cost, and government to protect quality. Instead, let government contain cost and let HMOs, doctors, and hospitals compete by quality and compassion.[16]

Relying on either competition or government alone is reckless. Had our Navy relied solely on battleships in the 1930s, the Battle of Midway would have been only an unopposed Japanese occupation.

Seventh, state government must assure that everyone is covered. This year, even without any improvement in coverage, total spending will be up roughly $2 billion over 1999 levels. But it would cost less than $1 billion to buy coverage for all of the 625,000 or so people now uninsured.[17] That's less than six months' increase in health spending—a deferral of price increases for six months. Still, the money used to protect uninsured people would continue to be available to pay for health care, and thereby to provide income to the hospitals and doctors and nurses and others who cared for the previously uninsured people.

Eighth, state government must wake from its decade-long health care siesta. Federal action may come too late for our state. State government should identify problems, diagnose causes, and work with caregivers, payors, and patients to design and test solutions. Lacking anything close to a trustworthy free market, the alternative to government action is stark, raving anarchy.

Critics of government programs in Canada or England should recognize that waiting times there for elective surgery reflect economies too weak to finance care at US levels, not flaws in their health care systems. Health care spending in Massachusetts this year may reach as high as four times the level in the U.K., and well more than double the Canadian level, measured in real resources per person.

Ninth, pay doctors fairly, without incentives to give too little or too much care. Freeing them from financial risk liberates them to think clinically. But we should also hold doctors accountable for spending our money carefully. Building such payment arrangements will require much thought and tinkering, but it can be done.

All this will require many years of continuous engagement, not just occasional postcards, from business, workers, and especially state government. Without a free market, government's absence makes anarchy inevitable.

We should begin these changes now, during the fat years of our state's economy. The $38 billion or so to be spent on health care here this year—almost double the state budget—is enough money to finance the care we need. We already enjoy the dollars and the doctors, the competence and the compassion, to take good care of all who live here. If we all heed the wake-up call from Harvard Pilgrim's comedown, we can avert the looming meltdown in coverage, cost and caregiver survival.

Notes

[1] Jack Reichman and others, "The Effect of the Massachusetts Health-Care Crisis on Ratings," New York: Standard & Poor's Ratings Direct, 24 January 2000, p. 2.

[2] [2] Richard A. Knox and Liz Kowalczyk, "Harvard May Lend Millions to Aid HMO," *Boston Globe*, 8 February 2000.

[3] See Alan Sager, Deborah Socolar, and Peter Hiam, "Public not served by merger of MGH, Brigham," Boston Business Journal, 14 January 1994, in which we concluded, "This is largely a formal merger to reduce price competition, one that does little to reduce costly duplication or to increase efficiency." Other health care mergers since then have repeated that pattern.

[4] Lehman Brothers, "eHealth—Where the New Things Are: How the Internet Is Transforming Healthcare," Harvard Business School Health Industry Alumni Association, New York, 18 January 2000.

[5] Indeed, interest rates for health care borrowers in Massachusetts and even throughout New England are likely to rise somewhat even without a default. See, for example, Jack Reichman and others, "The Effect of the Massachusetts Health-Care Crisis on Ratings," New York: Standard & Poor's Ratings Direct, 24 January 2000, pp. 1, 4, 6.

[6] Jack Needleman, "Nonprofit to For-profit Conversions by Hospitals and Health Plans: A Review," Boston: Pioneer Institute, 5 February 1999, p. 20; discussed in Alan Sager, "Comments on Jack Needleman's `Nonprofit to For-profit Conversion by Hospitals and Health Plans: A Review," Invited comments, Pioneer Institute Forum on Health Profit: Issues and Options in Non-profit and For-profit Health Care, Boston, 9 February 1999.

[7] Richard A. Knox and Liz Kowalczyk, "Harvard May Lend Millions to Aid HMO," *Boston Globe*, 8 February 2000.

[8] The ten-year term is reported as under consideration. See Liz Kowalczyk and Richard A. Knox, "Regulators Seek $225m to Aid HMO," *Boston Globe,* 9 February 2000.

[9] Liz Kowalczyk and Richard A. Knox, "Regulators Seek $225m to Aid HMO," *Boston Globe,* 9 February 2000.

[10] The proposal to borrow $175 million is reported in Liz Kowalczyk and Richard A. Knox, "Regulators Seek $225m to Aid HMO," *Boston Globe,* 9 February 2000.

According to the State Treasurer's Office, the Commonwealth of Massachusetts is currently able to sell ten-year general obligation bonds, repaid level term (like a self-amortizing mortgage) at an interest rate of 5.15 percent.

[11] David Warsh, "Why Not Harvard?" *Boston Globe*, 1 February 2000.

[12] Similarly, see Jack Reichman and others, in "The Effect of the Massachusetts Health-Care Crisis on Ratings," New York: Standard & Poor's Ratings Direct, 24 January 2000,

p. 6. They state that, "Under any scenario, Standard & Poor's believes that Massachusetts residents will pay more for health care in the short term, either directly through higher premiums or indirectly through state assessments."

[13] Health spending: Massachusetts: Access and Affordability Monitoring Project and Solutions for Progress estimates for 1999, plus a 5.5 percent rise to 2000; U.S.: Office of the Actuary, Health Care Financing Administration, estimates for 1998, + 6.0 percent to 1999 + 6.0 percent to 2000. See, for example, Katharine Levit, Cathy Cowan, Helen Lazenby, and others, "Health Spending in 1998: Signals of Change," *Health Affairs,* Vol. 19, No. 1 (January – February 2000), pp. 124-132; and www.hcfa.gov/stats/nhe-oact/hilites.htm.

Hospital spending and beds: American Hospital Association, *Hospital Statistics, 2000,* Chicago: American Hospital Publishing, 1999.

Physicians: Statistical Abstract of the United States, 1999, Table 197 (American Medical Association data). The estimates are for 31 December 1996.

Share of people in HMOs: Hoechst Marion Roussel, *HMO-PPO/Medicare/Medicaid Digest, Managed Care Digest Series, 1998, Kansas City, Mo.: Hoechst, Marion Roussel, 1998, pp. 18-19.*

Uninsured people: Jennifer A. Campbell, "Health Insurance Coverage, 1998," Current Population Reports, P60-208, Washington: U.S. Census Bureau, October 1999, Table 2.

Population estimates for 1999 and 2000: Population Projections Program, Population Division, U.S. Census Bureau, Annual Projections of the Total Resident Population as of July 1: Middle, Lowest, and Highest Series, 1999 to 2100, NP-T1, http://www.census.gov/population/projections/nation/summary/np-t1.txt.

[14] See, for example, http://www.massmed.org/physicians/resource/report2.pdf.

[15] See, for example, http://www.house.gov/berry/prescriptiondrugs/Resources/sager.pdf.

[16] Alan Sager and Deborah Socolar, "A 10-step Plan for Healthy HMOs," *Boston Globe* business op. ed., 10 September 1996.

[17] See http://www.massmed.org/physicians/resource/report2.pdf.