Testimony on Universal Health Care

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Rep. Chandler, Sen. Moore, and honorable members of the committee. Good afternoon, and thank you for the opportunity to testify before you again today.

We appear to support the general principles animating two bills, S. 531 and H. 1947.

We are happy to acknowledge our collaboration with Robert Brand and David Ford at Solutions for Progress, Inc., in Philadelphia.

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

INTRODUCTION

For the past ten years, we have been investigating methods of winning health care for all in Massachusetts without increasing costs. For about the same time, our colleagues at Solutions for Progress in Philadelphia have been developing models of the costs of universal coverage in many different states.

And for the past two years, we all have been working together to measure the costs of health care for all in Massachusetts.

The Senate Ways and Means Committee has asked us to provide them with our findings and analyses on this subject, and we have done so.

Today, we are here to report our findings and analyses to you because these findings and analyses are pertinent to two bills before you—S. 531 and H. 1947.

While we do not endorse specific language, we suggest that the general approaches taken by these bills are constructive and should be pursued vigorously and carefully. Here's why.

A. HEALTH CARE FOR ALL COSTS LESS

Current health spending in Massachusetts is enough to cover people who are now uninsured, to greatly expand benefits for people who are under-insured today, eliminate four-fifths of out-of-pocket costs, and still save a billion dollars a year.

B. COVERAGE IS THREATENED AND COSTS ARE RISING

In the wake of the failures of the Dukakis – McGovern universal health care bill in Massachusetts, and of the Clinton – Clinton federal bill, many people are discouraged. Some have concluded that health care for all is just too costly. They say we will have to accept the inevitability of rising health care costs, and that we will have to cut back on coverage to save money. That sparks incredible proposals like raising the age of eligibility for Medicare from 65 to 67.

Others say that we can cover more people and more services, but we will just have to pay a lot more money. More money for Medicaid coverage. Much more money for prescription drug coverage.

Our evidence points in a much more optimistic direction.

C. WHAT IS THE REAL COST OF HEALTH CARE FOR ALL?

First, projected health care spending in Massachusetts in 1999 will be around $36.8 billion. This is the base on which we build.

Please refer to Table 1.

Table 1 **PROJECTED 1999 MASSACHUSETTS HEALTH CARE COSTS, WITHOUT AND WITH REFORM**	**Costs and savings ($ billion)**
BASELINE: 1999 cost of care for Massachusetts beneficiaries (residents and workers from out of state), assuming no major reform or policy changes	**$36.8**
ADDED COSTS: $4.2 billion in new costs with reform	
Cover uninsured	+ $1.0
Comprehensive benefits for all	+ $2.8
Data; care coordination; new services for people with disabilities	+ $0.4
SUBTRACTED SAVINGS: $5.2 billion in new savings with reform	
Savings in administration of coverage	- $1.1
Savings in caregiver administration	- $2.5
More appropriate use of hospital care	- $0.8
Negotiating drug prices; budgeting construction and equipment	- $0.8
Total cost of care for Massachusetts beneficiaries with reform	**$35.8**
Change from baseline costs without reform: -2.8%	**-$1.0**

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

Added costs of coverage: $4.2 billion

We estimate that it would cost slightly under $1 billion to cover the 750,000 people who now lack health insurance. If the real number of uninsured people is somewhat less, the added cost of coverage would drop, but only by a little, if the newly-covered people are largely younger and healthier, as seems to be the case.

Interestingly, it will cost about much more—$2.8 billion—to fill in the gaps in protection for people who now have some health insurance. These gaps include services for which people often lack coverage—such as prescription drugs, nursing home care, and home care—and also the widespread out-of-pocket payments.

Including other new costs of new services for people with disabilities and of data collection and coordination, the added cost of new coverage totals $4.2 billion.

Saving money: $5.2 billion in total

Subtracting administrative costs: $3.6 billion

Savings in administration of insurance and coverage—through reduced need to determine eligibility, track progress toward meeting deductibles, and to pay huge numbers of individual claims: $1.1 billion

Hospitals', doctors', and other caregivers' savings in determining patient eligibility, collecting co-payments, and billing insurors: $2.5 billion

Other ways to save: $1.6 billion

More appropriate use of hospital care:	$0.8 billion
Negotiating drug prices:	$0.5 billion
Budgeting construction and equipment	$0.3 billion

D. COVERING MORE SERVICES AND MORE PEOPLE FOR LESS MONEY

The cost of more health care for all would be $1.0 billion less than today's world of less health care for some. One reason is that today's hospitals (especially) and doctors have the capacity to absorb additional patients at incremental costs that fall below today's average costs—since some costs are fixed.

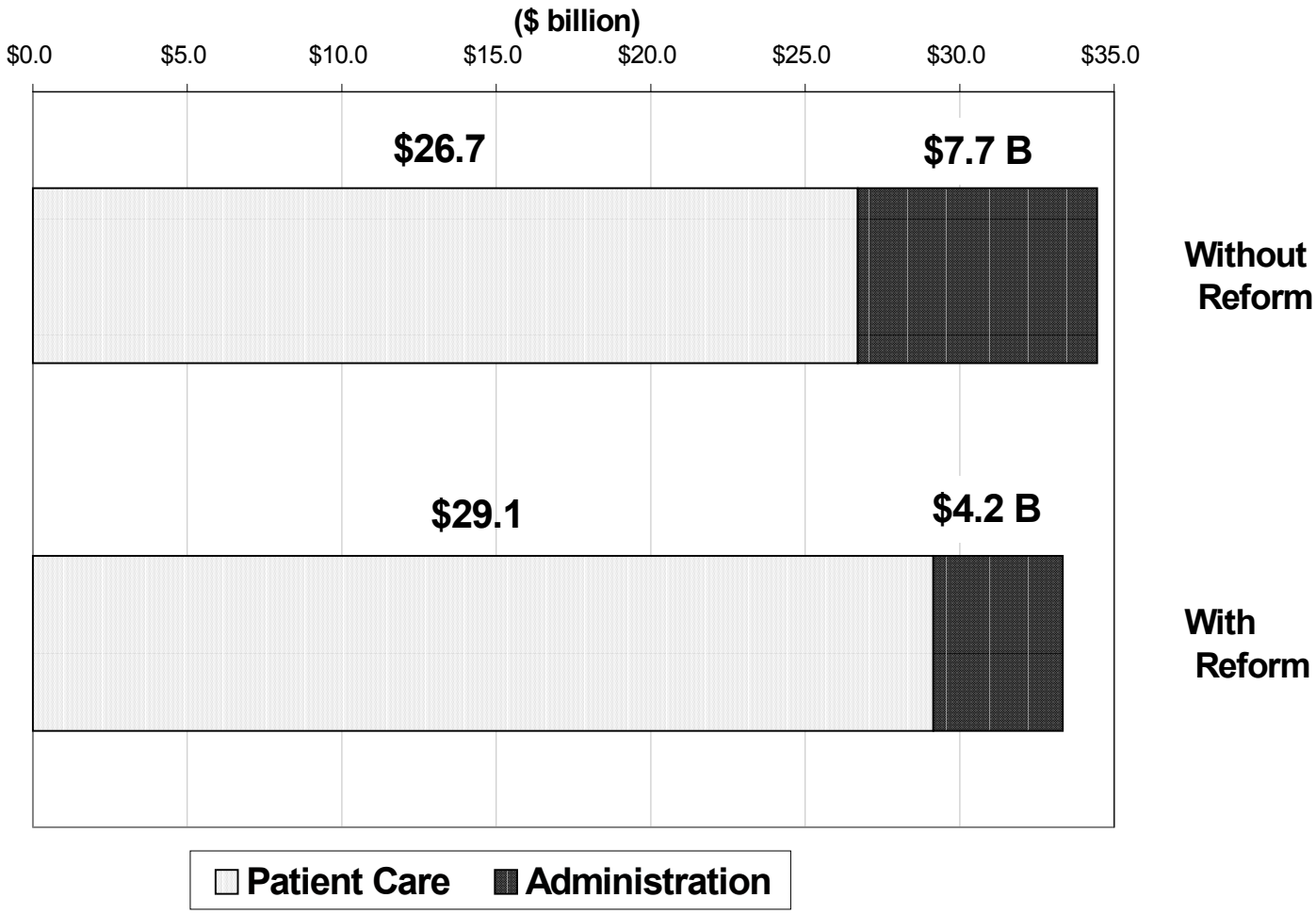
Here's another look:

The amount of money devoted to personal health care—caring for people when they are sick—would rise by $2.4 billion, from $26.7 billion to $29.1. That's an increase of 9.0 percent.

At the same time, the amount of money devoted to administration would fall by $3.5 billion, from $7.7 billion to $4.2 billion. That's a drop of 45.5 percent.

This chart shows this change.

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



E. FINDING THE DOLLARS

Table 2 spells out where the needed $35.8 billion would come from.

A few items are worth highlighting.

First, some $14 billion in private health insurance premiums would persist. Employers would continue to pay amounts equal to their 1999 health insurance burden, but only in 1999 dollars. Premiums would no longer rise with inflation. So gradually, the burden of insurance on employers would be completely eroded.

Second, out-of-pocket spending would nose-dive from $6.4 billion to $1.2 billion, a drop of fully 81.2 percent.

Third, taxes would rise by $3 billion. But this is not new health care spending. Instead, it substitutes for existing private out-of-pocket spending. The shift from private financing to public financing amounts to only 8.4 percent of total health spending in Massachusetts. It is the keystone of the financial plan for reform. This is a real example of spending money to save money.

This $ 3 billion substitute is what permits the administrative savings because it eliminates the need to process co-payments, deductibles, co-insurance, eligibility checks, and the other wasteful administrative activities.

This increase is also what guarantees universal coverage, even if people lose their job.

This increase is also what raises spending on actual health care services substantially—including 25 percent increases for physicians' clinical services and a 41 percent rise for home health care services.

TABLE 2 FINDING THE MONEY TO CARE FOR ALL MASSACHUSETTS RESIDENTS AND WORKERS	Funding source ($ billion)	Cost remaining to finance ($ billion)
Cost of care in 1999 after reform		$35.8
New funds from outside Massachusetts	$1.2	$34.6
Existing government health care funding continues	$16.5	
Patient payments continue for some non-medical costs of nursing home care and for non-prescription drugs	$1.2	$17.0
Privately-paid insurance premiums frozen on per worker basis	$13.9	$3.0
Tax of 1.5% on income and 1.0% on payroll	$3.0	$0

TABLE 3 DOLLAR SOURCES BEFORE AND AFTER REFORM Care for Mass. residents and workers	Before reform ($ billion)	After reform ($ billion)	Percent change for Massachusetts
Total funding needed	$36.8	$35.8	- 2.8%
New funding from out of state		$1.2	—
Current public funding	$16.5	$16.5	—
Continued personal spending for some non-medical nursing home costs and non-prescription drugs	$1.2	$1.2	—
Other in-state funding (currently private)	$19.2	$17.0	- 11.6%
TOTAL FUNDING	$36.8	$35.8	- 2.8%

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

F. MAKING THE POLITICAL CHOICES

Winning universal health care will not be easy. But it is the easiest problem to solve in Massachusetts in the sense that it is the only one that does not require more money.

The alternatives are more bleak than you will want to believe. The alternatives are higher spending, lower coverage, or both.

Incremental coverage improvements are better than no coverage improvements— much better —but they inevitably cost more money. That means more money for health care spending and less money for all other spending on everything else that you or your families care about— paying in rent or mortgage, food, heat, educating your children, cleaning the environment, safer streets, vacations—everything.

If you wanted to finance this level of comprehensive care incrementally, it would cost about $40.6 billion, or $4.8 billion more (that's a 13.4 percent increase) than the cost health care for all under the plan discussed here. That's the added cost of buying everyone in to today's wasteful system.

Incremental coverage is better than no coverage. When you're bleeding, you need a bandage. You can buy time by spending more to expand the senior pharmacy program. Teaching hospitals can buy time if they persuade Congress to give them more money. But the real solution is to better spend the money we already have.

There are other choices. Converting to affordable health care for all will mean incurring costs for retraining administrators and clerks who may need new skills for new and more productive jobs—jobs that enhance well-being of Americans. Some could be re-trained as nurses, home health aides, and others needed to provided care to patients. A good share of those conversion costs should be covered under federal aid, to help Massachusetts make a transition that will be safe for everyone.

Another choice will be to budget an adequate rainy day fund, so there will be enough money for health care at the bottom of the next recession. Need for care rises during bad economic times. This makes them the wrong times to raise taxes or to cut benefits.

G. CRITICISMS AND RESPONSES

1. Why can't Massachusetts just wait for federal reform?

Because Congress is not going to act. The liberal states and the conservative states can't agree on health reform. Nor can the rich and poor states. Nor can the states with lots of uninsured people or just a few. Nor can the states with high health costs or low costs.

Most important, Congress does not know what to do.

The states could provide that information. They are supposed to be the laboratories of democracy. But federal law now makes it hard for states to develop and test new approaches carefully, before a crisis hits.

Since the federal government is not able or willing to act to reform health care, it must get out of the states' way.

2. Can we really do this on our own?

Sure. We have the doctors and the dollars—and the competence and compassion—to finance the care that works for all the people who need it. We are big enough to try something new on our own, but small enough to manage it competently and to measure what works. Were Massachusetts a country, our health care spending would just about equal that of Australia, and it would surpass that of the Netherlands, or the Republic of Korea, Switzerland, Belgium, Poland, and many other nations.

3. Won't this approach mean bureaucratic control over health care?

No. It means *less* bureaucratic control over health care. Today, HMOs and insurors can constrain physicians' decisions and have even tried to gag physicians and prevent them from discussing some treatment options with patients. Today, price competition without a free market is resulting in payment methods that actually reward the doctors and hospitals that give less care to patients. Today, an HMO's stock price goes up when the share of its revenue devoted to patient care goes down.

Less bureaucratic control will be reflected in less administrative spending. This approach means much less bureaucratic or administrative spending and control. Ironically, in health care, most of today's bureaucracy is private, not public.

4. Won't this approach mean rationing of vitally needed care?

This approach will provide enough money to provide the care that works to all the patients who need it.

While spending less overall, this approach actually makes more money available for patient care.

Doctors and hospitals and other caregivers will still have to spend money carefully, but they will have enough to spend.

Britain rations a good deal. Canada rations less. Both do so because their economies are not in good shape and they don't have much money to spend on health care. But Massachusetts spending per person is more than three times that of Britain. So we will not ration. We will spend money carefully, and we will not waste it.

5. Who needs a tax increase? How can you seriously propose another tax increase when so many politicians want to cut taxes?

Because winning serious cost control and health care for all requires a tax increase. But because it is a substitute for existing out-of-pocket spending by sick people—and that out-of-pocket spending is really a tax on sickness, it is unfair to call this a tax increase. It's a substitute tax—it asks us to pay more when we are healthy and less when we are sick.

The $3 billion amounts to $1.37 per person per day. Real money.

And what does this buy?

First, guaranteed health care for each person. If you lose your job, you keep your health insurance. And you don't have to worry that you might lose your job because you've gotten too costly to insure.

Second, a huge boost in dollars for health care and a huge cut in dollars for bureaucratic waste. Some tax increases lead to more bureaucracy. This tax substitute is the keystone to buying less bureaucracy.

6. Won't this approach lower the quality of health care?

No. It will improve both quality and quantity of care. First, everyone will have coverage.

Second, most of the increase in cost of new coverage, indeed, will go to round out the benefits with prescription drugs, home health care, and other services—for people who already have insurance. They will get more than twice as much additional care as previously uninsured people.

Third, the share of the health care dollar going to medical care will rise, and the share going to administration will fall.

Fourth, physicians and hospitals will be paid adequate sums to provide needed care. They will not be paid in ways that allow them to make more money by giving less care. They will be free to focus on patients' clinical needs.

Fifth, under one option for delivering care, HMOs would all be paid the same risk-adjusted price, and would compete only by quality of care.

7. What's the hurry? Aren't health costs under control? Why plan all these big changes now? If it's not broke, don't fix it!

It is broken. Health care costs are resuming an upward spiral. Hospitals are closing and survivors are demanding still more money. People in Congress are talking seriously about raising the age of Medicare eligibility from 65 to 67. People in Congress are talking seriously about spending many additional billions on prescription drug coverage. Medicaid is expanding its coverage, but this also costs more money. What will happen at the bottom of the next recession?

The costs of more money for business as usual are unsupportable.

And we can't wait until the crisis hits. Then, the political demand for action will be high, but the ability to act will be low—unless we try out some sensible new ideas now—ideas that actually have worked in various ways in many other nations. There's an old saying that you must dig a well before you are thirsty. We need to prepare.

We can win health care for all of us—and at a cost we can all afford—but we have to work for that. It won't fall into our laps today.