This report is embargoed until 12:01 A.M. on Friday 3 March 2006

DURABLE HEALTH CARE FOR ALL WILL REQUIRE COST CONTROL

Health Cost's Share of Economy Up 38% Since 1987, While Uninsured Share of Residents Rose 78%

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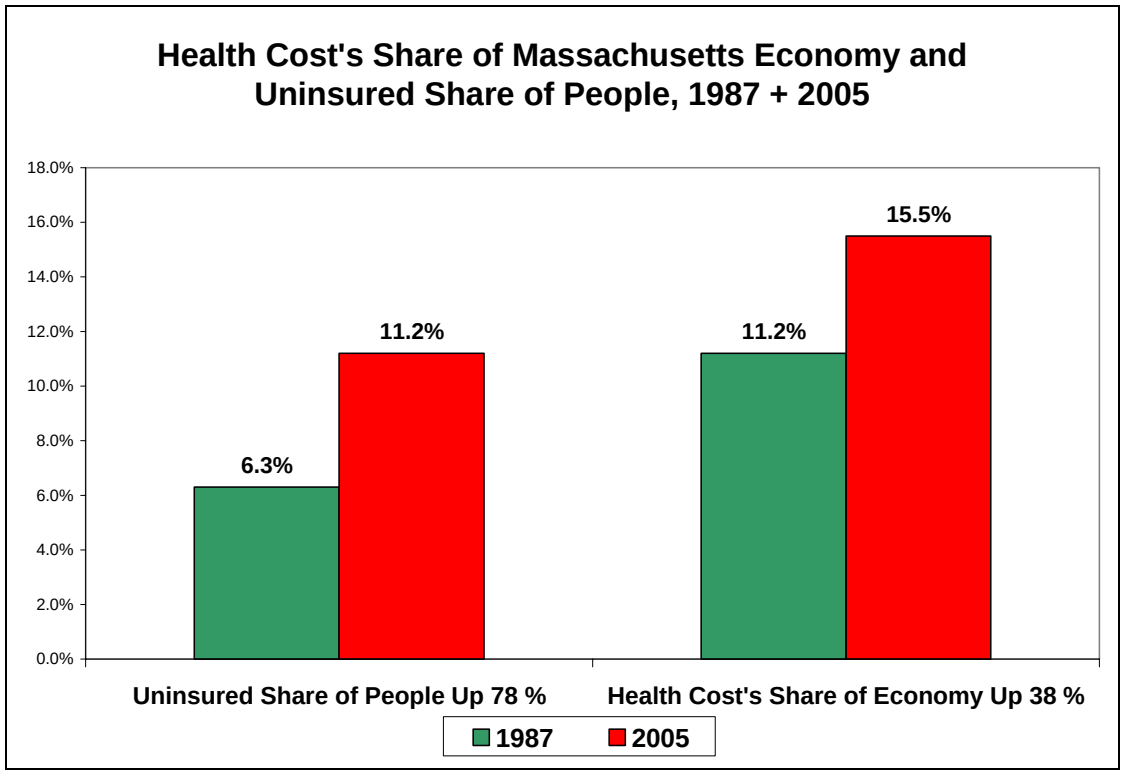
3 March 2006



KEY POINTS

Massachusetts health care and current reform plans are complex, so this report is long. Yet it's only about 1 page for each $1 billion spent on health care here.

1. Health care for all in Massachusetts is like the weather. Everyone talks about it but few want either to pay more to achieve it, or to act seriously to cut costs.
2. Since passage of the state's failed 1988 employer mandate, health care costs have risen by 38% as a share of the economy. Despite spending more—and probably because of rising costs—the share of residents uninsured rose 78%.
3. Even without reform, health costs this year will soar almost $4 billion—almost four times what the House bill adds to cover uninsured people.
4. Though costs are soaring, spending even more seems the shortest political path to insuring us all. But the added sums can't buy solid insurance policies.
5. Flimsy paper coverage may result. A numbers game of counting nominally-insured people may be replacing real financial protection. That's no solution. Many people are already under-insured and can't get needed care.
6. An even flimsier individual mandate attracts support because it doesn't yet face political opposition. But it is regressive, abandons responsibility to cut costs, and is a bad deal for patients, caregivers and taxpayers. Its administrative cost could exceed that of group plans by $250 million per $1 billion in added premiums.
7. The House payroll tax is fairer and job-friendlier than flat premiums. But its mandates and subsidies pour water on the sinking ship of private insurance. Private health insurance protects waste in health care, harming patients.
8. Rising public subsidies will be hard to fund. Health care costs here rose by 199% from 1988 to 2005, but the state's own revenues rose only 131%.
9. Hospitals seek higher Medicaid rates despite costs 44% above the U.S. average.
10. Although half of health spending is wasted on unneeded care, paperwork, high prices, and theft, cost control is not yet popular, for at least 10 reasons.
11. Today, the bill that could work can't pass, but the bill that can pass can't work. Still, the House bill does more good than harm and is worth supporting.
12. Succeed or fail, efforts to expand access will boost interest in cutting waste.
13. Doctors, not patients, are the key to cutting waste. They control 87% of health spending. It's vital to negotiate a clinical, legal, political, financial, and ethical deal that lets us trust doctors to care for us all well without spending more.
14. Today, high costs hinder coverage expansion. But having the world's highest health spending makes health care the easiest problem to solve here—if we squeeze out waste and use the savings to finance comprehensive care for all.
15. Only when patients, caregivers, payers, politicians, and voters demand that current spending finance full care for all will this state design, test, and adopt practical ways to cut cost—and reconcile private interests with the public interest.

SUMMARY

Overview

Massachusetts faces financial, political, and moral pressure to expand health insurance coverage. At this writing, a legislative conference committee appears stalemated in its effort to reconcile very different bills that passed the two chambers late in 2005. Legislation may be enacted to improve health insurance coverage, at least for some people, but at the price of still higher spending—in the state that already has the world's highest health care costs.

The House bill would substantially expand coverage. But the past year's debate has been focusing on approaches—including the governor's—that create, to varying degrees, four large and predictable risks:

- Higher and uncontrolled costs mean an unaffordable law that can't endure.
- Promoting purchase of private insurance is an uphill battle on a sinking ship.
- Individual mandates fragment responsibility for cost and coverage.
- Providing flimsy, paper coverage and boosting under-insurance is no solution.

In 1988, Massachusetts passed a well-intentioned universal health care law. It "failed because it did not even attempt to finance its coverage improvements with funds liberated by establishing effective cost controls." [1] Again in 2006, the bills before legislators don't try to squeeze current spending to finance expanded coverage.

Four realities present in 1988 persist today: a) political support for expanding coverage, b) very little support for—and some active opposition to—containing cost, c) a resulting need to spend more to finance the expanded coverage, and d) considerable opposition or inability to find the money needed to finance that expansion.

And two things have gotten substantially worse since 1988:

- health costs have risen substantially as a share of the state's economy, and
- the share of people uninsured has risen even faster.

It is striking to observe that Massachusetts health spending for business as usual would rise by $3.8 billion from 2005 to 2006, we project. This assumes no improvement in coverage. (Indeed, it probably embodies a continued rise in the number of residents lacking coverage.) [2]

This means that one year's rise in spending for business as usual is 4.5 times as great as the House bill's increase in spending to cover uninsured people—and 7.5 times as great as the governor's proposal.

In these circumstances, the legislature faces a choice between

- offering some uninsured people flimsy coverage (while forcing many to buy it with money they can't afford to spend), or
- increasing state spending substantially to subsidize coverage improvements.

Legislation to expand health coverage would relieve human suffering. We think that the House bill is, overall, a step forward. But it may be hard to pass and implement because it will require higher spending. One reason is that the legislature faces competing claims on its scarce tax dollars. Boosting local aid is one such claim. And one of the main reasons the cities and towns need more money is to pay the soaring costs of health insurance for their employees and retirees.

Today, as in 1988, it may well be that the law that will pass can't work, and the law that would work can't pass.

No matter the outcome of the present debate, legislators will need to debate and help to shape genuine cost controls.

- If the House bill does not pass because of fears of higher spending and unwillingness to come up with new money, the anger resulting from its failure will help build political pressure to control costs in ways that help finance coverage for all.
- If it does pass and if it is implemented, the high cost resulting from its success will help to build political pressure to control costs.

The House bill's traditional methods of expanding coverage—through purchase of more insurance policies—are flawed. They are not durably affordable.

- They allow Massachusetts health care costs to continue soaring simply to finance business as usual.
- On top of that, they add new spending for previously uninsured people on top of that.
- True cost controls are completely absent.
- State finances and the state's economy can't shoulder these costs.

And the increasingly skimpy coverage that these traditional methods buy will leave more Massachusetts residents under-insured, facing unmanageable costs when sick.

Even now, we estimate, at least 20 percent of residents lack any prescription drug coverage, 40 percent lack dental coverage, 75 percent of residents lack adequate mental health coverage, and over 80 percent are uninsured for long-term care.

Yet the job of winning affordable health care for all should be the easiest problem to solve in Massachusetts.

- Not easy—just easier than all the others. We have the world's highest health care spending, resources ample to cover everyone and preserve all needed caregivers.
- But about half of what we spend is wasted.

- Much of the enormous sums wasted in today's health care can be squeezed out by new types of cost control. The savings can be captured, recycled, and used to finance thorough health coverage for all.
- This would assure medical security—confidence that everyone who lives in Massachusetts can get needed and timely medical care without having to worry about the bill when sick and without having to worry about losing insurance coverage ever.

Realities of health care cost and coverage are likely, in time, to engender greater political support for laws that can both work and pass. To speed that day's arrival, we urge state government, employers, unions, advocates, caregivers, and other interested parties to get their arms around health care cost problems. [3]

The problems

Almost everyone favors expanding health insurance coverage in Massachusetts, but few are willing either to pay more [4] or to grapple seriously with cutting costs.

Their causes

The job of covering everyone has become more difficult since it was last attempted in 1987-1988. That's because, as Exhibit 1 of this report illustrates,

- the share of the state's economy consumed by health care costs has risen by 38 percent since 1987 (from 11.2 percent then to 15.5 percent in 2005),
- yet the share of people in Massachusetts who lack health insurance has risen by 78 percent (from 6.3 percent uninsured in 1987 to 11.2 percent in 2005).

Between 2005 and 2006 alone, the cost of financing business as usual for Massachusetts health care—without any improvements in coverage—is rising by almost $4 billion.

Further, from 1988 to 2005, health care spending here rose one and a half times as fast as the revenues raised by the state from taxes, fees, and the like. (Exhibit 4)

Massachusetts health care and hospital costs have long been highest among the states—and thus highest in the world. (Exhibit 3) Health care has steadily absorbed a growing share of a fragile state economy just to finance business as usual. High costs make it harder to spend still more money to cover more uninsured people.

Rising costs have made it harder for employers and workers to afford health insurance. Rates of health coverage through the job have dropped in Massachusetts, as they have nationally. Efforts to insure this state's people by

subsidizing or mandating purchase of private insurance—either through the employer or individually—therefore face an uphill fight on a sinking ship.

Together, these factors make it very expensive to cover everyone with good health insurance benefits.

At the same time, the federal government threatens to withhold some $385 - $650 million in funds under a Medicaid waiver if the state does not enact legislation to greatly expand insurance coverage.

Under these circumstances—higher costs, more uninsured people, and greater political pressure to act—some parties will be tempted to satisfy the federal requirement by offering skimpy or flimsy insurance benefits to as many people as possible, with the smallest possible increase in spending.

There's danger that this will degenerate into a numbers game about providing paper coverage.

Three types of solutions

To cover all of this state's people, three types of solutions are available:

- buy low-cost but skimpy coverage for uninsured people,
- buy today's standard benefits at great added cost, or
- finance solid coverage for all people by cutting health spending that's wasted today.

The first alternative is to publicly encourage flimsier insurance coverage because the premiums are cheaper. This, combined with an individual mandate and some state subsidies, is essentially the governor's approach. It will raise health spending substantially, though not as much as the House bill. That's because the governor's approach will cover fewer people and offer them less.

The governor's plan might be characterized as seeming to cover as many people as possible, at the lowest apparent public or political cost, while imposing costs and blame on individuals mandated to buy coverage. Promoting flimsy, paper insurance—with reduced benefits and requiring higher out-of-pocket payments when using care—will boost the number of people nominally insured but do little to improve actual access to care. And state-approved flimsification of benefits will legitimize reducing benefits for people who already have private or public coverage.

The governor's approach is a very bad idea. It would make more things worse than it makes better.

A second alternative is to provide uninsured people with something closer to today's standard coverage, through a combination of Medicaid expansions, employer

mandates, individual mandates, and other methods—and considerably more spending on health care. This is essentially the House bill's approach. The House bill moves beyond today's system, though, in starting to finance coverage with payroll taxes, not flat premiums. That advances equity and is less of a barrier to job creation.

This report gives greater attention to the House bill because it is the most conscientious and serious attempt to improve insurance coverage. The Senate bill receives much less attention here because it apparently does relatively little to improve insurance coverage. Even though the governor's proposal is no longer actively considered in legislators' current debate, this report discusses it from time to time because it has received some national attention and because it is favored by some powerful state business groups. Also, an individual mandate may seem politically attractive because individuals are not yet organized to oppose it.

The House bill, despite its lack of cost controls, and other problems, makes more things better than it makes worse.

Private health insurance has been melting down, though, and neither mandates nor public subsidies will be able to save it, particularly as underlying health costs continue to rise. Private health insurance may be evolving toward individual purchase (atomization) and toward de-insurance (or flimsification).

Continued reliance on traditional private health insurance—even with public subsidies—has the effect of protecting waste in health care—at the expense of both patients and payers.

The Massachusetts Taxpayers Foundation claims that the employer mandate's payroll tax would raise far less money than the House estimates. But the MTF apparently calculates only the revenue raised from "firms not offering insurance." Yet firms which cover few of their workers or provide very limited benefits are likely to spend too little on health care to fully offset the payroll tax requirement. So the payroll tax seems likely to raise substantially more revenue than the MTF suggests.

After claiming that the House bill would not substantially raise revenues, the MTF contradicts itself by worrying that an employer mandate would harm the state's economic and job growth. Actually, however, anything that raises health care costs here, including an individual mandate, could limit growth.

The third alternative is to finance improved coverage by squeezing out some of the vast sums wasted in health care. Today, this is off the table politically. That's not surprising.

- First, there is not yet any agreement that cutting cost by squeezing out waste is necessary to improve coverage.

- Second, some still believe that higher spending is necessary to finance new technology and to care for the growing numbers of older people.
- Third, some doubt cost control's feasibility. Given the failure of past competitive and regulatory attempts to contain cost, pessimism is common today. One economist involved in developing current legislation even says "'we have no clue how to lower health care costs.'" [5]
- Fourth, no method of containing cost enjoys good political currency. Single payer reforms promise to contain health costs by cutting administrative waste, and in other ways. But these reforms make many parties nervous. Further, much work remains to design and test improved ways to squeeze out waste and recycle it.
- Fifth, free market ideologues urge that patients be forced to pay more of their own health costs, in hope of driving down costs. This foolish idea wastes vital time by crowding out consideration of approaches that might actually both work and protect people.
- Sixth, cost-cutting is fiercely resisted by those in health care who fear losing revenue. (That's one reason to explore reforms that recycle savings to finance expanded access to care without higher cost—or revenue loss.[6])
- Seventh, cost control introduces even more complexity into political debates, which can delay pursuit of the seemingly simple objective of improving coverage. Political leaders, health care advocates, caregivers, employers, and other stakeholders have not yet developed the concepts or the tools to address this complexity.
- Eighth, there is today no broad or vigorous constituency for true health care cost control. Payers often find it easiest to lower their own costs by shifting more of the burden to patients or others. Advocates of better funding for education, environment, nutrition programs or other pressing needs rarely note that restraining medical expenses could free up funds for other things they care about.
- Ninth, cost-cutting is not a goal pursued with emotion, like covering us all. Nor is cost control a moral or ethical subject, yet. [7] Wasted money is not available to caregivers to meet patients' needs, and waste raises insurance costs, forcing cuts in coverage—but it is not yet widely recognized that waste kills.
- Tenth, it is not yet recognized that <u>waste is the greatest enemy of affordable health care for all</u>. But tomorrow, cutting waste will be central to fulfilling any hopes to expand health insurance coverage—such as those embodied in the House bill—and to protect the caregivers who provide health services.

We see reason to fear that <u>one-half of current Massachusetts health spending is wasted</u>. There are four broad types of waste. First is clinical waste, which stems mainly from financial incentives to over-serve, defensive medicine, lack of

information about what care is needed, and failure to use available information. Second is waste on administration caused mainly by mistrust between payers and caregivers, and also by unwarranted complexity associated with multiple payers and policies. Third is excess prices of prescription drugs, medical devices, and some salaries. Fourth is theft and fraud.

We focus on a new approach to reducing cost—by cutting waste—because traditional regulatory and market methods of cost control have generally not worked well.

To cut cost by squeezing out waste, it's essential to attack the various causes of waste. Attacking the causes requires changes in how people are covered, how doctors and hospitals are paid, and how care is organized. Some of the necessary reforms are distinct and incremental; others are more sweeping.

Many reforms require government action, particularly to create a financing framework. The key to successful design and implementation of most reforms, though, is the active engagement of our state's physicians. That's because physicians' decisions control some 87 percent of the spending on personal health care. [8] Doctors' gross practice incomes absorb about 21 percent of spending, but doctors retain only about eight percent. The circumstances under which doctors earn the eight percent strongly influence the effectiveness, equity, and efficiency with which the full 87 percent is marshaled. Doctors must therefore be central to any successful effort to spend money wisely.

Seriously attacking the causes of waste does not mean cutting the scope or level of coverage, forcing untrained patients to guess what care is appropriate. The governor calls for insurance policies with low premiums. These may look affordable, but they will have limited benefit packages and high deductibles and co-payments. Requiring people who need care to make high out-of-pocket payments is dangerous. It blocks use of vital care. It especially harms poorer and sicker patients. It shifts costs to caregivers, too, jeopardizing the survival of those who serve people who cannot pay. Flimsier insurance coverage won't contain cost safely.

Making sick patients pay more money out of pocket undermines health coverage, which spreads risk in order to remove financial barriers to needed care. Flimsification undermines medical security by creating more under-insured people. Under-insurance is a grave problem today. Many people counted as "insured" lack any prescription drug, dental, mental health, or long-term care coverage. And continual benefit cuts in response to rising costs mean that growing numbers of insured people cannot get needed care because they face low ceilings on benefits or high copayments. Under-insurance and cost-shifts to patients can't solve the problems of uninsured people.

Uncontrolled costs mean not only that care won't be affordable for today's uninsured people. It also means that legislation now being debated won't address the needs of most Massachusetts residents—those with insurance—because it fails to stop the current erosion of private and public coverage.

Looking forward

Without strong tools to reallocate the half of health spending now wasted on administering payment, unneeded care, high prices, and more, plans to cover us all will tend to unravel, as the 1988 law did. (See *9 Lessons from 1988 Law*, Appendix.)

When that happens, there will be greater recognition of the need to control cost, and greater appreciation that squeezing out wasted spending and recycling it is the only durably affordable way to finance health care for all in Massachusetts.

For now, our state's high health costs are an obstacle to covering everyone. Effective cost controls remain off the political table, as in 1988.

In the future, though, our high spending could instead become an asset once we decide to squeeze out waste, capture it, and recycle these savings to guarantee both secure coverage for all and adequate financing for all needed caregivers.

In the real world, durably affordable health care for all is ineluctably joined with cost control. Access to needed care will continue to erode without cost control—and covering everyone is essential to genuine, trustworthy cost controls. Cost control is therefore just as morally salient as health insurance coverage. And that makes it essential that we all begin to get our arms around the job of finding cost control solutions that work.

Massachusetts will move to squeeze out excess costs, capture the savings and recycle them to cover all residents just as soon as that becomes the path of least political resistance—and just as soon as we design and negotiate clinically, financially, organizationally, politically, legally, and ethically trustworthy methods of containing cost. Political resistance to cutting costs will fall in the wake of the present debate—whether it results in enactment of costly access improvements or whether advocates are disappointed. All who seek health care for all should therefore vigorously support designing and negotiating trustworthy methods of containing cost.

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I. LOOKING BACKWARD

On the 3rd of November 2005, the Massachusetts House of Representatives voted 131-22 for legislation to greatly expand the number of residents with health insurance coverage. [9] That bill is similar in many important ways to a previous—but failed—attempt to greatly expand health insurance coverage here.

In 1987-1988, the Massachusetts legislature debated and then passed a law mandating firms with more than five full-time employees to provide health insurance or pay a tax. That law used a patchwork of private and public plans to pursue coverage for all. The bill was signed on 21 April 1988.[10] The employer mandate was never implemented; it was finally repealed in the mid-1990s.

We have long argued that the 1988 law would fail and did fail mainly because it did not contain health care costs by squeezing out waste and using the savings to expand coverage. Instead, it relied on unsustainable promises of new money to finance broader insurance coverage. Most the proposed new spending on uninsured people was deemed unaffordable. It never materialized. One of the main reasons why it was hard to raise and spend more is that in 1988 Massachusetts already had the highest health costs in the nation—indeed, in the world.[11]

This year, Massachusetts again plans to rely on mandates and on higher spending to insure more people—again in the absence of effective cost controls.

Conditions have worsened deeply since the 1988 law was debated and passed. Health care costs have risen by two-fifths as a share of the state's economy. The share of the state's people without coverage has risen by three-quarters.

Over time, rising health costs have been the main cause of the drop in insurance coverage.[12] We should all therefore think hard about the feasibility of spending even more to expand coverage, as the House bill and governor's proposal would do.

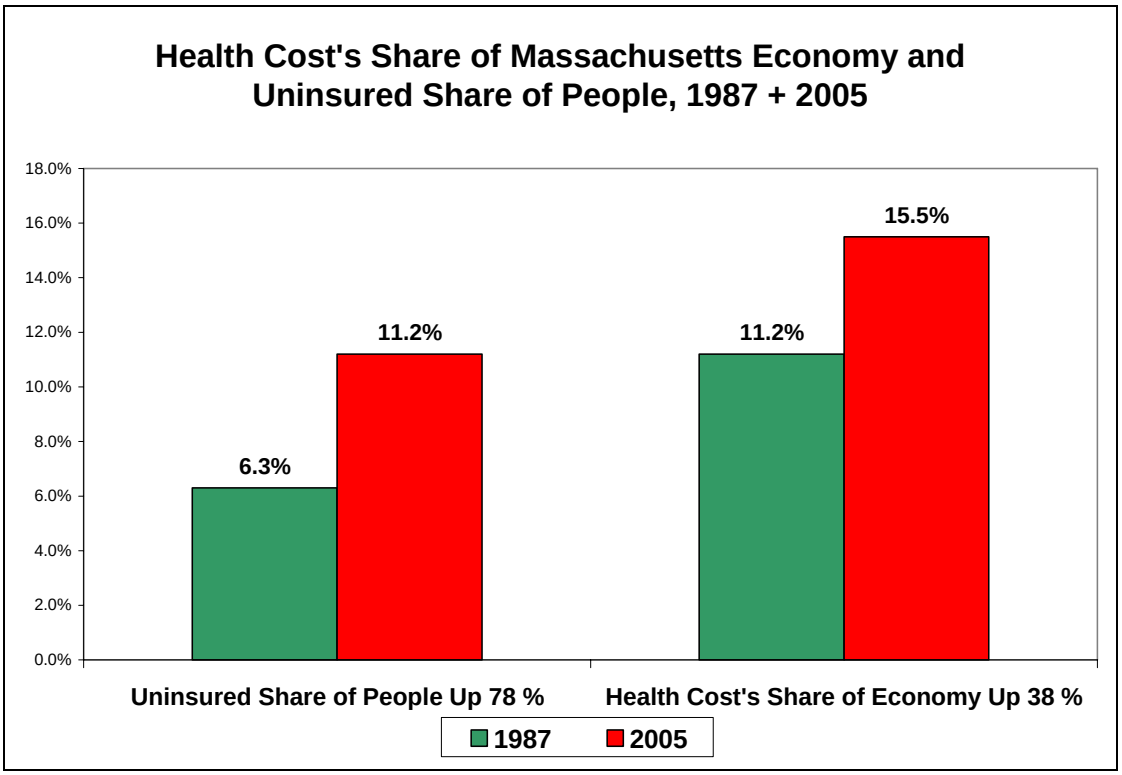
We urge support for the House bill nevertheless. But we urge doing so with open eyes—with sharp understanding of its shortcomings. Covering more people through state-subsidized purchase of private insurance under its combined employer and individual mandates—without serious cost controls—will require some combination of even higher spending and slimmer benefits. In the years ahead, more and more state dollars would be required to keep the mandated private insurance purchases affordable to families and employers. That money will be hard to obtain. So benefits would likely be cut further. Also, the proposed expansions of Medicaid eligibility will be hard to sustain at the bottom of every recession. Still, the House bill strives far more seriously for substantial coverage than the governor's plan, which would require individuals to buy flimsy or unaffordable coverage.

A. A few numbers. Between 1987 and 2005, health care's share of the Massachusetts economy rose from 11.2 percent to 15.5 percent—a rise of almost two-fifths, as shown in the following chart.[13]

Health care costs in 2005 in Massachusetts were $14.6 billion higher than they would have been if their share of the state's economy had remained at the 1987 level. This excess constitutes more than one-quarter of today's health care spending.

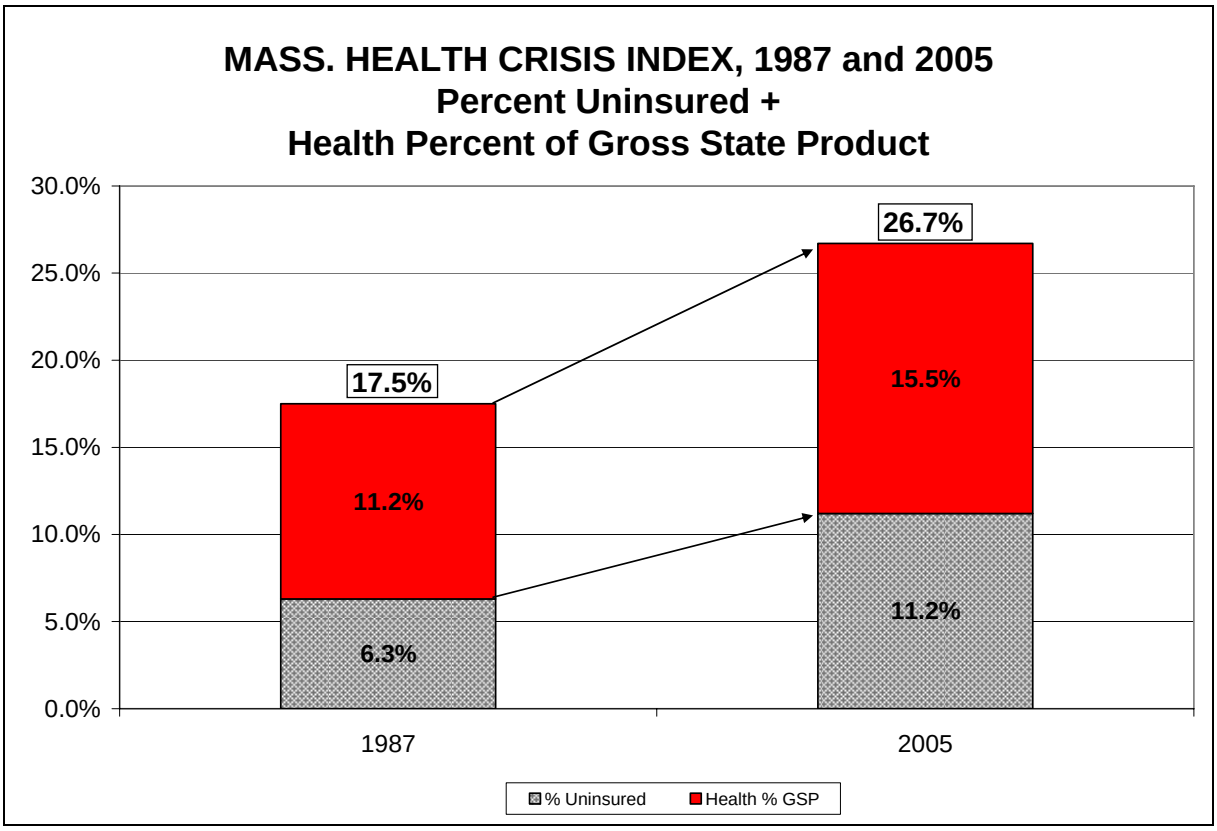
At the same time, the uninsured share of the population rose from 6.3 percent to 11.2 percent—a rise of over three-quarters. This means that some 300,000 more people are now uninsured than if the uninsured share of the state's population had remained at the 1987 level. [14]

Exhibit 1



The sum of health care's share of the economy and the share of people lacking insurance is a measure of the financial, human, and political stress facing health care. We call it a Health Crisis Index.[15] This index rose in Massachusetts by just over one-half between 1987 and 2005, from 17.5 to 26.7. This index is displayed in the second chart, below. It suggests need for reform is intensifying.

Exhibit 2



These numbers show that the job of winning durably affordable coverage for all residents of the Commonwealth got much harder between 1987 and 2005.

- Many more uninsured people have to be covered.
- Each must be covered at today's much higher costs per person.
- Much more money is needed in total. But willingness to provide much more money is undermined by the rise in insurance premiums and health care's rising share of the state's economy. So the job of insuring all Massachusetts residents is much more challenging than when the state last tried, in 1988.
- Many who provide health care or make money from health care are accustomed to steadily rising revenues for business as usual—apart from any improvement in coverage.
- Our high health spending is an obstacle to covering everyone today because effective cost controls remain off the political table, as in 1988.

Yet today's high spending could become an asset if we commit to effective cost controls that permit better use of current funds to cover us all. The key is to squeeze out waste from today's high spending, capture the savings, and recycle them to improve and protect coverage and to safeguard needed caregivers.

B. Some politics. In the face of the sharp rise of both components of the Health Crisis Index—health care's share of our economy and the uninsured share of our people—why has the political interest in improving coverage in Massachusetts been so high in 2005-2006? At least seven forces are at work:

1. The federal government threatens to withhold some $385 - $650 million if Massachusetts does not improve insurance coverage. This threat is widely considered to be credible. The federal threat has concentrated many minds, and the deadline is creating or building momentum for action. [16]

In 1996, a federal Medicaid waiver substantially increased federal spending to help finance this state's large expansion in Medicaid eligibility. [17] According to federal data, the number of people covered by Medicaid in Massachusetts rose from 715,000 in 1996 to 1,060,000 in 2000—an increase of 48 percent.[18]

The increased federal dollars controlled by the waiver can continue to flow only with the federal government's consent. As the state seeks to renew the expiring waiver, the federal government now threatens Massachusetts with loss of the $385 - $650 million (now used to cover a variety of Medicaid and uncompensated care costs) unless the state acts, somehow, to substantially reduce the number of people deemed to be "uninsured."

The governor's proposal would use the waiver money itself to subsidize private purchase of insurance; the House bill would use it mainly to expand Medicaid eligibility, restore some previously cut Medicaid benefits, and perhaps to subsidize costs of insuring low-income employees and their families.

There is some public confusion about the timing of the threat, the amount of money that is at risk, and what must be done to satisfy the terms of the 2005 agreement that the Romney administration negotiated with the federal government.

- ✓ The deadline is 30 June 2006 for the federal government to agree that the state has done enough to improve insurance coverage to merit extending the waiver. Because that federal determination will require review and assessment of changes in state law, the state would need to enact legislation well before the 30th of June. [19]
- ✓ In this report, we indicate that the sum at risk ranges from $385 million to $650 million because various apparently well-informed individuals have used those figures. The sum ultimately available to the state—that is, the sum that is at risk if federal officials don't approve state reform plans—apparently depends on a number of unpredictable factors.

- ✓ Similarly, there is considerable disagreement about how many residents of the Commonwealth must be newly insured to keep the at-risk federal dollars flowing to the state. This disagreement is captured by the differences between the House and Senate bills.

2. Presidential ambitions are visible, as they were in 1988. In one view, Governor Mitt Romney, with only a "thin political resume," "desperately wants to sign something he can call 'healthcare reform' and take it on the national political trail." [20] In another view, the governor offers a gamble that is a "plausible compromise." [21] Either way, the governor's public endorsement of action to insure everyone in Massachusetts has helped prepare the ground for passing legislation.

In 1987-1988, universal health care legislation in Massachusetts arose from concern that the growth of price competition in health care would hurt uninsured people, and from hard work by access advocates and leading legislators. But the law gained much momentum from Governor Michael Dukakis's presidential campaign. Notably, some legislators appeared to let their reservations about the bill be overridden by Potomac fever—excitement about the possibilities that would open if their former legislative colleague were to become president.

3. Some businesses that offer health insurance coverage voice frustration that they are not only saddled with the cost of coverage for their own employees—but must also pay for their competitors' employees' care. That's because uninsured workers and their families often rely on the state's Uncompensated Care Pool. The pool is financed largely by assessments on insurers/HMOs and on hospitals—which derive much of their revenue from private insurance bought by businesses and their employees. This argument was raised frequently in the 1987-1988 debate [22] and is still heard today. Indeed, the recent drop in the share of workers covered by job-based health insurance probably increased the burden of financing the Uncompensated Care Pool on those employers who continue to offer insurance. Were fewer people uninsured, those who pay for insurance would no longer need to include subsidies for hospital uncompensated care. The dollars involved are relatively small, as would be the savings to employers who now offer insurance, but the symbolic power of this issue is very large. (One problem, though, may be that current financing methods provide no way to ensure that insurance companies' or hospitals' savings are passed on to payers.)

A related concern has also gained recent attention—numerous profitable employers have been offering such limited or costly health insurance that many low-wage workers must turn not only to the hospital pool, but also to Medicaid and other public programs. Some parties tally such costs, publicize the

employers involved, and suggest these employers are ducking their fair share of health costs—thereby shifting the burden of payment to taxpayers. [23] [24] Such concerns just led Maryland legislators to enact a requirement that the largest employers spend at least eight percent of payroll on health care for their workers, or contribute the difference to the state's Medicaid program. [25]

4. Powerful insurers and caregiver organizations, while anxious to see more people insured, may also seek a variety of gains for themselves through the reform legislation. Today, apart from patient advocacy groups, the more visible public supporters of increased health insurance coverage include Blue Cross and Partners Health Care, a chain of hospitals centered on Mass General and the Brigham. (Indeed, Blue Cross and Partners jointly financed a set of costly ads on the *Boston Globe's* op-ed page in September and October of 2005.) Each supporter has grown increasingly powerful in its own realm. Each may desire to do public good. High executives in each organization have long been committed to improving insurance coverage.

At the same time, each may fear that the steady growth in health costs and in the number of uninsured people will fuel public pressure for reform. Each may also feel threatened by some types of reforms, and that its dominant position in its field will be more secure from criticism if it is seen to have publicly and successfully advocated wider insurance coverage.

Blue Cross of Massachusetts has been prominent in spurring reform. The Blue Cross Foundation, for example, financed three large studies by researchers at the Urban Institute that help provide arguments about choice of methods of covering more people here and some evidence on the costs of coverage.[26]

Apart from its interest in the public good, Blue Cross may seek several things for itself.

- ✓ Blue Cross's growing market power in Massachusetts might be challenged on anti-trust grounds. Blue Cross might seek to immunize itself against such challenges by acting—or being perceived to act—in the public interest through its support of efforts to insure more people.

- ✓ Blue Cross has pushed for the end of the $160 million annual assessment on insurers/HMOs that is used to help finance the Uncompensated Care Pool. All major legislative proposals would eliminate this $160 million annual assessment.

- ✓ Blue Cross may hope that it will be able to market insurance to many of the people who would be covered under a new state law.

At least two things are noteworthy about the Urban Institute studies of Massachusetts commissioned by the Blue Cross Foundation.

First, the Foundation limited the Urban Institute's work by declaring single payer reforms to be out-of-bounds. The Foundation says that it did this because it believed that single payer could not pass in the legislature. This suggests that the Foundation expected that passing a bill was possible.

The Foundation may have thought that raising consideration of single payer would undermine passage of seemingly simpler legislation that aimed to expand insurance coverage. It may have thought that debating single payer seriously might have muddied the political waters. Or that discussing single payer seriously might have frightened some important groups. That's because, by aiming to squeeze out waste, single payer would supplant long-standing methods of administration, payment, and movement of dollars.

(It is worth noting that two studies in Massachusetts, commissioned by the Massachusetts Medical Society in the mid-1990s, did find that single payer approaches would cover all uninsured people at lower cost. [27] Still, as discussed elsewhere in this report, we are urging a shift in focus. We urge comprehensive attention to reducing all four types of health care waste. Single payer remains a useful foundation or platform on which to build comprehensive health care reform.)

Second the Blue Cross Foundation released the Urban Institute reports at a series of programs at the John F. Kennedy Library, a venue with profound and powerful meaning in Massachusetts. The governor, Senate president, and House speaker made major addresses. Press coverage was extensive. Clearly, the Blue Cross-initiated effort galvanized—and probably helped to organize—concern and effort to expand insurance coverage.

5. Powerful hospitals, while anxious to see more people insured, may also seek a variety of gains for themselves through the reform legislation. In 1987-1988, Massachusetts hospitals joined employers that offered insurance in pushing for the universal health care law that ultimately passed. The bill provided for massive increases in hospital rates of payment, which had been regulated by the state. [28] These increases took effect immediately. But the law's main provision to improve coverage was to be implemented four years later. Its earlier advocates among hospitals and large employers were suddenly quiet as its main program—the play or pay mandate on employers—was repeatedly delayed and then repealed.

Hospital rates have since been de-regulated. Today, one of hospitals' main complaints is with the adequacy of the rates at which Massachusetts Medicaid pays them. All major legislative proposals would raise the Medicaid rates paid to

hospitals (and also health centers and physicians) up toward Medicare's rates. The House bill contains just under $100 million yearly for rate increases. The Senate bill seems to offer much more—perhaps as much as $300 million yearly.

Massachusetts hospital costs per person have been consistently highest in the nation. [29] That makes them the highest in the world. One of the main reasons is excessive reliance on costly teaching hospitals.

Partners Health Care (a visible supporter of expanded coverage, as noted above) might reason that if its high costs and surpluses are seen as an enemy of affordable coverage for all, it might face pressure to lower its own costs of care.[30]

Partners may feel vulnerable because it has been criticized as enjoying excessive market power. Because each HMO or insurer network must include Partners' hospitals and physicians—because they constitute such a dominant and indispensable share of the caregivers in eastern Massachusetts—Partners has been able to extract high rates of payment. [31]

But, were new legislation to succeed in covering today's uninsured people, Partners may hope that pressure would diminish. With some coverage in place for all, Partners might feel more secure in retaining its high cost structure as it pursues its medical missions of research, teaching, and patient care. In other words, a publicly legislated medical care floor (or minimum level of coverage) for all people might allow Partners to continue to raise the medical care ceiling for some people. [32]

At the same time, it is important to note that highly-placed individuals at Partners hold long-standing commitments to winning improved health insurance coverage. When James Mongan, head of Partners, recently advocated much higher health spending to cover uninsured people,[33] he may have been motivated partly by a desire to make Massachusetts health care safe for Partners' high costs, but it is likely that his stronger motivations were a desire to protect uninsured people and a belief that only higher spending would make that possible.

6. Health Care for All, the Greater Boston Interfaith Organization, and others have helped to organize substantial public support for expanding health coverage through the job and through Medicaid. Health Care for All has supported legislation and a ballot initiative that included an employer play-or-pay mandate.

Health Care for All has been a prominent supporter of the "big tent" approach to insuring more people. That means building a tent that shelters as many groups as possible, leaving as few as possible outside in opposition. Each group must get something—tangible, symbolic, or both—in exchange for its support. For this reason, the big tent can be a costly solution. Its supporters would argue, with

some justification, that this may be the only politically feasible way to win improved insurance coverage today.

Similarly, Senator Kennedy himself, the nation's most effective proponent of heath care coverage for all, has praised the House bill's employer mandate but said he would support compromises if necessary to build a consensus broad enough to win passage of substantial improvements in coverage. [34]

Most proponents of improved health insurance coverage in Massachusetts genuinely aim to help uninsured people. Most are willing to increase spending—often someone else's spending—in order to insure more people. The federal government's use of its Medicaid waiver leverage, the governor's ambitions, Senator Kennedy's support for improved coverage, frustrations of businesses that feel they pay their competitors' health care costs, the efforts of Blue Cross and some hospitals, and the organizing work of Health Care for All and others have created an environment in which insuring more people seems possible.

7. Finally, the Massachusetts economy is slowly recovering from the recession of 2001-2003. State government's finances are recovering somewhat faster, making it possible to contemplate using state dollars to subsidize an expansion of insurance coverage. Also, despite health care's rising share of the state's economy, that share is about at the national average. And despite the rising share of the state's people who are uninsured, that share remains below the national average.

C. A clear choice. Given a choice between continued failure to cover uninsured people and the House bill that promises to insure substantially more people, we'd certainly urge support for the legislation—even without cost controls.

Yet the clear dangers and considerable risks associated with this bill must not be ignored or minimized. It appears poised to repeat the mistakes of the 1988 Dukakis-era law—but in the face of a burden of health costs on the economy that is two-fifths higher than in 1988 and an uninsured share of the population that is three-quarters higher than in 1988.

These are very far from the worst mistakes in the world. Many more people would be protected against the cost of health care. They would enjoy much better coverage—and more affordable coverage—than under the governor's flimsy proposal for paper coverage. The state would avert the loss of some $385 - $650 million in federal Medicaid funds. That is, if something like the House bill passes and survives a possible gubernatorial veto.

And the state will be poised and—soon—obliged to think much harder about how to cover all people at affordable costs, and to preserve and protect all needed hospitals, physicians, and other caregivers.

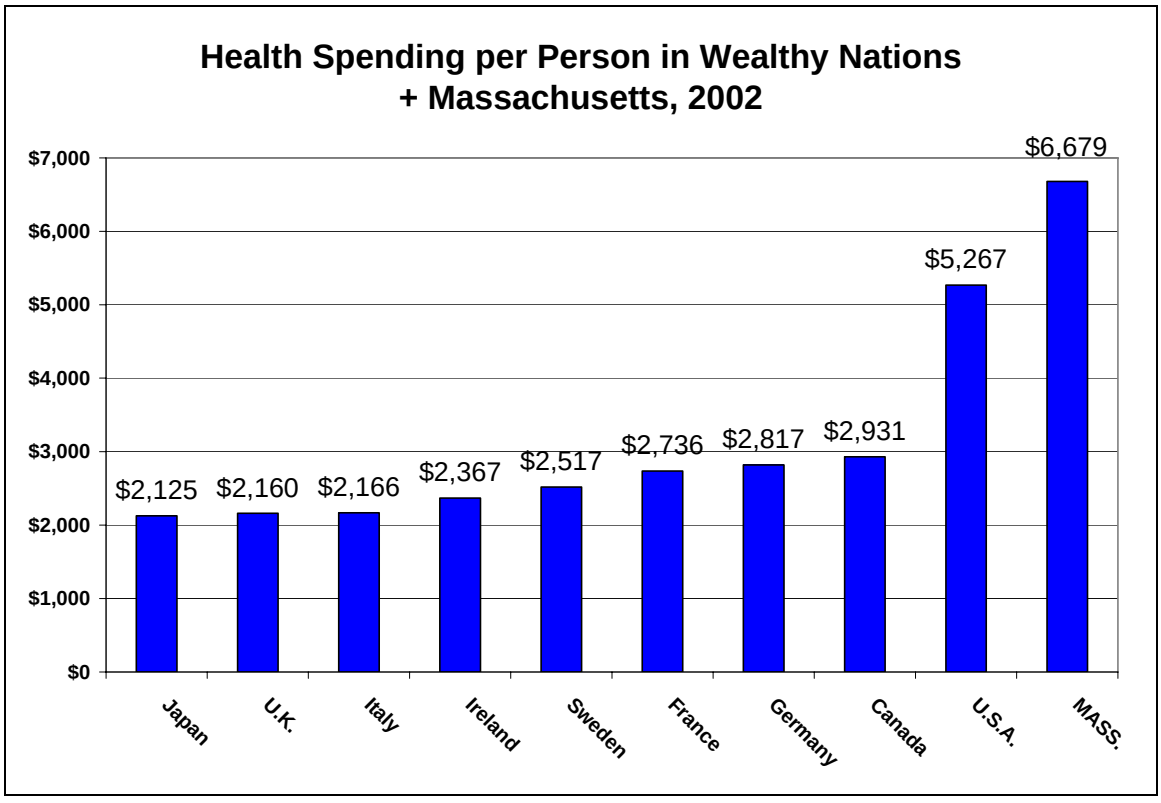
II. SEVEN CLEAR THREATS TO STABILITY OF OUR HEALTH CARE

We believe that controlling cost by cutting waste is essential to winning durably affordable insurance coverage. But there are seven additional reasons to work quickly to contain the cost of health care in our state—seven problems that threaten the stability of Massachusetts health care.

A. Massachusetts has the costliest health care in the world.

- Health care spending in Massachusetts totaled over $52 billion in 2005—more than $1 billion each week. [35]
- Health spending in Massachusetts was $11 billion higher in 2005 than it would have been if we spent at the national per-person average.
- Health care spending per person averaged about $8,200 here in 2005, or 27 percent above the U.S. average,[36] and more than in any other state.
- As the costliest state in the costliest nation, our employers, workers, and taxpayers are at a serious competitive disadvantage. In 2002, we find, Canadian, German, and French health spending per person was just over 42 percent of the Massachusetts level. In the United Kingdom, Italy, and Japan, it was about one-third of the Massachusetts level. [37]

Exhibit 3



- Massachusetts hospital spending is also higher, per person, than in any other state—44 percent above the national average in 2004. [38] That's up from 34.5 percent above average in 1987, when hospital revenues were regulated. Those 1987 cost controls were replaced by competitive financing policies in the 1988 universal health care law and in 1991 legislation.[39]

- Hewitt Associates' insurance premium survey places Boston highest among 14 large metro areas. [40]

- Another example: MetLife's 2005 survey of assisted living facility costs found Boston highest among 81 regions, 59 percent above the US average. [41]

B. About half of current health care spending is wasted on (in approximate order of importance) [42]

- Clinical waste. This includes unnecessary treatments and tests, arising mainly from financial incentives to over-serve, defensive medicine, lack of good evidence about what works, and lack of attention to—or good distribution of—the available evidence. [43]

- Administration and other non-care activities—what we call "solid waste." This includes unnecessary bureaucracy and paperwork, especially in the financing of care. This arises mainly from the mistrust between payers on the one hand, and doctors, hospitals, and caregivers in general on the other hand, that our current payment system fosters. It also stems from our needlessly complex patchwork of coverage and payment rules. Solid waste also includes funds squandered on mindless marketing and advertising, and on profits unjustified by genuine free markets, and the like. A growing share of health spending evidently goes to such non-care costs; for example, from 1993 to 2004, by the main government measure, insurance administration and profit rose over 50 percent faster than national health spending. [44]

- Excessive prices for prescription drugs and other medical products and services. [45]

- Outright fraud and theft. The biggest target for increased anti-fraud efforts, both public and private, should be certain providers or sellers of health care—not the patients. This is clear from the latest analyses of Medicaid fraud in New York State, for example. [46]

We suggest that these four types of waste constitute the greatest enemy of affordable health care for all residents of Massachusetts. Therefore, in our view,

any efforts to build support for improved coverage by providing unwarranted extra payments to hospitals (as discussed shortly) would be self-defeating.

In this connection, we note Robert Kuttner's recent powerful and incisive eulogy of the late Wisconsin Senator William Proxmire. Kuttner noted that:

> Proxmire was one of the rarest of political creatures, a tight-money populist…. He believed that powerful industries needed to be regulated in the public interest. But he was just as tough on government excess.
>
> His monthly Golden Fleece awards lampooning government waste were his way of telling taxpayers that if liberals wanted government to do great things, they needed to be even more vigilant than conservatives about government excess.[47]

C. Massachusetts health care is addicted to spending more money each year to finance business as usual. Current proposals feed that addiction.

- More health care money is spent on fewer insured people each year. Health spending here has been rising as a share of the state's economy even though the uninsured share of the population has been growing. High and rising costs are the main cause of drops in insurance coverage, as noted earlier.

- Massachusetts health spending for business as usual will rise by $3.8 billion from 2005 to 2006, we project. This assumes no improvement in coverage. (Indeed, it probably embodies a continued rise in the number of residents lacking coverage.) [48]

- The November 2005 House bill provides for substantial increases in Medicaid payments to hospitals—raising them toward Medicare levels—even though hospitals' median total margins have already risen from 0.3 percent in 2002 to 3.2 percent in the first three-quarters of fiscal 2005.[49] And even though hospital spending per person in Massachusetts soared to $2,357 per person in 2004, 44 percent higher than the national average. This is the greatest excess in a quarter-century. [50] Had we spent on hospital care at the national average in 2004, spending here would have fallen by $4.6 billion.

  In theory, the legislation would make "hospital rate increases effective after July 1, 2006 contingent upon performance benchmarks developed by the Office of Medicaid." [51] But we do not expect that the benchmarks that are set, if any, will disadvantage the costly teaching hospitals that today provide disproportionate shares of services to Medicaid patients. Yet some hospitals serving the most Medicaid patients are among the state's wealthiest.

  Therefore, about half of new Medicaid spending under across-the-board rate hikes would go to the state's 20 most prosperous hospitals. [52] The Medicaid

increase would not be adequate to measurably improve the survival chances of many needed but endangered hospitals. Instead, taxpayers' funds would be better used instead in targeted ways, to secure the survival of each needed but financially distressed hospitals, and to enhance the capacity of lower-cost non-teaching hospitals to serve Medicaid patients.

- Overall health care spending in Massachusetts in 2005 would have been $38.1 billion, or (as noted earlier) $14.6 billion lower than it actually was, if health care's share of the state's economy had stayed at its 1987 level.

- The Massachusetts economy in 2005 is 2.5 times its 1987 level. Holding health care spending to its 1987 share of the economy still would have allowed an enormous rise in that spending. Instead, by 2005, Massachusetts health spending grew to 3.4 times its 1987 level. [53]

- No forces now at work are likely to rein in health care cost increases.

D. There is great danger that when the state's economy stops growing—during the next bad recession—health care will crash through the windshield.

- Only substantial economic growth has kept health care's share of this state's economy remotely manageable—so far. No plans are in place to make health care in Massachusetts affordable for all who live here. No plans are in place to sustain the improvements in coverage offered by the House bill.
- Everyone who lives, works, or does business in Massachusetts knows that health insurance is growing increasingly unaffordable even during good economic times. Employers and employees find it hard to finance rising premiums through the job. Cities and towns are the canaries in the health care coal mine, we have found, as they face a combination of high health cost increases for municipal workers and slowly-growing local revenues. [54] Local and state governments will shortly be obliged by the Government Accounting Standards Board to reveal their unfunded health care liabilities to retirees, thereby endangering their abilities to borrow money. [55]
- When the real economy—adjusted for inflation—shrinks during the next deep recession, substantial outright cuts in health spending should be expected. But Massachusetts health caregivers—hospitals, doctors, drug makers, nursing homes, and others—and public and private payers—have no plans in place to cope with any outright cuts in health spending. They lack plans even to cope with flat spending.
- The risks to the Medicaid expansions and restorations in the House bill are even greater. Recessions cut state revenue, and this often leads to Medicaid cuts. Federal support for sustained rapid rises in Medicaid financing is in

doubt. Congress is likely to finance this year's tax cuts in part by cutting Medicaid financing.

- The U.S. economy is living on borrowed money, borrowed time, and borrowed Toyotas. Some 40 percent of the goods we consume are made overseas. The U.S. trade deficit's share of GDP rose from one percent in the mid-1990s to 5.7 percent in 2004.[56] It continued to grow during 2005. The deficit is financed by a combination of paper dollars, which other nations are still willing to accept, and sale of U.S. assets. The U.S. today produces too few goods and services that other nations are willing to buy. When other nations are unwilling to accept payment in dollars, Americans will have to sell them real goods and services, or buy less from them.
- It is very possible that the U.S. has assumed a role in the world's economy that parallels that played by Germany in the mid-1920s—borrowing from other nations to boost world-wide demand.
- With the economy so precarious, it is all the more worrisome that Massachusetts has a recent record of deeper recessions and slower recoveries than the nation as a whole. Further, the high cost of health insurance in Massachusetts (along with high housing costs and other factors) weakens our state's economy's capacity to generate jobs.
- Concern about health costs' rising share of the U.S. economy is growing. For example, the Congressional Budget Office's new long-term budget outlook asserted that:

> If past growth rates persist, spending for health care will eventually consume such a large share of the nation's output that real (inflation-adjusted) ***spending on other goods and services will have to decline sharply***. [57]

But many in health care see the world differently. Writing about national proposals to improve coverage, Mongan has asserted that "federal taxes are at their lowest level since 1959," and that a hike in taxes of more than $200 billion to finance health insurance for all Americans would be economically feasible. [58]

Arguing that such taxes are not feasible, however, are the combination of today's high health care spending, the likelihood that about one-half of that spending is wasted, the many other unmet needs and under-financed obligations of government, business, and families, and the unaffordability of boosting health's share of the economy.

Many state governments seem to understand this. Even though states' surpluses rose in 2005, often substantially, worries about Medicaid cost increases and fears of the next economic downturn and resulting state deficits are expected to make most states cautious about "approving new spending." [59]

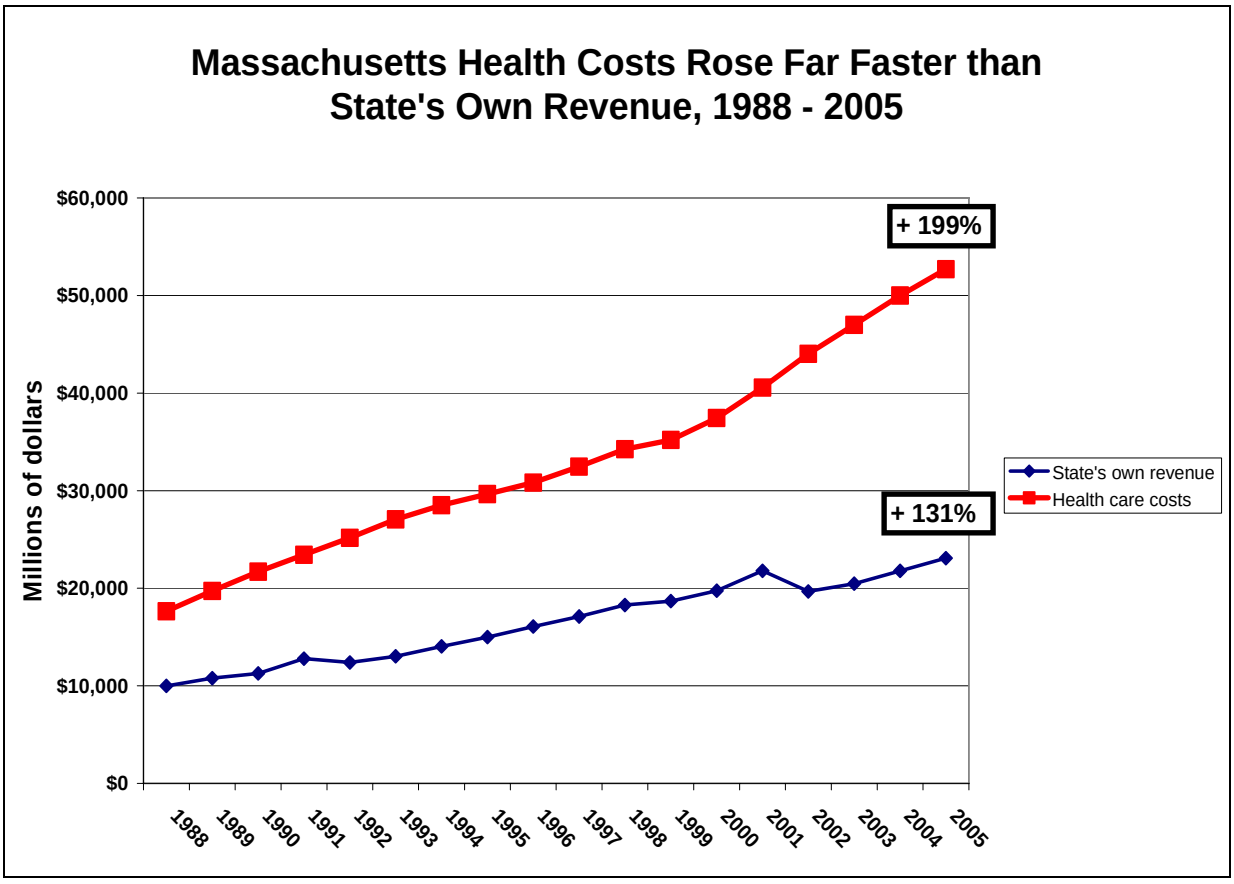
Moreover, at this writing, it appears that Congress will approve cuts in Medicaid. States will be authorized to charge unprecedented out-of-pocket payments to Medicaid patients. [60]

E. Health care costs have been rising much faster than the revenue raised by Massachusetts state government.

With uncontrolled health care costs rising far faster in Massachusetts than state revenues, the state will have difficulty finding the dollars to cover the growing costs of subsidizing insurance under either an employer mandate or an individual mandate. Similarly, the state will find it harder to pay for its share of improved Medicaid coverage, especially during the inevitable recessions and state fiscal crises.

The following exhibit contrasts trends in health care costs and in the state's own revenues (excluding federal grants and the like). It shows that state revenues from taxes, fees, and the lottery rose by 131 percent from 1988 to 2005. Meanwhile, health care spending in this state rose by 199 percent—fully one and a half times as fast. [61]

Exhibit 4



Local governments and their employees face a similar gap between health care cost and revenue. Indeed, as noted earlier, Massachusetts employees of cities and towns could well be the canaries in the health care coal mine. Local government revenues grow more slowly than state revenues, and local governments' spending on health care costs is particularly hard to control. [62]

F. Income inequality has been growing nationally and in Massachusetts, making it much harder for many individuals to afford health insurance—and harder for hospitals in lower-income communities to survive.

Incomes in Massachusetts have been getting steadily less equal since at least the 1970s. From the late 1970s to the late 1990s, real incomes of the poorest fifth of the state's families fell by 2 percent (that's after adjusting for inflation). At the same time, real incomes of the middle fifth rose by 17 percent, and the wealthiest fifth rose by 41 percent.

In the years 1998-2000, family incomes in Massachusetts were the fifth-least-equal in the United States. The average income for the top fifth of families was 10.5 times as great as the average for the bottom fifth. [63]

This rising inequality, coupled with the state's uncontrolled increase in health costs, makes it harder for many families to pay the premiums required to comply with individual mandates. And employers will find that health insurance premiums become a growing percentage of the incomes of lower-income workers—and therefore a greater percentage add-on to the cost of doing business.

Growing inequality makes it harder for even middle-income families to shoulder the rising out-of-pocket costs associated with flimsier insurance coverage.

As income inequality grows, there is also reason for concern that hospitals, doctors, and other caregivers may give growing attention to higher income patients who have more comprehensive coverage. [64] [65] Also, in recent decades, hospitals located in minority and low-income areas have been likelier to close; costly teaching hospitals have been likelier to survive. [66] Doctors in minority and low-income areas have been likelier to relocate as well.

These last two points raise the important question of whether issuing cards declaring that people have health insurance would translate into actual ability to obtain health care.

A shortage of nearby caregivers and growing reliance on costly teaching hospitals could combine with lower incomes and flimsy insurance coverage to create substantial barriers to care. This combination could hinder the

improvements in actual use of care—by people in need—that reform proponents seek.

The House bill promises almost $100 million annually in higher Medicaid payments to hospitals, doctors, and health centers. If hospitals, essentially, receive across-the-board rate increases, about one-half of the money (as noted above) would go to the 20 most prosperous hospitals in the state. [67] Relatively little would be done to protect needed but vulnerable institutions.

Across-the-board hikes may be a political lowest-common-denominator among hospitals. But they are neither needed, affordable, nor good health policy. They are not an efficient way to protect all needed hospitals or to support efforts by smaller hospitals and their physicians to serve Medicaid patients more aggressively.

G. Despite high spending, most people are under-insured. And under-insurance is a growing threat to medical security in Massachusetts.

Medical security means confidence in obtaining needed, competent, and timely care without having to worry about the bill when sick, and without having to worry about losing insurance coverage ever.

Rising health care costs threaten medical security for everyone who lives in Massachusetts.

State promotion of flimsy health insurance coverage would legitimize employers' efforts to cut their own spending by reducing benefits and by forcing employees to pay more of the premium or pay for more services out-of-pocket. Were a play-or-pay employer mandate to pass, we do not predict that employers would massively and immediately abandon direct provision of health insurance in favor of paying the less costly payroll tax. Rather, we predict that the state's legitimation of flimsier coverage would accelerate the erosion of benefits in employer-provided insurance. (And the payroll tax would not brake that trend because it is low compared to the share of payroll that insuring employers now tend to spend.)

Today, even people with mainstream health insurance through the job have commonly lacked adequate coverage—or even any coverage—in four important areas of health care. These are prescription drugs, dental care, long-term care, and mental health care.

- We have estimated that one-fifth of Massachusetts residents have no prescription drug coverage, and that at least ten percent more are under-insured. [68] That's at least 1.9 million people. The new Medicare Part D prescription drug plans may lower the number who lack drug benefits somewhat—but are likely to provide many with inadequate coverage.

- We estimate that two-fifths of Massachusetts residents lack meaningful dental insurance. That's 2.5 million people. [69]
- We estimate that over 80 percent of Massachusetts residents lack long-term care insurance. That's 5.1 million people. (And those with such insurance often find that it covers less of their needed care than expected, or that—as they age—they can't afford to keep costly policies, even as their need for long-term care grows.)
- We estimate that at least three-quarters of Massachusetts residents lack adequate mental health insurance. That's 4.8 million people.

III. FOUR LARGE AND PREDICTABLE RISKS OF CURRENT PLANS

Although the House bill, the Senate bill, and the governor's proposals differ greatly in their methods, aims, and compassion for uninsured people, all run four grave risks. To different degrees, all would

- engender higher health spending,
- force more people to buy failing private health insurance—which might be called *Titanicide*,
- oblige more and more individuals to buy health insurance coverage individually—which might be called atomization, and
- accelerate the spread of flimsy fig-leaf coverage—which might be called nakedizing.

All three bills promise to insure more people. The House bill and the governor's proposal promise to cover almost everyone and the Senate bill promises to cover one-half of the people now uninsured. [70] The House bill would probably come closest to meeting its promise; the governor's proposal and the Senate bill could fall substantially short. Gruber has asserted "that the Senate plan would cover, at most, an additional 50,000 people," excluding Medicaid expansions. [71] Because the Senate bill would apparently cover so few people, it is discussed only in passing in the rest of this report.

A. Higher spending

Apart from any coverage expansions, all major legislative plans (as noted earlier) would raise Medicaid rates for hospitals, health centers, and doctors. Also, each plan would use more new money to finance expansion of coverage. As with the state's 1988 universal health care law, these proposals would mean "a traditional political marriage, cemented with money for both hospitals and universal health care." The risk is that, once again, "By promising more money for access and more money for hospitals, it [will have] prepared a bill too great to be paid." [72]

1. The House bill would expand insurance protection through an employer play-or-pay mandate, broader Medicaid coverage, and an individual mandate. The House bill would retain substantial financing for uninsured people and other costs of uncompensated care provided by hospitals or health centers.

Under the House bill, many employers would be forced to provide health insurance coverage or pay a new tax. Public dollars, drawn from tobacco settlement payments, would subsidize the cost of insurance to employers and employees. All this represents new spending on health care.

To finance these expansions, the House has estimated that its bill would raise some $350 million from the play-or-pay tax on employers (which would be 5

percent or 7 percent of payroll, depending on number of employees), and also use some $300 million in tobacco settlement money, for a total of $650 million in state fiscal year (SFY) 2009. [73]

(Transferring the tobacco settlement money to subsidize purchase of health insurance is clearly new health care spending. That is because this money has been spent for the past two year to fill gaps in financing for existing state programs. If the tobacco settlement money is not replaced by higher state taxes or other revenues, those other programs must suffer.)

We assume here that individuals who are covered under the employer mandate will face some higher premium costs. But we also assume that higher premiums would be partly offset by the drop in out-of-pocket costs owing to new insurance coverage. (Uninsured patients' spending today, however, goes directly to pay for care, whereas with a mandate to buy insurance, more money will go to insurance company marketing, administration, and profit.)

The House bill would impose a residual individual mandate on individuals who can afford to buy health insurance. As with the employer mandate, we expect a rise in premiums and a partly offsetting drop in out-of-pocket costs.

We estimate, crudely, that the net increase in premiums and out-of-pocket health spending under the House bill's employer and individual mandate would total some $200 million.

Thus, we estimate, total new health care spending under the House bill would be $850 billion in 2005.

The House bill would also re-target some $830 million in existing spending, and use it to expand Medicaid coverage substantially; some of this money would also be devoted to the important job of sustaining payment for free care at hospitals and community health centers.

The Massachusetts Taxpayers Foundation (MTF) estimates the sum that would be raised by the employer play-or-pay tax at only $175 million, about half the $356 million estimated by the House. [74] The House bill would also drop the $160 million Uncompensated Care Pool assessment on insurers and HMOs. In the MTF's estimates, this would nearly nullify the revenue gain from the employer tax and leave the state with virtually no new money from employers, net.

If the MTF's revenue estimates are correct, the state would have to find replacement money to subsidize new insurance coverage. But the MTF does not seem to be correct.

The MTF seems to underestimate the revenue that would be raised by the proposed payroll tax. The MTF's revenue estimate appears to err by assuming

that the House bill's play-or-pay tax will apply only to the "Payroll of firms not offering insurance." [75] So, for example, citing state data that "two percent of firms with 100 or more employees do not offer health insurance," [76] the MTF assumes that only this two percent would be subject to the mandate and the tax. But merely knowing *how many offer insurance* says nothing about how much money that other 98 percent of large firms *actually spend* providing health insurance.

The House play-or-pay mandate would apply to all firms with more than ten employees. Employers' health insurance payments offset obligations to pay the new assessment. (The MTF acknowledges this in its text, but seems not to do so in its calculations.) In reality, Wal-Mart and many similar firms that spend little on insurance also would be subject to the tax in the House bill. [77] Some firms set workers' premium payments so high that few workers can afford to sign up for coverage. Some firms offer very limited benefits, deny coverage to many part-time workers, impose long waiting periods for benefits, and the like. In such firms, current spending on health insurance may be too low to fully offset the 5-7 percent payroll tax requirement. Thus, the legislation may raise substantially more tax revenue than the MTF suggests.

Further, the MTF seems to contradict itself when it asserts both
a) that the state will raise no new money from employers, net, and
b) that the House bill has "an expensive new payroll tax" that would place "an added burden on the Massachusetts economy." [78]

Something is much more important than the MTF's worry that an employer mandate would harm employment and economic growth in Massachusetts. It is that ***anything that increases the cost of health care in Massachusetts, including an individual mandate, could harm employment and economic growth here***. (Higher health care spending by anyone—employers, workers, patients, or government—means less money available for everything else.)

Moreover, a mandate on employers to provide insurance or pay a tax on payroll is probably more employment-friendly than traditional health insurance. A payroll tax is far less regressive than traditional flat insurance premiums, imposing less of a burden on low-wage workers and their employers. Because it does not punish employers that hire more full-time workers, health care costs would no longer hinder creation of full-time job opportunities. Also, group insurance through the employer typically wastes far less money on insurance administration than does individually purchased insurance, as discussed shortly.

Increasingly unaffordable health care cost is what will harm employment and economic growth in Massachusetts—just as high cost handicaps efforts to improve health insurance coverage.

2. The governor's proposal would have covered substantially fewer people than the House bill because it did not include either an employer mandate or an expansion in Medicaid coverage. Instead, it relied almost entirely on individual mandates to buy private insurance, backed by inadequate public subsidies that used recycled Medicaid waiver and uncompensated care dollars. The governor proposed to stop requiring coverage of certain state-mandated benefits, to start encouraging policies with high deductibles, and to seek such low premiums for the state-promoted insurance policies that they would inevitably include only meager benefits. [79]

Two different estimates drive home this point.

First, consider the share of state-wide health spending that might flow to currently uninsured people under the governor's proposal. Suppose, for simplicity, that about 10 percent of Massachusetts residents are now uninsured. That would be about 640,000 people. Further, suppose that the governor's proposal would direct about $1 billion now devoted to financing hospital uncompensated care and other things to subsidizing private insurance coverage for those 640,000 people. Suppose also that the governor's plan would raise other spending on uninsured people by another $500 million, as described shortly. That would mean spending $1.5 billion on uninsured people. Then, add an additional $500 million to reflect persisting out-of-pocket and other spending on the 640,000 people now uninsured.

Total spending on the 640,000 people would then be $2 billion, or an average of $3,100 per person. By contrast, $51.2 billion would remain to be spent on the remaining 5,760,000 people of the Commonwealth, for an average of $8,900 per person. [80]

Per person spending on people already insured would therefore be fully 2.9 times as much as per person spending on people newly insured under the governor's proposal. This manifests the skimpy coverage that the governor's proposal would finance for today's uninsured people. This remains true, we believe, even after adjusting for the demographic differences between today's uninsured and insured people. Many people now uninsured are relatively young and healthy, but many others are suffer chronic illness or other correlates of low incomes and low living standards. And relatively few uninsured people are children, whose average health costs are typically low. Many people now insured are older or disabled, but many enjoy good health associated with higher incomes and better living standards.

But under the governor's proposal, in practice, many patients would remain uninsured, either because they could not afford even the skimpy mandated insurance policies, or considered those policies to offer little value for money. State government is unlikely to be able to enforce compliance. Consider that

today, even in states with compulsory auto insurance, it is said that roughly one car in seven is not insured. [81]

Also, as discussed later, many more people would become under-insured if this proposal were adopted. If uninsured or under-insured people continued to obtain needed care at hospitals, the cost of that care would have to be met—either by replenishing the uncompensated care pool with tax dollars, by higher charges on insured hospital patients, or by depleting hospitals' reserves.

Even though the governor's plan proposed to cease reimbursing hospitals and health centers for providing free care, such uncompensated care would almost certainly continue to be provided, at substantial cost. This persisting expenditure must therefore be taken into account. The governor's plan did not do so. In that sense, it was spending the same dollars twice—once to subsidize policies bought under the individual mandate and again to cover residual costs of hospital and health center uncompensated care.

We estimate that, under the governor's plan, the added spending for premiums under the individual mandate, for increased out-of-pocket costs associated with greater use of health services, and for persisting hospital uncompensated care would have been about $500 million annually—a rise of about 1 percent over today's $52 billion in statewide health care spending.

Second, consider the financial adequacy of the proposal by former Massachusetts Secretary of Human Services Ronald Preston. Preston had asserted in May of 2004 that insurance coverage could not be expanded without new money. Bailey reports that Preston proposed imposing a tax on employers of $1,800 yearly for each full-time employee who was not insured. That was expected to raise some $950 million statewide annually. [82]

(This number is somewhat troubling, as it implies there are some 528,000 uninsured full-time employees in Massachusetts. It is likely that the Preston plan's $950 million in statewide spending did not rely exclusively on the proposed new employer tax. If the Preston plan would indeed have raised $950 in new revenue to finance insurance coverage, it might possibly have devoted slightly more money to improving coverage than does the House-passed bill. But that is, actually far from certain. The House bill also greatly expands Medicaid coverage, something the state administration has largely avoided.)

The governor's proposal simply omits the $950 million in new revenue that his own secretary of Health and Human Services considered essential.

Further, there is some question about whether even Preston's proposal would have been adequate. The play-or-pay provision of the McGovern-Dukakis

universal health care law of 1988 would have initially, in the early 1990s, required employers to pay $1,680 for each uninsured worker.

Thus, the Preston plan signals only a 7 percent increase in employer payments over about a decade and a half. During this period, annual health care spending in Massachusetts nearly tripled, we have calculated. Even after adding in the dollars that the governor proposed to shift from hospital uncompensated care and similar uses to subsidizing new individually-bought insurance, the sums available would not have been adequate to finance solid coverage for today's uninsured residents. Preston was banking on $230 per month policies for individuals. [83] This does not suffice to buy reasonably solid coverage in Massachusetts.

Without the Preston plan's added $950 million, either benefits must become even flimsier or individuals must cough up more money for higher premiums.

One reason why individual mandates are such a bad bargain is that, as noted shortly, individual health insurance policies typically devote much smaller shares of the premium to paying for actual health care, and much higher shares to marketing, advertising, administration, and profit.

Further, imposing a head tax of $1,800 yearly on each full-time employee is obviously a tax on full-time jobs. That would intensify our health insurance system's existing pressures on employers to substitute part-timers for full-timers. The House bill's proposal for a 5 or 7 percent tax on total payroll does not punish full-time employment.

* * *

Improvement in coverage—the number of additional people covered and the strength of that coverage—would be in rough proportion to the added spending. There's no free lunch. Not, that is, without squeezing out and better using health spending that now is wasted, and none of these plans try seriously to do that.

Further, the House bill is a strong half-measure and governor's proposal is a weak half-measure. By half measures, we mean that they raise Massachusetts health care spending still higher to insure more people but don't offer good, solid coverage. They don't dare increase spending by the sums that that would be required in today's system, and—for all the political reasons described elsewhere— they have been unable to consider the only alternative—thorough-going reforms that cut and recycle waste.

B. *Titanicide*

Both the House bill and the governor's proposal would force more people to buy private health insurance. The governor, as described earlier, would mandate that individuals buy insurance, and the House bill would combine an employer mandate with a softer individual mandate.

Their implicit aim seems to be health insurance for all, not health care for all. These are far from the same thing. Coverage on paper may well be too flimsy to permit people to get the care that they need.

We call it *Titanicide* to force more people to purchase private health insurance because doing so forces people to embark on a ship that will sink before many years have passed.

Private health insurance has been eroding steadily. In the four years between 1999/2000 and 2003/2004 alone, the share of Massachusetts workers receiving health insurance through the job shrank by about one-tenth, falling from 62.5 percent to 56.9 percent.[84] Massachusetts tied for the third-greatest rate of loss of job-based coverage in the nation.

John McDonough notes this deterioration, but then urges support for an employer mandate to buttress coverage through the job. [85] Abelson reports on widely-voiced sentiments that insurance through the job is the only contender for financing health insurance coverage in the U.S. [86] But this is a statement of desperation or of distaste for the alternatives—not a ringing endorsement.

Advocates of compulsory purchase of private insurance—through employer mandates or individual mandates—suppose that private purchase of health insurance is essentially sound, that it covers most people, and that more people need to be obliged to use it to cover themselves.

We disagree. Private health insurance is not essentially sound. There are reasons why it covers some people and not others. There are reasons why it is unwise to oblige more people to use it to cover themselves.

Private insurance *through the job* is not essentially sound. It is an undesirable and increasingly unattractive method of raising money to finance health care.

There are reasons why private health insurance coverage is melting down.

- ✓ It is a tax on jobs, especially on full-time jobs. It therefore penalizes job creation. To avoid paying for health care benefits, employers increasingly use part-timers, and consultants or independent contractors.
- ✓ It is regressive. Because premiums are a fixed dollar sum, they take a bigger share of the income of a low-income person. The higher premiums rise, the

harder low-income employees are hit. In the face of rising premium costs, employers boost employees' shares of the premium, as well as their out-of-pocket costs. Out-of-pocket costs are typically regressive also, because they fall most heavily on sick people, who tend to suffer lower incomes, other things equal.

- ✓ Smaller businesses with low average wages or profit margins are hit particularly hard.
- ✓ Most important of all, health costs—and therefore insurance premiums—have been rising far faster than businesses' wages or total revenues. Whether job-based or individually mandated, private insurance lacks effective cost controls and is spectacularly ill-equipped to squeeze out any of the four major types of health care waste—clinical, paperwork, excess prices, or fraud/theft.

  As a result, premium costs are soaring. Health insurance premium costs in the Boston metropolitan area are expected to rise by 93 percent from 2000 to 2006, leaving them almost $9,000 per employee. This is the highest of 14 large metropolitan areas in a recent survey. [87] Rising premium costs are the main predictor of loss of insurance coverage. [88]

  As health costs continue to rise faster than government revenue, the resulting rise in premiums will make it hard for the public to sustain any promised subsidies designed to encourage purchase of private health insurance.

<u>Private-sector financing of health insurance through the job covers fewer people than is generally thought, and there are reasons why it does not cover some people.</u>

First, it seems likely that traditional measures of private employers' financing of health insurance through the job substantially overstate their role in financing coverage. Carrasquillo and colleagues estimated that, even in 1996, only 43 percent of Americans "depended principally on health insurance paid for by private-sector employers." They find that the share of Americans covered through government insurance, 34 percent, is substantially greater than usually estimated. [89] This higher figure of 34 percent includes publicly-financed insurance provided to local, state, and federal employees.

Second, clear characteristics distinguish employers that offer insurance from those that don't, and employees who accept insurance from those who don't. Smaller employers, doing business in more competitive lines of work, and often with lower profit margins, are less likely to offer health insurance. Lower rates of offering insurance are also particularly common in labor-intensive and low-wage industries, where more employees must be covered per million dollars of revenue. In these industries, therefore, paying for insurance amounts to a bigger share of the employee's annual income—and therefore a bigger percentage add-on to the employer's cost of doing business. We've never met an owner of a

small business who refused to provide health insurance as a matter of principle, but we have met many who could not afford to provide it. Further, employees with lower incomes are typically less able to afford their shares of the premium, and are more likely to decline coverage when it is offered.

Stapling more dollars to more collars (or pouring water on the *Titanic).*

It is unwise to oblige more people to buy private insurance to protect themselves against the cost of health care. Buying more insurance policies means spending more money. The last thing that Massachusetts health care needs is higher spending. Were Massachusetts health care on fire, more money might be poured on like water, to put the fire out. But our health care is not on fire. Rather, like the *Titanic,* Massachusetts health care is leaking badly. Pouring in more money will make it founder faster.

Continued reliance on private health insurance, without saving money by squeezing out waste, is evolving toward atomization and de-insurance (or flimsification), as discussed in the next two sections.

Viewed in this way, continued reliance on traditional private health insurance—even with public subsidies—has the effect of protecting waste in health care—at the expense of both patients and payers.

Possibly, employer mandates may work as a stopgap to slow the erosion of coverage through the job for a while. But even if the employer mandate is effective in the short term, we worry that it is too weak to counter the forces that have been steadily undermining health insurance coverage through the job.

(The Massachusetts Taxpayers Foundation decries the employer mandate as failing to reverse the decline in the number of small employers offering insurance and failing to give non-insuring employers a financial incentive to provide coverage. But neither does the stance of the MTF when it "strongly recommends that the state adopt an individual mandate." [90] The Massachusetts Taxpayers Foundation also proposes greater public sector subsidies—tax expenditures—and flimsier coverage, which it euphemistically calls "flexible" insurance products and "a broader range of benefit packages." [91])

Some approaches rely on a carrot to persuade citizens of the Commonwealth to board the *Titanic;* others rely on a stick.

Carrots. The main carrot offered in current proposals is to subsidize insurance purchase. Financing sources include Tobacco Settlement funds, dollars raised by assessments on employers who haven't been insuring their workers, and

funds shifted from the state's Uncompensated Care pool. The problem here is that health insurance costs are going to rise much faster than the revenue from any of these sources. The subsidies will therefore become less and less adequate over time.

Three things will then happen, either alone or in some combination. Money to boost the subsidies might be found—but where? Insurance premiums might rise—but who will be able to afford them? Or the insurance coverage might become increasingly flimsy by cutting benefits or raising out-of-pocket costs.

In the near term, the House tries to limit needed subsidies by restricting which uninsured residents are eligible. Individuals could not get subsidized coverage if *eligible* in the past six months for insurance to which their employer (or a family member's employer) contributes at least 33 percent of individual premiums, or 20 percent of family premiums. [92] This remarkably low standard would deny help to residents whose employers offer only token contributions. (In contrast, in a major 2005 survey of employers providing health insurance, even in firms under 200 workers, employer payments of at least 50 percent—often far more—were the norm. So requirements to pay over half of the premium hit only six percent of workers in individual plans, and 23 percent with family coverage. [93]) This limit would, for some residents, turn the subsidy carrot into a stick, intensifying pressure to join employer plans. And the low standard sets a worrisome precedent for the state agency that would decide what constitutes "affordable" coverage that people could be required to buy.

Sticks. The main stick is the threat to financially punish people who don't buy insurance. Methods include withholding income tax refunds and denying drivers' license renewals to enforce the individual mandate. (Unspecified penalties would also enforce the employer play-or-pay mandate.)

As insurance costs go up, the governor and others who propose requiring purchase of private insurance will need bigger sticks. Or bigger subsidies. [94] Or flimsier and flimsier policies. There's no other choice—except actually reforming health care by cutting waste and recycling the savings.

Other nations do things differently. They make health care affordable for everyone in three ways.

- They keep costs down by putting health care on an explicit or implicit budget. Doctors give care with an eye toward how much money is available to pay for it. Also, they avoid wasting money on administering payment through thousands of different insurance plans. They negotiate prices with drug makers and caregivers.
- Second, at the same time, they cover everyone—typically with very low out-of-pocket costs. Spending constraints are then less likely to hurt people who are vulnerable to denial of needed care.

- Third, they ask everyone to pay in fair proportion to their ability to pay.

Making payments fair and proportionate means greater reliance on taxes. The payroll tax in the House bill's employer play-or-pay mandate is an important step for fairness and affordability of health coverage. For low-wage workers and low-margin employers, a 5 percent or 7 percent flat payroll tax is far less burdensome than today's regressive health insurance premiums.

Still, other measures could increase its fairness. While nominally paid by employers, this payroll tax will squeeze the pay of workers who struggle to afford food and shelter. [95] The amended House plan exempts high earnings from the tax—yet we've heard no discussion of exempting the first several thousand dollars of each worker's pay (as the Massachusetts income tax does). That would substantially ease the new tax's burden on people who live on little in this high-cost state.

Especially in light of the extreme income inequality in Massachusetts, discussed earlier, it would be still fairer to rely more on income taxes to finance care. (A *Boston Globe* editorial, for example, asserted that "a half-point increase in the income tax would generate enough money" to cover the uninsured. [96]) The valuable proposals to expand Medicaid eligibility do recognize that good, substantial private insurance coverage will never be affordable for low income people, and that broad-based tax-financing is essential for equity.

Traditional private insurance premiums are very regressive. They are generally flat dollar amounts, the same for everyone in a given group (say $12,000 per year currently for good family coverage through a Boston-area employer in 2005). Premiums therefore take a bigger percentage bite out of the income of a low income person than of a high income person. [97]

Even though the House bill and the governor's proposal increase spending, they don't increase it by enough to finance solid, traditional health insurance for newly-covered people. That's partly because good health insurance is becoming unaffordable for more and more people in Massachusetts, and partly because both plans fail to squeeze out waste.

Because health care costs are rising faster than likely subsidies, relying on private health insurance to cover previously uninsured residents of the Commonwealth condemns these residents to increasingly flimsy coverage. This might evolve into fig leaf coverage. We call this process nakedizing, and discuss it shortly.

C. Atomization

Individual mandates to purchase private insurance pose serious additional dangers.

If the individual mandate is so bad, why is it being discussed at all? One of the main reasons is that it might be a politically feasible way to raise more money. That's because uninsured people are not yet well-organized to oppose the mandate. They are unlikely to be able to afford to take out costly ads on the op-ed page of the *Boston Globe* to bemoan their inability to pay for health insurance.

But what is politically feasible is not always good health policy. Moreover, imposing a costly mandate on people who may not be able to afford it may engender a political backlash once the impact of the mandate makes itself felt on dozens or hundreds of thousands of people. And promising universal coverage but delivering only skimpy benefits could also lead to public alienation and anger.

Both the governor and the House propose to require every Massachusetts resident who is not otherwise covered to buy health insurance in the private market. The governor's individual mandate [98] would be more sweeping, stringent and punitive. The House uses the individual mandate simply to fill gaps left by its employer mandate and public program expansions, and acknowledges a need for some exemptions if the market does not offer affordable policies.

But in either case, such a mandate to buy private insurance forces individuals to try to protect themselves against unpredictable health care costs, and to contain those costs. The mandate is no substitute for social or public responsibility.

Recognizing that everyone needs coverage is progress. But relying on individual mandates and limited commercial insurance to make coverage affordable means avoiding proven solutions and, instead, promoting a risky policy with no record of success anywhere in the U.S. or the world. Single payer is often criticized as risky or unproven, but it is a paragon when compared to atomization.

These are many of the main risks or problems of individual mandates to buy private health insurance:

- An individual mandate cannot use the state's legislative, budgeting, purchasing, and organizational powers to plan, buy care, and protect people.
- An individual mandate ignores government's responsibility to control costs. It shifts that burden to individuals who need care—but who lack a medical education to know what care is vital. This mandate throws financially-struggling individuals into battle with insurance agents, insurors, and caregivers.

It makes patients kamikaze pilots in the cost control war. Citizens can't individually institute payment methods or other changes needed to cut cost in trustworthy ways. Individuals lack even the modest leverage that employers have today to negotiate a good deal—and have far less leverage than the state would as a whole.

- Individual mandates to buy private health insurance mean further fragmentation of the insurance market. Promoting individual purchase of insurance rather than common coverage for all (or even current insurance through the job) magnifies the threat of experience rating—forcing older or sicker people to pay much more.
- The early experience with Medicare Part D is not encouraging. A law requiring people to choose and buy private health insurance, could—even if a state agency helps coordinate information on plans—create distress and confusion many times greater than what we see now as Medicare enrollees struggle to weigh many differing privately-offered insurance policies for drugs alone.
- The individual mandate exemplifies growing failure to recognize that private markets and individual responsibility can't handle some problems. Is it a precursor to requiring us each to buy our own fire-hose, hydrant, and ladder?
- By permitting and encouraging skimpier insurance policies (with fewer required benefits and higher payments for sick people), the planned individual mandates reduce safeguards in the individual market, which historically offered bad deals. Rather than protecting the public, the individual mandate will force many people to purchase an inadequate—indeed, defective—product, a car missing essentials like wheels, lights, ignition, and brakes, under the guise of "basic" transportation.
- The governor's proposal is particularly moralistic and punitive, claiming that many people could afford to buy health insurance but choose not to do so. But the latest evidence suggests that the great majority of people who are offered health insurance buy it—when they can afford it. [99] In a similar vein, Cutler has found that employees' inability to afford insurance—not recklessness or indifference—is the main reason they decline to buy it. [100]
- As asserted earlier, notwithstanding the governor's claims that spending would not rise, an individual mandate requires new private spending for premiums.
- Individual mandates to buy insurance are especially regressive. They impose flat premiums for each cluster of people grouped by age, tobacco use, industry, and other predictors of health status and health spending. The people most likely to be hit by the mandate are low-income people working part-time, or for the smallest employers, or out of the job market. Given this state's income inequality, individual mandates would be particularly burdensome here. Mandates' cost would fall most heavily on older and sicker people.

- Even with the House employer play-or-pay plan, mandating individual insurance will legitimize employers' decisions to drop coverage entirely. The governor claims employers can't stop covering their workers because they must compete for workers. But soaring premiums outweigh such concerns for more and more employers. As a result, more and more jobs lack benefits. Examples include the rising use of part-timers, free-lancers, and long-term "consultants" doing state government work—even for health care agencies.

- The requirement for people to buy insurance, originally proposed by Blue Cross, is a giveaway to the insurance industry. The current bills set no minimum standard for the share of insurance premiums that must go to care. The mandate is also an invitation to bait and switch. What stops insurors from promising low premiums now, but boosting future prices sharply, forcing the state to expand its subsidies so lower-income citizens can still buy coverage?

- Talk of offering affordable $200 monthly individual premiums is just that—talk. Insurers will be permitted to charge more for those in different age groups, industries, regions of the state, and other categories, such as tobacco use. Would unsubsidized premiums really be affordable for a family with parents in their 50s, in a high-risk industry in costly Boston? Especially with predictors of a costly chronic illness added to the mix?

- Mandates to buy insurance individually may well result in a death spiral that undermines the newly available plans. When choosing among the new lower-priced insurance plans, people who suffer more health problems will tend to seek the ones with the most substantial benefits, while healthier people cluster in plans with lower premiums. But plans with better benefits will be hurt financially if they attract sicker members, so insurance companies in later years will tend to cut benefits, raise prices faster—or close those plans. Insurers eager to boost profits may try (subtly or not) to deter sicker people from enrolling, through de-marketing, restrictive benefits, and poor service.

- This plan increases waste on administering a fragmented system. It takes the money now collected in the uncompensated care pool and diverts it through insurance industry middle-men. This reduces the share available to pay for actual care. Instead of streamlining administration, as real reforms could, this would increase the bureaucracy of marketing and selling to more individuals. It also would entail needlessly complex layers of certification of coverage (as a worker covered through his spouse's employer, for example, would have to certify that both to his own employer and to the state on his tax form). And high marketing costs are likely, even with the proposed Insurance Exchange/Connector. In the individual market, competition historically has encouraged some highly inefficient practices. The Medicare Part D prescription drug program exemplifies

this. [101] So does the Medicare HMO program. Some HMOs spent over $1000 to recruit each senior. [102] (The potential added waste of an individual mandate is estimated shortly.)

- As a result, compared with what is commonly found in group insurance, mandating individual coverage will be likely to mean that a substantially lower share of the premium dollar is devoted to actually paying for health care. (This is the medical loss ratio or care share.) That's a bad deal for patients, caregivers, and payers—including the taxpayers, who would subsidize those purchases. Individual insurance policies tend to have visibly lower care shares than group insurance through the employer—since individual policies have higher administrative and marketing costs. That has long been recognized in federal policy, for example, which has required Medigap insurance to have minimum care shares of just 60 percent, and then more recently 65 percent, for individually-purchased plans. [103]

- State data for 2002-2004 indicate that, each year, a number of smaller insurers that target the individual and small group markets in Massachusetts had care shares under 75 percent, with some well under 50 percent. In contrast, Blue Cross and Blue Shield here had overall annual care shares of 84-86 percent and the other three major health insurers in this state, whose business is largely group plans, reportedly devoted 88-91 percent of revenues yearly to actual care. [104] (These four insurers' higher care shares also reflect that, as non-profits, they are not diverting resources to reward shareholders.) Further, unlike group policies, which tend to offer fairly similar benefits, [105] individual policies are often crafted with limited benefits to deter patients with costly illnesses from enrolling.

- If non-group (individual) plans average 65 percent care shares, the added non-care costs (administration, marketing, and profit) of mandates to buy individual health insurance policies could well equal $250 million for each $1 billion in added spending, an unconscionable waste. Compared with more efficient arrangements, one-quarter of added spending would be unavailable for care, or costs would be much higher than needed. The evidence here and nationally suggests that 90 percent care shares are easily attainable by large group insurers, and should be required (except for new insurers facing start-up costs). Indeed, with reforms to simplify and streamline financial administration along single-payer lines, care shares could feasibly reach 95 percent—with additional huge sums freed up for actual care because hospitals, doctors, and other caregivers would need to use far less of their revenues for financial administration

- Consider this statewide: We estimate that private health insurance financed some $18.5 billion in health care costs in Massachusetts in 2005. Every 5 percent drop in the care share means a diversion of an additional

$925 million from health care to administration, marketing, advertising, or profit, we calculate. [106]

- Contrary to some claims, forcing people to buy a commercial product to insure their cars and to insure against medical costs are not the same. Owning a car is a choice, existing and needing medical care are not. And, as mentioned earlier, about one Massachusetts resident in seven does not insure their car, despite compulsion.
- Massachusetts is already losing young workers to other states. This is mainly owing to lack of jobs and affordable housing. But, as the cost rises for flimsy mandated insurance policies that provide poor protection, this problem may grow. Or some Massachusetts residents may simply pretend to live in other states, just as some do now to avoid the high cost of mandated auto insurance.

D. Nakedizing

The governor and others promote use of lower-premium insurance—but they would achieve lower premiums by leaving patients only skimpily covered, not by genuinely cutting waste. For example, the MTF asserts that "all of the proposals now under consideration contain plans for new, low-premium health insurance products, possibly at half the price of current coverage." [107]

In today's market, without reform, you get less when you pay less. That means under-insurance—and thus illusory, paper coverage. Requiring "basic" coverage means inadequate coverage that will leave people to pay for much care on their own. Many people who become nominally insured would face such narrow benefit packages and such high out-of-pocket payment requirements that they still could not afford to use the care they need.

When people do use needed care, bankruptcy often results. Himmelstein and colleagues have found that about one-half of people filing for bankruptcy cited medical causes. [108] And fully three-fourths of people who were bankrupted by illness had health insurance. Making health insurance even flimsier, other things equal, will mean more bankruptcies. O'Brien has highlighted the importance of allowing people who are sick to fight their illness, and not have to worry about paying the bills. [109]

Proposed arrangements for flimsy coverage are precarious at the outset, even before they are undermined by the need for rising subsidies for the new insurance. Starkly, subsidized under-insurance and cost-shifts to patients don't durably solve the problems of uninsured people.

Private health insurance has been getting flimsier each year. Under-insurance takes two forms. One is the combination of a catastrophic insurance plan with a health savings account. Patients essentially spend their own money until the catastrophic policy kicks in. The other is the mini-med policy, inexpensive insurance with low caps on payments for hospital care and other costly services. [110]

Employees and their families pay bigger shares of the private health insurance premium. Yet, increasingly, they are under-insured, paying higher deductibles, co-payments, and co-insurance. There are several reasons for growing under-insurance. One is that health costs remain out of control.

Another is that some public officials, such as the president and governor, applaud flimsier insurance because, they claim, it will make sick patients into sharper consumers.

However, as the U.S. Comptroller General's forum on unsustainable health care cost trends concluded, even if one were to believe that, in the future, "linking consumer cost incentives to physician performance would be the most effective strategy" for containing costs, that is not yet feasible. Numerous kinds of essential data and measurement tools do not exist. [111] More starkly, as Berwick has said:

> I do not believe that making the individual American patient more "cost-sensitive" has any rationale in science, ethics, or evidence. It will fail, and it will fail miserably. It will result in a shifting of care away from the people who need it the most. It is a displacement of responsibility for changing the system. You know, if CalPERS or Xerox or GE can't change care through using its purchasing power, then I absolutely promise you that Mrs. Jones can't. The idea that she will now be more sensitive because she pays an extra ten bucks out of pocket is, to me, nearly stupid.[112]

When the president and governor applaud flimsier coverage that leaves patients increasingly naked financially, these politicians apparently act from either cynicism or ideology. Cynically, they may be aware that they don't know how to contain cost, and they therefore endorse flimsier coverage because they can't risk appearing to do nothing.

Ideologically, they may simply believe that health care will work better if it can somehow be forced to fit the assumptions of a freely competitive market. Perhaps they imagine that markets always work—even though health care's stark inability to satisfy any of the requirements of a genuine free market has long been evident to most of the world.

Whether stemming from cynicism or ideology, declaring a preference for flimsy coverage manifests ignorance of health care realities—and radical disregard

for the well-being of patients, especially those (as Berwick noted) most in need of care.

Requiring higher patient payments cannot control costs because it aims at the wrong target. [113] Successful cost controls must recognize that the sickest people account for the vast majority of health spending—69 percent of health costs in 1996 were for 10 percent of non-institutionalized Americans. [114] Health costs for seriously ill people largely reflect doctors' complex treatment decisions, and may be little affected by deductibles, co-payments and co-insurance.

Both the House and Senate bills, along with the governor's proposal, risk accelerating the decline in value of private and public health insurance coverage. To hold down the cost of insuring more people, all three plans promote the use of insurance with more limited benefits, combined with higher deductibles, co-insurance, and co-payments. The House bill, for example, allows insurers to offer young adults a new type of policy that covers preventive and catastrophic care well, but has high deductibles for care of those who get sick. [115]

The impact of promoting flimsy policies to cover uninsured patients isn't limited to people who are uninsured today.

- First, it will affect existing private coverage. If the legislature passes a new law that expands coverage at the price of flimsier benefits and higher out-of-pocket costs to patients and families, this will embolden more and more private employers to do the same— even faster than they already have been. Although employers may feel that they need to keep offering some insurance to attract workers, a new state law that ***legitimizes*** skimpy insurance will set a new and lower standard for insurance. This will encourage employers to trim their costs in similar fashion, reducing benefits and requiring higher patient payments. The state will thereby help to accelerate the shredding of today's private insurance coverage.

  We have suggested that some employers will find it less costly to pay the payroll tax than to continue to provide insurance coverage.[116] Against this, McDonough asserts that firms dropping coverage would be disadvantaged in competition for good workers.[117] While we'd like to hope McDonough is right, we worry that public action that legitimizes skimpier coverage will gradually lead more employers to settle for skimpier coverage for their workers. As more employers do this, fewer would be at a competitive disadvantage.

- Second, promoting flimsy private coverage will affect existing public coverage. As the adequacy of private coverage diminishes, pressure to reduce Medicaid and other state-funded benefits is likely to grow. Early in 2006, Congress is likely to approve provisions to allow states to force some Medicaid patients to pay higher out-of-pocket costs and also premiums.

Some observers argue that public programs should not provide substantially greater coverage than private plans (even though public programs cover many more people with serious disabilities who need specialized services, and many more poor people unable to afford any out-of-pocket payment for the cost of their care).

Also, as benefits erode under private insurance and under Medicaid, employees and retirees of local governments in Massachusetts are likely to face greater threats to their health insurance coverage.

The legislation now being considered thus would promote under-insurance not only for today's uninsured, but also among people who today have either private or public coverage. This sequence—accelerating the spread of under-insurance—poses great risks to patients, who may be forced either to forgo needed care owing to inability to pay, or to obtain care and face bankruptcy.

- Third, it affects caregivers. It poses serious financial risks to hospitals, doctors, and other caregivers, who will see a drop in insurance coverage for services to currently insured patients and a rise in bad debts (as patients find themselves unable to pay their new out-of-pocket obligations to caregivers).

Adopting flimsy benefit packages obviously hurts older, sicker patients the most. Because people in poorer health tend to have lower incomes, it also would be profoundly regressive. Requiring high out-of-pocket payments would compound the regressive burdens of the premiums imposed by an individual mandate.

Nakedizing patients by flimsifying their health insurance coverage is a process that the House bill and the governor's proposal would accelerate (though at different rates, as noted earlier) for at least nine reasons:

- These proposals do nothing to slow the rapid rise in health insurance premiums.
- They increase spending, but not sufficiently to finance solid insurance coverage for the additional people they'd propose to protect.
- That's partly because many people who are uninsured today have accumulated unmet health needs that will be costly to treat.
- Even flimsy policies would be costly in Massachusetts, so lower-income people would require expensive public subsidies before they could buy those policies.
- Worse, as discussed earlier, these public subsidies are not affordable for the long haul. That's because health care costs in our state—and therefore the cost of health insurance—are rising much faster than the public revenue available to subsidize the new insurance coverage.

- Even higher subsidies will be needed in the future to prevent the coverage for newly-insured people from growing still flimsier over time.
- With premiums rising, more and more middle income people, as E.J. Dionne recently noted, will require public subsidies to be able to continue afford health insurance. [118]
- With any downturn in the economy and state revenues, the proposals' lack of tools for genuine control of health costs will mean sharp cuts in insurance subsidies, and therefore still flimsier private and public coverage.
- And, as discussed above, legitimizing flimsier coverage will mean erosion of benefits and access to care even for today's insured.

Because the House bill would spend more, it would offer more substantial coverage than would the governor's plan. Also, the House bill retains safety net financing for uncompensated care that hospitals and health centers will inevitably have to continue to provide in the years ahead.

If the Commonwealth opts for gradual nakedizing—for skimpier coverage and higher patient out-of-pocket payments—patients will face greater barriers to needed care, caregivers will suffer growing bad debt problems, and public officials will need to revisit the coverage and cost questions with which the current debate began.

Despite passage of legislation in 2006 to expand insurance coverage, the search to ensure durable and affordable coverage for all people in our state would continue.

The only way to cover everyone affordably, and to secure the survival of needed caregivers, is to squeeze out waste and reallocate today's vast spending to cover us all.

That will require strong state government action to create a framework, slash administrative waste with simpler financing, cut prices, establish equitable coverage and ways of raising the money, and—most important—engage caregivers in the work of using already ample resources wisely to provide needed care to all.

As we wrote in 1989:

> Real cost control … requires changes that entail close cooperation of physicians, hospital by hospital, since physicians make the decisions that encumber the clinical resources—and therefore the bulk of the money that hospitals spend. And physicians have not been involved in the design or implementation of the law's access and hospital finance provisions. Methods of providing and paying for hospital and physician care must be coordinated.[119]

IV. CONCLUSION: LOOKING FORWARD

As we have noted, almost everyone favors expanding health insurance coverage in Massachusetts, but few want to pay more—and few want to tackle the real causes of the state's high costs.

The job of covering everyone has become more difficult since it was last attempted in 1987. That's because health care's share of the state's economy has risen by 38 percent since 1987, while the share of people in Massachusetts who lack health insurance has risen by 78 percent.

Higher health costs have made it harder for employers and employees to afford health insurance. The effort to insure the people of Massachusetts by subsidizing or mandating purchase of private insurance is therefore an uphill fight.

Also, as in 1987, Massachusetts has the costliest health care in the world. Together, these factors make it very expensive to cover everyone with good health insurance benefits.

- One alternative is to offer cheaper benefits, flimsier coverage.

- A second alternative is to spend considerably more money on health care, through a combination of Medicaid expansions, employer mandates, individual mandates, and other methods.

- The third alternative is to finance improved coverage by squeezing out waste from today's health care spending. Today, that is off the table politically. Tomorrow, it will be inevitable if we hope to protect health insurance coverage and the caregivers who provide health services.

A. Why is cutting cost by recycling waste off the political table?

There are at least ten reasons why debate hasn't yet focused on this vital strategy of recycling waste to finance expanded coverage:

- First, there is not yet any agreement that cutting cost by squeezing out waste is necessary to improve coverage.
- Second, some still believe that higher spending is necessary to finance new technology and to care for the growing numbers of older people.
- Third, some doubt cost control's feasibility. Given the failure of past competitive and regulatory attempts to contain cost, pessimism is common today. One economist involved in developing current legislation even says "'we have no clue how to lower health care costs.'" [120]

- Fourth, no method of containing cost enjoys good political currency. Single payer reforms promise to contain health costs by cutting administrative waste, and in other ways. But these reforms make many parties nervous. Further, much work remains to design and test improved ways to squeeze out waste and recycle it.
- Fifth, free market ideologues urge that patients be forced to pay more of their own health costs, in hope of driving down costs. This foolish idea wastes vital time by crowding out consideration of approaches that might actually both work and protect people.
- Sixth, cost-cutting is fiercely resisted by those in health care who fear losing revenue. (That's one reason to explore reforms that recycle savings to finance expanded access to care without higher cost—or revenue loss.[121])
- Seventh, cost control introduces even more complexity into political debates, which can delay pursuit of the seemingly simple objective of improving coverage. Political leaders, health care advocates, caregivers, employers, and other stakeholders have not yet developed the concepts or the tools to address this complexity.
- Eighth, there is today no broad or vigorous constituency for true health care cost control. Payers often find it easiest to lower their own costs by shifting more of the burden to patients or others. Advocates of better funding for education, housing, job training, environment, nutrition programs or other pressing needs rarely argue that restraining medical expenses could free up funds for other things they care about.
- Ninth, cost-cutting is not a goal pursued with emotion, like covering us all. Nor is cost control a moral or ethical subject, yet. [122] Wasted money is not available to caregivers to meet patients' needs, and waste raises insurance costs, forcing cuts in coverage—but it is not yet widely recognized that waste kills.
- Tenth, it is not yet recognized that <u>waste is the greatest enemy of affordable health care for all</u>. But tomorrow, cutting waste will be central to fulfilling any hopes to expand health insurance coverage—such as those embodied in the House bill—and to protect the caregivers who provide health services.

<u>To conclude, we do not criticize the seriousness, intelligence, or good intentions of the House bill's supporters. Rather, we are somewhat worried about the current adequacy of coverage under the House bill, and greatly worried about its financial feasibility in the years ahead</u>.

These worries are not likely to be considered during the present debate. That's because they raise a number of complex issues, and these have not been discussed or debated adequately to-date.

If something like the House bill emerges from conference committee and if, as would then be likely, it is passed by both House and Senate by margins wide enough to survive gubernatorial veto, it will be time to look to next steps.

B. Affordable health care for all is achievable without higher spending

These next steps should include efforts to squeeze waste out of Massachusetts health care and recycle the savings to build a firm foundation under health coverage for everyone who lives here.

Massachusetts absolutely can achieve affordable and high-quality health care for all. Health care spending in Massachusetts is already high enough to both fully cover today's uninsured and provide comprehensive coverage for the millions of under-insured citizens of our state.

Doing this would require vigorous action to better use the money that's already being spent. Sensible measures include

- cutting prescription drug prices through direct public action, an approach that the current Senate bill takes some steps to address ; [123]
- capping the share of revenue that insurers can use for marketing, other administration, and profit, as opposed to care (as mentioned earlier, a 90 percent standard should be easily attainable for established non-profit plans [124]);
- for greater savings, simplifying financing (with global budgeting, a single payer, and more) to eliminate the need for vast amounts of today's paper-pushing that concerns payment, not care;
- further, adopting malpractice reforms, followed by elimination of unneeded care prompted by defensive medicine and fear of malpractice litigation;
- changing the ways caregivers are paid, to reduce their financial incentives to provide still more unneeded tests and treatment;
- developing much better information about clinical standards for diagnosing and treating patients; and
- putting that information into doctors' hands in usable form.

Moving toward consolidated financing will make it easier to cut drug prices and adopt many of the other measures just noted. But while single payer is a very useful foundation for reform, it is no cure-all. It would cut a great deal of administrative waste if enacted, and that would make it much easier to expand coverage without spending more money—yet most of the waste in health care would remain. [125]

By putting all health spending on one budget, single payer would promote cost-controls rather than cost shifts. Once consolidated financing is seen not as a cure-all but as one logical element in a sensible package of health care financing and delivery reforms, it will be much easier to enact.

Since these things are not likely to be done imminently, providing solid coverage today for people who are uninsured today would require higher spending. Higher spending will be opposed by those who are asked to pay more. One of three things might then happen.

- ✓ It may be possible to assemble a political coalition strong enough to extract more money from Massachusetts taxpayers, employers, and families to finance solid coverage for more people. But that will be very costly, especially if hospitals extract higher Medicaid rates as a price of their support.
- ✓ If it is not possible to extract much money, the legislature may be forced to settle for an employer mandate that is less expensive because it offers only flimsy coverage.
- ✓ Alternatively, if business opposition to an employer play-or-pay mandate is too strong, the legislature may drift toward enacting an individual mandate—especially if that's expected to arouse less political opposition. The costs of such a mandate are likely to fall disproportionately on lower-income or older workers, and on people in ill health. The individual mandate will also mean higher spending.

Today's politicians, insurers, and hospitals think that they are hard-headed and realistic as they negotiate improved insurance coverage in 2006. They are wrong. They are living in the transient world of more money for business as usual in health care. That dream world is defined and shaped by political considerations, not by health care necessities or economic realities.

Increases in health care spending will burden the state's economy—no matter whether those increases are paid by state taxes, employer contributions, or individual payments. State subsidies, employer contributions, and employee contributions will not be able to keep pace with rising health care costs. Gains in Medicaid coverage will be hard to sustain during the next state fiscal crisis.

Health care costs can be controlled. And they must be controlled if health care is to be made affordable for all who live, work, or do business in this state.

At least five things will have to happen before costs are controlled, though.

- First is general agreement that cost control is essential to winning durable medical security and to rebuilding the state's economic competitiveness.

- Second is greater confidence that cost control is possible without damaging quality or disrupting coverage.
- Third is a workable political deal for health care cost control and reform, one that addresses the core needs of patients, doctors, hospitals, other caregivers, payers, politicians, and voters.
- Fourth, that will require hospitals, physicians, insurers, and others to recognize that more money for business as usual is not attainable.
- And it will require sharper public identification of the concrete benefits of cost control—that it will make possible specific good things, such as assured coverage for all residents and financial security for all needed and efficient caregivers.

Cost controls can best be implemented when married to affordable, comprehensive coverage. Only then can patients and others expect cost-cutting to be borne equitably, without denying some citizens of the Commonwealth access to vital care. Durably affordable coverage can be won—when all caregivers, payers, and political groups sit down to negotiate a political, legal, financial, clinical, and ethical deal. They will need to make serious compromises—and serious changes.

Massachusetts will move to squeeze out excess costs, capture the savings and recycle them to cover all residents just as soon as that becomes the path of least political resistance—and just as soon as we design and negotiate clinically, financially, organizationally, politically, legally, and ethically trustworthy methods of containing cost. Political resistance to cutting costs will fall in the wake of the present debate—whether it results in enactment of costly access improvements or whether advocates are disappointed. All who seek health care for all should therefore vigorously support designing and negotiating trustworthy methods of containing cost.

C. One hand for yourself and one hand for the ship.

Exhibit 5 is a picture of the U.S.S. *Constitution,* which was launched in 1797 and is now moored in Charlestown.

Exhibit 5

Its mainmast is 220 feet (67 meters) high. To furl and unfurl the sails, sailors would climb rope ladders and edge out on the yards (horizontal timbers attached to the masts) and tie and untie knots. They did this in storms, when the ship was rolling and pitching wildly, in total darkness, and in rain or snow. Discipline helped sailors do this. So did professional pride and group cohesion. Perhaps most important, sailors knew that the ship could easily be destroyed during storms if the sails were not adjusted properly. Accordingly, the sailors' motto was "one hand for yourself and one hand for the ship."

Understandably, each stakeholder in health care fights for its own interests. Caregivers seek more money for business as usual. Each payer tries to pay less or to shift costs to another payer (especially, today, to patients). Advocates of improved financial coverage seek higher spending to advance their aim.

This strategy has worked reasonably well for most parties until now. It may work a little longer, but probably not much longer. ***Each stakeholder therefore needs to give much more serious thought to what is essential to its own long-term self-interest and to ways to reconcile that self-interest with the needs of other stakeholders—and with the state's need for affordable and high-quality health care for all who live here***. [126]

Appendix – Excerpts from the paper

Nine Lessons for National Health Reform from the Failure of the 1988 Massachusetts Universal Health Insurance Law

As in 1988, Massachusetts seeks to expand health coverage without controlling cost. The state would again force patients to embark on the sinking ship of job-based health insurance. The state would again use patchwork plans that rely on multiple private insurers. The state would again decline to try to capture any of the half of health spending now wasted on unneeded services, administration, high prices, and outright theft. Hospitals and insuring employers are again on board because of promised new money. So it's helpful to consider the lessons from the 1988 law's failure.
— Alan Sager and Deborah Socolar, ***www.healthreformprogram.org***

Excerpts

9 Lessons from the Failure of the 1988 Massachusetts Universal Health Insurance Law

Alan Sager, Ph.D., Deborah Socolar, M.P.H., Peter Hiam, J.B.
Access and Affordability Monitoring Project,
Boston University School of Public Health
Presented at the American Public Health Association, San Francisco,
26 October 1993

INTRODUCTION

The 1988 Massachusetts universal health care law called for all residents…to be offered health insurance coverage by 1 April 1992. This was to be accomplished through a combination of a mandate on employers with more than five full-time workers to either provide insurance or pay a new tax, and a residual state program…. Early in 1991, the…legislature voted to delay implementation of the employer mandate for three years. The legislature has never… finance[d] the state's obligation. [The employer mandate was later repealed without being implemented.]

It is widely believed…that…. deep recession, …fiscal crisis, and the election of a new … Republican governor hostile to the 1988 law together explain its non-implementation.

We conclude otherwise. The law failed because it did not even attempt to finance its coverage improvements with funds liberated by establishing effective cost controls. Its universal access problems could not have been kept because their design was unaffordable—to business, government, and citizens alike—in any conceivable economic and political circumstances.

Massachusetts—even more obviously than the nation as a whole—already spends enough to care for every resident. Yet the 1988 law's design made existing high spending levels a barrier to universal coverage, rather than an opportunity….

9 LESSONS

1. The 1988 Massachusetts universal health care law failed in part because it provided only promises of cost control, not guarantees.

Many European nations…guarantee health care cost control by setting advance limits on how much can be spent on care. The promises of cost control in the Massachusetts law rested on hospital closings and bed [cuts], inter-hospital competition, and managed care…. [O]ur hospital costs per capita remain 35 to 40% above the national average…. [T]he…law's cost controls were speculative at best. They have been counter-productive in several respects….

2. Garnering narrow majorities for the universal health care law in the Massachusetts legislature helped to produce a bill that could not be implemented in any conceivable economic or political climate

This activity resembles that of the person looking for his keys under a street lamp (even though he dropped them… dozens of yards away) because "the light is better here." Securing passage… required abandoning any effective controls on hospital or other health costs, giving hospitals a great deal of new money [fast], …capping private sector contributions to the hospital free care pool, having the main employer mandate take effect only after four years, and forgiving [the smallest employers]… any obligation to help finance the law….

The main political jobs of negotiating the shape of the new law were to satisfy hospitals and businesses already providing health insurance. The core provisions benefiting both took effect soon after the law was implemented; both then withdrew effective political support for the remaining provisions, particularly the employer mandate to pay or play.

The Clinton administration…. concluded that single payor financing is politically infeasible owing to public reluctance to convert $400 to $600 billion in existing insurance and out-of-pocket spending to taxes. The Clinton administration has concluded, therefore, that the only alternative is an employer insurance mandate to raise money, combined with managed competition to contain cost. Ignored entirely is the breadth of evidence from most …industrial democracies….

3. Health care for all requires real cost control, not new money, along with methods of redistributing existing spending

It is vital to link realistic cost controls directly to new programs to improve coverage… [T]he obligation to find money to help people is the best motive to save money. The…. law saw no necessity to employ a mechanism to capture any savings …and recycle them to improve financial protections for patients lacking coverage. …[T]he law required large and visible increases in total health care spending in order to protect previously uninsured residents…

4. It is vital to provide everyone-- or at least a very large number of people- with valuable and tangible benefits very soon after the reform law passes

The 1988 Massachusetts universal health care law was scheduled to provide very few benefits until it had been in effect for about 4 years. Only then would the main universal health insurance mandate take effect….Because so few people benefited… soon after

[its passage, the]… law never created a substantial constituency of people with something to lose from its repeal….

To win support for passage and implementation...., it might be useful to include something like a new outpatient prescription drug benefit that would take effect within 90 days…. The net cost… would be [low], since it would preclude covering…drugs through job-based insurance. [It] could be financed… through a modest new tax, one that bought concrete and visible gains…. [and by government] actions designed to hold down …drug costs for all…. These actions could include establishing…government as the sole buyer of prescription drugs… [or other] steps that other nations have employed successfully. Again, guarantees, not promises.

5. It is vital to avoid regressive financing, especially that originating in punitive and moralistic outlooks or misdiagnosed problems

[T]he Clintons' proposals for premium payments, deductibles, and co-payments….will cost many low-income people substantially more than they can afford. This regressive financing proposal [reflects a] mistaken belief that our health care costs are so high in large part because Americans seek too much health care. (The far bigger problem is that caregivers provide too much, especially to people with good financial coverage.) The proposal also [aims at]… making patients more cost-sensitive. Tragically, instead of relieving many poor people about worries over whether to pay for health care or to buy food, this *will* require them to forgo the food.

6. If the states are to function as laboratories of democracy under any national health care reform plan, it will be vital to secure accurate information on what is attempted, how well it works, and why.

7. A number of other lessons… arise from the interaction between the 1988 law and the state's health care delivery and finance.

[H]ealth maintenance organizations…have not yet succeeded in containing health costs. [This state] assumed first place in the share of its population enrolled in [HMOs]…. [C]ompetition … cannot be trusted to yield up an acceptable, accessible, and affordable configuration of hospitals, doctors, and other caregivers. Over one-third of acute care hospitals in the state have closed since 1970 [and half from 1960 to 2005], with no discernible reductions in cost.

8. ***The Massachusetts experience suggests that merely manipulating financial incentives is not an effective cost control technique.***

[F]inancial incentives usually and inevitably overshoot the mark--both the…incentives to over- serve embodied in fee-for-service and cost reimbursement, and …incentives to underserve embodied in reliance on competing HMOs to contain cost…. Far better…to design payment mechanisms that are financially neutral because they allot finite sums to serve defined populations, and… pay this money to organizations that can be trusted to spend it carefully.

9. It is not feasible to fill in the remaining gaps in insurance coverage by designing special, small targeted insurance programs.

Some have argued that since private insurance…cover[s most] of the population, the remaining task of government is to design, subsidize, and/or encourage insurance

coverage for the [rest]. …[T]here are reasons why private health insurance has failed to cover some people.

a. The Massachusetts experience with patchwork fill-in programs reinforces this concern. It has proven complicated, administratively costly, and often ineffective to rely on traditional insurance mechanisms to cover special populations….[The] patchwork of plans leaves more seams and lots of small gaps, each requiring a new patch, a new program, and new coordination. The result is greater administrative cost and complexity, and greater barriers [for] people in need….

b. [V]oluntary …programs for small businesses…proved unsuccessful … [as did an] initiative that permits stripped-down benefits for small business plans. Enrollment was excruciatingly slow… [T]his points to the futility of voluntary programs to achieve universal coverage….

c. The …law never attempted to eliminate the high administrative costs associated with insurance coverage and processing of individual claims. Indeed, insurors' interests in *gaining business* were catered to, in that most citizens…were to gain their new coverage through private insurors even when the financing was public. [A] danger in relying on private insurors is that high-risk people will be left uncovered or that government will have to pay excessively to get insurors to take that business….

6 SUGGESTIONS FOR STATE HEALTH REFORM

Face reality. Health care costs have got to be controlled, so they grow no faster than the economy.... [N]o nation has contained health costs without covering everyone …[or] covered everyone without containing costs…. [B]oth tasks require building trust among…payors, patients, and caregivers. Any state-level reform plan should probably address 6 key concerns:

I. A ceiling on total health spending, so health keeps its fair share of the state economy, but no more.

2. Financial protection for everyone, a safe and solid foundation under each person, without worry of losing coverage when we change or lose jobs.

3. Methods of raising money and paying for services that separate the money from decisions about care, both for patients and for caregivers. This requires paying hospitals and doctors in ways that allow patients and payors to trust caregivers. It means avoiding financial incentives to over or under-serve. And it means removing financial barriers to seeking needed care, in part by raising money fairly.

4. Professional re-orientation by hospitals and doctors toward patients and payors. Caregivers will need to accept responsibilities to marshal *inevitably* limited resources to take care of everyone.

5. Freedom of choice of caregivers, including a well-paid family doctor for everyone who wants one, and freedom from worry that an employer's new negotiations with HMOs *will* force a change in family doctor.

6. The coverage and delivery systems must be organized in ways that hold them accountable for reaching and appropriately serving everyone. When multiple HMOs compete to serve fractions of a broad geographic area, there is no way to hold them accountable for under-care or over-care-either individually or collectively. It would be far better to see systems of service organized around geographically visible caregivers, with competition by quality and compassion across the borders of service areas (as most service areas overlap substantially), and with money following patient choice.

This package provides the foundations for the things we want from health care: freedom from financial worry, confidence that our doctors and hospitals will give us the care that works for us, and assurance that we will be able to reach a doctor who knows us any time of the day.

It would be important for state governments to bring together all interested parties, set goals and timetables for reaching them, and broker a new health care peace treaty. …Massachusetts cannot afford to [wait].

The original 26 October 1993 paper (12 pages) from which this excerpt is drawn,
Nine Lessons for National Health Reform from the Failure of the 1988 Massachusetts Universal Health Insurance Law,
is available on the
Access and Affordability Monitoring Project page of
www.healthreformprogram.org

Other work on this state's health care from www.healthreformprogram.org includes:

- "Health Care Myths, Realities," op-ed, *Boston Globe*, 11/5/05
- Identifying and Stabilizing All Needed Massachusetts Hospitals, testimony, 11/2/05
- Testimony on Prescription Drug Importing (and single Rx buyer) for Mass., 10/24/05
- "Why Are Mass. Health Costs Soaring…? *Municipal Advocate*, Summer 2005
- Uninsured in Massachusetts Now Highest in 7 Years, 8/30/05
- A Few Massachusetts Health Care Realities, 2005 Edition, 8/3/05
- $1 Billion a Week is Enough to Finance Health Care for All in Mass., 7/20/05
- Fixing Our Broken System Requires Incremental and Comprehensive Change, 10/25/03
- Crashing through the Windshield: Massachusetts Health Care in the Downturn, 8/6/02
- "Too Many Hospitals on Life Support: state should alter closings policy," *Globe*, 3/3/02
- We Can Win Affordable Medications for All, 4/17/01
- A Better Deal for Our Health Care Dollars, 4/2/01
- Financially Distressed Hosps. Need Targeted Aid, Not Across-board Medicaid Hike, 12/19/00
- Massachusetts Can Afford Health Care for All, universal coverage cost study, 11/2/00
- The World's Most Expensive Health Care, 10/2/00
- How Can We Fix Harvard Pilgrim's Problems without Making Ours Worse? 2/18/00
- "More Care at Less Cost," *Boston Globe*, 4/25/99
- Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution, 6/2/97
- "Imprudent, Impatient…: Are Hospitals Closing Too Fast…," *Boston Globe*, 4/27/97
- 750,000 Citizens of Massachusetts Lack Health Insurance, 11/28/95
- The World's Most Expensive Hospitals, 2/1/91
- Promise and Performance, Analysis of 1988 Mass. Universal Health Care Law, 4/9/89.

NOTES

[1] Alan Sager, Deborah Socolar, and Peter Hiam, J.B., "Nine Lessons for National Health Reform from the Failure of the 1988 Massachusetts Universal Health Insurance Law," Access and Affordability Monitoring Project, Boston University School of Public Health, presented at annual meeting of the American Public Health Association, San Francisco, 26 October 1993, www.healthreformprogram.org. (See also excerpts in appendix of this report.)

[2] This also assumes that spending here increases in parallel with the national projection of a 7.3 percent rise between 2005 and 2006. See Stephen Heffler and others, "U.S. Health Spending Projections for 2004-2014," *Health Affairs*, Web Exclusive, 23 February 2005; see also, Office of the Actuary, Center for Medicare and Medicaid Services, "National Health Expenditures, Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1993-2014."

[3] State of Washington Governor Christine Gregoire has just sketched a five-point health cost control strategy, and says she will provide details in January of 2006, to describe "'exactly how we intend to get our arms around health care costs.'" See Chris McGann, "Governor Forms Health Care Plan," *Seattle Post-Intelligencer,* 27 December 2005.

[4] See, for example, Robert Gavin, "CEOs Like Universal Health Insurance, But Business Can't Foot Bill, They Say," *Boston Globe*, 2 November 2005

[5] Jonathan Gruber, cited in Robin Lord, "Critics: Health Proposals Downplay Cost of Care," *Cape Cod Times,* 14 November 2005.

[6] See, for example, Alan Sager and Deborah Socolar, "Testimony on S. 375, the Safe and Affordable Prescription Drugs Act," 24 October 2005, www.healthreformprogram.org

[7] Scott S. Greenberger, "Interfaith Leaders Invoke Morality in Healthcare Debate," *Boston Globe*, 29 December 2005; James J. Mongan, "Healthcare as a moral imperative," *Boston Globe*, 27 November 2004, http://www.boston.com/news/globe/editorial_opinion/oped/articles/2004/11/27/healthcare_as_a_moral_imperative/.

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

[9] H. 4479.

[10] Chapter 23 of the Acts of 1988.

[11] The appendix presents excerpts from a 1993 paper, written with Peter Hiam, identifying nine lessons from the 1988 law's failure. See also our 1989 report, *Promise and Performance*, cited below.

[12] Todd Gilmer and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs*, Web Exclusive, 5 April 2005.

[13] We estimated Massachusetts health care spending from CMS state and national data, and obtained GSP data from the Bureau of Economic Affairs, U.S. Commerce Department.

[14] These are the shares reported by the Current Population Survey, the only source of reasonably consistent data for both years. State and other survey data indicate slightly lower figures currently and in the late 1980s. (In 1989, a state-sponsored survey found 8 percent of residents uninsured, while the CPS estimate was 8.5 percent. See Alan Sager, Deborah Socolar, and Peter Hiam, *Uninsured in Massachusetts*, Boston: Access and Affordability Monitoring Project, 28 November 1995, p. 32, www.healthreformprogram.org.) For 2005, we substituted the CPS share for the average of 2003 and 2004 because more recent data are not available. That is probably a conservative estimate of the 2005 share uninsured, since the trend was upward between 2003 and 2004.

[15] For a national analysis, see Alan Sager and Deborah Socolar, *Health Crisis Index Rose 37%, 1987 – 2003: Higher Spending Associated with Growth in Uninsured Share of Americans,* Boston: Health Reform Program, Boston University School of Public Health, 25 March 2005, www.healthreformprogram.org.

[16] Said one highly placed individual, "The waiver negotiations drove us" to act faster than we would have.

[17] John Holahan, Randall Bovbjerg, Alison Evans, Joshua Wiener, and Susan Flanagan, *Heath Policy for Low-income People in Massachusetts*, Washington: Urban Institute, November 1997, p. 10.

[18] See the data for each year at http://www.cms.hhs.gov/medicaid/msis/mstats.asp, access confirmed 13 December 2005.

[19] See Health Care for All, "When Is a Deadline Not a Deadline?" 7 January 2005, http://www.hcfama.org/blog/2006/01/health-reform-primer-i-when-is.html.

[20] Joan Vennochi, "Romney's Rush to Reform Healthcare," op-ed column, Boston *Globe,* 13 November 2005.

[21] For a wildly glowing view of Romney's "gamble," see Joe Klein, "The Republican Who Thinks Big on Health Care," *Time,* 4 December 2005.

[22] See, for example, Michael S. Dukakis, "An Unpleasant Diagnosis," op-ed, *Boston Globe*, 10 January 2005. It is noteworthy that Nelson Gifford, then-CEO of Dennison and head of the Massachusetts Business Roundtable, representing large employers, helped to marshal business support for the 1988 legislation.

[23] See, for example, Massachusetts Division of Health Care Finance and Policy, *Employers Who Have 50 or More Employees Using Public Assistance*, 1 February 2005.

[24] Such analyses, though, should not criticize Medicaid use by workers with disabilities or disabled dependents because public policies—CommonHealth in Massachusetts, and the Ticket to Work program nationally—appropriately facilitate retaining Medicaid's more comprehensive benefits while these citizens enter or remain in the workforce.

[25] This would affect only Wal-Mart, as it is reportedly the only large Maryland employer of more than 10,000 workers that does not spend eight percent. See, for example, Kristen Wyatt, "Md. Wal-Mart Told to Boost Health Care," Associated Press, 12 January 2006, http://news.yahoo.com/s/ap/20060113/ap_on_bi_ge/maryland_wal_mart

[26] See John Holahan, Randall Bovbjerg,, and Jack Hadley, *Caring for the Uninsured in Massachusetts: What Does It Cost, Who Pays, and What Would Full Coverage Add to Medical Spending*, Washington: Urban Institute, November 2004; Linda J. Blumberg, John Holahan, Alan Weil, and others, *Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications*, Washington: Urban Institute, June 2005; and Alison Cook, *Health Insurance Coverage and the Uninsured in Massachusetts*, Washington: Urban Institute, June 2005.

[27] See Alan Sager, Deborah Socolar, Robert Brand, and David Ford, *Massachusetts Can Afford Health Care for All: Covering Everyone Comprehensively without Spending More*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 November 2000, www.healthreformprogram.org; and Lewin Group, *Massachusetts Health Expenditure Model: Description and User's Guide*, Fairfax, Virginia: Lewin, 24 February 1998 (and summary report posted at www.massmed.org/pages/lewin.asp).

[28] Alan Sager, Deborah Socolar, and Peter Hiam, "Expenditures on Massachusetts Hospitals and Access: Original Promises and Expectations versus Actual Costs and Current Projections," Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 30 August 1989.

[29] American Hospital Association, *Hospital Statistics*, Chicago: The Association, annual editions.

[30] See, for example, Joan Vennochi, "Taming the Beast in State's Healthcare," op-ed, *Boston Globe*, 22 December 2005.

[31] See, for example, Charles D. Baker, Testimony at FTC/DOJ Hearings on Health Care and Competition, Washington, D.C., 28 February 2003, http://www.ftc.gov/ogc/healthcarehearings/docs/030228baker.pdf, access confirmed 9 January 2006.

[32] See Gerald Rosenthal, "Setting the Floor: A Missing Ingredient in an Effective Health Policy," *Journal of Health Politics, Policy, and Law*, Vol. 1, No. 1 (Spring 1976), pp. 2-4.

[33] See, for example, James J. Mongan, "Health Financing—Challenges and Opportunities, Coverage and Cost," Federal Reserve Bank of Boston, 50th Economic Conference, Chatham, Massachusetts, 17 June 2005; James J. Mongan, "Healthcare as a moral imperative," *Boston Globe*, 27 November 2004, http://www.boston.com/news/globe/editorial_opinion/oped/articles/2004/11/27/healthcare_as_a_moral_imperative/.

[34] Scott S. Greenberger, "Kennedy Joins Mass. Healthcare Push, Praises Mandates Proposed by House," *Boston Globe*, 5 December 2005.

[35] Calculated from 2005 U.S. personal health spending per person and Massachusetts excess over U.S. in 2000 (the 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.

[36] Federal government data on health expenditures in the states have long shown per capita health care spending in Massachusetts to substantially exceed the U.S. average. The latest per capita data from CMS put personal health spending for Massachusetts residents at 28 percent above the national average in 1998. (See per capita table at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip; also at http://www.cdc.gov/nchs/data/hus/hus05.pdf#summary, Table 145, access confirmed 4 January 2006.)

[37] See OECD Health Data 2004, www.oecd.org.

[39] For 2004 hospital spending per person, see American Hospital Association, *Hospital Statistics, 2006 edition*, Chicago: The Association, 2005. The 1987 figure was a drop from 40.7 percent in 1980; both figures calculated from earlier editions of *Hospital Statistics*, and presented in Alan Sager, Peter Hiam, and Deborah Socolar,

Promise and Performance: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing" (Chapter 23 of the Acts of 1988), Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989, p. 21, www.healthreformprogram.org.

[40] Hewitt Associates, "2005 Health Care Costs per Employee, Major Metropolitan Areas," Hewitt Health Value Initiative, 2005.

[41] MetLife, "The MetLife Market Survey of Assisted Living Costs," October 2005.

[42] Alan Sager and Deborah Socolar, *Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005: Recent Federal Report Unintentionally Obscures Massive Rise; Physicians' Decisions Key to Controlling Cost*, Data Brief No. 8, Boston: Health Reform Program, Boston University School of Public Health, 9 February 2005, www.healthreformprogram.org.

[43] Payments for many services needed to care for patients with diabetes exemplify financial incentives for clinical waste. Preventive services are under-paid while amputations (which could often be preventive by appropriate preventive care) are over-paid. This helps to lead to an infuriating combination of bad health care and higher-than-necessary costs. See Ian Urbina, "In the Treatment of Diabetes, Success often Does Not Pay," *New York Times*, 11 January 2006.

[44] CMS reported that national health spending rose 105 percent, from $916.5 billion in 1993 to $1877.6 billion in 2004, while spending on "Program Administration and Net Cost of Private Health Insurance" rose 158 percent, from $53.0 billion to $136.7 billion—a sum that now exceeds spending on nursing home care. (Cynthia Smith et al., "National Health Spending in 2004," *Health Affairs*, Jan.-Feb. 2006 (Vol. 25, No. 1), Exhibit 1. (This estimate of the cost of administering health coverage excludes the accelerating costs of paperwork borne by caregivers, which have been documented by Woolhandler, Himmelstein, and others.)

[45] See, for example, Alan Sager, "Winning Durably Affordable Innovative Drugs: A Few Lessons from the Arguments over Importing Drugs from Canada," Symposium on U.S. and Canadian Pharmaceutical Policy, University of Connecticut Law School, 29 October 2004, www.healthreformprogram.org; Alan Sager and Deborah Socolar, "2003 U.S. Prescription Drug Prices 81 Percent Higher than in Other Wealthy Nations," Data Brief No. 7, Boston: Health Reform Program, Boston University School of Public Health, 28 October 2004, www.healthreformprogram.org; Alan Sager, *Affidavit in Support of Governor Blagojevich's Petition to the FDA to authorize the State of Illinois to import prescription drugs from Canada*, 8 April 2004, http://www.affordabledrugs.il.gov/pdf/SagerAffidavit.pdf and www.healthrformprogram.org; and Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All*

and to Protect Research, with State-by State Savings, Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000.

[46] Michael Luo and Clifford J. Levy, "As Medicaid Balloons, Watchdog Force Shrinks," New York Times, 19 July 2005; and Richard Perez-Pena, "Hurdles to Clear before Medicaid Care," New York Times, 17 October 2005. Another example, Alan Sager and Deborah Socolar, "Vast Sums of Money Are Stolen from What We Spend to Delay Death, Treat Pain and Overcome Disability," Newsday, 3 August 2003.

[47] Robert Kuttner, "As Senator, a Tenacious Proxmire Had a Good Run," op-ed, *Boston Globe*, 17 December 2005.

[48] This also assumes that spending here increases in parallel with the national projection of a 7.3 percent rise between 2005 and 2006. See Stephen Heffler and others, "U.S. Health Spending Projections for 2004-2014," *Health Affairs*, Web Exclusive, 23 February 2005; see also, Office of the Actuary, Center for Medicare and Medicaid Services, "National Health Expenditures, Aggregate And Per Capita Amounts, And Share Of Gross Domestic Product (GDP), Selected Calendar Years 1993-2014."

[49] Massachusetts Division of Health Care Finance and Policy, Quarterly Acute Hospital Financial Report, FY05 Q3, October 2005, www.mass.gov/dhcfp.

[50] Health Reform Program calculations from American Hospital Association, *Hospital Statistics*, editions from 1980 to 2006, and U.S. Census annual population estimates.

[51] "Section by Section Summary of Health Care Access Redraft, Joint Committee on Health Care Financing" Section 19, amending MGL Chapter 118E, Section 13B, accessed 5 December 2005 at http://www.hcfama.org/act/Documents/PATHSectionbySection.pdf.

[52] Alan Sager and Deborah Socolar, Alan Sager and Deborah Socolar, *Many Massachusetts Hospitals Have Financial Problems, and These Must Be Addressed, but an Across-the-board Medicaid Rate Increase Is Not an Effective Solution*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 18 December 2000, www.healthreformprogram.org.

[53] Gross State Product data are from the U.S. Department of Commerce, Bureau of Economic Affairs, www.bea.gov. We estimated 2005 GSP by applying the 2003 – 2004 rate of increase to the 2004 GSP.

[54] Alan Sager and Deborah Socolar, "Why Are Massachusetts Health Care Costs Soaring? And Can Anything Be Done About It?" *Municipal Advocate*, Vol. 22, No. 1 (Summer 2005), pp. 11-15, 34, posted at www.healthreformprogram.org.

[55] Milt Freudenheim and Mary Williams Walsh, "The Next Retirement Time Bomb, *New York Times,* 11 December 2005.

[56] U.S. Census Bureau, *U.S. International Trade in Goods and Services,* September 2004.

[57] Congressional Budget Office, *The Long-Term Budget Outlook,* Washington: CBO, December 2005, emphasis supplied.

[58] James J. Mongan, "Health Financing—Challenges and Opportunities, Coverage and Cost," Federal Reserve Bank of Boston, 50th Economic Conference, Chatham, Massachusetts, 17 June 2005.

[59] T.R. Reid, "Revenue Is Starting to Burn Holes in States' Pockets," *Washington Post,* 21 December 2005.

[60] Robert Pear, "Budget Accord Could Mean Payments by Medicaid Recipients," *New York Times,* 20 December 2005.

[61] State's own revenue is calculated from data in Commonwealth of Massachusetts, Office of the State Comptroller, *Statutory Basis Financial Report,* Ten-Year Schedule of Revenue, various years, http://www.mass.gov/osc/Reports/05SBFR/SBFR_2005.html. Taxes, lotteries, assessments, and motor vehicle licenses and registrations were included. Massachusetts health spending is estimated by Health Reform Program, relying on state and federal data from the Office of the Actuary, CMS.

[62] Alan Sager and Deborah Socolar, "Why Are Massachusetts Health Care Costs Soaring? And Can Anything Be Done About It?" *Municipal Advocate,* Vol. 22, No. 1 (Summer 2005), pp. 11-15, 34, www.healthreformprogram.org.

[63] Jared Bernstein, Heather Boushey, Elizabeth McNichol, and Robert Zahradnik, , *Pulling Apart: A State-by-State Analysis of Income Trends, Washington: Center on Budget and Policy Priorities, Economic Policy Institute, April 2002,* http://www.epinet.org/studies/Pulling_Apart_2002.pdf. See also the Massachusetts Fact Sheet, at http://www.epinet.org/studies/pullingapart/statefactsheets/1-18-00sfp-ma.pdf, access to both confirmed 29 December 2005.

[64] Robert E. Hurley, Hoangmai H. Pham, and Gary Claxton, "A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities," *Health Affairs,* Web Exclusive, 6 December 2005.

[65] Dennis Cauchon and Julie Appleby, "Hospitals Go Where the Money Is," *USA Today,* 4 January 2006.

[66] See, for example, Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Service Research*, Vol. 18, No. 3 (Fall 1983), pp. 45l-48l.

[67] Alan Sager and Deborah Socolar, Alan Sager and Deborah Socolar, Many Massachusetts Hospitals Have Financial Problems, and These Must Be Addressed, but an Across-the-board Medicaid Rate Increase Is Not an Effective Solution, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 18 December 2000, www.healthreformprogram.org.

[68] Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research*, with State-by State Savings, Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000, www.healthreformprogram.org.

[69] We rely here on the scattered estimates of the share of residents of various states who lack dental insurance. See "Dental Service Use and Dental Insurance Coverage—United States, Behavioral Risk Factor Surveillance System, 1995," *MMWR*, Vol. 46, No. 50 (19 December 1997), pp. 1199-1203; and "Distribution of U.S. Adult Population with Dental and/or Health Insurance by Selected Demographic Characteristics," http://drc.nidr.nih.gov/report/dqs_tables/10.htm, access confirmed 4 January 2006. Health Care for All's oral health task force cited a slightly lower estimate that 2.3 million Massachusetts residents lack dental insurance (http://www.hcfama.org/index.cfm?fuseaction=page.viewPage&pageID=519, accessed 4 January 2006), an estimate which may reflect an older, lower estimate of the number who lack any health insurance.

[70] S. 2265.

[71] Scott S. Greenberger, "StateSenateOK's healthcare plan," *Boston Globe*, 10 November 2005, www.boston.com/news/local/articles/2005/11/10/state_senate_oks_healthcare_plan/. Gruber has worked closely with House leadership on their plan.

[72] Alan Sager, Peter Hiam, and Deborah Socolar, *Promise and Performance*: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing" (Chapter 23 of the Acts of 1988), Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989, p. 26, www.healthreformprogram.org.

[73] We rely mainly on data contained in several documents from the House Health Care Financing Committee, and figures from other sources, to estimate costs associated with the House bill. Interpretations of these data and conclusions drawn from them are ours.

[74] Massachusetts Taxpayers Foundation, "Health Care Reform: Expanding Access Without Sacrificing Jobs," December 2005, http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf, access confirmed 28 December 2005; Steve Bailey, "Shaky Math," *Boston Globe,* 9 December 2005; and Scott S. Greenberger, "Business Group Targets Healthcare Tax Proposal," *Boston Globe,* 23 December 2005.

[75] Massachusetts Taxpayers Foundation, Health Care Reform: Expanding Access Without Sacrificing Jobs, Boston: The Foundation, December 2005, p. 4.

[76] Massachusetts Taxpayers Foundation, Health Care Reform: Expanding Access Without Sacrificing Jobs, Boston: The Foundation, December 2005, p. 5.

[77] As noted elsewhere, new Maryland legislation targets Wal-Mart, the only one of that state's largest employers, with more than 10,000 workers, that does not spend at least eight percent of payroll on health care. (See, for example, Kristen Wyatt, "Md. Wal-Mart Told to Boost Health Care," Associated Press, 12 January 2006, http://news.yahoo.com/s/ap/20060113/ap_on_bi_ge/maryland_wal_mart.) Skimpier plans are, however, likely to be more common at smaller employers.

[78] Massachusetts Taxpayers Foundation, "Health Care Reform: Expanding Access Without Sacrificing Jobs," December 2005, http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf, access confirmed 28 December 2005.

[79] See, for example, Jeffrey Krasner, "Is a $200 Policy for Healthcare Realistic? Romney's Proposal Inadequate to Solve Crisis, Activists Say," *Boston Globe,* 2 November 2005.

[80] This calculation rests on our estimate of 2005 Massachusetts health spending of $52.7 billion, plus the $500 million in higher spending on previously uninsured people.

[81] Sen. Richard Moore, Massachusetts Student Health Policy Forum, 5 January 2006.

[82] Steve Bailey, "Preston's Blueprint," business column, *Boston Globe,* 11 January 2005.

[83] Steve Bailey, "Preston's Blueprint," business column, *Boston Globe,* 11 January 2005.

[84] Elise Gould, *Prognosis Worsens for Workers' Health Care: Fourth Consecutive Year of Decline in Employer-Provided Insurance Coverage,* Washington: Economic Policy Institute Briefing Paper No. 167, 20 October 2005, www.epi.org, accessed 2 November 2005.

[85] John E. McDonough, "The Health Insurance Meltdown," op-ed, *Boston Globe*, 27 December 2005.

[86] Reed Abelson, "Employer-Backed Health Care Is Here to Stay, for Lack of a Better Choice," *New York Times*, 5 December 2005.

[87] Hewitt Associates, "U.S. Companies Face Lowest Health Care Cost Increases Since 1999," Press Release, 10 October 2005, along with data for earlier years kindly provided by Hewitt Associates.

[88] Todd Gilmer and Richard Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs*, Web Exclusive, 5 April 2005.

[89] Olveen Carrasquillo, David U. Himmelstein, Steffie Woolhandler, and David H. Bor, "A Reappraisal of Private Employers' Role in Providing Health Insurance," *New England Journal of Medicine*, Vol. 340, No. 2 (14 January 1999), pp. 109-114. Of remaining people, 7 percent have self-purchased insurance and almost 15 percent have no insurance.

[90] Massachusetts Taxpayers Foundation, "Health Care Reform: Expanding Access Without Sacrificing Jobs," December 2005, pp. 1, 4-5, http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf, access confirmed 28 December 2005.

[91] Massachusetts Taxpayers Foundation, "Health Care Reform: Expanding Access Without Sacrificing Jobs," December 2005, p. 10, http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf, access confirmed 28 December 2005.

[92] House 4479, p. 29, on eligibility for Commonwealth Care Health Insurance.

[93] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005 Summary of Findings," 2005, p. 2, Exhibits C and D, http://www.kff.org/insurance/7315/sections/upload/7316.pdf.
Similar contributions are found in the 2003 data from the U.S. Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey, published July 2005 (Tables TIIC3 and TIID3), http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Index203.htm

[94] See, for example, E.J. Dionne, "Labor's Lost Story," *Washington Post*, 29 November 2005.

[95] This burden and the need for truly progressive financing is one reason why some advocates for vulnerable patients and for universal coverage oppose employer

mandates. (See, for example, "Perverse incentives," *Stayin' Alive*, 1November 2005, http://healthvsmedicine.blogspot.com/2005/11/perverse-incentives.html.)

[96] "Urgent care," *Boston Globe*, editorial, 6 January 2006.

[97] In a few instances, U.S. employers try to handle this more equitably. In the low-income state of West Virginia, for example, state employees contribute to health insurance premiums on an income-linked sliding scale. Personal communication, Dan Kurland, 2005. (See, for example, premiums posted at Public Employees Insurance Agency, www.westvirginia.com/peia/page.cfm?parent=118&section=263.)

[98] Though proposing a bill to require buying insurance, and enforcement with financial penalties, Governor Romney claimed, "`It's not a mandate. It's basically saying you have a personal responsibility to either pay your own way or get insurance.'" Seen Julie Appleby, "Mass. Gov. Romney's health care plan says everyone pays," *USA Today*, 4 July 2005, http://www.usatoday.com/money/industries/health/2005-07-04-health-insurance-usat_x.htm

[99] Holly Beck, "Young and Uninsured," *AlterNet,* 23 November 2005, http://www.alternet.org/wiretap/28435/?cID=60871#c60871.

[100] David M. Cutler, "Employee Costs and the Decline in Health Insurance Coverage," Cambridge: National Bureau of Economic Research, July 2002, Working Paper No. 9036, www.nber.org/papers/w9036.

[101] On high marketing spending, see Kelly McCormack, "Fred & Ethel, Drug-plan Shills," *The Hill,* 7 December 2005. On administrative complexity associated with the individual purchase of medications, see Ceci Connolly, "The States Step in as Medicare Falters," *Washington Post*, 14 January 2006; and Jane Gross, "Nursing Homes Confront New Drug Plan's Hurdles," *New York Times*, 15 January 2006.

[102] John Rother, American Association of Retired Persons, as quoted in Nancy Ann Jeffrey, "Medicare-Education Campaign Is Hit With Vigorous Criticism," *The Wall Street Journal*, 31 December 1997.

[103] National Bipartisan Commission on the Future of Medicare, "Private Supplemental Coverage Summary," 1999, Section II, http://thomas.loc.gov/medicare/K-P-1499.html. The minimum for group Medigap plans is 75 percent. OBRA 1990 raised the required medical loss ratio for individual Medigap plans from 60 percent to 65 percent. U.S. General Accounting Office, *Medigap Insurance: Compliance With Federal Standards Has Increased,* GAO/HEHS-98-66, March 1998, p. 11.

[104] Data collected annually under law by the Office of Patient Protection at the Massachusetts Department of Public Health shows that for 2002-2004, Fallon at 90-91 percent, Harvard-Pilgrim at 88-90 percent, and Tufts HMO at 89-91 percent in

those three years. See yearly reports on DPH website: 2005 report on 2004 data is at www.mass.gov/Eeohhs2/docs/dph/patient_protection/premium_revenue_05.doc

[105] Consult the Blue Cross, Tufts, and Harvard Pilgrim policies offered through large Massachusetts employers for examples.

[106] Relying on data just published in Cynthia Smith et al., "National Health Spending in 2004," *Health Affairs*, Jan.-Feb. 2006 (Vol. 25, No. 1), Exhibit 5, we calculated private health insurance's share of expenditure for health services and supplies at $18.5 billion. Five percent of that is $925 million.

[107] Massachusetts Taxpayers Foundation, "Health Care Reform: Expanding Access Without Sacrificing Jobs," December 2005, http://www.masstaxpayers.org/data/pdf/reports/health~1.pdf, access confirmed 28 December 2005.

[108] David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, Web Exclusive, 2 February 2005.

[109] Tom O'Brien, "Two Women, Two Cancers, Two Health-care Systems," *San Francisco Chronicle*, 29 December 2005.

[110] Vanessa Fuhrmans, "More Employers Try Limited Health Plans," *Wall Street Journal*, 17 January 2006. Ten large corporations expect to make the low-cost mini-med option available to some 900,000 workers and dependants starting in the spring of 2006.

[111] The Comptroller General's forum "agreed that as a practical matter, the lack of adequate comparable data today limits the ability to link incentives to patients' decisions." Further, participants noted that this could not be done

- "until tools are available to assess the quality of providers' care";
- it would necessitate "efficiency measures that have not yet been developed";
- "these measures would require medical experts to arrive at a consensus about whether a given treatment was necessary or elective";
- "a good efficiency measure needs to adjust for hospitals or physicians that take high-risk patients";
- "such measures also would require systematic collection of clinical outcome data";
- an independent entity would be needed to do such assessments;
- "cost incentives would need to be modified for low-income, uninsured, and chronically ill populations"; and
- they would have "limited effect" on the "high-cost patients who exceed their maximum for covered out-of-pocket costs."

(U.S. General Accounting Office, *Comptroller General's Forum on Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to*

Control Spending and Improve Value, GAO-04-793SP, 1May 2004, http://www.gao.gov/htext/d04793sp.html.) This discussion apparently did not address the enormous complexity that would face patients in any attempt to incorporate all of the above sorts of measures.

[112] Donald Berwick, quoted in Robert Galvin, "'A Deficiency of Will and Ambition,' A Conversation with Donald Berwick," *Health Affairs*, Web Exclusive, 12 January 2005, www.healthaffairs.org.

[113] Alan Sager and Deborah Socolar, *Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005: Recent Federal Report Unintentionally Obscures Massive Rise; Physicians' Decisions Key to Controlling Cost*, Data Brief No. 8, Boston: Health Reform Program, Boston University School of Public Health, 9 February 2005, www.healthreformprogram.org.

[114] M.L. Berk and A.C. Monheit, "The Concentration of Health Care Expenditures Revisited," *Health Affairs*, March-April 2001, pp. 204-213, Exhibit 1.

[115] House 4479, Section 70. Legislative proponents described this as having high deductibles "in the middle." PATH Caucus Presentation, 31 October 2005, p. 19, http://www.hcfama.org/act/Documents/PATHCaucusPresentation.pdf

[116] Alan Sager and Deborah Socolar, "Healthcare Myths, Realities," op-ed, *Boston Globe, 5 November 2005.*

[117] John E. McDonough, "The Health Insurance Meltdown," op-ed, *Boston Globe*, 27 December 2005.

[118] E.J. Dionne, "Labor's Lost Story," *Washington Post*, 29 November 2005.

[119] Alan Sager, Peter Hiam, and Deborah Socolar, *Promise and Performance*: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing" (Chapter 23 of the Acts of 1988), Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989, p. ii., www.healthreformprogram.org.

[120] Jonathan Gruber, cited in Robin Lord, "Critics: Health Proposals Downplay Cost of Care," *Cape Cod Times*, 14 November 2005.

[121] See, for example, Alan Sager and Deborah Socolar, "Testimony on S. 375, the Safe and Affordable Prescription Drugs Act," 24 October 2005, www.healthreformprogram.org.

[122] Scott S. Greenberger, "Interfaith Leaders Invoke Morality in Healthcare Debate," *Boston Globe*, 29 December 2005; James J. Mongan, "Healthcare as a moral

imperative," *Boston Globe*, 27 November 2004, http://www.boston.com/news/globe/editorial_opinion/oped/articles/2004/11/27/health_care_as_a_moral_imperative/.

[123] See S. 2282, Section 13A ½ (proposing Section 12B of Ch. 118E) and Section 58D.

[124] See, for example, H.3025, An Act Relative to Promoting the Efficient Use of Health Care Revenues.

[125] Alan Sager and Deborah Socolar, *$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, Joint Committee on Health Care Financing, Massachusetts General Court, State House, 20 July 2005.

[126] Alan Sager and Deborah Socolar, *Health Costs Absorb One-Quarter of Economic Growth, 2000 – 2005: Recent Federal Report Unintentionally Obscures Massive Rise; Physicians' Decisions Key to Controlling Cost*, Data Brief No. 8, Boston: Health Reform Program, Boston University School of Public Health, 9 February 2005, www.healthreformprogram.org.