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Massachusetts Can Afford Health Care for All

Covering Everyone Comprehensively Without Spending More

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SUMMARY

Massachusetts can provide health care for all its people—and save money.

In the approach to universal coverage examined here:

- Coverage would be comprehensive and secure.
- Patients and payors get a better deal, more care for less money.
- Most of the added care provided would aid people who are now partly insured.
- Cutting administrative waste frees 10 percent of health dollars to pay for more care.
- Reforms in financing and delivery of care would win other substantial savings.
- Over 80 percent of patients' out-of-pocket costs would be eliminated.
- Caregivers and patients make decisions without bureaucratic interference.
- Trustworthy payment methods enhance quality of care.
- Caregivers gain secure budgets; employers avoid continued premium increases.
- Replacing most out-of-pocket costs with public funds permits administrative savings.

In brief, we conclude that, largely because reforms would have permitted cutting 1999 administrative spending in Massachusetts health care by nearly half, or $3.6 billion, an additional $2.4 billion could have been used for actual care, while still saving $1 billion.

The apparent alternatives are not feasible:

- Adding the same benefits incrementally would cost over $5 billion more.
- Incremental strategies simply increase spending and fail to find administrative, clinical, and other savings.
- Waiting for federal action is dangerous and unnecessary. Massachusetts can afford coverage for all. The time to start planning is now.

The context—Massachusetts health care is in crisis.

- Our state's health costs are highest in the nation, 30 percent above the national average per person. If we spent at the national average, we would save $1,400 per person, or $8.7 billion statewide this year alone.

- Despite this high spending, many people are unable to afford the care they need—prescription drugs, home care, dental care, and others. Many people are also at risk because of managed care's financial incentives to provide fewer services. Still other people are at risk because of HMOs' unstable relations with hospitals and doctors.

- Although spending was already high, HMO premiums in greater Boston have risen by some 12 to 15 percent in the past year. Some employers and patients have suffered far bigger increases. Substantial further increases are expected for 2001 and for 2002.

- Despite high spending, many of our caregivers face financial distress. Many of our hospitals say they are running out of cash, one-quarter of our nursing homes are in bankruptcy, and home health agencies face financial distress.

- Despite high spending, many of our HMOs have also faced financial stress in the past few years.

- Despite high spending, less money goes to actual care than many people realize, because over one-fifth of each health care dollar today goes to administration.

- The private health insurance market has failed to make insurance affordable. Only the past decade's substantial expansions of government programs and extraordinary economic boom have prevented the number of uninsured people in Massachusetts from nearing one million.

One response to our state's health problems, popular in some quarters, is to boost spending on health care. But this will also boost financial burdens on all who live, work, and do business in the Commonwealth. More money for business as usual is not affordable.

Another response, popular in other quarters, is to insist that reform proposals are the problem. Those who respond in this way claim that reforming Massachusetts health care by improving coverage or by outlawing wrong-headed managed care practices would increase total spending. They cite several reports to buttress their claims.

We disagree that reform is the problem. The critics rely on reports that we find to be incomplete, inaccurate, or biased. We specifically find that the recent Massachusetts Taxpayers Foundation report on the costs of reform is fatally flawed in both substance and method.

Our analyses indicate that managed care, price competition, and hospital closings have failed to save money—and that alternative methods of cutting administrative and clinical waste are likely to succeed.

The critics of reform have failed to put forward proposals to contain costs, protect quality, and enhance coverage. Some of these critics instead seem to lean toward advocating more money for business as usual.

We predict that those who advocate more money for business as usual and who reject reform will lead Massachusetts medicine toward medical meltdown. That will mean more hospitals closing, more patients without insurance, and more employers bailing out of offering health coverage in favor of making only defined contributions toward health benefits. And it will mean more instability, more insecurity, more distrust in Massachusetts health care.

Although HMOs and insurors have raised premiums sharply, hospitals and doctors complain that they are not seeing higher payments. Much of the additional premiums will be used to rebuild HMO financial reserves. Some will pay for higher prescription drug spending, now rising at 15 to 20 percent yearly.

It now seems clear that the cost control proposals of recent years—managed care, price competition, and hospital closings, have not worked remotely as well as their proponents claimed.

For these and other reasons, our state has the world's most expensive health care, with many caregivers facing financial distress, and with growing concern that quality is suffering.

And all this is happening amidst the most prosperous economy in the history of the world. What will happen to our health care when we enter the next serious recession?

Spending on health care in Massachusetts is already enough to finance and deliver the care that works for all the people who need it. Ever-higher spending is not the answer.

The challenge is to make health care for all durably affordable, while protecting quality of care and the doctors, hospitals, and other caregivers whose efforts ensure quality.

Meeting this challenge requires well-designed and carefully implemented public action. Given the impossibility of anything approaching genuine free market competition in health care, the only alternative to careful government action is medical anarchy.

The evidence points to two recent and striking government successes in Massachusetts health care. First, Medicaid expansions have substantially reduced the number of people without insurance. Second, receivership legislation and subsequent careful action helped to stabilize the Harvard Pilgrim HMO. Market competition, by contrast, has failed to contain costs or to protect needed caregivers.

This report's analyses of Massachusetts health care indicate that public action can attain durably affordable and high-quality health care for all without increasing spending. These are our twelve main findings:

1. *Spending less: Massachusetts can afford to provide all necessary care to all its people while spending less.*

- Pooling, re-channeling, and better using existing health care dollars would have permitted saving $1 billion from 1999's estimated $36.8 billion in total payments for Massachusetts health care, even while covering everyone comprehensively.

- The savings winnable with reform would likely be even higher in future years, as health costs are rising sharply without reform. Massachusetts payors can avoid the expected rise in premiums.

- Today's strategies of managed care, price competition, and moving care out of hospitals are not containing costs, even though our state is near the top in the share

of our people in HMOs, and even though our number of hospital beds per thousand citizens is well below the national average. All who pay for care here face big cost increases.

2. *Covering everyone: Universal, comprehensive care reforms would cover everyone in Massachusetts— guaranteeing all-inclusive care, to aid today's under-insured and uninsured people. This will give us all medical security.*

- Massachusetts can act from both compassion and competence in covering all of the state's people comprehensively and affordably.

- Most citizens of the Commonwealth are under-insured today because they are unprotected against costs of long-term care and often other vital care as well. Many are in managed care plans that give financial incentives to provide less care.

- People will feel secure with guaranteed coverage. It will reduce stress, bankruptcies, job lock, and fear of job loss.

3. More care for less money: Universal, comprehensive health care with streamlined administration means more care without more cost, with more of each health care dollar actually going for care.

- In 1999 alone, the people of Massachusetts would have received approximately $2.4 billion more in actual health care services than without reform— a 9 percent rise in financing for actual patient care.

- That would support a rise of even more than 9 percent in the volume of health services used. The real (marginal) cost of serving added people is less than today's average, since caregivers can accommodate them without huge new fixed costs.

- With comprehensive coverage, we project substantially higher use of physician care, prescription drugs, home care, nursing home care, dental care, prescription drugs, and other health services.

- Funds for actual physician care alone would rise an estimated 25 percent, for example, and funds for nursing home care are projected to rise 16 percent.

- Payors, caregivers, and patients would each be getting a better deal than today.

4. Added costs of coverage: The biggest added costs and biggest volume of added services would go to fill the gaps in coverage for people who are already partly insured.

- The added costs of universal access to comprehensive benefits include $1 billion to cover the uninsured and $2.8 billion—nearly three times as much— to eliminate under-insurance.

- The $4.2 billion in total added costs would be more than offset by the savings available in a universal system with simplified administration.

- Ending under-insurance—eliminating patient cost-sharing and uncovered benefits—is projected to raise use of physician services by 17 percent, for example, and home care by 25 percent.

- Since Massachusetts has large physician and hospital bed supplies, care for more people would not cost as much per person as the average for those now insured.

5. Administrative savings: Covering everyone in one plan would win very substantial administrative savings— an estimated $3.6 billion, fully one-tenth of health spending.

- As administrative costs plunge from today's $7.7 billion down to $4.2 billion, vast resources could be reallocated from the payment bureaucracy to care—from fat to bone and muscle.

- Using a pooled financing source for all care would, for example, eliminate the need to process millions of claims; the need to screen out patients to avoid costly ones; and the need to determine patient eligibility and benefits under many different plans. Such simplification would have saved an estimated $1.1 billion on administering coverage in 1999 and $$2.5 billion on caregiver administration.

- We calculate that fully $1.6 - $2.1 billion is being spent on financial administration of physician services alone this year. Using new evidence from inside the health care industry, we estimate that $673 - $839 million could be saved through more efficient administration of physician care alone.

6. Ending patient cost-sharing would help people by eliminating over 80 percent of out-of-pocket spending for Massachusetts health care.

- Patient cost-sharing amounts to a sick tax which most heavily burdens people with chronic or serious illnesses or lower incomes. It deters use of needed care, fails to target the true causes of high costs, and often shifts costs to caregivers as well as patients.

- Aiding under-insured people by providing comprehensive benefits, and ending deductibles, co-payments, and most other out-of-pocket spending are both affordable and very important for cutting administrative costs.

Summary Table

PROJECTED 1999 MASS. HEALTH CARE COSTS, WITHOUT AND WITH REFORM	**($ billions)**
∗ BASELINE: 1999 cost of care for Massachusetts beneficiaries (residents plus workers from out of state), without major reform or policy changes	**$36.8**
With reform: • with comprehensive coverage for all, • without insurance companies, • without patient cost-sharing, • with reforms in financing and delivery of health care	
ADDED COSTS: $4.2 billion in new costs with reform	
Bring uninsured to average service use rates for people without public coverage	+ $ 1.0
Added service use for all when fill gaps in benefits and end patient cost-sharing	+ $ 2.8
Better care coordination, services for people with disabilities, and data collection	+ $ 0.4
Total of added costs	+ $ 4.2
Total cost for full coverage for all, before savings	$41.0
SUBTRACTED SAVINGS: $5.2 billion in new savings with reform	
Savings in administration of coverage	- $ 1.1
Savings in caregiver administration	- $ 2.5
More appropriate use of hospital care	- $ 0.8
Negotiating prescription drug prices	- $ 0.5
Budgeting construction and equipment	- $ 0.2
Total of subtracted savings	- $ 5.2
∗ Total cost of care for Massachusetts beneficiaries after reform	**$35.8**
Change from baseline without reform (- 2.8%)	**- $ 1.0**

(Note: Numbers may not add exactly to totals because of rounding.)

7. Clinical and other savings: Conservatively, reforms will win an additional $1.6 billion more in non-administrative savings— through more appropriate use of hospital care, negotiated drug price cuts, and capital budgets.

- As shown in the summary table above, total savings of $5.2 billion more than offset the cost of new coverage. Savings from streamlining administration combined with moderate clinical and other savings can, when captured and recycled, amply finance needed care for all.

- As a back-up, system-wide budgets will ensure costs stay within desired limits.

- Caregivers will be paid in ways that make the budgets real.

- Total health spending in Massachusetts is more than in many entire wealthy nations, so the state's purchasing power should suffice to win substantial price cuts from makers of prescription drugs and other medical supplies.

8. Quality will be enhanced: Covering everyone and ending today's financial pressures on caregivers to do less will protect quality of care, restoring trust. While caregivers will have to spend carefully, $36 billion is ample in Massachusetts to finance all the care that works for all the people who need it.

9. Incrementalism is unaffordable: ***Incremental coverage improvements are better than none— much better— but inevitably cost more money. Incremental measures to achieve universal, comprehensive coverage would be unaffordable, requiring health spending of at least $41 billion—over $5.2 billion above (14.5 percent above) what Massachusetts needs to spend to win coverage for all.***

10. Alternative financing: Regressive insurance payments must be stabilized and then reduced. Out-of-pocket payments must be cut. Today's $6.4 billion in out-of-pocket payments for Massachusetts health care effectively amount to a tax on people who get sick.

- Private insurance premiums should be frozen at today's levels, with employers required to maintain their constant dollar payments. The real or inflation-adjusted burden of paying these premiums will drop each year.

- Annual increases in payments for health care would be financed with public dollars. This will raise the money in more fair ways. It will also help to hold down health care spending.

- Some $3 billion in out-of-pocket payments should be replaced with broad -based state taxes. Doing so would shift less than one-twelfth (8.3 percent) of health spending from private to public spending.

- Substituting taxes for out-of-pocket payments is vital to winning immediate health care for all and lower administrative costs. Using one pool of money to pay for all care is essential to slashing administrative waste and to capping overall costs.

- Reforms described in this report would save an additional $1 billion, as noted earlier.

11. Benefiting us all: Insuring the uninsured is just one vital gain that comprehensive reforms would bring. Many aspects of such reform would benefit us all.

- All of us would be able to receive more care at lower cost.
- Cutting health care costs will free up money in family, business, charitable, and government budgets to meet many other pressing needs. And having healthier people will strengthen the Commonwealth in countless ways.

12. Delay is dangerous: Massachusetts cannot afford to wait for Congressional action. Nor can this state afford to wait for a crisis. Beginning to plan now for such comprehensive reforms is essential to avoid great harm to the state's people, to the trustworthiness of care, and to hospitals, physicians, nursing homes, home health agencies, and other valued health care resources.

- Today's cost control strategies are failing. More money for business as usual is not affordable.
- Higher costs will mean more cuts in coverage.
- Caregiver financial distress is growing.
- Delay is unnecessarily costly.
- Congress will not soon legislate health care for all and cost control— in part because states' economies, health costs and delivery, and share uninsured vary so widely.
- This state should not and cannot wait for unlikely Congressional action, since state-level reforms to cover everyone are clearly feasible without spending a penny more.
- State reform is the only likely path to universal coverage and cost control for years to come.

In summary, health care for all is affordable, and achieving it can be a win for all parties because current spending is already enough. Massachusetts can have health care security, health care freedom, and lower costs.

<u>Security</u>

- for patients and families, knowing that needed care is covered, and that caregivers no longer are rewarded for giving too much care or too little care
- for employers and employees, knowing that costs are capped and predictable
- for needed caregivers, knowing that their revenue budgets are stable, fair, and sufficient.

Freedom

- for patients, to select the caregivers they choose
- for caregivers and patients, to choose care without bureaucratic interference
- for workers, to choose their jobs without worrying that they will lose coverage
- for employers, to focus on running their business, not on searching for health plans.

Lower costs

- cuts in administrative waste and other reasonable savings are enough to offset the cost of expanded coverage and to reduce health care spending overall
- developers of cost-reducing medical technologies would rewarded
- advocates of higher health care spending must compete with advocates of other good things—including many others that are also vital to improving the health of citizens of the Commonwealth.

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BACKGROUND

This report estimates the costs of universal health care in Massachusetts and contrasts those costs with a continuation of our current system. It shows that universal health care for the people of Massachusetts is affordable. It offers alarming new evidence that

- business-as-usual in Massachusetts health care is not sustainable, and that
- business-as-usual is cheating the state's people by wasting huge sums on the private sector's payment bureaucracy at the expense of the care that we all need.

The Commonwealth is again debating whether to act to provide health coverage for all of its people. We offer this report in the hope that it will help the public and policy-makers to grapple with the complexity of our health care system, and to identify the benefits of universal access to comprehensive care with simplified administration.

The context—Massachusetts health care is in crisis.

- Our state's health costs are highest in the nation, 30 percent above the national average per person. If we spent at the national average, we would save $1,400 per person, or $8.7 billion statewide this year alone.[1]
- Despite this high spending, many people are unable to afford the care they need—prescription drugs, home care, dental care, and others. Many people are also at risk because of managed care's financial incentives to provide fewer services.
- Although spending was already high, HMO premiums in greater Boston have risen by some 12 to 15 percent in the past year. Some employers and patients have suffered far bigger increases. Substantial further increases are expected for 2001 and for 2002.
- Despite high spending, many of our caregivers face financial distress. Many of our hospitals say they are running out of cash, one-quarter of our nursing homes are in bankruptcy, and home health agencies face financial distress.
- Despite high spending, many of our HMOs have also faced financial stress in the past few years.
- Despite high spending, less money goes to actual care than many people realize, because over one-fifth of each health care dollar today goes to administration.
- The private health insurance market has failed to make insurance affordable. Only the past decade's substantial expansions of government programs, fueled in part by

an unusual economic boom, has prevented the number of uninsured people in Massachusetts from nearing one million.

One response to our state's health problems, popular in some quarters, is to boost spending on health care. But this will also boost financial burdens on all who live, work, and do business in the Commonwealth. More money for business as usual is not affordable.

Another response, popular in other quarters, is to insist that reform proposals are the problem. Those who respond in this way claim that costs would rise if Massachusetts were to reform health care by improving coverage or by outlawing wrong-headed managed care practices. They cite several reports to buttress their claims.

These reports are incomplete, inaccurate, or biased.

Comments on One Recent Report

The most glaringly weak report criticizing health care for all is that prepared by the Massachusetts Taxpayers Foundation.[2] This report sees only higher costs from reform. It does not even mention any offsetting savings. The head of the Taxpayers Foundation claimed that it is " 'common sense' " that providing coverage for all citizens would cost more money. He said that " 'It's perfectly clear that will result in astronomical cost increases.' "[3]

We believe that these statements, though undoubtedly meant sincerely, are simply not true. They ignore the substantial evidence that points in more optimistic directions.

The Taxpayers Foundation report calculated the cost health insurance for all by multiplying the estimated number of uninsured people in the state by the average single premium cost of insurance today. (It fails to provide the dollar cost of this insurance.) The Taxpayers Foundation then raises this figure by its own estimates of the effects of certain patients rights provisions contained in this year's ballot question number 5. Finally, the Foundation reduces its total by the uncompensated care pool's free care costs.

Unfortunately, the Taxpayers Foundation failed to provide a single summary dollar total for its own estimated costs of universal coverage.

The Taxpayers Foundation assumed only the most costly method of expanding insurance coverage—the cost of buying health insurance for those not covered.

Our own work has shown that this approach is indeed extraordinarily costly. We have estimated the price tag for incremental expansion alone—without reform—at roughly $41 billion for 1999, to provide coverage for today's uninsured and meet the needs of the uninsured.

Further, the Taxpayers Foundation did not calculate any possible offsetting savings from instituting health care for all. Worse, it failed even to mention the possibility of offsetting savings, though this subject has been studied and debated for over a decade, both in Massachusetts and nationally. This is a serious shortcoming.

Buying insurance coverage with new dollars is not the only way to cover more people and managed care techniques are not the only way to contain costs. Alternatives have been investigated and employed. Failure to consider these alternatives condemns the people of the Commonwealth to a tragic or hopeless choice—and an unnecessary choice—between holding down costs and winning medical security for all.

The Massachusetts Taxpayers Foundation also claimed that costs for insured people would skyrocket if the various patients rights provisions of ballot question 5 were to pass. The Taxpayers Foundation claimed that the patients' rights provisions alone would raise premiums from 26.2 to 60.5 percent. These figures are manifestly inflated and inaccurate.

The patients' rights provisions are largely beyond the scope of the present study. We therefore wish to briefly note only four points.

First, the Taxpayers Foundation's figures are absurd on their face. Massachusetts health care costs are already 30 percent above the national average. We are spending over $6,000 per person. How much more ***could*** we conceivably spend if patients enjoyed greater freedom to choose their own physician or to seek care from a specialist more freely? Not remotely as much as the Foundation says.

The absurdity comes home when we consider real numbers alongside the percentages. The patients rights provisions of question 5 overwhelmingly concern physician services. Let us assume for the sake of argument that physicians' care consumes as much as 35 percent of the cost of an HMO's health insurance premium.

Then, the claims that the patients' rights provisions would hike HMO premiums from 26.2 to 60.5 percent amount to asserting a rise in the costs of doctors' care of between 75 percent and 173 percent.[4] This is not credible.

As noted in Finding 4 of this report, we expect the lifting of benefit restrictions and cost-sharing requirements to yield only a 17 percent rise in physician services, based on experience elsewhere.[5] Moreover, it is appropriate to calculate the cost of additional care at marginal cost, not at today's average cost.

Second, Massachusetts health costs are extraordinarily high even though Massachusetts is near the top nationally in the share of our patients in HMOs. Managed care simply has not succeeded in holding down health care costs in our state. Therefore, why should restoring patient rights increase those costs?

The Massachusetts Taxpayers Foundation report assumes that managed care only saves money, not that it costs money by imposing administrative barriers. It ignores the failure of managed care to contain costs of care in this state. In this sense, there is reason for concern that managed care advocates are riding a dying horse.

Third, the Massachusetts Taxpayers Foundation failed to obtain independent estimates of the costs of the patients rights provisions of question 5. Instead, the Foundation asked the HMOs how much they thought they would raise premiums if question 5 were to pass. Given the HMOs' opposition to question 5, it is doubtful that the HMOs provided answers that were entirely objective.

Finally, an earlier estimate of the costs of patients rights' provisions like those in question 5 found that "The estimated HMO premium increases associated with the Petition would range from approximately 4 percent to nearly 10 percent."[6]

We disagree with these estimates, for a variety of reasons set out elsewhere.[7] It should be noted that these estimates, though financed by a Massachusetts HMO, were prepared independently. They are much lower than those the HMOs chose to submit to the Taxpayers Foundation.

A More Hopeful View

Our analyses of Massachusetts health spending indicate that managed care, price competition, and hospital closings have failed to save money—and that alternative methods of cutting administrative and clinical waste are likely to succeed.

The critics of reform have failed to put forward proposals to contain costs, protect quality, and enhance coverage. Some of these critics instead seem to lean toward advocating more money for business as usual.

We predict that those who advocate more money for business as usual and who reject reform will lead Massachusetts medicine toward medical meltdown. That will mean more hospitals closing, more patients without insurance, and more employers bailing out of offering health coverage in favor of making only defined contributions toward health benefits. It will mean more instability, more insecurity, more distrust in Massachusetts health care.

Although HMOs and insurors have raised premiums sharply, hospitals and doctors complain that they are not seeing higher payments. Much of the additional premiums are being used to rebuild HMO financial reserves. Some will pay for higher prescription drug spending, now rising at 15 to 20 percent yearly.

It now seems clear that the cost control proposals of recent years—managed care, price competition, and hospital closings, have not worked remotely as well as their proponents claimed.

For these and other reasons, our state has the world's most expensive health care, with many caregivers facing financial distress, and with growing concern that quality is suffering.

And all this is happening amidst the most prosperous economy in the history of the world. What will happen to our health care when we enter the next serious recession?

Spending on health care in Massachusetts is already enough to finance and deliver the care that works for all the people who need it. Ever-higher spending is not the answer.

The challenge is to make health care for all durably affordable, while protecting both quality of care and the doctors, hospitals, and other caregivers whose efforts ensure that quality.

Meeting this challenge requires well-designed and carefully implemented public action. Given the impossibility of anything approaching genuine free market competition in health care, the only alternative to careful government action is medical anarchy.

The evidence points to two recent and striking government successes in Massachusetts health care: Medicaid expansions have substantially reduced the number of people without insurance, and receivership legislation and subsequent careful action helped to stabilize the Harvard Pilgrim HMO. Market competition, by contrast, has failed to contain costs or to protect needed caregivers.

For the past 12 years, Solutions for Progress, Inc. and the Access and Affordability Monitoring Project of the Boston University School of Public Health have worked independently and collaboratively to study a range of policies for expanding access to high-quality, comprehensive health care at an affordable cost. We have studied and consulted for public agencies, voluntary health sector organizations, and private health care providers to help improve access and solve problems, while continuing to focus on the feasibility of affordably achieving health care coverage for all.

Solutions for Progress, a consulting group in Philadelphia, previously has developed models to estimate costs of different approaches to providing universal health coverage for several other states. The Access and Affordability Monitoring Project at the Boston University School of Public Health, established after passage of the state's 1988 universal health care law, has focused on access and cost problems in Massachusetts health care.

During 1997-98, commissioned by the Massachusetts Medical Society (MMS), we developed estimates of the cost of certain paths to health care for all in Massachusetts. We summarized those estimates in a December 1998 final report to the MMS.[8]

In April 1999, we updated and elaborated those estimates in a number of ways[9] —to reflect a faster-than-expected rise in prescription drug costs, for example—for legislative testimony and other brief descriptions of our findings.[10] The present report, consistent with the figures released earlier, offers substantial new detail and explanation. It shows how the Commonwealth can clearly achieve universal, comprehensive health care coverage without spending more. It identifies the specific expansions of health care that would benefit us all. And it includes recent evidence that current cost control methods are failing.

We believe that recent alarming health care news in Massachusetts makes this report particularly useful now.

- The state's largest health maintenance organization came to the brink of bankruptcy, and one-quarter of the state's nursing home beds are in facilities in bankruptcy.

- As we have long warned, competition has forced many hospitals to close. Access to needed services may now be deteriorating. Many surviving hospitals are running out of money; as they scramble to survive, quality of care may suffer.

- HMOs and other health care organizations, blaming tight financial margins, are cutting vital care—dropping prescription drug benefits for many seniors, for example.

- Employers and individuals face a second or third successive year of double-digit health insurance premium increases. Managed care, price competition, and the past decade or more of hospital closings and de-hospitalizing care have clearly failed to contain costs.

- New federal data show that even as insurors and caregivers complain of inadequate payment, Massachusetts health care costs are now at their highest level ever above the national per capita average—30 percent above—and are the world's highest.[11] If our state spent on health care at the generous national average, we would together save some $1,400 per person, or $8.7 billion this year alone. (Total health care spending per capita averages an estimated $4,747 this year nationally, but is an estimated $6,154 in Massachusetts.)

And there is some good news: many Massachusetts residents are newly covered under expanded Medicaid programs. But these use public funding in a system that views private funding as the norm. And that private system is failing to control costs. The gains in improved coverage are vulnerable. The number of people without insurance will climb steadily as health costs rise. That number will soar in the next recession.

This report builds up estimates, for each major type of care, of the cost of providing comprehensive care to us all. It concludes that the savings of a reformed system would more than offset the added costs of comprehensive care. The new federal data on the enormous sums now being spent on care in Massachusetts confirm, from another

direction, this report's finding that current spending is already enough to finance universal coverage.

None of the changes in Massachusetts in the months since the estimates used in this report were prepared alter that fundamental picture. Indeed, the federal data on the 30 percent excess suggest that today's spending may provide even more resources that could be better used. Readers might note several implications of recent changes in Massachusetts health care:

- Recent gains reducing the number of uninsured people mean that current health care spending is probably higher than projected here.
- Those gains also mean that the *added* costs of bringing everyone up to today's average level of coverage are probably smaller than projected here.
- The Balanced Budget Act's 1997 cuts in hospital care and home health care are not reflected here, so current spending in those sectors may be slightly lower than shown.
- Prescription drug spending has risen even faster than projected here. So have opportunities for saving drug costs and recycling the savings to fill all needed prescriptions without increasing spending.
- The administrative costs of today's payment and insurance systems have apparently risen faster than projected here.
- These estimates do not reflect some recent increases in government spending, or the steeper-than-projected rise in health insurance premiums.
- Thus, while estimates for some sectors warrant revision, these would likely mean little change in the overall estimates of the cost of today's care or of covering us all.

INTRODUCTION

The debate about health care for all starts usually with the question, *"Can we afford care for everyone?"*

No reasonable person wants citizens of the Commonwealth to continue to suffer the preventable worry, pain, disability, and deaths that accompany exclusion from the health system. And no reasonable person wants the Commonwealth and others who pay for care to continue bearing the extra costs and waste of the untreated illness, the emergency treatment, and the cost-shifting that occur today.

For more than three years, we have been developing and refining a set of models of the costs of health care for all in Massachusetts. We consistently find that ***the cost of health care in the Commonwealth in the absence of reform exceeds the projected cost of comprehensive, universal coverage with simplified administration.***

The plan examined here would provide all Massachusetts residents and workers with comprehensive health care benefits, including prescription drugs and long-term care. Besides insuring those who are uninsured today, it would fill in the many gaps in coverage for today's insured, giving substantial new benefits to us all. Patients would have free choice of doctors, hospitals, and other caregivers. The plan would free patients and caregivers from bureaucratic interference with decisions about the appropriate course of care. And it would eliminate most deductibles, co-payments, benefit caps, and other patient cost-sharing requirements. This coverage would pay for all care out of one pool, without using insurance companies. We call this a pooled all payor plan. It permits genuine cost containment, rather than today's prevalent cost-shifting. It also facilitates a range of financing and delivery reforms that would cut administrative and other waste.

Our model starts with estimates of health care costs in 1999 under the current system. Our overall estimates of spending on personal health care in Massachusetts in 1999 are confirmed by recently-released federal data. [12] These estimates ignore any new efforts to improve coverage or to reform the financing or delivery of care. These estimates encompass care of all Massachusetts residents and workers—including residents treated elsewhere and Massachusetts workers who live in other states—as well as the relatively small amounts of "export" care given by the state's tertiary care hospitals and other caregivers to people from outside the state.

Building on this base, we detail the added service use and costs arising with universal care, including filling gaps in coverage for all. Next, we estimate clinical, administrative, and other savings that might reasonably be won under the specified reforms—here, the pooled payor plan. After showing the overall expected savings (or added cost) of achieving universal care with specified reforms, the model addresses financing options.

The body of this report presents 12 of our major findings. For readability, most of the documentation of the model and estimates is presented in appendices. Appendix I walks readers through the model's steps, giving highlights of the evidence,

assumptions, and results. It offers more detail on many of the estimates described briefly in the Findings, reinforcing those points. Appendix III, available separately, presents the model spreadsheets themselves, and their explanatory notes and sources.

Because some desired data are not available and the future can never be known precisely, any such estimates must be approximate. But we think the estimates we have been developing are reasonable. They are comprehensive because they consider both the savings and the costs associated with winning health care for all. They rest on evidence and assumptions documented in detail in the "Notes" section of the model printout in Appendix III. Making explicit the data and assumptions used in the model permits concerned parties to join in discussion and refinement of the cost and savings projections offered here.[13]

We invite comparison of our work—its analysis of both benefits and costs of reform, and its detailed specification of evidence, calculations, and assumptions—with the work of others that seeks to estimate the cost of health care for all.

Appendix II identifies questions and criticisms that have been raised about the approach proposed here and offers responses.

I. FINDINGS

Finding 1 – Spending less: *Massachusetts can afford to provide all necessary care to all its people while spending less. Saving $1 billion of 1999's estimated $36.8 billion in public and private payments for health care here while covering us all would have required pooling, re-channeling, and better using today's health care dollars.*[14]

Universal, comprehensive care in a unified system with simplified administration, we conclude, actually would cost $35.8 billion, or $1 billion less—about 2.8 percent less—than the cost of the state's current health system.[15] Savings from reform would likely be even higher the future, since health costs are rising sharply in the absence of reform.

Alternatively, trying to achieve universal, comprehensive coverage in Massachusetts under today's system, as Table 1 shows, would have cost $41.0 billion in 1999. That is $5.2 billion more—one-seventh more (or 14.5 percent more)—than coverage for all would cost with the financing and delivery reforms proposed here. Clearly, seeking access to needed care for all without extensive reforms would require enormous spending increases, which would be both unaffordable and politically implausible.

Table 1

Impact of Different Reform Strategies on Cost of Massachusetts Health Care

In 1999, for Massachusetts residents and workers:	
Baseline cost of current health care system and policies	$36.8 billion
Cost of care with universal, comprehensive coverage under current financing and care delivery policies	$41.0 billion
Cost of care with universal, comprehensive coverage, with financing and care delivery reforms	**$35.8 billion**

With reform, however, huge savings are readily achievable. Currently, over one dollar in every five spent on Massachusetts health care is consumed by administration— or more than $7.7 billion out of $36.8 billion in total health spending in 1999. (Knowledgeable observers suggest that insurors' and caregivers' claims processing and related costs may account for as much as one-fourth of private insurors' costs.[16]) And many of those who pay for care today face inordinately high prices for pharmaceuticals, durable medical equipment, and other medical commodities. We anticipate savings on those purchases and savings from creation of a streamlined, patient-friendly, and

business-like administrative structure, with health care on a predictable budget. These reforms would make it possible to finance and provide quality health care for all—and to save money.

With $35.8 billion, a reformed system can assure all of this state's 6.2 million people equal coverage for efficient and comprehensive care, filling the gaps for the under-insured as well as insuring the uninsured. As detailed in later Findings, the system modeled here would:

- substantially expand the use of health care without raising total costs,
- create a trustworthy financing structure for patients, physicians, hospitals, payors, and other stakeholders,
- sharply reduce paperwork and streamline administration,
- free caregivers' decision-making and time to focus on patients, instead of on payment and paperwork,
- support competition based on quality and access rather than on price,
- take advantage of the collective buying power of the state's entire population,
- protect payors from continued steep increases in health insurance premiums,
- replace cost shifting with genuine cost containment, and
- as a back-up to ensure cost control, set an annual budget for health spending.

We conclude that

- ***Health care for all is affordable at the state level.***
- Covering everyone is essential to genuine and safe cost containment.
- Today's strategies of managed care, price competition, and shifting care from hospitals to non-hospital sites are not containing costs in Massachusetts.[17] Reasonable savings can fund ***$2.4 billion in additional, actual health care*** while cutting total spending by $1 billion.
- Filling the gaps for people with limited coverage is reform's biggest cost.
- Eliminating most out-of-pocket spending is vital to cutting administrative costs.
- ***Nearly half of today's $7.7 billion in administrative spending can be cut.*** Ending the role of insurance companies in health care would save an estimated $1.1 billion on administering coverage and $2.5 billion on caregiver administration.
- The state's substantial physician supplies and adequate hospital bed supplies help assure that care for more people would cost less per person than the average for those now insured.
- With higher total health spending than many rich nations, the state's buying power would suffice to win very substantial price cuts from makers of drugs and supplies.
- Reformed financing can minimize incentives for doctors and hospitals to under-serve or over-serve, and help to restore patients' trust in caregivers while containing costs.
- ***Health care for all does NOT require higher spending or a huge tax increase.***
- Federal reform is unlikely. State reform is the only available path to coverage for all.

Finding 2 — Covering everyone: *The universal, comprehensive care reforms examined here will cover everyone in Massachusetts— guaranteeing all-inclusive care, to aid today's under-insured people as well as uninsured people. It will give us all medical security.*

The reform plan discussed here can fully cover everyone who lives or works in the Commonwealth. All people covered could have comprehensive, equitable benefits without the barriers imposed by the ineffective and often hazardous cost controls common in today's fragmented coverages and insuror practices. Trying to secure coverage for needed care now resembles doing a jigsaw puzzle with many pieces missing.

As one example of today's jigsaw puzzle, consider the possibility, announced on 23 October 2000, that the Tufts HMO would not be able to sign a contract with Partners Health Care. If this threat materializes, patients enrolled in Tufts would have to find new doctors and hospitals if they wanted to stay with Tufts, or find a new HMO if they wanted to stay with Partners physicians or hospitals.

But the reform plan proposed here would secure solid, seamless coverage.

Thus, besides insuring the uninsured, this reform plan will fill the gaps in coverage for us all. It offers free choice of caregivers and comprehensive benefits— including full coverage of, for example,

- prescription drugs,
- home care,
- nursing home care, and
- adaptive equipment.

These improvements will substantially expand access to needed care for virtually everyone now privately insured as well as for seniors and people with disabilities now on Medicare.

Universal access would mean presumptive eligibility: if you live in Massachusetts, you are guaranteed gap-free coverage without filling out complex applications or struggling to decipher your policy's terms. This will eliminate the problem of uninsurance.

And insurance eligibility limits and cost-shifting practices would no longer force patients and doctors into a band-aid approach to care (using the wrong, but covered medication, for example, or delaying needed surgery because of unaffordable deductibles and co-insurance). Caregivers will be able to treat each patient's real health care needs.

Together, these advantages of reforms would end a great source of worry for everyone in Massachusetts. All the state's people could rest secure that they and their families will have coverage for all the care they need, and financial protection against the costs of care— and that this coverage will not disappear if they lose or change their jobs.

Further, people would have no need to fear that they might lose their jobs because they or their families have gotten too costly to insure. Providing everyone with guaranteed coverage for all needed health care thus will reduce bankruptcies, job lock, fear of job loss, and social stress.

The reforms discussed in this report would not solve all health care financing and delivery problems for all time. Health costs would certainly still continue to rise because the population is aging and expensive new interventions are being developed. New crises will arise periodically. But the reforms proposed here would place Massachusetts health care on a considerably firmer foundation. That would make rising costs and new crises substantially easier to manage.

Massachusetts can act from both compassion and competence in covering all of the state's people comprehensively and affordably.

This analysis used the U.S. Census Bureau's estimate that Massachusetts had 755,000 uninsured people in 1997, or one of every eight residents. Similar numbers of people had lacked coverage in each annual survey since 1994.[18] The most recent Census Bureau data put the estimate for 1999 at 648,000 Massachusetts residents uninsured.[19]

Owing mainly to recent expansions of Medicaid programs, however, there is evidence that the number of uninsured people in the state fell in 1998 and 1999. A state-sponsored 1998 study (using different methods than the Census Bureau) estimated that the state's uninsured population was just 496,000 at the time of the survey,[20] and a preliminary report on a similar state survey this year puts it still lower, at 366,000.[21]

To the extent that the number of uninsured Massachusetts residents has fallen below the 766,000 figure used in this analysis, the actual *added* cost of covering all those who are still uninsured would be proportionately smaller than the estimate of roughly $1.0 billion developed in this analysis. Using an estimate of the number of people uninsured in Massachusetts that may well be high is a conservative assumption. That is, it helps avoid under-estimating the cost of insuring the uninsured.

(That $1.0 billion figure reflects the cost of bringing uninsured people up to today's average level of coverage, *before* covering services for which the average person today is under-insured.) Note, on the other hand, that if the number insured has risen, current health care spending is likely to be slightly higher than estimated here.

Further, there is reason to fear that the number of people uninsured will rise sharply in the next inevitable recession, as it did in the last one. Over a million people in Massachusetts could easily wind up uninsured in such a downturn. Acting now to secure coverage for all will be far easier than waiting for catastrophe to strike.

Growing gaps in coverage must also be addressed. These include:

- large and unmonitored increases in co-payments and other cost-sharing requirements,
- exclusions of benefits like prescription drugs (which recently hit many in Massachusetts who had coverage through Medicare HMOs), and
- managed care financial incentives to under-serve.

These gaps leave many Massachusetts residents under-insured. Some cannot pay for the health care services they need, and some go without adequate food or heat while they pay excessive sums for care. And many live in fear that they and their families will be unable to afford needed care, or worry as much about devastating financial burdens of any substantial illness as about the health burdens.

Estimates of how many people are under-insured vary widely with definitions used. For example,

- One-quarter of the insured people in the state's own 1998 survey reported that lack of coverage meant they had problems accessing care, and 30 percent of the insured reported confronting financial barriers to needed care.[22]
- One study's definition suggested about 700,000 people were under-insured in Massachusetts in the mid-1990s,[23] but that counted only privately-insured, non-elderly residents *at risk of* out-of-pocket spending exceeding 10 percent of income. That is a strict definition in one important respect: many people may have difficulty obtaining needed care even if the costs of their care total far less than 10 percent of their income. But even by that definition, a very large share of seniors are under-insured as well, because of the gaping holes in Medicare benefits.
- A national estimate is that "the typical Medicare beneficiary already pays about 20 percent of income on Medicare premiums, cost-sharing, and health services that Medicare doesn't cover, without even counting spending for long-term care."[24]
- And a new study found that, for one of six households headed by people under age 65, at least one-tenth of family income *actually* goes to health insurance premiums and out-of-pocket costs. Fully half of all households headed by someone over 65 *actually* spend more than 10 percent of family income on health care.[25]

As noted, some definitions of the under-insured count only people who incurred high costs in a certain period or were unable to obtain all the care they needed. Those definitions ignore the countless people with meager benefits who did not happen to fall ill during the time in question. Yet any solution for the problems of the under-insured cannot target only those who will get sick, because that is not predictable. Protection for everyone is the only solution.

Further, nearly everyone in the state is under-insured, arguably, and therefore medically insecure, because only the wealthiest can be sure of securing adequate long-term care, and because HMO financial incentives mean that many nominally insured people risk denial of needed care.

Finding 3 — More care for less money: *Universal, comprehensive health care with trustworthy and streamlined administration means that more of each health care dollar actually goes for care. In 1999 alone, the people of Massachusetts would have received approximately $2.4 billion more in actual health care services than without reform— a 9.0 percent rise in financing for actual patient care. This means more money for caregivers to provide that care. Pooled buying power and other factors also would lower the average cost of many goods and services, permitting an even larger rise in the volume of care provided, without higher spending.*

Today, many uninsured and even middle-income under-insured people go without needed care because they lack coverage and ability to pay, or are stymied by bureaucracy or by health plans or caregivers facing financial and competitive incentives to limit care. Some finally receive care only when they need costly emergency services. Current policies thus often deter use of appropriate levels of care— care that would improve the health of vulnerable populations and simultaneously control costs.

Largely by slashing $3.6 billion in administrative waste, the proposed reforms will permit a $2.4 billion rise in spending on actual patient care— an increase of fully 9.0 percent in spending on patient care.

Spending on actual care in the Commonwealth, as opposed to administration, would increase for 1999 from $26.7 billion to $29.1 billion. (See Figure 1, at the end of this Finding. It shows spending on personal health care, both actual care and administration; it omits research and public health expenditures.)

Table 2 and Figure 2 show the anticipated changes in spending in each sector of health care with such reform. The top portion of the table shows the increases in *spending* that we project for five sectors:

- physician care,
- dental care,
- nursing home care,
- home care, and
- other professional services.

Total spending in those sectors would rise, between 8% and 41% in each sector. Money would be re-allocated from other sectors where spending falls—mainly from the administration of insurance. (Insurance administration is included in Table 2 and Figure 2 as *part of* 'Program Administration and Net Cost of Insurance.[26])

Further, in each of those sectors, the percentage rise in *service use* with reform would be larger than the corresponding percentage rise in spending, for two reasons.

First, as just discussed, the share of total spending consumed by administration would fall. It would fall substantially in certain sectors (see Table 3 and Figure 3). So the administrative cost and thus also the total cost of serving each patient would be lower

after reform. Especially in sectors that now have substantial billing-related administrative costs, each dollar spent would pay for more actual patient care after reform than before, as Table 3 shows. And caregivers—freed from much of their financial paperwork—would have more time to devote to patients, thus permitting care that is less rushed and boosting the system's capacity to meet all patients' needs.

Second, the state's existing capacity can accommodate some added patients before having to incur new fixed costs. For example, Massachusetts has an ample physician supply, as evidenced by its ratio of patient care physicians to population—the highest among the states.[27] Capacity to absorb more patients varies with the resources available in each sector of health care. In parts of the state, for much of each year, acute hospitals still have numerous empty beds. As noted elsewhere, however, more hospital closings or bed reductions could leave inadequate capacity to serve today's under-served patients who would gain financial access after reform.

For both these reasons, the real (marginal) cost of caring for additional people would be less, per person, than the current cost of serving those already in the system. Overall, therefore, the cost for each unit of service will decline, on average.

So, in proportions that vary by sector, a given increase in spending would finance an even larger increase in use of care. And the projected 9.0 percent overall rise in spending on actual care would support a rise of more than 9.0 percent in the volume of health care services that Massachusetts beneficiaries receive.

In only two sectors would total expenditures be substantially reduced under the proposed universal access reform than they are today, as shown in the lower half of Table 2:

- We project a very substantial cut (44%) in spending for the administration of health insurance coverage. After the added costs of new data collection needs, projected annual savings total $0.9 billion.

- For hospital care, total costs would fall 15%—or $1.7 billion in 1999, we estimate — as a result of huge administrative savings. Yet non-administrative spending on hospitals, spending on actual hospital care, would be essentially stable (see Table 3 and Figure 3). Some declines in hospital use (from substitution of more appropriate care and elimination of today's persisting incentives to over-use costly services) would partially offset the increased use of services by today's under-served. But since some needed hospitals are experiencing financial distress today, ***it would be appropriate to consider allocating some of the $1.0 billion in overall savings achieved under this reform plan to stabilizing needed but financially stressed hospitals.***

Increases in physician services, nursing home, and home care use in a universal, comprehensive system are affordable because funds would be re-allocated from the two sectors just discussed, in which spending would drop. That reallocation would also support higher spending and use of dental care and other professional services.

For prescription drugs, reforms would unify the state's now fragmented buying power for price negotiations with drug makers. This would permit winning some of the extraordinary savings now won by every wealthy nation outside the U.S. So prices of most prescription drugs would fall. Because of that, and because everyone would have coverage, prescription use rates and the volume sold would rise. The Commonwealth's citizens would obtain many more medications than today for a comparable total cost, as Table 2 shows. (Similarly, pooled purchasing power would cut prices on durable medical equipment, supporting expanded access without higher spending.)

In summary, the proposed reforms would increase use of health care services while reducing overall cost. Service use would rise to help improve care for all Massachusetts residents as well as to meet the special needs of the uninsured.

Current policies endanger people's health and lead to use of expensive resources for simple problems. ***We conclude that Massachusetts can afford to encourage appropriate levels of health care utilization by everyone, including many middle-income, nominally insured people who are now under-served.*** Establishing one payment system for all Massachusetts health care would permit better use of valuable health care resources—to increase care and decrease paperwork, and to encourage provision of care when it is needed and cost-effective rather than simply when it will be reimbursed.

Figure 1

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

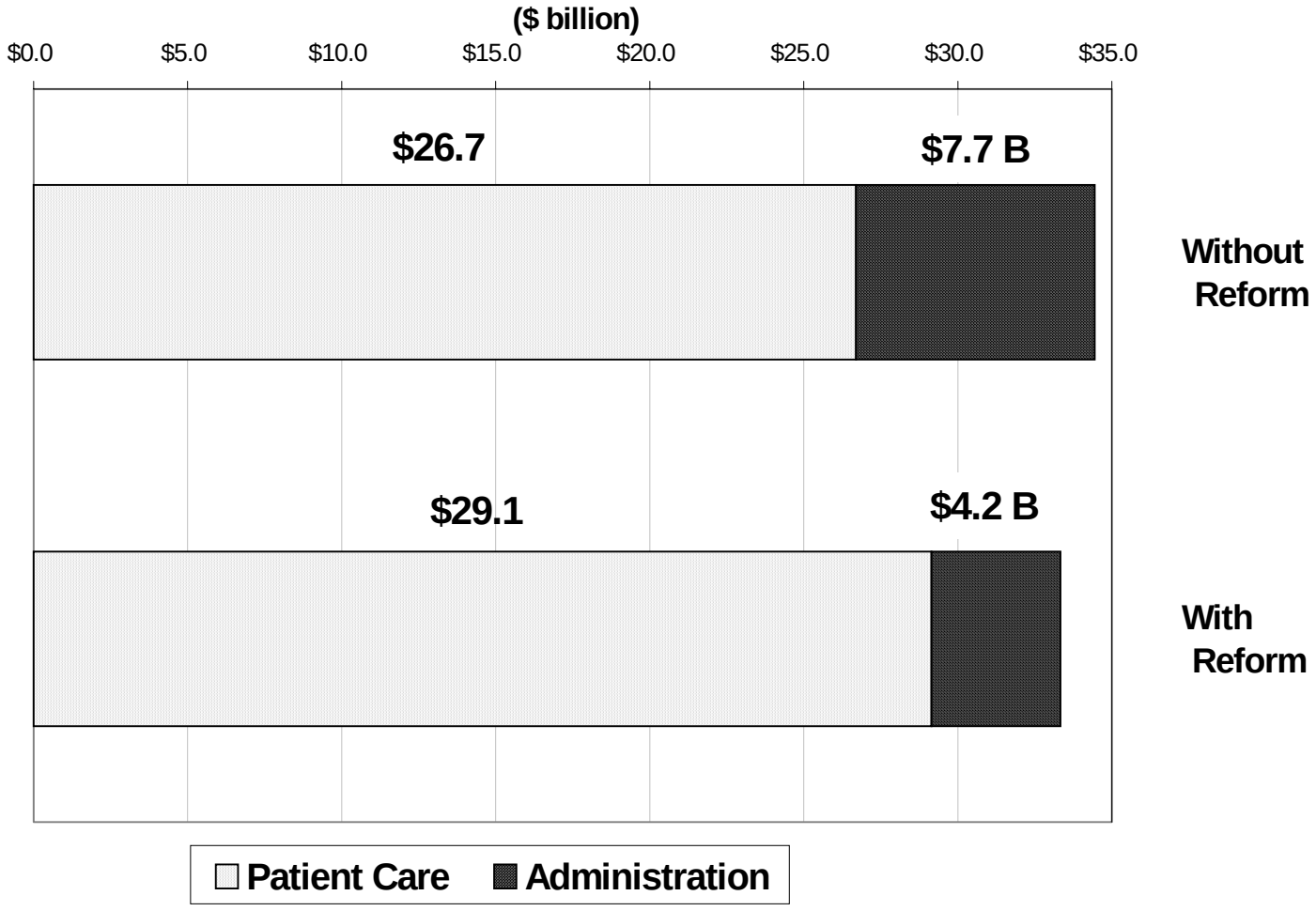


Table 2

Change in Spending in Major Health Sectors with a Universal, Comprehensive Health Care Delivery System, and with Simplified Administration

Major areas of expenditure (health sector)	Estimated 1999 expenditures if no reform for Massachusetts residents ($ billion)	Estimated 1999 expenditures with universal access and simplified administration for Mass. residents and workers ($ billion)	Percent change *
Areas of rising expenditure			
Physician Services	$5.4	$5.8	8.1%
Nursing Home Care	$4.3	$4.8	12.0%
Home Health Care	$1.7	$2.4	41.1%
Dental Services	$1.2	$1.6	27.5%
Other Professional Services	$2.6	$3.0	13.0%
Areas of declining expenditure			
Hospital Care	$11.9	$10.2	** -14.7%
Program Admin. and Net Cost of Private Health Insurance ***	$2.0	$1.1	-44.4%
OTHER: Areas of stable expenditure			
Prescription Drugs and Medical Non-Durables	$3.2	$3.1	**** -3.5%
Vision Products and Durable Equipment	$0.3	$0.3	
Other Personal Health Care	$1.0	$1.1	
Research	$1.5	$1.6	
Government Public Health Activities	$0.9	$0.9	
Care of non-resident workers/dependents	$0.8		
TOTAL	$36.8	$35.8	-2.8%

Notes:

* In data on type of care, population served before reform is Massachusetts residents only; after reform, data on type of care include service to non-resident workers in Massachusetts and their dependents. In "Before" column, the $0.8 billion for their care is only in "Total."

** Savings on hospital administration are $1.8 billion, so hospitals can provide more services.

*** This includes the cost of administering private and public coverage, and insurors' profits.

**** Though medication use rises, prices fall, slightly more than offsetting the rise in volume.

Figure 2

Health Spending by Sector for Mass. Beneficiaries Before and After Reform, 1999

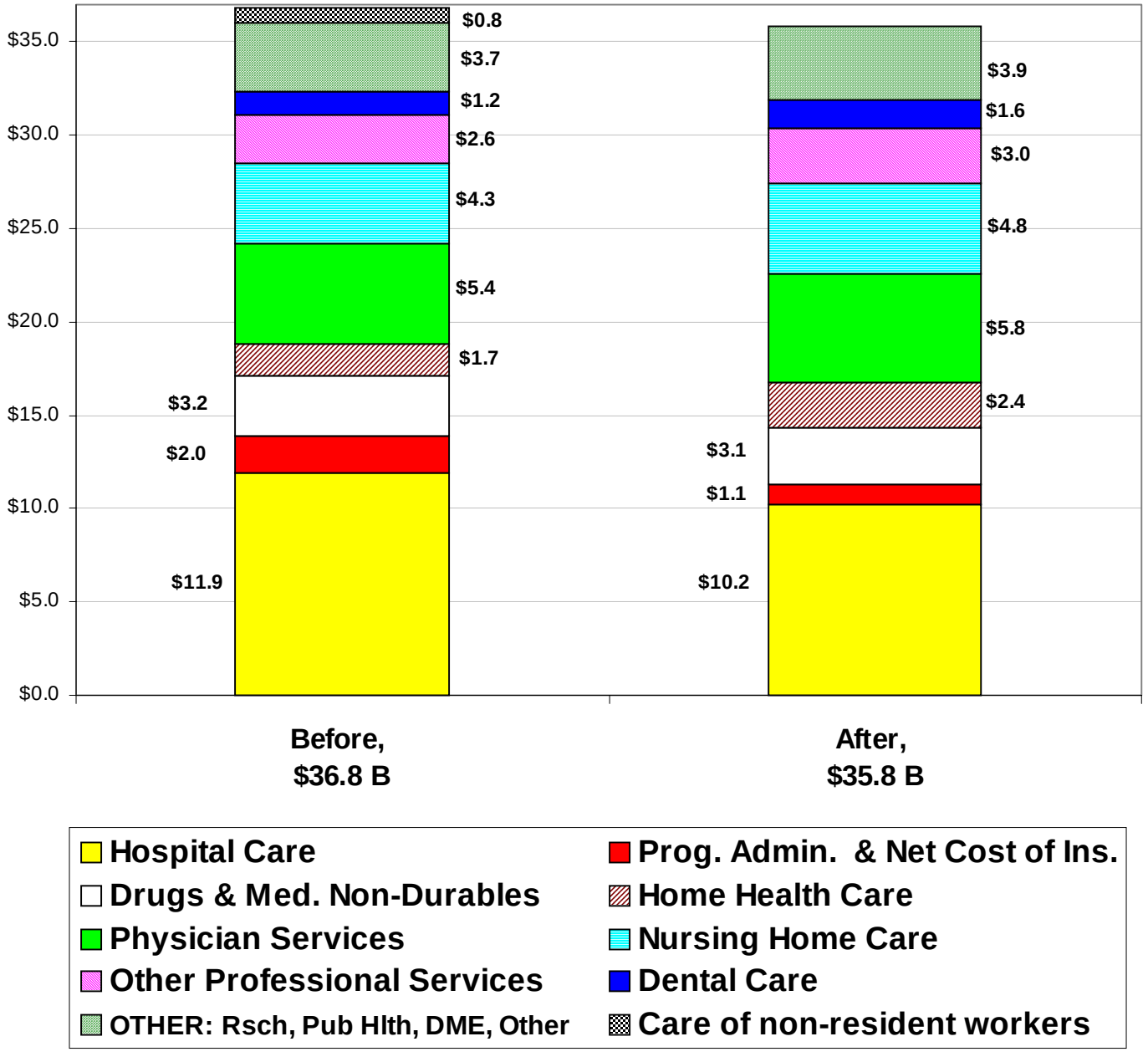


Table 3

Shares of Spending for Actual Care and Administration in Major Health Care Sectors without and with Reform

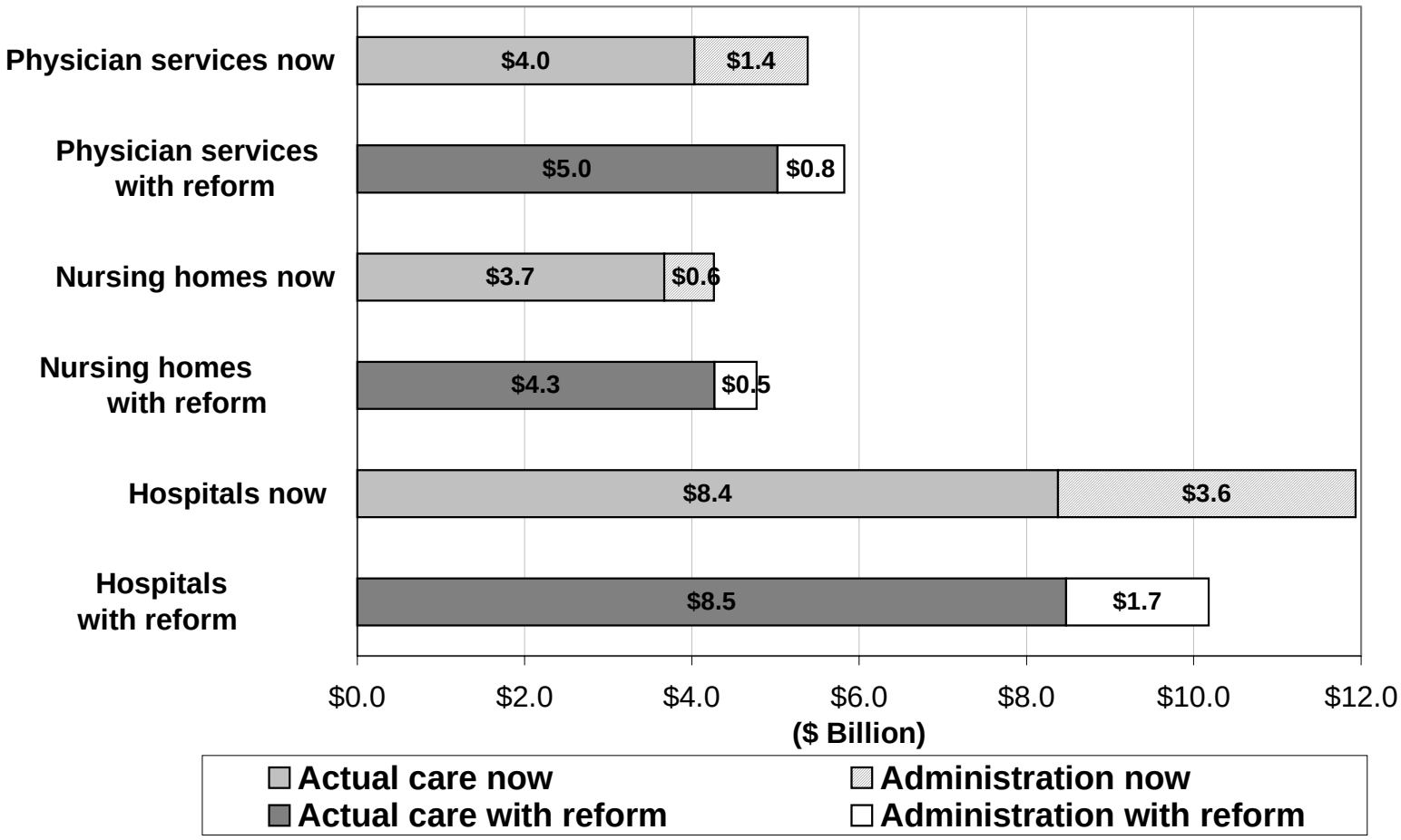
Major areas of expenditure (health sector)	Estimated 1999 expenditures if no reform for Massachusetts residents ($ billion and share of spending in sector)		Estimated 1999 expenditures with universal access and simplified administration For Mass. residents and workers ($ billion and share of spending in sector)		Percent change in total funds for sector*	Percent change in funds for actual care *	Percent change in funds for admini-stration
	CARE	ADMIN.	CARE	ADMIN.			
Physician Services	$4.0 74%	$1.4 26%	$5.0 86%	$0.8 14%	+ 8%	+25%	-41%
Nursing Home Care	$3.7 86%	$0.6 14%	$4.3 90%	$0.5 10%	+12%	+16%	-15%
Hospital Care	$8.4 70%	$3.6 30%	$8.5 83%	$1.7 17%	-15%	+ 1%	-52%

Note:

* Population served changes after reform, to include Massachusetts workers (and their families) who live outside the state.

Figure 3

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

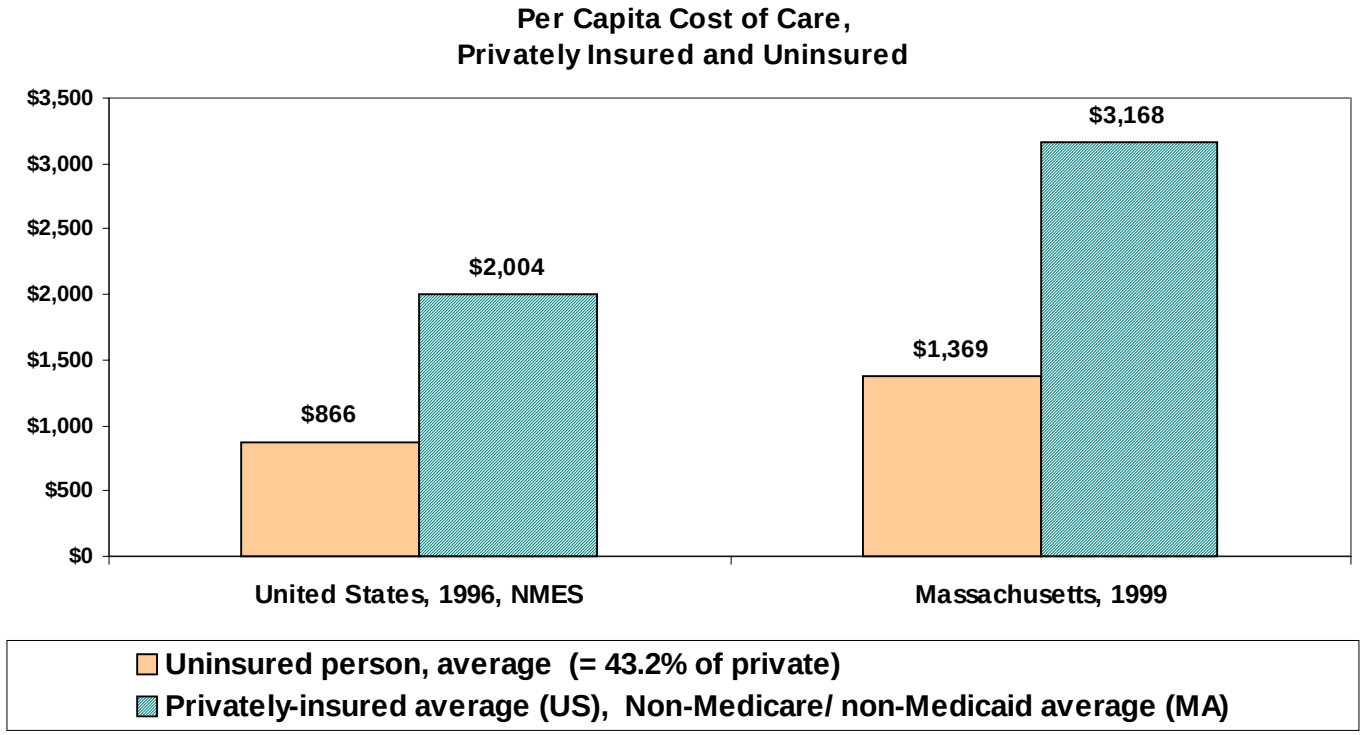


Finding 4 – Added costs of coverage: *The added costs of universal access to comprehensive benefits include $1.0 billion to cover the uninsured and $2.8 billion— or nearly three times as much— to eliminate under-insurance by filling the gaps in coverage for people who are only partly insured currently. The $4.2 billion in total added costs would be more than offset by the savings available in a universal system with simplified administration.*

Our model uses a wide range of reported research to reliably estimate effects of access to comprehensive care for all in Massachusetts. With a thorough estimate of current health costs, we can then predict the impact of alternative policies. We estimate the higher spending and use rates that may accompany universal access to comprehensive care, and the savings associated with care for all and simpler administration.

To estimate the additional cost of insuring the uninsured, we used a national survey that reported that health spending for the average privately-insured American was 2.3 times the average for uninsured people.[28] It is reasonable to assume that coverage will raise health care use rates for the uninsured here by a similar proportion. (See Figure 4.)

Figure 4



But the state's ample physician supply and substantial hospital capacity mean that adding services for a newly insured person would cost less than the average cost of

such services today for people already insured. We do not anticipate huge new fixed costs—of hospital construction, for example—to meet the new demand. (This is largely because, as Finding 7 notes, we project an offsetting reduction in hospital use owing to elimination of unnecessary care when patients receive more timely care and when caregiver payment incentives to over-serve are minimized. Further cuts in the state's hospital bed capacity could, however, mean that enormously costly expansions of capacity would be required to serve people who have new or expanded coverage—and would thus make insuring the uninsured vastly more costly.[29])

The cost of bringing roughly 766,000 uninsured Massachusetts residents[30] up to the state's average level of care, we find, would total slightly less than $1.0 billion, or 2.6 percent of baseline spending. As discussed in Finding 2, if the number of uninsured people now is smaller, as recent evidence suggests, then the cost of insuring them would be reduced proportionately.)

Ending under-insurance of people with some coverage will cost nearly three times that sum. Besides eliminating out-of-pocket costs, our reform plan gives everyone comprehensive benefits, including dental and long-term care, and prescription drugs. We project that the elimination of patient cost-sharing and of uncovered benefits will substantially increase the use of most types of care, as shown in Table 4.[31] *These coverage expansions are projected to raise use of physician services by 17 percent,[32] for example, with hospital care rising 10 percent,[33] and home care 25 percent*.[34]

In total, we estimate the real (marginal) cost of sufficient care to end under-insurance at $2.8 billion. As noted earlier, since this state has large supplies of hospital services and physicians, and since most current fixed costs are covered at today's volumes of care, services can be expanded substantially before incurring new fixed costs. Caring for more people will not cost as much, per person, as the average for people now insured—assuming, again, that the state does not go too far in cutting hospital capacity.

Better care coordination, data collection, and new services for people with disabilities, estimated at $0.4 billion, bring total new costs of care for all to $4.2 billion. But that is before tallying reform's opportunities for savings, which more than offset the new costs.

Just one-fourth of the total new costs of coverage expansion goes to insuring the uninsured, we estimate. Roughly 70 percent of the rise in spending and service use after reform would be for people who are now insured, but who face gaps in benefits and other cost-sharing barriers to needed care.

But only when the gaps in coverage for under-insured people are filled as well—when both types of coverage expansion are done together—can Massachusetts save money while preserving the quality and trustworthiness of care. It is only when everyone is covered using a pooled funding source that clinical costs can be contained safely and fairly, that paperwork and bureaucracy can be slashed, and that statewide purchasing power can be put to work.

If, however, coverage were expanded without undertaking substantial reform of health care financing and delivery, the cost would be impossibly high. To simply extend today's inefficient, costly, and bureaucratic coverage to everyone and provide comprehensive benefits for all would add $4.2 billion for new care to the state's current $36.8 billion in health spending. That would raise Massachusetts health care costs by 11.4 percent, to $41.0 billion.

Table 4

Additional Expenditures of a Universal, Comprehensive Health Care Delivery System with Simplified Administration

Area of Increased Expenditure	Additional Costs of New Coverage ($ billion)
Higher service use of currently uninsured Bringing them to average use levels of privately-insured (in all categories of care combined)	$ 1.0
Higher service use from ending under-insurance for all Reducing cost-sharing, filling benefit gaps	$ 2.8
More use of hospital services	$ 0.5
More use of physician services	$ 0.7
More use of prescription drugs	$ 0.2
More use of nursing home services	$ 0.4
More use of home care services	$ 0.4
More use of dental care	$ 0.3
More use of other professional services	$ 0.2
More use of medical durables	$ 0.02
More use of other personal health care	$ 0.1
Increased use of rehab services, attendant care and assistive technology	$ 0.2
Increased cost of data collection and management	$ 0.2
TOTAL INCREASED COSTS OF A UNIVERSAL, COMPREHENSIVE SYSTEM WITH SIMPLIFIED ADMINISTRATION	$ 4.2
Savings in universal, comprehensive system with simplified administration (see Table 5)	$ 5.2
Costs minus Savings	- $ 1.0 (a net saving)

Finding 5 – Administrative savings: *Covering everyone in a single plan would permit enormous administrative savings— an estimated $3.6 billion, or fully 10 percent of current health spending in 1999. As administrative costs plunge from today's $7.7 billion or more down to roughly $4.2 billion, vast resources could be reallocated from bureaucracy to care. But there would still be ample sums to pay for efficient administration of care and coverage.*

Besides the added costs just described, comprehensive reform would create enormous new opportunities for savings which must also be tallied. First of all, having everyone in one, pooled, all-inclusive plan, instead of hundreds or thousands of different plans, would eliminate the insurance bureaucracy and bring huge administrative savings.

An estimated $7.7 billion was spent on health care administration in 1999 in the Commonwealth, or 22.4 percent of the $34.4 billion spent on personal health care and administration of coverage.[35] But with a pooled source financing care for all of the state's people, and with no patient cost-sharing in most sectors, administrative spending would plummet to $4.2 billion. That would be just 12.6 percent of the $33.3 billion in projected personal health spending with reform. (Please refer back to Figure 1. Numbers may not add to totals because of rounding.)

Administrative savings would amount to fully 10 percent of total health spending—$3.6 billion in 1999, enough to offset most of the new costs of health care for all. This is the major reason why comprehensive benefits for all Massachusetts residents and workers would cost less in a pooled payor plan than projected health costs without reform. Removing insurance companies from health care will lower the cost of care for us all.

Today's insurers spend heavily on unproductive non-care expenses of many kinds:

- on paperwork to bill patients and to pay caregivers less,
- on processing huge numbers of claims for individual services,
- on underwriting and other efforts to avoid enrolling the sick people who need coverage most,
- on advertising, and
- on returns to stockholders.

We estimate, very conservatively, that insurance administration will consume 11 percent ($1.4 billion) of projected private health insurance spending for Massachusetts residents in 1999 without reform. Using the U.S. General Accounting Office finding that using a single payor could cut the cost of administering coverage by 79 percent, Massachusetts could save $1.1 billion.[36]

Even larger would be the savings on caregiver administration—the largest category of savings projected here. Under comprehensive reforms, knowing that everyone is covered and that payment is secure, caregivers could drop several huge tasks:

- determining patient eligibility,
- determining patient benefits, and

- seeking reimbursement from insurors and patients through billing and collections.

Today, for example, administration consumes about 29 percent of hospitals' costs—or almost one-tenth of all health care spending in Massachusetts. With universal coverage but without insurance companies, those costs could be cut roughly in half, we estimate, dropping to the 14 percent level of Canadian hospitals. That alone could save $1.9 billion, as Table 3 showed—or nearly five percent of today's health care costs. That would still leave $1.7 billion for hospital administration here.

As Table 3 showed, this model estimates that simplifying administration for physicians could save another $600 million. That would also free up doctors' and support staff's time for patient needs. It would mean saving about 10 percent of current spending on physicians—and permitting that sum to be devoted to care, rather than paperwork. If Massachusetts has 20,000 patient care physicians, that $600 million saved represents $30,000 per physician, or perhaps most of the cost of a billing clerk, including fringe benefits.

We calculate that fully $1.6 - $2.1 billion is being spent on financial administration of physician services alone this year. Using new evidence from inside the health care industry, we estimate that $673 - $839 million (40.9 percent of the $1.6 - $2.1 billion) could be saved through more efficient administration of physician care alone.[37]

But even if the savings on financial administration of physician services total just $600 million (as in Table 3), combining that with the administrative savings on hospital care and insurance (plus small administrative savings in other sectors) yields a total of $3.6 billion in savings from cutting bureaucracy and paper-pushing. That is one of every ten dollars in Massachusetts health care.

Eliminating nearly all categories of out-of-pocket costs is essential to achieving these administrative savings, as the next Finding discusses.

In addition, covering everyone in a pooled plan would permit replacing today's pervasive cost-shifts— whether between payors, between sectors, to patients, or to caregivers— with true cost containment.

Finding 6 – Ending patient cost-sharing is vital: *The reforms discussed in this report would eliminate 81.2 percent of out-of-pocket spending for Massachusetts health care. Aiding under-insured people by providing comprehensive benefits, and ending deductibles, co-payments, and most other out-of-pocket spending is both affordable and very important for cutting administrative costs.*

Patients today pay $6.4 billion in out-of-pocket costs for care, including deductibles, co-payments, co-insurance, and services not covered by insurance. That is effectively a tax on sick people which amounts to 17.4 percent of total 1999 health spending.

Under this reform proposal, patients' out-of-pocket costs statewide would drop steeply, from $6.4 billion to $1.2 billion— or just 3.3 percent of the estimated $35.8 billion in health spending. The plan would thus eliminate four-fifths (81.2 percent) of today's out-of-pocket spending for Massachusetts beneficiaries.

Patient cost-sharing would continue in only two sectors. Patients would continue to pay for non-prescription drugs and medical supplies (unless prescribed). Long-term nursing home patients would make modest contributions towards the non-medical (housing and food) costs of their nursing home stays—costs they would have if living on their own.

Eliminating most patient cost-sharing is affordable because as a cost control strategy, such requirements are ineffective, failing to target the true sources of high costs. Most decisions to use costly services are made not by patients, but by physicians and other caregivers after patients have entered care.

Further, a system that substantially eliminates cost-sharing through simplified administration will devote more money to care and will spend less money in total.

But retaining patient cost-sharing requirements would mean perpetuating today's inefficient billing bureaucracies, and a financing system that deters needed care and shifts costs. All these problems would raise costs:

- The need to handle cash and partial payments creates an administrative system that is both expensive and unfriendly to patients.

- Continuing patient cost-sharing would oblige wasteful and costly record-keeping to bill patients and track payments towards deductibles. It also would prompt demand for supplemental insurance to cover out-of-pocket costs.

- Most important, requiring patients to pay at the point of service discourages use of services. And cost-sharing is as likely to cut out essential services as unnecessary or marginal ones.[38] Therefore, if cost-sharing requirements persist, patients will continue needing to use costly hospital care after failing to get appropriate care at earlier stages of their illnesses. Physician, dental, and other professional care, prescription drugs, vision products, home care, and other personal health care all would be less available if cost-sharing continues than they would in a universal,

comprehensive system that has no cost sharing in most sectors. And the system without patient cost-sharing would be more efficient and less costly overall.

- Finally, cost-sharing requirements shift costs. Cost-sharing puts the greatest financial burdens on those patients who are chronically or seriously ill and are therefore least able to carry those costs. The impact is most severe for people who have lower incomes, both because a given payment is harder to make than for higher-income patients and because poorer people tend to have poorer health status.

  In addition, caregivers often find that patients cannot pay the sums required under cost-sharing rules— perhaps a co-payment in a pharmacy, a deductible before insurance will cover physician visits, or co-insurance for a hospital stay. When someone cannot pay as required, caregivers are forced to choose between turning away a person who needs care and absorbing the unpaid cost-sharing themselves. So cost-sharing rules at times shift costs to caregivers as well as to patients.

Finding 7 – Clinical and other savings: *Conservatively, reforms will win $1.6 billion more in non-administrative savings— through more appropriate use of hospital care, negotiated drug price cuts, and capital budgets. Total savings of $5.2 billion more than offset the cost of new coverage. As a back-up, system-wide budgets will ensure costs stay within desired limits. Caregivers will be paid in ways that make the budgets real.*

Nationally, a robust literature questions the efficiency and efficacy of many medical interventions. The state's unusually high surgery rate[39] and other evidence suggest that unnecessary care explains much of the Massachusetts cost problem.[40] Yet many of the state's people are clearly under-treated. Our health care cost model assumes that medical practice will improve with the changed incentives under the proposed reforms.

We start with use levels of today's system, then estimate the effects of higher service use for the state's under-served patients, identifying the potential for improving care patterns when cost barriers are eliminated. For example, timely primary care might avert some hospitalizations, avoiding both human pain and $150 million annually.

Table 5

Savings of a Universal, Comprehensive Health Care Delivery System with Simplified Administration

Area of Savings	Amount of Savings ($ million)
Clinical savings and cost controls	
Savings from more timely, appropriate treatment of ambulatory sensitive conditions	$ 0.1
Savings from more appropriate use of hospital care	$ 0.6
Savings from capital planning and cap on capital spending	$ 0.2
Savings from bulk purchasing discounts on prescription drugs	$ 0.5
Savings from price negotiations / bulk purchasing discounts on durable medical equipment	$ 0.03
Reduction in workers comp medical payments	$ 0.01
Administrative savings	
Savings from simplified administration — private health insurance overhead	$ 1.1
Savings from simplified administration — hospitals	$ 1.9
Savings from simplified administration — physician practices	$ 0.6
Savings from simplified administration — nursing homes	$ 0.1
Savings from simplified administration — dental care	$ 0.01
TOTAL SAVINGS	$ 5.2
Increased costs in universal, comprehensive system (from Table 4)	**$ 4.2**
Savings minus increased costs (from Table 4): surplus of savings over additional expenses of universal, comprehensive care with simplified administration	**$ 1.0**

We estimate clinical savings at 5 percent of current hospital spending alone, or $0.6 billion. Conservatively, we do not count any such savings outside the hospital sector.

Today, it has become increasingly apparent that state and/or federal government action to contain drug prices is vital.[41] This analysis assumed that Massachusetts negotiations or bulk purchasing could achieve cuts of 24 percent in prescription drug manufacturers' prices.[42] That would have saved over $0.5 billion in 1999. This appears to be a conservative estimate. In 1997-98, the world's brand name drug makers accepted prices in other well-off nations even lower relative to those they charged in the U.S. In Sweden, for example, their prices averaged 32 percent below those of the U.S.,[43] even though Sweden has less than half this state's health care purchasing power.[44] So it seems highly likely that Massachusetts would have sufficient bargaining power with prescription drug makers to win wholesale price reductions of at least 24 percent. (We have recently described an alternative approach which would win even larger price reductions and all needed medications for the state's citizens, while protecting drug makers' revenues and profits; that approach may be advantageous politically.[45])

Finally, a statewide budget for health care capital and equipment would spare us from paying for empty new hospital buildings or a duplicative medical arms race.

These and related cost controls and clinical changes would save $1.6 billion. Combined with the $3.6 billion in administrative cuts, the reformed system's total savings are $5.2 billion— more than offsetting the $4.2 billion cost of expanded coverage. Further, when everyone is covered comprehensively in a pooled system, cost controls can be both more reliable and safer, as discussed in the next Finding.

To assure the system's ability to live within desired spending limits, we provide for budgets for overall health spending, hospitals, physicians, and perhaps other sectors. These can help free doctors and patients from interference with their autonomy in choosing the best care, given available resources. And a budget can be adjusted, with public accountability, to reflect need for care and for cost control. Total spending will be generous by any standard. No universal and comprehensive health care system can work unless it can control costs and assure fair access and comprehensive benefits.

Methods of paying caregivers will be consonant with adherence to budgeted spending levels. Otherwise, budgets would only be nominal and abstract, and easily exceeded. Health care budgets will help relieve cost pressures on the budgets of all who pay for care— employers, families, and taxpayers. But caregivers will benefit, too. Budgets will mean secure and predictable revenues. That should aid the stability and survival of all caregivers, and especially of those who today struggle to serve uninsured patients.

Thus, budgets serve to reassure both payors and caregivers. And because they are a backstop on cost containment, they permit elimination of managed care's incentives to under-serve and bureaucratic second-guessing of caregivers—which should reassure patients. The increase in the funding available for actual care would also reassure

payors, caregivers, and patients that Massachusetts would be getting a better deal than prevails today.

Savings on administration and the moderate clinical and other savings discussed here, when captured and recycled, can amply finance needed care for all. The savings cut the cost of Massachusetts care to $35.8 billion— again, *$1.0 billion* below pre-reform costs.

Spending on actual patient care will rise by $2.4 billion. And this 9.0 percent rise in spending on patient care will purchase an even larger increase in the volume of services provided, since there is capacity to absorb more patients today without new fixed costs and current fixed costs had been covered with today's volume of care.

Annual savings would likely be even higher than $1 billion in future years, as health costs are expected to rise sharply without reform.

Finding 8 – Quality will be enhanced: *Covering everyone and ending today's financial pressures on caregivers to do less will protect quality of care, restoring trust. While caregivers will have to spend carefully, $36 billion is ample in Massachusetts to finance all the care that works for all the people who need it.*

In a universal system providing comprehensive care with simplified administration, efforts to contain costs can be more certain of success, yet far less hazardous than such efforts are under today's strategies of managed care and price competition.

Care will be more trustworthy when all people are covered and when doctors are no longer rewarded for doing less. Under those circumstances, the Commonwealth and individual patients will be better able to trust that doctors will cut waste safely and spend money wisely. Caregivers will no longer feel they must deny care that is needed to control costs, or that they must provide unneeded care to raise their incomes. Care-giving decisions will no longer be influenced by some people's lack of coverage, or by financial incentives for caregivers— only by clinical needs, patients' choices among appropriate treatments, and the need to make good use of inevitably limited resources.

The proposed reforms will mean less bureaucratic control over care. Combining the cost control back-up tool of health care budgets with financially neutral methods of paying caregivers can provide vital protections for the quality of care. It can allow the reformed system to free doctors and patients from bureaucratic second-guessing and interference with their autonomy in choosing the best, most effective care, given available resources.

This approach will improve both quality and quantity of care. Everyone will have coverage— comprehensive coverage. Further, with less money spent on bureaucracy, more of the Commonwealth's health spending will support actual care.

Many concerns that people express today about the quality of actual or anticipated care in their HMOs are actually concerns that needed care will be denied, either because of limited benefits or because of competitive and financial incentives for plans or caregivers to limit care. But the proposed reforms will end such incentives to under-serve. And no longer will doctors need to fear loss of their contracts if they prescribe high levels of services. So the proposed reforms will end the perverse disincentives to accept sicker patients that confront doctors today. Finally, with full coverage and the freedom to choose their individual caregivers or their networks of caregivers, patients' choices will be driven by caregiver quality, convenience, and compassion.

The Commonwealth's projected $35.8 in total health spending after reform will be generous by any standard— about three times the western European average per person.[46] While outlays to hospitals and doctors will be held to annual budgets and they will certainly have to spend money carefully, there is no need to fear British-style waiting lists for care, since spending will be over three and one-half times Britain's. Spending will be enough to finance the care that works for everyone who needs it. Rather than cutting care, Massachusetts can recycle today's administrative and other waste to finance more services for all— in a less bureaucratic, more patient-friendly system.

Finding 9 — Incrementalism is unaffordable: *Incremental coverage improvements are better than none at all— much better— but they inevitably cost more money. Incremental measures to achieve universal, comprehensive coverage would be intolerably costly, requiring health spending of at least $41 billion— or at least $5.2 billion above (14.5 percent above) the sum that Massachusetts needs to spend to win coverage for all.*

It's common to assert that providing health care for all is desirable but too expensive. As we have shown, however, that assertion is wrong. The savings achievable when universal, comprehensive care is paid for from a single pool more than offset the cost of expanded services.

Those who assert that universal coverage is too costly often suggest that the state or the nation can progress gradually, incrementally, towards health care for all:

- Many who think of universal coverage think mainly about insuring the uninsured. But the biggest, costliest gaps to fill—in assuring that everyone can afford needed care—are the gaps in care for people who are under-insured and have unmet needs for prescription drugs, long-term care, and other services, as discussed in Finding 4.

- Others might hope to achieve the comprehensive coverage proposed here, simply by adding coverage expansions to insure the uninsured and to fill gaps in benefits. But without changing current ways of paying for care, Massachusetts would forfeit the opportunity to use current spending better. That means spending enormous new sums to expand coverage.

As compared with today's $36.8 billion cost of care, moving to universal, comprehensive care by just adding benefits and coverage expansions— without reform's opportunity for savings— would cost at least $41.0 billion. That is the added cost of buying everyone into comprehensive coverage in today's wasteful system—insuring the uninsured and addressing the needs of the under-insured. That cost of an incremental strategy is $4.2 billion above current spending, an 11.4 percent rise.

The contrast with the reform plan presented here is even more dramatic, because an incremental approach forgoes the opportunity to win any of the savings achievable with the reforms proposed here. Keeping a multi-payor system would mean preserving enormous administrative waste, continuing a fragmented market with exorbitant prices for prescription drugs and medical equipment, and retaining hazardous and ineffective financing methods that often shift costs, rather than controlling them.

So the $41.0 billion price tag for comprehensive coverage achieved incrementally is 14.5 percent more than this reform plan's $35.8 billion cost. Thus, in 1999 alone, the cost of trying to insure everyone in today's multi-payor system would be at least $5.2 billion more than Massachusetts needs to spend to win coverage for all**.**

It may well be that the number of people who are uninsured today is lower than in these estimates, and the incremental cost of bringing them up to today's average level of coverage is therefore lower than estimated here. But the cost of expanding benefits to assure comprehensive coverage for all arguably is rising because of deterioration in benefits—for example, recent cuts in prescription drug coverage.

Worse, the $41.0 billion cost estimate for the incremental path to universal coverage is a very conservative one. It relies on the estimates presented earlier of the added costs of insuring the uninsured and eliminating under-insurance. As described in Finding 4, however, the added volumes of care would be paid for at their marginal (actual) cost. That saving is made possible by the proposed reforms in health care financing. But simply buying comprehensive coverage for all under today's system would mean having no mechanism for assuring that caregivers' added volume is compensated at marginal cost. If hospitals, physicians, and other caregivers—along with HMOs and other health insurors—each collected payment at current average levels (or at average cost), the sum required to insure us all would soar.

Sometimes incremental, stop-gap measures are urgently needed—a bandage to stop the bleeding. But the real solution is to better spend the huge sums already spent on care in the Commonwealth. That is partly because any coverage expansions that raise costs will, in a patchwork, multi-payor system, spur an intensification of the unfair, risky, and ineffective cost control attempts that prevail today. Providing equitable, comprehensive coverage to everyone in Massachusetts is essential to genuinely and safely containing health care costs.

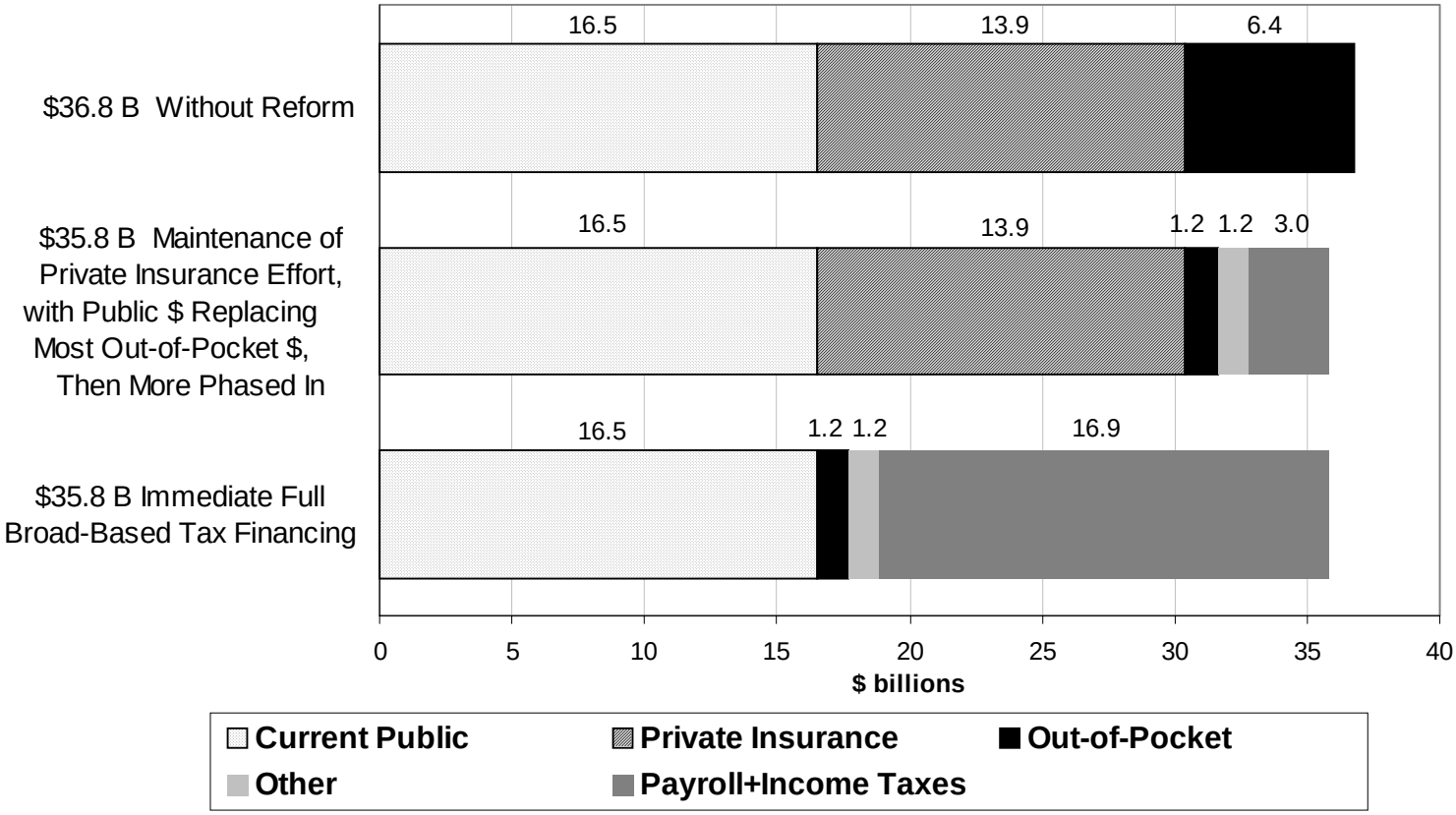
Better use of today's health dollars is needed, most importantly, because more money to expand health coverage would mean less money available for everything else that everyone—individuals and families, business, charities, and government—cares about. If new coverage uses money not now in health care, there will be fewer resources for paying for rent or mortgages, food, heat, education, a cleaner environment, making streets safer, repairing infrastructure. If health care costs rise, there will be less for everyone to buy any non-health care products and spend on non-health care services. The higher health spending inevitable with an incremental strategy would keep business costs disproportionately high, making Massachusetts and its products less competitive.

Finding 10 – Alternative financing: *Today's $6.4 billion in out-of-pocket payments for Massachusetts health care constitute a sickness tax. In addition to the $1 billion of that sum that reforms could save, fully $3 billion should be replaced with broadly-raised state taxes. Substituting $3 billion in income and payroll taxes for $3 billion in sickness taxes— coinsurance, deductibles, and payments for services not covered today— would shift the source of one-twelfth (8.3 percent) of Massachusetts health spending. These substitute taxes are vital to winning immediate health care for all and lower costs.*

Today, public sources (federal, state, and local) pay about $16.5 billion towards Massachusetts health care, or nearly half (44.8 percent) the cost of care.[47] Of the $36.8 billion total for 1999, patients pay $6.4 billion (17.4 percent) out-of-pocket. Private insurance payments account for virtually all the remaining $13.9 billion, as shown in Figure 5.

Figure 5

Raising the Money for Massachusetts Health Care in 1999:
Current, Fully Tax-Financed, and Phased-In Public Financing



We assume the current $16.5 billion in public funds for care will persist. But how should Massachusetts raise the rest of the money needed to pay for the state's health care?

Traditional single-payor reform models use broad-based taxes, such as payroll or income taxes, to finance almost all care. These tend to be more equitable funding sources, less regressive than flat premium payments. For the state to start immediately to finance care solely with broad-based taxes, roughly half of current health spending must be converted to taxes. In that model, $16.9 billion in taxes would be needed to substitute for most of today's private insurance and out-of-pocket spending.[48] (See Figure 5.) Given reform's savings, the huge taxes would be more than offset by falling private and out-of-pocket costs. But such a great shift in the way money for care is raised would cause far more disruption and discontent over taxes than is necessary. This approach is widely viewed as politically unrealistic, and is not likely to receive serious attention.

But a modified approach is much more realistic politically, we believe. To secure immediate universal, comprehensive coverage, Massachusetts does not need to immediately convert all current health spending to broad-based public financing. Nor does Massachusetts need to impose a $16.9 billion tax increase.

An alternative strategy would require raising only the taxes needed to replace most out-of-pocket spending. By pooling current insurance payments with other funds for care, it would win immediate care for all and cost control. It phases in more equitable financing gradually.

TABLE 6 FINDING THE MONEY TO CARE FOR ALL MASSACHUSETTS RESIDENTS AND WORKERS	**Funding source ($ billion)**	**Cost remaining to finance ($ billion)**
Cost of care in 1999 after reform		$35.8
New out-of-state financing (from federal govt. and employers of Mass. residents)	$1.2	$34.6
Existing government health care funding continues	$16.5	$18.1
Continued patient out-of-pocket payment s (for non-prescription drugs, and for capped patient contribution towards housing cost of long-term nursing home care)	$1.2	$17.0
Privately-paid insurance premiums per worker frozen in 1999 dollars	$13.9	$3.0
Public spending to substitute for out-of-pocket payments, raised with tax of 1.5% on income and 1.0% on payroll	$3.0	$0

(Note: Numbers may not exactly add to totals because of rounding.)

Today's out-of-pocket costs are $6.4 billion, but the sum to be tax-financed in this approach would be less— $3.0 billion. That reflects reform's $1 billion in savings, patients' continued

$1.2 billion in out-of-pocket payments for two types of care, and an estimated $1.2 billion in new out-of-state revenue[49]— shown as "other" in the Figure. (See also Table 6. Table 8 in Appendix I summarizes the sources of funding before and after reform.) To raise $3.0 billion, projections from past years' state revenues suggest, taxes on the order of 1.5 percent on personal income and 1.0 percent on employer payrolls should suffice.

This money would not be new health care spending. And these should not be viewed as new taxes. Instead, they are a substitute for today's tax on sick people.

Everyone would spend a little more when healthy to eliminate the untenable financial costs of care that today burden people already struggling with injury or illness. As noted earlier, under the proposed comprehensive coverage reforms, out-of-pocket spending would plummet from $6.4 billion to $1.2 billion— a drop of fully 81.2 percent.

At the same time, this approach would freeze the $13.9 billion in current private insurance spending, thus **capping the premium liability of private payors**. It would require maintenance of effort in premium payments on a per worker basis, in 1999 dollars. Thus, premiums would not rise for inflation as they are now doing, and are expected to continue doing. Rather, inflation would gradually erode their real cost.

Instead of being paid to insurance companies and HMOs, these sums would go into the state trust fund, where they would be pooled with current public funding.

In future years, health care costs will rise owing to a combination of general inflation in the economy, an aging population, and (probably) persisting development of cost-increasing technology. Some of the money to cover these higher costs will come from Washington, through higher Medicare and Medicaid payments. The rest will need to be generated within the state. Gradual increases in public payments for health care can be expected. It is the higher public payments that allow the capping of private insurance payments.

Using one pool of money to pay for all care is vital to all these pressing goals:

- slashing administrative waste, and using the money instead for more care for us all,
- replacing today's pervasive cost-shifting with genuine cost containment, and
- providing equitable coverage.

In this financing plan, use of public funds to substitute for most out-of-pocket spending is what permits eliminating all the costly bureaucracy involved in collecting co-payments and co-insurance, tracking deductibles, and checking whether services are included in a patient's benefit package. These substitute taxes are the keystone of the financing reform, making possible the administrative savings that finance more care for everyone. This is a real example of spending money to save money.

By converting less than one-twelfth (8.3 percent) of today's total health spending from private to public financing, the Commonwealth can immediately guarantee comprehensive health care for all its people.

Finding 11 – Benefiting us all: *Insuring the uninsured is just one important improvement that comprehensive reforms would bring. Many aspects of these reforms would benefit us all.*

This plan would cover all uninsured people, but that is only one of its benefits. It would mean better care for us all, for many reasons. Among other advantages, it would:

- **provide everyone with a wider range of benefits than most people receive today,**
- **shift $2.4 billion in current spending from administration to care, raising spending on actual care by 9.0 percent**— which supports an even greater expansion in services,
- allow free choice of caregivers,
- make care more trustworthy again, by helping to eliminate caregivers' financial incentives to withhold needed services or to give unnecessary services,
- reduce prescription drug prices to give everyone coverage without spending more,
- greatly expand access to home care and nursing home care,
- **slash by over 80 percent the out-of-pocket payments** that today impose financial burdens (often, unmanageable ones) on people already burdened with illness,
- **free caregivers' and patients' decision-making from bureaucratic interference**,
- free caregivers' and patients' time from bureaucracy and paperwork,
- stop fears that job loss or government budget cuts will end peoples' health coverage,
- stop fears that people may lose jobs because they have gotten too costly to insure,
- help to stabilize needed caregivers, especially in lower-income communities where they may struggle today because needs are great and many patients lack coverage,
- **get us all a better deal, assuring that far more of each health dollar is used for care**,
- free up money in family, business, charitable, and government budgets to meet many other pressing needs,
- and— the goal of all care— improve the health and well-being of the people of the Commonwealth, which will strengthen Massachusetts in countless ways.

Finding 12 – Delay is dangerous: *Massachusetts cannot afford to wait for Congressional action. Nor can this state afford to wait for a crisis to act. Beginning to plan now for such comprehensive reforms is essential to avoid irreversible harm to the state's people, to the trustworthiness of care, and to valued health care resources.*

Massachusetts cannot simply wait for federal action to expand health care coverage, because spending here is already so high that this state, especially, cannot afford to throw more money at hospitals, drug companies, and others in health care. And Massachusetts need not wait for federal action, because spending here is already high enough to provide comprehensive benefits to all without spending a penny more.

Besides, the federal government is not going to act in time to save Massachusetts health care from melting down. Congress cannot be expected to act soon to legislate health care for all and cost control. That is partly because Congress does not know what to do, and partly because one-size-fits-all solutions are not likely to work in health care, since states vary so widely in their economies, health care costs and delivery systems, percent uninsured, and politics.

But delay is unaffordable for Massachusetts. Today's strategies of managed care, price competition, and shifting care from hospitals to non-hospital settings have not succeeded in containing costs.

And costs are rising. At the same time, access to needed care is deteriorating, drastically in some cases— for example, for prescription drugs and home care for some Massachusetts seniors. The number of people with private health insurance fell substantially in the mid- to late-1990s. Managed care and for-profit health care organizations are eroding trust in the quality of care. Community hospitals are closing. For over a year, many health care organizations have been loudly clamoring for more money for business as usual.[50]

Yet these are the economy's fat years. What will happen in the lean years— the next inevitable recession? Consider just two of the likely problems:

- In the last downturn in Massachusetts— the troubled economy of the late 1980s and early 1990s— the number of uninsured people rose by over 300,000, nearly doubling, and then it continued to climb even after the state began adding jobs.[51] The numbers would have climbed far faster if Medicaid had not grown substantially. If private coverage declines nearly as severely in the next recession, the state could easily wind up with over one million people uninsured. And will the recent publicly-funded health care coverages be sustained if state revenues drop in a recession?

- Recently, several large health care organizations— HMOs and physician practice networks— have gone bankrupt in other states. This state's largest HMO spent months in receivership, teetering on the brink of bankruptcy. Today, some teaching hospitals in Massachusetts may be crying wolf, asking for more money while bemoaning operating losses[52] and ignoring substantial surpluses from investment

income. But some hospitals, nursing homes, home care agencies, and other caregivers are genuinely stressed today. And in a recession, if Massachusetts hospitals have not begun operating in a sustainable fashion, and if hundreds of thousands of people lose coverage and the ability to pay for care, closings of hospitals and loss of other caregivers here would accelerate— depriving many communities of vital ER and other services. And note that hospitals, for example, are not merely buildings and equipment, but organizations of human caregivers with special knowledge of their community; once closed, those assets may be impossible to restore. Further, as some hospitals close, others will gain regional monopolies and thus gain the power to raise prices freely.

Some health care observers say that a crisis will be needed to impel action on universal coverage and cost control. But the dangers are too great to wait for a crisis. And when a crisis arrives, it will be too late to act carefully and with knowledge of what to do and how to do it.

To protect the people of the Commonwealth and all that is valuable in Massachusetts health care, reform efforts must begin now. The tasks are many: Anticipate diverse contingencies that may arise— both without reform and with reform. Plan. Test. Evaluate. Negotiate. Design workable administrative mechanisms. Help hospitals and physicians get comfortable with reform.

State reform is the only likely path to universal coverage for years to come.

More care at less cost is in reach. It is now clear that comprehensive health care for all is affordable— and that appropriate reforms can even achieve this while saving money.

Massachusetts faces a choice: continue to pay for wasteful private administration (while access to care suffers and costs climb) or achieve health care for all. It is increasingly clear that doing both is impossible.

And each year of delay means $1 billion or more of health care waste that could be used to meet families' and employers' and the state's other pressing needs. And each year of delay, countless people suffer and even die for lack of vitally needed care.

DISCUSSION

For decades, our national and state governments have grappled with the issues of how to make health care universal, comprehensive, affordable, accessible and high quality. The post-war era has seen many legislative attempts to build toward a system of universal care, including:

- the Truman administration plan of 1948
- Medicare and Medicaid in 1965
- the Nixon plan for universal health care, which lost by only one vote in 1973
- the 1988 plan in Massachusetts and the early '90s plan in Washington state to assure universal access to health care
- the effort of President Clinton to develop a nationwide system of managed care in 1993 and 1994
- the current federal and state incremental efforts to expand coverage through Medicaid expansion and children's health programs, while other access issues are debated in the arenas of managed care patient protection, and expansion of Medicare benefits to include prescription drugs and more preventive care.

Government, business, unions, communities and health care advocates have worked in governmental and private settings to create a responsive, affordable, accessible and quality-oriented health care system.

Yet for all of these efforts, the nation has managed to establish a health care system that

- excludes 1 in 6 Americans from any health insurance
- is a major reason for personal bankruptcies nationally
- continues to distribute mortality and morbidity by race, class, and gender
- has placed enormous barriers between health professionals and consumers, undermining their ability to decide on necessary care in an atmosphere of trust
- is so expensive that it drives out other needed social consumption
- cannot begin to plan for the health and social needs of a changing population
- has become the choice feeding ground for high-profit fraud and white collar crime
- offers no system-wide programs of quality enhancement, health promotion and disease prevention.

The reforms proposed here would provide access for everyone in Massachusetts (with presumptive eligibility— that is, without complex applications and administrative barriers) to a single, high standard of care at a predictable and efficient cost. Such a system offers the opportunity to solve many daunting and persistent problems which incremental reforms have failed to solve. Our study of health care costs in Massachusetts shows that universal, comprehensive health care with simplified administration— what we called a pooled payor plan—is both affordable and beneficial.

Developing and implementing a $36,000,000,000 system, however, requires substantial effort by all stakeholders to ensure that it can operate with wide public trust and within a predictable, efficient budget.

It means grappling with questions such as these: How can Massachusetts make a system that is patient-friendly? How can Massachusetts target resources to improve care for vulnerable populations and provide better care for all of its people? How can the system be financed affordably? How can reforms assure an efficient and accountable system?

This report shows that the needed money is already available within health care. And thus this report shows that Massachusetts can succeed for all of its people.

The task of all stakeholders— advocates, caregivers, patients, business people, and labor— working with their elected representatives, is to develop the broad consensus necessary to build a sustainable, efficient, universal, and comprehensive health care system.

The alternative to providing secure health care coverage for all residents of the Commonwealth, while containing costs and protecting quality of services, is medical meltdown. Private actions—through price competition, managed care, and hospital closings—have failed to contain costs in durable or acceptable ways. After a short respite, health care costs and premiums are again soaring in Massachusetts—while many hospitals, nursing homes, and other caregivers suffer financial distress.

Critics of proposals such as that offered in this report offer no alternative—other than more money for business as usual. But that is a prescription for higher prices, higher costs, continued caregiver financial distress, and erosion of hard-won coverage improvements. It is also a prescription for medical meltdown and anarchy. Students of health care such as Reinhardt are now predicting that the next recession will see employer abandonment of managed care.[53] Employers would then offer only fixed contributions for health care costs—effectively turning each employee into a fighter for cost control. This tactic may serve as a political smokescreen, behind which employers and managed care companies may retreat from the cost control battlefield, but it will not save money. And it will not address Americans' need for affordable health care for all.

Only public action can ensure health care for all while containing costs and protecting quality.

We hope that the Commonwealth will accept this challenge for the benefit of all.

Appendix I

HIGHLIGHTS AND OUTLINE OF MODEL AND ESTIMATES

We outline here the major steps involved in reaching our bottom line conclusion— that Massachusetts can win comprehensive health care for all while saving money. These highlights of our estimates offer a few examples of the evidence and assumptions used, to convey a sense of the types of issues involved.

This material intentionally overlaps that presented in the Findings, but offers a different look, emphasizing the way the analysis was done as much as its results. And this presentation offers more detail on many aspects of the findings as well. (Full documentation is presented in the model spreadsheets and notes, in Appendix III.)

A brief comment on precision: Throughout, cost and savings estimates are presented in billions of dollars and tenths of billions— $0.6 billion, for example, or the equivalent, $600 million. Many individual estimates and their components were calculated using available data in millions of dollars. But because of the incompleteness and approximate nature of many health care cost data, we wish to avoid over-stating the precision of these estimates. We therefore round here to the nearest $100 million. While $100 million is certainly a large sum, it is less than three-tenths of one percent (.28 percent) of the estimated $36.8 billion in Massachusetts health spending in 1999.

What coverage is proposed?

This plan would provide all Massachusetts residents and workers with comprehensive, equal health care benefits, including dental and long-term care. Besides insuring people who are now uninsured, this plan fills in the gaps in coverage for today's insured, giving substantial new benefits to us all.

It would cover the cost of all necessary health care, excluding only non-prescription drugs and non-durable medical supplies (unless prescribed), and some of the housing costs of nursing home care.

By filling gaps in benefits and ending most patient cost-sharing requirements, this plan would eliminate over four-fifths of out-of-pocket costs. The plan gives patients free choice of doctors, hospitals, and other caregivers. And it frees patients and caregivers from bureaucratic interference with decisions about the appropriate course of care.

This coverage would use a system of pooled financing without insurance companies. It includes a range of financing and delivery reforms that would cut administrative and other waste. This will enable the people of Massachusetts to get much more care, while saving money.

Who will be covered?

The plan analyzed here would cover all Massachusetts residents and workers. This report refers to these groups, together, as "Massachusetts beneficiaries."

So the nearly 6.2 million people who live in Massachusetts would all have coverage. In addition, our estimates assume that, for simplicity, efficiency, and workplace equity, the roughly 150,000 people who work in Massachusetts but live outside the state (and their dependents) would get the same coverage that Massachusetts residents receive.

Many discussions of universal health insurance focus solely on the goal of providing some coverage to all. But besides insuring the uninsured, this plan is designed to eliminate the diverse problems of under-insurance, such as these.

- In a recent survey, about one-third of Boston-area uninsured respondents reported difficulty getting care, as did about one-seventh of the privately insured.[54] One-quarter of the insured people in the state's own 1998 survey reported that lack of coverage meant they had problems accessing care, and 30 percent of the insured reported confronting financial barriers to needed care.[55]

- One study's[56] definition of the under-insured counted people at risk of out-of-pocket spending (excluding health insurance premiums) that exceeds 10 percent of family income. By that standard, we calculated previously, Massachusetts in 1994 may have had 660,000 under-insured people among privately-insured non-elderly residents, or nearly one-fifth of that population.[57]

- As shown by the current debate over drug coverage for seniors and the lack of long-term care coverage for many who need it, people with today's Medicare coverage also are often under-insured. A recent national survey found that medical costs and premiums *actually* consumed at least 10 percent of income for *fully half* of families headed by seniors.[58]

- The same survey showed that medical costs and premiums *actually* consumed at least 10 percent of income for one-sixth of households headed by people under age 65.

Yet these definitions may be too restrictive. There are good reasons to consider far more of this state's population under-insured:

- Costs amounting to less than 10 percent of income may well keep many people from getting needed care.

- Managed care plans' incentives to limit care mean that most people risk having difficulty getting coverage for needed care.

- Arguably, nearly everyone insured today should be considered under-insured. Only the wealthiest people tend to have adequate coverage and money to pay for needed long term care.

- Definitions of the under-insured which emphasize people incurring high costs or unable to obtain needed care fail to include the countless people with meager benefits who did not happen to fall ill in the year studied. A solution for the problems of the under-insured cannot target only those who will get sick, because that is not predictable.

Thus, providing protection against the costs of care for everyone is manifestly the only way to fill the gaps for the under-insured people of the Commonwealth.

Outline of model:

- We first estimate the costs of care in 1999 absent reform—total health care spending, personal health care spending, and spending for each major type of care. (Details of how we have prepared those estimates are not presented here.)

- Next, we estimate the costs of
  a) bringing uninsured people's care to the private average, and
  b) filling gaps in benefits and eliminating cost-sharing for all patients.

- We then estimate savings from
  a) administrative simplification, and
  b) financing and delivery reforms,
  to determine the post-reform cost of care.

- Finally, we consider revenues for financing care after reform, both
  a) those from out-of-state sources, and
  b) those to be raised in the state.

Current costs. We estimated costs for each health care sector assuming no policy changes. At the time these estimates were prepared, the most recent cost data available for each state were data through 1993 from the U.S. Health Care Financing Administration (HCFA).

Those data and actual mid-1990s Massachusetts hospital and nursing home cost data underlie our projections of the cost of care absent reform.[59]

Our overall cost estimates appear quite reliable. An independent estimate differed from ours by less than 1 percent.[60] And our related estimate of personal health care

spending for 1998 was recently confirmed by a very close estimate from the U.S. Health Care Financing Administration; our estimate was only four-tenths of a percent higher.[61]

The 1993 HCFA data showed Massachusetts per capita costs to be the highest among the states, both for care provided *by Massachusetts caregivers* and for care provided *to Massachusetts residents*. (The latter point indicates that the state's high per capita health costs cannot be explained by use of Massachusetts caregivers by patients from outside the state.)**[62]** And Massachusetts was again highest in new HCFA data on 1998 per capita caregiver payments.

As the highest cost state in the highest cost nation, Massachusetts has the world's highest health spending.[63] We look back to 1996 to make international comparisons:

- Estimated Massachusetts total health spending level in 1996 of $4,993 per person[64] meant that this state's costs were nearly double (93 percent above) those of Switzerland, the nation with the next highest health care spending, after the U.S.A.[65]

- *Massachusetts health costs were nearly triple (2.8 times) the median among the 20 wealthy democracies with the highest health costs.* Massachusetts health care costs were roughly three and one-half times the level in the U.K. in 1996.[66]

Even as the uninsured share of residents in Massachusetts doubled after 1987,[67] and the state rose to lead the nation in HMO penetration,[68] the federal data show that per capita health care spending here actually *rose* relative to the U.S. average, reaching 29 percent above in 1993, and 30 percent above in 1998—the greatest excess ever. [69] Hospital costs per capita in Massachusetts did decline slightly relative to the U.S. average in that period. But non-hospital costs per capita rose sharply against the national average. [70] So the state's overall health care spending climbed faster than the nation's. These data indicate that current approaches to coverage and cost control—managed care, hospital closings,[71] de-hospitalization of care, and the like— have not been working.

Our reform analysis focused on 1999. We estimated 1999 per capita health spending in the state (in the absence of reform) at $5,840— generous, by international standards, to finance needed care.[72]

The projected 1999 cost of care for Massachusetts beneficiaries is <u>$36.8 billion</u> without reform— our main benchmark or baseline for comparison with the costs of health care after reform.[73] (<u>Cost estimates that are underlined in the text are shown in Table 7, which summarizes the added costs and the savings obtained with reform</u>).

1. To assess the cost of comprehensive insurance for all without insurance companies, we started with the cost of increased use of health services.

a) Estimated cost to bring use of care by the uninsured to the privately-insured average.

In 1996 projections from the National Medical Expenditure Survey,[74] per capita spending for uninsured Americans was 43.2 percent of the average for the privately insured. To put it another way, spending on the privately insured was 2.3 times the average for uninsured people.

The model assumes that having coverage would raise by that much the use and cost of care for roughly three-quarters of a million uninsured people in Massachusetts. (The uninsured population estimate is discussed shortly.) As a proxy for private insurance spending, we substituted the state's per capita average for non-Medicaid, non-Medicare spending.[75] We estimated that coverage would raise use rates and spending for the uninsured up from 43.2 percent of that level.

(Our model makes such assumptions explicit and visible. We hope that readers will take advantage of the model's transparency to consider the effects of alternative assumptions. If, for example, a reader believes that the extent of under-service of the uninsured is greater, and that smaller sums are spent today on care of the uninsured, the appropriate figure can be substituted for the 43.2 percent estimate; the estimated cost of bringing the uninsured up to average levels of service would rise proportionately. If more is already spent on the uninsured, the estimated sums needed would decline proportionately.)

Table 7

PROJECTED 1999 MASS. HEALTH CARE COSTS, WITHOUT AND WITH REFORM	**($ billions)**
∗ BASELINE: 1999 cost of care for Massachusetts beneficiaries (residents and workers from out of state), without major reform or policy changes	**$36.8**
With reform: • with comprehensive coverage for all, • without insurance companies, • without patient cost-sharing, • with reforms in financing and delivery of health care	
ADDED COSTS: $4.2 billion in new costs with reform	
Bring uninsured to average service use rates for people without public coverage	+ $ 1.0
Added service use for all when fill gaps in benefits and end patient cost-sharing	+ $ 2.8
Better care coordination, services for people with disabilities, and data collection	+ $ 0.4
Total of added costs	+ $ 4.2
Total cost for full coverage for all, before savings	$41.0
SUBTRACTED SAVINGS: $5.2 billion in new savings with reform	
Savings in administration of coverage	- $ 1.1
Savings in caregiver administration	- $ 2.5
More appropriate use of hospital care	- $ 0.8
Negotiating prescription drug prices	- $ 0.5
Budgeting construction and equipment	- $ 0.2
Total of subtracted savings	- $ 5.2
∗ Total cost of care for Massachusetts beneficiaries after reform	**$35.8**
Change from baseline without reform (- 2.8%)	**- $ 1.0**

(Note: Numbers may not add exactly to totals because of rounding.)

But the next step in the model's calculations recognizes that, for other reasons, the 43.2 percent figure yields an over-estimate of the cost. The state has ample supplies of physicians and still has sufficient hospital beds that use can rise to accommodate new patients in most regions without requiring construction or other new fixed costs. (We assume the added hospital care of newly covered patients will be partially offset by some reduction in avoidable use because patients will receive more timely preventive care and because reformed payment methods will minimize caregiver incentives to provide unnecessary services.) Without substantial new fixed costs, therefore, it will not cost as much per person to care for additional people as the average cost for people now insured. Using differing marginal cost estimates for each major sector, we

estimated, as shown in Table 7, that the added use of care for uninsured people would cost slightly below $1.0 billion.[76]

The estimate of the number of uninsured Massachusetts residents is worth comment. To avoid underestimating the cost of insuring the uninsured, our calculations—conservatively—have continued to use the U.S. Census Bureau's recent peak estimate for Massachusetts of 766,000 uninsured in 1996.[77] Primarily because of recent expansions of eligibility for public coverages, there is evidence that the number of uninsured people in the Commonwealth has been dropping since 1998. To the extent that the actual current number of uninsured people is smaller than 766,000, the actual cost of covering them would be proportionately smaller than $1.0 billion.

Bringing the uninsured up to the private average level of coverage in essence adds them to the under-insured population, because serious gaps in coverage are commonplace. The next step is to estimate the added costs of filling in such gaps in benefits.

b) Estimated added use if patient cost-sharing ends and everyone gains full benefits.

Here we estimate the added costs of making coverage comprehensive for all. This means providing coverage for all needed care.[78] These estimates assume that the only exclusions from coverage are non-prescription drugs and medical supplies; limited patient cost-sharing would also continue for the housing costs of nursing home care. Eliminating other cost-sharing means eliminating deductibles and benefit caps, as well as co-payments and co-insurance.

For several health care sectors, the following sample elements of the model provide highlights of our findings and the sorts of assumptions involved and issues considered. (Note that some of these increases in service use and costs are partially offset later in these calculations by projected reductions.)

- Hospital care: We assumed (as the U.S. General Accounting Office estimated in a 1991 study)[79] that ending cost-sharing would raise hospital use by 10 percent for all beneficiaries, including the newly insured. With current hospital capacity, the real, marginal (incremental) cost for added patients would be 60 percent of the average cost of care, we estimate. In total, we project $0.5 billion in new costs for added hospital care to serve formerly under-insured people.

- Physician care: The biggest cost for added services to the under-insured, $0.7 billion, would be for physician care. We assumed a 17 percent rise in services,[80] at a marginal cost of 75 percent of average cost.

- Prescription drugs: We separately estimated unmet need for insured and uninsured people under and over age 65. We conservatively project a 12 percent rise in use if all are covered with no cost-sharing.

- Nursing home care: Since few people have good nursing home benefits, a national study estimated that a 20 percent rise in nursing home use may be appropriate. Use in Massachusetts is higher than average, so we estimated that a 10 percent rise is needed. Patients would still pay, at a modest rate, for room and board (a housing cost, not a medical cost).

- Home care: Even though use of home care in Massachusetts appears to be above the U.S. average, very substantial increases are needed here as well as nationally. Filling gaps in coverage and eliminating cost-sharing are projected to raise use of home care for Massachusetts beneficiaries by 25 percent.[81]

Total added service use from ending most patient cost-sharing would have a marginal cost of about $2.8 billion, we estimate, as shown in Table 7. Thus, the $1 billion estimated cost of bringing uninsured people up to the level of today's typical coverage is only about one-third the cost of dealing with under-insurance— raising everyone up to a full benefit package and eliminating most patient cost-sharing.

- One important conclusion: We estimate that about *70 percent of the rise in service use and spending after reform would be for people who are now insured,* but who face gaps in benefits and other cost-sharing barriers to needed care.

The estimates include a few other categories of added costs under reform. We anticipate $0.4 billion in new costs for better care coordination, for data collection, and for new services for people with disabilities.

Thus, as the top part of Table 7 shows, the apparent added costs of the expanded system would equal $4.2 billion, and the apparent total costs of health care would be $41.0 billion. These estimates show the cost of simply expanding coverage in today's inefficient system. They do not yet factor in the enormous new savings that could be won by reducing bureaucracy, by cost controls, and by reforms in the delivery of care.

2. Insurance for all without insurance companies brings administrative savings.

a) Large savings are available in insuror administration.

Today's numerous competing insurors spend heavily on medical underwriting to avoid needy patients, on paperwork to bill patients and to try to pay caregivers less, and advertising and marketing. (In addition, in for-profit insurors and HMOs, health care dollars are diverted from care to shareholders.) We conservatively estimated the administrative share of private insurance cost at 11.0 percent, or $1.4 billion in Massachusetts in 1999 before reform. The U.S. General Accounting Office concluded that having a single payor for health care in the United States could reduce the cost of administering coverage by 79 percent.[82]

That suggests Massachusetts could win $1.1 billion in ***savings on the insuror side,*** as noted in Table 7. (Perhaps $0.2 billion of the savings will be offset by the higher data collection costs noted earlier, so we project a net drop of $0.9 billion in costs of administering coverage.)

b) But savings on caregiver administration would be even greater.

Having everyone covered in a pooled plan with no insurance companies, and eliminating patient cost-sharing, would eliminate the need for caregivers to make huge efforts to secure payment (billing and collections for huge numbers of individual claims, verifying patient benefits, and the like **advertising, marketing,** For example,

- Using three years of Massachusetts hospital Medicare cost reports,[83] we found hospital administration is 28.7 percent of total hospital costs in this state, or $3.6 billion for 1999. With pooled payments and no hospital cost-sharing, we assume that hospitals could reach a 14.3 percent administrative cost level seen in Canadian public hospitals in 1993-94.

  So in Massachusetts, we project, hospitals could eliminate $1.9 billion in wasteful administration— saving 14 percent of their costs. *That would mean saving fully 5 percent of state health care costs*.

- The projected $0.6 billion drop in physician administration would mean saving roughly 40 percent of their administrative costs. That amounts to *savings of 10 percent of total costs for physician care through reduction in paperwork.*[84]

In total, we project ***savings on caregiver administration*** of $2.5 billion, as shown on Table 7.

Today, caregiver and insuror administration combined amount to more than $7.7 billion. So administrative costs now consume over one-fifth of Massachusetts health care spending. With the proposed reforms, the total sum spent on administration in 1999 would be cut by 45 percent, to $4.2 billion.

Reform would thus achieve savings of $3.6 billion on administration alone. By streamlining administration of health care coverage and financing, the people, employers, government, and caregivers of Massachusetts could *save one out of every ten health care dollars spent today.*

3. Other large savings are available in several areas through reforms in the delivery of care and through other financing reforms.

- Substantial clinical waste persists today despite managed care. Nationwide, the value of much care is unproven. The potential for clinical savings may be especially great here because Massachusetts seems to have an especially elaborate style of

medical practice— with per capita surgery rates, for example, 12–20 percent above the national average in recent years.[85] (The elaborate practice style may be in part because Massachusetts has so many teaching hospitals, and in part because the state's high physician-to-population ratio means patients are scarcer than in other states, so physicians here may tend to do more.) And some fee-for-service sectors persist, encouraging over-service.

At the same time, lack of coverage and HMOs' financial incentives to limit care both leave many patients under-served.

So using financially neutral payment methods for caregivers will be vital— both to contain cost and to help assure that patients get appropriate care. These methods could include fee-for-time,[86] salaries, or fee-for-service with budgets and rate cuts if volume rises. We estimate ***clinical savings*** at 5 percent of current *hospital* spending alone, or $0.6 billion under a pooled-payor system with minimal cost-sharing. *Conservatively, we assume no such savings in other sectors.*

- We anticipate that universal coverage would enable many Massachusetts residents to receive timely primary care, thus preventing conditions from worsening and requiring use of more costly care. ***Reducing ambulatory care-sensitive hospitalizations*** by about half could save $140 million. (These are shown in the table, together with the above direct clinical savings within hospital care, as a total of $0.8 billion in projected clinical savings with reform.)

- This analysis assumed that Massachusetts drug price negotiations or bulk purchasing could achieve price cuts of 24 percent. In the early 1990s, drug manufacturers accepted wholesale prices in Canada that were 24 percent lower, on average, than those they charged in the U.S. for the same products.[87] And prices abroad have been falling. Data for 1997-1998 showed that the world's brand name drug makers in other well-off nations have been accepting prices even lower relative to those charged in the U.S.—37 percent below U.S. prices in Canada, and 32 percent below in Sweden, for example.[88] Yet total health spending in this state is more than double that of Sweden, so Sweden wins those drug discounts with less than half this state's health care purchasing power. With ***state price negotiations or bulk purchasing to cut wholesale drug prices here moderately***, only by 24 percent, on average, the savings on price alone could reach $0.5 billion. Most of those savings on price would be offset by higher use—a higher volume of sales. The end result is more medications for more people at a similar total cost.

- Similarly, the state could seek discounts through state price negotiations for durable medical equipment. We project modest savings in this sector.

- ***Capital planning and a state cap on capital spending*** could save $0.2 billion in 1999, we estimate. A statewide capital budget for health care would spare us from paying hospitals for the medical arms race that now yields unneeded construction

and duplicative equipment and services. It would also help to stabilize needed caregivers.

As a back-up, system-wide budgets will ensure that costs stay within desired limits.

In total, we estimate that cost controls and clinical changes could win $1.6 billion in savings. (See Table 7.)

4. Estimated cost of coverage with no insurance companies and no cost-sharing.

Combined, the projected administrative and non-administrative savings available under reform would total $5.2 billion, or fully *one-seventh of Massachusetts health spending*. This is, as noted earlier, more than sufficient to offset the added costs of providing full coverage to all.

Taking into account these savings, we estimate that the total cost of comprehensive benefits for all Massachusetts beneficiaries in 1999 would be $35.8 billion.

- *This constitutes savings of $1.0 billion (2.8 percent) as compared to projected 1999 costs without reform*.

In summary, comprehensive care for all can be provided for less than current spending. The $3.6 billion decline in administrative spending will permit the amount of *money devoted to actual patient care to rise by $2.4 billion*, from $26.7 billion to $29.1 billion.

Thus, largely by eliminating the layers of administrative waste in today's multi-payor system of health care financing, Massachusetts can *increase spending on actual patient care by 9.0 percent while cutting total spending by $1 billion.*

In certain health care sectors, rising service use will offset some or all of the savings. We expect the following changes in spending on the major sectors of Massachusetts health care:

- Much less— an estimated $0.9 billion less— will be spent on the administration of coverage.

- Administrative savings of $1.8 billion in hospitals will permit essentially level spending on actual hospital services, despite a reduction in total hospital spending.

- Everyone will have prescription drug coverage, while statewide discounts on the wholesale (manufacturers') prices of drugs will reduce unit costs. So although volume of medications used will rise, Massachusetts can hold stable or slightly reduce total spending on prescription drugs.

- The decline in spending on administration of coverage and financial administration of hospital will free up money for substantially higher expenditures on home health care, nursing home care, and physician services, with smaller dollar increases in other sectors.

As a result, total spending can drop by $1 billion even as everyone gains comprehensive coverage.

These changes will permit very large increases in the actual volume of care provided. For example:

- Given the added spending for the uninsured and the under-insured, total spending on physician care rises, even after the projected savings are taken into account.

  But the share of physician resources used for patients— rather than paperwork— will rise even more sharply. (Please refer back to Figure 3.) As noted earlier, we project $0.6 billion saved on physicians' administrative costs. This, along with some reallocation of health care resources from other sectors, will support expanded care for the previously uninsured as well as an estimated 17 percent rise in use of physician care even for already-insured Massachusetts residents.

  The expansion in actual care provided would exceed the spending increase both because some slack capacity can absorb new patients without new fixed costs[89] and because of the administrative savings. Also, since physicians would have to spend far less time on billing-related paperwork, they would have more time for patients, so capacity would in fact rise.

5. Eliminating most cost-sharing protects people and saves money.

- Patient cost-sharing is not a constructive cost-control strategy. Requiring patients to pay deductibles, copayments, and co-insurance— and to pay for any uncovered services— forces patients to second-guess their caregivers. Cost-sharing deters timely care— a sick tax that especially burdens poorer and sicker people. If patients cannot pay, caregivers must choose between turning them away or taking a loss, so what is called "patient cost-sharing" sometimes instead shifts costs to caregivers. Further, patient cost-sharing does not target the source of high costs, the more expensive services that caregivers—not patients— select.[90]

- Patient cost-sharing is administratively burdensome. If patient cost-sharing persisted in most health care sectors, it would sharply limit the administrative streamlining and savings that could be won under an all-inclusive coverage plan with pooled payment. Continuing cost-sharing would require, for example, continued insuror and caregiver systems to track progress toward meeting deductibles and to bill patients; it would also require continued liability insurance (auto, malpractice, workers comp) to pay uncovered medical costs.

- Under the reform plan proposed here, patients would continue to be responsible only (as noted earlier) for non-prescription medications, and for modest contributions towards the housing (non-medical) costs of long-term nursing home stays. This plan would eliminate over four-fifths of current out-of-pocket spending.

6. Budgeting

Even with coverage declining, hospitals closing, and HMOs pressing to cut care, health care cost increases are accelerating. Our estimates show that comprehensive care for all, with no insurance companies or cost-sharing, could be achieved for less than is spent now.

But as a back-up, the surest way to keep cost in desired limits is to set budgets for health care spending overall, and for hospitals, capital spending, and perhaps physician care and other sectors. Hospital budgets should include case mix adjustment, and marginal cost adjustment for volume change. And the budgets can be adjusted, with accountability, to respond to need for both care and cost control.

All needed hospitals should be assured the revenue they require to delivery high-quality care, as long as they are operated efficiently. One pooled payor would be accountable for providing needed revenues. Today's inter-payor games—where most payors try to shift the burden to all the other payors, and where no one takes responsibility for hospitals' health—would end.

When combined with financially neutral payment methods (see above), budgets could free doctors and patients from interference with their decisions on the best care, given available resources. Today, even as costs soar, many people are denied needed care by lack of insurance and ability to pay, or by HMO bureaucrats second-guessing caregivers' decisions. Some pretend this is not rationing. Tomorrow, ending financial incentives to under-serve or over-serve will allow patients to trust doctors and other caregivers to make careful trade-offs, to use inevitably finite resources wisely to benefit us all.

Total health spending will be generous by any standard— about three times the western European average.[91] So there is no need to fear British-style waiting lists for care, because spending will be *over* three times Britain's. Spending will be enough to finance the care that works for everyone who needs it. Rather than cutting care, Massachusetts can use today's wasted health spending to finance greater access for all.

Complementary reforms in the delivery of care would also help ensure, for example, that care is available where needed.

7. Net cost after new out-of-state financing

A limited infusion of new funds would come from non-Massachusetts sources, we project. First, additional federal funding (estimated at over $0.7 billion) is likely, mainly because Medicare patients would use more care after removal of the access barriers now posed by requirements to pay deductibles and co-insurance.

We also assume that many out-of-state employers of Massachusetts residents[92] would contribute (estimated at over $0.4 billion) to the state plan, since that would cost less than buying private insurance. These funds would reduce the net cost of universal coverage to Massachusetts by approximately $1.2 billion. Taking into account these funds, the projected net cost of care for Massachusetts would be $34.6 billion, down $2.2 billion, or 6.0 percent, from costs without reform.

8. How much financing is not now public, and how might it be generated?

Most past coverage expansions and many universal health care proposals involve buying coverage for each uncovered person, a strategy that would require new spending. We have shown that ***new money is not needed***— existing spending suffices. But how much money needed for universal coverage is not now in the public sector, and how might it be raised? (Please see Table 6, in Findings.)

Without reform, an estimated 44.8 percent of health spending for Massachusetts residents and out-of-state workers would come from public sources. We assume that after reform, the current $16.5 billion in public funding would continue. And with reform, as just noted, perhaps $0.7 billion in new federal funds can be expected— combining with contributions from out-of-state employers to total $1.2 billion in added funding from outside the state.

And as noted earlier, also continuing would be $1.2 billion in patients' out-of-pocket payments for non-prescription drugs and contributions towards nursing home room and board.

So to reach the projected total of $35.8 billion in health care spending for universal health care for Massachusetts residents and workers, would require an additional $17.0 billion. That is fully 11.6 percent less than the $19.2 billion in private spending needed to finance the rest of Massachusetts health care today.

That $19.2 billion being replaced includes $5.3 billion in out-of-pocket spending projected for 1999 in the absence of reform, and $13.9 billion in projected private health insurance spending. Because the reform plan uses health care dollars more efficiently, it would use $17.0 billion to pay for more services than can be bought for that $19.2 billion in pre-reform private funding.

Option A is full public financing: If the reform plan were to be entirely publicly-funded, new taxes would raise that entire remaining $17.0 billion in needed health financing. To

raise that $17.0 billion more, in order to publicly-finance all care in Massachusetts would require a 5.0 percent personal income tax and a 9.7 percent employer payroll tax, or some equivalent combination of new taxes.

With current public spending continuing, the reductions in the system's total costs mean that less money is needed to substitute for private spending. Even so, that would be a enormous sum to convert abruptly to tax financing (although the latter would certainly be more equitable than current financing). This option is not politically realistic today or for the foreseeable future.

Option B is partial public financing: We therefore outline an alternative worth considering. We suggest starting by raising only the taxes needed to replace out-of-pocket spending.

Option B would win immediate care for all and cost containment, but use much smaller new taxes, phasing in more equitable financing gradually. Rather than immediately replacing all private spending with tax financing, this approach would freeze the $13.9 billion in current private insurance spending for the near term. It would require maintenance of effort in premium payments on a per worker basis, in 1999 dollars. Instead of being paid to insurance companies and HMOs, these sums would be paid into the state pooled payor trust fund.

Thus, premiums would not rise for inflation as they are now doing—and are projected to continue doing. This reform would cap the premium liability of private payors— and shrink it, over time, in real dollars.

Tax financing therefore would initially be required only to replace most out-of-pocket spending — less the system's savings. Projections forward from earlier data on state tax revenues[93] suggests that roughly a 1.5 percent personal income tax and 1.0 percent employer payroll tax should suffice to raise the needed $3.0 billion.

But this is not new health care spending. These are substitute taxes, not new taxes. Out-of-pocket spending— the current tax on sick people— would plummet from $6.4 billion to $1.2 billion, a drop of fully 81.2 percent. (That is achievable partly because of the substitute taxes, and partly because the system overall would be less costly.)

TABLE 8 DOLLAR SOURCES BEFORE AND AFTER REFORM Care for Mass. residents and workers	Before Reform ($ billion)	After reform ($ billion)	Percent change for Massachusetts
Total funding needed	$36.8	$35.8	- 2.8%
New funding from out of state		$ 1.2	—
Current public funding	$16.5	$16.5	—
Continued personal spending (for some non-medical nursing home costs and for non-prescription drugs)	$ 1.2	$ 1.2	—
Other in-state funding (currently private)	$19.2	$17.0	- 11.6%
TOTAL FUNDING	$36.8	$35.8	- 2.8%

(Note: Numbers may not exactly add to totals because of rounding.)

Thus, the substitute taxes would free everyone in Massachusetts from most out-of-pocket health care costs. But they have an even more vital role. Shifting just 8.4 percent of total post-reform health spending in Massachusetts from private to public financing is essential, the keystone of the financial plan for reform. This is an example of spending money to save money.

By eliminating most out-of-pocket spending, these substitute taxes would make possible the huge savings on administration that permit financing expanded coverage for us all. They are essential to draining today's swamp of paperwork processing— co-insurance, deductibles, eligibility checks, and the like. Thus, these taxes permit re-channeling today's dollars to spend substantially more on actual health care services, while cutting overall costs. And they are what guarantees universal, comprehensive coverage.

Meanwhile, both the frozen premiums and the new tax revenues replacing out-of-pocket spending would be pooled with existing public funds for health care. Multiple funding sources would pay *in* to the pooled payor trust fund, and would provide all the money needed for all-inclusive coverage now. The insurors would exit. Having all the money in one fund to pay *out* is what matters to gain equitable care, eliminate the administrative waste of multiple payors, and substitute cost control for cost shifts.

With such a pooled payor fund, even if money flows *into* it from multiple sources— as it does in Canada— the state could *win immediate, comprehensive care for all, and immediate cost containment*. Raising the money equitably is also important, but

pursuing that gradually permits starting reform with much smaller new taxes, while getting all the savings and other benefits of single payor financing.

Most single payor proposals would finance all health care with tax dollars. But the strategy of using new taxes only to replace out-of-pocket spending, rather than all private spending, has important advantages. It reduces the political obstacle that losers are always louder than winners, and losers would strongly fight a sudden enormous increase in their taxes even though premium savings for others would offset these tax increases.

With this approach, more equitable ways of raising the needed revenue would be phased in over years, perhaps mainly by using public dollars to finance any planned spending increases. In subsequent years, public dollars would be required to cover the increases in health care costs associated with general inflation, population aging, and any cost-raising new technologies. Public dollars for health care would have to compete with public dollars for other goods and services. This increase in public spending is what makes it possible to cap and freeze private employer spending on insurance at current levels. Gradually, this new public financing would grow to surpass the frozen premiums.

Raising money equitably is important. But to pursue that goal gradually permits getting comprehensive care for all now, with much smaller new taxes than with an immediate move to full public financing, yet with all the savings and other benefits of single payor.

9. The Massachusetts Economy, Health Care Reform, and the Need for Action

With health care costs contained and with a healthier workforce, Massachusetts will thrive.

This plan is good for business.

Massachusetts employers who already provide health care coverage will benefit from stabilized, predictable, and gradually declining costs.

Employers who do not provide coverage also benefit. Unlike the employer mandate approach of the state's failed 1988 universal health care law or the Clintons' failed 1993 proposals, this plan does not impose on small businesses a crushing requirement to pay large, flat premiums— which would be an unfair and regressive tax, and a substantial tax deterring job creation. Instead, this approach uses the money that is already available in health care. And it does ask businesses not yet pulling their weight to begin to pay something toward health coverage, but only a much more affordable payroll tax. This is a low cost for businesses with low-wage workers— the kinds of businesses that do not provide health insurance. For a worker paid $18,000 yearly, for example, if the payroll tax were 1 percent, the employer would pay just $180 per year.

And workers who have access to needed health care for themselves and their families will be healthier, less anxious, and more productive.

Another positive— and a source of savings not counted here— is in addition to the savings on the cost of coverage itself. Benefits managers could turn their attention to other problems. Employers would no longer be burdened and distracted from their main work with the increasingly complex tasks of seeking, comparing, contracting, and managing health insurance coverage.

Such reforms will also mean employment-related changes within health care, and within the insurance industry. Converting to affordable health care for all will mean incurring costs for retraining administrators and clerks who may need new skills for new and more productive jobs— jobs that enhance well-being of Americans. Some could be re-trained as nurses, home health aides, and others needed to provide care to patients. A good share of those conversion costs should be covered under federal aid, to help Massachusetts make a transition that will be safe for everyone.

State government should also consider the importance of budgeting an adequate rainy day fund, so that there will be enough money for health care at the bottom of the next recession. Need for care rises during bad economic times. This makes them the wrong times to raise taxes or to cut benefits.

A related measure is also vital. Massachusetts needs to begin to plan for different contingencies in health care. If problem A arises, what are the realistic responses? Problem B? And so on. (These might include the bankruptcy of the lone hospital system serving a large part of the state; bankruptcy of a major health insuror or HMO; cuts in Medicare payment rates to move Massachusetts down towards the national average; and many other concerns.) Hospitals themselves, airports, and civil defense agencies have contingency plans to deal with various emergencies. The Commonwealth needs a contingency plan for medical meltdown. The legislature should appropriate $500,000 to begin this job now.

Finally, state government must act to carefully implement comprehensive coverage for all with reformed financing of care, or Massachusetts risks seeing, in the next recession, catastrophic increases in the state's uninsured population, collapse of major insurors, and massive de-stabilization of needed caregivers. Some observers may suggest that only such a disaster will motivate lawmakers to enact substantial reforms to cover everyone and contain cost, but in a crisis at the bottom of a recession would be the worst time for such efforts. Funds will be scarce. Time to plan carefully will be non-existent. Instead, with a one-time infusion of funds to finance the transition and planning, the needed reforms should be planned and implemented in good economic times— now. There will not be a better time.

Conclusion

A state-level effort to cover all people is vitally needed in Massachusetts, and this analysis shows it is feasible.

Those who pay for health care in Massachusetts spend far more than payors do in any other state, 30 percent above the national per capita average.[94] The same federal government data show that spending on the state's caregivers in 1998, per resident, was 77 percent higher in Massachusetts than in Idaho— the highest and lowest cost states, respectively, and four percent higher than in New York, the next highest state.[95]

Some observers might suggest that the spending figure for Massachusetts was elevated by patients seeking care here from outside the state. An analysis that combined spending on care in-state and out-of-state care for each state's residents, however, found that spending was still 75 percent higher, per capita, in Massachusetts than in the lowest cost state (Utah)— and again was the highest in the nation.[96]

The state's extraordinarily high spending levels are long-standing. They have prevailed throughout the past decade even though Massachusetts for several years ranked first or second among the states in rate of HMO enrollment[97] and even though in the mid-1990s, the state ranked as low as 21st in the percentage of residents who had health coverage.[98]

So current strategies for cost-control and coverage are clearly not working. State action is urgently needed.

But analysis of the cost of insuring the uninsured and filling today's gaps in coverage for everyone— along with the opportunities for saving with streamlined administration and trustworthy, equitable coverage— shows that the Commonwealth can do the job without spending a penny more.

Appendix II
RESPONSES TO POSSIBLE CRITICISMS OF THE PLAN

Many questions have been raised concerning the health care for all reforms that have been discussed publicly over the past year or so. We have inventoried many of those questions and prepared answers to them.

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

First, because Congress is not going to act. Why not? There are several reasons:

Certainly, many were burned by the failure of the Clintons' proposals in 1993-1994, and now regard health reform as a political third rail.

More important, because the states, their needs, and politics are extremely diverse. So the liberal states and the conservative states can't agree on health reform. Nor can the rich and poor states. Nor can the states with lots of uninsured people or just a few. Nor can the states with high health costs or low costs.

Most important, Congress does not know what to do. The lack of evidence on which types of reforms would contain cost and cover all Americans was one of the main reasons, though largely unacknowledged, for the failure of the Clintons' proposals in 1993 and 1994.

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

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

Second, Massachusetts cannot wait to address the pressing problems of high costs and lack of coverage because the state will eventually have to grapple with designing its own reforms in any case. States differ greatly in their health care delivery systems and resources. For example, among the states in 1997, Massachusetts had the most patient care physicians per resident— 2.4 times as many as Idaho and Mississippi each had, and more than twice as many as in six other states as well.[99] And federal data show that spending on the state's caregivers in 1998, per resident, was 77 percent higher in Massachusetts than in Idaho— then the highest and lowest cost states, respectively.[100]

No single path to reform will work for such diverse states.

Third, Massachusetts cannot wait for federal reform because of the dangers posed by high and rising health care costs here. High costs are

- disadvantaging the state economically by raising the cost of doing business,
- draining family, business, and government resources that could be used to meet many other needs,
- encouraging ineffective, risky, and trust-destroying practices aimed at cutting costs,
- de-stabilizing fine health care organizations, and
- driving down levels of private health coverage, adding to the ranks of the uninsured.

And if this state does not move to contain its highest-in-the-nation health costs, then any eventual federal reforms are likely to hit hard, requiring abrupt— and thus harmful— spending cuts in Massachusetts to finance greater equity in health care expenditures and resources.

2. Can we really do this on our own?

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

Federal waivers would be required to liberate the states to experiment carefully. Waivers would be needed to better use existing Medicaid and Medicare funds. Another waiver would be needed to relax the stranglehold which the 1974 Employee Retirement Income Security Act (ERISA) now has on state reform. Today, ERISA blocks states from many health care reforms that affect large employers, those that self-insure against health costs. Some large national corporations and unions like the ERISA prohibition because they think it gives them more control over health costs, more control over bargaining benefits, and more freedom from the cost of complying with individual state requirements. They are short-sighted.

Maryland's recent experience with its one-state all-payor experiment in hospital payments does suggest that the durability even of a reform that had been successful for decades can be threatened by competition from across state borders, and by other factors.

But this is not a reason to refrain from trying new things. If they really do work, they are likely to catch on.

3. If Massachusetts promises cost control and universal coverage in one state, won't people without health insurance move here from other states?

That is always a small potential danger. Some Americans have moved to Canada in recent decades to win guarantees of health care coverage.

But the danger is largely exaggerated. Massachusetts has little to fear. Where would the newcomers live? The cost of housing here is high, as is the cost of living generally. Little new housing is being built. What jobs would the new arrivals find? A few people might move here, but for $36 billion, we can work that out also. (Also, please note that this fear runs counter to the fear that these reforms won't work.)

4. If Massachusetts legislates cost control and universal coverage, won't business flee?

Why would they? Most Massachusetts employers would face a lower overall cost of doing business owing to the $1 billion annual cut in health care costs. That makes it less expensive to live in Massachusetts, so employers would face less pressure to raise wages or salaries, and employees would enjoy higher standards of living, other things equal.

Additionally, employers that now offer health insurance would experience a freeze in their regressive payments for health insurance. The new one percent payroll tax they would face would be less costly to most employers than the expense of a steady rise in private health insurance—which have been rising by 12 to 15 percent or more for many employers, and are projected to continue steep increases. Small businesses in the state report that their premiums have risen an average of 15 to 25 percent yearly for the past three years.[101]

In past years, many employers that did not provide health insurance complained bitterly that mandates to provide insurance (such as those in the 1988 Dukakis universal health insurance law or the Clintons' 1993 proposal) would unfairly burden smaller businesses whose payrolls were large shares of their total costs, and that operated in competitive industries. But it would be right to ask employers who do not yet provide health insurance to begin paying their fair shares. A payroll tax is much more fair than insurance financing.

(In other words, this plan is good for business. It does not burden small businesses with a crushing employer mandate to provide insurance—an unfair and regressive tax, and a tax on jobs. It uses the money that's already available. Gradually, it does ask businesses not yet pulling their weight to begin to pay something affordable toward health insurance—but only a payroll tax. This is a low cost for businesses with low-wage workers—the kinds of businesses that don't provide health insurance.)

Therefore, as it became necessary, over time, to raise health care spending to keep pace with inflation, one candidate for generating the needed money would be to gradually increase the payroll tax. But employers' frozen health insurance contributions would be credited against such tax liabilities in excess of the one percent levied on all employers.

5. Everyone knows that the government can't do anything right, so how can it run the health care system?

While funding would be public, care would be private. No one wants government to run health care delivery. Our proposal is for the money to be pooled in one reservoir. Care for all people would be financed from that reservoir. Doctors, hospital administrators, and others would determine how the money is actually spent to provide care.

The alternative to public reform is continued private price increases, hospital closings, insecurity, medical meltdown, and anarchy.

6. Isn't this a radical approach? Health insurance covers most people today—and between two-thirds and three-quarters of uninsured people are working or are dependents of people who are working—so why not simply require that all employers buy health insurance for their workers and dependents?

This is a practical approach, not a radical approach. What is radically foolish is to imagine that it is possible to continue to rely on private insurance. Most uninsured people do work, and there are important reasons why their employers are not able to afford health insurance for them. These reasons include the regressive nature of financing, low profit margins, and the relatively high burden that insurance financing imposes on firms that are labor intensive and employ large numbers of lower-wage workers.

As bad as are the financial prospects for relying on insurance expansions to cover everyone, the political prospects are even worse. Witness the fury of small business against the Massachusetts universal health care law of 1988 and against the Clintons' proposals of 1993.

Private health insurance through the job does cover most people today, but the number with private insurance fell steadily for much of the 1990s. Only the explosive growth in coverage by the Medicaid program has prevented the number of uninsured people nationally from rising even higher than it has.

One of the main reasons people are losing health insurance is that many of the jobs that provide health insurance seem to be shrinking, while jobs that provide health insurance seem to be increasing. Further, as reason would suggest and as Kronick and Gilmer

have shown,[102] higher cost means lower insurance coverage. The rise in health costs predicted for the years ahead can therefore be expected to result in lower rates of insurance.

7. How will we cover unemployed people?

All permanent residents of Massachusetts would qualify for coverage. Each covered person would receive a card that certified that they were insured. All cards would be backed financially by the $36 billion pooled in the trust fund's reservoir.

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

No. It means less bureaucratic control over health care. Today, HMOs and insurors can constrain physicians' decisions and have even tried to gag physicians and prevent them from discussing some treatment options with patients. Today, price competition without a free market is resulting in payment methods that actually reward the doctors and hospitals that give less care to patients. Today, an HMO's stock price goes up when the share of its revenue devoted to patient care goes down. Today, HMOs and insurors use "economic credentialing" of doctors, terminating their contracts if they prescribe high levels of services, but without considering how sick the doctors' patients are— and thus are making doctors increasingly reluctant to accept sicker patients.

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

9. But how can there be less bureaucracy when the $36 billion in Massachusetts health spending would be controlled by a new government agency?

All health spending would be collected in one reservoir or trust fund. The trustees—those who must spend the money—would negotiate with doctors, hospitals, and other groups about fair and adequate ways to pay for care. The evidence from every other nation is clear that this method means less bureaucracy and less administrative waste.

Having one payor won't mean government-run health care. The state's multitude of doctors, hospitals, and other caregivers would continue to work independently but would be paid from a single pool of funds. This is similar to the long-standing role of Medicare in paying for hospital care. Medicare has never run hospitals. It has simply provided a single source of payment to the nation's multitude of independent hospitals for serving seniors and citizens with disabilities.

10. But how can we trust Beacon Hill with $36 billion in health care spending?

Beacon Hill would not control the money. The trustees would be insulated from political pressure by long-term appointments. The legislature and the governor could not interfere with how the $36 billion would be spent. The trustees' obligation would be to finance health care for all with the available money.

Each year, the trustees might require additional money to keep pace with costs of legitimate inflation. Then, they would have to go to the legislature to request the additional money. Those who sought more money for health care would therefore have to compete with those who sought more money for education for schools, roads, criminal justice—or tax cuts.

Spending $36 billion a year on anything will always have some political aspects. Health care is about life and death, but it is also about money, prestige, and power. The challenge is set up arrangements for collecting the money and for paying caregivers that cover all citizens of the Commonwealth and that contain cost, while assuring the best quality of care.

It is clear that today's arrangements are failing. First, costs rise. Expanding Medicaid to cover more people costs money. So will covering the teaching hospitals' deficits or providing a new prescription drug benefit by traditional methods.

Second, more people risk loss of coverage. The number of uninsured people may have been cut recently, but at the cost of still higher spending. But higher premiums in the future will mean further cuts in private insurance coverage. Things will worsen at the bottom of the next recession.

Today's traditional solutions of managed care, price competition, and hospital closings have not saved money or covered more people. Our state faces higher costs, more uninsured people, and probably both.

Today's HMOs and insurance companies cannot be trusted to fix health care. We must therefore construct other arrangements that we can trust.

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

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

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

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

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

12. Who needs a tax increase? We are over-taxed already. How can you seriously propose another tax increase when so many politicians want to cut taxes?

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

The $3 billion amounts to $1.37 per person per day. That is real money.

And what does this buy?

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

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

Are we over-taxed already? Compared to when? How do our tax rates compare with those of past years?

Compared to who? How do our tax rates compare with those in other nations?

And compared to what? What value do we get for our tax dollars?

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

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

Second, nearly everyone today is under-insured, but that will stop. Most of the increase in cost of new coverage, indeed, will go to round out the benefits with prescription drugs, home health care, and other services—for people who already have insurance. They will get more than twice as much additional care as previously uninsured people.

Third, the share of the health care dollar going to medical care will rise, and the share going to administration will fall. And the share of caregivers' time— for physicians, nurses, social workers, pharmacists, and many others— used for paperwork will fall, so the amount of time devoted to patients can rise.

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

Fifth, patients will have free choice of caregivers. So patients will vote with their feet based on caregivers' quality— including their competence, compassion, and accessibility— since the cost of care will no longer be an issue. Under one option for delivering care, patients would choose networks of caregivers (re-oriented versions of HMOs), which would all be paid the same risk-adjusted price, and would compete only by quality of care.

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

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

The cost of more money for business as usual is insupportable.

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

15. Even if it is broken now, shouldn't we just wait until a crisis arises. Everyone knows that Americans are conservative and don't entertain big changes until it's almost too late.

Many of us are fond of paraphrasing Winston Churchill, who said that he could always trust the Americans to do what's right—after they had first tried everything else.

According to Doyle, Victor Fuchs of Stanford "believes that comprehensive reform of the U.S. medical system will come only after a major political crisis as might accompany war, depression or widespread civil unrest. Such a crisis might arise and medical costs reach ever higher and threaten Social Security, Medicare and other popular programs; there could be political upheaval of such magnitude that medical reform will seem to be the easy solution."[103]

All this would be comforting were it not the most dangerous idea alive in health care today.

It is true that the political pressure to act is low today. But the need to act is high. When a crisis does arrive, the political pressure to act will be high but the ability to act—successfully—will be low.

Imagine a depression and the accompanying political upheaval. Money to finance health care will be in short supply. Still, many would expect single payor reforms to restore the health care they had known before the crisis. When expectations exceed resources, disappointment is inevitable.

Worse, hurried, half-baked, and ill-coordinated attempts to respond to the next crisis could easily make things worse, and alienate patients, taxpayers, and caregivers alike. We don't need more reasons for cynicism, mistrust, and alienation in our nation.

It is dangerous to put reform efforts on hold until the inevitable crisis hits. This is the time to prepare, in accord with another old saying: "Dig a well before you are thirsty." When the crisis hits, people and politicians will demand simply answers to complicated questions, and they will want them yesterday. There will be no time to plan and test and tinker and modify.

16. Health care is so complicated. How can you hope to fix it with one simple plan? [104]

We recognize the complexity. The plan we have offered is a beginning of financing reform, not the end. It outlines a sound method of pooling available dollars, paying caregivers in simpler ways, and using the savings to expand benefits very substantially.

A host of questions must still be addressed. What will be specific methods of paying hospitals, doctors, and other caregivers? How will spending on care be kept at the level of available revenue? How will caregivers and researchers be encouraged to discover more cost-reducing technologies and fewer cost-increasing technologies?

And as many other questions must be answered when we look beyond financing care to the actual delivery of care to sick people. How will care be organized—will HMOs still have a role, for example?

Some of these questions can be answered well today. Others require more work. But one of the most important jobs ahead of us is to start the work now, while we still have time, before Massachusetts health care melts down.

17. But that's socialized medicine you're talking about!

No, it is not. Socialized medicine means that doctors work for the government or that hospitals are owned by the government. We are not proposing anything like that.

We are proposing that everyone would have health insurance. Providing health care for all encourages us to acknowledge our common vulnerability and mortality and to care for and about each other. This is a social commitment that we owe one another when we are sick, aging, vulnerable, and dying.

18. But the Clintons already tried to institute a universal health care system and they failed miserably. If they couldn't succeed with all their clout and resources how can we?

Of course, they failed. They struck out swinging on three successive pitches: First, their plan would have raised spending substantially because it required a mandate on all employers to provide health insurance. This angered small business (justifiably) and increased costs (unjustifiably).

Second, they attempted a one-size fits all states national solution. The states are so different. Some are liberal and others conservative. Some are wealthy and others are poor. Some have high health costs and others low. Some have lots of uninsured people and others have few.

Third, they promoted a top-down federal solution before Congress or anyone else had any confidence in their ideas. Their solution was largely untried anywhere in the world.

On top of this, when the insurance industry, the right wing ideologues, or others criticized their bill—sometimes with justification and other times without justification—they did a terrible job of fighting back or of setting the record straight.

The Clintons' failure means that their diagnoses or treatments failed. It does not mean there is no need for a cure—or that a cure is impossible.

19. But they are having so much trouble in Canada. Canadian doctors are coming here. Canadian nurses are coming here. Canadian patients are flooding into Buffalo and Detroit. So how can you propose a Canadian plan for Massachusetts?

First, we are not proposing a Canadian plan. We are proposing a Massachusetts plan. Our state will have to craft its own arrangements—its own methods of paying doctors and hospitals and all the rest.

Second, most Canadians like their health care very much. They have a terrific deal, overall: affordable and high-quality care for everyone. A small number of Canadian physicians move to the USA. Naturally, they are the ones who did not like conditions in Canada. The overwhelming share of Canadian physicians remain in Canada. On balance, they seem to like things there.

Lately, Canadian health care has exhibited some strains. These are attributable to one thing: not enough money for care. Why not? Because the Canadian economy has not been in good shape for some years. As a result, Canadians made a decision to slow the rate of increase in their health care spending. Today, many Canadians feel that these restraints may have been too tight, and spending can be expected to rise in at least some provinces.

It is worth noting that while some Canadians come to the USA for care, some Americans move to Canada to become eligible for health insurance. And many Americans travel to Canada to buy medications there because the prices are lower.

20. I don't want my payments for health care to be used to buy services for people who don't take care of themselves.

That's understandable. But that is how insurance through the job works now. Most health problems are caused by bad luck or inevitable aging. Most health costs have little to do with taking care of ourselves. After all, the medical researchers can't seem to decide about whether caffeine, eggs, or butter are bad for us. How can we take care of ourselves if we don't know what to do?

Is there anyone who hasn't sometimes eaten too much, drunk too much, run a yellow light, and the like? Most of us will need costly care if we are lucky enough to live long enough to become old and sick.

Instead of focusing on what other people get, why not concentrate on what you will get, such as more care at lower cost; and more trustworthy care because doctors will be

liberated to think about what services you need, not about what services will make them more money. In health care, most of us seek confidence that we will be able to get the right care when we are sick, and that we will have competent doctors who are looking out for our best interests. These are what the current arrangements are taking away from us. Our proposals are designed to restore good care.

21. The health care reforms that you propose sound good, but everything has its problems. What happens if something goes wrong. Aren't you asking us to bet a lot on a good idea but an untried one?

Many of the things we describe have been tried in many nations. We borrow some pieces here and there and combine them with ideas of our own. The plan we set out is not the final, perfect plan. It is the first step toward reform. Going further will take a lot of hard work.

Some people approach health care reform system as though they were going to buy a car or stereo. They want to buy the perfect system, that comes with a ten-year warranty and they can return it if it isn't always in perfect working order.

But we are talking about complicated health care matters that involve money, power, organizational design, and life and death. Therefore, health reform is not a consumer purchase. It is about a long-term political fight. It is about creating a human system, one that, no matter how perfect it starts out, will inevitably break down and need fixing and which will require vigilance to maintain.

22. Isn't this just another utopian plan?

This is actually the most realistic approach because it contains cost, covers everyone, and protects quality.

And it is the most realistic approach because it avoids the extremes of Panglossian fantasy that our present health care world is the best of all possible health care worlds, on one hand, and of apocalyptic crisis engendering heavenly health care reform, on the other hand.

Instead, this reform—like any other thing worth having—will have to be earned. It will require a great deal of hard work. The benefits will not simply fall into our laps. We will have to plan carefully, implement prudently, and evaluate honestly. We will have to work with patients, caregivers, payors, and other stakeholders. Everyone's legitimate concerns will have to be considered and, when possible, addressed.

In the real world, we have to choose among real alternatives. Today's popular remedies—managed care, price competition, and hospital closings—are not saving money. They are resulting in rising numbers of uninsured people. They are enticing physicians and hospitals to withhold care from patients and to market to healthier people in order to cut costs, and to game and sometimes abuse the methods of payment in order to raise revenue. It would be unkind and imprudent to abandon our patients and our health care to the tender mercies of a failed market.

In the real world, the choice is among these remedies popular today, even more extreme market solutions like medical savings accounts, and an all payor – health care for all plan like that described here.

If you don't like this health care for all plan, you will probably be forced to accept a real world of managed care and price competition in which comprehensive market failure results in less care for fewer people at greater cost. In time, this will become manifestly intolerable for everyone.

Politically, that is clearly not yet so. Most people's second choice is to do nothing, as at least one observer and student of health care suggests.[105] But the job of health care analysts is not to decide what is possible politically today, but to try to figure out what might just work better than today's arrangements.

23. Is this plan then nothing more than a call for reckless experimentation on our precious health care services?

Today's health care debates are surprisingly sterile. That is partly because we have so few new ideas, and even fewer ways to make them work. We know much more about probable problems than we do about possible solutions.

Consider other fields, such as public education, that are about as important as health care. We see huge ferment. Supporters of school choice, small schools, charter schools, teacher testing, mentoring, student testing, portfolio assessment, and other ideas are winning the right to experiment, to test their ideas. We have admitted the need to do better, and have embraced the possibility that we actually can do better.

Nothing similar is found in health care. Instead, we witness sterile and largely ideological dominance of managed care and price competition. No fall-back position has been prepared against the very real chance that they will fail.

The plan advanced in this report embodies two ideas. One is an outline of a specific financing reform that promises universal coverage in combination with cost control. The other is that we must get off the dime and start tinkering with many new approaches, so we are not caught unprepared by a health care Pearl Harbor.

Appendix III

Model Spreadsheets and Notes

The Model Spreadsheets and Notes, Appendix III, are available separately upon request. These indicate the sources of data used and show the methods of calculation used. The assumptions used in these calculations are documented in detail in the Notes section.

Making explicit the data and assumptions used in the model enables readers to assess them, and permits concerned parties to join in discussion and refinement of the cost and savings projections offered here. Readers may wish to test the effects of altering some of the component estimates and assumptions. This may be done in a careful reading of the Model Notes, but is most easily done in interactive use of the model on computer.

In addition to the reform model summarized in this report's Findings, and outlined step-by-step in Appendix II, the spreadsheets and notes detail a second and third approach to providing universal coverage.

The second approach is similar to the pooled payor reform strategy discussed in this report, but retains substantial patient cost-sharing requirements—and thus retains substantial barriers to care. It also means forgoing many of the administrative savings that can be achieved by eliminating the need to collect and track payments from millions of patients.

The third approach to universal coverage modeled in the spreadsheet relies on today's managed care to contain costs. With continued patient cost sharing and more limited benefits than the model discussed in the body of the report, it too would retain substantial barriers to needed care and forgo savings on administration, pooled purchasing of medications, and more. It offers much more limited coverage than the model discussed here, yet it would cost more.

In contrast to this third approach, the report's $41 billion estimate for an incremental strategy is the cost of providing the same scope of benefits as in the pooled payor model without patient cost-sharing. So the third approach presented in the spreadsheets would cost less than that $41 billion estimate simply because its benefits would be far more restrictive, failing to fill many of the needs of the under-insured.

NOTES

[1] Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/ . See Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[2] Massachusetts Taxpayers Foundation, *The Costs of Question 5 to Massachusetts Taxpayers, Employers, and Consumers,* Boston: The Foundation, October 2000.

[3] Michael Widmer, cited in John Mcelhenny, "Universal Health Care Would Cost Billions, Study Says," Associated Press, 12 October 2000, 6:43 P.M.

[4] Assume that an average annual premium for individual coverage is $2,500. The cost of doctors' services would be $875 if 35 percent of the total premium went to physicians. A rise in total premiums of 26.2 percent means an increase of $655 in costs. And $655 is fully 75 percent of the $875 original cost of doctors' services. The comparable figures for a 60.5 percent premium rise are $1,513 and 173 percent. Changing the doctors' share of the premium, or the size of the premium for single people, has little effect on these figures. They would also be little affected by use of other services that might reasonably be influenced by the ballot initiative. And patients cannot generate increases in other (non-physician) services. Costly services must generally be ordered by doctors for patients—and professional standards and accountability would deter physicians from over-using them on that scale.

[5] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67. The estimate is that physician service use would rise 17 percent when full benefits are established and out-of-pocket costs eliminated. This estimate, used by the GAO and in our model, represents the average of the Rand Health Insurance Experiment estimate (31%) and Canada's experience.

[6] Kenneth E. Thorpe, "Potential Impacts of Certain Provisions of Massachusetts Initiative Petition 99-4," in Massachusetts Health Policy Forum Issue Brief No. 8, April 2000, Appendix 1.

[7] Alan Sager and Deborah Socolar, *Balancing the Scales: A Brief Response to the Critics of the Ballot Initiative to Promote Access to Quality Health Care for All Residents of the Commonwealth,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 6 April 2000.

[8] Solutions for Progress, Inc. and the Access and Affordability Monitoring Project, Boston University School of Public Health, *Universal Comprehensive Coverage: A*

Report to the Massachusetts Medical Society, Philadelphia: Solutions for Progress, December 1998. The report is available on the internet as "Report 2" at http://www.massmed.org/pages/lewin.asp,
or directly at http://www.massmed.org/pages/2lewin.pdf

[9] The main differences between the estimates in this report and those in our report to the Massachusetts Medical Society include these:

- Estimated current costs were updated in April 1999 for faster than expected rise in prescription drug spending.
- Proposed coverage now excludes non-prescription drugs and non-durable medical supplies (which patients will therefore continue to pay for out-of-pocket).
- The proposed modest patient contributions towards housing costs of long-term nursing home care (an estimated $443 million statewide in 1999) are included as out-of-pocket costs in the model, rather than simply described in text.
- Cost increases are included to reflect higher use of dental and other professional care, durable medical equipment, and "other" personal health care (using the Health Care Financing Administration's National Health Accounts categories) resulting from the elimination of patient cost-sharing requirements.
- Administrative savings are calculated for dental services after reform.
- Prescription drug price discount is calculated on spending at wholesale (rather than retail) level, which reduces the projected savings.
- Savings are projected for price discounts on purchases of durable medical equipment.

(See Solutions for Progress, Inc. and the Access and Affordability Monitoring Project, Boston University School of Public Health, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*, Philadelphia: Solutions for Progress, December 1998, http://www.massmed.org/pages/2lewin.pdf)

[10] See Alan Sager, Deborah Socolar, David Ford, and Robert Brand, "More Care at Less Cost," *Boston Globe*, Focus, 25 April 1999; Alan Sager and Deborah Socolar, "Testimony on Universal Health Care," testimony to the Joint Committee on Health Care, Massachusetts General Court, 27 April 1999.

[11] Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/ . These figures are calculated from the HCFA data for earlier years as follows. HCFA provides estimates of personal health care spending through 1998 for the states and nation, including the annual average rate of increase from 1980 to 1998. We updated the Massachusetts per capita personal health care figure for 1999 and for 2000, applying HCFA's figure for the average year-to-year rise. HCFA has published a 1998 estimate of total health care spending nationally; to estimate total health spending for Massachusetts, we used the national ratio of total health care spending to personal health care. Finally, we calculated a statewide figure using estimated 2000 population (raising the U.S. Census Bureau's published Massachusetts population for 1999 by the amount of the 1998-1999 rise).

See also Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[12] The estimate of 1999 personal health care spending in this report builds on earlier estimates presented in two reports to the Massachusetts Medical Society, and elsewhere. In 1997, our projection of 1998 personal health care spending in Massachusetts was $30,164,000,000. That was just four-tenths of a percent over the just-released U.S. Health Care Financing Administration estimate of $30,039,000,000. (Our estimate of 1999 costs was updated in April 1999 to reflect some of the faster-than-expected rise in prescription drug spending.)

See United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/. Solutions for Progress and Access and Affordability Monitoring Project, *Health Care Costs in Massachusetts, 1966-1996 and Projections through 2005*, *A Report to the Massachusetts Medical Society*, November 1997; Solutions for Progress and Access and Affordability Monitoring Project, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*, Philadelphia: Solutions for Progress, December 1998, http://www.massmed.org/pages/2lewin.pdf. And see Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

Note that the just-mentioned personal health care spending estimates exclude the costs of health care research, administration of private health insurance, and government public health programs. Those are included in estimates of total health care spending. In this report, aggregate statewide cost estimates generally refer to total health care spending in Massachusetts plus spending for care of Massachusetts workers who live outside of the state, and their dependents.

[13] The printout of the Model Spreadsheets and Notes, in Appendix III, notes the sources of data and shows the methods of calculation used. Readers may wish to test the effects of altering some of the component estimates and assumptions. This may be done in a careful reading of the Model Notes, but is most easily done in interactive use of the model on computer.

[14] A few comments on the treatment of "necessary care" in these estimates: The projections presented here are built on estimates of health care spending that include all categories of care now paid for by any party. These estimates assume the proposed

coverage would exclude only non-prescription drugs and non-durable medical supplies (but they could be covered when prescribed).

Note that total health spending, and thus these estimates, include experimental treatments and non-traditional, "alternative" forms of treatment. Many of these are reimbursable by few, if any, health insurors today— but, arguably, some (such as care in clinical trials) should be covered. Others might appropriately be excluded. Omitting coverage for numerous unproven alternative treatments would lower the universal health care plan's cost proportionately. (As a result, if patients chose to continue them, out-of-pocket spending might persist at slightly higher levels than projected here.)

[15] Throughout this report, cost and savings estimates are presented in billions of dollars and tenths of billions— $0.6 billion, for example (or $600 million). Many of the individual estimates and their components were calculated using available data in terms of millions of dollars. But because of the incompleteness and approximate nature of many health care cost data, we wish to avoid over-stating the precision of these estimates. We therefore are rounding here to the nearest $100 million. While $100 million is certainly a large sum, it is less than three-tenths of one percent (.28 percent) of the current $36.8 billion in Massachusetts health spending.

[16] See, for example, "The Challenges of Practice Management: An Interview with James L. Heffernan," *Healthcare Financial Management*, Vol. 54, No. 10, October 2000, p. 75. The article notes that "Heffernan is CFO and treasurer of the Massachusetts General Physicians Organization," the major physician group at the Massachusetts General Hospital.

[17] See Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm And see, for example, on Massachusetts health care organizations' campaign for higher funding, Jennifer Heldt Powell, "Health care mission launched," *Boston Herald*, 19 May 1999. On HMO and insuror increases in required premiums and patient costs, see, for example, Alex Pham, "Harvard Pilgrim loses $94m; vows a hike in premiums," *Boston Globe*, 1 May 1999; David B. Caruso, "HMOs to hike rates—Skyrocketing drug prices part of blame," *Metrowest Daily News*, 9 May 1999; Alex Pham, "All of State's Major HMOs Report Operating Losses; Insurers Estimate Premiums will be Hiked 5%-105 When Contracts Renewed," *Boston Globe*, 15 May 1999; Alex Pham, "Tufts HMO to Double Copayments for Top Drugs," *Boston Globe*, 2 April 1999. On de-hospitalization, see Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution*, Boston: Boston University School of Public Health, The Project, 2 June 1997.

[18] Robert L. Bennefield, "Health Insurance Coverage: 1997," *Current Population Reports*, United States Department of Commerce, Bureau of the Census, P60-202, September 1998, Table 1. See also Access and Affordability Monitoring Project,

Massachusetts Uninsured in 1997, Boston: The Project, 25 September 1998; Access and Affordability Monitoring Project, *Three-Quarters of a Million Citizens of the Commonwealth— One Person in Eight— Now Lack Health Insurance Coverage*, 2nd edition, Boston: The Project, 28 November 1995.

[19] *Health Insurance Coverage: 1999*, United States Bureau of the Census, 28 September 2000, http://www.census.gov/hhes/www/hlthin99.html. See also Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, *Massachusetts Residents Uninsured in 1999*, Boston: Boston University School of Public Health, The Project, 28 September 2000.

[20] Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents*, Boston: The Division, October 1998, p. 10.

[21] Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents: Preliminary 2000 Findings,* Boston: The Division, 24 August 2000. Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents, Boston: The Division, October 1998.*

[22] Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents*, Boston: The Division, October 1998, p. 25.

[23] Pamela Farley Short and Jessica S. Banthin, "New Estimates of the Underinsured Younger Than 65 Years," *JAMA*, Vol. 274 (25 October 1995), pp. 1302-1306. Defining the underinsured as people *at risk* of out-of-pocket spending exceeding 10 percent of family income— they estimated that the number of under-insured people nationally had risen to 29 million in 1994. That was 18.9 percent of privately-insured Americans under age 65, up from 12.6 percent a decade earlier. If the number under-insured in Massachusetts was proportional to the national level, we estimated that 660,000 were under-insured in 1994, by that strict definition. See Access and Affordability Monitoring Project, *Three-quarters of a Million Massachusetts Residents— One Person in Eight— Now Lack Health Insurance Coverage: The Problem Must Be Acknowledged and New Remedies Are Needed*, 2nd edition, Boston: The Project, 28 November 1995.

[24] Judith Feder and Marilyn Moon, “Can Medicare Survive Its Saviors?” *The American Prospect*, May-June 1999, http://epn.org/prospect/44/44feder.html

[25] Gail Shearer, *The Health Care Divide: Unfair Financial Burdens*, Washington, D.C.: Consumers Union, 10 August 2000, http://www.consumersunion.org/health/divide/divide.htm.
See also press release at http://www.consumersunion.org/health/dividepr.htm

[26] That also includes private insurors’ profits, and the costs of administering public coverage programs. Categories or sectors of health care spending used in this report are those of the U.S. Health Care Financing Administration’s National Health Accounts

and State Health Accounts through the mid-1990s (preceding the latest revisions in the State Health Accounts).

[27] Calculations from American Medical Association data reported in National Center for Health Statistics, *Health, United States, 1999*, Hyattsville, Maryland, 1999, Table 102, http://www.cdc.gov/nchs/products/pubs/pubd/hus/tables/99hus102.pdf.

[28] For projections from the National Medical Expenditure Survey, see "Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-based population, 1996-2005," Agency for Health Care Policy and Research, December 1997, Table 8.

[29] The past several years of hospital closings and bed reductions have reduced the slack capacity in the system. We have been gravely concerned that any further such cuts will leave the state without the capacity to meet growing demand as the population ages, or as expanded coverage gives all Massachusetts residents financial access to needed hospital care. See, for example, Alan Sager and Deborah Socolar, *Massachusetts Hospital Costs Per Person Have Risen Much Faster Than the National Average, 1997-1998: 1st Report on the Massachusetts Medical Meltdown*, Boston: Access and Affordability Monitoring Project, 16 December 1999; Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," testimony to the Massachusetts Health Care Committee, 20 May 1999; Alan Sager and Deborah Socolar, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution-- Early Findings from the Massachusetts Hospital Reconfiguration Study*, Boston: Access and Affordability Monitoring Project, 2 June 1997.

[30] As discussed in Finding 2, this analysis assumes the state has 766,000 uninsured people. That was the U.S. Census Bureau's recent peak estimate of the uninsured in Massachusetts, as reported in Robert L. Bennefield, "Health Insurance Coverage: 1996," *Current Population Reports*, United States Department of Commerce, Bureau of the Census, P60-199, September 1997, Table F. Using an estimate of the number uninsured that may be high is a conservative assumption, in that it helps avoid under-estimating the cost of insuring the uninsured.

[31] For hospital care, the increases in use of care will be partially offset by elimination of unnecessary care, as discussed later. And for most sectors, the spending increases will be offset, at least in part, by sources of savings discussed shortly.

[32] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67. The estimate is that physician service use would rise 17 percent when full benefits are established and out-of-pocket costs eliminated. This estimate, used by the GAO and in our model, represents the average of the Rand Health Insurance Experiment estimate (31%) and Canada's experience.

[33] That was the impact of eliminating cost sharing for hospital services estimated in United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67.

[34] This reflects estimates that very substantial increases in home care use are needed nationally, but that today's home care use in Massachusetts is above the U.S. average. Some have estimated that 50-100 percent increases in community and home health care use by the elderly would be legitimate. (See Charlene Harrington, Christine Cassel, and others, "A National Long-Term Care Program for the United States," *JAMA*, Vol. 266, No. 21, p. 3025, citing the Pepper Commission report and Rivlin and Weiner, *Caring for the Disabled Elderly: Who Will Pay?* Washington, DC: Brookings Institution, 1988.)

The cost estimates here assume a 75 percent rise in home care is currently needed nationally. (While this may be a reasonable estimate to reflect substantial human need, estimates of the need for home care may be particularly soft, in part because of the difficulty of distinguishing home health care strictly from homemaker services, personal care, and social services.)

Massachusetts Medicare patients receiving home care reportedly had 31 percent more visits per patient than the U.S. average recently (United States General Accounting Office, *Medicare: Home Health Utilization*, GAO/HEHS-96-16, Appendix II, p. 36, Figure ll.2.). The estimates here assume that this rate applies to all Massachusetts home care use, and that a 25 percent additional rise in use would be needed to reach an optimal level.

[35] These totals exclude expenditures for research and for government public health activity.

[36] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 65; United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 8.

[37] Calculated from spending data for 1998 provided in United States Health Care Financing Administration, "1980-1998 State Health Care Expenditures Estimates," 29 September 2000, www.hcfa.gov/stats/nhe-oact/stateestimates/ ; United States Health Care Financing Administration, "National Health Expenditures, 1998," www.hcfa.gov/states/nhe-oact/hilites.htm ; and updated to 2000. Estimates of costs of administration of physician payments calculated from "The Challenges of Practice Management: An Interview with James L. Heffernan," *Healthcare Financial Management,* Vol.. 54, No. 10 (October 2000), pp. 75-78, and from our estimate of 25.2 percent for administration, as used elsewhere in this report. Administrative savings are taken at 40.9 percent of the current spending on administration of physician services, as has been done elsewhere in this report.

[38] See, for example, Kathleen Lohr et al., "Use of medical care in the Rand Health Insurance Experiment: diagnosis and service-specific analyses in a randomized controlled trial," *Medical Care* (September 1986), Supplement, p. S72, S 78; Gregory E. Simon, et al., "Impact of Visit Copayments on Outpatient Mental Health Utilization by Members of a Health Maintenance Organization," *American Journal of Psychiatry*, Vol. 153, No. 3 (March 1996), pp. 331-8; C.E. Reeder and Arthur A. Nelson, "The Differential Impact of Copayment on Drug Use in a Medicaid Population," *Inquiry*, Vol. 22 (Winter 1985), pp. 396-403; Brian L. Harris et al., "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care*, Vol. 28, No. 10 (October 1990), pp. 907-917; Morris Barer et al., *Lies, Damned Lies, and Health Care Zombies: Discredited Ideas that Will Not Die*, Houston: University of Texas Health Policy Institute, Discussion Paper 10, March 1998, pp. 21-31.

[39] Access and Affordability Monitoring Project calculation from American Hospital Association, *Hospital Statistics*, Chicago: The Association, annual editions.

[40] See Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[41] See, for example, Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research (State-by-State Savings*), Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000; Alan Sager and Deborah Socolar, *Affordable Medications for Americans*, Report for the Prescription Drug Task Force of the United States House of Representatives, 27 July 1999, http://www.house.gov/berry/prescriptiondrugs/Resources/sager.pdf

[42] In the early 1990s, drug manufacturers accepted wholesale prices in Canada that were 24 percent lower, on average, than those they charged in the U.S. for the same products. (U.S. General Accounting Office, *Prescription Drugs: Companies Typically Charge More in the United States Than in Canada*, Washington: GAO, September 1992, GAO/HRD-92-110, pp. 10-11.)

[43] See, for example, Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research (State-by-State Savings*), Boston: Health Reform Program, Boston University School of Public Health, 5 Oct. 2000, http://dcc2.bumc.bu.edu/lcmerr/UShealthreform.htm Calculations from 1997 price data in Patented Medicine Prices Review Board, *Trends in Patented Drug Prices,* Ottawa: The Board, September 1998, PMPRB Study Series S-9811, http://www.pmprb-cepmb.gc.ca/pdf/rm-pat-e.pdf, and 1998 data in Patented Medicine Prices Review Board, *Eleventh Annual Report,* Year Ending December 21, 1998, Ottawa: The Board, 1999, p. 21, figure 9, http://www.pmprb-cepmb.gc.ca/.

[44] Access and Affordability Monitoring Project calculations from *OECD Health Data 98*, OECD: Paris, 1998 (www.oecd.org).

[45] See Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research (State-by-State Savings*), Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000, http://dcc2.bumc.bu.edu/lcmerr/UShealthreform.htm

[46] Access and Affordability Monitoring Project calculations from *OECD Health Data 98*, OECD: Paris, 1998 (www.oecd.org).

[47] This under-estimates government's actual role in paying for health care because in these data, employer-paid health insurance is counted as private spending even for government employees. Nationwide, in 1996, an estimated 22.2 million workers and dependents (or one-twelfth of the population) had health insurance paid for by a government employer, according to Olveen Carrasquillo et al., "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.

[48] This estimate assumes that roughly $1.2 billion in out-of-pocket spending would continue, as discussed earlier, and that another $1.2 billion (called "other" on the graph) would come from higher federal funding (owing mainly to higher Medicare use rates) along with employer contributions for Massachusetts residents working outside the state.

[49] The $1.2 billion from out of state includes a projected $0.5 billion rise in federal funding for Medicare and $0.2 billion for Medicaid, because elimination of patient cost-sharing requirements would raise use rates for people now covered by those programs. It also includes a projected $0.4 billion in employer contributions for Massachusetts residents working outside the state.

[50] See, for example, Joan Vennochi, "Health care leaders take a step to stop the bleeding," *Boston Globe*, 25 May 1999; Steven Syre and Charles Stein, "Taking steps to shift the pain," *Boston Globe*, 25 May 1999.

[51] Access and Affordability Monitoring Project, *Three-quarters of a Million Massachusetts Residents— One Person in Eight— Now Lack Health Insurance Coverage: The Problem Must Be Acknowledged and New Remedies Are Needed*, 2nd edition, Boston: The Project, 28 November 1995.

[52] Alex Pham, "Early losses cited by area hospitals; Medicare cuts blamed for woes in first quarter," *Boston Globe*, 19 March 1999.

[53] Christian Murray, "Expert Predicts Next Wave in Health Care Insurance," *Newsday,* 26 October 2000.

[54] Peter J. Cunningham and Peter Kemper, "Ability to Obtain Medical Care for the Uninsured— How Much Does It Vary Across Communities," *JAMA*, Vol. 280, No. 10 (9 September 1998), pp. 921-927. People were deemed to have had difficulty getting care "if the reasons cited for postponing or not receiving care include the cost of care (including lack of insurance), problems with health insurance or obtaining referrals, difficulty finding physicians or making appointments, proximity to clinicians, and transportation problems" (p. 923). Data for that analysis came from the Community Tracking Study sponsored by the Robert Wood Johnson Foundation.

[55] Massachusetts Division of Health Care Finance and Policy, *Health Insurance Status of Massachusetts Residents*, Boston: The Division, October 1998, p. 25.

[56] See earlier note describing these estimates. Pamela Farley Short and Jessica S. Banthin, "New Estimates of the Underinsured Younger Than 65 Years," *JAMA*, Vol. 274 (25 October 1995), pp. 1302-1306. Access and Affordability Monitoring Project, *Three-quarters of a Million Massachusetts Residents— One Person in Eight— Now Lack Health Insurance Coverage: The Problem Must Be Acknowledged and New Remedies Are Needed*, 2nd edition, Boston: The Project, 28 November 1995.

[57] Our estimate using the Short and Banthin definition assumed that the number of under-insured people in Massachusetts was proportionate to the U.S. total. See Access and Affordability Monitoring Project, *Three-quarters of a Million Massachusetts Residents— One Person in Eight— Now Lack Health Insurance Coverage: The Problem Must Be Acknowledged and New Remedies Are Needed*, 2nd edition, Boston: The Project, 28 November 1995. As we noted there, some factors may tend to elevate the actual number of under-insured people in the Massachusetts population, relative to the national average, while other factors may tend to lower it. This estimate assumed that those factors offset each other. For example, following Short and Banthin, the under-insured here are calculated as a percentage of the privately-insured population. Because more of Massachusetts' population has private health insurance, the percentage of our population that is under-insured also would tend to be higher than nationally (while other states would have higher uninsured populations). On the other hand, in this relatively high-income state, private health plans may have, on average, somewhat more comprehensive benefits than is typical in the nation as a whole— and that would tend to reduce the under-insured population.

[58] Gail Shearer, *The Health Care Divide: Unfair Financial Burdens*, Washington, D.C.: Consumers Union, 10 August 2000,
http://www.consumersunion.org/health/divide/divide.htm.
See also press release at http://www.consumersunion.org/health/dividepr.htm

[59] These projections are available through the year 2005.

[60] In our report to the Massachusetts Medical Society, we estimated the 1999 cost of care for Massachusetts *residents* alone at $35.382 billion. (Solutions for Progress, Inc.

and the Access and Affordability Monitoring Project, Boston University School of Public Health, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*, Philadelphia: Solutions for Progress, December 1998, p. 6.) A separate, independent report to the medical society, using different methods, estimated 1999 costs of care for Massachusetts residents at $35.607 billion— less than one percent more. (John F. Sheils and others, *Massachusetts Comparative Projected Health Expenditure Model*, Fairfax, VA: The Lewin Group, Inc., December 18, 1998, p. 8.)

[61] Our 1997 projection of 1998 personal health care spending in Massachusetts was $30,164,000,000. The just-released U.S. Health Care Financing Administration estimate is $30,039,000,000. See United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/. Solutions for Progress and Access and Affordability Monitoring Project, *Health Care Costs in Massachusetts, 1966-1996 and Projections through 2005*, *A Report to the Massachusetts Medical Society*, November 1997; Solutions for Progress and Access and Affordability Monitoring Project, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*, Philadelphia: Solutions for Progress, December 1998, http://www.massmed.org/pages/2lewin.pdf. And see Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[62] Unpublished 1993 U.S. Health Care Financing Administration data, and Joy Basu, "Border-Crossing Adjustment and Personal Health Care Spending by State," *Health Care Financing Review*, Vol. 18, No. 1 (Fall 1996), p. 226, Table 5.

[63] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[64] AAMP calculation from HFCA personal health spending data for Massachusetts, again using the national ratio, personal health spending is 89 percent of total health spending.

[65] OECD *Health Data 98*. See www.oecd.org.

[66] Calculations from OECD *Health Data 98*. See www.oecd.org.

[67] Access and Affordability Monitoring Project, *Massachusetts Uninsured in 1997*, Boston: The Project, 25 September 1998.

[68] *Managed Care Digest*, 1994 HMO Edition, Kansas City, MO: Marion Merrill Dow, 1994.

[69] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm Calculations from U.S. Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/

[70] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[71] See Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, *Before It's Too Late: Why Hospital Closings Are Becoming a Problem, Not a Solution*, Boston: Boston University School of Public Health, The Project, 2 June 1997.

[72] This represents total health care spending, not simply spending on personal health care.

[73] As noted, the reform plan would include Massachusetts workers who live out of state. Projected 1999 cost of care for Massachusetts residents alone is $36.1 billion.

[74] "Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-based population, 1996-2005," Agency for Health Care Policy and Research, December 1997, Table 8.

[75] Since most data on private insurance costs are proprietary, spending data on privately-insured people in Massachusetts are not available.

[76] The estimates of marginal cost used in this model, for the major health care sectors in Massachusetts in 1999, were 95 percent of average cost for home health care services, 85 percent for nursing home care, 75 percent for physician care, and 40 percent for hospital care.

[77] Robert L. Bennefield, "Health Insurance Coverage: 1996," *Current Population Reports*, United States Department of Commerce, Bureau of the Census, P60-199, September 1997, Table F. As discussed in the main body of this report, the estimates here use the Census Bureau's 1997 estimate that 755,000 Massachusetts residents were uninsured, as reported in Robert L. Bennefield, "Health Insurance Coverage: 1997," *Current Population Reports*, United States Department of Commerce, Bureau of the Census, P60-202, September 1998, Table 1.

[78] The projections presented here are built on estimates of health care spending that include all categories of care now paid for by any party. These estimates assume the

proposed coverage would exclude only non-prescription drugs and non-durable medical supplies (but they could be covered when prescribed).

Note that total health spending, and thus these estimates, include experimental treatments and non-traditional, "alternative" forms of treatment. Many of these are reimbursable by few, if any, health insurors today— but, arguably, some (such as care in clinical trials) should be covered. Others might appropriately be excluded. Omitting coverage for numerous unproven alternative treatments would lower the universal health care plan's cost proportionately. (As a result, if patients chose to continue them, out-of-pocket spending might persist at slightly higher levels than projected here.)

[79] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67.

[80] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67. The estimate is that physician service use would rise 17 percent when full benefits are established and out-of-pocket costs eliminated. This estimate, used by the GAO and in our model, represents the average of the Rand Health Insurance Experiment estimate (31%) and Canada's experience.

[81] As noted earlier, some have estimated that 50-100 percent increases in community and home health care use by the elderly would be legitimate. (See Charlene Harrington, Christine Cassel, and others, "A National Long-Term Care Program for the United States," *JAMA*, Vol. 266, No. 21, p. 3025, citing the Pepper Commission report and Rivlin and Weiner, *Caring for the Disabled Elderly: Who Will Pay?* Washington, DC: Brookings Institution, 1988.)

The cost estimates here assume a 75 percent rise in home care is currently needed nationally. (While this may be a reasonable estimate to reflect substantial human need, estimates of the need for home care may be particularly soft, in part because of the difficulty of distinguishing home health care strictly from homemaker services, personal care, and social services.)

Massachusetts Medicare patients receiving home care reportedly had 31 percent more visits per patient than the U.S. average recently (United States General Accounting Office, *Medicare: Home Health Utilization*, GAO/HEHS-96-16, Appendix II, p. 36, Figure ll.2.). The estimates here assume that this rate applies to all Massachusetts home care use, and that a 25 percent additional rise in use would be needed to reach an optimal level.

[82] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 65; United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 8.

[83] Methods used were from Steffie Woolhandler et al., "Administrative Costs in U.S. Hospitals," New England Journal of Medicine, Vol. 329, No. 6 (5 August 1993), p. 402. As corrected in Steffie Woolhandler and David U. Himmelstein, letter, New England Journal of Medicine, Vol. 331, No. 5 (4 August 1994), p. 336.

[84] See United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 8. Estimates of current physician administrative costs use data from the Medical Group Management Association, "Cost Survey: 1993 report based on 1992 data," Englewood, Colorado, December, 1993, p. 21, Table 1G.

[85]Access and Affordability Monitoring Project calculation from American Hospital Association, *Hospital Statistics*, Chicago: The Association, annual editions.

[86] Tom J. Wachtel and Michael D. Stein, "Fee-for-Time System: A Conceptual Framework for an Incentive-neutral Method of Physician Payment," *JAMA*, Vol. 270, No. 10 (8 September 1993), pp. 1226-1229.

[87] U.S. General Accounting Office, Prescription Drugs: Companies Typically Charge More in the United States Than in Canada, Washington: GAO, September 1992, GAO/HRD-92-110, pp. 10-11.

[88] See, for example, Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research (State-by-State Savings*), Boston: Health Reform Program, Boston University School of Public Health, 5 Oct. 2000, http://dcc2.bumc.bu.edu/lcmerr/UShealthreform.htm Calculations from 1997 price data in Patented Medicine Prices Review Board, *Trends in Patented Drug Prices,* Ottawa: The Board, September 1998, PMPRB Study Series S-9811, http://www.pmprb-cepmb.gc.ca/pdf/rm-pat-e.pdf, and 1998 data in Patented Medicine Prices Review Board, *Eleventh Annual Report,* Year Ending December 21, 1998, Ottawa: The Board, 1999, p. 21, figure 9, http://www.pmprb-cepmb.gc.ca/.

[89] For added physician services, the marginal cost is estimated at 75 percent of the current average cost per unit of service.

[90] M. Edith Rasell, "Cost Sharing in Health Insurance – A Reexamination," *New England Journal of Medicine*, Vol. 332, No. 17 (27 April 1995), pp. 1164-1168.

[91] Calculated from *OECD Health Data 98*, OECD: Paris, 1998 (www.oecd.org)

[92] Census Bureau data indicate that, in 1990, about 5% of Massachusetts residents worked in other New England states or Maine. (Journey-to-work and Migration Statistics, U.S. Census Bureau, Population Division.)

[93] These projections used Department of Revenue *Statistics of Income* reports on 1993 and 1994, the latest detailed data available in 1998.

[94] See Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health: 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm

[95] Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/.

[96] See Joy Basu, "Border-Crossing Adjustment and Personal Health Care Spending by State," *Health Care Financing Review*, Vol. 18, No. 1 (Fall 1996), p. 226, Table 5.

[97] Hoechst Marion Roussel, *Managed Care Digest*, Kansas City, MO: 1998 and earlier years.

[98] Ranking of U.S. Census Bureau data by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project. See Access and Affordability Monitoring Project, *766,000 Massachusetts Residents Lacked Health Insurance in 1996 – the Largest Number Recorded*, Boston: Boston University School of Public Health, The Project, September 1997.

[99] American Medical Association data, as reported in *Health, United States, 1999,* Hyattsville, Md.: National Center for Health Statistics, 2000, Table 102.

[100] Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/.

[101] Cromwell Schubarth, "At small firms, health costs causing fits," *Boston Herald*, 30 October 2000.

[102] Richard Kronick and Todd Gilmer, "Explaining the Decline in Insurance Coverage, 1979 – 1995," *Health Affairs*, Vol. 18, No. 2 (March-April 1999), pp. 30-47.

[103] Roger Doyle, "Health Care Costs," *Scientific American,* April 1999, http://www.sciam.com/1999/0499issue/0499numbers.html.

[104] See, for example, Alan Sager, Deborah Socolar, David Ford, and Robert Brand, "More Care at Less Cost," *Boston Globe*, Focus, 25 April 1999.

[105] This insight is generally attributed to Stuart Altman.