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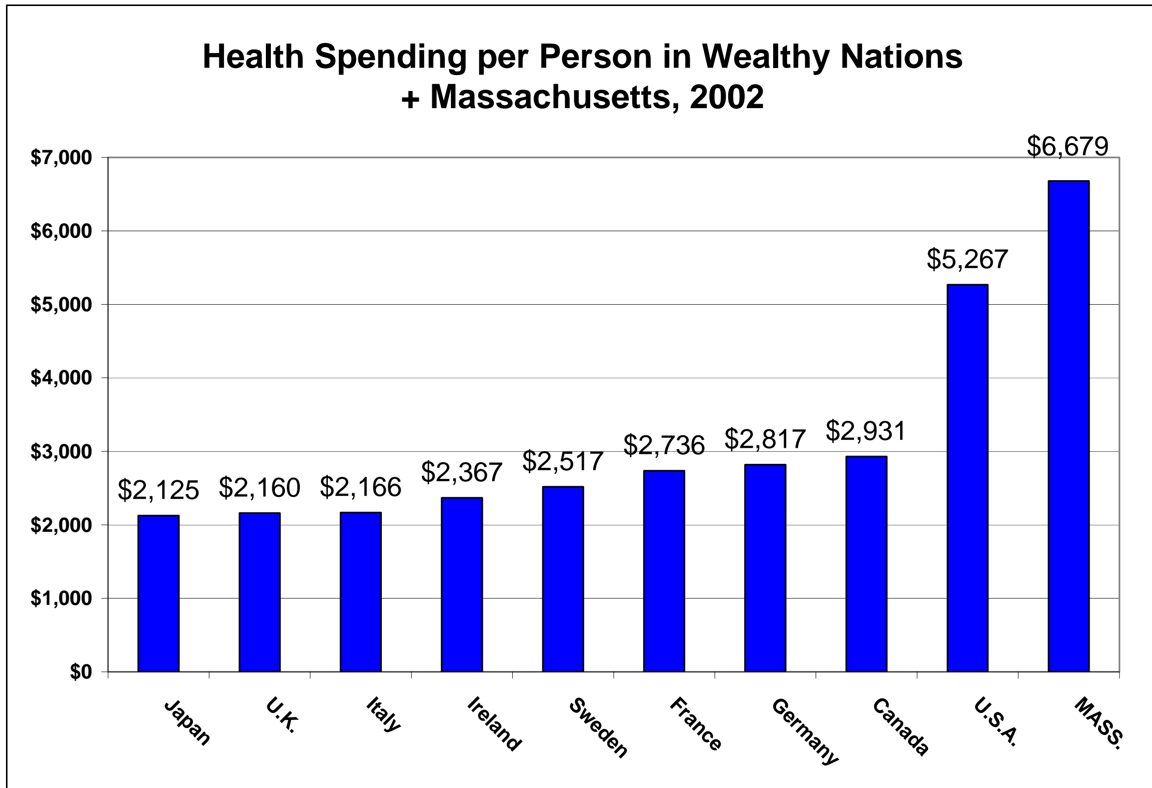
$1 BILLION PER WEEK IS ENOUGH

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



A Report Submitted as Testimony on

S. 755, An Act to Establish the Massachusetts Health Care Trust

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Joint Committee on Health Care Financing,
Massachusetts General Court
Room A - 2, State House
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***Disclaimer**: As always, we write and speak only for ourselves, not on behalf of Boston University or any of its components.*

Massachusetts has the costliest health care in the world.

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

Contingency planning for
an unpredictable future
is vital.

Please consider these three expert predictions—

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

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

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

Massachusetts already has the resources to take care of us all

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

SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

This report makes ten main points—

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

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

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

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

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

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

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

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

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

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

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

We must not re-draw that fatally flawed design.

Introduction

As health care spending in Massachusetts has soared to $1 billion per week, 18.5 percent of personal income, the numbers of people uninsured and under-insured have grown. The governor's proposal talks about expanding health insurance coverage while controlling cost, but appears unlikely to do so.

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

High costs are the main enemy of winning and retaining high-quality health insurance coverage and health care for all who live in Massachusetts. It is therefore *essential* to combine cost controls with coverage improvements. At the same time, it is *safe* to combine cost controls with coverage improvements because about one-half of current health care spending is wasted.

Consolidated financing is the best foundation on which to build medical security. It offers tools to squeeze out and recycle most of the half of health spending now wasted. By pooling statewide health care revenues and paying for all care out of that pool, these reforms facilitate winning savings in all four categories of waste:

- Simplifying and streamlining the way we pay for care permits great immediate savings on administration.
- It provides a valuable vehicle for negotiating a package deal with drug makers to combine lower drug prices, higher volume, and protection for research.
- It makes apparent, by putting a boundary around the sums available for care, that theft kills, taking money that would otherwise be devoted to needed care. This gives vital motivation to efforts to reduce health care fraud and theft.
- Most important, pooling the money while covering everyone provides the best context in which to motivate caregivers to weed out clinical waste, so the resources can be better used to provide needed care.

Central to cutting waste will be engaging physicians in the challenge of using our resources well to cover everyone. Shifting costs to patients can neither contain costs nor weed out inappropriate care.

This report offers 10 points addressing the challenges for the state in acting now to contain health care costs and make coverage for all affordable.

State government must start and sustain a mature political, financial, and clinical conversation about how to do so. We must not repeat the errors of the 1988 Massachusetts universal health care law. That law failed financially because its design relied on new money—rather than financing expanded access by squeezing out and recycling waste.

1. Massachusetts health care is the costliest of any state's, so it is the costliest on earth—triple the spending per person in the United Kingdom, Italy, and Japan.

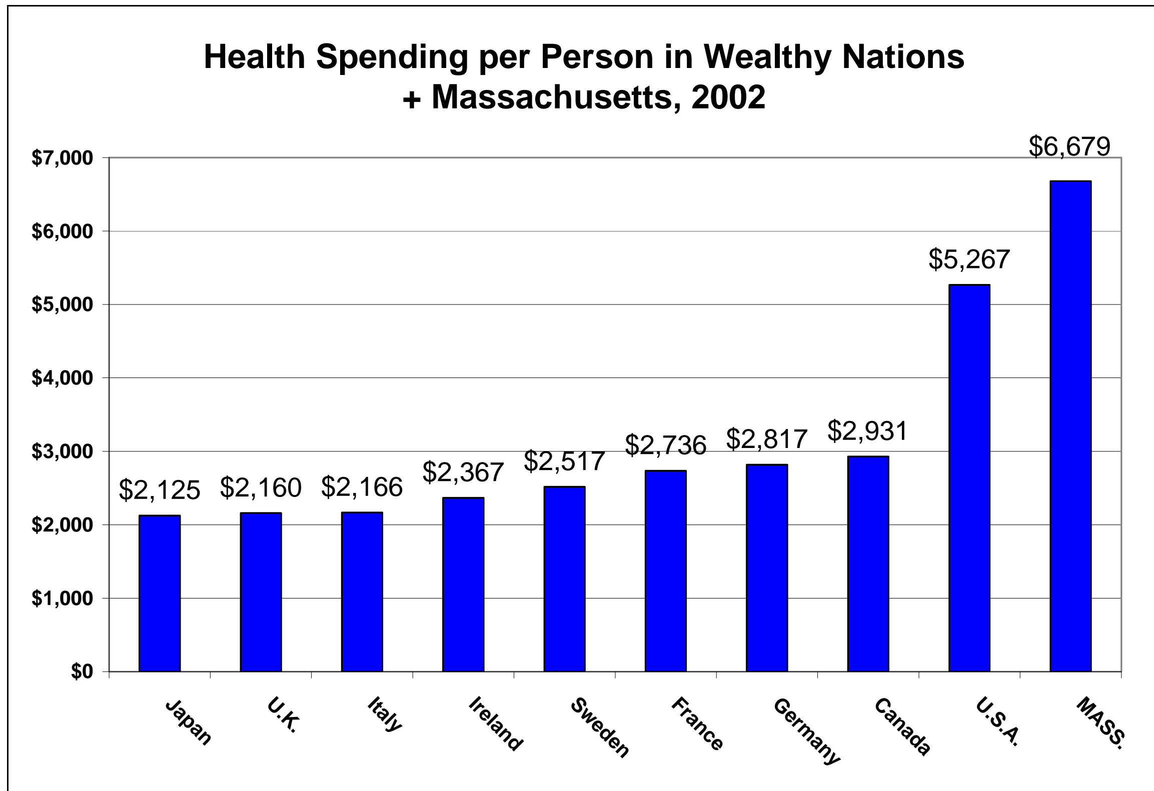
This year's health spending in Massachusetts is about $52.7 billion (about double the total state budget). That is $1 billion each week. It should be enough to provide good coverage for all who live here. Yet some 7-10 percent of residents are uninsured and growing numbers are under-insured.

Health care in the United States is the costliest among the nations. And in Massachusetts, federal data have long clearly shown, health care spending per person is higher than in any other state.

As the costliest state in the costliest nation, we suffer the world's highest health care costs. The following exhibit illustrates the huge spending gaps that result. Massachusetts health spending per person in Massachusetts is approximately

- 27 percent above the U.S. average[1]
- two-and-one-quarter times the per person averages in Canada and Germany
- triple the averages in the United Kingdom, Italy, and Japan.[2]

Exhibit 1



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

This year, calculations from federal projections indicate that per person health care spending in Massachusetts will be about $8,280, versus $6,477 nationally.[3]

So we will spend about $52.7 billion on health care in 2005, or $1 billion weekly.

But if health spending in Massachusetts were at the already generous national average, we would save about $11 billion this year alone.

By all reasonable standards, current spending should already be adequate to finance the care that works for all residents of Massachusetts. Yet, instead, we see soaring insurance premiums and rising numbers of uninsured people.

Other wealthy nations spend much less per person on health care than does the U.S., even though their populations are substantially older. They cover everyone and live longer, even though they generally smoke and drink more than we do. Their citizens are generally happier with their health care, surveys find.

The experience of other nations indicates that U.S. health care spending—and even more clearly, the much higher spending in Massachusetts—should be enough to finance good care for all.

Some people will say, "Not so fast."

They will assert that shares of this state's high spending are rationalized by economic growth and jobs, by education or research in our teaching hospitals, by service to patients from other states, by higher quality, by higher costs of living, and the like.

They will say that more money is needed to finance care for all, or that care for all can be afforded only by providing meager coverage—deliberate under-insurance—to many. And some will claim that reliance on the market will suffice to contain costs.

They are wrong.

This year's $52.7 billion (a sum that is about double the state budget) is being spent, and it is all going somewhere. The important questions are

- whether we are getting our money's worth,
- whether we can continue to sustain our extraordinarily costly care, and
- how we can use the existing money to finance durable medical security for all who live in our state.

There is more than international evidence to suggest we don't get our money's worth, and existing spending here should be enough to take care of us all well.

As discussed below, within U.S. health spending—and Massachusetts health spending—about one-half appears to be wasted today on administration, theft, excess prices, and services that are unneeded or unnecessarily intensive.

Costs are so high in this state in part because our health care is extraordinarily specialized. Massachusetts (as discussed later) is the state most heavily reliant on teaching hospitals and procedure-oriented specialist physicians.

Rising numbers of uninsured and under-insured people

One reason why it should be possible to stretch the $1 billion in weekly health spending to cover everyone in Massachusetts is that we do a relatively good job, compared to other states, of providing health coverage. In 2002-2003, this state ranked sixth best on the share of people with private or public insurance.

But the share of people without health insurance has been rising. No matter which survey you choose to use, federal or state, we are in trouble.

According to federal Current Population Survey data in August of 2004,

- 10.3 percent of Massachusetts residents lack health insurance (2002+2003 average)
- sixth best among the states, and
- 10.3 percent uninsured means over 600,000 people without coverage year-round, plus many additional people uninsured for parts of years.

According to the governor's PowerPoint proposal of 21 June 2005 (and state-collected data), we have some 460,000 uninsured people. Definitions and methods may account for the difference between federal and state estimates.

Much more important than the difference between the two numbers is that both are increasing over time, and can be expected to continue to increase as health costs rise steadily.

Rising costs are the greatest threat to sustaining health insurance coverage for people who have it. Rising costs also block extending durable coverage to people who don't yet have it.

Politically, it may prove possible to enact a law that promises expanded health insurance coverage. Politically, it may look difficult to enact cost controls. Yet this means a law that is politically viable but not financially viable.

The number of uninsured people is growing partly because employees' share of health insurance premiums is also increasing steadily over time. Rising employee premium shares (a growing percentage of rapidly rising premiums) deter many employees from enrolling in employer-offered health insurance.

Under-insurance is also a great and growing problem today. It, too, reflects cost-shifting to patients in private—and public—insurance. Required deductibles, co-payments, and co-insurance are growing. Coverage for needed long-term care and mental health services is weak and becoming weaker for many people. Over 1 million Massachusetts residents—about one in six—have no insurance for prescription drugs. With the steady loss of retiree health benefits and rising prescription drug costs, the number of people lacking drug coverage is growing steadily, and Medicare's skimpy new benefit appears unlikely to fill the gap.

2. The governor's proposal pays lip service to the idea of covering us all without higher spending. Yet it appears likely to raise spending while leaving most newly-insured people without adequate protection.

It skates lightly over the cost problems we face, lacking provisions to address sources of high costs and waste. It sets a dangerous precedent of accommodating our high costs by adopting skimpy coverage. This might win a short-term political numbers game, counting people presumably insured, but would worsen the trend toward widespread under-insurance.

Governor Romney's plan enjoys surface appeal, because it seems to offer health insurance coverage to everyone, and because it does not seem to require new money.

These are reasonable concepts. Unfortunately, the governor's plan rests excessively on increased spending and on weak coverage, not on real cost cuts or real engagement with the problems plaguing Massachusetts health care.

While the governor's plan may therefore be politically clever, its substance does not respect the clinical and financial realities of Massachusetts health care. In this respect, his current proposal roughly parallels the health care PowerPoint presentation used during his gubernatorial campaign. That document asserted that increasing the federal government's share of the cost of Medicaid was a workable idea—as if that were a matter determined by political demands or maneuvering rather than set by formula that applies nation-wide. Congress, however, has conspicuously not accepted the governor's assertion.

The governor now promises to fill gaps to try to get health insurance coverage to essentially everyone in Massachusetts. He would do this through a combination of higher Medicaid spending, re-targeting of hospital uncompensated care dollars, and financial penalties on people who don't buy insurance.

There are problems with each of these three aspects of the governor's proposal. The main problem is that the numbers don't add up—so it won't contain costs and therefore won't win health security for the people of Massachusetts.

The numbers in the governor's plan don't add up for several reasons:
a) Massachusetts health care is costly but the governor's plan does not seriously attack the causes of high costs,
b) The governor's plan actually increases health spending in Massachusetts (thereby making it even less financially sustainable).
c) The plan's benefits are likely to be so skimpy as to deny medical security to most people to whom it would offer insurance. Further, by shifting costs to patients and promoting skimpy coverage, this would set an example of avoiding serious work to contain costs and would encourage the overall trend towards under-insurance.

a) The governor's proposal does not seriously attack any of the causes of high costs in Massachusetts.

The governor's plan seems to offer only one concrete step to cut administrative waste, clinical waste, excess prices, or fraud and theft. This is the effort to assign some newly-insured patients to a primary care physician or clinic, one that would aim to get to know the patient and coordinate care. Apart from this, the proposal offers vague, unsubstantiated, confusing, and even ideological language.

One example: The governor's 21 June 2005 PowerPoint presentation asserts, "Private insurance is better, cheaper and more efficient than government run healthcare." This claim is not documented. Administrative overhead in private insurance is substantially higher than in Medicare or Medicaid. Further, "government run healthcare" is not an option under discussion by anyone in the United States. Public financing is under discussion, but governmental provision of the money is very far from government-run health care.

A second example: The governor's PowerPoint refers to "A shared vision: reform based on market solutions." What market solutions are imagined? We are not told directly. But earlier proposals from the governor have featured meager insurance coverage that forces patients to pay substantial sums out-of-pocket. These might include deductibles as high as $5,000 yearly.[4]

High deductibles would make insurance premiums more affordable, but would not make the costs that patients face for needed health care (premiums plus out-of-pocket payments) more affordable.

Having less insurance does lead many patients to try to use less care. But this is not an effective or clinically appropriate way to save money.

- It is not effective because the great majority of health costs are incurred by a small majority of very sick individuals.[5] These patients are costly because they are sick, and because their doctors order costly care to treat them.

- It is not clinically appropriate because most patients have only limited information to guide the complex decisions involved about appropriate ways to diagnose and treat their clinical problems. We train and license doctors and other professionals to make or guide such decisions. Out-of-pocket payments do discourage some patients from using some services, but much evidence shows that they deter both vital and unneeded services. Relatively few patients have the knowledge to separate the chaff from the wheat.

This sort of market solution is bad medicine. Seeking health care is not at all like buying a toaster oven.

Instead of addressing the causes of health care waste endemic in the U.S.—and the particular causes of exceptionally high costs in Massachusetts—the governor's proposal essentially accepts high costs and then tries to find a way to offer coverage, or the appearance of coverage, despite those high costs.

The governor's proposal skates lightly over cost control issues, barely scraping the surface. This renders his plan only a Zamboni machine away from invisibility. To tackle and contain health costs, we need linebackers, not ice skaters.

Switching metaphors, General McClellan in the Civil War was popular with Union soldiers of the Army of the Potomac, offering good food, equipment, training, and parades—the military equivalent of bread and circuses. He was dramatic and clever as a general, moving his troops into strategic positions. But he would not fight effectively, thereby missing at least two strong chances to end a bloody war quickly. He constantly exaggerated the enemy's strength and his own weakness. Grant and Sherman won the war, mainly by confronting and crushing the enemy, not dancing around it. They brought the Union's enormous resources to bear.

Our governor, like many failed generals, is calling his proposal an advance, but it is really yet another retreat from the fight to contain costs.

<u>b) The governor's proposal actually increases health spending in Massachusetts.</u>

First, the governor's proposal would apparently increase Medicaid spending by $400 million to cover some 106,000 uninsured residents of the Commonwealth who are today thought to be eligible for Medicaid but are not yet enrolled. Half of this money would apparently be federal cost-sharing.

Expansions of Medicaid—nationwide and in Massachusetts—have been tremendously valuable, bringing vital new coverage to a great many poor and under-served citizens. Many or most Medicaid expansions, however, are done in ways that require higher spending.

Massachusetts has always been high in share spent on Medicaid. In 1998, the last year for which data are available, Massachusetts was fourth-highest in the nation in Medicaid share of personal health spending.[6]

It is simply not realistic to expect Congress to continue to allow Medicaid to keep growing.[7] The governor's proposal to rely more heavily on Medicaid, while politically attractive today, is not likely to be financially durable tomorrow. Moreover, it may lead to increased pressure to cut prices for Medicaid services. That is appropriate in some areas, such as winning lower prices for prescription drugs. But in other areas, it runs afoul of hospital demands for higher payments from Medicaid, and also of a recent court decision requiring higher Medicaid payments for dental care.[8]

Second, the governor's proposal of 21 June 2005 identifies some 204,000 uninsured people in Massachusetts whose family incomes exceed 300 percent of the federal poverty level. They reportedly comprise a surprising 44 percent of the 460,000 uninsured people identified by state surveys. These individuals would be offered "Commonwealth Care," with premiums of less than $200 monthly and deductibles between $250 and $1,000 yearly per person.

How much would this cost? Let us set aside, for the moment, the question of whether deductibles this low can co-exist with premiums this low. Suppose that average premium per person turns out to be $200 monthly or $2,400 annually, and that all eligible people enroll. This $2,400, for the estimated 204,000 uninsured people with incomes more than three times the federal poverty level, would yield a gross premium cost of some $489,600,000 annually statewide.

The $400 million in higher Medicaid spending and $490 million in Commonwealth Care premiums sum to $890 million in added spending for health coverage.

Suppose that half of this $890 million simply substitutes for sums now financing care, either out-of-pocket or through various subsidies, and half finances greater use of health care than previously, plus the administrative costs of additional insurance. That would mean that the governor is calling for a rise of $445 million in health spending, on top of the $52.7 billion already spent this year.

To this must be added the considerable sums that insurers, hospitals, physicians, and other caregivers expect in higher Medicaid payment rates.

This is not cost control. It is higher state tax-financed spending, higher federal tax-financed spending, and higher spending by individuals.

Further, the governor's proposal apparently calls for substantial hikes in out-of-pocket costs, which are discussed below.

<u>c) The governor's plan's benefits are so skimpy that it denies medical security to most of people it would offer insurance.</u>

Medical security means that a patient can be confident of getting the care needed to diagnose and treat an illness, without having to worry about the bill when sick, and without having to worry about losing health insurance ever.

By contrast, proposals for "basic" coverage and increased cost "sharing" are methods of expanding <u>under</u>-insurance. They will fail to protect people adequately and they will fail to actually control costs. High out-of-pocket costs deny medical security today by blocking patients from obtaining needed care in a

timely way. Failure to contain health care costs means rising health insurance premiums. Inability to afford those premiums denies medical security tomorrow.

The governor's proposal appears to require hikes in out-of-pocket costs—higher co-payments for visits to physicians and for medications than prevail in today's private insurance market. And while the governor's proposal claims a deductible of only $250 – $1,000 annually per person, a Blue Cross discussion of his plan in 2004 estimated that a premium of $150 monthly per person would require an annual deductible of about $5,000 annually per person.[9]

The Blue Cross estimate meant a total of $6,800 in premium plus deductible yearly for each person ($150 monthly times 12, plus $5000). If that estimate is valid, and all else equal, then a premium of $2,400 annually would translate into a deductible of $4,400 yearly per person ($2,400 plus $4,400 equals $6,800). That is far from the $250 - $1,000 claimed in the governor's PowerPoint proposal of 21 June 2005. Deductibles of $4,400 for individuals suggest deductibles for a family near or over $10,000. This is essentially like catastrophic coverage.

And this plan apparently lacks any relief from the deductible gap for the many low-and middle-income families for whom such sums would present an enormous barrier to obtaining needed care.

In addition is the issue of scope of benefits. The governor has suggested modeling coverage on the Healthy New York plan. But that plan "is stripped of some coverage that may come with a plan sponsored by an employer. It does not, for instance, include mental health or substance-abuse treatment," the *New York Times* observed last week.[10]   The governor's 21 June 2005 PowerPoint slides indicate otherwise, possibly pointing to a need for clarification.

The governor has claimed to be proposing more than basic, bare bones insurance—but has offered no evidence to suggest that his financial strategies can achieve this.

More important, the governor's plan would have to hike out-of-pocket costs to high levels if it is to retain broad benefits while holding premiums under $200 monthly per person. The resulting skimpy (broad but shallow) coverage would move many of today's uninsured people to the category of under-insured—still unable to afford care they need.

It also would worsen the trend toward widespread under-insurance among people already insured. In the private sector, the governor's model of providing skimpy coverage, rather than actually tackling our cost problems, would encourage employers to adopt skimpy policies as well.

Thus, while apparently aiming to protect uninsured people, the governor proposes to increase spending, to refrain from addressing the causes of high

costs, and to offer only flimsy benefits. These add up to a dangerous accommodation to our state's highest-in-the-world health care costs.

This plan may let the governor win a short-term political game of counting the number of people who supposedly have coverage. But it appears likely to give bad coverage to most of those who are uninsured today. And it would set a precedent of adopting skimpy coverage instead of working on ways to squeeze out and re-capture the enormous waste in the system, to recycle the savings for good coverage for all. Skimpy, watered-down coverage means rationing health care by ability to pay.

There have long been three main ways to approach reform of health care:

- Should we contain cost first?
- Should we expand access first?
- Should we do both at once?

Expanding access first—by employer mandates, for example—was not an unreasonable idea 15 years ago, when spending was much lower than today. And political support for helping people has always been greater than political support for containing costs. But even then, as a strategy for achieving coverage for all, it seemed unlikely to succeed.

The governor's present proposal, though, is a particularly bad idea, because it that offers expansion with such skimpy coverage that it amounts to a smokescreen for increased rationing by ability to pay. Because this is rationing by ability to pay masked as universal coverage, it might be called "O-Mitted Care."

The governor talks little about delivery system changes. But when he talks about coverage to help keep people out of the emergency room, for example, he fails to address the difficulties that many people on Medicaid face in finding a physician as an on-going primary caregiver, or to find certain medical specialists or dentists. His proposals for weak coverage and high out-of-pocket costs may make it even harder for ostensibly newly-insured patients to win real primary care than it is for many Medicaid patients. Such concerns make it vital to address the actual delivery of care, not financial alone.

* * *

These analyses necessarily rest on the somewhat meager data on the governor's plan that have been presented publicly to date. We hope and expect that the governor will be able to offer a more detailed proposal shortly. Those details may or may not warrant revision of these analyses.

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

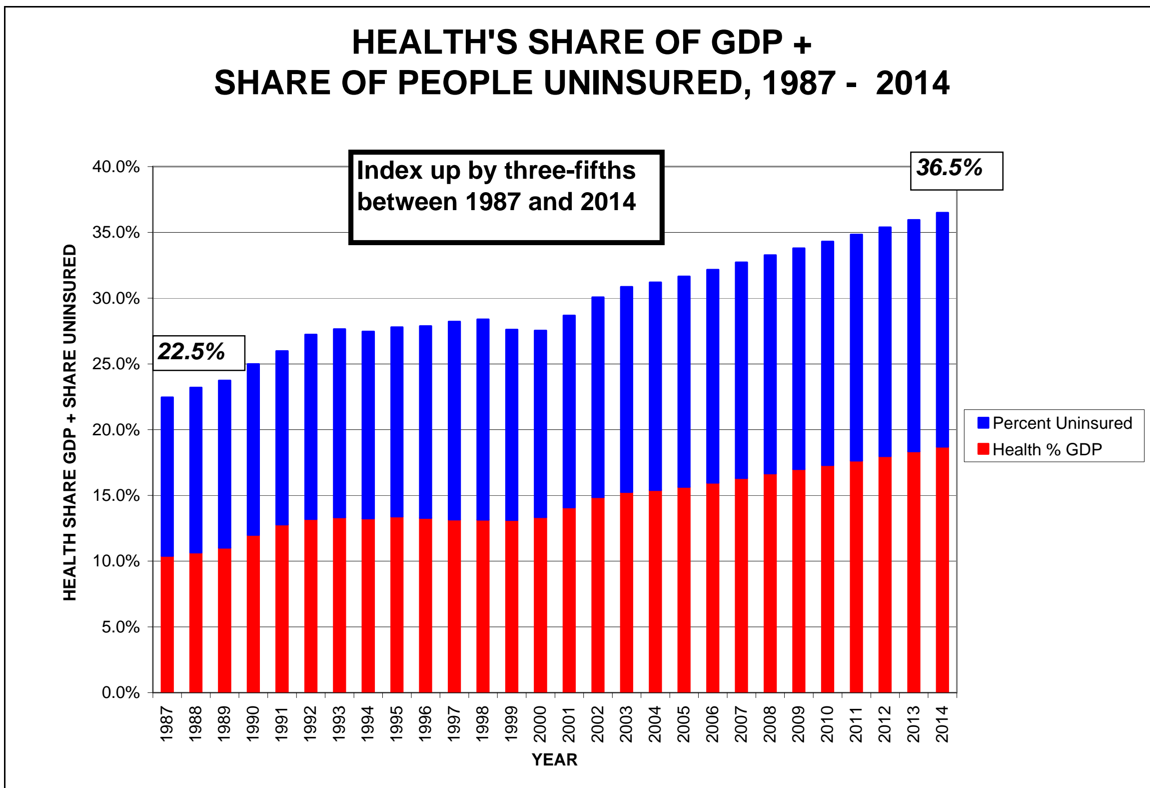
Skating around cost problems will not win real financial coverage for all who live in this state. Legislators and others involved with Massachusetts health care must adopt strategies to grapple seriously with our soaring health cost burden.

Health care is absorbing a growing share of the U.S. economy. Health care's share of Gross Domestic Product (GDP) rose from 10.4 percent in 1987 to some 15.6 percent this year. It is now projected to reach 18.7 percent in 2014.

Rising spending is not buying us improved insurance coverage. Just the reverse—higher costs are the main contributor to loss of job-based health coverage and also to Medicaid eligibility cuts. So the share uninsured is rising along with rising costs. The share of Americans without insurance rose from 12.1 percent in 1987 to some 16.0 percent this year, and is projected to hit 17.8 percent in 2014.[11]

Adding health care's share of GDP and uninsured people's share of U.S. population yields a Health Crisis Index. This is projected to rise from 22.5 percent in 1987 to 36.5 percent in 2014—up over three-fifths in one generation.[12]

Exhibit 2



Strikingly, rising health costs absorbed one-quarter of all U.S. economic growth between 2000 and 2005, we found in a recent study.[13] Health spending growth averaged 8.1 percent yearly, compared with GDP's 4.8 percent. The nation would be spending one-seventh less this year on health care if health care's share of GDP had stayed at the 13.2 percent that it consumed five years ago.

Exhibit 3

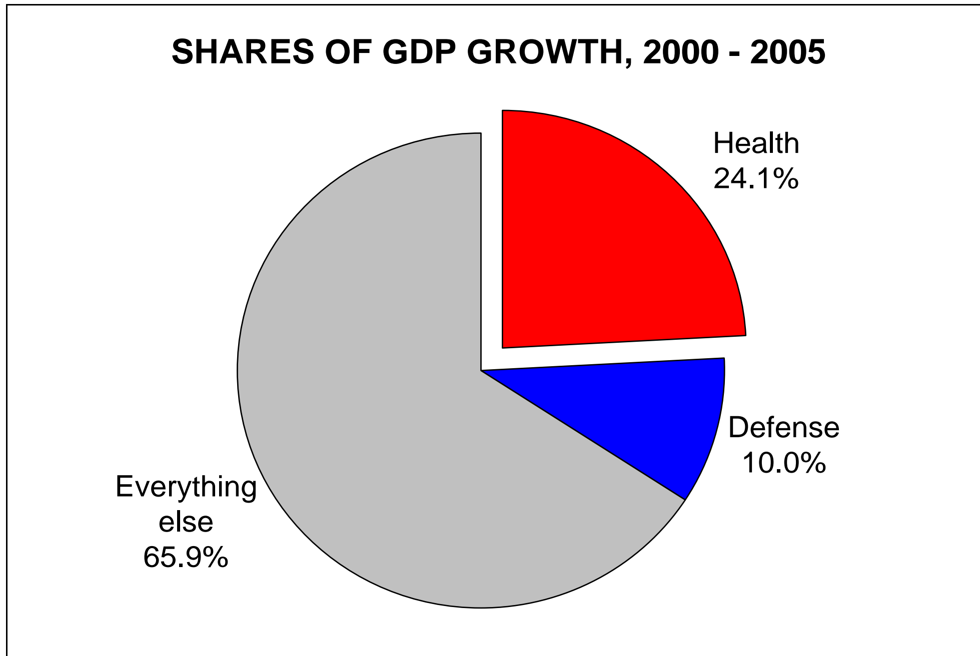
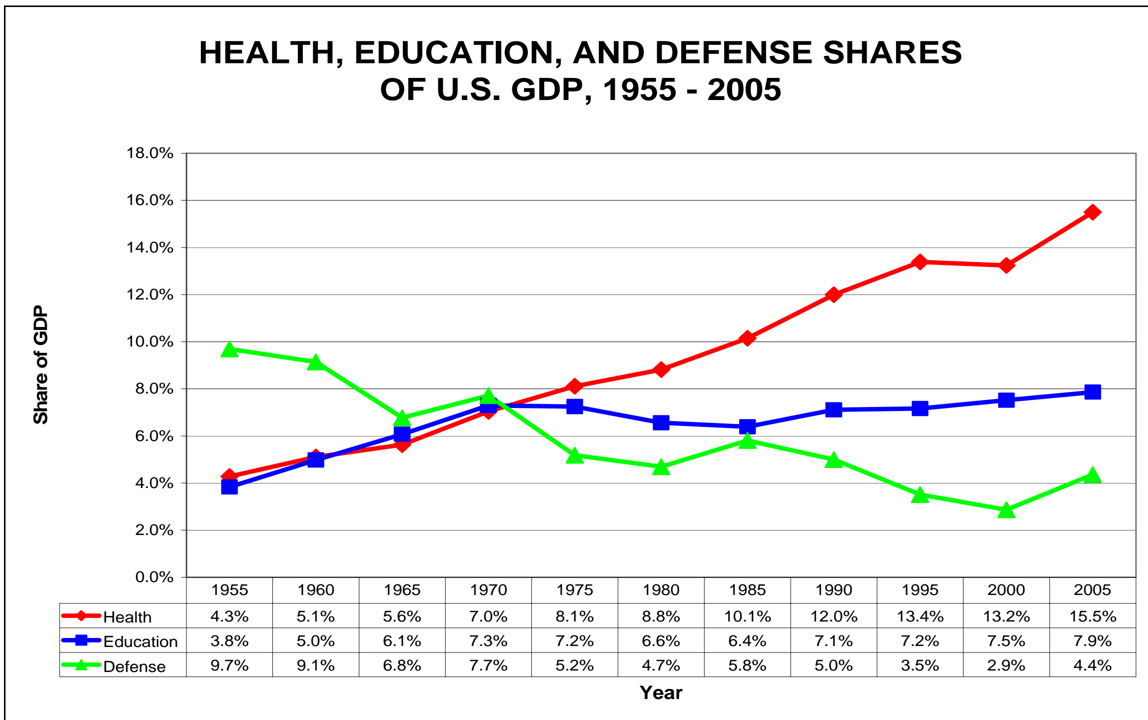


Exhibit 4



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

Few Americans realize that health spending is now almost four times defense spending and double education spending. In 1970, by contrast, the three sectors absorbed roughly equal shares of GDP.

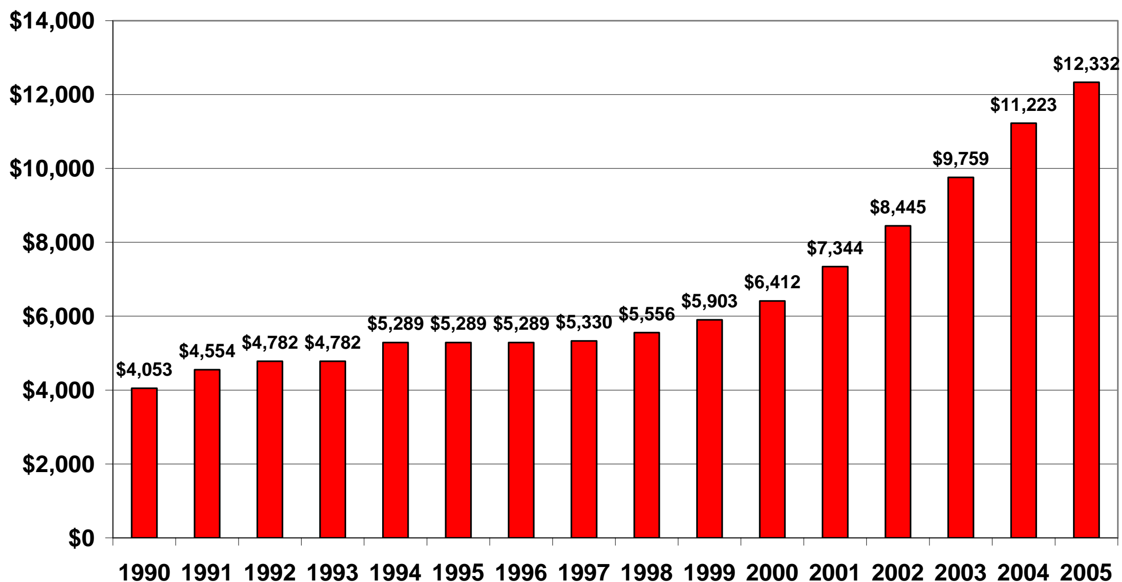
* * *

In Massachusetts, too, the health cost burden is growing. We suffered an estimated 41 percent rise in total health spending here from 2000 to 2005.

As the next chart shows, the cost of a family health insurance premium (for a stable benefit package at a large employer) has more than doubled in six years.

Exhibit 5

FAMILY HEALTH INSURANCE ANNUAL PREMIUM,
STEADY BENEFIT PACKAGE, BIG EMPLOYER,
EASTERN MASSACHUSETTS, 1990-2005



The rise in health spending has accelerated recently. So consider real health care spending per person in Massachusetts, adjusted for inflation:

- From 1997 to 2005, we had a real rise of 22.5 percent in health spending.

- Health spending here rose from $6,705 in 1997 (stated in constant 2005 dollars) to $7,156 in 2001—up 6.7 percent over four years in real terms.

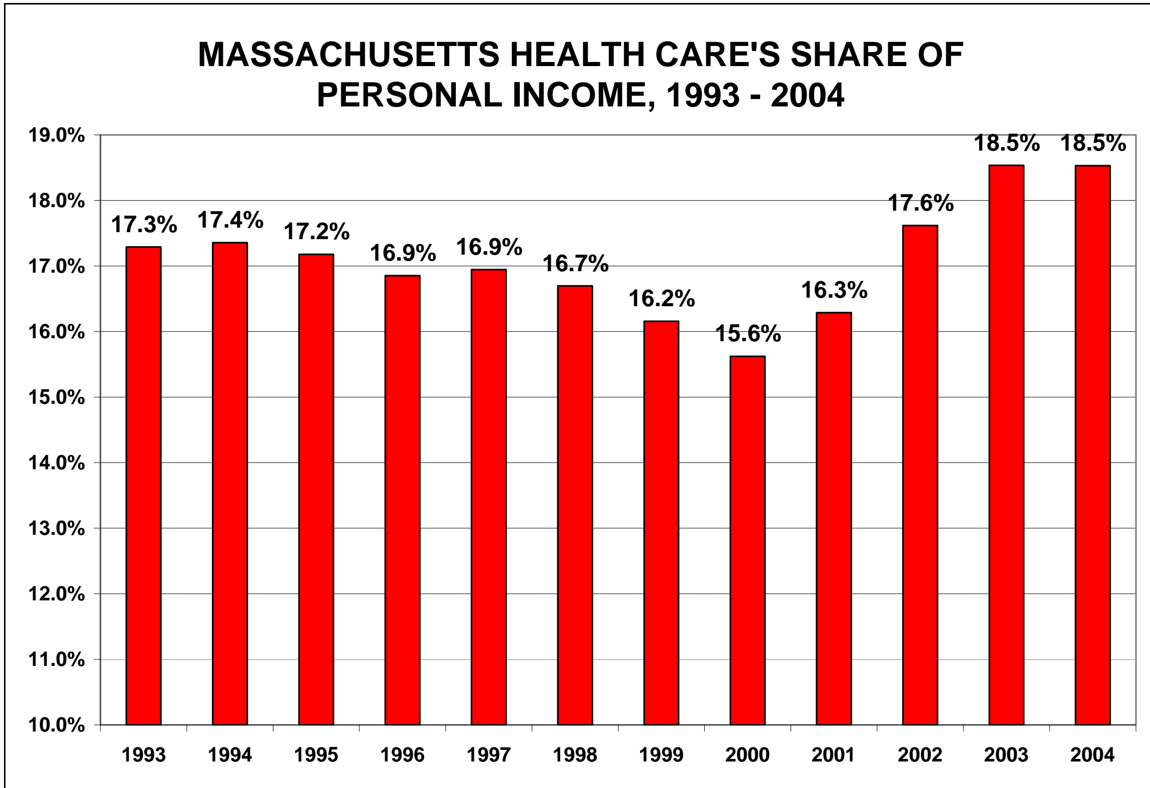
- But from 2001 to 2005, it has risen to an estimated $8,280—up 15.7 percent. That is more than twice as fast an increase as in the previous four years.

Health care is now consuming a greater share of personal income in this state than ever before. After dipping to 15.6 percent of personal income in 2000, health spending has jumped to an estimated 18.5 percent in 2003 and 2004.

Such increases are not sustainable.

Health care costs are crowding out everything else that we care about.

Exhibit 6



Massachusetts Senate Bill 755 is the only proposal before the legislature that offers serious cost controls for grappling with these unsustainable trends in the Commonwealth's health care.

As discussed below, the general approach of this bill could provide a foundation for genuinely addressing the sources of rising costs, rather than, like other proposals, simply shifting costs to patients or allowing costs to continue to soar.

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

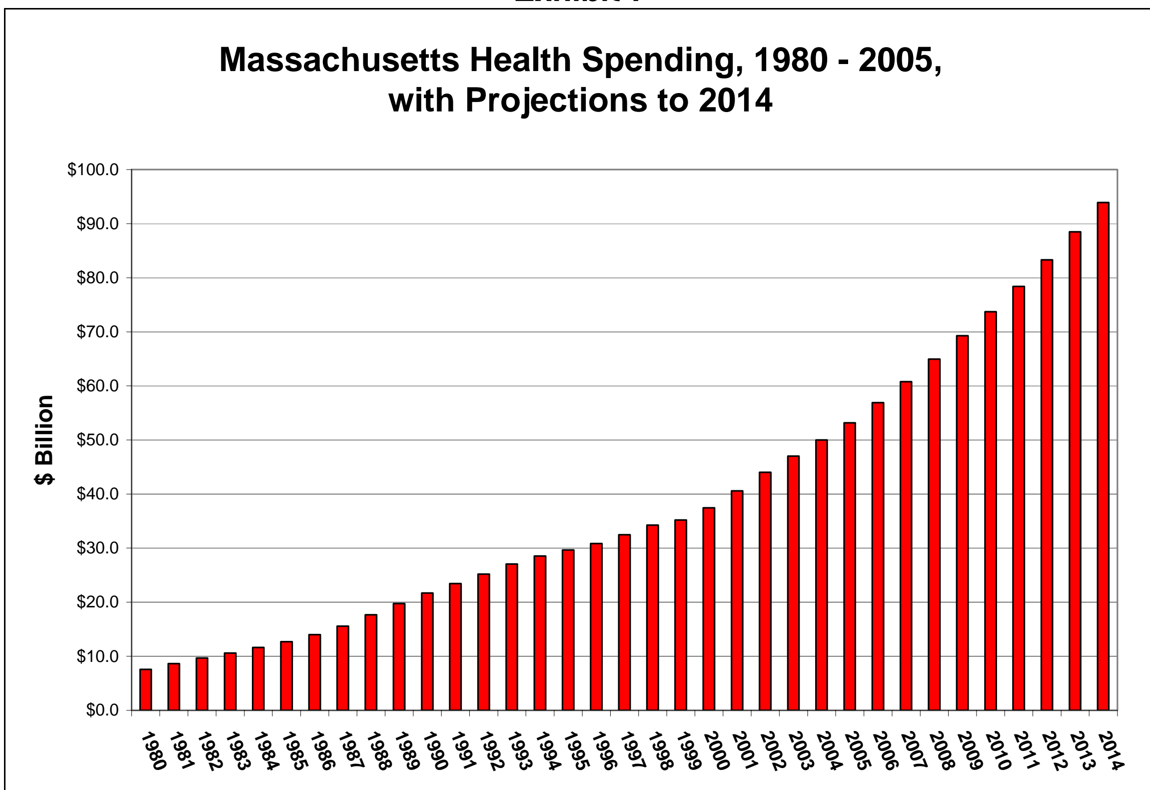
After the estimated 41 percent rise in total Massachusetts health spending between 2000 and 2005, our hospitals, doctors, and other caregivers have become even more accustomed to relying on more money for business as usual.

Yet many hospitals remain in deficit. Doctors earn less here than in other states.

All this means that Massachusetts doctors, hospitals, other caregivers, employers, state government, and other payers are ill-prepared to face revenue constraints. They are badly equipped to cope with a freeze in real revenue available to pay for health care, let alone a drop in real revenue—such as would accompany a deep and prolonged recession.

Exhibit 7 shows projected health spending here nearing $95 billion in 2014.

Exhibit 7



That estimate, which rests in part on recently-published federal health spending projections, does not allow for a deep and prolonged recession.

It is hard to imagine where this money would come from. And expanding health spending even further to expand access to care seems implausible.

Health's share of the economy is projected to continue to rise steadily both nationally and in Massachusetts. It is hard to be confident that employers, governments, and individuals will be able or willing to continue to increase payments for health care as rapidly as they have in the past. They will probably not provide as much money as caregivers would like to have. Caregivers are not prepared to cope with the looming financial gap between their expectations or perceived needs, and payers' ability and willingness to write checks.

So unless we begin soon to make our health care durably affordable and sustainable, it runs the risk of financial disaster in the next deep recession.

Some economists soothingly and smoothly reassure us that it has always been politically and financially possible to find the money that hospitals, doctors, and other caregivers demanded. But pressures to address other needs, and worries about the federal debt, trade deficit, and soundness of the economy overall, raise doubts that money will flow so generously to health care in the future.

Other economists or health care leaders insist that higher health care spending buys better health, and that an aging population or better technology require higher spending. But—as noted earlier—other wealthy nations typically spend one-half as much on health care as the U.S. does (even though their populations are much older than ours), and enjoy much better health outcomes.

The problems that will lead to medical meltdown in Massachusetts are real. They are pressing. They will destabilize health care in this state—if they are allowed to worsen and if state government does not prepare to deal with them.

The worst time to figure out how to address a crisis is after it hits. If we face a medical meltdown—with one million or more uninsured, dozens of hospitals closing or bankrupt, and doctors driving cabs—it will be too late to plan carefully. Legislating in an atmosphere of panic, with starkly inadequate financing, and with no experience with what works and does not, is likely to result in disaster.

It will be helpful to design and test real reforms now, before the storm. It is vital to bring together the key actors to think about how to craft health care that covers us all, pays all parties fairly, encourages efficient and effective care, and is durably affordable. Only state government can do this job. Legislators should consider establishing a permanent emergency health care commission, similar to the Ward Commission, to devote continuous attention to shaping affordable and high-quality health care for all who live, work, and do business in Massachusetts.

5. We can put Massachusetts health care on a stable, affordable footing—if we better use our current high spending. About half of health spending nationally is wasted—on administering health care financing, on theft, on unnecessary services, and on excessively high prices.

Reallocating the wasted sums is vital to providing needed care to all and stabilizing caregivers. In this state, wasting half of health spending means wasting about $26 billion this year—roughly equal to the total state budget. Cutting waste from about 50 percent to 20 percent ($10 billion this year) would free up nearly one-third of our spending ($16 billion this year) to expand care for people now uninsured and otherwise under-served.

Nationally, about half of health care spending is wasted, in four main ways:

- unproductive paperwork generated by the way we pay for care,
- unneeded, unnecessarily intensive, or incompetent services,
- excessively high prices for drugs, equipment, and services, and
- fraud or other theft.

These four types of waste are described in the Health Reform Program's 9 February 2005 report on rising health costs.[14]

As noted there, waste in the form of unneeded, excessively intensive, or incompetent clinical service appears the most costly type, with many sources:

- lack of evidence about what care works to diagnose or treat an illness,
- uneven use of existing evidence,
- dissemination of inaccurate or misleading information by self-interested parties,
- incompetence or impairment of a relatively small share of caregivers,
- financial incentives to over- or under-serve in various methods of payment,
- maldistribution of hospitals or doctors, geographically or by specialization,
- excessively self-interested behavior by some caregivers,
- defensive medicine spurred by fear of malpractice litigation,
- demands by some patients for unnecessary care, and the like.

But other problems, too, often mean wasted spending, when delayed care causes costly complications. Such expense could have been averted but for

- patients' failure to seek needed care—by at least as many patients as demand unnecessary care,
- financial barriers associated with lack of insurance that prevent many patients from seeking care, and

- non-financial barriers like lack of nearby caregivers.

Today's prevailing view is that the main way to reduce clinical waste is to put more burden on patients, rather than doctors, to decide what care they need. As discussed elsewhere, this strategy is both ineffective and dangerous.

For one thing, making patients pay more out-of-pocket predictably causes many patients to seek less care, but—in part because they lack good information—much of the care that's cut would have been helpful.

For another, caregivers can be expected to respond to some patients' reduced use by doing more for the patients who do continue to seek services. [15]

Much clinical waste can be eliminated through

- more financially neutral methods of paying doctors that reward competence and kindness and energy,
- insurance or other financial protection for all patients,
- better spatial and specialty distribution of hospitals and doctors,
- replacement of tort-based malpractice litigation with other methods of compensating those harmed and of addressing incompetence, and
- better use of information on what care is effective, efficient, and appropriate for which patients, and development of still better information.

But on that last point—research on what care is most appropriate in what circumstances has been sadly limited. The nation is increasingly recognizing the lack, for example, of past head-to-head studies of many drug types, and the lack of careful comparisons of various procedures. An unknown but possibly large share of research findings may have been distorted by sponsors' financial interests. So years of analyses will be needed to develop detailed understanding or protocols for addressing many major clinical conditions.

Whatever the state of information, however, as discussed below, physicians and other knowledgeable caregivers must take on the central role in the challenge of reducing clinical waste. The job of husbanding inevitably limited resources and marshaling them to do as much good as possible must rest on individual doctors' decisions about the needs of patients, both individually and collectively. (This should, of course, be done in consultation with patients and their families as appropriate, ideally in the context of stable patient-caregiver relationships.)

Some of the waste—clinical and non-clinical—in today's health care is inevitable and irreducible. (There will always, for example, be some problems of incompetence or inadequate dissemination of information that lead to provision of inappropriate, unnecessary services.) It appears likely, however, that most waste can be squeezed out and recycled to finance care for today's uninsured people, to improve quality, and to hold down spending increases.

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

Exhibit 8

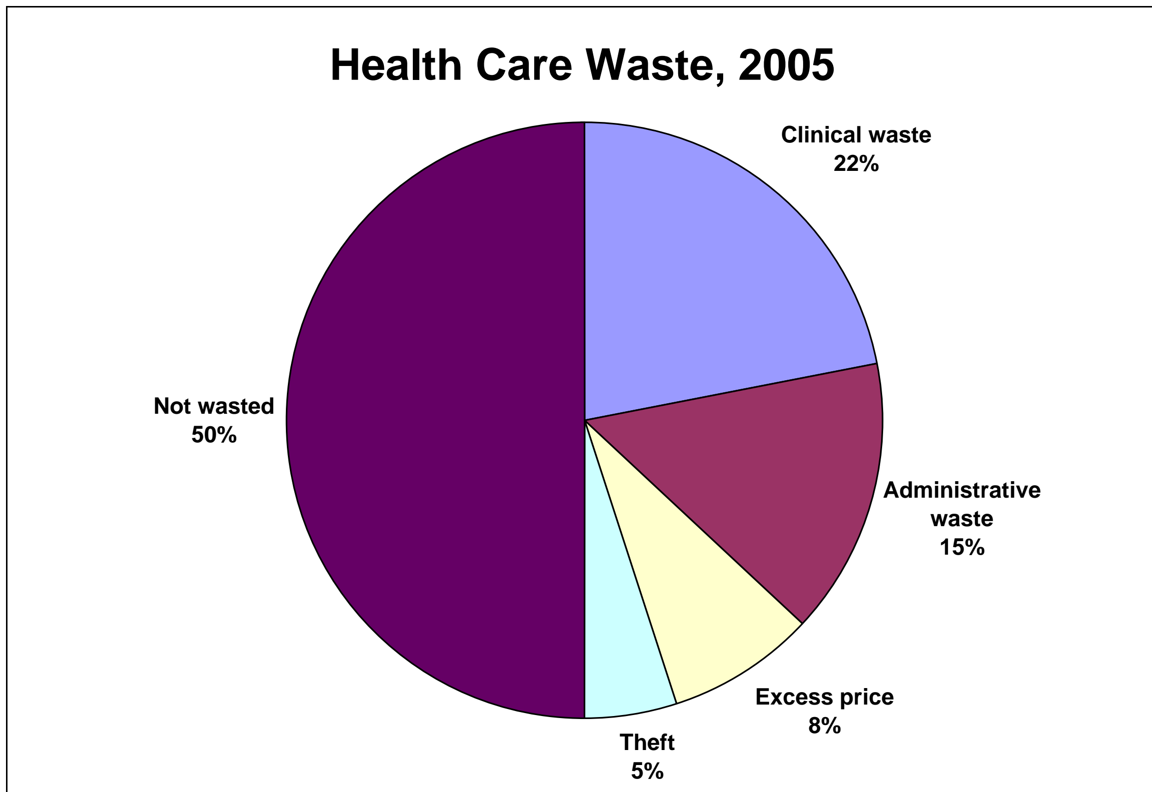


Exhibit 9

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

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

With over $52 billion spent on health care in Massachusetts in 2005, if a similar proportion is wasted here as in the nation as a whole, the wasted half of total health care spending in this state (private and public) equals just over $26 billion.

That's a sum roughly equal to the total state budget.

Assume that 20 percent of health spending, although wasted, cannot be saved. Even so, we would benefit enormously by cutting waste in Massachusetts health care from about 50 percent ($26 billion) of total health spending to about 20 percent ($10.5 billion this year). That would free up nearly one-third ($15.5 billion this year) of current health care spending, so that it could be used for better purposes.

That money could be used

- to finance care for Massachusetts residents who are uninsured today, and
- to round out service to people who are under-insured or otherwise under-served.
- Sums left over could be used to address hunger, the environment, education, or other pressing needs—steps which would also help to improve health.

Some of that waste can be squeezed out quickly, and some will take much more time, but to make care durably affordable, it will be vital to focus continually on converting this fat to meat and bone—using currently wasted spending more appropriately. (In our earlier studies of the affordability of universal coverage in Massachusetts, we and colleagues have suggested that savings of 14 percent overall from current spending might quickly be reallocated to expand access, though implementation of consolidated financing, prescription drug bulk purchasing, and other reforms, as discussed below.)

The governor's proposal, the Senate president's proposal, and the employer mandate proposal would do little or nothing to address the massive problem of waste in our costliest-on-earth health care system.

6. Massachusetts health care costs are especially high in part because we use extraordinarily specialized caregivers, relying very heavily on teaching hospitals and specialist physicians.

The types of hospitals and physicians available in Massachusetts help to shape our unusually costly patterns of care.

Some groups (hospitals and others) deny this state's health care costs are high or claim they are justified by a variety of factors.

Yet if health care spending here were at the U.S. average per person, we would save some $11-12 billion in Massachusetts this year alone. Actual spending of $8,280 here means a current total of $52.7 billion. If we instead spent statewide at the U.S. average per person of about $6,477, the total would amount to approximately $41.5 billion this year.

Some of our state's higher-than-average costs are legitimately attributable to

- higher wages,
- research,
- service to patients from other states,
- a slightly older population,
- and the like.

But *more* of our higher costs have long actually been associated with

- serving more patients in costly teaching hospitals (highest rate of any state),
- relying heavily on hospitals to provide outpatient (non-emergency) care, even though that tends to be much more costly than care in doctors' offices,
- the highest physician-to-population ratio among the states,
- a tradition of relatively elaborate and expensive care, and
- higher spending on nursing home care.

This is not just a hospital problem.

Massachusetts health care costs per person are higher than average in virtually every sector of health care.

This is true even though Massachusetts has long been one of the states with the greatest share of its residents enrolled in managed care, as the following exhibit shows.

Exhibit 10

Massachusetts has the resources to take care of us all

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

Sources: See endnotes.[16]

* * *

The state's high costs are associated with several caregiver crises confronting Massachusetts health care.

Hospital Closings
Nearly half of the state's hospitals closed between 1960 and 2002, as Exhibit 11 shows. Among survivors to 1990, over one-quarter closed by 2002. If closings continue at a similar pace, we may be left in 2010 with fewer than 60 hospitals.

Our analyses of Massachusetts and other data show that the lower-cost, more efficient hospitals are slightly more likely to close. This evidence runs contrary to the view that market competition will spur less efficient, costlier hospitals to greater efficiency, or force them to close. Hospitals in lower-income cities and towns are also likelier to close—even though those tend to be communities with a high level of unmet need for health care. Closings of smaller and mid-size

community hospitals are forcing more and more patients to travel farther to seek care at costly teaching hospitals.

Because hospitals have been shrinking, Exhibit 12 shows that hospital bed capacity statewide fell in the 1990s even faster than the number of hospitals. In the next decade, as the aging population collides with shrinking hospital capacity, our state is likely to face shortages of thousands of hospital beds. Construction costs will soon approach $1 million per bed. This parallels the crisis many cities and towns face in replacing closed schools in the past 20 years.

Exhibit 11

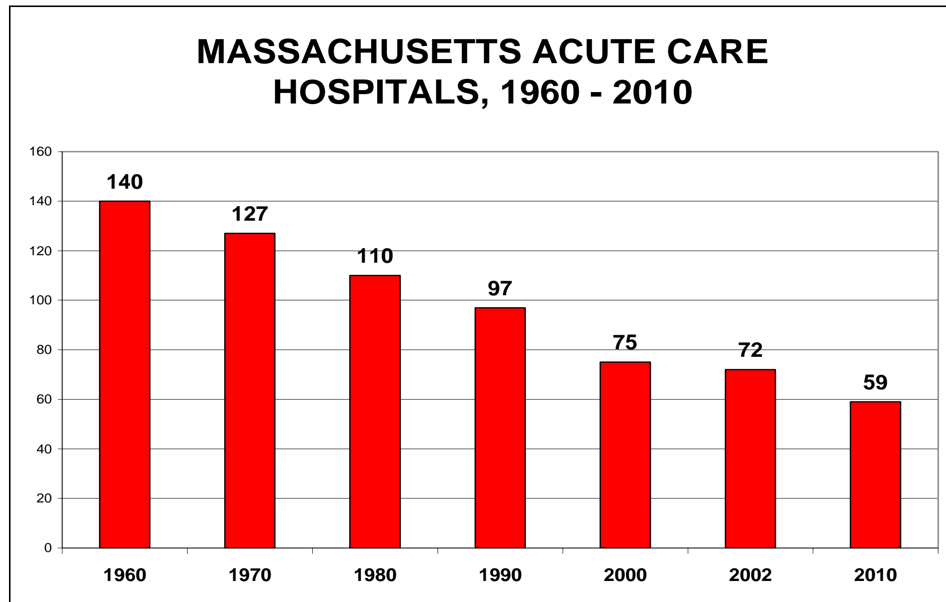


Exhibit 12

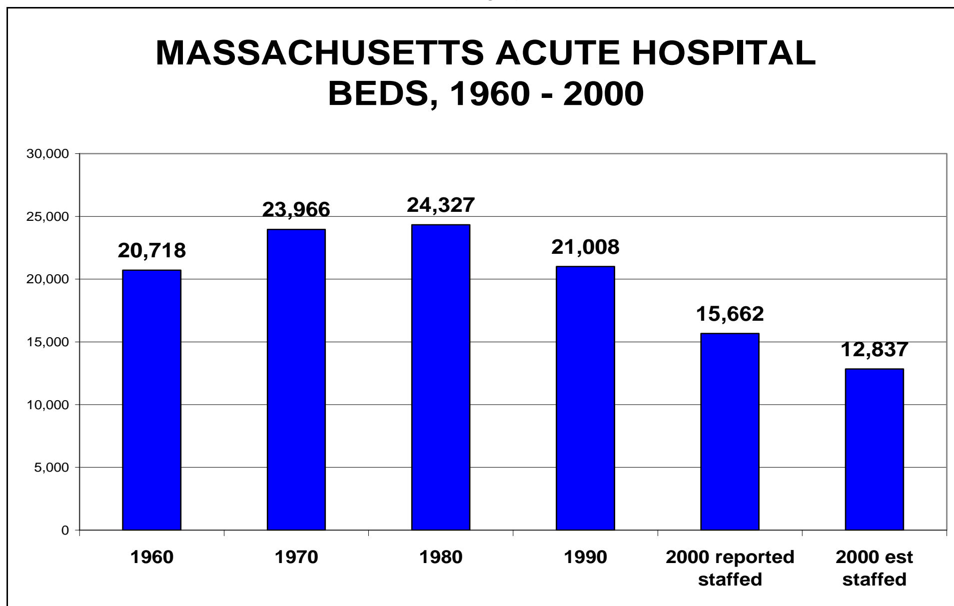


Exhibit 13

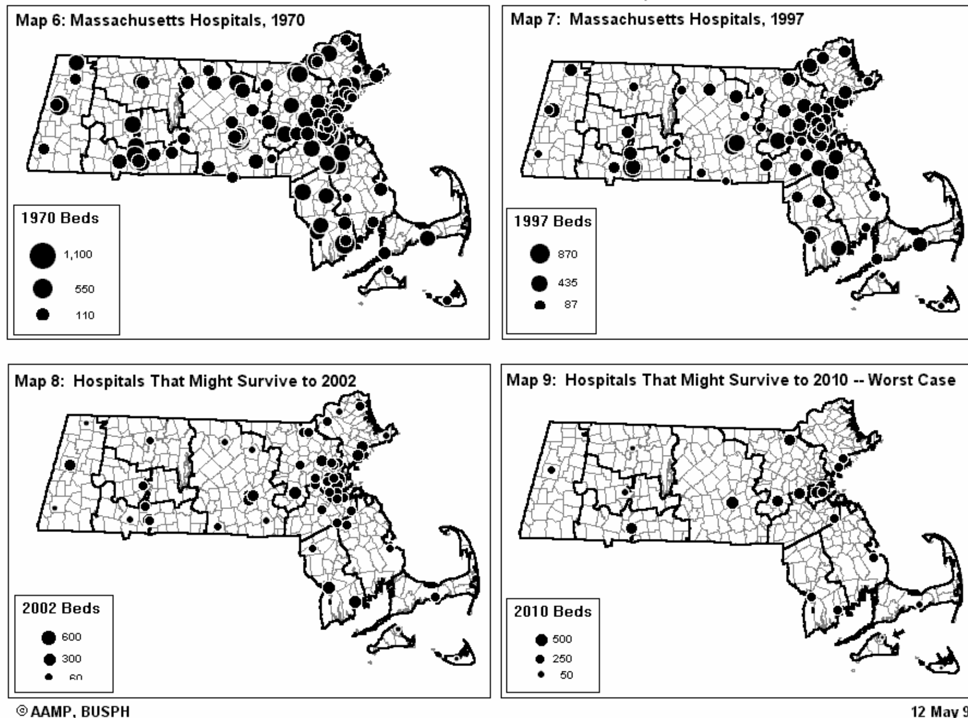


Exhibit 13 shows the number, size, and distribution of hospitals across the state in 1970 and then in 1997, when the maps were prepared. If use of hospitals had been reduced to the rates that many managed care proponents were advocating then, the number of hospitals surviving to 2002 and 2010 would have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

Nursing Home Closings

Some nursing homes have been closed that will be needed before too many years have passed. In some regions of the state, beds are already scarce.

Nursing Shortages

The state's shortage of hospital capacity is exacerbated by a shortage of nurses to staff the surviving hospital beds. Massachusetts is first in the nation in the number of RNs per 1,000 residents. Yet we seem to have a substantial shortage of nurses willing to work in acute care hospitals.

Physician Complaints
Massachusetts leads all states in doctors per 1,000 people, with 54 percent more than the national average in 2002. We are first also in patient-care physicians alone, excluding researchers, educators, and administrators.

As we have noted previously, the physician-to-population ratio has generally been rising faster here than nationally even since the late 1980s, when the Massachusetts Medical Society first claimed publicly that physicians were fleeing this state. [17] These trends in the physician supply nationally and in Massachusetts are shown in Exhibit 14.

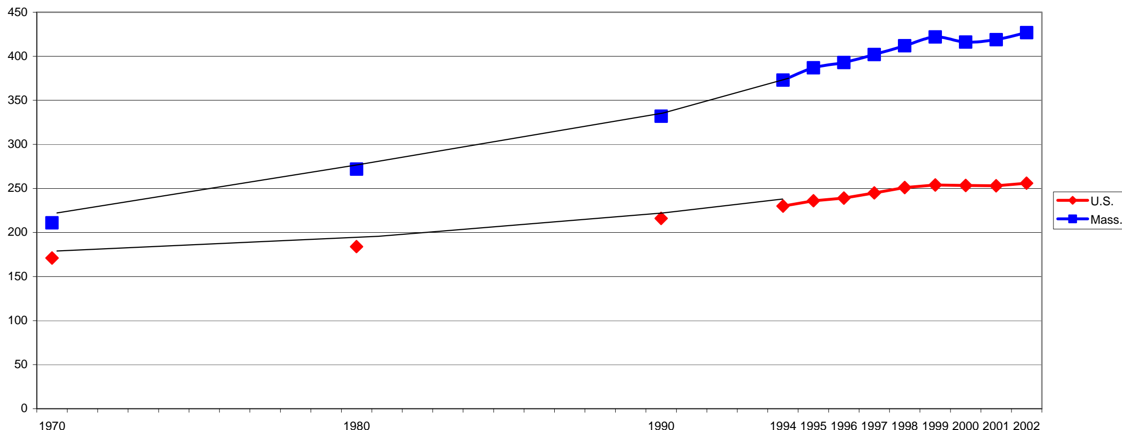
Yet despite—or, more likely, in large part because of—this very substantial physician supply, Massachusetts physicians often receive lower incomes than their counterparts in other states. Spending on physicians and related services in Massachusetts totaled some $8.7 billion in 2000, the last year for which comparable data are available. This averaged $1,370 per person, 17.2 percent above the U.S. average and fifth-highest in the nation.

The large numbers of physicians here mean that there are fewer patients per physician. So, although spending on physician care per Massachusetts resident is high, spreading those sums over so many physicians means relatively lower incomes than in other states.

This is all the more striking because Massachusetts has long had one of the most highly specialized arrays of physicians in the nation. Calculations from American Medical Association data indicate that, in 2002, specialists constituted 71.3 percent of Massachusetts physicians, 12 percent above the national average.

Exhibit 14

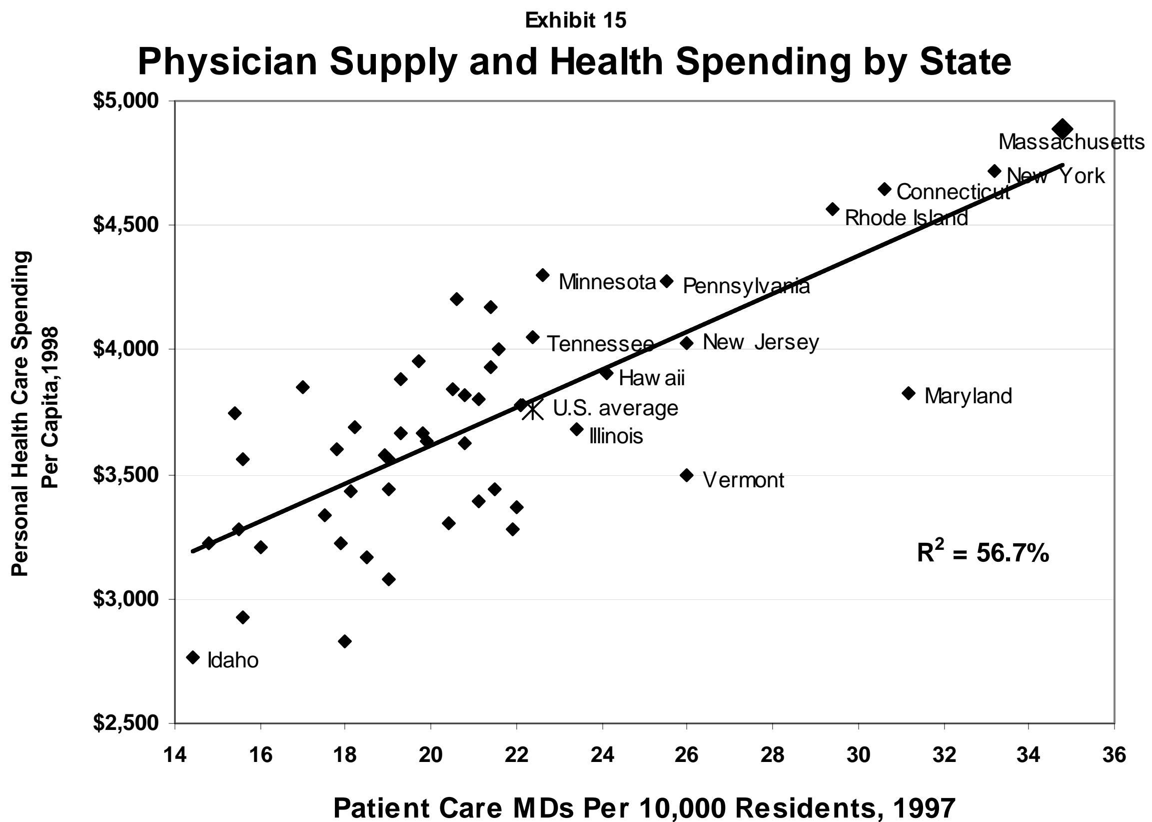
MASSACHUSETTS AND U.S. ACTIVE NON-FEDERAL PHYSICIANS PER 100,000 RESIDENTS, 1970 - 2002



Our highest-in-the-nation supply of physicians may well be contributing to our highest-in-the-nation health care costs. Across the nation, as Exhibit 15 shows, states with higher physician-to-population ratios also tend to have higher per person health care costs.

Where there are higher physician-to-population ratios, and thus relatively fewer patients per physician, there may be a tendency for doctors to provide more visits and other services to each patients. If they face a relative shortage of patients, they have the time, for example, to see individual patients more frequently.

This would tend to boost our health care costs—regardless of whether there is any conscious or unconscious tendency on the part of some physicians to seek to hike their incomes by raising the volume of services they provide.



7. The aim of health care cannot be immortality—but medical security is achievable. Consolidating the many streams that now finance care into a single pool to pay for all care provides the best foundation on which to build medical security.

This is partly because it permits huge administrative savings right away that can finance expanded coverage. Spending to administer health care financing would fall about 45 percent, and this would permit a substantial rise in spending on actual care—about 9 percent. Pooling the money also makes it much easier to lower drug prices, reduce fraud, and—most important—encourage and enable doctors to spend money carefully to provide the care that works to all who need it.

It is essential to define more clearly what we aim to achieve by devoting so much effort and money to health care in Massachusetts. If we don't define what we're trying to do, how will we know if we've succeeded?

Consider the simple aim of "medical security," which means

a) confidence that we will all get the care needed to treat and avert illness, pain, disability, and premature death in a competent and timely manner,
b) without having to worry about the bill when sick, and
c) without having to worry about losing insurance coverage—ever.

The single payer approach, by capping spending and committing to cover all residents of the Commonwealth, offers by far the best platform for spending money carefully, avoiding rationing by ability to pay, and reducing health care waste.

Single payer reforms, by themselves, would go far to reduce administrative waste associated with complexity—costs of determining eligibility for care, and costs of coping with dozens of insurers' forms and formularies, rules and referral requirements.

This cut in administrative waste would liberate substantial sums to begin the jobs of improving coverage for uninsured people, and of rounding out benefits for the even greater number of under-insured people in our state.

Equally important, this cut would win credibility and build momentum for advancing reforms in care delivery and payment—reforms that would cut both clinical waste and also most of the share of administrative waste (a substantial share) that is generated by mistrust between payers and caregivers.

Working with colleagues at Solutions for Progress in Philadelphia, we modeled and documented the cost of universal comprehensive coverage for all who live and work in Massachusetts, in studies for the Massachusetts Medical Society

(1998), findings shared with the Senate Ways and Means Committee (1999), legislative testimony (1999), and a detailed publicly-released report (2000).

We highlight here elements of those findings and analyses pertinent to the challenges facing Massachusetts, and to bills before the legislature—including S. 755. While we do not endorse specific language, we suggest that the general approaches taken by S. 755 are constructive and worth pursuing vigorously and carefully. This is why.

Our 1998-2000 findings showed—not simply through international comparisons but by building up a detailed estimate—that current health spending here already suffices to cover everyone well. Because so much is wasted today, current spending is enough

- to cover people who are now uninsured,
- to greatly expand benefits for people who are under-insured today—which means most of the population,
- to eliminate four-fifths of out-of-pocket costs of patients, and
- to still save money overall.

Some analysts conclude that comprehensive health care for all is just too costly. They say we will have to accept the inevitability of rising health care costs—or that only market forces can slow cost increases. Either assertion justifies cutting back on coverage to save money. These analysts support plans that rely on high deductibles and bare-bones insurance.

Others say that we can cover more people and more services, but we will just have to pay a lot more money. Some propose more money for Medicaid coverage. Congress, unwilling to act to cut drug prices, assumed that much more money nationally is needed to finance even a meager Medicare prescription drug coverage.

Our evidence points in a more optimistic direction. As Exhibit 16 shows, our analyses found that, with consolidated financing (single payer) and other reforms that it helps make possible,

- The state could achieve savings of about 14 percent of health spending. Given 2005 spending of $52.7 billion, that means saving roughly $7.5 billion if the same percentage prevails today.

That would be more than enough to pay for covering all uninsured people and filling the gaps in care for the under-insured—including covering all prescription drug costs and much long-term care for currently under-insured residents of the Commonwealth.

- The additions entailed a rise of 11.4 percent of health spending. At current spending levels, that would mean cost increases this year of about $5.8 billion to provide comprehensive coverage to all.

Exhibit 16 **PROJECTED 2005 MASSACHUSETTS HEALTH CARE COSTS, WITHOUT AND WITH REFORMS including coverage for all and consolidated financing** **assuming that proportions from 1999 analysis persist** [18]	**Costs and savings ($ billion)**
BASELINE: 2005 cost of care for Massachusetts, without reform	**$52.7**
ADDED COSTS: <u>$5.8 billion in new costs with reform</u>	
Bring uninsured people to the average level of coverage	+ $5.8
Address under-insurance with comprehensive benefits for all	
Data; care coordination; new services for people with disability	$58.5
SUBTRACTED SAVINGS: <u>$7.5 billion in new savings with reform</u>	
Savings in administration of coverage and financing	- $7.5
Savings in caregivers' administration of financing	
More appropriate use of hospital and other clinical care	
Negotiating drug prices; budgeting construction and equipment	- $51.0
Total cost of care for Mass. residents with reform, 2005	**$51.0**
Change from baseline costs – net saving from reform, 2005 (~3%)	**-$1.7**

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

Let us look at these estimates in a little more detail.

Added costs of universal, comprehensive coverage:
11.4% of health spending, about $5.8 billion in 2005

- We estimated in 1999 that, to cover the 750,000 people who then lacked health insurance, would require a rise of less than 3 percent in health

spending. (This meant bringing the uninsured up to the average level of coverage in the under-65 population.) If the number of uninsured people today is less, added costs of coverage would drop.

- The bigger, costlier challenge is to fill gaps in protection for the under-insured. These growing gaps include services for which people often lack coverage—such as prescription drugs, nursing home care, and home care—and widespread out-of-pocket payments. This is where most added spending would go.

In 1999, we estimated the total added cost of new coverage at 11.4 percent. If similar proportions prevailed today, that would mean a rise of about $5.8 billion.

Savings available with consolidated financing and other reforms: 14% of total spending, about $7.5 billion in 2005

- Consolidating financing into a single pool would permit very large savings in the administration of insurance and coverage—through reduced need to determine eligibility, track progress toward meeting deductibles, and to pay huge numbers of individual claims.

- Even greater would be hospitals', doctors', and other caregivers' savings in determining patient eligibility, collecting co-payments, and billing insurors.

- Providing timely access to care and reducing financial incentives to overserve would help facilitate substantial clinical savings, such as in reducing avoidable use of hospital care.

- Other components of estimated savings include the effects of negotiating drug prices statewide, and budgeting for construction and equipment costs.

In 1999, we estimated the total savings of single payer and related reforms that it would facilitate at 14 percent of baseline spending. If similar proportions prevailed today, that would mean savings of about $7.5 billion.

In summary, providing *more* health care for *all* Massachusetts residents would have cost 2-3 percent *less* than the existing world of less health care for some. That amounted to about $1 billion in 1999, and the savings would be about $1.7 billion if all the same proportions prevailed today.

One reason for the net saving is that the cost of the added volume of services is less than many observers might expect. Many hospitals and doctors have capacity to serve added patients at incremental costs below today's average costs—since some costs are fixed. If, for example, they need not build new beds to absorb newly insured patients, then serving the added patients would cost less

than the current average, which includes the fixed costs of the existing facility. (Similarly, the cost of manufacturing a higher volume of pills is pennies on the dollar of retail costs, once drug makers' fixed costs of research and factory construction are covered.) Providers often do not acknowledge that their real costs for added volume to serve those now shut out of the system would be below today's average cost. Planning for reform entails realistically estimating slack capacity and of the real, marginal cost of higher volume.

But the biggest reason why health care for all would cost less after these reforms is that the sums spent for administering health care financing would fall by about 45 percent. (In 1999, that would have been a drop from $7.7 billion to $4.2 billion.)

The amount of money saved on administration would be enough to offset most of the new costs of providing health care for all who are currently uninsured and costs of filling gaps in needed care for today's under-insured. So it is largely the administrative savings that make possible a rise in spending devoted to personal health care—caring for people when they are sick.

Cutting administrative waste would permit increasing spending on actual care by about 9 percent.

Exhibit 17 on the following page illustrates how the reduction in administrative spending permits both a decline in overall spending and a rise in spending for actual care.

That could help support very substantial increases in services in some sectors.

In similar form, Exhibit 18 (also drawn from our 1999 analysis) shows, for physicians, nursing homes, and hospitals, the estimated shift of resources with such reforms. Both the reforms overall and the reduced cost for caregivers' financial administrative work would mean that substantial new resources could be allocated to actual care.

In most sectors, there also would be other shifts of resources. There would be a decline in the unnecessary services induced by today's financial incentives and by barriers today to timely care (barriers that result in avoidable hospitalizations, for example). This decline would be more than offset by the volume of expanded service to people who are today under-served.

So, for example, in 1999, we projected that these reforms could together support

- a rise in spending of about 25 percent for physicians' actual clinical services (from $4 billion to $5 billion at 1999 spending levels – see Exhibit 18), and

- a rise in spending of about 41 percent for home health care services.

Exhibit 17 [19]

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

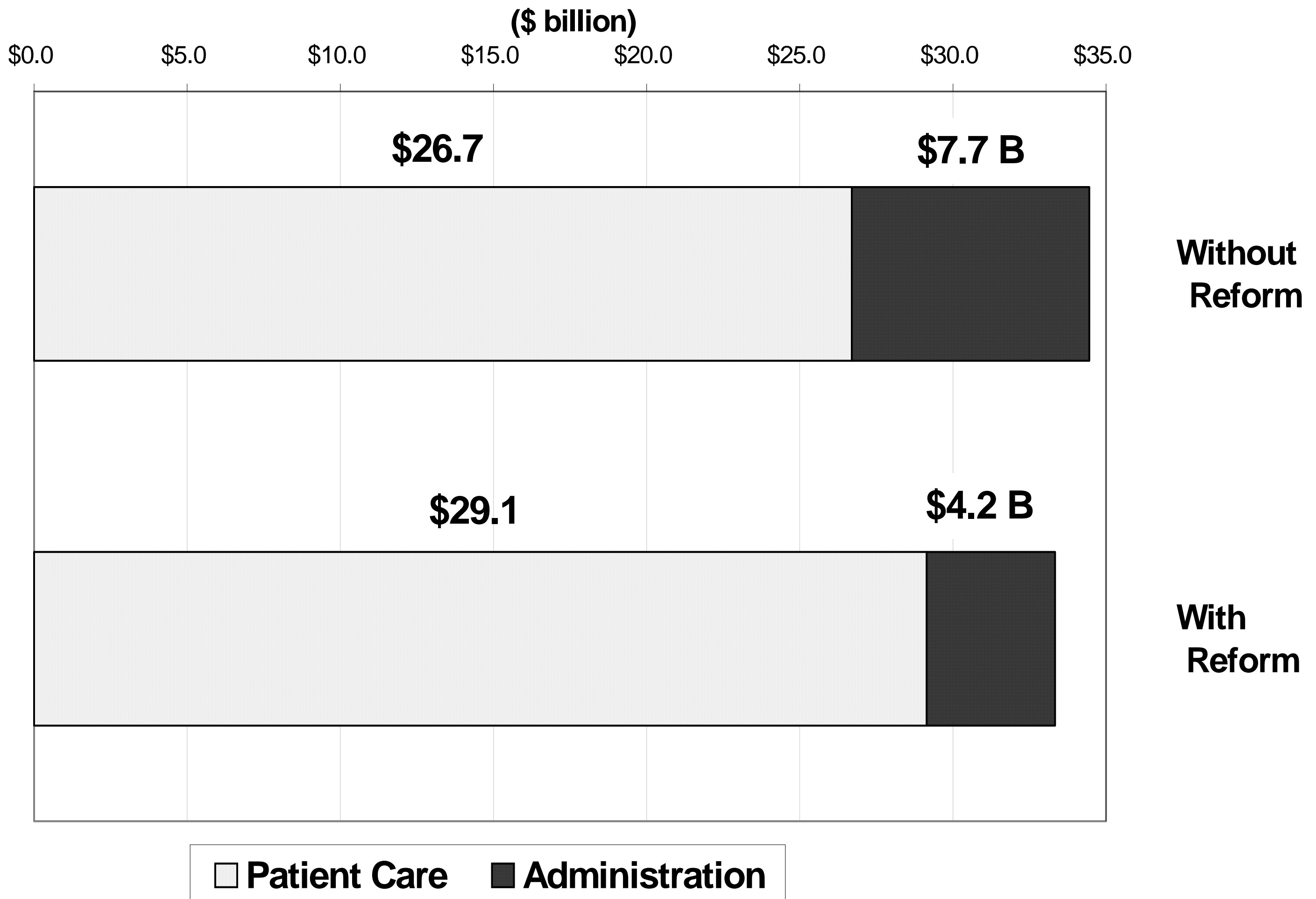
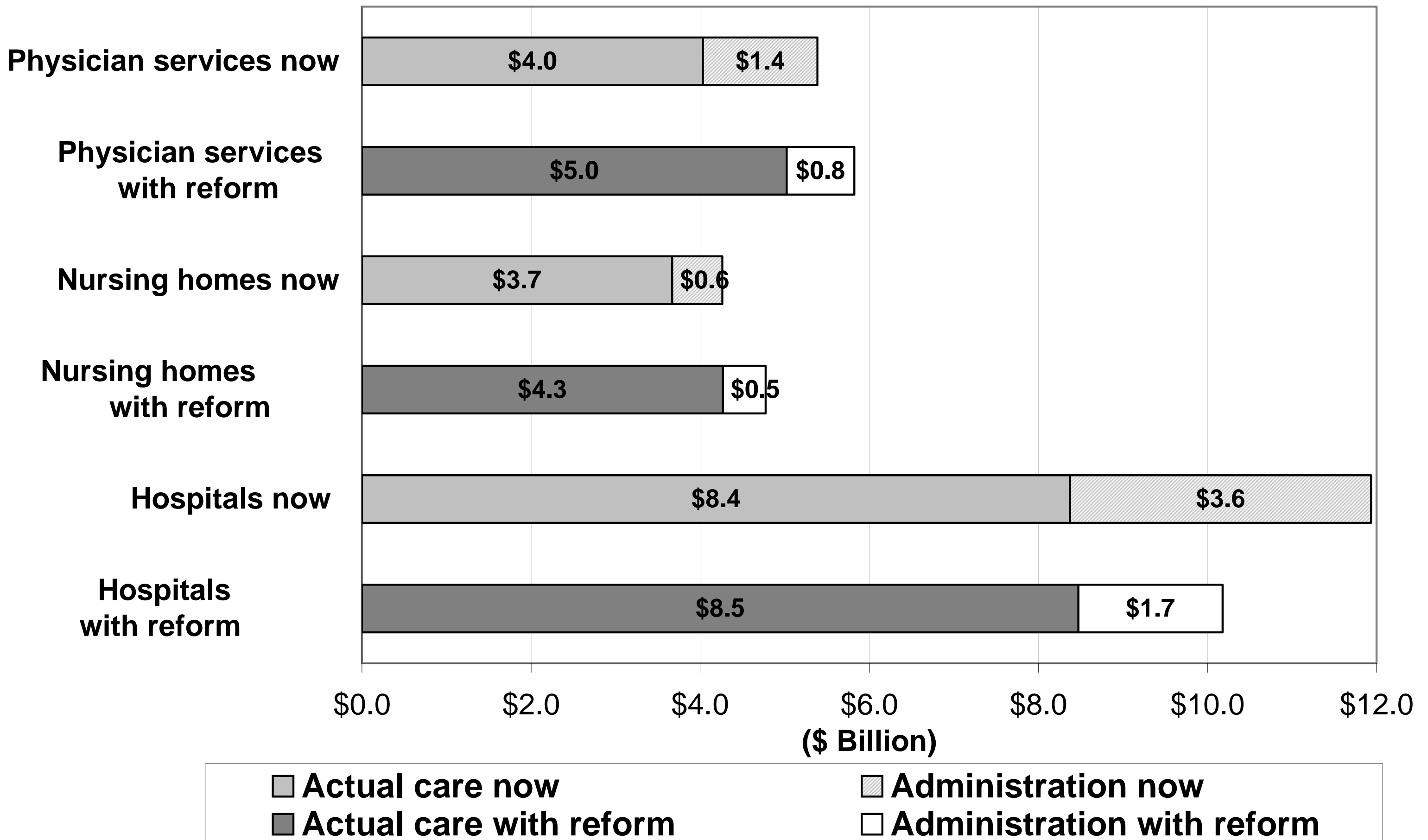


EXHIBIT 18 [20]



To achieve these savings, the first step is to pool the money now spent on health care. That makes it possible to immediately cover everyone equitably, to slash administrative costs, and to work to contain other costs.

Unless all health care revenue is pooled in one place, administrative waste will be hard to eradicate and it will be hard to cover everyone or contain clinical or other waste.

How can these streams of money be pooled together?

We have urged an alternative to traditional single-payer plans (which rely mainly on 1-2 broad-based taxes to finance care). Our November 2000 report spells out where the needed money would come from to cover everyone without higher spending.

Revenue can be pooled in one of two ways:

- combining all of today's public streams of money, and replacing private health insurance and today's out-of-pocket spending with new tax money,

- or combining all of today's public streams and existing private health insurance premiums (all paid into a single state pool), replacing only most out-of-pocket spending with new tax money. This could be called a pooled multi-payer approach. It can win almost all the benefits of traditional single payer plans, while reducing the size of the necessary tax increase and the changes in who pays more and who pays less.

The second approach means a tax rise about one-fourth as great as when private insurance is also replaced by public financing. A maintenance of effort rule would freeze private insurance payments, with the money paid into a new state pool. This relieves employers of the risk of soaring premiums. [21]

In both approaches, because money is pooled, spending can, for the first time, be capped. Health care would have a budget, just like state government, families, and everything else in the real world.

A few other points are worth highlighting:

- Out-of-pocket spending by patients would nose-dive by about 80 percent.

- In the pooled multi-payer approach, taxes would rise only by enough to substitute for existing private out-of-pocket spending, less the system's overall savings. This is not new health care spending. The shift from private financing to public financing amounts to only about 8 percent of total health spending in Massachusetts. [22] Yet this substitute is what permits the administrative savings. It eliminates the need to process co-payments, deductibles, co-insurance, eligibility checks, and other wasteful administrative activities. This increase is also what guarantees universal coverage.

Pooling all funds to pay for care makes it much easier to contain cost.

Administrative waste is reduced by instituting one method of paying doctors, one for hospitals, and the like, and simple, equitable coverage. Caregivers find it easier and cheaper to bill. Payers find it easier to pay. We have estimated very substantial administrative savings.

Consolidating the revenue also makes it much easier to squeeze out clinical waste and theft. If the dollars are known to be finite, doctors who seek money to finance needed care that is not being provided today owing to lack of funds will be motivated to identify wasted money in hopes that it can be reallocated. Theft is easier to fight because, when dollars are known to be finite, the connection between theft and harm to patients is clearer. Stealing money deprives patients of needed care. This motivates whistle-blowing and more careful monitoring of spending.

Pooling the money in one place also facilitates covering everyone within a budget. That is because doctors, who receive or control some 87 percent of the health dollar (as discussed below), can be asked and obliged to spend money as carefully as possible. Doctors know where the clinical waste is to be found. They can squeeze it out. When this is done under an overall budget, the dollars saved by eliminating excessive or low-value care can be marshaled to slow spending increases and to help previously under-served patients.

Consolidated financing is essential to financing comprehensive health care for all residents of Massachusetts.

Looking ahead, though, it is not enough—by itself—to ensure affordable medical security for years ahead.

That is because the clinical portion of health care costs continue a relentless rise. One important element is that most providers of medical services and products—hospitals, doctors, drug makers, medical supply firms, and more—continue to be financially rewarded for increasing the volume of services or products that they provide. So methods are needed to restrain that rise, to ensure that use rates and costs do not continue on an escalator that slams against any ceilings that may be set in global budgeting.

The relentless rise in clinical cost also is partly attributable to the aging of the population and development of costly new medical advances like expensive new drugs, surgical treatments, and transplants. But what good are these medical advances if all residents can't afford them? Everyone who lives or works in Massachusetts deserves medical security. This first requires deciding what "medical security" really means. It then requires making sure that the state shapes health care—both delivery and financing—to reach this goal. If we don't deliberately plan to succeed, we are probably planning to fail.

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

Consolidated financing is essential to cutting administrative costs—which is essential to financing comprehensive health care for all. But consolidated financing is not enough by itself to ensure affordable medical security for years ahead, as the population ages and costly medical advances are made. For the future, affordable high-quality health care for all Massachusetts residents requires finding the clinical waste as well within the state's vast but finite health dollars. Doctors, hospitals, and other caregivers must be paid in financially neutral ways that encourage, liberate, and require them to spend money carefully. "Professionalism within a budget" can help balance the books, getting as much health care as possible to the people who need it.

Physicians' decisions essentially control the vast majority of health spending, but few mechanisms exist today to aid doctors in weeding out waste, spending money carefully, and taking responsibility for stretching the huge sums already available in order to cover all 6.4 million citizens of the Commonwealth.

Reforms to finance care for all must be designed in ways that offer effective mechanisms to support, persuade, and oblige physicians to play the central role in eliminating wasted services and using our resources to cover everyone well.

The governor's, the Senate president's, and the employer mandate proposals would do little or nothing to engage Massachusetts physicians in the job of squeezing out health care waste and recycling it to cover all residents of the Commonwealth. Therefore, they would do little to slow the rise in health costs.

Some cost-cutters would cut insurance coverage and force patients to pay more when sick in hopes that patients would shop more carefully.

But today's failures to contain clinical and other waste are in large part the result of fanatical devotion to market solutions even though there can be no free market in health care. The marketeers' theological insistence that people who need care are "consumers" leads to such cost-control strategies that rely on patients to evaluate what care they need or value enough to pay for.

These efforts aim to make patients, rather than professional caregivers (consulting with patients as appropriate in the context of trusting and continuous relationships) the center of the cost-cutting universe. Insistence that patients can and must decide what is appropriate care is just as deluded as the medieval

insistence that the earth is the center of the universe and resistance to new science that recognized, instead, that the earth revolves around the sun.

Patients lack information to do this job. And, as discussed below, most of the costly decisions are made by doctors.

Proponents of making patients pay more are often a) financially secure and easily able to pay more out-of-pocket, b) naïve about how health care works, c) entranced by the theoretical beauty of a free market (one that in reality does not and cannot function in health care), d) more able than the average person to obtain medical information from physicians—friends or family members, or e) indifferent to the real-world harm that cutting insurance coverage would cause.

Boosting under-insurance is the real result of today's received wisdom that the way to cut cost is by cost-shifting to individuals and patients – the latest flaccid concepts that entrance the glibberati.

Under-insurance will rise whether the cost-shift comes by requiring higher premium shares (which spur forced selection of skimpier coverage), by raising out of pocket costs for patients, or by reducing benefit packages (including the limited package that the governor apparently supports).

And this will not succeed in containing costs.

To successfully and appropriately limit health care cost increases will require buy-in from caregivers (particularly doctors), as well as from employers, other payers, and especially patients. Acceptance of cost controls will be much easier to obtain

- if cost controls are accompanied by a commitment—and by actual mechanisms—to recycle savings to cover more people and expand access for the under-insured,
- if all parties see that more money for business as usual is starkly unaffordable,
- if caregivers are promised adequate and secure revenue, and if cost controls target actual waste or fat.

It is vital to involve caregivers centrally in cutting costs. Even with today's far-from-perfect information, doctors and other caregivers know where much or most of the waste is located. So to cut unneeded services and other waste, we must rely most

- not on the bludgeon of HMO/insurer regulations (which failed),
- not on the risky pass-the-buck policy of requiring high patient payments, and forcing patients to deny themselves care,

- not on the gamble of omitting coverage for certain services,
- but rather on the scalpel of careful decision-making by physicians (paid in ways to minimize incentives either to under- or over-serve).

Patients' decisions are not the right target for cost controls

Patients are not the key to containing health costs. It is mistaken to consider patients "consumers." Consumers in a genuine free market require good information about price and quality of products being bought. That information is usually lacking or very difficult to acquire in health care. The great majority of patients depend on doctors for information, inevitably.

Yet today, in what appears to be the most widely-touted strategy for containing the cost of health coverage, many private and public payers are requiring higher patient co-payments, co-insurance, and deductibles, and dropping certain benefits entirely. But as discussed below, this appears likely to put patients at risk, while doing more to shift costs than to contain them overall.

One account of recently-released cost data noted that a slower rise in U.S. health costs appeared attributable to "Policies that make it harder for the poor, the elderly and the disabled to get treatment…." [23] As a result of such cost-shifts, a recent study concluded that in 2004, 14.3 million Americans under age 65—most of whom were insured—spent over one-quarter of their incomes on health care.[24]

The president and his allies advocate further expanding use of high deductibles and related measures to make sick people bear a larger share of health care costs, to increase their attention to costs.[25] But forcing sick people to pay more—trumpeted as "empowering consumers"—constitutes a reckless, buck-passing policy that actively promotes under-insurance.

By diminishing the broad sharing of costs through public or private insurance, "patient cost-sharing," as it is called, moves us backwards, increasing the numbers of people under-insured and uninsured. Worse, requiring people who need care to pay more is a tax on the sick. This sickness tax is regressive, because sicker people tend to have lower incomes—and poorer people also tend to be sicker.[26]

Reducing coverage by requiring more patient payments will doubtless reduce use of care by average Americans, and encourage patients to try to second-guess the tests and treatments that their physicians prescribe.

But there is evidence that these changes are ***not*** clinically safe, and no evidence that they cut costs overall.[27] Non-physicians cannot readily tell whether care is needed.

Requiring higher out-of-pocket payments puts all patients at risk. People with high out-of-pocket costs who are poor and sick are especially likely to forgo care—both vital and inessential care—and thus to needlessly suffer pain, disability, even death.[28] Under these circumstances, de-insuring patients and then asking them to decide what care they need is a little like asking them to serve as untrained kamikaze pilots in the war on health costs.

Further, the financial result is often higher cost for delayed treatment.

The potential for savings is reduced in another way. Notably, patients use fewer services as out-of-pocket costs rise, resulting in a drop in caregivers' incomes. In response, caregivers can be expected to raise their prices or to treat their remaining patients more intensively.[29]

Some physicians and other caregivers may support high-deductible insurance plans today because they hope to charge full undiscounted prices to patients with health savings accounts (HSAs). But it is not clear that these higher prices will offset the revenue loss caused by the drop in the number of well-insured patients. Physicians may also be demoralized by pressure to do still more for well-insured or higher-income patients and to do still less for patients who can pay less.

Many low-income patients will simply forgo needed care (rather than trying to persuade doctors, hospitals, or pharmacies to forgo collecting the increased out-of-pocket share). When higher out-of-pocket payment requirements pose a barrier to care for patients, many or most caregivers will simply cease to serve them.

Today's policies neither expect nor encourage caregivers to absorb those costs. But boosting patients' required payments may be especially dangerous for public hospitals, health centers, and other caregivers who are likely to continue to try to serve their many low-income patients. This policy could jeopardize the very survival of those vitally-needed caregivers. Controlling costs in other ways will therefore be especially important to those caregivers.

Most important, <u>requiring higher patient payments cannot work to control costs because it aims at the wrong target</u>. Designers of successful cost controls must recognize that a relatively small number of seriously ill people account for the vast majority of health spending—69 percent of health costs in 1996 were for 10 percent of non-institutionalized Americans.[30]

The costs incurred for seriously ill people largely reflect complex treatment decisions by their physicians, and may be little affected by requiring higher co-payments and deductibles. A patient's main decision, it has been said, is whether to initiate the process of care by visiting a physician.

Many well-intentioned people may today accept the argument that Americans must be educated and encouraged to weigh value of services and their cost before using care. This is dangerously misguided.

- Good cost data are not generally available.
- Most Americans contribute little to the nation's health costs, while, as just noted, over two-thirds of health costs are for just 10 percent of Americans.
- We cannot turn patients into mini-MDs who know enough about the cost and clinical pros and cons of tests, treatments, and caregivers to safely second-guess their physicians' decisions.
- Time for patient education for health maintenance and treatment is often scant, and will diminish further if patients must focus on cost comparisons.
- A huge share of patients—especially those needing the most care—will simply never be able to investigate and grapple with detailed efficacy and cost information. Hearing and vision problems, cognitive difficulties, language barriers, and low literacy are obstacles for a great many Americans.[31] Pain, anxiety, and often a need for fast decisions compound these difficulties.

Forcing ill people to focus on weighing efficacy and cost is unhelpful and irresponsible.

Perhaps many of the experts who call for boosting patients' out-of-pocket costs—in hopes of spurring patients to make better medical decisions—are themselves related to physicians, live next door to physicians, or otherwise have speedy access to reliable medical information. Most Americans lack that sort of access. When illness or injury hits, most Americans are worried, pressed for time, and can find it hard to identify and weigh the voluminous and often-conflicting medical information available on the web and elsewhere. Don't we ask physicians to complete four years of college, four years of medical school, and multiple years of residencies and fellowships so that they can learn what care we need?

Health care consumerism is an ideological smokescreen and an abdication of responsibility. No other nation relies heavily on patients to contain health costs. A nation that devotes $1.9 trillion to health care should not turn to patients to contain cost. This is a reckless gamble, one unsupported by evidence.

Caregivers and payers are increasingly embracing evidence-based clinical medicine—just the opposite of putting patients at greater financial risk in order to encourage them to carefully try to figure out what care is worth the money. Similarly, rather than letting ideology drive policy, government should pursue evidence-based health policy and financing.

Calling patients "consumers" is a smokescreen for abdication of political responsibility in favor of a theoretical free market. This offers the appearance of cost containment. It allows federal or state governments to abandon

responsibility both for cost containment itself and for the health the American people. It is doomed to fail politically, financially, and medically. But many people will suffer unnecessarily before the smokescreen is dispelled, and before the myth of a free market in health care is discredited.

Reliance on the market cannot succeed. Containing health costs is hard and complicated work. It requires an understanding of the realities of health care, not the theory of the market. It requires addressing how doctors spend money now and what they need to spend it better. It requires better ways to pay doctors. It requires more evidence about what care works and which patients need it. It requires ways to set budgets and liberate doctors to spend money to do as much good as possible, while serving all of us. It requires making tough political deals with doctors, hospitals, other caregivers, patients, and payers.

Doing these things requires testing and evaluating what actually works. That means hard work, not slogans. The risk of economic crisis and medical meltdown should spur us all to find ways to craft durably affordable health care. A "spirit of one hand for yourself and one for the ship" may help to encourage all of us to make good compromises to keep Massachusetts health care afloat.

If the big, strategic decisions in health care are made carefully—a commitment to limiting cost and covering all people, physician agreement to spend finite dollars as carefully as possible, building robust budgeting and management methods, greater use of evidence, paying caregivers in trustworthy ways, and the like—health care can then regulate itself from day to day. The new arrangements won't be perfect. But they will be real and they will work.

Engaging doctors is the key to controlling costs

There has been little discussion about the major alternative to today's trend of leaving cost-control to gravely under-insured patients.

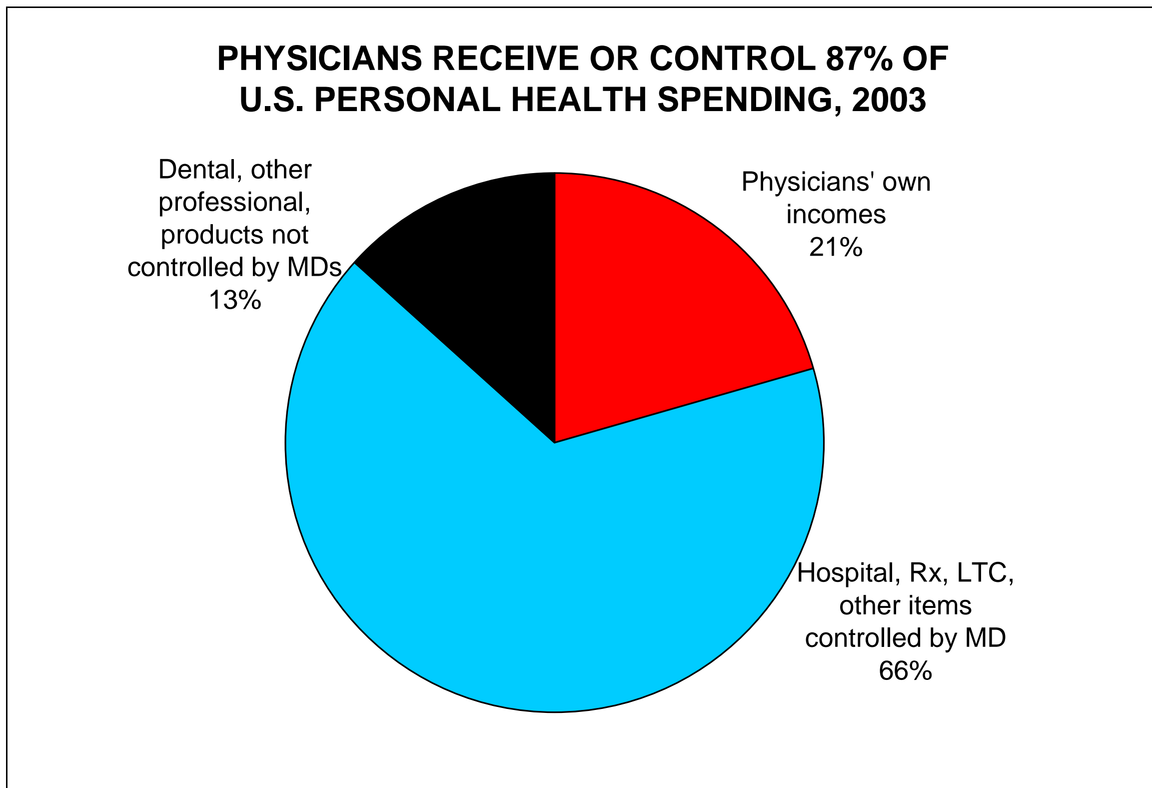
Costs can indeed by cut patient-by-patient in a safe and effective manner, but not by patients themselves. To be effective, this type of retail, patient-by-patient cost control would have to be implemented by physicians. Doctors—consulting with patients as appropriate, and ideally in the context of trusting, long-standing relationships—will decide what services are needed and effective for each patient. Each decision will need to take into account the inevitable limits on the money available to spend.

One reason is that, as shown in this exhibit, it is physicians' decisions that control fully 87 percent of the personal health care dollar.[32]

Physicians' own gross incomes (including the expenses of operating their practices) represent approximately 21 percent of personal health care spending.

In addition, however, physician decisions determine the allocation of a large share of the health care dollar because they determine patients' use of hospitals, prescription drugs, long term care (LTC), and many other health care goods and services. These amount to an additional 66 percent of personal health spending. Only the remaining 13 percent of personal health spending is neither physicians' income nor controlled by physicians' decisions.

Exhibit 19 [33]



When we note that physicians' decisions control these types of spending, we do not suggest that physicians act unilaterally or arbitrarily. They do increasingly rely on evidence and clinical guidelines whenever possible. They do consider patients' and families' preferences. Still, it is individual doctors who admit individual patients to hospitals, order tests, perform surgery, prescribe drugs, and the like. Their guidance, advice, and pressure are generally decisive.

One reason, then, to focus on physicians' decisions is that they control most spending.

The second is that many physicians already know where much of the clinical waste is located. If not, they could be given better information about what care works, and for whom. Further, they know which of their colleagues are incompetent or actually dangerous.

The third—and most important—reason is that improving doctors' individual decisions offers the most careful, clinically effective, and humanly acceptable method of slowing health cost increases—and of doing so in a way that liberates the savings to finance coverage for all. A related benefit is a drop in administrative costs engendered by mistrust.

This requires that doctors—who make the key decisions about how the great bulk of health care dollars are spent—are particularly empowered to spend money carefully. This should begin by recognizing that doctors traditionally get about one-fifth of the health care dollar nationally. They should be assured this money, to be divided up among them in reasonable proportion to competence, kindness, effort, and other factors.

But doctors also should be encouraged, liberated, and required to allocate another two-thirds of the remaining money (excepting only dollars needed by dentists and other independent caregivers, plus public health agencies, and researchers) to provide the care that all Massachusetts residents need. Doctors would have to spend all of that money on their patients, and could not spend more. They could not personally benefit by economizing on care. This approach encourages patients and payers to trust doctors' decisions.

If a physician does not provide a certain service to a certain patient, the reason would not be to enrich a physician or a for-profit HMO. Rather, the only reason for denying a service would be to make that service available to another patient who needed it more.

This is nothing more than spending money carefully—getting as much health care as possible to the people who need it. This is nothing more than recognizing that all people need health care but that dollars are always going to be limited. Pathology is remorseless but resources are finite.

Another reason to focus now on physicians' role in reform is that when physicians oppose a reform, they can frustrate and undermine it. Consider the single payer example. Even though a number of studies have shown that single payer plans could finance coverage for all Americans while substantially cutting both administrative waste and overall health spending, [34] these plans have gone nowhere politically.

Addressing uncertainty about the effects of reform

One reason why they have not been adopted yet is opposition from physicians. This stems mainly from worry about incomes and outcomes—fear for their incomes and uncertainty about what their lives and their abilities to care for their patients would actually be like after implementing reform.

Were individual physicians to favor a certain health care reform and then to tell their patients that they were confident that this reform was likely to contain cost in ways that protected coverage and quality of care, the general public's hesitations about this reform would dissipate rapidly.

(Some HMOs and insurers might continue to oppose reform because it threatened their role and profit, or eliminated them entirely, but these organizations are not influential enough to block valuable change once physicians, patients, governments, and employers are generally on board, we judge.)

The great uncertainty concerning single payer is, what will the actual delivery of care and methods and adequacy of payment for services will be like after implementation. Single payer advocates have not yet been able to describe these in ways that are sufficiently concrete, specific, convincing, and attractive to physicians or patients.

The great advantage of single payer is that, by greatly simplifying and cutting the cost of administering payments, the nation or individual states could free up very large sums for actual care.

And by capping spending and committing to cover us all, single payer reforms offer by far the best platform for engaging physicians in the job of using money wisely to cover everyone.

Some studies of single payer assume that spending on actual health services will be held to a certain level simply by legislative decisions, such as by establishing a budget ceiling for most or all health care.

But how that ceiling would be enforced is not yet clear. Therefore, it is essential to describe how doctors, hospitals, and other caregivers would behave to allocate available resources under the ceiling, to actually serve all patients.

If the ceiling on actual health spending is set only by an act of a legislature—if it is not made real by doctors' actual decisions—the ceiling will probably be exceeded and costs of care will continue to climb. (Alternatively, if the legislature is determined to enforce a ceiling, it would have to act forcefully by cutting fees, incomes, or other things. These acts would probably infuriate both patients and caregivers.) Then, single payer's success in cutting administrative waste would amount only to moving health care a few steps back on the cost escalator. That is no small achievement, but it is not sufficient.

Designing methods of slowing that escalator are essential. Other factors, especially payment methods that reward caregivers for doing more, would continue to move health care spending upward, seemingly inexorably—to slam into the ceiling.

What, then, will shape doctors' behavior? The challenge is to change health spending patterns from today's open-ended practices, to avoid repeatedly hitting that ceiling, forcing constant debate over whether to raise it, or forcing legislatures to enforce the ceiling in peremptory ways. How would health budgets actually be implemented in the U.S., and how would budgets affect decisions about what care is provided?

It is essential to answer this question convincingly and with doctors' participation. Only doctors' active support can discredit the inevitable successors of Harry and Louise, the television actors whose commercials did much to undermine the Clintons' health reform plans of 1993-1994.

Designing and testing new arrangements

Advocates' descriptions of a single payer future are not yet convincingly specific because they cannot yet describe—have not yet designed—the actual mechanisms for organizing services and paying caregivers under single payer. This is not a criticism of the single payer advocates themselves. Designing and testing these mechanisms is a lengthy, complicated, and expensive job.

When single payer reformers and others design and test payment methods that doctors understand and accept—and when a political deal between doctors and payers is successfully negotiated—doctors will urge their patients to vote for reform.

This process of designing and testing of payment methods and related arrangements —seeking trustworthy ways to channel inevitably limited resources to meet a defined population's health care needs—is a vital stage of reforming health care. To win physicians' and the public's confidence, much of that testing will probably have to come before passage of national legislation, rather than after. Indeed, actually enacting single payer legislation may well be one of the later steps in the process of health care reform, not one of the first.

Because current arrangements are crumbling around us, and because careful testing could not be done amid economic collapse or medical meltdown, *starting testing now is crucial*—to try different arrangements for enabling and obliging cooperative physicians to marshal finite budgets to comprehensively serve a defined community.

Arrangements to support physician decision-making

Implementing retail-level cost control solutions will entail encouraging more careful decision-making by physicians about what services are needed and effective for each patient. Because pathology is remorseless but resources are finite, each decision will need to take into account the inevitable limits on the

money available to spend. Variations on this approach have been called "bedside rationing"[35] or "professionalism within a budget." [36]

Consider the opportunities and options if health care were on a budget, and all Americans enrolled in one of many organizations that hold those budgets. Savings gained by eliminating ineffective—even harmful—over-treatment and care of marginal value would remain in the budget and would have to be used to help finance care for all patients. Arrangements like these have long been in effect in traditional prepaid group practices, like the Kaiser HMOs, that pay physicians by salary.[37] Looser networks of office-based physicians could be employed as well.

It is important to include both options because, over the past three decades, most patients have shown that they do not wish to change physicians to take advantage of new financing or delivery arrangements, and most physicians have shown that they do not wish to be paid by salary. (This might change, depending on the adequacy of the salaries, physicians' comfort with new organizational arrangements, and the feasibility of sustaining fee-for-service practices. Some physicians, especially in poorer areas where fewer patients can pay, and in many rural areas, might actively prefer the more secure income a salary would provide.) Therefore, it is important to design and test methods of inducing non-salaried physicians to mirror the behavior of their colleagues in salaried prepaid group 0practices by accepting responsibility for spending money carefully on behalf of groups of patients. Physicians in other wealthy nations seem generally to behave as if they are doing this.

Supply constraints have proven successful in other nations.[38] It appears that some U.S. physicians adopt needlessly intensive and costly practice patterns because they are rewarded financially for doing so, because of the lack of good information on what care works or which patients need what does work, and because the nation's physicians and hospitals are excessively specialized. Some work in settings that encourage or at least facilitate elaborate practice patterns—with unnecessary testing and the like—because the unnecessary services are so readily available. Patients are more likely given unneeded specialist visits, tests and procedures because of the large share of U.S. medical care provided in hospitals (instead of in community physicians' offices), and the large share of hospital care that is in teaching hospitals.

Unnecessary care is also facilitated by the nation's and this state's over-specialized and maldistributed physician supply, which gives some geographic areas a physician surplus and (from the physicians' view) a patient shortage. Modulating fee-for-service and other payment methods that now reward unneeded services would help to reduce unnecessary services, but addressing supply issues may also be necessary. We also must address our medical culture and attitudes in the broader society which give more prestige—as well as

financial reward—to more aggressive interventions and services than to careful history-taking, counseling, preventive services, rehabilitation, and the like.

Physicians may be essential to careful containment of health costs and to covering us all, but that does not make it easy to involve them. Evidence about the usefulness of many medical interventions is lacking. Physicians often don't know the costs of various services. Many physicians prefer market-driven cost containment methods. Accustomed to today's clinical patterns and financial incentives, it will not be easy to persuade physicians to take on larger roles. Accustomed to independence—what some might call freedom without responsibility—physicians may be reluctant to accept financial limits, let alone take on the job of allocating resources.

Physicians understandably have criticized skimpy insurance policies that deny coverage for services essential to many patients, or that impose burdensome bureaucratic requirements for physicians to obtain prior approval and the like. The alternative to such external constraints, however, is to take responsibility for wisely using available resources—operating within a budget—to achieve the maximum benefit for patients.

Creating physician-directed retail cost controls and enabling them to work will probably require ten main things:

1. paying physicians in ways that reward competence, effort, and kindness, that markedly reduce incentives to over-serve or under-serve, and that therefore make it clear to each patient that care will be denied only when it is ineffective or when another patient has greater need of the resources;
2. providing physicians with increasingly valid and clear evidence about the clinical value of all important diagnostic and therapeutic interventions, and simple information about the marginal cost of each;
3. educating and orienting physicians to use this information to offer—or deny— care with one eye on the needs of the patient before them and the other eye on the needs of all other patients;
4. developing simple, fair, and sturdy structures for enrolling patients and administering budgets;
5. ensuring standards of equity of patient care by gender, race, ethnicity, religion, age, disability, sexual orientation, and other characteristics;
6. organizing doctors to empower them act as more capable, effective negotiating partners, and to provide them with skills needed to act collegially;
7. encouraging physicians to work more cooperatively with nurses and other clinicians, and with administrators who will help them manage budgets and spend money more carefully;
8. persuading doctors that taking on the job of cost containment—rather than leaving such decisions to insurers—is essential to their long-term

economic well-being, to their professional self-esteem, and even to making health care durably affordable for all Americans;
9. educating and supporting physicians in sharing decision-making responsibilities with patients and families as appropriate; and
10. in all these ways, encouraging, empowering, rewarding, and educating physicians to take on the role of fiduciaries, holding in trust the prime responsibility for marshaling the available resources to serve us all.

There are several tools that are widely discussed today as the basis for controlling cost, and particularly for cutting clinical waste. These include computerizing medical records, to help reduce duplicative testing, errors, and other problems caused when a patient's history is not available or legible. Another recent emphasis is on provision of better evidence about what care is effective, and under what circumstances, for which sorts of patients.

Both of these tools have valuable potential, but that will not likely come to fruition without other substantial reforms. Such technical fixes are not likely to make much difference if physicians are not motivated to use them. Tools will rust away in the toolbox if carpenters are not comfortable using them.

And such technical tools to cut waste will surely fail if physicians retain financial incentives to over-serve (if, for example, fee-for-service payment methods persist) or to under-serve (if lack of insurance persists, and if payment methods such as capitation persist, or for-profit health insurer and provider organizations).

So technical measures to improve available information and evidence are valuable, but will not lead to appropriate allocation of resources unless they are taken up in the context of financing reforms.

Generally, the most acceptable motives for cutting costs are to keep all needed care affordable for presently covered patients, and to expand financial protection to presently uninsured patients. Cost controls must make sense clinically, financially, and ethically. Then, they will make irresistible political sense as well.

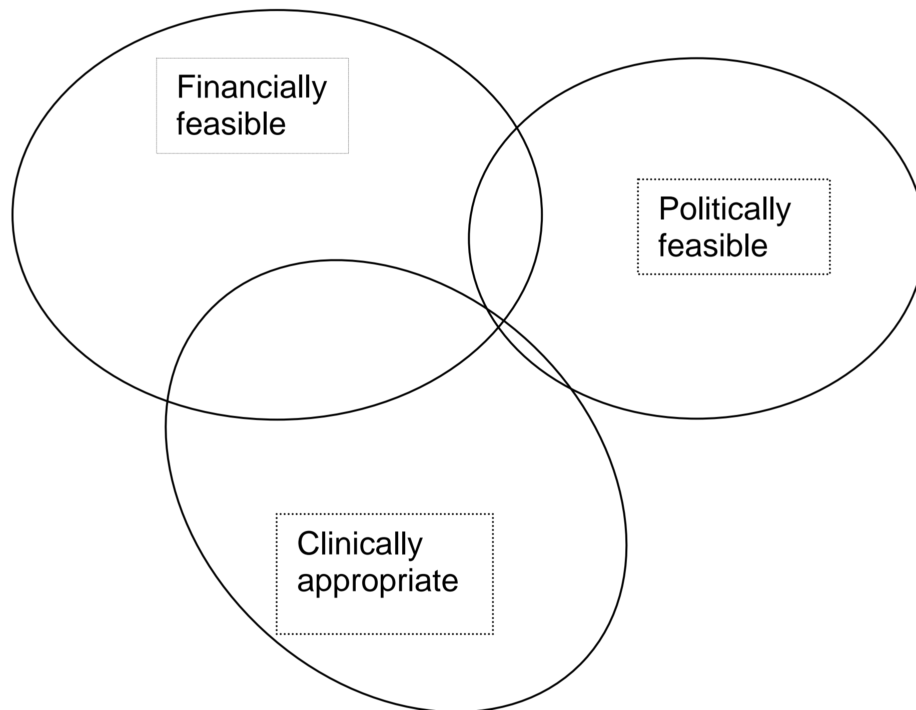
9. Legislators and state health care officials must initiate and sustain a mature political, medical, and financial conversation about how to contain cost; make coverage for all who live here durably affordable; and sustain all needed hospitals, doctors, nurses, long-term care providers, and other caregivers. Only state government can keep everyone at the table.

We have suggested that Massachusetts health care is not moving in a financially sustainable direction. We have therefore called for planning to anticipate the contingency that more money for business as usual will cease to flow, and even the contingency that less real money will be available to finance health care here.

State government has a ***fiduciary obligation*** to think about the “what if.” What if a serious recession hits? What if Massachusetts health care melts down? What would that look like? How badly would those who need or give care be hurt? How badly would the state’s economy be hurt?

In Massachusetts health care today, there is virtually no overlap among what is politically attractive, what is financially feasible, and what is clinically appropriate. Exhibit 20 sketches the current degree of overlap among the three.

Exhibit 20



Today's public, political conversation about improving coverage is abstract and unrealistic because it concerns the politically attractive subject of increasing coverage while paying little attention to financial and clinical realities.

Caregivers want more money. Patient and access advocates want better coverage. Payers want to spend less. Today, proposals to expand coverage enjoy visible support from some leading politicians, from some hospitals and other caregivers, from Blue Cross and other insurers, and from some patient advocates.

Some of these parties simply favor broader health insurance coverage unambiguously. But others support improved coverage partly because it is right, and partly because they seek higher rates of Medicaid payment or relief from financing their contributions to the state's Uncompensated Care Pool.

It is useful to look forward beyond this year's politics. Down the road, whether the governor's proposal passes, whether an employer mandate passes, whether mainly symbolic provisions pass, or whether nothing passes, the core problems of high cost, vulnerable coverage, and caregiver financial insecurity will persist.

Therefore, it is essential to engage health care's main stakeholders in a mature political, financial, and clinical conversation. This means moving beyond shallow financing changes to making a coordinated attack on both coverage and cost problems. It means moving beyond talking about raising money to finance coverage to making coordinated reforms in raising money, paying caregivers, organizing caregivers' efforts. It means attacking the four main types of health care waste.

The main stakeholders are:

- people who need care and those who represent them, mainly elected officials, unions, and various access advocates;

- HMOs, insurers, and other financial intermediaries;

- people who pay for care, mainly taxpayers, employees and unions, employers, state government;

- people and organizations giving care, mainly physicians, nurses, other professionals and non-professionals, hospitals, nursing homes, home care agencies, community health centers, pharmacists, drug makers, medical suppliers, and others.

The three groups of stakeholders will probably need to engage and converse about:

- ✓ Crafting acceptable and effective ways to contain cost. These will entail little or no reliance on a few simple, sweeping, or wholesale cost controls—or on exposing patients to greater out-of-pocket costs. Instead, they will place great reliance on physician decisions, one-by-one, to weed out unnecessary or ineffective care. This approach is essential because, as Sherlock Holmes said, "When you have eliminated the impossible, whatever remains, however improbable, must be the truth." Building physicians', payers', and patients' confidence in these arrangements requires designing and testing acceptable and effective ways to enroll patients, establish and monitor budgets, pay physicians, organize care, and evaluate results.

- ✓ Anticipating unpleasant contingencies. U.S. health care today rests on the hope that more money to finance business as usual will continue to flow. It is spectacularly unprepared for the contingency that economic weaknesses will constrain revenue growth. This is folly. Real harm to patients and caregivers will result from a failure to prepare.

- ✓ Negotiating and testing political deals to assure affordable and high-quality health care for all Americans. Since an acceptably-functioning free market is impossible to attain in health care (with the exception of eyeglasses and contact lenses), public action is essential to limit cost and expand coverage. As long as U.S. health care continues to lack both a free market and competent government action, the nation will continue to suffer anarchic cost explosions. These explosions will be followed, in time, by equally anarchic—though possibly more harmful—revenue restrictions.

  Since economics inevitably fails in health care, government and politics are the only alternative to anarchy. Political deals will have to offer each party something important. They would be somewhat easier to negotiate if all parties accepted the principle of "one hand for yourself and one for the ship" as a way to balance selfish and selfless interests. The big, broad political decisions and deals—for example, determining how much health spending should grow—should be crafted and judged strategically. Doing this strategically means coordinating financial, budgetary, and organizational structures that liberate and oblige willing physicians to spend money in a careful and trustworthy manner. If the devil is in the details, the details should be left to physicians to address angelically, patient-by-patient. Only the big decisions should be made politically.

These are the sorts of specific questions that would need to be addressed:

- Under different circumstances, how much money is likely to be available to finance health care for all citizens of the Commonwealth?

- How can the money that's available best be used?
- How can doctors, hospitals, other caregivers, insurers and HMOs, and other parties be organized and paid to take responsibility for spending inevitably finite dollars to win high-quality and affordable health care for all?
- What sensible political package deals can we craft between payers and caregivers—especially with physicians—to promote equity, economy, and accountability? For example, if physicians agreed to squeeze out waste, to stretch existing dollars to cover all people, and to accept financially neutral methods of payment, most paperwork could be eliminated—as could the threat of malpractice litigation.

The state also needs to support various decentralized efforts to design and test payment methods, budgeting, patient enrollment policies and other arrangements that encourage, oblige, and help doctors to wisely use inevitably limited resources to serve a population well. Proving their practicality in state, local, and other efforts will help develop understanding of what works and build support for broader reforms.

Consolidating financing into a single payer is an entirely reasonable financing reform. By pooling almost all health care dollars in one reservoir, it becomes possible to cover all people and begin to contain cost. As noted earlier, some administrative savings, from simplification of eligibility and from reducing complexity of paperwork, become visible quickly. (Other administrative savings may be facilitated by single payer reforms but require the development of greater levels of trust between payers and caregivers.)

By winning large savings immediately in the administration of health care financing, we can expand coverage to all. But we should recognize that single payer financing is not a mechanical solution, a magic bullet, a cure-all for making care durably affordable. We must also quickly move to seek other savings, to cut unnecessary care, excess prices and profits, and other forms of waste on the delivery side, in order to make health care for all sustainable into the future.

Winning high-quality health care for everyone who lives, works, or does business in Massachusetts will require hard and sustained work. That's because it demands attention to political, financial, and clinical matters.

10. The aim of providing coverage to all in Massachusetts has again won political visibility this year. But the universal coverage horse has many riders. These include hospitals, doctors, and nursing homes that seek higher Medicaid payments; and employers and insurers that want to cut their payments to the Uncompensated Care Pool.

Most proposals combine increased coverage, increased payments to caregivers, and increased cost. A similar combination shaped Chapter 23 of the Acts of 1988, the Massachusetts law that promised universal health care—a law that won the votes to pass narrowly but could not be implemented financially. The 1988 law ultimately failed politically because its coverage expansions were to begin four years after passage, but higher hospital payments began immediately, letting hospitals withdraw support for implementing the access provisions. It failed financially because its coverage expansions relied on implausible new spending—instead of squeezing out and recycling waste in what was even then the costliest state.[39] **We must not re-draw that fatally flawed design.**

Today, it is understandable that each stakeholder in health care thinks mainly of its own needs.

- Hospitals say they are losing money and demand higher Medicaid payments. Doctors and nursing homes also seek higher Medicaid payments. Drug makers seek ever higher profit.

- Insurers and hospitals would like to cut their financial contributions to the Uncompensated Care Pool.

- Employers decry higher premiums. But since wellness, prevention, managed care, price competition, and hospital closings have all failed to slow premium hikes, employers have essentially given up. Giving up includes increasing employee premium shares and raising patients' out-of-pocket costs. Employers that insure their workers would like to cease paying into the Uncompensated Care Pool, one that may finance care for employees of competitors that don't provide insurance.

- State government has little money to spend and no desire to raise taxes—but it would like to win coverage for all. The less money it has to spend, and the less it pursues effective cost controls, the less adequate will be the benefits it offers to newly insured people.

Each group seeks more money (or, for payers, less money) for business as usual. Those who think this can last long are deluding themselves.

Winning universal health care will not be easy. But it is easier to solve than other problems in Massachusetts because it is the only one that does not require more money.

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

Incremental political improvements

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

Financing comprehensive care for all incrementally would cost over 13 percent more than the cost health care for all under a single payer universal care plan, our 1999 analysis concluded. That's the added cost of buying everyone in to today's wasteful system.

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

A real political deal

Without a functioning free market in health care, containing cost and covering all people will require some public—and therefore political—intervention. This intervention should be limited to the big decisions. These include deciding how much money is available to spend on health care, and requiring that all people are financially protected. Additionally, political decisions will be needed to spark, design, finance, and test, a wide variety of administrative mechanisms to create and monitor the budgets that doctors will need to spend carefully. The ones that work should be selected for wide dissemination.

Making this real will require much more than goodwill. It will require a political deal that addresses the needs and issues troubling each sector. Here, for example, are the outlines of several illustrative deals:

- Physicians could be assured free medical school tuition, relief from most of the administrative costs they now bear, and relief from tort liability if they

agreed, in return, to manage inevitably finite dollars on behalf of groups of patients using better evidence, and the like.

- All needed hospitals might agree to be paid revenue guaranteed to cover the cost of efficient provision of needed types and volumes of service, in exchange for cooperating with one another to identify patient needs and avoid duplication. Flexible budgets, adjusted for case mix, might be employed to generate needed revenue.

- Drug makers might agree to accept much lower prices in exchange for guarantees that revenue lost from price cuts would be replaced by payments for the resulting higher volumes of prescriptions. Drug makers could be persuaded to innovate by the lure of very large payments for success. Payments for a new drug might be keyed to both its clinical value and the money it saves by displacing existing costly therapies. Consider the value of a very effective medication to prevent Alzheimer's.

Years of rich financial rewards to caregivers, rising health spending, and assertions that selfish behavior is justified by Adam Smith's invisible hand (which does convert private greed to the public good) have eroded some of the spirit of cooperation and public service that was once more common in U.S. health care. Without a free market in health care to convert private greed into the public good, pursuit of private or individual self-interest does not affordably advance the nation's health.

There will be much more elbow room to craft good political deals to address the real needs of each group of caregivers, payers, and patients; to contain cost; and to cover all Americans if greater goodwill and willingness to compromise are present. Recognition of the huge sums spent on health care already, and the huge share that is wasted, will help spur willingness to compromise. So will the worry that health care business as usual is unsustainable. One other thing may help.

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

Exhibit 21 is a picture of the U.S.S. *Constitution,* which was launched in 1797 and is now moored in the Charlestown district of Boston, Massachusetts.

Its mainmast is 220 feet (67 meters) high. To furl and unfurl the sails, sailors would climb rope ladders and edge out on the yards (horizontal timbers attached to the masts) and tie and untie knots. They did this in storms, when the ship was rolling and pitching wildly, in total darkness, and in rain or snow. Discipline helped sailors do this. So did professional pride and group cohesion. Perhaps most important, sailors knew that the ship could easily be destroyed during

storms if the sails were not adjusted properly. Accordingly, the sailors' motto was "one hand for yourself and one hand for the ship."

Exhibit 21

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

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

Unaffordable health costs and the fragile U.S. economy pose great risk of a medical meltdown, which would cost tens of millions more Americans their coverage, and drive huge numbers of caregivers out of business, destroying invaluable medical resources and leaving all Americans vulnerable. Indeed, our high costs in Massachusetts make us, in some ways, particularly vulnerable.

The nation and this state are is unlikely to avoid such a medical meltdown unless physicians, hospitals, drug makers, and other caregivers recognize the value of securing financial stability for themselves—and for health care across the country—in return for wholeheartedly taking on the job of covering all people with the dollars available.

Years of institutional, financial, and other rivalries have spurred inter-hospital competition. It has probably hiked costs, duplicated equipment, and distorted patterns of patient care toward profitable services and away from uninsured

patients. Hospitals should think more about the needs of the people who live nearby, and how to address them. They should be paid for doing so.

Many drug makers have learned to make very high profits while investing less than they should in high-risk innovative research. They have instead adopted conservative strategies of boosting revenues through the three M's—marketing and advertising, mergers and acquisitions, and me-too drugs—along with price increases on existing medications. Who can blame them? They have a well-founded fear of price controls because they are victims of their own financial success in quadrupling revenues garnered in the U.S. over the past decade—revenues that today amount to one-half of their world-wide totals. They should make a commitment to ensuring that all Americans obtain all appropriately-prescribed medications in return for added payments that simply cover the added (though surprisingly small) incremental cost of manufacturing the additional pills.

Many payers have learned to make money by avoiding costly patients, shift costs to other payers, and other techniques. They should instead move to pool their expertise to sponsor a wide variety of alternative methods of organizing physicians to contain cost and boost appropriateness of care.

Doctors' role in spending money carefully has always been central. At the same time, it is enormously difficult to inform physicians, create appropriate incentives for them, and configure physicians' practices, budgets, and responsibilities to groups of patients.

The nation must avoid burdening patients, politicians, payers, physicians, and other caregivers with yet another generation of irritating, infuriating, and demoralizing traditional wholesale cost controls. It will be hard for physicians to take responsibility for controlling costs carefully, but other strategies either do not contain costs, or do so by cutting quality and access.

Most physicians won't want to change how they do things. They are naturally conservative, like most of us. But the alternative is intolerable. To avoid radical external controls, physicians may have to conclude (to paraphrase Pogo) that "we have met the solution and it is us."

Every other nation has figured out how to cover all people and enjoy better health outcomes in a more or less satisfactory manner—so there is good reason to be optimistic.

Still, some may think that all this is just too complicated. Too many elements must be identified, analyzed, adjusted, and coordinated. That might be true. On the other hand, reshaping many aspects of the actual delivery of the 87 percent of personal health services that is controlled by physicians might be much easier to accomplish if improvements in a number of areas are coordinated. Physicians who work with better evidence; who are liberated to focus mainly on clinical

need, and less on financial incentives; who are the trusted fiduciaries and principal guardians of the nation's health; who have much less paperwork; and who can't be sued might just enjoy their jobs much more.

Since careful physician allocation of budgeted resources is the only open path to making care affordable for all, this nation and its doctors should start along that path quickly.

Throughout, patients and physicians—along with nurses and other clinicians—should recognize, as they usually do, that pathology is remorseless and resources are finite. Immortality is not an option, so medical care has never saved a single life. It does delay death, relieve pain, and overcome disability—and that is why we are devoting $1.9 trillion to medical care this year nationwide, and over $52 billion in Massachusetts.

Both in the Commonwealth and nationally, it is therefore useful to set for health care a clear, honest, realistic, and achievable goal, one commensurate with human and medical realities. We suggest that the goal should be "medical security," which offers to each patient well-justified confidence that he or she will receive needed and effective and competent medical care in a timely manner without having to worry about the bill when sick—or about losing insurance coverage ever.

APPENDIX - CRITICISMS AND RESPONSES

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

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

Most important, Congress does not know what to do. The states could provide that information. They are supposed to be the laboratories of democracy.

But federal law now makes it hard for states to develop and test new approaches carefully, before a crisis hits. Since the federal government is not able or willing to act to reform health care, it must get out of the states' way.[40]

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, the Republic of Korea, Switzerland, Belgium, Poland, and many other nations.

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

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

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

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

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

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

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

Britain rations a good deal. Canada rations less. Both do so because their economies are not in good shape and they don't have much money to spend on health care.

But Massachusetts spending per person is more than three times that of Britain,[41] and more than twice that of Canada. So we will not ration. We will spend money carefully, and we will not waste it.

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

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

And what does this buy?

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

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

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

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

Second, most of the increase in cost of new coverage will go not to today's uninsured, but to fill gaps in coverage for the insured. It will go to round out the benefits with prescription drugs, home health care, and other services—for people who already have insurance. People who are now under-insured will get more than twice as much additional care as previously uninsured people.

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

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

Fifth, under one option for delivering care, non-profit networks of caregivers—HMOs operating under new incentives—would all be paid the same risk-adjusted price, and would compete only by quality of care.

7. Can't we just put some patches on coverage and rein in costs without all these big changes? Aren't small steps are the only ones that can pass?

As in the past, it may be that the law that can work can't pass and the law that can pass can't work.

But the costs of more money for business as usual are unsupportable.

And what will happen at the bottom of the next recession?

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

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

NOTES

[1] Federal data from CMS on state health expenditures for 2000.

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

[3] Federal data from CMS on state health expenditures for 2000 indicate that per person costs in Massachusetts have remained an estimated 27 percent above the U.S. average.

[4] Liz Kowalczyk, "Insurers Cite Drawbacks to More Affordable Health Plans," *Boston Globe,* 23 November 2004.

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

[6] Health Care Financing Administration, personal health spending by payer, 1980 – 1998.

[7] See, for example, U.S. Sen. Chuck Grassley, "Grassley asks states for information about use of contingency-fee Medicaid consultants," news release, 14 July 2005. The senator, chairman of the Senate Committee on Finance, is quoted there stating, " 'Medicaid spending is increasing faster than current budget limitations can afford.' "

[8] Stephen Smith, "State Must Improve Dental Care for Needy, Judge Rules," *Boston Globe,* 16 July 2005.

[9] Liz Kowalczyk, "Insurers Cite Drawbacks to More Affordable Health Plans," *Boston Globe,* 23 November 2004.

[10] J. Alex Tarquinio, "Solo Health Insurance: Possible, Yes, but Not Easy," *New York Times*, 10 July 2005, http://www.nytimes.com/2005/07/10/business/yourmoney/10insure.html

[11] Todd Gilmer and Richard Kronick, "It's The Premiums, Stupid: Projections Of The Uninsured Through 2013," *Health Affairs* web exclusive, 5 April 2005, www.healthaffairs.org

[12] Alan Sager and Deborah Socolar, *Health Crisis Index Rose 37%, 1987-2003: Higher Spending Associated with Growth in Uninsured Share of Americans*, 25 March 2005, www.healthreformprogram.org

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

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

[15] M.C. Fahs, "Physician Response to the United Mineworkers' cost-sharing program: the other side of the coin," *Health Services Research*, Vol. 27, No. 1 (April 1992), pp. 25-45.

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

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

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

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

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

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

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

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

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

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

[17] Alan Sager, *The Sky Is Falling: The Mass. Medical Society Reports on the "Physician Shortage,* Boston University School of Public Health, September 1988, www.healthreformprogram.org

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

[19] Exhibit is drawn from Alan Sager and Deborah Socolar, "Testimony on Universal Health Care" to the Joint Committee on Health Care, Massachusetts General Court, April 1999.

[20] Exhibit is drawn from Access and Affordability Monitoring Project and Solutions for Progress, *Massachusetts Can Afford Health Care for All*, 2 November 2000, www.healthreformprogram.org

[21] Employers would continue to pay amounts equal to their current health insurance burden, but only in today's dollars. Premiums would no longer rise with inflation. So gradually, the burden of insurance on employers would be completely eroded.

[22] In 1999's $36 billion health care system, this would have been about $3 billion. If the same proportions prevailed in today's $52.7 billion system, it would require about $5.4 billion in new taxes to substitute for most out-of-pocket costs.

[23] Birgitta Forsberg, "Health care costs see slower growth; Disadvantaged lost benefits, report says," San Francisco Chronicle, 11 January 2005.

[24] That was a rise from 11.6 million in 2000. Analysis by Lewin Associates for Families USA, as cited in William M. Welch, "Health costs rising faster than incomes, study says," *USA Today*, 27 September 2004, http://www.usatoday.com/news/health/2004-09-27-healthcare-usat_x.htm.

[25] See, for example, Michael A. Fletcher, "Bush Promotes Health Savings Accounts," *Washington Post*, 27 January 2005, http://www.washingtonpost.com/wp-dyn/articles/A39782-2005Jan26.html; Ricardo Alonso-Zaldivar, "Healthcare Overhaul Is Quietly Underway," Los Angeles Times, See also, for example, Newt Gingrich, "Conservatives Should Vote 'Yes' on Medicare," Wall Street Journal, 20 November 2003. Discussing Health Savings Accounts, for people under 65 to use with high-deductible insurance, he urged "shifting away from the failed…third-party payer model and back to a market-mediated...model, where the customer [pays] his own first health dollars…."

[26] Also regressive are proposals to reduce Medicaid coverage for poor people to free up money in order to expand coverage for people who are less poor. (See, for example,

Robert Pear, "Bush Nominee Wants States to Get Medicaid Flexibility," *New York Times*, 19 January 2005.)

[27] For a substantial survey of the evidence on both the barriers to needed care and the effect on costs, see M. Edith Rasell, "Cost Sharing in Health Insurance -- A Reexamination," [Sounding Board], *New England Journal of Medicine* 332 (27 April 1995), pp. 1164-1168.

[28] See, for example, Robert H. Brook and others, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," *New England Journal of Medicine* 309 (8 December 1983), pp. 1426-34.

[29] M.C. Fahs, "Physician Response to the United Mineworkers' cost-sharing program: the other side of the coin," *Health Services Research*, Vol. 27, No. 1 (April 1992), pp. 25-45.

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

[31] Other barriers to gathering information are financial. Many patients cannot afford a computer, some cannot even afford a home telephone, and some lack the time needed because they must work multiple jobs. Many observers and policy-makers suggest that patients should get health care price information on the internet, but a spring 2004 survey found that a financially-based "significant digital divide could leave those most in need with less information on which to base important health care decisions." Of the 64 percent of seniors with yearly household incomes below $20,000, less than one-sixth (15 percent) have ever used the internet, the survey found. See Kaiser Family Foundation, "Online Health Information Poised to Become Important Resource For Seniors, But Not There Yet: Digital Divide Puts Many Seniors At Disadvantage," news release, 12 January 2005, http://www.kff.org/entmedia/entmedia011205nr.cfm, access confirmed 1 February 2005.

[32] Personal health care spending finances the services received by individual patients. It therefore excludes sums spent on research, construction, government public health activities, coverage administration, and insurance company profits.

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

[34] Congressional Budget Office, *Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates,* Washington: Congressional Budget Office, April 1993; Robert Brand, Deborah Socolar, David Ford, and Alan Sager, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society,* December 1998 (an updated version is posted at http://dcc2.bumc.bu.edu/hs/sager/110100/UHC%201%20Nov%2000%20FINAL.pdf, access confirmed 25 January 2005); John F. Sheils and Randall A. Haught, *The Health Care for All Californians Act: Cost and Economic Impacts Ana*lysis, Fairfax, Virginia: The Lewin Group, 19 January 2005, http://www.healthcareforall.org/lewin.pdf, access confirmed 3 February 2005.

[35] E. H. Morreim, "Fiscal Scarcity and the Inevitability of Bedside Budget Rationing," *Archives of Internal Medicine,* Vol. 149, No. 5 (1 May 1989), pp. 1012-1015.

[36] Joseph White, "Markets, Budgets, and Health Care Cost Control," *Health Affairs*, Vol. 13, No. 3 (fall 1993), pp. 44-57.

[37] Steve Lohr, "Is Kaiser the Future of American Health Care?" *New York Times, 31 October 2004.*

[38] See, for example, Brian Abel-Smith, "Cost Containment and New Priorities in the European Community," *Milbank Memorial Fund Quarterly*, Vol. 70, No.3 (1992), pp. 393-416.

[39] See Alan Sager and Deborah Socolar, "Nine Lessons for National Health Reform from the Failure of the 1988 Massachusetts Universal Health Care Law," 26 October 1993; Alan Sager and Deborah Socolar, *Promise and Performance: Analysis of the Massachusetts 1988 Universal Health Care Law*, 9 April 1989, 9 April 1989, both available at www.healthreformprogram.org;

[40] Federal legislation to assist states in achieving universal coverage has been filed by Rep. John Tierney (MA), as well as by the late Sen. Paul Wellstone (MN), with a proposal now sponsored by Rep. Tammy Baldwin (WI). See also, for example, George Silver, "Health Care: Beyond Markets," *Washington Post,* 11 November 2004, http://www.washingtonpost.com/ac2/wp-dyn/A41307-2004Nov10

[41] For example, in 2002, U.S. health spending per capita of $5,267 was over 2.4 times the United Kingdom's $2,160. So if spending in Massachusetts continued at 27 percent above the U.S. average, it would be slightly more than three times spending in the U.S. (OECD Health Data 2004).