Municipal Advocate

The Massachusetts Municipal Association

health care

What's Driving Costs?

Opportunities for Managing Costs

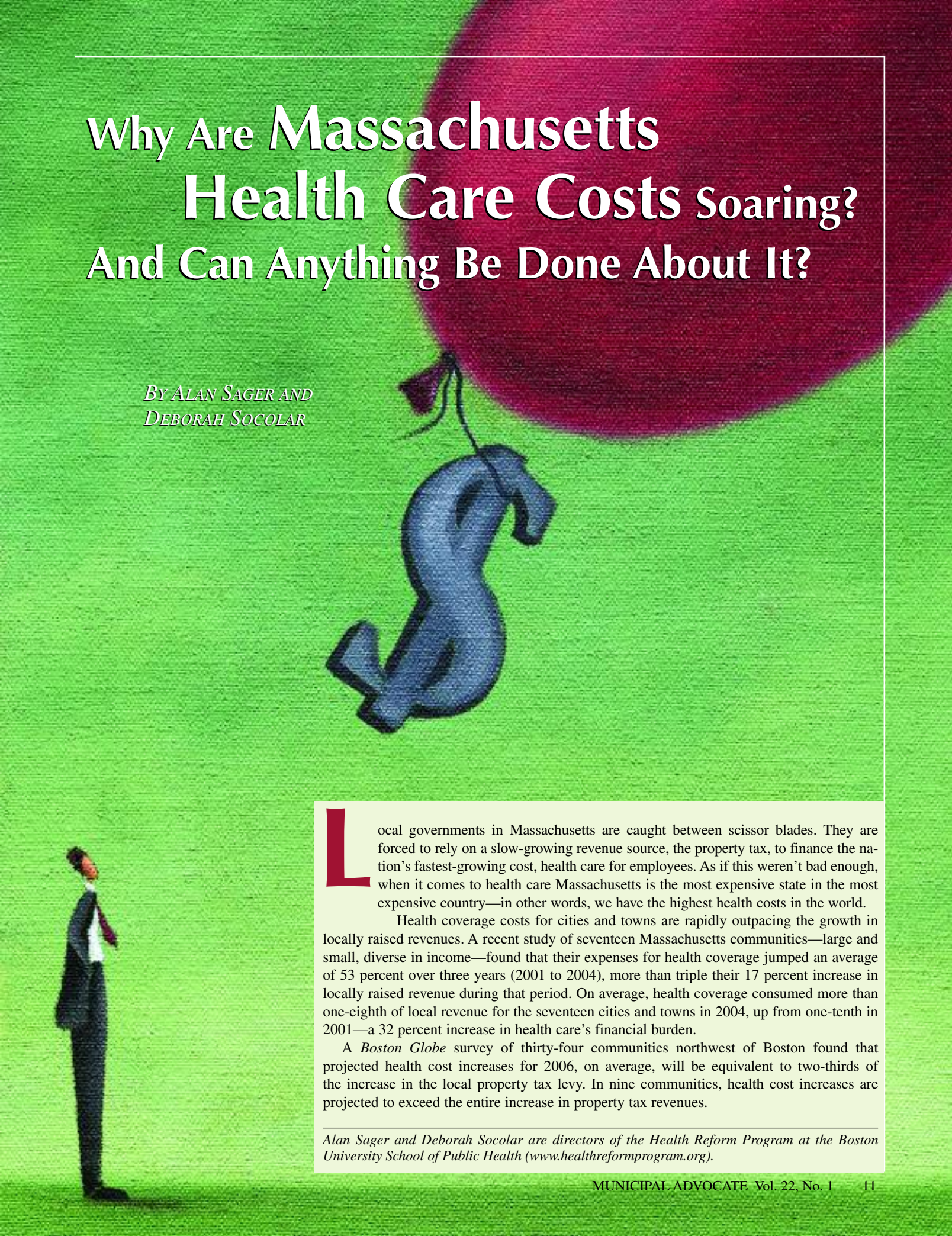
Wellness Program Primer

New GASB Rules

Medicare Part D Explained

Why Are Massachusetts Health Care Costs Soaring? And Can Anything Be Done About It?

By Alan Sager and Deborah Socolar



Local governments in Massachusetts are caught between scissor blades. They are forced to rely on a slow-growing revenue source, the property tax, to finance the nation's fastest-growing cost, health care for employees. As if this weren't bad enough, when it comes to health care Massachusetts is the most expensive state in the most expensive country—in other words, we have the highest health costs in the world.

Health coverage costs for cities and towns are rapidly outpacing the growth in locally raised revenues. A recent study of seventeen Massachusetts communities—large and small, diverse in income—found that their expenses for health coverage jumped an average of 53 percent over three years (2001 to 2004), more than triple their 17 percent increase in locally raised revenue during that period. On average, health coverage consumed more than one-eighth of local revenue for the seventeen cities and towns in 2004, up from one-tenth in 2001—a 32 percent increase in health care's financial burden.

A *Boston Globe* survey of thirty-four communities northwest of Boston found that projected health cost increases for 2006, on average, will be equivalent to two-thirds of the increase in the local property tax levy. In nine communities, health cost increases are projected to exceed the entire increase in property tax revenues.

Alan Sager and Deborah Socolar are directors of the Health Reform Program at the Boston University School of Public Health (www.healthreformprogram.org).

Local Challenges

Cities and towns across the nation face particular problems in financing health care costs. Employers' health insurance costs averaged $1.87 hourly and 7.3 percent of total compensation for civilian workers nationwide in December 2004, but those costs for state and local government workers were much higher: $3.55 hourly and 10.1 percent of total compensation, according to the U.S. Bureau of Labor Statistics. Employee health insurance costs for state and local governments are rising even faster than total spending on health care itself.

Why are public sector insurance costs higher? One factor is age. Government employs relatively few young workers. The share of workers nationally who are age 45 or older is 31 percent in the private sector, but 46 percent in local government, the Rockefeller Institute of Government estimates. This age gap is greatest in New England, where those age 45 and older constitute 33 percent of the private work force but 54 percent of the work force in local government.

Teaching and much other local government work requires skilled staff, and good benefits help retain experienced employees. But health costs rise steadily with age. Compared with costs for people aged 19 to 44, spending on personal health care nationally in 1999 was 37 percent higher for people aged 45 to 54, and more than 100 percent higher for those aged 55 to 64, according to data from the Centers for Medicare and Medicaid Services (CMS).

Along with age, possible explanations for higher health insurance costs for local governments include more generous coverage and a unionized work force that understandably fights efforts to cut benefits.

Even simple arithmetic works against cities and towns. As health costs rise, the base for the next year's increase also grows. With premiums averaging more than $12,000 yearly for family coverage, a 15 percent increase means an additional cost of $1,800. A 15 percent increase mattered little when premiums were a tiny share of local budgets, but those days are gone. Health costs averaged 13 percent of locally raised revenue in 2004 in the seventeen cities and towns we examined.

The Massachusetts Difference

In 2002, U.S. health spending was more than twice the per person average for wealthy European nations, and Massachusetts was more than one-quarter above the U.S. level. (See chart, below.) Using data from the CMS, we project that health spending in Massachusetts will average $1 billion per week during 2005—a projected $52.7 billion for the year. That's about double the state budget. CMS data indicate that spending per person here is 27 percent above the national average, or about $8,200 per person—substantially higher than the second-ranked state, New York. If health care spending per person in Massachusetts fell to the U.S. average, we would save $11.1 billion in 2005 alone. (This extra spending in Massachusetts today goes disproportionately to hospital, long-term, and physician care.) As a share of the economy, though, health spending in Massachusetts in 2000 was near the U.S. average, at 11.7 percent of gross state product, according to data from the CMS and the Bureau of Economic Analysis.

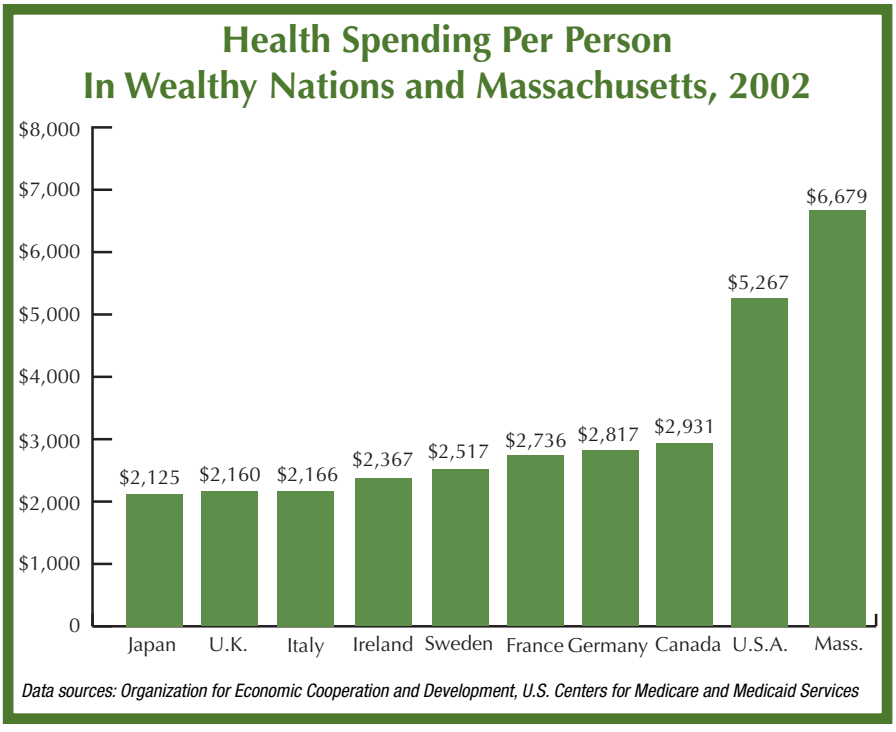
Some hospitals, physicians, and other caregivers—and some access advocates—argue that even higher spending is needed to improve quality or coverage, and that the added spending is affordable. Others disagree. They contend that health care costs are increasing at unaffordable rates throughout the U.S., including Massachusetts.

From 2000 to 2005, we calculated that health care absorbed fully one-quarter of U.S. economic growth, based on data from the CMS and the Office of Management and Budget. Had health spending remained at its year 2000 share of the economy, the nation would have saved $1 trillion by 2005. (Even so, 2005 spending would still have been $340 billion above the 2000 level.) In Massachusetts, we estimate, total health spending has risen 40 percent in those five years.

What is it about Massachusetts that makes it the leader in health care costs? There are three key factors:

• Hospitals: Massachusetts has the nation's most costly hospitals. Data from the American Hospital Association show that hospital spending per person in Massachusetts was $2,176 in 2003, 41 percent above the national average. Hospitals blame high costs here on an older population, service to patients from other states, high wages, and the like—things that neither hospitals nor state government can control. These explanations, though, are far from the whole story.

Massachusetts leads the nation in the use of costly teaching hospitals. One-half of all hospitals in the state have closed



Data sources: Organization for Economic Cooperation and Development, U.S. Centers for Medicare and Medicaid Services

since 1960. All were community hospitals. Their closings force many displaced patients to seek care at more costly teaching hospitals. Our state's surgery rate is one-sixth above the national average, and hospitals here employ 36 percent more workers per 1,000 citizens than in the nation as a whole. Hospital use for outpatient care is two-thirds above the U.S. average—surprising, since this state has the highest physician-to-population ratio.

Hospitals are not evenly distributed throughout the state. Growing shares of beds are concentrated not only in teaching hospitals, but also in large cities, with fewer in small cities and suburbs.

• Physicians: Spending per person on physician care in Massachusetts is 19 percent above the U.S. average, according to data from the CMS. But with 54 percent more patient-care doctors than average, in relation to population, our higher spending is spread among many more doctors. So the average doctor makes less here. Why, then, do they stay? Largely because so many trained here and like living here. (They like some places more than others. As with hospitals, physicians' offices are not well distributed around the state.)

Excessive specialization also boosts costs. The U.S. has the most specialized doctors in the world, and Massachusetts has one of the highest specialist shares in the U.S.

• Prescription drugs: Drug spending per person in Massachusetts is almost 10 percent above the national average. Our prices and use rates exceed national levels.

Cost Control Failures

High Massachusetts costs float on an ocean of high U.S. health costs. The problem is pervasive. Some blame the high and rising costs on an aging population, new technologies, or efforts to boost coverage. As it turns out, these explanations are not very persuasive.

The U.S. population is indeed aging—from 9.2 percent over age 65 in 1960 to 12.4 percent in 2000, and a projected 20 percent in 2030. Yet many wealthy European nations have much older populations, and they still manage to cover all residents while spending far less than we do.

And it's true that some new technologies do boost costs, but that is not inevitable. In the rest of the economy, new technologies typically reduce costs. Health care differs because it lacks incentives for cost-cutting innovations.

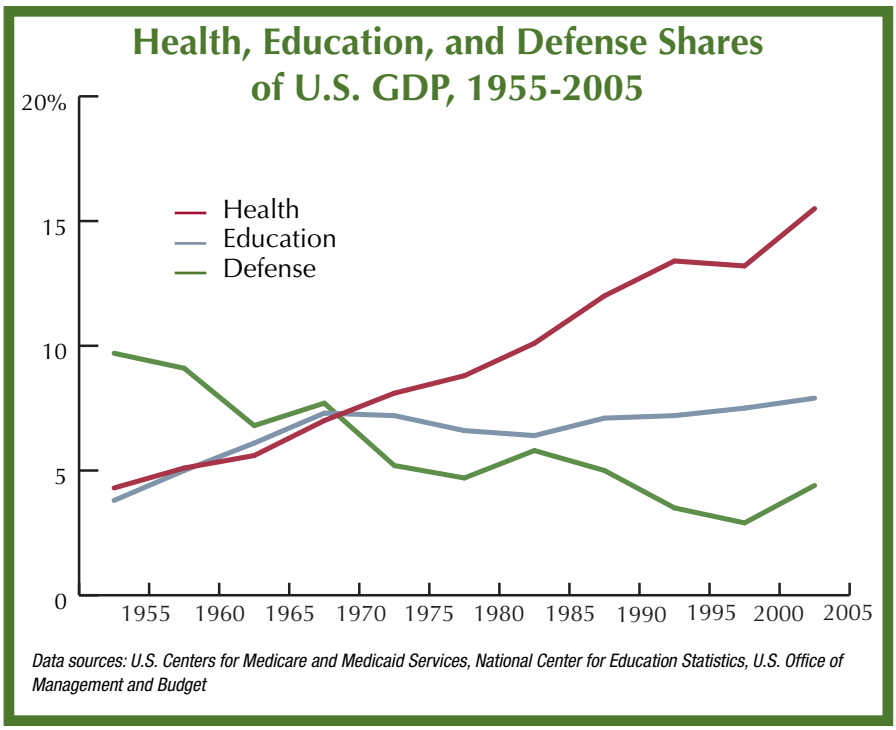
Without either effective government action or an effective free market, we have suffered from health care financial anarchy.

It is also hard to blame cost increases on improved coverage, since U.S. health spending has risen in recent decades even while the uninsured share of Americans has grown.

The root causes of today's health care crisis actually go back many years. Indeed, there has been little effective political or financial pressure to contain costs, despite public posturing, and despite the large share of current spending that is wasted.

For twenty-five years after World War II, a booming economy and public preferences boosted health spending. Health care's share of the economy rose from 4.3 percent in 1955 to 7 percent in 1970. (See chart, below.) Education rose even faster, while defense's share fell. Despite ups and downs in the economy since 1970, health care has more than doubled its share of the economy. (Education, in contrast, has been held below 8 percent, and defense shrank until recently.) Health spending is now almost four times defense spending, and about double education spending.

The continued rise in health care spending is remarkable because payers began in 1972 to fight health cost increases through both regulation and competition. Medicare tried to regulate hospital payments. States tried to regulate hospital capital spending. Medicare moved hospitals and then doctors to payment by formulas. Medicaid programs tried to hold down fees. Governments tried to promote price competition among hospitals. HMOs promised to compete by price and quality. All these efforts failed. Worse, as payers forced doctors, hospitals, and other caregivers to justify their bills, caregivers found ways to benefit under the new rules—gaming the system. The resulting paperwork war greatly magnified administrative waste.



Data sources: U.S. Centers for Medicare and Medicaid Services, National Center for Education Statistics, U.S. Office of Management and Budget

Why have cost controls failed? Here are five key reasons:

1. Caregivers had come to feel entitled to ever-higher revenues during the blank-check years after 1945. When Medicare cut payment rates, hospitals and doctors may have felt justified to increase volume, or to bill more aggressively. Hospitals merged and HMOs merged so they would not have to compete. Hospitals and doctors gravitated toward more specialized and profitable types of care. Drug makers aggressively advertised and promoted drugs to doctors and patients. The desires of hospitals, doctors, drug makers, nursing homes and other caregivers to boost their revenue were stronger and more politically powerful than payers' desires to contain their spending.

2. Most Americans don't see the connection between spending more on health care and finding the money to pay for it. This translates into weak political support for cost control. Most Americans assume that employers pay for job-based coverage, and fail to recognize that payment ultimately derives from lower take-home pay, higher prices for the employer's products, and higher taxes to offset tax subsidies granted to the employer.

3. Doctors were spurred to give more care by a combination of fee-for-service (piecework) payment arrangements that rewarded doing more, and by fear of being sued for malpractice if they did not do enough.

4. Doctors have had few reasons to economize. They seldom have budgets or other opportunities to cut waste and recycle savings to improve coverage or quality. Doctors became accustomed to spending what they thought appropriate for their patients—or financially and legally desirable for themselves—with little regard to cost to patients or payers.

5. Government regulatory actions to contain costs were often ineffective political compromises and ripe for gaming by caregivers. But controls relying on competition also failed—owing to health care's repeated and probably inevitable inability to function like a free market. Lacking the restraint of a genuine free market's invisible hand, the rhetoric of competition has merely rationalized greedy and self-interested behavior by some caregivers and payers. Without either effective government action or an effective free market, we have suffered from health care financial anarchy.

Current proposals to contain costs by increasing out-of-pocket payments for the insured—in theory to make patients more careful consumers—are likewise bound to fail. It is doctors, not patients, who are trained to diagnose illnesses and make treatment decisions. Here, market rhetoric is being used to mask cuts in care.

Abundant Waste

Failed cost controls have left standing four main areas of waste in health care. Together, we estimate that these absorb fully one-half of all health spending today.

The biggest is clinical waste—unnecessary care, sometimes motivated by payment methods that reward it, and sometimes motivated by fear of being sued. Also, evidence about how to diagnose or treat different patients is often simply lacking. When evidence indicates that less care is preferable, it may be ignored by some physicians, hospitals, or drug makers.

The second-biggest is administrative waste, which arises from both complexity and mistrust. Complexity stems from assuring eligibility for care, and managing dozens of payers' different forms, rules and billing procedures. Much more administrative waste arises from mistrust. As caregivers resisted cost cutting, payers relied on indirect financial suffocation and denial of claims. When caregivers learned how to bill to avoid denial, payers devised more complicated requirements. And so on. We call this "death by a thousand paper cuts."

Excess prices are a substantial problem. U.S. prescription drug prices are so high that 300 million Americans (one-twentieth of the world) generate one-half of drug makers' revenues and two-thirds of their profits. Also consider the prices of

Changes in Health Cost, Local Revenue, and Health Cost Burden

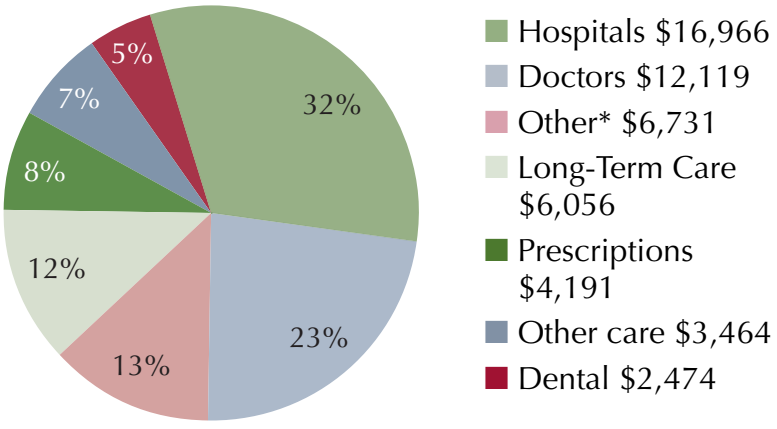
Average for 17 Massachusetts Cities/Towns, 2001-2004

Health insurance and health trust fund expenses	Local levy and receipts (excludes state/federal aid)	Health coverage cost as share of revenue raised locally
+53%	+17%	+32%

Source: Calculations from data reported to Department of Revenue

Massachusetts Health Spending by Type of Care

2005 ($ millions)



* The "other" category includes insurance administration and profit, research, and government public health activities.

Source: Health Reform Program projections based on data from the Centers for Medicare and Medicaid Services

medical supplies and equipment, and some incomes. For example, the average incomes of U.S. physicians are about three times those in other wealthy nations.

Fraud also boosts costs. Health care theft is not a victimless crime. If some caregivers or suppliers over-bill, other needed care is not delivered, which causes avoidable pain and disability, and premature death. In the future, if patients must be served within defined budgets, it will be much clearer that theft has terrible consequences.

Wasted health care spending could be squeezed out and recycled to protect all Americans—including people who are now well-insured, under-insured and uninsured. With so much waste today, higher spending is not necessary to cover all Americans well.

Causes for Concern

All public and private payers worry about how to find the money to cover soaring health care costs. Unfortunately, Massachusetts cities and towns are the canaries in the health cost coal mine. Through no fault of their own, local governments here are locked in a high-friction marriage between slow revenue growth and the world's highest health care costs. Doubts about the long-term robustness of the U.S. and Massachusetts economies reinforce pressure to make health care costs durably affordable for cities and towns here.

The federal deficit and trade deficit combined reached more than nine percent of the economy in 2004, up from 1.7 percent in 2000. These deficits are financed mainly by borrowing from overseas. Will foreign nations continue to lend us money to buy their cars, electronics and oil? This nation is living on borrowed money, borrowed time, and borrowed Toyotas. Meanwhile, our government is aggressively using the tools of monetary policy (low interest rates) and fiscal policy (huge federal deficits) that are usually reserved to combat deep recessions. What tools will still be available if things get worse?

With doctors, hospitals, and other caregivers apparently addicted to more money to finance business as usual, health care is entirely unprepared to cope with a deep recession and with the resulting freeze in revenue—or reduction in revenue—for health care. It's no wonder that 49 percent of Americans worry about health costs, more than the share worried about paying the mortgage or rent (29 percent) or a terrorist attack (19 percent), according to a spring 2005 poll by the Kaiser Family Foundation.

The aim of medical care should be medical security—confidence that each of us will get competent and timely care when we need it, without having to worry about the bill, and without having to worry about losing insurance coverage ever. With U.S. health spending by far the highest in the world, we are paying enough to finance the care that works for all Americans, and to win medical security. It is essential to make health care durably affordable for all, in good economic times and bad.

Local Attempts

Local governments in Massachusetts continue their efforts to restrain their health care costs in an attempt to forestall local budget crises, but these attempts typically amount to trimming around the edges and are quickly overwhelmed by more cost increases. Virtually any avenue pursued by local governments has limitations.

Local governments often try to save money by shifting costs—increasing employee shares of the premium, increasing co-payments and other out-of-pocket costs, and encouraging the use of less costly care. But increasing the employee share of premiums or out-of-pocket costs is effectively a pay cut, something employees can be expected to resist. And both steps unfairly burden lower-income patients and those with chronic illnesses.

In many parts of Massachusetts, such as greater Boston, it is also harmful to raise co-payments in order to promote the use of less-costly hospitals because few non-teaching hospitals remain open. Forcing patients to pay more punishes patients for the failure of government and the market to sustain efficient and low-cost hospitals.

continued on page 34

Some Massachusetts Health Care Realities

	Mass.	U.S.	Mass. vs. U.S.	Mass. Rank
Projected health spending, 2005	$52.7 billion	$1.9 trillion		
Projected health spending/person, 2005	$8,420	$6,477	+ 30%	1
Hospital spending/person, 2002	$2,019	$1,445	+ 40%	1
Patient-care doctors/1,000 people, 2002	3.92	2.54	+ 54%	1
Share of people in HMOs, 2004	37.4%	23.7%	+ 58%	3
Share of people lacking health insurance, 2002-03	10.3%	15.4%	- 33%	45

Data sources: U.S. Centers for Medicare and Medicaid Services, American Hospital Association, American Medical Association, U.S. Census Bureau

MMA Conducts Health Care Cost Survey

The MMA has conducted a survey designed to assess municipal health care costs from fiscal 2001 through fiscal 2005.

The MMA worked with the Massachusetts Taxpayers Foundation to collect this data, which was included in a first-ever special MTF report on health care costs.

The MMA identified a representative sample of fifty-one communities from throughout the state to participate in the survey.

Look for the MTF report and additional MMA analysis of health care costs on the MMA web site (mma.org).

Continued from page 15

Public health techniques of reducing tobacco use and promoting exercise and better diet choices can all work to improve health, and are worthwhile endeavors, but they are limited in their ability to save money.

Some experts exhort local governments to shop more carefully for health insurance, to self-insure, and to find more lower-priced networks of doctors, hospitals and other caregivers. Governments have certainly tried to do the first two. The third is hard. Employees have resisted switching caregivers and using restricted networks. And it is not clear whether these networks save by greater efficiency, or by simply providing less care.

Prescription drugs do offer an opportunity for more intelligent buying. Traditionally, pharmacy benefit managers have often cut self-interested deals with drug makers that appear to violate fiduciary duties to employers. The University of Michigan found it could win big savings by contracting with a pharmacy benefit manager that agreed to work in fully transparent ways that benefit only the university. Massachusetts municipalities might carve out prescription drugs from health insurance and unite statewide to buy through one pharmacy benefit manager. Savings would be even greater if the Group Insurance Commission, Medicaid, and private employers signed on.

The reality, however, is that local governments have little long-term leverage over the elements of financing, professional practices, caregiver specialization, and power that help to make Massachusetts health care the world's costliest. An added problem is that health insurance premium increases are light one year but very heavy the next. A few costly illnesses, movement in the insurance underwriting cycle, or a rapid rise in underlying health costs makes stable budgeting almost impossible.

A State Opportunity

It appears that any meaningful, long-term solutions to the health care crisis are going to have to come from upper levels of government. Unfortunately, though, federal action is currently impossible. Health care talk in Washington today mainly concerns cutting Medicaid and promoting high-deductible plans with health savings accounts. These are cost shifts, not solutions, and they hurt both patients and caregivers.

State government, however, with its clout as a sizable payer, could exercise powerful leverage over health costs, particularly in partnership with caregivers. State government would be motivated to exercise its clout to contain health costs if it faced greater financial exposure. With this in mind, cities and towns might advocate legislation that would require the state to pick up a substantial portion of the increase in local governments' health costs each year.

Further, the state can identify and help to stabilize all needed and efficient hospitals, especially the low-cost community hospitals that are most vulnerable to closing. Similarly, state government is best placed to work to attract and retain more primary care physicians in Massachusetts, and to limit growth in the number of specialist physicians.

The state can promote evidence-based medicine—as Oregon and others are doing for medications. It could cease paying for services that don't work or are not needed by certain patients. It could help to cut waste by putting ceilings on the shares of insurers' and HMOs' revenues that could be devoted to administration, marketing and advertising, and profit.

Perhaps most important, state government could work to devise new methods of organizing and financing health care, and to negotiate the political and financial deals that will make those methods attractive to physicians and to hospitals.

One option would be to sponsor doctor-directed groups, averaging perhaps fifty physicians, that would voluntarily enroll defined groups of patients and that would receive risk-adjusted budgets. The physicians would be obliged to stretch the available budget to care for all patients by spending money carefully, monitoring quality, and ensuring access. In return, they would be exempted from malpractice suits and would see a marked reduction in paperwork. Effective mechanisms for weeding out dangerous doctors and for compensating victims of medical harm would replace the tort system.

To forge a durable deal, elected state officials need to be asked to talk openly, seriously, and honestly about the importance of stabilizing health care spending in Massachusetts—and about practical ways to do so. Inevitably, this entails honest conversations with our state's 22,000 active patient-care physicians. It is doctors who, in consultation with patients and families, make the decisions that expend 87 percent of each health care dollar. The central role of doctors in health care reform follows from this simple fact. Negotiating a workable political and financial deal with our state's doctors is at the heart of making high-quality health care durably affordable to all who pay for care in Massachusetts, and accessible to all public employees and all other citizens.

These are only some possible approaches. Several sound ideas should be tried and evaluated. The key aim is to negotiate a health care peace treaty that protects all patients, caregivers, and payers, and that will be sustainable during good and bad economic times. Without reform, health costs will continue growing at unaffordable rates. If used efficiently and compassionately, current annual spending of more than $52 billion will finance medical security for all who live or work in Massachusetts.