Testimony of

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HEALTH CARE PROVIDER AND PAYER COSTS
AND COST TRENDS

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My name is Stuart H. Altman and I am the Sol. C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis University. I have enjoyed living in the Commonwealth for the last 33 years. During that time I have served on the Board of the Beth Israel Hospital and currently I am a member of the Board of Tufts Medical Center. In 2000-2002, I was co-chair of the Governors and Legislative Health Care Task Force. I have served on a number of Federal commissions including Chair of the Prospective Payment Assessment Commission which was charged with advising the President and the Congress on how to pay for institutional care under the Medicare program. In addition, I am on the Board of several private and not for profit health insurers and home health companies none of whom have a significant presence in Massachusetts. It is a privilege for me to join with the other distinguished speakers at these important hearings on Health Care Provider and Payer Costs and Cost Trends in the state of Massachusetts.

Massachusetts is very fortunate to have one of the best health care delivery system in the nation. Our medical schools, teaching hospitals and health plans routinely rank in the highest categories of quality and innovation. They, along with our universities, have helped spawn countless numbers of innovative medical technology and pharmaceutical companies that have created many thousands of well paying jobs. Collectively it is fair to say that Massachusetts is a “Medical Mecca.” It is, therefore, not surprising that the Health Care Cost Trend Report that we are discussing at these hearings highlight that a Massachusetts patient is much more likely than patients in other parts of the country to receive medical treatment in a teaching hospital and to receive care from a highly trained specialist.
We should be proud of these facts and be careful that any changes we make in how we pay for medical care in the future or how we restructure the health care delivery system not damage the unique characteristics of the Massachusetts medical system. But we do have a problem, a serious problem. The financial cost of maintaining this fine system has grown so rapidly that there is concern that its maintenance, over time, is unsustainable. Also, the leaders of government in Massachusetts have a special responsibility to assure that the cost of health insurance does not reach levels that make it unaffordable to many citizens of the state. The Commonwealth’s landmark health reform legislation requires that all citizens have healthcare coverage and that employers help support that coverage. The legislation also requires that such coverage be affordable. If health care costs continue to grow at rates substantially above inflation and wage growth, this requirement of affordability inevitably will be violated for more and more individuals and employers.

Over the last two days you have heard that total per capita spending for health care in the Commonwealth of Massachusetts grew by 33 percent from 2000 to 2004 and private expenditures per insured grew by an additional 15 percent between 2006 and 2008, While state numbers for total spending are not known beyond 2004, we know, from other sources, that for the period 2002 to 2008 average employer-based health insurance premiums for family coverage grew in Massachusetts by 47 percent. During the same period the comparable growth for the U.S. was 38 percent. Both sources suggest that per capita spending is higher in Massachusetts than the nation and is growing faster. In contrast to these high medical spending growth rates
general inflation in both the state and the nation has been quite moderate. General wages have also grown at a much smaller rate.

This rapid growth in health spending is consuming an ever larger percentage of the total income of the state and the nation. In 2009, health spending for the country will consume 17.3 percent of GDP and approach $2.5 trillion. Several studies suggest that the growth in health care spending is leading to lower monetary wages for workers and fewer jobs available in other sectors of the economy. That the problem is serious seems clear. But developing a plan that slows the growth in spending without negatively affecting the availability of needed medical services or the quality of these services will not be easy. The federal government and several states, including Massachusetts, have tried in the past to slow the spending growth trend with limited success. But while we should learn from past failures, they should not prevent us from trying anew.

Some suggest that if we eliminate waste and fraud in the system or restructure our medical malpractice system the urgency of finding another solution is eliminated. I don’t agree. Sure there are savings to be made if we attack these issues and I would support working on both of them. But that will not be enough to significantly “bend the cost trend” More fundamental changes are required.

We have a choice other than continuing down the current inflationary path. We could maintain our current delivery and payment system and just limit spending by cutting provider reimbursement rates. Alternatively we could reduce the benefits covered by third parties or require high patient cost
sharing. The U.S. has tried both approaches and both have demonstrated that they either don’t work to hold down spending for any length of time or they lead to reduced access to care and questionable decisions by consumers about the types of care they seek. That doesn’t mean that there may not be short-term benefits to a temporary limit of the prices paid for medical care and insurance. During the 1970’s the federal government limited the prices that hospitals and doctors could charge and several states introduce various limits on hospital pricing. Some of these efforts did show improvements in the medical inflationary trend rate. But success from such strategies has been shown to be short-term at best and ultimately all but one of the programs was disbanded. What we have learned is that if we leave in place all the forces that were pushing for higher spending and simply imposed a government regulatory mechanism, the medical system ultimately wins out and the country or state returns to its long run spending path. Alternatively, asking consumers by themselves to be the force that changes the system and bends the cost curve doesn’t work either. In the end we must change the delivery system.

We, in Massachusetts, have the opportunity to initiate changes that might be more difficult at the national level. Our strong and well integrated delivery and financing system provides a better foundation to implement structural reforms than most other parts of the country. With that in mind, let me outline one possible structure of a new Massachusetts health care system.
DEVELOPING ACCOUNTABLE CARE ORGANIZATIONS

We must move away from our current silo based system where care is provided in a piece meal fashion with limited coordination to a system that is organized to deliver all necessary care for a patient in a more efficient manner. We also need to increase the role of patients by providing better information about the quality and value of the care delivered by different providers and create appropriate incentives for them to choose the care they need wisely. If we make these changes there is the real possibility that we can lower the cost of care over time and increase its quality. Many now believe, as I do, that we should restructure our delivery system by developing competitive “Accountable Care Organizations” (ACO). These ACOs should either provide all necessary care directly or facilitate the provision of the necessary care to treat patients that join their organization. As an alternative, the system could be designed to require an ACO to provide all the care necessary for a specific illness in a defined time period. As discussed below, an ACO could be one highly integrated care system capable of providing all the care necessary itself or a group of providers that combine for purposes of creating a “virtual integrated system”.

The goal of an ACO should be to provide this care in an efficient manner such that it can reduce costs while maintaining or improving quality. To encourage the development of these organizations we must replace the current fee-for-service system with one that pays a bundled payment for all the care needed by a patient or all the care needed to treat a specified illness in a specified time period. Where fee-for-services encourages fragmented care from multiple providers with the potential for the duplication of
services or the provision of services with limited value, these alternative bundle payment mechanisms with appropriate quality standards have the incentives to encourage better outcomes at lower costs. To guard against an ACO that functions under a bundle payment skimping on needed care, it is important that the quality standards have strong safeguards against such a possibility.

A critical element of well functioning ACO’s is the use of different types of health professionals in accordance with their technical competence and relative efficiency. Where appropriate, a well trained specialist might be the provider of choice. In another situation a nurse practitioner or physician extender would be the best option. Some believe the key to making such an organization work is that it should be primary care driven. In many situations this might be the preferred option, but I do not believe it is either necessary or always appropriate. As was discussed previously, much of the health care in Massachusetts is organized around a number of high quality teaching hospitals staffed by large numbers of specialty trained physicians. This is what we are and in many ways it has served us well. Let us build on it. This doesn’t rule out that in some areas a primary care centered ACO or “medical home” might prove to be the most effective. Regardless of its size and structure, any ACO that hopes to be efficient and operate within a budget must include an adequate primary care system.

A well functioning ACO should strive to improve its efficiency by providing appropriate preventative and early diagnostic care. Where advanced care is needed the organization should focus on developing efficient treatment protocols that attempt to minimize the use of expensive testing, costly
procedures and medication by using evidence-based treatment guidelines. By creating better patient education and more available ambulatory care the ACO should be able to reduce its amount of preventable emergency room visits and costly hospitalizations. To accomplish these goals, ACOs are likely to need many non physicians to coordinate care in our increasingly complex medical system. Traditionally, these coordinated services have not been reimbursed under a fee-for-service system. Under a global or bundled payment system with quality standards, the ACO will have the incentive to select the appropriate services needed and who should provide them.

**HOW DO WE GET THERE**

Much as I would like to see a quick change in the health care system, history strongly dictates that if we are to develop a system that has long term sustainability it must be gradual. Some organizations in the Commonwealth are ready for the new world today and eagerly look to make it happen. Others are open to a new way of operating but need time. Still others--while not opposed--just don’t yet know how to make it happen. And finally, there will be a group that will strongly resist such changes. How do we proceed?

There are various approaches to developing this new delivery and reimbursement system. My colleagues and I at Brandeis have developed one such model that Massachusetts could adopt. Under this approach the state would establish an annual global budget target and quality patient care standards. Providers would select to be in one of three groupings or tiers. The first group would be those organizations that are ready today to create a
functioning ACO. This group would be responsible for all the care of the population that selects them under a predetermined budget. It is likely that most organizations that fall into this first group would be large multi-specialty “integrated delivery systems.” As such these organizations would assume the most risk if they do not stay within the budget but have the most to gain if they do.

The second group would consist of organizations that could provide segments of the care necessary but would agree to link up with other organizations to form a virtual integrated delivery system. While the total tier would operate under a targeted budget cap, each virtual provider group and units within that group would continue to be paid on a fee-for-service basis. At the end of a specified period actual total expenditures for each virtual group would be compared to the target. If expenditures are less each unit within the group would benefit. Likewise if total expenditures exceed the target each unit would be required to pay back some portion of the excess. Thus, each delivery unit would assume some risk but could benefit if the total organization lives within the budget and meets some or all of the quality standards.

The third tier would be delivery units that wish to continue to operate as they do today. Each unit would continue to be paid fee-for-service but in total all units in this third tier would be held accountable to a total budget target. If expenditures are below the target, each unit would not receive any additional payments but, if actual expenditures exceed the target, each unit would be required to pay some portion of the excess. An important difference between the second and third tier is that there is no central system that coordinates
care among the separate provider units in the third tier. Units in this residual fee-for-service tier also would have limited opportunity to receive extra payment for higher quality care. It is expected that as the system matures and the benefits of being in a higher tier become clear, provider units will develop the capacity to transition to a higher tier.

Quality standards would be established by the state or an entity created by the state. These standards would be revised periodically as new information becomes available as to what type of care generates the best outcomes. Merit increases would be financed by across-the-board reductions in annual payment updates for all providers. Providers that attempt to skimp on necessary care would be penalized. Since each tier would be under a budget target with strong quality standards there would be financial incentives to provide care in the most efficient manner without jeopardizing quality. One issue that must be addressed is that a provider unit could face financial risk because of the poorer health status of the patient population it serves as opposed to the risk of not providing care in the most efficient manner. The first type of risk is called “Insurance Risk”, the second “Clinical Risk”. To minimize insurance risk, budget targets and performance expectations would need to be adjusted for the medical status of the patients enrolled in the unit. It is also important that each unit have a patient population of sufficient size.

**WHO PAYS AND HOW MUCH**

Currently, as reported in these hearings, the various private and public payer groups pay different amounts for the same service and different provider
units receive different amounts as well. There is also the important issue of
the size of the initial budget and the annual update in the budget. Initially it
is probably advisable to start with the current spending pattern. Over time,
however, if some provider units benefit from operating under the budget
target and provide higher quality care while others fail on both fronts, the
resulting differences in reimbursement levels will change. It is likely that
even after the system is in operation, different payers would pay somewhat
different amounts, e.g., Medicaid would probably continue to pay lower
rates.

To make this system work some state authorized organization needs to help
restructure the payment system and establish future spending targets. It is
unlikely that the market as currently configured can accomplish these tasks.
Blue Cross/Blue Shield is to be commended for creating its alternative
contracting system. By necessity, however, providers voluntarily chose to
participate and Medicaid and Medicare do not participate. Thus the BCBS
system will not significantly impact on total state healthcare spending.
Therefore, the state needs to create an entity with the power to establish the
methodology that determines the annual budget targets for each provider or
provider tier and the amounts paid by each payer. It is important that
Medicare and Medicaid participate in the process, given their growing size.
To do this the state would need to seek a waiver from the federal
government to change the way it pays for care. While it is possible for the
state to operate its program without Medicare and Medicaid its likely
success would be severely limited. Also, it should also be understood that if
they are not included fiscal problems will lead to lower and lower payment
rates by both governmental programs.
This entity could either be a unit of state government or a quasi governmental organization with a legal mandate from the state to develop and operate the new system. There are a number of examples of quasi government entities that operate in such a manner such as MedPac at the federal level and the Connector here in Massachusetts. In the one state that has such an entity, Maryland, their rate setting commission operates as a quasi governmental entity. I would recommend that this entity be given an initial five year charter with annual reporting responsibilities. Under certain proscribed conditions the Governor or the state legislature could intervene in the activities of the entity during the five year period. But such intervention should be only for very serious issues. It is possible that after the system is established and the appropriate incentives are in place, it would not be necessary for the entity to continue. A permanent regulatory process brings with it, its own serious set of problems. The decision on whether to keep the entity in operation after the initial five years would require the Governor and legislature to evaluate how well the system is working during the final fifth year. However, even if the entity is eliminated, the state would need to continue to set annual spending targets and evaluate the total spending of each provider unit relative to the target.

Since there are three provider tiers and one for those who wish to stay in the current business fee-for-service grouping, each provider unit would be free to select which tier to join and how it would be organized. What is critical, however, is that the third tier---those that continue to operate as currently---not be given a free pass in terms of how much it can receive in payments. A total budget target for that tier must be established and it should be designed
to be less than what is likely to happen without such a process. How much less is an important issue and should be left to the new state designated entity. Alternatively, the state in establishing the entity could dictate the long-term spending targets. While the goal of the entire process is to reduce the long-term spending growth trend, it must be realized that many of the inflationary forces in health care are national or global and not within the control of any state provider unit. Therefore the new state entity should take into account national spending trends in establishing its annual update amount. Nevertheless, Massachusetts cannot afford to wait for federal actions. There is much that could be done by the state today to develop a more efficient health care system and lower its spending trend.

THE ROLE OF THE PATIENT

One final but important issue is the role of the patient. From the point of view of the provider unit, if they are to be held responsible for the efficiency of care delivered to their patients, it is necessary for the patient to stay within their system for the budgeted period. From the patient perspective freedom to choose their provider has been shown to be very important. I would suggest that patients be allowed to seek care outside the system they select but only if they pay a fee to their select provider unit to make that choice. There are other patient choice options that could be established and I would leave the final choice to the established state entity.
SUMMARY

Health care in Massachusetts is in general of high quality and an important engine of our entire economy. But the growth in its costs is creating serious problems for those who pay its bill and for jobs in other business sectors. Inflation in healthcare is a national problem and negatively affects every region of the country. However, because of our health reform legislation, we in Massachusetts have a special responsibility to do something to moderate its growth.

The development of a less costly system requires a shift away from current fee-for-service payments to one that bundles payments and provides incentives for quality care. Under one possible scenario outlined in this essay, provider units would be free to join one of three payer groups, with units in the first tier ready to provide all necessary care, units in the second willing to link up with others to assure that all care is provided, and a third tier of units that do not wish to change their operation.

The state needs to establish an entity to oversee the creation and operation of such a system or one with similar goals. Such an entity can either be part of state government or somewhat independent. This entity would be required to establish the methodology for the changing the payment system and establishing budget targets for each provider tier. Since it will take several years to initiate such a system, I would suggest that the state provide authorization to such an entity for five years. It is possible, that if the system is working well after the five years, the entity could be eliminated. The state
would need to continue to provide budget targets and evaluate the performance of each provider unit annually.