

Testimony
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Committee on Finance
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Mr. Chairman and members of the committee, thank you for giving me the opportunity to participate in this roundtable discussion on methods for financing what I hope will be a comprehensive package of legislative changes to reform our health care system. 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 had the privilege over the last 38 years to serve in a variety of positions in Federal and State government including Deputy Assistant Secretary for Health Care Policy and Evaluation in the Department of Health, Education and Welfare, 1971-1976; Chairman of the Prospective Payment Assessment Commission (ProPac) 1984-1996; and a member of the Bi-Partisan Commission on The Future of Medicare 1998-2001.

I understand that there is a strong wish by many to pay for any expansion in health care coverage to the millions of Americans who lack any third party health care coverage with savings generated by either reducing what is now paid for care or by limiting the amount and types of care currently being provided. I share the view that there is substantial waste and excess in our current health care delivery system and that we can save substantial sums by reforming this system. But to attempt significant provider payment cuts before we provide adequate financial coverage for all Americans or in conjunction with expanding coverage would, I believe, be a serious mistake. Moreover, to make the uninsured, who are mostly the working poor, be the victims of our nation's inability to curb health care costs is clearly unfair.

Unless we change the way we provide services, any serious reductions in the payment levels for services will, I fear, lead to a reduction in access to care and/or the quality of the care provided. To change the delivery system we must move away from our current fee-for-service system to a payment system that rewards not more services, but appropriate services. Appropriate services often involve individuals who coordinate care as opposed to deliver services. Such care is most often found in what have been called "integrated delivery systems". By developing integrated delivery systems we have the potential to reduce payment levels for services over time without negatively affecting access and quality. Several members of the first roundtable panel and many of the options

prepared by your staff focused on different ways to restructure the payment system and, therefore, I will not go into detail on how such changes could occur. Nevertheless, permit me again to emphasize that these changes need to precede any serious reduction in payments for services so as to avoid negatively affecting Americans ability to access care and the quality of care provided.

As you know, Mr. Chairman, the Commonwealth of Massachusetts, has legislated a series of changes in the way its citizens are financially protected against the costs of health care services such that almost all residents of the state are now insured. These changes were legislated as the first stage of a two stage process. The second stage, which is now being designed, will attempt to rein in the fast growing cost of health care. In fact, this month a special commission established by the state legislature on Health Care Payment Reform is scheduled to recommend a global payment system that would set a total payment amount for each patient that covers all that person's care for an entire year. In order to make such a system work the State will be seeking CMS' permission to cover Medicare and Medicaid patients as well. The hope is that by creating a global payment, and limiting its growth, health care cost growth in Massachusetts could be reduced from 8 percent a year to 5 percent.

I would propose that your committee contemplate a version of the Massachusetts model by developing a 10 year plan whereby over the course of this period the cost of expanding coverage to all Americans is paid for by health care delivery system reform with the major portion of these savings occurring towards the end of the time frame. This would allow time for the system to adjust to the new structure I discussed above. I realize this is a long phase-in period but past attempts to change our cumbersome health care system quickly have failed because they required too many changes too fast.

RECOMMENDED CHANGES IN HEALTH CARE PAYMENTS

State Administered All Payer Systems

As we phase-in changes to the health care delivery system I would recommend that the federal government encourage more states to establish all-payer systems that would tie Medicare and Medicaid payments for doctors, hospitals and other health care services to payments generated by private insurance. Government payments have become too large to be treated separately from private payments. With the shifting of power at the local delivery level from private payers to hospitals and doctors, health care providers in many localities have been able to make up lower governmental payments with higher private payments. This so called “cost-shifting” has been an important force pushing up annual private insurance rate increases to double digit levels leading many employers, public and private to reduce benefits or eliminate coverage all together. Such all-payer systems should not be thought of as “price control” mechanisms which simply limit the growth in fee-for-service prices. Rather they should be designed to help create the global or bundle payment systems discussed above.

Initially the total amount spent in each state should approximate current spending with the current differential in public and private payment amounts maintained. Over time the increase in payments for each payer could be limited as the delivery system becomes more efficient. In order to insure that the reductions in private payments lead to premium reductions, the medical loss ratios and the administrative costs of private insurers would also need to be regulated. Without such a state run system I don't believe we could link together public and private payments or foster a restructured delivery system except for a few pioneer delivery systems. States should have the flexibility to either require providers to accept these new payment systems or allow voluntary participation. If the approach is voluntary those provider groups that choose to stay in traditional fee-for-service should face more limited payment increases. Providers in states that choose not to participate in such a program should also receive more limited federal payment increases. As an added

inducement for states to establish these All-Payer Systems, the federal government should help support the administrative costs of operating such a system.

Future Hospital Payment Updates

Hospitals play a key role in our health care system and must be a core component of any integrated delivery system. As we transition to more bundled or global payments any future hospital update amounts paid through the Medicare PPS system should recognize that as hospitals develop more comprehensive health information technology systems, with the help of federal HIT funding, they should use these systems to develop more efficient and lower cost care. Hence I would recommend that Medpac consider increasing its productivity offset to medical inflation thereby lowering the annual PPS update amount. Again these reductions should be phased in to allow hospitals the time to make the necessary but time consuming changes in their delivery of care.

Disproportionate Share, Critical Access and Community Health Center Payments

Massachusetts used a portion of the funds set aside by the states' (Hospital Uncompensated Care Pool) to support the expansion of coverage. The rationale of course was that when all or almost all individuals are insured the amount of uncompensated care provided by hospitals and other health care providers falls or is even eliminated. We could expect such changes to occur nationally as well as universal coverage is approached. Therefore it is appropriate that those health care providers that currently receive extra payments to help support the care they provide to the uninsured and other low income or hard to treat patients,(i.e., those who do not speak English) should have such payments reduced. However, we have learned in Massachusetts that many of the extra costs associated with providing services to such special populations would continue even if they are insured whether they are in the inner city or in sparsely populated rural areas. Therefore a portion of the current extra payments for such providers need to be

continued. Again I would suggest that Medpac analyze this issue and recommend how and in what amounts such payments be reduced.

High Cost Case Re-insurance

It is well known that 80 percent of US health care expenditures are for the sickest 20 percent of the patients. Some private insurers try to protect themselves against the possibility that they could be responsible for the cost of such patients by developing techniques to limit coverage for individuals that might be in this group. Most insurers also limit their financial exposure by purchasing high cost reinsurance. Clearly the former activities should be outlawed and the purchase of re-insurance is expensive and is ultimately passed on in the form of higher premiums. I would suggest that the US could both reduce the overall cost of treating such high cost patients and reduce the cost of reinsurance by establishing a governmental reinsurance system. Such a system could be established through a state all-payer structure or through local or state health insurance exchanges. Each payer group would be asked to pay for a portion of the expenses in relationship to an actuarial estimate of their likely high cost cases. This new reinsurance entity would be responsible for a proportion of the high cost case expenses, e.g., 75%. So as to reduce the overall costs of treating such patients over time each appropriate state or local entity would be required to develop a high cost disease management system in consultation with the federal government. The federal government would evaluate the success of the different disease management systems and help incorporate those that work the best throughout the country.

Physicians

The key to changing the delivery system rests with the physician community. Many physicians seem eager to become part of a new structure for providing care but unfortunately many appear resistant to change. As long as the payment system continues to reward maintaining the status quo I fear that less change will occur than is needed. To help encourage more physician participation in systems that provide higher quality care and more efficient care, I would suggest that your committee consider rewarding those

physicians that help create or join integrated delivery system by paying those systems the full RBRVS payment in the coming years. I would also suggest that you support an extra payment for those groups that show real results in meeting approved quality standards. For those physicians that continue to function in the current fee-for-service system I would recommend that the legislated SGR reductions go into effect. As a final inducement to create these new delivery systems I would suggest that consideration be given to restructuring the medical liability system that governs their services. I will leave it to others to suggest how such a system would function.

SUMMARY

Most importantly we need to develop a system for providing health insurance coverage for all American. And, yes over time we should and can pay for the added costs of such expansion with efficiencies from our current health care delivery system. But such cost savings cannot occur over night and will require some fundamental changes in the way we pay for and deliver care. It would be unfair to ask the millions of uninsured American to wait for those of us who are well insured or who provide health care services to change our system. Instead we should follow the lead of Massachusetts and expand coverage immediately while we set in place mechanism that over a 10 year period will both improve the quality of care and lower its costs.

Thank you Mr. Chairman and members of the committee for giving me the opportunity to express my opinions on these most important social issues.