Health Care Reform in Massachusetts: Implications for State Health Care Policies

By Charles Baker

A well-known Stanford economist once said: "In recent years, almost every American family has become acutely aware of the soaring cost of medical care, the difficulties of access to physicians, and the mounting health problems of our society. According to many observers, the U.S. health care system is 'in crisis'."

Now, that quote will certainly sound familiar to most of you, as well as accurate and timely. But it really ought not to be terribly timely, because the quote is from a book written by Victor Fuchs called *Who Shall Live*, published in 1974—eighteen years ago.

The health care debate is not new. We have been discussing it since the 1940s. While the debate has gone round and round, most people agree that the U.S. health care system, for the most part, delivers better care faster to the vast majority of its citizens than other systems in most countries.

This is not to say we don't have problems. We do. And many of them have gotten considerably worse, particularly in the areas of cost containment and access to care. After fifteen years of a variety of cost containment strategies, we are still well on our way to spending 15 percent of GNP on health care, and we still have 35 million citizens at any given time who don't have health insurance. In addition, we have new studies suggesting that about 25 percent of what we do in health care either doesn't make any difference at all or makes things worse.

The More You Spend, The More You Make. I am surprised the system hasn't collapsed already, given the way it's structured. Nobody really cares very much about cost, which is virtually invisible to the consumer and the provider, particularly at the point of delivery. Health insurance is a fully tax-deductible benefit to employers. Payments throughout the system are based on a historical, cost-plus model, which means that if you're a provider, a doctor, or a hospital, the more money you spend, the more money you make. Physicians are paid primarily using a fee-for-service system, which means the more they do, the more they make. These factors do not encourage anybody providing services to minimize cost. They mostly encourage them to maximize reimbursements.

Originally, the federal government's role was to worry about supply. The last of the Hill-Burton money that built hospitals was funneled out of the federal system over the last few years, just when we decided we had 40 percent more hospital beds in the United States than we needed. We also worried about physician supply. So we built a bunch of new medical schools. It worked. Physician supply has risen about 45 percent, on a per capita basis, since 1970. But every new physician adds about $600,000 to the cost of operating the health care system. Still, many of our distributive problems remain unsolved.

Medicare, the federal health insurance system for the elderly and disabled, is a terrific health care program—if your point of reference is about 1968. Now, it has all sorts of problems. Many of these are due to the fact that it is hard for government to move as quickly as technology does. But it is a program with an enormous role to play in America's health care system. So even if we state officials were interested in improving our own health care systems, Medicare's huge size would limit our ability to have much of an impact.

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Medicaid: a Tong War. Medicaid, the federal state health program for the poor and indigent, is schizophrenic. On the one hand, you have a federal bureaucracy interested in homogenizing Medicaid and making it a "one size fits all" program for all fifty states. On the other hand, you have people like me, doing just the opposite, trying to create a Medicaid program that works most appropriately and effectively for the people in my state. And believe me, this is a Tong War, a struggle of monumental proportions between massive bureaucracies.

If I had to pick the single thing the federal government ought to do, it would be to make a decision to either nationalize the Medicaid program or really federalize it. I can't tell you how much time and energy is wasted in bureaucratic fights. On the one hand, there is a huge bureaucracy representing federal interests that could not be any more different than mine at the state level. On the other hand, my folks at the state level are punching back, trying to do the best we can to represent our state's interests.

The prevailing notion that Medicaid is a state-administered and jointly-funded federal state program is absurd. We cannot change a comma, a paragraph, a period, or a semi-colon in our Medicaid program without getting several people in the federal government to sign off on it. That's not to say they're bad people, or that their interests are significantly different than ours. But on the day-to-day level, this is a preposterous way to run a railroad.

Who is Supposed to Fix It? What about private insurers? The private payer community is not terribly effective in dealing with health care. They are a lot more interested in acting as investment companies than acting like health care providers. What about the business community? The business community does not seem to know what it wants. It depends on where one sits, I suppose. In any case, all the key players in society seem to be waiting for the medical community to fall on its sword.

Well, I can promise you one thing: the medical community is not going to fall on its sword. If we decide that the right way to fix what's broken in health care is to wait for the health care industry, if we wait for them to be the vehicle through which we control and contain costs, if we wait for them to restructure the delivery of medical services, we are all going to be waiting a very long time.

Obviously, consumers are confused by all of this. By 91 to 8, they believe that everyone's entitled to all the health care that money can buy. But, less than 10 percent would pay an additional hundred bucks to fund such a goal.

To deal with this problem, the federal government seems to be saying, "Let the states experiment." We can be the laboratories. We can tailor reforms to local conditions. It's easier to build support there.

As a fact of political life, I would be wholly supportive of the notion of state experimentation. But, as long as Medicare is 40 percent of hospital revenues and 25 percent of health care expenditures in my state, as long as Medicaid is 10 percent of hospital revenues and 50 percent of long-term care spending, and as long as that corporate, federal tax deduction law sits out there, adding $50 billion in federal tax expenditures to the health care system plus a really wacky set of bad incentives, the notion that somehow the states can make it all better is misleading at best.

This is not to say that states shouldn't try to do positive things. In Massachusetts, we have tried to do a number of things within the limited framework in which we're allowed to operate. Perhaps the most important was changing dramatically our hospital finance system this past December. For ten years, Massachusetts had the second most heavily regulated hospital finance system in the United States. The only one I can think of that would be comparable would be the Maryland hospital financing system. Everybody in Massachusetts agreed—after ten years of experience—that our rate-based, regulated system really was a great game for lawyers and accountants, who operated

under the basic assumption that they would always win, no matter what the rules were. Gaming in health care is a very real issue, and in our type of a regulatory environment it was even more so.

More important, Massachusetts created a system in which the best way for a hospital to secure an increased rate of reimbursement was simply to demonstrate an increased set of costs. The result of such an incentive system was inevitable. Over that ten-year period, hospital costs in Massachusetts were anywhere from 30 percent to 40 percent above the national average.

We decided the burden of proof to continue such a model rested on those who supported the status quo. Letting them defend it, we proposed moving toward a much more competitive, market-based process. The legislature agreed with us, and in December, Governor Weld signed legislation that moved the Commonwealth completely out of a rate-based reimbursement model and into a fully competitive hospital finance system.

Health Care at "Suggested Retail Price." Three things happened as a result of this hospital finance reform. First, there are very few charge-based payers left in Massachusetts. This is very good for the health care industry. Charges, the way in which people talk about hospital prices, are the equivalent of "suggested retail price." Anybody who pays charges in health care, just as anybody who pays suggested retail at Bloomingdale's, or buys a car at suggested retail, is an idiot. Yet, for years and years and years, we've always talked about such charges as if they were prices. Hospital charges are irrelevant.

Second, we encouraged a significant amount of risk sharing between payers and providers. It is working. Many big purchasers of hospital services are entering into risk-shared relationships with hospitals for the first time. So you now have a Blue Cross or an HCHP saying to a Mass. General Hospital, "I want twenty of your beds, and I will pay you X-amount of dollars per day for those twenty beds per year. My risk is that I'm going to pay you this amount guaranteed. Your risk is that's all you're going to get." And these types of relationships, for the first time, are establishing real prices between purchasers and providers.

Third, hospitals in Massachusetts are finally starting to affiliate, consolidate, and merge. My guess is over the course of the next several years, we'll probably lose 15 percent to 20 percent of our hospital capacity. We should have lost it five years ago. It is long overdue.

More important, instead of having some rate-based model determining which hospitals succeed or which fail, the market is going to determine which hospitals succeed or fail.

Balancing Caseloads and Spending. While the rest of the health care industry responds to this changing environment, our Medicaid program is also changing. Medicaid spending in Massachusetts grew at an average rate of 21 percent per year from 1987 to 1991. Its caseload grew about 5 1/2 percent per year over the same period of time. So spending was growing 4 times faster than the caseload. In our last fiscal year, ending on June 30, Medicaid spending grew by 8 percent. The caseload grew by 7 percent. So Medicaid spending in Massachusetts, caseload adjusted, was relatively flat in FY 1992. This is a remarkable accomplishment.

Over the long term, we're implementing probably the largest Medicaid-managed care initiative in the United States. It's a fully state-wide program, and involves about 475,000 recipients.

On the acute and primary care side, we have two basic programs. One is an HMO program. It is exactly what you might think it is. Medicaid purchases services from an HMO at a capitated rate, somebody enrolls in the HMO, risk is shared between the HMO and the state, and that's that. This will take care of about 100,000 Medicaid recipients.

The other 375,000 Medicaid recipients are going to be served through a very large independent physician association. We've already got 1,000 physicians signed up in Massachusetts to be primary care clinicians under this program. We are busily enrolling Medicaid recipients with these primary

care physicians. Many of these recipients are choosing primary care physicians for the very first time. These physicians will then be responsible for overseeing all the services that are provided to these people. Everybody in Medicaid should be enrolled with a Primary Care Clinician or with an HMO by December 31st.

The Contractor as Overseer and Supplier. In addition, we have fully capitated and privatized mental health and substance abuse services. The winning bidder was Mental Health Management of America. They are building a mental health and substance abuse service network for us, to be fully in place by the end of December. In effect, the contractor will be the payor for Medicaid services. The contractor will be the overseer. The contractor will be the supplier. All we're going to do is pay him the capitation rate to provide services to Medicaid-eligible recipients.

This does two things. First, it takes getting paid as a Medicaid provider out from under all of the federal criteria associated with getting paid, which can be very, very complicated. The contractor doesn't have to abide by standard state claims processing rules. All the contractor has to do is write its contracts, develop its network, and pay its subcontractors for the services it provides under whatever arrangement it wants. The federal government then worries about whether or not the capitation rate we're paying to these people is less than what would otherwise be the fee-for-service average.

Secondly, we get real data. One of the great things about having a vendor developing a network like this is they have the ability and the expertise to choose software, hardware, and computer expertise that governments can't get as effectively and as quickly. By the end of calendar year 1993, we are going to have the best database on the way the Medicaid population uses the mental health and substance abuse system in Massachusetts that has ever been developed.

Our managed care initiative is big, aggressive, and one-of-a-kind. But if we pull it off—and I think we will—it's something a lot of other states are going to pick up on along the way.

More broadly, if someone gave me a quick wish list on what I would like to see from the federal level to pursue state-based reform, the most important thing would be to cut the cord on the federal tax deduction for employer-purchased health insurance. I've come to the conclusion that there is probably no more significant problem with the health care system in this country than this peculiar tax treatment of employer-based insurance.

We have a small business health care purchasing problem in this country. We have a non-group purchasing problem in this country for people who can't get health insurance through the work place. We have a problem for those who are temporarily unemployed. We have a portability problem when people go from one job to another.

Responsibility Should Not Be With Employer. These problems are all a function of the fact that we have a system that for some cockamamie reason is based on the assumption that your job is where you get your health insurance. It was nothing more than a political decision that was made in the 1940s, during wage and price controls, so that Congress could give something to labor. It has no basis in anything other than that, and it's virtually impossible for me to conceive of how states can be the laboratories as long as all of the reform proposals we can pursue have to be employer-based.

Look at what any state pursuing real, consumer-driven reform runs up against—a federal system running in the opposite direction!

But mark my word, if whatever we do in this country to fix health care involves an employer-based plan, it won't work. Employers are not in the business of managing health care. Employers are in the business of making products and making money and providing jobs. The only way we're ever going to get to the bottom of the health care problem is to create a mechanism in which the people who are purchasing the insurance and using the system are the same people. There just aren't the right set of incentives for an employer, ultimately, to make the same types of intelligent decisions

about purchasing health care and using the health care system as there are for an individual to do that.

The More You Buy, the Bigger the Break. Second, whatever federal tax support is available to subsidize health insurance ought to be based on income, and not on how much insurance one purchases. Under the current employer-based model, the more insurance you buy, the bigger the federal tax break you get. This is why Ford and GM have far more insurance than they need, while Bill and Ted's Garage has none. One of the things I really like about the Heritage Consumer Choice proposal is that it calls attention to the progressivity issue. People with big health expenses ought to get bigger subsidies than people with low health expenses, as a percent of their income overall. This approach would certainly turn the value of the existing federal tax expenditure on its head—appropriately!

Third, the federal government should use the tax code to support medical savings accounts. The reason I raise this is the 80/20 rule: 80 percent of the population doesn't get sick in a given year. Twenty percent of the population generates the vast majority of what we spend on health care. I oversee a Medicaid program that finances about 70 percent of the long-term care expenditures in Massachusetts. I look at the demographics and I can't, for the life of me, imagine how we can possibly continue to fund 75 percent of long-term care expenditures with any sort of publicly based entity. But I look at a medical savings account idea and I see an opportunity to take advantage of the time-value of money. Why does health care have to be a pay-as-you-go system, if 80 percent of the population doesn't get very sick in a given year?

If someone had said to me, "Charlie, you can put $500 in the bank every year and plan to use it for medical expenses, and you can roll it over every year," and I'd been doing that for the last fifteen years, I could be on my way, by the time I was 65, to putting together a fairly serious nest egg together to be applied toward the cost of my long-term care. Trust me, the demographics simply do not work. There is not enough public money, even if you took everything—assets, income, name it —from everybody making $200,000 a year or more to finance the entire long-term care structure that this country's going to need, if we have to pay for it all with a public program on a pay-as-you-go basis. And if we don't start thinking now about creating incentives for people to save for their long-term care expenses when they retire, people my age, and the age of most of the people in this room, are going to drown in the costs.

One final point. Short of some really significant reform at the federal level, the states will continue to wrestle with this stuff. Some of us may even try to do some things against our better instincts, simply because we're going to feel obligated to do something. But I'm not sure the states can make this work on their own.

We can do a lot of things. But fundamentally, we will be cobbling things together that run up against a whole set of federal laws and regulations going in the opposite direction from where we'll be trying to go. This is going to create a significant amount of bureaucratic tension. If, ultimately, we leave this as a "let the states experiment" approach, and don't do anything at the federal level to make experimentation on the state level more user-friendly, most state-based experiments aren't going work. This will lead, ultimately, to a federal solution that will be neither appropriate nor effective.