Testimony of

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Good morning. My name is Stuart H. Altman. I am the Sol C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management, Brandeis University. I very much appreciate the opportunity to discuss with you my views concerning why this country has recently witnessed the largest increases in health care costs in more than a decade. Per your request, I will focus my discussion on national trends and those specific to Boston and the state of Massachusetts. I understand that your primary concerns center on whether lack of adequate competition among key components of the health system has helped fuel the current rapid escalation in health care spending.

My background as a health economist has primarily focused on understanding national trends in health spending and the changing structure of the US health care delivery system. But, in the spring of 2000 I was appointed by the governor of Massachusetts and the leadership of the state legislature to be Co-Chair of a Task Force to study several serious problems in the Massachusetts health system. The task force was formed following a series of events that demonstrated that many of the critical elements of the states health system---insurers, hospitals, and nursing homes--- were in serious financial shape. During the next 15 months, with the help of senior analysts from the Division of Health Care Policy and Research and a number of well-respected health system experts from around the state, we analyzed the state's health care system. Much of my comments today follow from that study. I would like to provide you with a complete copy of this report that is included in Appendix A. I also would like to include a copy of a paper that I wrote along with several of my colleagues at the Heller School concerning the recent escalation of health care spending. (Appendix B).

I don't think it is possible to understand recent events in either Massachusetts or the nation without an appreciation of the extraordinary changes that occurred in the health system during the decade of the 1990's. In the decade preceding the 90's, few constraints limited health spending. Neither market forces or government programs seriously limited the size and growth of the most expensive components of the health care delivery system and the prevalence of third party coverage dominated by private fee-for-service insurance assured the system that sufficient funds would keep most providers financially sound even though substantial excess capacity existed. Although government ---Medicare and Medicaid--- attempted to limit their hospital and physician payments, higher private payments were more than sufficient to make up the difference. For example, in 1992 while these government programs paid hospitals at rates below (average) costs, private insurers paid rates equal to 130 percent of costs (See Chart 1). These high private payments helped support a hospital system with an average US staffed bed vacancy rate in 1993 of 40 percent. In Massachusetts, the bed vacancy rate was 34 percent. (Throughout my testimony I will at times refer to Massachusetts's wide statistics rather than Boston. Given the history of the state, patient preferences and physician referral patterns to Boston hospitals play a dominant role throughout much of the state. Where applicable and where data is available I will focus only on Boston.)

Faced with high single digit and double digit health insurance premium increases for much of the previous decade, employers in the 90's attempted to lower their costs by encouraging or forcing their employees to shift from traditional fee-for-service insurance into various forms of "managed care".

By 1995, the percentage of workers in the most tightly forms of managed health insurance plans (Health Maintenance Organizations) reached almost 20 percent, up from less than 5 percent 15 years earlier. In addition, more than 30 percent of employees were in some form of managed care plan. The Boston area had one of the highest penetrations of managed care plans in the country reaching 52 percent by 1998. Pressure from these managed care plans helped reduce spending for inpatient hospital use throughout the US and in 1997 it fell by an annual rate of slightly more than 5.0 percent, the fourth year in a row that spending declined (Chart 2). These financial conditions forced many hospitals in the US to reduce their bed supply and others to close altogether. In total, hospital bed capacity in the US declined by 11 percent between 1990 and 1999. A similar trend developed in Massachusetts and Boston. Hospital bed capacity fell by 25 percent in the state and 28 percent in Boston (Chart 3). This reduction in capacity was facilitated, in part, by the consolidation and merging of hospitals and hospital systems. The number of hospitals involved in merger activities reached a high for the US of 768 in 1996 (12.4% of the entire industry) (Chart 4). In Massachusetts 35 percent of acute hospitals were involved in merger activities (29 hospitals) (Chart 5). The combination of mergers and bed closings plus the upward turn in hospital admissions resulted in occupancy rates climbing after reaching a low in 1996 (59% for Massachusetts). By 2001 the Massachusetts occupancy rate had climbed to 64 percent. Some believe the true occupancy rate today is much higher when measured correctly at midday rather than midnight.

The Task Force also focused on issues related to the Physician marketplace in Massachusetts. We received testimony that highlighted the fact that

physician incomes in the state adjusted for cost-of-living was declining (Chart 6). The Task Force and its Finance Working Group concluded, however, that this fact has not deterred physicians from living and working in the state and that the overall per capita supply of physicians in the state is the highest in the country. In 1999, Massachusetts had a per 100,000 population number of licensed and practicing physicians of 454, which was 59 percent above the national average and significantly higher than any other state (Chart 7). Nevertheless, there was concern that in certain specialties including anesthesia, radiology, dermatology and child and adolescent psychiatry some shortages appear to exist.

The Boston area (Suffolk and Middlesex counties) had 10 separate full service teaching hospitals at the beginning of the decade. Through a series of mergers, the number was reduced to 6 systems. Of the 35 acute care hospitals in the Boston area in 1993, 10 closed entirely and bed capacity in the city fell by 2652 (28%). Interestingly, whereas bed capacity of urban community hospitals in Boston fell by 48 percent, the reduction of teaching hospital beds was much smaller (5%). Thus teaching hospital beds as a percentage of total beds in the Boston area increased from 48 percent to 63 percent (Table 1). This result was somewhat unexpected as it was initially anticipated that managed care plans would shift patients away from the more expensive teaching hospitals to less expensive community hospitals. The net result is that Massachusetts patients use teaching hospitals, both inpatient and outpatient, more than any other state and this contributes to the higher per capita health care spending levels in the state (Chart 8). It must be remembered, however, that this trend towards greater use of teaching hospitals persisted during a period of time when managed care insurers were

at their strongest level. My own assessment is that this result was not because managed care plans did not try to refocus patient care, but because of substantial "pushback" by patients and the lack of influence by Massachusetts employers to change this behavior. Massachusetts is dominated by small and/or high tech firms that have not been aggressive in trying to change the health care use of their employees.

In spite of the consolidation in the hospital sector, the financial conditions of hospital did not improve in most markets, and with the implementation of tighter restrictions in federal Medicare payments generated by the 1997 Balanced Budget Act, hospital operating margins in the US declined in 2000 to 2.0 percent, the 4th straight yearly decline (Chart 9). The situation was more serious in Massachusetts. Operating margins for all hospitals in the state for 2000, averaged –1.4 percent. The situation has improved somewhat recently, but the median operating margin in 2002 was only slightly above zero (0.2 percent).

Ironically, the year 2000 was also marked by serious financial conditions for many of the nation's managed care companies. In Massachusetts the imminent financial collapse of one of the state's largest health insurers, Harvard Pilgrim Health Plan, was the principal reason for the establishment of the Massachusetts Task Force. Health insurers, pressured by competition and the goal of increasing market share, kept lowering premiums and spending considerable sums to expand into new markets. This occurred even though by 1997 their underlying health costs were rising.

Much of this picture has changed quite dramatically in the last few years. While managed care plans helped lower health care costs, a serious backlash against managed care developed among providers, patients and politicians. In many states, legislation was enacted to restrict the cost cutting actions of managed care plans. This was particularly true in Massachusetts. More and more physicians and physician groups refused to participate in capitation arrangements with managed care plans. Even many employers, who had been among the stronger supporters of managed care, were unwilling to support tighter restrictions on the use of health care services by their employees. As a result, the market shifted away from those health insurers with the most rigorous forms of managed care. As shown in Chart 10, Preferred Provider type health insurance, which is a much less restrictive type of coverage, now dominates the health insurance market and in 2002, for the first time in recent years, coverage by Health Maintenance Organizations actually declined.

Not surprisingly, with less bed capacity, higher occupancy rates and looser forms of private health insurance, the balance of market power shifted in favor of hospitals and physicians. Also, health insurers changed their tactics and rather than trying to buy market share with premiums that were below costs, they raised their premiums at a rate the country had not seen since the late 1980's. Since 1999, health insurance premiums throughout the US have risen annually by double-digit amounts (Chart 11). A similar trend developed in Massachusetts (Chart 12).

The higher insurance premiums, in part, reflected higher payments to hospitals and physicians. But, it also reflected greater utilization of medical

services. Inpatient hospital use that declined steadily in the early 1990's reversed direction after 1997 and since 1999 it has been growing at positive rates (Chart 2). The higher payments and greater utilization helped improve hospital margins throughout much of the country. As indicated previously margins in Massachusetts's hospitals, however, still lag behind most other areas, with operating margins slightly above the zero mark. For all hospitals in the Boston area, average operating margins in 2002 was somewhat lower –0.4%, and for teaching hospitals only it was 0.67 percent (Chart 13). Although non- teaching hospital margins in the Boston area improved significantly in the last two years, they still registered a –1.84 percent in 2002.

The increases in hospital margins throughout the US and in Massachusetts, while positive, have been limited by substantial increases in hospital expenses. Several studies have suggested that these higher expenses are primarily the result of paying more for several shortage categories of workers and the need for hospitals to add new types of patient care and information technologies. Whether all the cost increases were justified or resulted from inappropriate market power by hospitals and other provider groups is difficult to determine on an aggregative basis. Such a determination requires a case-by-case analysis.

The low margins for Massachusetts hospitals is quite surprising given the general impression that per capita health care spending in Massachusetts is among the highest in the country. This was an issue of particular concern to the Task Force. That is, how is it possible for most of the health care providers and insurers in the state to be in the red when per capita health

care spending is supposed to be so high? Not surprisingly, the answer is complicated. There is no question, on an unadjusted basis, per capita health spending in Massachusetts is substantially higher than the US average. As seen in Chart 14, per capita health spending in Massachusetts was 30 per cent higher than the US average. At least some of the difference in spending, however, results from the greater inflow of medical research funding to the state and the fact that Massachusetts and Boston train a disproportionate number of physicians, particularly at the graduate level. Much of these added expenses for research and education are paid for by the federal government and are included in the unadjusted spending levels. When these outside funds are subtracted and the higher cost-of-living expenses in Massachusetts are factored in, the 30 per cent gap is reduced by about half (16 percent). But, there is little doubt that substantial sums are added to the medical bills of Massachusetts' patients for the uncovered portions of the funds spent by teaching hospitals for education and research.

Medical education and research is a leading industry of the state, and there appears to be little interest in changing this by either politicians or employers. There is also the perception, and the likely reality, that for many patients, the coexistence of teaching, research and patient care generates higher quality care at teaching hospitals. This doesn't mean, however, that all patients treated at teaching hospitals need this higher level of quality and the Task Force concluded that substantial savings could be realized if some patients with less serious illnesses were shifted to lower cost community hospitals. The Task Force urged both state government and the private sector to develop programs to accomplish this end. Ultimately, such a repositioning will require the continued existence of a vibrant community hospital system

in Boston and throughout the state. This is possible if, as is likely, additional hospital beds are needed in the coming decade and a larger share of these beds are developed at community hospitals. It would also require either a voluntary or forced shifting of patients away from the more expensive institutions. Unfortunately, I don't see either of these events happening. Patients have shown no willingness to change their hospital preferences and physician referral patterns continue to favor teaching hospitals. These forces could not be stopped when managed care power was at its height and surely they will persist in the current, less restrictive, health insurance environment. Further, the financial condition of most urban community hospitals in the state is very weak, and they will not be able to secure the necessary capital for such expansion. In fact, several more community hospitals could close in the next few years without the intervention of state and local governments. During the year and a half tenure of the Task Force, three community hospitals were within days of closing and were saved by the intervention of government. However, the financial conditions of state and local government make additional interventions highly unlikely.

The Task Force reported that Massachusetts' patients use the outpatient services of teaching hospitals more extensively than patients in other sections of the country (Chart 15). This also adds to the higher spending rate in Massachusetts. On the negative spending side, the private hospital payment to cost ratio in Massachusetts is the lowest in the country. For example, this ratio was 96.4 in 1999, suggesting that Massachusetts' hospitals received lower private payments per patient than the average cost of care. The average private payment-to-cost rate for all hospitals in the US was 112.3 (Table 2). Thus, there has been and continues to be a much

smaller hospital mark up above costs for private patients in Massachusetts than in other states. There is also evidence to suggest that the fees paid for physician services are lower in Massachusetts than in some other sections of the country. The net result is that actual health care expenses for private patients in Massachusetts, while high, are only slightly larger than the average for the US. In 1998 the monthly premium differential in Massachusetts was 12 percent higher than for the US as a whole (Chart 16). A comparison of the health insurance expenses in Boston with other major metropolitan areas shows a similar result, with Boston health insurance costs per employee 10% above the average for these cities (Chart 17). Thus, while there are a number of unique forces affecting the Massachusetts and Boston health care markets, many of the same factors that are pushing health care spending levels to almost record growth rates in this state are operating throughout the country as well.

In summary, I am quite pessimistic that the current escalation in health care spending will soon slow down. New and expensive technologies continue to come on line, hospital capacity and use of in-patient care and other expensive services that had been declining is now growing, there are much fewer constraints being imposed by health insurers, and the population is aging. The paper I co-authored that appears in Appendix B goes into more detail on why we believe that this upward trend will continue. Although I support the need to preserve and enhance competitive markets, I do not believe that anti competitive behavior on the part of providers or insurers was a key factor in the recent growth in health care spending. If mergers had been an important factor in the escalation of health care spending and the improved financial condition of hospitals and other providers, it is likely that

this trend would have continued. In fact, there is less consolidation today in the provider system than there was 5 years ago. Hospital merger activity has reached its lowest level in more than a decade, and there appears to be more divorces of old mergers than creation of new ones. Similarly, any consolidation in the payer market has had limited effect on the health care spending trend. There is growing evidence that the balance of power has shifted away from payers in most markets with payment amounts and service use increasing. This does not mean that there are not examples of inappropriate and perhaps illegal behavior on the part of providers or payers, or that in some markets reduced choice has not affected spending rates, but rather that such behavior has had relatively little impact on the overall current inflationary trends in Massachusetts, in Boston, or the country.

We as consumers and politicians forced the market to eliminate many cost containment activities, to make available complete freedom of choice of our health care providers and to limit the restrictions on what services we use or how much they cost. We also endeavored to preserve comprehensive health insurance protection with limited patient cost sharing. Insurers, hospitals, and physicians responded and the result is our current rate of health inflation. True, many health care professionals (and politicians) sided with consumers, or were in the vanguard of those who fought managed care and restrictions by government. But, in the end, it was we, as American consumers that demanded more access to the most expensive forms of medical care. If reform is to happen, it must start with a change in attitude among consumers (and voters). The current jump in health spending with employees paying a much larger share of the cost may help to change consumer attitudes. However, we can't expect consumers alone to change

the growth trend of health spending. They will need help from insurers, providers and employers. They will also need the active assistance of government. The FTC and DOJ can surely help. Collusive activities among providers or insurers that prevents consumers from having meaningful choices of options must be prevented. But government must do much more. In our paper (Appendix B), we outlined a number of activities that government can undertake to assist in lowering the spending growth rate to levels that can be sustained over time.

Thank you for the opportunity to make this presentation.