



Testimony to the Joint Committee on Health Care Financing

by Joshua Archambault

Monday, May 16, 2011



Testimony on H 1849 “An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments”

Thank you to Chairman Moore and Chairman Walsh and to the Committee members for the opportunity to speak with you today. My name is Josh Archambault, Director of Health Care Policy at Pioneer Institute.

The issue before the Committee today—the Governor’s proposal¹ to change the payment methodologies for the delivery of health care—would as currently written set up a framework for momentous regulatory intervention in the health care marketplace, and possible significant adverse impacts on health care access and spending in the Commonwealth.

The issues of greatest concern are:

- 1) The Heavy Hand of and Role of Regulation:** The 26 + instances in which major policy decisions are left to be made in the regulatory process.
- 2) Accountable Care Organizations or Bust:** The overreliance of the proposal on Accountable Care Organizations while the data on cost savings and health outcomes is mixed at best, and nonexistent for many quality measures.
- 3) Where is the Consumer?:** The lack of serious engagement of consumers with decision making tools and financial incentives to empower them to be better consumers of both health insurance and health care services.
- 4) Timing & Expectations:** The realistic timeframe for reform to have a reductionary impact in health care spending is at least 5-10 years, with an increase in spending likely in the short term. In other words, the Governor’s plan is a long term play. These reforms will mean little to small employers that are seeing double digit premium increases for the third or fourth year now, and that trend will not change under this plan.

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5) Medicaid: The Medicaid program accounts for over 30 percent of the state budget, and is crowding out spending on other public goods and providing suboptimal access to health care services for the population served. From a state budget perspective, any health care spending containment strategy must tackle reforming this program.

There is near universal agreement that the upward trend in health care spending is unsustainable and the current system provides perverse incentives. However, I think it is important to emphasize that payment reform is a means to an end, not the end in itself. The goal of any bill should not be to establish a majority of accountable care organizations (ACOs) or to have lots of different payment methodologies in place, it should be to provide the best quality care while simultaneously reducing the increases in health care spending. I worry the Governor's bill relies too heavily on the regulatory process-- and the discretion of regulators and state officials-- to regulate and rate-set our way out of the health care spending problem.

The Commonwealth doesn't have a cost problem, we have a spending problem. A cost problem suggests you should price set. Simply setting prices will just get you "less costly" procedures, with more price shifting of course, but not better care. Our spending problem is that we spend too much on procedures that people don't value the outcomes. It is estimated that 30-40% of spending is on unhelpful care. We need to organize a system in which the spending decisions are ultimately with the family and not a bureaucrat.

At its most basic level, the bill is attempting to return a majority of our health care system to a form of capitation. Not a bad thing per se, but a situation all stakeholders should be entering into with their eyes wide open. Any effort to control health care spending needs to focus on engaging consumers, promoting transparency of cost and quality data, targeting the 20% of patients that account for 80% of health care spending, and reform the Medicaid program.

Finally, and certainly not unimportant, is the timeframe for this proposal. The crisis of health care insurance increases for small companies in

Massachusetts is now. Many of them will struggle to keep offering insurance while they wait for the 5-10 years that are needed for any comprehensive payment reform changes to have an impact.

It is important to acknowledge, there are two fundamentally different ways the Commonwealth can choose to "bend the cost curve." The first is some form of the Governor's proposal of regulating the market into submission. The economic issues of this approach are many and quite weighty. There is the real possibility of our health care market becoming less competitive and innovative, more consolidated, and much more expensive under the vision being laid out.

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The second approach is one in which the Commonwealth lays out a very broad framework to incentivize integration, innovative service delivery, and rewards consumer engagement. This approach produces fewer economic issues and is much more likely to lead to long-term savings.

Accountable Care Organizations (ACO)

Policy changes do not operate in a vacuum. Federal law and regulations will translate into big change for Massachusetts, especially on the formation of accountable care organizations (ACO). The Governor's bill includes language that states as such-- the proposal is meant to be consistent with any applicable federal laws or regulations governing ACOs. The March 31st release of federal guidelines for Medicare ACOs, are widely expected to shape the characteristics of all ACOs in the marketplace in the future. So we must take the reaction from stakeholders seriously to the proposed regulations. Simply put, they have not been positive.

The health systems that are seen as the closest to the ACO model already—Mayo Clinic, Geisinger Health System, Intermountain Healthcare, Cleveland Clinic—have publically stated that they will not participate in the program due to numerous concerns about the risk level of losses, disincentives to take care of patients with lots of health care needs, and quality measures that go into effect too quickly. A recent American Medical Group Association survey found that 93 percent of their members would not enroll either. But why?

The research on government sanctioned ACOs are not promising. The best test case is probably the Centers for Medicare and Medicaid Services’s (CMS) demonstration project with the Physician Group Practice (PGP). Dr. Trent Haywood and Keith Kosel’s study “The ACO Model — A Three-Year Financial Loss?”² examined the data from the demonstration. The prognosis was bleak.

While ACOs may have great promise in helping to reform our health care delivery system, it is clear they are not a panacea, and their complexity should cause policymakers to pause before forcing patients and providers into them.

Dr. Haywood and Kosel conclude from the outcomes of the demonstration that for an “ACO making the mean initial investment of \$1.7 million [they] will require the unlikely margin of 20% for the 3-year period envisioned by CMS.” With a 5-year time horizon, the required margin to break even is lowered to 13%. However, as the CMS regulations lay out, the current Medicare Shared Savings Program anticipates a minimum performance period of only 3 years. It is hard to imagine ACOs being economically able to return 20% profits every year, or politically inclined to do so. This analysis should pose serious questions about the assumption that ACOs will realize significant savings in the near future.

An additional savings concern is the need for community hospitals to be properly equipped to be

a cornerstone of any ACO it participates in. The Governor’s bill is silent when it comes to the challenge of getting community hospitals in a financial and technical position to be able to accomplish this goal.

There are also legitimate concerns about ACO market power. Dr. Robert Kocher, former Special Assistant to the President for Healthcare and Economic Policy, along with his co-author, found in another paper that the incentives inherent in the ACO model are for hospitals to pick up more physicians— possibly leading to greater market power.³ A real concern is the potential for hospitals to convert greater market power into higher prices and less competition. Mindful of the findings of the Attorney General’s report which “determined that high prices and price variation are largely correlated with market share,” this is a troublesome incentive in the ACO model.⁴

While ACOs may have great promise in helping to reform our health care delivery system, it is clear they are not a panacea, and their complexity should cause policymakers to pause before forcing patients and providers into them. If the Commonwealth takes a heavy regulatory approach they will need to have reliable answers for many of these questions before proceeding forward.

- How formulaic will ACOs have to be to get approved?
- How will payments work for referrals outside of an ACO?
- What will prevent HMO v2.0 backlash?
- How will care received out of state be handled?
- Who finances care provided at an ACO emergency room for uninsured folks that live in Rhode Island or New Hampshire?
- How will federal employees with federal insurance be impacted by reform?
- Why does the Governor’s bill not include Civil Monetary Penalty Law (CMP) in the federal laws to be waived?⁵
- Will there be minimum provider participation requirements for an ACO to qualify?

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- Where do the resources for upgrades to information technology for community hospitals and smaller ACOs come from?
- Will smaller ACOs be equipped to take the amount of risk management that is required under the proposed federal regulations?
- How will the Division of Health Care Finance and Policy (DHCFP) know whether or not an ACO possesses the competencies necessary?
- Will all ACOs be required to take the same amount of risk in Massachusetts?
- Can low cost, high quality fee-for-service providers still serve lower cost patients, such as those between 18-35?
- June 2015 is the date set for ACOs to predominate in Massachusetts. What is the state going to do to push this? The bill contains very little detail on this matter.
- What role will “minutes clinics” play in an ACO?
- The economic incentives for ACOs are to under provide care for patients. What are the safeguards to prevent underutilization of services and protections against inappropriate denials of services or treatment? What is the appeal process for those needing immediate care? Will there be additional costs to increase the load at the Office for Patient Protection (OPP)?
- Will health outcomes data be collected to determine which ACOs are working?
- Who is financially responsible for the clinical outcomes beyond the control of a clinician? The bill says clinicians will not be held liable. Does this mean insurers, consumers, or the state?
- How will capitated, bundled, and global payments be set?
- If ACOs are utilized in Medicare and Medicaid plans, how will alternative payments compare to the current under reimbursement levels?
- Is there a limit to the number of ACOs a specialist can practice in?
- Can a doctor see both alternative payment and fee-for-service (FFS) patients? Can an ACO provider group include FFS patients? What percentage of FFS?
- What are the tools to keep a patient in an ACO? The draft federal regulations contain none.
- How will patient records be shared from ACO to ACO, or with non ACOs? Will ACOs be allowed/required to share that information? How will the Coordinating Council know what percent of care is provided outside of an ACO? How will that information be reported? Will it get back to the original ACO of the patient?
- How far reaching geographically will an ACO be allowed/ or are limited to be?
- How will the AG prove that providers are cost shifting to recoup charges? The economic incentives under an ACO is to cost shift heavily especially on any remaining FFS patients.
- What is the threshold for excess consolidation in a marketplace? Under the proposed federal standards, some believe, Partners Healthcare would not reach that threshold, and we have seen the resulting price disparities of that.
- Why does section 17 subsection 5B appear to prohibit provider bundling of services? For example, a teaching hospital would be prohibited from requiring coverage at their community hospitals. Doesn't this prevent integration of care, the goal of ACOs?

Alternative Payment Methods

One of the most interesting, and often overlooked findings of the Attorney General's report on cost drivers, was that the method by which a provider was paid did not correlate with better quality care, or even less expensive care.⁶

The theory of switching to alternative payment methodologies is sound, and some anecdotal evidence seems encouraging. Yet it remains questionable how the Legislature and the Governor can endorse a proposal in which a largely unaccountable commission pushes a majority of providers to an unproven alternative payment method that fails to fully engage patients. Perhaps a formal test is needed

with objective inquire for different kinds of payment methods. An independent review would be necessary in order to provide analysis and future guidance.

Health Care Resource Planning:

There are two ways to slow the spending associated with new health care infrastructure. The state can set up regulations that act as caps or market interventions to attempt to control spending. The other is a more useful and empowering process. For example, re-imagining the regulatory environment behind Determination of Need from one that simply rejects the building of health care infrastructure, to one that rewards institutions that promote integration in their care model. While the goals of a resource planning process make sense from an academic perspective, the practice must be understood in a larger discussion of tradeoffs.

- What are the tradeoffs for future innovation with a strict determination process?
- Will the Department of Public Health (DPH) ever be in a position to politicize the health determination process?
- Would it be possible for them to force providers to open a service in a rural area before opening another different kind of service the provider would prefer?
- Why aren't there any representatives from the provider community on the health planning council to determine what the projections for need are for 5 years?
- Is the Commonwealth locking health infrastructure inequalities into place?

Division of Insurance (DOI) “enhanced tools” to review premium increases

The Governor often publicly states that one of his greatest accomplishments in health care has been the Division of Insurance’s rejection of premium increases. However, one year of average base rate increases of less than 10 percent is “kicking the can” down the road, since many small companies are receiving double digit premium increases for the third or fourth year in a row.

While the rejected premium increases made for good political rhetoric, what will the situation look like in 3-5 years if business owners are renewing for the 4th or 5th time in a row at a 15-20% increase, even with automatic rejection of some premium increases? Or what will the products on the table look like from the non-profit insurers that are taking losses? How long will they remain in the State?

The ability for rate setting by DOI in the bill, is not only unwise, but will have significant long-term negative impacts in the market. Rate-setting often leads to gaming of a system to try to take advantage of the rules, and sets up the possibility to pick winners and losers. In addition, as written, the bill would not allow for regional differences in rates. I think the Chairmen will agree that medical care does not look exactly the same in Uxbridge as it does in Lynn. Questions to consider are:

- What are the tools to pressure providers to reduce costs when DOI is rejecting carrier’s increases?
- Will there be lawsuits from providers as insurers seek to break contracts? That seems to defeat the overall goal of this bill to reduce costs.

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Coordinating/Advisory Council

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The Council is tasked with making sure data submission and other requirements are implemented

in order to not unduly burden any entity or individual, they should be mindful that feedback from the federal CMS ACO guidelines have been widely criticized for this exact burden.

Malpractice reform

Pioneer will be releasing a policy brief on this matter soon and will reserve comment until that research is finished.

The caution I bring will be echoed by many others today, what I lack is a financial interest in the outcome of any bill that passes. Instead, I am here today to stress the importance of engaging consumers in any change of the health care delivery system. Without more informed quality and cost conscious consumers, we will return back here in 5 to 10 years to determine the next top down approach to contain spending. My advice is to go slowly now, and get the incentives correct the first time, instead of regulating a strategy into practice that has limited data and mixed outcomes.

About Pioneer

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to improve the quality of life in Massachusetts through civic discourse and intellectually rigorous, data-driven public policy solutions based on free market principles, individual liberty and responsibility, and the ideal of effective, limited and accountable government.

Endnotes

1. H 1849 “An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments”
2. Trent Haywood, M.D., and Keith Kosel. (2011) [The ACO Model — A Three-Year Financial Loss?](#) *New England Journal of Medicine*. March 23. Available at: <http://healthpolicyandreform.nejm.org/?p=13937>
3. Robert Kocher, M.D. and Nikhil Sahni. (2011) [Hospitals’ Race to Employ Physicians– The Logic Behind a Money-Losing Proposition](#). *New England Journal of Medicine*. March 30. Available at: <http://healthpolicyandreform.nejm.org/?p=14045>
4. Ibid.
5. A CMP waiver would apply to distributions of shared savings where hospitals and physicians are each ACO participants or providers/suppliers, so long as payments are not made knowingly to induce limitation or reduction of medically necessary services. My understanding is that a CMP waiver would be needed so that a state ACO contract would not be considered a financial relationship, remuneration, or an inducement for Stark II, AKS or CMP purposes.
6. Office of Attorney General. (2010). Examination of Health Care Cost Trends and Cost Drivers. March 16. Available at: http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf
“Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for risk-sharing providers than for providers paid on a fee-for-service basis.”



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