Can Massachusetts and The U.S. Moderate Growth In Healthcare Spending?

Stuart H. Altman

Sol C. Chaikin Professor of National Health Policy
The Heller School, Brandeis University
The Issue Is Not Whether It Is Possible To Control The Growth In Healthcare Spending

The Issue Is Whether Massachusetts or the U.S. Has The Political Will to Control Healthcare Spending
Up To Now The Answer Has Been---NO!
Massachusetts and the U.S. Has Tried To Control Health Spending In The Past ---

*BUT***---With Limited Success and For a Limited Time Period*
WHY?
Those Who Stand To Lose Convince Enough of Us That ---

• It Will Lead to Lower Quality Care?
• It Will Reduce Access to Care
• It Will Reduce The Number of Jobs Healthcare in Our Community?
• It Won’t Work
Will The Future Be More of The Same?

I DON’T THINK SO!
The “Boogey Man” Is Demographics (Medicare) and Growing Numbers of Medicaid Patients

*If We Don’t Find a Way To Change The Economics of Health Care Most Providers Will Face Declining Prices For Their Services*
Even Without Health Reform ---
Government Patients Will Dominate Institutional Expenses

Proportion Of Hospital Expenses Attributed To Patients By Payer Source
Will Hospitals and Physicians Be Able to Rely On Charging Private Patients More To Make Up For Lower Government Payments?

Unlikely!
Can Private Insurance Payments Continue To Pay For The Shortfall In Government Payments

Hospital Payment-to-Cost Ratios
(Government Ratios Maintained at Current Levels)

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2005, for community hospitals.
(1) Includes Medicaid Disproportionate Share payments.
Is There An Alternative To a

HEALTH CARE BROWN-OUT

The Alternative Is Lower Service Payments Which Will Occur as Greater Proportion of Patients Paid by Medicaid and Medicare
Is The Federal Health Care Reform Defined---
“Accountable Care Organizations (ACO’s)” The Answer?

Sounds Nice But What Are They Anyway?
Many Alternative Approaches To Redesigning Payment and Delivery System
Federal ACO’s are Designed To Avoid Main Problems of HMOs of The 1990’s

• Providers Will Not Be Required To Assume Risk
  – ACO’s is a “Shared Savings System”. Each Groups Starts From Their Current Spending Levels

• Patients Will Not Be Locked Into a Delivery System They Don’t Trust
  – Patients Need to Sign Up With PCP But Can Change PCP or Network With No Penalty
Different Possible Models of ACOs

• Primary Care Physician Groups as Major Sponsor
  – Contract With Specialists and Hospitals
• Multispecialty Physician Groups
• Community Hospitals as Sponsor
• Major Teaching Hospitals
• Health Plans
A Possible Alternative

Massachusetts Blue Cross/Blue Shield
AQC is One Option
Key Issues

- Against What Benchmark is a Provider Group Judged
- Do Provider Groups Take Some Risk
- Are Patients Required To Join a Provider Group
- Can Patients Seek Care Outside Group and If So Are There Penalties
Some Economists Concerned That a Limited Number of Integrated Delivery Systems Could Lead to Higher Costs!!!

Could Create Mini-Monopolies That Will Control Prices.

Are There Penalties for Exceeding The Budgeted Benchmark?
Many Provider Organizations Are Considering Creating a ACO Type System

But Some Are Concerned About The Need for Upfront Expense:---Could Innovation Center Funding Help?
We Will Hear About Several This Morning!