Paul Hattis Testimony on Behalf of GBIO Re: Setting 2018 Cost Growth Benchmark

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I am Paul Hattis, a member of the Strategy and Health Care Teams of the Greater Boston Interfaith Organization, a community organization representing about 50 primarily religious congregations who come together to advance social justice.

Thank you for the opportunity to allow us to testify on this important policy topic and hear why we strongly believe that the benchmark should remain at 3.1%.

When the 2012 Cost Containment Law in our state was being negotiated, GBIO along with the Associated Industries of Massachusetts, strongly advocated that the Legislature create an overall health care spending benchmark. We continue to be struck by the staggering estimates of waste in health care spending in our country and of course, even in our own state. Academics, (including Dr. Berwick, our Consumer Advocate on the HPC), have consistently published estimates that somewhere between 20 and 35% of all health care spending adds little value. At the last HPC Board meeting, health economist and HPC Board Member David Cutler, noted that in his own conversations with health care executives, they estimate about 25% of hospital spending could be cut without any harm to overall patient care.

In 2012, based on this evidence and the perception that the Massachusetts health care delivery system seemed indifferent to this amount of waste, we advocated for a benchmark of GSP less 2% for a period of about five years. Our 2012 recommendation came after seeing data showing compounded growth in personal health care spending since the mid-1960s at a rate of GDP plus 2 to 2.5%--though admittedly a bit slower in the last few years. We live in a state with some of the highest health care spending in the world. Targeting a level for a state benchmark where there is some pressure to cut waste and in so doing, restrain growing the portion of GDP devoted to health care seemed prudent to us—given all of the other demands for resources to make our lives better. With a health care industry that had been advocating for GSP plus 2% during the debate over Chapter 224, we accepted the 'split the difference' solution which created a benchmark that set the benchmark at PGSP for 5 years followed by 5 years where targeted spending would be slightly less than the predicted growth of the economy.

We arrive now in 2017 where the exercise of annual economic forecasting of predicted real economic growth plus inflation (PGSP) has resulted in the setting of a cost growth benchmark of 3.6% every year. We all have observed that for the first three years of available data, the overall annual per capita THCE growth, with some annual variation, has averaged just under 3.6%. However, I highlight the fact that the actual nominal GSP growth in the state for the period of 2012 through 2015, averaged just over 3.4% on an annualized basis. So, even though we can say that we have averaged an annual THCE per capita growth rate essentially at the benchmark, the amount of resources actually devoted to health care spending as a percentage of GSP in Massachusetts has risen slightly since 2012.

So based on this history and reality alone, a fair argument could be made that leaving it at 3.1% is really just part of an effort to support a bit of a catch-up towards the initial 5 year goal that the legislature gave us—to more or less hold total health care spending to the same GDP level back in 2012.

But I think there is even a more compelling reason that should lead you to hold the line at a 3.1% benchmark set by the current law.

Even with the Republican plan now public, a good deal of uncertainty remains over what will happen in Washington with national health care policy—including with Medicaid. The newly revealed Trumpcare plan for Medicaid appears to ultimately reduce the flow of Medicaid dollars to states by proposing a per capita amount based on how much each state was spending per capita in fiscal year 2016. Though not clear what amount of per capita growth will be allowed for the fiscal years before 2020, I would imagine that in our state, this issue could be dictated by the approved Medicaid waiver. In any event, when you combine these proposed Medicaid changes with the very little growth in recent years for Medicare per capita spending (1.4% per capita annually 2010 to 2015), the likely net result from these government payer trends is, as Chairman Altman has recently warned, that commercial spending is left to be 'the ATM' for the health care provider industry. Imagine the pressure this will create in commercial price negotiations as providers seek to grow revenues on a per capita basis going forward.

So given this reality—it seems to us at GBIO, that this is no time to take the 'foot off the brake' in terms of the overall THCI benchmark. In a positive way, the insurers will tell you, that the psychological effect of the benchmark has affected health care negotiations and has likely resulted in less spending on physician and hospital care since the 2012 law went into effect. Yes, there are certain factors which are difficult to control like pharma prices and demand for new, specialty drugs. And yes, if overall drug spending per capita rises further because of pricing or innovation, this will eat up some of the 'allowed growth' related to the benchmark. But we are all smart enough to look at the data, and adjust our thinking and our rhetoric accordingly. And yes, you Commissioners have the discretion with respect to whether or not to impose a Performance Improvement Plan on an individual insurer or provider group even if they are above the benchmark.

But to respond now by raising the targeted benchmark up from 3.1 to some higher number permitted—the highest being 3.6%--seems to be the wrong thing to do and the wrong message to give in this year of uncertainty. No matter how it all shakes out—system, business and household affordability demand that we reduce health care spending. And I remind you all, that if government per capita growth is likely to be much less than the benchmark—this already allows for higher growth than the overall benchmark on the commercial side.

I worry, that should you push the benchmark up to 3.6%, you are giving permission for *an additional $300 million dollars of essentially, commercial spending* to take place. Monies that come out of consumers' and employers' pockets. It is also no secret that out-of-pocket spending for people is growing faster than the state benchmark each and every year in the private insurance space.

And unless some sort of price variation scheme along the lines of the Governor's proposal or some other approach which constrains what the well paid providers can receive for rate increases, we all know who will be first in line to claim their share of that additional commercial spending. And no--it isn't our independent community hospitals and physicians who generally get a piece of that action…it is our crown jewel hospitals and their physician groups who, with their market power, push to the head of the line to grab that money. That is the reality we see year in and year out.

Your job Commissioners is to try *to protect us* from that likely reality—*not to hasten it.*

Thank you for the opportunity to provide testimony today.