Paul Hattis Testimony on Behalf of GBIO Re: Setting 2019 Cost Growth Benchmark

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I am Paul Hattis, a member of the Health Care Team of the Greater Boston Interfaith Organization, a community organization representing about 50 primarily religious congregations who come together to advance social justice, including issues related to access, cost and quality of health care.

Thank you for the opportunity to allow us to testify in this second annual hearing that is focused on whether the HPC should recommend raising the GBIO-AIM growth benchmark level of 3.1% to a higher level--as much as 3.6% target for 2019. Like last year—we say to you again: DON'T DO IT!

As I testified to last year, 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 which needed to be set for some number of years at a level that is less than the expected growth of our state economy. The legislature responded to our two organizations' call by setting the level at 0.5% less than the predicted growth in the economy for years six to ten following the passage of the law. We now find ourselves in that period.

Despite some success in MA since 2012 in moderating our annual spending increases as compared to the prior decade's trend, GBIO continues to be struck by the staggering amount of waste in health care spending in our country and of course, even in our own state. While there are many causes--a recent JAMA article by Papanicolas et al reminds us that the late Uwe Reinhardt's observation that "It's the Prices Stupid"—meaning: it is unjustifiably high commercial prices paid to providers or vendors that contribute significantly to wasteful healthcare spending in the US. This is what distinguishes our health care system from other OECD nations. And we know from the data that you, the HPC, site every year in your reports, that problem is even exaggerated in our state with health care providers, where over 80% of care is delivered by providers who are paid prices in the highest two quartiles of comparative pricing. And of course, added to that, as you continually note, is that some of our providers with significant market share and/or brand name in that highest quartile are paid supra-normal prices because of unchecked bargaining power.

The failure of our state legislature to deal with that source of waste is indefensible. Though the Senate in this session to its credit, has passed a provision to try to begin to deal with provider price variation; let's see what the House does this spring. I could not think of a better way to honor the memory of Representative Kocot than for his colleagues to pass a law this spring which reduces the overpayment to a few hospitals to help support the needs of the underpaid providers—all while keeping total health care spending in check.

But in the face of this gaping price variation wound: *Commissioners*--keeping the benchmark as low as possible under the law—while admittedly a weak band-aid for legislative inaction against price variation—at the margin, we think has some value for adding a bit more discipline to commercial price negotiations. Yes, even with the most powerful providers. Said slightly differently, if you decide to recommend raising the total spending growth benchmark—if it does influence real health care spending—it is because that higher conceptual level primarily drives the commercial prices providers are paid, not the utilization. So if you decide to raise the benchmark to 3.6%---people won't get more care,

there will only be a conceptual kitty for market participants to fight over for price increases, which would then be $300 million or so larger than it needed to be.

Why give away our money like that?

Let me turn to a second reason for maintaining the GBIO-AIM Benchmark of 3.1%

As our good Chairman of the HPC often notes—the Commission is not a regulator. The power is primarily bully pulpit power. That is generally true—although I'm not sure you are exercising your modest, but real regulatory power to the extent that you really have it. For example, I and everyone else here, are sitting and waiting for the first Performance Improvement Plan to come down. Just sitting and waiting….

In addition, as you know the new drumbeat of developments this year in the provider acquisition space, has lead DPH, a regulator of sorts, to propose some conditions on acquisitions that it reviews as part of the DON process.

Specifically, after your review of the Partners proposed acquisition of Mass Eye and Ear, where your report noted that spending could increase by tens of millions of dollars annually if Partners was allowed to raise MEE prices to the levels that it currently extracts from insurers for its hospitals, that very fine report moved DPH to spring into action--and attempt to write a set of conditions tied to its giving approval to the proposed acquisition. While it is beyond the scope of my testimony today to detail how DPH could and should have crafted a better and more thoughtful set of conditions then it did—suffice it to say, they did write one condition for that acquisition that ties the annual allowable price increase for MEE rates to the level of the cost growth benchmark.

In addition, DPH has now come out with a set of proposed conditions for the BI-Lahey et al merger *before* you have finished your analysis and report—conditions which one hopes--can be modified or improved, if warranted, based on your analysis of that transaction. While it was unfortunate that they couldn't wait for your report, I do understand that this was not an intentional front running maneuver on their part; as DPH is required to respond to their own statutory deadline under the DON laws related to their review of applications.

In any event, their proposed set of conditions for BI Lahey et al includes one tied to total per capita TME spending, where it appears that they are making a requirement that TME spending growth each year for the combined health system's (i.e. primary care practices') measured patients to be no more than the benchmark rate in effect each year.

My referencing these DON approvals with conditions is to drive home the point that at least for these affected providers—your keeping the benchmark at 3.1% will likely lead to less total spending in our state than if your raise the 2019 level to 3.6% Mr. Chairman and Commissioners—even with primarily bully pulpit power, here is a real spending control opportunity that you can directly affect by your decision about the benchmark level.

Finally—and perhaps most compelling to GBIO from a social justice perspective, is the very thoughtful, recent, Health Affairs article on US Health Care spending written by Commissioner Cutler. Let me quote from his conclusion: "Every dollar that is spent on medical care is one less dollar available for addressing the problems of an unequal society, and one more dollar that is difficult for much of the

population to pay. One of the goals for health policy must be to reduce social and economic disparities, not increase them."

Professor Cutler is reminding us, that sadly, in the US, health care financing is a regressive enterprise. It doesn't have to be—but the way we currently do it—and you can read his brief article to understand the causative factors tied to both governmental and commercial health care financing--means that the more we spend on healthcare, the more we tend to create greater inequities for those who are economically in the bottom half of American society—increasingly really for more than half of American society—including for many residents of our state.

So keeping the benchmark growth rate as low as possible under the law at 3.1%--is at least one important way for the HPC to say that it is on the side of those wanting to reduce disparities between the haves and have nots in MA.

Thanks for the opportunity to testify today on behalf of GBIO.