**Donald M. Berwick, MD, MPP**

**131 Lake Avenue**

**Newton, MA 02459**

8 April 2022

Health Policy Commission

50 Milk Street, 8th Floor

Boston, MA 02109

Dear HPC Colleagues:

Due to international travel, I am unable to attend our important April 13, 2022, meeting. I regret that, and would like, in the alternative, to share some thoughts in writing. In so doing, I know that am not benefitting from the discussion that will occur at that meeting, which would, of course, have further shaped my views.

I believe that we should set the next benchmark at 3.1%. My reasons are as follows.

The Massachusetts legislature was wise to have enacted Chapter 224. In passing that law, and setting up the supportive functions of CHIA and the HPC, the legislature was recognizing a difficult fact: that rising total health care costs in the Commonwealth were, in effect, confiscating opportunities for honoring other worthy public and private priorities, and that, without external forces, the health care delivery systems and health plans themselves were unlikely to exercise the self-restraint to return resources to those other uses, or to limit their own further growth.

This is serious effort to enhance the overall vitality, equity, and social investment in our communities. Priorities other than health care are urgent and meaningful in people’s lives; priorities like education, transportation, supports for aging, housing, and more. We can see the threat to those priorities in the numbers so ably brought forward by the dedicated staffs of CHIA and the HPC year after year – a soaring share of the budget going to health care, rising much faster than inflation or wages year after year. Health care premiums chewing into pocketbooks. More poignantly, we can hear it, year after year, in the testimony at our annual Cost Trends Hearings from small businesses, consumer representatives, and people in touch with the out-of-pocket burdens on our residents, especially, but by no means only, residents with lower incomes.

No doubt, health care in our Commonwealth is a crown jewel; we should nurture and protect it. But a balance must be struck, because what health care takes others do not get. Every nickel health care spends comes from the people of the Commonwealth – its workers – who have many needs beyond health care.

Thanks in part to Chapter 224, CHIA, and the HPC, we have bent the curve, slightly. We would be more out of balance without it. But we are not in balance between the interests of health care and other worthy interests; far from it. Massachusetts remains the second most costly state in the union in per capita total health care spend. We are nowhere near the lowest; nowhere near even the median. And without considerable external pressure, the health care system, itself, will not find the will to change that.

The benchmark we set is not a prediction; it is a prescription, informed by our best guess at the needs of the people of the Commonwealth across the board, not just for health care. Unless that prescription is clear and forceful, change will elude us.

It is, of course, a difficult year in so many ways – not least the pandemic and the high rate of inflation. Those who argue for a high benchmark, will cite those pressures on health care. My reply is that those pressures are on all of us – ask small business owners, workers, taxpayers, and social service agencies — and it is exactly those pressures that make it more important, not less, for health care to own its job of reducing costs now. I am confident that health care systems can do so without harm to patients, but only if they are required to. Health care’s easiest answer – its answer for decades – has been to raise prices, not to change delivery so as to reduce costs while protecting patients, and it is prices, more than anything else, that have driven our Commonwealth’s total costs of care skyward.

To advocates who claim special pleading for health care given recent inflation – that health care, above all other sectors, must be protected against consumer price inflation, I would point out that, literally for decades, health care prices in the Commonwealth have been rising much faster than inflation; those increases have been compounded mathematically and are now baked into the price structures. As our staff have reported, between the years 2000 and 2020, average total costs of family health care premiums in Massachusetts rose from $7,341, to $21,965. In that same interval, the cost of a compact car in dollars did not change at all. By that measure, health care has already been protected far more than have workers’ wages, small businesses, or people on fixed incomes. And remember, a benchmark of 3.1% is still an increase, not a decrease, in total expenditures. I wonder what sectors, other than health care, would not be delighted and surprised to be guaranteed that.

In our 2021 Annual Report, the Health Policy Commission laid out a set of recommended policy changes to give our state more tools for containing health care costs, aiming for better results than we have seen so far. I urge that the legislature study and act on those recommendations as quickly as possible. Meanwhile, we, the HPC, can only use the few tools we do have, and the most significant one among them is the benchmark. It is a signal of what this Commonwealth needs to do to preserve and enhance its total vitality as a total community, using a wider visual field than just its health care systems.

I am aware that setting a benchmark of 3.1% (as opposed to 3.6%) would trigger legislative review of our recommendation. I would welcome that. After a decade of work by the HPC, the legislature would be well-advised to revisit its original intention, and test again its own will to contain our health care costs so that the fuller needs of the Commonwealth can be better met. I would hope that, in so doing, it would conclude, as we have, that stronger measures will be required to achieve success, such as those we have recommended and beyond.

One final point: All regulatory agencies in government properly exercise discretion in their use of their statutory powers. So should the HPC. Within the broad array of health care organizations potentially subject to the 3.1% benchmark are many in truly special circumstances and with whom the HPC should use special discretion: safety-net providers, small and sole-source community hospitals, those with an especially large Medicaid share, those whose prices are already low for this state, and those who have already exhibited discipline in lowering prices. HPC’s scrutiny and action should be concentrated to the extent feasible on higher priced providers, those serving a lower proportion of economically disadvantaged communities, and those who have not already taken effective action to reduce prices.

Our health care community is truly a brilliant one, full of innovators, dedicated staff, and capable leaders. For its total wellbeing, this Commonwealth needs that brilliance focused fully on the Triple Aim: better care for individuals, better health for populations, and lower per capita cost. I have no doubt we can achieve that combination, but the will for the third component – lower cost – is essential. It is in part to provide that will that the legislature created the HPC. I see the current moment as a crucial test of that resolve.

Sincerely,

Donald M. Berwick, MD, MPP