Office of the Inspector General
Commonwealth of Massachusetts

Inspector General Gregory W. Sullivan's Testimony before the Joint Committee on Health Care Financing, October 2009

Thank you, Chairman Moore, for allowing me the opportunity to testify before your hearing today. I am Greg Sullivan, State Inspector General. I serve as a member of the Massachusetts Health Care Quality and Cost Council. I have been an active member of that council for more than three years and have spent a great deal of my time and the time of my staff looking for ways to save money in the health care system.

Since the passage of Chapter 58, health insurance premiums have increased at an alarming rate. Our office has recently looked at the quarterly health insurance rate filings at the Division of Insurance and here's what we see. Blue Cross Blue Shield of Massachusetts, the largest insurer, has increased its filed rates for its most popular small group and large group insurance products by 45-50% since the reform was passed. That's 45-50% percent in three-and-a-half years. For Harvard Pilgrim Health Care, the corresponding increases are 35-45% for small group and 25-40% for large group. And for Tufts Health Plan the numbers are about 35% for small group and 25% for large group.

Since January of this year, when Governor Patrick called upon the insurers and providers to keep costs in check in the short term, premiums have gone up substantially. Since January, Blue Cross has increased its filed rates for its most popular insurance products by an annualized rate of about 16% for small group and 13-14% for large group. At Harvard Pilgrim, the corresponding rate increases are 8-9% for small group and 7% for large group. And for Tufts, the increases are 9-10% for small group and 8-9% for large group. Governor Patrick's Division of Insurance is looking at these premiums right now. The Boston Globe recently reported that premiums next year are expected to increase by about 10% on average. It's safe to say that the free market has not done a very effective job of containing insurance premiums.

My interest in appearing before you today is to sound a warning. While there may have been unanimous support within the Commission for its recommended payment reforms, this was in large part due to the fact that the details were not spelled out. And somewhere in those details will be included, will have to be included, controversial elements to control cost. To me, the great success of the Commission is that its members were bold in identifying that we must get away from fee-for-service in Massachusetts, and that represents a really important step forward in the history of our Commonwealth.

If our state government is going to mandate that everyone has health insurance and that providers and insurers rearrange themselves into a global payment system, then that government has a concomitant responsibility to insure that insurance premiums be made affordable. That is why I am recommending that from the outset, the reform payment plan include a requirement that capitated rates be submitted in advance for review and approval or disapproval by the

government of Massachusetts. This approval/disapproval could be done by the Division of Insurance and the Department of the Attorney General, or by some other combination of agencies. And secondly, I recommend that the Office of the Attorney General and the Division of Insurance be given authority to review carefully and set forth rules to protect against anticompetitive behavior in the structure of the new Accountable Care Organization (ACO) system.

Mr. Chairman, I know that you have filed legislation to try and address the increasing cost of health care premiums in Massachusetts as an innovation, and I think that that is commendable. What are we doing to control insurance premiums in the short run? Even assuming the most optimistic time frame required to plan and implement the global payment proposal, health insurance premiums five years from now could easily be 60 to 70% higher than they are today. We need to adopt aggressive short-term cost containment measures. We are in a crisis situation that needs immediate action, not action in a 5 to 10 year time horizon.

I'd like to discuss some concerns I have about consolidated provider networks. Following its hearings in 2003, the Federal Trade Commission issued a report that cited that most studies that had been conducted of the relationship between competition and hospital prices had found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are profit or not for profit. One of the persons who testified at that hearing was Charles D. Baker. He was then CEO of Harvard Pilgrim. He said that many hospital systems throughout Massachusetts, particularly in geographical areas where they have virtually monopolies, also control significant numbers of salaried or affiliated physicians. In most cases no health plan, i.e. insurer, can do business with any one component piece of these delivery systems without doing business with the entire delivery system. That is, ironically, the provider equivalent of an "all-products clause" often cited in antitrust complaints. The FTC also said that for much of our history federal and state regulators, judges, and academics have seen health care as "a special good" to which normal economics forces do not apply.

Skepticism about competition in health care continues. Since we have adopted a commendable goal of coordinating care in the hopes of achieving efficiencies, we have to be mindful of recent history. When the 1115 waiver was granted in the late 90's, the MCOs began to expand by consolidating with other provider entities beyond their immediate geographical area. History shows that when those MCOs expanded their coverage area, they did so in many cases by luring providers with offers of higher rates of compensation. They offered to pay providers more to join their consolidated network, and competition became almost a reverse economy where the competition was not based on low price, but on higher provider reimbursement. This is not a good system in this environment. That is why I advocate that the Attorney General and the Division of Insurance be empowered with broad authority from the beginning of this process to protect against anti-competitive practices in system design and implementation.

As a practical example, the legislature and many other bodies have identified the importance of directing patients to lesser-cost, high-quality providers. In this context, the make-up and operation of the ACOs become very important. Let's take for example the very prestigious teaching hospitals in Boston. Will they, the teaching hospitals such as Partners affiliated group, participate in just one ACO? Will they participate in multiple ACOs? When those ACOs are formed, what will be the economic force that motivates the ACOs to direct patients away from

the more expensive teaching hospitals to less expensive settings? These are some of the issues that concern me in considering where we are going and what we are going to do.

Andrew Dreyfus from Blue Cross wrote last year in the CommonHealth blog: "The global payment does not represent a reduction from current payment levels. The global payment is based on actual costs." My concluding comment, therefore, is this: What is it in this proposal that would put downward pressure on actual costs? What is it? I don't see it, except for the reform of getting away from fee-for-service. Beyond that, I don't see it. I don't see the downward pressure on costs and that's why I believe that a global payment ACO structure must include review and approval of capitated global payment rates by the government in order to contain costs under this system. That is why I also recommend that the Attorney General's Office and the Division of Insurance be empowered to make sure that the system does not have anti-competitive elements.

Thank you very much, Mr. Chairman.