



The Growing Gap Between Medicare and Commercial Hospital Payments: Should We Be Concerned?

2018 Gustav O. Lienhard Award Lecture Perfected Transcript

(transcript has been edited for readability)

February 27, 2019
National Academy of Sciences Building
Washington, DC

The Gustav O. Lienhard Award, established in 1986, is presented annually by the National Academy of Medicine in honor of Gustav O. Lienhard, Chairman of the Robert Wood Johnson Foundation's Board of Trustees from 1971 to 1986. The award - a medal and \$40,000 - recognizes individuals for outstanding achievement in improving health care services in the United States. The Gustav O. Lienhard Award Lecture is delivered by that year's award winner, on the topic of their choosing. **Dr. Stuart Altman** received the award in 2018 in recognition of his pioneering role in national health policy and health services research. His lecture was titled "The Growing Gap Between Medicare and Commercial Hospital Payments: Should We Be Concerned?"

Stuart Altman is currently Sol C. Chaikin Professor of National Health Policy at Brandeis University. Over the last 50 years as an economist, Dr. Altman has helped improve the health insurance system in the U.S. and the efficiency of its delivery system. Dr. Altman has demonstrated leadership through service on several federal and state government advisory boards, beginning with his role as deputy assistant secretary for planning and evaluation/health at the U.S. Department of Health Education and Welfare under the Nixon administration. His work in this role helped spur the growth of comprehensive managed care plans and funded an important study measuring the impact of cost sharing on medical service use.

To facilitate better research to support health policy decision-making, Dr. Altman and colleagues formed the Association for Health Services Research in 1981. Now AcademyHealth, the organization has more than 4,000 members and hosts a prominent U.S. health services research conference. Dr. Altman served as chairman of ProPAC, an independent commission to advise Congress on Medicare payment policy. Under his leadership, ProPAC became a widely respected source for unbiased, impactful analysis, and its recommendations frequently led to important policy changes.

STUART ALTMAN (2018 Gustav O. Lienhard Award Winner)

Well, what a pleasure. Every time I walk into this building, I feel a little chill. I mean, it's hard to think back. But I think it was in the late 1960s I came here for the first time. Even before the beginning, as the IOM was being formed. I'm so proud to have received the Lienhard Award. I knew Gus. I spent more than a few times with him in the beginning of the Robert Wood Johnson Foundation's transition, so this is really a pleasure.

But that's where the pleasure ends. I'm really nervous about this talk. I mean, I don't get nervous that often about giving talks. I would have been dead a long time ago because I give a lot of them. But I said to myself, now, what could I possibly tell this group that they don't already know? And I finally decided – nothing.

[CHUCKLES]

So I decided to turn the table around, and to bring up a topic I don't really know the answer to. But I increasingly think it's becoming a very serious public problem. I anticipated a little bit the audience that was going to be here. I said, there's no one in this audience that what I'm going to talk about couldn't affect as we go forward. So let me proceed, and just lay out the facts as I've put them together.

[CHUCKLES]

[SLIDE 3]

Medicare Program Established in 1965

*Medicare Beneficiaries Would Have
Complete Access to All Approved
Hospitals*

All right. So let's go back. When this country passed Medicare and Medicaid in 1965, and some of you know this very well, the commitment that was made in the passage of the Act was that both Medicare and Medicaid would pay hospitals and doctors what they were getting in the private sector. And in fact, much of the original payment system, as you know, was really modeled after Blue Cross around the country. So that was the commitment: that Medicare would pay. And as a result, Medicare beneficiaries would have access to all the medical personnel, physicians, hospitals, and so on.

[SLIDE 4]

Medicare Hospital Payment System

Paid Hospitals Based on a Modified Blue Cross Cost Reporting System---Rates Similar To Those Paid By Commercial Payers

And as all of you know, we went forward with an essentially retrospective cost-based reimbursement system. Some of us very early on began to say, oh my God, what are we doing? By paying hospitals what they spend – guess what – they spend more! So by even the late 1960s (and I came to HEW (Health, Education, and Welfare) in 1971,) we were facing this very rapid growth in spending, and many of us were trying to figure out how we could change this system.

[SLIDE 5]

Medicare Hospital Payment System Changed in 1983 to a Pre-Determined DRG System

But Total Hospital Payments Set to Closely Follow Amounts Paid Under Previous Cost-Based System

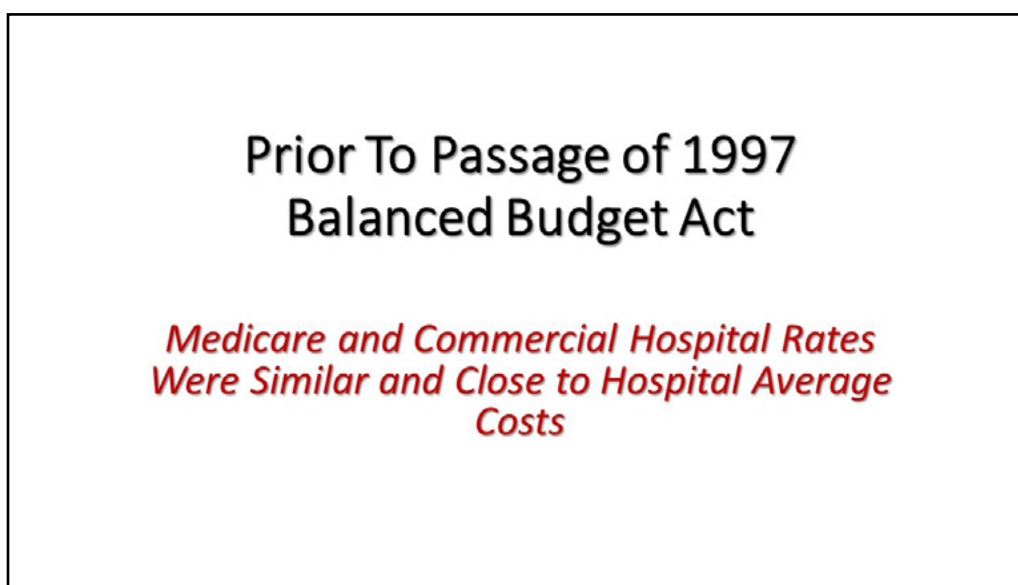
So finally after many fits and starts – in 1983 the country decided that it would fundamentally restructure the Medicare hospital and payment system and introduce the prospective payment, DRG system. But – and this is important – in restructuring and changing how the payment system would operate, the decision was made that initially overall payments to the hospital industry would be similar to what had been paid before. Only after an introductory period, we hoped, would the new incentives lower spending. So – we then said to these special strange people called “actuaries”, okay, we’re going to totally change how we pay for hospital care, but you have to figure out what these

new rates will be so that the total amount spent by Medicare for hospital care will be exactly the same as it would have been had we not changed the rates.

Well, they missed by a couple of billion dollars for a couple of years. And as a result hospitals wound up with a little more money than they expected. Like about \$9 billion! But that's another story. We won't talk about that now.

[CHUCKLES]

[SLIDE 6]



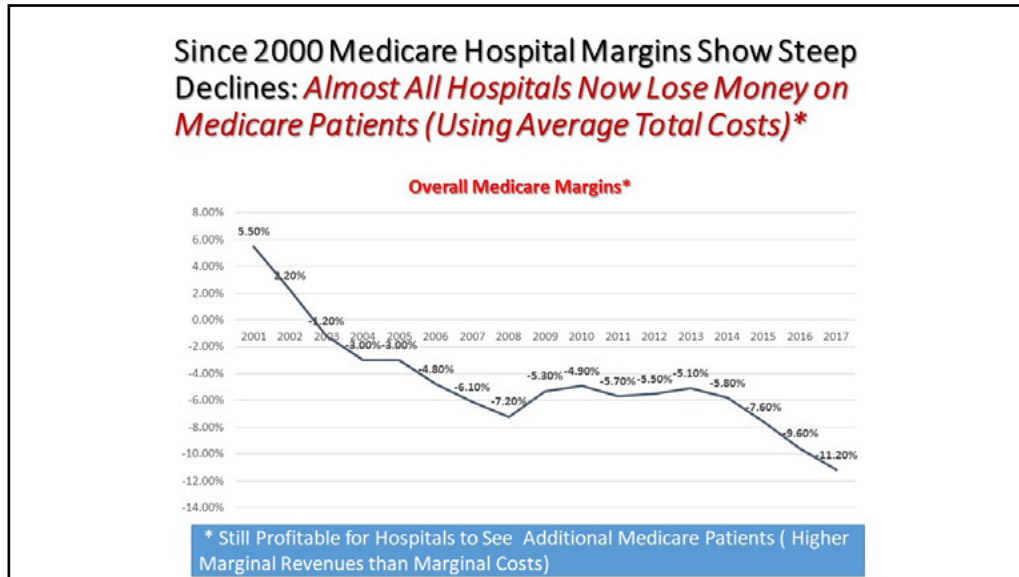
Anyway, for most years, up until the late 1990s, if you looked at the payment expenditures from Medicare and from private [insurance], the gap was really quite small. Even as late as 1998, the difference between Medicare payment rates and private insurance rates was almost infinitesimal.

[SLIDE 7]

I started looking at this gap a year or two ago and realized that it was growing substantially. I was surprised, but when I discussed it with some of you or read the literature or looked at MedPAC reports, it didn't seem to be a big deal. Nobody seemed that concerned. Finally, there seems to be growing interest in this gap, particularly as we begin to debate the introduction of a Medicare For All system and how health care services would be paid under such a new system. Clearly this is going to be a very important issue. For those of you who are involved in one way or another with an academic medical centers and with the funding of research at these centers, what I'm going to talk about really gets at the heart [of your work].

Now, the date shown on this slide, only goes through 2012. But you already see how much the gap between private and Medicare rates has grown. In a few minutes I will show more recent information. It is clear that these two payment systems are on very different paths. Medicare—for some good and maybe some not so good reasons, but mostly for good reasons—is on its own glide path. Its payments are not related to the costs as hospitals see it. Medicare payments appear to be much more related to either what Medicare thinks hospitals costs should be or to the possible budget implications of different payment amounts. And so the gap is getting wider and wider.

[SLIDE 8]



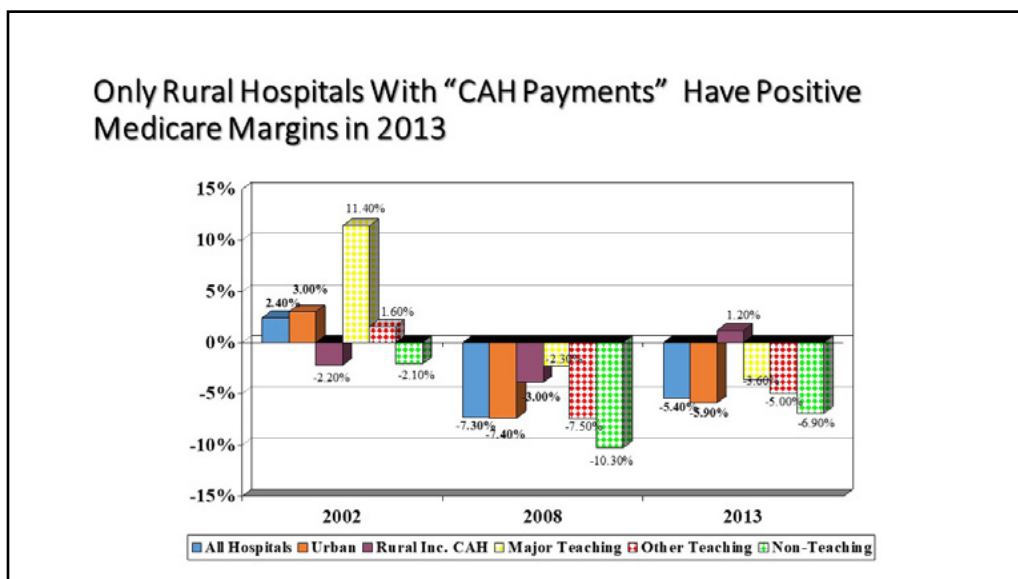
Medicare, which used to be – and again, I want to make it very clear—I’m not arguing that Medicare is underpaying. But we have to put that aside. We really need to look at the implications of what we’re doing. And for a long time, we have not looked at that. So what’s happened to the relationship of Medicare payments to what are measured as the cost of treating Medicare patients – so called Medicare Margins? If you go back to the 1990s these Medicare Margins were quite substantial. As a matter of fact, it was one of the key reasons why we had the big disagreement over the size of the cuts in the Balanced Budget Act and the closing of the government under President Clinton. Many of you probably remember that it was in part related to Republicans wanting to substantially cut Medicare payments to hospitals, arguing that the “profits” being made by hospitals from government were too high. Even Democrats agreed—the battle was over how much to cut Medicare payments. And clearly, even though most agree that President Clinton and the Democrats won the battle, the Balanced Budget Act of 1997 did substantially reduce Medicare payments to both hospitals and physicians. And look what happened. And you know this. So like I said, I’m not telling you necessarily anything new. By 2017 these very high positive margins of the 1990s have turned into an average Medicare Margin of a **negative 11.2%**.

[SLIDE 9]

Even Teaching Hospitals Which
Had Significant Positive Medicare
Margins Now Show Losses

Now, I know many of you either work for or represent teaching hospitals in America. I too have positive feelings about many of our teaching hospitals, having served on several of their boards. Yes, I realize some teaching centers don't like me as much as they used to. But that's my job as Chair of the Massachusetts Health Policy Commission. Non-paid, that is. Anyway, teaching hospitals did quite well under the DRG payment system for almost 20 years after it began. They were among the hospitals receiving the highest Medicare Margins.

[SLIDE 10]



So if you look back, even to 2002, that checkered big tower there [referring to Slide 10] were the margins of teaching hospitals. Higher than any other hospital group for a variety of reasons. Not the least of which was the extra payments for teaching that were built into the DRG payment system.

But as we move later into the 2000 period, even our big, high-paid teaching hospitals are now under water along with most other hospital groups – even if you go to 2013, every hospital group (except one, which are critical access small rural hospitals) is now losing money on Medicare. Now, I want to make it very clear. We're talking about averages here.

[SLIDE 11]

SO— Should We Be Concerned?

Are Hospitals In Financial Trouble?
Are There Winners and Losers With Current Hospital Payment System?
Are Medicare Beneficiaries Being Denied Services in Some Hospitals?

So everybody knows this. And if you don't, I'll explain it to you. So the question is, so what? Should we be concerned?

So let's play this one out for a little while. Are hospitals in serious financial trouble? Which hospitals are the winners and which are the losers with the current hospital payment system? And perhaps most importantly, are Medicare beneficiaries being denied services in some hospitals as a result of this?

[SLIDE 12]

**High Private Insurance
Payments Relative to Costs
Keep Hospital Systems
Profitable!**

***YES I KNOW---Hospital Cost Shifting
Doesn't Exist***

***And If Medicare Paid More Its Unlikely That
It Would Lower Private Payments***

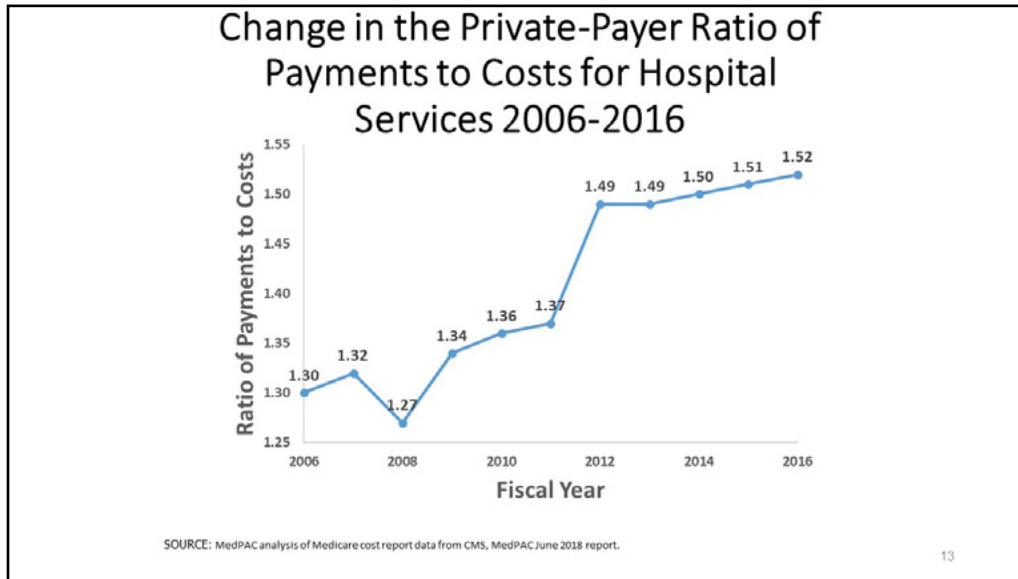
Does Hospital "Cost Shifting" Exist?

Let's look at that gap between what hospitals receive from private insurance and what they receive from government [Medicare]. Now, for many years, the term "cost shifting" was bandied around. That is – do hospitals operate as if they have a budget, which is independently created based on the costs that they are facing, and do they then they try to find the revenue to meet that budget? And, if one sector of the system pays too little, they go to another sector to get more. Or in reverse, if one system pays more, do they agree to accept less from the other systems?

Many health care analysts, often economists who were trained in good classical economic theory, argue that, "Oh no! That is not the way hospitals operate – they are like any other profit making organization – they try to maximize revenue from all payers and don't play one payment system off against the other." Also some who work for Medicare argue that what government pays has nothing to do with what private [insurers] pay. "Also don't blame us for the so-called negative Medicare Margins or the high private rates. We believe that what we pay is in line with what "true" hospital costs should be."

While I do believe there is much cost shifting that does exist, I understand that it varies from market to market and according to the relative bargaining powers of the payers and providers. Probably the best article that I've ever read that explains this dynamic is the one by Jamie Robinson, back almost ten years ago. He demonstrated that some hospitals do have the capacity to pretty much dictate [how much they are reimbursed] and some hospitals are forced to accept what the payer will pay.

[SLIDE 13]

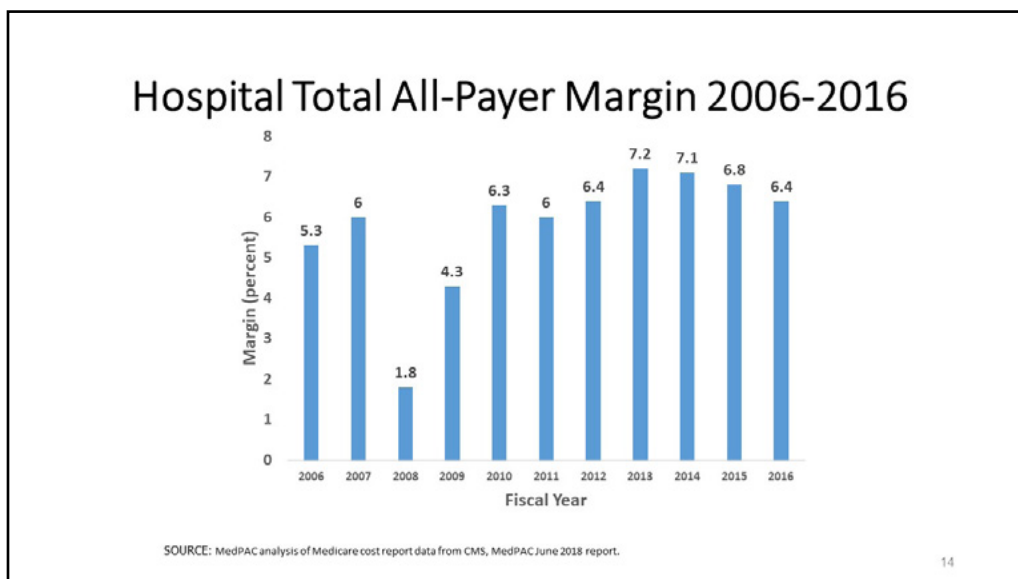


But regardless of whether there is cost shifting or not, no one can seriously argue that a significant gap has been created between what government pays for hospital care and what private insurance pays, and that this gap is getting wider and wider. Also it seems clear that private payers are paying far more than the cost of the care their patients receive.

In 2016 the average private payers paid 50+% more than the cost of care and probably 70% or 80% more than what Medicare paid. But that's the average.

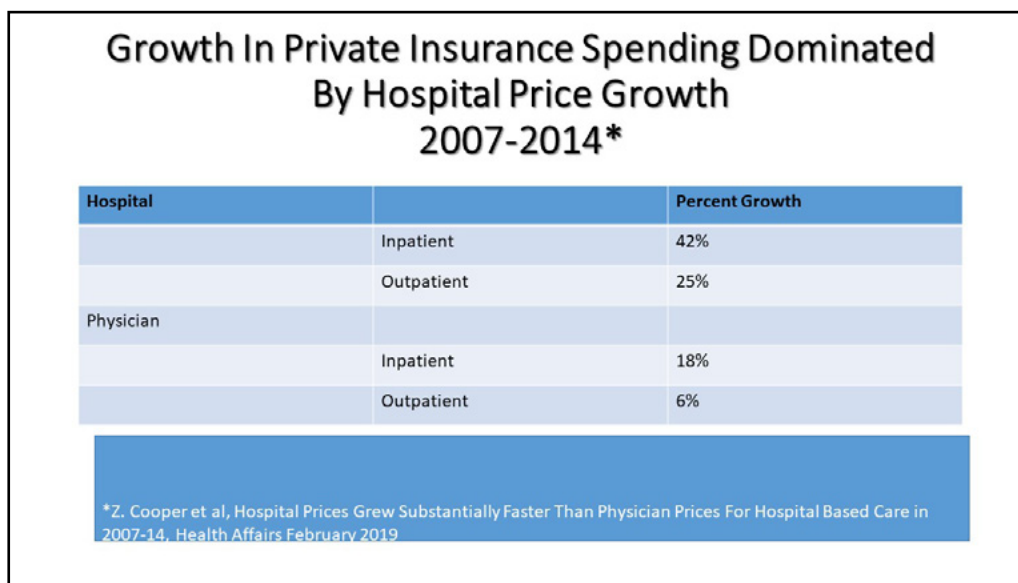
If you go around this country, you'll find some areas, like Northern California, where some hospitals are getting from private payers 180% to 200% above Medicare rates.

[SLIDE 14]



But, no tears for the hospital industry. On average, overall margins or profits are very strong. I just read yesterday, in 2017, the total hospital margin from all payers including government was over 7%. So no tears for hospitals. Let's look at the next slide.

[SLIDE 15]



Why Are Health Care Costs So High and Continue to Increase?

The second argument that we've been having as a research community is what's driving health care costs. We've heard all this stuff about excess or unnecessary utilization of health services or, as some would call it, "waste." And that if we could substantially reduce such excesses, we could save a tremendous amount of money. Dr. Bob Brook, who was at UCLA and RAND in 1971, estimated that the U.S. health system wasted 40% of what it paid for. Interesting that the estimates today are also 40%. The only difference is the number of zeros in the 40%. In 1971, the U.S. spent \$75 billion for its health care – today it is close to \$3.4 trillion! Well, I must admit, I've never been part of the waste police. If you compare us to Europe, where they are spending so much less than we are, they use more hospital days. They go to the doctor more often. Yeah, they get somewhat less MRIs. The truth of the matter is, as my good friend Uwe Reinhard said often – it's the prices, stupid.

What's happening is that this spending in our health care system is being increasingly being supported by the growth in private insurance spending. While I have focused my remarks about hospital care, we could say the same for physician care as well, although the gap between government and private rates are not as high. So what we're seeing – and I've said this to the insurance industry. I've said this to employers. You have become the great ATM machine in the sky for the American health care system. The extra payments that you are now paying are huge and they are continuing to grow.

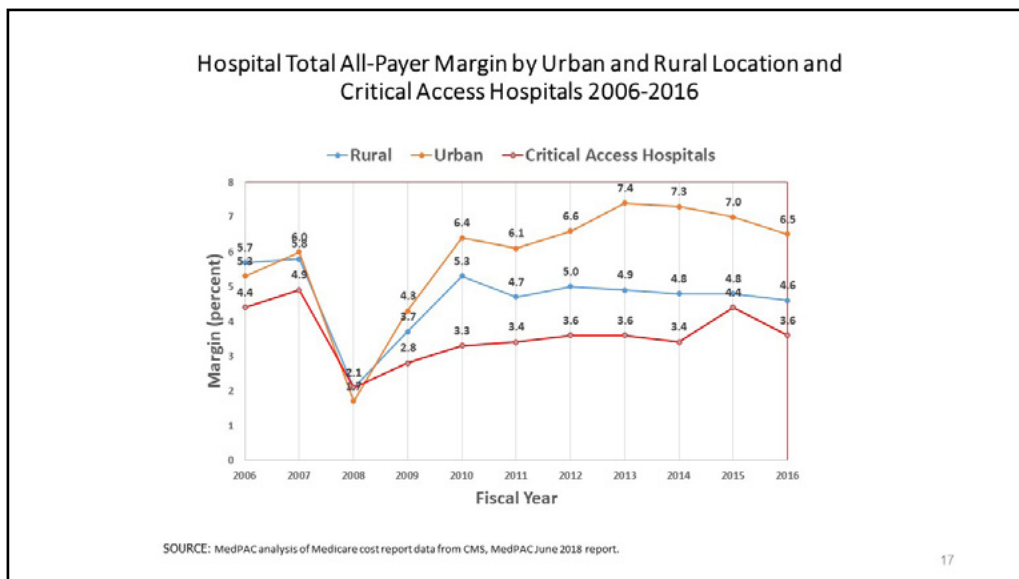
[SLIDE 16]

But The Growing Asymmetry Between Government and Private Payments Does Affect Different Types of Hospitals Differently

Also Ratio of Private to Medicare Hospital Payments Are Significantly Different in Different Regions

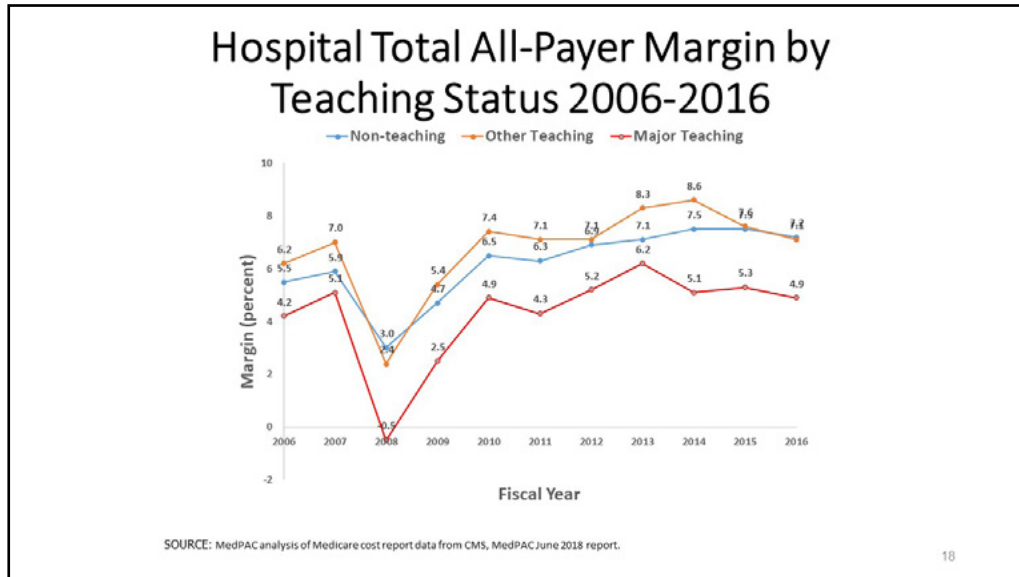
So the question is, so what? Well, I do believe there is a “so what” here. And it is something that you, we, really need to take seriously. What we do about it is what I really want to talk to you about. Because doing something about it is not so easy.

[SLIDE 17]



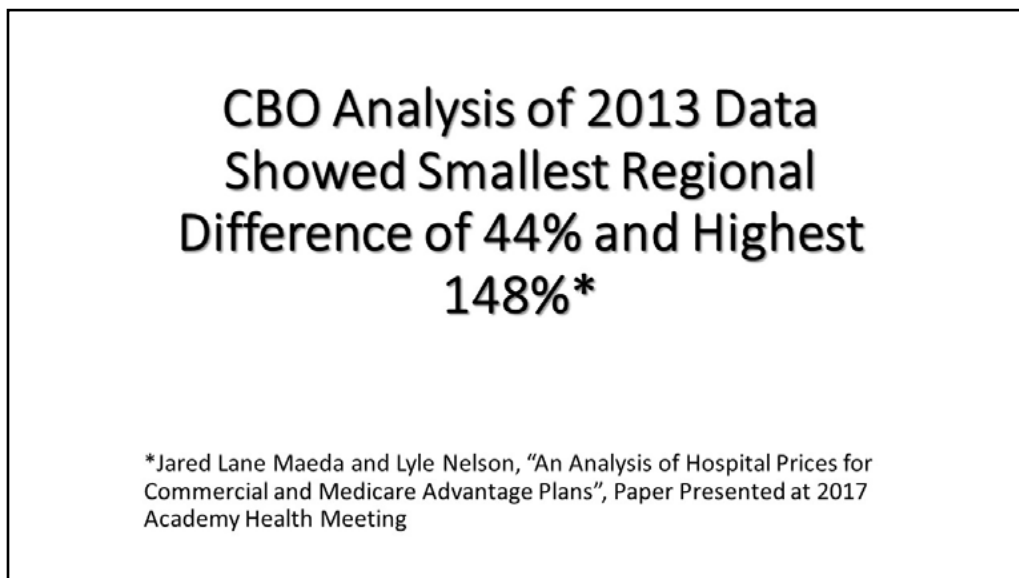
First of all, as I said, it varies all over the country. And it varies by the type of hospital as to how well they are doing. So this is a chart that was recently put together. It shows margins by type of hospital – rural, urban, and critical access hospitals. As you see overall urban hospitals are doing well with rural hospitals in the middle and critical access at the lower end. Critical access hospitals do very well from Medicare since they are no longer paid through the DRG payment system but very poorly from private insurance.

[SLIDE 18]



If you look by teaching status, our big teaching hospitals, as I said, were doing fine under Medicare. Well, they are not doing so fine when you look at total margins compared to other teaching or non-teaching hospitals.

[SLIDE 19]



CBO, in 2013, showed that the gap varies. In some regions the gap is small, 44%. In other regions it's 148%. That's an average. There are more and more examples of 200% to 300% differences between private insurance and Medicare.

[SLIDE 20]

Financial Survivability of Hospitals

- As Gap Widens Financial Survivability Less Depended on Efficiency and More on Patient Mix and Regional Power Over Pvt. Insurance Companies

In 2013*

- 55% of Highly Profitable Hospitals Were For-Profit (25% of Total Hospitals)
- But Many Not-for-Profit Also Highly Profitable (7 of 10 Most Profitable)
- Having Strong Regional Power Key to Profitability
- 2 of 10 Most Profitable Were Big Teaching Although Most Are Lower Profit
- Hospital in Systems Do Much Better Than Independent Institutions
- Public and Rural Hospitals Have The Highest Losses

*Bai and Anderson, "A More Detailed Understanding Of Factors Associated With Hospital Profitability", Health Affairs May 2016

So what have MedPAC reports said about these gaps? Very little. Now, I know, we must have somebody here from MedPAC. I was an old ProPAC guy. I love MedPAC. I read their reports thoroughly. But I think MedPAC has been a little slow at the switch on this issue. I think they need to take this issue more seriously. Their argument for not supporting higher Medicare payments was that so-called "efficient" hospitals were able to make a decent margin on Medicare rates. More recently even these so-called efficient hospitals are losing money¹. Interestingly, 55% of the highly profitable hospitals were for-profit. But many not-for-profit hospitals were also doing well, including 7 of the 10 most profitable. Also, while some teaching hospitals are really getting beat up, there are some teaching hospitals that are doing very well – 2 of the 10 most profitable hospitals in the U.S. were big teaching hospitals. Hospitals and systems do much better than independent institutions. Public and rural hospitals have the largest losses.

So we're beginning to see – well, it's been going on for a while. That while there have been big winners in our hospital system there have also been big losers. The question is whether the right types of institutions are in the two categories. Is it right or good for the health system that hospitals which have a high proportion of private pay patients and/or have significant bargaining power do well while institutions that see significant numbers of government patients, and are not powerful in bargaining with private insurers do poorly?

[SLIDE 21]

**In Massachusetts Which Has Had High
Private Rates But Constrained Growth in
Rates in Recent Years Gap was 57% in
2016**

***Differences in Rates Vary By Type of
Procedure and Higher for Outpatient
Services***

1 (Since this talk, MedPAC has recommended a much larger increase in Medicare hospital payments).

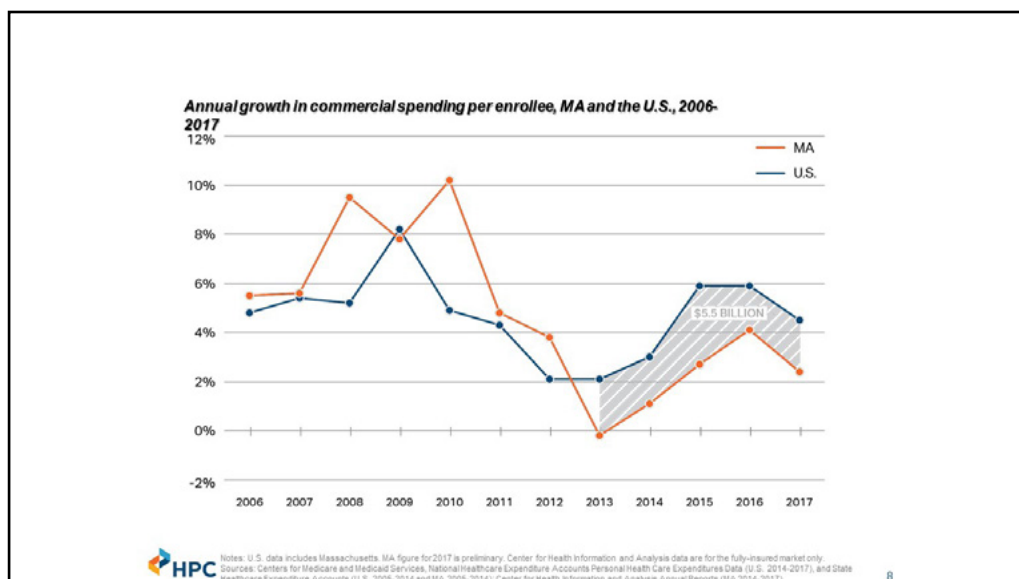
The Massachusetts Story

So let me switch gears and discuss a little about what is happening in Massachusetts, because we have learned a few things. Now, for those of you who have not followed the activities in Massachusetts, in 2006, the state passed comprehensive universal health care legislation. Many of the components of this legislation are similar to those in the Affordable Care Act.

Massachusetts, as the entire country does, has two problems: we have an access problem, and we have a cost problem. But the designers of the Massachusetts reform legislation decided that they were not going to try to solve both at the same time. Many other wise people, not necessarily in this room, said, oh, you have to solve them together. Well, I learned a long time ago, and I now call it Altman's rule – if you try to solve both of these problems at the same time, you will solve neither of them. Because the political system will defeat you. I learned this lesson sadly during the ill-fated attempts at reform during Nixon and Clinton.

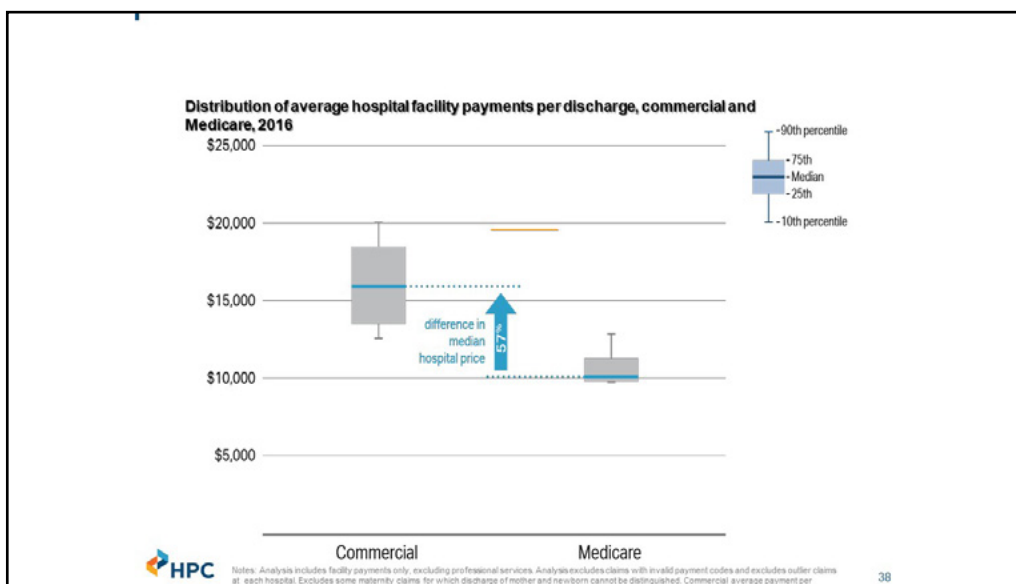
And so both Massachusetts and the Affordable Care Act were designed to deal with access first. At least in Massachusetts the political forces said, then we'll deal with costs. Lo and behold, surprise of surprises, the state did pass a law to provide greater access in 2006. And in 2012, the state did pass a pretty serious cost containment law. The key to the cost containment law was a commitment on the part of the state to be concerned, most importantly, about total health care spending in the state. Not just its Medicaid budget. Second, that the total spending in the state should not grow by more than the growth in state income. At that point the growth amount was pegged at 3.6%. Now it's pegged at 3.1%. To make sure that the state knew what was going on, it established two semi-independent entities. One called CHIA (the Center for Health Information and Analysis) which is tasked to collect and publish detailed information on all aspects of the state's health care system. Second, the HPC, the Health Policy Commission, which is responsible for monitoring these costs, finding out why they are going up, and how to do something about limiting their growth. The HPC has 11 commissioners and full-time staff. In designing CHIA and the HPC the designers of the legislation asked me what I thought would work. And since I'm a big believer in the ProPAC and MedPAC model, I told them. Okay, they said, we will set it up that way, and will you Chair the HPC? I think they said please. But I said of course I would do it. And I've been chairing the HPC since 2012.

[SLIDE 22]



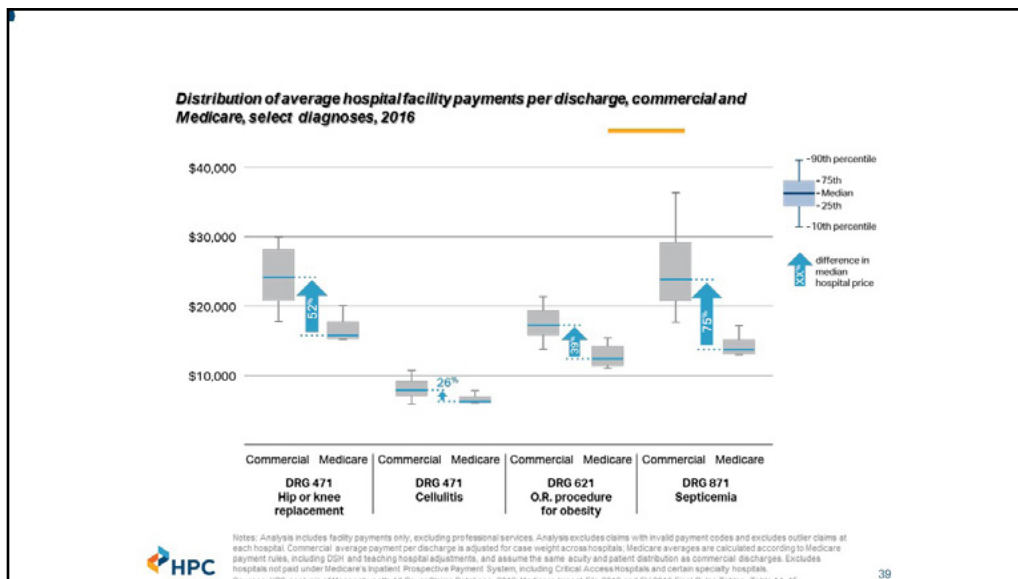
The key to the success of what we have done in Massachusetts to moderate the growth in health costs is the quality and quantity of the detailed information the state collects on every provider and every health plan. Two weeks ago, the HPC issued a cost report that describes in detail the growth in costs by sector and the price increases for private and public health plans. We also indicated if overall spending growth and growth by sector were within the approved benchmark. This is a report we are required to complete each year. Much of the basic information that the HPC analyzed comes from CHIA. To give you some feel for the results of the HPC analysis, see the information in the following Chart. [referring to Slide 23] The orange line refers to the rates of growth in commercial spending per enrollee in Massachusetts. The blue line is the growth in average commercial rates for the U.S. You will notice from 2000 until 2012, the orange line (which again is the growth rate in Massachusetts) was substantially higher than the blue one, which is the average U.S. commercial spending rate growth.

[SLIDE 23]



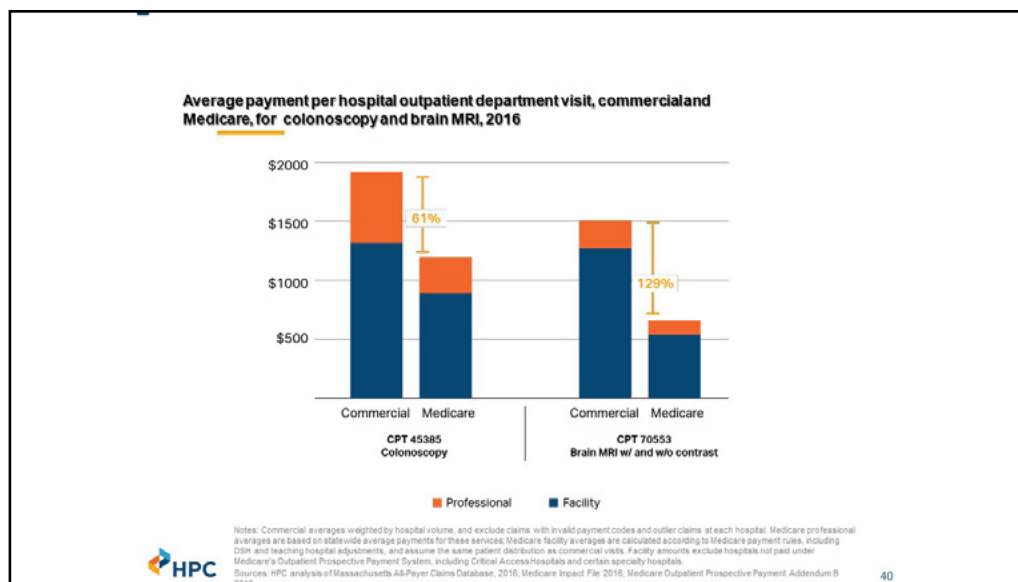
Since 2012, Massachusetts's growth rate has been under the U.S. average. And if you estimate the potential savings to private payers in Massachusetts compared to the U.S. average, it amounts to \$5.5 billion. But let's look below the surface. First, if you look at the difference in average hospital payments per discharge, commercial and Medicare, you'll notice the average gap in Massachusetts is 57% with the highest rate at 80%. While this is high, it is lower than many states, as I mentioned before.

[SLIDE 24]



We also looked at different payment rates by procedure. So for hips and joints, the gap is about 50%. Don't ask me why. I don't know. Cellulitis shows a very little gap. Operating room procedures for obesity, fairly small gap. A very large gap in septicemia. We have it by every procedure classification. So we now know that there are substantial differences in the gap by hospital and by procedure.

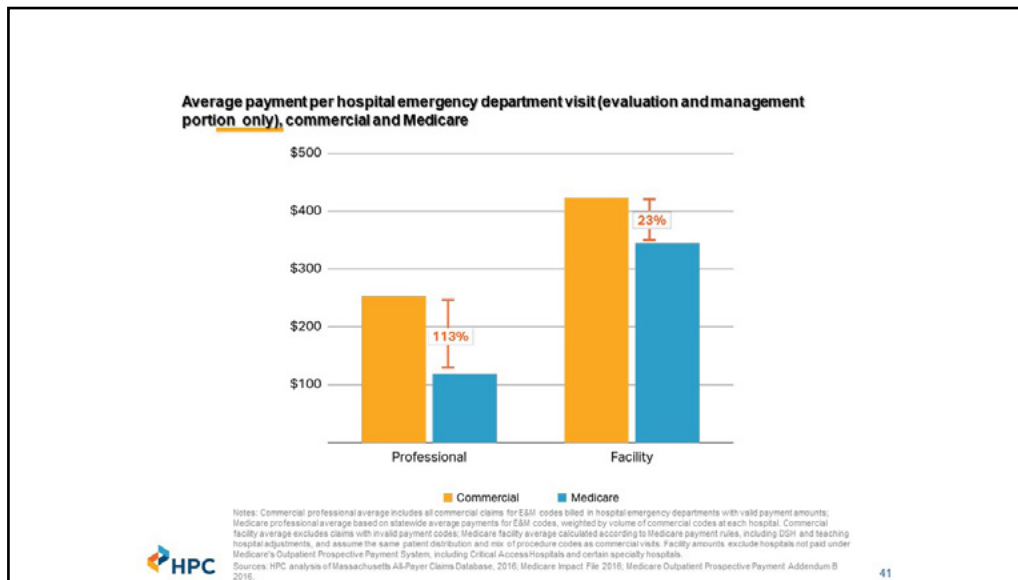
[SLIDE 25]



Look at average payment per hospital outpatient department. Take colonoscopy. First of all, the professional or physician payment amount is in orange, and here's how much the facility gets, from both commercial payers, and Medicare.

Here is brain MRIs. Again, you'll notice that the facility payment rate is much higher than even the professional rate. And again, here is Medicare. And here the gap is 129% between the Medicare rate and what private insurance pays.

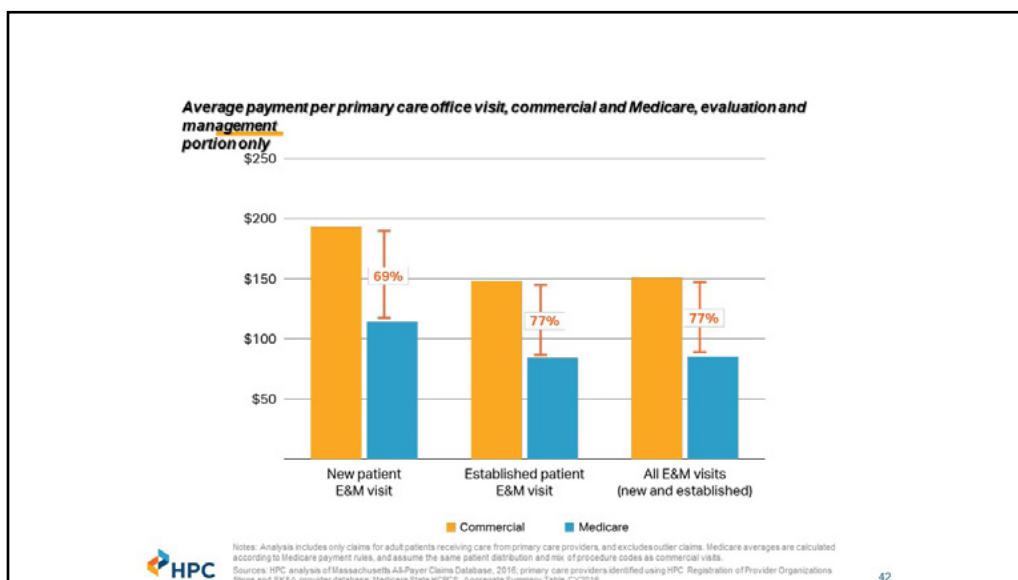
[SLIDE 26]



Another example is for average payments for hospital Emergency Departments. So there's a gap on the professional side of over 113% between Medicare and commercial payments. On the facilities side, the gap is much smaller.

Now, I have shown all of these estimates to indicate how much we know about the prices paid and their rates of growth. This allows our analysts to discuss with each of the provider or payer units what has gone on and maybe what can be changed in the future.

[SLIDE 27]



This slide shows the gap between new patients and established patients. Clearly on every level there is a substantial gap between what is paid by commercial payers and what is paid by Medicare.

[SLIDE 28]

For Medicare Patients: *No Cause for Concern NOW*

“Most of our payment adequacy indicators for hospitals are positive but 2016 Medicare margins remain negative for most hospitals and were -1.0 percent for median relatively efficient providers” (Medpac March 2018 Report)

So we now come to the ultimate question—so what? MedPAC has said several times that they are not so worried about this issue. No one is being denied access to care in the Medicare program. Hospitals are doing alright. We have a certain number of hospitals which we call efficient hospitals that are doing fine. So no big deal. Okay, right now that's true. There may be one person in America that's been denied hospital care. But it's not a serious problem.

Play this one out for five to ten years. Can you tell me and be completely sure that if this gap keeps getting wider and wider, we will not see hospitals begin to cater to non-Medicare patients? And you may say, well, that would never happen. Well, let's look at the physician side.

[SLIDE 30]

Hospitals Face Growing Government and Declining Pvt. Patient Growth

Will This Lead to Less Growth in Revenue and Constraints on Hospital Cost Growth or More Focused Emphasis on Services for Private Patients?

If we look at the availability of physician services to Medicare patients it depends on where you live. If you live in my part of the world [Boston, MA] and in DC and in Los Angeles and San Francisco, the concept of concierge medicine is really beginning to grow. Sure, you go to other parts of the country

and you say “concierge medicine”, they have no idea what it is. Now, I will say among friends here, I think concierge medicine is illegal. It’s fattening. And I must admit, I joined it.

[CHUCKLES]

So why is it illegal? Well, as far as I know, there’s a law somewhere in the books of the federal government that says it’s against the law for a doctor to charge more for a Medicare procedure than what Medicare pays. Maybe just a little bit of difference, so you can get a little extra. Well, the concierge doctors charge you an upfront amount of money, depending on where you live. From, I don’t know, \$1,000 to \$5,000, whatever. So for many years, I just said, this is craziness. This is illegal. What services are concierge doctors providing to Medicare patients that are different from non-concierge doctors?

And after losing three primary care physicians in four years, the final one, nice guy, good doctor, he said, “I’ve had it, I’m going concierge.” So I thought about this for a while. And I said, what do you do that allows you to charge this extra rate? And I finally figured it out. A concierge doctor promises to love their patients. So I went to this guy. Honest. I’m among friends here. I said to him, I will join you under one condition. I do not want to be illegal. And I don’t want you to be illegal. So every time I come to see you, you have to hug me.

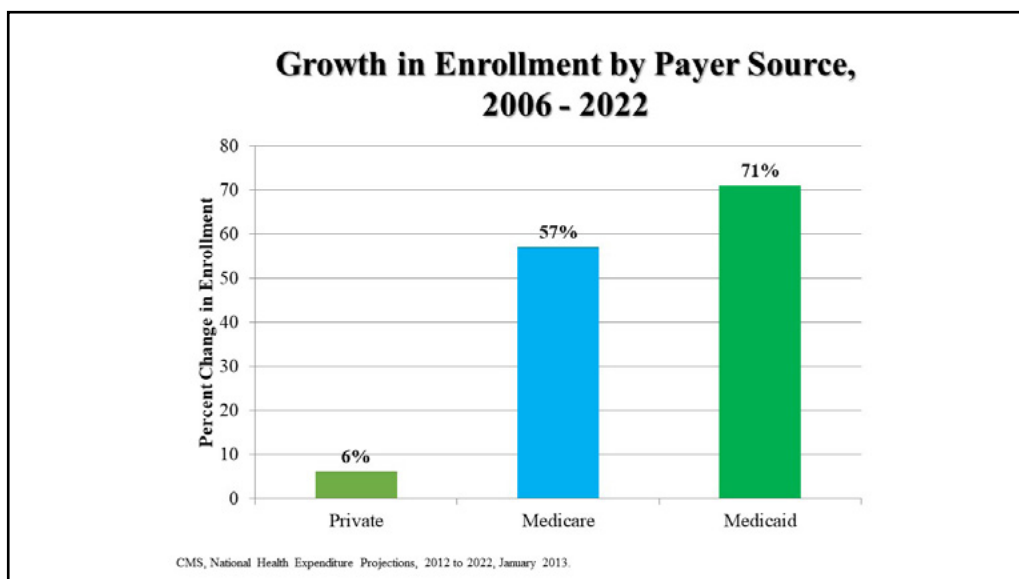
[CHUCKLES]

And he does. He’s not the warmest guy. It’s not the best hug I ever got. But the reality is that is the reason why concierge medicine is considered legal – there’s no code in the Medicare dictionary for love.

[CHUCKLES]

One of these days you’re going to see hospitals with a big sign with a heart on it: “I love you, pay \$5,000.” And then in addition to that, Medicare will pay the difference. I don’t know when that will come. But it’s coming!

[SLIDE 31]



But I do know this: **hospitals are doing alright**. And the truth is, and MedPAC has indicated this as well, on the margin, Medicare patients are still profitable for most hospitals. We're talking about averages. So even though a hospital claims they are losing 11% to 12% on Medicare patients, the next Medicare patient that walks in the door is still worth treating. Given all their fixed costs, most hospitals will get more revenue than it cost them for that additional patient. But let's look at other trends that are going on.

If you project out into the future, there's going to be almost no growth in private insurance. All of the growth that's going to occur, and this is independent of the Affordable Care Act, is really in Medicare and Medicaid.

[SLIDE 32]

If Medicare Payments Continue to Be
Constrained and Pvt. Payments Grow---
*Could There Be Access Limits for Medicare
Patients?*

The Growing Use of Restrictions on Physician
Coverage for Medicare Patients--- *"Concierge
Care"* --- Could be Just The Beginning

Now, if Medicare continues to be constrained and private payments grows, could there be access limits for Medicare? And remember what is happening for Medicare patients seeking primary care and being pushed to go on concierge medicine.

[SLIDE 33]

Let Me Be Very Clear---*I am NOT
Advocating for Higher Hospital
Payments*

**I Believe as Do Many Economists That Health
Care Spending Can Only Be Constrained by
Reducing The Growth in Revenues**

Now, let me be very clear. I am not advocating more money being given to hospitals. I do believe this country is already spending too much for health care. I also believe that the only way to constrain spending is to constrain spending. You never are going to save enough money by just trying to limit what are considered excess services.

A couple of years ago I got a call from an analyst for a newspaper out of New York. And she said, please explain to me why health costs are so high in the U.S. I said how much time do you have? She said, all the time you need. Anyway, I went on for about 45 minutes. I gave one of the best lectures I ever gave in my life. I talked about all of the different forces and stuff like that. And of course the next day I immediately ran to the newspaper to see what she quoted. You know, like most of us. So I looked at the newspaper and she wrote this long article. And there was this one half a sentence: Professor Altman says “if you want to spend less money, spend less money.”

[CHUCKLES]

At that point I used to Google my name. And the next day I got a Google alert and somebody said that was the stupidest quote they had ever read. Well, I believe it's not stupid. I believe the reality is that if you want to slow the growth in spending, you have to slow the growth in spending, and have the industry deal with less revenue—because like any industry, if you keep giving it more money, it will figure out a way to spend it. As a former president of a university, I can guarantee you that if we get a doubling in the amount of philanthropy, we're going to figure out very good reasons to spend that money. So I'm not blaming the health industry. Every industry is the same.

[SLIDE 34]

**But Should Constraints Only Come From
Lower Government Payments and
Should Government Ignore The Growth
of Relative Private Rates---In Three
States---Maryland and Massachusetts
and Rhode Island The Answer is NO!**

So I'm not here advocating that we should be spending more in health care. But should the constraints only come from the government side? I think that is increasingly dangerous, in many different ways. As I said, it's going to affect access for government patients. It's going to affect winners and losers, depending upon their patient mix. I'm sorry for those of you who are strong advocates of MedPAC—I do not believe that the hospitals they listed as more efficient are necessarily more efficient. It has a lot to do with the mix of their patients.

The third thing is, as I pointed out, I don't think this is going to continue. I'm not saying 2017 is the turning point. But I've been told that we are increasingly going to see private insurers constrain what they pay hospitals. You are seeing more and more of what we call limited or tiered networks that pay lower rates to network providers. Yes, there is some complaining about them as being too

restrictive. But it's a way that the insurance industry and employers are fighting against paying very high rates.

So this idea that somehow the great ATM machine in the sky is just going to continue to print money—I don't think it's going to happen. But most importantly, I don't think it's healthy for the American health care system to have the constraint only on one side of the equation.

So let's look at what Massachusetts is doing, what Rhode Island is doing, what Maryland is doing, and how many other states are now beginning to say, we have responsibility, not only for our Medicaid program, but for total health care spending in our state. Which means we are going to have to constrain private spending as well as public spending.

The question is whether the federal government also needs to look at this issue. So the question I leave you with, and would welcome a discussion about, is what do we do about this issue? First of all, do you think it's a problem? Second, if you do, how do we deal with it? And by the way, the discussion about Medicare for All is going to hinge very much on this issue—If all of a sudden we take the ATM machine and we close it down, what are the implications for hospital care and for the entire health care systems? Again, I'm not shedding any tears for hospitals. Although I care more about them now than I used to.

[CHUCKLES]

Somehow the gray hair and falling apart has an impact on me. But be that as it may, the point is that we need to think seriously about who pays what for health care. So let me stop now and I would welcome discussions about this. No physical violence if you have a different opinion. But I also most importantly want to know if a) you think it's a problem, and b), how we should deal with it. So thank you very much.

[APPLAUSE]

****END OF LECTURE****

Inaugural Gustav O. Lienhard Award Lecture Agenda

February 27, 2019

Washington, DC

- 4:30pm **Registration**
- 4:45pm **Opening Remarks**
Victor J. Dzau, President, National Academy of Medicine
- 5:00pm **Systemic and Health Consequences of the Payment Gap Between Medicare and Private Insurance**
Stuart Altman, Sol C. Chaikin Professor of National Health Policy, Brandeis University
- 5:40pm **Audience Q&A**
- 6:00pm **Reception**
- 7:00pm **Adjourn**

2018 Gustav O. Lienhard Award for Advancement of Health Care

Stuart Altman

Sol C. Chaikin Professor of National Health Policy
The Heller School for Social Policy and Management, Brandeis University



For his pioneering role in national health policy and health services research, the National Academy of Medicine (NAM) issued the 2018 Gustav O. Lienhard Award for Advancement of Health Care to Stuart Altman, PhD. Over the last 50 years as an economist, Altman has helped improve the health insurance system in the U.S. and the efficiency of its delivery system. Altman has demonstrated leadership through service on several federal and state government advisory boards, beginning with his role as deputy assistant secretary for planning and evaluation/health at the U.S. Department of Health Education and Welfare under the Nixon administration. His work in this role helped spur the growth of comprehensive managed care plans and funded an important study measuring the impact of cost sharing on medical service use. Altman has acted as adviser to five U.S. presidential administrations in total.

During his time at Brandeis University, Altman founded the Schneider Institutes for Health Policy, a research center best known for developing the Social HMO, which integrated financing for acute services, long-term care, and social supports to provide more effective coordinated care for elderly adults. To facilitate better research to support health policy decision-making, Altman and colleagues formed the Association for Health Services Research in 1981. Now AcademyHealth, the organization has more than 4,000 members and hosts a prominent U.S. health services research conference.

Altman served as chairman of ProPAC, an independent commission to advise Congress on Medicare payment policy. Under his leadership, ProPAC became a widely respected source for unbiased, impactful analysis, and its recommendations frequently led to important policy changes. In addition to his leadership in national health policy, Altman's work as chairman of the Health Policy Commission in Massachusetts led to reports and recommendations that are considered a model approach for states trying to control health spending but averse to regulating it directly. Altman is a member of the NAM.

"With his deep understanding in a wide array of issues across the U.S. health care system and expertise in Medicare policy, Dr. Altman has been an exceptional leader and staunch advocate of high-quality, objective analysis and health services research to guide policy and create a more fair and effective health care system," said NAM President Victor J. Dzau. "His work has made an important impact on the health care of our nation. He is most deserving of this prestigious award."

About the Lienhard Award

The Gustav O. Lienhard Award, established in 1986, is presented annually by the National Academy of Medicine in honor of Gustav O. Lienhard, Chairman of the Robert Wood Johnson Foundation's Board of Trustees from 1971 to 1986. The award—a medal and \$40,000—recognizes individuals for outstanding achievement in improving health care services in the United States. Support for the award is provided by the Robert Wood Johnson Foundation. Each year, a selection committee appointed by the NAM reviews nominations based on selection criteria that reflect the ideals and work of Mr. Lienhard and the Robert Wood Johnson Foundation. The 2018 selection committee was chaired by Glenn D. Steele, chairman, GSteele Health Solutions.

Past Recipients

2017

Diane E. Meier, MD

Icahn School of Medicine at Mount Sinai Hospital

2016

David Cella, PhD

Northwestern University Feinberg School of Medicine

2015

Robert L. Brent, MD, PhD

Thomas Jefferson University
Nemours/Alfred I. DuPont Hospital for Children

2014

Linda Aiken, PhD, RN

University of Pennsylvania School of Nursing

2013

Steven A. Schroeder, MD

University of California, San Francisco Smoking Cessation Leadership Center

2012

Donald M. Berwick, MD

Institute for Healthcare Improvement
Centers for Medicare & Medicaid Services

2011

Jerold F. Lucey, MD

University of Vermont College of Medicine

2010

Joseph A. Califano, Jr.

National Center on Addiction and Substance Abuse
Columbia University

2009

Thomas E. Starzl, MD, PhD

University of Pittsburgh School of Medicine
Thomas E. Starzl Transplantation Institute

2008

John E. Wennberg, MD, MPH

Dartmouth Institute for Health Policy and Clinical Practice

2007

Howard H. Hiatt, MD

Harvard Medical School

2006

Aaron T. Beck, MD

University of Pennsylvania
Beck Institute for Cognitive Therapy and Research

2005

Robert H. Brook, MD, ScD

RAND Health
University of California, Los Angeles

2004

Kenneth W. Kizer, MD, MPH

National Quality Forum

2003

B. Jaye Anno, PhD

Bernard P. Harrison, JD

National Commission on Correctional Health Care

2002

Kathryn E. Barnard, PhD, RN

University of Washington

T. Berry Brazelton, MD

Brazelton Foundation, Inc.

2001

Ruth Watson Lubic, RN, CNM, EdD

District of Columbia Developing Families Center

2000

Philip R. Lee, MD

University of California, San Francisco

1999

Elma L. Holder, MSPH

National Citizens' Coalition for Nursing Home Reform

1998

H. Jack Geiger, MD

City University of New York Medical School

1997

Lester Breslow, MD, MPH

University of California, Los Angeles

1996

Robert N. Butler, MD

Mount Sinai School of Medicine

T. Franklin Williams, MD

University of Rochester School of Medicine

1995

Lawrence L. Weed, MD

University of Vermont

1994

Bylye Y. Avery

National Black Women's Health Project

1993

David E. Rogers, MD

Cornell University Medical College

1992

C. Everett Koop, MD, ScD

Dartmouth Medical School

Faye G. Abdellah, EdD, ScD, RN

Uniformed Services University of the Health Sciences

1991

Robert M. Ball, MA

National Academy of Social Insurance

1990

Henry K. Silver, MD

University of Colorado Health Sciences Center

Loretta C. Ford, EdD, RN

University of Rochester

1989

Robert J. Haggerty, MD

William T. Grant Foundation

1988

Marie-Louis Ansak

On Lok Senior Health Services

1987

Ernest W. Seward, MD

University of Rochester Medical Center

1986

Julius B. Richmond, MD

Harvard University