

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION



TECHNICAL APPENDIX B2
SUMMARY OF KEY 2013 GOVERNMENT REPORTS

ADDENDUM TO 2013 COST TRENDS REPORT

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Summary

This technical appendix is a compilation of the executive summaries of key health care reports published by the Center for Health Information and Analysis (CHIA) and the Office of the Attorney General (AGO) that significantly informed and contributed to the Commission's 2013 Annual Report. These include:

- CHIA's Annual Report on the Massachusetts Health Care Market
- CHIA's Total Health Care Expenditures
- AGO's Examination of Health Care Cost Trends and Cost drivers

1 Center for Health Information and Analysis

1.1 Annual Report on the Massachusetts Health Care Market

Executive summary as prepared by CHIA: Massachusetts has achieved near-universal health coverage since 2006, when the first phase of health care reform was implemented under Chapter 58 of the Acts of 2006, Massachusetts' landmark health care reform bill. Massachusetts recently entered into the next phase of reform when Chapter 224 of the Acts of 2012 (Chapter 224) was passed, which focuses on lowering health care costs while maintaining or increasing the quality of care delivered in Massachusetts.

The 2013 *Annual Report on the Massachusetts Health Care Market* includes information on health care costs and quality with in-depth analyses of the commercial health care market, including premiums, coverage, and spending. The Center for Health Information and Analysis (the Center) will continue to assess the impact of particular Chapter 224 initiatives on public and commercial market health care trends to increase transparency in the Massachusetts health care payment and delivery system.

Most Massachusetts residents receive their health care coverage through their employers (62% in 2011) although in recent years this population has shifted somewhat to public coverage. In a continuing trend, the health coverage available through Massachusetts employers in 2011 cost more and had lower benefit value. Between 2009 and 2011, premiums rose by 9.7% to pay for benefits that decreased by 5%. Consistent with this trend, employees are paying increasingly more out-of-pocket for their health care. Deductibles have grown in Massachusetts by more than 40% between 2009 and 2011, approaching the national average.

The Massachusetts commercial health care insurance market remains concentrated with a few large payers that account for the vast majority of enrollees. Blue Cross Blue Shield (BCBS), Harvard Pilgrim HealthCare (HPHC) and Tufts Health Plan (Tufts) make up nearly 80% of the commercial market; BCBS alone accounts for 45%.

Within the commercial health insurance market, spending for member care rose 3.8% between 2010 and 2011. There has been some transition from fee-for-service (FFS) to alternative payment methods, but only in commercial HMO products. In 2012, 39% of total commercial payments were made within a global payment/budget framework (all within HMO products), while the majority of payments (61%) were made using the FFS method. Meanwhile, enrollment in HMOs dropped from 63% in 2011 to 59% in 2012.

The majority of commercial health care payments continued to be made to high priced providers. In 2011 and 2012, approximately 80% of health care spending for acute hospitals and physicians was concentrated in higher priced providers. Furthermore, most commercial payments went to a few large provider systems. Partners HealthCare System (Partners) received over three times the

amount paid to the next largest system, CareGroup (28.4% and 9.2%, respectively). Of the overall commercial payments to acute hospitals, Partners received approximately one-third, another third went to all other hospital systems combined, and the remaining third was paid to all hospitals not affiliated with a system. Of total physician group payments, Partners accounted for nearly one-quarter, almost 2.5 times higher than the second largest physician group system, Atrius Health.

Full report available here:

<http://www.mass.gov/chia/researcher/hcf-data-resources/information-on-the-massachusetts-health-care-system/2013-annual-report-on-the-massachusetts-healthcare-mark.html>

1.2 Total Health Care Expenditures

Executive summary as prepared by CHIA: The purpose of this paper is to describe the methodology for calculating total health care expenditures (THCE) for the Commonwealth of Massachusetts. Chapter 224 of the Acts of 2012 requires that the Center for Health Information and Analysis (the Center) report on THCE each year to monitor the rate of growth and measure the Commonwealth's progress toward meeting its health care cost growth benchmark.

The Center's approach to the THCE calculation aims to support its intended uses: analysis of state-level expenditures and the annual growth rate as well as to support analysis of potential drivers of cost growth. Toward that end, the Center's THCE model uses data reported timely and directly by Massachusetts commercial payers, the Centers for Medicare and Medicaid Services (CMS) and MassHealth, the Massachusetts Medicaid program. Since the model was designed to meet specific statutory requirements, it should be used only for Massachusetts-specific analysis and not for national comparison.

This paper provides background information on the Center's legislative requirements regarding the THCE calculation, discusses the objectives and intended uses of THCE, and presents the Center's methodological approach. This paper also describes the model's elements and data sources, and a comparison to other measures.

Based on the Center's model, THCE for Massachusetts residents in 2011 was about \$48.6 billion (\$7,351 per capita). Expenditures from commercially insured populations accounted for 36% of THCE, while expenditures from populations covered by public programs accounted for 59%. The net cost of private health in

The Commonwealth's initiative to link the growth in health care spending with the projected growth in gross state product is a first-in-the-nation approach to health care cost reform. The calculation of THCE represents an important opportunity for the Commonwealth to measure the progress of its cost containment efforts. The Center will report for the first time on the growth of THCE in 2013 in its *Annual Report on the Massachusetts Health Care Market* in August of 2014.

Full report available here:

<http://www.mass.gov/chia/docs/r/pubs/13/thce-methodology.pdf>

2 Office of Attorney General

2.1 Examination of Health Care Cost Trends and Cost Drivers

Executive summary prepared by the AGO: This is the Office of the Attorney General’s (AGO) third report examining health care cost trends and cost drivers in Massachusetts. In our 2010 and 2011 Reports, the AGO identified market dysfunctions that have resulted in escalating health care costs that are not explained by the value of services provided. Since those Reports, health plans, providers, and purchasers have taken steps designed to lower costs, promote efficiency, and improve health care delivery in Massachusetts. Examples include efforts to promote tiered network products, global payment arrangements, and contractual provisions that reward quality. The legislature has also encouraged better market function by promoting transparency and establishing new infrastructure to measure and oversee these market changes.

This Report analyzes recent market developments, focusing on identifying significant trends that hold promise, or pose challenges, for the Commonwealth’s efforts to promote efficient and effective delivery of health care. We examine market developments and their implications for three categories of market participants: Purchasers (Part I of the Report), Health Plans (Part II), and Providers (Part III). The conduct and choices of these market participants directly impact health care spending levels in Massachusetts.

Our principal findings in each of these categories are:

I. Purchasers/Consumersⁱ

- A. Purchasers have increasingly moved to tiered and limited network products.
- B. Purchasers have increasingly moved to PPO products, including self-insured PPO products, and away from fully-insured HMO products.
- C. Purchasers have increasingly moved to high-deductible products (in general, defined in this Report as products with an annual individual deductible of \$1,000 or more).
- D. Purchaser enrollment trends have significant implications for health plans designing products and for providers managing risk contracts.

ⁱ In this Report, “purchasers” include employers (who purchase insurance products for their employees), employees (who select among available product designs and benefits), and individual consumers (who obtain health care services and who may also shop for insurance directly through the individual market). Depending on the context, “consumers” are also sometimes referred to as “members” (e.g., when describing membership in different insurance products) or as “patients” (e.g., when discussing treatment or care received).

II. Health Plansⁱⁱ

- A. Health plans continue to pay providers widely different amounts to care for patients of comparable health.
- B. Variation in provider total medical expenses (“TME”) exists across Massachusetts and within separate geographic areas.
- C. Growth in prices of medical services, not utilization, is still the primary cost driver for each of the major commercial health plans in Massachusetts.
- D. The design of health plan products affects risk selection (which types of consumers tend to purchase which types of products), total medical spending, and care management.

III. Providers

- A. Providers are taking on increased performance risk under extremely complex contracts that lack consistency in incenting providers to coordinate care, manage costs, and successfully take on risk.
- B. Providers are taking on increased insurance risk without consistent mitigation by health plans. That is, contracts between health plans and providers vary widely with respect to protecting against extraordinary claims and adjusting for the health status of the provider’s patient population.
- C. Providers are aligning in ways that are not explained by care coordination or risk contracting requirements, though those reasons are often cited. Provider consolidation and alignments have significant market implications that should be measured and monitored, particularly where consolidation may reduce access to lower-cost options for consumers and undermine efforts to promote value-based decisions by purchasers.

These market trends can sometimes be in tension, or work at cross-purposes. For example, many health plans have taken steps to promote global risk contracts as a cost saving mechanism. But since these contracts generally apply only to HMO and POS members, purchasers’ shift to PPO products is in tension with the promotion of risk contracts. In another example, trends in risk contracting and provider alignments often encourage providers to keep care “in system.” These trends can be in tension with the growth in tiered and high cost-sharing products that incent

ⁱⁱ In this Report, “health plans” are sometimes referred to as “payers,” e.g., when discussing government payer programs, or in other contexts where “payer” is more commonly used. We received data from the four largest commercial health plans in Massachusetts: Blue Cross Blue Shield (“BCBS”), Fallon Community Health Plan (“FCHP”), Harvard Pilgrim Health Care (“HPHC”), and Tufts Health Plan (“THP”). Throughout this Report, we refer to these health plans as “major” commercial health plans in Massachusetts.

consumers to choose providers based on quality and efficiency, which may or may not correspond with keeping care “in system.”

This Report (Part IV) suggests ways that regulators – e.g., the Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA) (formerly the Division of Health Care Finance and Policy (DHCFP)), and the Division of Insurance (DOI) – may help the market address some of these tensions. We recommend:

- HPC and CHIA, in developing the provider registration program and reporting requirement, should require sufficiently detailed information about operations and finances across all books of business to support other key regulatory functions (e.g., certification of accountable care organizations, certification of risk bearing provider organizations, evaluation of the impact of provider operations on the state health care cost growth benchmark). For example, HPC and CHIA should require providers to submit information concerning whether the provider’s physicians are employed or affiliated, how payments are structured from the provider to its physicians, and information concerning key provisions in physician participation and/or employment agreements.
- In assessing the cost and market impact of proposed provider alignments, HPC should consider proposed changes in contract prices, any expected changes in referral patterns, market share, and volume to higher cost facilities, and the impact of all of these factors on total costs to consumers and purchasers across all lines of business. This includes analysis of any potential increase in hospital or physician payment rates due to a proposed provider alignment (e.g., if a lower paid physician group aligns with a higher paid physician group). To make such an analysis, HPC should require providers to explain any anticipated impact on costs and provide analysis to support how and when the proposed alignment would reduce health care costs.
- CHIA should require quarterly reporting by private and public payers to track the effects of different health plan product designs and payment arrangements including the reporting of TME, utilization, cost, and quality by product design and payment arrangement.
- DOI should develop minimum standards to protect risk-bearing providers from excessive insurance risk (e.g., develop a consistent approach to adjusting for changes in health status and exclude extraordinary claims from risk budgets).
- CHIA and DOI should require regular reporting from public and private payers of information sufficient to monitor trends in premiums, health status, product design and payment methodology in the merged market, large groups and self-insured groups, and across those groups to track cost and market changes over time. This includes developing more consistent product definitions so that information is reported uniformly.

Because of the finite scope of our examination, this Report does not and could not report on all of the efforts being made to improve our health care system. Our goal is not to assess who is right or wrong, but to measure and report on market initiatives that may inform policy discussions and government oversight of total health care spending. The AGO greatly appreciates the courtesy and cooperation of the market participants who provided information for this examination.ⁱⁱⁱ We look forward to our continued collective efforts to ensure that affordable, high quality health care is available to all Massachusetts residents.

Full report available here:

<http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>

ⁱⁱⁱ The AGO issued civil investigative demands pursuant to G.L. c. 118G, § 6½(b) to four major Massachusetts health

plans and eleven provider organizations. We gathered detailed cost, quality, financial, and operational information, including risk contracts and settlements; health care cost, utilization, and total medical expenses data; information on plan membership, product design, and benefit design; analysis of provider financial, operational, and business performance; physician contracts; and documents related to provider consolidations and affiliations. In addition, we conducted nearly three dozen interviews and meetings with providers, health plans, health care experts, consumer advocates, employers, and other key stakeholders. To assist in its review, the AGO engaged consultants with extensive experience in the Massachusetts health care market, including an actuarial consulting firm and experts in the areas of payer-provider contracting and health care quality measurement and evaluation.