Commonwealth of Massachusetts

Health Policy Commission

Health Care Cost Trends Hearing 2013

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

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Health Care In Massachusetts

We benefit from:

- Shared responsibility of employers, individuals, health plans and providers
- Highly rated health plans and hospitals
- Model for health care reform

We are challenged by:

- Trends in health care spending exceeding economic growth
- Lack of price transparency
- Lack of incentives for right care at right location

Massachusetts Is a National Leader in Health Care Reform

YEAR	MASSACHUSETTS HEALTH CARE REFORM	
2006	Chapter 58 – Health Reform	
	• Individual Mandate • Employer Responsibility	• Medicaid Expansion • Insurance Exchange
2008	Chapter 305 – Cost Containment Legislation I • AG Authority to Examine Cost Trends	
2010	Chapter 288 – Cost Containment Legislation II • Transparency • Tiered/Limited Network Products • Reform of Unfair Contracting Practices	
2012	Chapter 224 – Cost Containment Legislation III • Oversight of Payment Reform & Provider Registration • Benchmark Health Spending to Gross State Product • Price Transparency for Consumers	

AGO Cost Trend Examination

Examined recent market efforts designed to improve health care cost and use:

1. How are purchasers responding to new health plan designs and transparency?
2. How are health plans moving to incent purchasers and providers to make value-based decisions?
3. How and why are provider groups realigning to deliver care?

1. PURCHASERS

Employers and individual health care purchasers have increasingly:

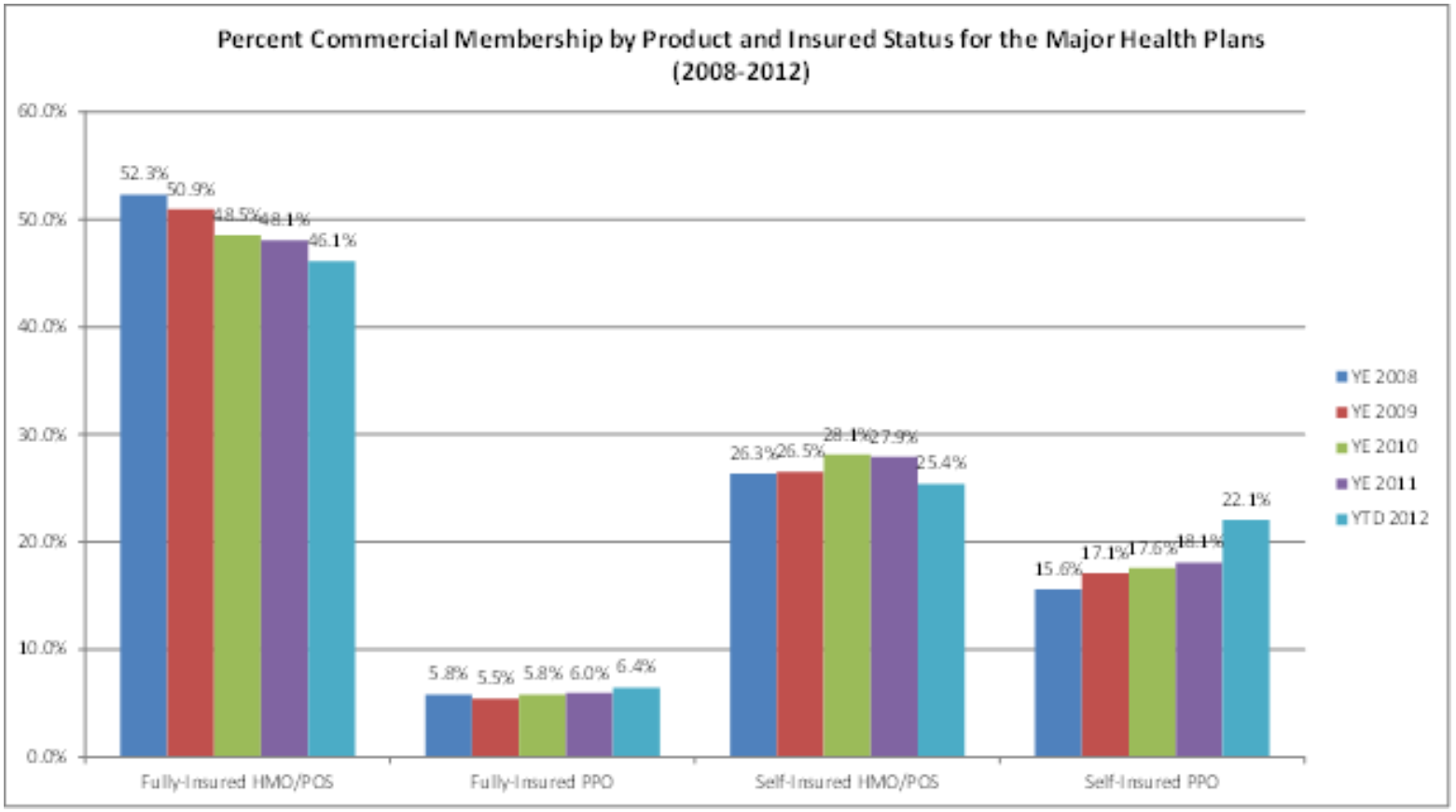
- Moved to health insurance products with tiered networks
- Moved to PPO products and away from HMO products
- Moved to high-deductible health plans

Purchasers Increasingly Moving to Tiered and Limited Network Products

Growth in Tiered v. Limited Network Membership

	YE 2008		YTD 2012	
	Tiered	Limited	Tiered	Limited
BCBS	12,987	0	168,656	0
FCHP	0	34,402	13,142	40,169
HPHC	47,490	0	88,938	3,852
THP	108,693	1,848	154,177	8,666
Total	**169,170**	**36,250**	**424,913**	**52,687**

Purchasers Have Increasingly Moved To PPO Products, Including Self-Insured PPO Products, And Away From Fully-Insured HMO Products



Purchasers Have Increasingly Moved To High-Deductible Products

- From 2008 to 2010, proportion of individual market enrolled in high-deductible products increased from 45% to 55%.
- During same time period, small group plan enrollment in high-deductible products increased from 2% to 27%.
- Trends in Massachusetts are consistent with national trends.

Purchaser Decisions Affect Health Plans and Providers Implementing Risk Contracts

- Increased enrollment in PPO impacts provider performance under risk and PPO/HMO revenue streams.
- Consumer incentives under products that encourage value-based purchasing may come into tension with provider incentives.
- Products designed to help consumers make value-based decisions can also help providers direct patients to the appropriate care at the appropriate location.

2. HEALTH PLANS

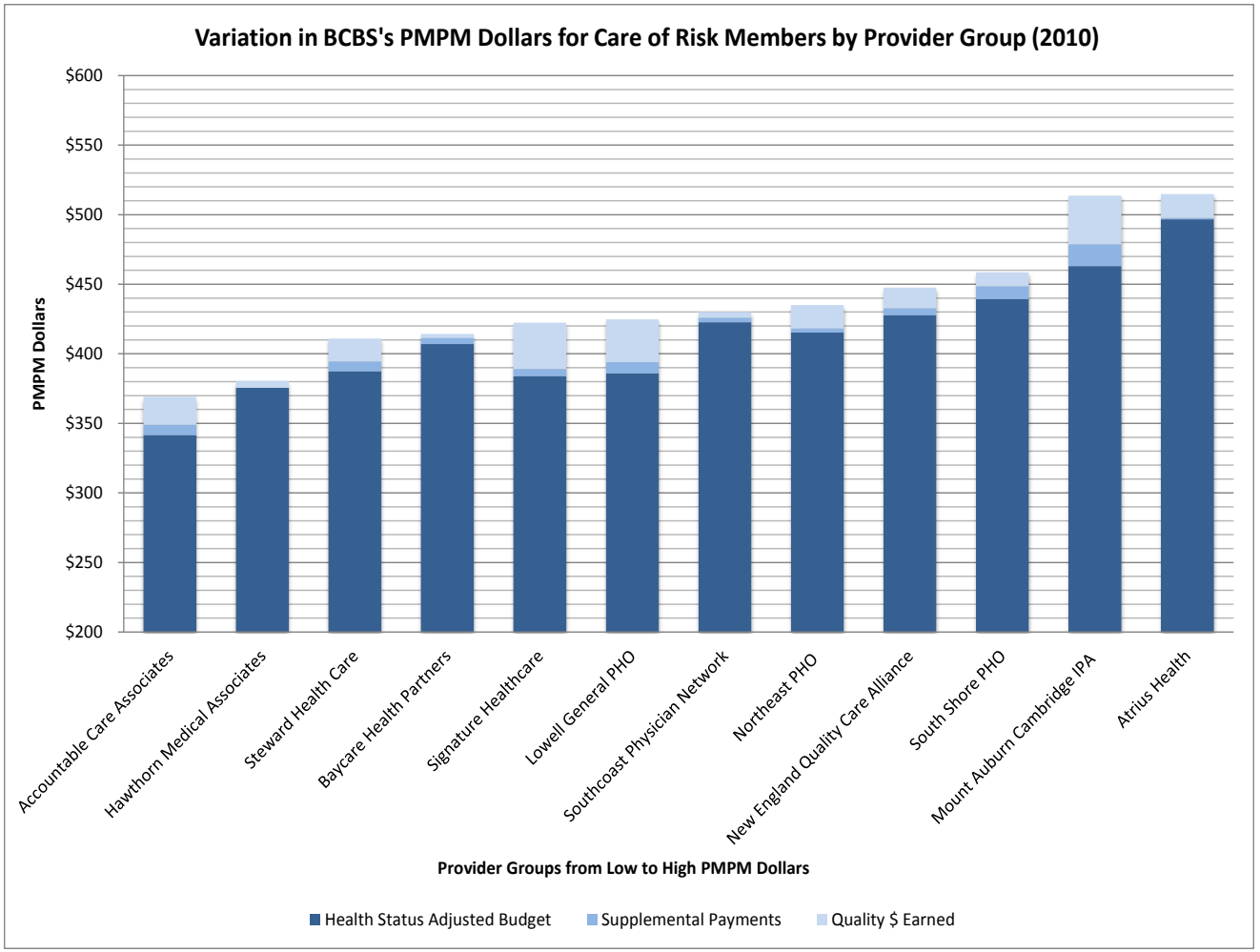
Health plans negotiate different amounts with providers to care for patients of comparable health, reflected in variation in:

- Risk budgets
- PPO and HMO payment rates
- Across providers serving different populations that vary by health status and geographic area

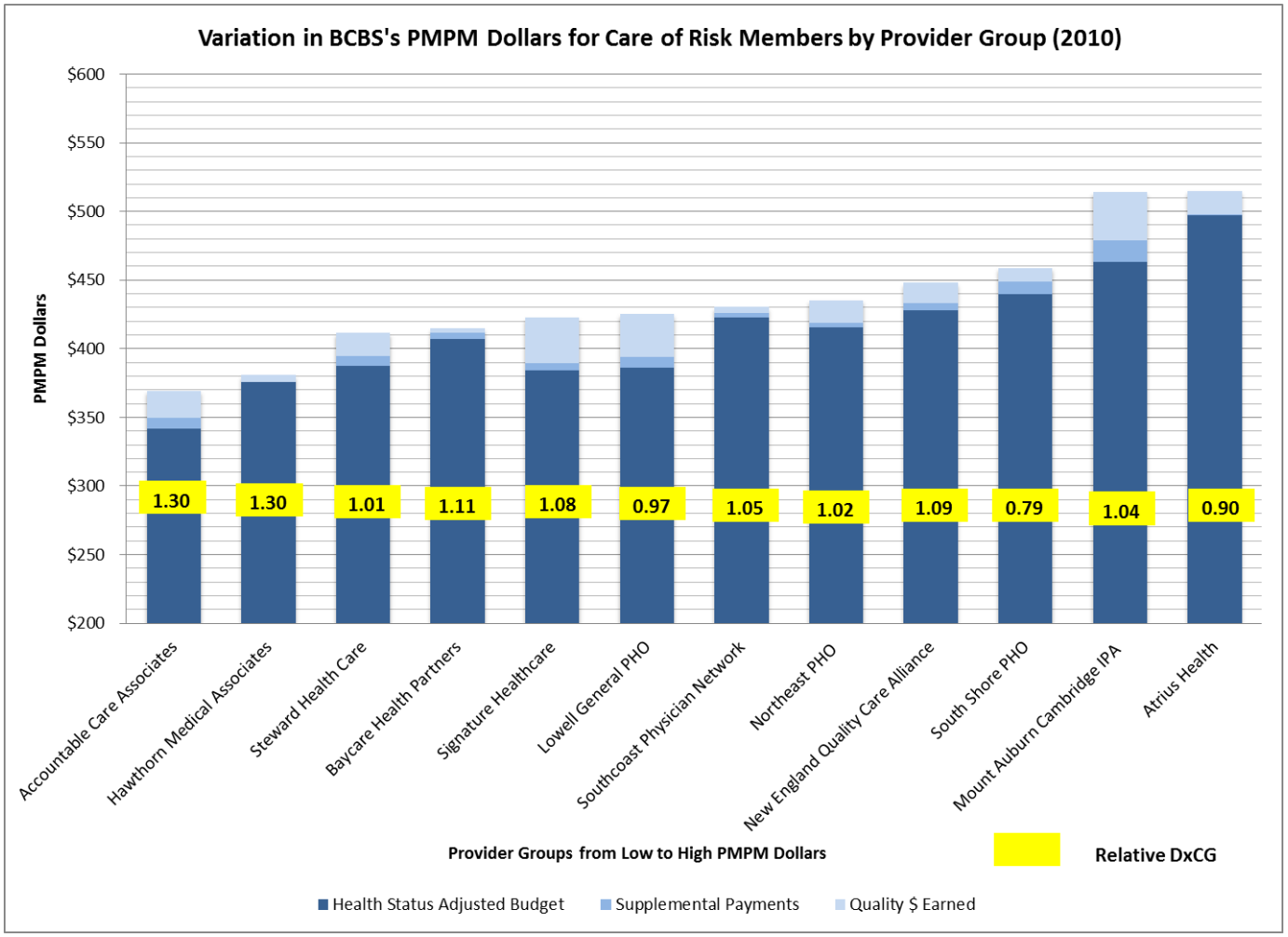
Health plan product designs impact:

- Risk selection (consumer purchasing based on health)
- Total medical spending
- Care management

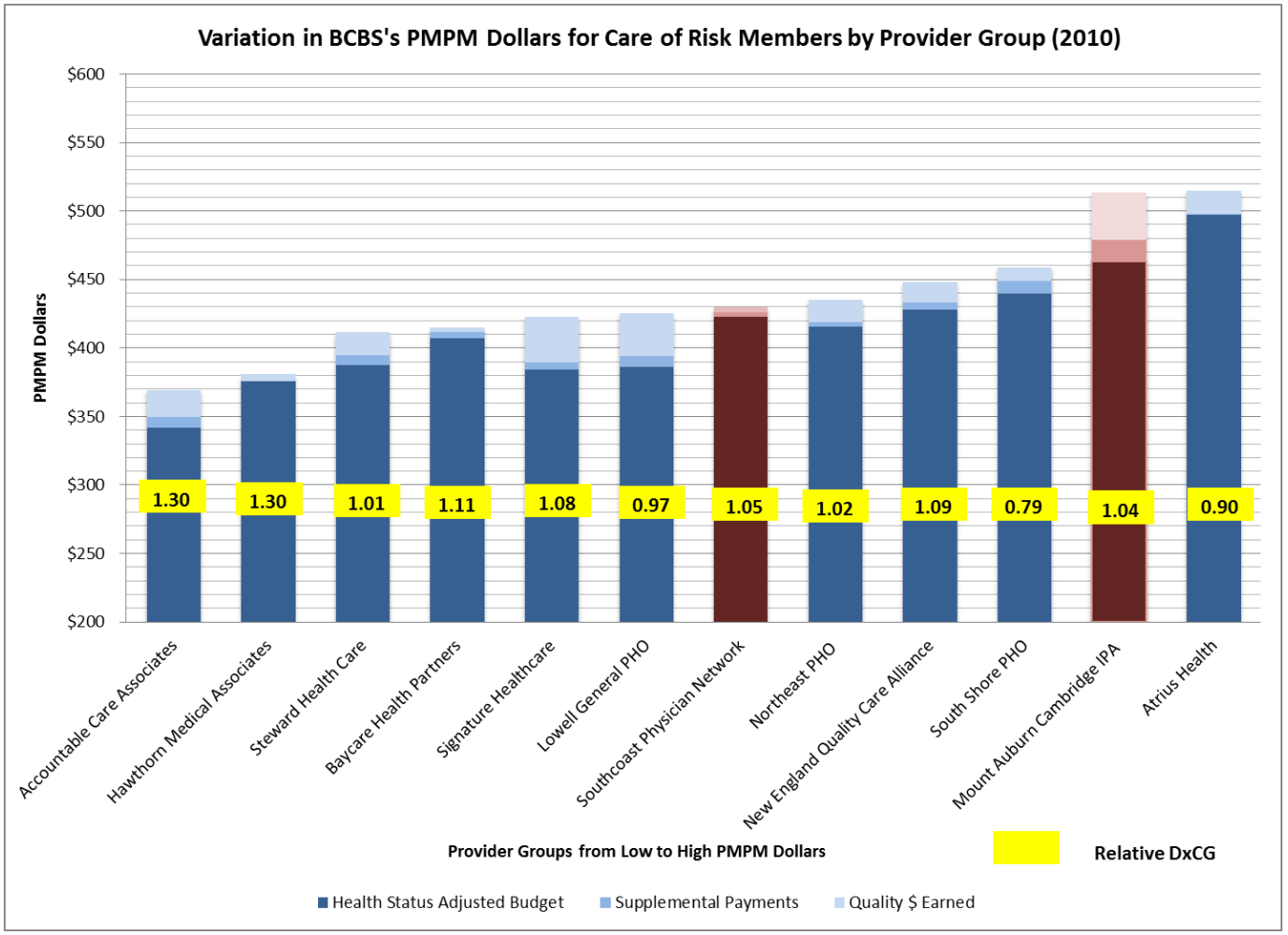
Variation in Risk Budgets Not Explained by Health Status of Populations Being Care For



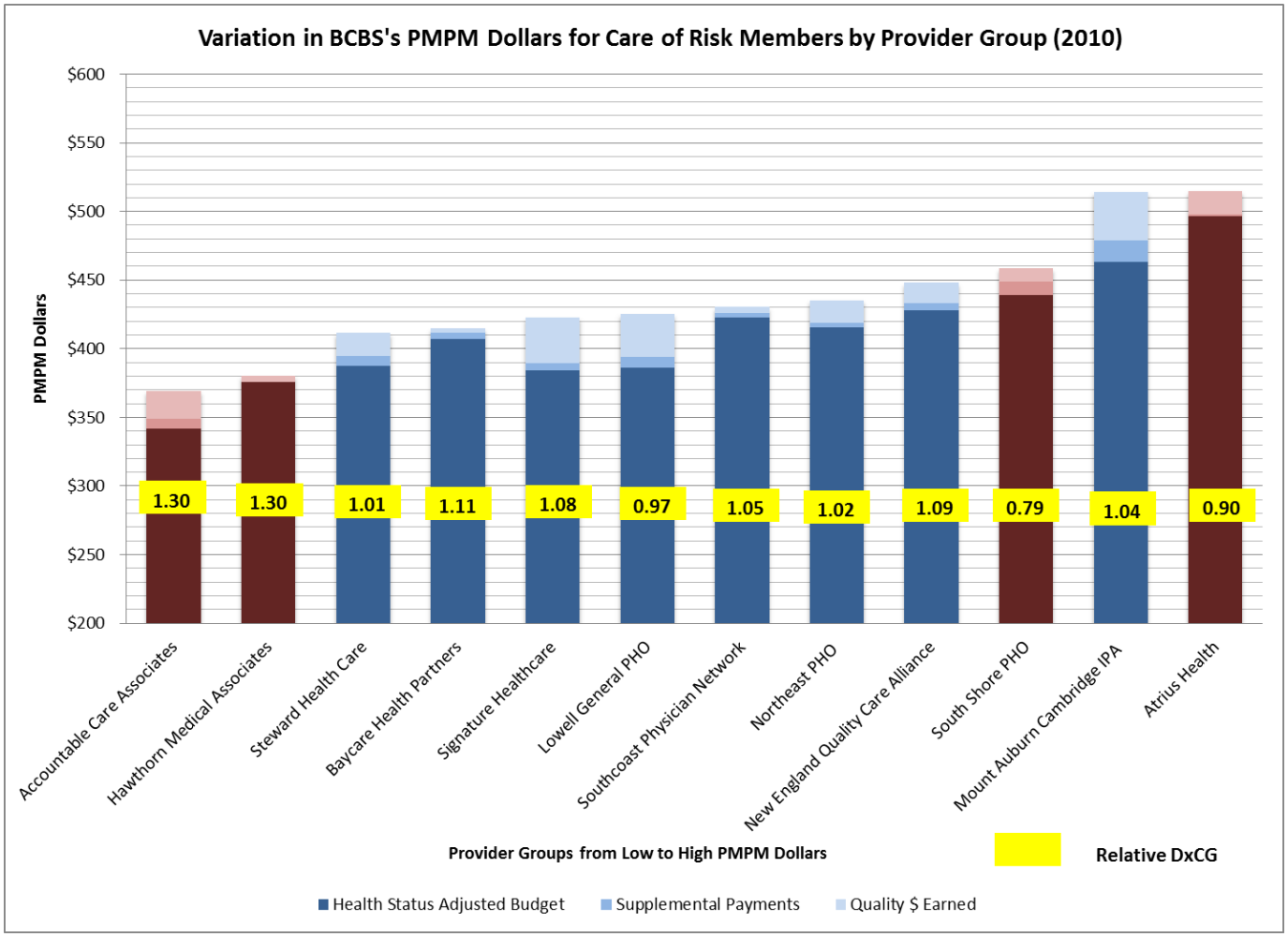
Providers Care for Very Different Populations Under Risk Contracts



Budget Variation Significant Even for Providers Caring for Populations of Equivalent Relative Health Status (1.04-1.05)

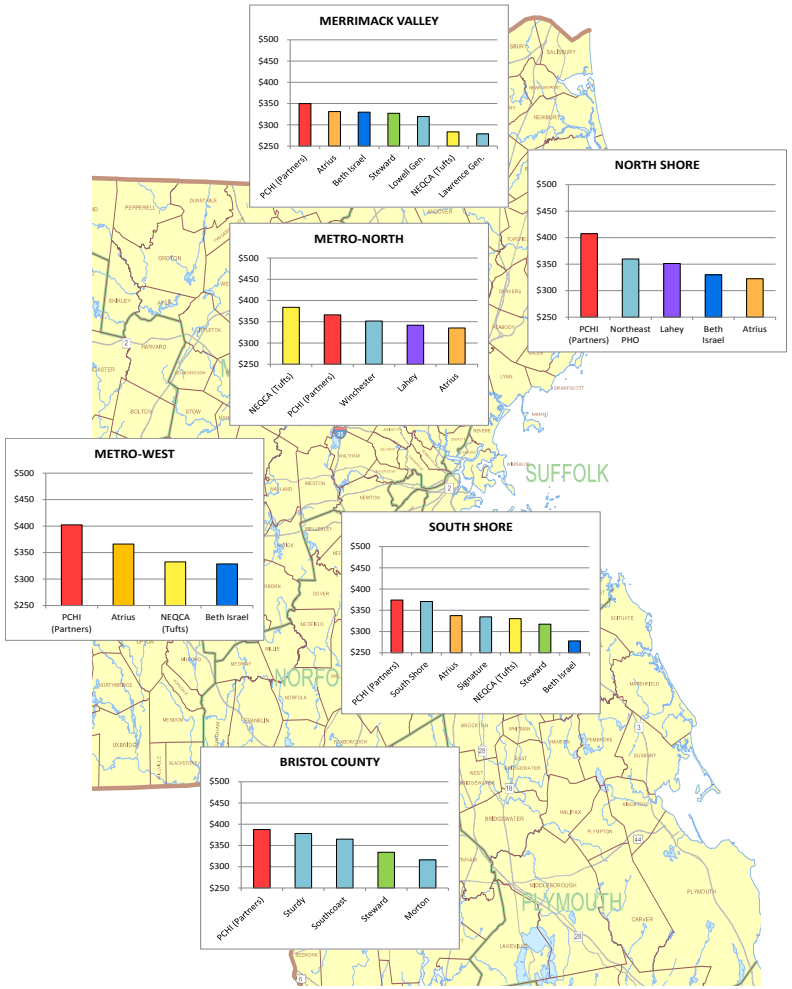


Budget Variation Significant for Providers Caring for Very Different Populations

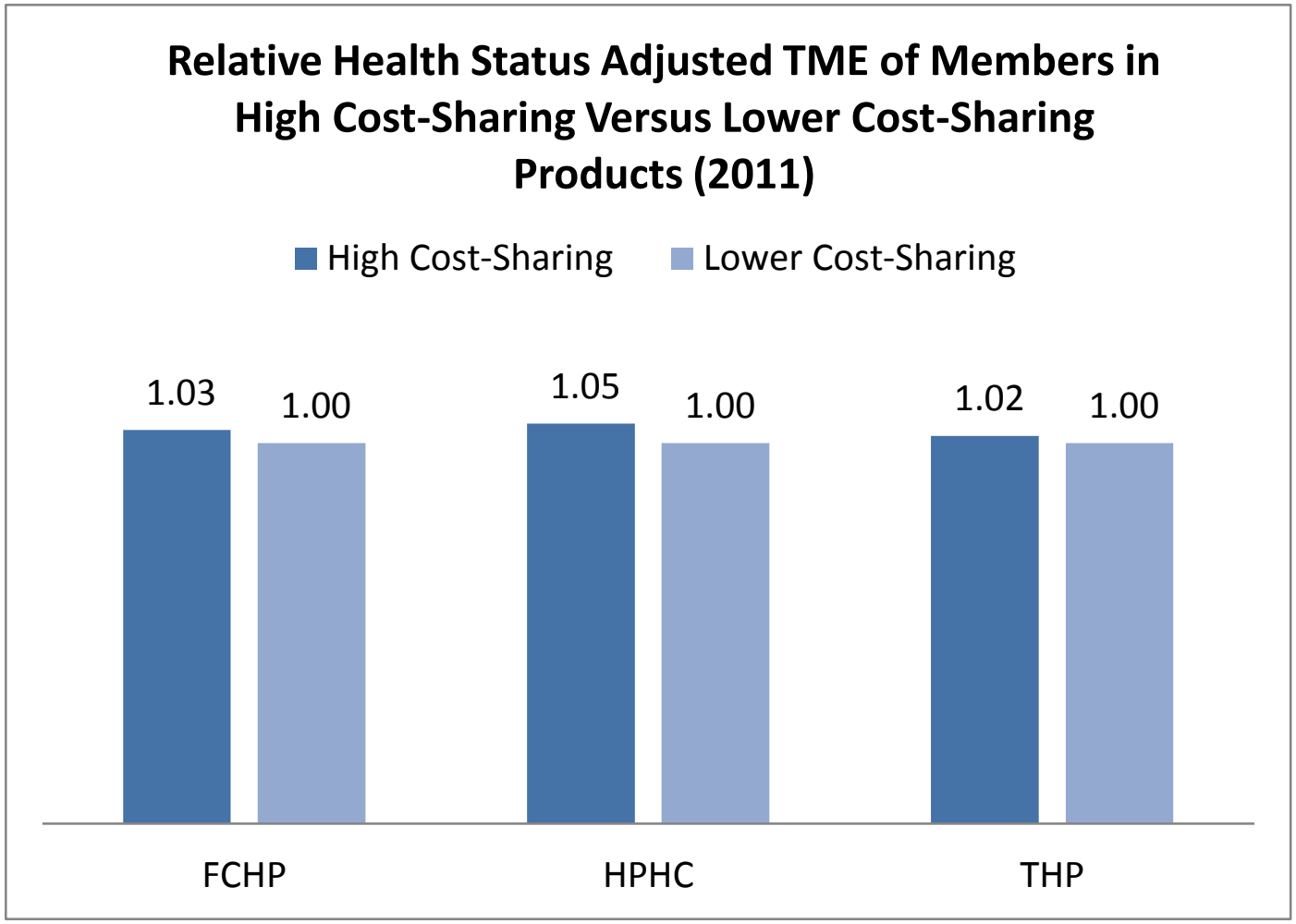


Variation in Provider TME Exists Across Massachusetts and Within Separate Geographic Areas

Variation in a Major Health Plan's Provider Group TME by Region (2011)



Certain Products Appear to Be Associated with Lower Medical Spending on a Health Status Adjusted Basis



Health Plans Can Support Prudent Purchasing and Incentivize Efficient Care Delivery

- Risk contracts and other payment arrangements can encourage efficient, high quality care delivery if reimbursement is tied to value.
- Products can encourage consumers to seek appropriate care at the appropriate location.
- We should continue to examine the performance of different products to assess their impact on costs and care delivery.

3. PROVIDERS

- Providers are entering new risk contracts and are taking on increased insurance risk without consistent mitigation by health plans.
- Provider consolidations and alignments are taking place without adequate analysis of the potential benefits and cost implications.

Providers Are Taking On Increased Insurance Risk Without Consistent Mitigation By Health Plans

ADJUSTMENTS PRESENT IN 2012 RISK CONTRACTS				
	BCBS	HPHC	THP	CMS (P-ACO)
Health Status	Yes	Sometimes	Sometimes	No
Mandated Benefits	Sometimes	No	No	Yes
Unit Price	Sometimes	No	No	n/a

The Impact of Provider Alignments Should Be Measured and Monitored

- Providers serve patient populations that vary by health status and size:
  - 2011 health status scores of provider systems with the least healthy populations ranged from 1.7 to 2.3 times that of provider systems with the healthiest populations for three major MA health plans.
  - Acton Medical Associates manages roughly 6,100 risk lives under three commercial risk contracts.
  - Larger systems manage more than 50,000 risk lives under individual risk contracts.
- Potential benefits of provider alignments should be balanced against concerns of increasing market leverage and reducing consumer options.

Providers Can Support Prudent Purchasing Decisions and Efficient Care Delivery

- Providers should support prudent purchasing decisions by directing patients to obtain the right care at the right location.
- Providers should support efficient care delivery through internal efforts to coordinate care and by directing care to more efficient providers when appropriate.

Data Accuracy

- Data Sources
  - Publicly Available
  - Information received directly from carriers and providers
- Importance of Data Accuracy
- Data Improvements

Working Together

- We must continue to work with purchasers, health plans and providers to promote a value-based health care market.
- We need timely and accurate information to monitor and address tensions and unintended consequences that may result from efforts by purchasers, health plans and providers to change how we use and pay for health care services.

Protecting Consumers

- The Office of the Attorney General will continue to use its authority to promote appropriate transparency to empower consumers to make value-based decisions.
- We will continue to use our authority to protect consumers from unfair practices that restrict access to necessary health care services, including behavioral health care services, or result in inflated costs.

RESOURCES

- Attorney General's Examinations of Health Care Cost Drivers:
  1. http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf
  2. http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf
  3. http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf

- Massachusetts Health Care Cost Containment Legislation:

  http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288

  http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

- Center for Health Information & Analysis Reports:

  http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf

  http://www.mass.gov/chia/docs/r/pubs/13/relative-price-variation-report-2013-02-28.pdf

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Health Care Cost Trends Hearing 2013

Addressing Impact of Provider Consolidation

Paul B. Ginsburg, Ph.D.

Testimony presented to Massachusetts Health Policy Commission, October 2, 2013

Powerful Trend towards Provider Consolidation

- Understanding the Trend
  - Context of Consolidation
  - Drivers of Consolidation
- Impact of Trend
- Particular Impact of Hospital-Physician Consolidation
- Policy Responses

Trends in Provider Consolidation

- Hospital consolidation is on the rise:
  - Over 1,000 hospital mergers since mid-90s (Gaynor)
  - Consolidation slowed in the past decade, but has picked up recently
  - Most urban areas are now dominated by 1-3 large hospital systems

Drivers of Provider Consolidation

- Increased leverage/revenue
- Respond to push for coordinated and integrated care
  - HIT and quality reporting requirements
- Future requirements appear daunting to smaller hospitals and medical practices
  - Motivating mergers with larger organizations
- Advocates of coordinated care:
  - Accept some additional consolidation
  - Put in place mechanisms to contain price increases

Impact of Provider Consolidation

- Research shows that consolidation drives up prices (Gaynor, Kleiner, Schneider, Dafny)
  - Hospitals mergers have led to price increases of 3.5-53 percent (Gaynor)
- Range of increase is affected by availability of competitive options
- Providers with “must have” status have substantial leverage even when concentration is low
- Higher prices lead to higher insurance premiums
  - Burden to consumers, employees, employers, governments

Recent Challenge of Hospital-Physician Consolidation (1)

- Hospital acquisition or affiliation with physician groups and employment of physicians
  - The most active area of consolidation
  - Strong direct effects on prices
    - Hospitals negotiate much higher prices for services of employed physicians
    - Addition of a facility fee
    - Indications of higher hospital prices as well

Recent Challenge of Hospital-Physician Consolidation (2)

- Challenges for purchasers beyond price increases
  - Obstacle to insurers' steering of patients to high-value providers
    - PCPs and specialists locked into referring to system
  - Discourages development of physician organizations
    - Reduced potential for competition in ACO/risk contracting market

Care Coordination with Less Consolidation

- Small physician practices can join IPA or larger group instead of becoming hospital employees
- Hospital can develop contractual relations looser than ownership
  - Not only physician organizations, but other providers
  - For example, rather than purchase post-acute providers, hospitals can identify those worthy of contractual relationship

Need for Steps to Limit Impacts on Prices

- Market approaches
  - Steps by employers/insurers to engage patient/consumer to seek lower-priced providers
    - Incentives
    - Information
- Government efforts to facilitate market approaches

Better Information on Price and Quality for Enrollees

- Online tools for enrollees
  - Customize to relevant insurance product and enrollee's deductible/account
- Scope will grow with increasing deductibles
  - But most opportunities on outpatient side
  - Inpatient pricing much more complex
    - Other approaches involving less price data have more promise

Limited Networks

- Fewer providers in network leads to lower prices in two ways: steering and increased leverage
- Public more receptive now than in 1990s
  - Affordability challenges are larger
  - ACA exchanges and subsidies create ideal incentive structure
    - Absence of “one size fits all” requirements that apply to employer-sponsored insurance
- Potential regulatory obstacles from network adequacy

Tiered Networks

- Potential for broader appeal than limited networks
  - Less of a commitment by enrollee
  - Potentially more effective if done by service line
- But prominent hospitals can block through refusal to contract

Reference Pricing

- More aggressive approach to tiers
  - Stronger patient incentives
  - But applies to relatively small share of spending
- Works best with discrete outpatient procedures
  - Colonoscopy
  - MRI
  - Cataract surgery
- Carriers split on priority to give to approach

Fostering Physician Organizations (1)

- Potential upside
  - More competitive hospital market
    - Reduce attractiveness of hospital employment
    - Protect use of incentives to steer patients to higher-value hospitals and specialists
      - Results from AQC evaluations
  - Potentially more effective performance under global payment incentives than hospital-led organizations
    - Less conflicted incentives

Fostering Physician Organizations (2)

- Financial/technical assistance to organizations
  - BCBSNC HIT subsidies for practices
  - CareFirst BCBS PCMH initiative
    - Global incentives and information provision for PCPs
    - Pods for small PCP practices
- Purchase of physician organizations
  - Insurers (United purchase of Monarch IPA)
  - Others (e.g. DaVita purchase of HealthCare Partners)
    - Capital injections support expansion

Government Actions to Foster Market Approaches (1)

- Regulation of hospital contracting practices
  - Prohibit demands for tier placement
  - Prohibit all or none system contracting
- Require plans to provide real-time price data for enrollees
- Support for physician organizations
  - Loans/grants to establish infrastructure
  - Easier requirements for ACOs (Medicare)
  - Eliminate higher Medicare payments for physician services in hospitals (MedPAC proposal)

Government Actions to Foster Market Approaches (2)

- Broader access to physician-specific data for profiling
  - Medicare Part B claims data
  - State all-payer claims data

Conclusions

- Strong trend towards provider consolidation in response to challenging environment
  - Potential to facilitate integration and coordination, but also potential for higher prices
- Both private sector and government can take steps to address increasing provider leverage on prices through market approaches
- Degree of success will determine whether direct regulation is pursued

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CATALYST FOR PAYMENT REFORM

EMPOWERING PURCHASERS: ADVANCING TRANSPARENCY, INFORMATION, AND INCENTIVES

Suzanne Delbanco, Ph.D.
Executive Director
October 2, 2013

Who We Are

Catalyst for Payment Reform (CPR) is an independent, non-profit corporation working on behalf of large employers and public health care purchasers to catalyze improvements in how we pay for health services and to promote higher-value care in the U.S.

- 3M
- Aircraft Gear Corp.
- Aon Hewitt
- Arizona Health Care Cost Containment System (Medicaid)
- AT&T
- Bloomin' Brands
- The Boeing Company
- CalPERS
- Capital One
- Carslon
- Comcast
- Dow Chemical Company
- eBay, Inc.
- Equity Healthcare
- GE
- Group Insurance Commission, Commonwealth of MA
- The Home Depot
- Ingersoll Rand
- IBM
- Marriott International, Inc.
- Ohio Dept. of Jobs and Family Services (Medicaid)
- Ohio PERS
- Pennsylvania Employees Benefit Trust Fund
- Pitney Bowes
- Safeway, Inc.
- South Carolina Health & Human Services (Medicaid)
- TennCare (Medicaid)
- Verizon Communications, Inc.
- Wal-Mart Stores, Inc.
- The Walt Disney Company
- Wells Fargo & Company

What We Focus On

Shared Agenda

Payment designed to cut waste or reflect/support performance

- Value-oriented payment that creates incentives to improve quality and contain costs
- 20% by 2020 as measured by National and Regional Scorecards

Special Initiatives

- Price transparency
- Reference and value pricing
- Maternity care payment reform

Environment

- Provider market power
- Private-public alignment
- Alternative routes to value
- Critical mass and a consistent ask

What We Do: CPR's Two-Pronged Strategy

Market-Based Action

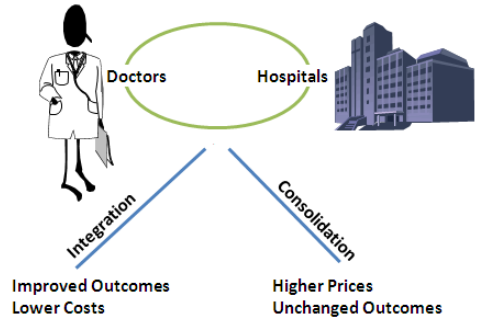
- Aligned purchaser agenda – short-term wins, longer-term bold approaches
- Clear signals to plans – RFIs, contracts, user group discussions and metrics, transparency tool specs
- Toolkit for local action – health plan user group toolkit, Market Assessment Tool, regional scorecards, action briefs, joint pilots, etc.

Shine Light on Urgency to Spur Reform

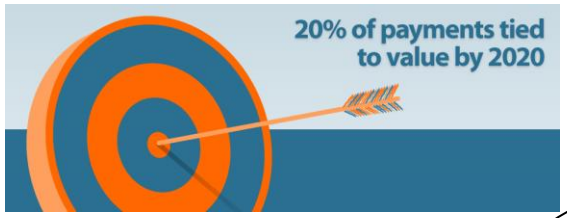
- Accountability: National Scorecard and Compendium on Payment Reform
- Raise visibility of payment variation
- Price Transparency State Report Card & statement
- Highlight provider market power issues & potential solutions

Market-Based Reforms with Wind in their Sails Across the Nation

Provider Consolidation – vertical and horizontal



Payment Reform "Arms Race"

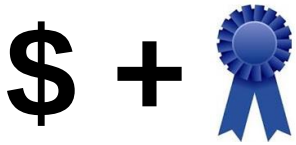


Delivery Reform – ACOs, PCMH, high-intensity primary care, group visits

Employers Shaking Up the Market – high-performance networks, direct contracting, medical tourism

New Markets for Insurance – Private exchanges, state reforms, state exchanges

Engaging Consumers with Incentives: VBID, reference pricing, tiered networks



Engaging Consumers with Information: open notes, shared decision making, true informed consent, comparative effectiveness

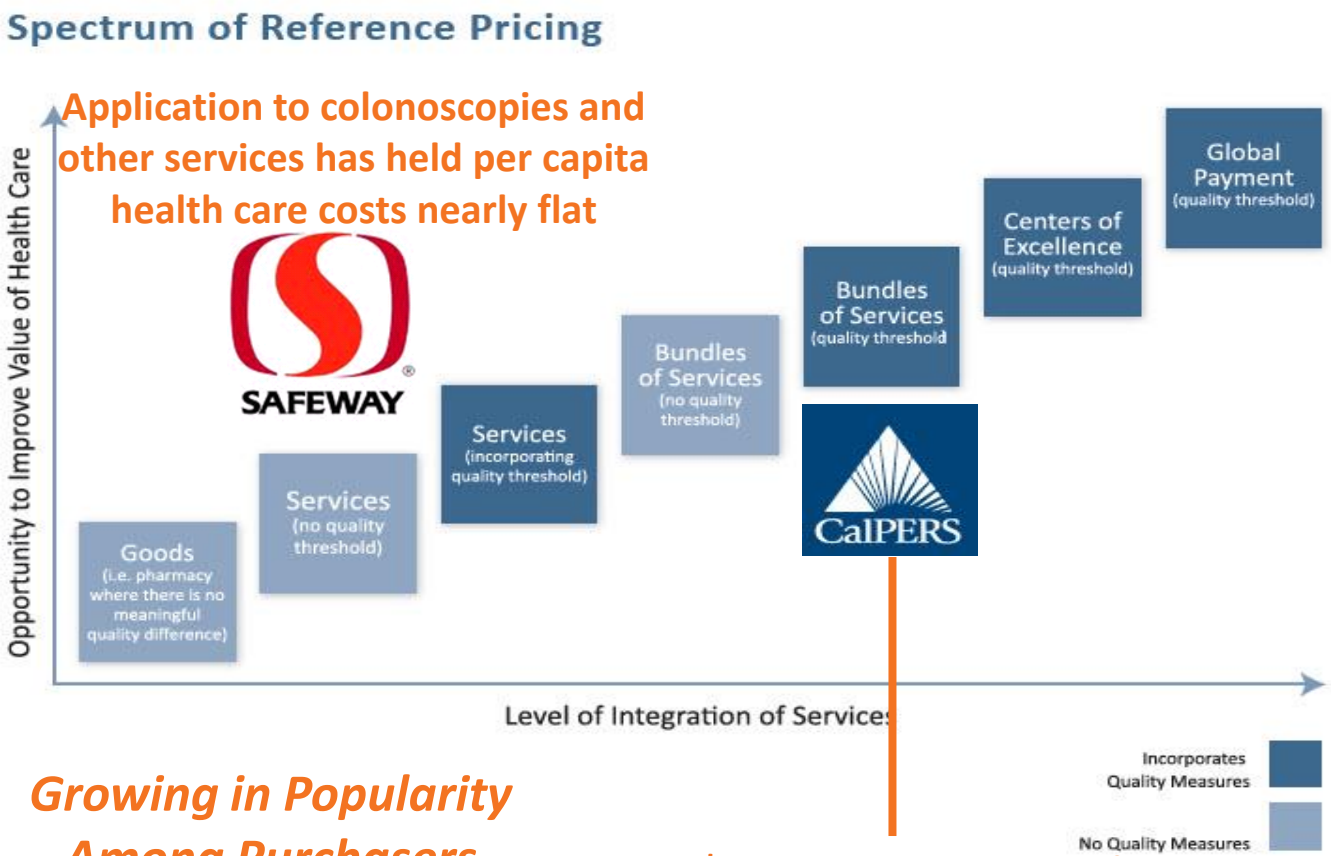
ACA

What are Purchasers Trying Today?

Consumerism, Benefit design, and Decision Support Tools:

- Consumer Directed Health Plans/Account-Based Plans
- Cost Sharing and Centers of Excellence
- Evidence-Based Plan Designs & Value-Based Insurance Designs
- Employee Cost Sharing
- Reference Pricing
- Reward/Penalize Health Improvement Activities
- Aggressive Management of Pharmacy Benefits
- Transparency
- Shared Decision Making
- Participation in ACOs and PCMHs

From Reference to Value Pricing



Growing in Popularity Among Purchasers Nationally: 5% in 2013; 15% in 2014*

**NBGH/Towers Watson*

Over $3 million in savings in first year of hip/knee replacement program; some high-priced providers renegotiated

Reference Pricing *establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount.*

Value Pricing *is when quality is also taken into consideration in addition to the standard price.*

- *Signal to providers that payment variation isn't tolerable*
- *Engages Consumers*

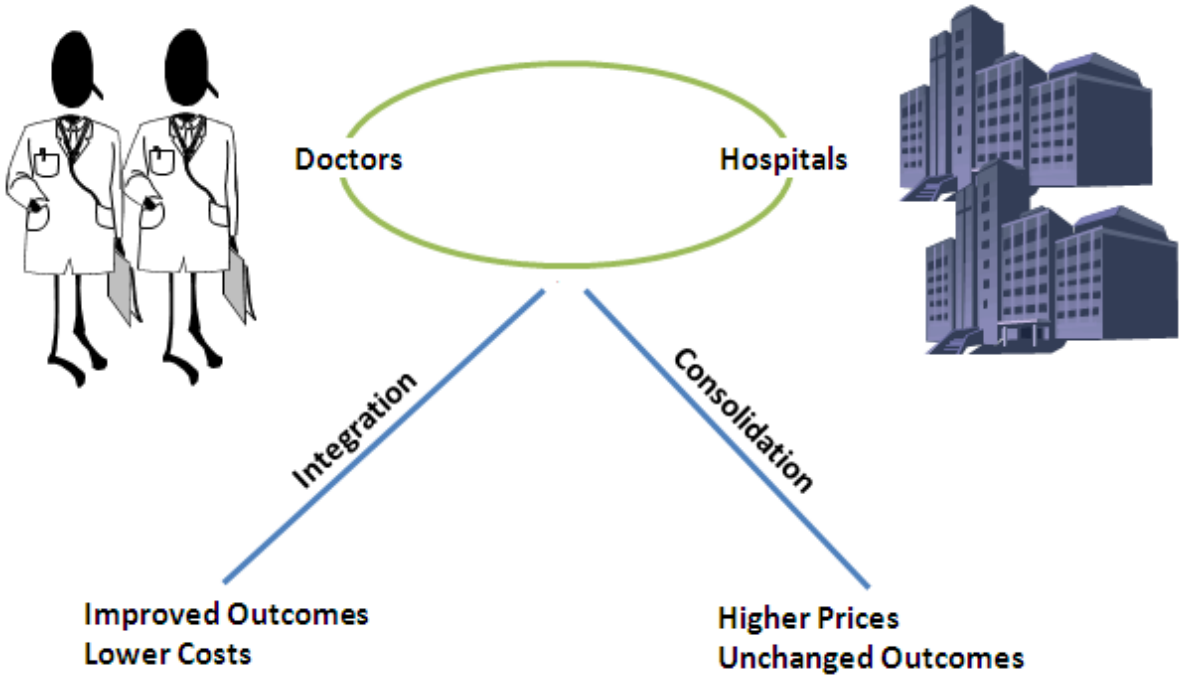
What are Purchasers Trying Today?

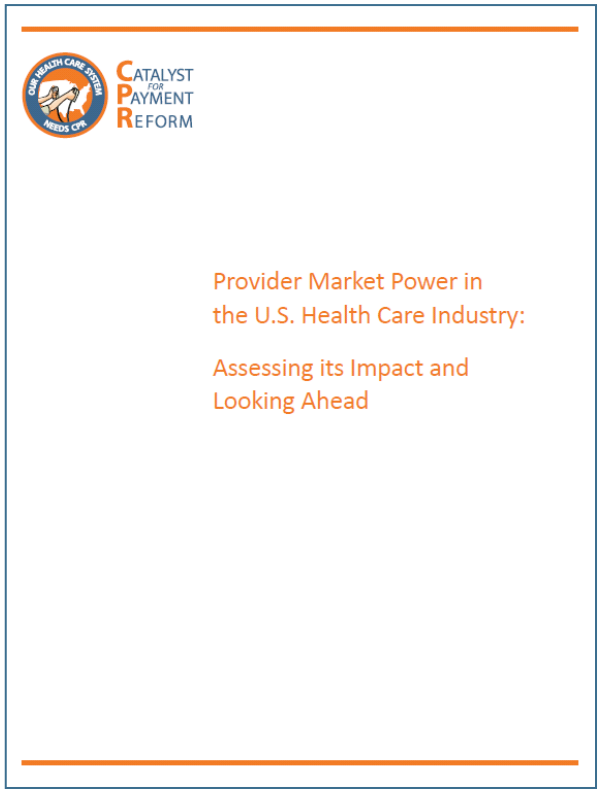
Network design, alternative sources of care:

- Limited, narrow, tiered or customized high-performance networks (e.g. Group Insurance Commission)
- Onsite, Near Site, or Mobile Clinics
- Telehealth
- Direct contracting

Provider Market Power: Bringing Issue to Forefront

Price is the leading driver of health care cost growth today





Consolidation pushes payments 3% higher nationwide

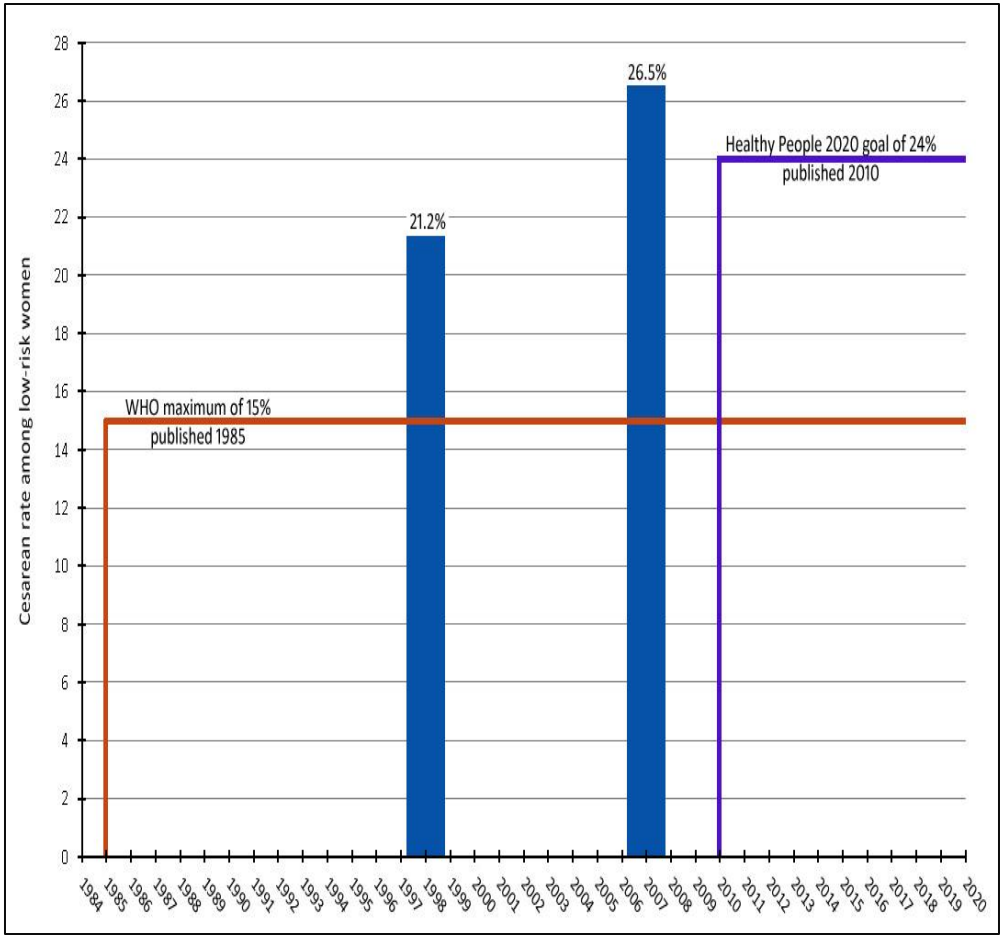
What are Purchasers Trying Today?

Payment Reform

- PCMH
- ACOs
- Bundled payment
- Non-payment for care that doesn't follow guidelines

Fix How we Pay for Maternity Care

- **Practice patterns straying from the evidence**
  - Pre-term elective births
  - Unnecessary intervention
  - Worse outcomes and higher costs
- **The way we pay today creates incentives for unnecessary intervention**
  - Need to insert right incentives
  - Blended, bundled payment
  - Non-payment for early elective deliveries



US is moving farther away from goals

What are Purchasers Trying Today?

Efforts to improve employee health:

- High-Cost Case Management Programs
- Financial Incentives for Health Improvement
- Require Employee Engagement to Receive Health Benefits

Road Map

- **Leg 1:** Discounts in return for volume
- **Leg 2:** Unfettered access, insulation from costs
- **Leg 3:** Awareness of variation and poor value, engaging consumers, transparency, creating incentives, seeking alternative sources of care

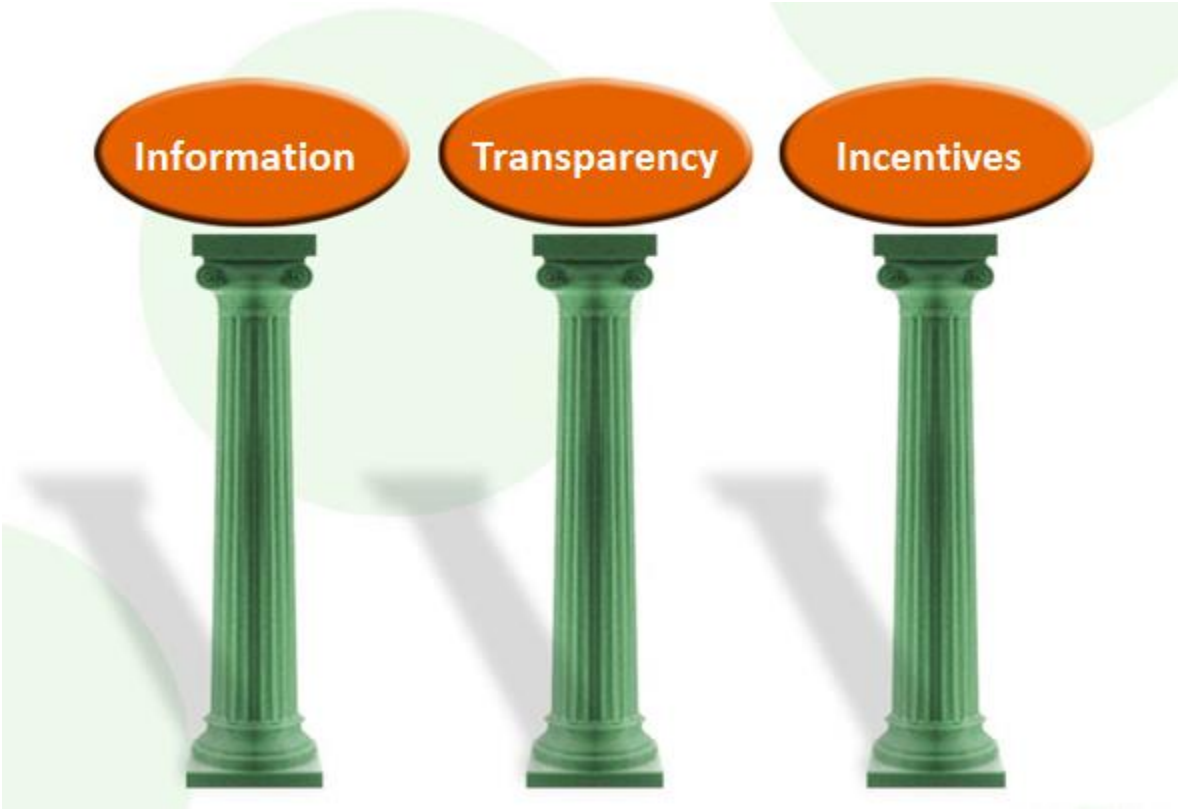
- **Leg 4:** Shaping provider and consumer behavior with a stronger market, identification of best overall value, payment varying with quality and cost, willingness to select select providers, public and private exchanges…

WHERE IS THE HEALTH CARE SYSTEM GOING? WHAT'S THE NEXT LEG OF THE JOURNEY? WHO TAKES THE WHEEL?

We are here

LOOKOUT FOR NEW OPPORTUNITIES

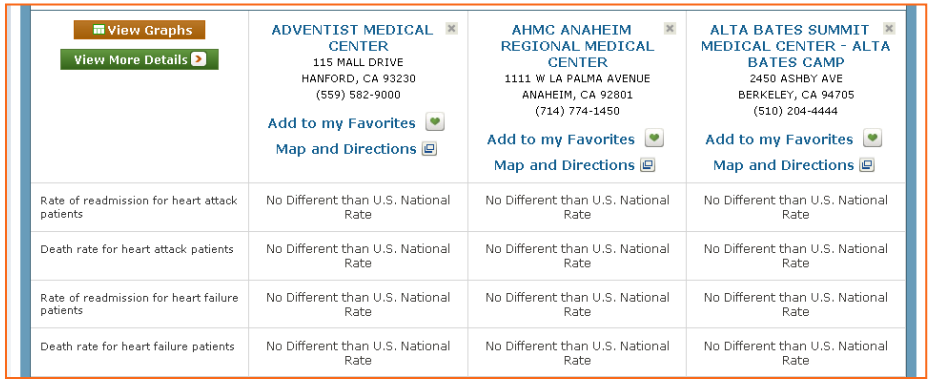
Three Pillars



Information

Huge quality variation

- Quality Measures would be different if set by purchasers: measures on areas of performance where improvement could lead to the greatest reduction in harm, with the greatest variation on quality and price, areas of greatest cost
- Instead we have measures that are easy to collect and show little variation across providers and meaningless to consumers
- But we know enough to know there are massive failures



Huge payment variation (amounts)

Table 6: Observed Prices for Selected High-Volume Maternity DRGs by Severity of Illness, 2009

APR-DRG and severity	Minimum price	Median price	Average price	Maximum price	Difference between maximum and minimum price	Ratio of maximum to minimum price
Cesarean delivery (540)						
Severity 1	$3,244	$7,598	$7,859	$15,915	$12,671	4.9
Severity 2	$2,828	$8,718	$9,338	$20,424	$17,596	7.2
Severity 3	$3,621	$11,389	$13,266	$26,018	$22,397	7.2
Severity 4	$9,600	$17,134	$19,156	$30,660	$21,059	3.2
Vaginal delivery (560)						
Severity 1	$1,810	$4,990	$5,225	$11,066	$9,256	6.1
Severity 2	$2,182	$5,692	$5,884	$12,177	$9,995	5.6
Severity 3	$2,812	$6,450	$7,656	$20,446	$17,634	7.3

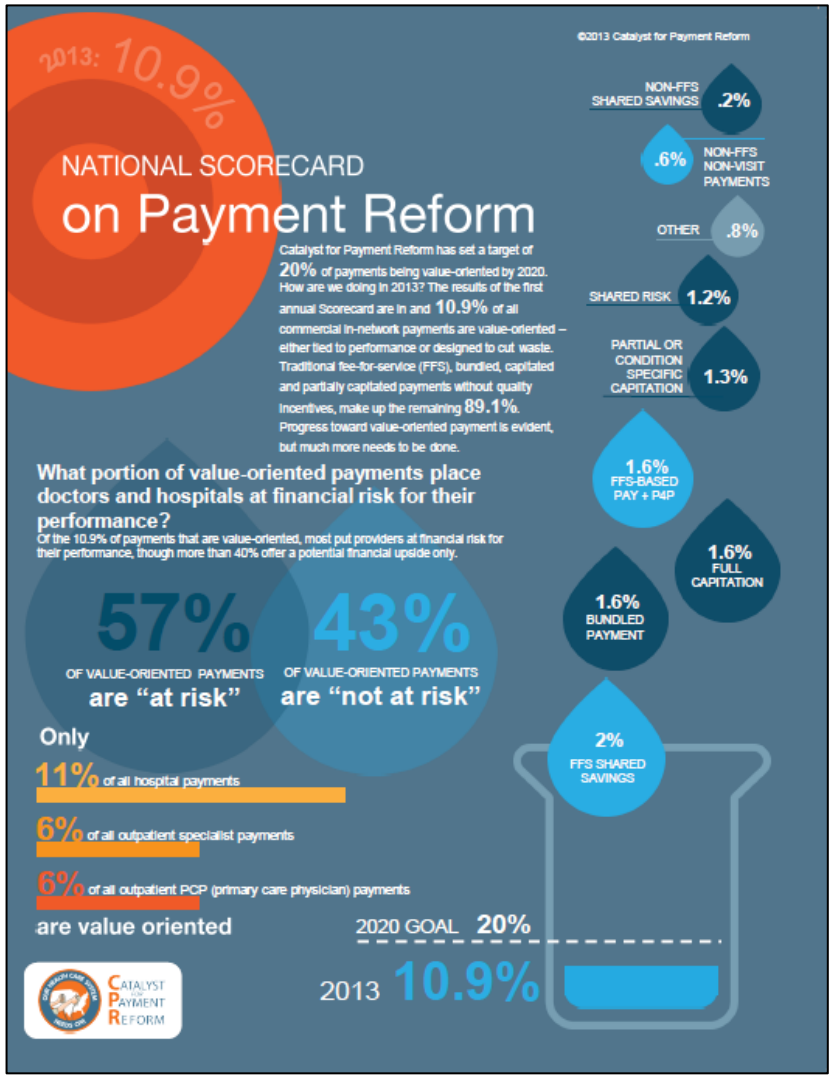
Source: Mathematica Policy Research analysis of private insured and self-insured fee-for-service claims for Massachusetts residents.

Note: Payments include patient cost-sharing in fee-for-service coverage. Payments made under managed care contracts are not included.

Huge payment variation (methods)

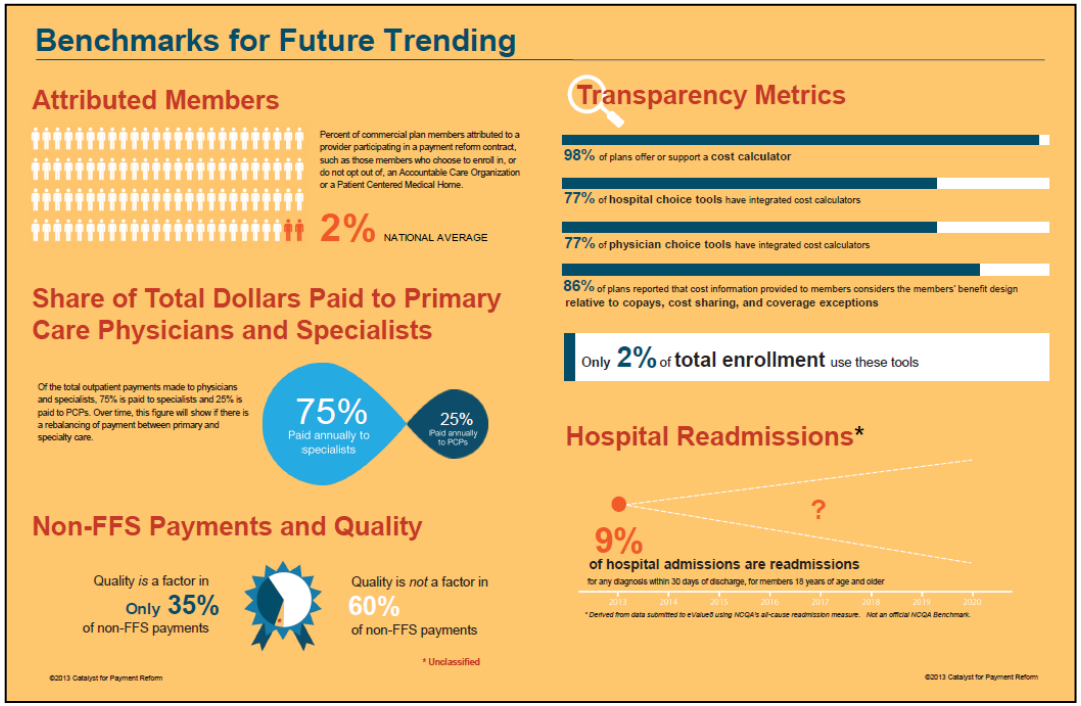
- See CPR's Scorecards…

National Scorecard on Payment Reform: Baseline



- 2010 estimate was 1-3% of payments were tied to performance
- 2013 Scorecard found 10.9% of commercial in-network payments are value-oriented
- 57% of the value-oriented payment is considered "at-risk"
- 11% of payment to hospitals is value-oriented
- 6% of outpatient specialist and PCP payment is value-oriented
- Scorecard results possibly biased upward

National Scorecard on Payment Reform: Benchmark Metrics



USA TODAY

Slow Progress On Efforts To Pay Docs, Hospitals For 'Value,' Not Volume

HealthAffairs
AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

Payment Reform: A Promising Beginning, But Less Talk And More Action Is Needed

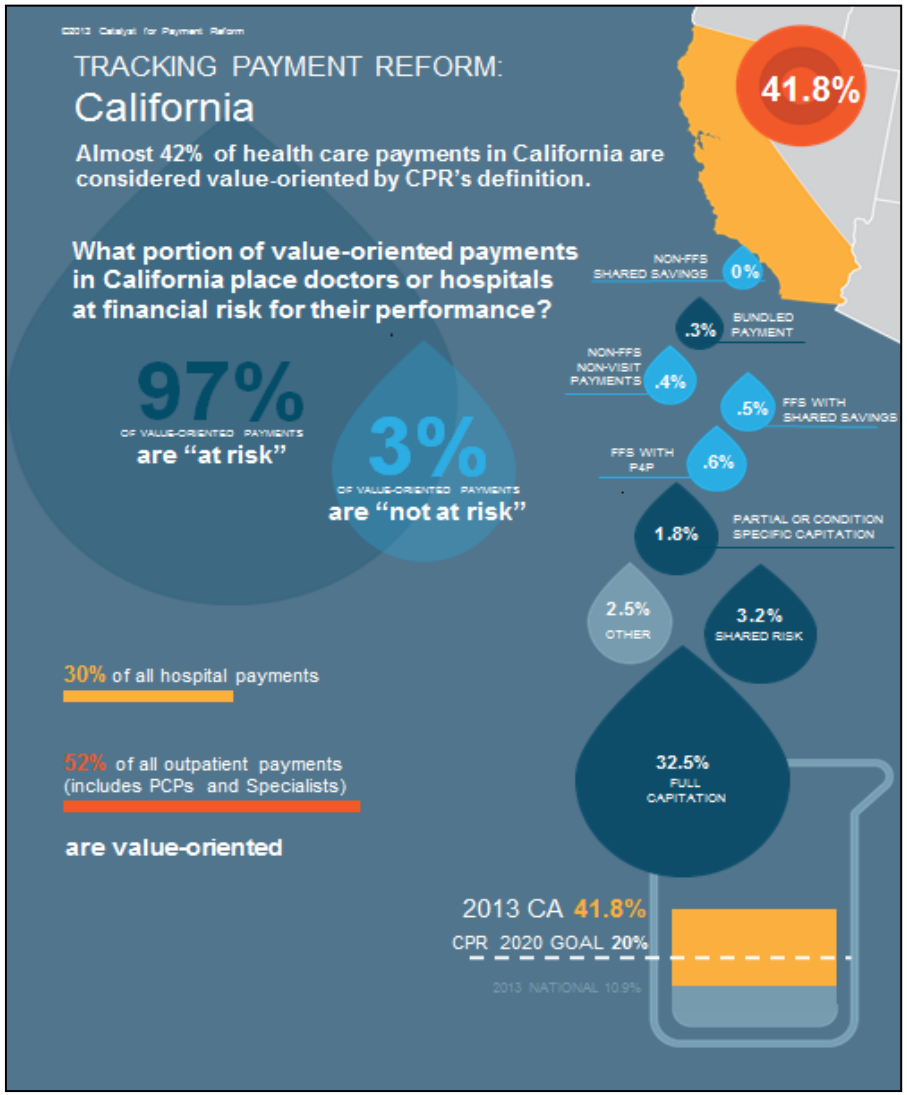
The Washington Post

How Fortune 500 companies plan to cut health costs: Act like Medicare

ModernHealthcare.com

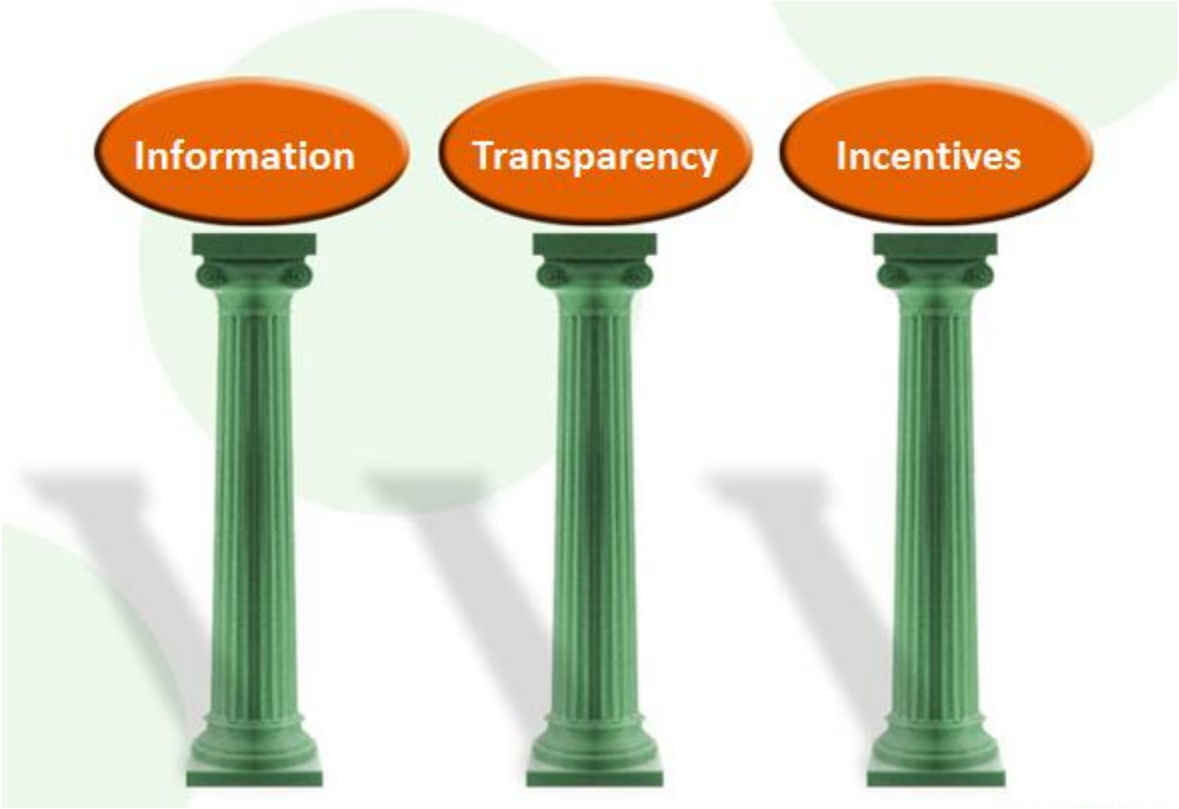
Value-based insurance plans gain momentum

California Scorecard on Payment Reform: Released 9/27/13



- 41.8% of commercial in-network payments are value-oriented
- 97% of the value-oriented payment is considered "at-risk"
- 32.5% of California's payment is capitation with quality
- 36% of commercial health plan members are "attributed"
- CA's health care spending per capita ($6,238) is 9th lowest in the nation
- But, huge variation across payers, examples of poor quality: maternal mortality, cesarean deliveries, flu vaccines and diabetes screenings
- **Where's the value in value-oriented?**

Three Pillars



Transparency

Quality Transparency

- Head start, especially for hospitals
- Voluntary efforts will fall short – Leapfrog Group

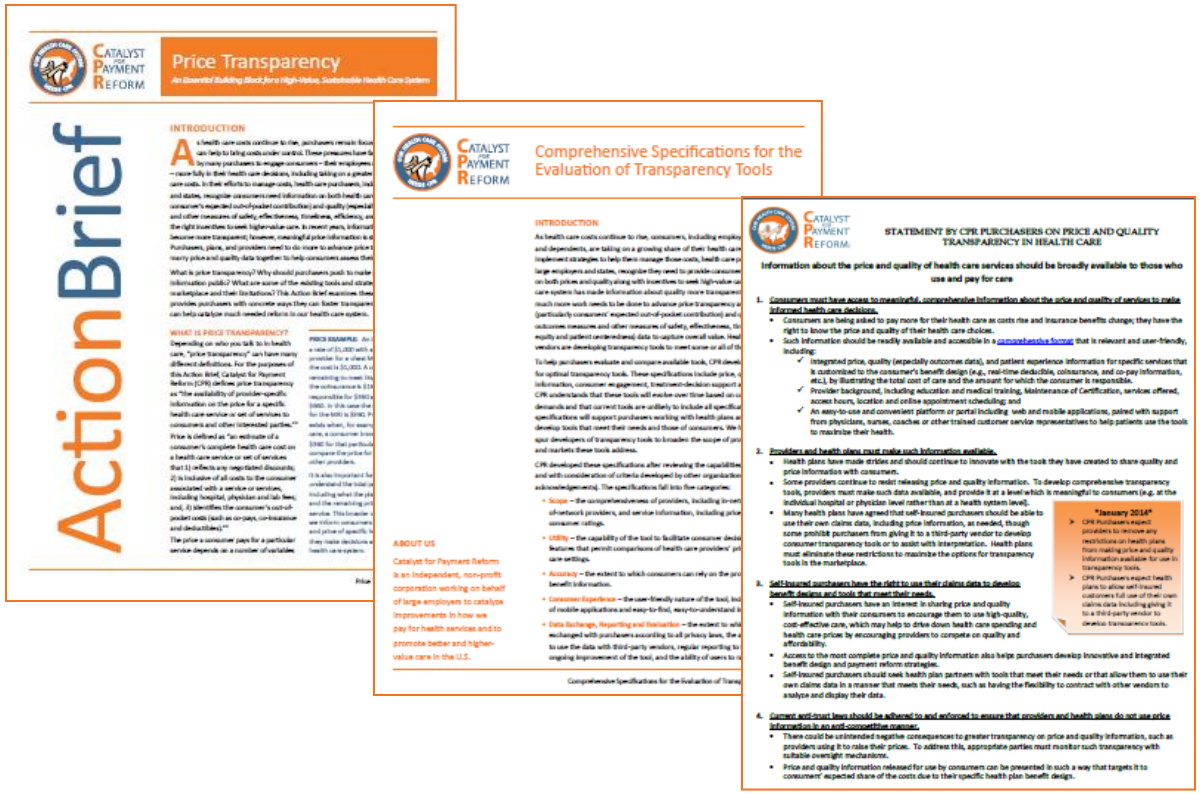
Price Transparency

- Private and public efforts (34 states with laws)
- Medicare has some tools
- Private sector competing for appetite

Best Overall Value

- Combining quality with price information
- Consumers will make the right choices

Understanding the Cost & Value of Care



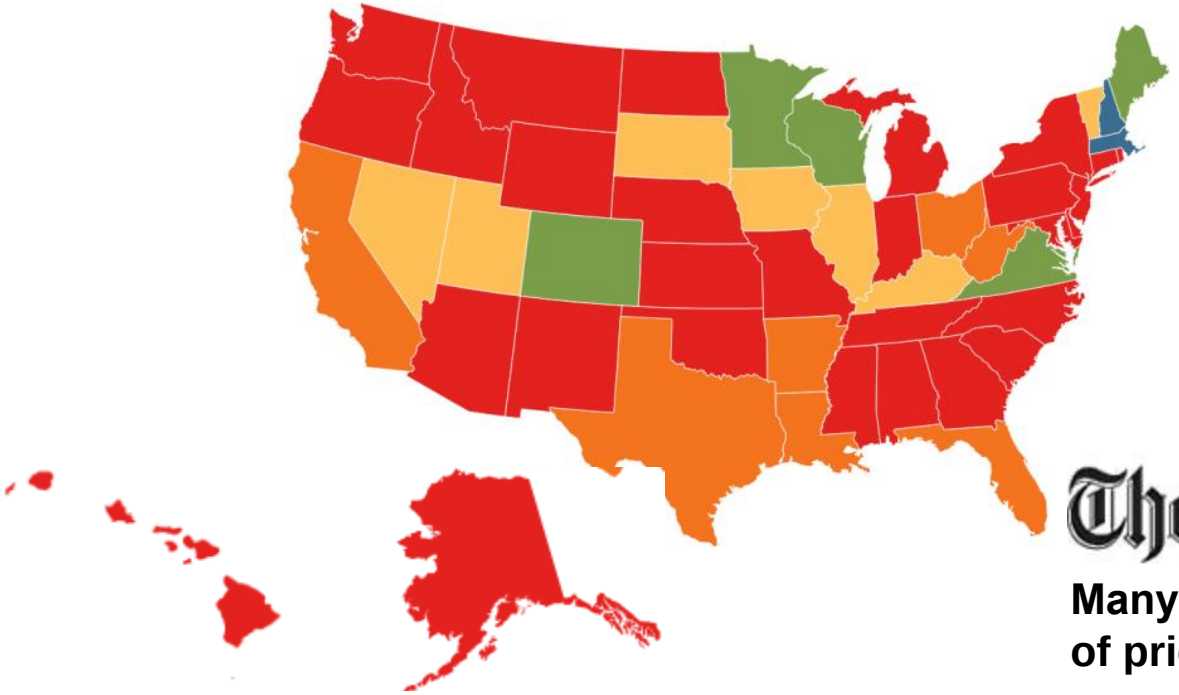
Fall 2013

Evaluation of Consumer Transparency Tools

Report on State of the Art of Transparency Tools

Updated Specifications for Transparency Tools

2013 Report Card on State Price Transparency Laws



GRADE	FROM	TO
A	60%	100%
B	50%	59%
C	40%	49%
D	30%	39%
F	0%	29%

Forbes

Health Care Prices Remain A Mystery In Most States

The Washington Post

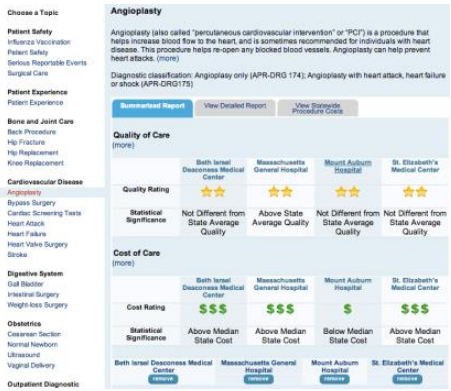
Many states don't require disclosure of prices for medical procedures

THE WALL STREET JOURNAL.

Most of U.S. flunks health price transparency test: study

Best Practices: Massachusetts

- One of only two states in the nation to receive and A grade (in addition to New Hampshire) – ***but on a scale!***
- Myhealthcareoptions – *only* most common inpatient and outpatient services and procedures and no user customization
- Will this progress or stop short here?



State	Level of Transparency	Scope of Providers			Scope of Price			Scope of Services			Grade
		Both Practitioners & Facilities	Health Care Practitioner or Facility	Subset of Either Practitioner or Facility	Both	Paid Amounts	Charges	All IP & OP	All IP or OP	Most common IP or OP	
MA	State Only	✓			✓			✓			A
	Upon Request				✓				✓		
	Report		✓				✓	✓			
	Website	✓				✓				✓	

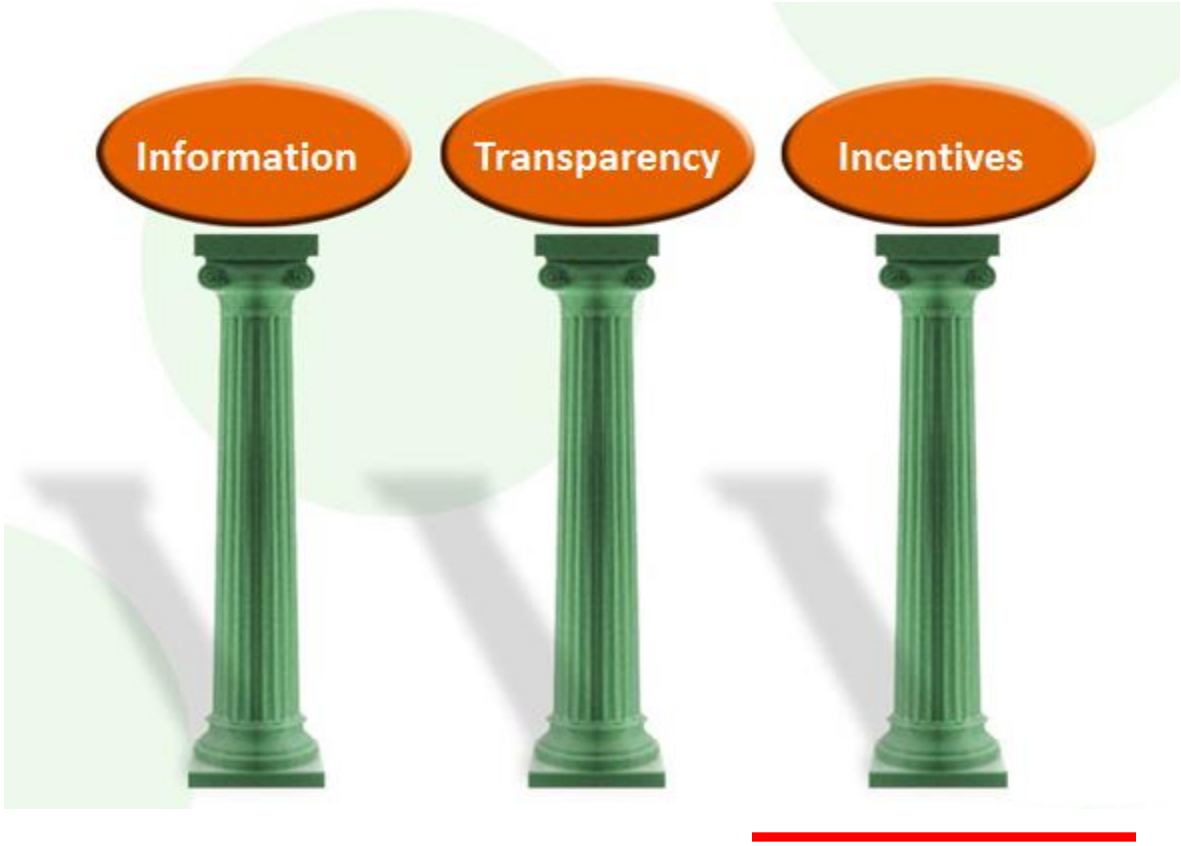
Best Practices: New Hampshire

Detailed estimates for Vaginal Birth and New Baby (inpatient)

Procedure: Vaginal Birth and New Baby (inpatient)
Insurance Plan: CIGNA, Preferred Provider Organization (PPO)
Within: 50 miles of 03301
Deductible and Coinsurance Amount: $1,500.00 / 20%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
ALICE PECK DAY MEMORIAL HOSPITAL	$2342	$3372	$5714	LOW	MEDIUM	ALICE PECK DAY MEMORIAL HOSPITAL 603.448.3121
SPEARE MEMORIAL HOSPITAL	$2447	$3792	$6239	MEDIUM	VERY HIGH	SPEARE MEMORIAL HOSPITAL 603.536.1120
MONADNOCK COMMUNITY HOSPITAL	$2683	$4732	$7415	LOW	LOW	MONADNOCK COMMUNITY HOSPITAL 603.924.7191
PARKLAND MEDICAL CENTER	$2995	$5980	$8975	LOW	MEDIUM	PARKLAND MEDICAL CENTER 603.432.1500
ST JOSEPH HOSPITAL	$3054	$6219	$9273	LOW	HIGH	ST JOSEPH HOSPITAL 603.882.3000
ELLIOT HOSPITAL	$3062	$6249	$9311	HIGH	HIGH	ELLIOT HOSPITAL 603.669.5300
CATHOLIC MEDICAL CENTER	$3121	$6487	$9608	HIGH	HIGH	CATHOLIC MEDICAL CENTER 800.437.9666
CHESHIRE MEDICAL CENTER	$3218	$6876	$10094	HIGH	MEDIUM	CHESHIRE MEDICAL CENTER 603.254.5400

Three Pillars



Big Picture

There is momentum behind transforming payment to providers and incentives for consumers. . .

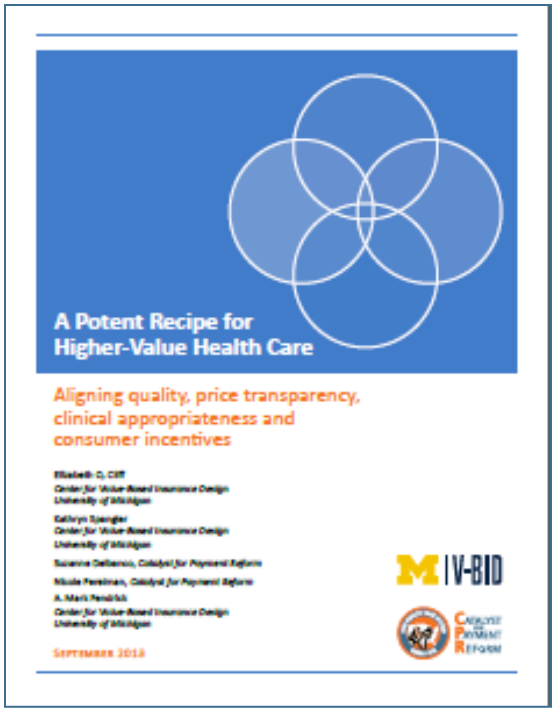
- Health Reform Included Several "Game Changers" - Some Will Take Time And They Will Be Disruptive
- Focus On Specific Models – But Is There Some 'Irrational Exuberance' At Work?
- We Still Know Very Little About What Works
- Our Current System Will Be Around For A While - And We Shouldn't Ignore It

Provider Incentives

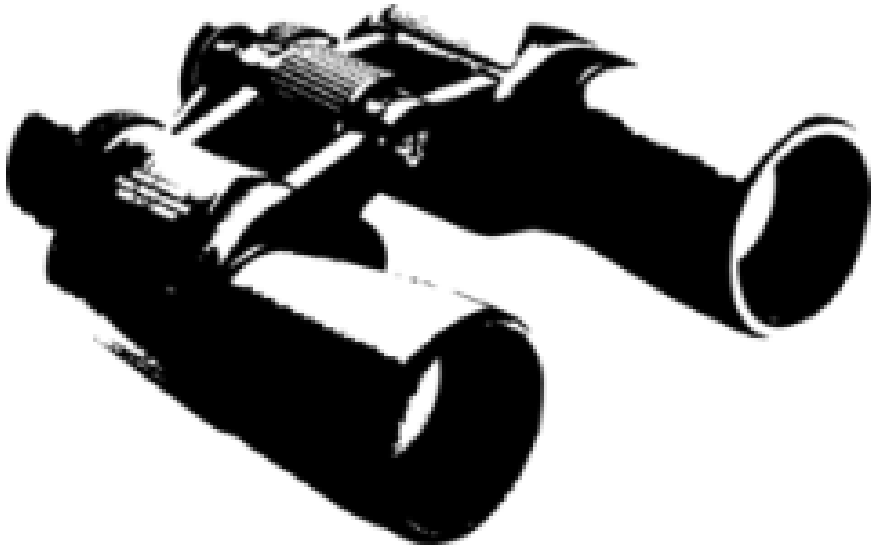
- Migration from carrots to carrots & sticks
- Any carrots have to be sustainable
- Savings don't reach the end users
  - Many approaches being modeled, but translation of savings to purchasers and affordability hasn't happened – at the end of the day, it's about the price
- Competition can be its own incentive

Consumer Incentives

- Information must be paired with incentives
- Examples: Reference pricing, select provider networks, centers of excellence, value-based insurance design
- With the right information, consumers will choose a high-quality provider (defined as lowest price with best quality) 80 to 90 percent of the time



All Eyes on Massachusetts



Questions to Ponder

- How will the patient experience change over the next 5-7 years as a result of these trends?"
- How will provider behavior change as they are increasingly at financial risk for their performance on cost and quality?
- What will be the role of the health insurer?
- Will employers use their potential leverage to drive reforms to make health care higher-quality and more affordable?

What could shift the current direction of reforms?

Contact

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Commonwealth of Massachusetts

Health Policy Commission

Health Care Cost Trends Hearing 2013