Commonwealth of Massachusetts

Health Policy Commission

2014 Health Care Cost Trends Hearing

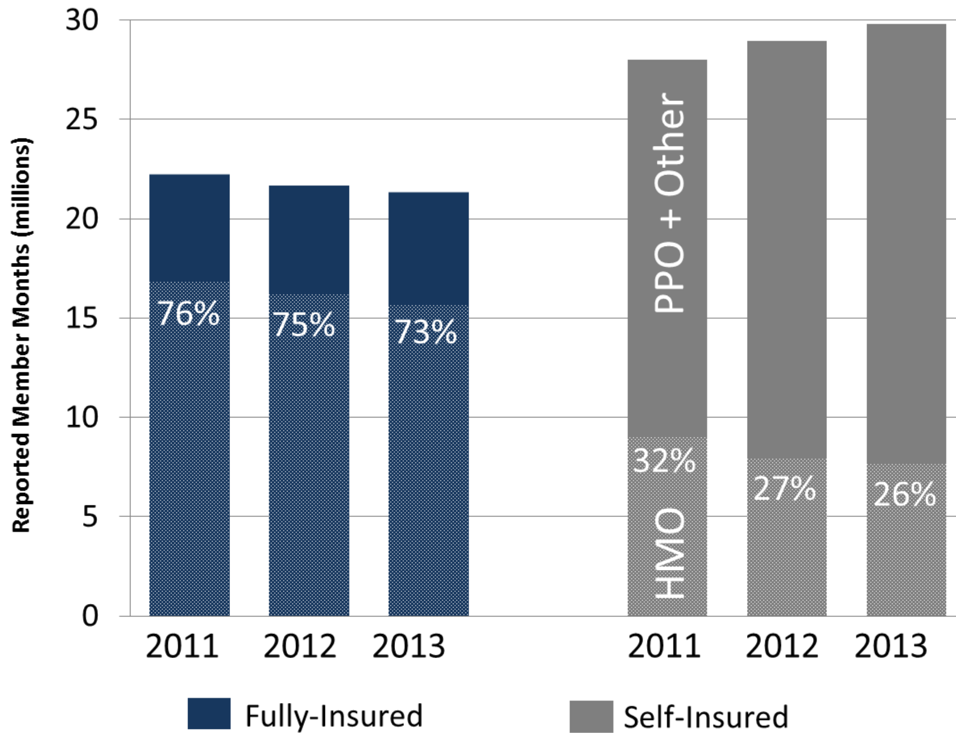
Panel 1

Meeting the Cost Growth Benchmark

Panel 2

Alternative Payment Methods

Two related trends affect the commercial market



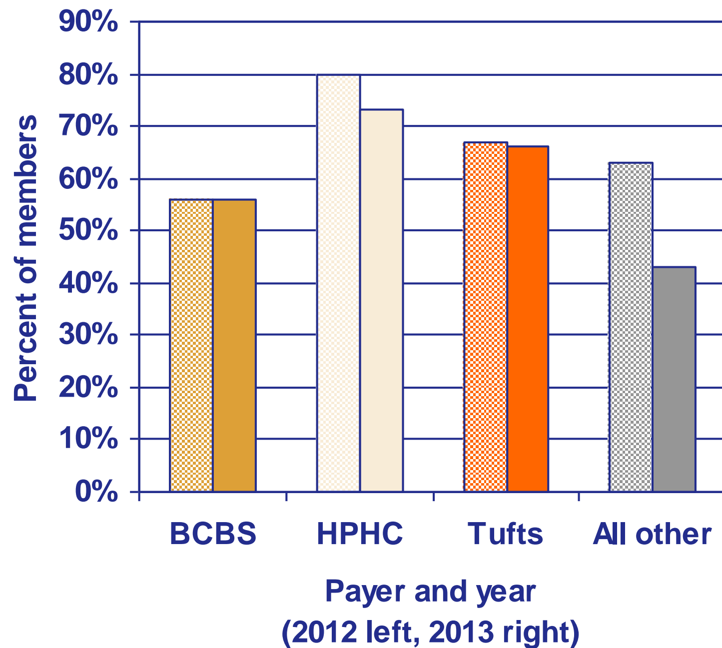
Declining enrollment in fully-insured plans and in HMOs.

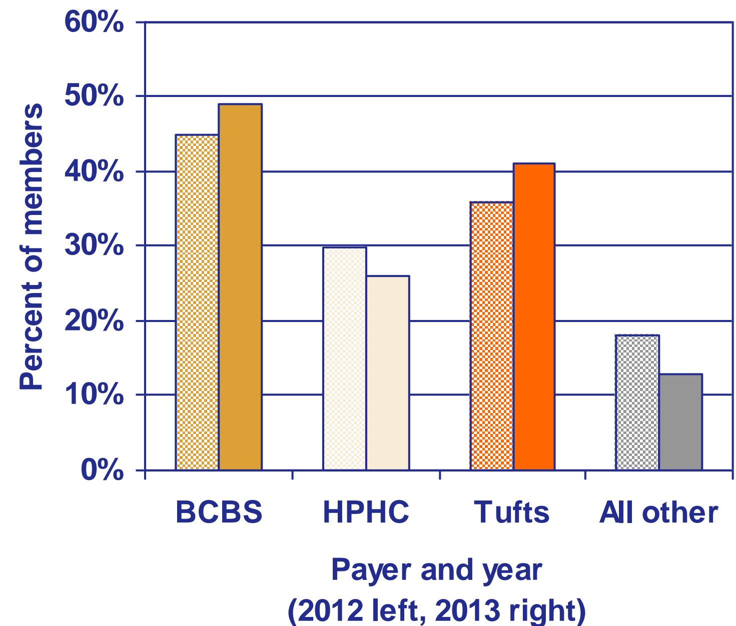
In today's market, APMs are mainly used within HMO-type plans.

Total HMO Membership in Massachusetts			Change Over Time	
2011	2012	2013	2011-2012	2012-2013
51.5%	47.5%	45.7%	-4.0pp	-1.8pp

Source: Center for Health Information and Analysis.

All major payers show declining HMO membership and slow or negative growth in percentage of members covered by APMs.





Many providers testified that standardizing APM elements would improve efficiency, but some payers prioritized flexibility. Operational challenges remain.

Risk Adjustment	▪ Standardization eliminates uncertainty, simplifies administration, aids in comparisons. ▪ Flexibility accounts for differences among providers. ▪ Providers see socioeconomic factors and behavioral health missing in adjustment methodologies. Payers tend to find methodologies sufficient.
Data and Quality Metrics	▪ Providers seek real-time data on financial, administrative, and clinical metrics. ▪ Many varying quality measures increase administrative burden, but allow for tailoring to providers' improvement needs and specific populations served. ▪ Many providers lack systems to share quality information with each other, and payers have not always been able to bridge the gap.
Patient Attribution	▪ A working group, consisting of payers and providers, is developing a standardized PPO attribution methodology. ▪ Many providers question the value in holding PCPs responsible for patient costs absent referral management. ▪ Providers are also concerned about the accuracy of attribution methods that rely on claims history, not patients' choice of provider.

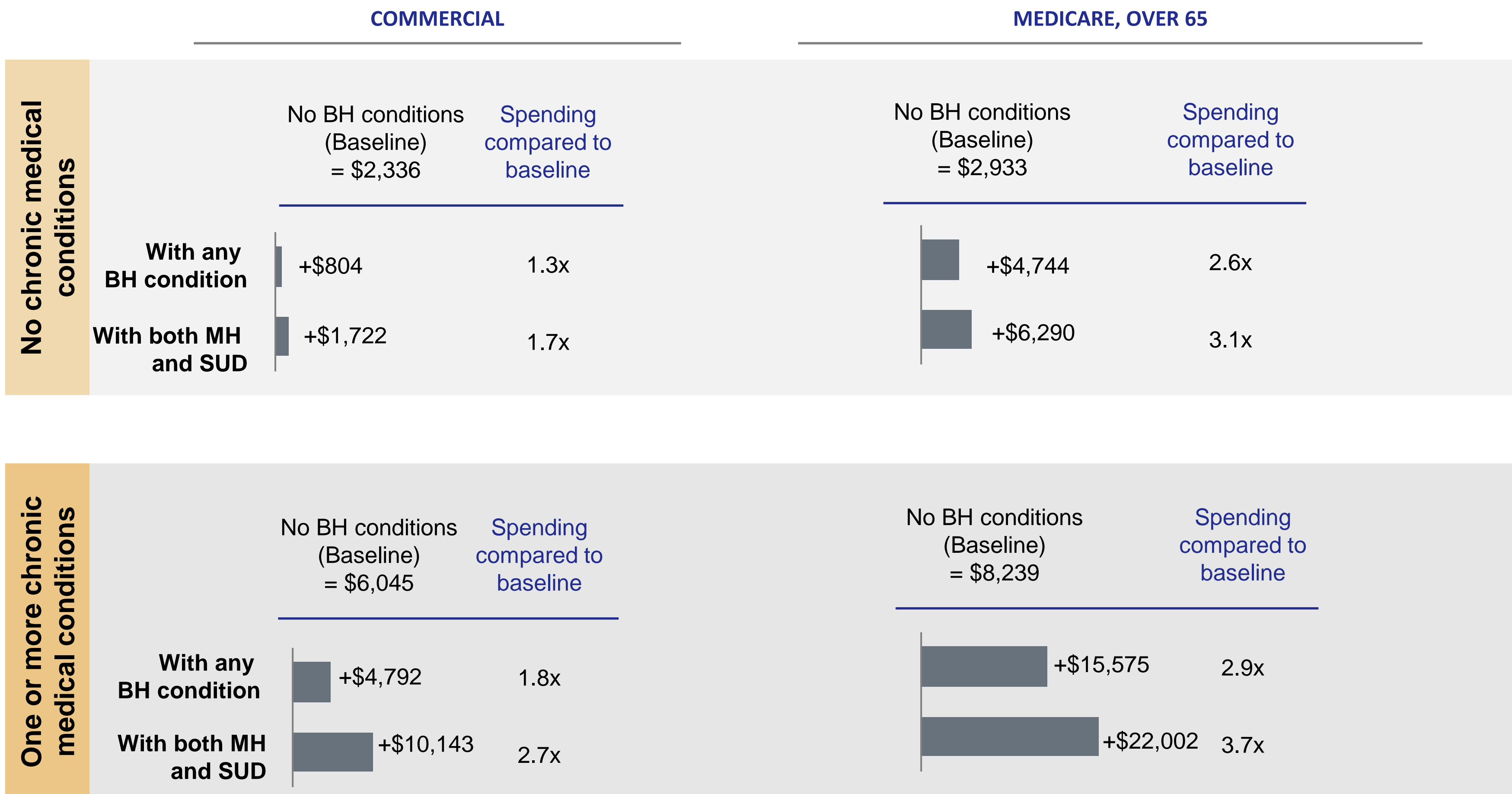
Source: Pre-Filed Testimony, Sept. 2014.

Panel 3

Challenges and Opportunities to Coordinating Care: Behavioral Health

For patients with behavioral health conditions, spending is higher for other medical conditions, suggesting the potential value of integration.

Per person claims-based medical expenditures on non-behavioral health conditions based on presence of behavioral health (BH) comorbidity†, 2012 (Commercial) and 2011 (Medicare)*



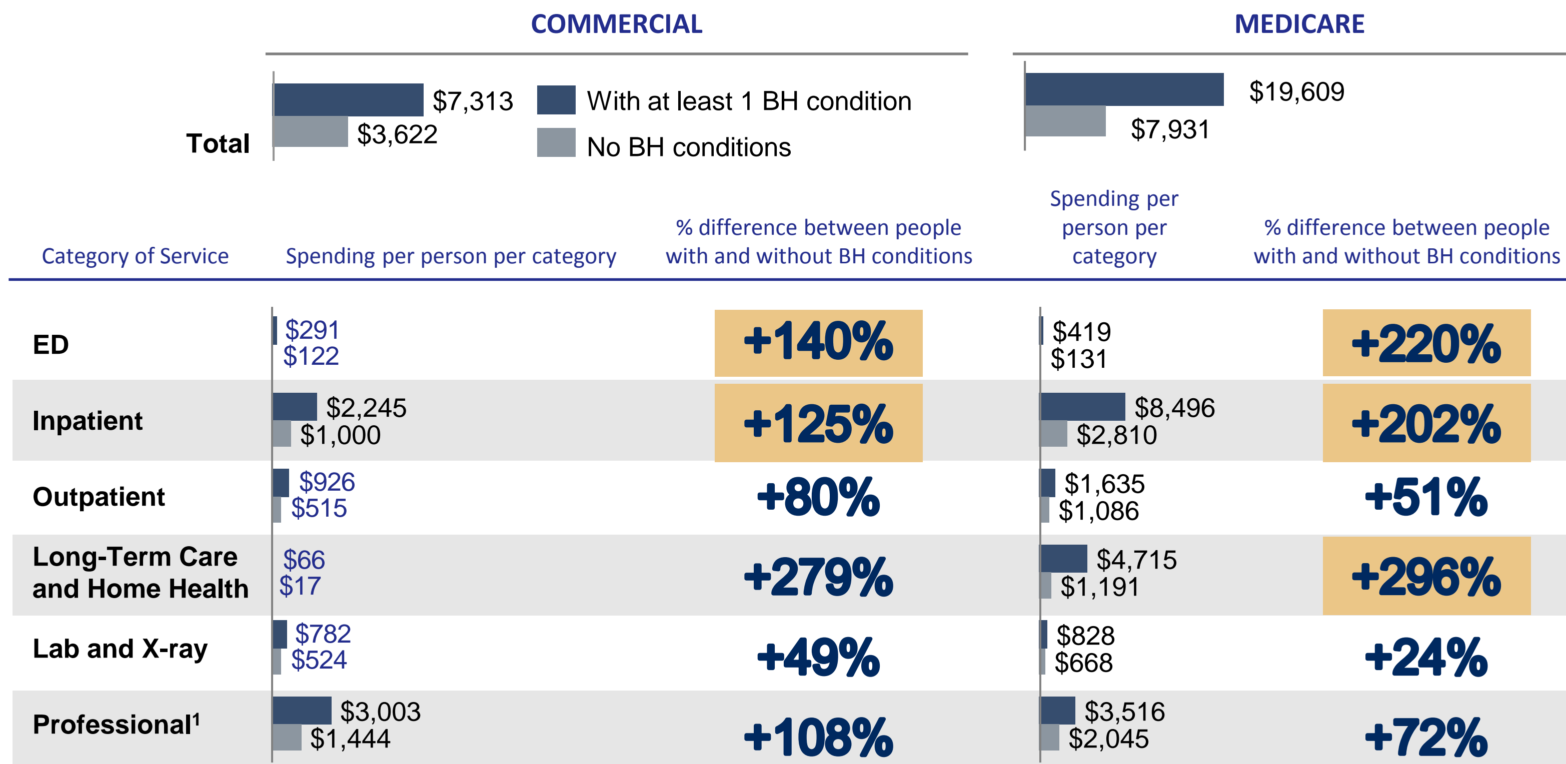
* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software. Expenditures for non-behavioral health conditions were identified using Optum ETG episode grouper. Additional detail is available in a technical appendix.

Higher spending for people with behavioral health conditions is concentrated in inpatient and ED spending.

SPENDING BY CATEGORY OF SERVICE FOR PATIENTS WITH AND WITHOUT BEHAVIORAL HEALTH CONDITIONS

Claims-based medical expenditures by category of service†, for people with and without behavioral health (BH) conditions‡, 2011*



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† For detailed definitions of categories of service, see CHIA and HPC publication, "Massachusetts Commercial Medical Care Spending: Findings from the All-Payer Claims Database." Lab/x-ray category includes professional services associated with laboratory and imaging.

‡ Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software

Market participants identified persistent challenges to behavioral health care and integration.

- Delivery system issues
  - Insufficient resources to meet patient needs
    - Including beds, providers, community resources and services

- Payment issues
  - Standard fee-for-service payment models
    - Separate co-payments for BH and medical visits
    - Rules against same day-billing

- BH carve-outs – advantages/ disadvantages

- Data limitations

- Need for culture change - more collaboration, less stigma

- The special needs of the population
  - For some, poverty, lack of stable housing, and other basic needs impedes treatment and recovery
  - Low levels of social support
  - Difficulty with self-care and follow-up
  - Frequent co-occurring conditions – multiple BH conditions or BH and medical conditions

Source: Pre-Filed Testimony, Sept. 2014.

Panel 4

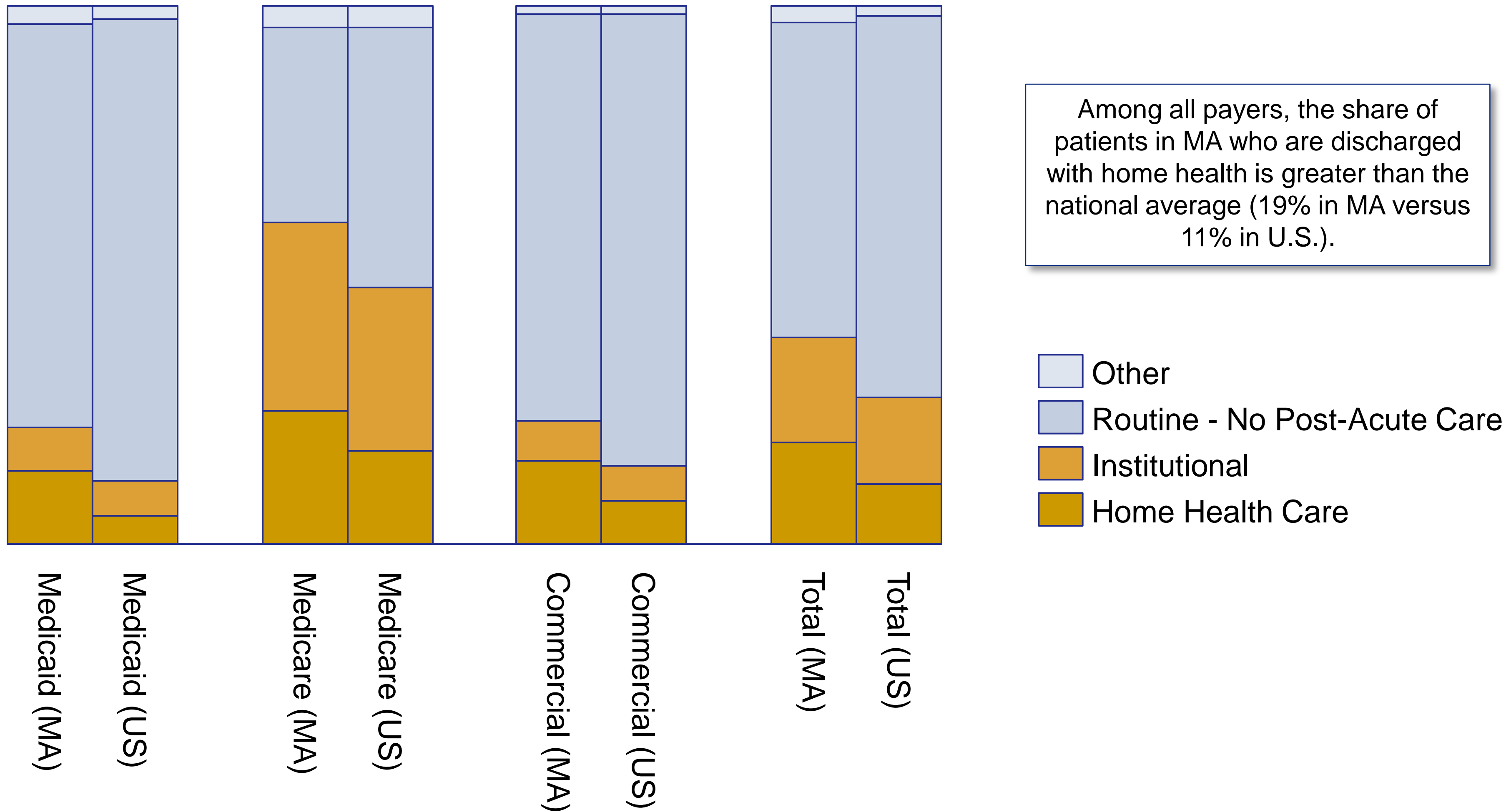
Challenges and Opportunities to Coordinating Care: Post-Acute Care

Compared to the average U.S. patient, Massachusetts patients are more likely to be discharged to post-acute care after a hospitalization.

- Adjusting for patients' demographic and clinical characteristics and for the type and intensity of inpatient care delivered, we estimate that Massachusetts hospitals are **2.1 times as likely to discharge patients to either skilled nursing facilities or home health agencies** relative to the national average, based on 2011 data
- Rates of discharge to post-acute care vary widely across Massachusetts hospitals

Notes: Relative probabilities of discharge to post-acute care and of choice of post-acute care setting were estimated using a logistic regression model that adjusted for: age, sex, payer, income, length of stay, DRG, patient comorbidities, APR-DRG illness severity score, and APR-DRG risk of mortality score using a 2011 national inpatient sample from the Healthcare Cost and Utilization Project.

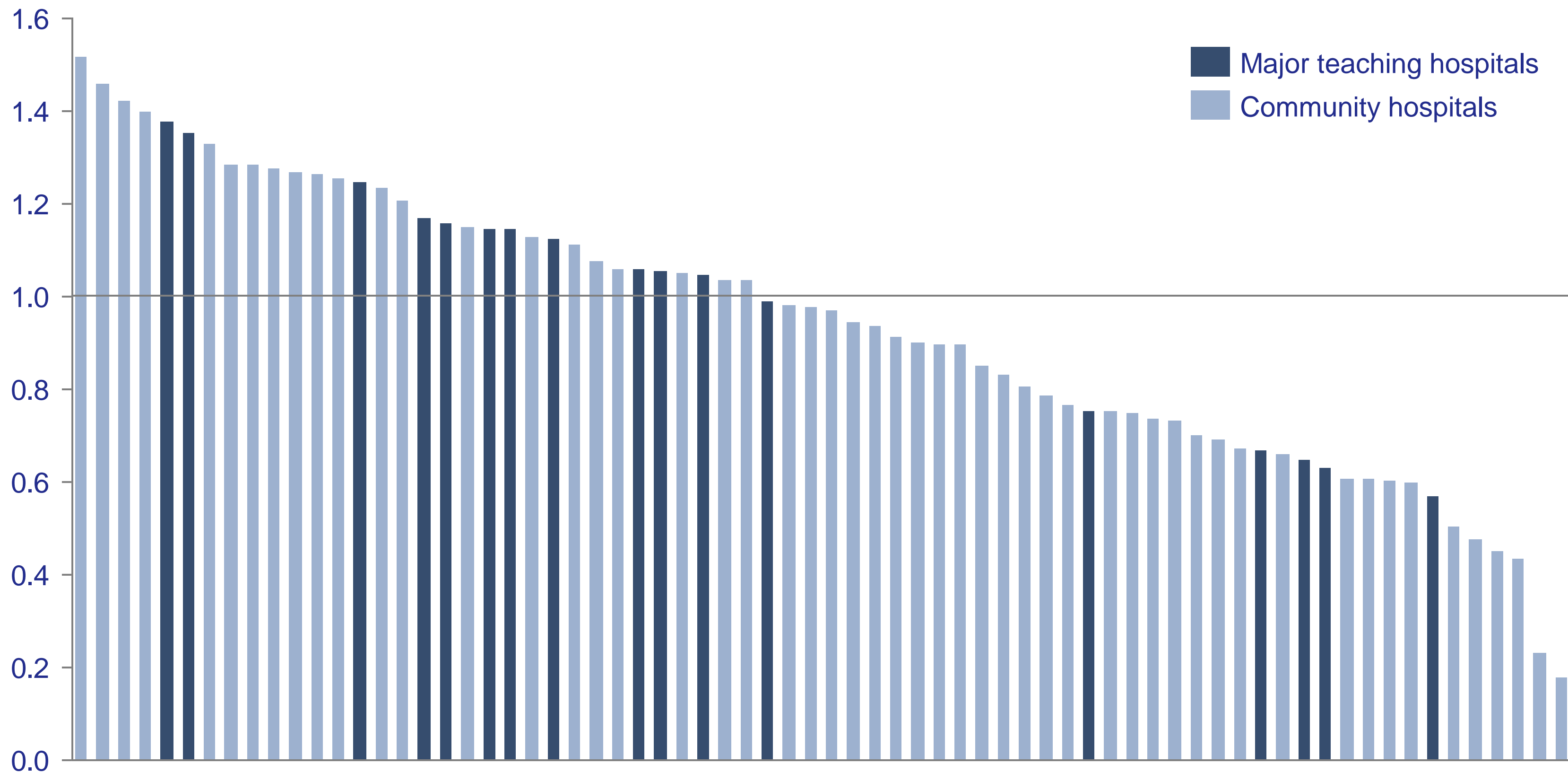
Home health use drives higher rate of post-acute care in Massachusetts.



*Institutional includes skilled nursing facility, short-term hospital, intermediate care facility, another type of facility including inpatient rehabilitation facility and long-term care hospital.
**Other includes against medical advice, died, alive destination unknown, not recorded.

Source: Health Care Cost and Utilization Project; Census Bureau; HPC analysis.

Massachusetts hospitals vary widely in their rate of post-acute care use.



* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the state volume-weighted average rate equal to 1.0.

† Discharge to nursing facility as a proportion of total discharges to either nursing facility or home health.

Source: Massachusetts Health Data Consortium, 2012; HPC analysis.

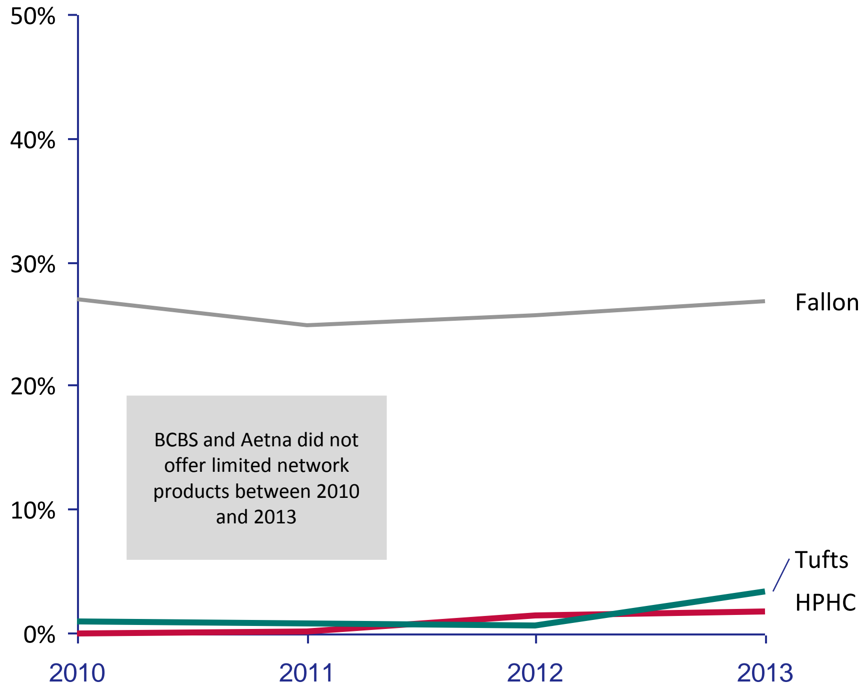
Panel 5

Promoting a Value Based Market: Insurance Market Trends

Value-oriented insurance products are slowly gaining ground.

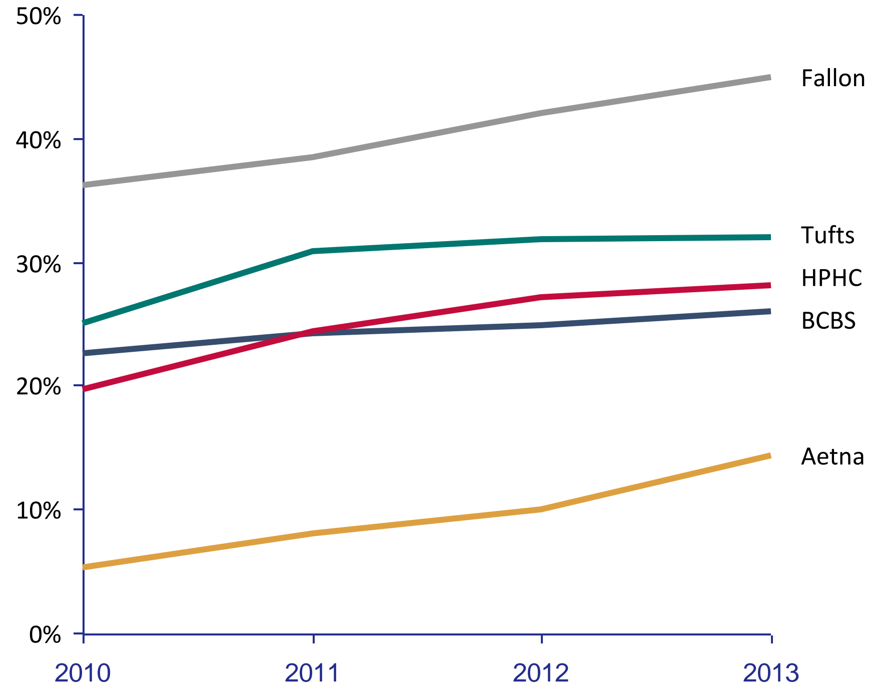
LIMITED NETWORK PRODUCTS

Enrollment in limited network products as % of total Commercial enrollment, 2010-2013



HIGH COST-SHARING PLANS

Enrollment in high cost-sharing plans as % of total Commercial enrollment, 2010-2013



Payers	BCBS	HPHC	Tufts	Aetna	Fallon
Total Commercial Enrollment 2013 (M)	1.45M	0.61M	0.34M	0.18M	0.13M

Note: Enrollment in Tufts Health Plan limited network products does not include enrollment in Commercial GIC limited network products

Source: Pre-filed Testimony, Sept. 2014.

The Group Insurance Commission offers state employees a range of insurance choices (including limited network plans) and information on premiums and coverage.

STATE EMPLOYEE HEALTH PLAN RATES

GIC PLAN RATES EFFECTIVE JULY 1, 2014

Compare the rates of these plans with the other options and see how much you will save every month!

		For Employees Hired *Before July 1, 2003* 20% *Employee Pays Monthly*		For Employees Hired *On or After July 1, 2003* 25% *Employee Pays Monthly*	
BASIC LIFE INSURANCE ONLY **$5,000 Coverage**		$1.26		$1.58	
HEALTH PLAN (Premium includes Basic Life Insurance)	**PLAN TYPE**	**INDIVIDUAL**	**FAMILY**	**INDIVIDUAL**	**FAMILY**
Fallon Health Direct Care ✓	HMO	$97.52	$232.28	$121.90	$290.35
Fallon Health Select Care	HMO	123.85	295.47	154.82	369.34
Harvard Pilgrim Independence Plan	PPO	137.94	334.77	172.43	418.46
Harvard Pilgrim Primary Choice Plan ✓	HMO	110.60	268.06	138.26	335.09
Health New England ✓	HMO	97.25	239.25	121.57	299.07
NHP Care (Neighborhood Health Plan) ✓	HMO	93.97	246.95	117.47	308.69
Tufts Health Plan Navigator	PPO	124.74	299.59	155.93	374.49
Tufts Health Plan Spirit ✓	EPO (HMO-type)	100.94	241.50	126.18	301.88
UniCare State Indemnity Plan/ Basic *with CIC* * *(Comprehensive)*	Indemnity	221.55	514.95	266.39	619.20
UniCare State Indemnity Plan/ Basic *without CIC* *(Non-Comprehensive)*	Indemnity	179.31	416.97	224.15	521.22
UniCare State Indemnity Plan/ Community Choice ✓	PPO-type	92.23	219.58	115.30	274.49
UniCare State Indemnity Plan/PLUS	PPO-type	132.12	313.55	165.15	391.94

* CIC is an enrollee-pay-all benefit.

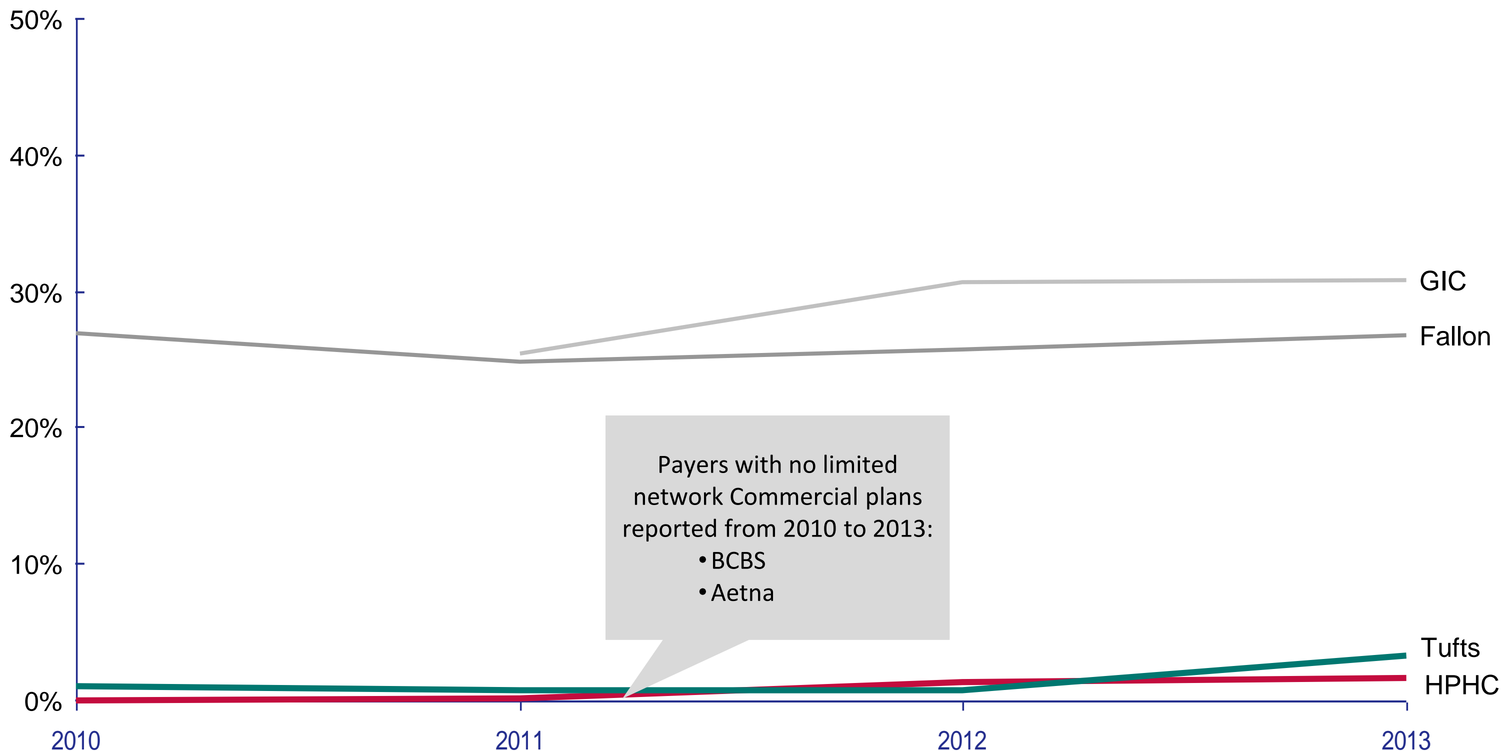
Note: Coverage information not shown.

Source: Group Insurance Commission

Although market-wide enrollment is narrow networks is low, narrow networks have 30 percent of the market among GIC members.

GIC MEMBERS ARE ABLE TO COMPARE PRODUCTS, AND 30 PERCENT CHOSE A LIMITED NETWORK PLAN

Enrollment in limited network products as % of total Commercial enrollment, 2010-2013



	BCBS	HPHC	Tufts	Aetna	Fallon	GIC
Total Commercial Enrollment 2013 (M)	1.45M	0.61M	0.34M	0.18M	0.13M	0.11M

Note: The GIC administers health benefits for state employees. It offers a choice of plans from multiple payers.

Source: Pre-filed Testimony, Sept. 2014, and GIC enrollment data.

Payers and providers stated they were complying with price transparency requirements and cited several challenges.

Experience

- Payers reported telephone and web access to price information within 48 hours.
- Providers reported a range of processes to provide price information.
- Commonly requested procedures:
  - Lab tests and imaging,
  - Mammography,
  - Pregnancy-related procedures,
  - Psychiatric evaluation / psychotherapy
  - Shoulder and knee arthroscopies
  - Colonoscopies
  - Dermatology procedures,
  - Gastric bypass,
  - Initial office visits,
  - Joint replacement
- Aetna stated that, in 2011, 60% of members requesting price information chose lower cost providers, saving on average $612 on allowed expenses and $170 on out-of-pocket costs.

Challenges

- Pricing transparency is only possible for services that are anticipated and well-defined.
- Even for these services, prices may vary unpredictably.
- Changing clinical circumstances may lead to changes in services required.
- Price transparency requires communication between payers and providers regarding the exact nature of services planned (CPT codes).
- Price transparency also requires patients' understanding precisely what services are planned.

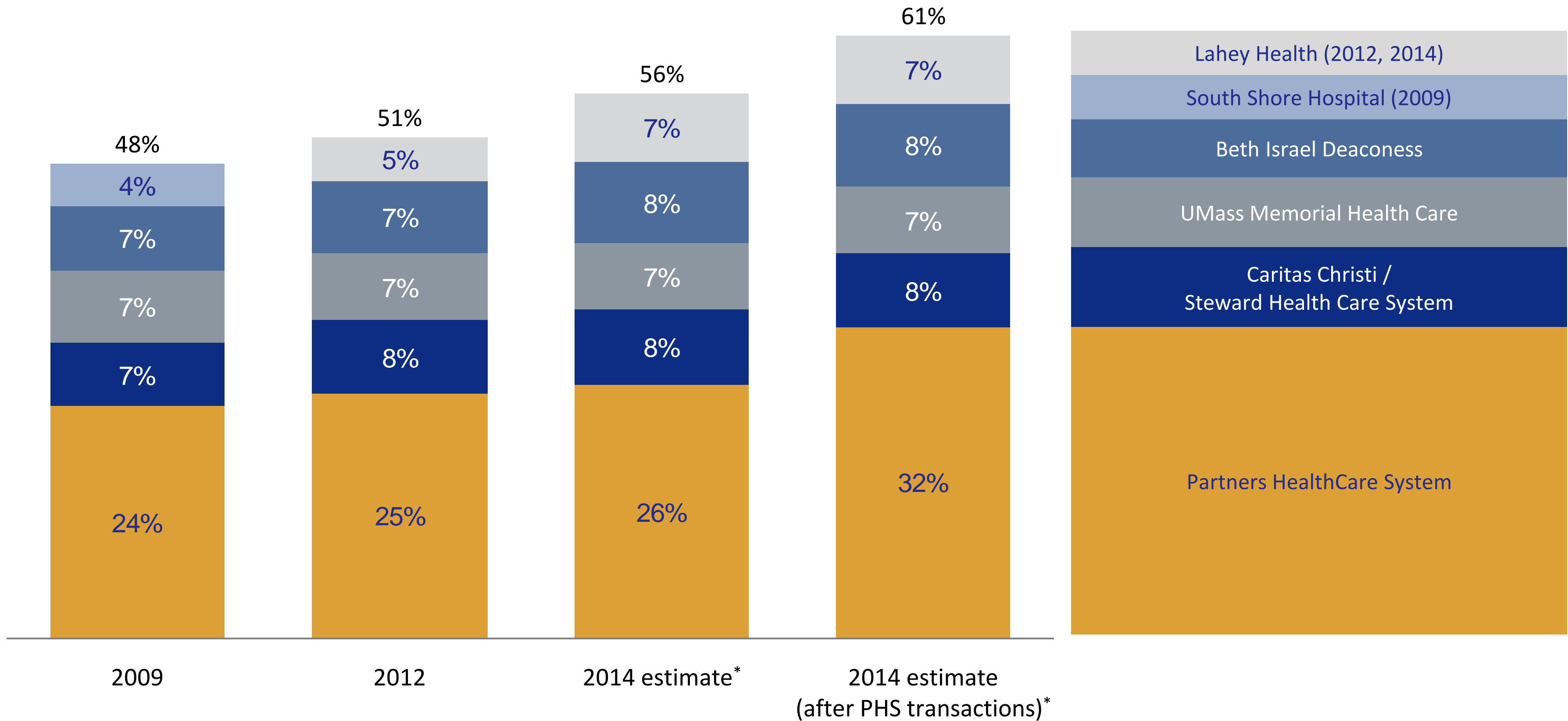
Source: Pre-Filed Testimony, Sept. 2014.

Panel 6

Promoting a Value Based Market: Provider Market Trends

Inpatient concentration has increased since 2009.

CONCENTRATION OF COMMERCIAL INPATIENT CARE IN MASSACHUSETTS



* 2014 data not yet available. Based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data

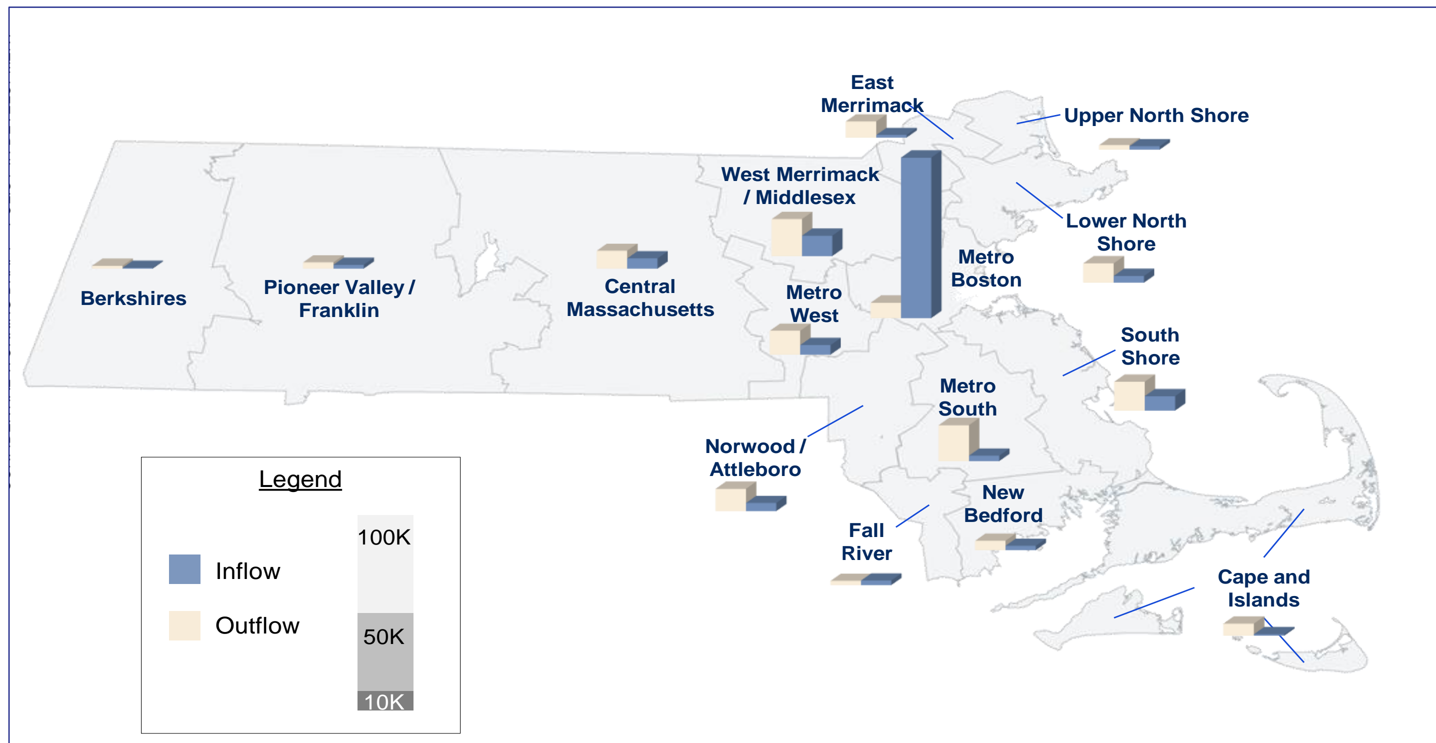
† Includes South Shore Hospital and Hallmark Health hospitals within Partners HealthCare System

Source: Center for Health Information and Analysis; HPC analysis

Many Massachusetts residents leave their home region to seek inpatient care in metro Boston.

Discharge flows in and out of Massachusetts regions, for Massachusetts residents only

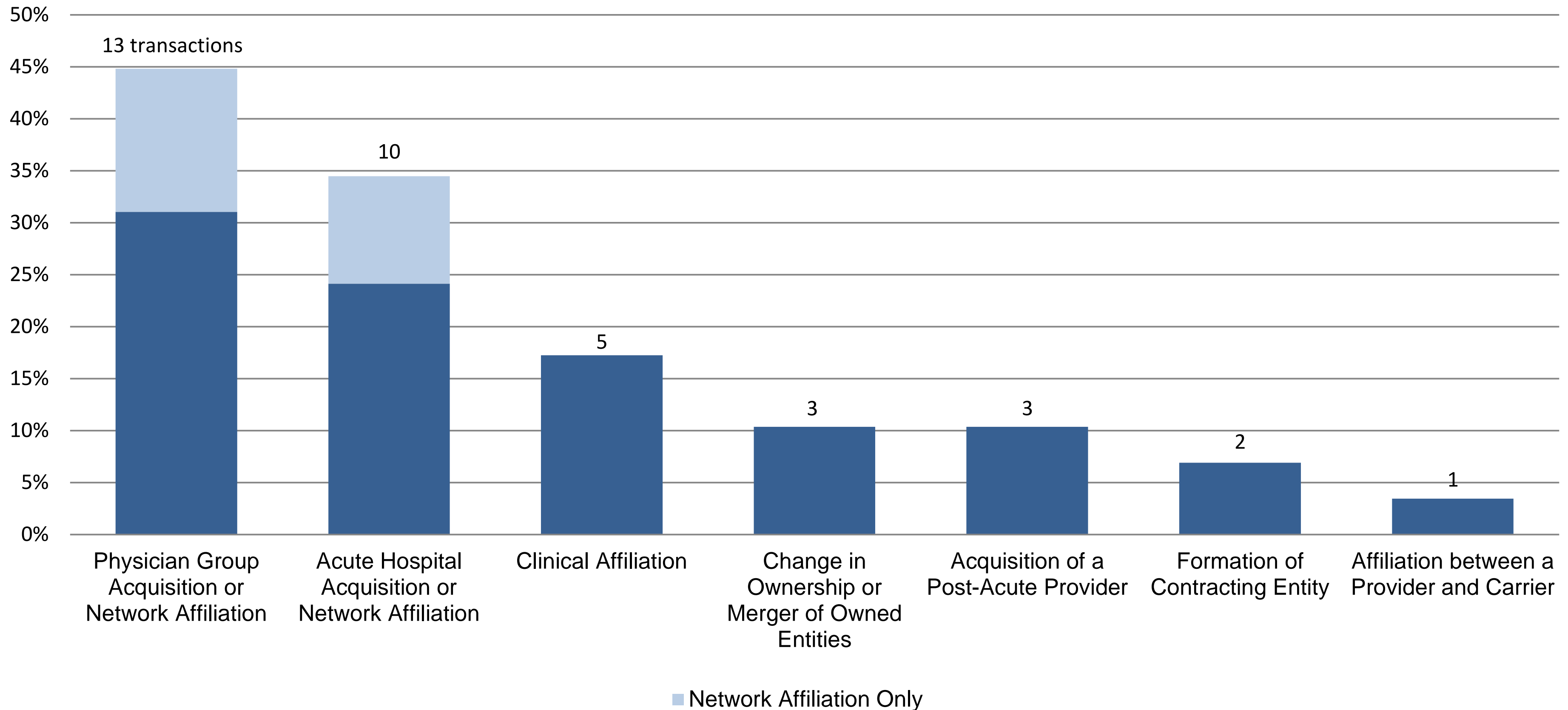
Number of discharges for non-transfer volume, 2012



Inflow: Discharges at hospitals in region for patients who reside outside of region.
Outflow: Discharges at hospitals outside of region for patients who reside in region.

Source: Center for Health Information and Analysis; HPC Analysis.

The provider market is dynamic. Not all models of integration and care coordination require corporate ownership.



Percentages sum to more than 100% as some transactions are more than one type

Source: Material change notices received by HPC, April 2013-present. Represents 29 separate transactions.

Public Testimony

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