MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Annual Health Care

COST TRENDS HEARING

OCTOBER 16, 2018

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Up Next
Presentation on CHIA's Annual Report
Presentation on State Perspective on Health Care Cost Trends

Presentation to the Health Policy Commission: CHIA's Annual Report

CENTER FOR HEALTH INFORMATION AND ANALYSIS

HPC

Agenda

- Overview
- Total Health Care Expenditures
- Public Insurance Programs
- Commercial Insurance
- Questions

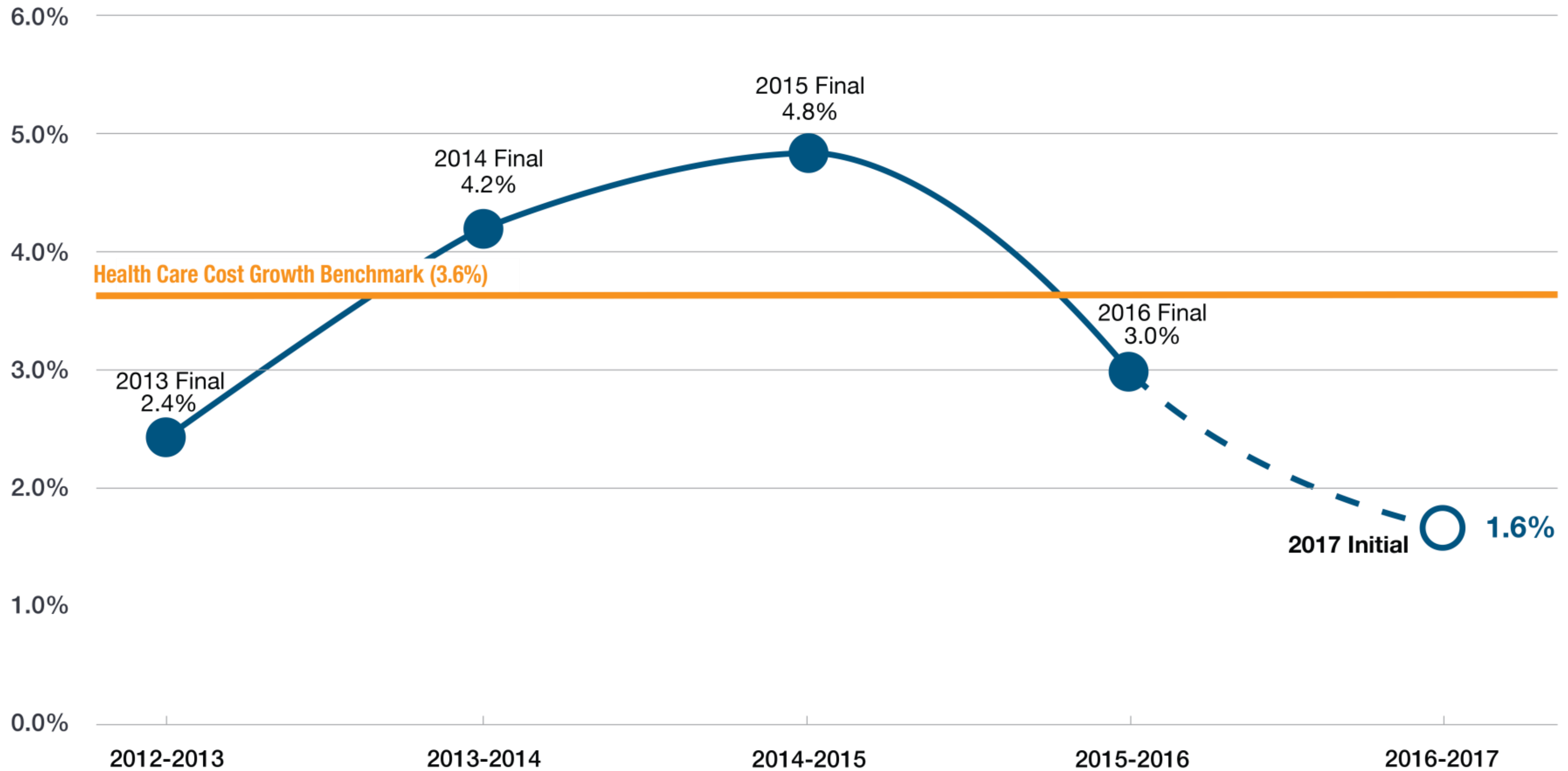
Overview

- CHIA's role in establishing the metrics to evaluate the performance of the Massachusetts health care system
- Annual Report publication materials
  - 100+ page report
  - Extensive databooks
  - Technical documentation
- Acknowledgments
  - Data submitters for their role in facilitating this report through supplemental filings
  - CHIA's staff & actuaries for their work producing the report

Total Health Care Expenditures (THCE)

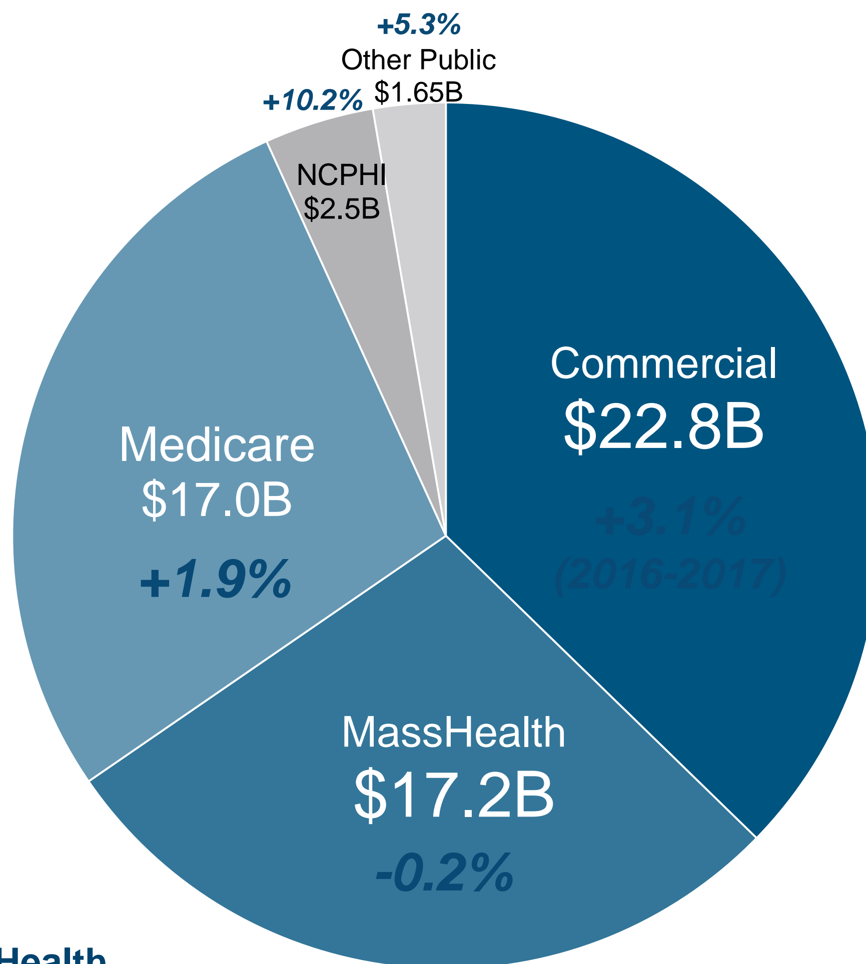
$61.1B	**Total Health Care Expenditures**
$8,907	**THCE per capita**
1.6%	**Growth rate per capita**

Total Health Care Expenditures
Growth Rates, 2012-2017



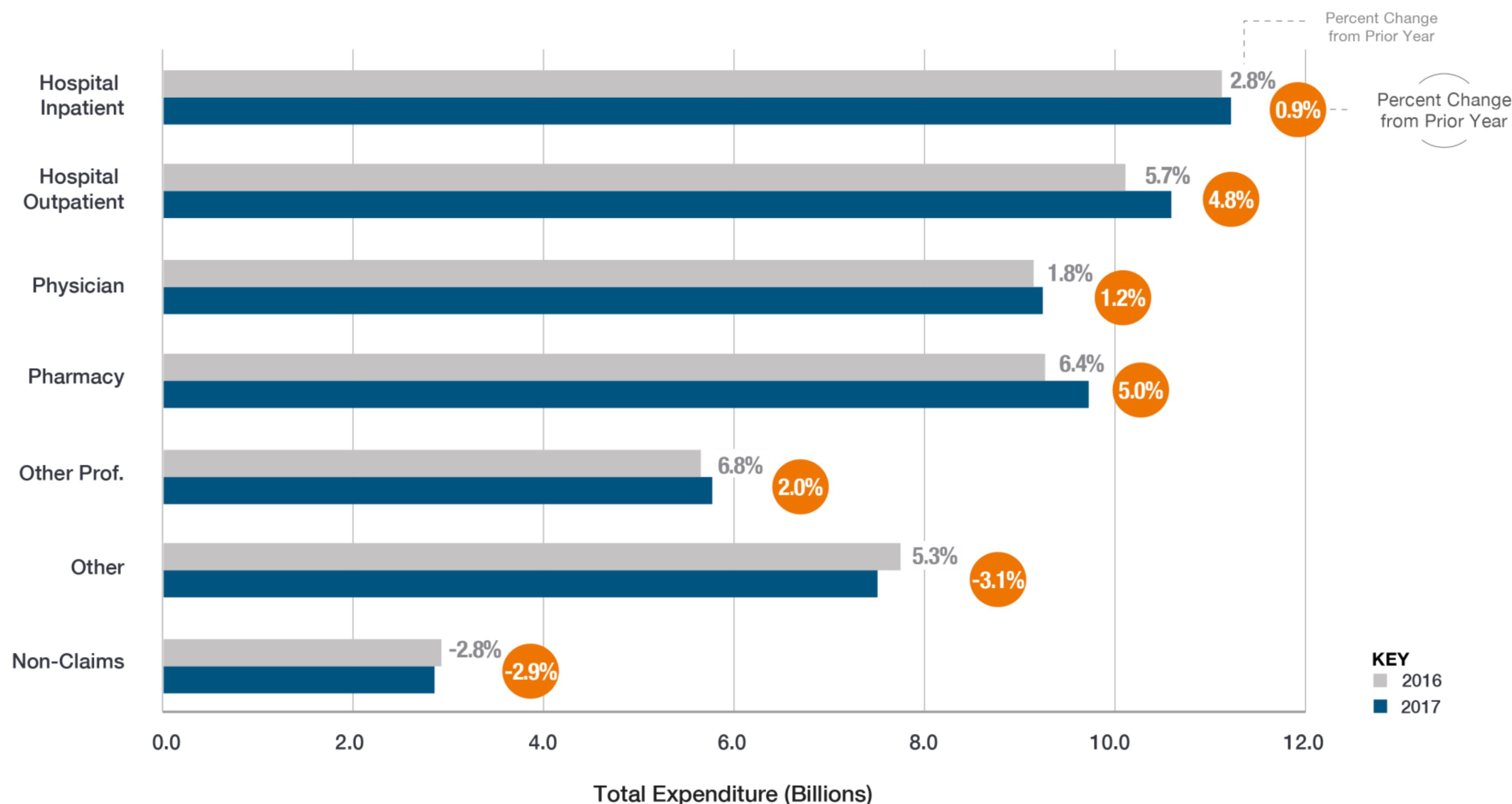
THE INITIAL ESTIMATE OF THCE PER CAPITA GROWTH IS 1.6% FOR 2017, THE SECOND CONSECUTIVE YEAR IT FELL BELOW THE HEALTH CARE COST GROWTH BENCHMARK.

Total Health Care Expenditures
Insurance Categories, 2017



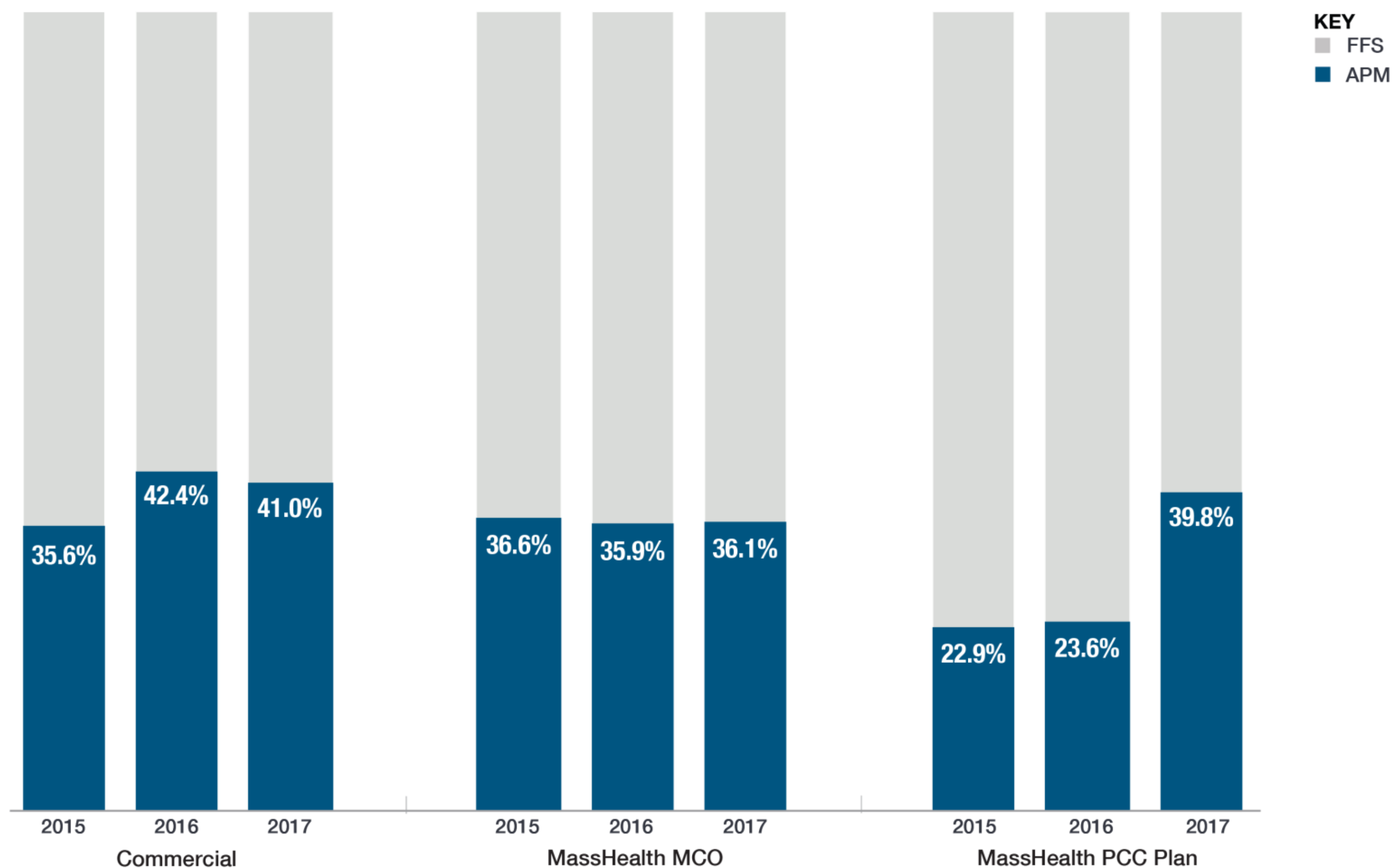
$61.1B **Total Health Care Expenditures**

Total Health Care Expenditures
Service Categories, 2016-2017



HEALTH CARE SPENDING DECELERATED ACROSS ALL SERVICE CATEGORIES, WITH THE HIGHEST GROWTH IN PHARMACY AND OUTPATIENT SPENDING.

Alternative Payment Methods
Insurance Categories, 2015-2017



IN 2017, THE LARGEST INCREASE IN APM ADOPTION RATES WAS IN THE MASSHEALTH PCC PLAN.

Public Insurance Programs
MassHealth

$17.2B MassHealth Expenditures, 2017

-0.2% Expenditure Trend, 2016-2017

-2.4% Member Months, 2016-2017

For more information, see **page 14** of CHIA's *Annual Report*

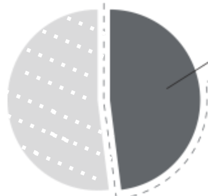
Public Insurance Programs
MassHealth MCO Service Categories, 2016-2017

Service Category	2016	2017	Percent Change in 2016 Final TME	Percent Change in 2017 Preliminary TME
Hospital Inpatient	$99	$99	8.4%	0.4%
Hospital Outpatient	$98	$99	0.5%	1.0%
Physician	$65	$65	2.2%	0.2%
Pharmacy	$97	$110	12.2%	13.0%
Other Prof.	$19	$21	4.8%	9.7%
Other	$25	$25	5.5%	0.7%
Non-Claims	$42	$48	2.3%	13.5%

$0 $20 $40 $60 $80 $100 $120

TME Per Member Per Month (PMPM)

KEY
2016
2017



MassHealth MCOs

PHARMACY SPENDING PMPM CONTINUED TO GROW FASTER THAN OTHER SERVICES, BECOMING THE LARGEST CATEGORY IN 2017.

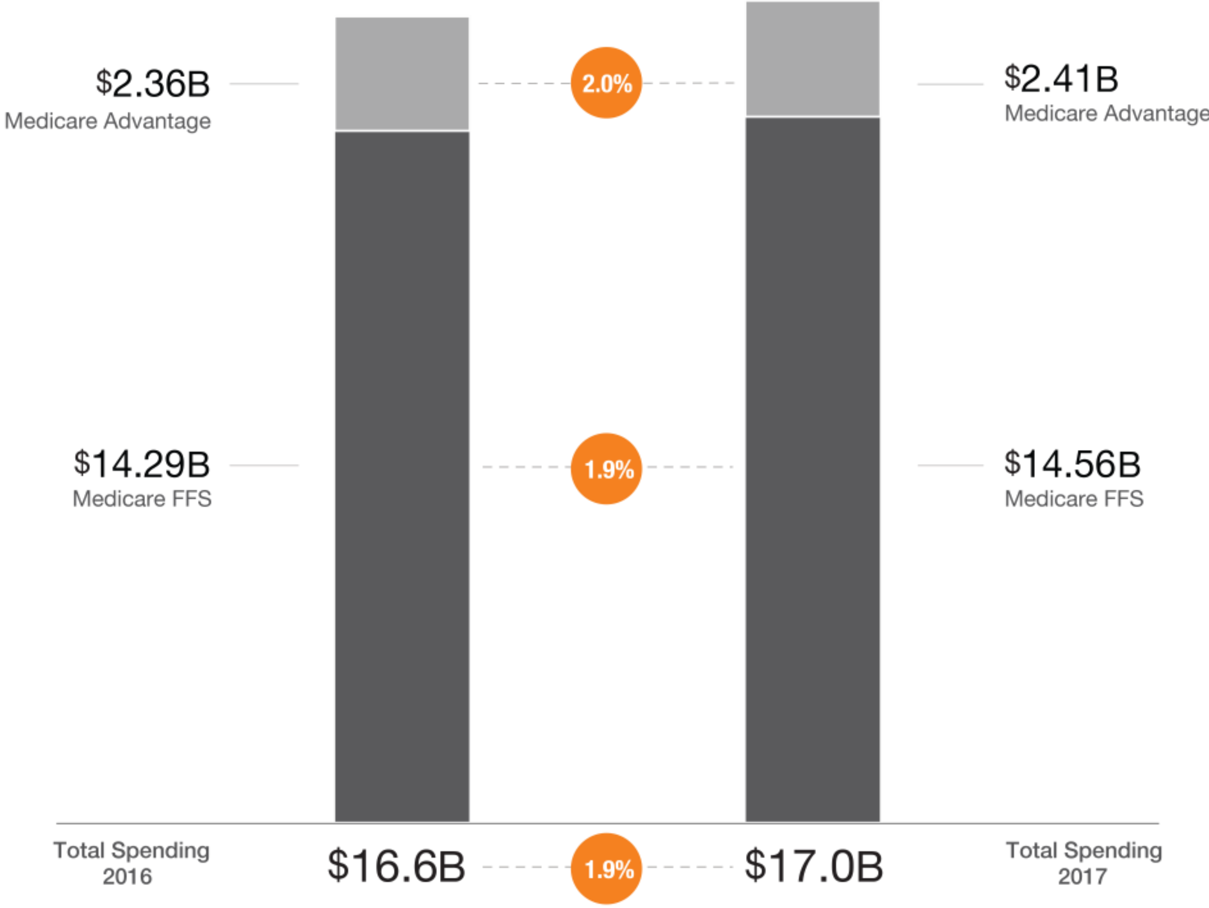
Public Insurance Programs
Medicare

$17.0B — Medicare Expenditures, 2017

1.9% — Expenditure Trend, 2016-2017

2.4% — Beneficiaries, 2016-2017

Public Insurance Programs
Medicare Program Spending, 2016-2017



MEDICARE EXPENDITURES GREW AT SIMILAR RATES FOR BENEFICIARIES COVERED UNDER TRADITIONAL AND MEDICARE ADVANTAGE.

Commercial Insurance

$22.8B — **Commercial Expenditures, 2017**

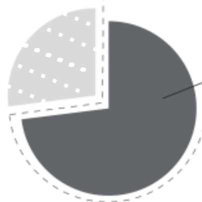
3.1% — **Expenditure Trend, 2016-2017**

0.4% — **Member Months, 2016-2017**

Commercial Insurance
Service Categories, 2016-2017

Service Category	2016	2017	Percent Change in 2016 Final TME	Percent Change in 2017 Preliminary TME
Hospital Inpatient	$81	$81	4.3%	0.8%
Hospital Outpatient	$115	$120	5.4%	4.6%
Physician	$122	$122	2.0%	0.4%
Pharmacy	$89	$91	3.9%	3.2%
Other Prof.	$26	$27	5.3%	6.5%
Other	$24	$23	10.6%	-2.1%
Non-Claims	$18	$19	-0.1%	8.8%

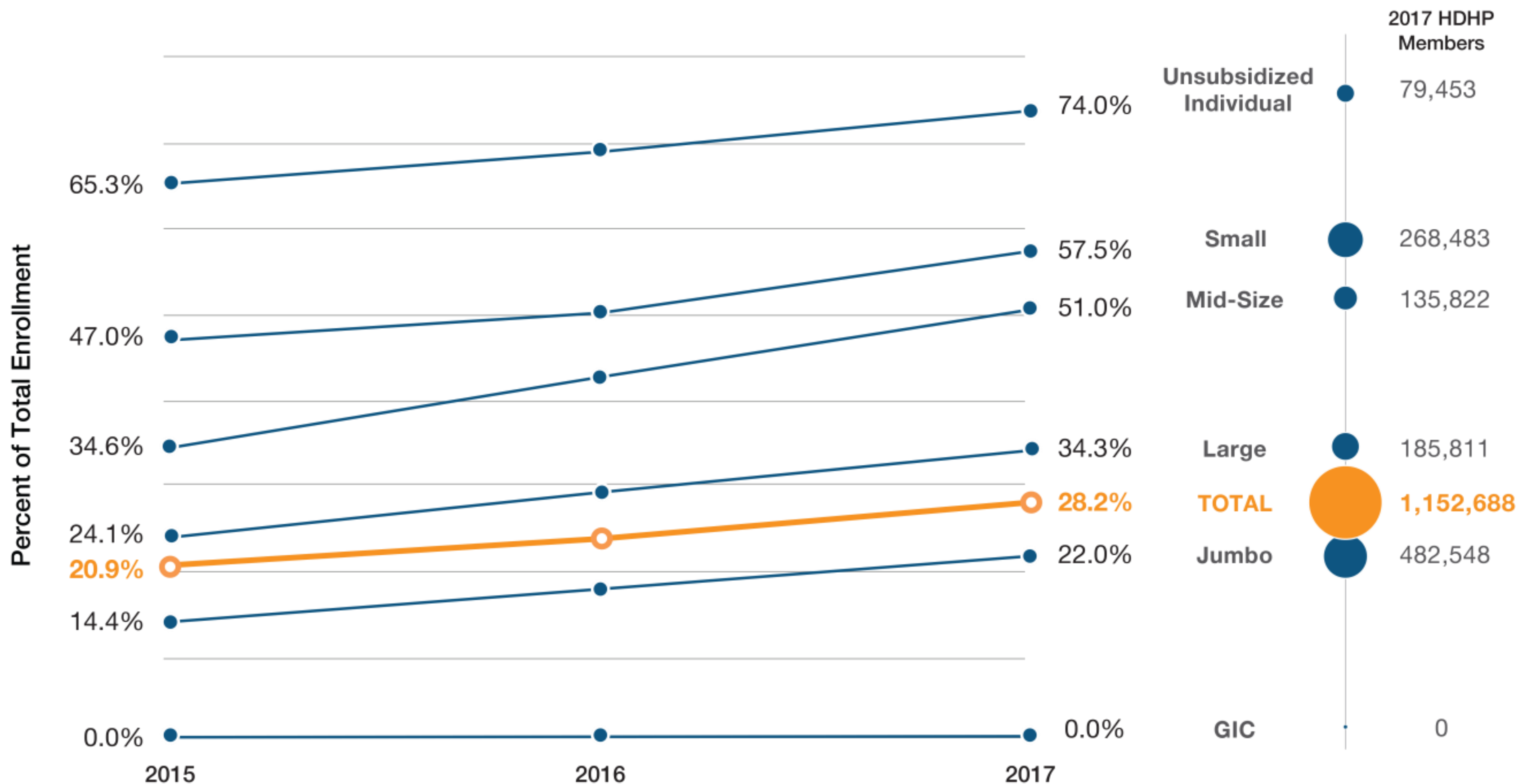
TME Per Member Per Month (PMPM)



COMMERCIAL SPENDING PMPM SLOWED ACROSS THE FOUR MAJOR SERVICE CATEGORIES IN 2017.

Commercial Insurance

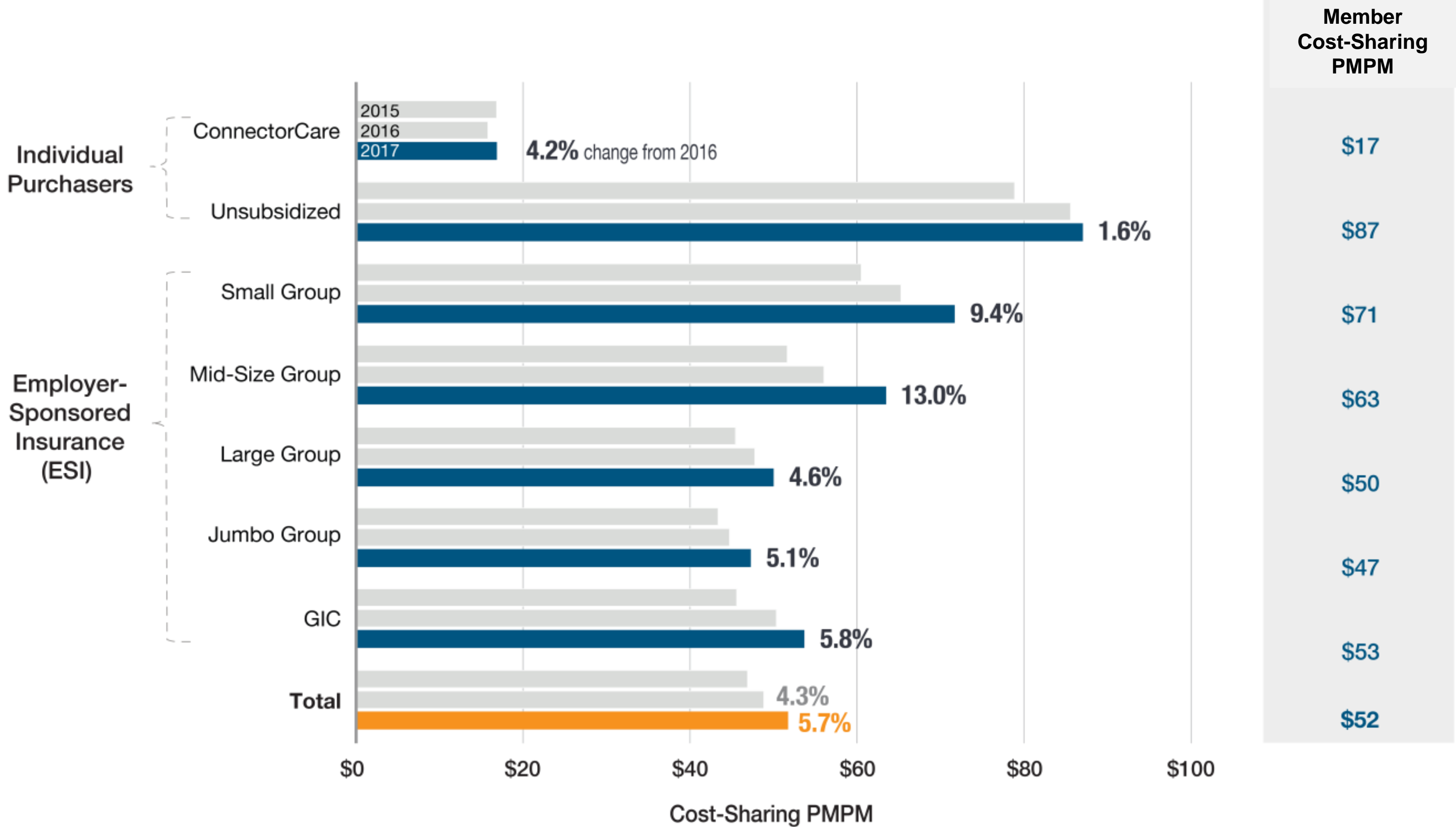
High Deductible Health Plans by Market Sector, 2015-2017



IN 2017, MORE THAN ONE IN FOUR (28.2%) MASSACHUSETTS CONTRACT MEMBERS WERE ENROLLED IN AN HDHP. THESE PLANS WERE MORE COMMON AMONG SMALLER EMPLOYER GROUP PURCHASERS.

For more information, see **page 66** of CHIA's *Annual Report*

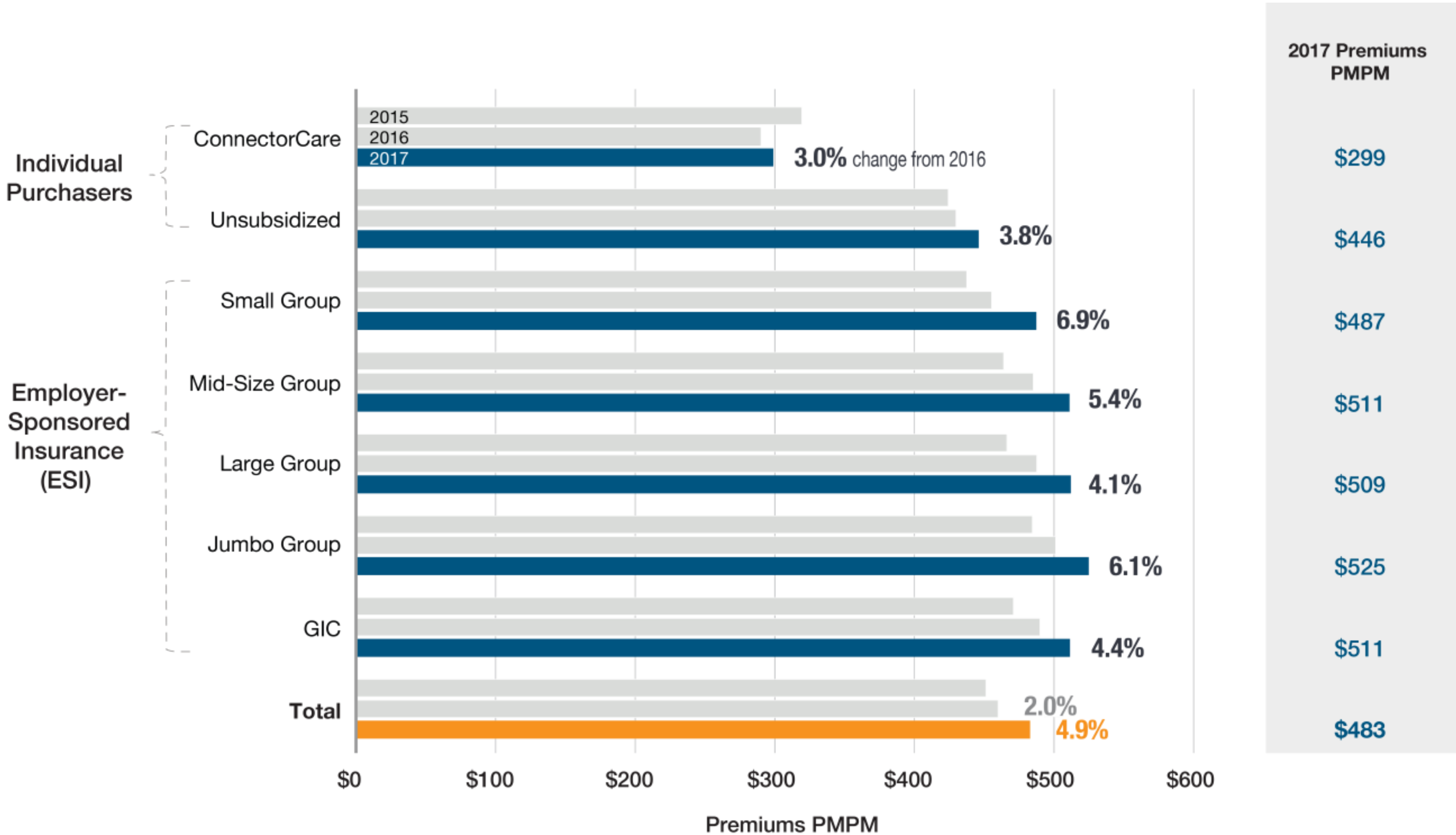
Commercial Insurance
Cost-Sharing by Market Sector, 2015-2017



MEMBER COST-SHARING CONTINUED TO BE HIGHER, AND GREW FASTER, AMONG SMALLER EMPLOYER GROUPS.

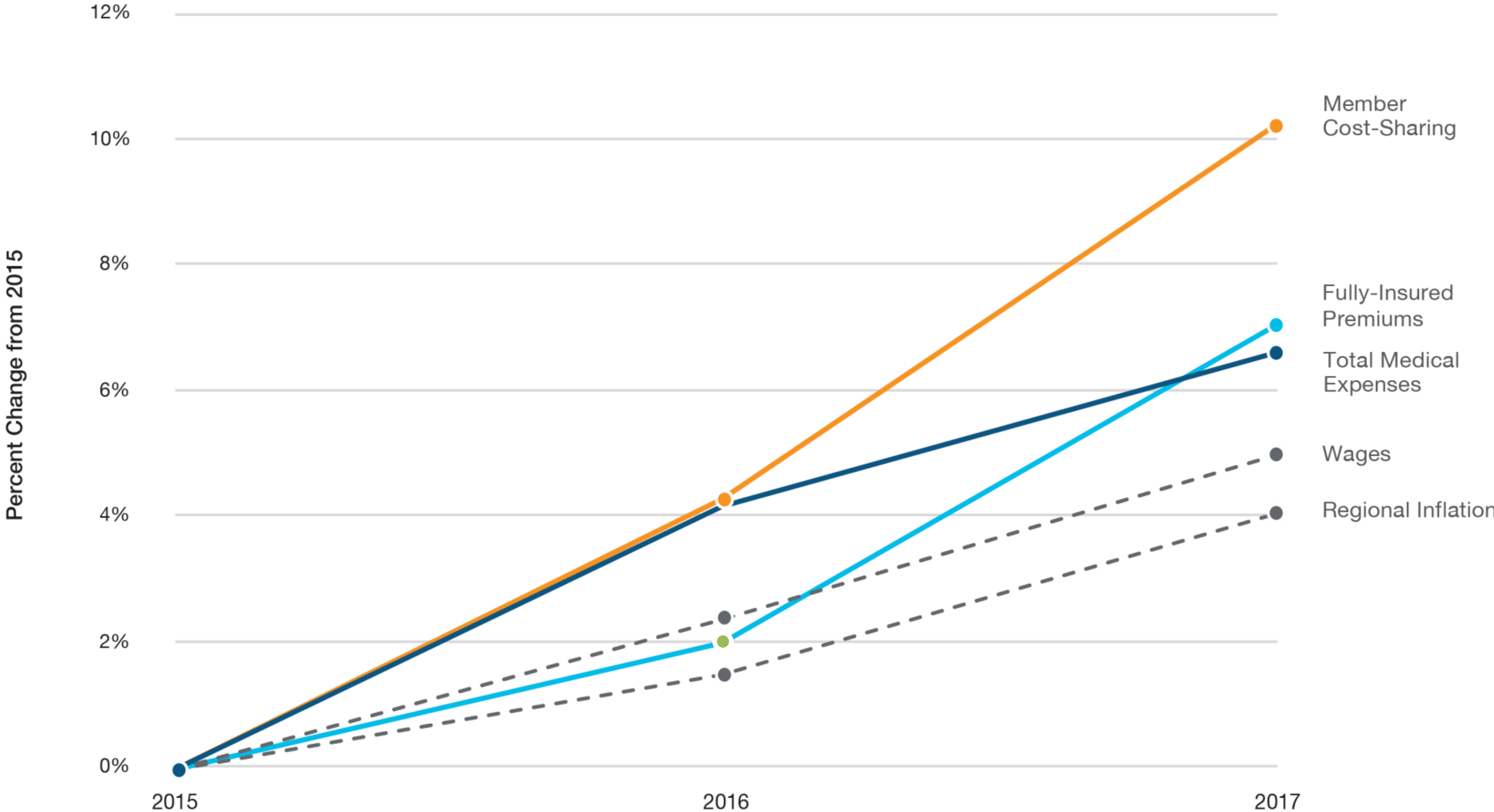
Commercial Insurance

Fully-Insured Premiums by Market Sector, 2015-2017



FULLY-INSURED PREMIUMS INCREASED BY 4.9% FROM 2016 TO 2017. SMALL GROUP MEMBERS EXPERIENCED THE LARGEST PERCENTAGE INCREASE (+6.9%).

Commercial Insurance
Expense Trends, 2015-2017



MEMBER COST-SHARING AND FULLY-INSURED PREMIUMS GREW FASTER THAN WAGES AND INFLATION IN 2017.

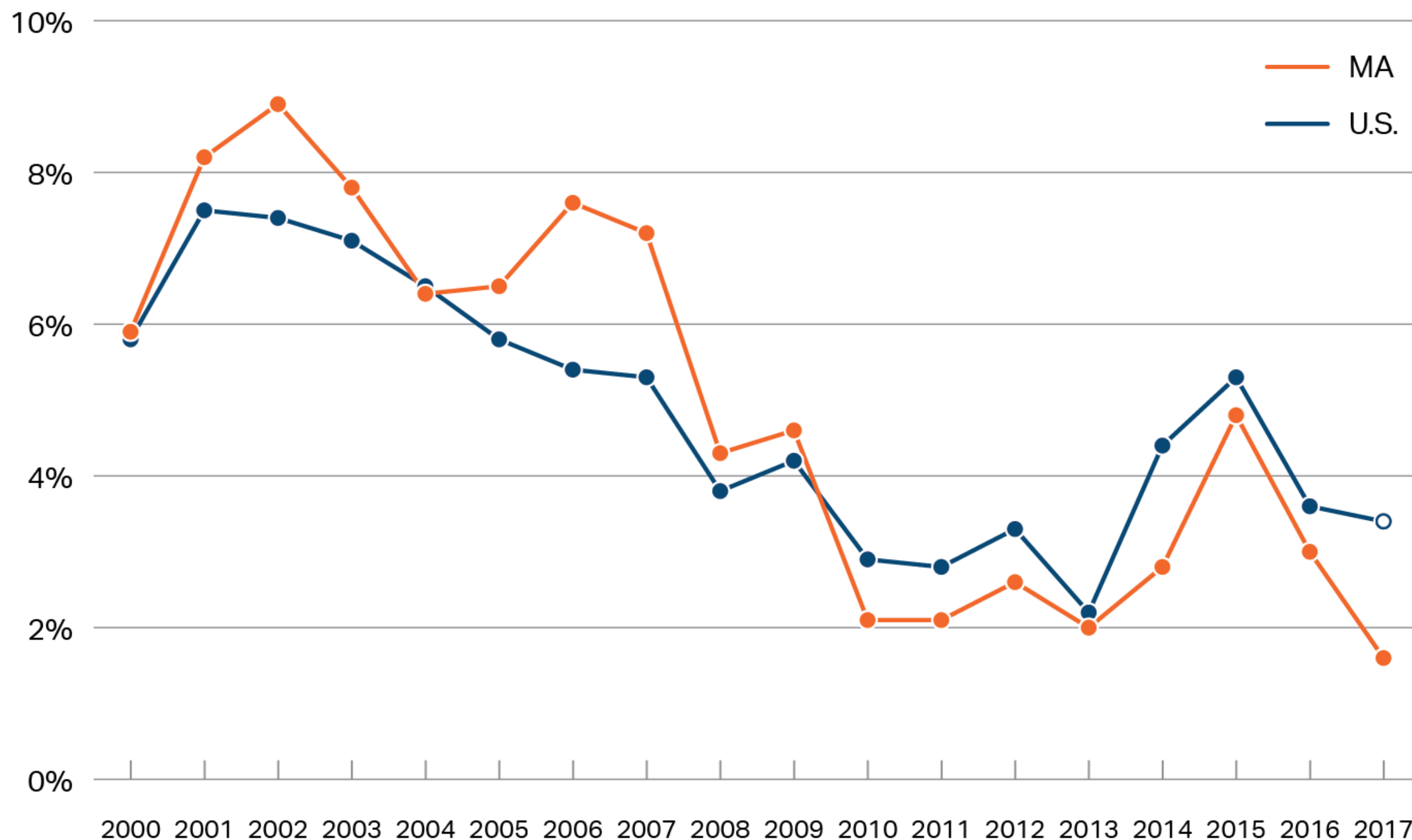
Note: Total Medical Expenses reflects commercial full-claim only.

State Perspective on Health Care Cost Trends

Dr. David Auerbach
Director of Research and Cost Trends, Massachusetts Health Policy Commission

In 2017, total healthcare spending growth in Massachusetts was well below the national rate, continuing a multi-year trend

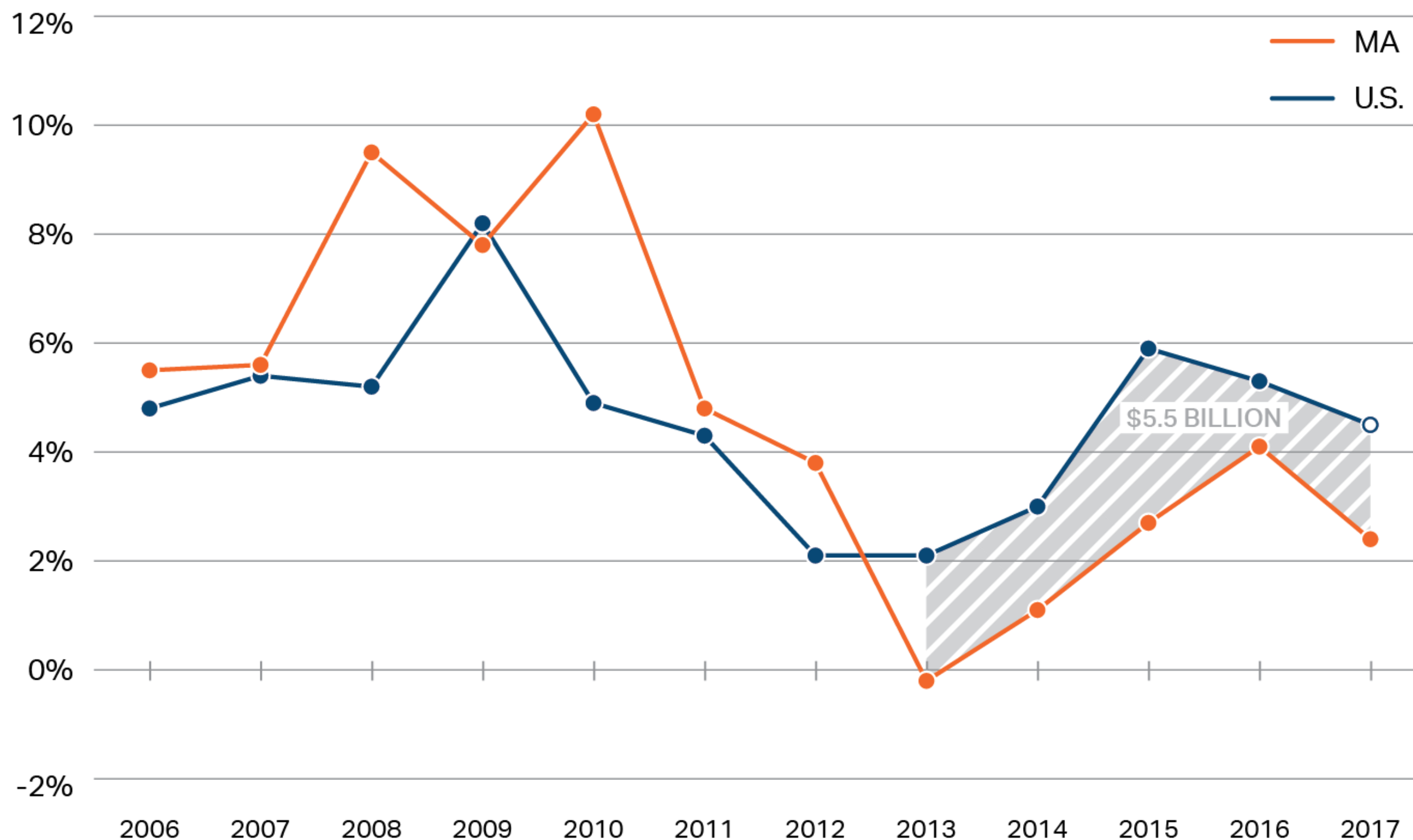
Annual growth in per-capita healthcare spending, MA and the U.S., 2000 – 2017



Notes: US data include MA. US and MA figures for 2017 are preliminary.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017) and State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis Annual Report THCE Databooks (MA 2014-2017).

Commercial spending growth in Massachusetts has been below the national rate since 2013, generating billions in avoided spending

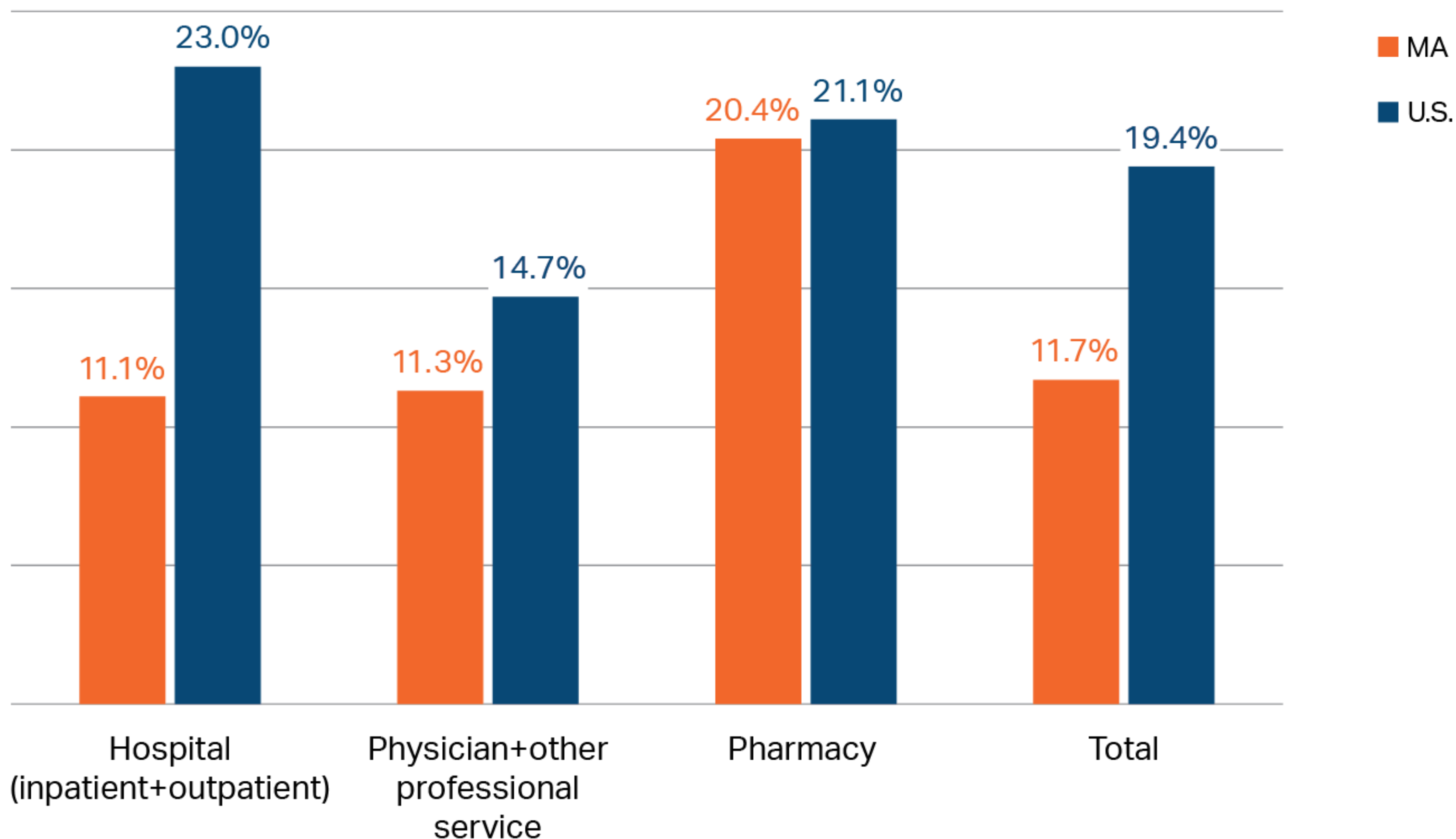
Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017



Notes: US data includes Massachusetts. US and MA figures for 2017 are preliminary.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017) and State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis Annual Report TME Databooks (MA 2014-2017).

Since 2013, total hospital spending growth (inpatient and outpatient) in Massachusetts has been far below national growth rates

2013 – 2017 cumulative growth in commercial spending by service category, MA and U.S.

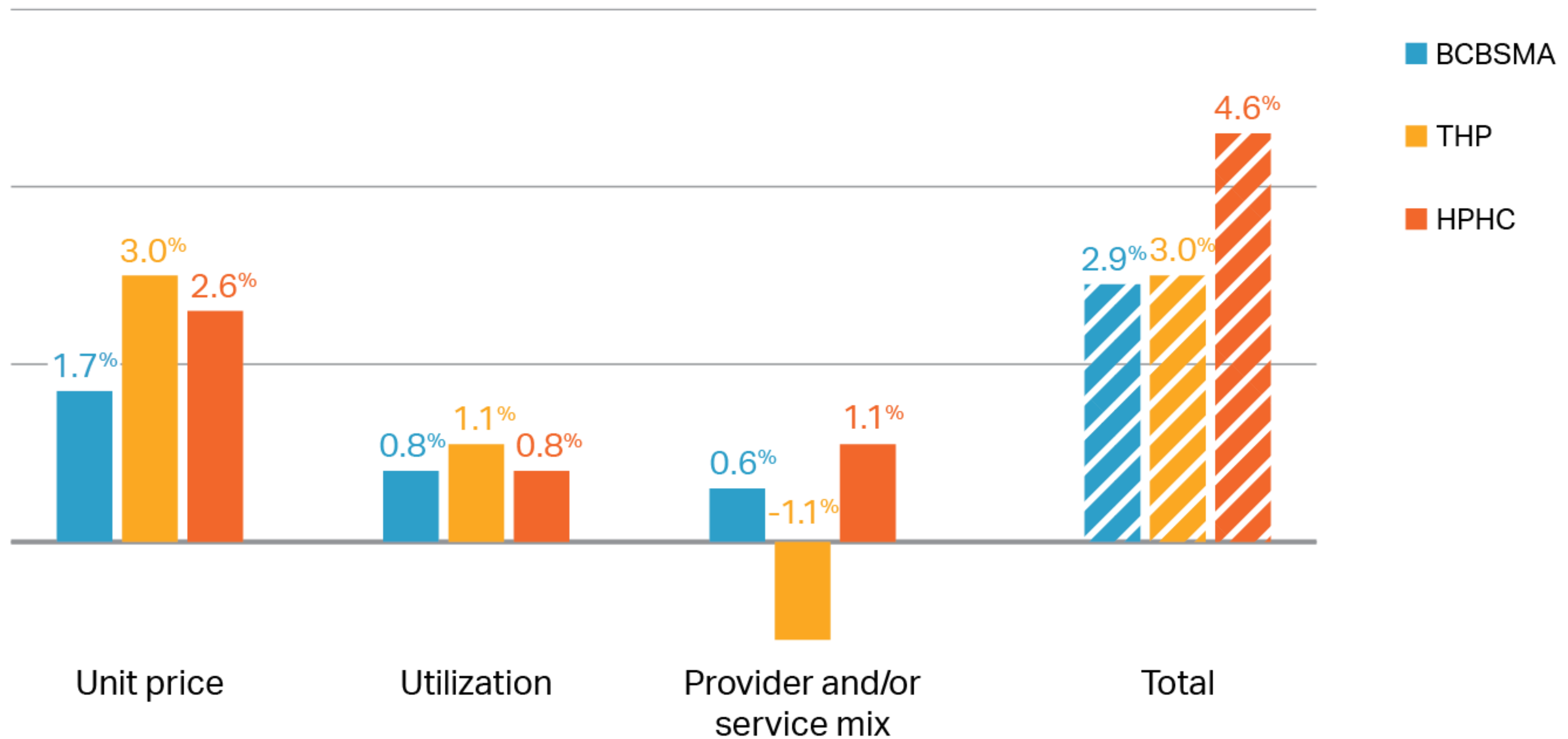


If Massachusetts commercial spending grew at the national rate from 2013-2017, residents would have spent $1.7B more in 2017 alone ($367 per person)

Notes: US data include Massachusetts. Pharmacy spending is net of rebates.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts, Private Health Insurance Expenditures and Enrollment Data (U.S. 2013-2017); Center for Health Information and Analysis Annual Reports (MA 2013-2017).

Unit price was the largest spending driver for the top three commercial health plans in Massachusetts between 2015 and 2017

Average annual growth in spending by component for top 3 payers, 2015 – 2017

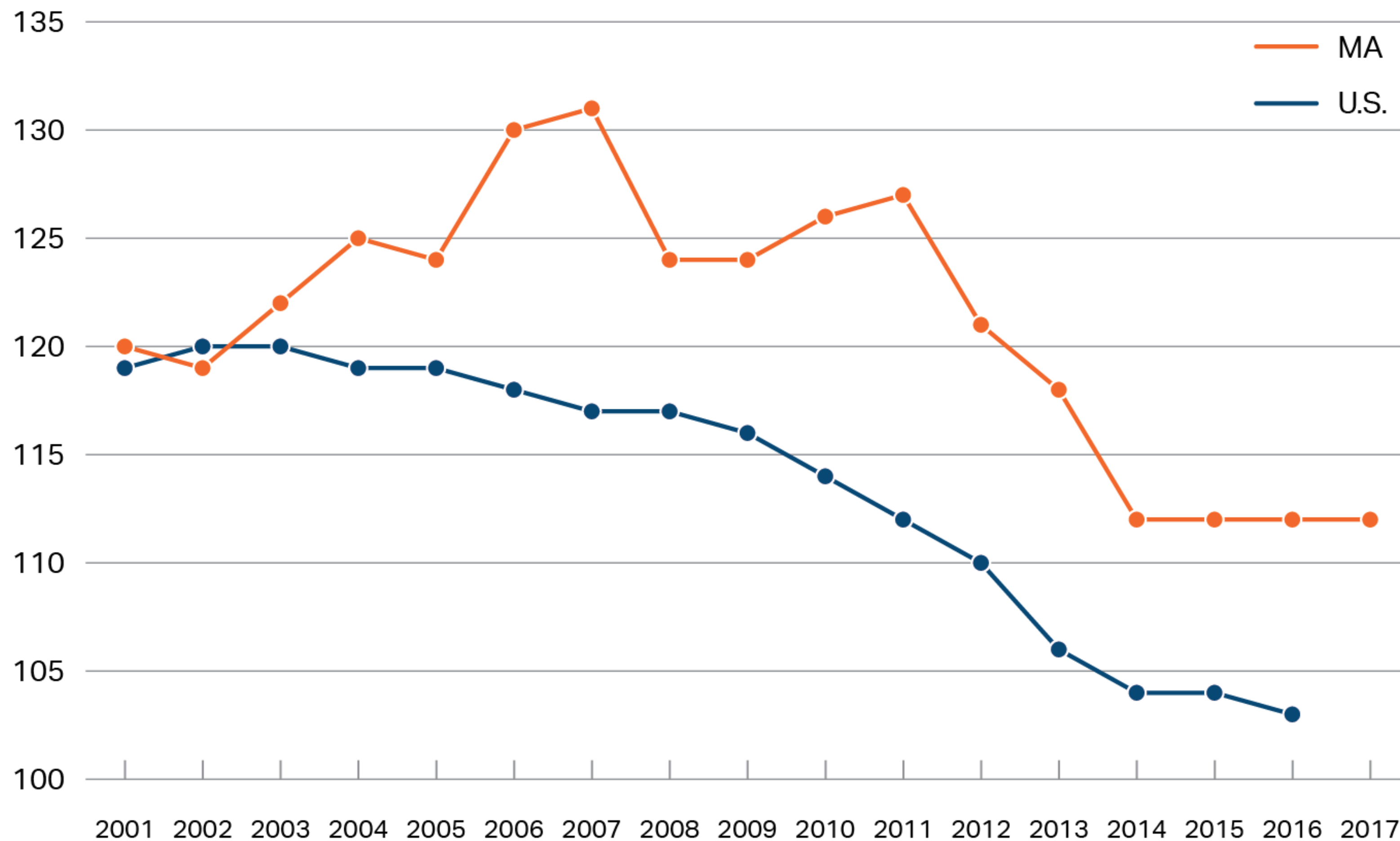


Notes: Average of medical expenditure trend by year 2015-2017. BCBSMA = Blue Cross Blue Shield of Massachusetts; THP = Tufts Health Plan; HPHC = Harvard Pilgrim Health Care.

Source: HPC analysis of Pre-Filed Testimony Pursuant to the 2018 Annual Cost Trends Hearing

Massachusetts inpatient hospital admission rates show little change since 2014 and continue to exceed the U.S. average

Inpatient hospital admission rate per 1,000 residents, MA and the U.S., 2001-2017



Notes: US data include Massachusetts.
Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2016), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2017).

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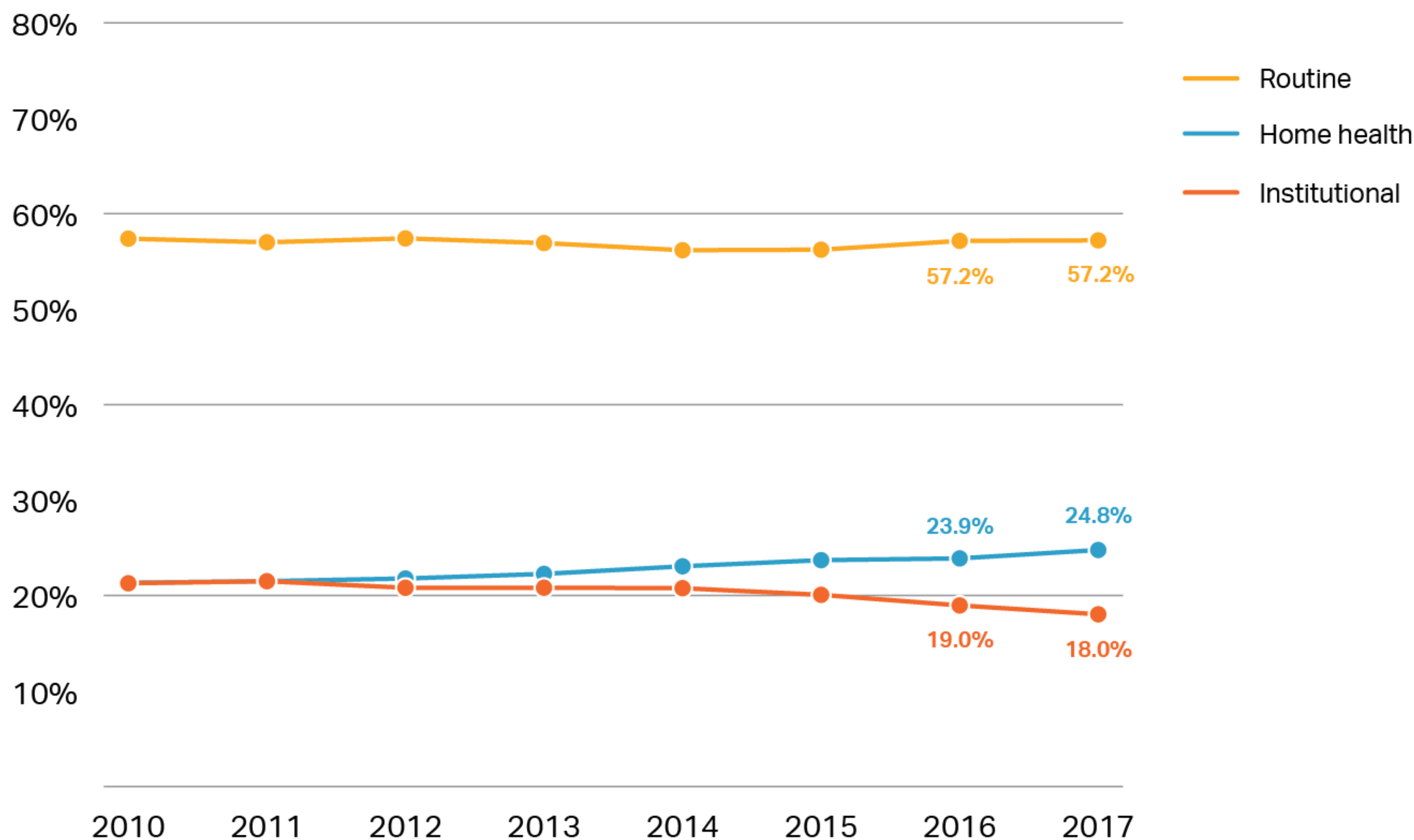
Across all inpatient discharges, the rate of discharge to institutional post-acute care continued to decline in 2017

MA rates of discharge to post-acute care settings following an inpatient admission, 2010-2017

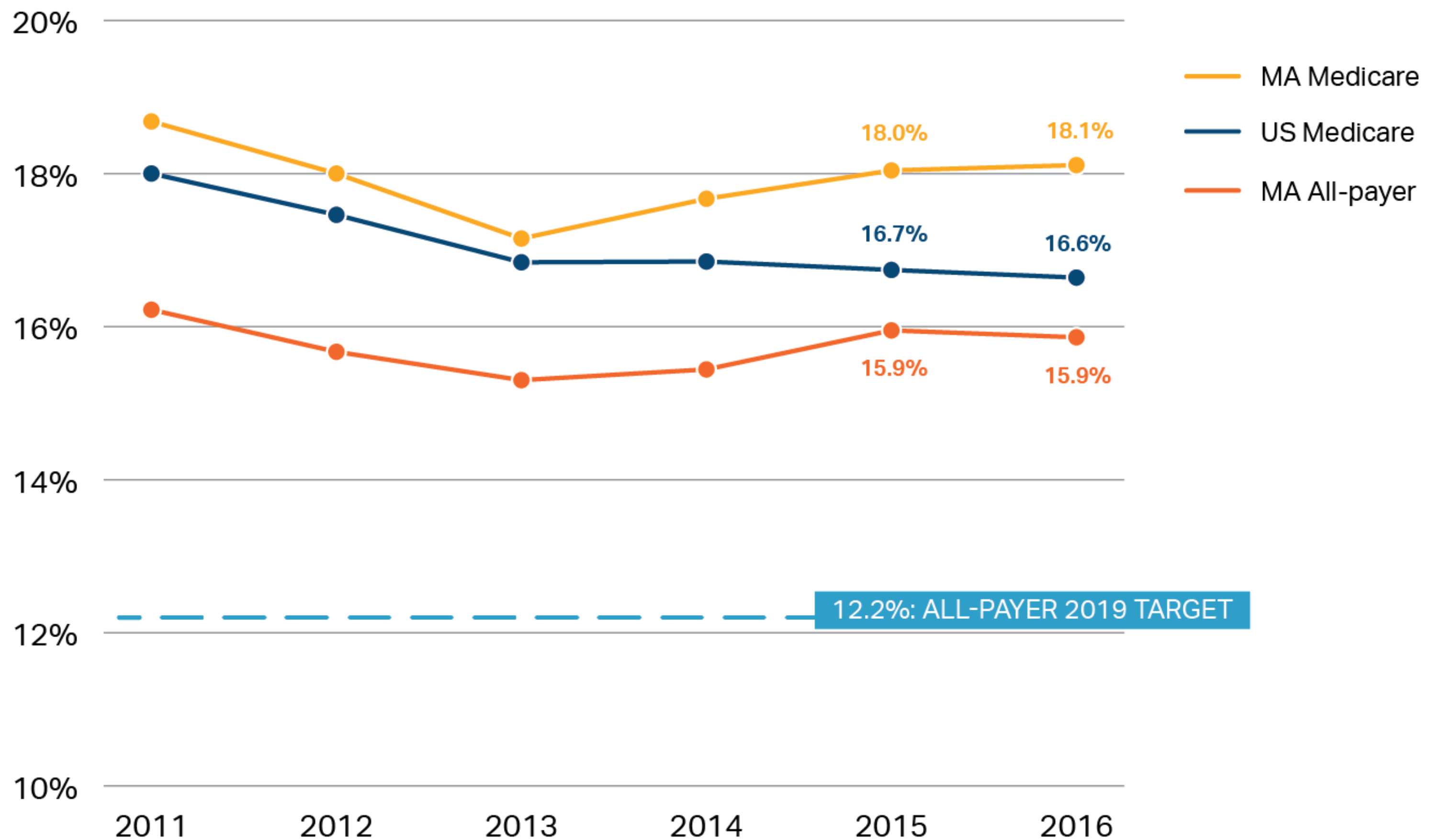


Note: Out-of-state residents are excluded. Rates adjusted for age, sex, and changes in DRG mix. Several hospitals were excluded (UMass, Clinton, Cape Cod, Falmouth, Marlborough) due to coding irregularities in the database.
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2010-2017).

HPC

Massachusetts readmission rates did not show any improvement in 2016

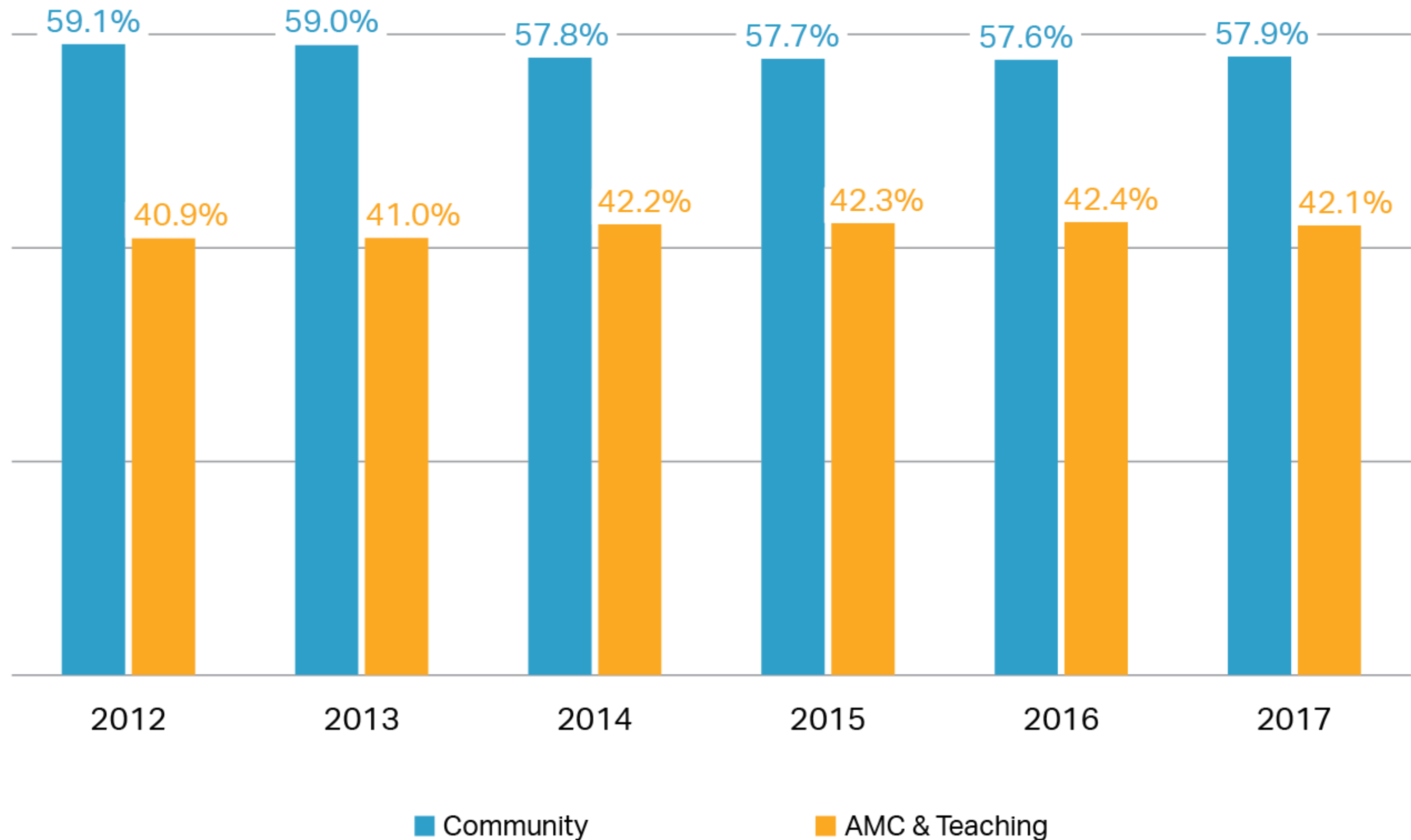
Thirty-day readmission rates, MA and the U.S., 2011-2016



Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare 2011-2016); Center for Health Information and Analysis (MA All-payer 2011-2016).

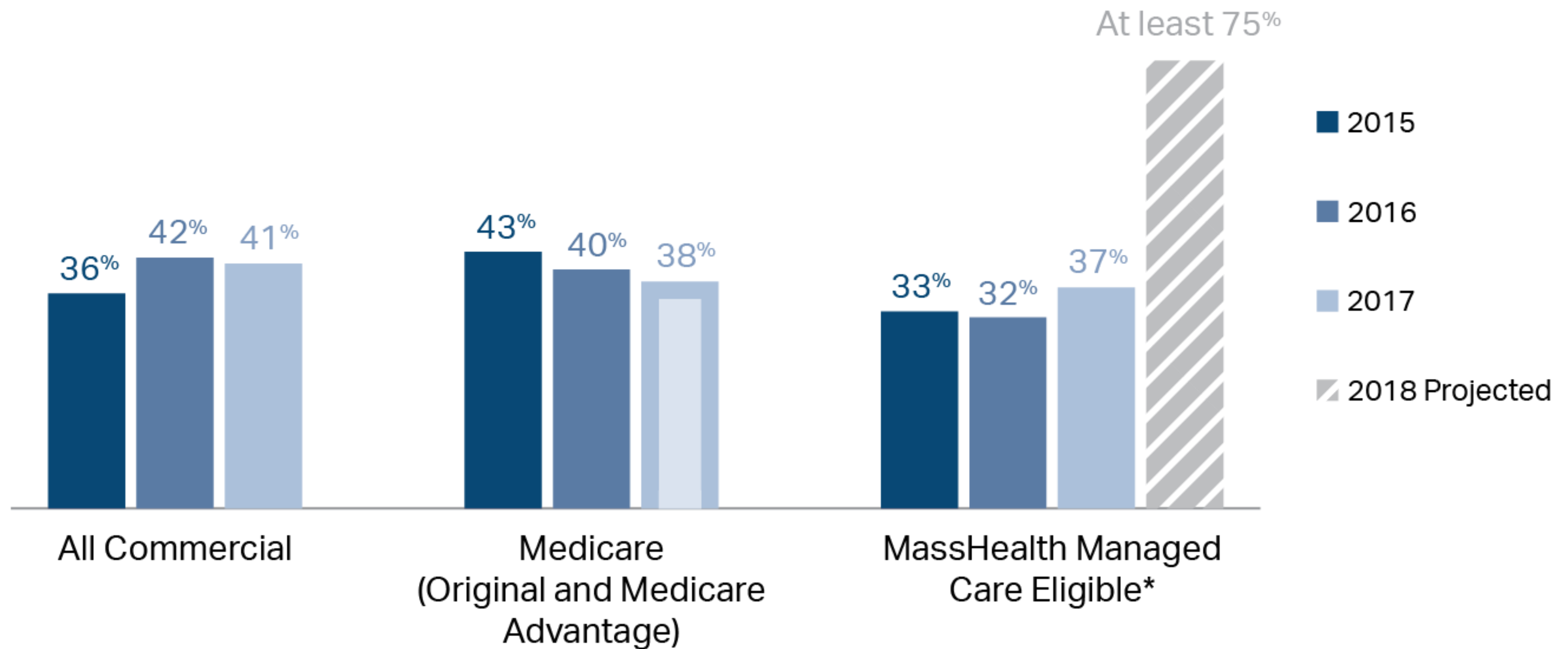
2017 was the first year with a small increase in community hospitals' share of community-appropriate discharges since 2012

MA share of community appropriate discharges by hospital type, 2012-2017



Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs.
Sources: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database (2012-2017).

Overall APM adoption was relatively unchanged in 2017, but by 2018 MassHealth's ACO program should drive statewide APM coverage toward 50%



Notes: Original Medicare data for 2017 is a preliminary estimate.
Source: Centers for Medicare and Medicaid Services (Original Medicare 2015-2017); HPC analysis of Center for Health Information and Analysis Annual Report APM Databooks (Commercial 2015-2017); additional data supplied by MassHealth (MassHealth 2018).
* Managed care eligible includes MCO and PCC Plans, including new ACO options in 2018

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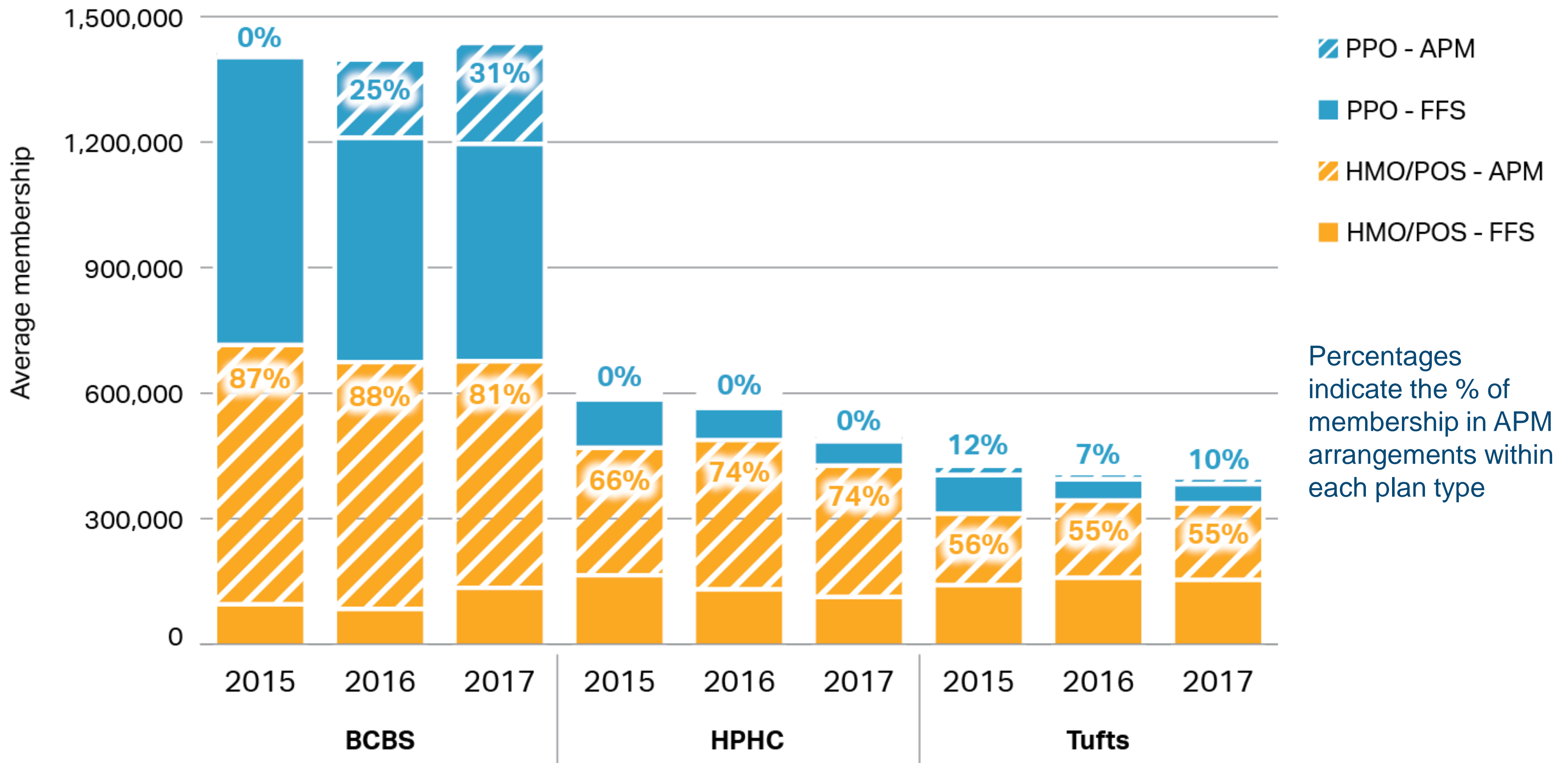
In 2017, Blue Cross Blue Shield of Massachusetts continued to lead the commercial market in APM adoption for PPO members



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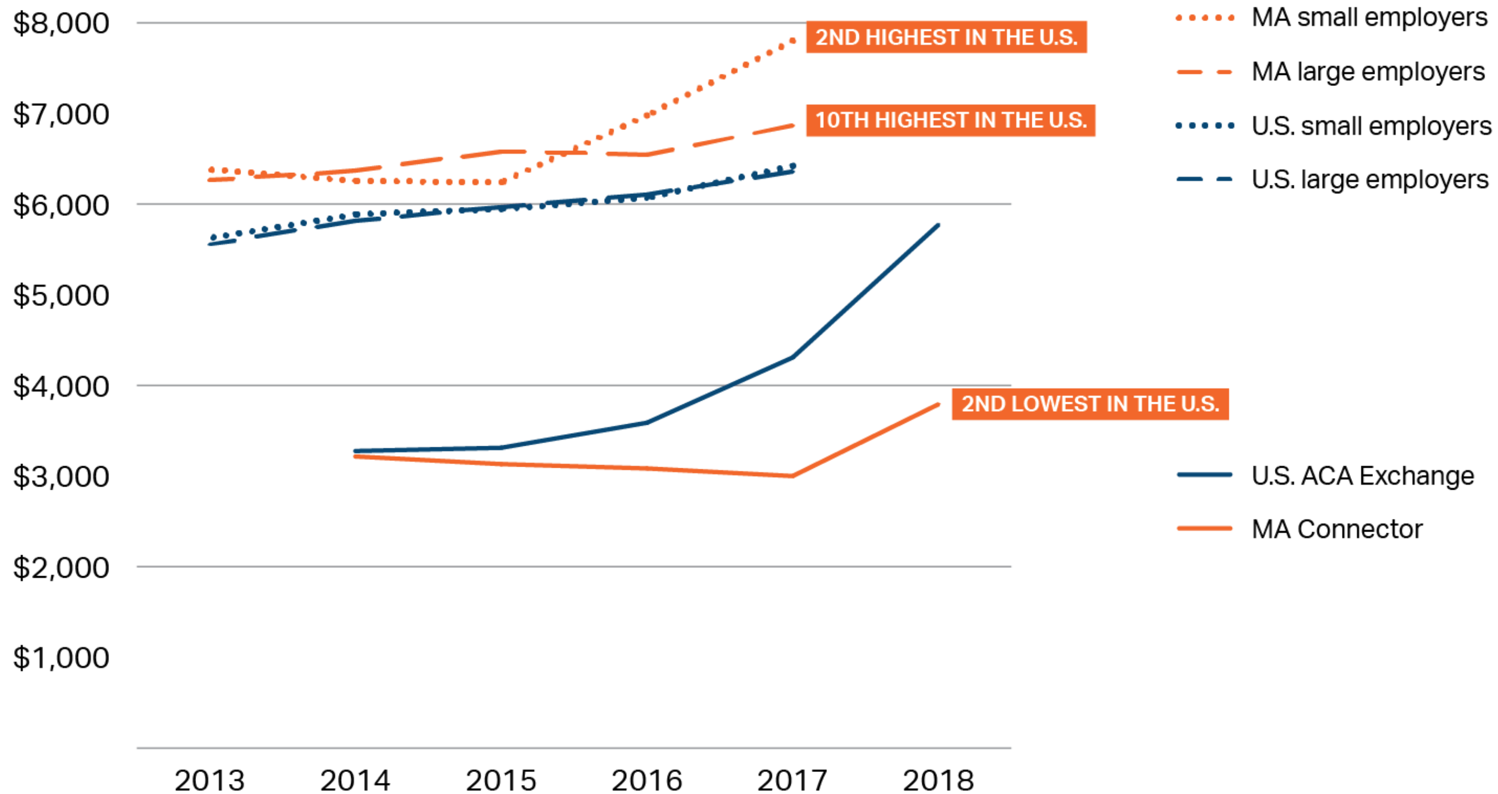
Source: HPC analysis of Center for Health Information and Analysis Annual Report APM Databooks (2015-2017).

While Massachusetts has among the highest premiums in employer markets, particularly for small employers, Connector premiums continue to rank among the lowest in state exchanges in 2018

Annual premiums for single coverage in the employer market and average annual unsubsidized benchmark premium for a 40-year-old in the ACA Exchanges, MA and the U.S., 2013-2018



Notes: US data include Massachusetts. Employer premiums are based on the average premium according to a large sample of employers within each state. Small employers are those with less than 50 employees; large employers are those with 50 or more employees. Exchange data represent the weighted average annual premium for the second-lowest silver (Benchmark) plan based on county level data in each state. These plans have an actuarial value of 70%, compared to 85%-90% for a typical employer plan, and are thus not directly comparable to the employer plans.
Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov (marketplace premiums 2014-2018); US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017).

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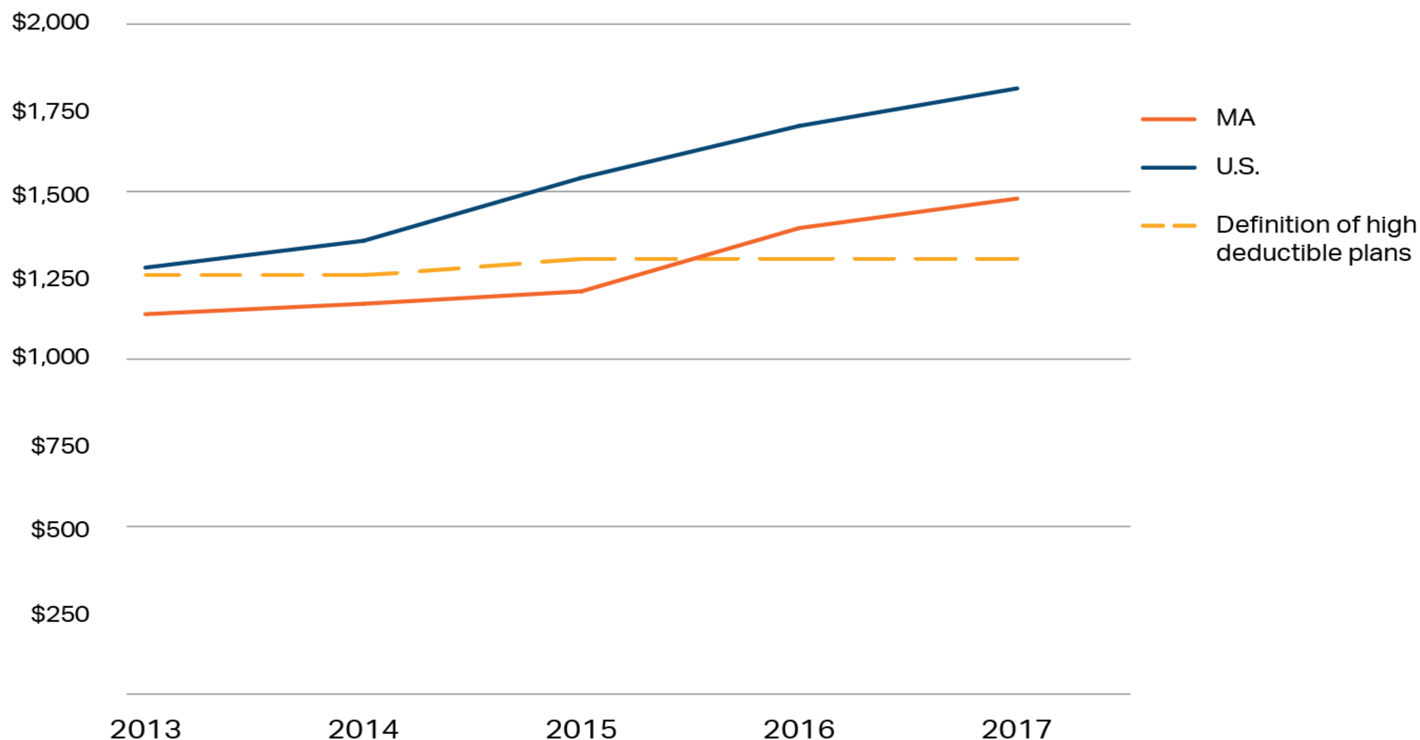
Massachusetts continues to have lower deductibles than the US, although the average deductible exceeds the IRS definition for high deductible plans

Average deductible for single coverage in the employer market, MA and the U.S., 2013-2017



The increase in high deductible plans in Massachusetts may have lowered overall commercial spending growth in 2017 by roughly 0.2 percentage points*

Notes: US data include Massachusetts. Employer deductibles are based on the average deductible according to a large sample of employers within each state. Employer plans that do not have a deductible aren't included in the average deductible calculation.
Sources: US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017); Internal Revenue Service (for definition of high deductible plans 2013-2017).
* Calculation based on increase in proportion of plans that are high deductible plans in Massachusetts in 2017 and Baicker, Katherine, William H. Dow, and Jonathan Wolfson. "Health savings accounts: Implications for health spending." *National Tax Journal* (2006): 463-475.

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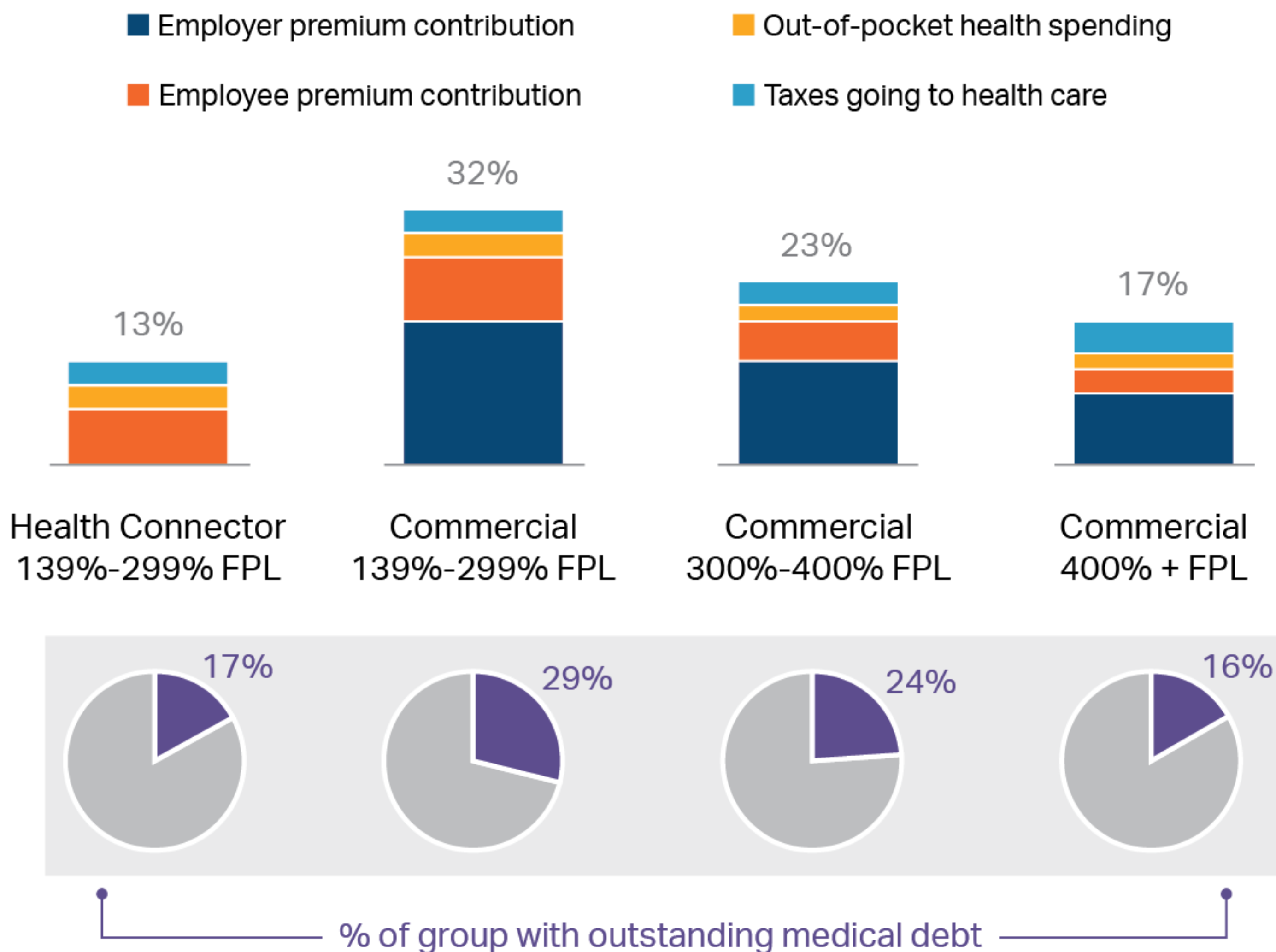
Nearly a third of total income for lower-income, commercially insured residents is consumed by health care costs, leading to higher rates of outstanding medical debt



Note: Figures rounded to nearest whole number. Total income represents total family income and includes employer payments, if any, toward health insurance premiums. One-person families and families with children and two adults are included in the analysis. Data are combined using survey weights which represent the population of Massachusetts. Insurance status is self-reported in the survey. "Commercial" represents insurance received through work or a union; "Health Connector " represents all private, non-group plans available through the Health Connector.

Sources: Massachusetts Health Interview Survey (CHIA), data from 2017 on 1,633 respondents from family- and single-headed households with employer-sponsored and private health insurance, representing roughly 2.9 million state residents. Other data sources include the US Agency for Healthcare Research and Quality US and state government tax and budget data.

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OCTOBER 16, 2018

Up Next
Keynote Presentation by Dr. Ashish Jha

U.S. Healthcare Spending: International Context, National Trends, and Getting to High-Value Care

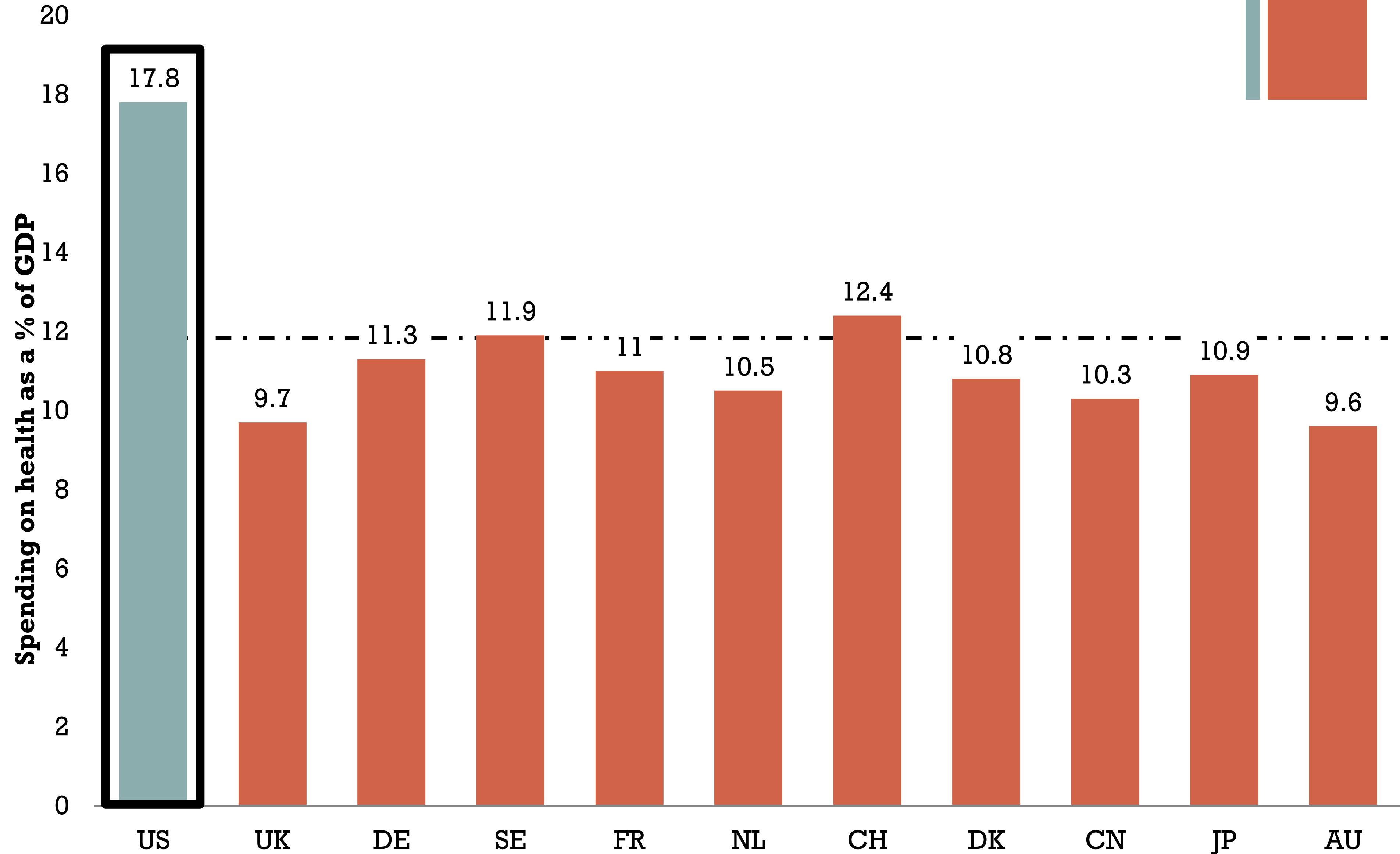
Ashish K. Jha, MD, MPH
October 16, 2018

Agenda

- International context: how does US spending and utilization compare with other countries?
- How did the ACA try to address our cost and quality problems? Has it worked?
- What does this mean for MA?

+ How does US spending compare to other countries?

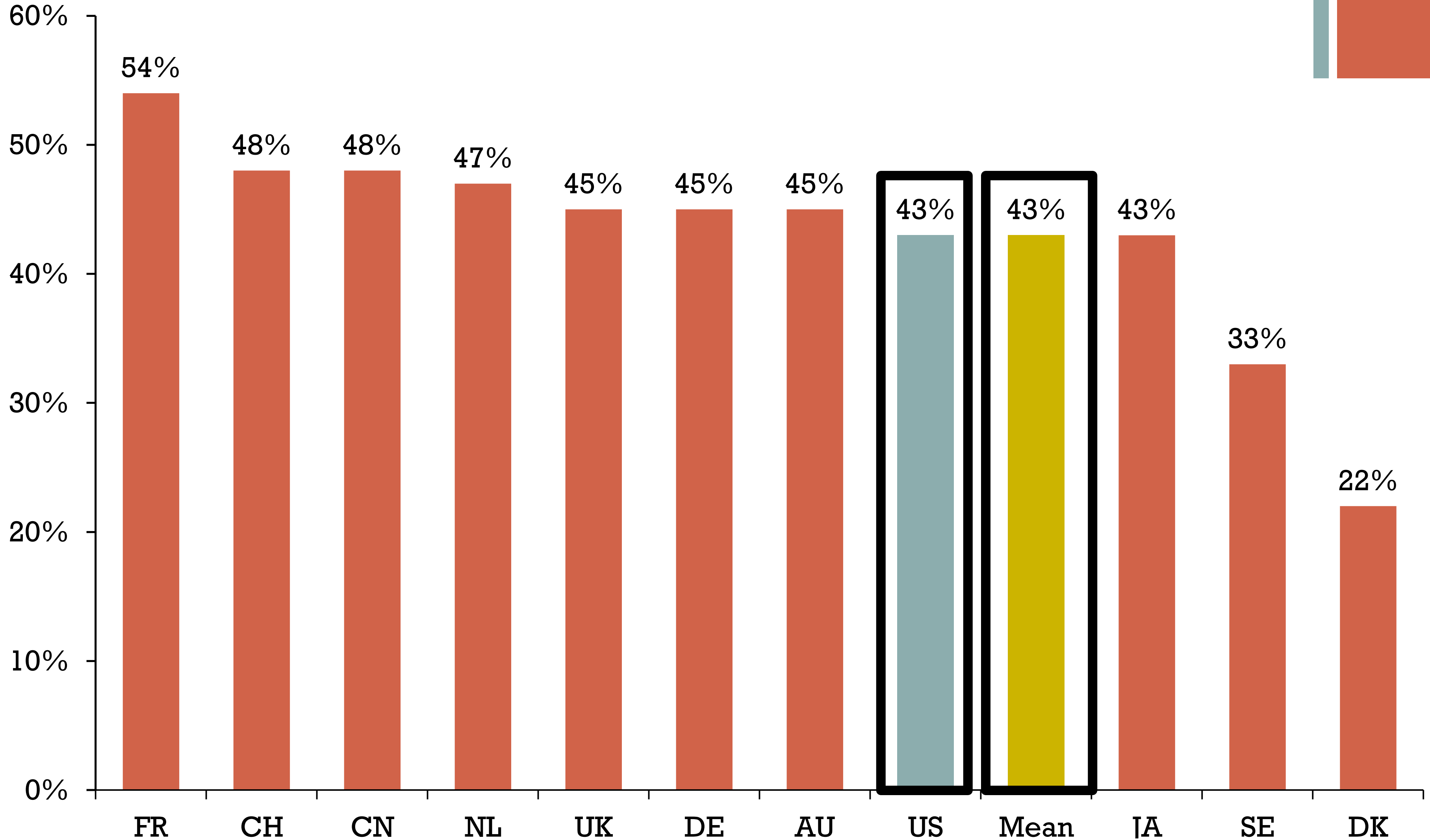
+ Total healthcare spending, 2016



Why?

Hypothesis #1: Too many specialists, not enough primary care

Primary care as % of MDs



Total Spending = Quantity X Price

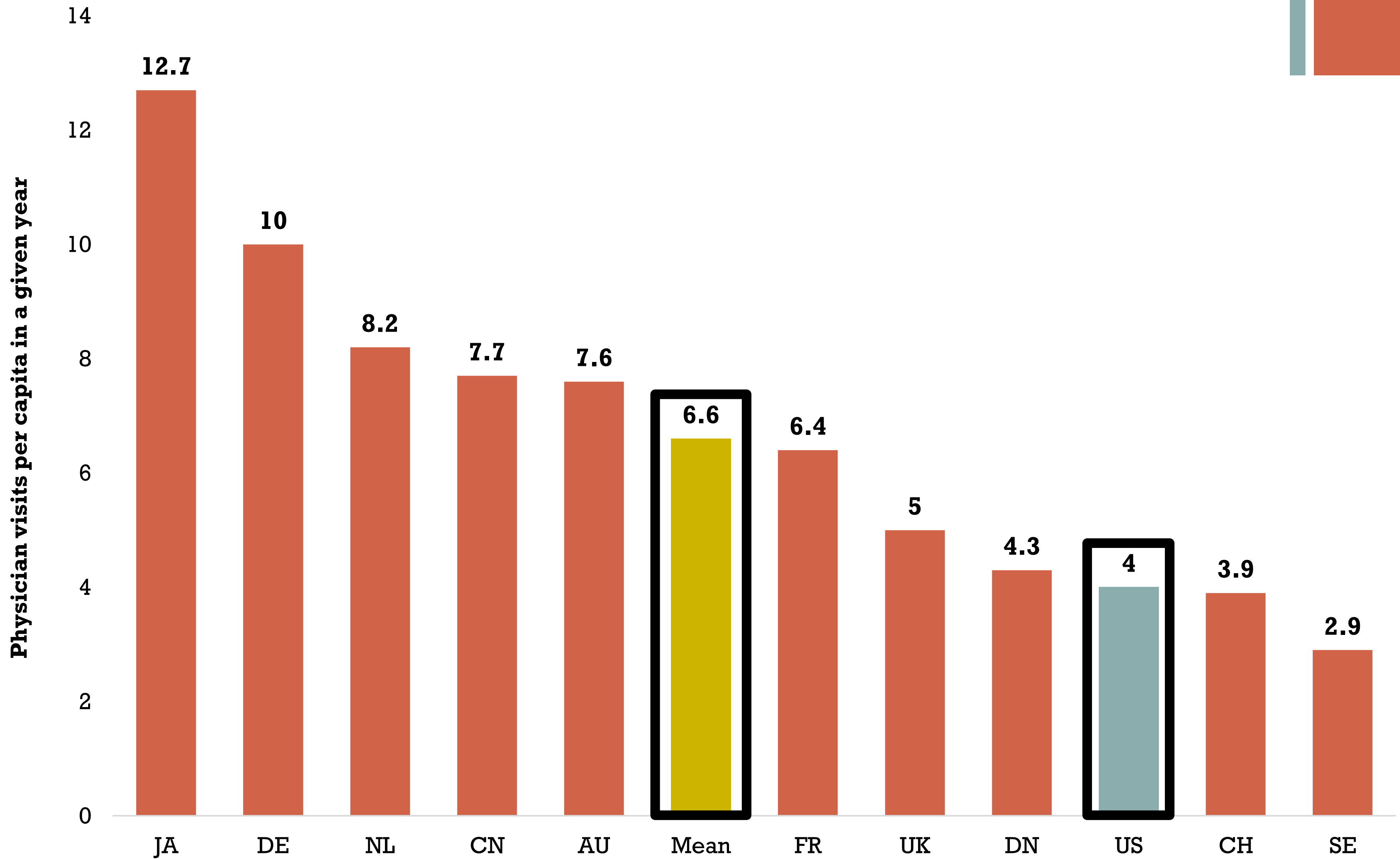
Our culture of overuse

Total Spending = Quantity X Price

Overutilization theory #1

We are quick to go to the doctor

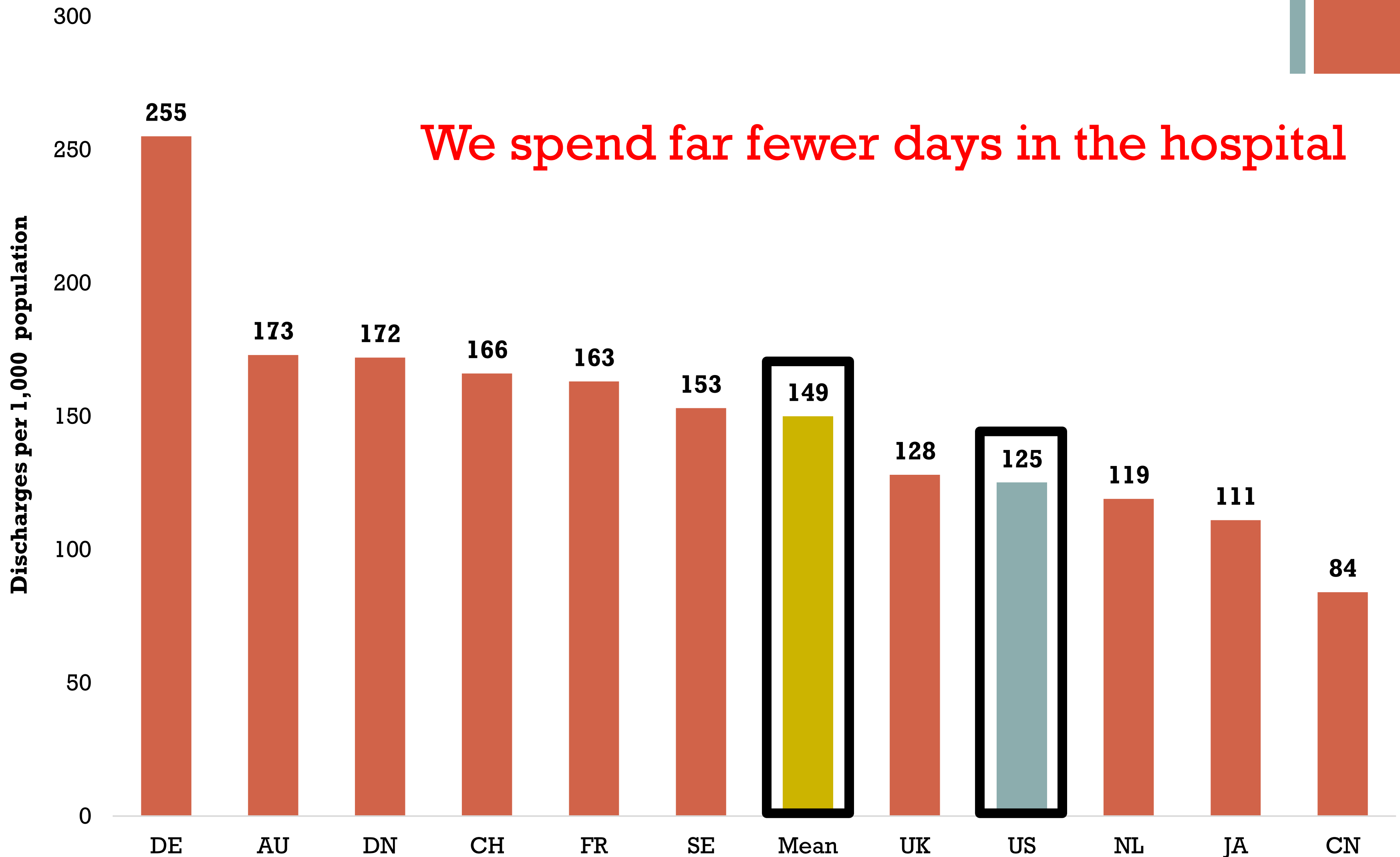
Doctor visits



Overutilization theory #2

Not enough prevention and primary care leads to too many hospitalizations

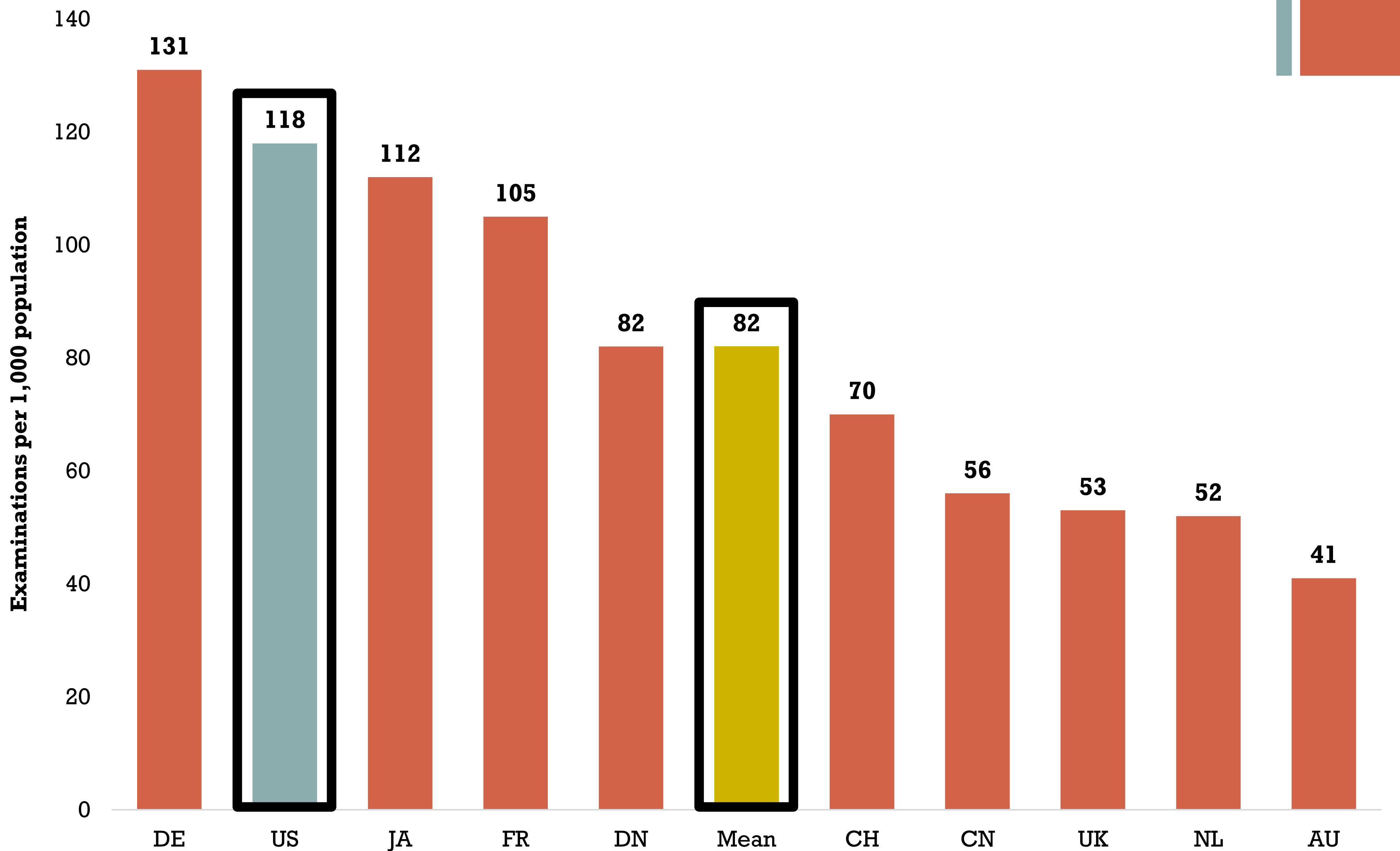
Hospital discharges



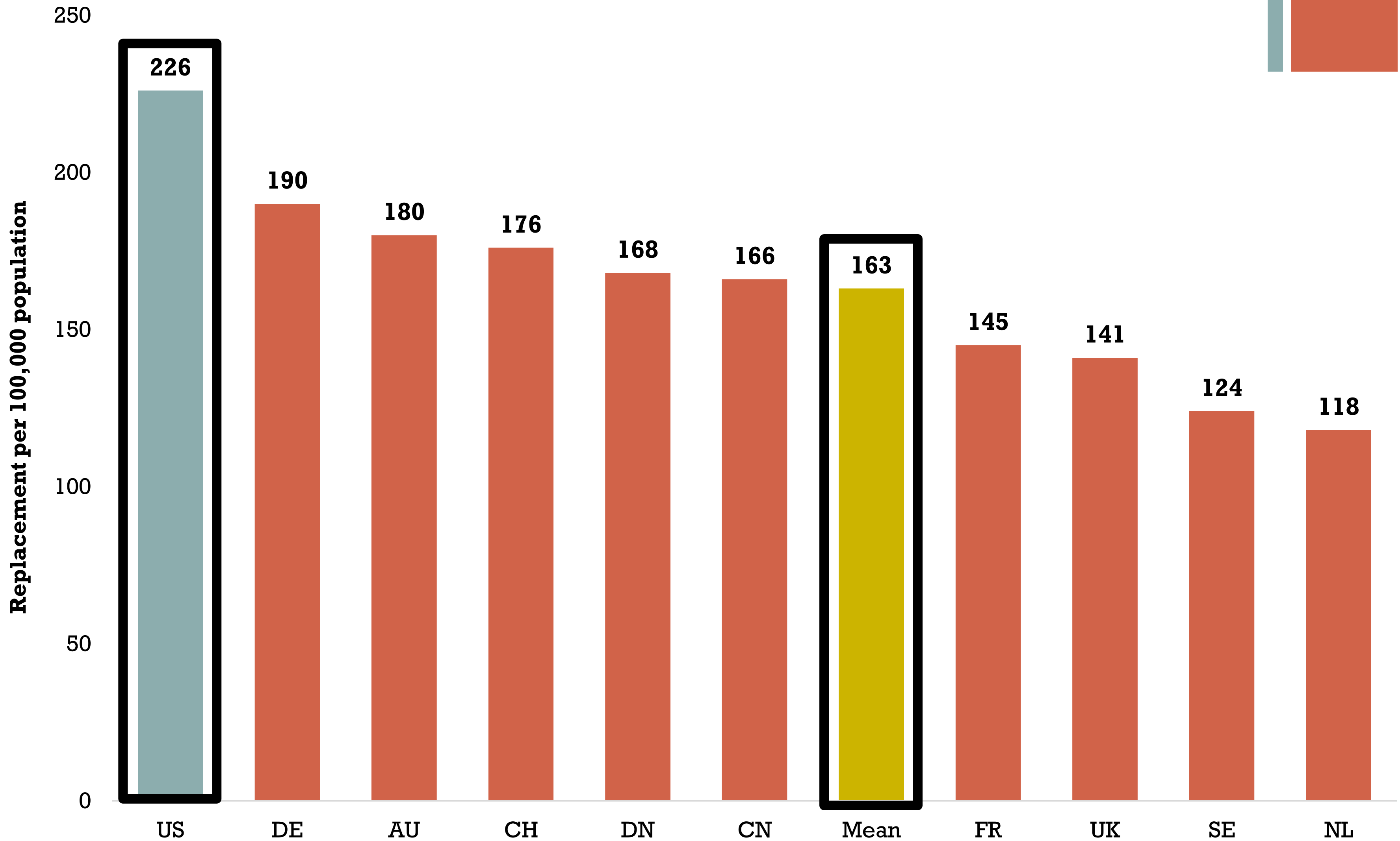
Overutilization theory #3

We use too many tests and procedures

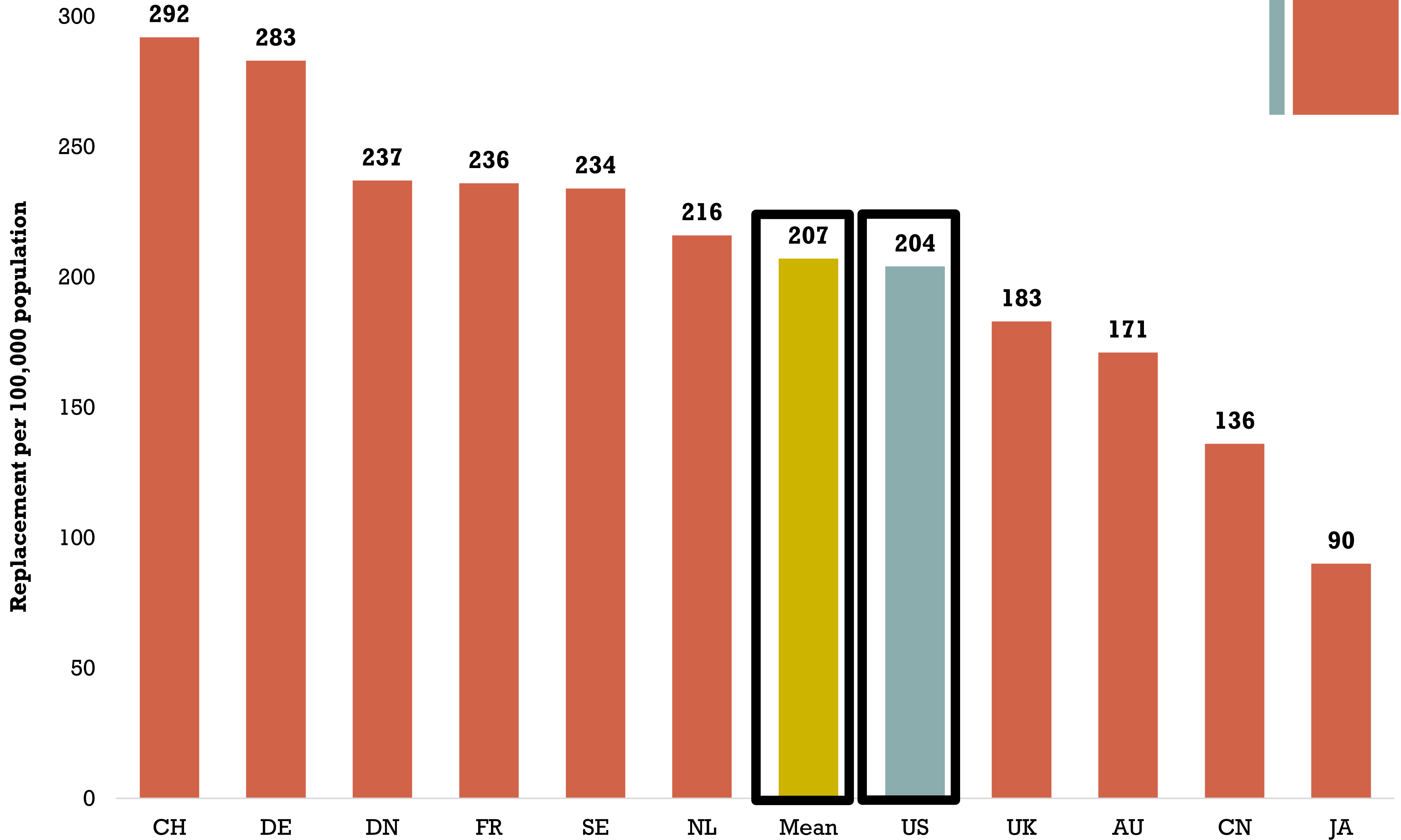
MRI examinations



Total knee replacement



Total hip replacement



Coronary angioplasty

Procedures per 100,000 population

DE	US	NL	FR	Mean	SE	JA	DK	AU	CN	UK
393	248	248	237	217	205	193	190	172	157	128

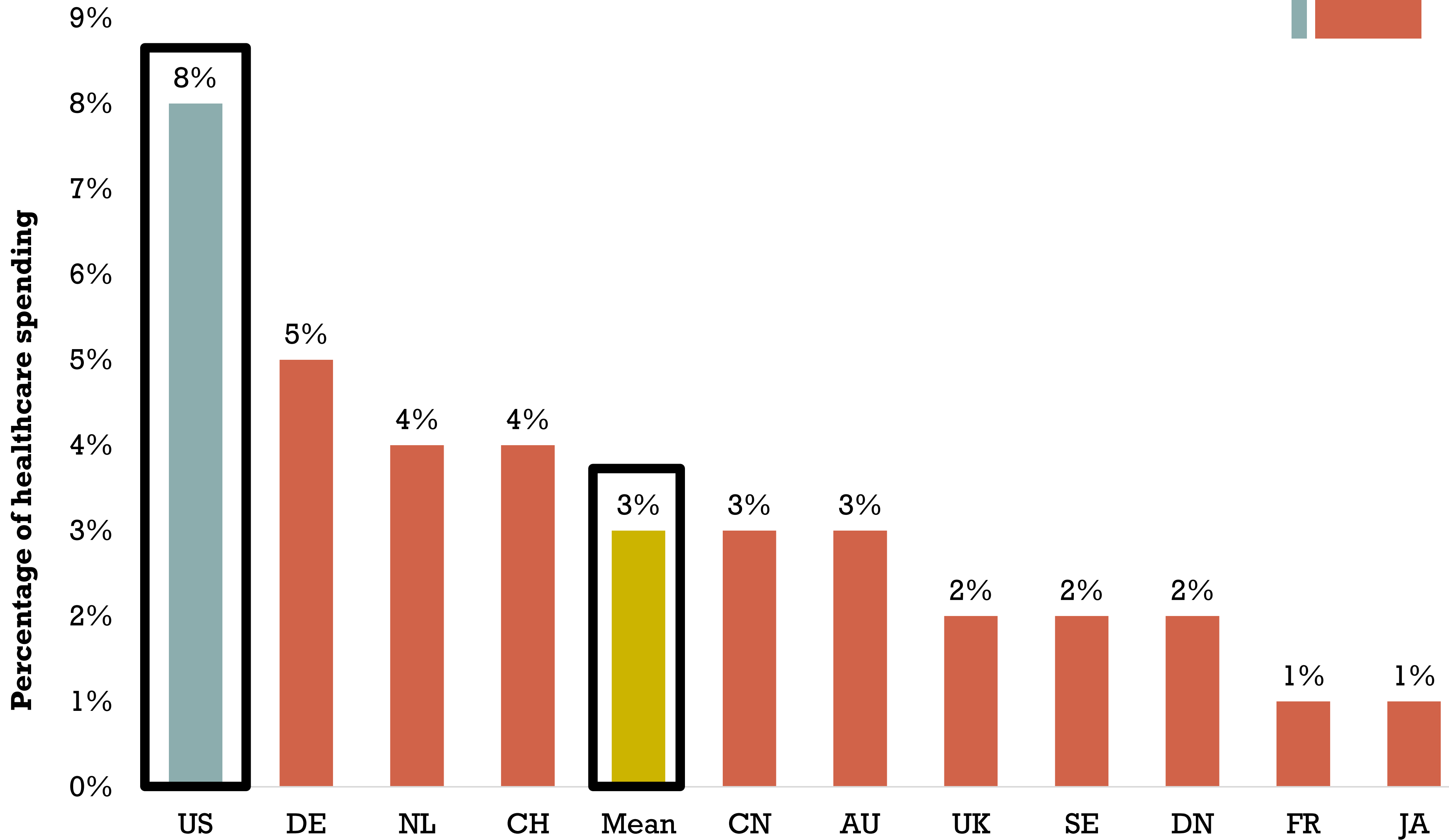
So is it utilization?

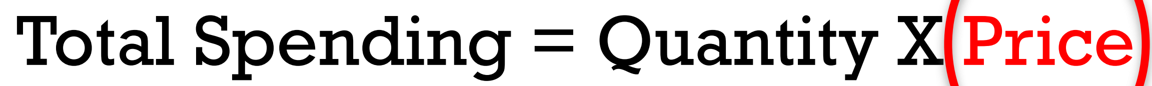
- Higher US costs not primarily about utilization
- We have fewer hospitalizations, doctor visits
- Tests and Procedures a mixed bag:
  - We do a lot more MRIs, TKRs, Angioplasties
  - We do fewer hip replacements
- Bottom line:
  - We're above average on some things
  - We're below average on other things
  - On average, we are pretty average

OK– so what is it?

Administrative waste

Governance, administration spending




Total Spending = Quantity X Price

Prices

Prices of what?

Pharmaceuticals!

Total Spending (USD Per Capita)

Total Pharmaceutical Spending (USD per capita)

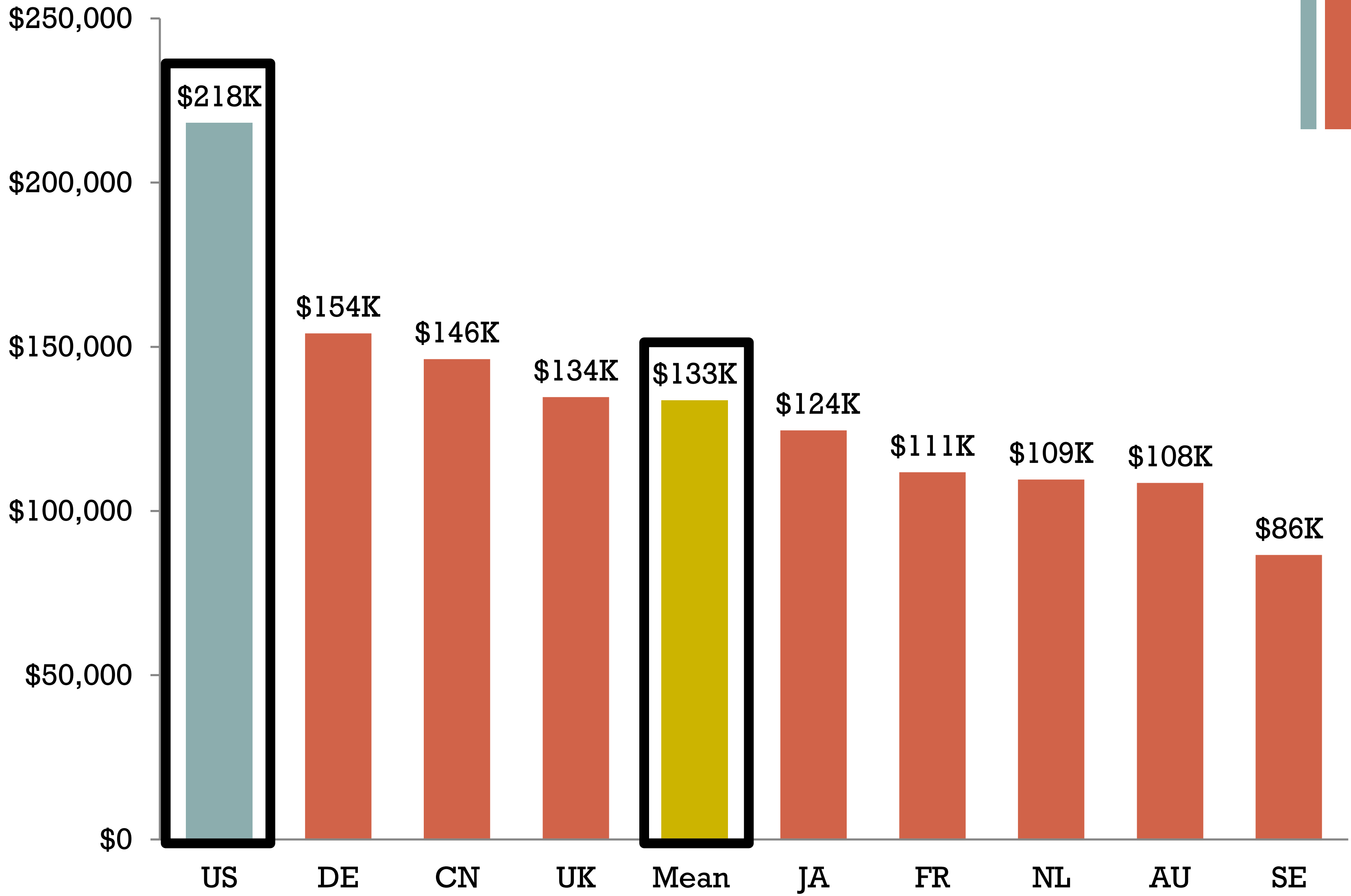
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0

US	CH	JA	UK	Mean	FR	DN	DE	CN	SE	AU	NL
$1,443	$939	$837	$779	$749	$697	$675	$667	$613	$566	$560	$466

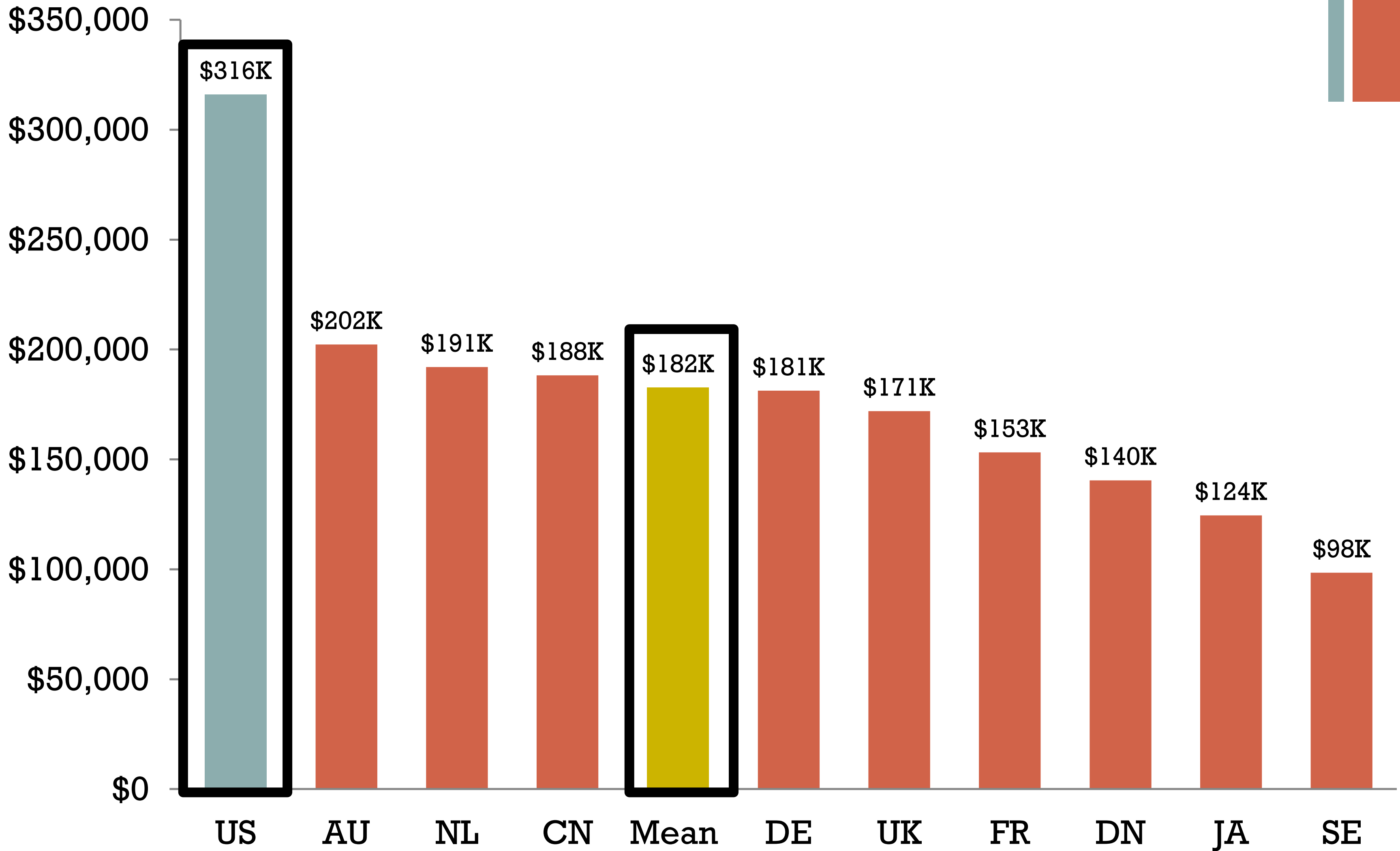
Pharma makes up about 15% of all HC spending

So that can't be the whole story

Generalist Physician Salaries



Specialist Physician Salaries



Nurse Salaries

Country	Salary
US	$74K
NL	$65K
AU	$64K
DN	$58K
CN	$55K
DE	$53K
Mean	$51K
UK	$49K
JA	$44K
FR	$42K

$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0

CT Scan Abdomen

$900
$800
$700
$600
$500
$400
$300
$200
$100
$0

$844
$483
$383
$233
$85

US
New Zealand
Switzerland
South Africa
Spain

International Federation of Health Plans 2015

Appendectomy

Country	Cost
US	$15,930
New Zealand	$6,199
Switzerland	$6,040
Australia	$3,814
Spain	$2,003
South Africa	$1,786

International Federation of Health Plans 2015

So what makes US HC so expensive?

Summary

- Hypotheses unlikely to explain difference:
  - Primary care/specialist mix
  - Overutilization
- High costs driven primarily by:
  - Administrative costs
  - High prices
- We can still save money by reducing quantity

+ What have we largely focused on?

Total Spending = Quantity X Price

Causes of our system dysfunction

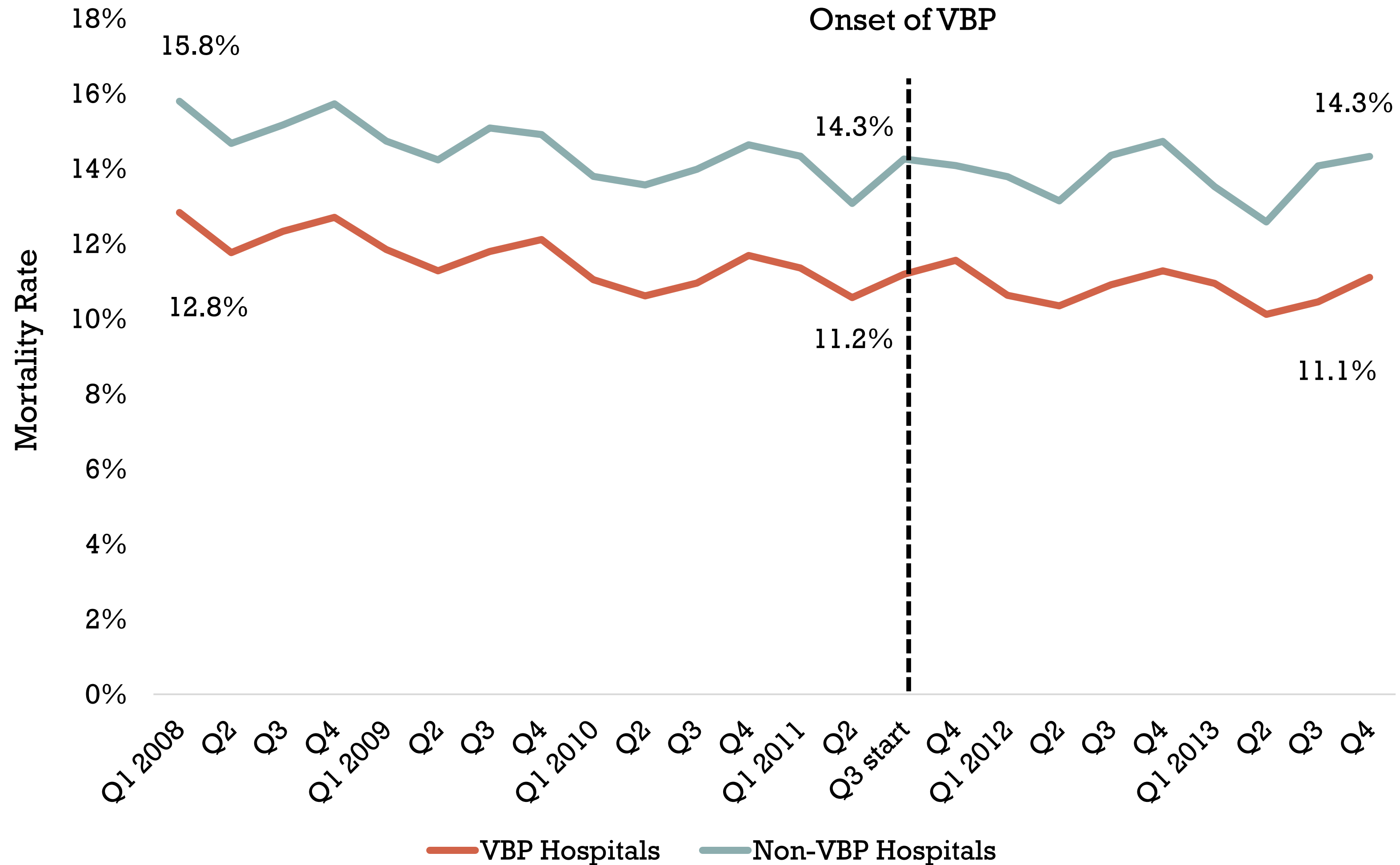
- Fragmentation
- How we pay for care (FFS, lack of incentives)
- Inadequate transparency
- Inadequate competition
- Inadequate patient “skin in the game”

What did the ACA do to fix things?

- Change how we pay for things
  - Hospital readmissions reduction program
  - Value-based purchasing
- Hold providers accountable
  - Patient-centered medical home
  - Accountable Care Organizations
- Centrally manage innovation
  - CMMI
- Investment in Health IT

So has the ACA worked?

+ Value-based payment has had little effect



Figueroa et al. BMJ 2016

Value-based payments in hospitals

- Readmission rates have fallen about 2.5%
  - About 2/3 of that is due to coding
  - Some (weak) evidence that it made mortality worse
  - Impact overall quite controversial

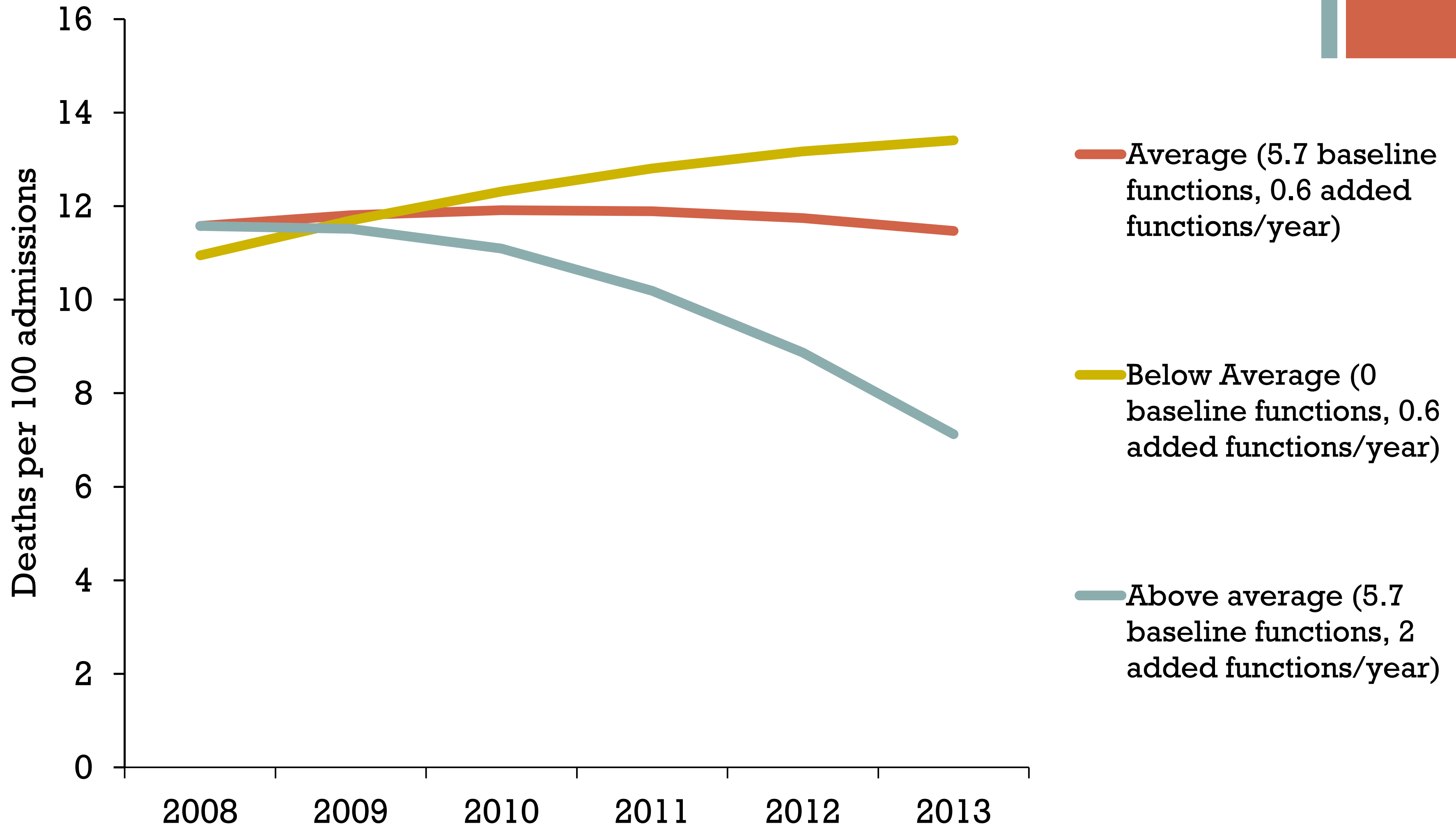
Ibrahim et al. JAMA Internal Medicine 2017; Gupta et al. JAMA Cardiology, 2017; Jha & Pronovost, NEJM, 2015

+ Primary Care Initiative (CPCI)

- CPCI targeted 502 primary care practices in 7 U.S. regions
  - Spending did not decrease enough to cover care management fees
  - After 4 years, no change in overall spending growth, modest impact on quality
    - 2% lower growth in ED visits

Peikes et al Health Affairs 2018

EHR impact on mortality, 2008-2013

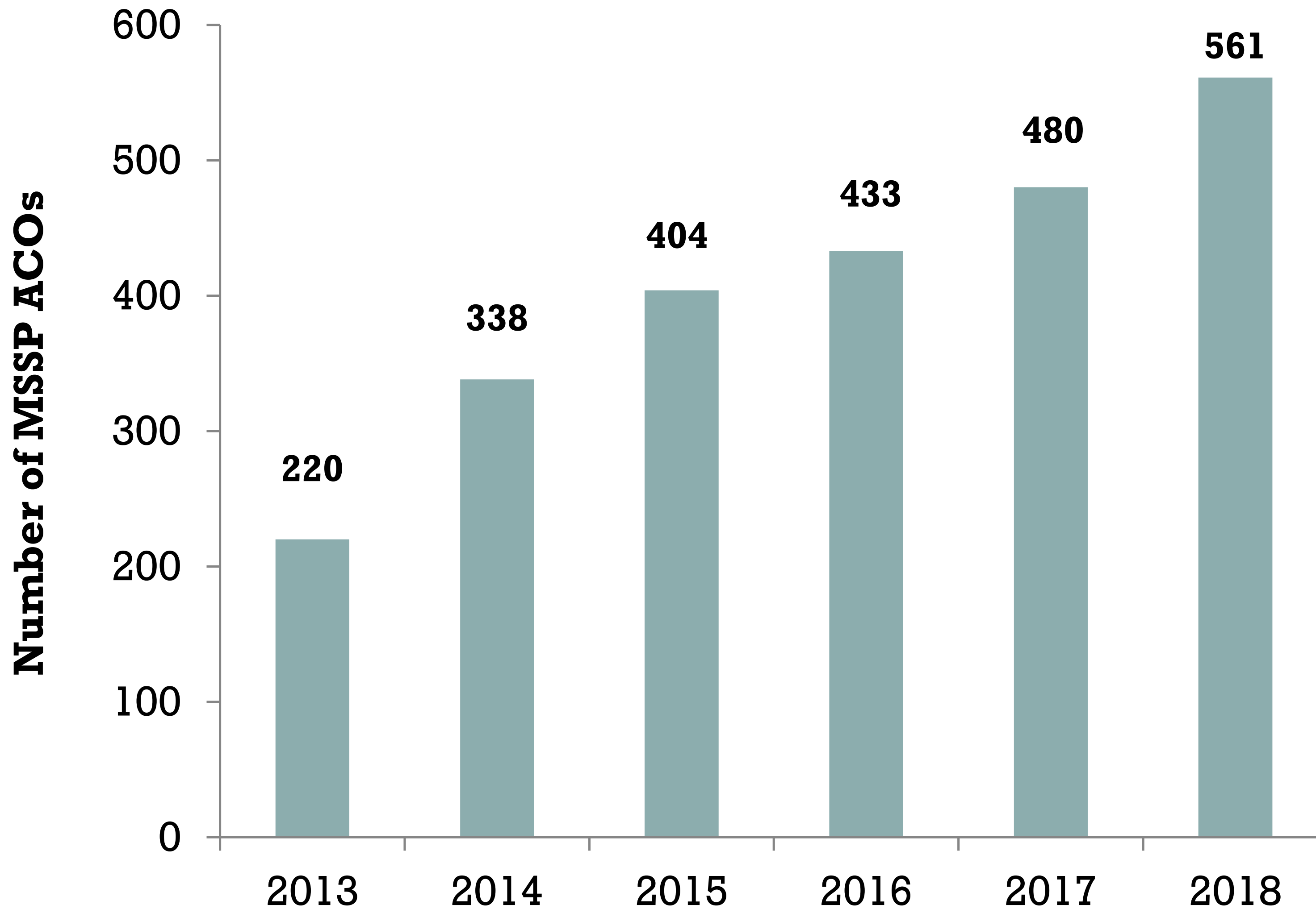


+ Bundled Payments

- The findings are mixed
  - **For medical conditions:** no change in spending or quality
  - **For surgical conditions:** associated with decreases in spending and small quality improvements
    - 4%-20% decrease in per-episode spending for joint replacement
- Why?
  - Different spending patterns
  - Different services provided in post-acute settings
  - Different types of patients

Dummit JAMA 2016, Joynt et al NEJM 2018, Navathe JAMA 2017, Navathe Health Affairs 2018

Number of ACOs continues to grow



Center for Medicare and Medicaid Services

Impact of ACOs on Quality & Cost

- How are they doing? Two alternative views:
  - McWilliams et al. consistently find 2-5% savings, by cohort:
    - 2012: 4.9%
    - 2013: 3.5%
    - 2014: 1.6%
- Impact on quality?
  - A few positive changes in pt experience, little on outcomes
- All the savings are in physician-led ACOs

McWilliams NEJM 2018

A summary of where we have been

- ACA spurred LOTS of activity
- Some of it is making a real difference
- Much of it has focused on quantity
  - Medicare led
  - Prices are fixed
  - Relative prices are not…

+ What's next?

- Push towards price transparency
- Payment Reform:
  - More risk to providers
    - Bundled payments, ACOs, Capitation
- More risk to payers (from CMS):
  - MA
- More engagement of consumers
  - Tiering coming to Medicare?
- Some efforts on prices
  - But probably not enough

What does this mean for MA?

+

The future of MA healthcare

- Value-based care is important
  - Promote more bundles
  - Promote more ACOs
  - Intensively study which models work and don't – and adjust accordingly
- Value-based strategies not nearly enough
- We must deal with the 800 pound gorilla: prices
  - Price regulation versus competition

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2018 Annual Health Care

COST TRENDS HEARING

OCTOBER 16, 2018

Up Next
Witness Panel 1: Meeting the Health Care Cost Growth Benchmark

Witness Panel 1

Meeting the Health Care Cost Growth Benchmark - Top Trends in Care Delivery and Payment Reform

Witness Panel 1: Meeting the Health Care Cost Growth Benchmark – Top Trends in Care Delivery and Payment Reform

Witnesses

Mr. Michael Carson, President and CEO	Harvard Pilgrim Health Care
Mr. Normand Deschene, CEO	Wellforce
Dr. Mark Keroack, President and CEO	Baystate Health
Mr. David Segal, President and CEO	Neighborhood Health Plan
Ms. Liora Stone, Owner and President	Precision Engineering, Inc., Uxbridge

Goals

This panel will discuss strategies to meet the health care cost growth benchmark in 2019 and beyond by tackling issues such as the scalability of innovations in care delivery, the lack of uptake in alternative payment methods, high levels of spending on pharmaceuticals and medical devices, and the future of the Massachusetts health care system.

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Up Next

Witness Panel 2: Innovations to Enhance Timely Access to Primary and Behavioral Health Care

Witness Panel 2

Innovations to Enhance Timely Access to Primary and Behavioral Health Care

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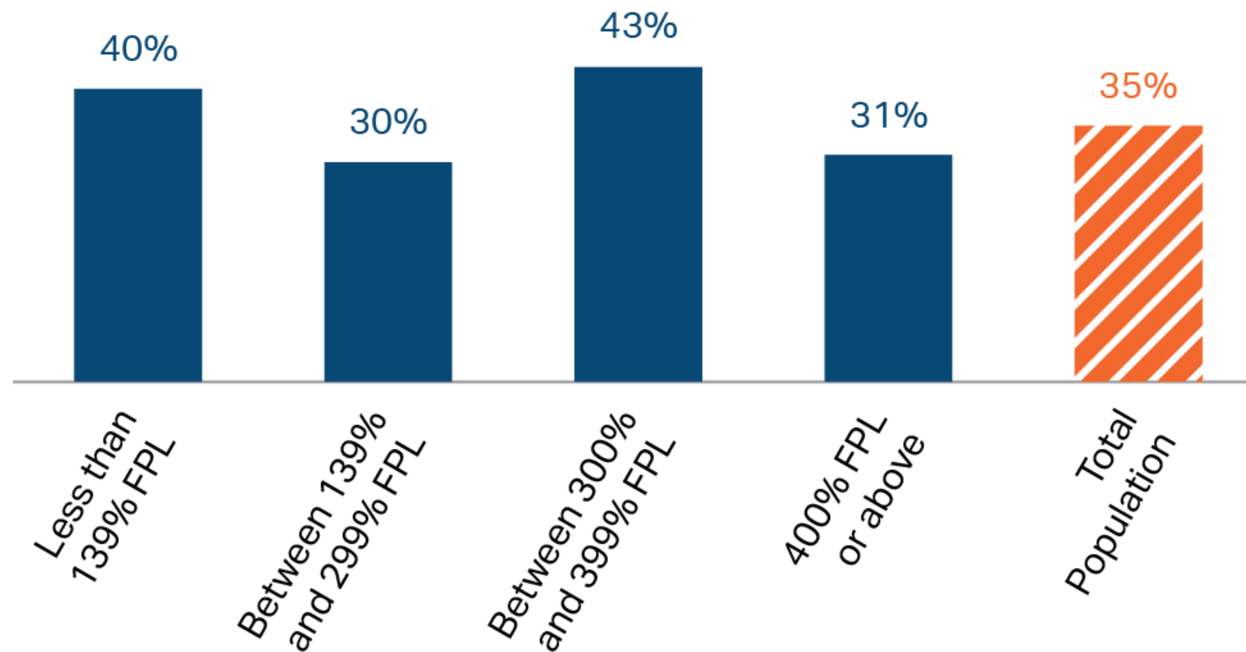
More than a third of Massachusetts residents reported that their last ED visit was not for an emergency in 2017

Percentage reporting "most recent emergency room visit in past 12 months was for a non-emergency condition" by family income, 2017



Of those with a non-emergent ED visit . . .

57%

visited because they were unable to get an appointment

68%

visited because they were unable to access care after normal operating hours

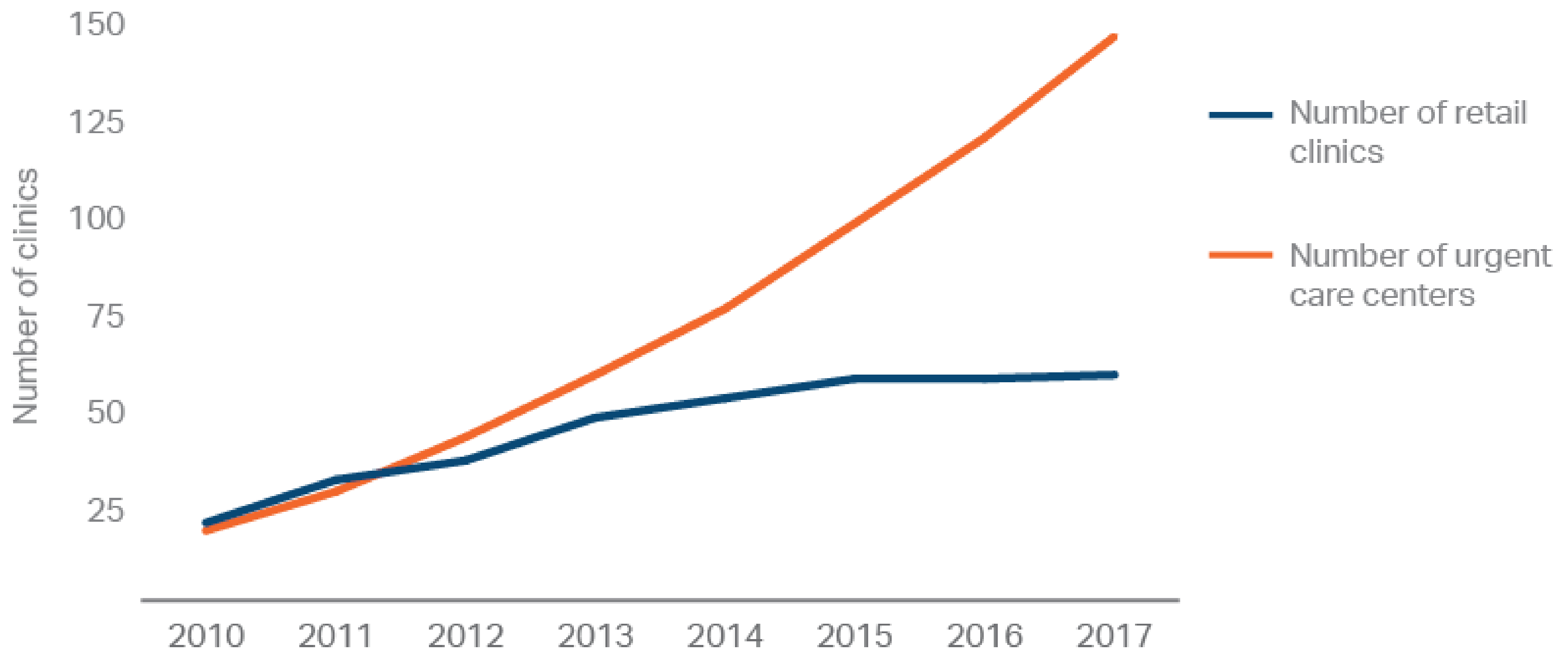
HPC

Note: FPL stands for "Federal Poverty Level."

Source: HPC's analysis of CHIA's Massachusetts Health Insurance Survey, 2017

The number of urgent care centers and retail clinics serving MA residents has grown strikingly since 2010, although at different rates

Number of urgent care centers and retail clinics in Massachusetts, 2010 - 2018

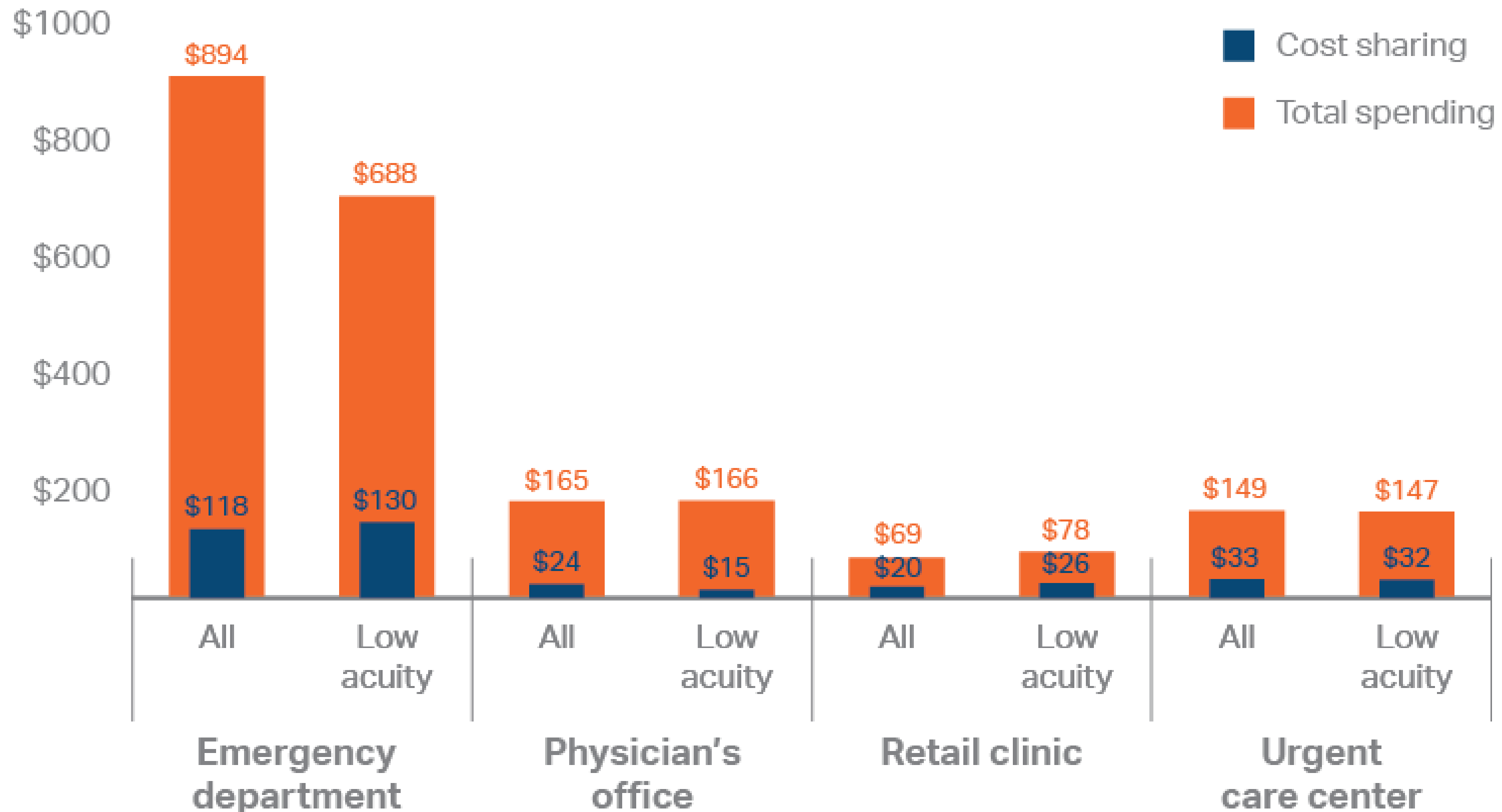


Notes: HPC defines urgent care centers as serving at least all adult patients on a walk-in (non-appointment) basis and having service hours beyond normal weekday business hours.

Sources: HPC identified urgent care centers through sources including licensure data from the Massachusetts Department of Public Health, data from the Centers for Medicare and Medicaid Services, insurers' online directories of providers, and the websites of the clinics and their affiliated organizations. Retail clinics are identified through their licensure as limited service clinics with the Massachusetts Department of Public Health; CVS Minute Clinics are the only retail clinics operating in Massachusetts as of August 2018.

Visit costs, including patient cost sharing, vary substantially by care site

Average total spending and cost sharing per visit, all conditions vs low acuity conditions, 2015



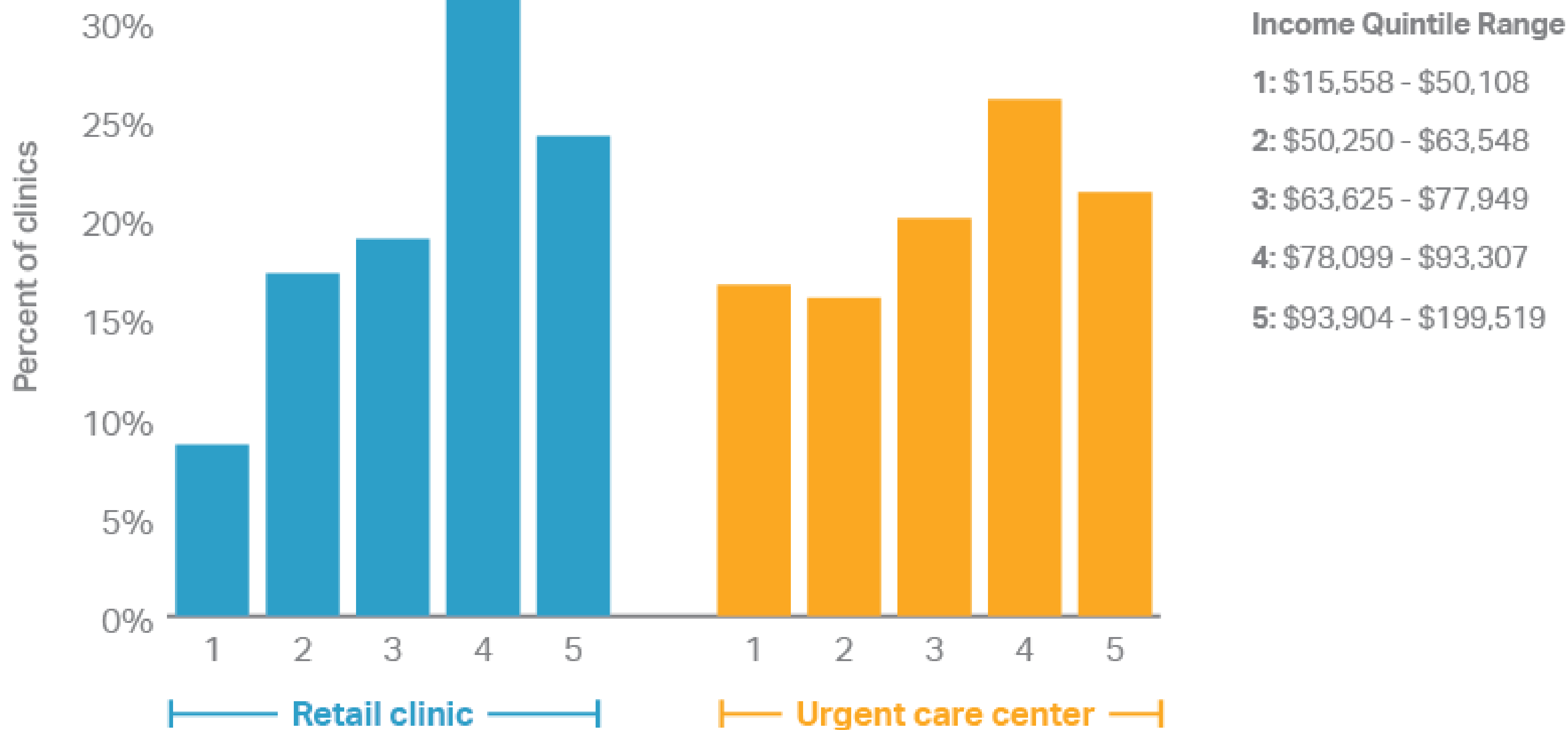
HPC

Notes: Data does not include facility fee costs.

Sources: HPC analysis of All-Payer Claims Database, 2015

Retail clinics and urgent care centers are disproportionately located in higher income areas, although urgent care centers are more broadly distributed

Distribution of alternative care sites by median income of clinic location zip code



HPC

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Providers reported varied perspectives on the impact of growth in alternative care sites

Impact on the Emergency Department
Uncertain effect on volume

*"…it is not clear to us that the proliferation of urgent care centers in our service area has affected overall utilization of emergency departments. Instead, we **continue to see ED utilization increase**, even while urgent care encounters increase as well."*

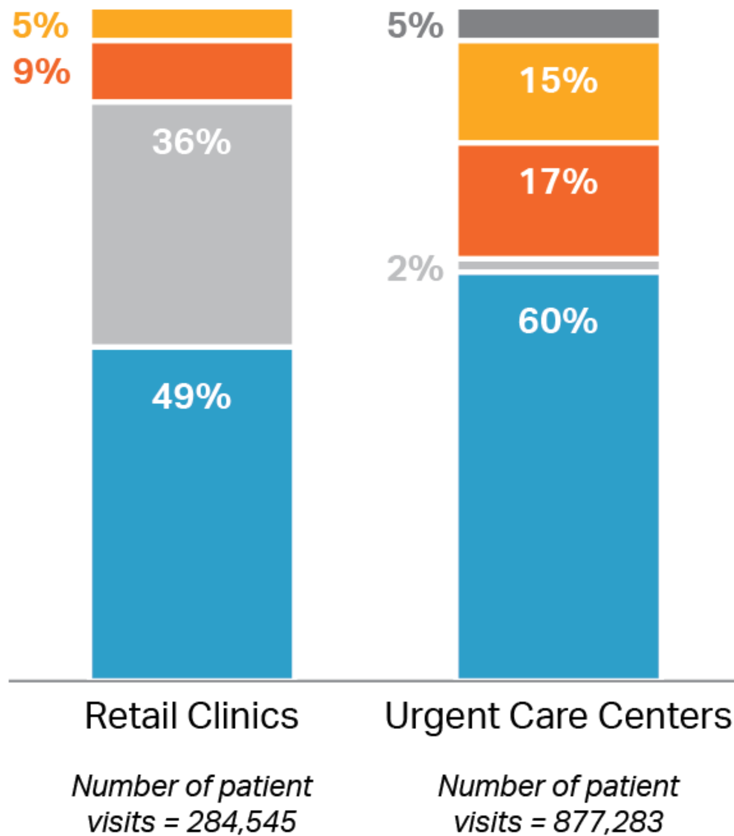
Impact on Primary Care
May attract routine care versus more complex patients

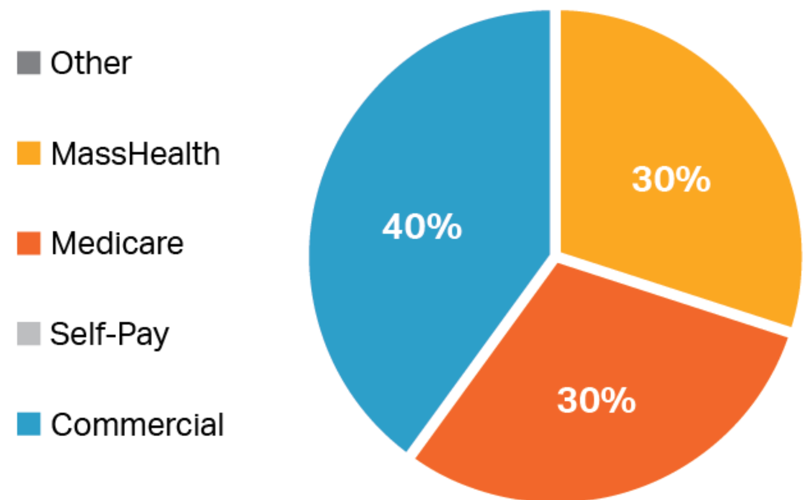
*"…we are concerned that for many patients, urgent care services are replacing comprehensive primary care due to the convenience of access to an urgent care center, resulting in **greater fragmentation of primary care**."*

Impact on Increasing Access to Appropriate Care
Potential for greater access at lower cost sites

*Alternative care sites may "assist patients with having access to the appropriate level of care.... **hospitals will be able to focus on the higher levels of care** they are intended for. This focus should allow for more **timely access and higher quality outcomes for patients…** During times of physician and advanced provider shortages, they provide a **lower cost alternative than emergency services**."*

Commercial payers represent a greater share of revenue for retail clinics and urgent care centers than health care spending overall in MA





Notes: Data weighted by respondent size, based on volume of unique patient visits. Based on responses received through pre-filed testimony, the number of unique patient visits at retail clinics totaled 284,545. The number of unique patient visits at urgent care centers totaled 1,029,034; however, only 877,283 are included in the graph. Minute Clinic was the respondent for retail clinics. Urgent care center respondents included in the graph are [see above for list]. Care Well and Berkshire Health Systems were not included because they did not provide distribution of revenue by payer.

Sources: HPC analysis of 2017 alternative care site data submitted through pre-filed testimony and 2017 Total Health Care Expenditure data from CHIA Datebooks.

Witness Panel 2: Innovations to Enhance Timely Access to Primary and Behavioral Health Care

Witnesses

Dr. Timothy Ferris, Chairman and CEO	Massachusetts General Physicians Organization
Dr. Gene Green, President and CEO	South Shore Health System
Mr. Manny Lopes, President and CEO	East Boston Neighborhood Health Center
Mr. Edward Moore, President and CEO	Harrington Healthcare System
Dr. Kristina Orio, Medical Director and Lead Physician	AFC Urgent Care

Goals

The goal of this panel is to showcase emerging models of enhancing patient access to high-quality, convenient health care, especially behavioral health care and care for vulnerable populations. Focus areas will include: the growth in urgent care centers, including urgent behavioral health care, telemedicine, digital health technology solutions, mobile-integrated health, and other strategies to engage patients in care in the community, and reduce unnecessary emergency department and hospital utilization.

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Up Next
Public Testimony Opportunity

Public Testimony

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Tomorrow:

Day Two of the Health Care Cost Trends Hearing

Hearing begins at 9:15 AM

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