2021

HEALTH CARE COST TRENDS HEARING

THE HEARING WILL BEGIN AT 12:00PM ON WEDNESDAY, NOVEMBER 17

MASSACHUSETTS
HEALTH POLICY COMMISSION

#CTH21

2021 HEALTH CARE COST TRENDS HEARING

OPENING REMARKS

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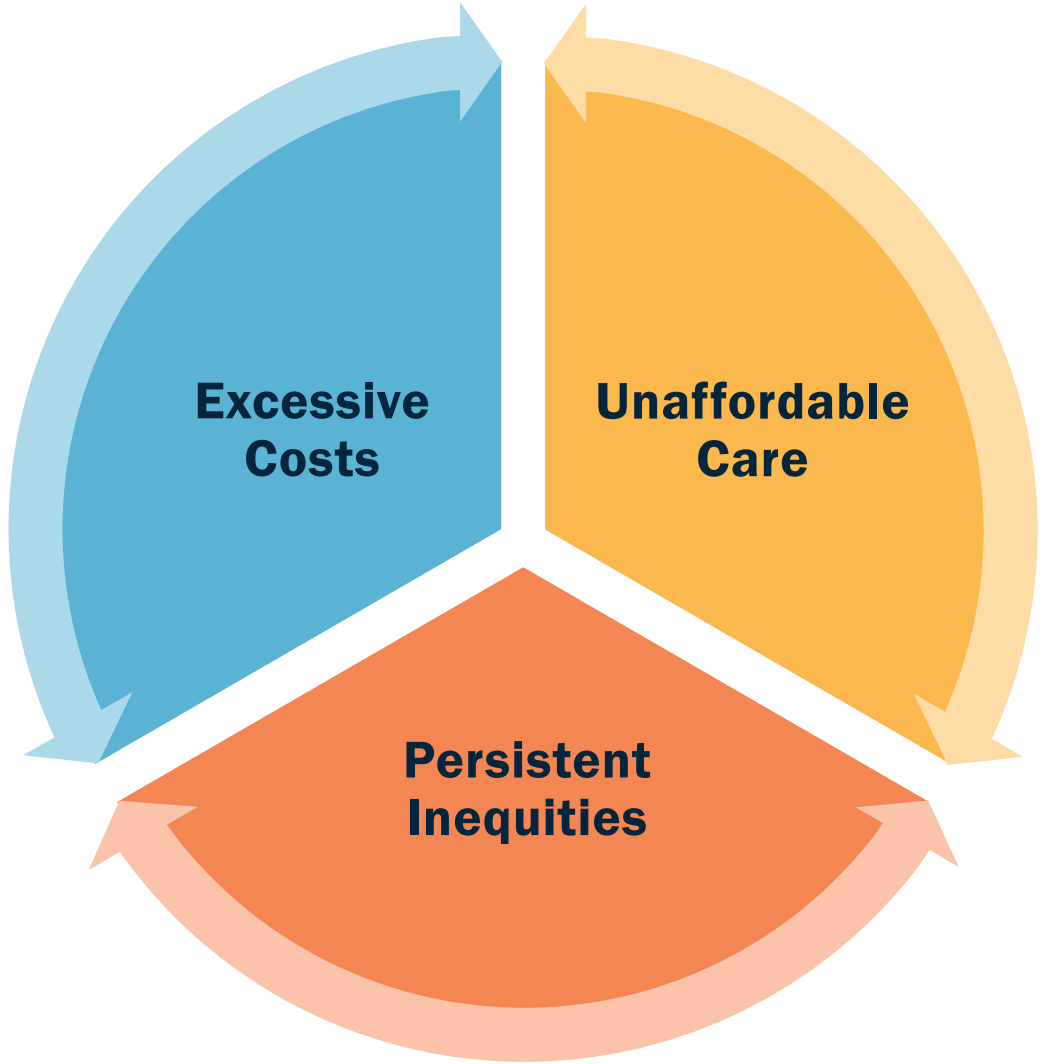
Health Care Spending and Affordability in Massachusetts

David Seltz, Executive Director
Dr. David Auerbach, Senior Director of Research and Cost Trends

The experience of the COVID-19 pandemic has exacerbated three interconnected challenges of the Massachusetts health care system.



Provider Perspectives on the Impact of COVID-19: Key Themes from 2021 Testimony

PATIENT IMPACTS

Health Disparities
Providers described **severe health disparities** highlighted by COVID. Many noted deferred care, especially for chronic conditions and barriers to telehealth.

Behavioral Health
Providers noted a **surge in demand for behavioral health** services, especially for children.

Financial Challenges
Providers commented on financial challenges for patients, sometimes leading to **care avoidance** and **increased food and housing instability**.

PROVIDER AND SYSTEM IMPACTS

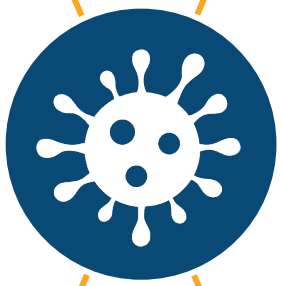
Workforce
Providers noted **workforce shortages**. Many appreciated streamlined licensure and expanded scope of practice. Most reported high levels of staff burnout.

Telehealth
Providers noted the **positive shift to telehealth** but acknowledged continuing barriers for some patients.

Financial Challenges
Providers described **financial challenges** from significant changes to patient volume, services, payer mix, COVID-related supplies, and more.

Source: HPC 2021 Pre-Filed Testimony. Available at https://www.mass.gov/info-details/testimony-for-the-2021-health-care-cost-trends-hearing. N=20 provider organizations.

Health Plan Perspectives on the Impact of COVID-19: Key Themes from 2021 Testimony



Behavioral Health

Health plans noted a surge in **demand for behavioral health services** and an uptick in mental health and substance use disorders as well as "diseases of despair."

Telehealth

Health plans reported **very substantial increases in telehealth**, which members found to be safer, quicker, easier, and more convenient, although some expressed concerns that members did not have the technological capabilities to use telehealth.

Deferred Care

Health plans observed **deferral and/or elimination of services** early in the pandemic, leading to increased acuity later. Several noted a resurgence of demand in 2021.

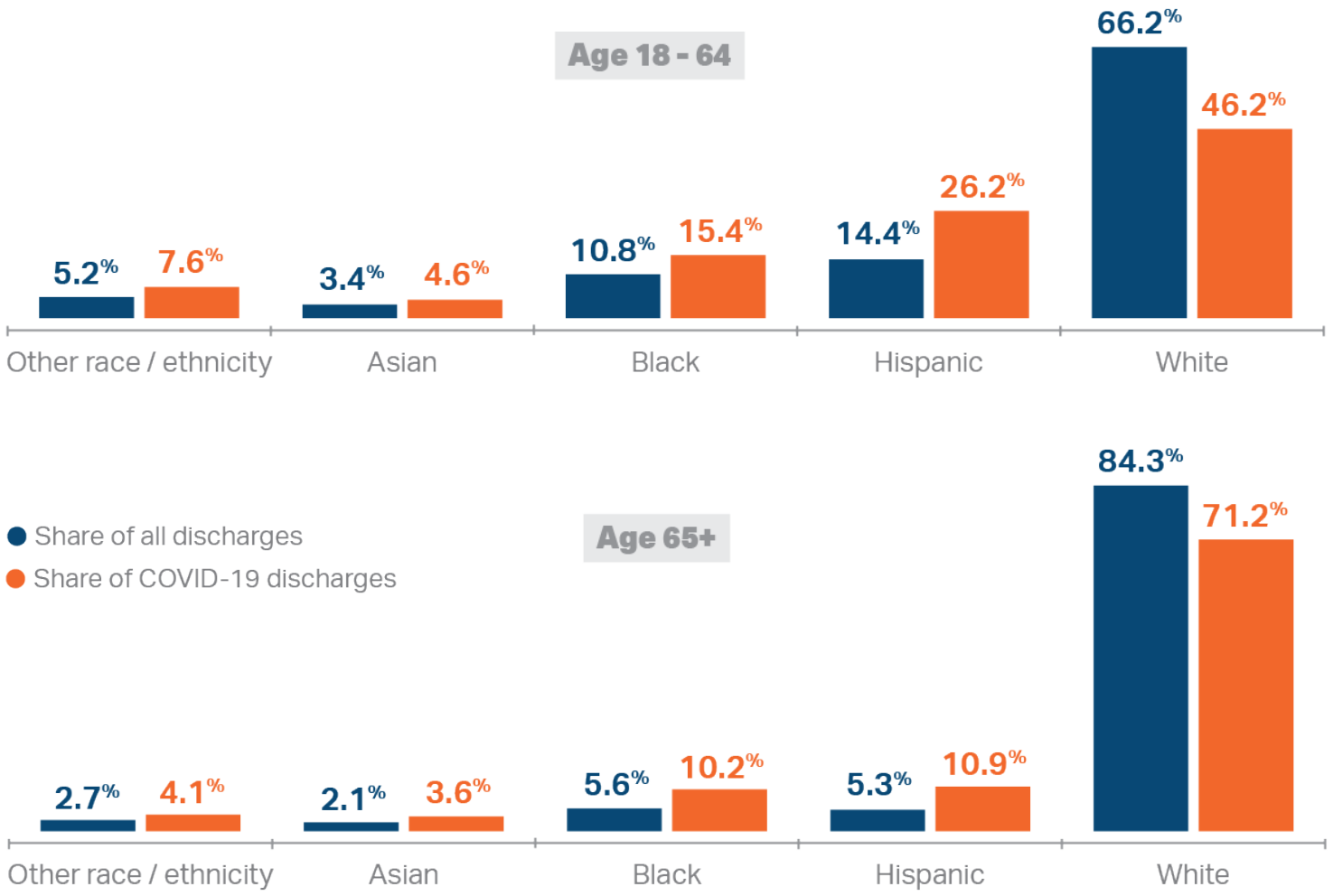
Health Equity

Health plans described health equity implications of the pandemic and **the need for better data collection on disparities.** Some also noted the exacerbation of food insecurity, and increased need for rental and economic relief.

Source: HPC 2021 Pre-Filed Testimony. Available at https://www.mass.gov/info-details/testimony-for-the-2021-health-care-cost-trends-hearing. N=10 health plan organizations.

Hispanic and Black patients comprised a disproportionate share of COVID-19-related hospital admissions in 2020 and 2021.

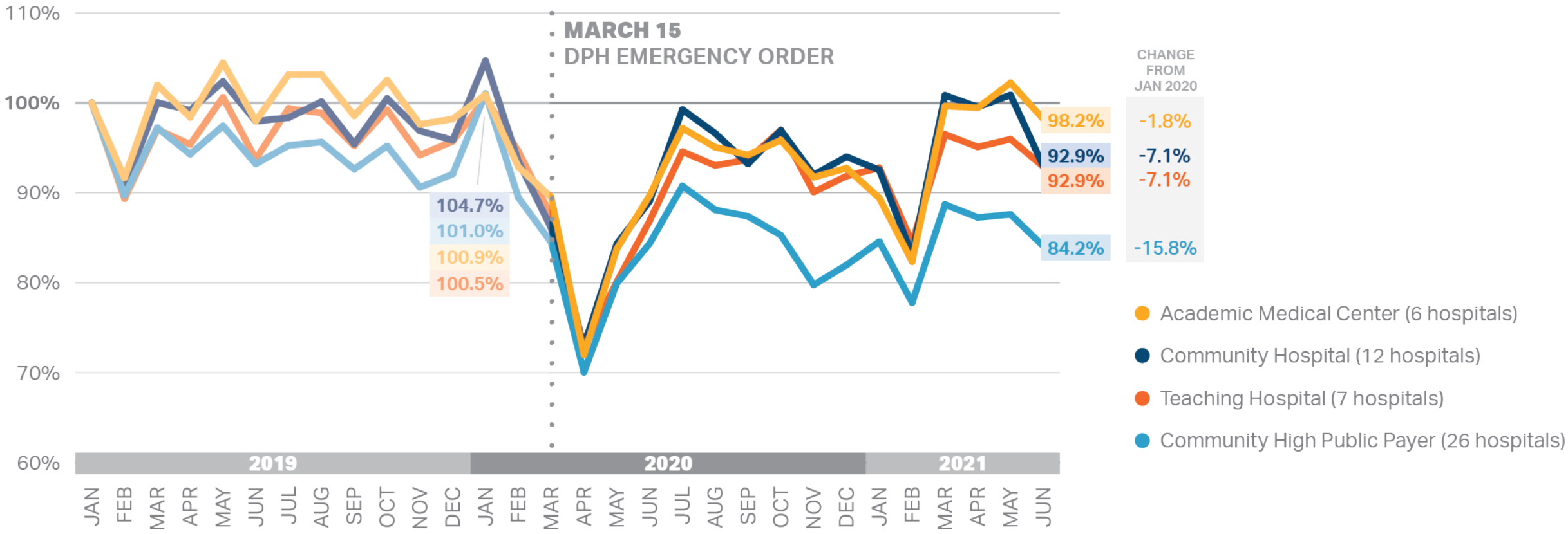
Inpatient hospital admissions by race/ethnicity between January 2020 and June 2021



Notes: Hispanic category includes Hispanic ethnicity with any race. Other Race includes American Indian/Alaska Native, Native Hawaiian, other Pacific Islander, or other race. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.
Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2020, and FYTD2021 (as of June 2021 submission).

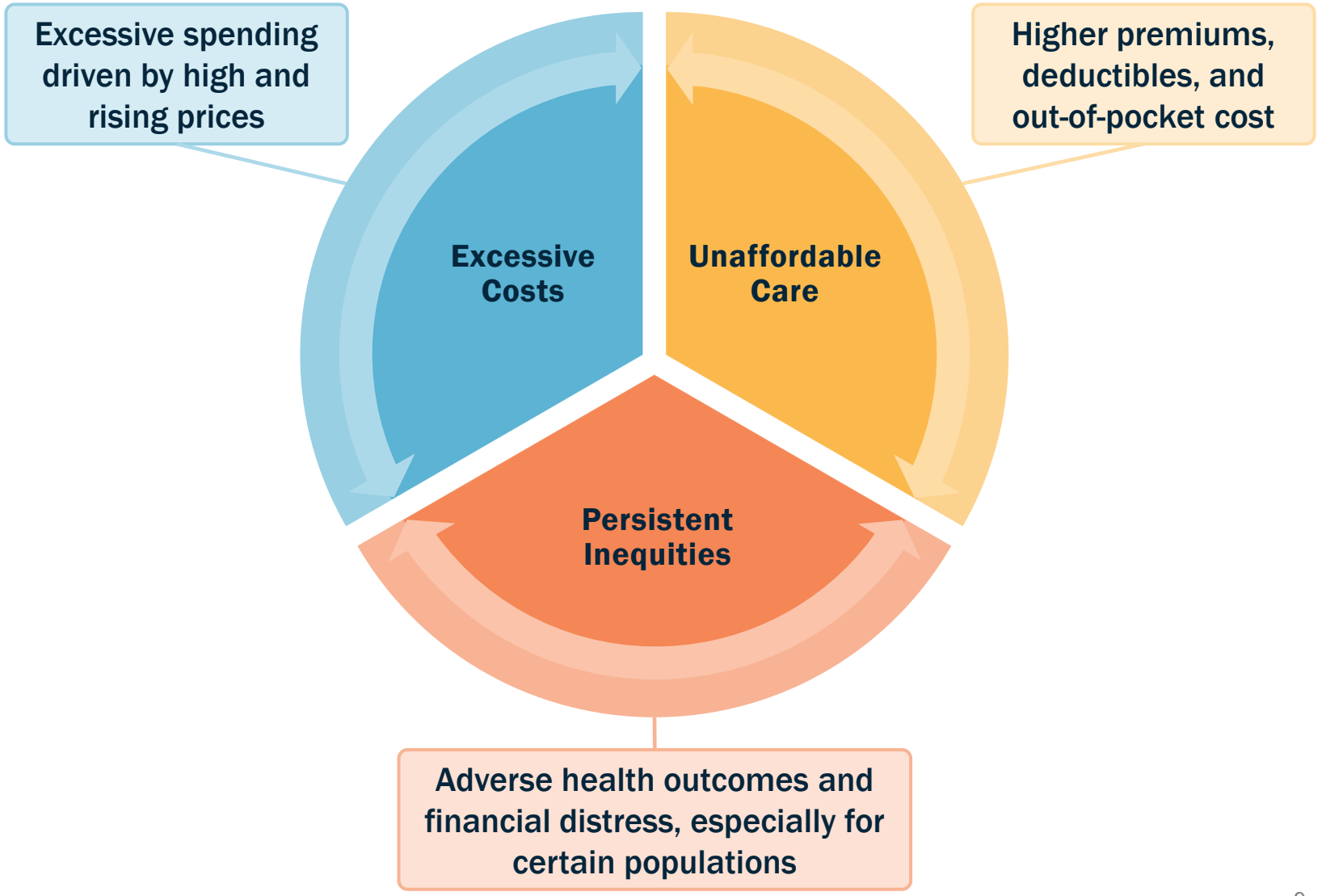
Through June 2021, patient volume at Community High Public Payer hospitals was still far below the pre-pandemic baseline, unlike at Academic Medical Centers.

Inpatient hospital discharges by hospital cohort, percentage relative to January 2019

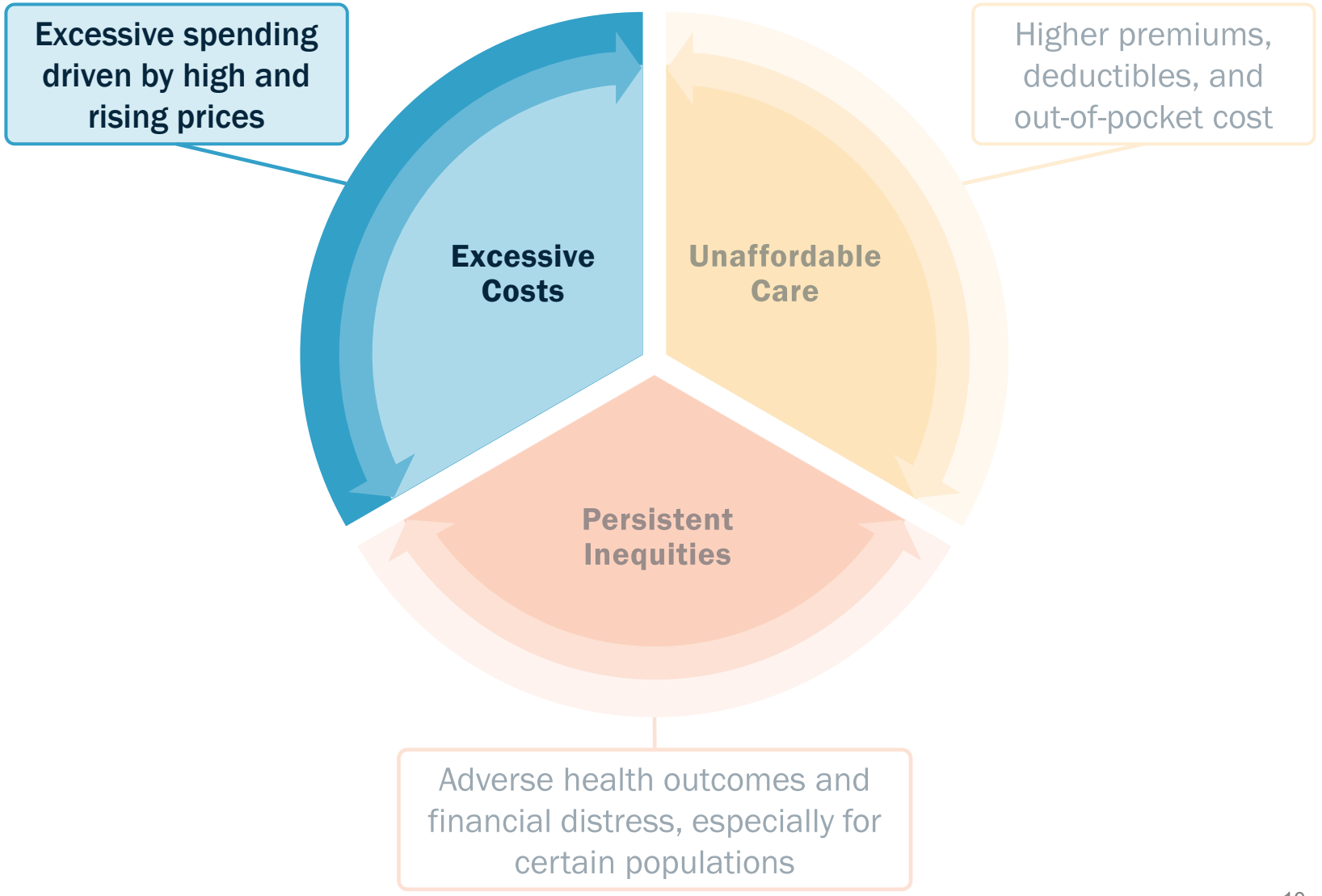


Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2020, and FYTD2021 (as of June 2021 submission).

Declining affordability, which can lead to missed care, adverse health outcomes, and financial distress, is a direct consequence of higher prices and premiums.

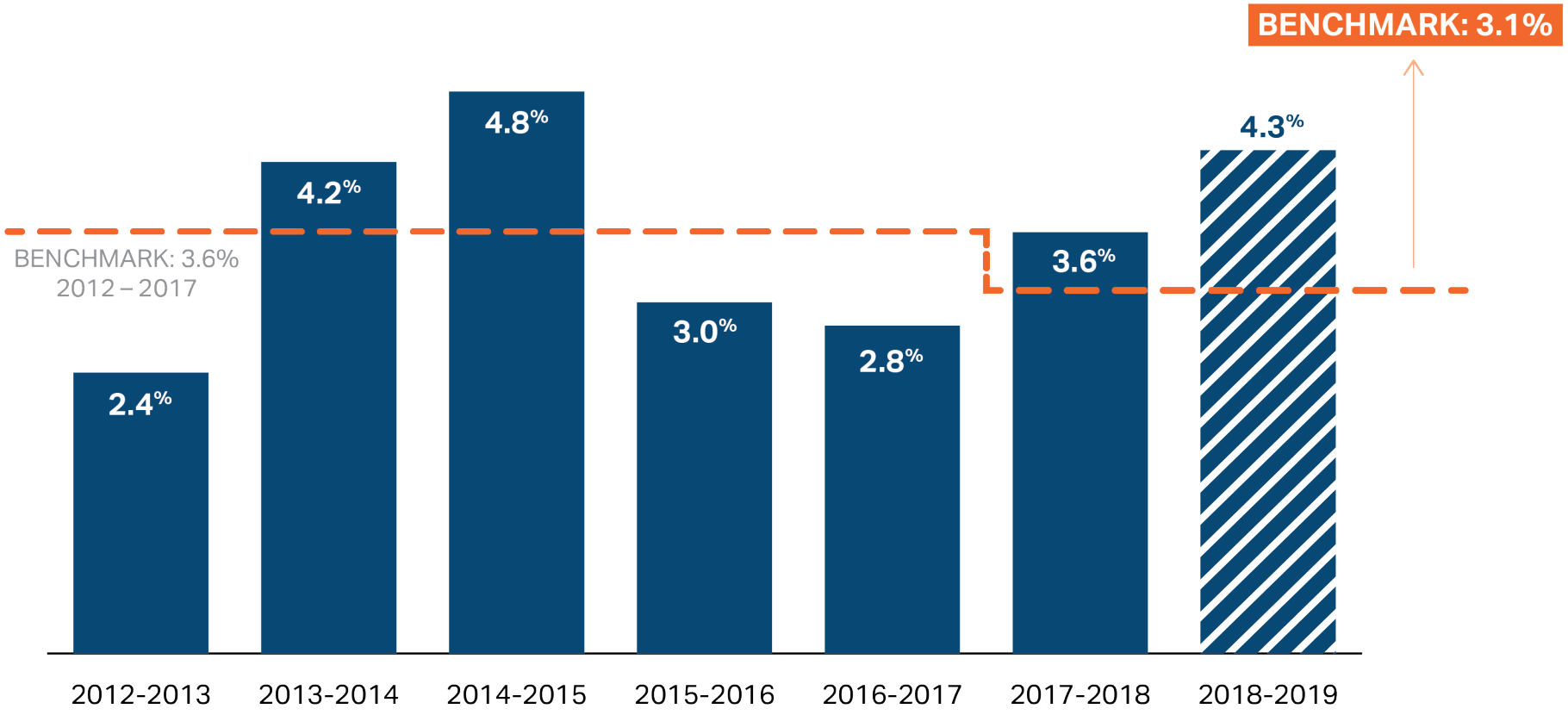


The excessive cost of health care has been driven by high and rising prices.



Growth in total health care spending has accelerated and exceeded the health care cost growth benchmark in 2018 and 2019.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2019

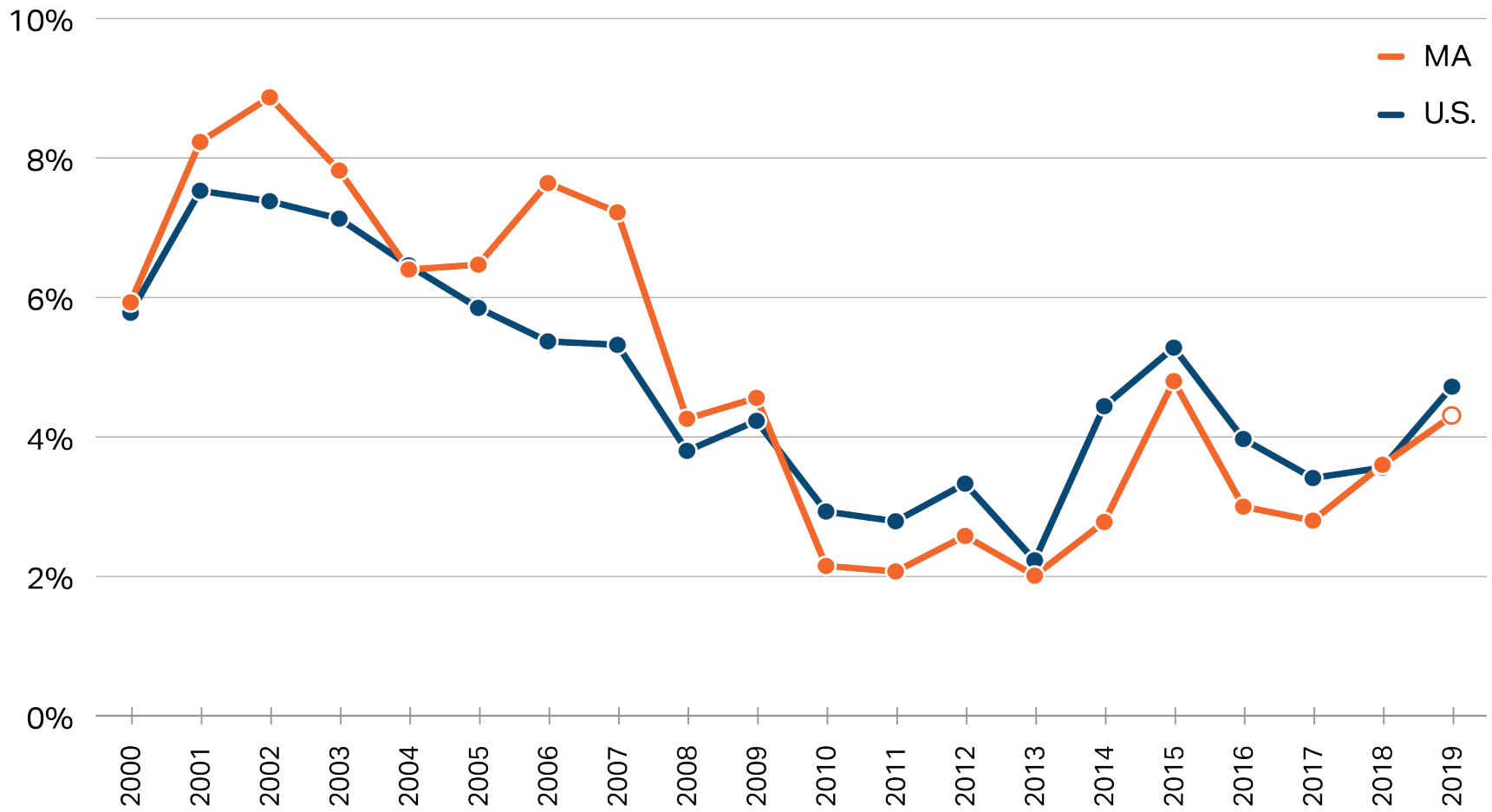


Commercial spending per enrollee grew 4.6% in 2018 and 4.1% in 2019

Notes: 2018-2019 spending growth is preliminary.
Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2020.

Massachusetts spending growth has been below the U.S. since 2010, but the gap nearly closed in 2018 and 2019.

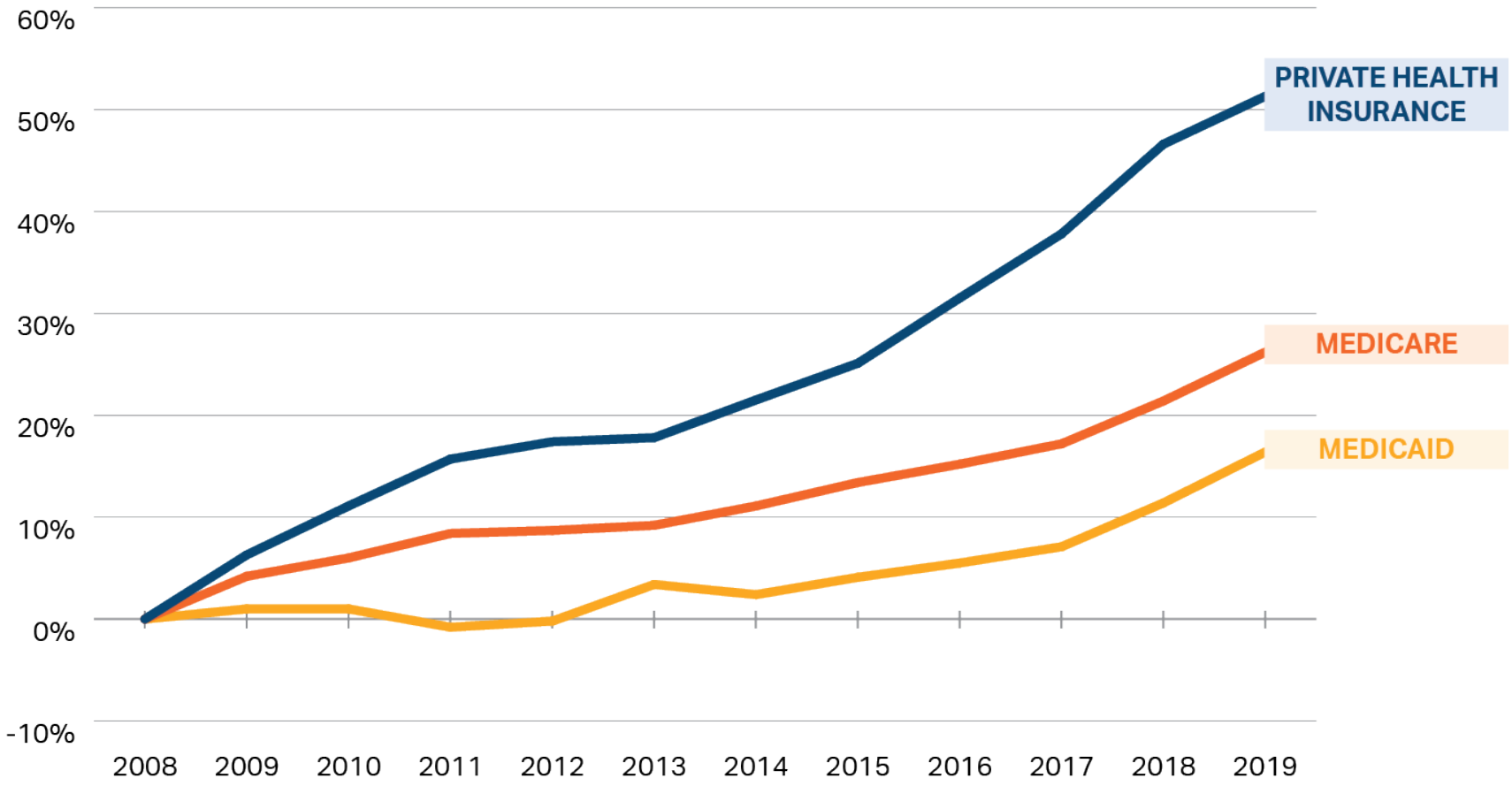
Massachusetts and national annual per-capita total health care spending growth, 2000 to 2019



Notes: U.S. data includes Massachusetts. Massachusetts 2018-2019 spending growth estimate is preliminary.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2019 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2019

Private health insurance spending is growing faster than Medicare and Medicaid across the U.S., largely due to provider and prescription drug price increases.

Cumulative growth in spending per enrollee by type of coverage since 2008; National Health Expenditures



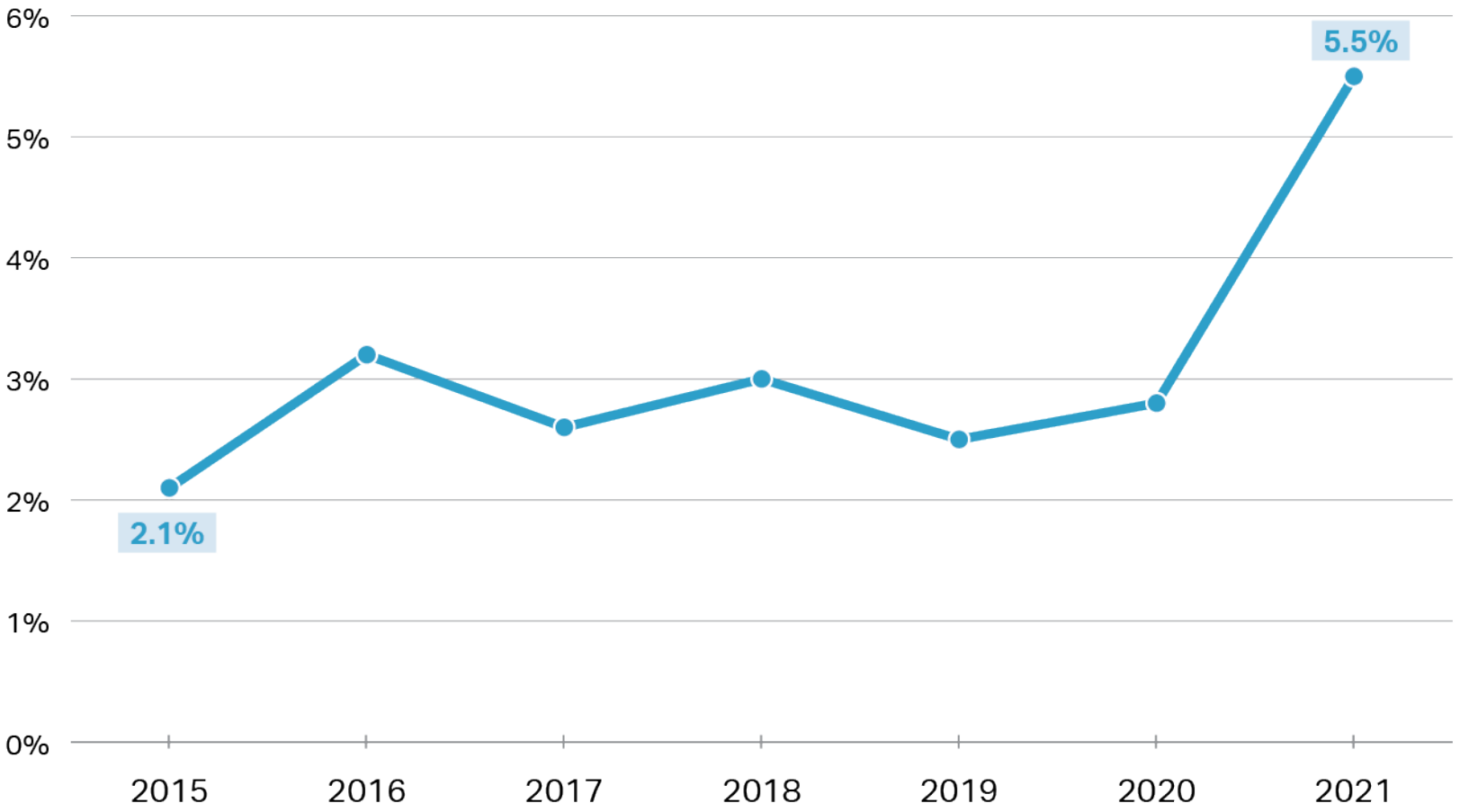
Commercial price increases were highest in hospitals from 2015 to 2019:

- Hospital inpatient: 30.8%
- Hospital outpatient: 22.5%
- Prescription drugs: 13.6%
- Professional services: 13.0%

Sources: Peterson-KFF Health System Tracker: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start; https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf

Nationally, commercial hospital prices spiked in late 2020 and early 2021.

Annual growth in commercial hospital prices from July of the previous year to July of the month shown



Source: Altarum Institute, Health Sector Economic Briefs. https://altarum.org/solution/health-sector-spending. Underlying data provided to the HPC by the Altarum Institute. Prices based on underlying producer price index data for hospitals provided by the Bureau of Labor Statistics

Prices – particularly hospital prices – are also a major driver of commercial spending growth in Massachusetts.

Massachusetts price growth overall

- Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care all reported annual prices grew from 2015 to 2018 more than twice the rate of utilization.
- The Health Care Cost Institute found that Massachusetts commercial health care prices grew 15.6% from 2014 to 2018 while utilization grew 7.0%.

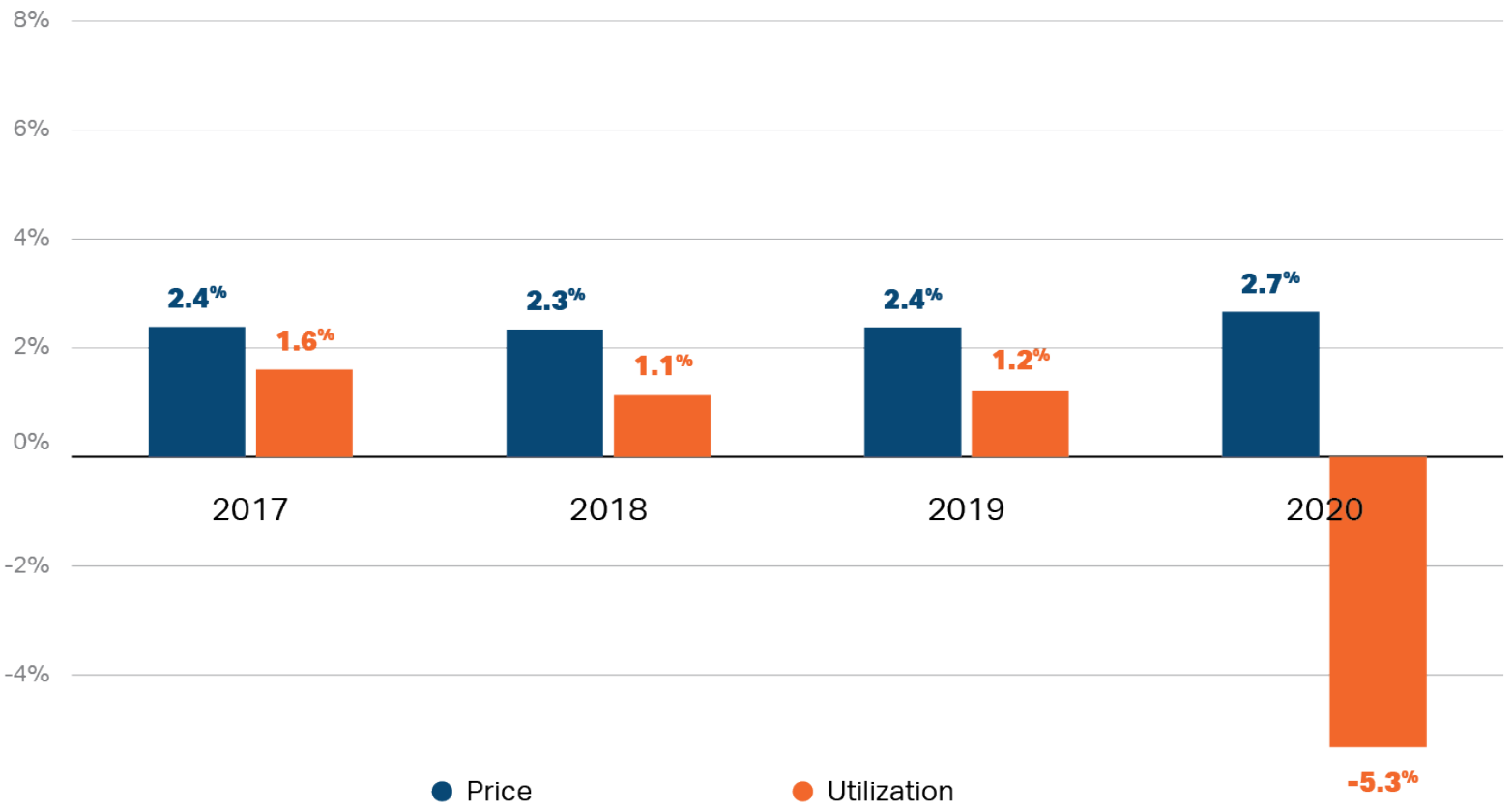
Massachusetts price growth by category, 2016 to 2018 (2021 Cost Trends Report)

- Hospital inpatient services: 9.1%
- Hospital outpatient services: 6.6%
- Office-based services: 4.4%

Sources: HCCI 2018 Health Care Cost and Utilization Report. Available at: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report; Massachusetts Health Policy Commission. 2021 Cost Trends Report. Sept. 2021. Available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

Commercial price growth continued to drive total spending growth in 2019 and accelerated further in 2020.

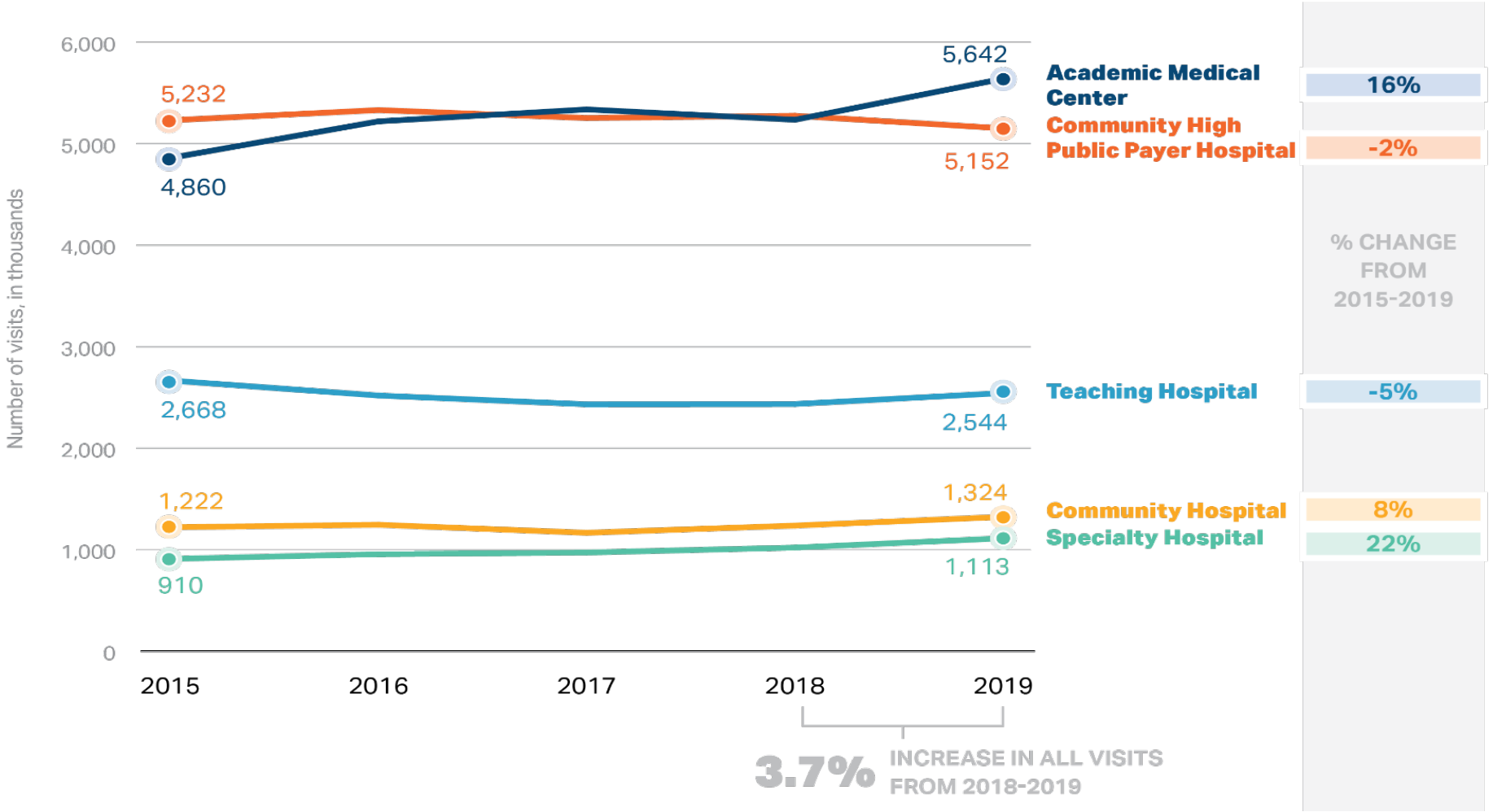
Percentage change in commercial unit costs (prices) and utilization for BCBSMA, THP, HPHC, and United from the previous calendar year to the year shown



Source: Pre-Filed Testimony submitted to the HPC in advance of the 2021 Annual Cost Trends Hearing. Data represent the enrollment-weighted average of payer-reported decomposition of spending growth for the four largest commercial payers by private commercial enrollment. Provider and service mix components of spending growth not shown. Enrollment weights based on the Center for Health Information and Analysis Enrollment Trends reports for June 15 of each year shown.

Spending increases when care shifts from lower-priced to higher-priced settings.

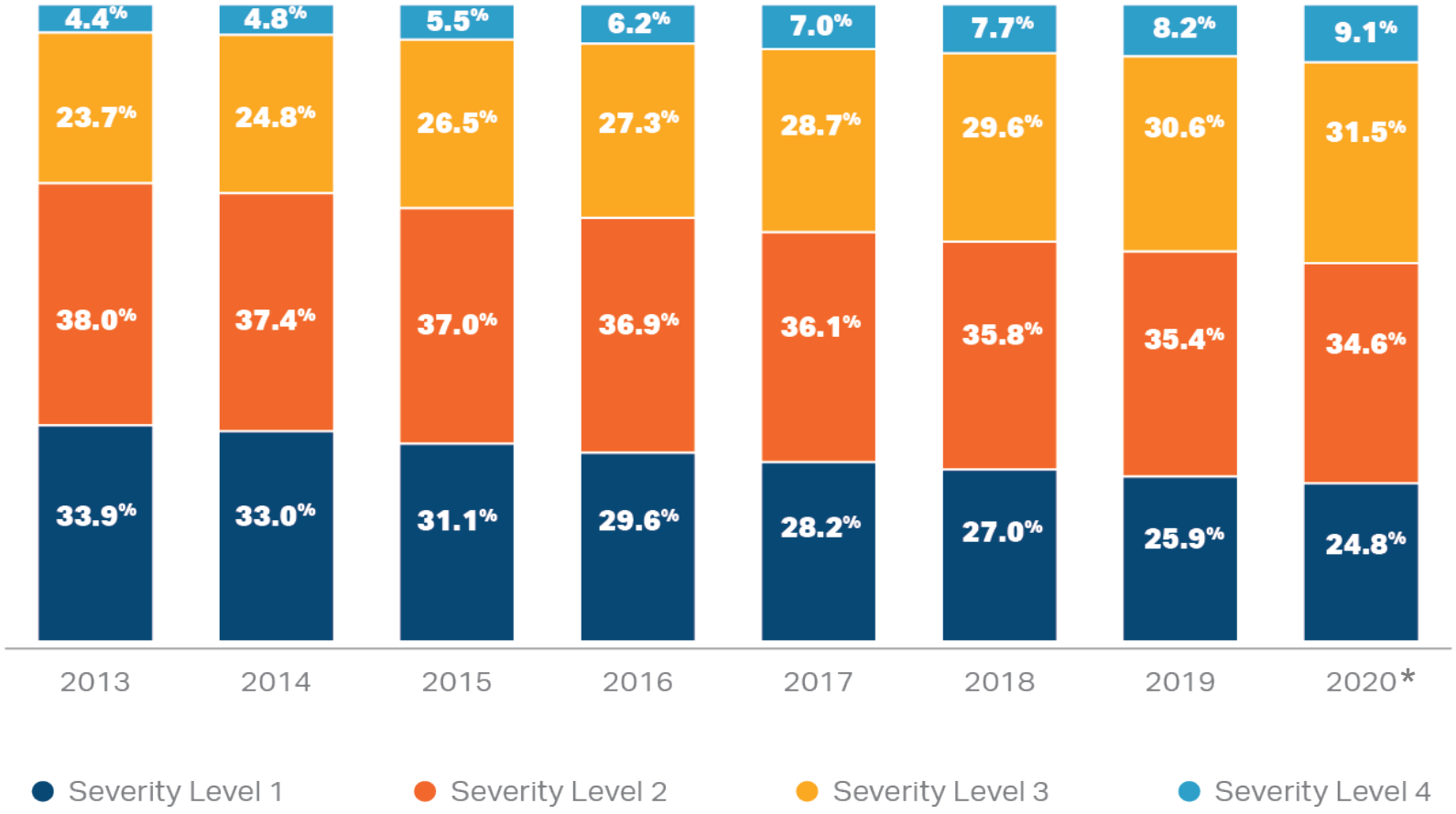
Number of hospital outpatient visits (all payers) by hospital cohort, FY2015 to FY2019



Data from the Massachusetts Center for Health Information and Analysis, Acute Hospital Profiles, 2015-9. https://www.chiamass.gov/hospital-profiles/. Outpatient visits are reported by the hospitals. CHIA Relative Price and provider price variation: https://www.chiamass.gov/relative-price-and-provider-price-variation/

Hospital admissions continue to be coded at increasingly higher severity levels, also contributing to higher spending.

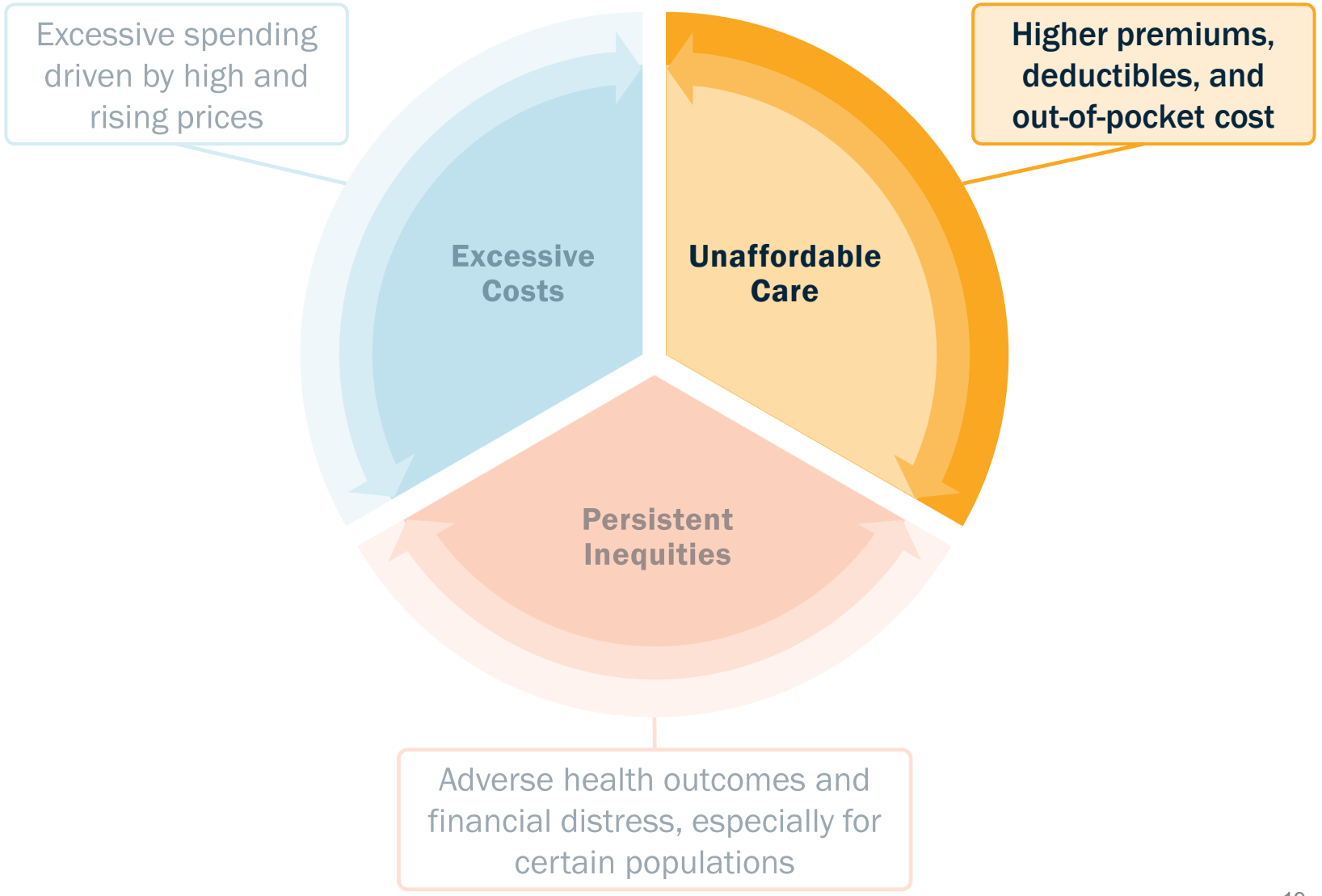
Proportion of hospital admissions at each severity/complications level, 2013 to 2020



- Average spending per hospital admission at each severity level
  - Level 1: $6,600
  - Level 2: $9,200
  - Level 3: $13,100
  - Level 4: $39,000

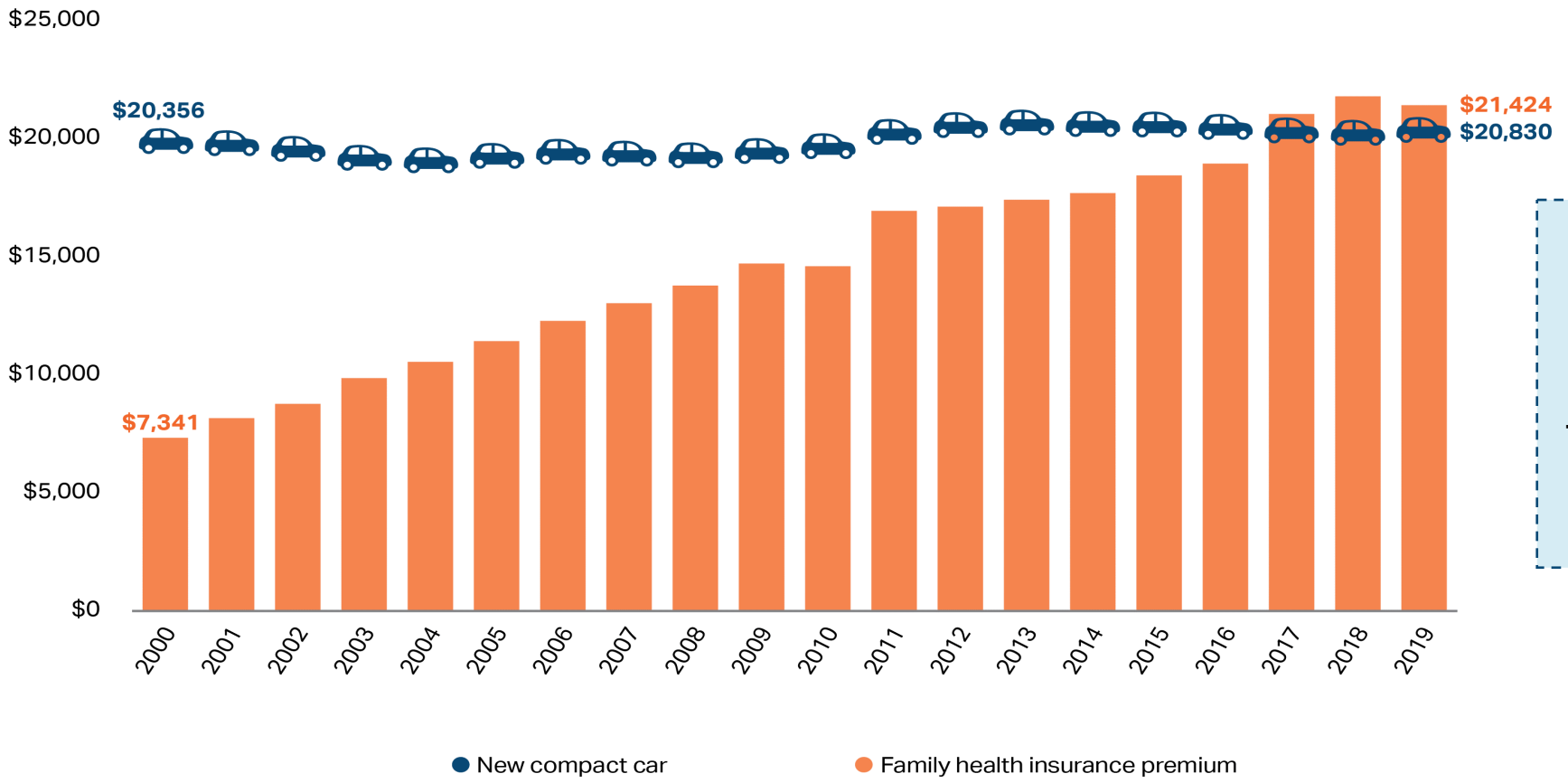
Notes: APR-DRG Level 1 is least severe and Level 4 is most severe. *COVID hospitalizations have been excluded from 2020 data. Spending amounts are based on MassHealth Rate Year 2019 payment levels and DRG weights not including hospital-specific multipliers and excluding outlier payments. These rates were applied to the full Massachusetts FY 2019 distribution of discharges across all payers.
Sources: CHIA HIDD Acute Case-mix Database, 2013-2020; APR-DRG classification system

Increased spending and high prices are reflected in the higher premiums and out-of-pocket costs borne by residents.



In 2000, premiums for family health insurance in Massachusetts were 1/3 the cost of a new compact car. Since 2017, premiums have been higher and continue to grow.

Average total cost for Massachusetts family health insurance premiums and national cost of a new compact car

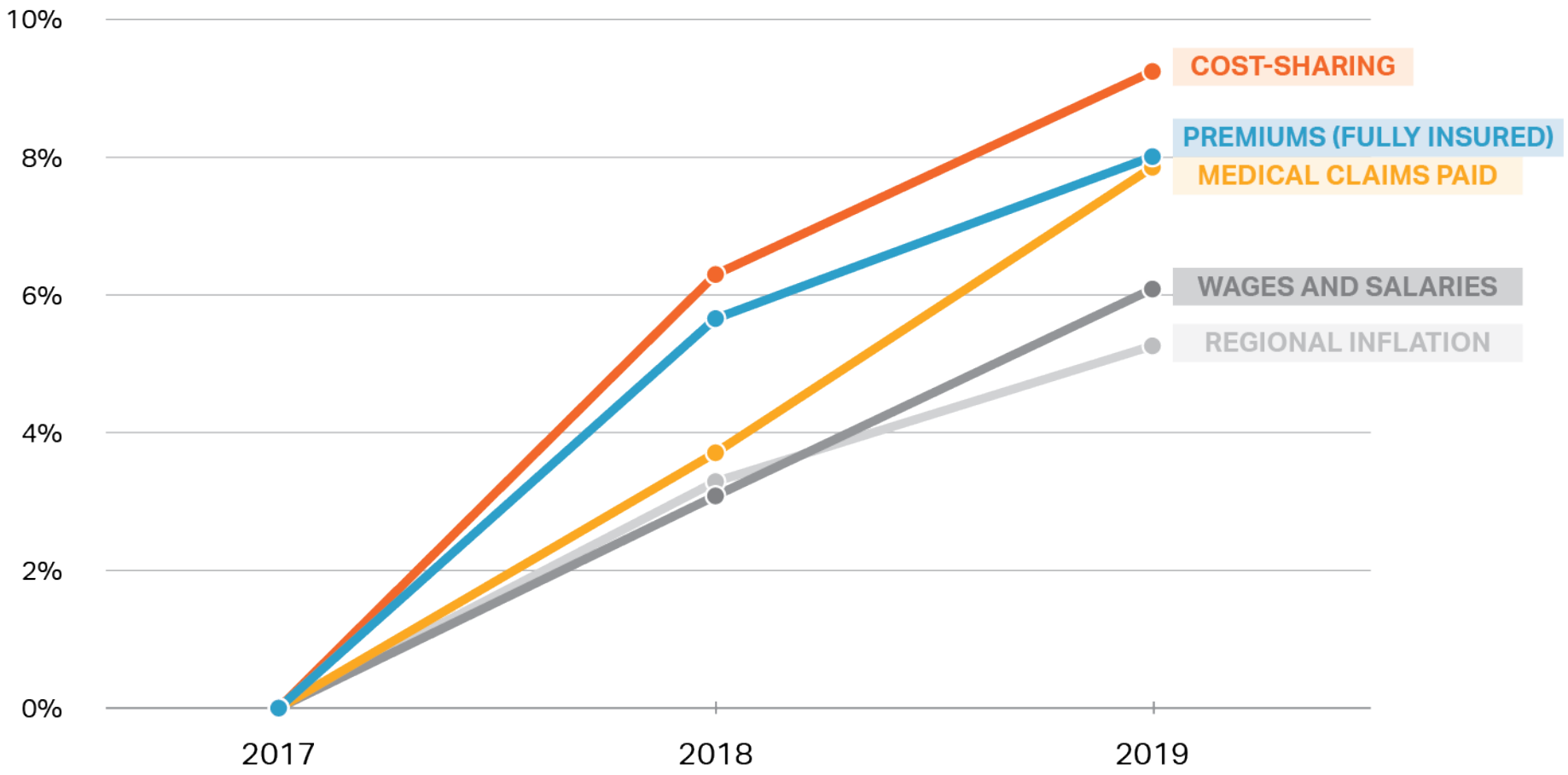


In 2019, health insurance premiums for Massachusetts families were the 5th highest in the U.S.

Notes. Data are in normal dollars of the year shown.
Sources: Family Health Insurance premiums are for Massachusetts from the Agency for Health Care Quality – Medical Expenditure Panel Survey, Insurance Component. Car cost information is based on car-specific inflation from the BLS and the compact car price index from Kelly Blue Book. https://www.prnewswire.com/news-releases/average-new-car-prices-up-nearly-4-percent-year-over-year-for-may-2019-according-to-kelley-blue-book-300860710.html

Member cost sharing and premiums rose faster than wages and inflation between 2017 and 2019.

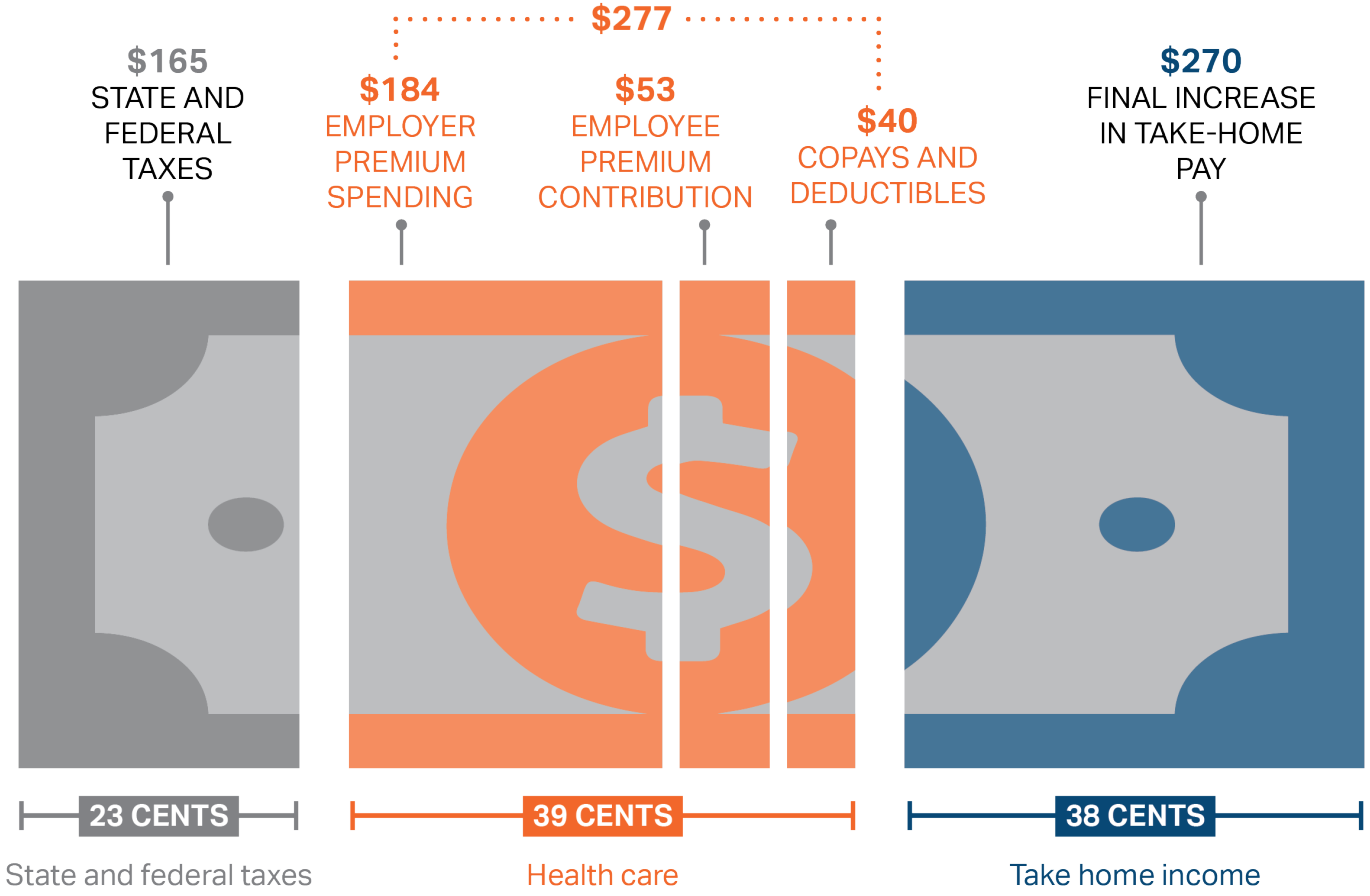
Cumulative percentage growth in each quantity starting from 2017



Massachusetts Center for Health Information and Analysis, 2021 Annual Report. https://www.chiamass.gov/annual-report/

Nearly 40 cents of every additional dollar earned by Massachusetts families between 2016 and 2018 went to health care.

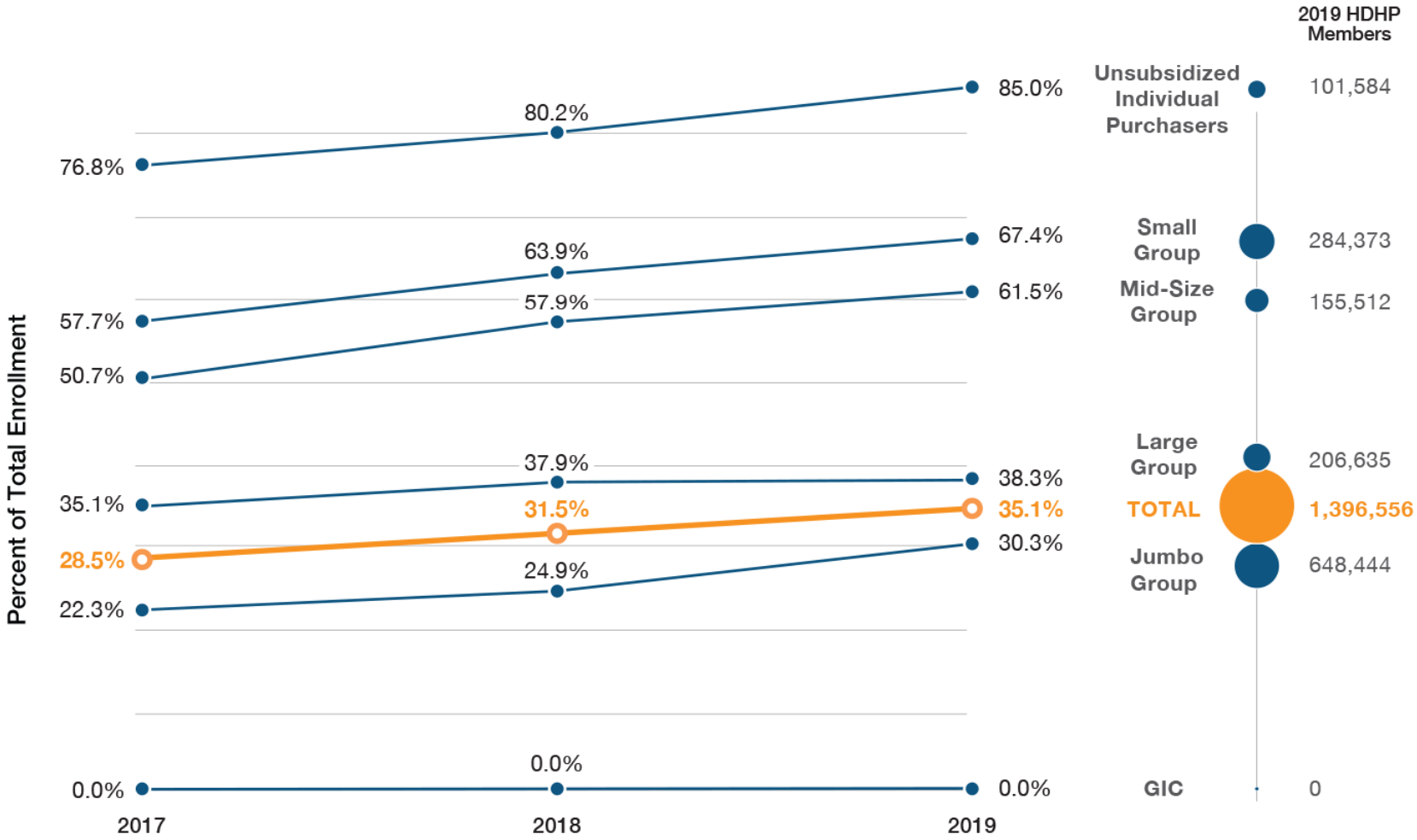
Allocation of the increase in monthly compensation between 2016 and 2018 for a median Massachusetts family with health insurance through an employer



Notes: Data represent Massachusetts families who obtain private health insurance through an employer. Massachusetts median family income grew from $95,207 to $101,548 over the period while mean family employer-sponsored insurance premiums grew from $18,955 to $21,801. Compensation is defined as employer premium contributions plus income as recorded in the ACS and is considered earnings. All premium payments are assumed non-taxable. Tax figures include income, payroll, and state income tax.
Sources: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component (premiums) American Community Survey (ACS) 1-year files (income), and Center for Health Information and Analysis 2019 Annual Report (cost sharing).

The percentage of commercially-insured residents with high deductible health plans grew markedly from 2017 to 2019, especially for those working for smaller employers.

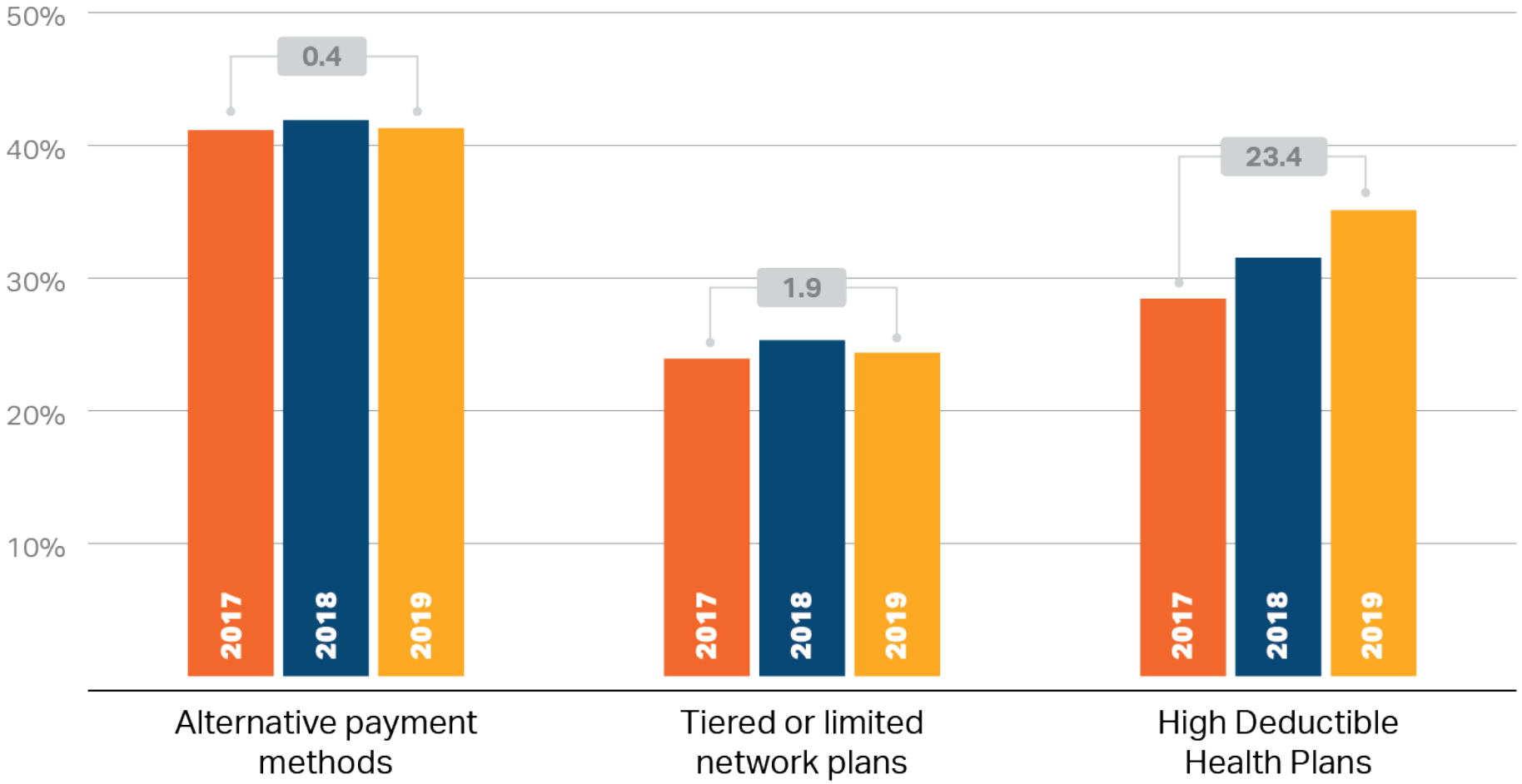
Percentage of commercially-insured Massachusetts residents with high deductible plans, by group size: 2017 to 2019



Source: Massachusetts Center for Health Information and Analysis, 2021 Annual Report. https://www.chiamass.gov/annual-report/. High deductible plans are defined as single plans with a deductible over $1,350 per year or family plans with a deductible over $2,700.

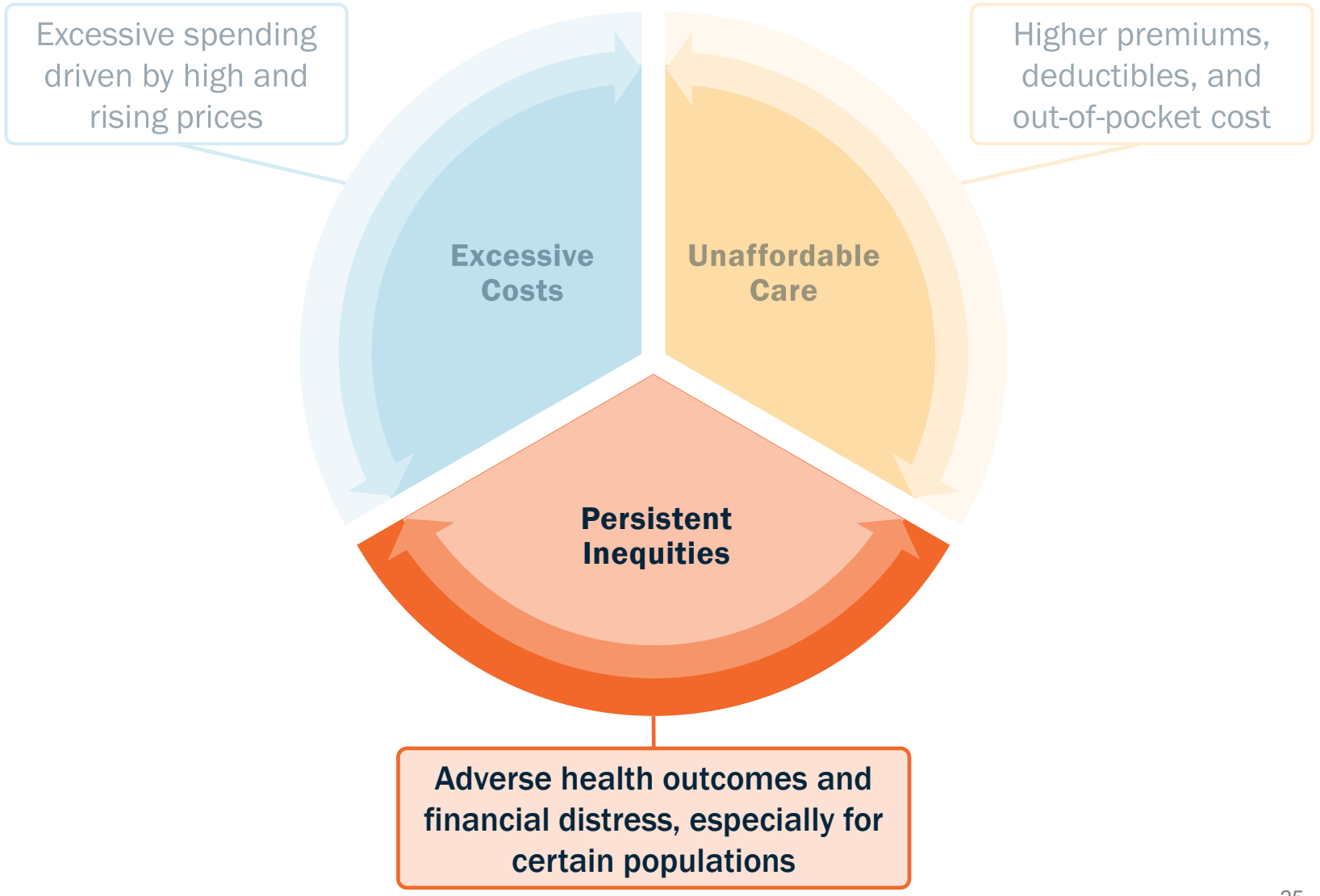
In contrast to the growth in high deductible health plans, alternative payment methods and tiered or limited network plans have stalled.

Percentage of commercial enrollment in Massachusetts in each type of plan; percentage of commercially-insured members for whom their care is paid under a payer-provider arrangement involving a global or limited budget



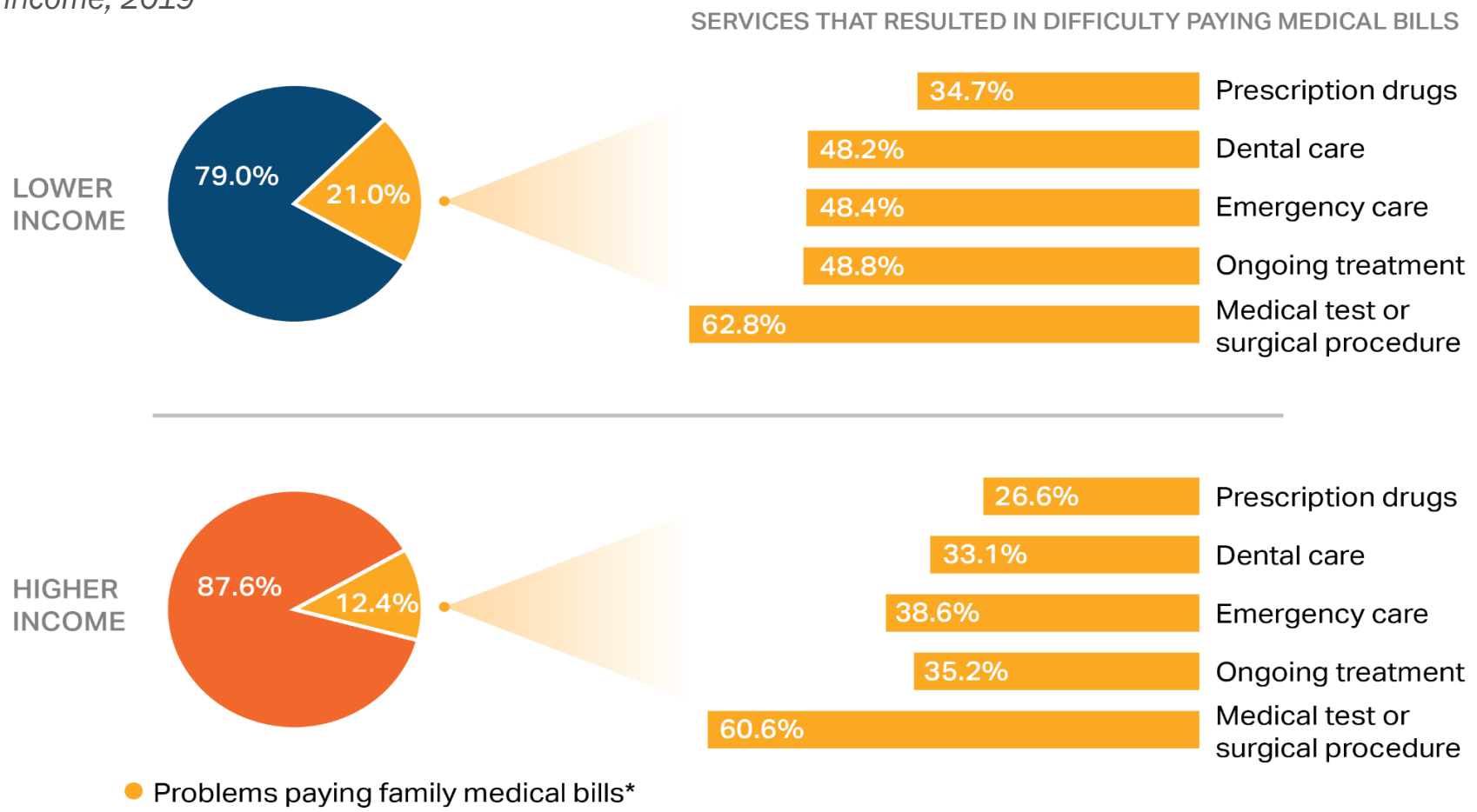
Source: Massachusetts Center for Health Information and Analysis, 2021 *Annual Report*. https://www.chiamass.gov/annual-report/. Categories are not mutually exclusive.

Higher premiums and out-of-pocket costs lead to adverse health outcomes and financial distress, exacerbating inequities.



Commercially-insured residents with lower incomes were almost twice as likely to struggle with medical bills resulting from common services.

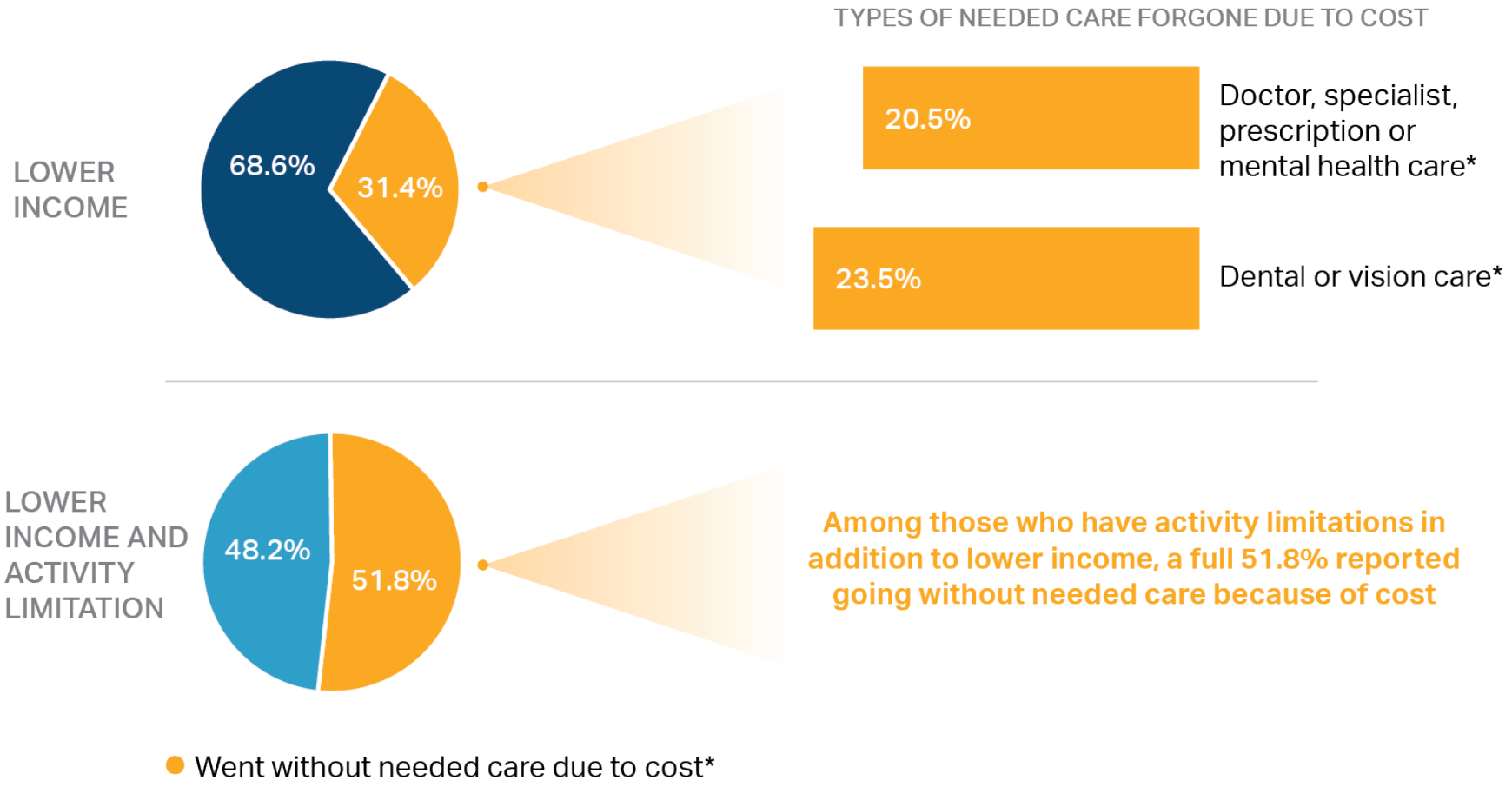
Percent of commercially-insured adults with problems paying family medical bills and services that resulted in difficulty paying medical bills by household income, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019.
Question text: "In the past 12 months, did you have any problems paying or were you unable to pay any medical bills?" "What types of medical services led to those medical bills?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income were much more likely to go without needed health care or prescription drugs because of cost.

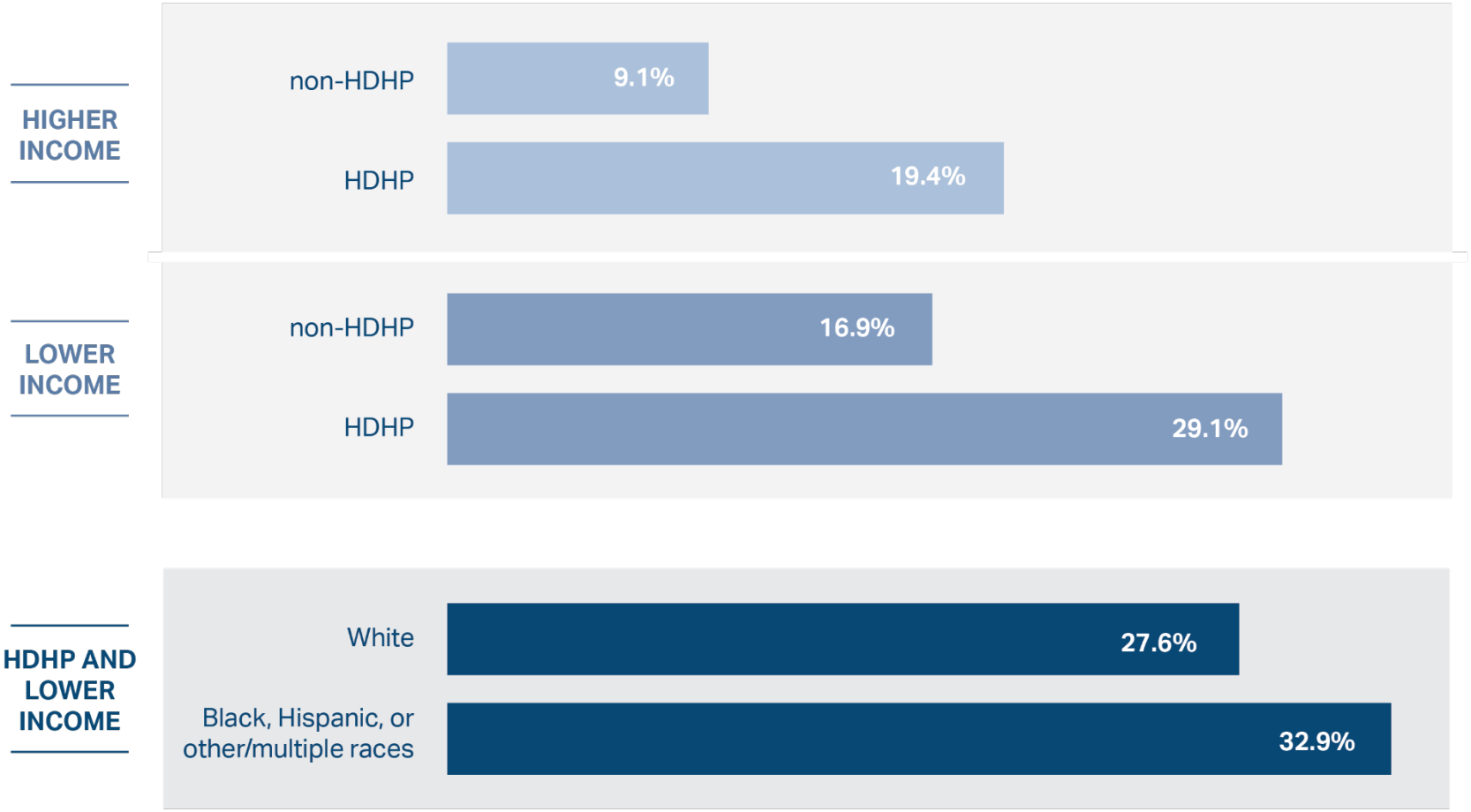
Percent of commercially-insured adults who went without needed care because of cost and types of needed care forgone by household income, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019.
Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "...not fill a prescription for medicine needed for you", "... not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed", "not get dental care that you needed", "not get vision care that you needed"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with high deductible plans were twice as likely to go without needed health care or prescription drugs because of cost.

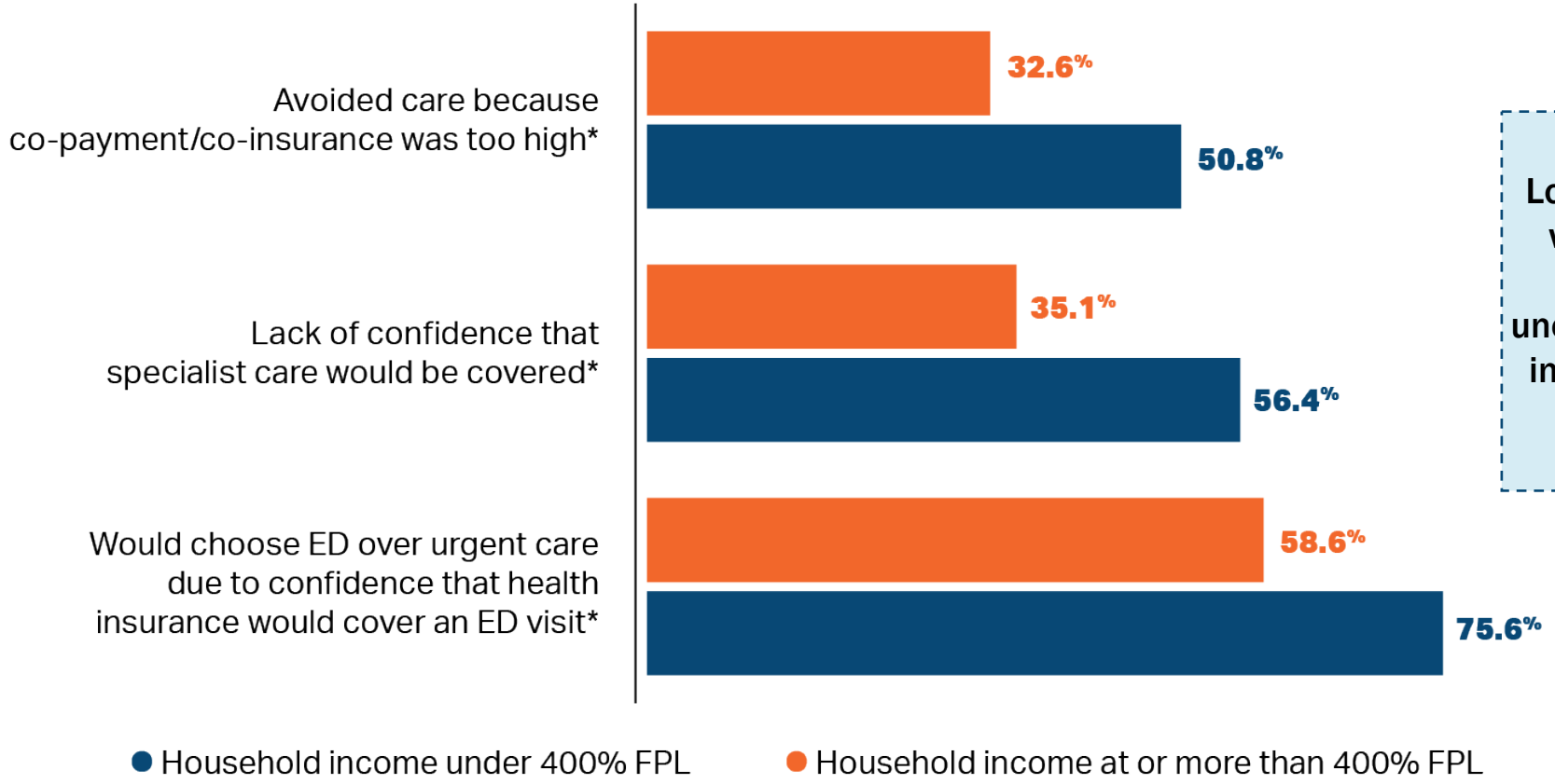
Percent of commercially-insured Massachusetts adults who said they went without needed doctor care, specialist care, mental health care or prescription drugs, 2019



Notes: 'Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Question text: “Because of cost, did you go without needed ___ care”, where the categories for types of care included those noted above as well as vision care, dental care, medical equipment, or care from an NP, PA or CNM.
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income avoided care because of copays/coinsurance and lack of confidence that needed care would be covered.

Percent of commercially-insured adults who avoided needed care because of cost or lacked confidence in coverage, by household income status, 2019



Low-income residents were more likely to experience an unexpected medical bill in the last 12 months (55% vs 39%).

Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019.
* indicates significance at P<0.05 level.
Question text: "Would any of these be important reasons for you to choose a hospital emergency room over an urgent care center or retail clinic?" "The last time you went without needed care because of cost was it because of any of the following?" "How confident are you that you know whether or not the following would be covered by your health insurance plan if it was needed?" "In the past 12 months, have you or any of your immediate family members received a medical bill where the health insurance plan paid much less than expected, or did not pay anything at all?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey and 2019 MHIS Recontact Survey

In a recent 2021 survey, more than half of Massachusetts adults experienced a health care affordability burden in the past year.

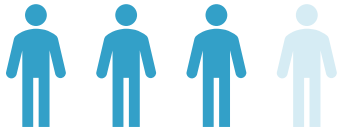
Percent of Massachusetts adults who reported the following outcomes based on survey of 1,158 Massachusetts adults, May 2021

46% of Massachusetts adults delayed or skipped care due to cost, including:

- Skipped needed dental care (27%)
- Delayed going to the doctor or having a procedure done (25%)
- Cut pills in half, skipped doses of medicine, or did not fill a prescription (22%)

Almost **10%** of adults reported that due to the cost of medical bills, they:

- Were unable to pay for basic necessities like food, heat, or housing
- Used up all or most of their savings
- Were contacted by a collection agency

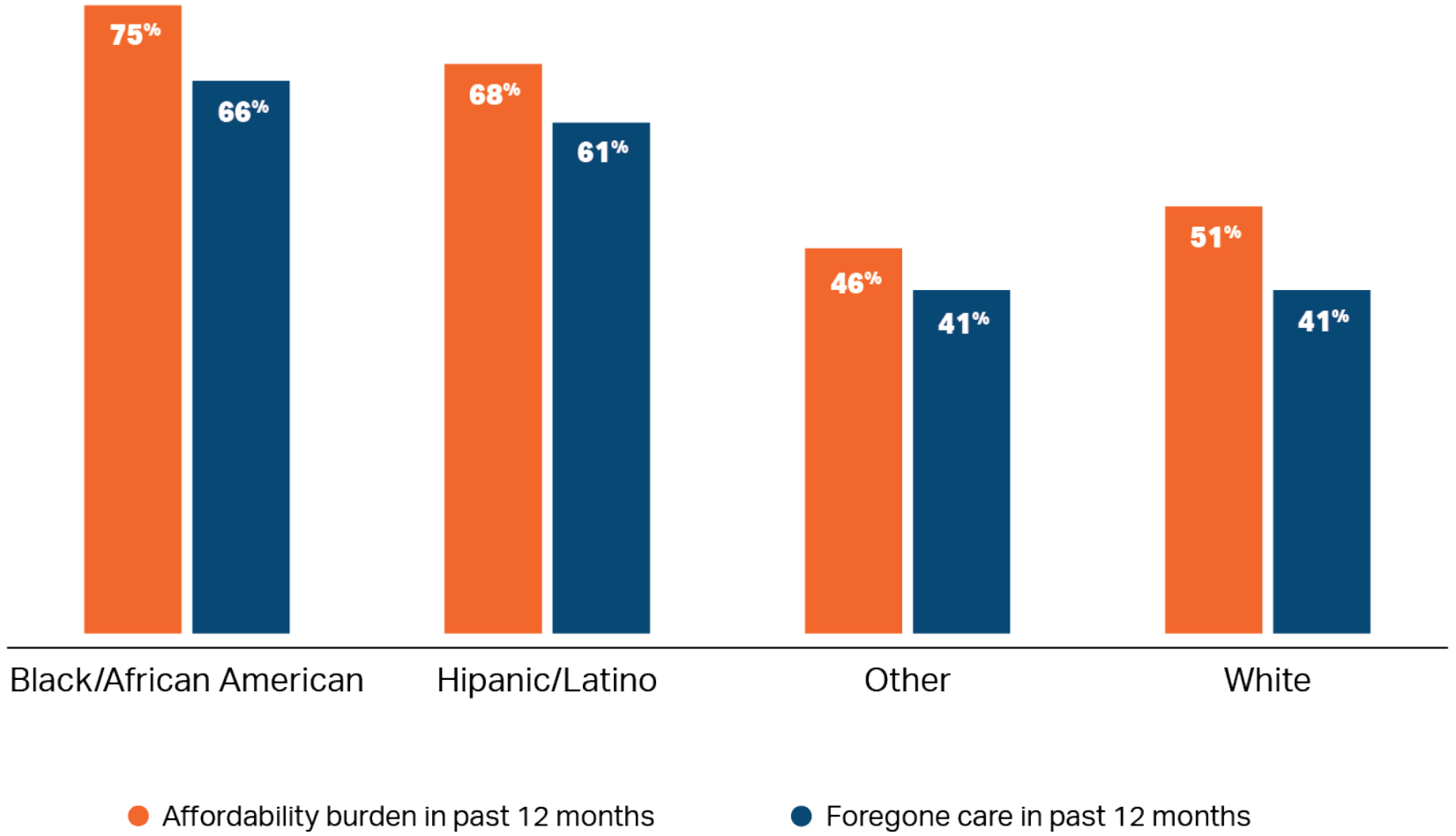


3 in 4 Massachusetts residents are worried about affording health care in the future.

Source: Altarum Healthcare Value Hub, Data Brief 97, September 2021," Massachusetts Residents Struggle to Afford High Healthcare Costs; Worry About Affording Care, Leading to Support for Government Actions to Address High Healthcare Costs". Data based on survey of 1,158 Massachusetts adults conducted in May, 2021.

Affordability burdens and foregone care are greater for residents of color.

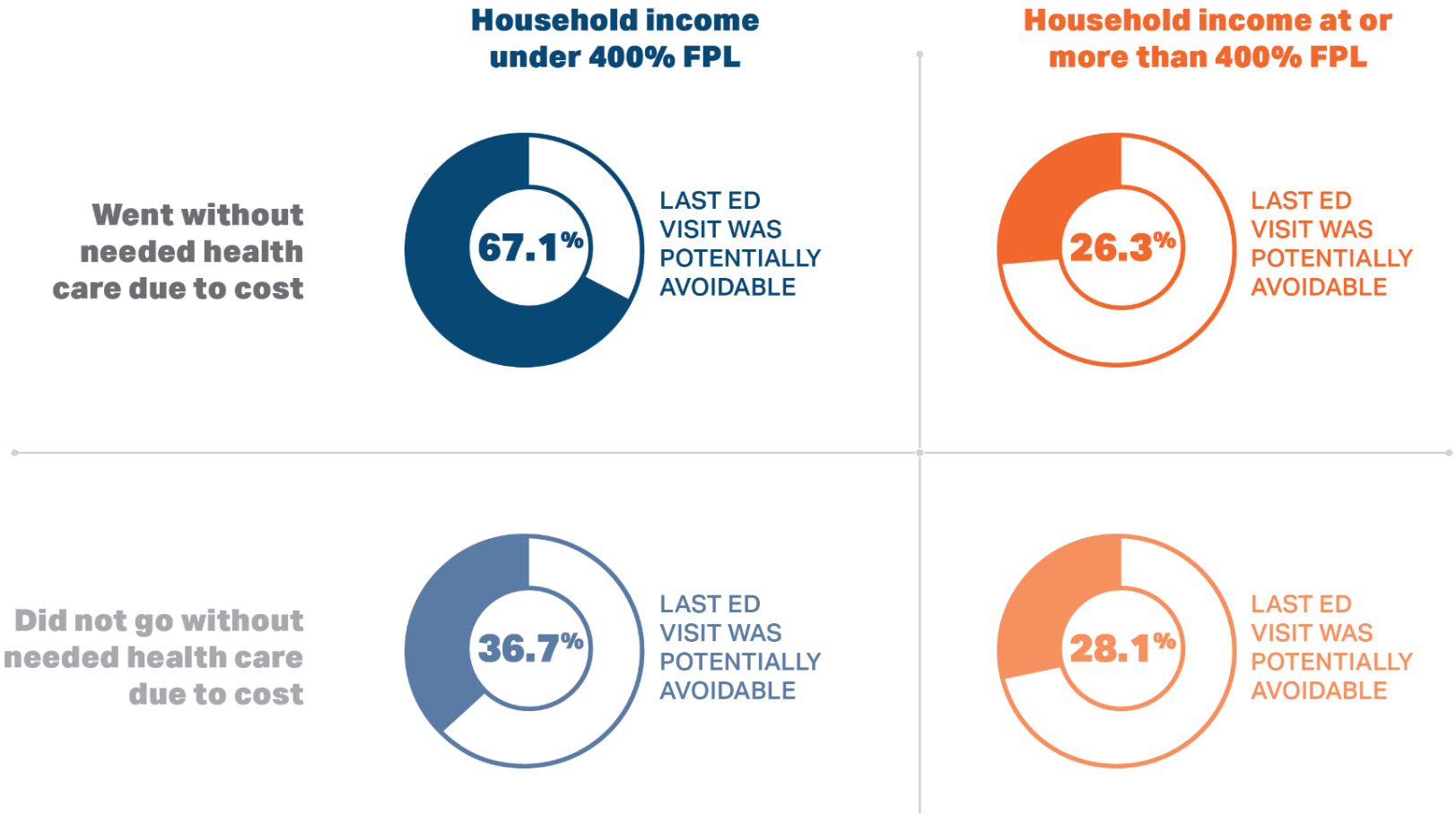
Percentage of Massachusetts survey respondents reporting affordability burdens or foregone care in the past 12 months, by race and ethnicity, 2021



Notes: Affordability burden defined as any of the following: 1) Being uninsured due to cost, 2) Delaying or foregoing health care due to cost, or 3) Struggling to pay medical bills.
Source: Altarum Healthcare Value Hub, Data Brief 97, September 2021," Massachusetts Residents Struggle to Afford High Healthcare Costs; Worry About Affording Care, Leading to Support for Government Actions to Address High Healthcare Costs". Data based on survey of 1,158 Massachusetts adults conducted in May, 2021.

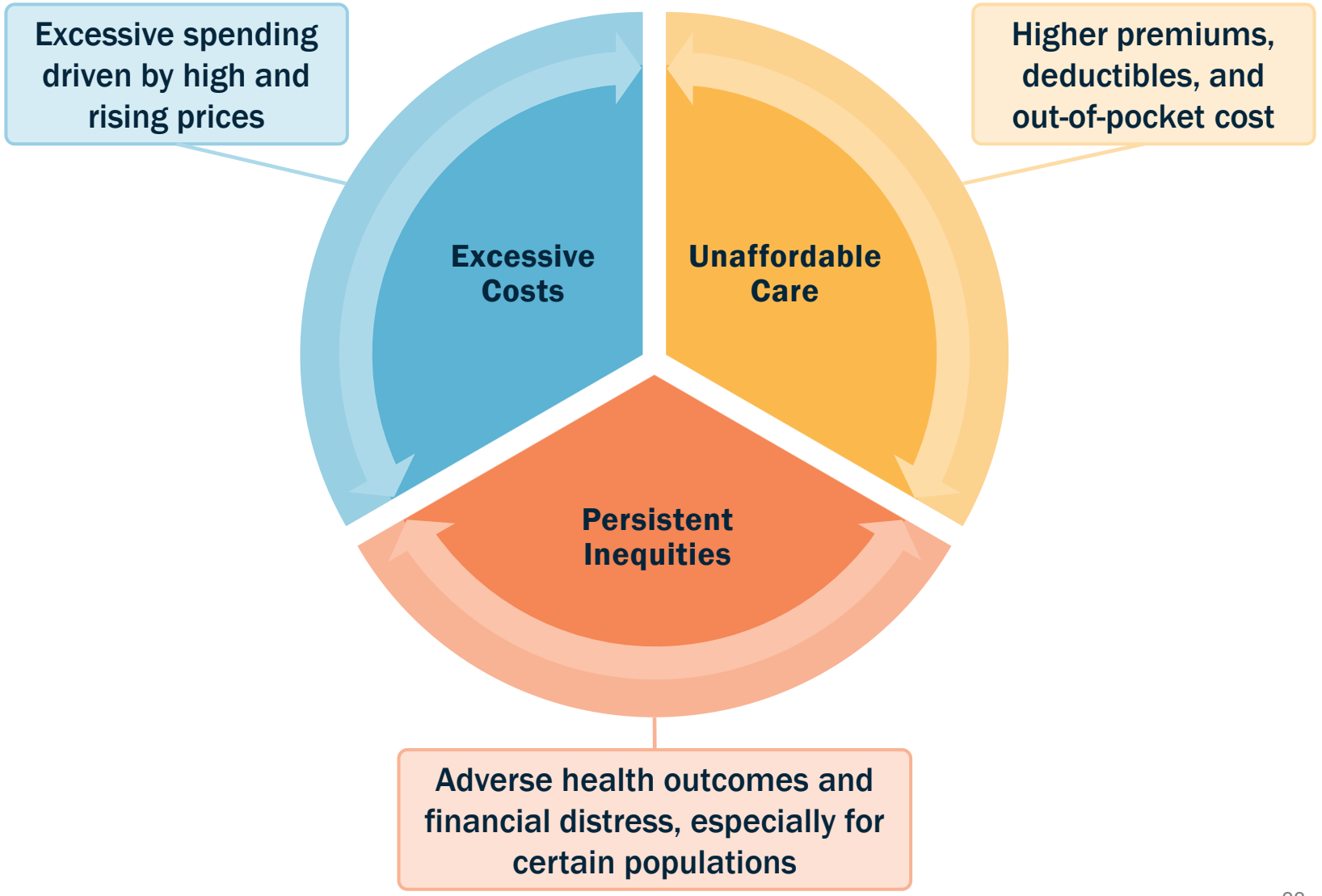
Those who earn a lower income and went without needed care due to cost were twice as likely to have had a potentially avoidable ED visit.

Percent of commercially-insured adults whose last ED visit was potentially avoidable, by household income and unmet health care needs due to cost, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Needed health care includes doctor, specialist, prescription drug, and mental health care. Clockwise from upper left quadrant, estimated number of Massachusetts residents whose last ED visit was potentially avoidable: 32,210/48,031, 18,421/70,097, 89,246/317,376, and 57,464/156,749.
Question text: "The last time you went to a hospital emergency room, was it for a condition that you thought could have been treated by a regular doctor if he or she had been available?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Unless urgently addressed, these concerning trends will result in a health care system that is increasingly unaffordable for Massachusetts and will deepen long-standing health inequities.



Even a modest reduction in growth of commercial spending would lead to better care and significant savings for Massachusetts families.

If Massachusetts health care spending grew 2.5% annually from 2020 to 2026 versus the current trajectory of 4%:

Total spending on health care would be reduced by

$13.7 billion

10% lower
family premiums ($25,500 vs. $28,200)
*in 2026

$8,700 more
in take-home pay per worker
2020-2026

$1,024
Saved in out of pocket spending
2020-2026

Less care avoided due to cost
Fewer financial harms

Premium data based on the Medical Expenditure Panel Survey – Insurance component. Calculations assume a 25% family tax rate and that reductions in premium spending are converted to employee wages that face federal and state taxes. Out of pocket cost estimates from Massachusetts Center for Health Information and Analysis (CHIA) data showing that these costs are roughly 10% as high as premiums. Total enrollment in commercial insurance is from CHIA's enrollment trends data.

The HPC's 2021 Policy Recommendations

As the Commonwealth approaches the **ten-year anniversary** of its benchmark-anchored cost containment effort, the HPC recommends the Commonwealth take immediate action to strengthen and enhance the state's strategy for addressing the intersecting challenges of **cost containment, affordability, and health equity** to improve outcomes and lower costs for all. In addition to implementing the following items, this includes sustaining the successful innovations made during the COVID-19 pandemic, such as expanded access to telehealth, workforce flexibilities, and new care models.

AREAS OF FOCUS

1	2	3	4	5
Strengthen Accountability for Excessive Spending	Constrain Excessive Provider Prices	Make Health Plans Accountable for Affordability	Advance Health Equity for All	Implement Targeted Strategies and Policies

2021 HEALTH CARE COST TRENDS HEARING

NEXT UP

KEYNOTE ADDRESS:
WRONGED BY WRONG PRICES: PROTECTING CONSUMERS IN HEALTHCARE MARKETS

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MASSACHUSETTS HEALTH POLICY COMMISSION

#CTH21

Wronged by Wrong Prices: Protecting Consumers in Healthcare Markets

Leemore S. Dafny, PhD, Bruce V. Rauner Professor of Business Administration

Massachusetts Health Policy Commission Cost Trends Hearing
November 17, 2021

HARVARD | BUSINESS | SCHOOL

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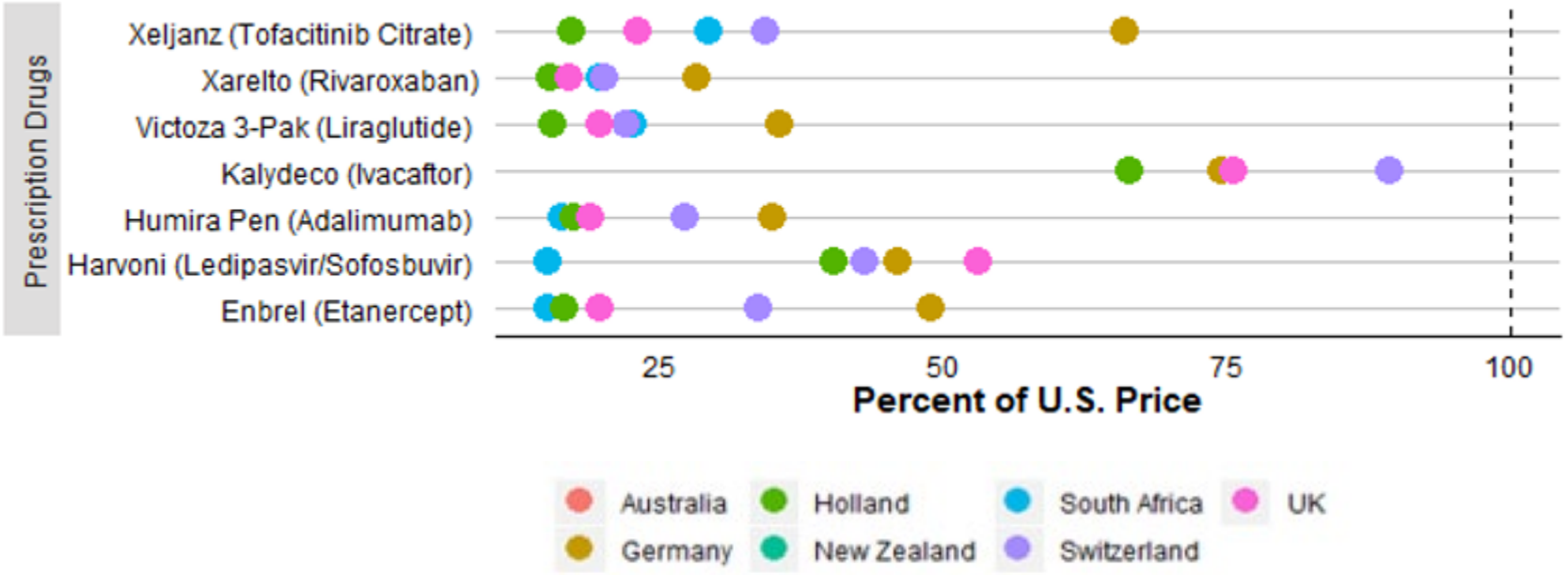
JOHN F. KENNEDY SCHOOL OF GOVERNMENT

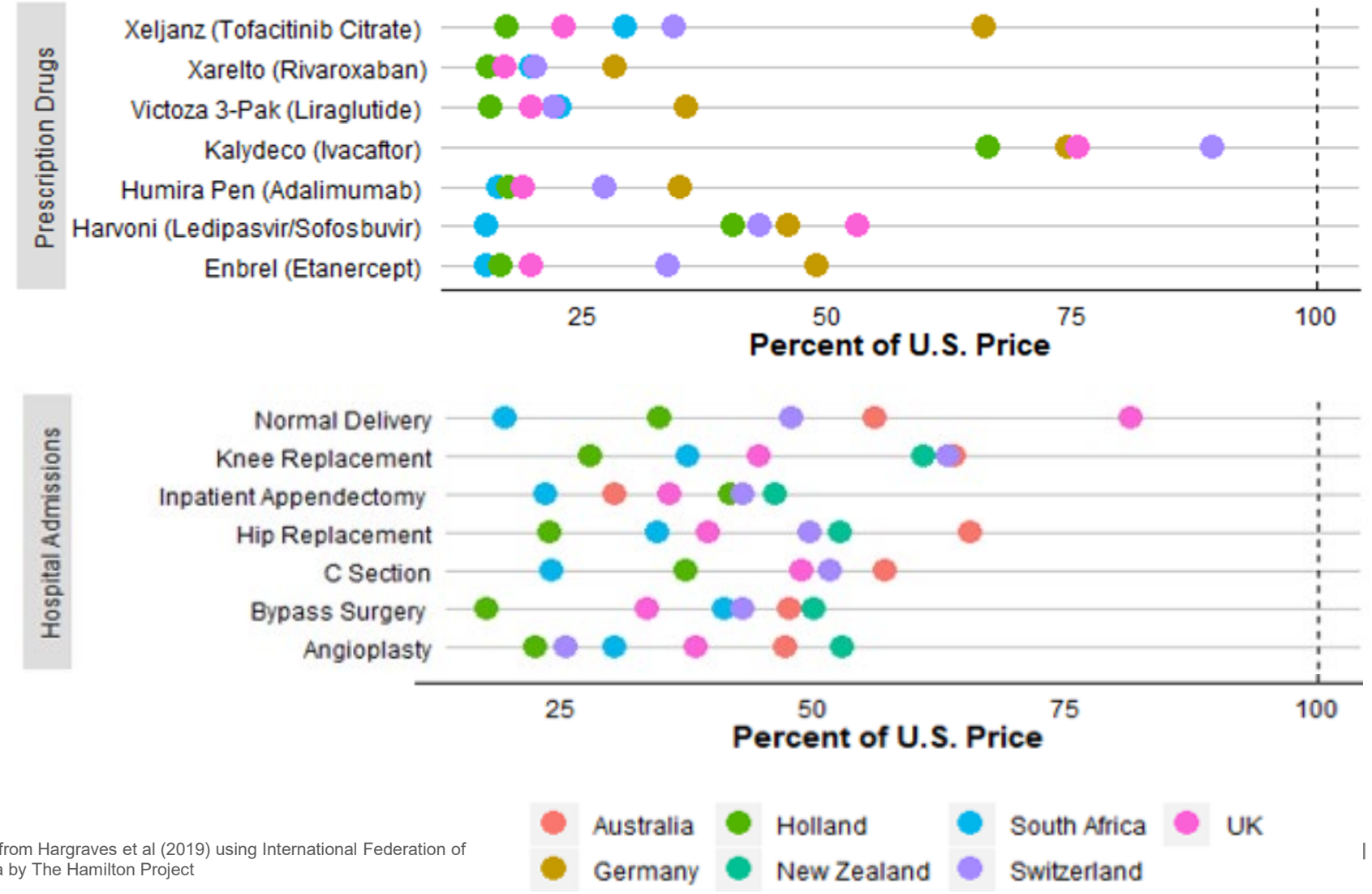
Agenda

- Prices are wrong
- Why prices matter
- What the state (and regulators) can do about it

It's well-known that the US pays much higher prices for branded drugs

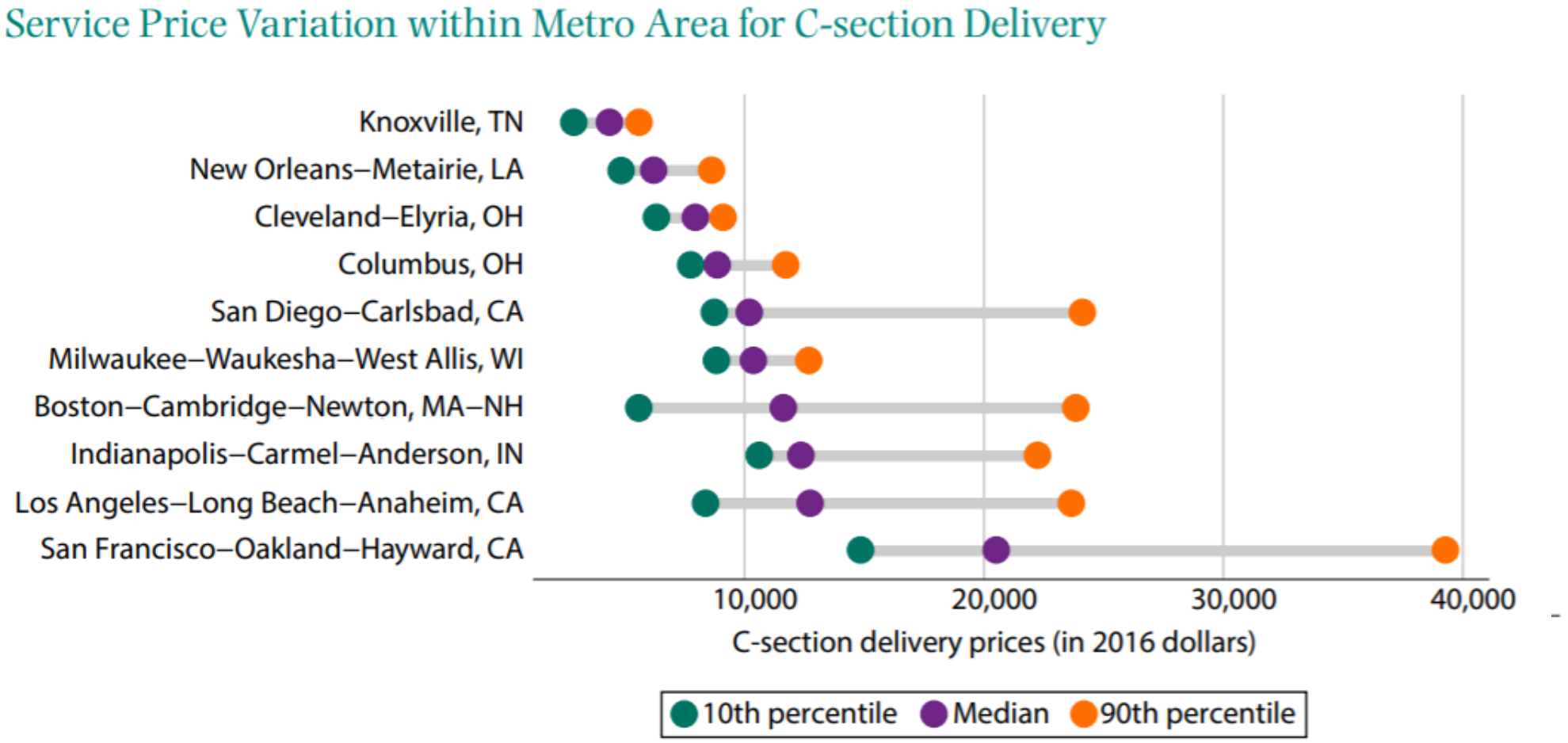


It's less well-known that the US pays much higher prices for hospital services, too



Source: Adapted from Hargraves et al (2019) using International Federation of Health Plans Data by The Hamilton Project

We also pay *different* prices for the same inpatient services in the same markets…

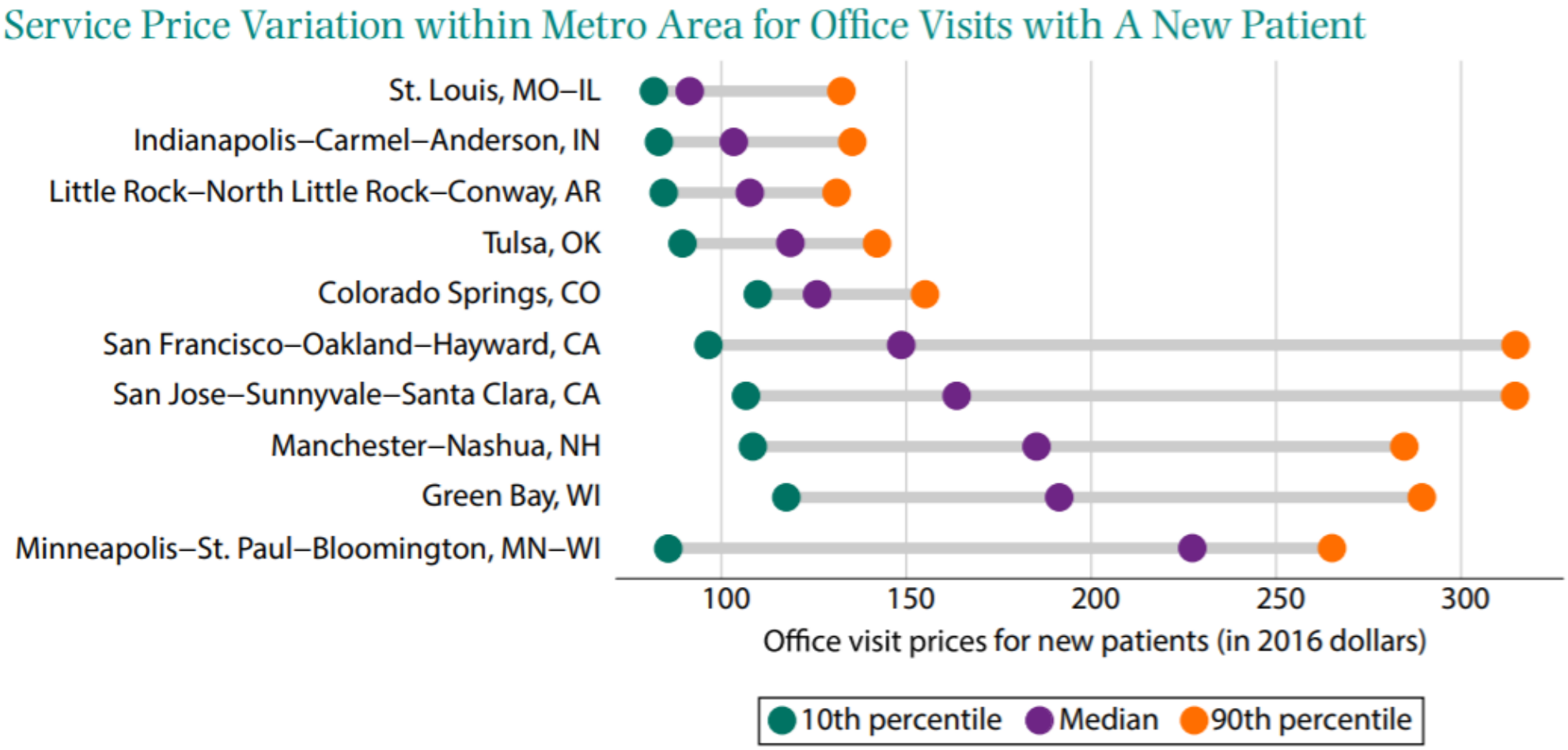


Source: Adapted from Kennedy et al. (2019) using Health Care Cost Institute data.

Notes: Percentiles (10th, median, 90th) show within-metro variation in price for the indicated service. Metro areas are defined as the 112 core-based statistical areas in the United States. A select group of metro areas is shown.

THE HAMILTON PROJECT BROOKINGS

…and for the same outpatient services



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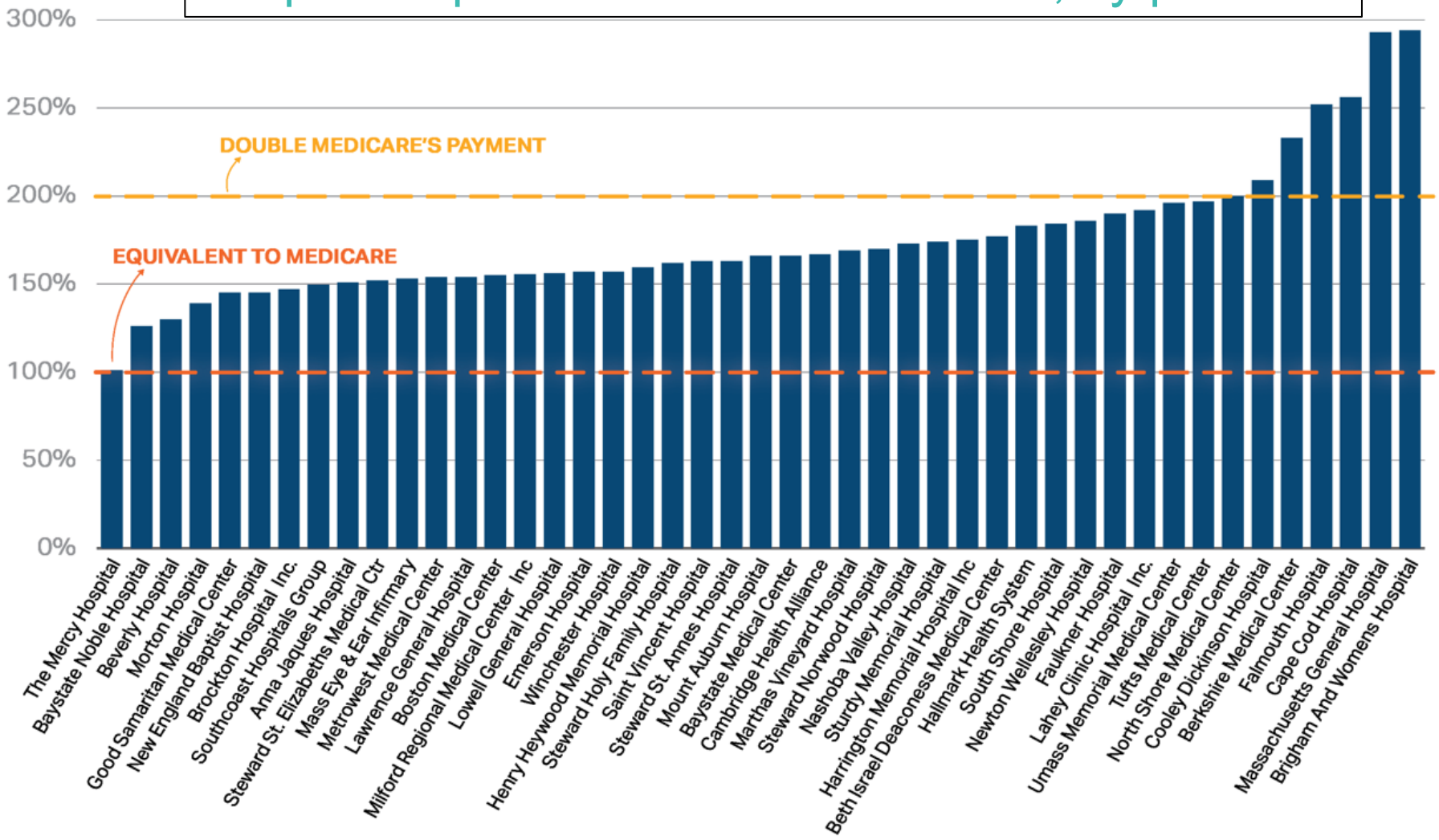
Plenty of price variation in Massachusetts too (1/2)

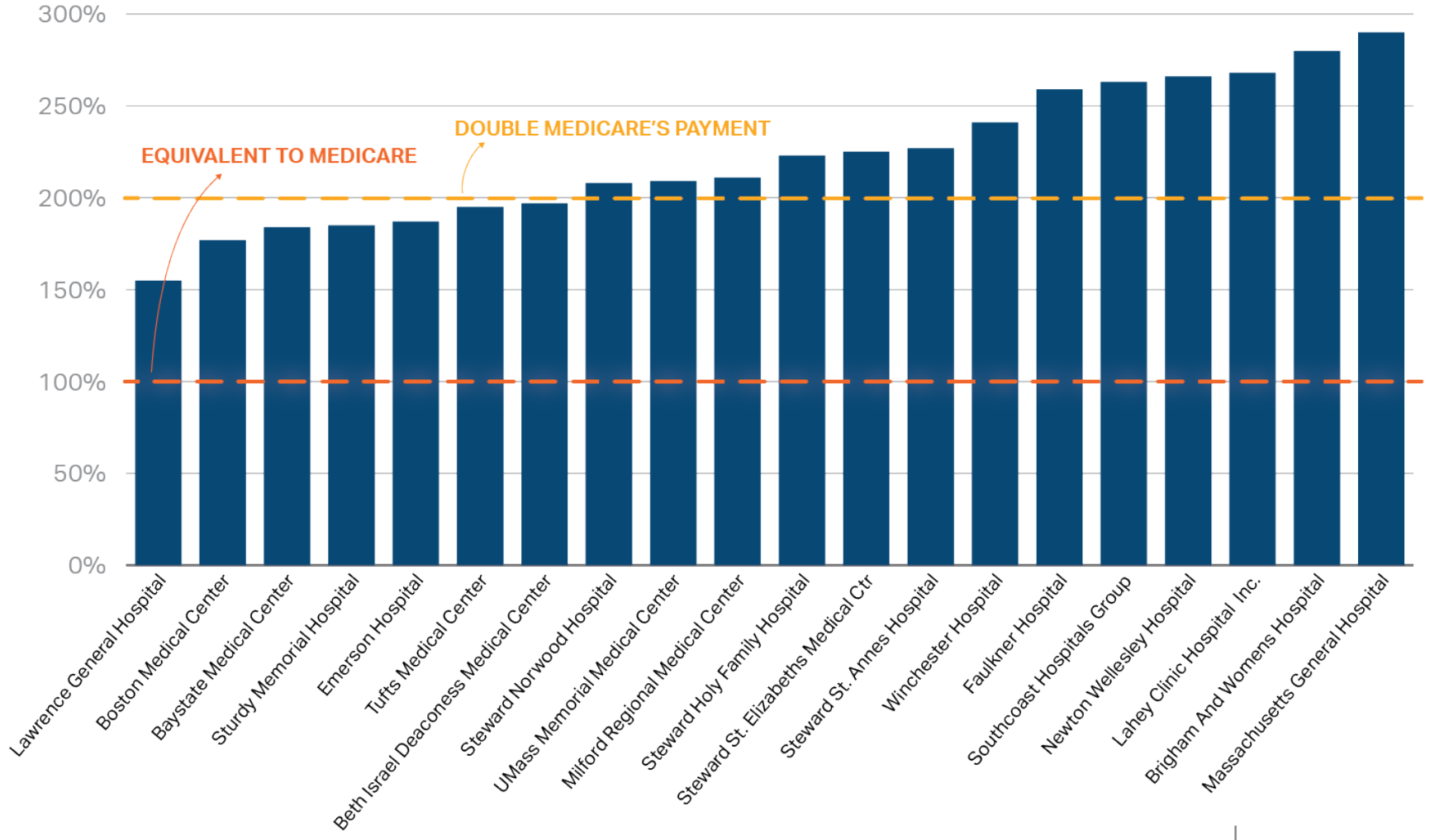
Outpatient prices relative to Medicare, by provider



Source: Massachusetts Health Policy Commission's analysis of data from Whaley et al, "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative," *RAND* 2021, https://www.rand.org/pubs/research_reports/RR4394.html; *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021*

Plenty of price variation in Massachusetts too (1/2)

Inpatient prices relative to Medicare, by provider



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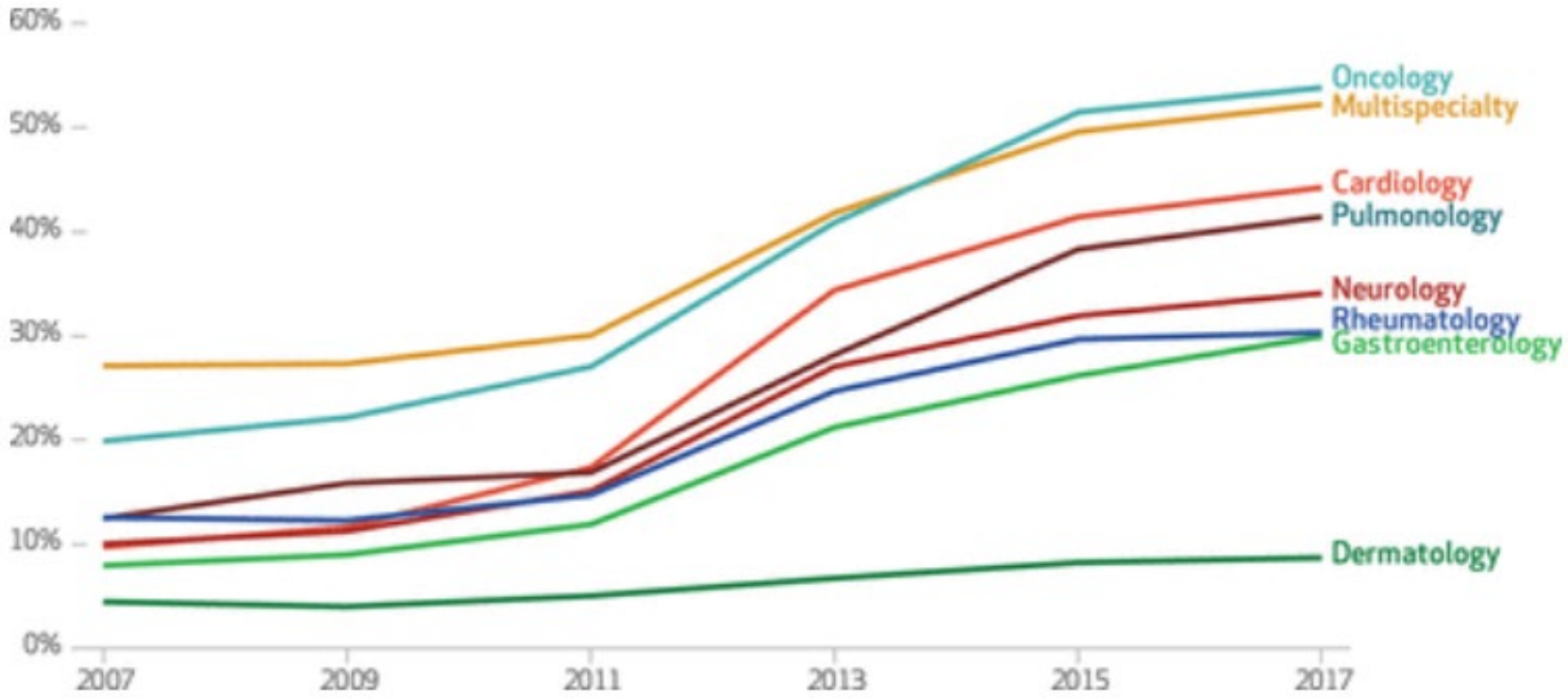
Why wrong prices matter (1/3)

- We use prices to allocate resources
  - High prices in health care attract resources (human and financial, public and private) to the sector…and away from other sectors
  - Variable prices affect organizational structure

Higher payments for hospital-based services may be one driver of physician practice acquisition

Percent of physician practices reporting hospital/system ownership

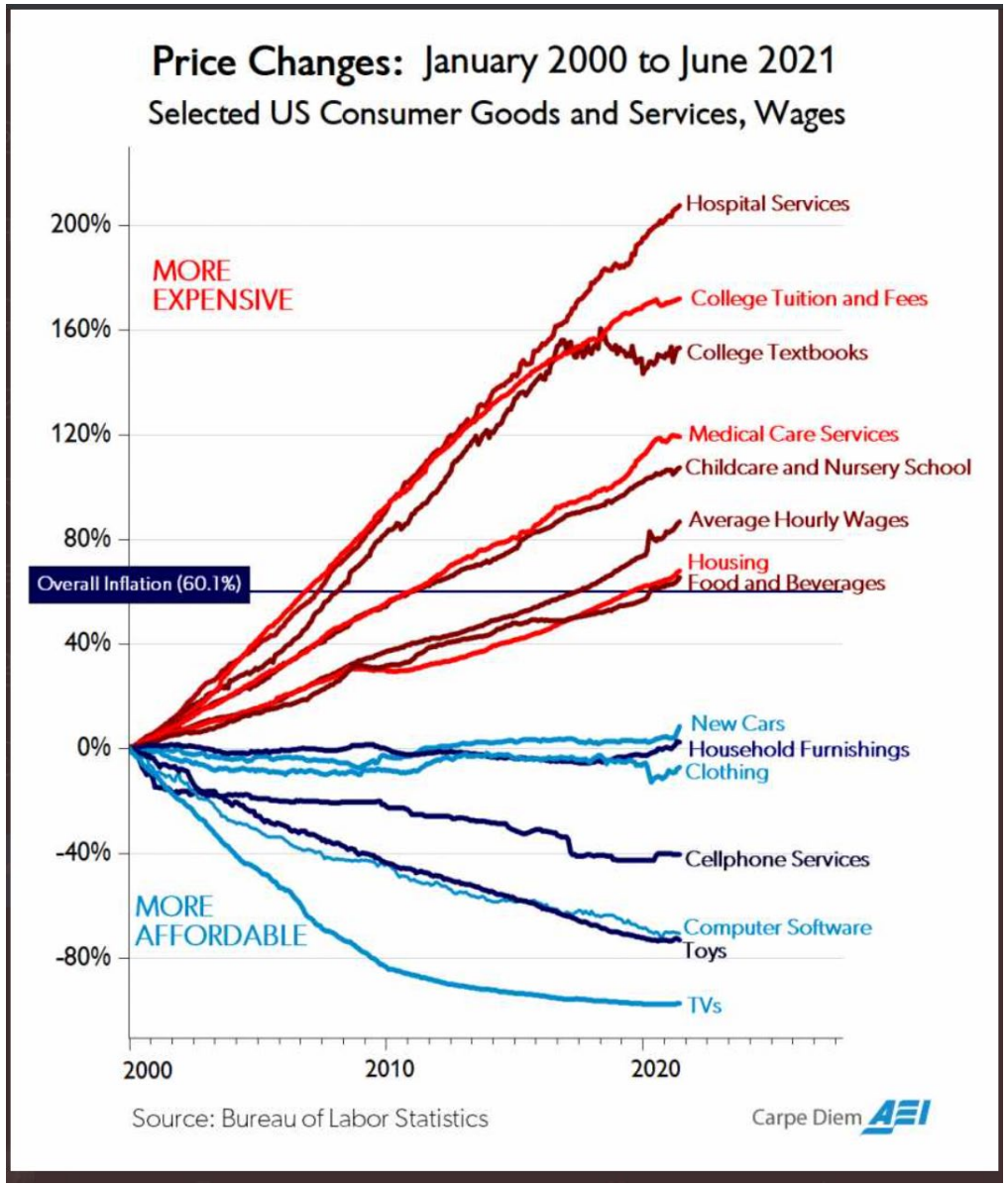


Source: Nikpay et al, "Hospital-Physician Consolidation Accelerated In The Past Decade In Cardiology, Oncology," *Health Affairs* 2018.

Why prices matter (2/3)

- We use prices to allocate resources
  - High prices in health care attract resources (human and financial, public and private) to the sector…and away from other sectors
  - Variable prices affect organizational structure
- Wrong prices create domino effects

Prices for hospital services in particular have soared



Why prices matter (2/3)

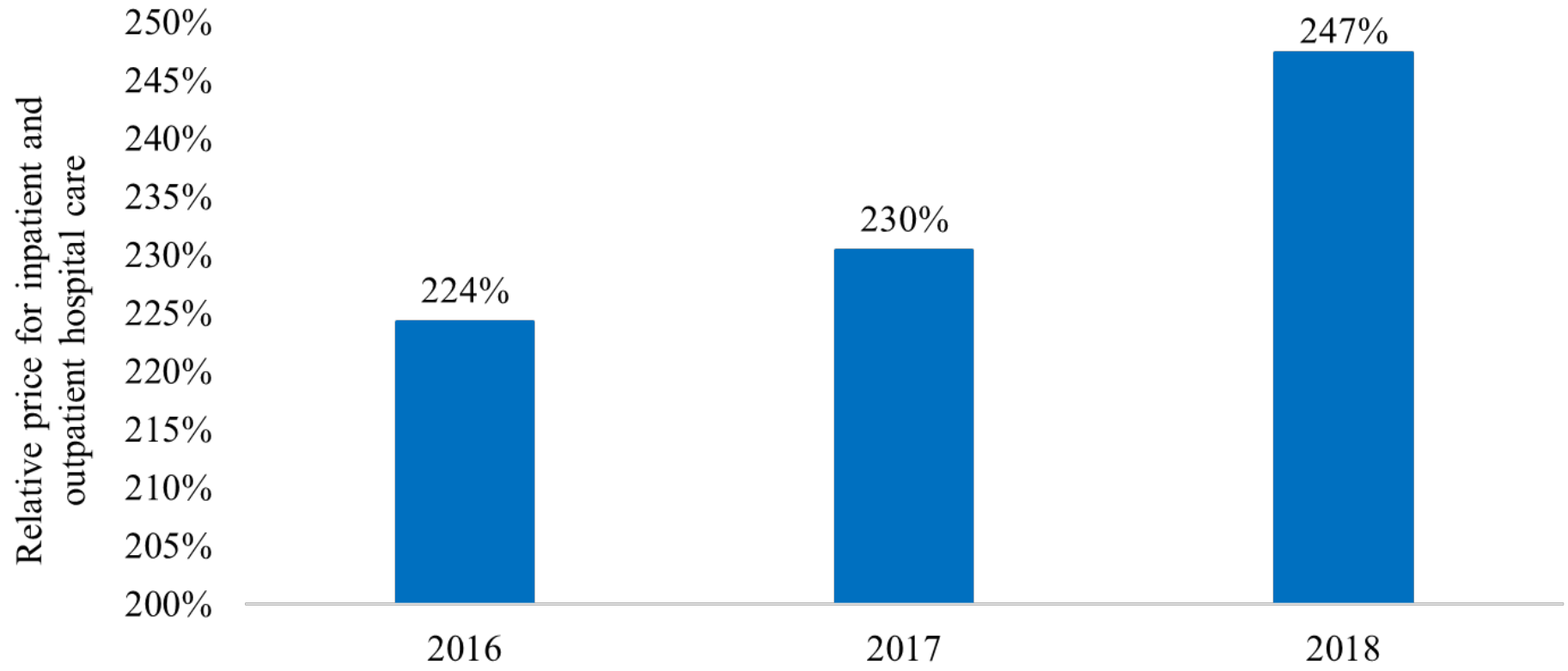
- We use prices to allocate resources
  - High prices in health care attract resources (human and financial, public and private) to the sector…and away from other sectors
  - Variable prices affect organizational structure
- Wrong prices create domino effects
  - Workarounds
    - to keep patients out of the hospital/ancillary services (and countervailing efforts by hospitals)
    - to manage specialty drug spending (and coupon/copay assistance by biopharma)

Why prices matter (3/3)

- We use prices to allocate resources
  - High prices in health care attract resources (human and financial, public and private) to the sector…and away from other sectors
  - Variable prices affect organizational structure
- Wrong prices create domino effects
  - Workarounds
    - to keep patients out of the hospital/ancillary services (and countervailing efforts by hospitals)
    - to manage specialty drug spending (and coupon/copay assistance by biopharma)
- Prices are driving higher premiums → higher deductibles and cost-sharing → poor health choices and outcomes & inequity

Nationally, hospital prices are growing rapidly

Average actual spending per commercial enrollee compared to spending priced at Medicare rates



Source: Whaley et al. (2020) "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative"

Prices – particularly hospital prices – are also a major driver of commercial spending growth in Massachusetts.

Massachusetts price growth overall

- Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care all reported annual prices grew from 2015 to 2018 more than twice the rate of utilization.
- The Health Care Cost Institute found that Massachusetts commercial health care prices grew 15.6% from 2014 to 2018 while utilization grew 7.0%.

Massachusetts price growth by category, 2016 to 2018 (2021 Cost Trends Report)

- Hospital inpatient services: 9.1%
- Hospital outpatient services: 6.6%
- Office-based services: 4.4%

Sources: HCCI 2018 Health Care Cost and Utilization Report. Available at: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report; Massachusetts Health Policy Commission. 2021 Cost Trends Report. Sept. 2021. Available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

What to do? (1/2)

- Insist on paying lower prices
  - Drug-pricing reform proposals include: Medicare “negotiating” price, relying on other countries to cap/set price, capping price growth

National because drug markets are national

  - Service pricing reform proposals: Medicare *already* sets its prices, but private sector is on its own

Can be state-level because provider markets are local and insurers are regulated by states

What to do (2/2)?

(1) All payers pay uniform rate set by state regulator

(2) “Public option” insurance plans with access to regulated price rates

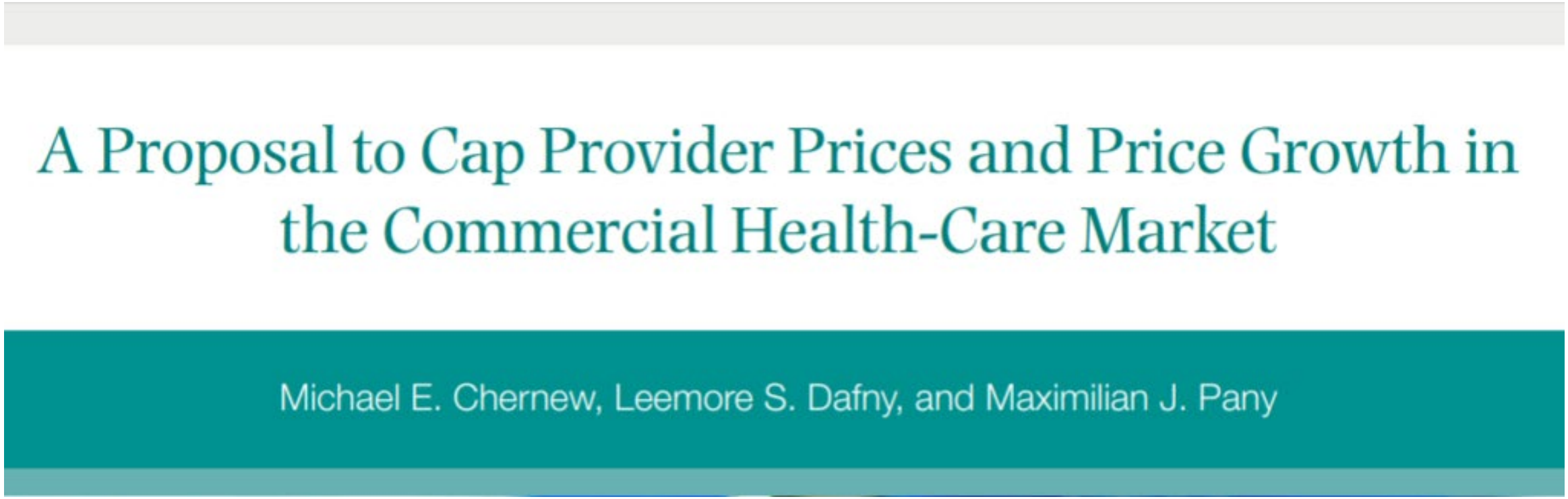
(3) Cap commercial price levels and/or growth rates

(4) Set global caps (e.g., caps on total medical expenditure levels or growth)

Price caps (1/3)

- Benefits of price caps (over price-setting)
  - Doesn't require an administrative authority to set prices
  - Market forces can operate beneath the cap, (potentially) rewarding providers who offer "better" services (broadly defined)
  - Less disruptive (unless caps set low)
  - Blunts incentive to consolidate/expand & negotiate higher rates
- Many details to decide
  - How to set cap and how it will evolve over time
  - Unit of service, e.g. DRG, RVU, episode of care
  - Apply to all prices or just out-of-network
  - How to enforce and how to ensure benefits passed through to consumers

We simulated the effect of price caps on national spending



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BROOKINGS

We proposed service-level caps based on local market prices

- For every inpatient and outpatient service (e.g., DRG and CPT)
  - ➢ Use distribution of MSA commercial prices to set cap, e.g 5 times the 20th percentile, 2 times the 50th percentile or the 90th percentile

Alternative caps:

5 x 20th = $875
2 x 50th = $850
1 x 90th = $875

Note: Illustrative example; does not use actual data

Estimated National Savings from Alternative Price Caps on Inpatient Admissions

Percentile of price distribution	Multiple	% of admissions affected	% savings
20th	5	5	9
50th	2	9	13
90th	1	12	8

Notes: (1) Caps vary by DRG and MSA (2) The 20th and 50th percentile caps are themselves capped at the 75th percentile nationwide

Estimated National Savings from Alternative Price Caps on *Out-of-Network* Inpatient Admissions

Percentile of price distribution	Multiple	% of admissions affected	% savings
20th	5	0.4	1.1
50th	2	0.5	1.2
90th	1	0.3	1.0

Notes: (1) Caps vary by DRG and MSA (2) The 20th and 50th percentile caps are themselves capped at the 75th percentile nationwide (3) Assumes no effect on in-network prices

We proposed supplementing with price growth caps and flexible oversight

- Price *growth* caps impact *all* providers (not just those beneath the cap)
  - Version 1: all subject to same caps
  - Version 2: higher-priced providers subjected to more stringent caps
- Can establish growth caps without level caps
- Additional oversight
  - Monitoring/regulatory body to monitor evasion, to ensure that "side payments" (e.g., via alternative payment mechanisms) and/or gaming don't undo the effect of price regulation, e.g. by monitoring TME

Several states have introduced service price caps that apply to certain insurance plans

Montana (2016)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services ▪ Cap is **234%** of Medicare rates (for average price of all services) ▪ All major hospitals are in network, due to public pressure
Oregon (2019)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services ▪ Cap is **200**% of Medicare rates (for in-network services) ▪ Cap is **185%** of Medicare rates (for out-of-network services)
Washington (2019) Colorado (2021) Nevada (2021)	▪ **Created public options** offered through private insurers ▪ Cap is **160**% of Medicare rates in Washington ▪ Floor is **155**% of Medicare rates in Colorado, but lower rates can be mandated by insurance commission if premium targets not met ▪ All three states set provider participation requirements

Source: *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021 (*see https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Two states cap price growth for plans regulated by state insurance commissioners

Rhode Island (2010)	▪ **Cap on price growth in insurer-hospital contracts** subject to rate review and approval by Office of Health Insurance Commissioner. ▪ Cap is **Medicare iPPS growth + 1 percent** ▪ Growth is defined using average of inpatient and outpatient services
Delaware (2021)	▪ **Cap on price growth for non-professional services in insurer-hospital contracts** subject to rate review and approval by Department of Insurance ▪ Cap is **CPI + 1 percent** (begins at 3 percent in 2022, hits 1 percent by 2024) ▪ Non-professional services are inpatient hospital, outpatient hospital, and other medical services like home health

Source: Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. Health Affairs, 38(2), 237-245; *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021* (see https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Rhode Island's reforms have slowed fee for service spending

- Rhode Island's spending initially above control states
- Spending growth declined in Rhode Island starting in 2012; spending was **15%** below control states by 2016
- Most of the savings came via a reduction in **spending per hospital inpatient visit.**
- Cost-sharing also dropped markedly
- Quality of care was unchanged

"Rhode Island's experience thus suggests that mandated price control measures may effectively leverage state regulatory power to reduce healthcare costs, particularly in areas where the market power of providers is greater than insurers."
– Baum et al. Health Affairs, 2019

Source: Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. Health Affairs, 38(2), 237-245; *Meeting of the Market Oversight and Transparency Committee, HPC, October 6, 2021* (see https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Challenges (2/2)

- Caps could impact ability and incentive to improve quality of services
  - No compelling evidence that increases in price lead to increases in quality
  - Oversight could enable price changes that don't increase TME
- Caps set in advance may not be optimal in light of current market developments, e.g. wage growth/workforce retention challenges
  - Need mechanism for short-term departures from target that reflect unexpected increases *or* decreases in costs
- Caps in Massachusetts could affect ability to recruit/retain top medical talent

Discussion

- Healthcare prices are wrong, and they're wrong in Massachusetts too
  - Market power is a key driver of price; curbing monopoly prices – with requirements the price cuts be passed through (perhaps by supplementing price level/growth caps with premium growth caps) – should help protect consumers
- In Massachusetts, key issue is place of service, so consider variants like tougher caps for outpatient hospital services (i.e., closer to site-neutral payments)
- Identifying and facilitating ways to take *out* costs is essential

2021

HEALTH CARE COST TRENDS HEARING

NEXT UP

WITNESS PANEL 1

MODERATOR:
COMMISSIONER MARTY COHEN, VICE CHAIR

MICHAEL DANDORPH, PRESIDENT AND CEO, WELLFORCE HEALTH SYSTEM

DR. ERIC DICKSON, PRESIDENT AND CEO, UMASS MEMORIAL HEALTH

ANDREW DREYFUS, PRESIDENT AND CEO, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

DR. ANNE KLIBANSKI, PRESIDENT AND CEO, MASS GENERAL BRIGHAM

DR. KEVIN TABB, PRESIDENT AND CEO, BETH ISRAEL LAHEY HEALTH

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WITNESS PANEL 2

MODERATOR:
COMMISSIONER BARBARA BLAKENEY

DR. CHARLES ANDERSON, PRESIDENT AND CEO, THE DIMOCK CENTER

ERIN FUSE BROWN, DIRECTOR OF THE CENTER FOR LAW, HEALTH & SOCIETY, GEORGIA STATE UNIVERSITY

AUDREY GASTEIER, CHIEF OF POLICY AND STRATEGY, MASSACHUSETTS HEALTH CONNECTOR

AMY ROSENTHAL, EXECUTIVE DIRECTOR, HEALTH CARE FOR ALL

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