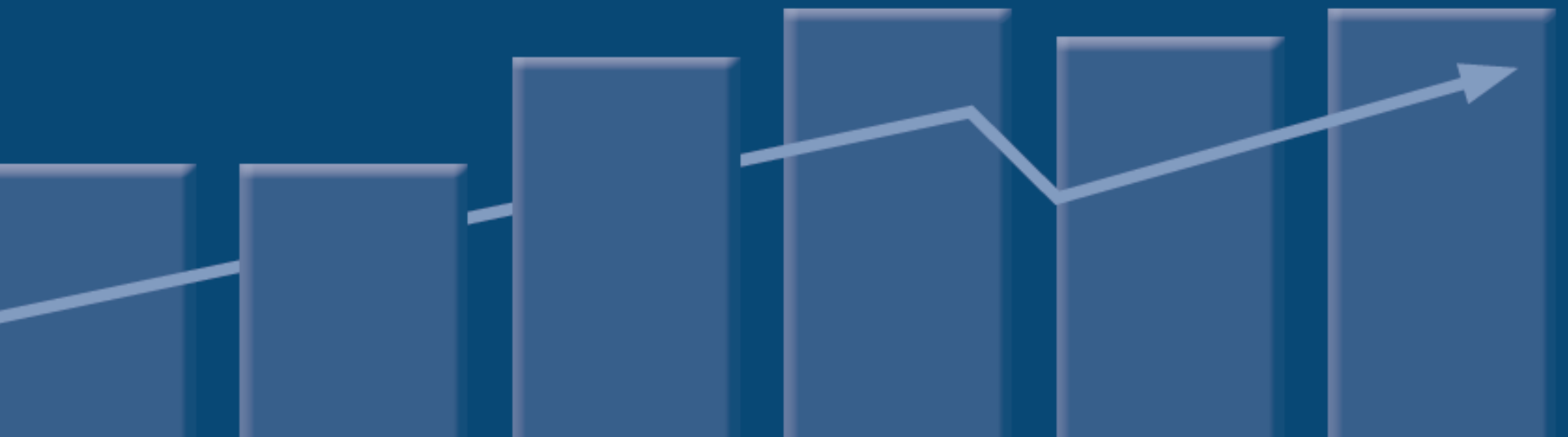
MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK



MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
- Presentation from Altarum Institute
- Public Testimony

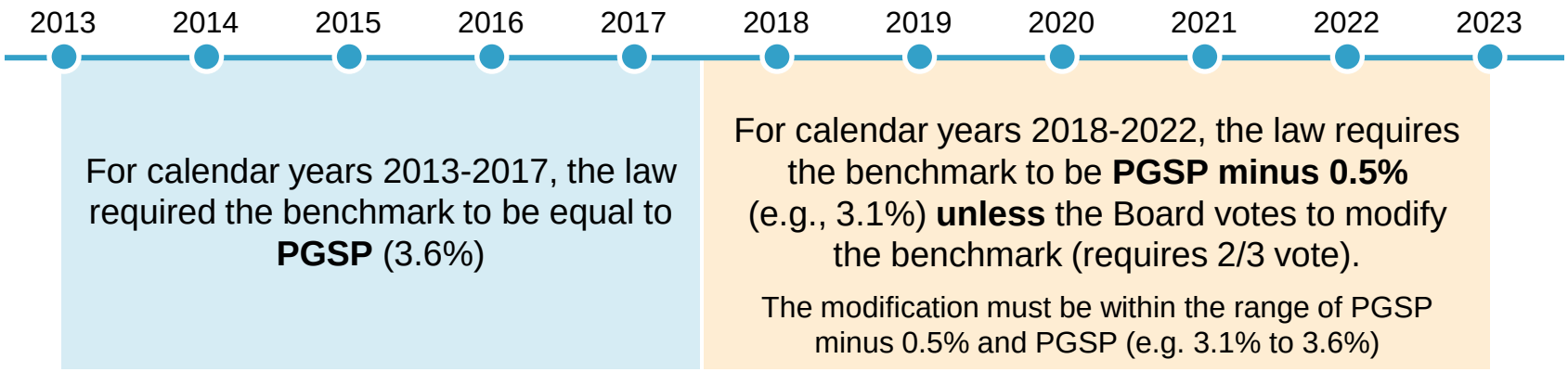
MASSACHUSETTS
HEALTH POLICY COMMISSION

- **Statutory Process and Proposed Factors**
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
- Presentation from Altarum Institute
- Public Testimony

Benchmark Modification Process Overview

- For the first time, in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for calendar year 2018)**, pursuant to a public hearing process and engagement with the Legislature.

- The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January 15 (when the PGSP is established in the consensus revenue process) and April 15.



Benchmark Modification Process – Key Steps

HPC Role

- HPC Board must hold a **public hearing** prior to making any modification of the benchmark
- Hearing must consider testimony, information, and data on whether modification of the benchmark is warranted:
  - **Data**: CHIA annual report, other CHIA data, or other data considered by the Board
  - **Information**: "health care provider, provider organization, and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system"
  - **Testimony**: representative sample of providers, provider organizations, payers and other parties determined by HPC
  - The Joint Committee on Health Care Financing may participate in the hearing
- Following a potential vote to modify, the HPC Board **must submit notice** of its intent to modify the benchmark to the Joint Committee

Legislative Process

- Joint Committee to hold a public hearing within 30 days of notice
- Joint Committee to submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing
- If the General Court does not act within 45 days of public hearing, the HPC Board's modification of the benchmark automatically takes effect

Factors to Consider in Determination of Whether an Adjustment is Reasonably Warranted

1. Massachusetts' performance to date
2. Impact of enrollment and demographic changes on performance
3. Financial impact of modifying the benchmark
4. Significant changes to the state or federal health care landscape
5. Role of the benchmark in the HPC's statutory responsibilities
6. Feedback from market participants and interested parties

Benchmark Modification Process

January 11, 2017

Board discussed process for potential modification of benchmark for calendar year 2018; Board authorized ED to submit notice of hearing on *potential* modification of benchmark to Joint Committee on Health Care Financing and schedule a hearing

January 15, 2017

3.6% PGSP established in consensus revenue process

February 8, 2017

Board discussed hearing agenda, factors to be considered in potential modification

March 8, 2017

Board hearing on potential modification of benchmark

March 29, 2017

Board votes whether to modify benchmark; if Board votes to modify, submit notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2017

Statutory deadline for Board to set benchmark

April 2017

Joint Committee holds a hearing within 30 days of notice

May 2017

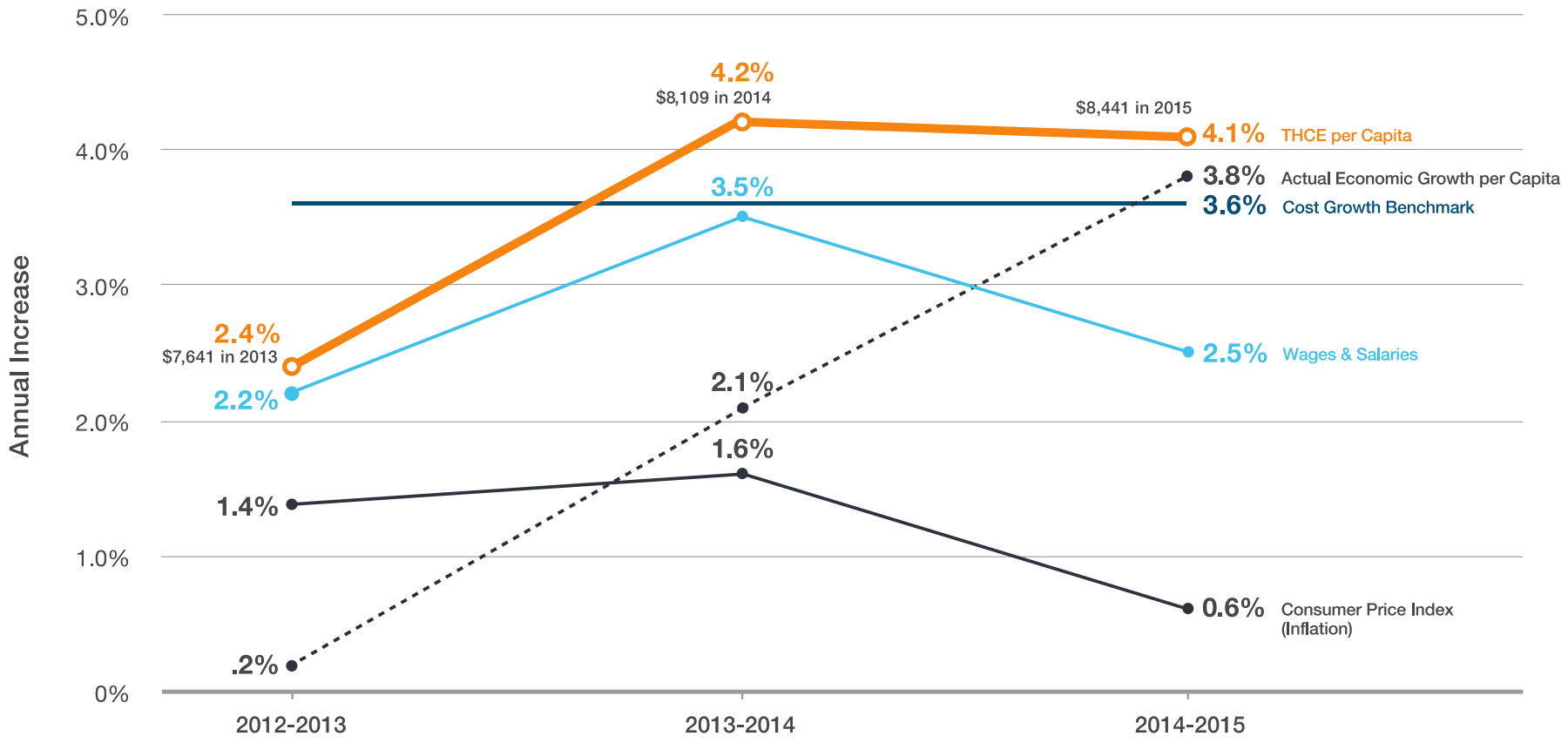
Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; legislature has 45 days from hearing to enact legislation which may establish benchmark; if not legislation, then Board vote to modify takes effect

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
  - **Massachusetts Health Care Spending Performance, 2013-2015**
- Presentation from the Health Policy Commission
- Presentation from Altarum Institute
- Public Testimony

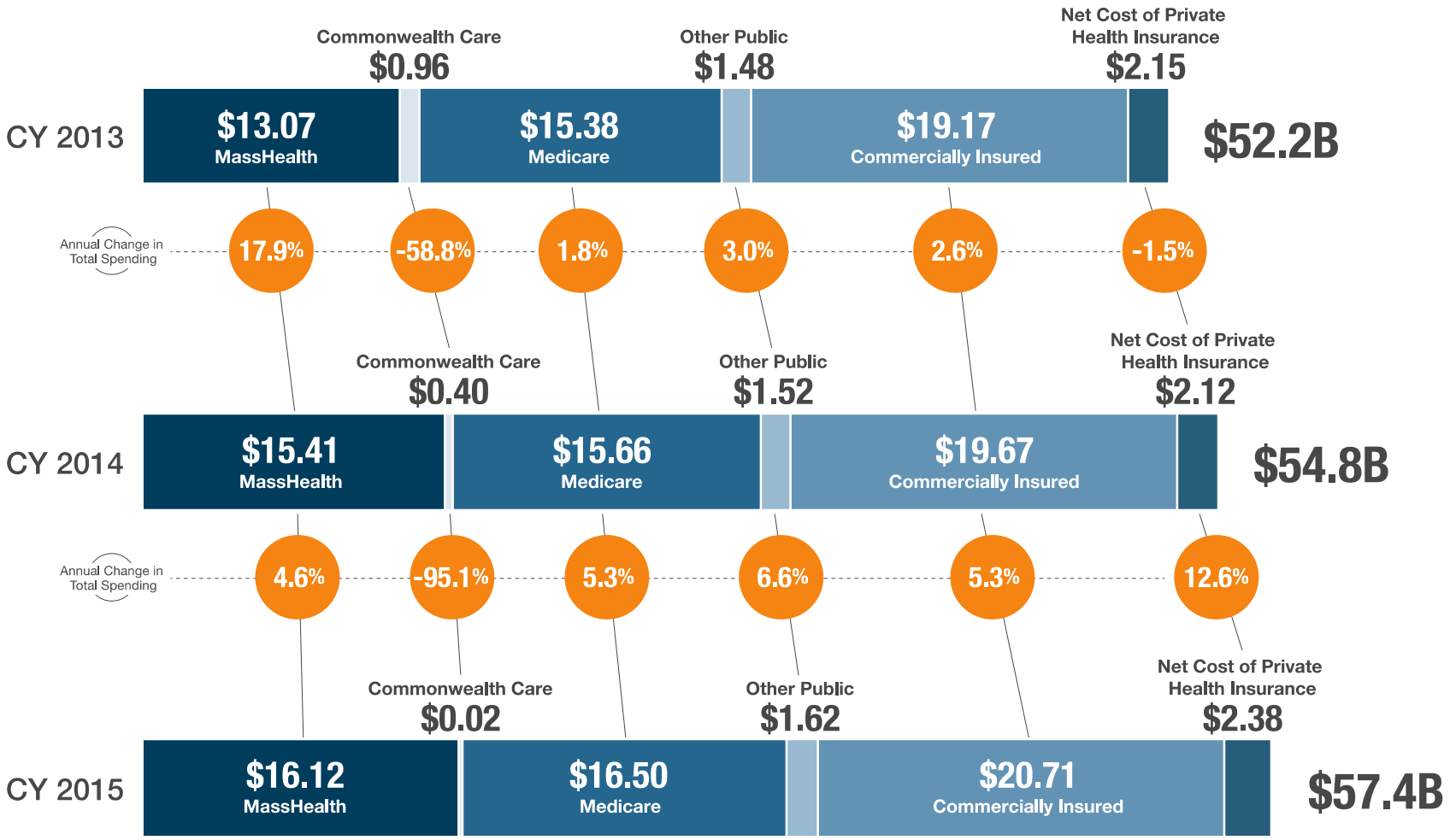
Total Health Care Expenditure Growth in the Commonwealth, 2012-2015



Note: Actual Economic Growth was computed as the sum of real GDP per capita for Massachusetts, as reported by the Bureau of Economic Analysis, and the consumer price index for the Boston-Brockton-Nashua area, as reported by the Bureau of Labor Statistics. This methodology reflects the Commonwealth's Executive Office for Administration and Finance's actual economic growth calculation pursuant to 7H 1/2 (c) of M.G.L. Ch. 29.
Sources: THCE: Payer reported data to CHIA and other public sources; Cost Growth Benchmark: Health Policy Commission; Gross State Product: U.S. Bureau of Economic Analysis; Consumer Price Index: Bureau of Labor Statistics; Wages and Salaries: Bureau of Labor Statistics.

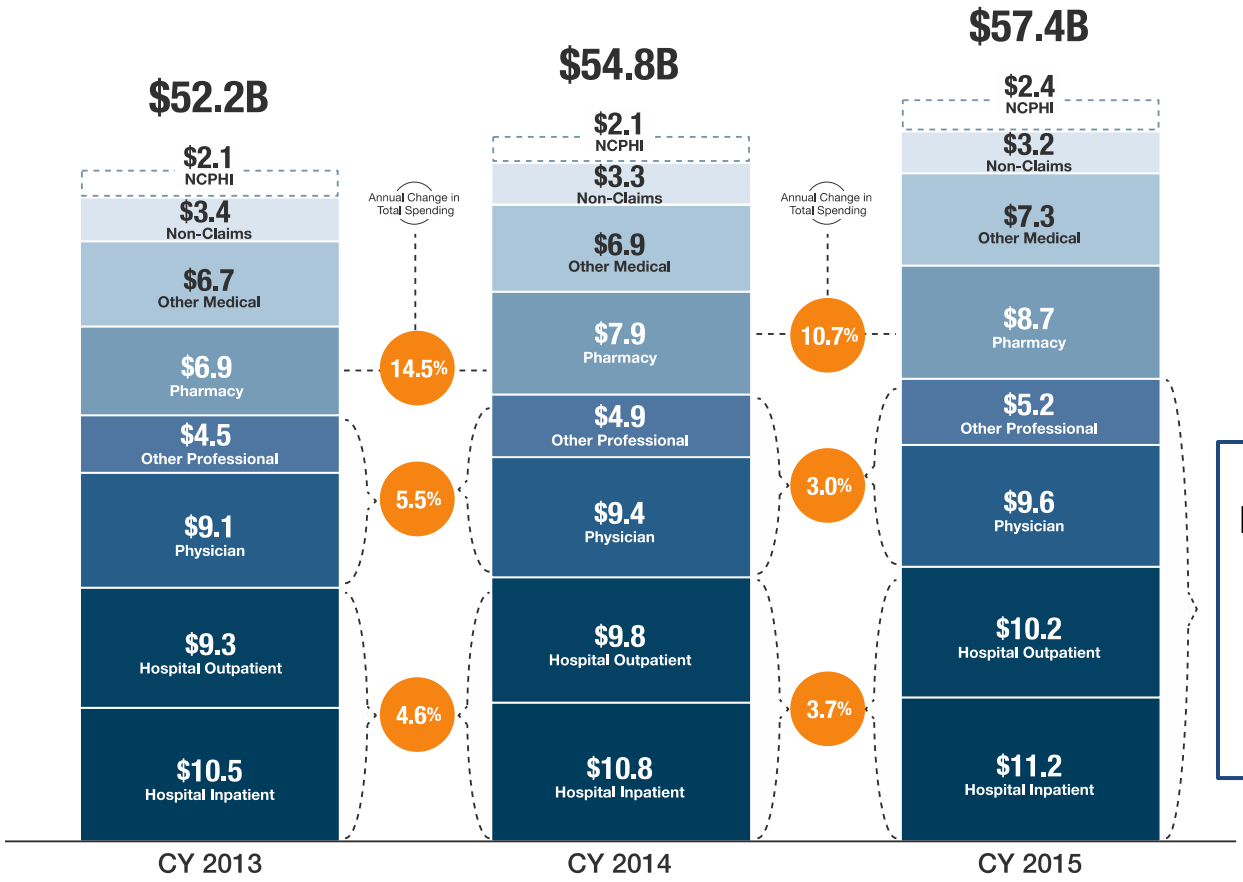
CHIA.

Total Health Care Expenditures by Coverage Type, 2013-2015



Note: All dollar amounts are in billions.
Source: Payer reported data to CHIA and other public sources.

Total Health Care Expenditures in the Commonwealth, by Service Category, 2013-2015



Between 2013 and 2015, health care spending grew by $5.2 billion, of which 55% ($2.9B) was attributable to hospital and professional spending.*

Notes: All dollar amounts are in billions. This data includes spending for commercially-insured, MassHealth (MCO, PCC, FFS), Medicare (Parts A, B, C and D), and Commonwealth Care. Because service category level data was not available for SCO, PACE, Veteran Affairs, the Health Safety Net, or non-TME filers (totaling $3.8 billion in 2015), expenditures for these programs were allocated to each service category in accordance with the existing proportion of total expenditures. Pharmacy expenditures do not account for pharmaceutical rebates. Due to rounding components may not sum to total. *This excludes the net cost of private health insurance (NCPHI).

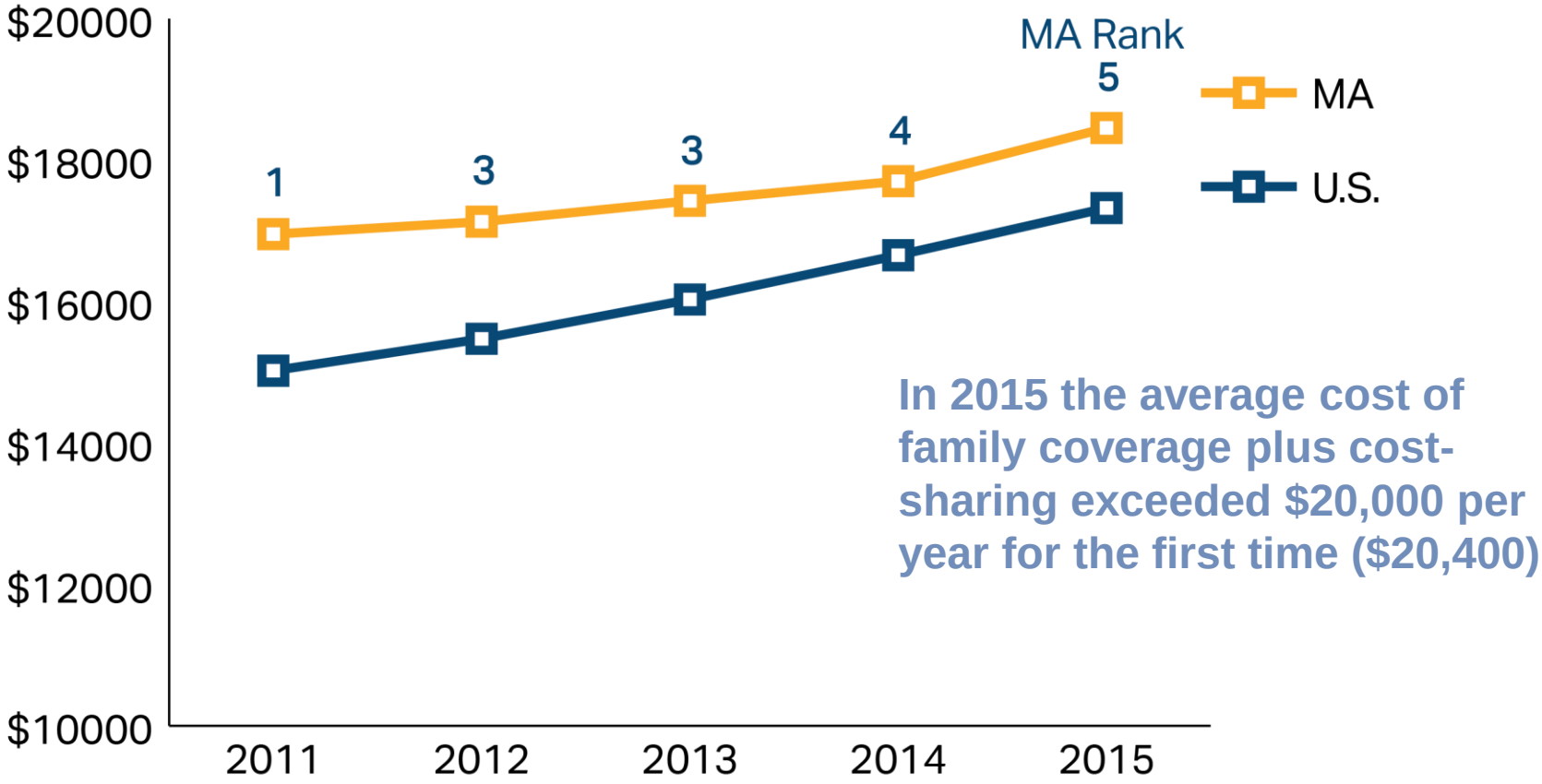
CHIA.

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
  - **Select Findings from the 2016 Cost Trends Report**
  - Impact of Aging Population
  - Opportunities for Improvement
- Presentation from Altarum Institute
- Public Testimony

Massachusetts residents pay among the highest health insurance premiums in the US

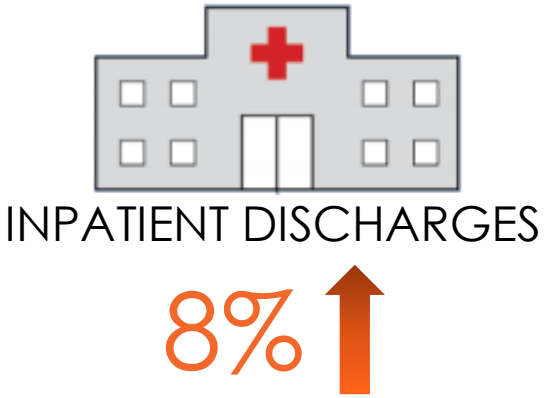
Annual premium for employer-based family health insurance, $

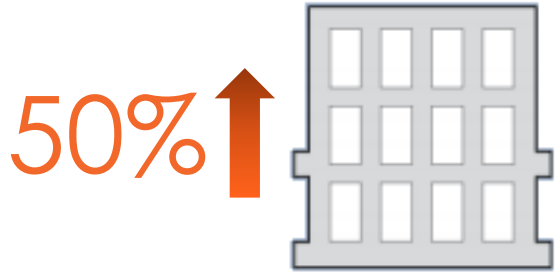


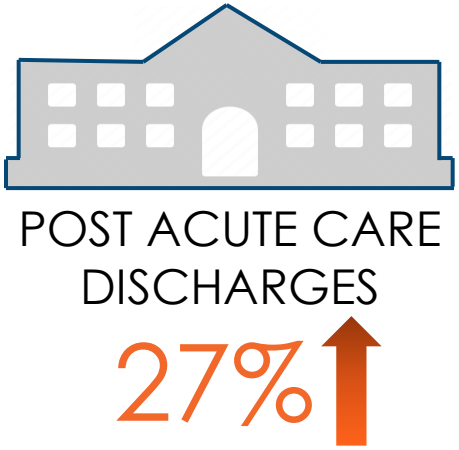
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component

Massachusetts uses high-cost settings of care to a much greater degree than the U.S., including hospital outpatient utilization that is 50% above the national average

Hospital use in MA and U.S., per 1,000 population, 2014; Discharge destination following an inpatient admission, by payer, 2013



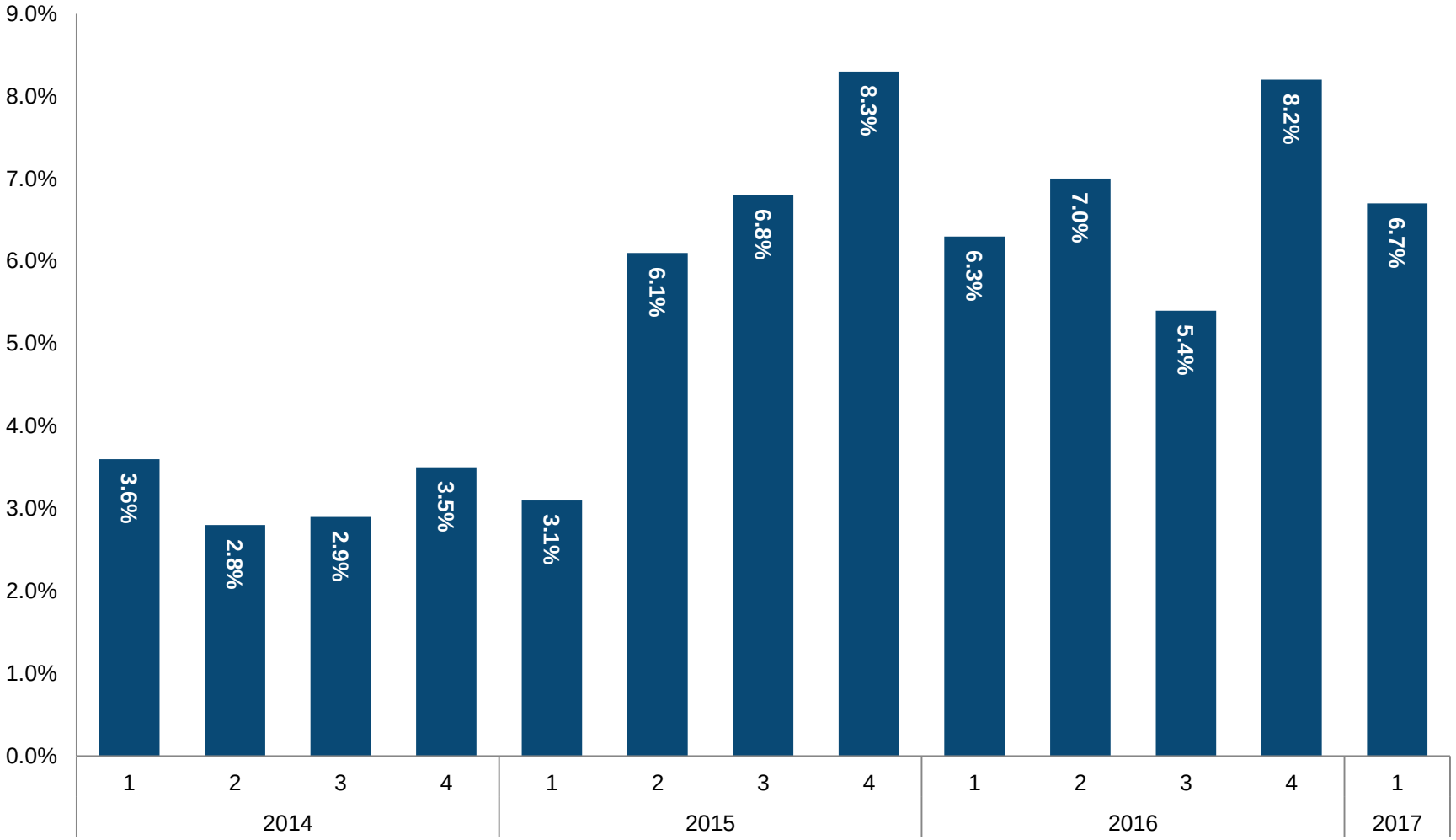




Source: HPC, Kaiser Family Foundation analysis of American Hospital Association data, 2014, Healthcare Cost and Utilization Project data, 2013; PAC=post-acute care. Institutional includes skilled nursing facilities, short-term hospitals, intermediate care facilities (ICF), and another type of facility.

Over the last 8 quarters, average merged market health insurance rates have increased 5.4-8.3%

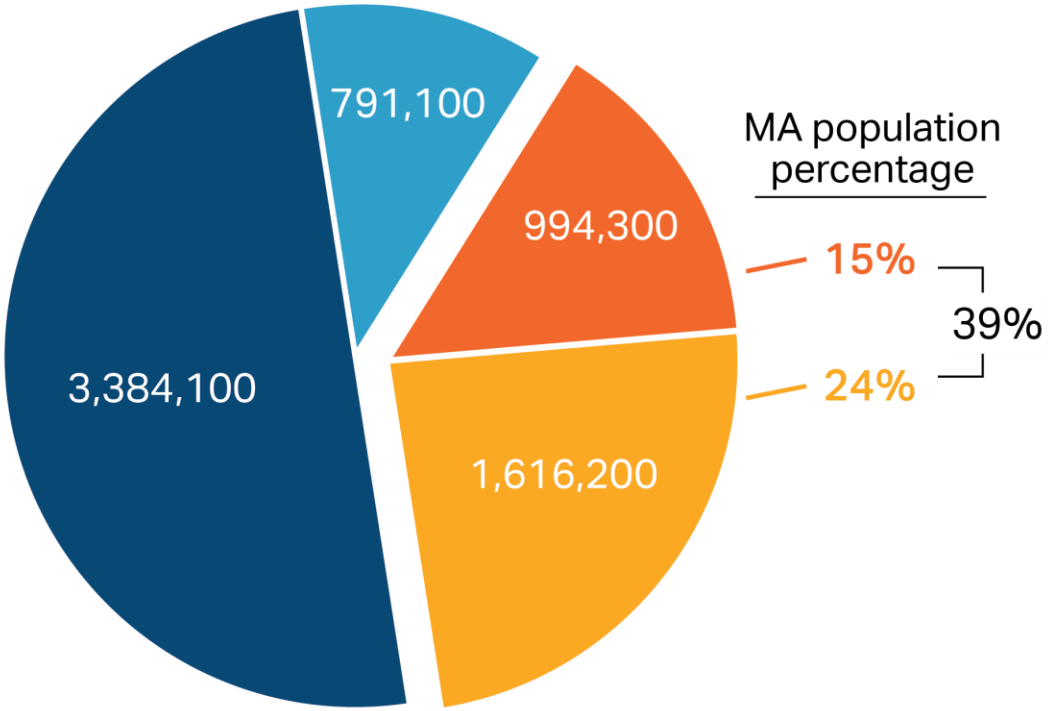
Weighted average annual rate increase for insurance products (merged market)



Source: DOI

Massachusetts has a considerable portion of residents at low to middle income levels, and ranks among the highest states in income inequality

Number of state residents at each household income level, 2015



MA RANK

6TH

HIGHEST INCOME INEQUALITY

Under 100% FPL (less than $20,000)

100-199% FPL ($20,000 - $40,000)

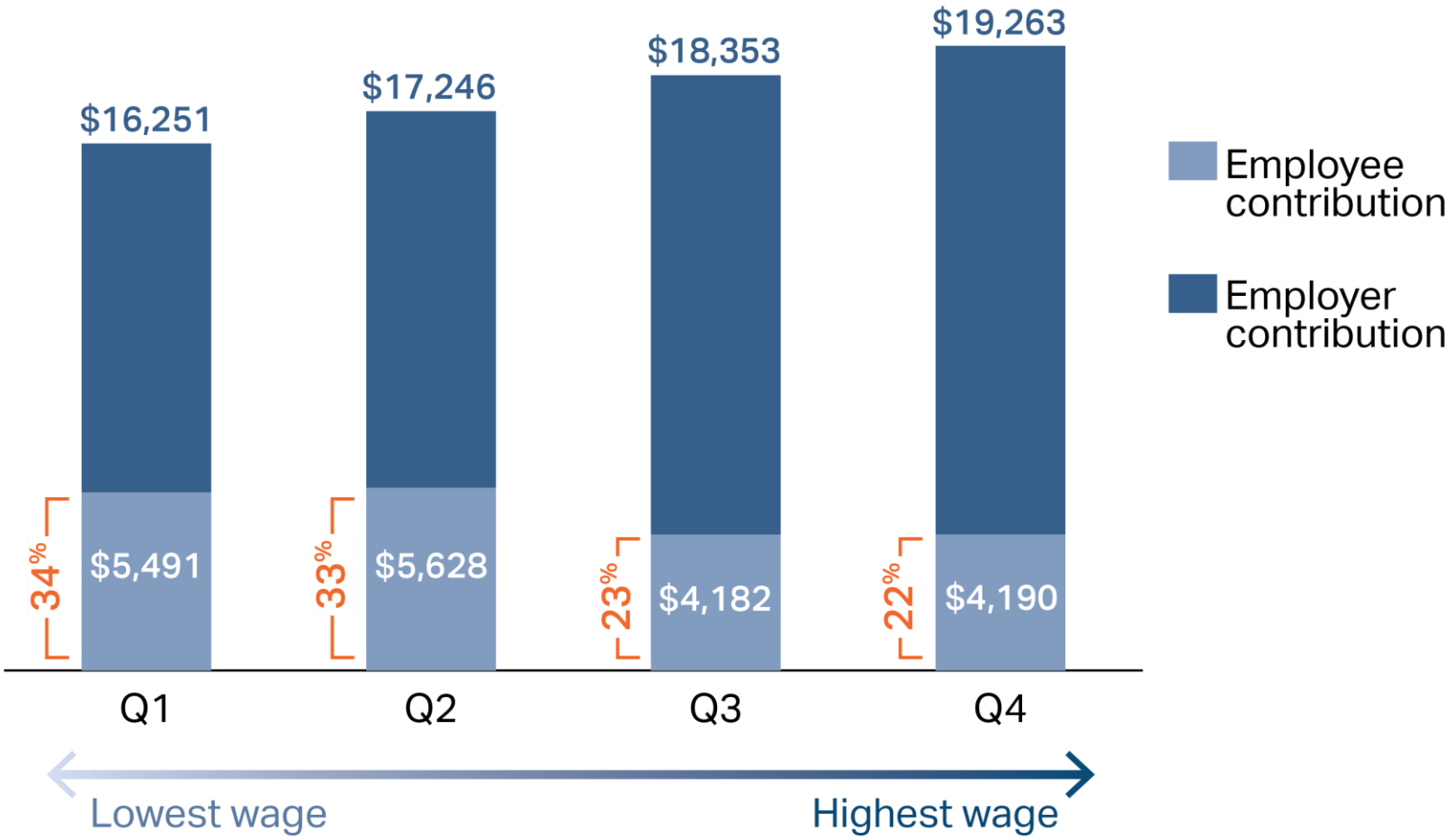
200-399% FPL ($40,000 - $80,000)

400%+ FPL ($80,000+)

Note: Dollar values are for a family of two adults and one child.
Source: Current Population Survey as reported by Kaiser Family Foundation; Posey KB. American Community Survey Briefs, Household Income: 2015. United States Census Bureau. 2016 Sep.

On average, employees of lower wage employers contribute both a greater share *and* total dollar amount to the cost of their health insurance compared to employees of higher wage employers

Average family premiums and employee contributions, by wage quartile, 2015

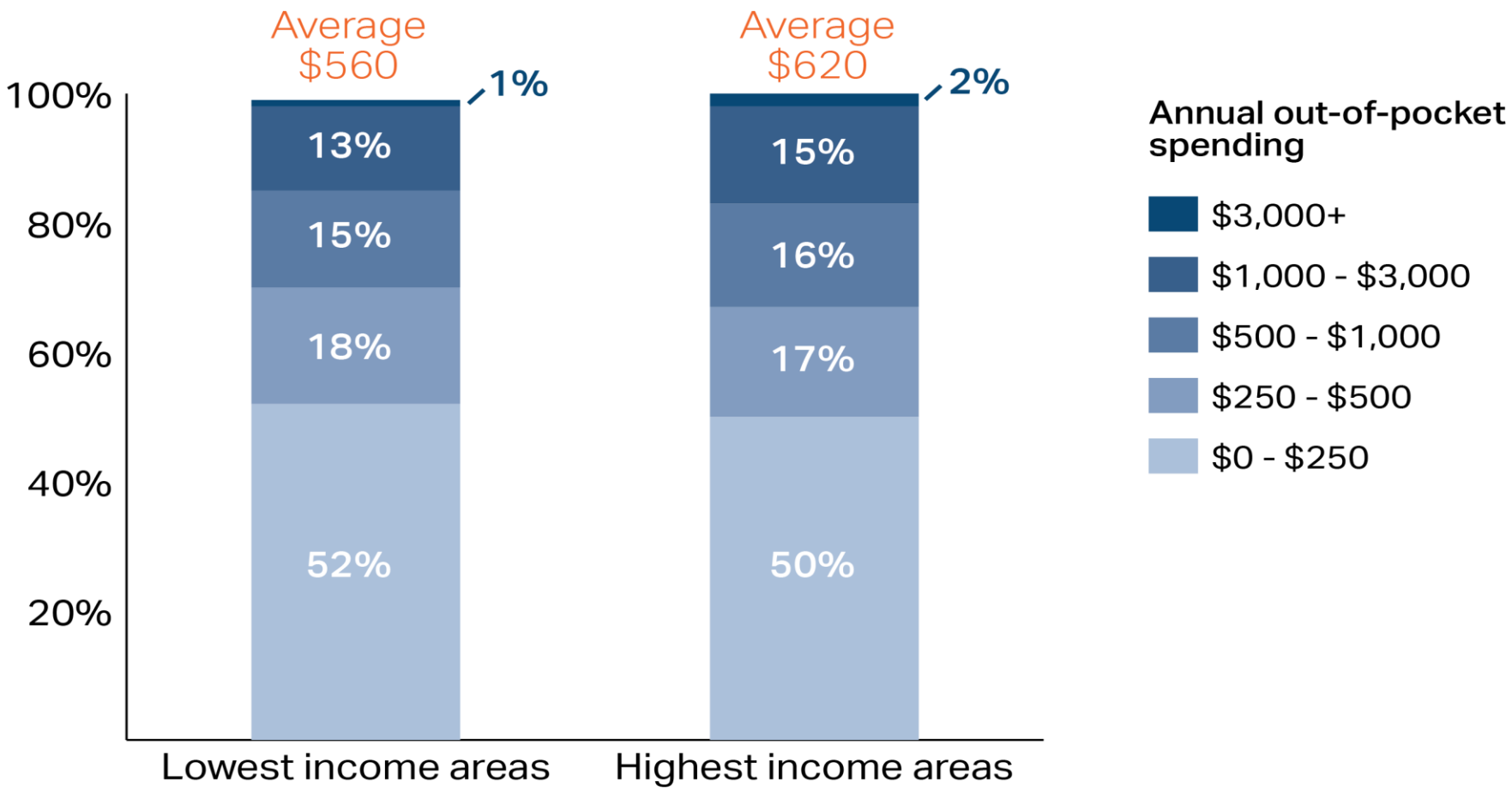


Average premium plus typical cost sharing was **$20,400** in 2015 while the average wage was **$64,116**

Source: Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015; Executive Office of Labor and Workforce Development 2015 Massachusetts Workforce and Labor Area Review

Residents in low and high income areas face similar out-of-pocket healthcare costs

Percent of residents, by annual out-of-pocket spending, 2014



Notes: Spending includes only out-of-pocket spending within insurance benefits (e.g. copays and deductibles) and is conditional on having non-zero spending. Lowest income areas represent the quartile of zip codes in the state with the lowest household median income. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care. Data do not include spending outside of health insurance such as dental care, over-the-counter medications, or privately-paid mental health visits.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2014

Since 2013, out-of-pocket costs have increased by ~10-12%, driven in part by increased enrollment in high-deductible health plans

OUT-OF-POCKET COSTS

2013-2015

6% ↑ in deductible levels for single coverage, to an annual average of $1,202 per member

10% ↑ in total cost-sharing for small employer groups, to an annual average of $737 per member

12% ↑ in total cost-sharing for large employer groups, to an annual average of $582 per member

HIGH DEDUCTIBLE HEALTH PLANS

2013-2015

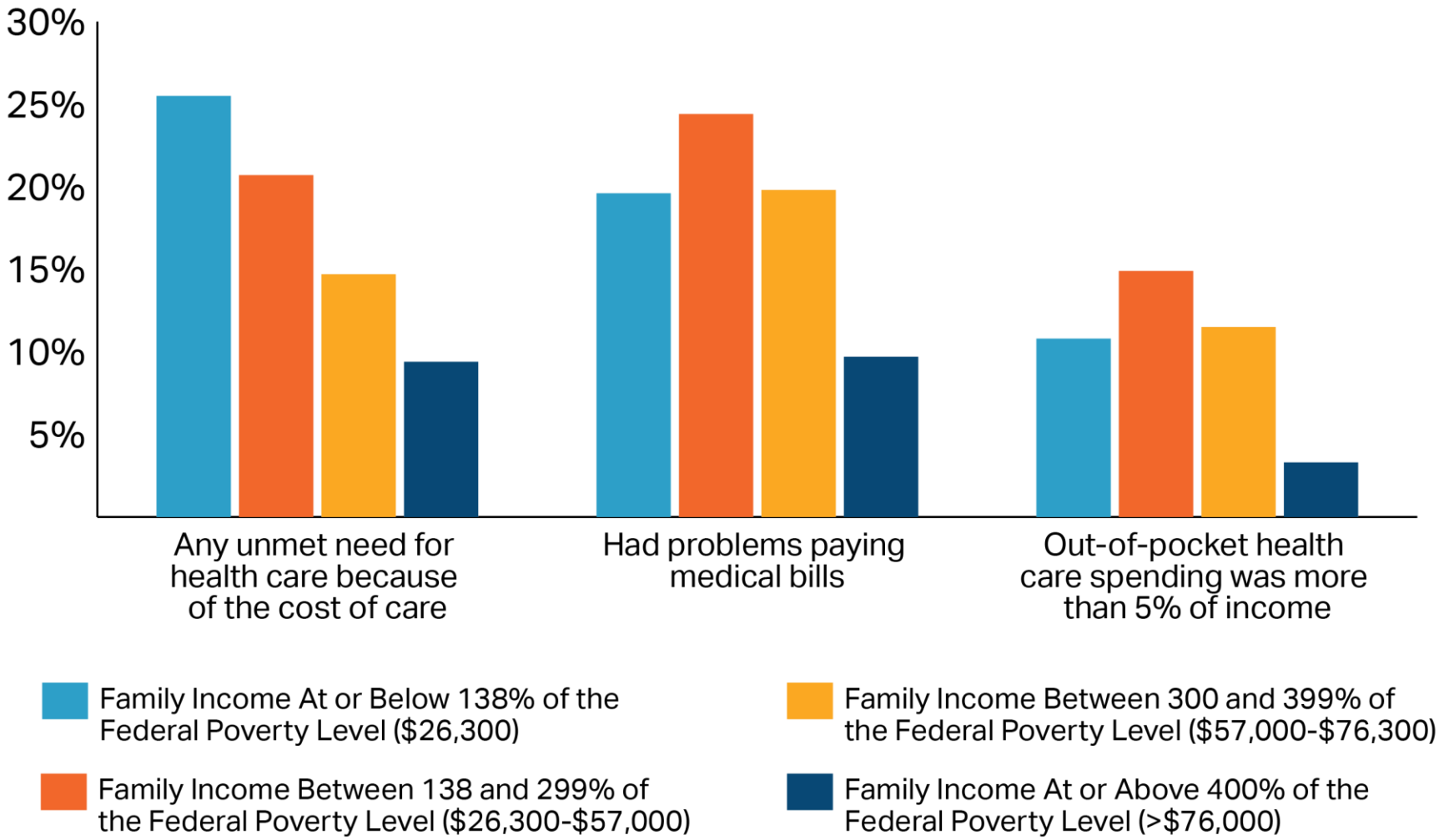
39% ↑ in the number of people covered by HDHPs, with 21.1% of commercial lives enrolled

HPC

* High Deductible Health Plan, defined as individual deductible >$1250 in 2013, >1300 in 2015. Deductible levels are for individuals with any deductible
Source: CHIA, Agency for Healthcare Research and Quality.

Overall affordability of health care continues to be a challenge for many in Massachusetts

Percent of respondents saying they experienced the following in the past 12 months, by income



Source: Center for Health Information and Analysis, Massachusetts Health Interview Survey, 2015. Income ranges shown are for a family of two adults and one child. Out of pocket spending includes all health care spending including for non-covered services

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
  - Select Findings from the 2016 Cost Trends Report
  - **Impact of Aging Population**
  - Opportunities for Improvement
- Presentation from Altarum Institute
- Public Testimony

Population aging

The Massachusetts population is aging

	2011	2015	2019
Average age	38.8 years	39.4 years	40.2 years
% of state residents 65+	13.9%	15.4%	17.0%

Older residents have higher spending

Age	0-18	19-44	45-64	65-84	85+
Average PMPY spending	$3,394	$4,260	$9,091	$16,123	$30,972

Relative population aging contributes consistently to THCE per capita growth

	2012-2015	2016-2019
THCE growth per year due to relative aging	+0.5%	+0.6%

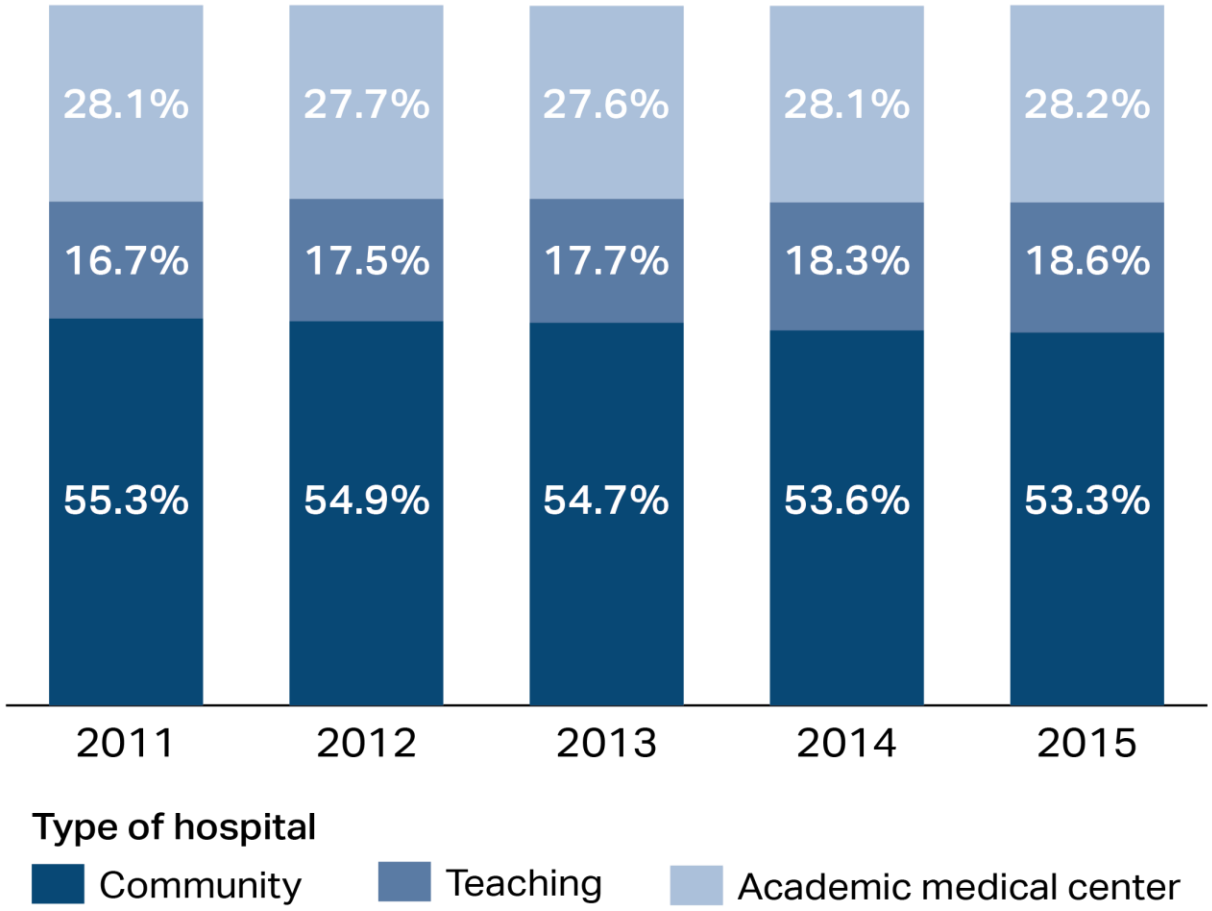
Notes: Resident spending by age bracket are national CMS estimates.

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
  - Select Findings from the 2016 Cost Trends Report
  - Impact of Aging Population
  - **Opportunities for Improvement**
- Presentation from Altarum Institute
- Public Testimony

Inpatient care that could safely and effectively be provided in community hospitals is increasingly being provided by teaching hospitals

Share of community appropriate discharges, by hospital type, 2011-2015

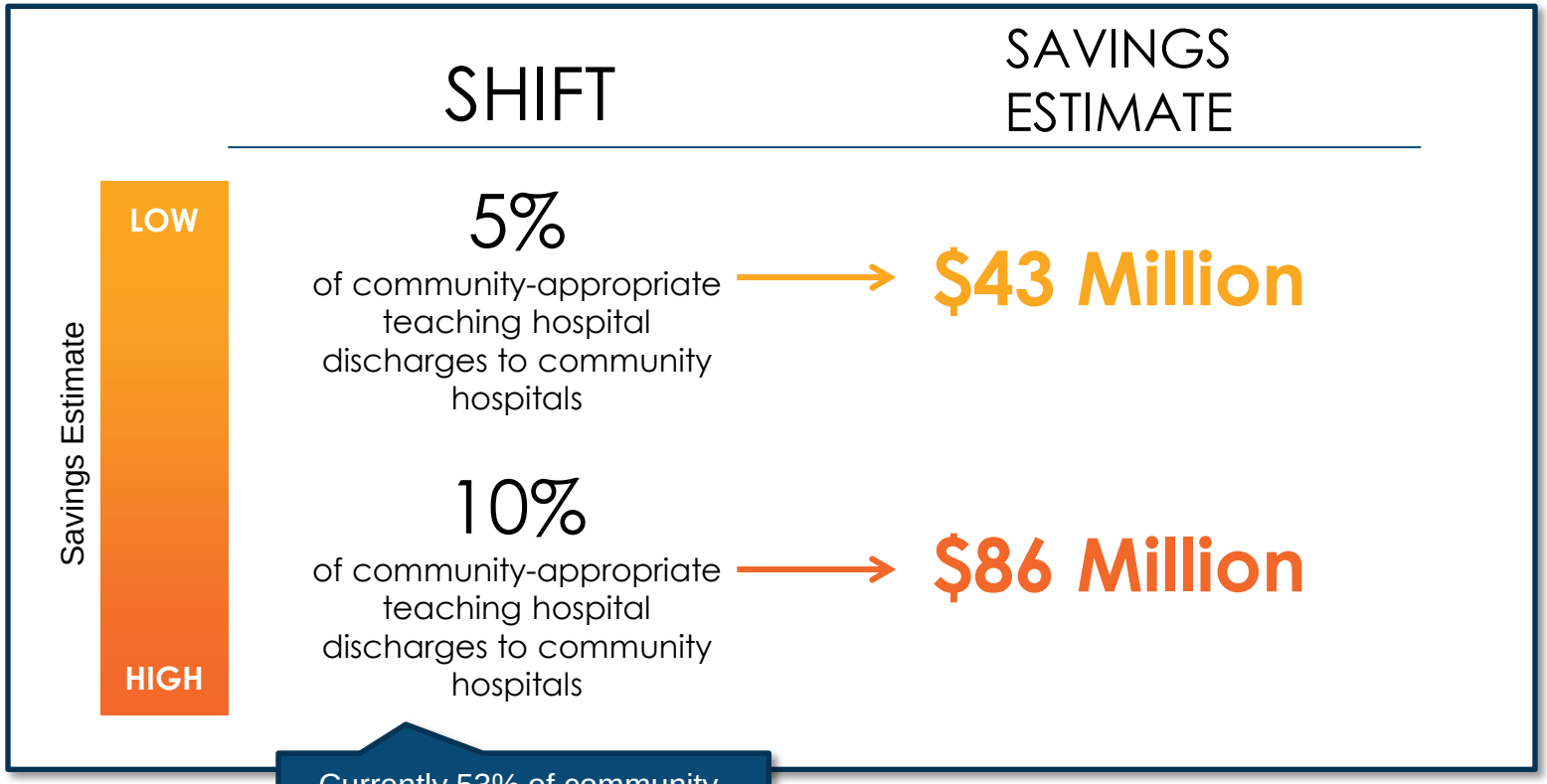


Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis (CHIA) defines community hospitals as general acute care hospitals that do not support large teaching and research programs. Teaching hospitals are defined as hospitals that report at least 25 full-time equivalent medical school residents per one hundred inpatient beds in accordance with Medicare Payment Advisory Commission (MedPAC) guidelines. Academic medical centers are a subset of teaching hospitals characterized by (1) extensive research and teaching programs, (2) extensive resources for tertiary and quaternary care, (3) principal teaching hospitals for their respective medical schools, and (4) full service hospitals with case mix intensity greater than 5 percent above the statewide average.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

HPC

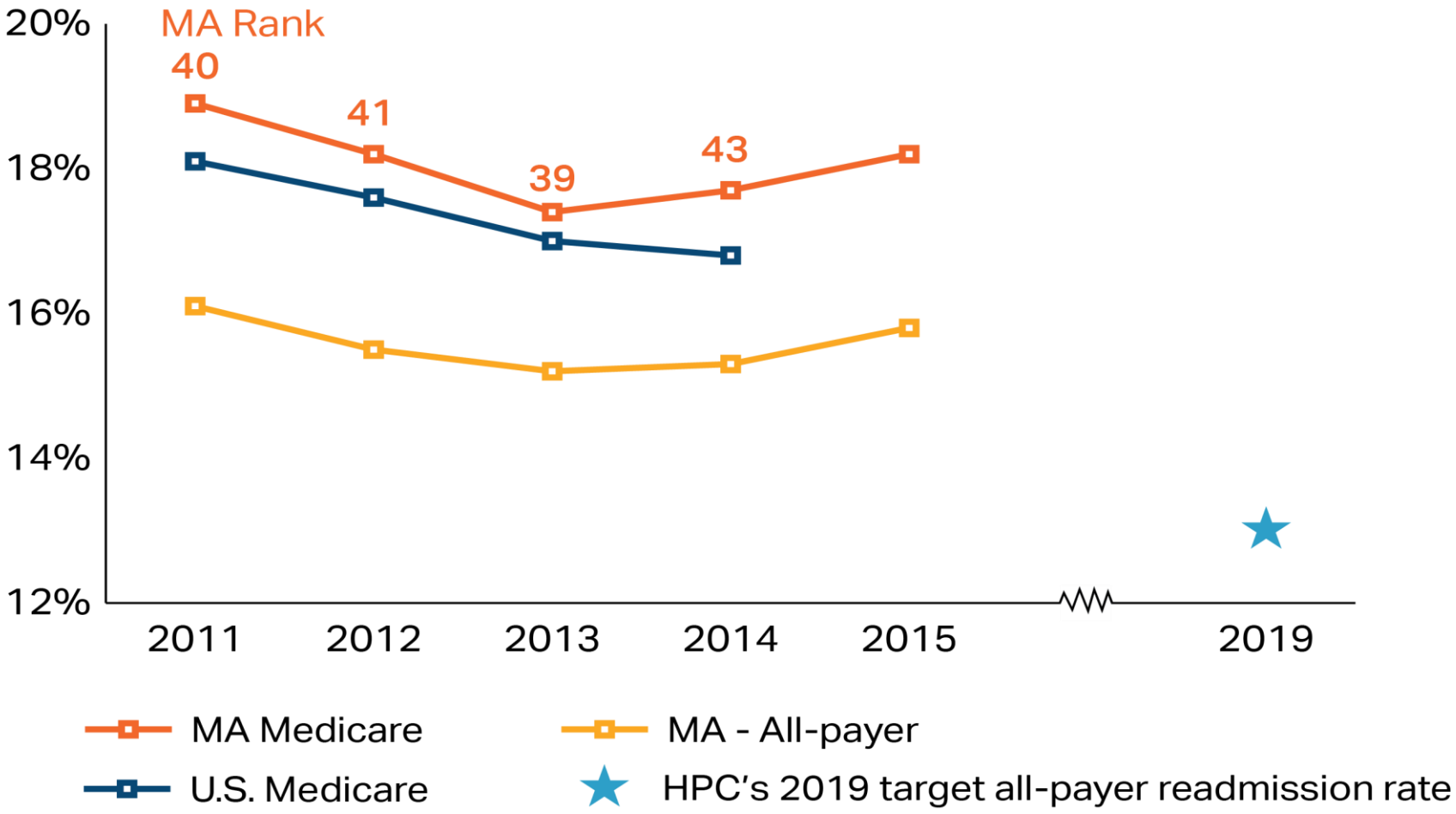
Cost estimate I. Shift community-appropriate inpatient care to community hospitals

Cost Trends Report, Recommendation 6:
The Commonwealth, payers, and providers should work to redirect community-appropriate inpatient care to high value, community settings.



Massachusetts hospital readmissions began increasing in 2014 after a sustained decline

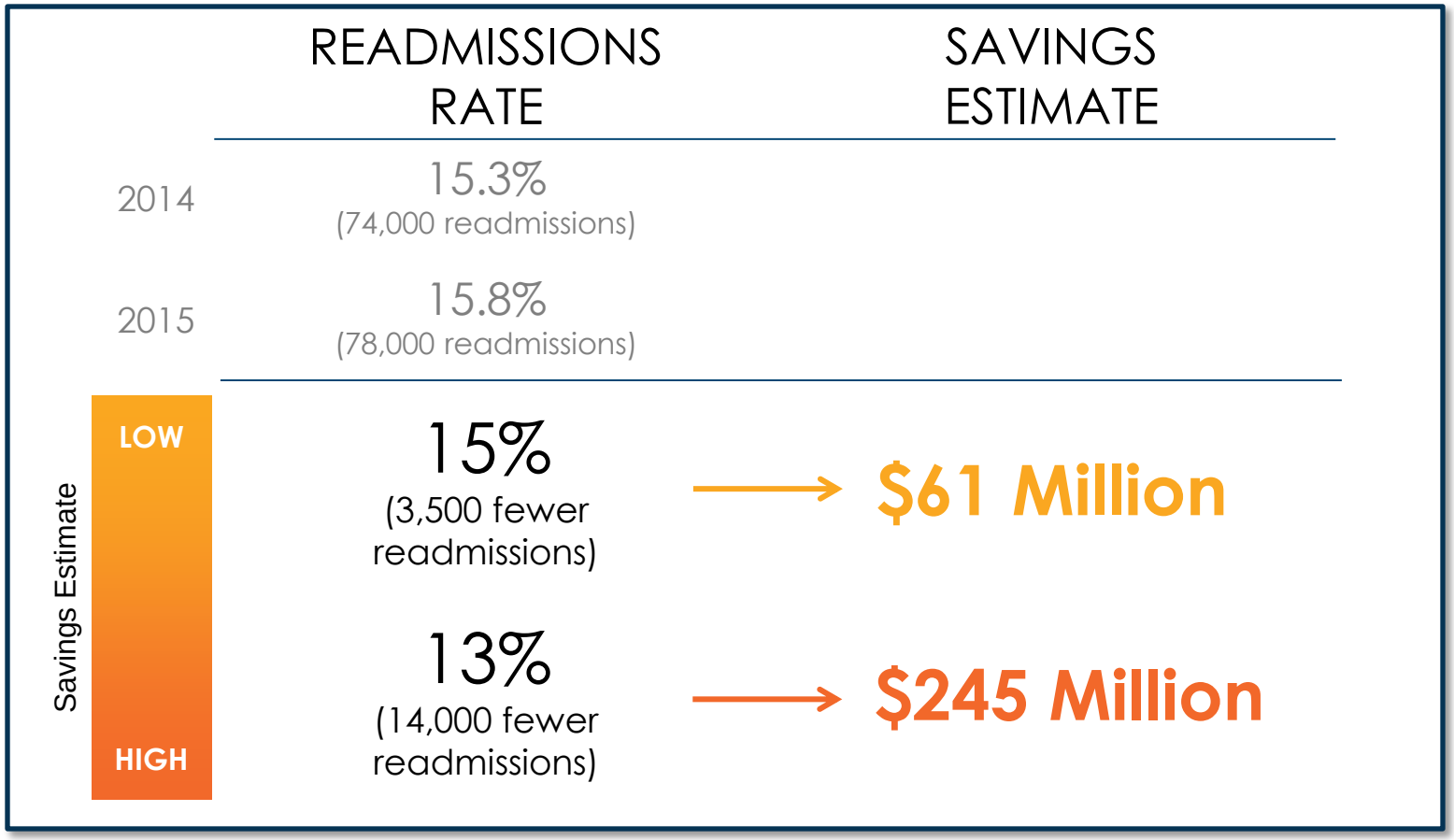
Thirty-day readmission rate, by payer, MA and the U.S., 2011-2014



Sources: Centers for Medicare and Medicaid Services (U.S. Medicare and MA Medicare 2011-2013); Center for Health Information and Analysis (all-payer and MA Medicare 2014-2015)

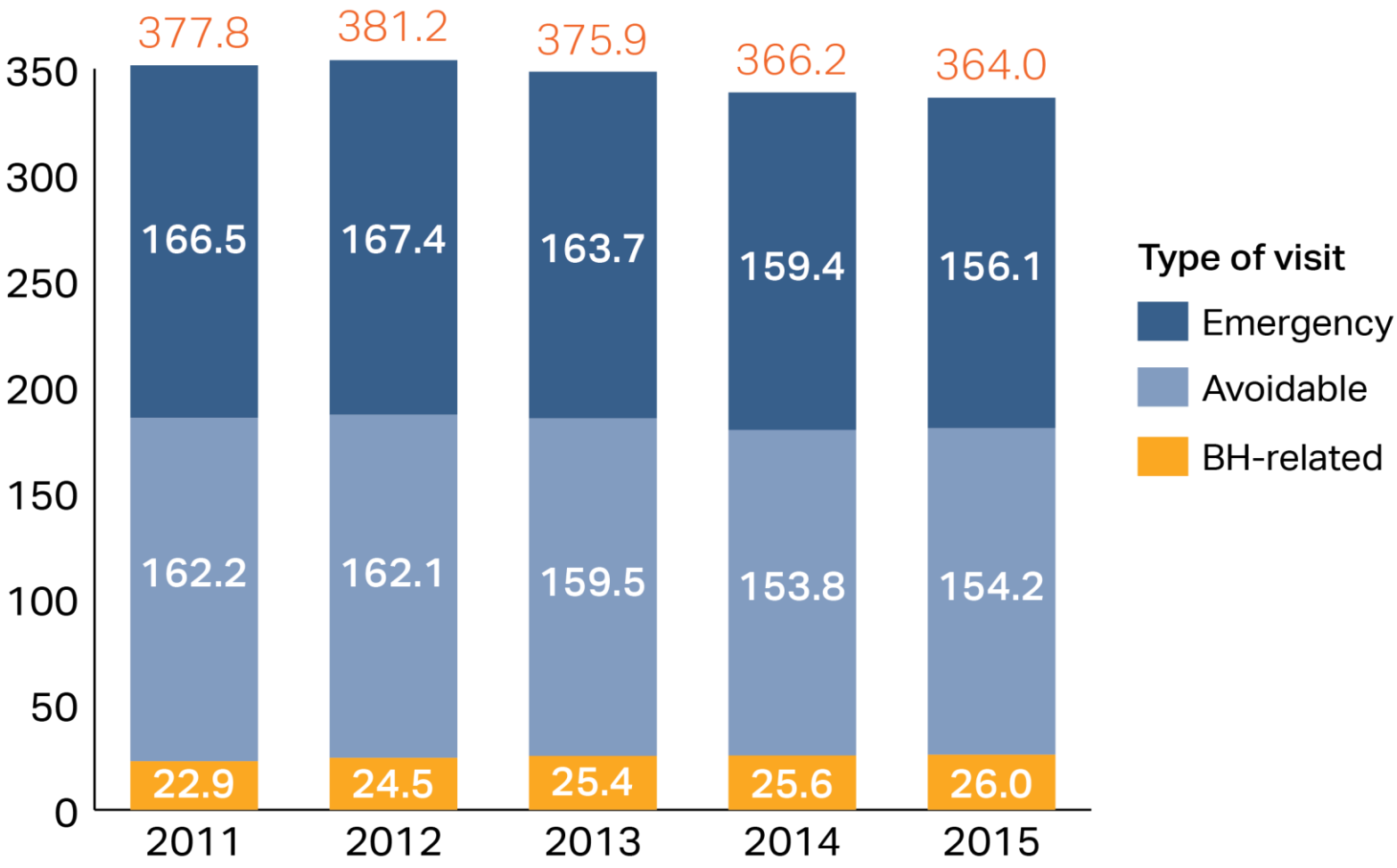
Cost estimate II: Reduce hospital readmissions

Cost Trends Report, Recommendation 7a:
The Commonwealth should achieve a 20 percent reduction in all-cause, all-payer 30-day hospital readmissions relative to the 2013 level, attaining an all-payer **readmission rate below 13 percent by 2019**.



Avoidable ED visits account for over 40% of total ED visits

ED visits by category, per 1,000 population, 2011-2015

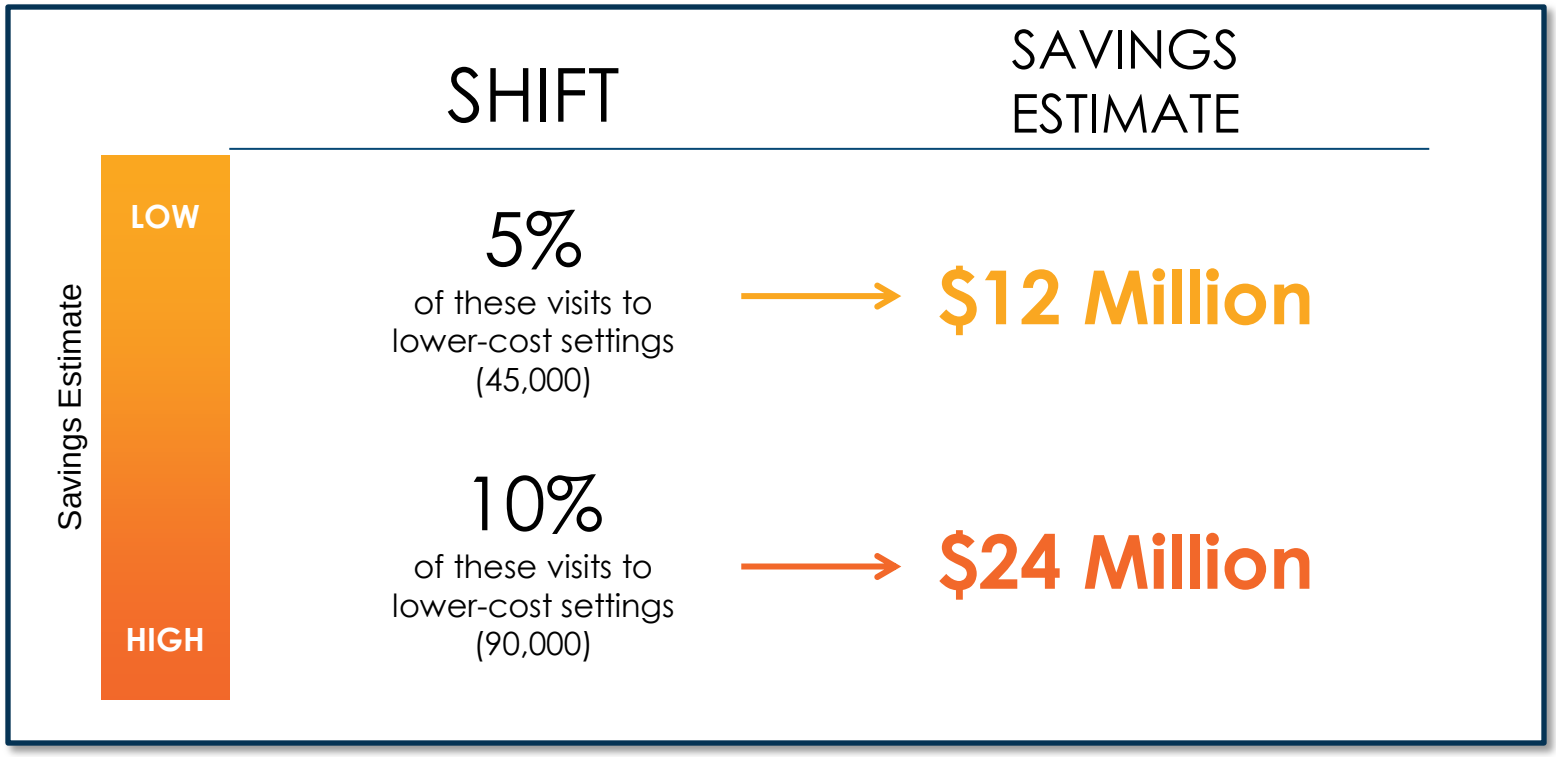


Notes: ED= emergency department; BH= behavioral health. Definition of ED categories based on NYU Billings Algorithm categorization of a patient's primary diagnosis and are mutually exclusive. BH ED visits includes any discharge with a primary mental health, substance use disorder, or alcohol-related diagnosis code. Emergency visits include the Billings categories of emergency and emergent, ED care preventable; avoidable visits include the Billings categories of non-emergent and emergent, primary care treatable. One category, unclassified visits, also grew during this time period, but is not shown here. Some non-Massachusetts residents are included in the number of ED visits. In 2015, 4% of all ED visits in Massachusetts were made by non-Massachusetts residents.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

HPC

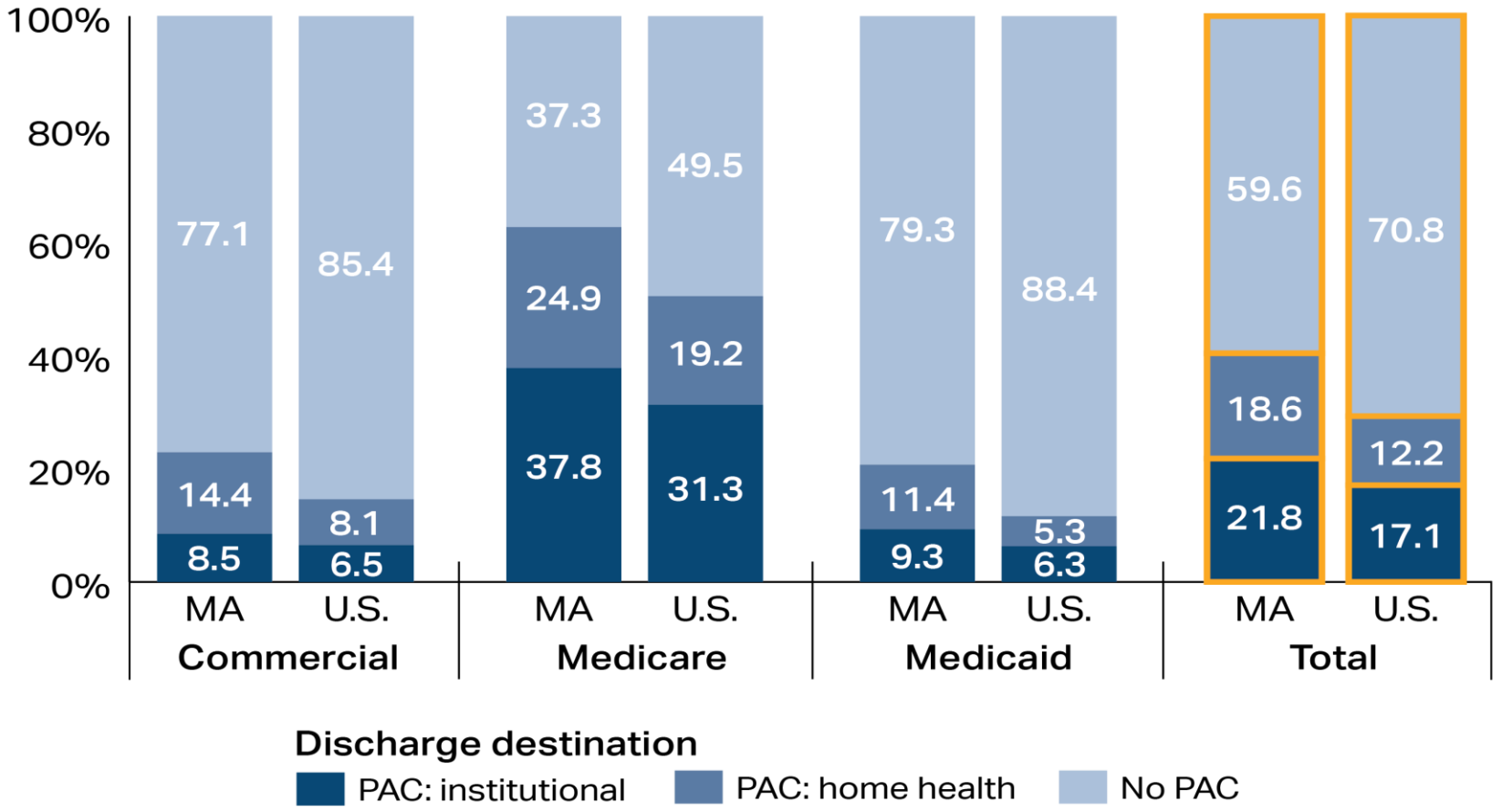
Cost estimate III. Reduce avoidable ED visits

Cost Trends Report, Recommendation 7:
The Commonwealth should continue to focus on strengthening partnerships between the health care delivery system and community-based organizations in order to reduce the unnecessary hospital use and other institutional care.



Massachusetts has a higher rate of discharge to institutional PAC than the U.S. average

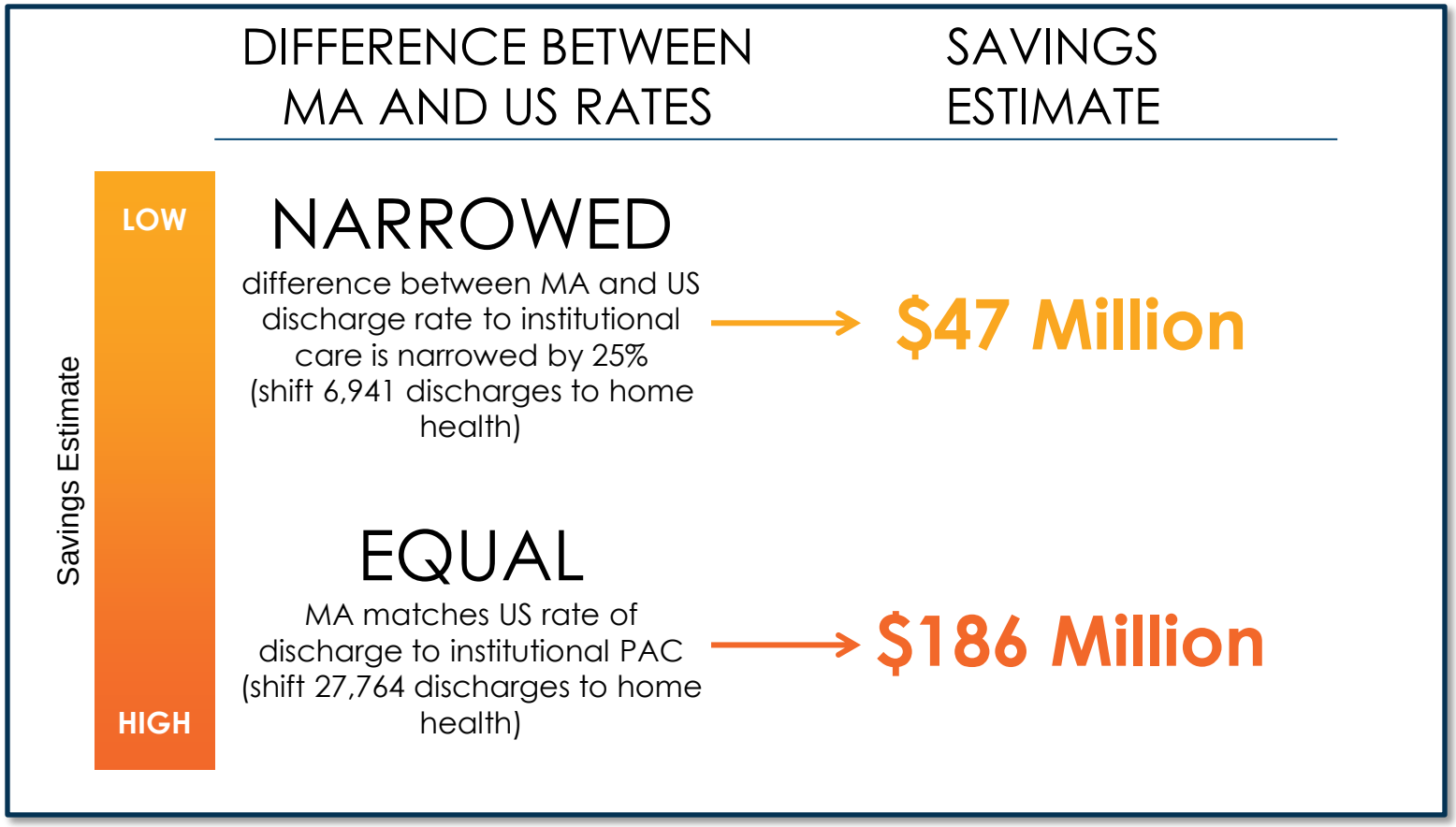
Discharge destination following an inpatient admission, by payer, 2013



Notes: PAC=post-acute care. Institutional includes skilled nursing facilities, short-term hospitals, intermediate care facilities (ICF), and another type of facility.
Sources: HPC analysis of Healthcare Cost and Utilization Project (HCUP) Massachusetts State Inpatient Database & Nationwide Inpatient Sample Survey, 2013

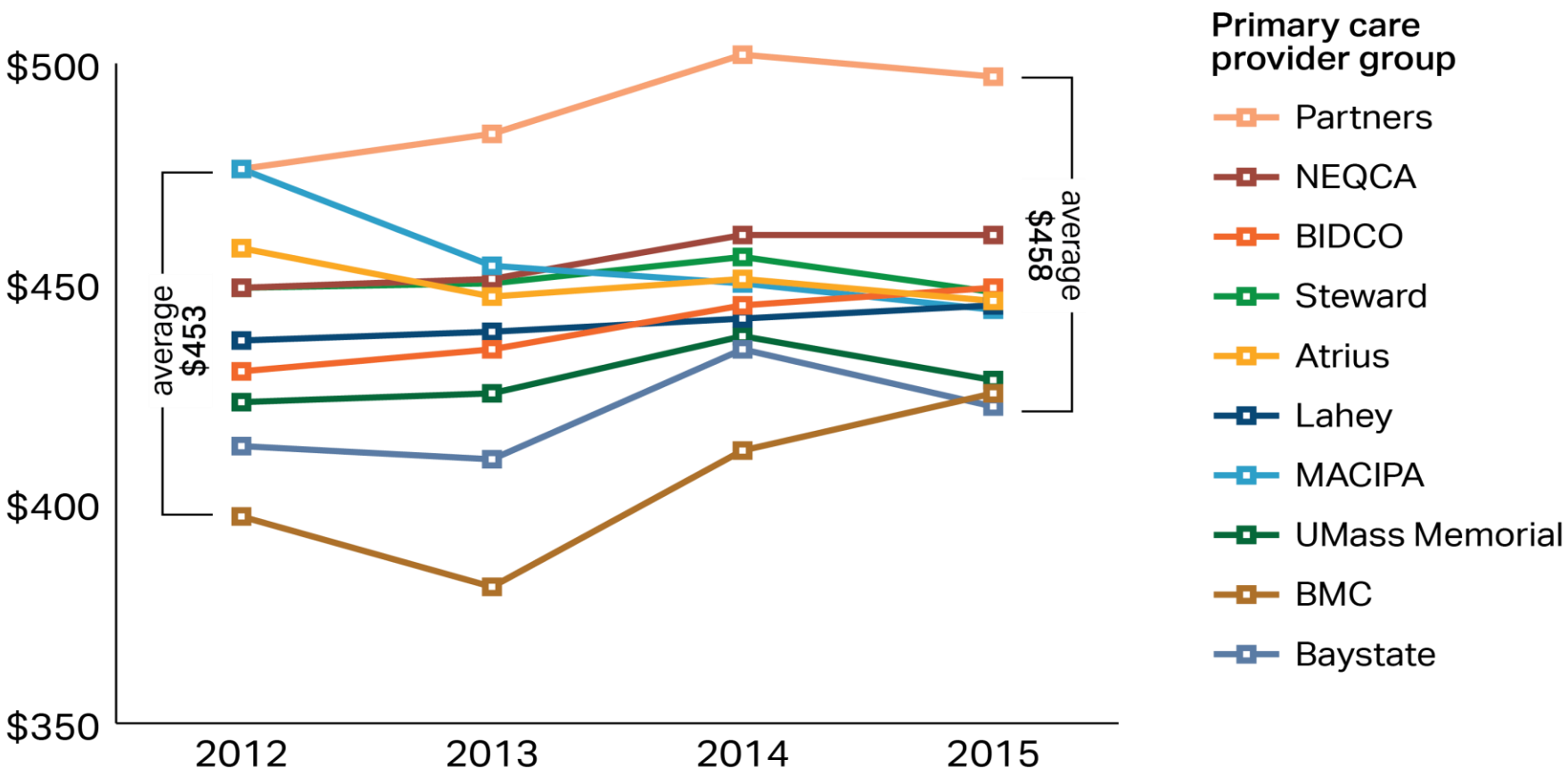
Cost estimate IV. Reduce use of institutional Post-Acute Care (PAC)

Cost Trends Report, Recommendation 7c:
The Commonwealth should achieve a 5 percentage point reduction in the rate of discharge to institutional post-acute care to meet the national average (22% in MA, 17% national) by 2020.



TME by PCP group has converged somewhat over time, with the exception of Partners

Blended health status adjusted TME, per member per month, 2012-2015

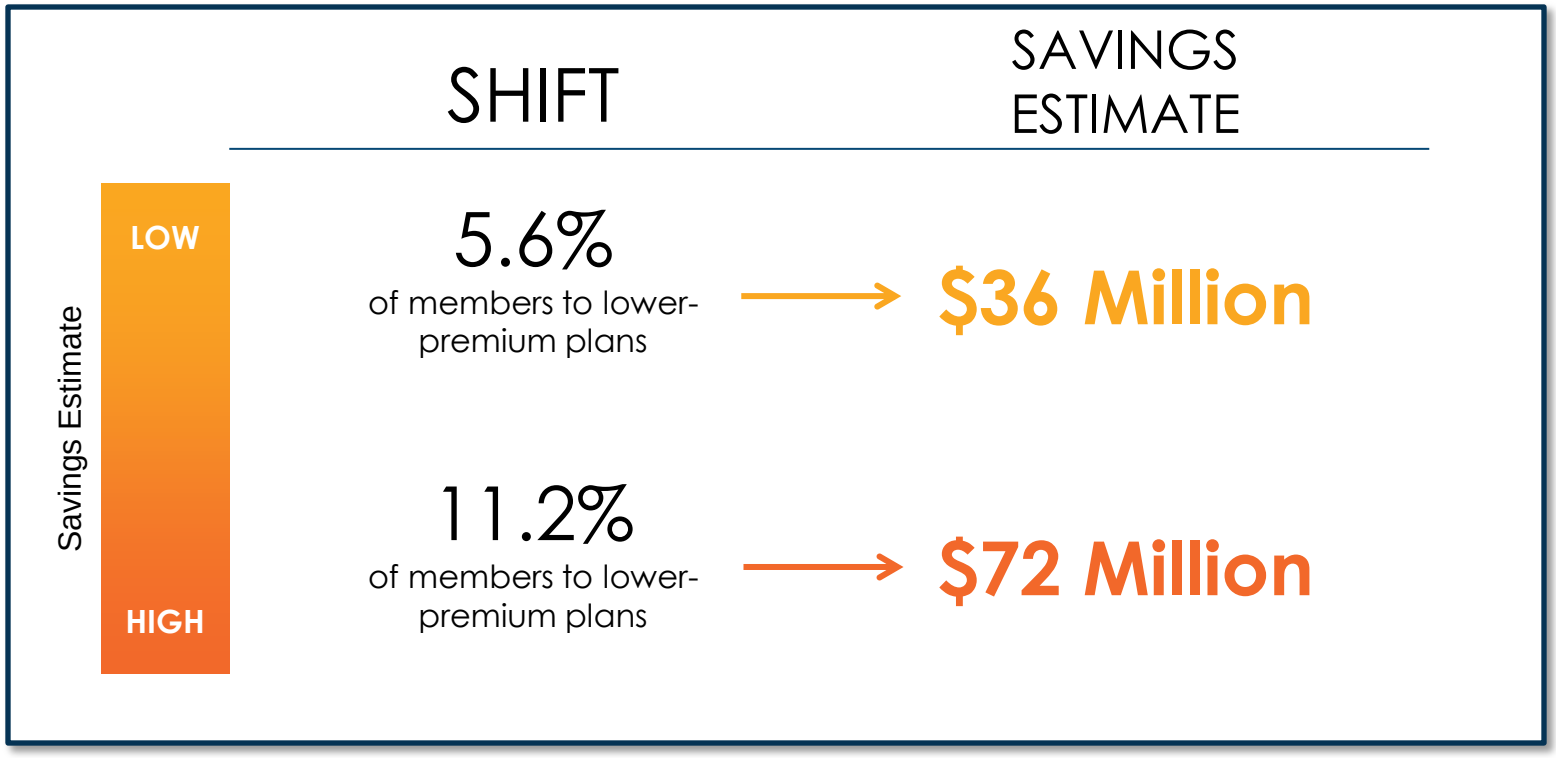


Notes: TME= total medical expenses, Blended TME is the combined normalized health status adjusted TME weighted across the three largest commercial payers (see Technical Appendix for details). Analysis includes the 10 largest primary care groups as identified by the Center for Health Information and Analysis (CHIA) in terms of member-months: Partners Community Physicians Organization (Partners); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); Mount Auburn Cambridge IPA (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); and Baycare Health Partners (Baycare).

Source: HPC analysis of Center for Health Information and Analysis 2016 Annual Report TME Databook

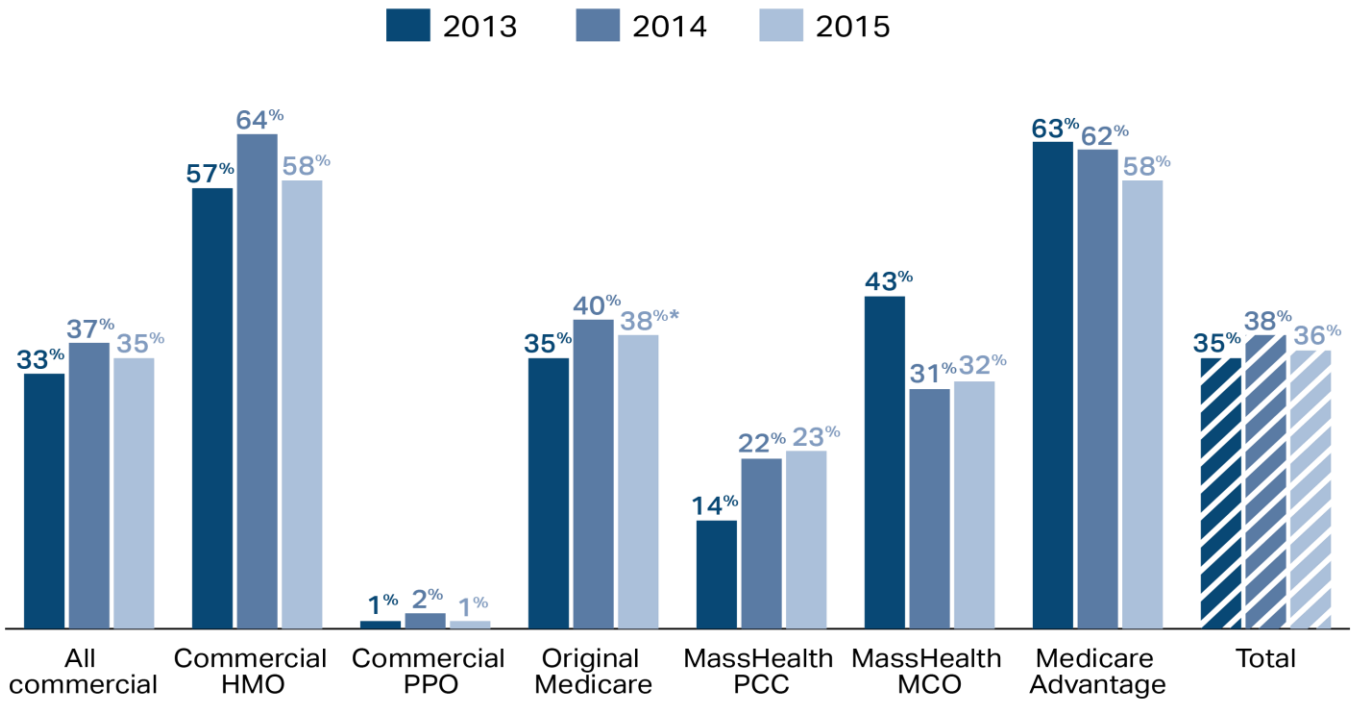
Cost estimate V: Adjust premiums based on TME for PCP groups

Cost Trends Report, Recommendation 1:
Payer should continue to innovate and provide new mechanisms that reward consumers for making high-value choices, including…Offering members incentives at the time of PCP selection, with the level of incentives tied to the differences in the total cost of care associated with this PCP



While progress on APMs stalled in 2015, there are several promising developments for 2016 and beyond

Proportion of member months under APMs, by insurance category, CY 2013-2015



- Commercial: Developments in expanding APMs into PPO products, including one major commercial payer which is extending its APM to PPO members served by several large providers systems
- Medicare: Implementation of MACRA to link quality to physician payments, adoption of the Next Generation ACO program, and introduction of new bundled payment initiatives
- MassHealth: Implementation of MassHealth ACO program, as supported the Delivery System Reform Incentive Program (DSRIP) and the amended 1115 waiver

HPC

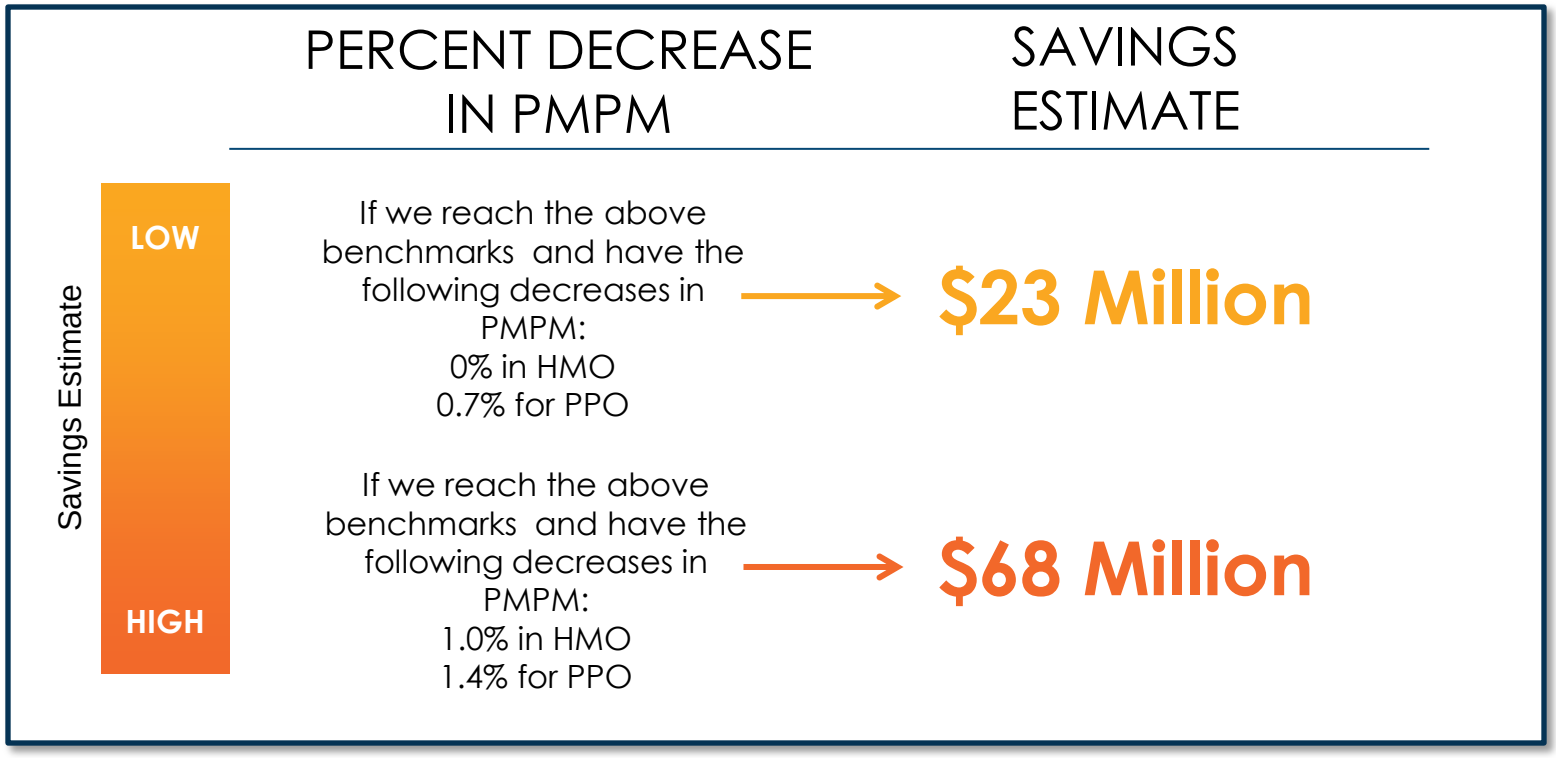
Notes: * denotes that 2015 results based on preliminary estimates. Original Medicare= fee-for-service, APM= alternative payment method, CY= calendar year, PPO= preferred provider organization, MACRA= Medicare Access and CHIA Reauthorization Act of 2015, ACO= accountable care organization.

Sources: Centers for Medicare and Medicaid Services, 2013-2015; Center for Health Information and Analysis 2016 Annual Report APM Databook

Cost estimate VI. Increase APM coverage

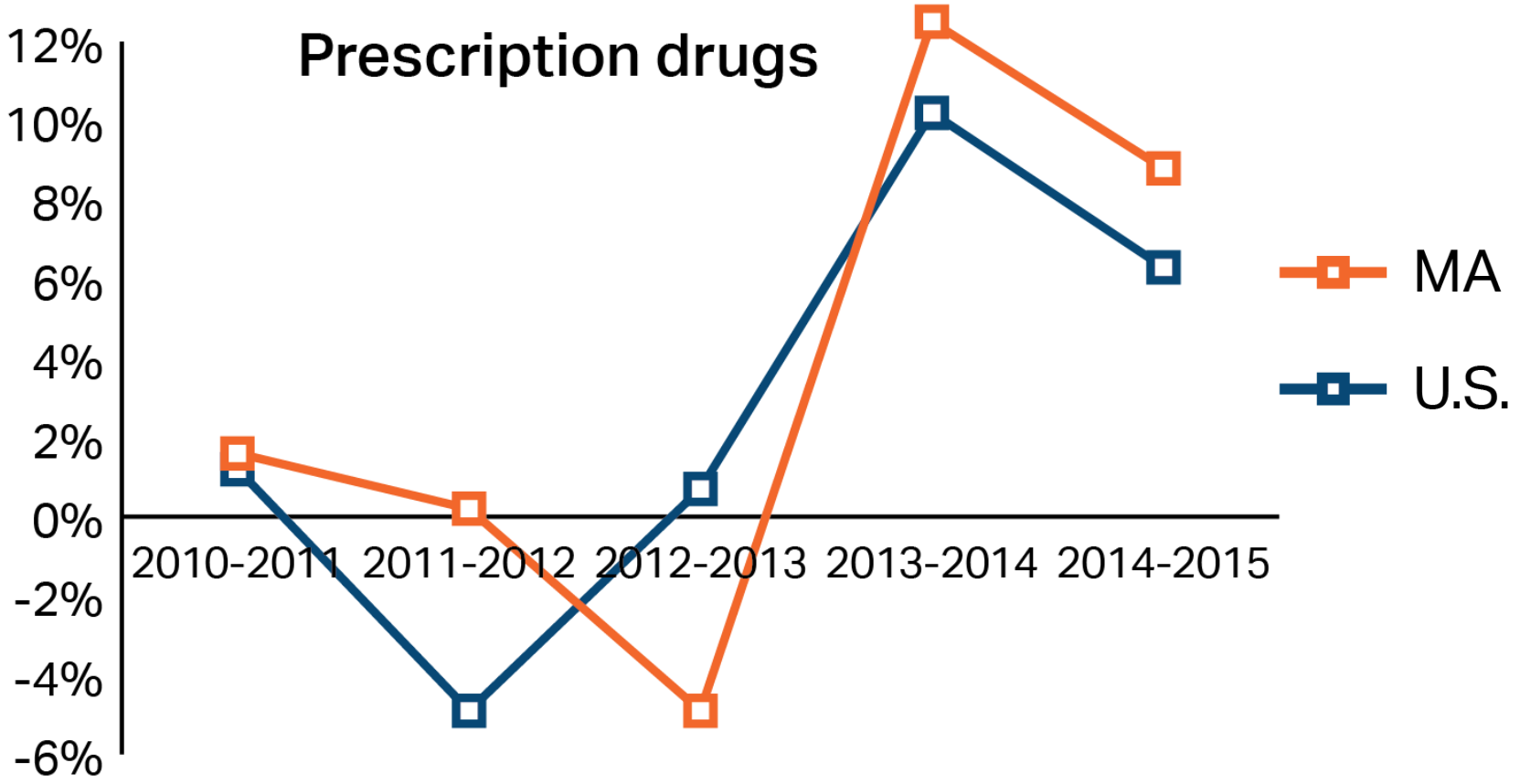
Cost Trends Report, Recommendation 10:
Payers and providers should continue to focus on increasing adoption of alternative payment methods (APMs):

- APMs for HMO patients: 80% by 2017
- APMs for PPO patients: 1/3 by 2017



Drug spending growth in MA was higher than the national average in 2014 and 2015.

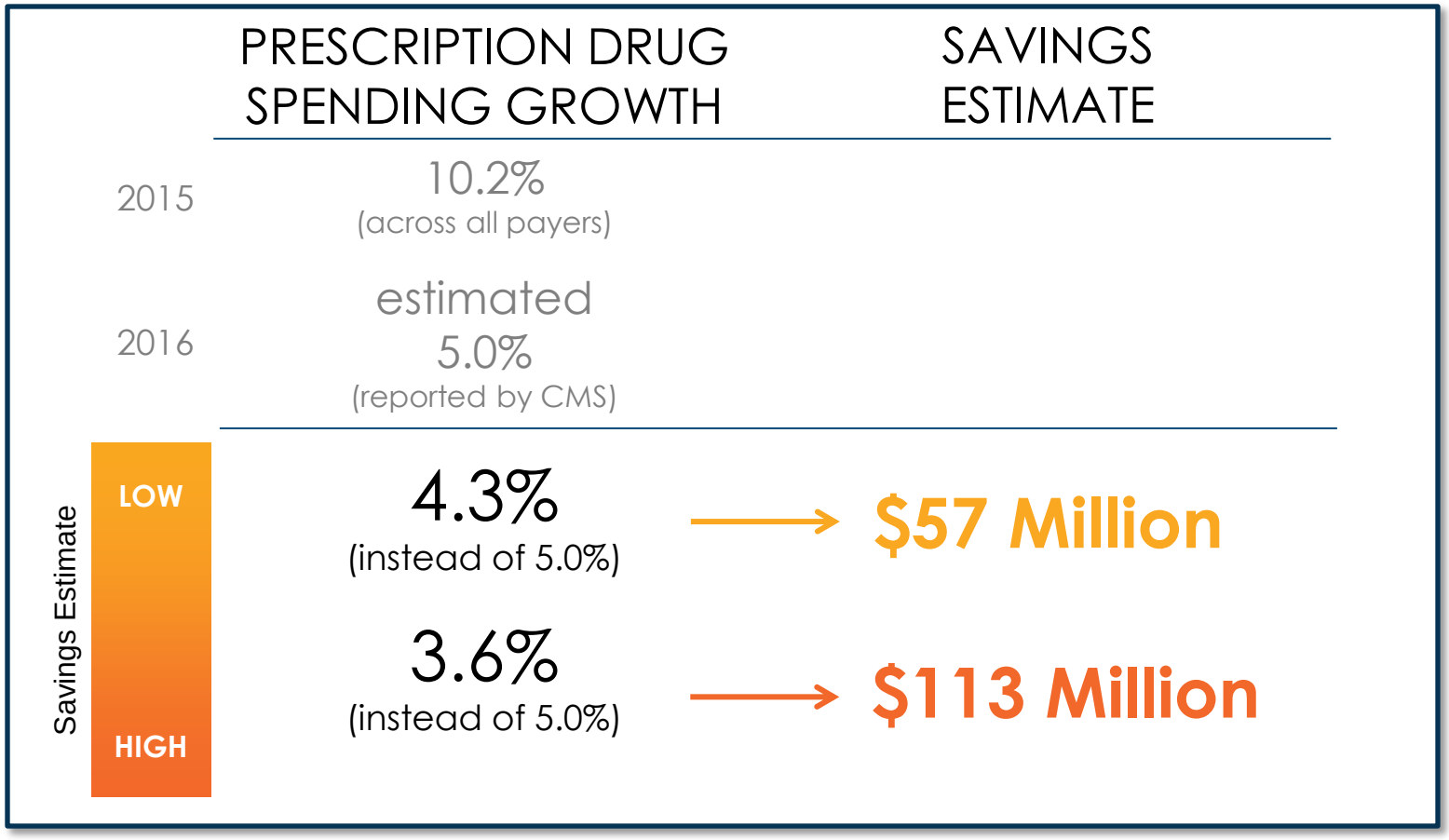
Annual growth in commercial spending, per enrollee, MA and the U.S., 2010-2015 (not including impact of rebates and discounts)



Source: Center for Medicare and Medicaid Services (CMS) and Center for Health Information and Analysis, 2009-2015
Notes: Massachusetts data are for full-claims only. CMS data are from the private health insurance subset of the personal health care expenditure series.

Cost estimate VII. Reduce growth rate of Prescription Drug spending

Cost Trends Report, Recommendation 2:
The Commonwealth should take action to reduce increases in drug spending



Savings scenarios: Summary

Scenario	'Low' savings	'High' savings
I. Shift community-appropriate care	$43m	$86m
II. Reduce readmissions	$61m	$245m
III. Reduce avoidable ED use	$12m	$24m
IV. Reduce use of institutional PAC	$47m	$186m
V. Adjust premiums based on PCP TME	$36m	$72m
VI. Increase participation in APMs	$23m	$68m
VII. Reduce rate of growth in Rx drug spending	$57m	$113m
Total	$279 million (~0.5% THCE)	$794 million (~1.3% THCE)

MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
- **Presentation from Altarum Institute**
- Public Testimony

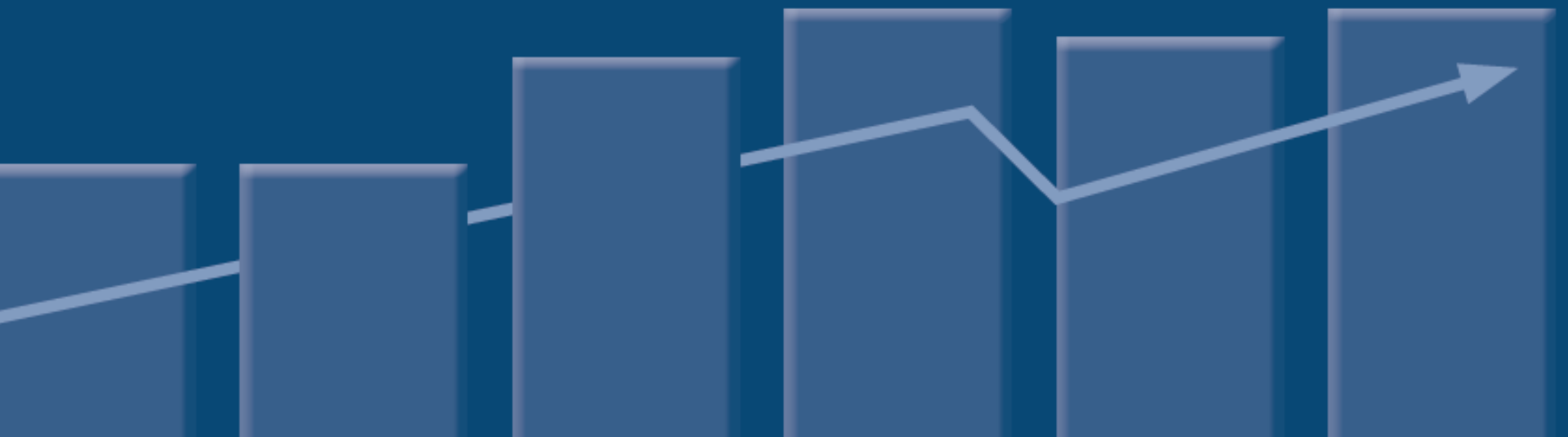
MASSACHUSETTS
HEALTH POLICY COMMISSION

- Statutory Process and Proposed Factors
- Presentation from the Center for Health Information and Analysis
- Presentation from the Health Policy Commission
- Presentation from Altarum Institute
- **Public Testimony**

MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE

HEALTH CARE COST GROWTH BENCHMARK



Appendix

Cost estimate I. Shift community appropriate care to community hospitals

Cost Trends Report, Recommendation 6: *"The Commonwealth, payers, and providers should work to redirect community-appropriate care to high value, community settings."*

Background/Assumptions

- In 2014, there were 219,000 community-appropriate discharges that took place at teaching hospitals (including AMCs), with an average case mix index of 1.07.
- The average revenue for these discharges were **$14,800** in teaching hospitals versus **$10,900** for equivalent discharges at community hospitals.

Savings Estimates

Low: Shift 5% (~11,000) of these discharges to community hospitals such that the % of community-appropriate discharges served by community hospitals increases from 53.3% to 55.6%

  - ***Savings: $43 million***

High: Shift 10% (~22,000) of these discharges to community hospitals such that the % of community-appropriate discharges served by community hospitals increases from 53.3% to 58.0%

  - ***Savings: $86 million***

Cost estimate II: Reduce hospital readmissions

Cost Trends Report Recommendation 7a: "*The Commonwealth should achieve a 20 percent reduction in all-cause, all-payer 30-day hospital readmissions relative to the 2013 level, attaining an all-payer* ***readmission rate below 13 percent by 2019****.*"

Background/Assumptions

- In 2015, there were 78,000 readmissions, up from 74,000 in 2014. The all-payer all-cause readmission rate increased from 15.3% to 15.8% from 2014 to 2015.
- Average cost of readmissions in 2015: $13,400 (MassHealth), $15,100 (Medicare), $15,500 (Commercial)
- Assume we reduce readmissions from all payers in the same proportion to achieve the target rate
- No additional costs to achieve a reduction in readmissions

Savings estimates

Low: 15% readmission rate (3,500 fewer readmissions)

- ***Savings: $61 million***

High: 13% readmission rate (14,000 fewer readmissions)

- ***Savings: $245 million***

Cost estimate III. Reduce avoidable ED visits

Cost Trends Report, Recommendation 7: The Commonwealth should continue to focus on strengthening partnerships between the health care delivery system and community-based organizations in order to reduce the unnecessary hospital use and other institutional care.

Background/Assumptions

- 900,982 ED visits for the Medicare, Medicaid, and Commercial population were considered avoidable in 2015 (45% of all visits)
- Assume ED visits for avoidable or primary care-preventable conditions shift to lower-cost settings (physician offices, urgent care centers, retail clinics) in similar proportion to use of those settings today (85%-10%-5%)
- Estimate costs of visits by setting based on APCD (Commercial) and other literature; Assume cost differentials by setting are half as large for MassHealth and between MassHealth and Commercial for Medicare

Savings Estimates

Low: Shift 5% (45,000) of these visits to lower-cost settings

  – ***Savings: $12m***

High: Shift 10% (90,000) of these visits to lower-cost settings

  – ***Savings: $24m***

Cost estimate IV. Reduce use of institutional Post-Acute Care (PAC)

Cost Trends Report, Recommendation 7 (c) "*The Commonwealth should achieve a 5 percentage point reduction in the rate of discharge to institutional post-acute care to meet the national average (22% in MA, 17% national) by 2020.*"

Background/Assumptions

- In 2014, there were 130,251 hospital discharges to institutional PAC in MA (21.8% of all discharges)
- For low-acuity hip and knee replacements (DRG 470), average institutional PAC spending was $9,652 and home health spending was $2,942
- Use this as a representative spending differential

Savings Estimate

Low: Shift 5% (6,941 discharges) of institutional PAC discharges to home health, reducing rate of institutional PAC use from 21.8% to 20.6%

- ***Savings: $46.6 million***

High: Shift 21% (27,764 discharges) of institutional PAC discharges to home health, reducing rate of institutional PAC use from 21.8% to National rate of 17.1%

- ***Savings: $186 million***

Cost estimate V: Adjust premiums based on TME for PCP groups

Cost Trends Report (2015), Recommendation 1 "*Payer should continue to innovate and provide new mechanisms that reward consumers for making high-value choices, including…Offering members incentives at the time of PCP selection, with the level of incentives tied to the differences in the total cost of care associated with this PCP"*

Background/Assumptions

- HSA TME (blended by top three payers) by parent provider group varied 15% in 2015; more by individual payer
  - Use wider premium variation of local provider groups (from Harvard Pilgrim as representative of commercial market)
- Proposal calls for adjusting premiums in direct proportion to PCP group TME, keeping the average premium constant
- Assume enrollees shift to lower-premiums at rates consistent with the literature*

Savings Estimate

Low: 5.6% of members shift to lower-premium plans

- Savings: $36 million

High: 11.2% of members shift to lower-premium plans

- Savings: $72 million

*Gruber, Jonathan et al. "Controlling health care costs through limited network insurance plans." *American Economic Journal*. 2016.
*Frank, Matthew B. et al. "The impact of a tiered network on hospital choice." *Health Services Research*. 2015.
*Ringel, Jeanne S. et al. "The Elasticity of Demand for Healthcare: A Review of the Literature and Its Applications to the Military Health System." *RAND Health.*

Cost estimate VI. Increase APM coverage

Cost Trends Report, Recommendation 10: *"Payers and providers should continue to focus on increasing adoption of alternative payment methods (APMs):"*

- *APMs for HMO patients: 80% by 2017*
- *APMs for PPO patients: 1/3 by 2017*

Background/Assumptions

- In 2015, 58.5% of HMO patients and 1.1% of PPO patients were covered under APMs
- Low estimate of savings from APMs*: 0% for HMO: 0.7% for PPO
- High estimate of savings from APMs*: 1% for HMO: 1.4% for PPO

Savings Estimates

Low: Reach APM targets with low savings estimate

- ***Savings: $23 million***

High: Reach APM targets with high savings estimate

- ***Savings: $68 million***

*Song, Zirui, et al. "Changes in health care spending and quality 4 years into global payment." *New England Journal of Medicine* 371.18 (2014): 1704-1714.
*McWilliams, J. Michael, et al. "Early performance of accountable care organizations in Medicare." *New England Journal of Medicine* 374.24 (2016): 2357-2366.

HPC

Cost estimate VII. Reduce growth rate of Prescription Drug spending

Cost Trends Report, Recommendation 2: *"The Commonwealth should take action to reduce increases in drug spending"*

Background/Assumptions

- In 2015, prescription drug spending grew 10.2% across all payers and markets (8.8% per capita in the commercial market)
- 2016 growth has been estimated as 5.0% by CMS
- Assume we are able to hold 2016 per capita growth to 3.6%

Savings Estimates

Low: Prescription drug spending grows 4.3% instead of 5.0%

- ***Savings: $57 million***

High: Prescription drug spending grows 3.6% instead of 5.0%

- ***Savings: $113 million***

HPC

Note: CMS estimates include rebates.
Source: Centers for Medicare and Medicaid Services, 2016.