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Dr. Stuart Altman, Chair
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Dr. Altman:

Re: State Cost Growth Benchmark

Thank you for the opportunity to offer comments as the Health Policy Commission considers the adjusting the cost growth benchmark for 2018 and beyond. As you are aware, the 3.6% cost growth benchmark was set through a process established in Chapter 224 of the Acts of 2012. The Commission has outlined a number of factors that may be considered when deciding is an adjustment to the benchmark is warranted. These factors include:

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 HPC's statutory responsibilities
6. Feedback from market participants and interested parties

When reviewing **Massachusetts' performance to date**, the cost growth benchmark has been exceeded in two of the past three years. From 2014 to 2015 total health care expenditures (THCE) increased by 4.1%, exceeding the 3.6% benchmark. However, when looking at different components of THCE, and within that, major categories of commercial spending, there is wide variation in levels of growth.

While we do not advocate that THCE be disaggregated and the benchmark be separately applied to each component of THCE, it is instructive to see what factors have driven THCE growth to fall beneath or above the benchmark since passage of Ch. 224.

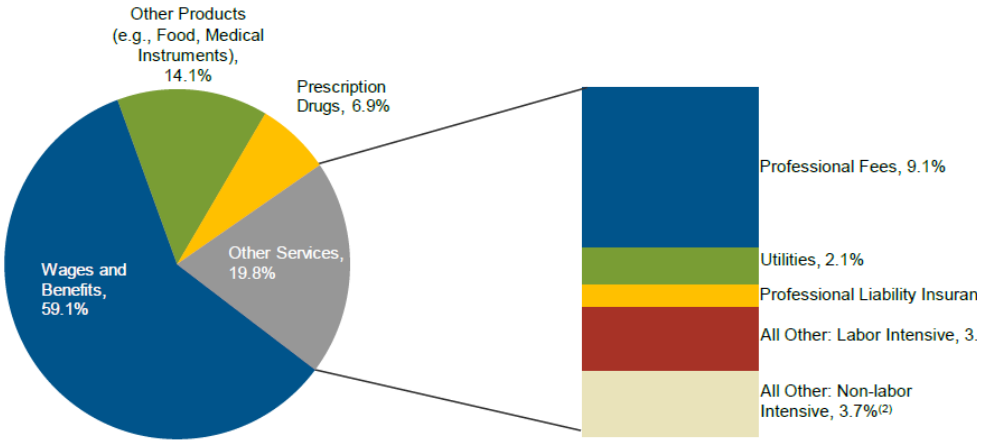
Components of THCE	Change 2014 - 15	Growth vs. Benchmark
Net Cost of Private Insurance	12.6%	▲
Commercial	5.3%	▲
Prescription Drugs	8.8%	▲
Hospital Inpatient	2.9%	▼
Hospital Outpatient	2.2%	▼
Physician Services	1.9%	▼
MassHealth	4.6%	▲

The differences in the growth rates for different components of THCE illustrate how the performance in one can be offset by growth in the others and how many of the cost drivers are beyond the direct control of the different sectors. For example, taxes and assessments imposed by the Affordable Care Act, growth in MassHealth enrollment, new drugs and innovative medical devices are all significant cost drivers, but largely beyond the direct control of hospitals, payers and state government.

Hospital spending growth has fallen below the benchmark in all three time periods measures by the Center for Health Information Analysis. However, growth in the 2014 to 2015 time period indicated upward pressure on hospital spending (from 1.7% in 2013/14 to 2.9% in 2014/15).

The cost pressures facing hospitals are intense and in many cases beyond the complete control of hospitals. As the chart to the right indicates, nearly 60% of hospital costs are labor costs. This portion of hospital spending is subject to inflationary pressure as workers expect cost of living adjustments to keep pace with inflation.

Hospital Costs by Type of Expense



Source: AHA analysis of Centers for Medicare and Medicaid Services data, using base year 2010 weights.
(1) Does not include capital.
(2) Includes postage and telephone expenses.

As the Commission and CHIA have documented, growth in prescription drug spending has far outpaced inflation and the cost growth benchmark. A significant portion of overall costs in hospitals - particularly academic medical centers and specialty hospitals - is the result of prescription drugs.

While hospitals have made considerable progress in slowing rates of cost growth, through greater operating efficiencies and adoption of new models of care delivery and payment, there are still factors that are largely beyond the direct control of hospital leaders and this a factor when considering to adjust the cost growth benchmark.

Another factor that the HPC should consider when setting the cost growth benchmark is **significant change to the state or federal health care landscape**. As Congress considers repealing and replacing the Affordable Care Act and transitioning Medicaid funding to a per capita cap model, there will be significant consequences both locally and nationally. The next several years will bring an unprecedented level of uncertainly to healthcare in the United States.

We encourage the Commission to take these factors - the level of uncertainty in healthcare both locally and nationally, previous performance on the benchmark and the varying degree of ability to directly control certain elements of THCE - into consideration as it weighs adjusting the cost growth benchmark.

Regardless of where the benchmark is ultimately set, our member hospitals are committed to continuing the hard work of reducing cost growth during times of intense upward pressure on costs and significant uncertainty at the federal level. We are also committed to working with the Commission and our partners in the healthcare sector on initiatives aimed at addressing those cost drivers that are not within in our direct control

Sincerely,

John Erwin
Executive Director