11 Beacon Street, Suite 710
Boston, MA 02108
Phone: 617-723-6100
Fax: 617-723-6111
www.cobth.org

March 28, 2018

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

Senator James Welch, Chair
Committee on Health Care Financing
Massachusetts State House
Boston, MA 02133

Rep. Jeffrey Roy, Vice Chair
Committee on Health Care Financing
Massachusetts State House
Boston, MA 02133

Dear Dr. Altman, Senator Welch and Representative Roy:

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 2019. The current 3.1% cost growth benchmark was set through a process established in Chapter 224 of the Acts of 2012 and the Commission has outlined a number of factors that may be considered when deciding whether 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 for which final figures are available. Initial figures for 2015-16 show an increase of 2.8%, below the benchmark of 3.6%. When looking at different components of THCE, and within that, the major categories of commercial spending, there remains wide variation in levels of growth.

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

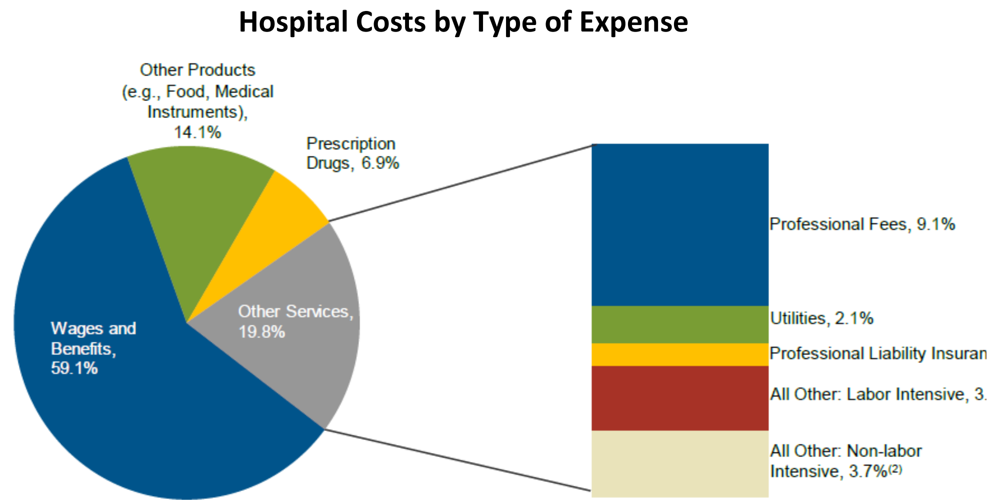
Components of THCE	Change 2015 - 16	Growth vs. Benchmark
Net Cost of Private Insurance	-4.7%	▼
Commercial	3.4%	▼
Prescription Drugs	6.4%	▲
Hospital Inpatient	2.2%	▼
Hospital Outpatient	5.5%	▲
Physician Services	1.7%	▼
MassHealth	4.4%	▲
Medicare	3.3%	▼
Other Public	-2.0%	▼
Total	**2.8%**	▼

Beth Israel Deaconess Medical Center · Boston Children's Hospital · Boston Medical Center · Brigham and Women's Faulkner Hospital
Brigham and Women's Hospital · Cambridge Health Alliance · Dana-Farber Cancer Institute · Lahey Hospital & Medical Center
Massachusetts Eye and Ear · Massachusetts General Hospital · Steward St. Elizabeth's Medical Center · Tufts Medical Center

The differences in the growth rates for different components of THCE illustrate how performance in one area 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, the cost of new drugs and innovative medical devices are all significant cost drivers, but are largely beyond the direct control of hospitals, payers and state government.

Hospital inpatient spending fell below the benchmark last year, while hospital outpatient spending was above the benchmark. 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, yet there are still factors that are largely beyond the direct control of hospital leaders.

The cost pressures hospitals face 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 at least keep pace with inflation.



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.

In addition to typical inflationary pressures on labor costs, a pending **nurse staffing ballot initiative** which mandates specific nurse-to-patient ratios, would have a significant impact on hospital costs and the entire healthcare system. It is estimated that if approved, this unfunded mandate could increase hospital costs by more than **$800M** in its first year, jeopardizing the viability of those hospitals with already razor thin operating margins. There are no scientific studies that indicate this mandate will improve the quality of care for patients in Massachusetts. Instead, this required spending would crowd out others areas of potential hospital investments aimed at increasing efficiency and improving access and patient safety.

Another area where hospitals have limited ability to impact cost growth is in the area of **pharmaceutical spending**. As the Commission and Center for Health Information Analysis have documented, growth in prescription drug spending has far outpaced inflation and the cost growth benchmark in recent years. A significant portion of overall costs in hospitals - particularly academic medical centers and specialty hospitals - is the result of prescription drug prices.

Lastly, an important factor the HPC should consider when setting the cost growth benchmark is significant **uncertainty at the federal level** as it relates to health policy. As Congress and the Trump Administration continue efforts to undermine the Affordable Care Act, consider major changes to Medicaid funding and the 340B drug pricing program, 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.

COBTH supports maintaining the cost growth benchmark at its current 3.1%, but cautions the Commission to be mindful of the many factors outside the control of providers, payers and the Commonwealth that may make meeting this target difficult.

Regardless of where the benchmark is 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