HEALTH CARE FOR ALL

www.hcfama.org

One Federal Street
Boston, MA 02110

617.350.7279 Office
617.350.0974 TTY
800.272.4232 HelpLine

Submitted electronically to HPC-Testimony@state.ma.us

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Lois Johnson, General Counsel
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Re: Health Care Cost Growth Benchmark for Calendar Year 2019

Dear General Counsel Johnson:

On behalf of Health Care For All (HCFA), thank you for the opportunity to submit testimony regarding potential modification of the health care cost growth benchmark for the average growth in total health care expenditures for calendar year 2019. HCFA works in support of policies that advance health care justice, advocating for affordable, accessible, and high quality care, particularly for the most vulnerable residents of Massachusetts.

Health care costs are one of the most significant issues facing Massachusetts residents. Even as cost growth has moderated somewhat, consumers continue to face growing cost-sharing, and difficulty affording their health care. This is particularly true for those least able to afford it – those with lower incomes. Data from the 2017 Massachusetts Health Insurance Survey (MHIS)[1] provides strong evidence that even as cost growth has moderated somewhat, Massachusetts consumers continue to face growing cost-sharing and difficulty affording their health care. This is particularly true for those least able to afford the costs – those with lower incomes. In 2017, nearly one in 10 (8.8 percent) Massachusetts respondents were considered *underinsured* – despite having health insurance coverage all year, they nevertheless reported spending 10 percent or more of their family income on out-of-pocket health care expenses. Low income respondents were more likely to be underinsured. Additionally, over one in eight respondents in fair or poor health or with an activity limitation were underinsured, as were nearly one in eight elderly respondents, likely reflecting in part their higher use of the health care system.

[1] Center for Health Information and Analysis. Findings From the 2017 Massachusetts Health Insurance Survey (December 2017). http://www.chiamass.gov/assets/docs/r/survey/mhis-2017/2017-MHIS-Report.pdf (prepared by Laura Skopec and Sharon K. Long, Urban Institute and Susan Sherr, David Dutwin and Kathy Langdale, SSRS)

For many Massachusetts consumers, high costs present an insurmountable barrier to accessing the health care services they need. Over a quarter of survey respondents reported an unmet need for medical or dental care in the previous 12 months due to cost. With approximately two-thirds of those with an unmet need reporting that they were covered by health insurance at the time, these numbers once again show underinsurance as a major problem in the Commonwealth. The most common types of unmet need for care due to cost were dental care (15.6 percent) and prescription drugs (9.8 percent).

High costs frequently pose a significant financial challenge to consumers even when they are able to access care. Seventeen percent of survey respondents reported family medical debt. Of these respondents, more than three in four incurred all of those medical bills while they and their family members had health insurance. Finally, in 2017, nearly one in four Massachusetts respondents reported spending $3,000 or more out-of-pocket over the past 12 months for health care for their family (24.9 percent) – excluding premiums.

Similarly, the August 2017 report from the Center for Health Information and Analysis (CHIA) found that low-wage workers are less likely to be offered insurance by their employer, have lower take-up rates of coverage when it is offered, and face significantly higher cost sharing in their coverage.[2] These increasing co-pays and deductibles have become an obstacle to good health care. According to the most recent CHIA Annual Report on the Performance of the Massachusetts Health Care System, high deductible health plans are now 21.8% of the commercial market – and increased consumer cost-sharing, which rose by 4.4% between 2015 and 2016, outpaced inflation, wage growth, and premiums. [3]

People who have low incomes and those who are in poor health or have chronic conditions needing regular care or medication experience even greater difficulties with the high cost of health care. Studies show that for vulnerable populations, increased cost-sharing is associated with adverse health outcomes.[4] Recent HPC findings confirm that MA residents with low to middle incomes face a higher burden of health care costs relative to income.[5] The 2016 Attorney General's Examination of Health Care Cost Trends and Cost Drivers found that in the Massachusetts commercial insurance market, health care spending relative to health burden continues to be higher for patients from higher income communities than for patients from lower income communities.[6] In other words, while people with commercial coverage with lower incomes are less healthy than members with higher incomes, the system allocates fewer health care dollars on those with the highest health needs.

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[2] Center for Health Information and Analysis, The Benefits Divide: Workers at Lower-Wage Firms and Employer-Sponsored Insurance in Massachusetts (August 2017). Available at http://www.chiamass.gov/assets/docs/r/pubs/17/mes-research-brief-august-2017.pdf.

[3] Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System: 2017. Available at: http://www.chiamass.gov/annual-report/

[4] Swartz, K. Cost-Sharing: Effects on Spending and Outcomes, Robert Wood Johnson Foundation (December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1.

[5] Health Policy Commission Board Meeting Presentation, Slide 25 (January 11, 2017), available at: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170111-commission-document-presentation.pdf.

[6] Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General (October 2016), available at: http://www.mass.gov/ago/docs/healthcare/cc-market-101316.pdf.

Given the ongoing challenges with health care affordability for our state's residents, we believe it is critically important to continue to pursue approaches that signal to the health care community that current efforts to address costs are insufficient. We therefore recommend that the HPC set the 2019 benchmark at equal to the potential gross state product minus 0.5 percent, or 3.1%.

We further recommend that the state and HPC continue to support ways to leverage other tools and strategies that we know have an impact on health care costs. For example, the Prevention and Wellness Trust Fund (PWTF) has increased access to preventive services for nearly 1 million people across every region of the Commonwealth. The PWTF invests in evidence-based community interventions that keep residents healthy and safe and is helping to transform and strengthen the links between clinical care and community-based services. An independent evaluator found positive results on health impacts, cost effectiveness, and potential for cost savings – and concluded that the program warrants further investment. Yet the program sunsetted recently, and the re-authorization is still pending before the legislature. With the advent of MassHealth ACOs, the PWTF can focus on community prevention activities that complement the member-focused work of ACOs.

Integration of oral health into ACOs is another area where we can achieve significant cost savings and improve health outcomes. For example, the HPC reported that in 2014 there were 36,060 preventable oral health-related hospital emergency department (ED) visits which cost the Commonwealth between $14.8-$36 million, and that MassHealth was the primary payer (48.8%) for these visits.[7] ED usage for preventable dental conditions is often due to a variety of factors, including inadequate coverage of dental services and insufficient access to oral health care in community-based settings. However, ED providers are generally ill-equipped to render appropriate dental treatment and frequently prescribe antibiotics and pain medication (including opioids) to temporarily ameliorate the pain. As a result, the underlying dental condition remains untreated while medical spending continues to rise.

Therefore, we strongly agree with the HPC policy brief recommendation that integrating oral health into broader health system delivery and payment reform models (PCMHs and ACOs) may improve access to dental services and enhance health outcomes. We also applaud the inclusion of an oral health quality metric in the MassHealth ACO quality measure slate as an important step for oral health integration in Massachusetts. However, we urge the HPC to include oral health as a priority area in the ACO and PCMH certification programs, the HPC's Health Care Innovation Investment Program (HCII), and throughout the health care system more broadly, to minimize expensive ED visits/medical expenditures for preventable dental diseases and to improve overall health and wellbeing.

Another strategy proven effective at addressing rising out-of-pocket costs for consumers is called "value-based insurance design" (VBID), which aligns patients' out-of-pocket costs with the value of

[7] Massachusetts Health Policy Commission Policy Brief (August 2016) available at: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/oral-health-policy-brief.pdf

health services. Cost-effective treatments can help reduce the need for expensive acute care, yet high cost-sharing reduces their use. Research shows that certain medications and services for chronic conditions such as hypertension, high cholesterol, diabetes, asthma, depression, and HIV/AIDS are considered "high value," because they provide large health benefits with comparatively low costs. The health system should therefore encourage patients to use these treatments, instead of imposing high co-pays and deductibles that discourage their use. Removing cost barriers to essential, high-value health services through VBID results in significant increases in patient compliance with recommended treatments, while also being cost-neutral, and even potentially cost-saving overall in the long term.

In one study, for example, nearly 6,000 patients who had just suffered a heart attack were prescribed drugs known to reduce the chance of another heart attack, such as statins or beta-blockers. Half of the patients had their co-pays for these drugs waived; the other half paid the usual fee. As a result, more people in the zero co-pay group took the drugs, and improved their health; they were 31% less likely to have a stroke, 11% less likely to have another major "vascular episode" and 16% less likely to have a heart attack or other related complications. Furthermore, these benefits came without increasing overall health costs for the insurers.[8]

Massachusetts is already experimenting with VBID. For example, Neighborhood Health Plan is now offering new insurance options that waive members' out-of-pocket costs for a selection of common treatments and prescription drugs. The services for which co-pays are waived include nutritional counseling for diabetics, rehabilitation for heart patients, and acupuncture and physical therapy for patients suffering from pain.[9] In addition, the Health Connector has eliminated co-pays for medication-assisted treatment for addiction, and is looking towards expanding this approach.[10]

We also know that growth in prescription drug costs has been the leading factor in the state's health care cost growth, significantly contributing to the Commonwealth surpassing the benchmark from 2014-2016. We should join other states such as California and Oregon by requiring drug manufacturers to justify their charges by being transparent about the actual costs that go into their complicated pricing schemes, opening up about how much drugs actually cost to manufacture, how much people in other countries pay, the true price charged for the drug in Massachusetts, and the research and advertising costs for the most expensive drugs. With this information, our state would finally have the information necessary to dig into high drug prices and hold drug companies accountable, and the public would have the opportunity to judge if we are getting good value for the billions spent on prescription drugs each year.

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[8] Choudhry, Niteesh K. et al, *Full Coverage for Preventive Medications after Myocardial Infarction*, New England Journal of Medicine, December 2011.

[9] McCluskey, Priyanka Dayal. "Neighborhood Health Plan to waive some copays." *The Boston Globe*. November 6, 2017. Available at: https://www.bostonglobe.com/business/2017/11/06/neighborhood-health-plan-waive-some-copays/G1C3TVF9F5RBNTSD65p9xJ/story.html

[10] Freyer, Felice J. "Health Connector will eliminate copays for addiction treatment." *The Boston Globe*. July 15, 2016. Available at: https://www.bostonglobe.com/metro/2016/07/14/health-connector-eliminates-copays-for-addiction-treatment/WoKPjLIkoi2uWfk6zjp04K/story.html.

While we support pursuing an aggressive benchmark for health care spending, including premiums and out-of-pocket costs for consumers, we additionally urge the HPC to consider these and other tools that our health care system and state policymakers can leverage to ensure that consumer and patient affordability are at the forefront of efforts to address costs.

Thank you again for the opportunity to provide testimony on the critical issue of how to most effectively tackle rising health care costs in the Commonwealth. Please don't hesitate to contact us with any questions at brosman@hcfama.org or 617-275-2920.

Sincerely,

Brian Rosman
Policy and Government Relations Director
Health Care For All

cc: Health Policy Commission Board of Directors