MASSACHUSETTS
HEALTH POLICY COMMISSION

HEARING TO DETERMINE THE 2023

HEALTH CARE COST GROWTH BENCHMARK

Agenda

WELCOME

Opening Remarks

Benchmark Modification Process

Center for Health Information and Analysis (CHIA) Annual Report

Report on State Spending Performance

Keynote Presentation and Discussion

Public Testimony

2023 Health Care Cost Growth Benchmark Hearing

WELCOME Dr. Stuart Altman, Chair, HPC	**12:00 PM**
REMARKS Senator Cindy Friedman, Chair, Joint Committee on Health Care Financing Representative John Lawn, Chair, Joint Committee on Health Care Financing	**12:05 PM**
BENCHMARK MODIFICATION PROCESS David Seltz, Executive Director, HPC	**12:15 PM**
CENTER FOR HEALTH INFORMATION AND ANALYSIS ANNUAL REPORT Ray Campbell, Executive Director, CHIA Ashley Storms, Director of Health Informatics and Reporting, CHIA Lauren Coakley Sears, Manager of Health Informatics and Reporting, CHIA	**12:35 PM**
REPORT ON STATE SPENDING PERFORMANCE Dr. David Auerbach, Director of Research and Cost Trends, HPC	**12:55 PM**
KEYNOTE PRESENTATION AND DISCUSSION Dr. Aditi Sen, Director of Research and Policy, Health Care Cost Institute	**1:15 PM**
PUBLIC TESTIMONY	**2:00 PM**
ADJOURN	**3:00 PM**

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In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark

- Sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a cap on spending or provider-specific prices** but is a measurable goal for moderating excessive health care spending growth and **advancing health care affordability**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans** and submit to public monitoring.
- A PIP of an individual provider or health plan is only required following a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

1-5 years

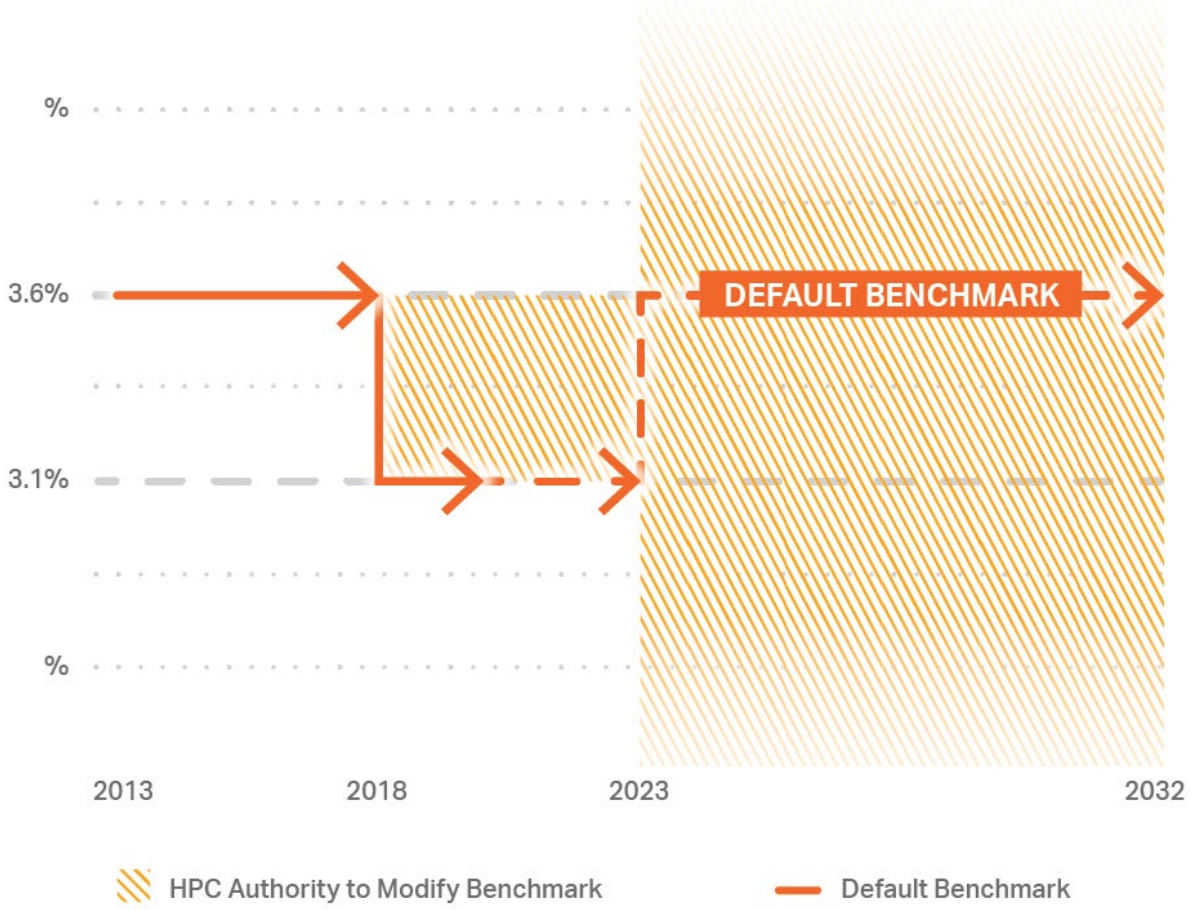
Benchmark established by law at PGSP (3.6%)

6-10 years

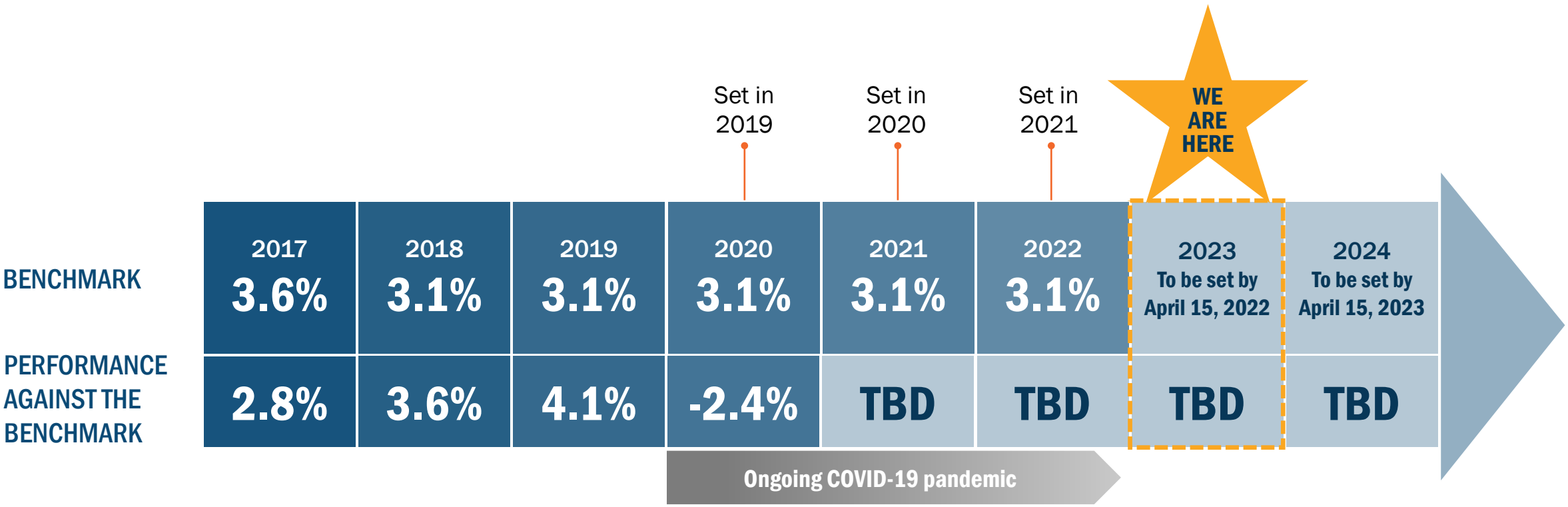
Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.

10-20 years

Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



The health care cost growth benchmark is set prospectively for the upcoming calendar year, while actual performance is measured retrospectively.



Benchmark Modification Process: Key Steps

HPC PROCESS TO MODIFY

- The HPC's Board must hold a **public hearing** prior to making any modification of the benchmark.
- Hearing must consider **data** and **stakeholder testimony** on whether modification of the benchmark is warranted.
- Members of the Joint Committee on Health Care Financing participate in the hearing.
- If the HPC's Board votes to maintain the benchmark at the default rate of 3.6%, the **annual process is complete**.
- If the HPC's Board votes to modify the benchmark to any other number, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for further legislative review**.

POTENTIAL LEGISLATIVE REVIEW

- Following notice from the HPC of an intent to modify, the Joint Committee must hold a public hearing within 30 days.
- The Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing.
- The General Court must act within 45 days of public hearing or the HPC Board's modification of the benchmark takes effect.

Benchmark Modification Process: 2022 Timeline

December 21, 2021
3.6% PGSP established in consensus revenue process

March 16, 2022
Public hearing of HPC Board and Joint Committee on potential modification of benchmark

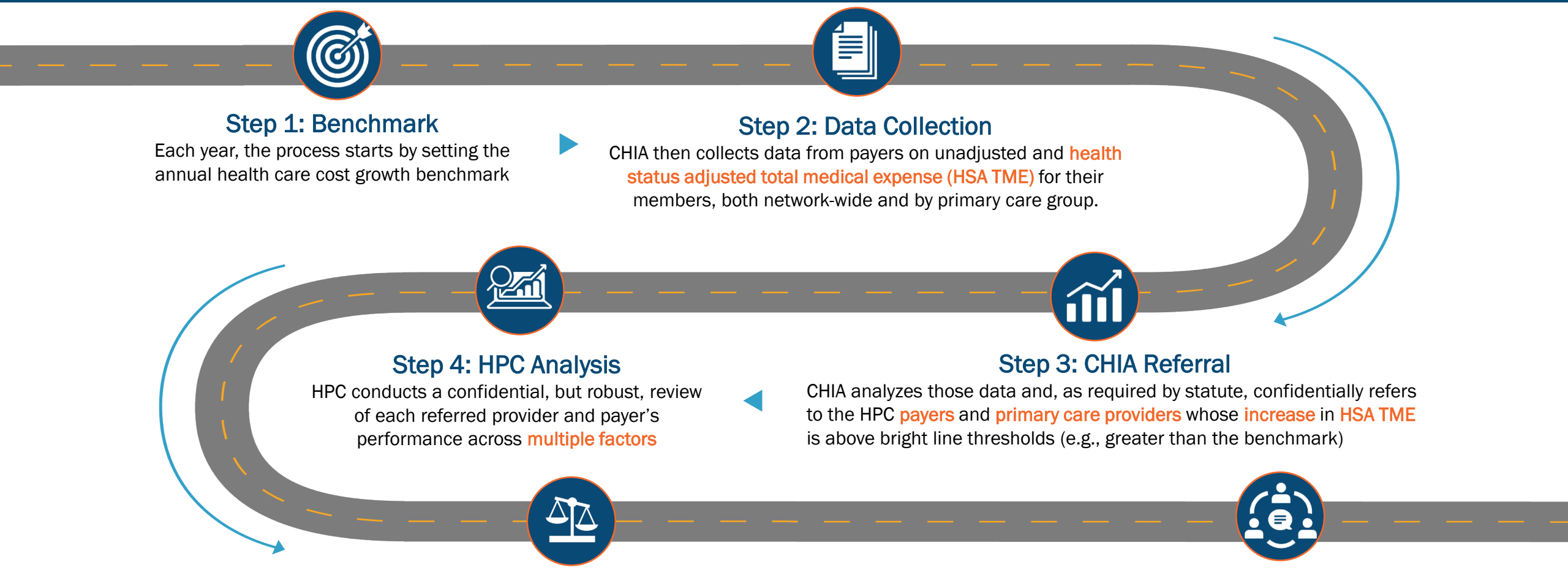
April 13, 2022
HPC Board votes whether to modify benchmark; if HPC Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2022
Statutory deadline for HPC Board to set benchmark

April/May 2022
Joint Committee holds a hearing within 30 days of notice

May/June 2022
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 no legislation is enacted, the HPC Board's vote to modify takes effect.

Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and health status adjusted total medical expense (HSA TME) for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC payers and primary care providers whose increase in HSA TME is above bright line thresholds (e.g., greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across multiple factors

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the HPC Board votes to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

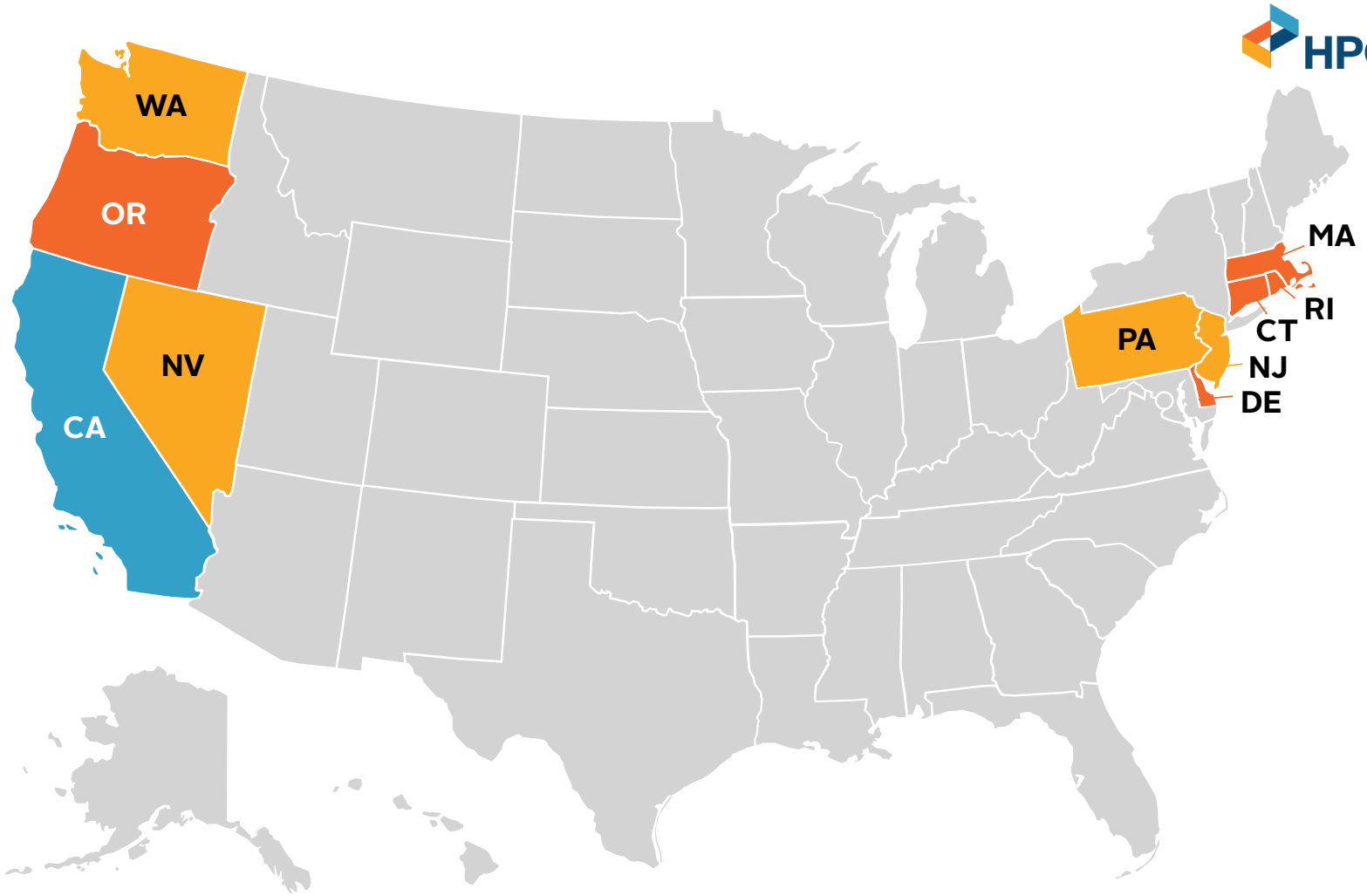
The payer or provider must propose the PIP and is subject to ongoing monitoring by the HPC during the 18-month implementation. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

Performance Improvement Plans: Factors Reviewed by the Commission

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies significant concerns about the Entity's costs and determines that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

Five states have now established statewide health care cost growth targets, ranging from 2.9% to 3.4%, with many additional states considering similar proposals.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

WATCHDOG

Monitor and intervene when necessary to assure market performance

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

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CENTER FOR HEALTH INFORMATION AND ANALYSIS (CHIA) ANNUAL REPORT

Report on State Spending Performance

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Performance of the Massachusetts Health Care System

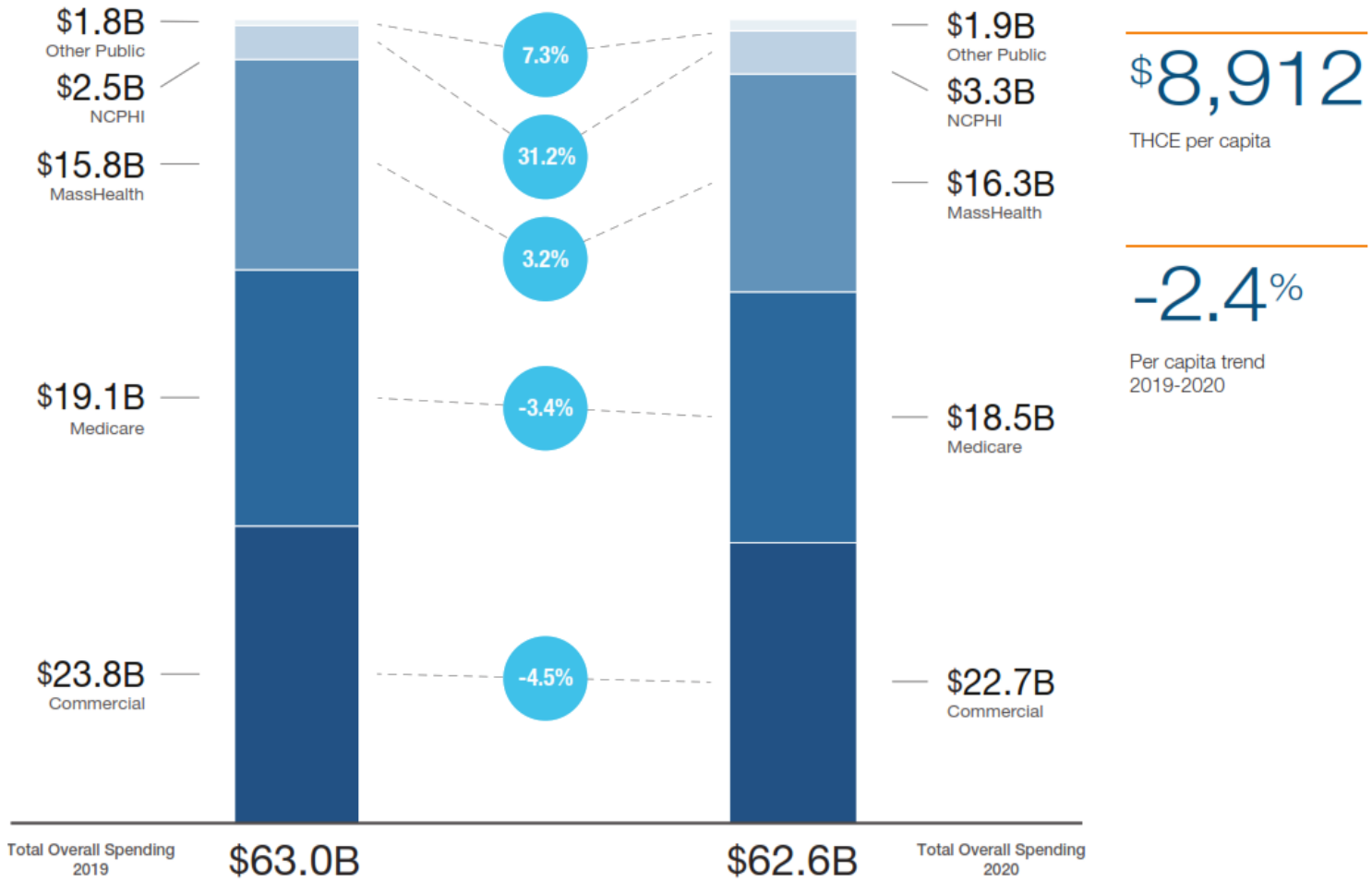
Annual Report
March 2022

CENTER FOR HEALTH INFORMATION AND ANALYSIS

CHIA.

Total Health Care Expenditures

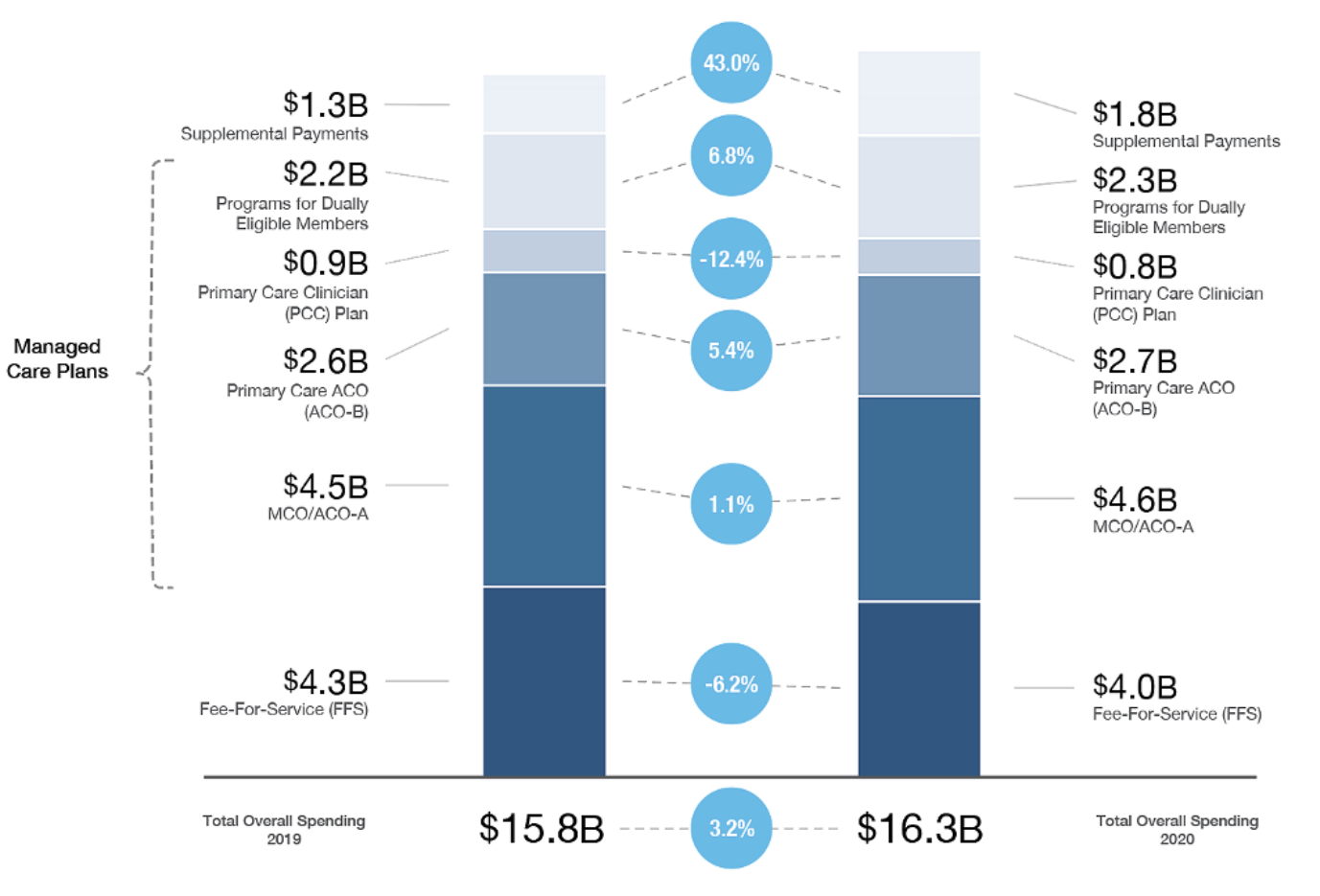
Components of Total Health Care Expenditures, 2019-2020



THCE decreased from 2019 to 2020, driven by declines in commercial and Medicare spending.

Total Health Care Expenditures

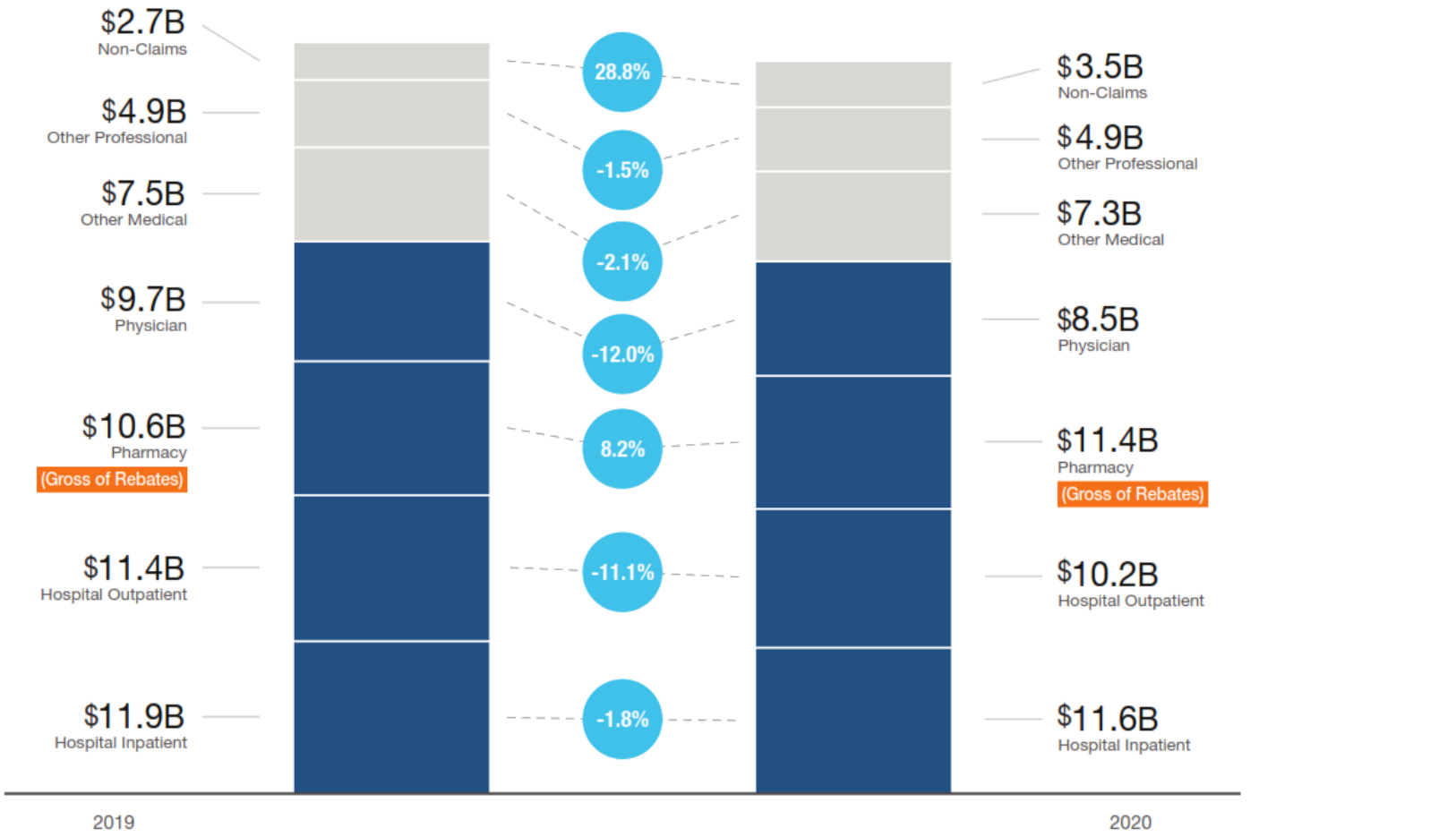
MassHealth Spending by Program Type, 2019-2020



Overall MassHealth spending increased 3.2% between 2019 and 2020, driven by increased enrollment and new supplemental payments relating to COVID-19.

Total Health Care Expenditures

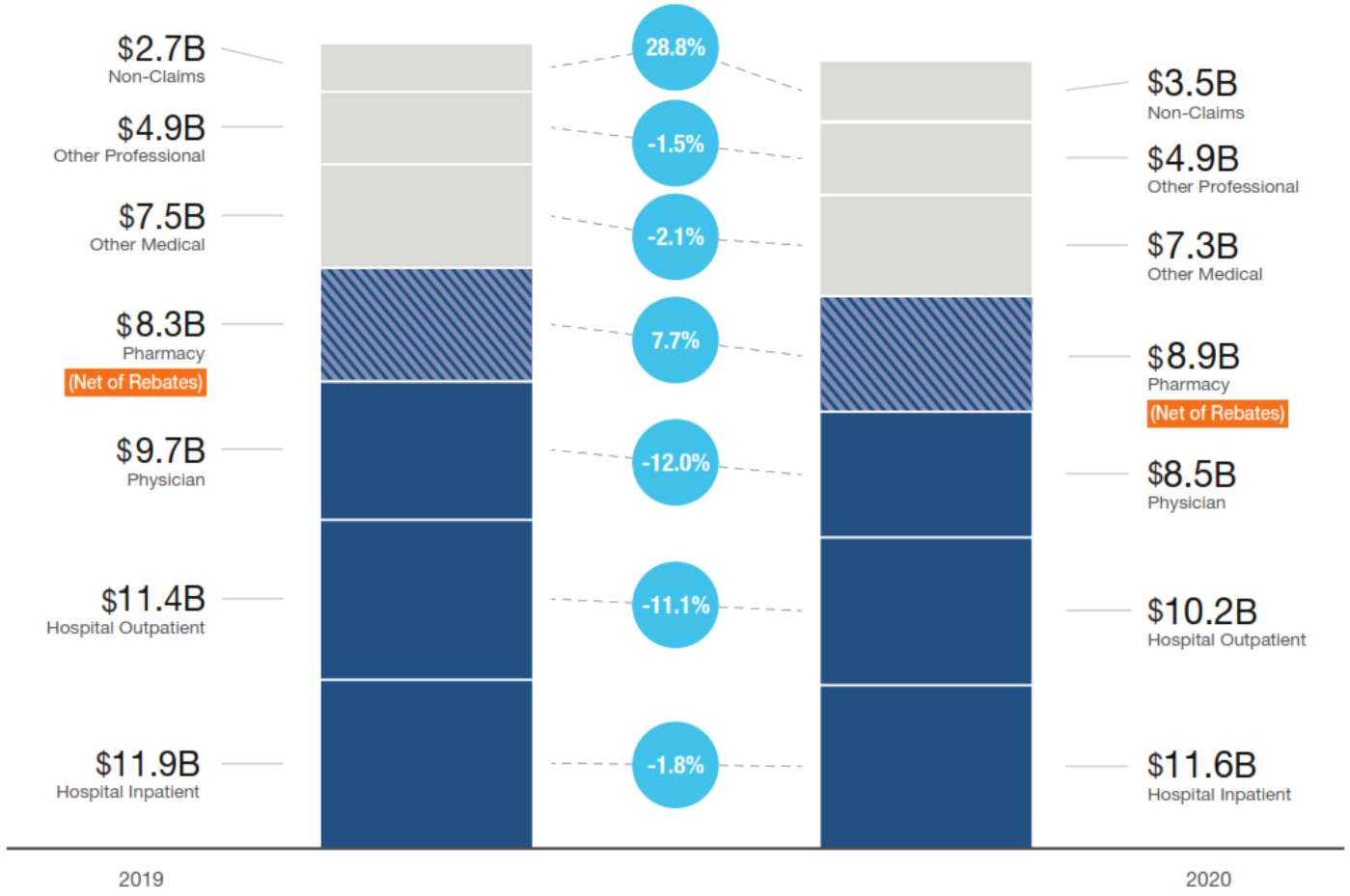
Spending by Service Category: Gross of Prescription Drug Rebates, 2019-2020



Non-claims and pharmacy spending growth accelerated from 2019 to 2020, while spending in all other service categories decreased.

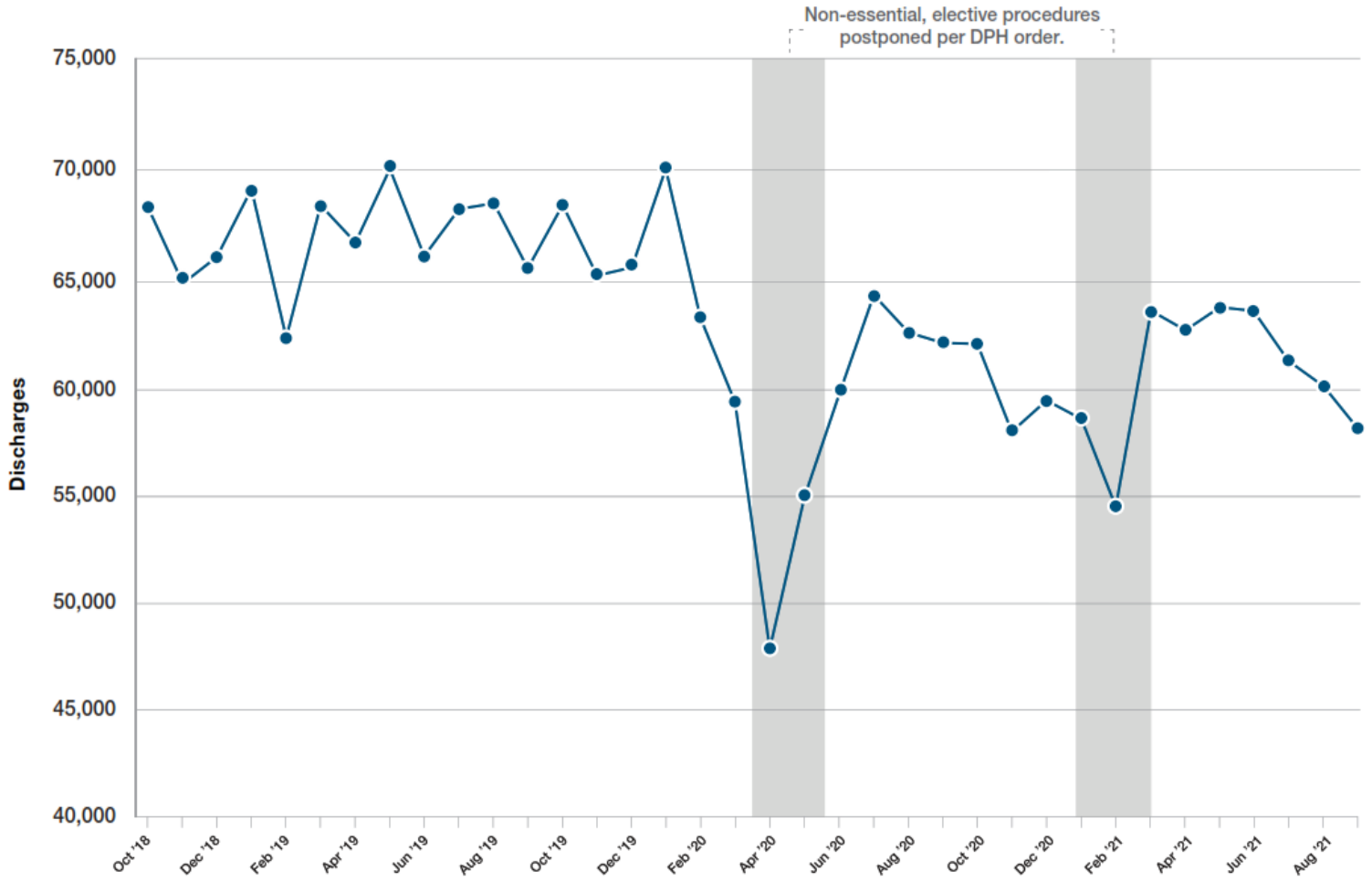
Total Health Care Expenditures

Spending by Service Category: Net of Prescription Drug Rebates, 2019-2020



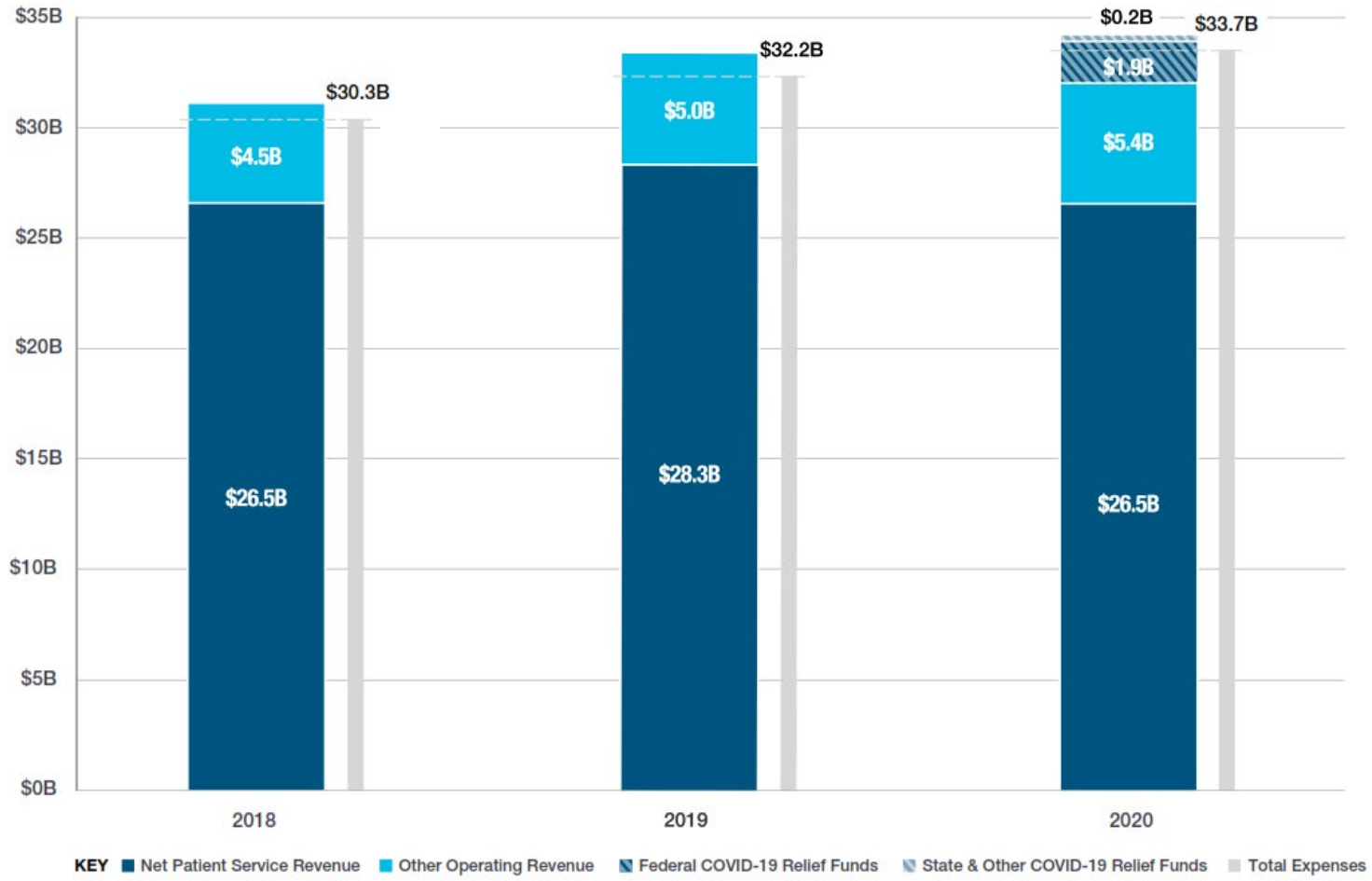
Net of prescription drug rebates, pharmacy spending increased 7.7% in 2020, correlating with slowed growth in overall rebates in many public insurance categories and converging with the gross trend (+8.2%).

Total Acute Care Hospital Inpatient Discharges, October 2018 to September 2021



During peak periods of COVID-19 cases, inpatient discharge volume declined due to a decrease in the number of adult, non-obstetric discharges.

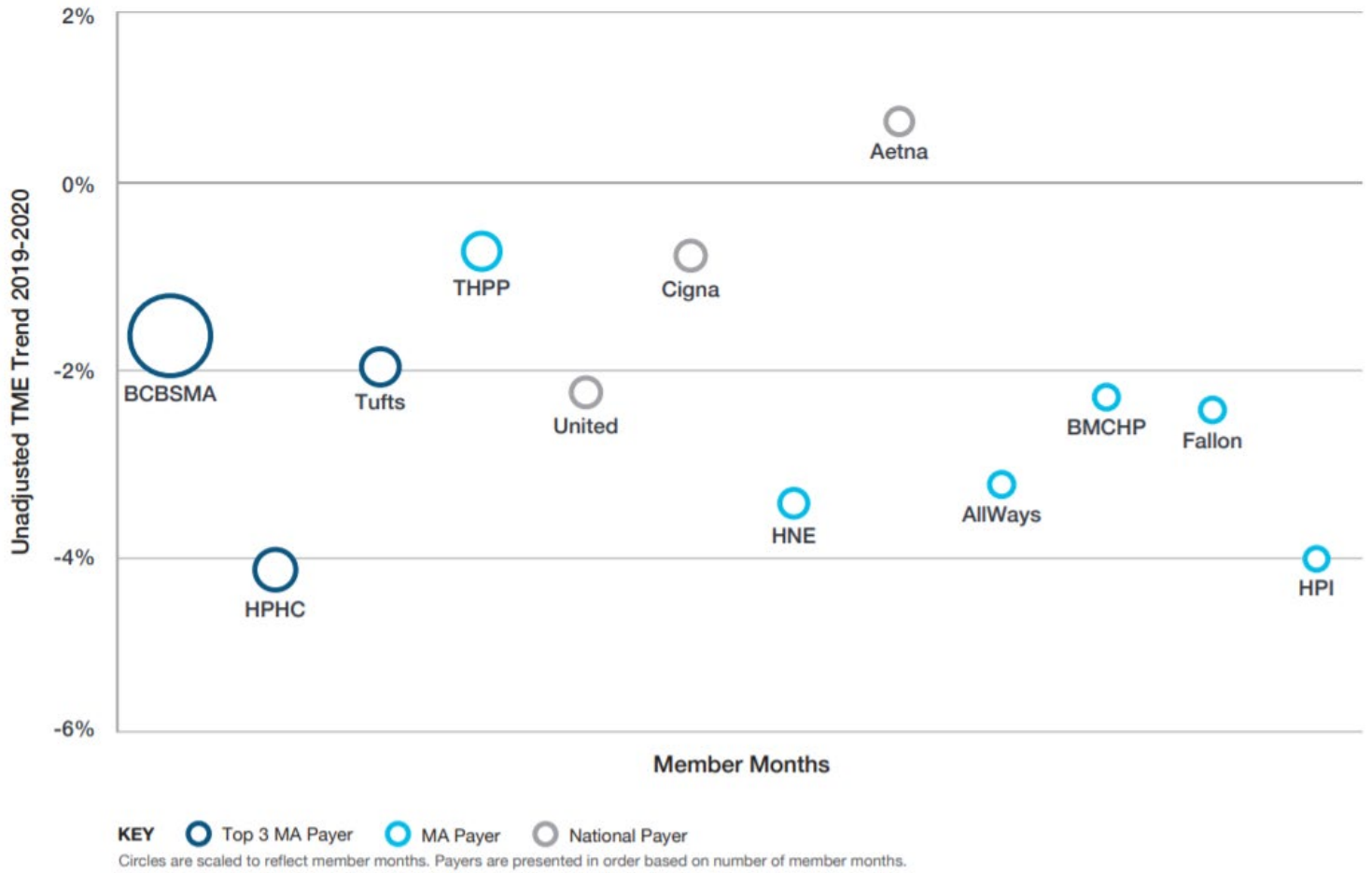
Hospital Operating Revenue and Expense Trends



Federal and state COVID-19 relief funds bolstered hospitals' operating revenue in HFY 2020, as aggregate net patient service revenue decreased by $1.8 billion.

Change in Total Medical Expenses (TME)

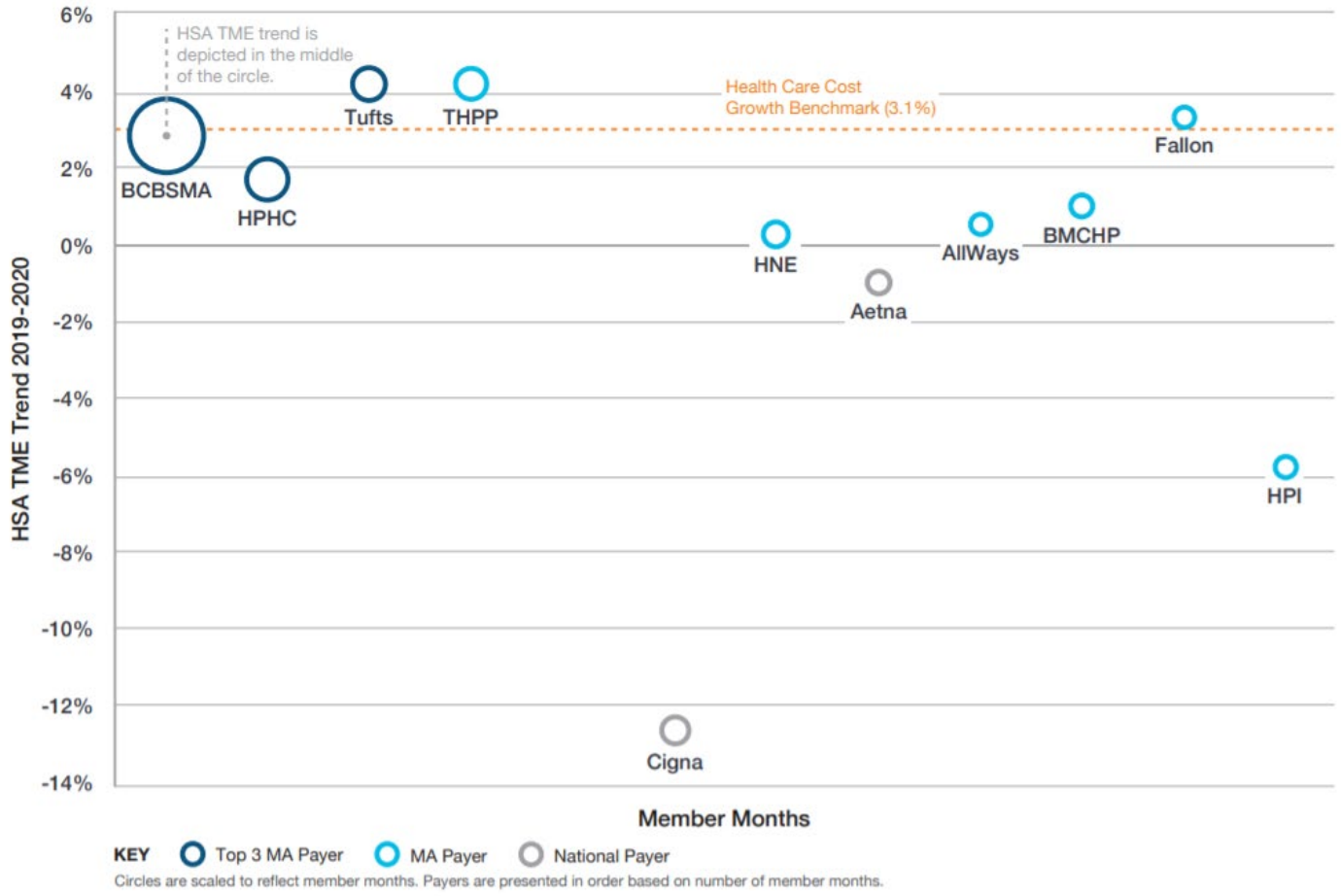
Unadjusted PMPM Trends by Payer, 2019-2020



All commercial payers reported unadjusted TME growth below the benchmark in 2020, with all but one payers reporting negative PMPM spending trends.

Change in Total Medical Expenses (TME)

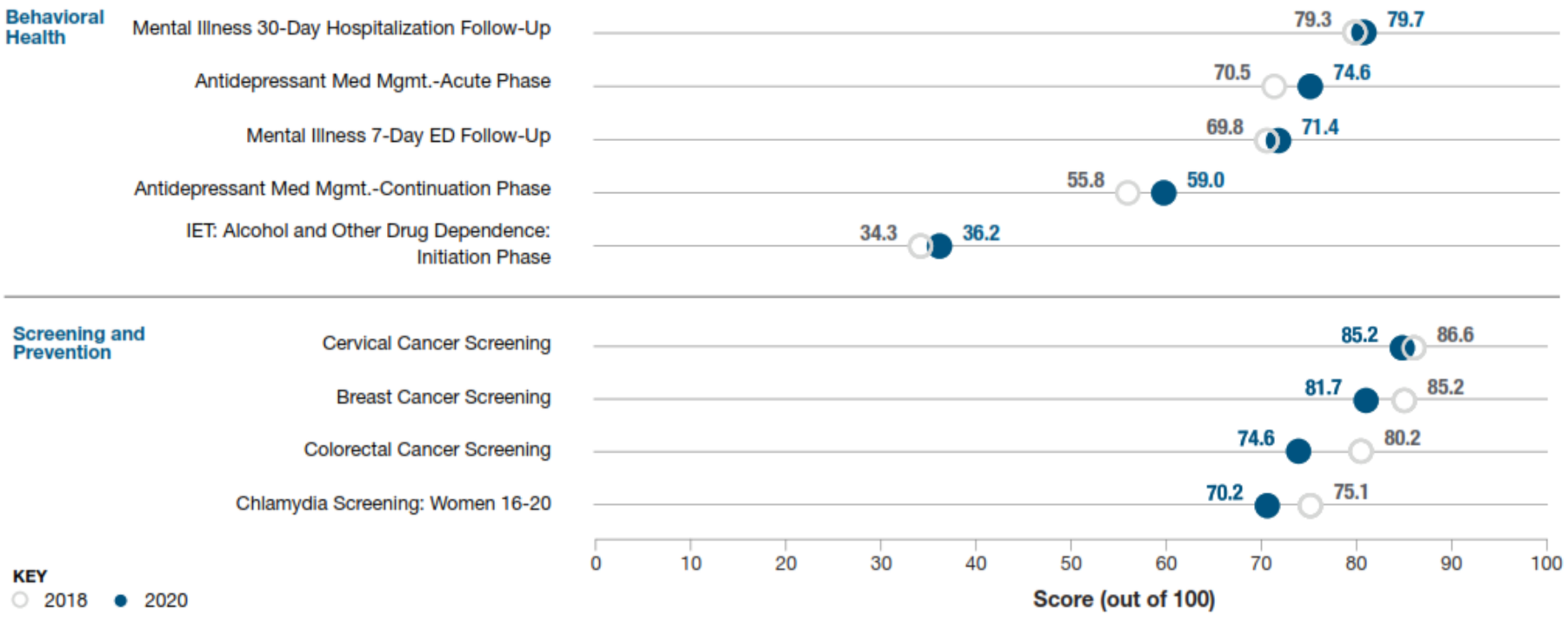
Health Status Adjusted (HSA) PMPM Trends by Payer, 2019-2020



HSA TME trends varied across commercial payers as decreased utilization drove lower risk score trends in many networks.

Quality of Care

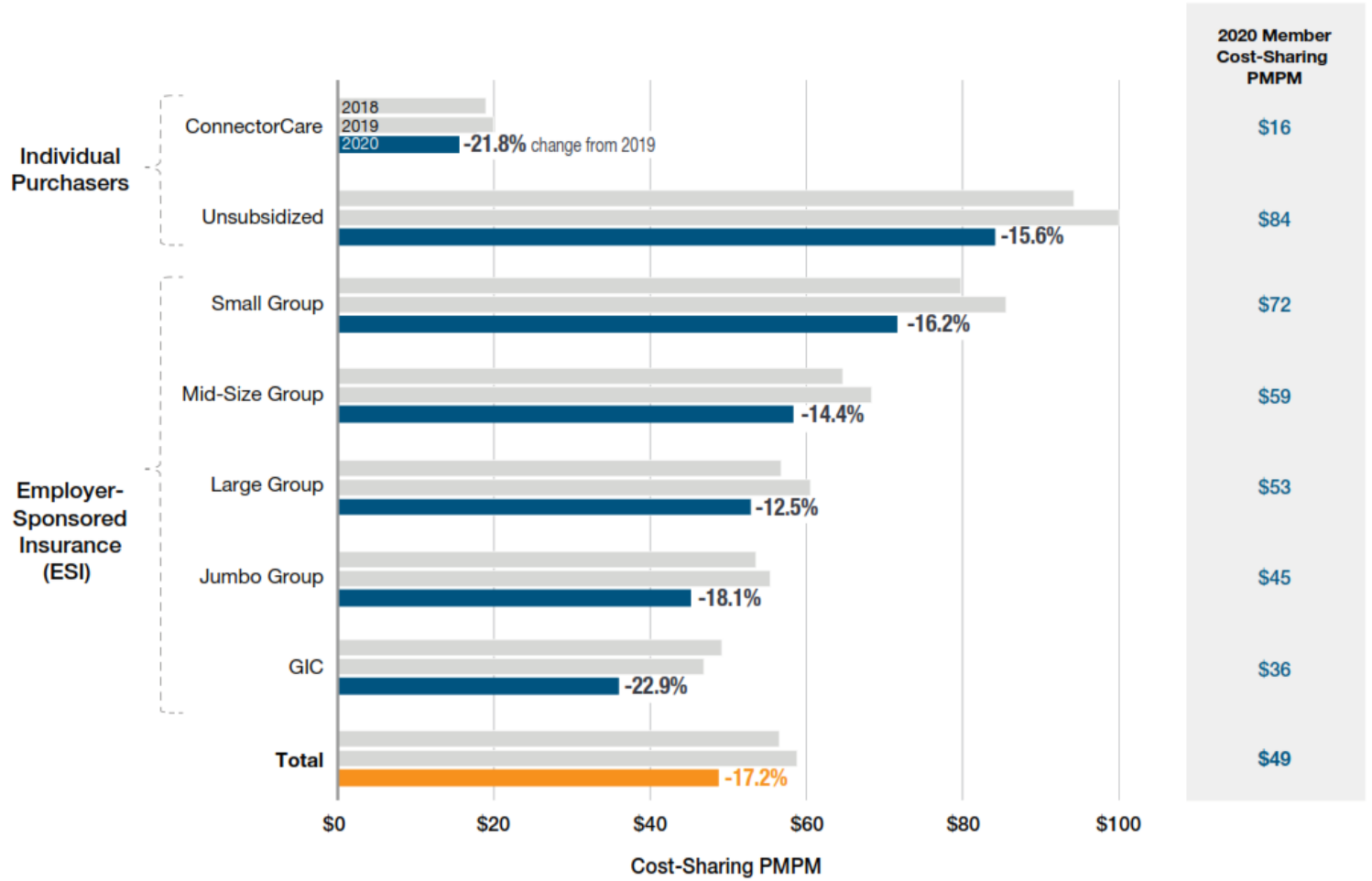
Statewide Scores on Selected Clinical Quality Measures, 2018 and 2020



HEDIS scores were higher in 2020 than in 2018 for measures in the Behavioral Health domain and lower for measures in the Screening and Prevention domain.

Private Commercial Insurance

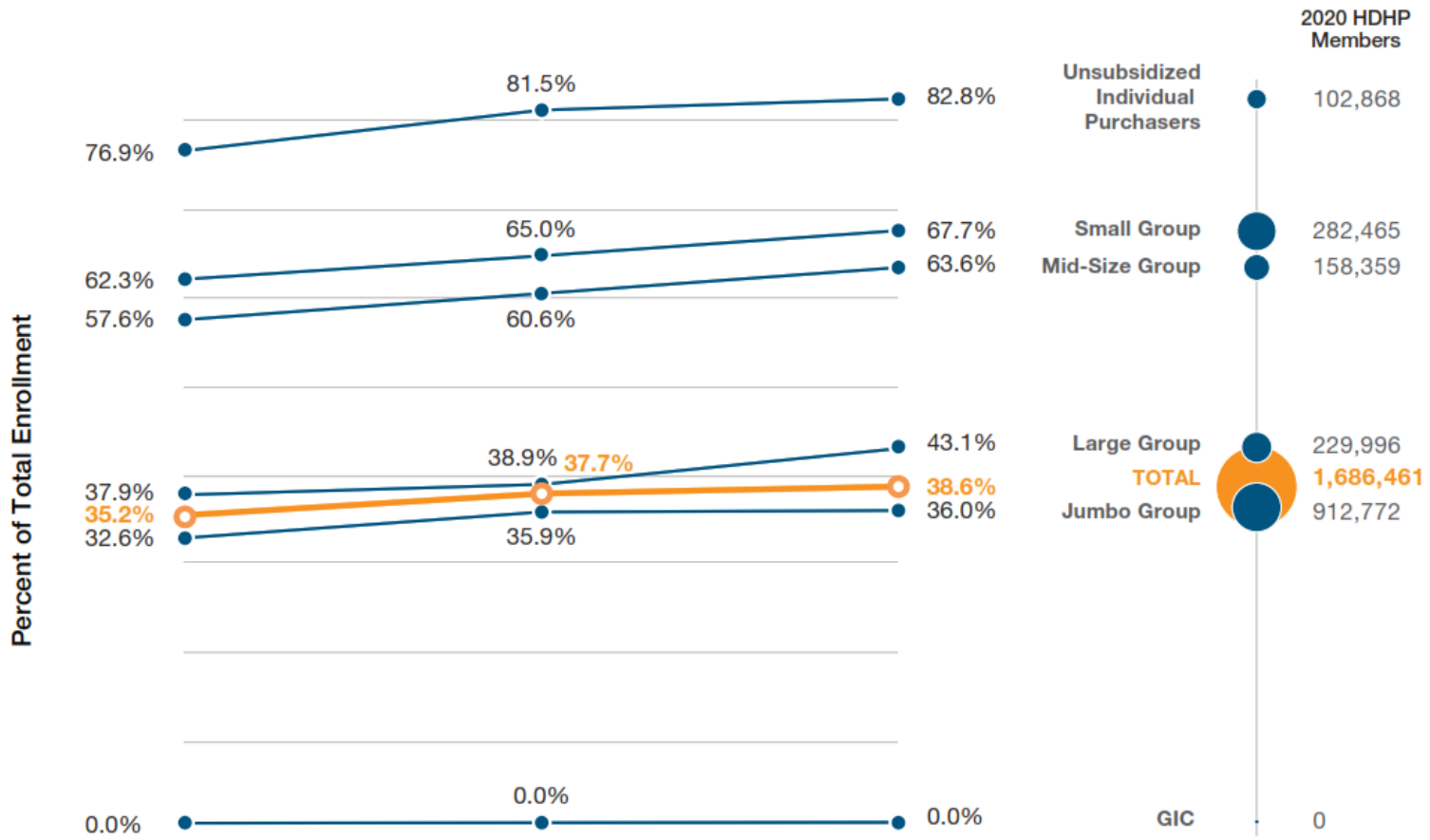
Member Cost-Sharing by Market Sector, 2018-2020



Member cost-sharing fell 17.2% to $49 PMPM in 2020, as overall commercial spending declined. Members covered by larger employers had lower cost-sharing and higher plan benefit levels.

Private Commercial Insurance

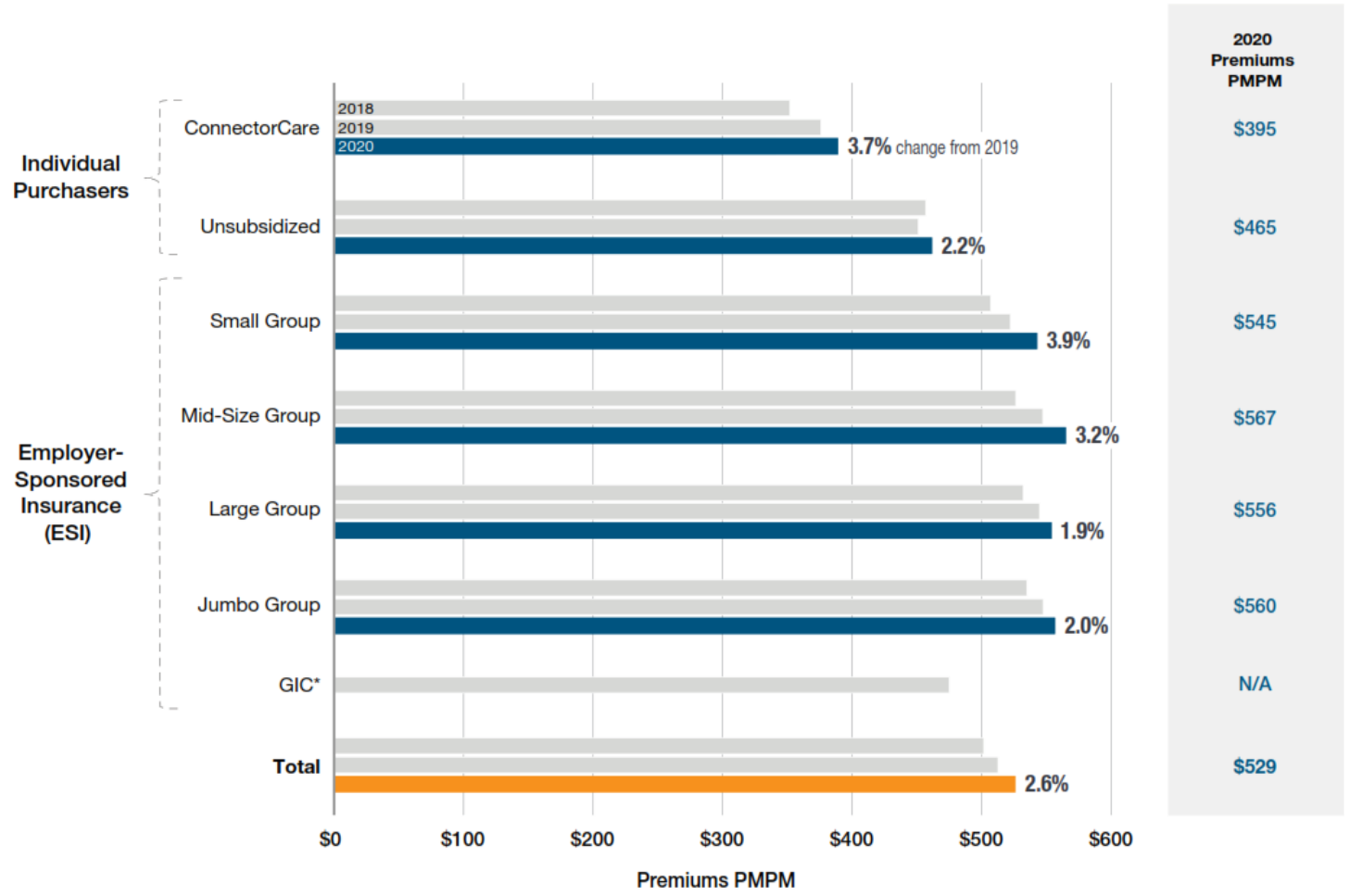
High Deductible Health Plan Enrollment by Market Sector, 2018-2020



In 2020, 82.8% of unsubsidized individual purchasers and over 60% of members covered by small and mid-size employers were enrolled in plans with individual policy deductibles of $1,400 or more.

Private Commercial Insurance

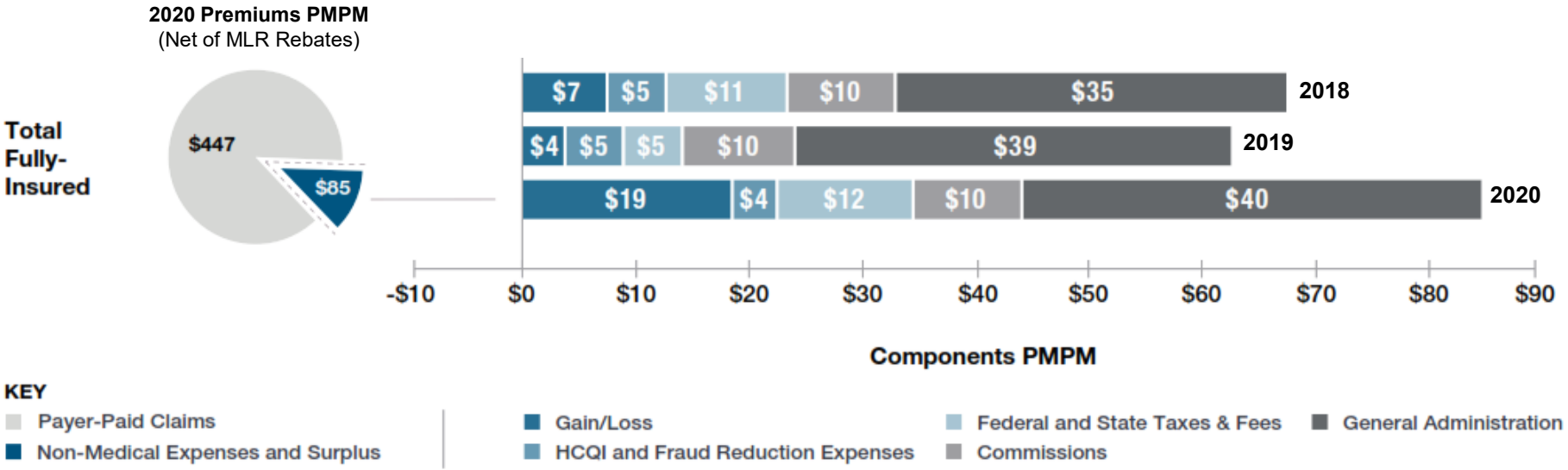
Fully-Insured Premiums by Market Sector, 2018-2020



Fully-insured premiums increased by 2.6% from 2019 to 2020, after growing 2.3% in the prior year. Premium rates for 2020 coverage were developed before the pandemic using historical data.

Private Commercial Insurance

Fully-Insured Non-Medical Expense Components and Surplus, 2018-2020



In 2020, payers spent $40 PMPM on general administration, the largest component of non-medical expenses and surplus. Payer surplus (gains) grew to $19 PMPM amid unexpectedly low utilization of health care services.

Sample of More Recent CHIA Data

Hospital Utilization and Financial Trends

- Hospital Inpatient Discharge Reporting; data through December 2021
  Currently available

- Quarterly Hospital Financial Performance Report; data through September 2021
  - *Data through December 2021 forthcoming in March*

Health Insurance Enrollment

- Enrollment Trends; data through March 2021
  - *Data through September 2021 forthcoming in March*

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REPORT ON STATE SPENDING PERFORMANCE

- 2020 Spending Trends
- Affordability
- Expectations for 2021: National
- Expectations for 2021: Massachusetts

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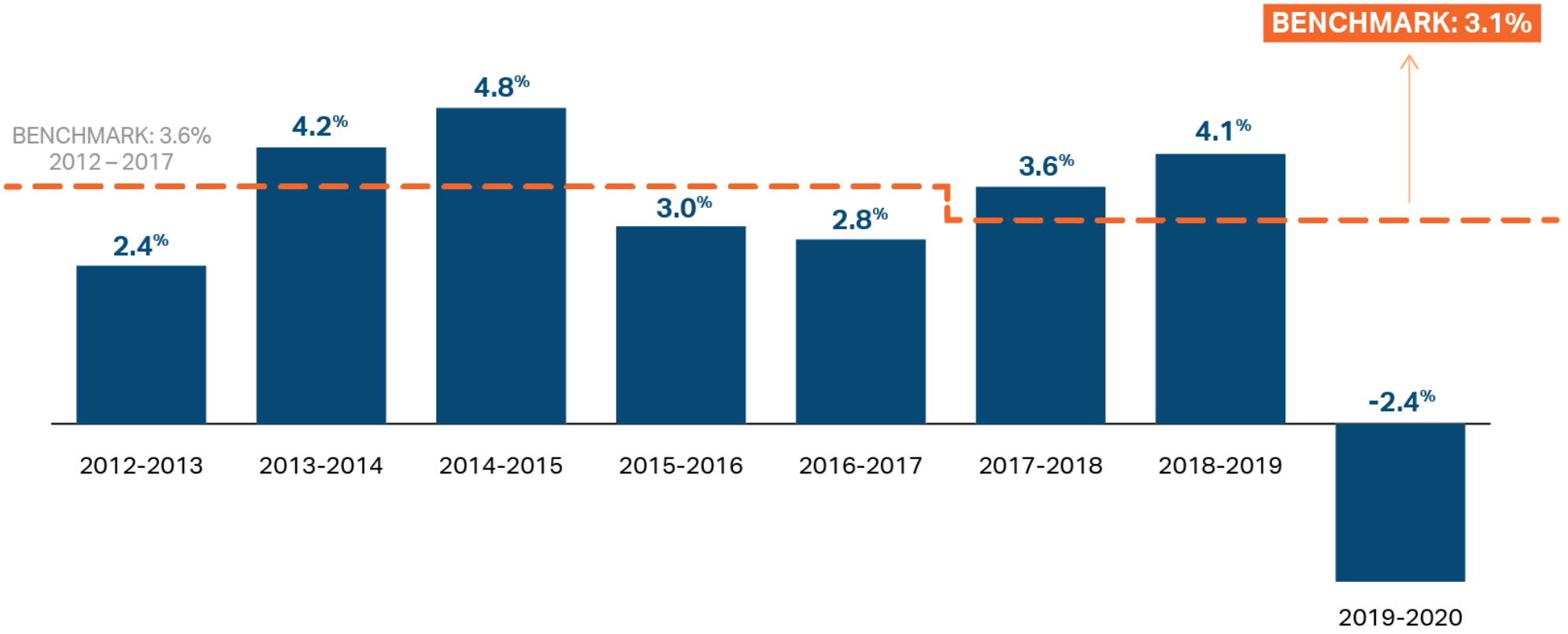
After exceeding the benchmark in 2018 and 2019, total spending declined in 2020 due to reduced use of care resulting from the COVID-19 pandemic.

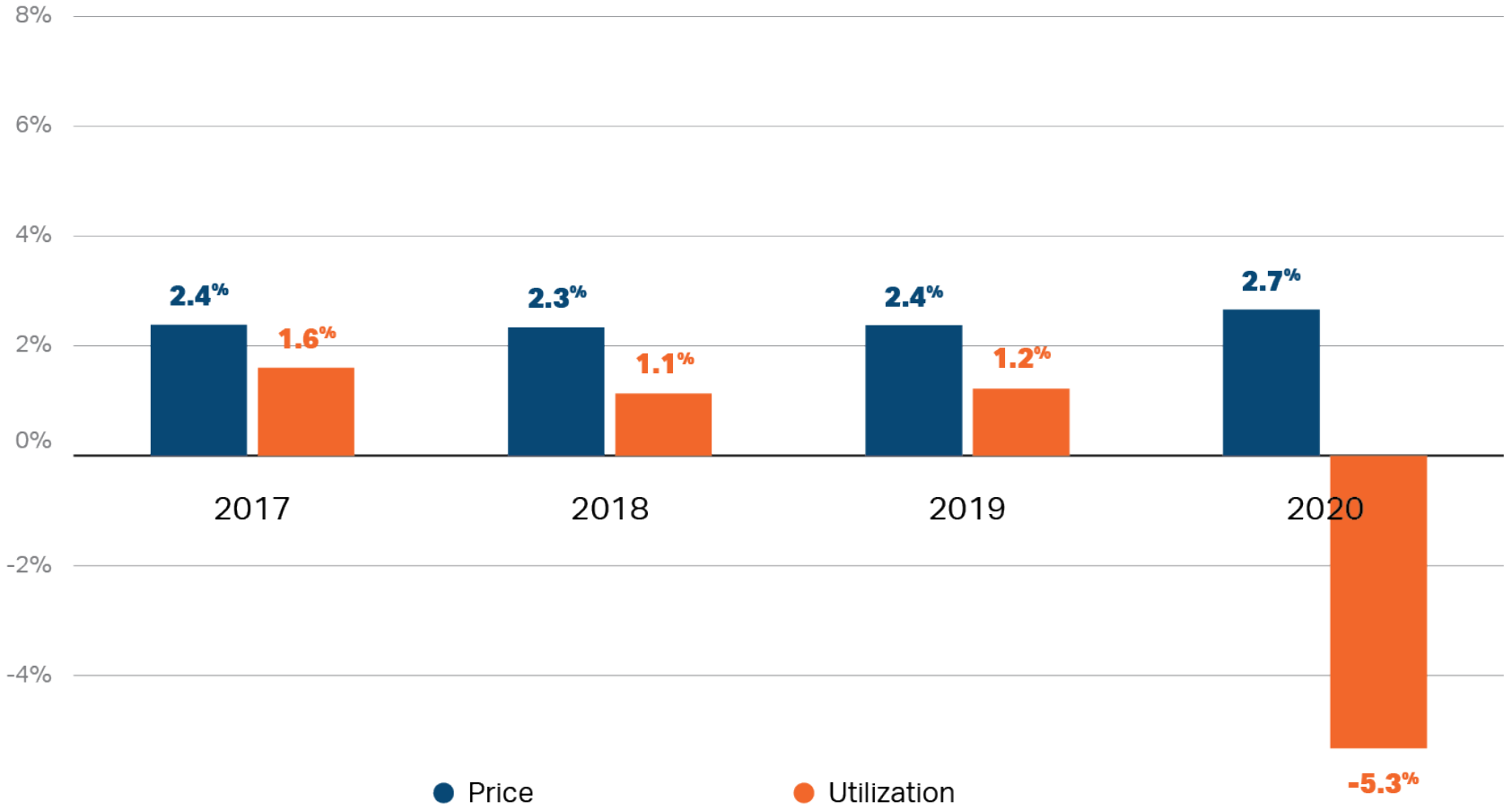
Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2020



Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2022.

The decline in spending in 2020 was entirely due to a reduction in use of care. Commercial prices for care accelerated 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.

Commercial price growth was greater in hospital settings than in other settings.

Massachusetts commercial price growth by category, 2018 to 2020

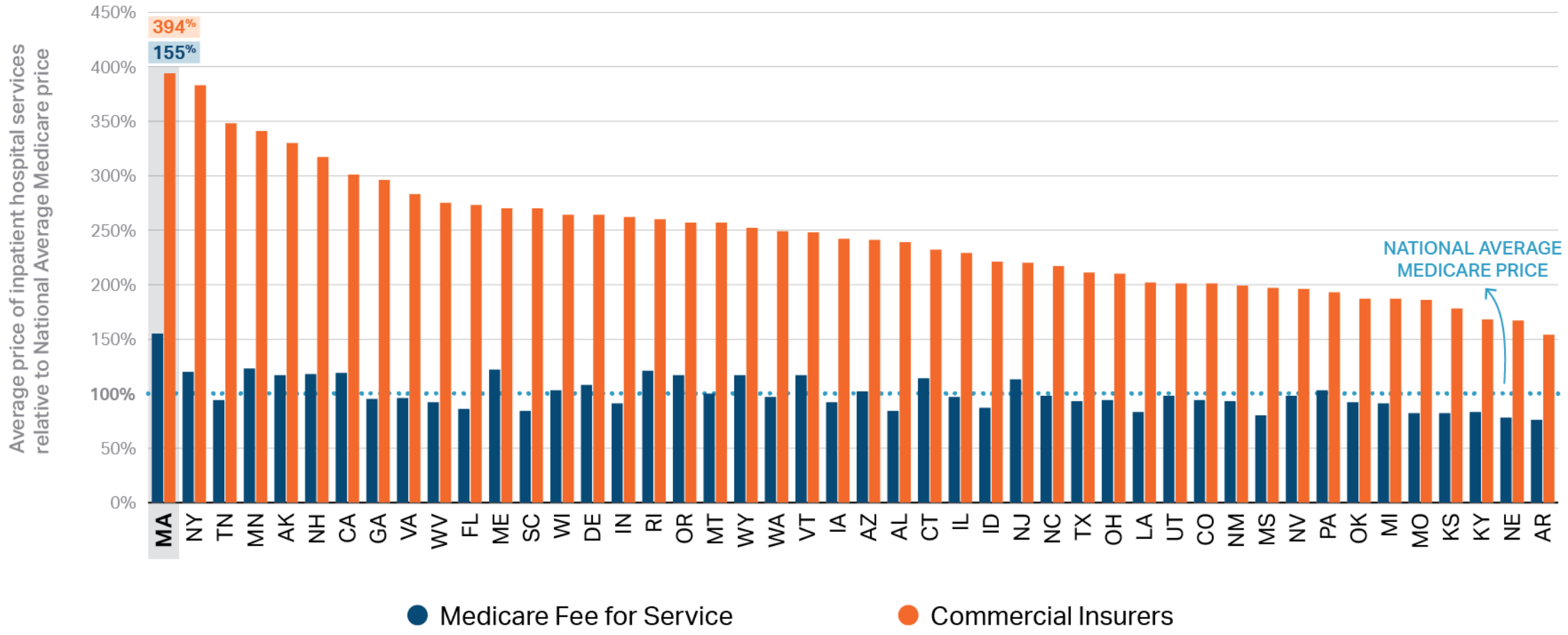
- Hospital inpatient stays: **9.1%**
  - *Price growth was 4.5% in 2018-19 and 4.6% in 2019-20*
  - *~3% of commercial inpatient stays were COVID-related in 2020*
- Hospital outpatient visits and services: **5.8%**
- Office-based services: **3.2%**

Notes: Price growth for outpatient and office-based services is computed at the level of the procedure code encounter. Average payment growth for inpatient stays includes both facility and professional claims for an inpatient stay. Inpatient stays were identified by MS-DRG (thus price growth does not include trends in coding higher-severity DRGs). Services and stays were weighted by their 2018 aggregate spending. For more detail, please see 2021 CTR Price Chart Pack.

Sources: Massachusetts Health Policy Commission analysis of CHIA's Hospital Inpatient Discharge Database, 2020 and CHIA's All-Payer Claims database, 2018-2020. The APCD price and payment analyses only examined commercial BCBSMA, Tufts, HPHC, Anthem, and AllWays.

Compared to other states, Massachusetts inpatient hospital prices were already high in 2018, according to the Congressional Budget Office.

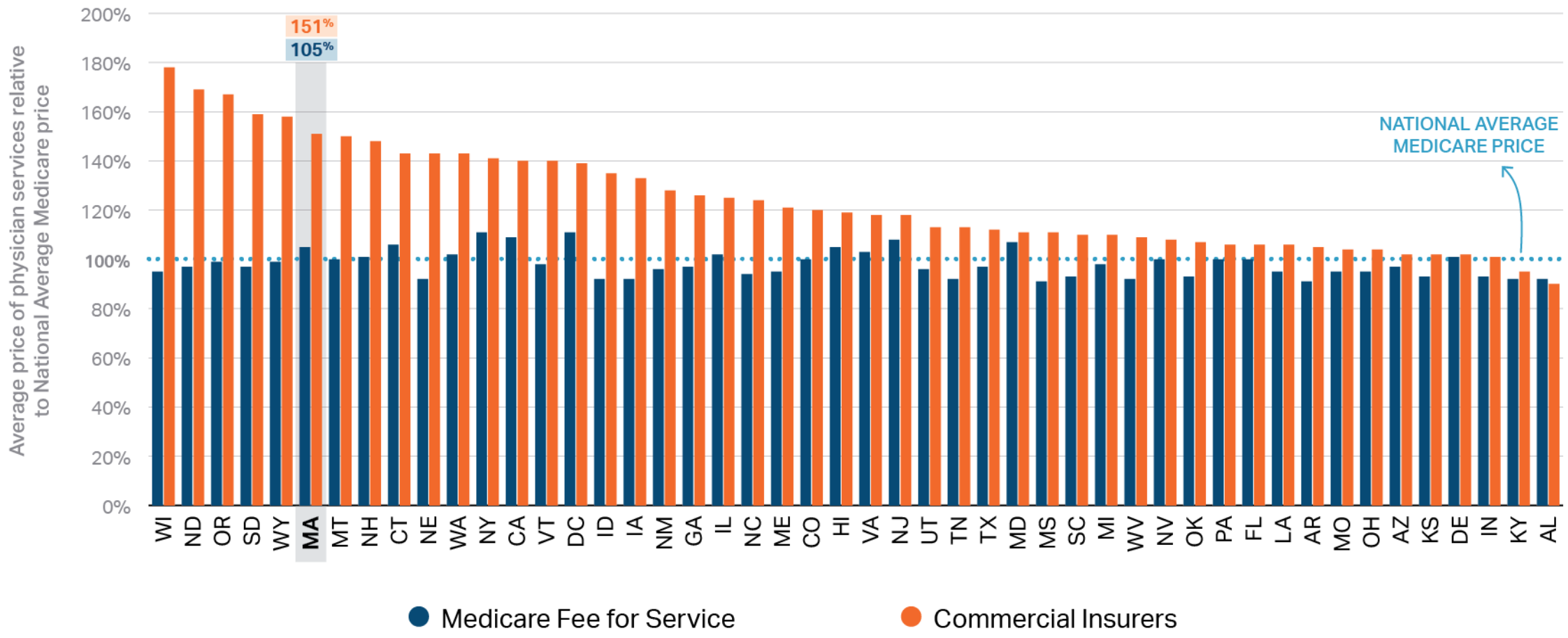
Commercial and Medicare hospital inpatient prices relative to the national average Medicare price, as a percentage, 2018



Source: https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf. Underlying data from CBO's analysis of aggregate data from Christopher M. Whaley and others, Nationwide Evaluation of Health Care Paid by Private Plans: Findings From Round 3 of an Employer-Led Transparency Initiative, RR-4394-RWJ (RAND, 2020), https://doi.org/10.7249/RR4394. Data originate from 120 self-insured employers who participated in the study.

Massachusetts also had among the highest prices for physician services in the U.S. in 2017.

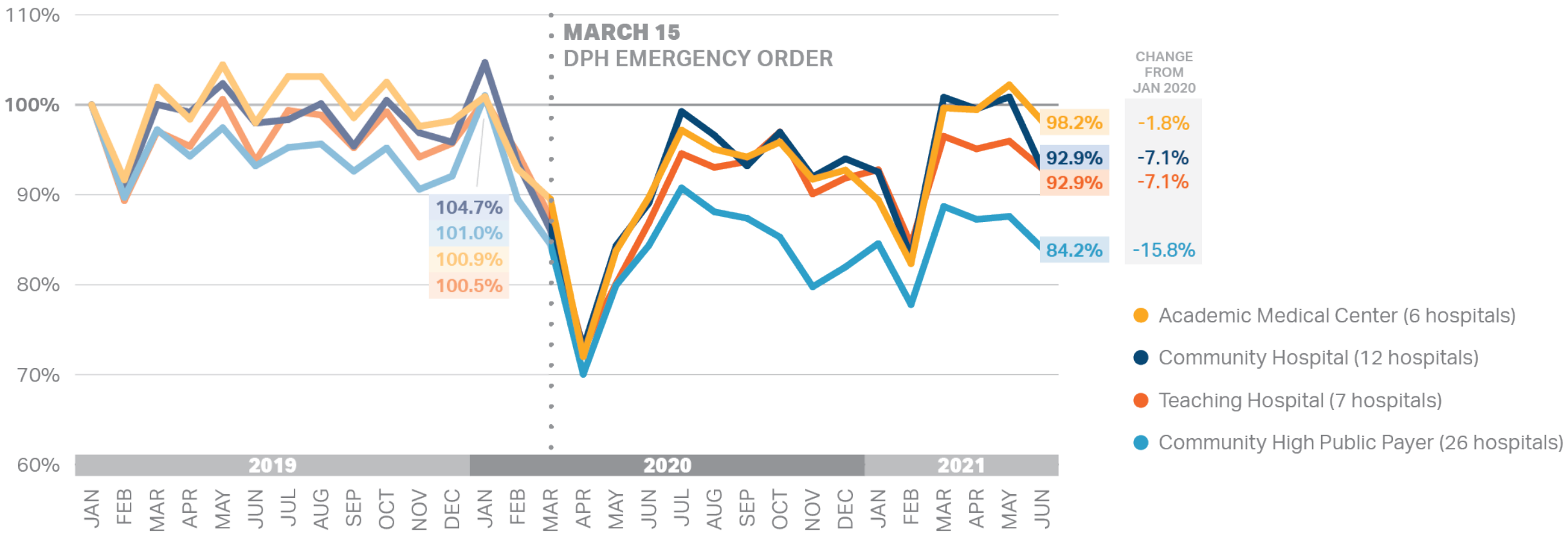
Commercial and Medicare physician prices relative to the national average Medicare price, as a percentage, 2017



Data source: CBO's analysis of aggregate data from Bill Johnson and others, "Comparing Commercial and Medicare Professional Service Prices: Public Use File" (Health Care Cost Institute, August 13, 2020), https://tinyurl.com/3xux3hzj. Underlying data originate from Aetna, United Health care and Humana.

Price increases also reflect shifts toward higher-priced settings of care.

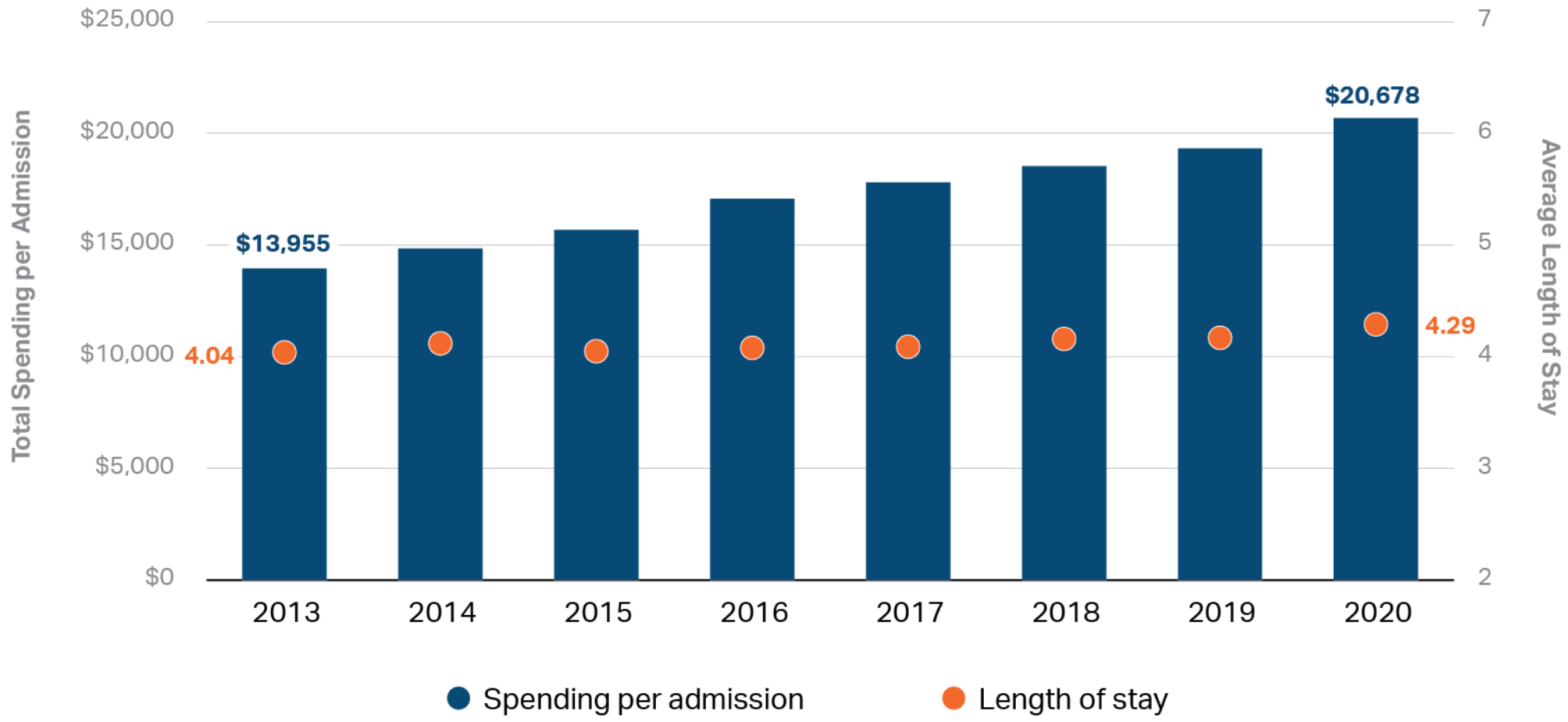
Inpatient hospital discharges by hospital cohort, percentage relative to January 2019



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

Overall, commercial spending per hospital discharge increased 7.0% in 2020 and 48% since 2013.

Total inpatient spending per commercial discharge and average length of stay for commercial hospital stays, 2013-2020



Notes: Certain discharges were excluded from the analysis including transfers, rehabilitation stays, those from Shriner's Hospital, and those with LOS more than 180 days.
Sources: CHIA Hospital Inpatient Discharge Data, 2013-2020 (volume and LOS). Spending data are derived from full and partial-claims commercial spending by category for 2016-9 and full claims only from 2013-6 (based on data availability) from the Massachusetts Center for Health Information and Analysis' Annual reports from 2013-2022.

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- 2020 Spending Trends
- **AFFORDABILITY**
- Expectations for 2021: National
- Expectations for 2021: Massachusetts

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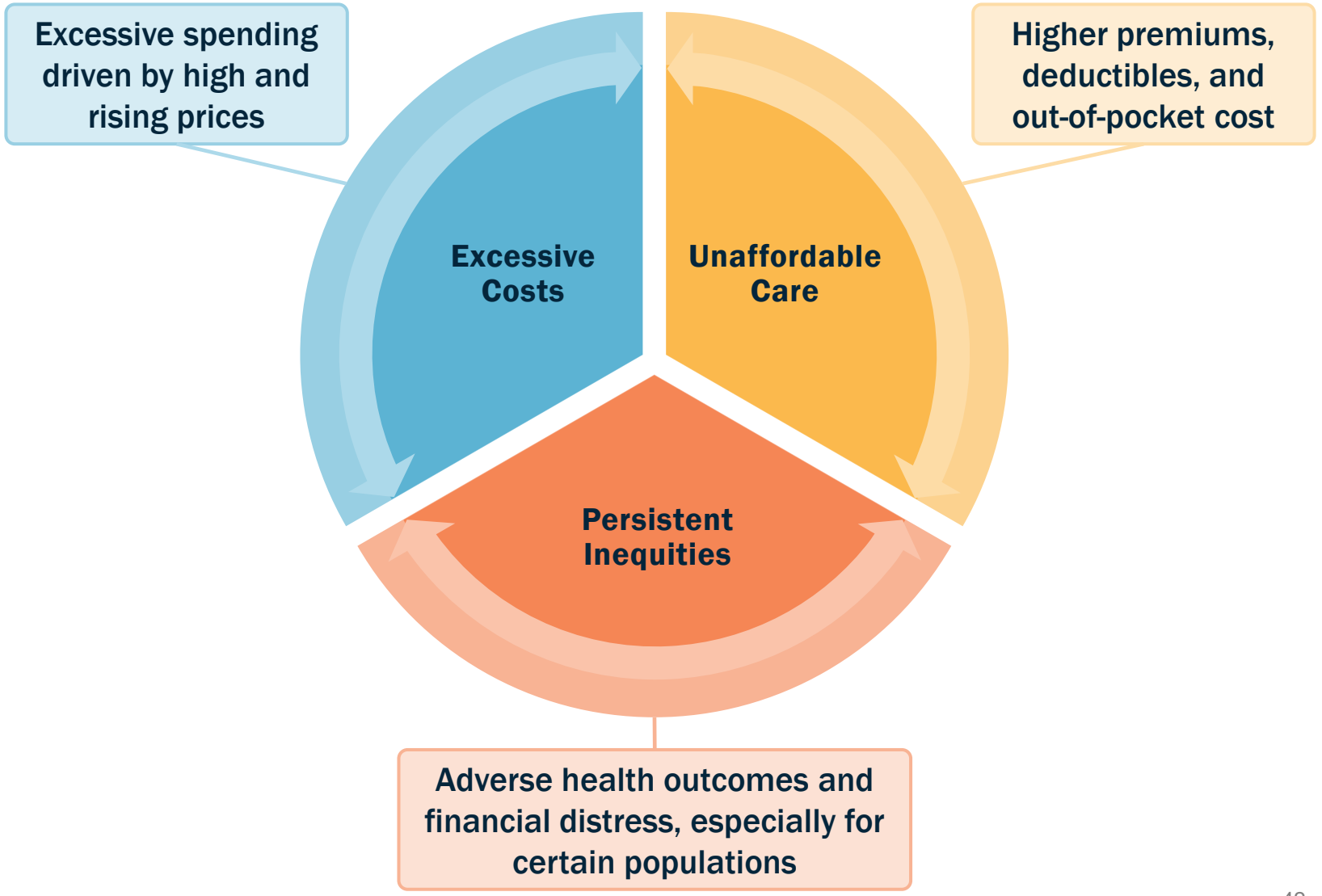
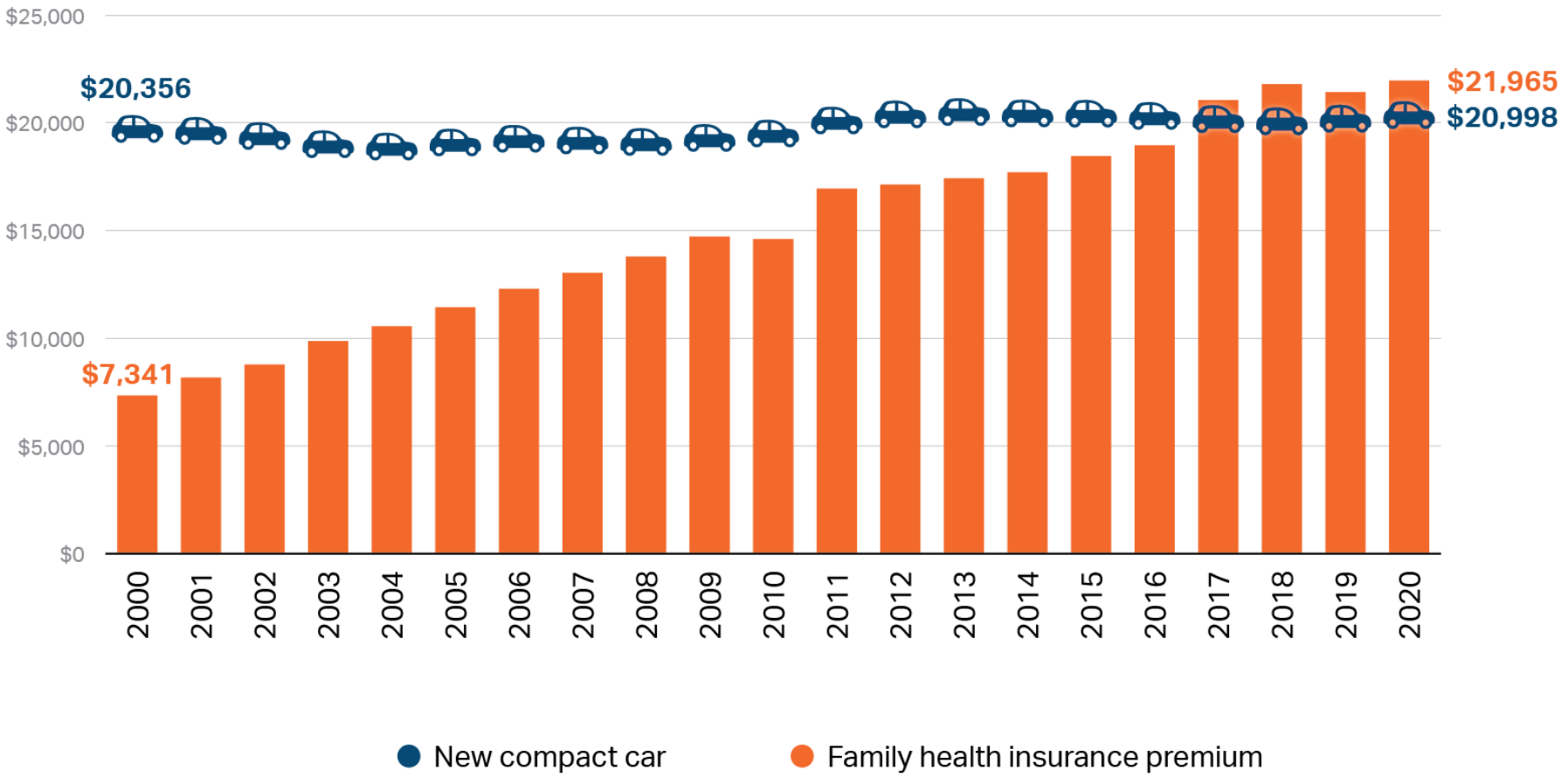
Declining affordability, which can lead to missed care, adverse health outcomes, and financial distress, is a direct consequence of higher prices and premiums.



Massachusetts family health insurance premiums grew an additional $500 annually in 2020, adding to financial burdens.

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



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

In 2020:

- Premiums for Massachusetts families were the 7th highest in the U.S.
- 10% of premiums exceeded $30,000 annually (or $2,500 monthly).

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

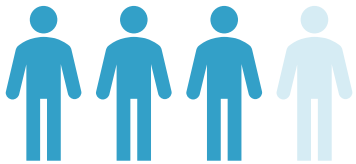
Percent of Massachusetts adults who reported the following outcomes based on survey of 1,158 Massachusetts adults, May 2021

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

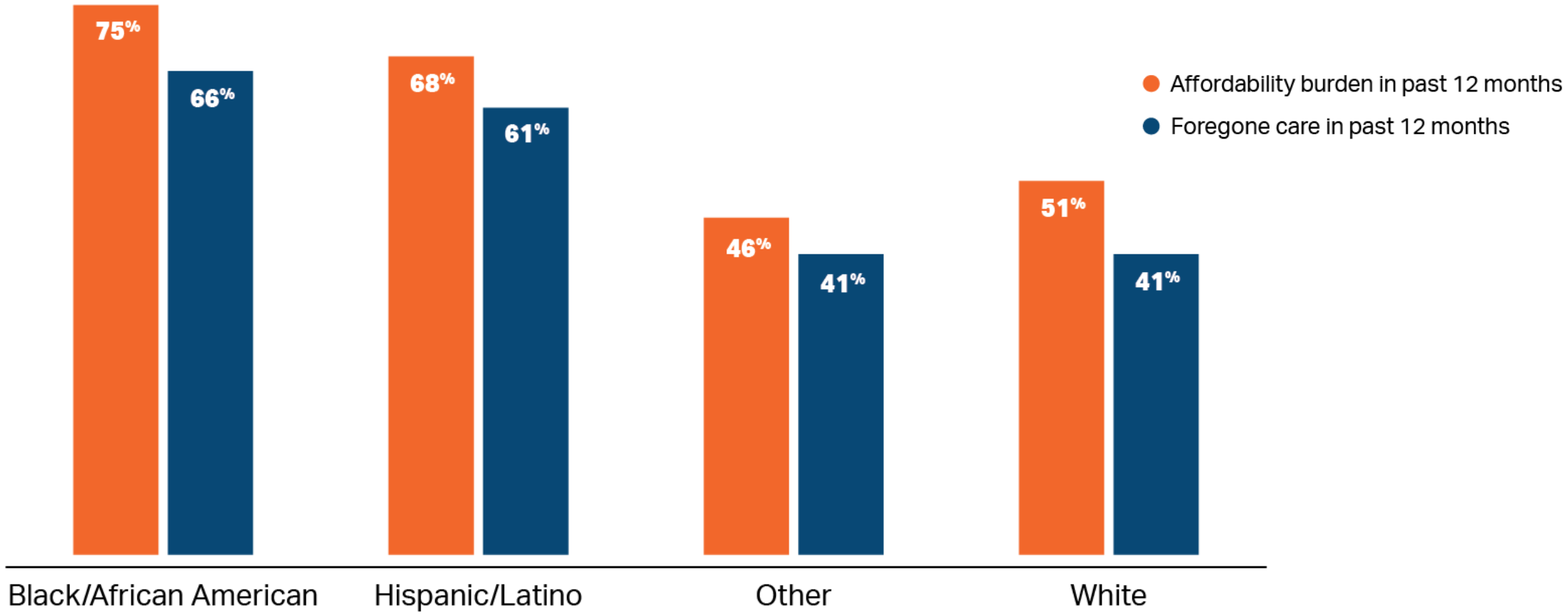


3 in 4 Massachusetts residents are worried about affording health care in the future.

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.

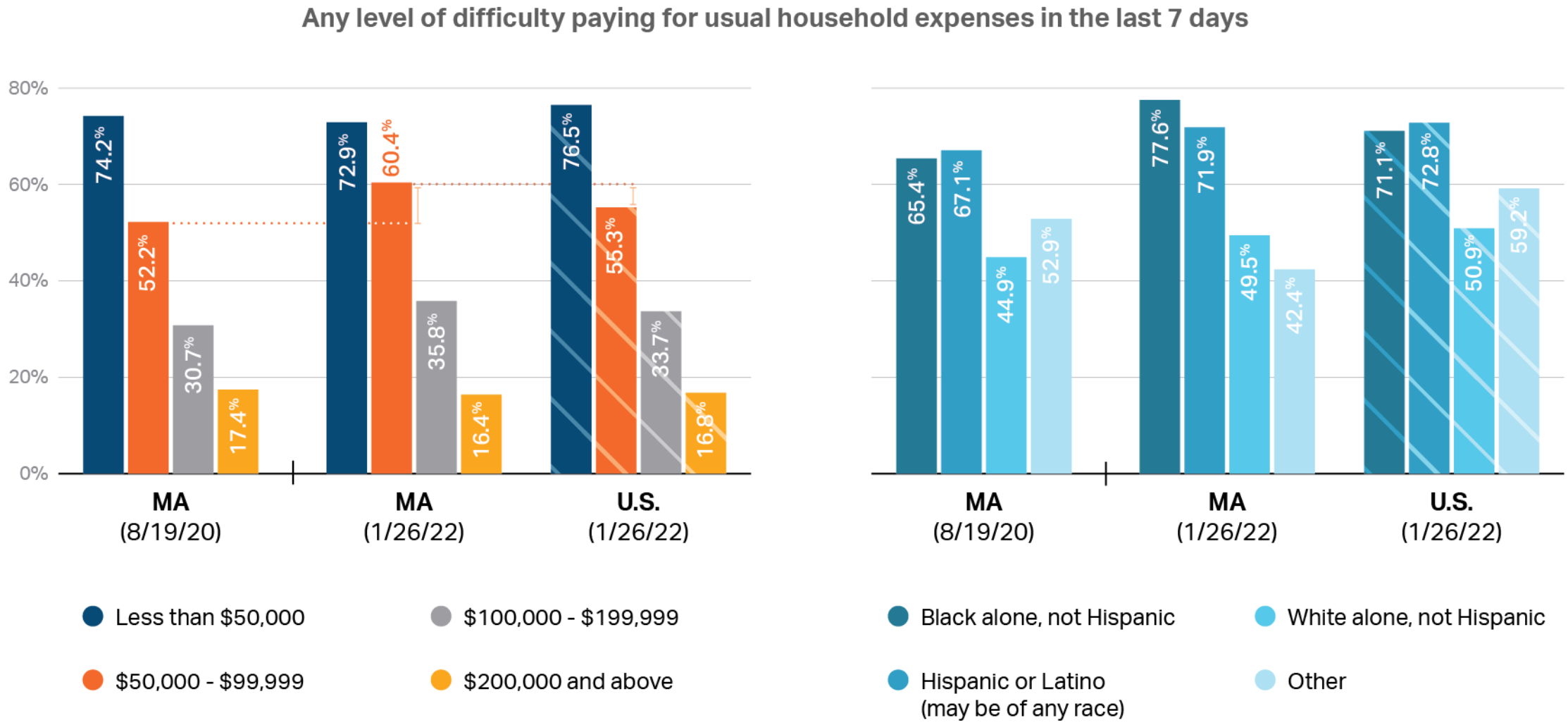
Affordability burdens and foregone care are greater for residents of color.

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



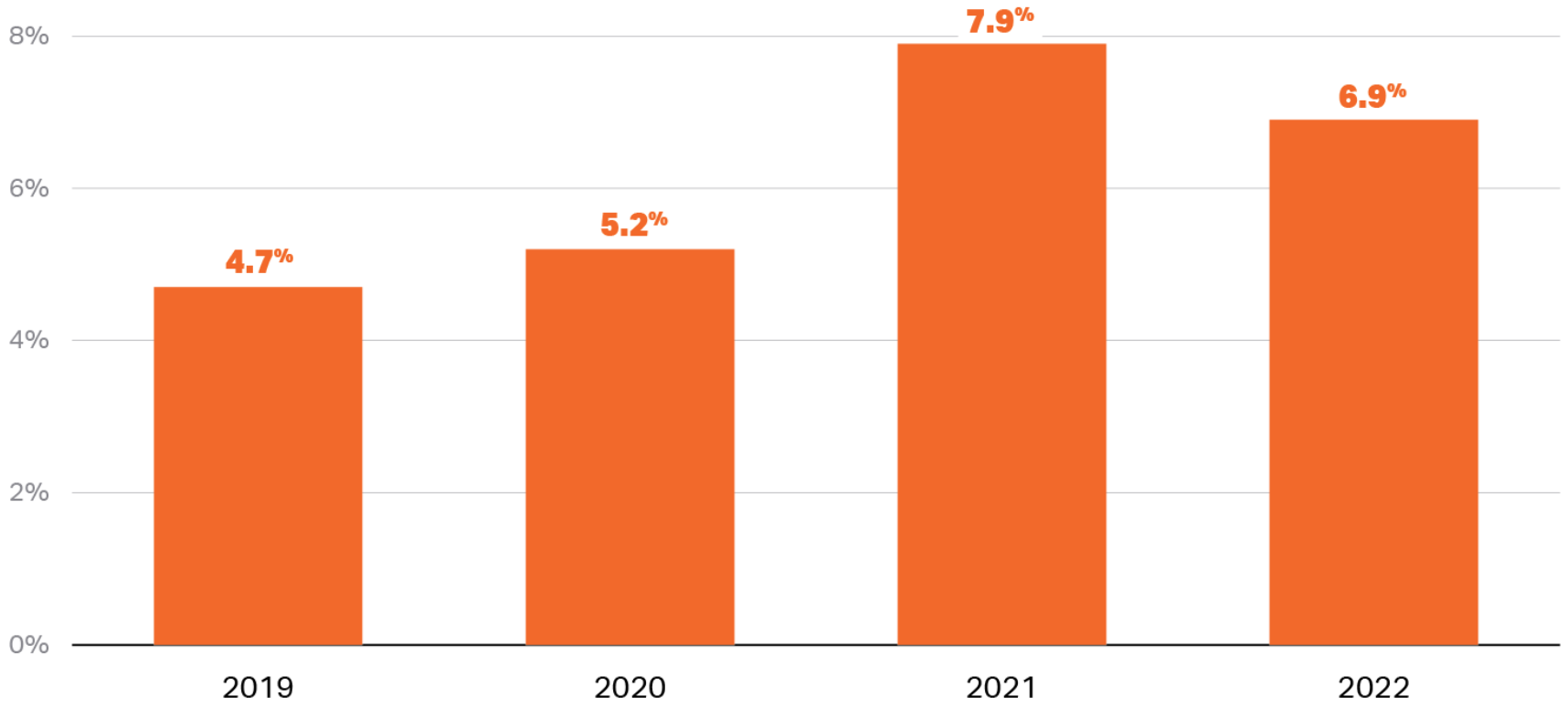
Notes: Affordability burden defined as any of the following: 1) Being uninsured due to cost, 2) Delaying or foregoing health care due to cost, or 3) Struggling to pay medical bills.
Source: Altarum Healthcare Value Hub, Data Brief 97, September 2021," Massachusetts Residents Struggle to Afford High Healthcare 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.

60% of Massachusetts residents with lower income had difficulty paying basic household bills in January 2022, more than in August 2020 and more than in the U.S. overall.



Premiums in the Massachusetts merged market (small group and Connector) grew markedly in 2021 and 2022.

Approved final average rate increases among plan members of the Massachusetts merged market for the rate year shown



Source: Massachusetts Division of Insurance as reported in: https://www.healthinsurance.org/health-insurance-marketplaces/massachusetts/

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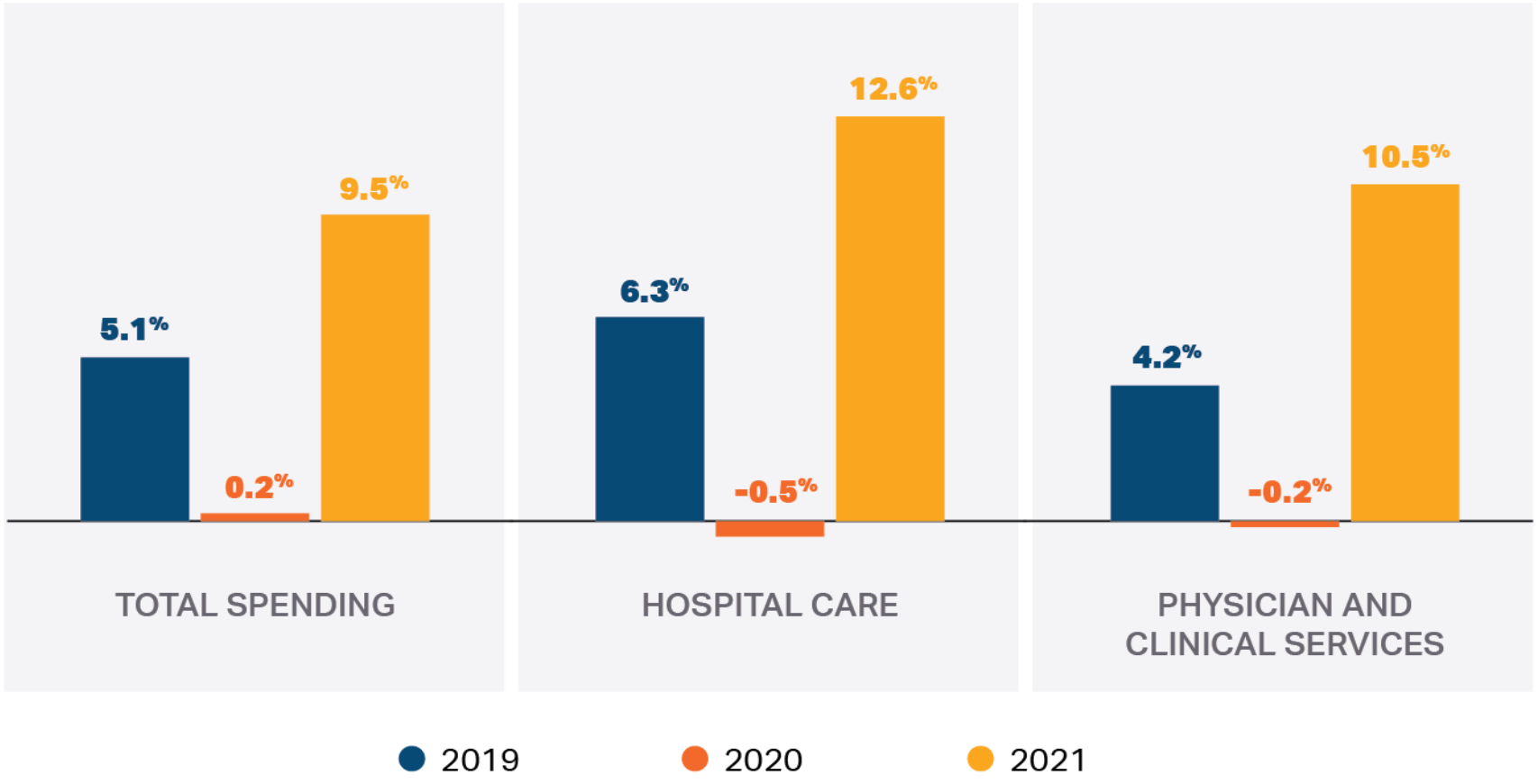
- 2020 Spending Trends
- Affordability
- **EXPECTATIONS FOR 2021: NATIONAL**
- Expectations for 2021: Massachusetts

Keynote Presentation and Discussion

Public Testimony

National health care spending was flat in 2020 and grew nearly 10% in 2021.

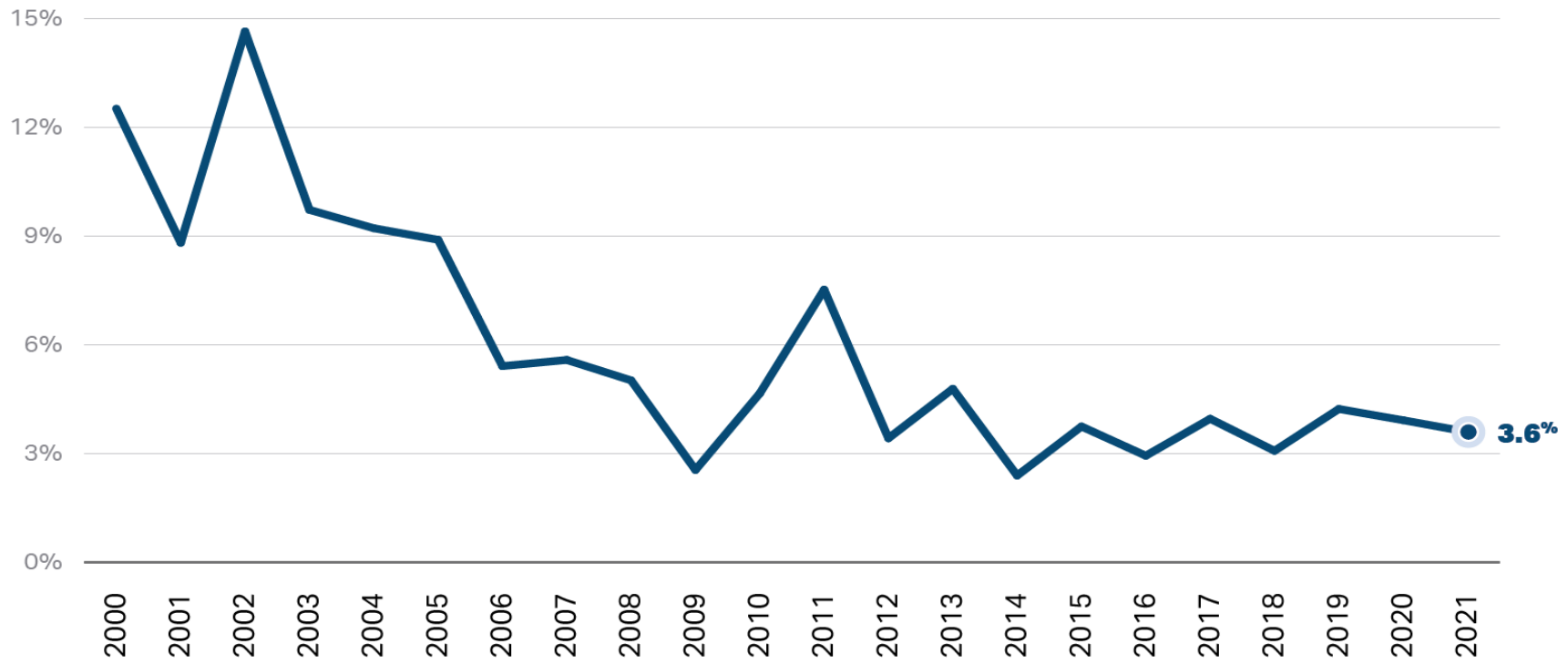
National growth in health care spending for the year shown relative to the previous year, by sector, all payers



Notes: Data do not include federal supplemental COVID-related spending such as from the CARES act or the paycheck protection program.
Sources: Data provided to the HPC by the Altarum Institute and based on data from spending briefs such as here: https://altarum.org/publications/february-2022-health-sector-economic-indicators-briefs
Underlying data from the US Bureau of Economic Analysis.

National employer-sponsored health insurance premiums grew 3.9% in 2020 and 3.6% in 2021.

Annual growth in single-coverage full premium between the previous year and the year shown

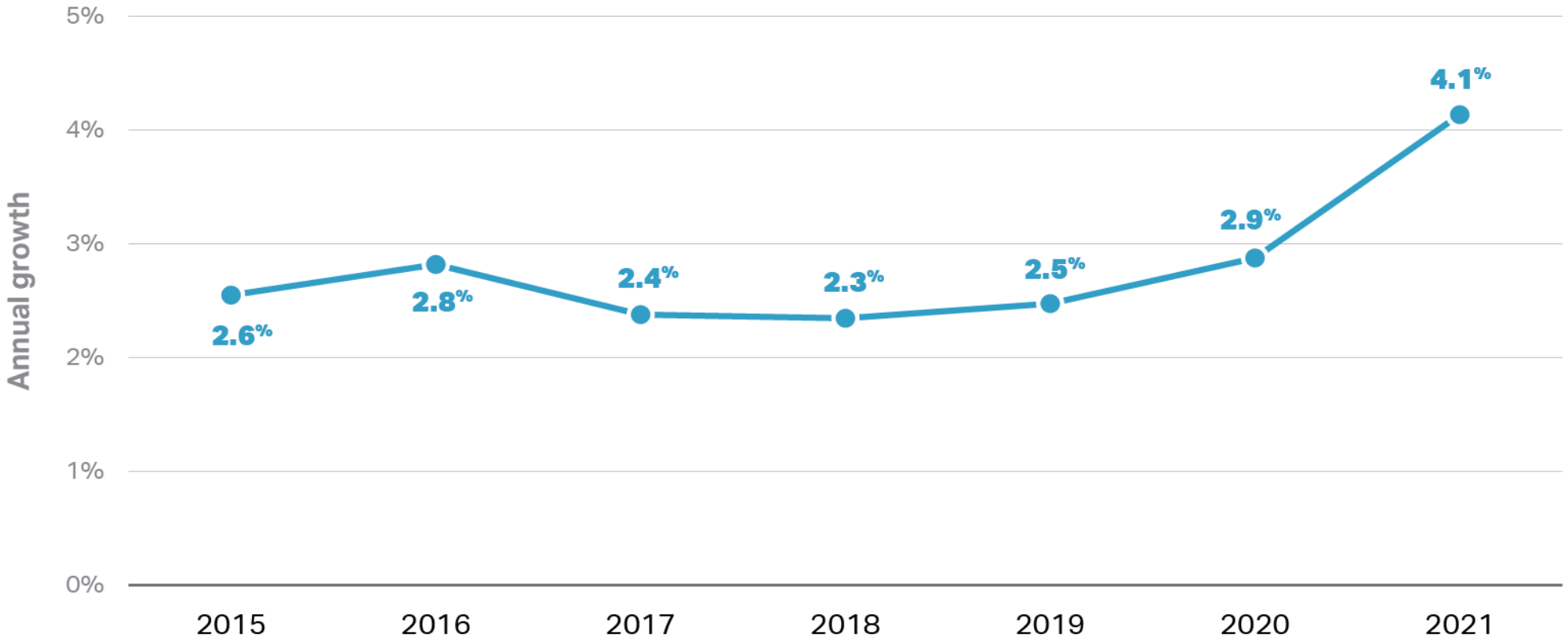


In a review of 311 individual market rate filings from across the U.S., **85%** expected a negligible impact or no impact of COVID on spending growth in 2022.

Source: Kaiser Family Foundation/Health Educational Research Trust Employer Health Benefits Survey. www.kff.org/health-costs/report/2021-employer-health-benefits-survey/. Insurer filings suggest COVID-19 will not drive health spending in 2022. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/insurer-filings-suggest-covid-19-pandemic-will-not-drive-health-spending-in-2022/

National commercial hospital prices accelerated in 2021.

Annual growth in commercial hospital prices from the previous calendar year to the year shown.



Source: Altarum Institute, Health Sector Economic Briefs: Price brief. Underlying data provided to the HPC by the Altarum Institute. Prices based on underlying producer price index data for hospitals calculated by the Bureau of Labor Statistics

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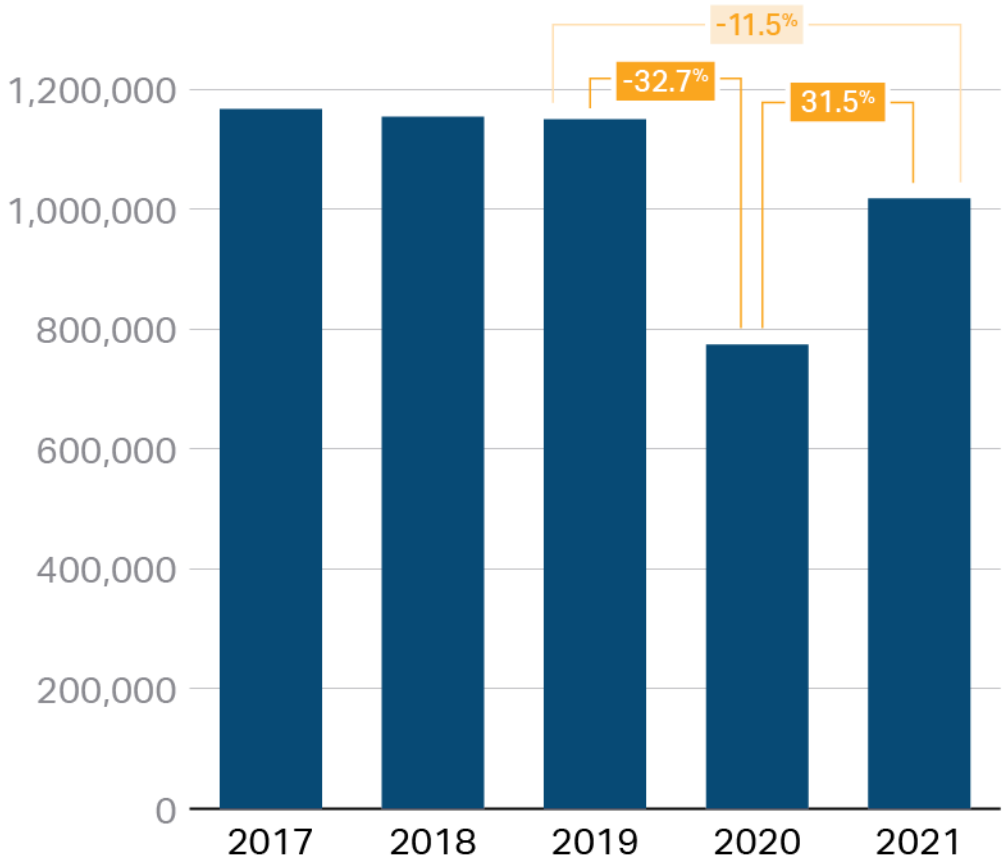
- Expectations for 2021: National
- **EXPECTATIONS FOR 2021: MASSACHUSETTS**

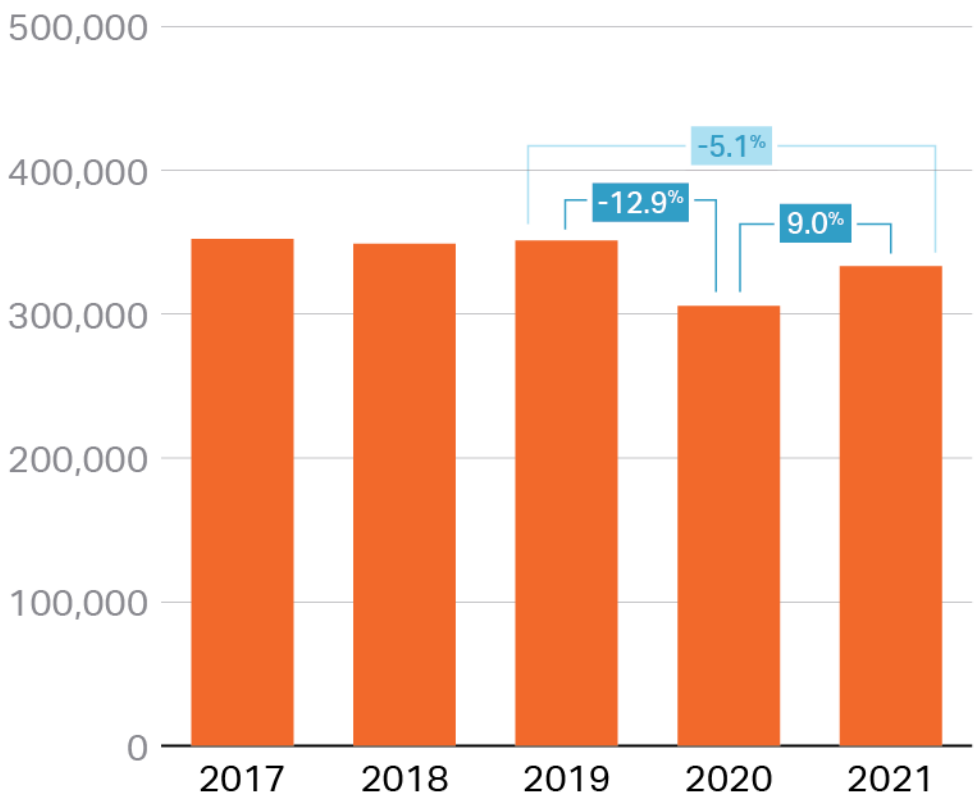
Keynote Presentation and Discussion

Public Testimony

After dropping dramatically in 2020, emergency department and inpatient hospital volume in 2021 nearly reached 2019 levels.



ED VISITS
(March through September)

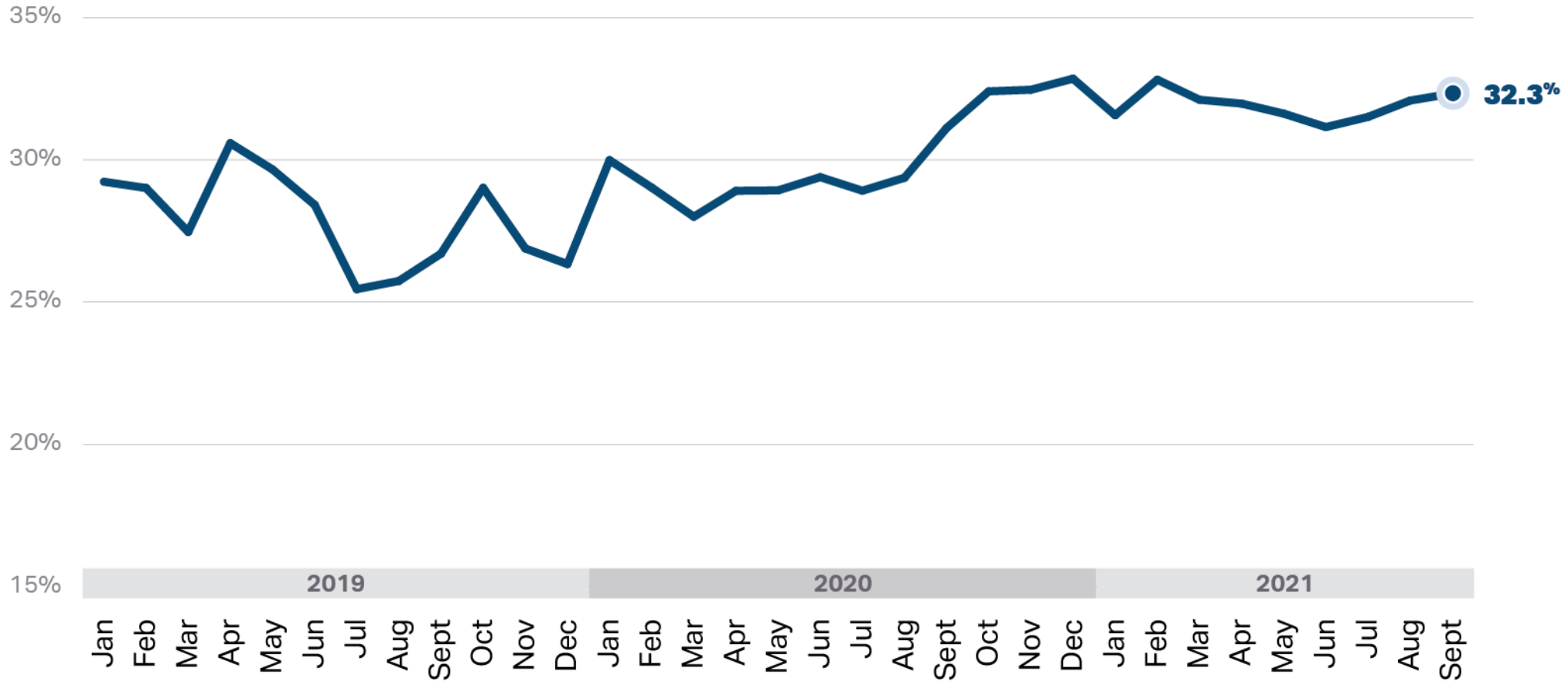


DISCHARGES
(March through September)

Notes: Visits shown occurred between March 15 and Sept 15 of each year, to provide the best possible comparison with 2020 when the impact of COVID was at its greatest.
Sources: Health Policy Commission analysis of CHIA emergency department database and hospital inpatient database, 2017-2021.

Approximately one-third of patients admitted to the ED in late 2020 and 2021 for behavioral health reasons were boarded for more than 12 hours, a higher rate than before the pandemic.

Percent of behavioral health ED visits that resulted in boarding, January 2019 to September 2021

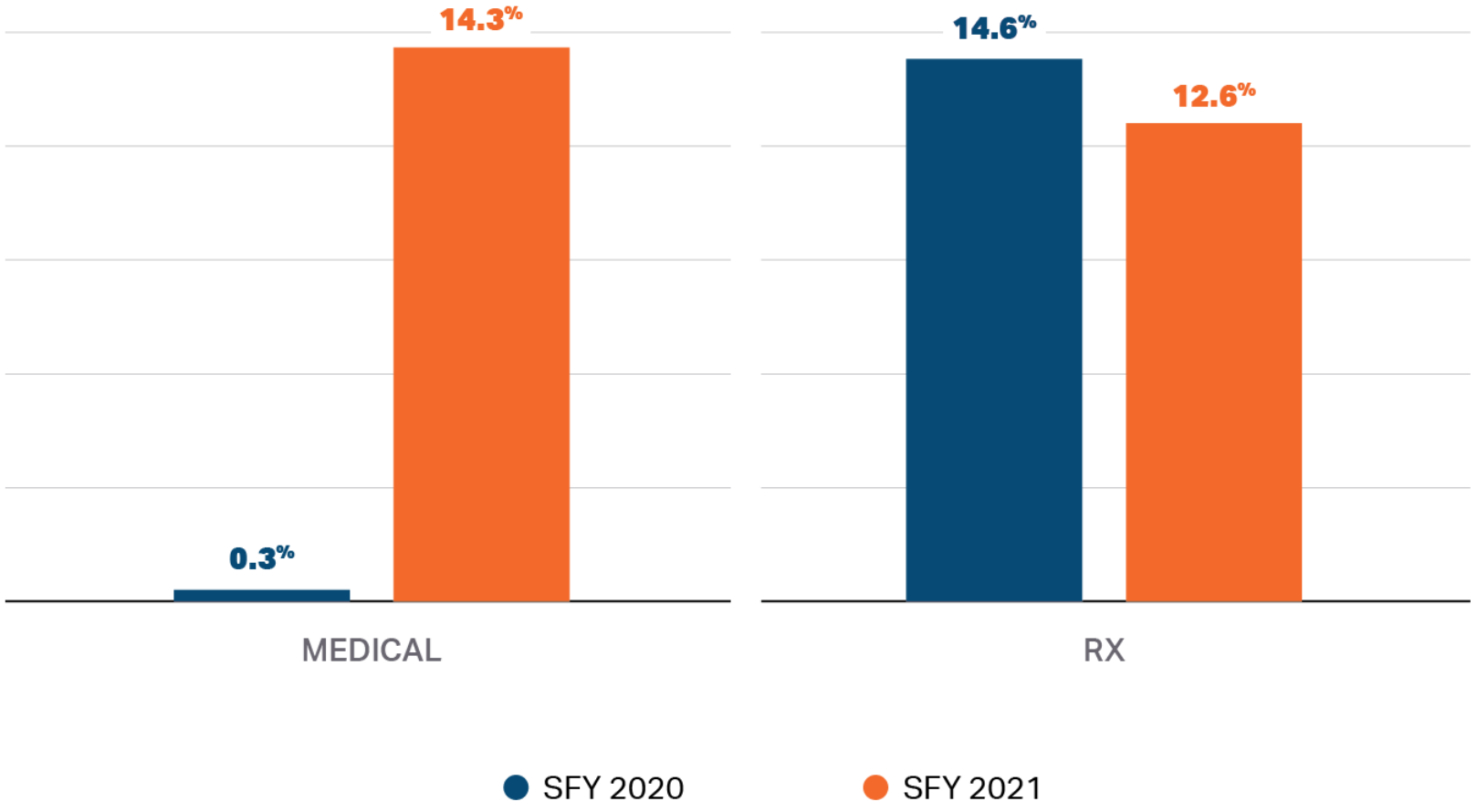


Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034). ED sites were excluded if they had incomplete data or for data irregularities in the length of stay variable (6 ED sites).

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019-FY2020, preliminary FY2021.

Similar to the national trend, spending growth in the GIC increased by over 10% in 2021.

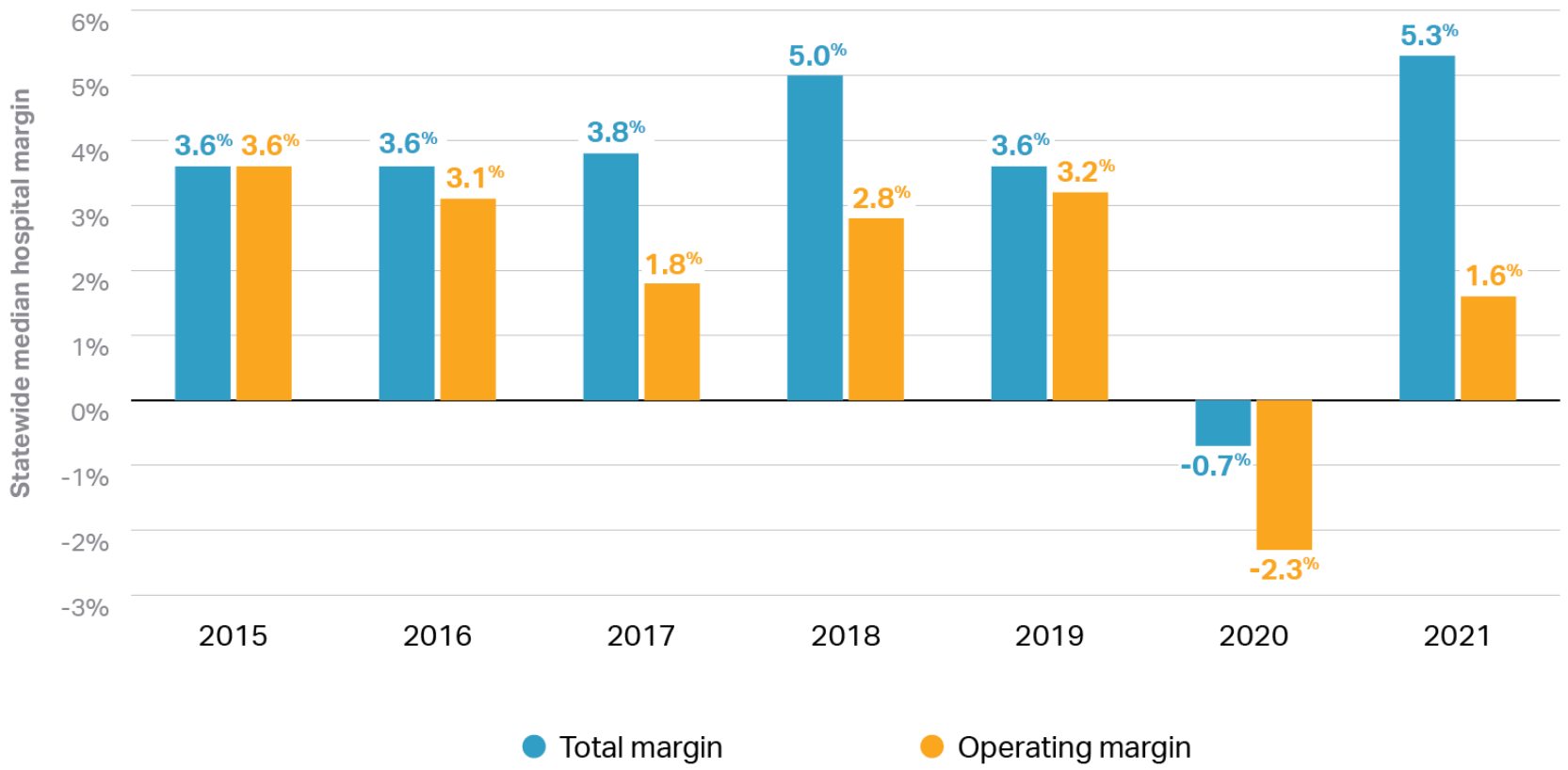
Change in medical and prescription drug spending (gross) for GIC enrollees between July 1 of the previous year and June 30 of the year shown.



Data sourced from the Group Insurance Commission MedInsight Claims Data Warehouse. Includes all claims incurred by GIC non-Medicare subscribers with Active employment status and their covered dependents between State Fiscal Year 2019 and 2021. Claims run-out was not included for any of the fiscal years shown (claims incurred and paid through June of each year), therefore inpatient trends may not be fully reflected in the medical trend. These figures do not account for the impact of non-claims payments or prescription drug rebates.

Hospital finances have experienced volatility during the pandemic, with significant variation across hospitals.

Statewide median total and operating hospital margins for the 9-month period ending in June of the year shown.



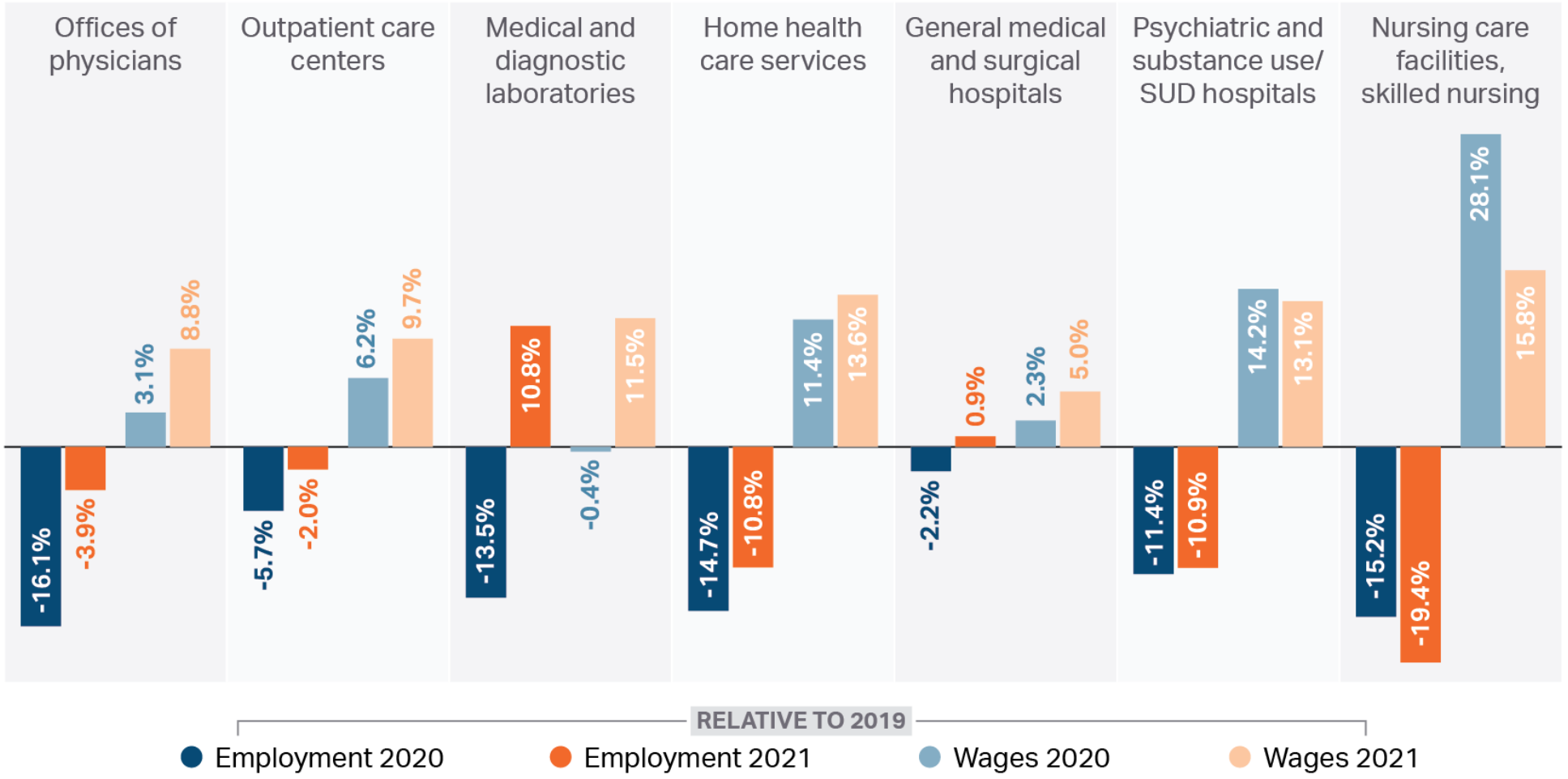
Notes: Data represent 9 months with the exception of Tenet, Steward and Shriners for which data represents 6 months ending June 30, 2021. Cambridge and Mercy Medical Center are not included. The data includes 59 of the 61 Massachusetts acute hospitals. In FY 2020 and 2021 the total and non-operating margins include COVID-19 relief funds reported as operating revenue. Total hospital margins (shown) include both operating and non-operating margins combined. There was an accounting change in FY 2020 that included unrealized investment gains or losses in non-operating margins.

Source: Massachusetts Center for Health Information and Analysis, *Hospital and Health System Financial Performance*. https://www.chiamass.gov/hospital-financial-performance/

- From 2020 to 2021, aggregate net patient service revenue grew 16.7% ($3B) while aggregate expenses grew 8.3% ($1.9B).
- 2021 financial data covers the time period prior to the introduction of the Delta and Omicron COVID-19 variants.

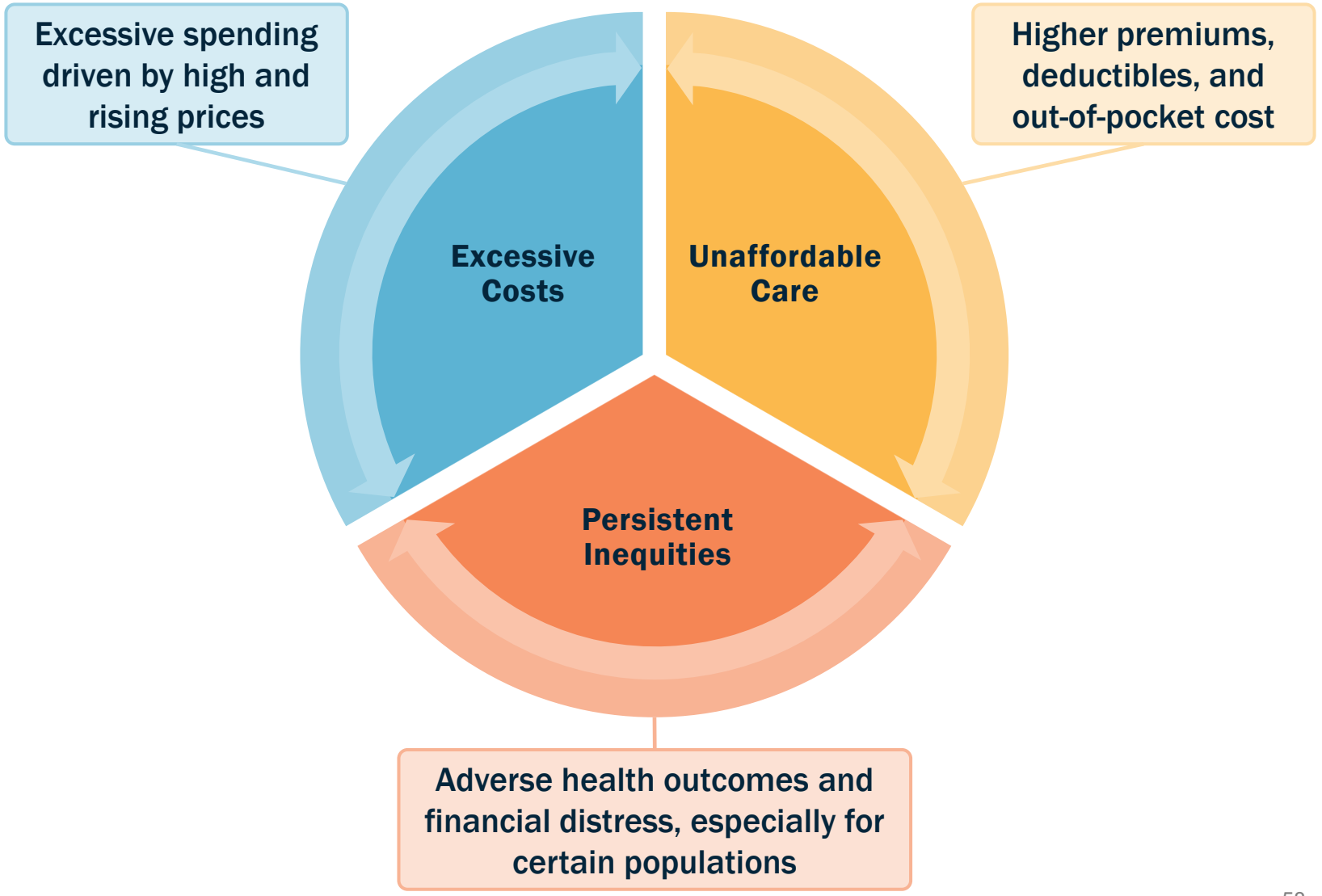
All health care sectors experienced significant volatility in employment levels and wages in 2020 and 2021, contributing to workforce challenges.

Change in second quarter (CY) employment and average wages in the year shown relative to Q2 2019



Bureau of Labor Statistics, Quarterly Census of Employment and Wages. https://lmi.dua.eol.mass.gov/LMI/EmploymentAndWages. Data obtained via the Massachusetts Department of Unemployment Assistance.

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.



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

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 3.1% annually from 2019 to 2026 versus the recent trajectory of 4%:

Total spending on health care would be reduced by

$8.3 billion

6% lower
family premiums ($26,500 vs. $28,200)
*in 2026

$5,300 more
in take-home pay per worker
*2020-2026

$622
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.

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HEALTH CARE
COST INSTITUTE

Health Care Prices: A National Perspective

Aditi P. Sen
Director of Research and Policy

Hearing on the Potential Modification of the 2023 Health Care Cost Growth Benchmark

March 16, 2022

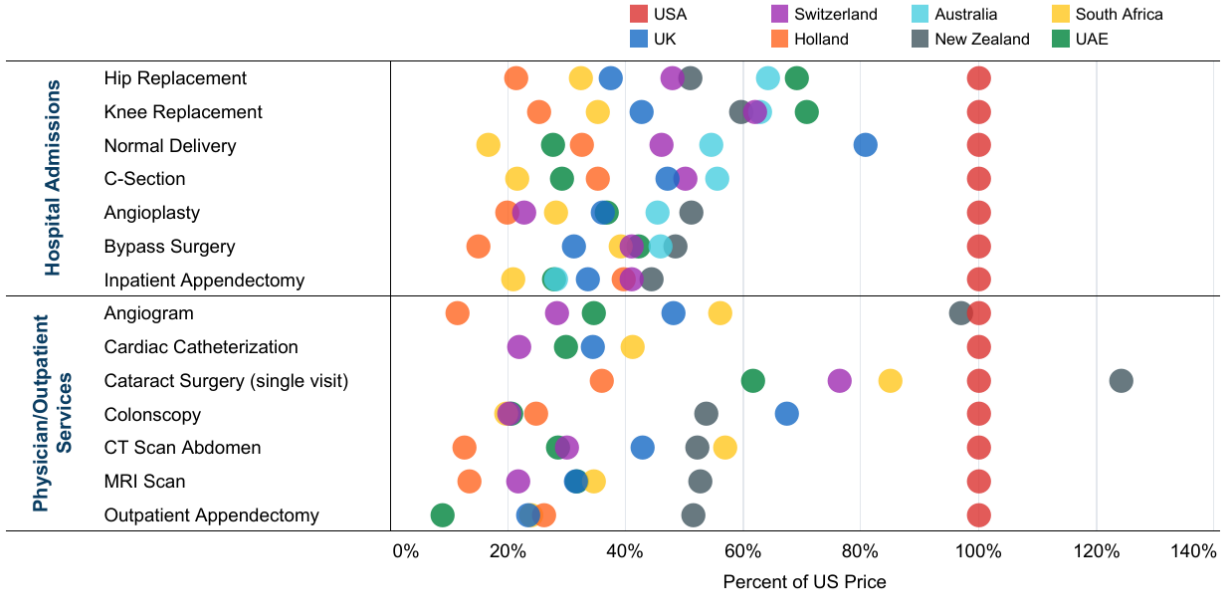
Agenda

- The role of prices in driving spending nationally and why high prices matter
- A closer look at prices:
  - Rising prices for services where use is declining
  - The significant and growing differential between commercial prices and Medicare rates
  - Disparate prices across settings for the same services
  - Substantial variation in price within systems
  - Impact of private equity acquisition on prices
- What is driving prices up and what are the options for state policymakers to reduce prices?
- Wrap-Up: A long view of prices and health care spending

Prices: High and Highly-Variable

- Higher prices than other countries
- Significant variation in prices for the same services:
  - Within markets (across hospitals, payers)
  - Within hospitals (across payers)
  - Within systems (across hospitals)
  - Across settings (physician office vs. outpatient)
  - Across payers (commercial vs. Medicare)
- Link between price and quality is not clearly established and varies across markets and hospitals – many high-quality hospitals with relatively lower prices
- Price variation not explained by patient severity/casemix

Figure 1: Medical Prices in 2017 as a Percent of US Prices



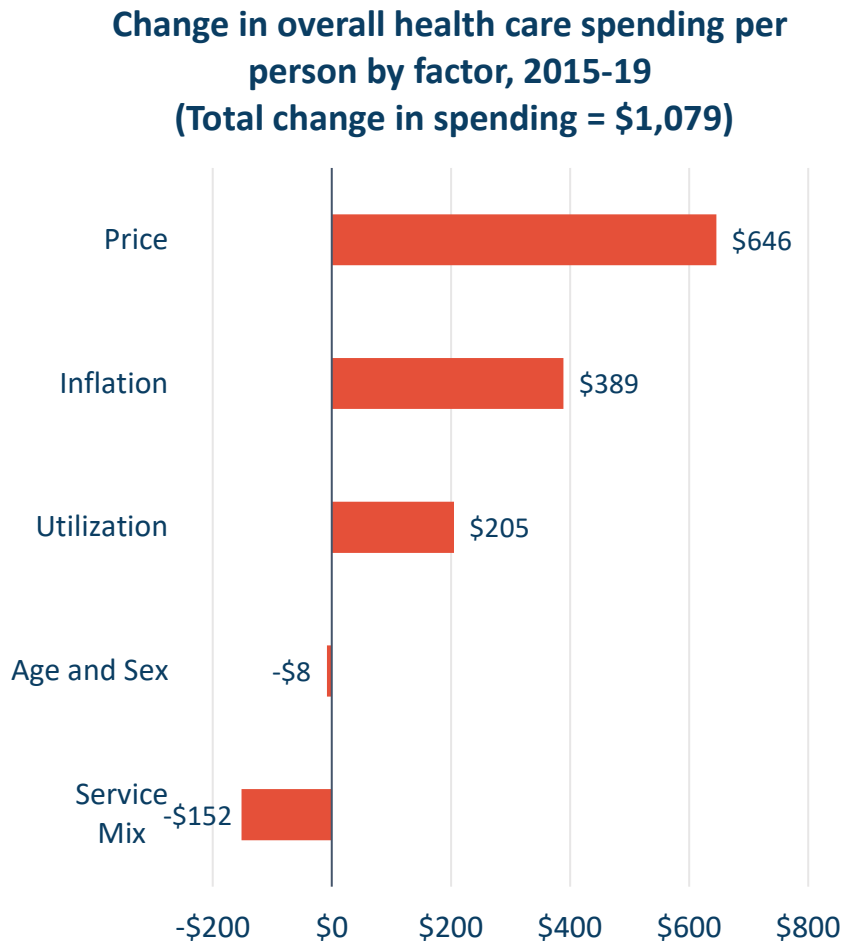
HCCI International comparisons of health care prices from the 2017 iFHP survey (2019)

Why do high prices matter?

- Barrier to accessing needed care
- Translate to higher premiums, less generous insurance, lower wages
- Exacerbate inequities in health care access and outcomes
  - Low-income individuals spend a substantially greater proportion of income on out-of-pocket costs for health care services and health insurance (e.g., premiums, deductibles)
  - About half of households do not have enough liquid assets to pay a typical employer plan deductible and almost two in three households do not have enough resources to cover a higher-end deductible of private health plans (KFF 2022)
- Affect structure of health care markets and firms
- Divert resources away from other sectors
- Incentive to create work-arounds that have broader implications for consumer access as well as health care markets and spending, e.g., drug copay coupons

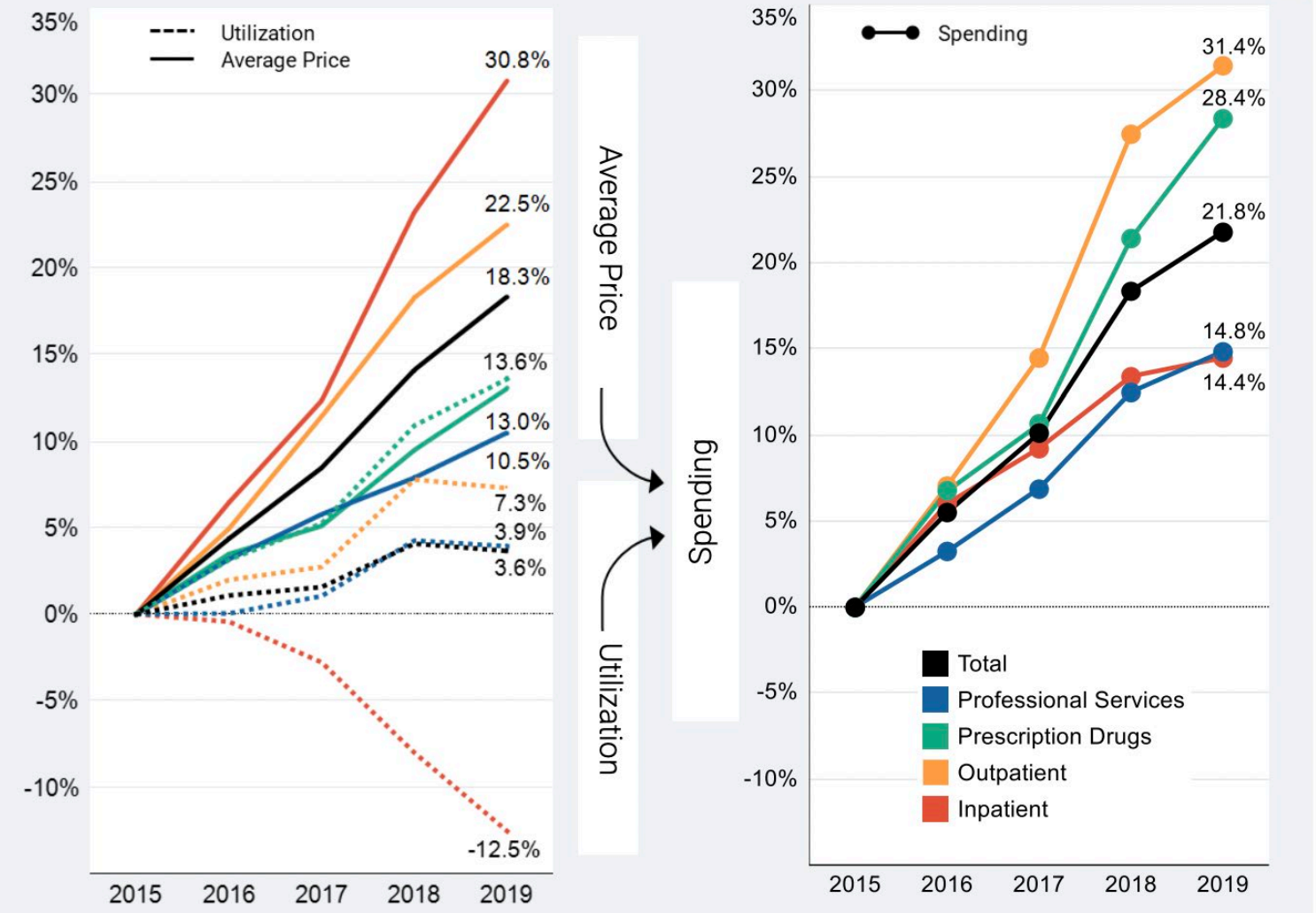
Growing price pressure driving up health care spending

- In 2019, average annual health care spending on inpatient, outpatient, and physician services + prescription drugs for people with employer-sponsored insurance was $6,001
- From 2015 to 2019, spending grew 22%
- ~2/3 of the increase was due to growth in service prices



Prices up across services, driving spending

Figure 4: Cumulative Change in Spending per Person, Utilization, and Average Price by Service Category

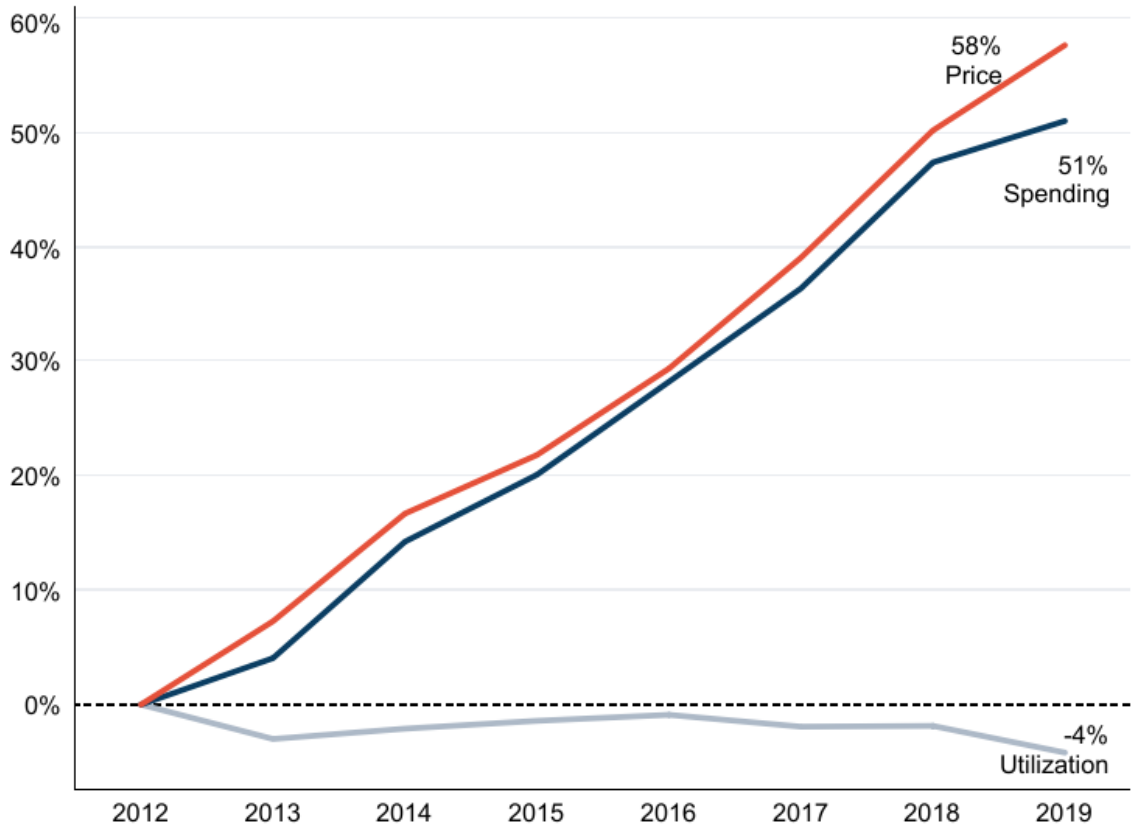


Note: All numbers presented in charts are available as downloadable data tables.

A closer look at prices: Rising prices for services where use is declining

- Inpatient services
  - Utilization down 12.5% (2015-19)
  - Prices up 31% → spending up 14%
- ER services
  - Utilization down 4% (2012-19)
  - Prices up 58% → spending up 51%
  - Coding of ER visits has shifted towards more severe, higher priced codes.
- Physician-administered drugs
  - Average price of administered drug nearly doubled over 2014-18 ($470 to $813).
  - The increase in spending on administered drugs accounted for 39% of the increase in spending on physician services (2014-18)

Figure 1: Cumulative Change in National **Spending**, Utilization, and **Price** of All ER Visits from 2012 to 2019

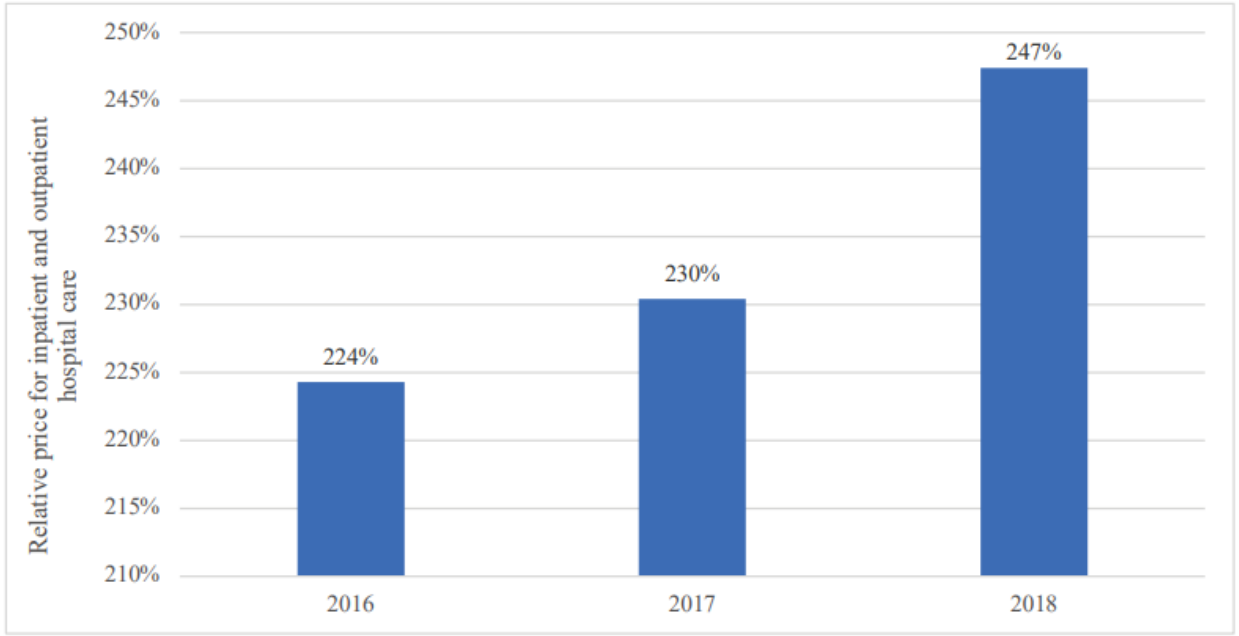


HCCI "Ouch!: New Data reveals ER spending increased by 51% from 2012 – 2019, with patient out of pocket payments increasing by 85%" (2021); HCCI 2019 Health Care Cost and Utilization Report; HCCI 2018 Health Care Cost and Utilization Report

A closer look at prices: Commercial vs. Medicare

- Prices paid by private health plans are higher and growing faster than Medicare
  - Commercial insurers paid 247% of what Medicare would have paid for the same services at the same facilities.
  - Up from 224% in 2016
- Over 50% of inpatient admissions were paid above 150% of Medicare; almost 33% paid above 200%
- Medicare is a useful benchmark – not necessarily an endpoint for prices
  - Medicare rates are comparable across hospitals and take into account regional factors and clinical factors
  - Process for setting Medicare (administered) prices is transparent

Figure 4.1. All-State Trends in Relative Prices

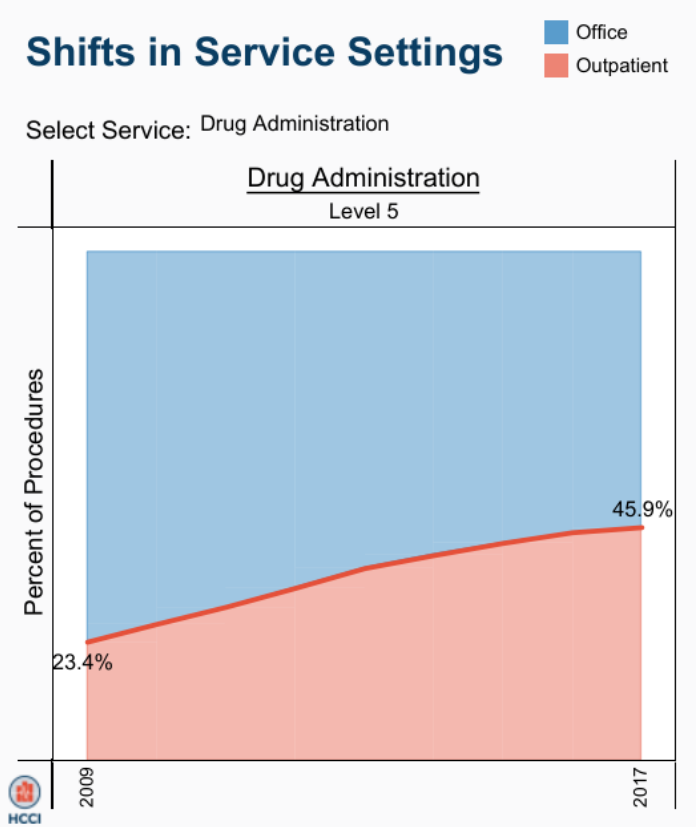


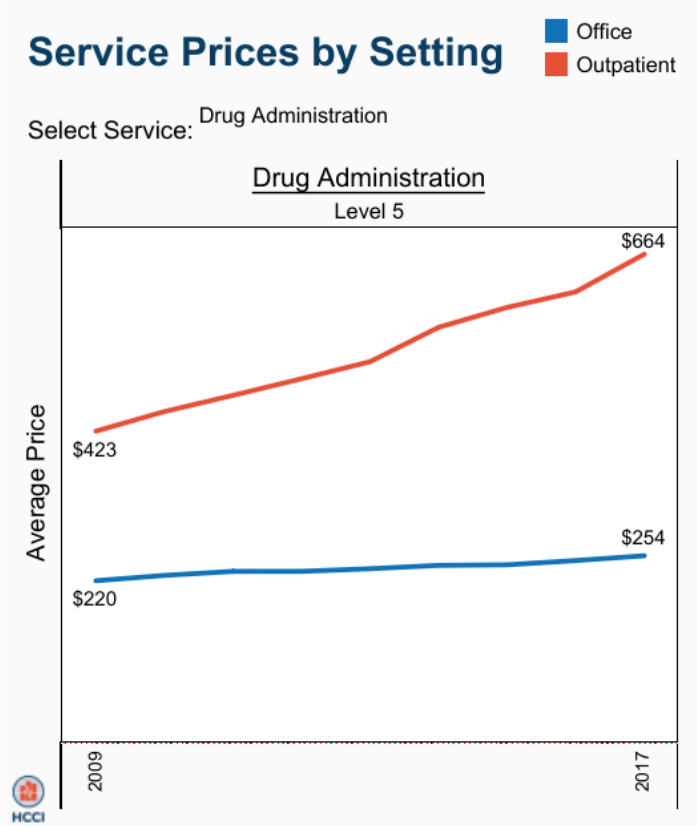
NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. Prices include prices for inpatient and outpatient services and group facility and professional fees.

RAND "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative." 2020.
KFF "Half of Admissions in the Large Group Market Are Paid Above 150% of Medicare Rates, Excluding Maternity Admissions." 2022.

A closer look at prices: Across settings

- We examined 46 services provided in both outpatient and office settings determined by MedPAC to be safe and appropriate when provided in an office.
- Outpatient prices were higher for every service in every year than the price for the same service provided in an office setting.
- Services are increasingly shifting from office to outpatient settings



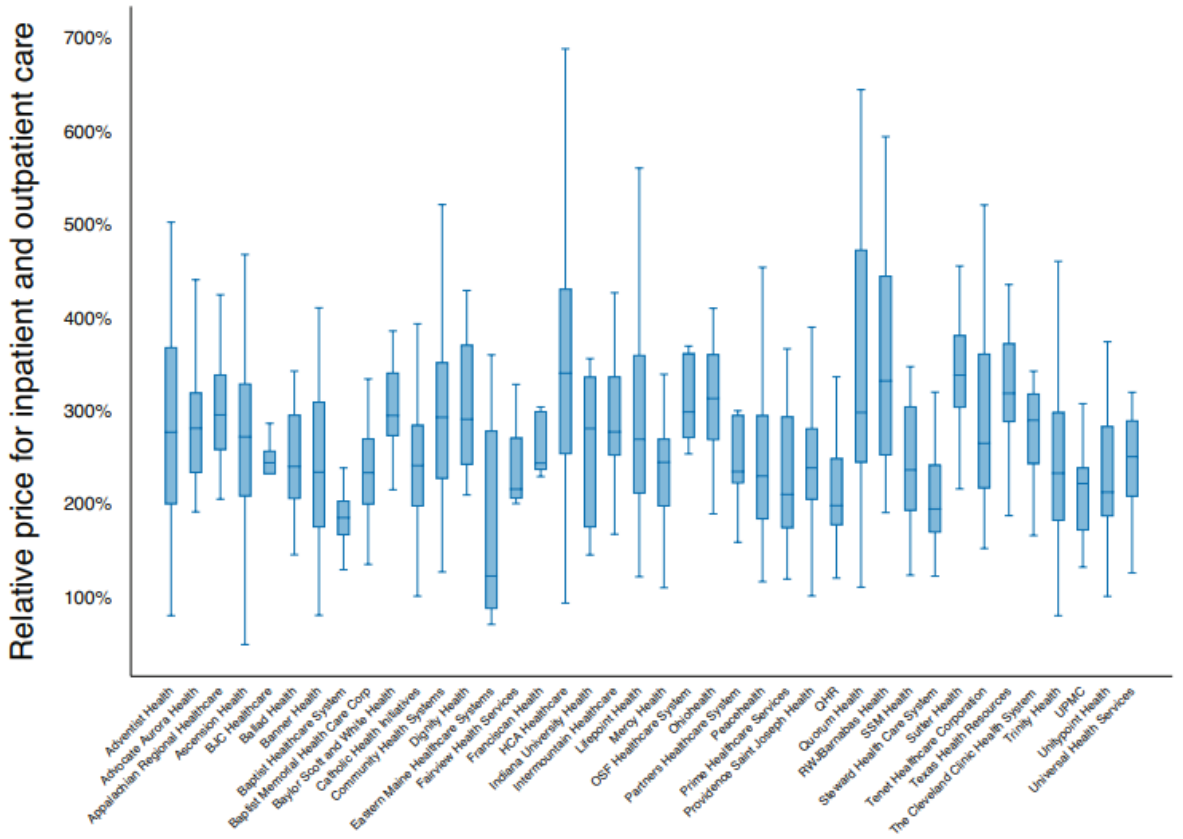


HCCI "Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices" 2019

A closer look at prices: Within systems

- Wide variation in hospital prices across many large systems
- In the average system, the hospital with the 75th percentile price has prices 32% higher than the hospital with the 25th percentile price – suggesting that prices vary more within a system than across systems

Figure 4.4. Distribution of Relative Prices, by Hospital System, 2016–2018



NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas. For each hospital system, this figure denotes the 25th-percentile, median (50th-percentile), and 75th-percentile relative prices for hospitals in the system. Only systems with ten or more hospitals included.

RAND "Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative." 2020.

A closer look at prices: Impact of private equity acquisition

- Among acute care hospitals acquired by PE firms (Bruch, Gondi, Song, 2020):
  - Increases in hospital charges and charge to cost ratios
  - Increases in case mix index (upcoding?)
  - Reduction in percent of patients discharged covered by Medicare (suggests increase in percent covered by private insurance)

- Among dermatology practices acquired by PE firms (Braun et al., 2021):
  - Prices paid to PE dermatologists for routine medical visits were 3–5% higher than those paid to non-PE dermatologists

- Among anesthesiologists after an outpatient facility contracted with the physician management company (La Forgia et al., 2022):
  - Allowed amounts increased by 16.5%
  - Unit price increased by 18.7%
  - When physician management company was PE-backed, prices rose 26% (vs. 13% when not)

Upward Pressure on Prices

- Increasing consolidation
  - Horizontal and vertical integration associated with higher prices
- Growing role of private equity
- Limited leverage by insurers, employers
  - We found that large self-insured employers had concentrated market power in very few areas (Eisenberg et al., 2021)
  - The mean value of our employer market power measure was **62** for 2016, compared with the mean value of **5410** for hospital market power.
- Though increased prices translate into higher premiums, effects are dampened because
  - Premium contributions by employer vs. employee may not be salient to individuals
  - Premium contributions are generally excluded from taxes
- Links between higher provider rates and labor market outcomes such as wages, health insurance offerings (e.g., narrower benefits) are indirect

What actions are state policymakers taking to lower prices?

Indirect Approaches

- Price transparency
- Cost growth benchmarks
- Insurance regulation/design (e.g., rate review, tiered networks, reference pricing)
- Improving provider market competition

Direct Approaches

- Price caps/regulation for specific:
  - Populations (e.g., state employees, public option enrollees)
  - Services (e.g., out-of-network, facility-based)
  - Providers (e.g., high priced)

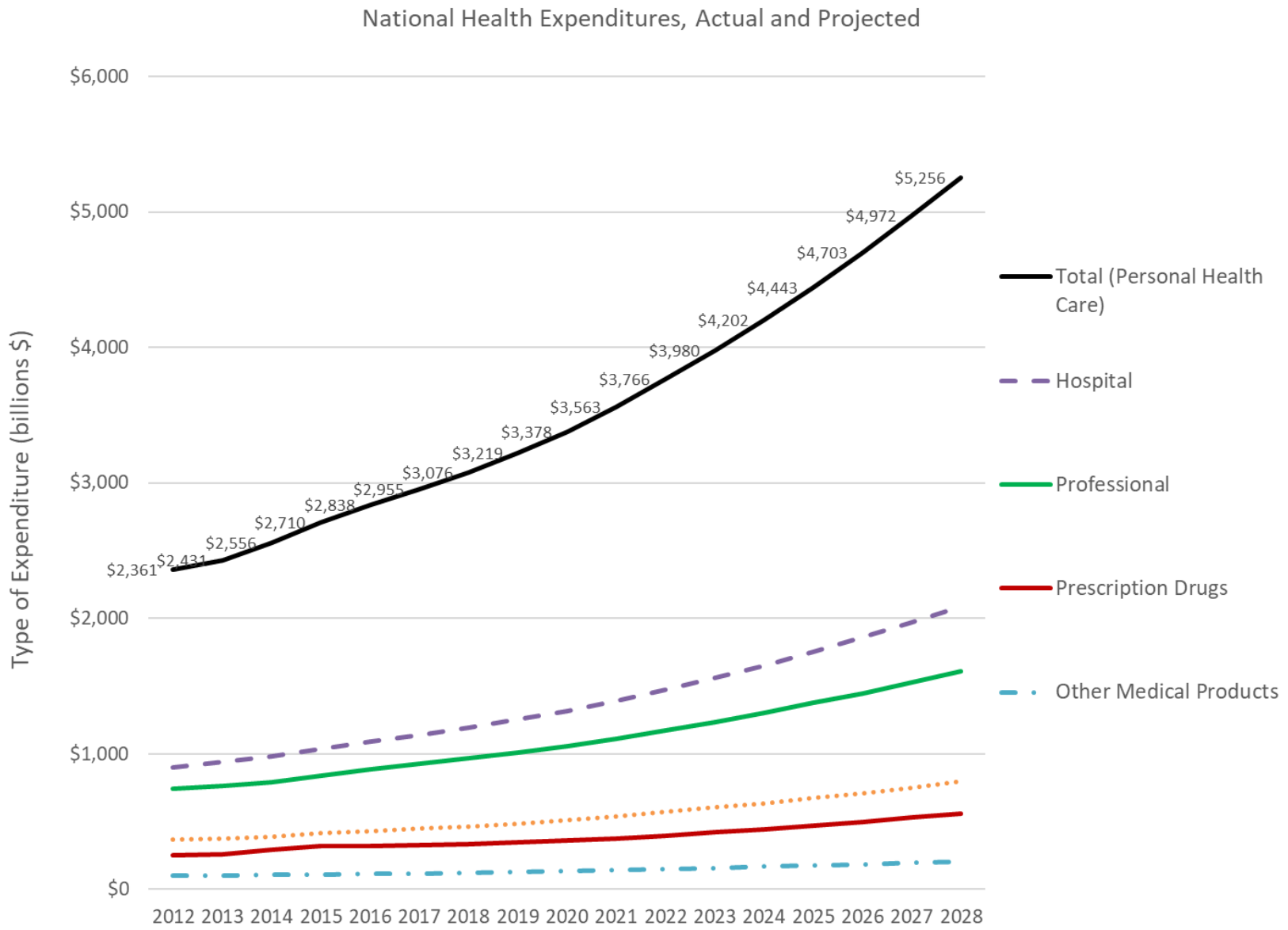
In any context, need to consider options for structure and level of cap

→ Central role of data and analyses in these efforts; MA data and capacity to use data for policy design/implementation is a model for many other states

States actions range from indirect to direct

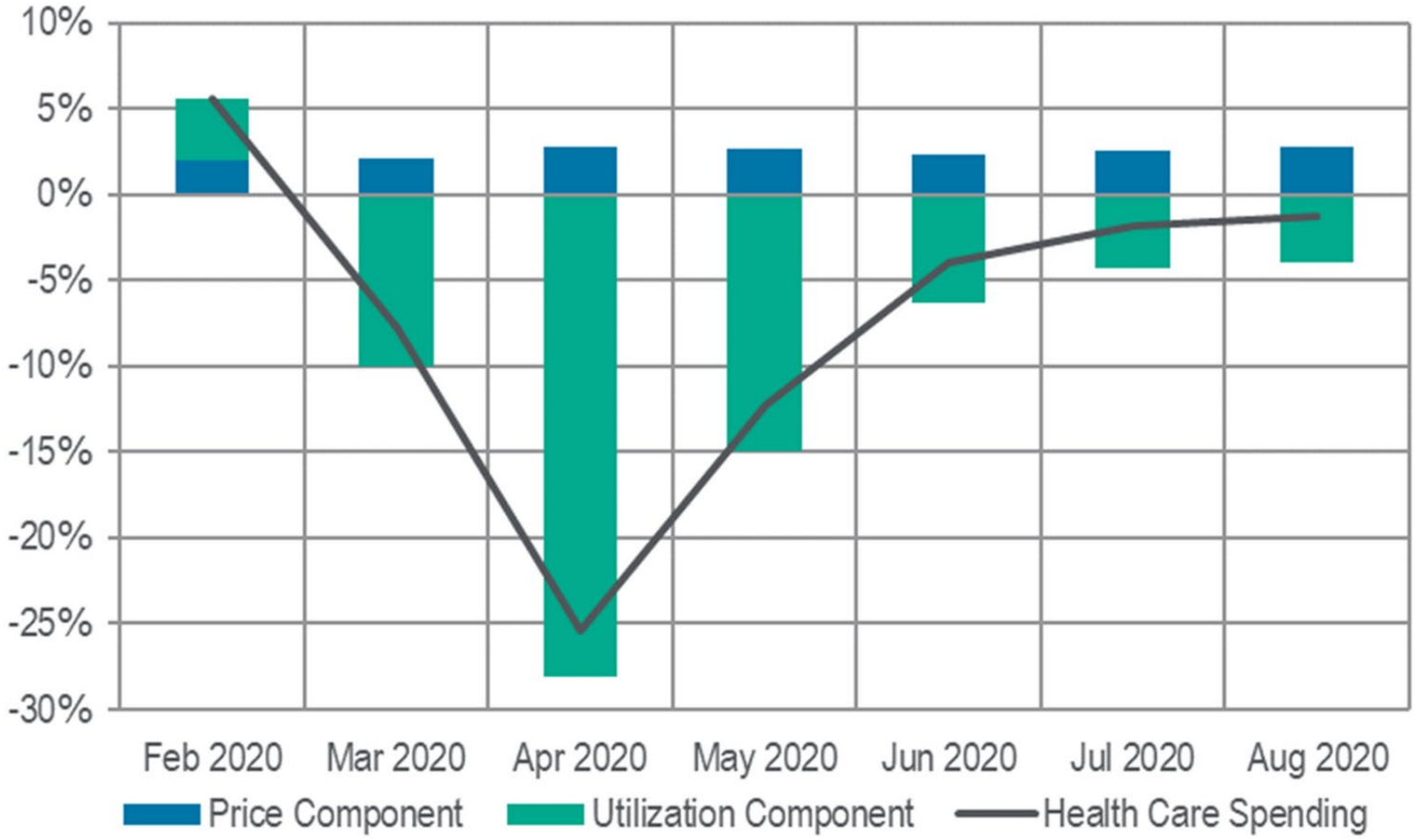
Health care spending benchmarks	MA, DE [3%], RI [3.2%], OR [3.4%], CT [2.9%], WA [TBD]
Health insurance rate review and approval process	Ex: RI imposes inflation caps and diagnoses-based payments on insurer-provider contracts
Premium reduction requirements in a public option	CO: 5% premium reduction for 2023 NV: 5% prem reduction + inflation cap
Regulating rates for out-of-network health care services	Lots of states, mix of payment standards, with implications for overall effects on rates
Benchmarking prices to Medicare in public option	Aggregate reimbursement cap at 160% Medicare in WA public option program
Benchmarking prices in state employee plans	Reference-based pricing to Medicare in MT, OR plans → reported savings

Wrap-up: A long view of health care spending and prices



Office of the Actuary, Centers for Medicare and Medicaid Services

Prices increased even as use fell in 2020

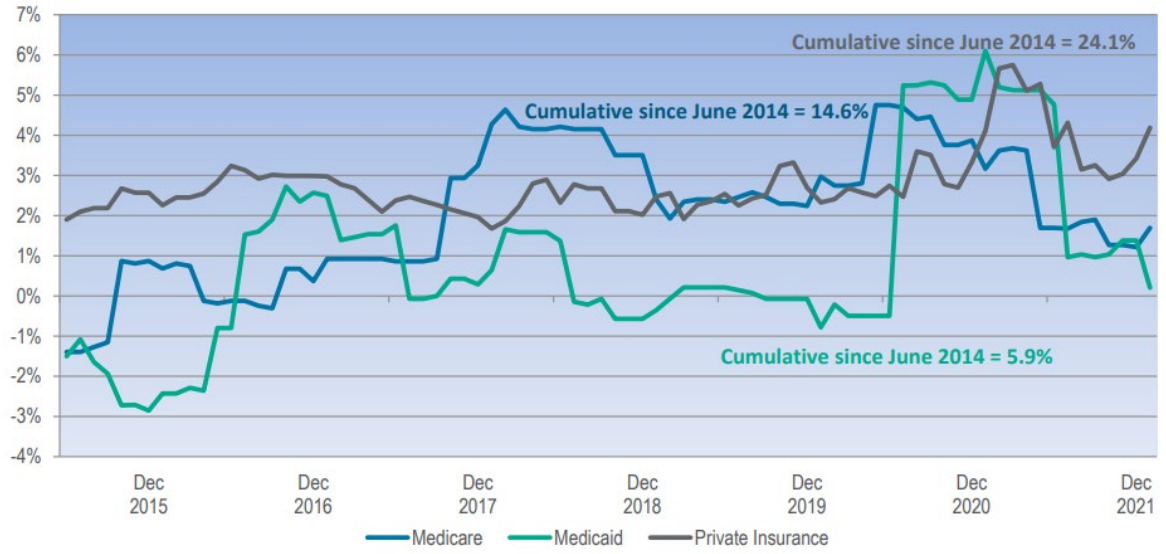


Rhyan, C., Turner, A. & Miller, G. Tracking the U.S. health sector: the impact of the COVID-19 pandemic. Bus Econ 55, 267–278 (2020)

Prices increased even as use fell in 2020

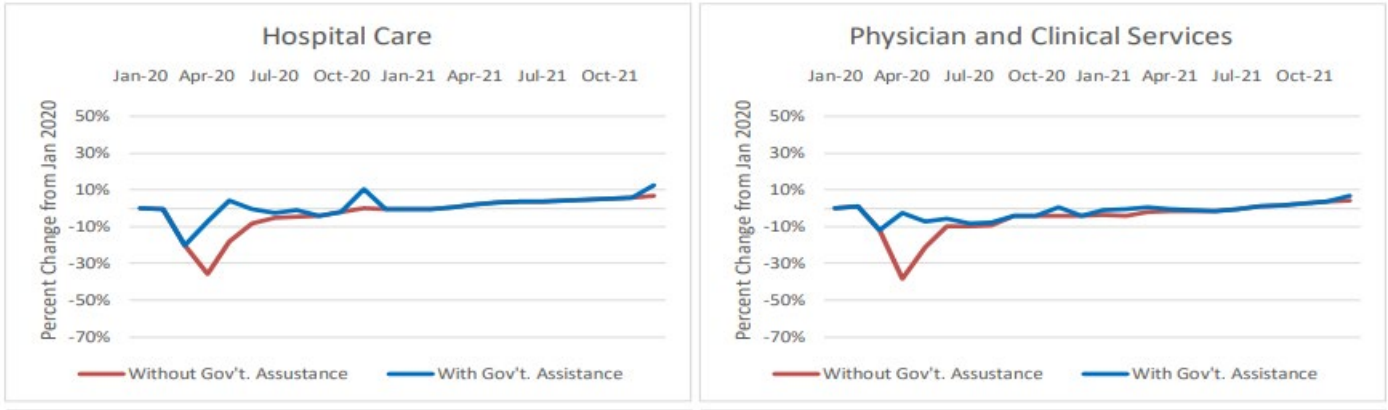
- Hospital prices for care paid for by private insurance increased by 4.2% in January
  - Steady rise from October 2021, when the rate was 2.9% year over year
- With government assistance, spending on hospital care and physician services exceeded the January 2020 level by December 2021
- Among health care components, hospital services were the fastest growing in terms of price growth.
  - Prescription drug price growth also positive in January vs. a year ago, ending streak of negative price growth

Exhibit 6. Year-over-Year Change in Hospital Price Growth by Payer



Source: Altarum analysis of monthly BLS data.

Exhibit 2. Percent Change in Spending Since January 2020, by Major Category



Conclusions

- **Prices for health care services continue to rise**, especially:
  - Hospital inpatient
  - ER
  - Physician-administered drugs
- **Prescription drug spending** is also rising due to price increases and increases in use/intensity
- **Shifting care** to higher priced settings
  - Office → outpatient
  - Lower-priced hospitals to higher-priced hospitals
- "**Upcoding**" practices likely driving up spending

- Evidence suggests that, when faced with lower prices, hospitals reduce costs and become more efficient
- Increasing affordability requires addressing high prices, premiums, cost-sharing structures
- There are a range of options that states are considering and implementing to control health care costs and improve access to and affordability of services

Agenda

Welcome

Opening Remarks

Benchmark Modification Process

Center for Health Information and Analysis (CHIA) Annual Report

Report on State Spending Performance

Keynote Presentation and Discussion

PUBLIC TESTIMONY

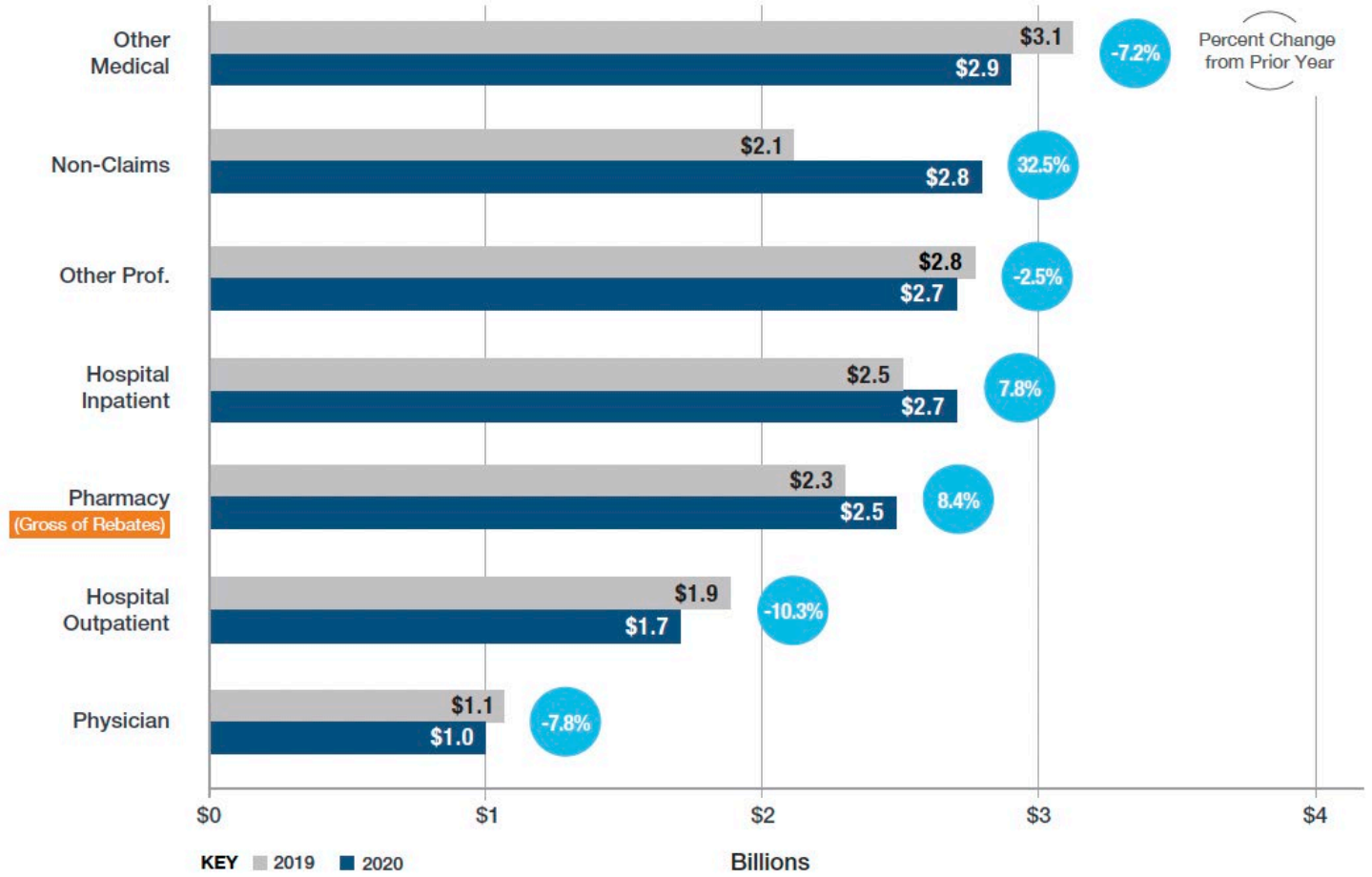
Public Testimony

- **Deb Wilson**, President and CEO, Lawrence General Hospital
- **Liz Leahy**, Chief of Staff and Vice President of Advocacy and Engagement, Massachusetts Association of Health Plans
- **Christopher Carlozzi**, State Director, National Federation of Independent Business
- **Steve Walsh**, President and CEO, Massachusetts Health and Hospital Association
- **Alex Sheff**, Co-Director of Policy and Government Affairs, Health Care for All
- **Jon Hurst**, President, Retailers of Massachusetts

ADDITIONAL CHARTS

MassHealth

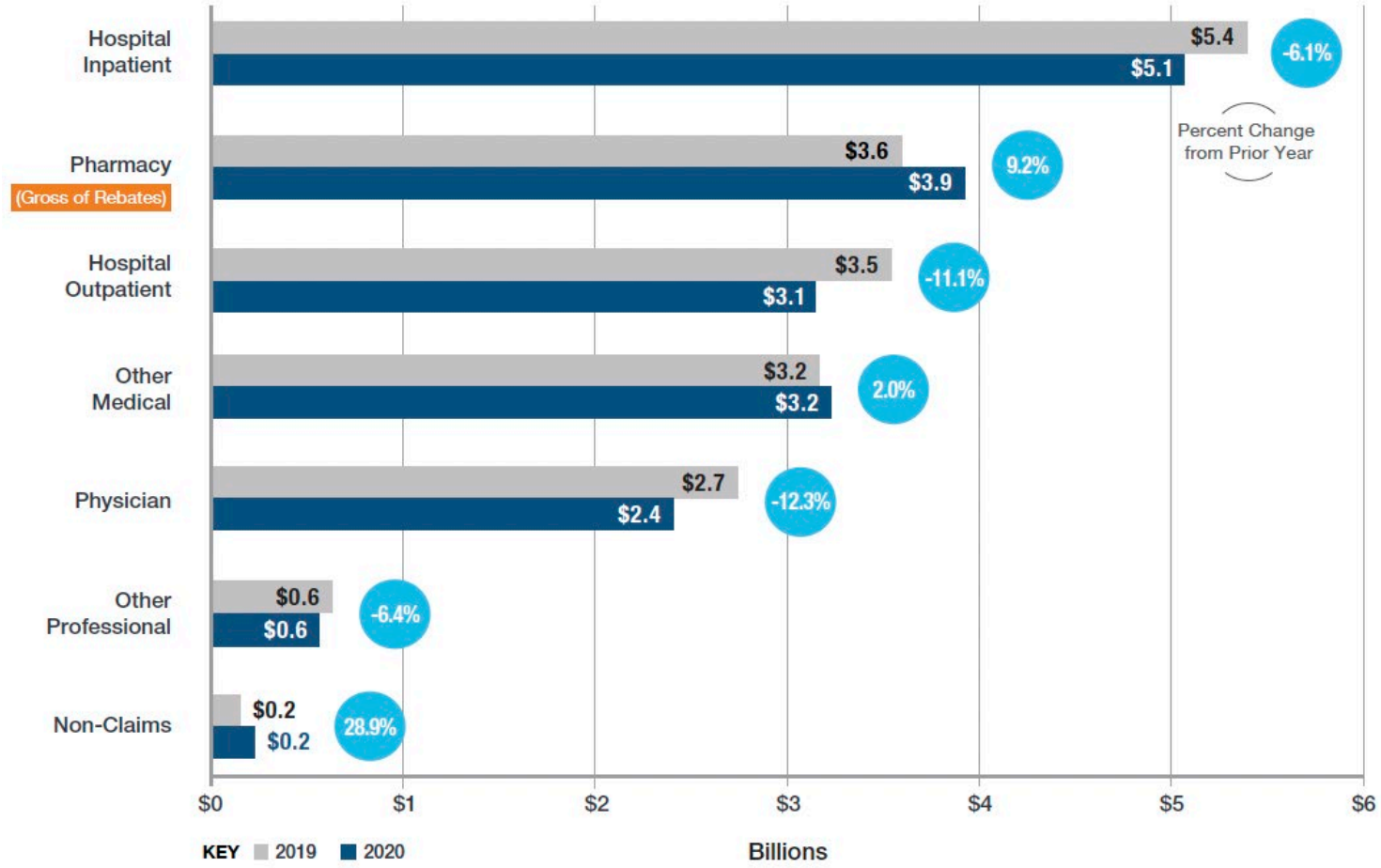
Spending by Service Category, 2019-2020



Non-claims spending grew 32.5% to become the second largest MassHealth service category, while pharmacy and hospital inpatient spending also increased.

Medicare

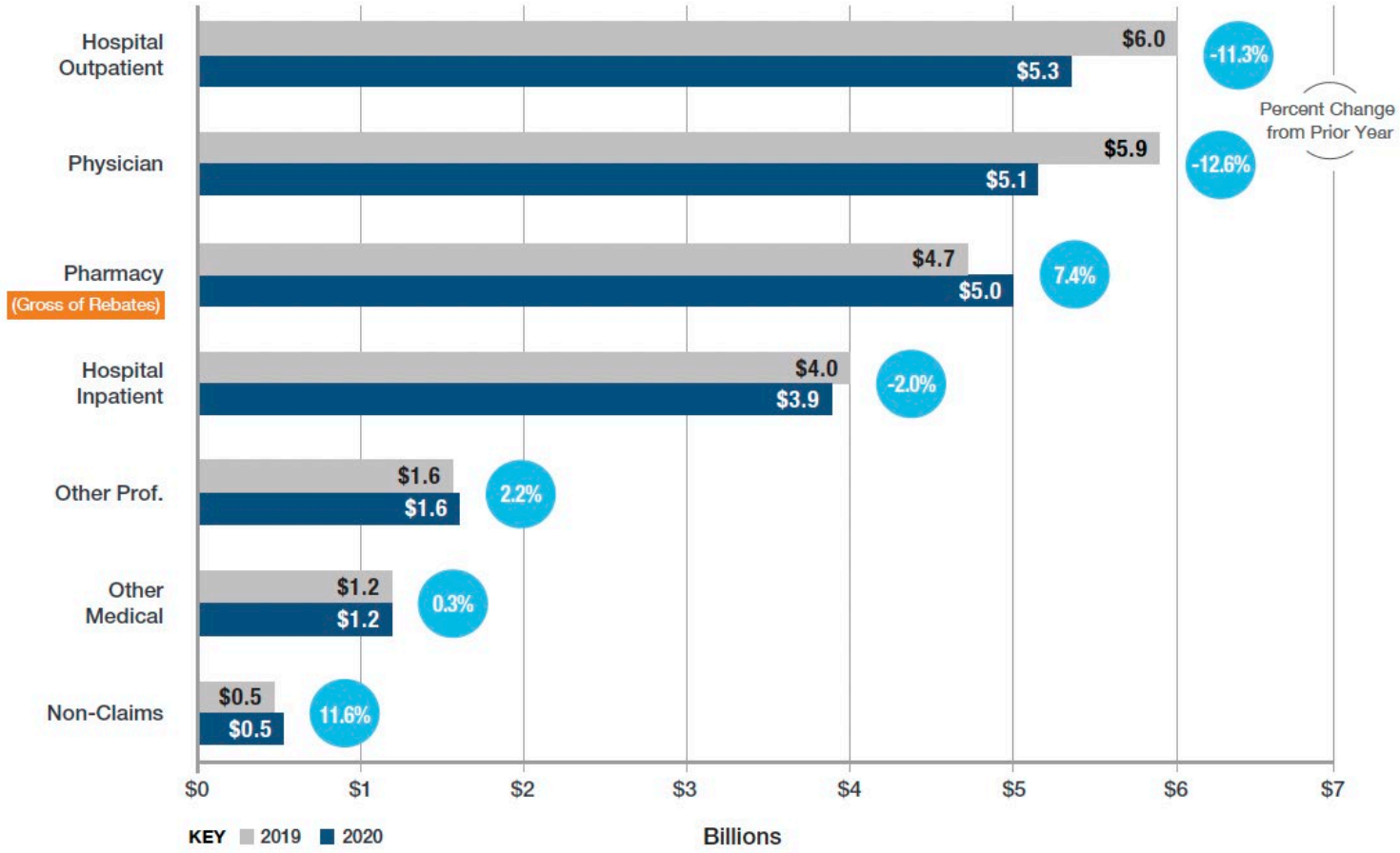
Spending by Service Category, 2019-2020



Medicare spending declined from 2019 to 2020, driven by decreases in hospital inpatient, hospital outpatient, and physician spending.

Commercial

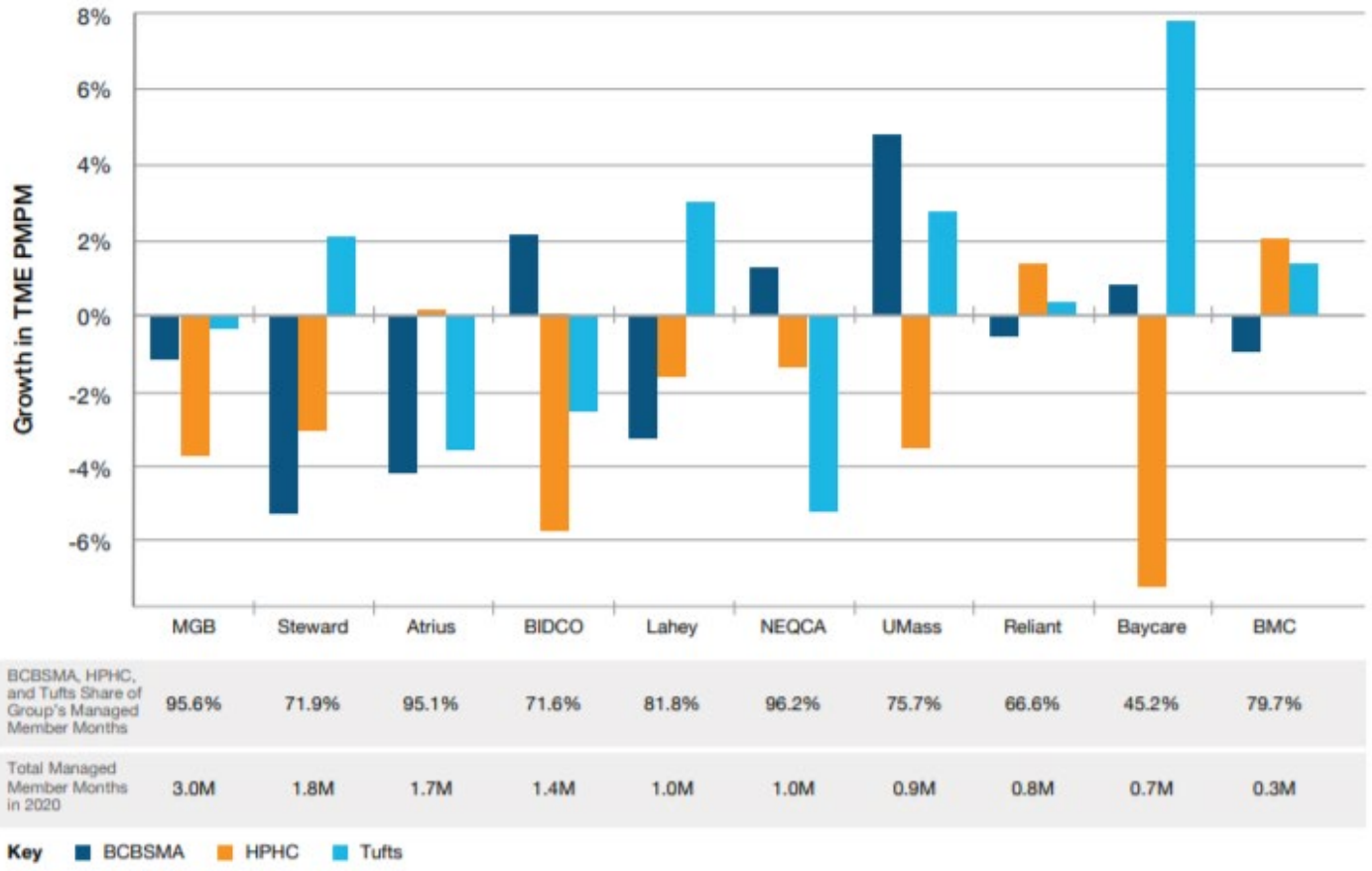
Spending by Service Category, 2019-2020



Commercial spending declined from 2019 to 2020 due to decreases in hospital outpatient and physician spending, the two largest commercial service categories.

Change in Total Medical Expenses (TME)

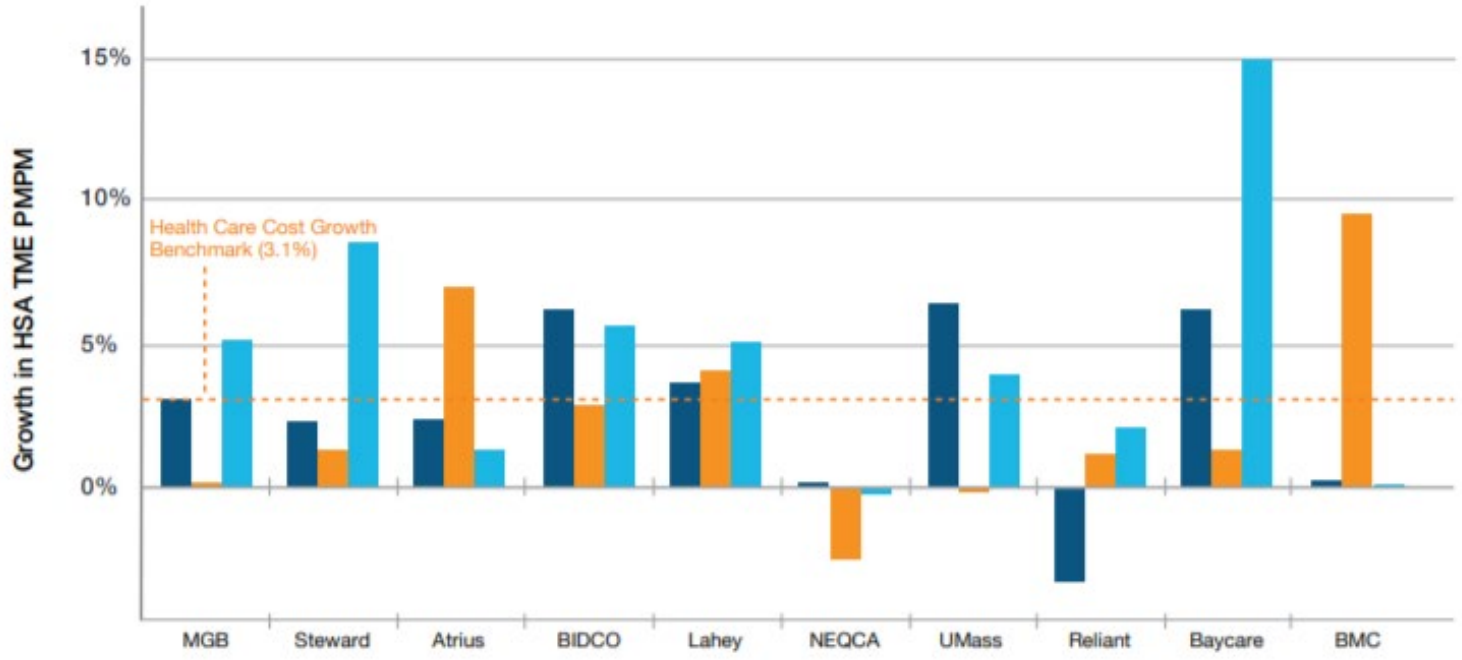
Unadjusted PMPM Trends by Managing Physician Group, 2019-2020



The 10 largest physician groups all experienced a decrease in TME in at least one payer network in 2020.

Change in Total Medical Expenses (TME)

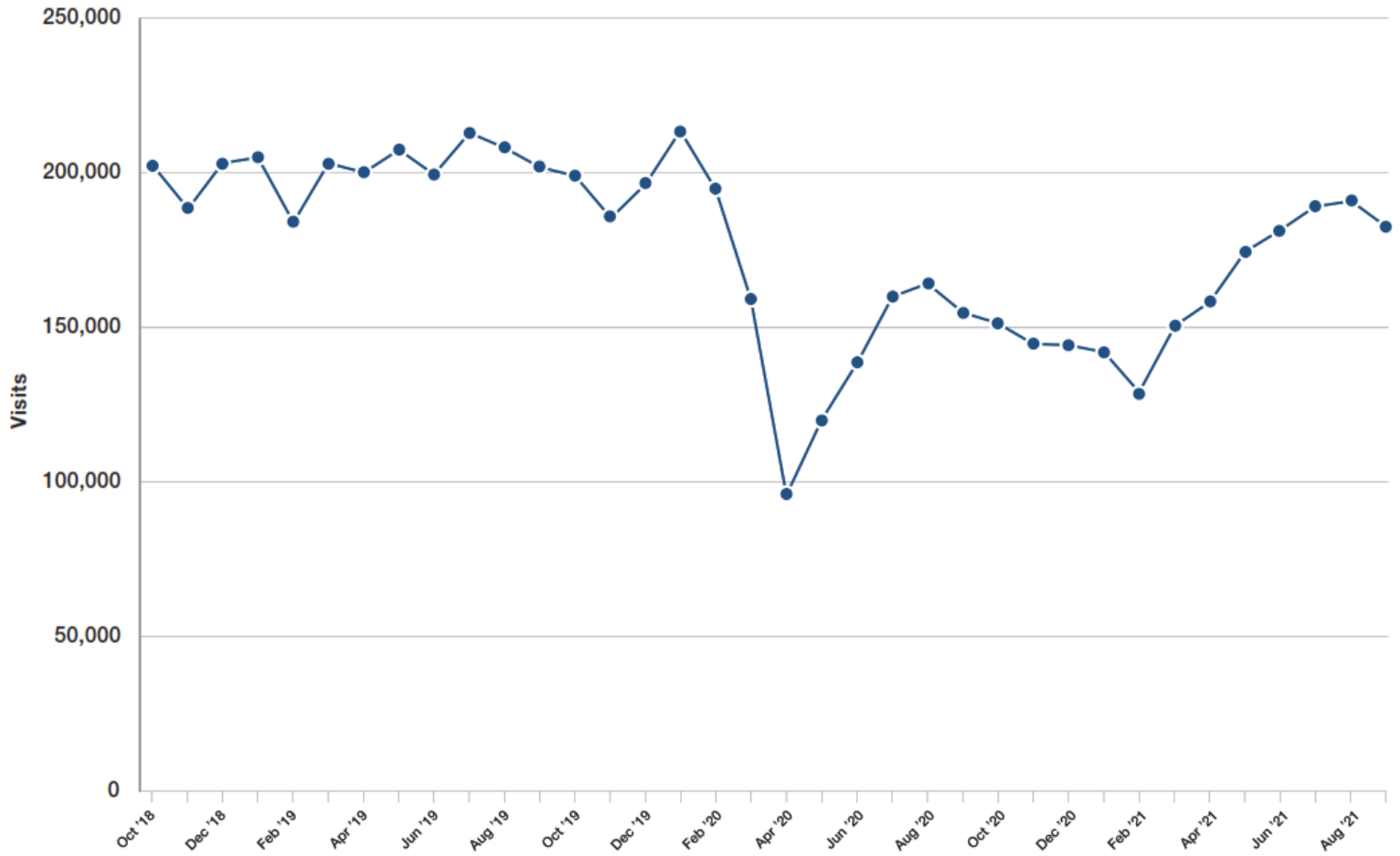
HSA PMPM Trends by Managing Physician Group, 2019-2020



	MGB	Steward	Atrius	BIDCO	Lahey	NEQCA	UMass	Reliant	Baycare	BMC
BCBSMA, HPHC, and Tufts Share of Group's Managed Member Months	95.6%	71.9%	95.1%	71.6%	81.8%	96.2%	75.7%	66.6%	45.2%	79.7%
Total Managed Member Months in 2020	3.0M	1.8M	1.7M	1.4M	1.0M	1.0M	0.9M	0.8M	0.7M	0.3M

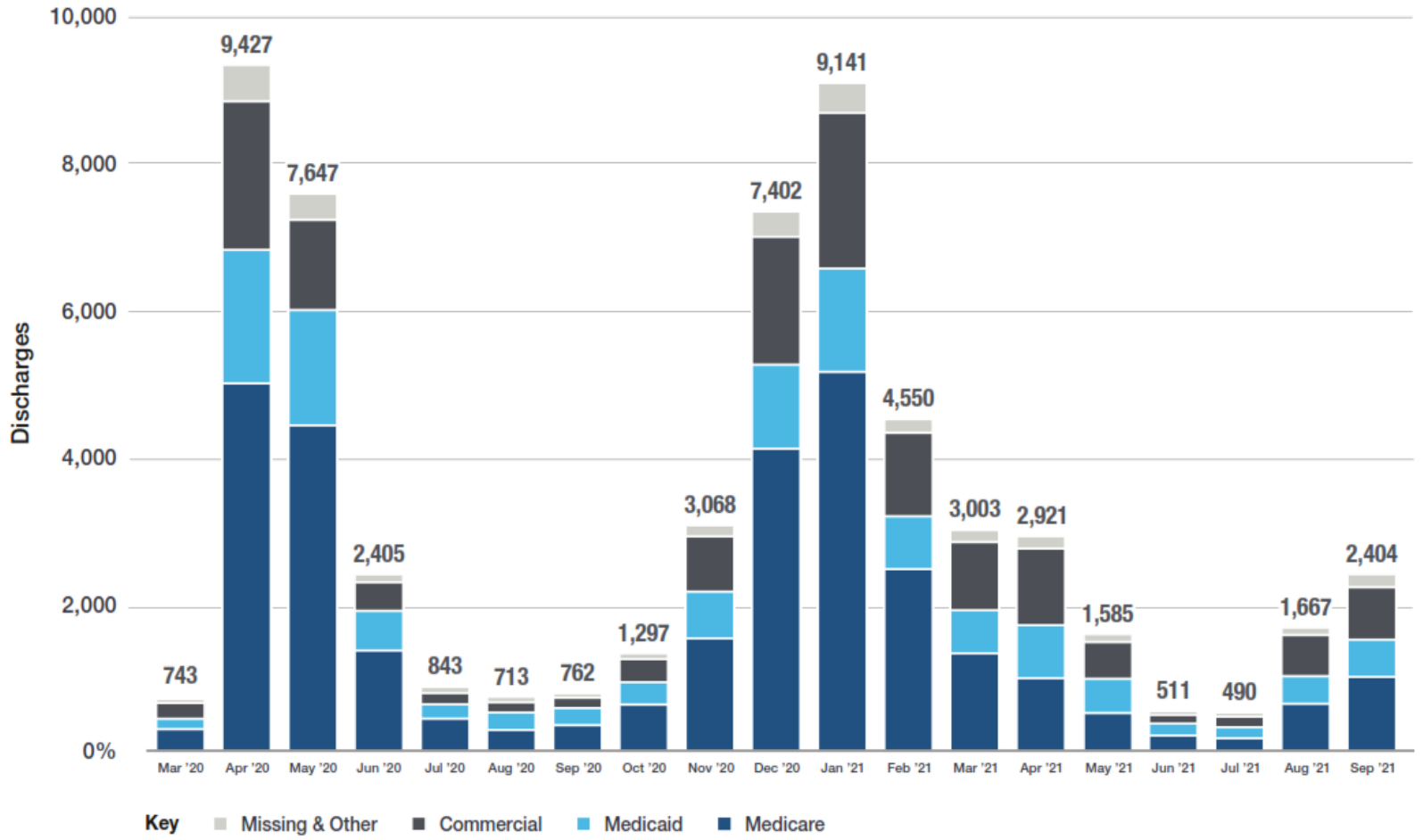
Eight of the 10 largest physician groups had HSA TME growth above the 3.1% benchmark in at least one of the payer's network.

Emergency Department Treat-and-Release Visits, October 2018 to September 2021



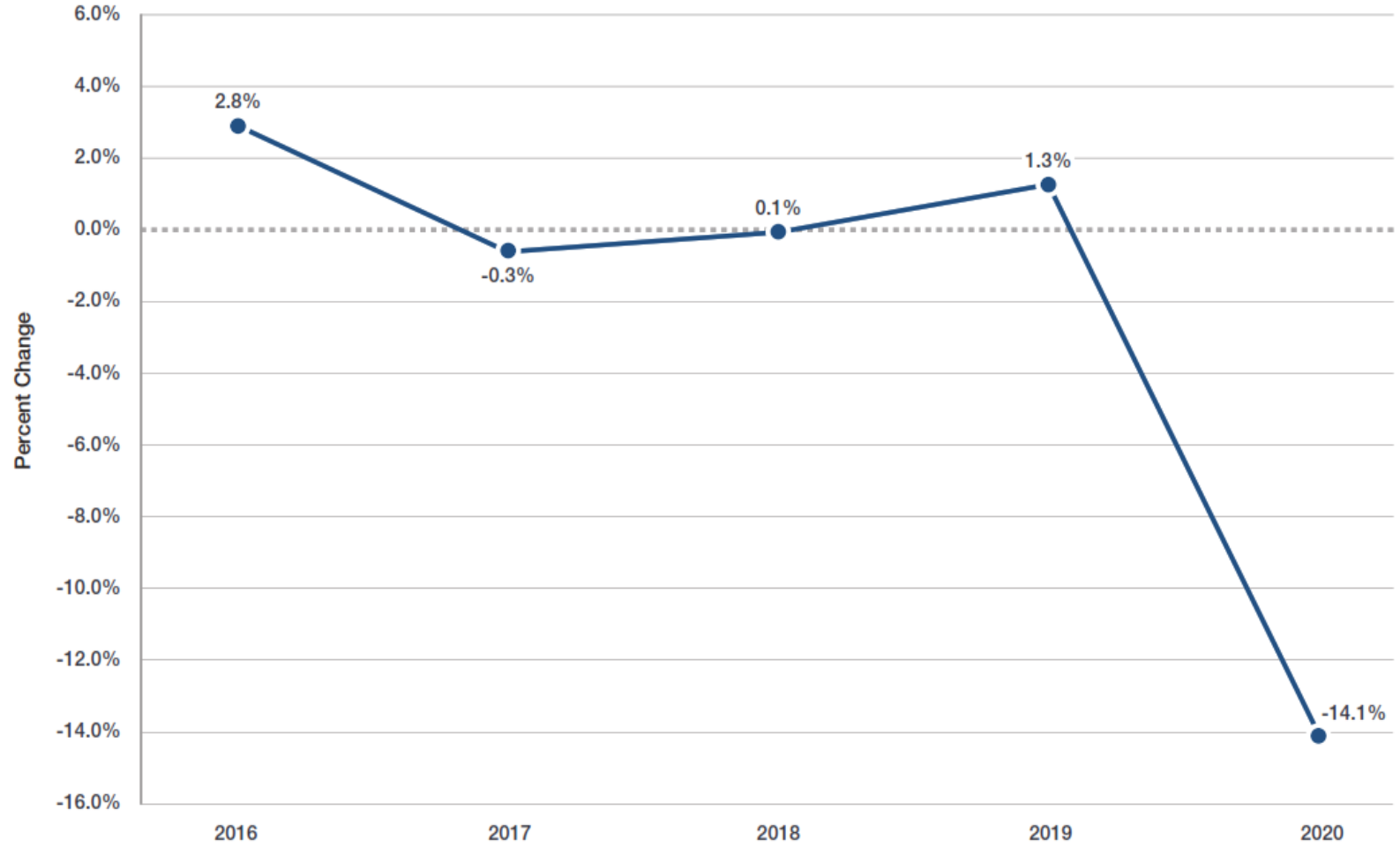
Similar to trends in inpatient discharges, the volume of ED visits fell during peak periods of COVID-19 cases.

Acute Care Hospital Inpatient Discharges Related to COVID-19 by Payer Type, March 2020 to September 2021



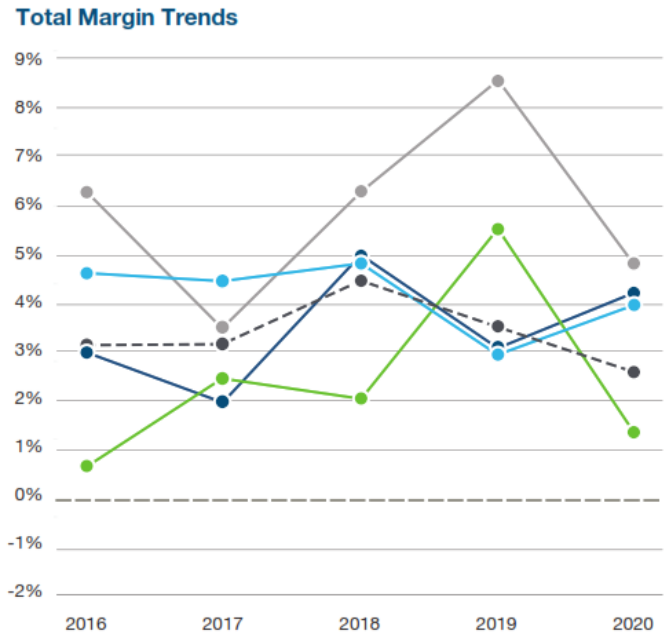
Inpatient visits associated with an expected primary payer type of Medicare made up over half of inpatient discharges associated with a COVID-19 diagnosis.

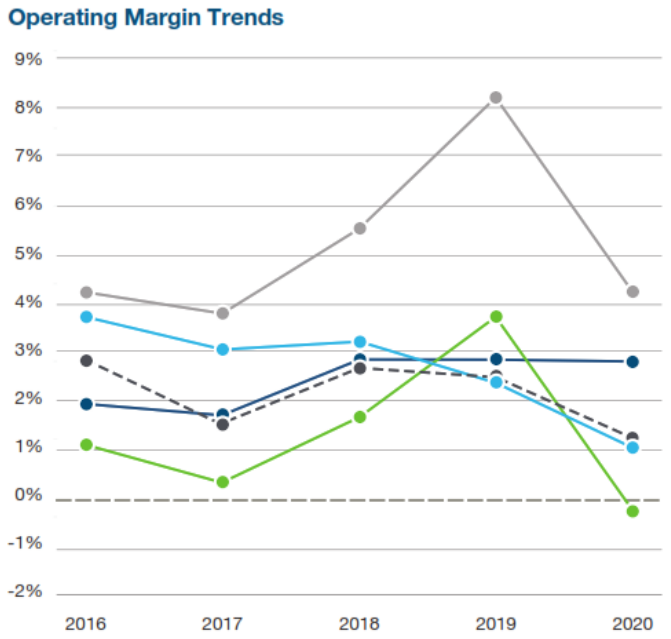
Median Acute Hospital Change in Outpatient Visits from Prior Year



In HFY 2020, the majority of acute hospitals reported a decrease in outpatient visits from the prior year.

HFY 2016-2020 Total and Operating Margin Trends by Hospital Cohort





Statewide Acute — Academic Medical Center — Teaching Hospital — Community Hospital — Community-High Public Payer

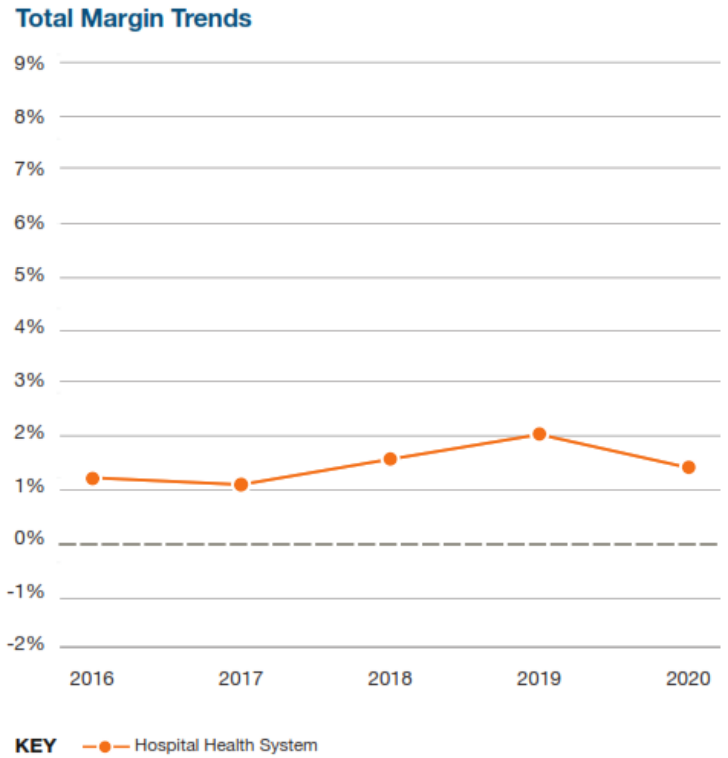
	2016	2017	2018	2019	2020
Statewide Median	**3.1%**	**3.2%**	**4.5%**	**3.5%**	**2.6%**
Academic Medical Center	3.0%	2.0%	5.0%	3.1%	4.2%
Teaching Hospital	6.2%	3.5%	6.3%	8.6%	4.8%
Community Hospital	0.7%	2.6%	2.1%	5.6%	1.4%
Community-High Public Payer	4.7%	4.5%	4.8%	3.0%	4.0%

	2016	2017	2018	2019	2020
Statewide Median	**2.8%**	**1.6%**	**2.7%**	**2.5%**	**1.3%**
Academic Medical Center	1.9%	1.8%	2.8%	2.8%	2.8%
Teaching Hospital	4.3%	3.9%	5.6%	8.2%	4.2%
Community Hospital	1.1%	0.3%	1.8%	3.7%	-0.3%
Community-High Public Payer	3.8%	3.1%	3.2%	2.4%	1.0%

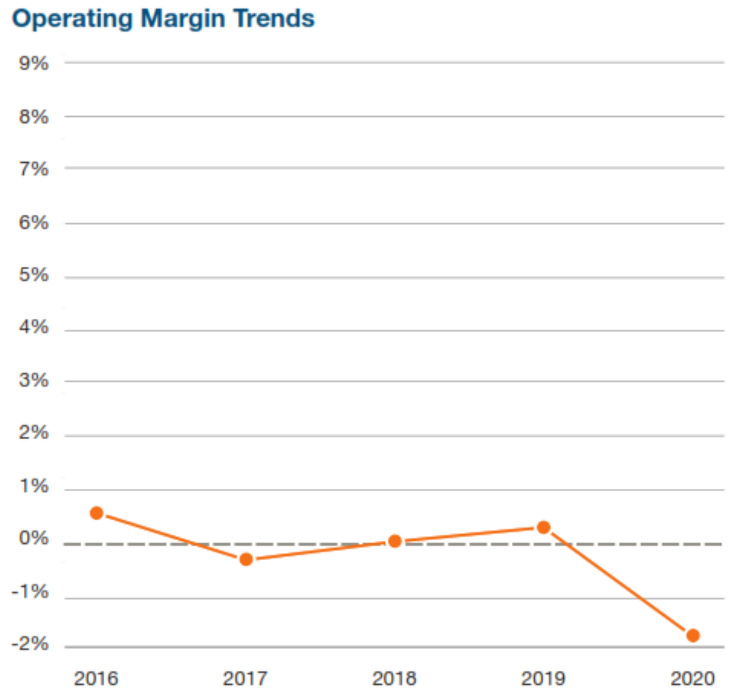
The median acute hospital total margin in HFY 2020 was 2.6%, a decrease of 0.9 percentage points from the prior fiscal year. All hospital cohorts had positive median total margins in HFY 2020.

CHIA.

HFY 2016-2020 Hospital Health System Median Trends



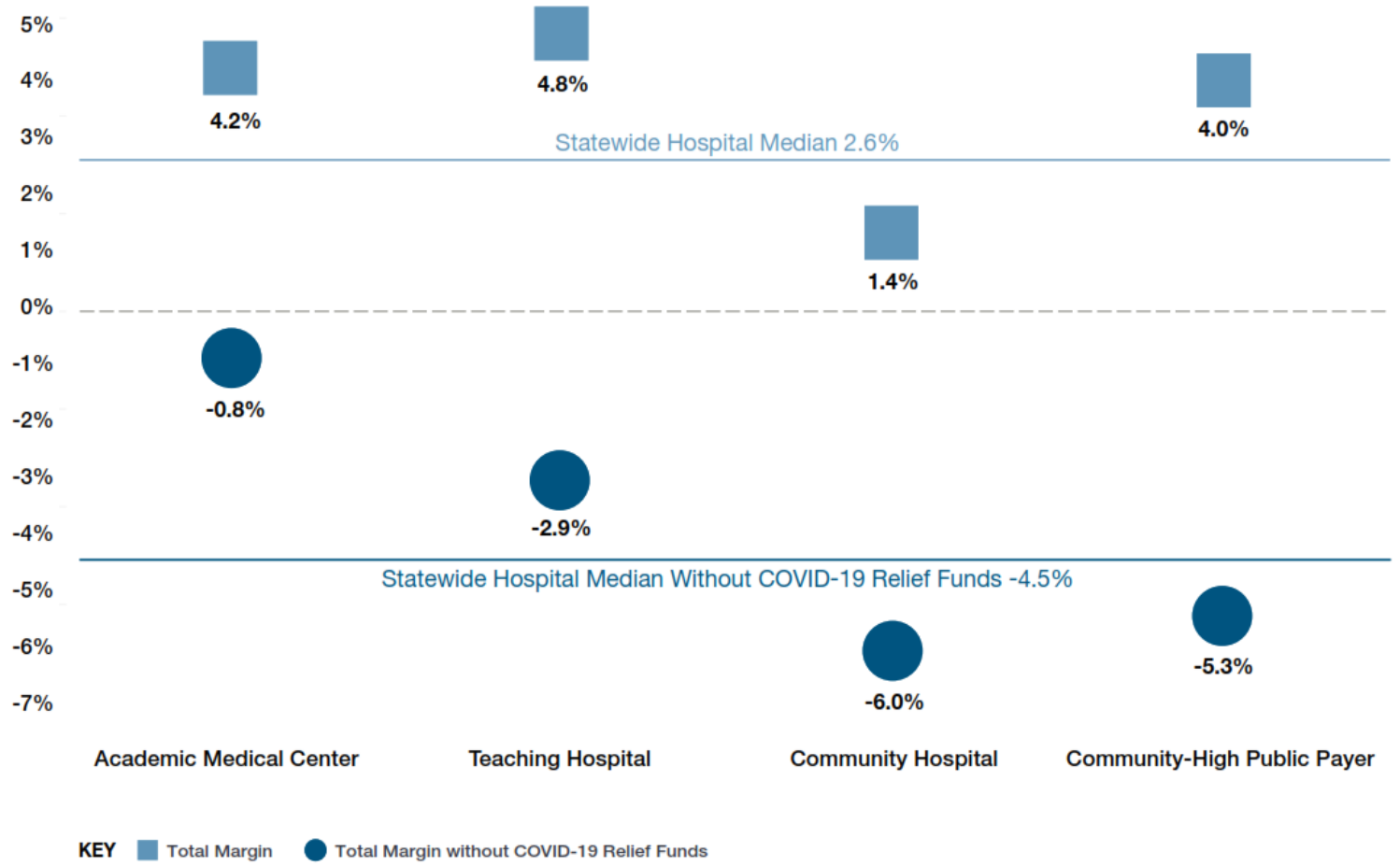
	2016	2017	2018	2019	2020
Hospital Health System	1.2%	1.1%	1.6%	2.2%	1.4%



	2016	2017	2018	2019	2020
Hospital Health System	0.5%	-0.4%	0.0%	0.3%	-1.8%

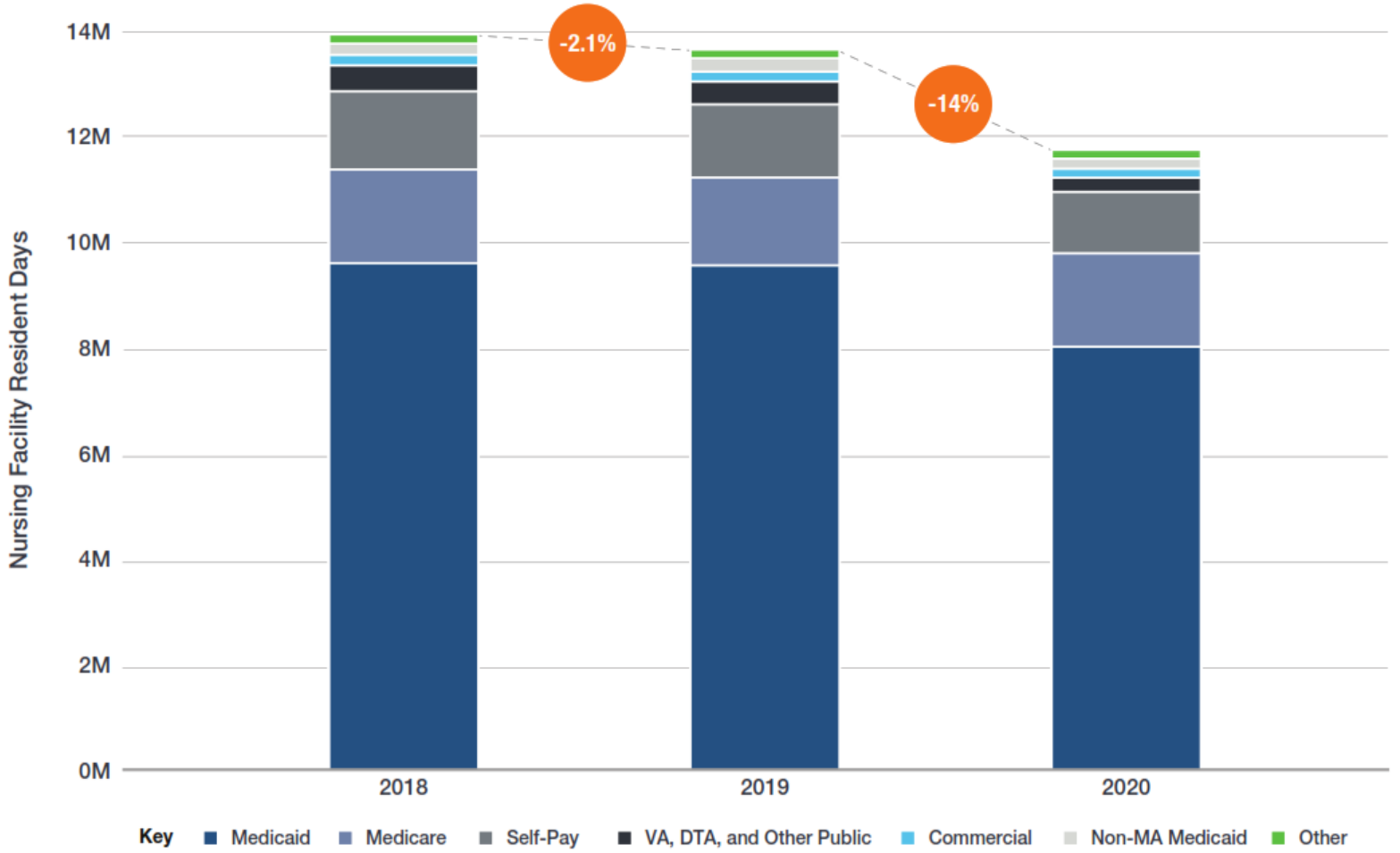
In HFY 2020, the median total and operating margins for hospital health systems decreased from the prior year.

HFY 2020 Median Total Margin by Hospital Cohort, With and Without COVID-19 Relief Funds



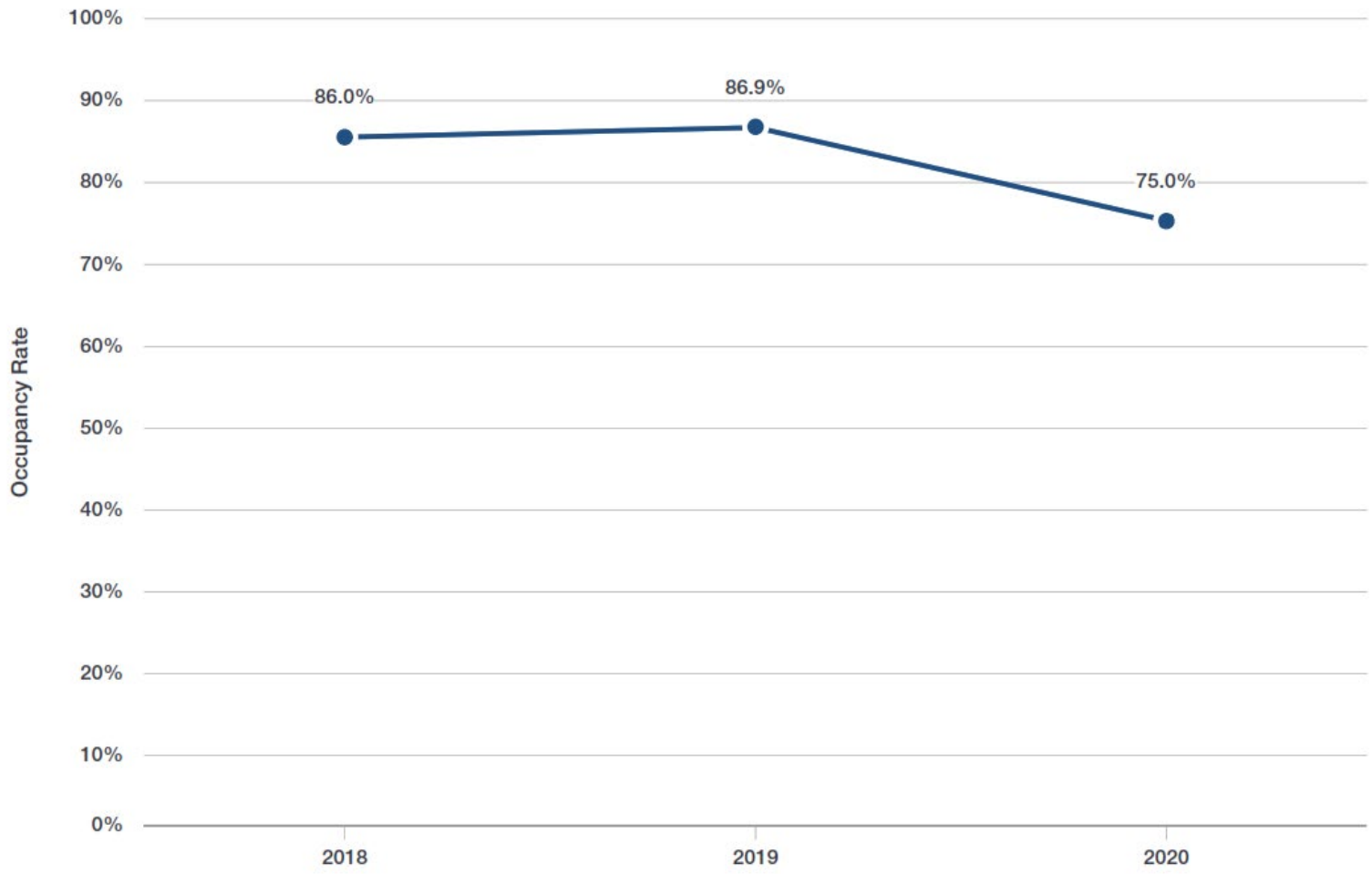
All hospital cohorts would have experienced negative median total margins without COVID-19 relief funds.

Nursing Facility Utilization, by Payer Type



Overall nursing facility resident days declined by 15.8% between 2018 and 2020.

Nursing Facility Occupancy Rates



Nursing facility occupancy decreased from 86.0% in 2018 to 75.0% in 2020.

Total Facilities, Total Beds, and Median Occupancy by County, 2020

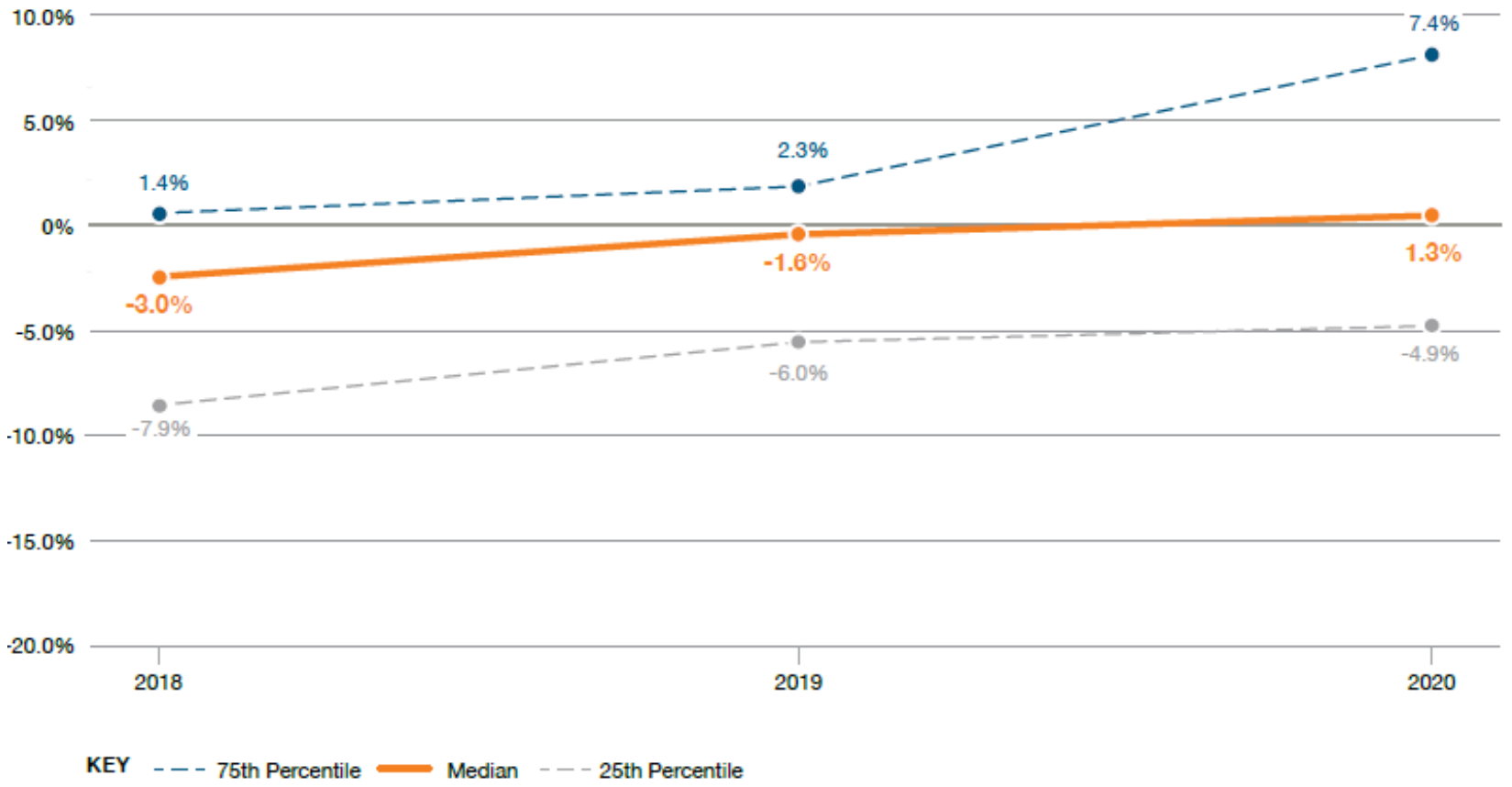
County	Total Facilities	Operating Beds	Median Occupancy
Barnstable	16	1,767	75.0%
Berkshire	12	1,370	85.8%
Bristol	31	4,038	79.0%
Dukes	1	74	57.9%
Essex	47	5,207	74.5%
Franklin	4	428	83.8%
Hampden	29	3,467	72.8%
Hampshire	6	784	73.0%
Middlesex	71	8,724	73.2%
Nantucket	1	45	80.0%
Norfolk	36	4,147	75.2%
Plymouth	29	3,498	76.0%
Suffolk	24	2,979	79.3%
Worcester	50	6,102	79.3%
Total	**357**	**42,630**	**76.7%**

KEY

- Increase by >5% compared to 2018
- Decrease between 5 and 10% compared to 2018
- Decrease by >10% compared to 2018

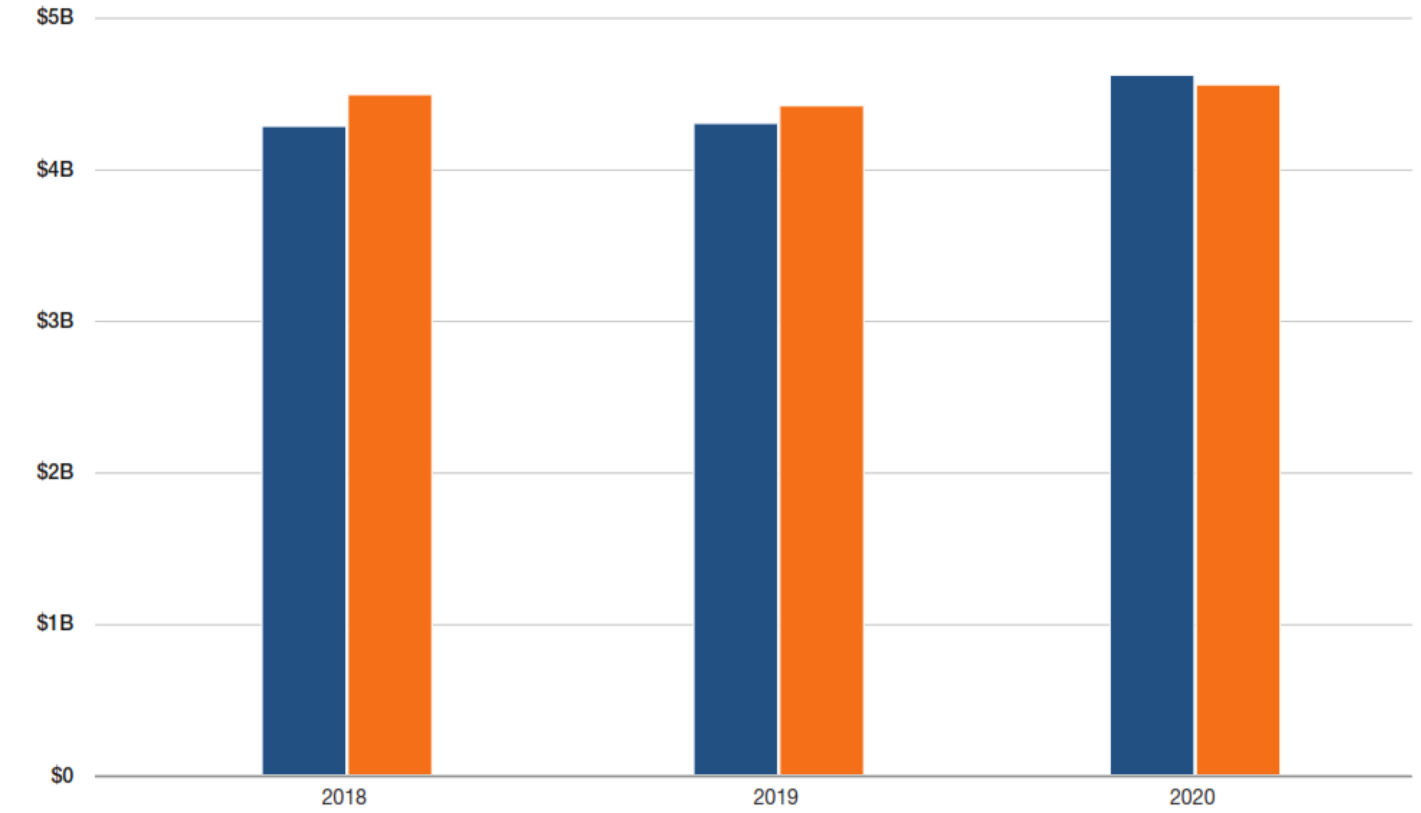
Middlesex County had the highest number of total facilities and operating beds in 2020, while Franklin County had the lowest among counties with more than one facility.

Nursing Facility Median Total Margin



The nursing facility median total margin increased from -3.0% in 2018 to 1.3% in 2020.

Nursing Facility Total Revenue and Expenses

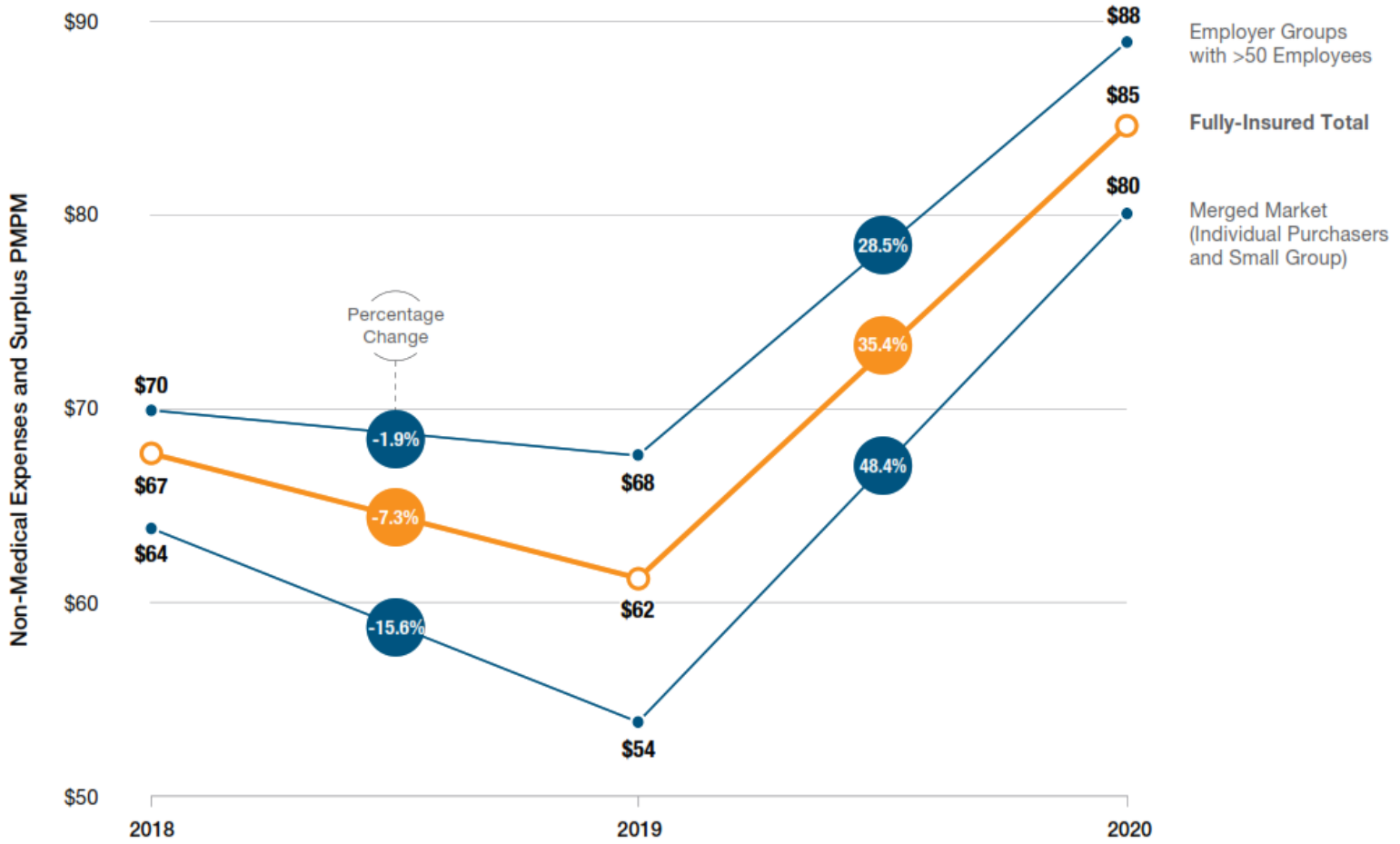


	2018	2019	2020
Total Reported Revenue	4,310,888,835	4,357,328,859	4,460,354,170
Total Reported Expense	4,485,697,890	4,438,804,654	4,562,181,593

In 2020, the total revenue including COVID relief funding slightly exceeded total expenses.

Private Commercial Insurance

Fully-Insured Non-Medical Expenses and Surplus by Market Segment, 2018-2020



After covering members' medical claims, $85 PMPM remained from fully-insured premiums in 2020, a 35.4% increase from 2019. This growth was driven by unexpectedly low health care spending.