Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

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AGO Cost Trends Examinations

- Authority to conduct examinations:
  - G.L. c. 12, § 11N to monitor trends in the health care market.
  - G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued since 2010.

Questions Presented

I. How do population health risk scores compare with community-level indicators of health and health care access?

II. How does the Centers for Medicare & Medicaid Services risk adjustment program shift funds across insurers serving different populations?

III. How do service closures and lack of capital investment by hospitals in low-cost networks risk further limiting access to care in low-income communities?

What is Health Status Adjustment?

- Health status adjustment (or “risk adjustment”) is a technique used to “equalize” the amount of dollars available to pay for health care services according to a patient’s likely need.
- Health status adjustment begins with assigning a health risk score to a patient or a population. Most risk score formulas rely on the patient’s (or population’s) “claims history” – their prior use of services and their accumulated diagnoses, plus age and gender.
- A higher risk score, in theory, reflects a sicker patient or population.
- Risk scores can be used to “adjust” the dollar amounts allocated to that patient’s (or population’s) care, so that resources will be matched to likely need – eliminating a financial incentive to discriminate against sicker people or populations.

Health Status and Access Barriers: An illustration

Rachel is a single mother of two living in Taunton. She works two jobs and uses her sick time to bring her children in for annual physical exams. Rachel has been having cold-like symptoms along with recurrent fevers but has not seen a doctor due to limited childcare and her work schedules. Recently, she noticed a lump under her arm. She decided to wait to see if her symptoms resolve or worsen before making a doctor's appointment.

Susan, a lawyer and mother in Newton, notices some changes in her health that concern her. With help from her childcare provider, she takes the day off work and drives to her doctor for an appointment the second week after her symptoms start. At her appointment, Susan's provider runs blood tests, records several diagnoses on her chart, and schedules follow-up appointments for an MRI and further diagnostic tests, which Susan confirms work for her.

Merged Market Risk Adjustment Program: Theory vs. Reality

- The merged market risk adjustment program, required by the ACA and implemented by CMS, transfers funds from insurers who cover lower-risk (i.e., healthier) members to insurers who cover higher-risk (i.e., sicker) members in the Massachusetts merged market.
- The goal is to disincentivize health plans from cherry picking healthy members and deliver funds to health plans with relatively sicker members to pay for greater anticipated services.
- When this works as intended, funds are transferred within the insurance system to patient groups with greater medical need. However, when risk adjustment is calculated based on members' health care utilization history, the formula rewards those with higher utilization. Utilization reflects both need and access to care.

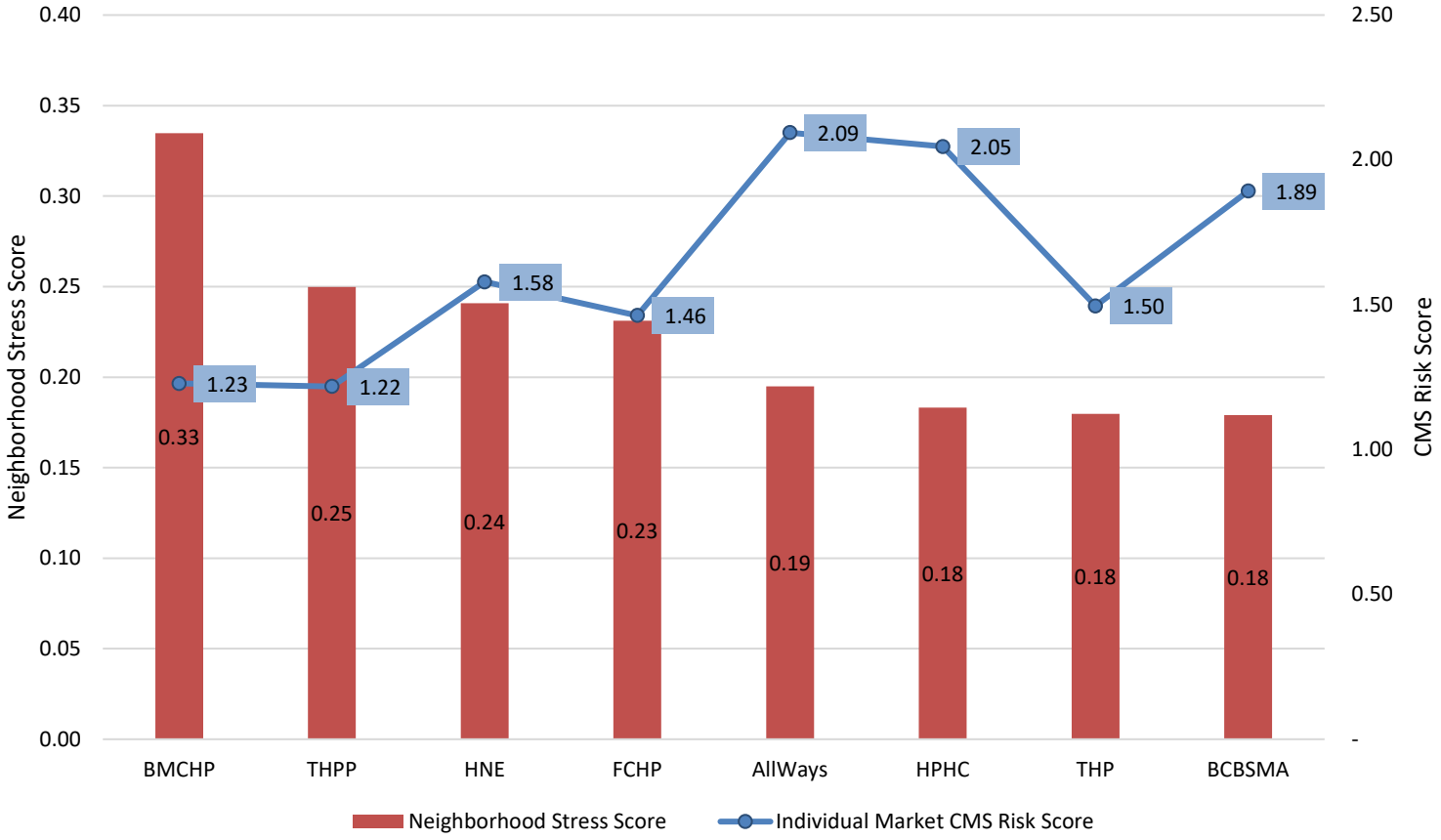
Key Findings

Insurers with lower CMS risk scores serve members from communities with:

- higher Neighborhood Stress Scores,
- worse self-reported health scores,
- more barriers to accessing health care services,
- and lower rates of preventive care.

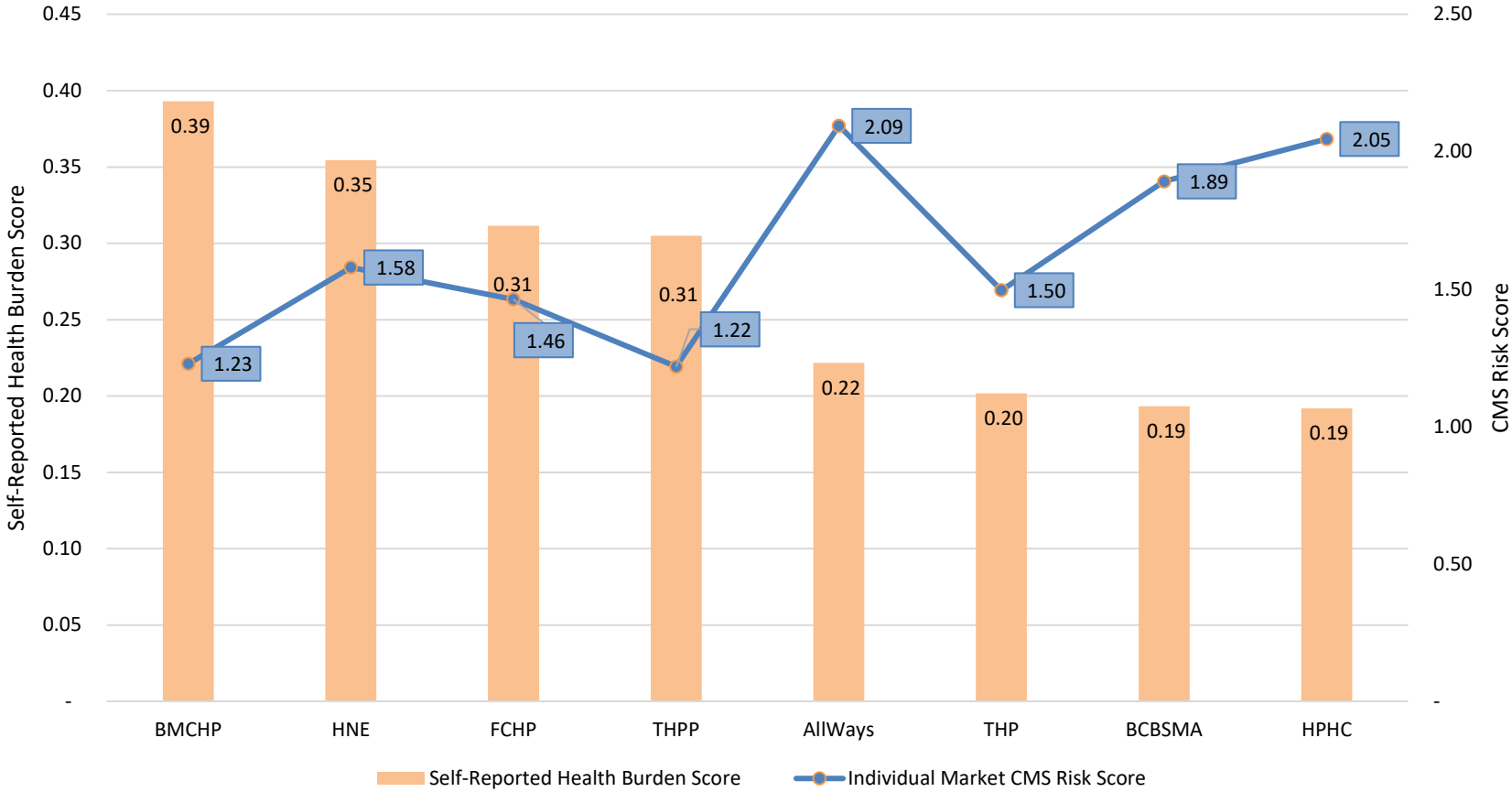
Insurers with Lower Risk Scores Serve Members from Communities with Higher Neighborhood Stress Scores

Figure 3: Neighborhood Stress Score vs. Individual Market CMS Risk Score

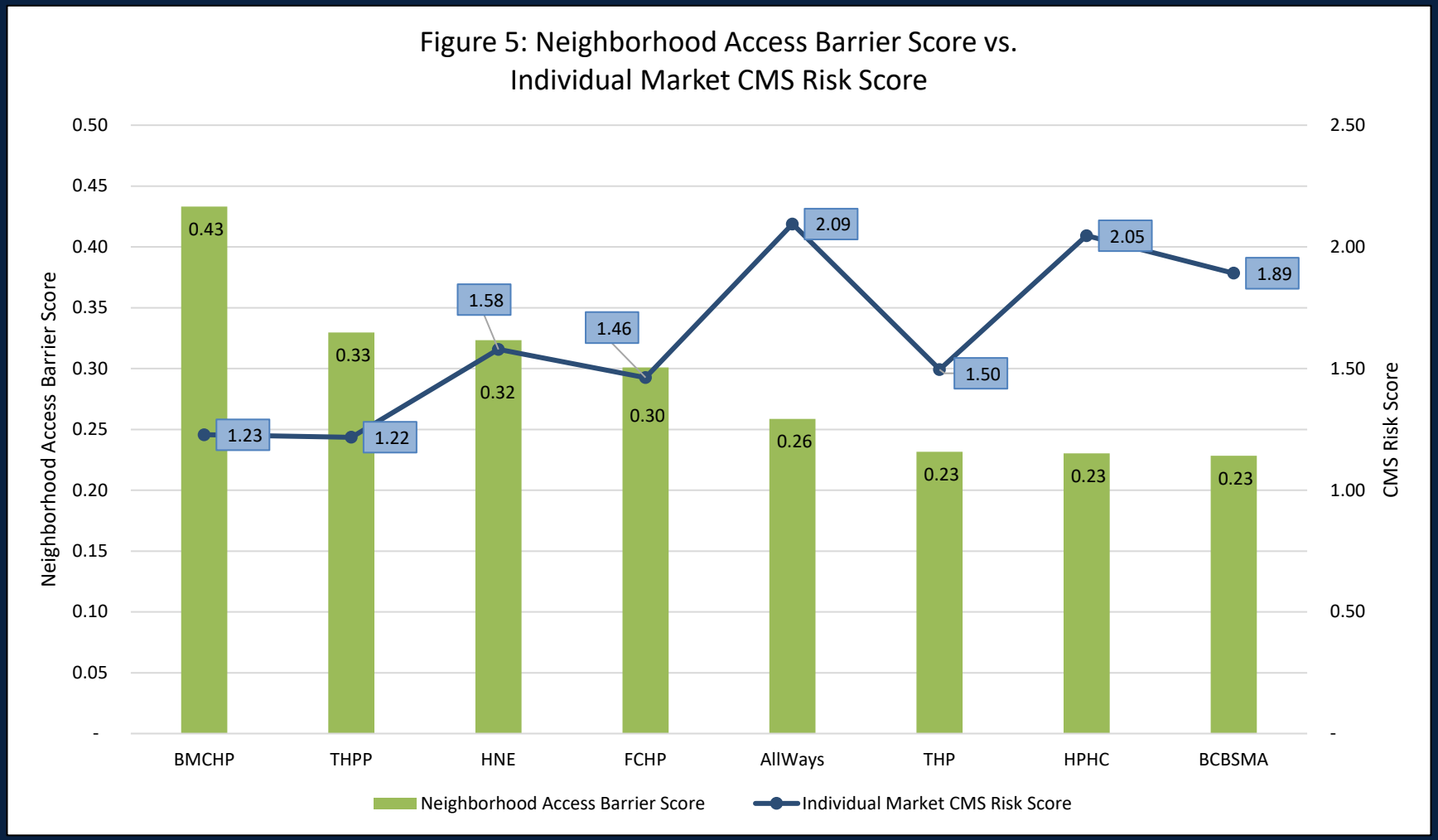


Insurers with Lower Risk Scores Serve Members from Communities with Higher Self-Reported Health Burdens

Figure 4: Self-Reported Health Burden Score vs. Individual Market CMS Risk Score



Insurers with Lower Risk Scores Serve Members from Communities with Higher Neighborhood Access Barriers



Insurers with Lower Risk Scores Serve Members from Communities with Lower Rates of Preventive Care

Figure 6: Missed Preventive Care Score vs. Individual Market CMS Risk Score (2019)

How do we explain this dynamic?

- Healthy members of all income levels tend to select the lowest cost plans, knowing they are unlikely to use services.
  - This is what risk adjustment is meant to address.
- Low-income members, both healthy and sick, tend to select the lowest cost plans. If they need services, they are more likely to face barriers to accessing services, like transportation, childcare, broadband access, or mistrust of the system.
  - Our study suggests that these barriers to access artificially deflate the risk scores of patients and populations who actually bear considerable health risk.

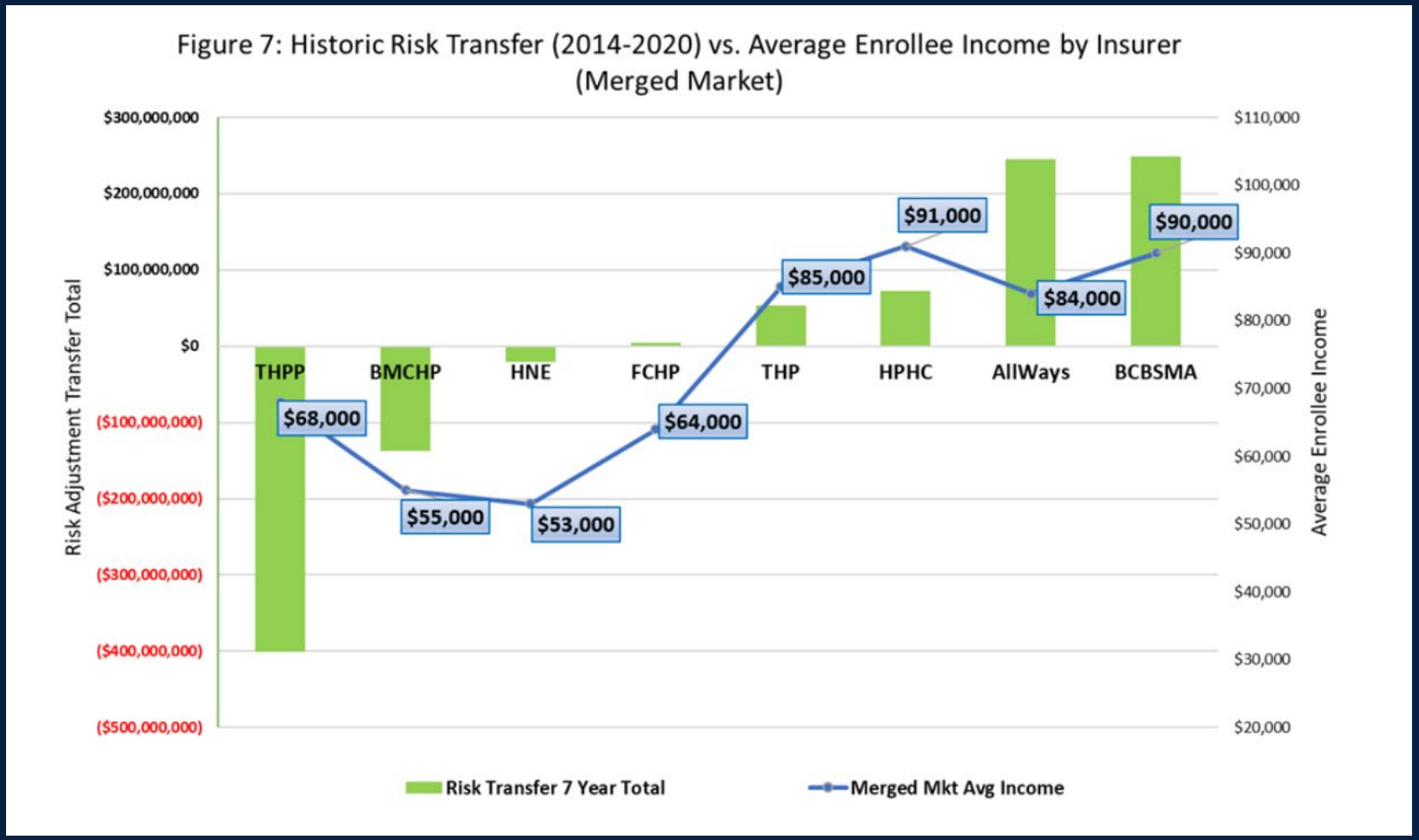
Questions Presented

I. How do population health risk scores compare with community-level indicators of health and health care access?

II. How does the Centers for Medicare & Medicaid Services risk adjustment program shift funds across insurers serving different populations?

III. How do service closures and lack of capital investment by hospitals in low-cost networks risk further limiting access to care in low-income communities?

Risk Transfer Payments are Diverting Funds Away From Carriers Serving Lower Income Enrollees



Risk transfer dollars are seven-year accumulation of transfers from historic risk adjustment reports (specific reports varied over 7 years 2014-2020)

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Underfunding of Safety Net Providers

- The risk adjustment program's redistribution of dollars away from insurers that contract with low-cost hospitals correlates with — and may compound — access challenges that low-income communities face because of essential health service closures and lack of capital investment by hospitals that serve those communities.
- In the next slide, we use public data to show that hospitals in lower-cost insurance networks — which tend to be safety-net hospitals with high levels of patients covered by public payers — are more likely to have reduced services and investments in facilities than other hospitals, resulting in even greater access barriers for the communities those hospitals serve.

Hospitals in Lower Cost Insurer Networks Are More Likely to Close Services Necessary to the Community and Are Less Likely to Invest in Substantial Capital Projects

	Percent of Hospitals with Closures of Essential Services Necessary to the Community (2016-2022)	Total Hospital Determination of Need Investment (2016-2022)
MA hospitals included in the lowest-cost network Hospitals (42 hospitals)	31%	$1.4B
MA hospitals included in only the highest-cost networks (19 hospitals)	9%	$4B

AGO Recommendations

1. Payers and providers should incorporate social determinants of health, such as access to transportation, housing, childcare, and broadband, in approaches to health status adjustment.
2. Payers and providers should develop new initiatives and incentives to help patients overcome barriers to accessing health care services.
3. Massachusetts and CMS should partner to scrutinize unintended equity implications of the CMS risk adjustment methodology, including by examining opportunities to include social determinants of health and modify the use of the statewide average premium.
4. Policymakers should pursue fundamental changes to cost containment policy with the goal of preserving safety net providers which are so critical to lower-income residents in high-stress communities.