



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.
- This examination focuses on the distribution of health care spending in the commercial market.
- Examined commercial spending across communities of different income levels and across employer groups.



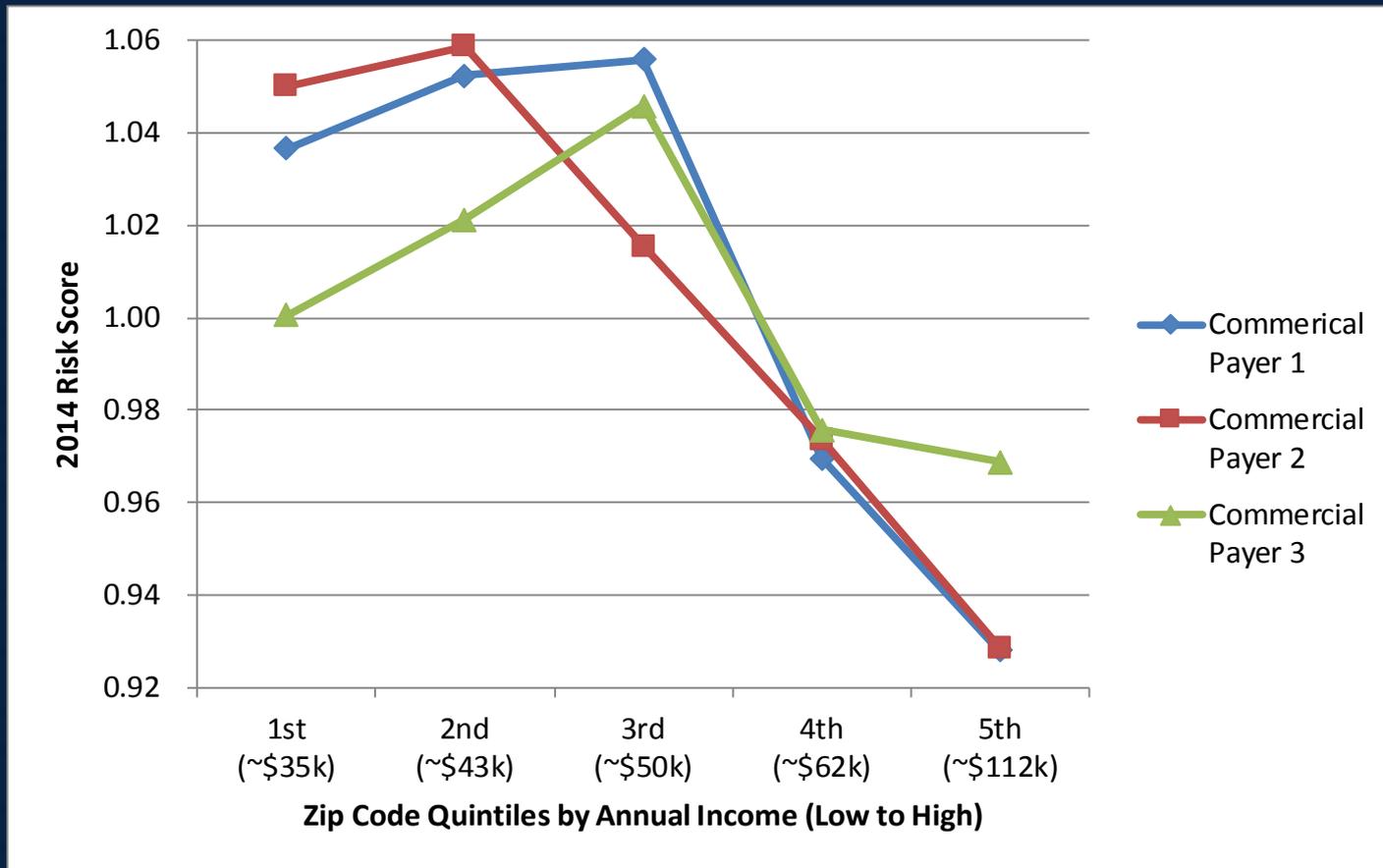
Questions Presented

- I. How are commercial health care dollars being distributed across communities of different income levels relative to health need?
- II. Are there spending differences attributable to members' provider choices within and between similarly situated employer groups?
- III. Can approaches to setting premiums be improved to reward employers and consumers who seek out high quality, lower cost care?



Higher Income Communities Are Generally Healthier

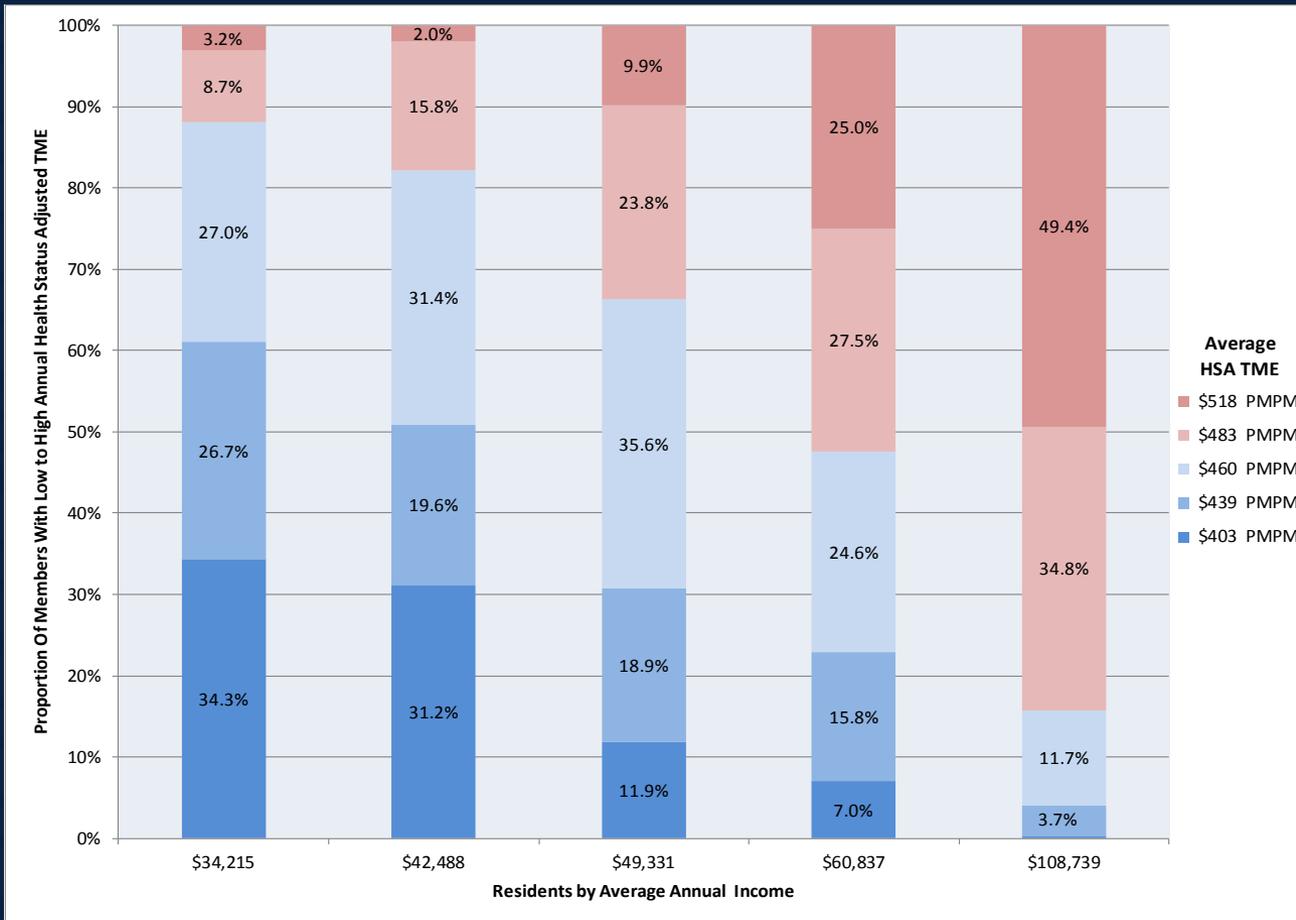
Health Risk Scores for Low and High Income Communities





We Continue to Spend More on Commercial Patients from Higher Income Communities Relative to Health Burden

Distribution of a Major Payer's Members by Income and Health Risk Adjusted Medical Spending (2014)





This Higher Spending on Higher Income Communities Is Likely Driven by a Number of Factors

- Lower-income communities may utilize less health care, notwithstanding health need, for a variety of reasons:
 - Lower income communities disproportionately experience structural barriers to accessing health care, like access to transportation and paid sick leave.
 - Changes in benefit design, like the trend toward high deductible health plans (HDHPs), can also disproportionately impact lower income communities. For example, lower income families enrolled in HDHPs are more likely than higher income families to delay or forgo care.
- On average, residents of lower and higher income communities may also use a different mix of health care providers. To the extent affluent communities use higher priced providers more often than lower-income communities, more is spent on their care because it is costlier.



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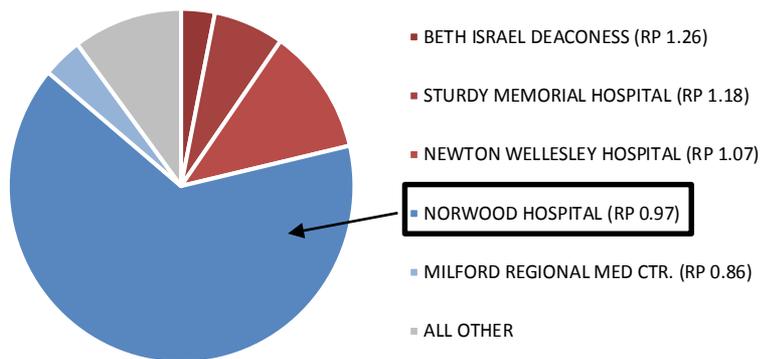
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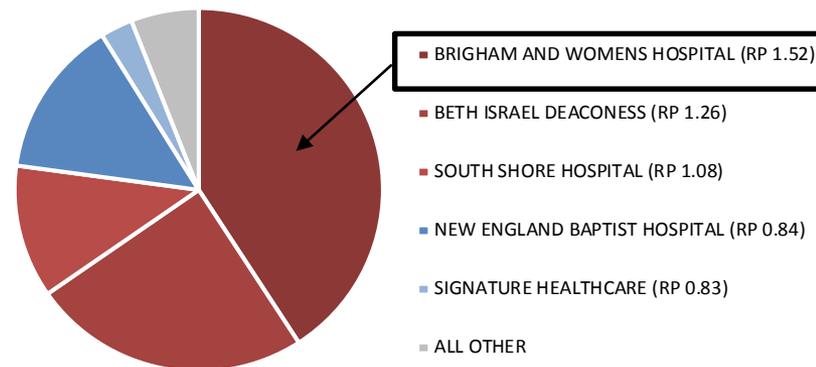
Differences in the Mix of Hospitals Used by Two Similarly Situated Employer Groups

Top Five Hospitals Used by Two Small Employers Located in Metrowest, MA (By 2014 Claims Revenue)

Employer A: Top Five Hospitals by Revenue
Group Relative Price: 1.03



Employer B: Top Five Hospitals by Revenue
Group Relative Price: 1.20





Other Examples of Differences in Hospital Mix Across Pairs of Similarly Situated Employer Groups

	Employer 1	Average Price of Hospitals Used	Employer 2	Average Price of Hospitals Used	Difference in Avg Price of Hospitals Used
Metrowest Region	Employer A	1.03	Employer B	1.20	16.5%
Boston Region	Employer C	1.07	Employer D	1.22	14.0%
Cape/Islands Region	Employer E	1.25	Employer F	1.38	10.4%
Central Region	Employer G	1.03	Employer H	1.26	22.3%
Northeast Region	Employer I	0.84	Employer J	1.09	29.8%
Southeast Region	Employer K	0.93	Employer L	1.18	26.9%
West Region	Employer M	0.91	Employer N	1.32	45.1%



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Premiums Socialize the Costs of Provider Choice

- When premiums in a shared risk pool (like the merged market or a large employer like the GIC) do not account for provider efficiency, the risk pool socializes a number of costs.
 - The costs associated with the group's health needs, and
 - The costs associated with certain members' use of higher priced providers.



An Alternative Model: Premiums That Account for Provider Efficiency

Differentiating Premiums Based on Patient's Choice of PCP Group While Continuing to Socialize Health Risk

	Provider Relative Efficiency	Traditional Monthly Premium	Differentiated Monthly Premium	Exemplar Employer Contribution (set at 80% of Prov. A premium)	Exemplar Employee Contribution
Provider A	0.88	\$584	\$514	\$411	\$103
Provider B	0.92	\$584	\$537	\$411	\$126
Provider C	0.96	\$584	\$561	\$411	\$150
Provider D	0.97	\$584	\$566	\$411	\$155
Provider E	1.00	\$584	\$584	\$411	\$173
Provider F	1.00	\$584	\$584	\$411	\$173
Provider G	1.01	\$584	\$590	\$411	\$179
Provider H	1.06	\$584	\$619	\$411	\$208



Recommendations

- Monitor the relationship between health care spending and health burden:
 - Track the allocation of health care dollars under global budgets.
 - Monitor the impact of plan design on access to health care services across different communities.
 - Examine whether higher health care spending on more affluent communities is contributing to income-based disparities in health outcomes.



Recommendations

- Sharpen available tools to reward more efficient health care delivery:
 - Explore product designs that offer consumer incentives at the point-of-enrollment.
 - Engage the employer community to demand timely and easily compared information on the cost and quality of different insurance plans and provider systems.
 - Evaluate provider performance under the statewide cost growth benchmark in ways that take into account differences in provider efficiency.