Up Next
Presentation by CHIA
and the HPC

Annual Health Care
Cost Trends Hearing

CTH
2016
2015 THCE Growth

Factors Underlying Growth in THCE

Changes in the Merged Market

Member Cost-Sharing

APM Adoption
Total Health Care Expenditures grew by 4.1%, exceeding the 3.6% cost growth benchmark set by the Health Policy Commission.

Annual Change in Total Spending

- **12.6%**: Net Cost of Private Health Insurance
  - **Commercial**
  - **MassHealth**
  - **Medicare**
  - **Other Public/Discontinued Programs**

- **5.3%**

- **4.6%**

- **5.3%**

- **-14.5%**

**$57.4B Total Overall Spending**

- **Percent Change per capita from 2014-2015**
  - **4.1%**
  - **$8,441 THCE per capita**
Payers reported prescription drug spending of $8.1 billion, representing 15% of THCE. Pharmacy spending accounted for 36% of the growth in THCE.

**Note:** Pharmacy data shown above excludes insurance categories for which pharmacy spending data is unavailable (e.g., HSN, VA, MSP).
Shifts in coverage contributed to an uptick in enrollment that drove growth in THCE. Comparing enrollment against medical spending reveals PMPM spending either declined or grew moderately for major coverage categories.
Individual enrollment in the commercial market more than doubled as new forms of subsidized and unsubsidized coverage became available. These members were associated with lower premiums, impacting the market as a whole.
Private commercial member cost-sharing continues to increase faster than inflation, wage growth, and overall cost of insurance coverage.

One in five commercial members were enrolled in a high deductible health plan.
After several years of gains, the proportion of commercial members whose care was paid for through an alternative payment method fell by approximately two percentage points, to 35% of the market.
THCE grew 4.1%, exceeding the benchmark (3.6%)

Pharmacy accounted for 36% of the growth in THCE

Shifts in enrollment increased overall spending, but PMPM spending only rose moderately

An influx of individual purchasers entered the private market into lower-premium plans, deflating overall market trends

Member cost-sharing outpaced the overall cost of insurance

One in five commercial members were enrolled in an HDHP

The proportion of commercial members whose care was paid for using APMs fell approximately 2 percentage points, to 35% of the market

CONCLUSION
Per-capita health care spending growth in Massachusetts has been generally in line with the benchmark.

Annual growth in Total Health Care Expenditures per capita from previous year

- THCE per capita
- THCE per capita with drug spending growth at 3.6%

Source: Massachusetts Center for Health Information and Analysis
Massachusetts commercial premium growth has been modest since 2012 compared to the U.S., even accounting for cost-sharing

Annual growth in health insurance premium spending per enrollee from previous year

Sources: US data and MA data from 2005-2009: Centers for Medicare and Medicaid Services, State and National Health Expenditure Accounts, private health insurance expenditures and enrollment. MA 2009-2015: Massachusetts Center for Health Information and Analysis
Unit price growth continues to be the major driver of spending increases while utilization growth is flat, 2014-2015

Annual growth in spending per enrollee due to each component

Source: Pre-filed testimony submitted by payers to the Health Policy Commission, 2016
Per-person spending growth in Medicare and MassHealth has also been modest

Annual per capita growth per enrollee from previous year

Source: Centers for Medicare and Medicaid Services (Medicare) and Center for Health Information and Analysis (MassHealth)
Massachusetts residents still pay among the highest health insurance premiums in the US

Annual premium for employer-based family health insurance, $

In 2015 the average cost of family coverage plus cost-sharing exceeded $20,000 per year for the first time ($20,400)

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component
The share of care that could be appropriately provided in a community hospital setting has not grown

Percent of community-appropriate commercial discharges by hospital type

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Hospital</th>
<th>AMC</th>
<th>Teaching Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>50.4%</td>
<td>49.3%</td>
<td>17.3%</td>
</tr>
<tr>
<td>2012</td>
<td>49.3%</td>
<td>49.3%</td>
<td>17.3%</td>
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<tr>
<td>2013</td>
<td>49.3%</td>
<td>49.3%</td>
<td>17.3%</td>
</tr>
<tr>
<td>2014</td>
<td>48.2%</td>
<td>49.3%</td>
<td>17.3%</td>
</tr>
<tr>
<td>2015</td>
<td>48.7%</td>
<td>49.3%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>

Discharge data from the Center for Health Information and Analysis
Massachusetts spends more per Medicare beneficiary than the rest of the U.S., particularly for inpatient and post-acute care.

Annual spending per fee-for-service beneficiary, 2015

Source: Centers for Medicare and Medicaid Services
Though the gap has closed somewhat, Massachusetts continues to use hospital settings more intensively than the U.S.

**Hospital Use in Massachusetts and the U.S., 2010-2014**

**ED Visits per 1,000 persons**

**Outpatient Visits per 1,000 persons**

**Inpatient Admissions per 1,000 persons**

<table>
<thead>
<tr>
<th>Difference MA-US</th>
<th>2010</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>58%</td>
<td>50%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>17%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation analysis of American Hospital Association data
Medicare readmission rates have also declined but are higher than a majority of states

Source: Centers for Medicare and Medicaid Services
Although we are a high-income state, Massachusetts has a considerable portion of residents at middle-income levels.

Number of state residents at each household income level, 2015

- Under 100% FPL (<$19,078): 3,384,100
- 100-199% FPL ($19,078 - $38,156): 791,100
- 200-399% FPL ($38,156 - $76,312): 994,300
- 400%+ FPL (> $76,312): 1,616,200

MA population percentage:
- Under 100% FPL: 15%
- 100-199% FPL: 24%
- 200-399% FPL: 39%

Source: Current Population Survey as reported by Kaiser Family Foundation. Dollar values are for a family of two adults and one child.
Lower- and higher-income employees pay similar amounts in health insurance premiums

Per member per month premium spending for single coverage

Average monthly premium for single-coverage

Low-wage firm: Most employees earn less than $25/hr

High-wage firm: 75% or more employees earn more than $25/hr

Source: Center for Health Information and Analysis, Massachusetts Employer Survey, 2014. Premiums include employee and employer contribution combined
Annual out of pocket spending is similar for individuals in low- and high-income areas of the state

% of residents, by income of region within Massachusetts, 2013

Source: Massachusetts All-payer claims database. Lowest income areas represent the quartile of zip codes in the state with the lowest median income. Spending includes only out of pocket spending within insurance benefits (e.g. copays and deductibles). Spending data is conditional on having non-zero spending.
Overall affordability of health care continues to be a challenge for many low and middle income residents

Percent of respondents saying they experienced the following in the past 12 months, by income

Source: Center for Health Information and Analysis, Massachusetts Health Interview Survey, 2015. Income ranges shown are for a family of two adults and one child. Out of pocket spending includes all health care spending including for non-covered services.
Top areas of concern noted by payers and providers in 2016

**PROVIDERS**

- Prescription drug costs (~50%)
- Labor costs and wage pressure
- Commercial payment rates for behavioral health

**PAYERS**

- Prescription drug spending increases (100% of payers)
  - Most also noted lack of transparency in drug pricing
- Provider consolidation and price variation

Source: pre-filed testimony submitted to the Health Policy Commission in advance of the 2016 Cost Trends Hearing
Up Next
Presentation by Dr. Robert Berenson

Annual Health Care Cost Trends Hearing

CTH 2016
Provider Consolidation and Price Variation: A National Perspective

Robert A. Berenson, M.D.
Institute Fellow, The Urban Institute
rberenson@urban.org

Massachusetts Health Policy Commission
Cost Trends Hearing
Boston
17 October 2016
The Presentation Will:

• Establish the importance of prices as a primary driver of excessive spending
• Explore consolidation as one -- but not the only – reason for pricing power and price variations
• Review the evidence about the impact of consolidation on cost and quality
• Present an overview of policy options to address high and variable prices, with emphasis on states
• Discuss whether payment reform is part of the problem or part of the solution
Prices Are the Major Reason US Spending Exceeds the Rest of the World
• Whether as per capita spending or as percentage of GDP spent on health care
• “It's the prices, stupid: why the United States is so different from other countries.” – Anderson et al., *Health Affairs*, 2003
• *Accounting for the Cost of Health Care in the United States* – McKinsey Global Institute, 2008
  “Input costs – including doctors’ and nurses’ salaries, drugs, and other medical supplies, and the profits of private participants in the system – explain the largest portion of additional spending… [the $650 billion extra the US spends compared to world norms]”
Trends in Payment to Cost Ratios

- Aggregate hospital payment-to-cost ratios for private payers increased from about 116% in 2000 to 144% in 2014 (was up to 149% in 2012 from 135% in 2011)

  AHA Annual Survey Data for Chart 4.6, for 2014, *AHA Trendwatch Chartbook, 2016*

- Some evidence of a slowdown in price increases in recent years, although some discrepancy in data sources used, i.e., whether Medicare Advantage is included

- “Medical Expenditure Panel Survey” data reveal that standardized private insurer payment rates in 2012 were approximately 75 percent greater than Medicare’s – a sharp increase from the differential of approximately 10 percent in the period 1996-2001.”

  Selden et al., Health Affairs, Dec. 2015:2147
Factors Accounting for Growth in Per Capita National Health Expenditures, 04-14

Changes in Utilization and Prices of Medical Subservice Categories: 2014

The Price Variations Are Huge and Persistent

- Across 8 markets, from surveys, average inpatient rates ranged from 147% of Medicare in Miami to 210% in SF but ranged up to 500% for inpatient and 700% for outpatient care

- Within market variations were marked also – hospitals at the 25th percentile in LA County received 84% of Medicare payment levels while the 75th percentile got 184%


- From review of paid claims in 13 markets, the average highest priced hospital was paid 60% more than the lowest priced for inpatient services and >100% more for outpatient

- In 3 markets, the highest priced got >2X’s lowest priced for inpatient care

  White, Bond, and Reschovsky. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." Center for Studying Health System Change Research Brief no. 27, 2013.

- MA Commission found hospital price variations consistent since 2010 and increased somewhat for physicians since 2009
“The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured”

Using HCCI data based supplied by Aetna, Humana, and UnitedHealth (27.6% of those with ESI), Cooper et al (Dec 2015) found:

- Per capita spending varies by a factor of 3 across 306 Hospital Referral Areas, with very weak correlation to Medicare per capita spending
- Variation in providers’ transaction prices is the primary driver of spending variation for privately insured
- Large dispersion of inpatient prices and for 7 homogeneous procedures, e.g., hospital prices for lower-limb MRI vary by a factor of 12 across US and on average two-fold within HRRs
- Hospital prices in “monopoly” markets are 15.3% higher than in markets with 4 or more hospitals
The Consolidation Frame

• Many frame the pricing power problem as consolidation, supported by evidence that finds that beyond a fairly low threshold, additional size does not improve quality or efficiency – but may actually make them worse

• But this frame:
  - ignores that there are high prices enjoyed by “must haves” as well in non-consolidated markets and which don’t do M&A
  - ignores the reality of “have-nots,” which are price takers and have relatively low payments, often below Medicare
  - points to antitrust policy as the prime antidote, rather than as just one tool to address pricing issues
  - and slides over strong views about the concept of ACOs as a community-based entity of some kind featuring collaboration rather than competition
Leverage Factors Unrelated to Concentration/Consolidation

- While concentration is the main story (and a major consideration re ACOs), other factors contribute to growing provider market power over prices and contract “terms and conditions”
  - Employer rejection of narrow networks
  - Reputation
  - Geography
  - Leveraging particular “monopoly” services – sometimes fostered by understandable regulatory exclusion of market competitors
Haves and Have-Nots

- While hospitals receive 175% of Medicare on average, anecdotally, it seems clear that many “haves” obtain >250% of Medicare, and as high as 500-600%
- But other hospitals accept even less than Medicare rates, because they have few commercially insured patients and are rarely if ever must haves in commercial insurance networks
- MedPAC finds that commercial insurance physician fees are at about 120-125% of Medicare overall but, anecdotally, in Miami, Las Vegas, and other places, physicians are “price takers,” accepting 60-70% of Medicare fee schedule rates, while in an unnamed mid-west city rates can be as high as 900%
The RWJF Synthesis Project
The Impact of Hospital Consolidation– Update, June 2012

Summary of key findings:

1. Hospital consolidation generally results in higher prices (with new evidence since 2012 confirming these findings)

2. Hospital *competition* improves quality of care

3. Physician-hospital consolidation has not led to either improved quality or reduced costs

4. Consolidation without integration does not improve performance

5. Consolidation between physicians and hospitals is fast increasing (although for various reasons, including to take advantage of FFS payment rules, not only to form ACOs able to receive population-based payments)
Why Antitrust Can’t Be the Only or Even the Primary Policy Lever

• Many local markets can’t readily support competition among major health care providers
• There are often justifiable, practical reasons for consolidations to take place, and some may improve quality and efficiency in particular situations -- but they can also lead to market power with increased prices as a derivative of the new, worthy arrangement
• The horse is out of the barn, after two major eras of hospital merger “mania”
“While the antitrust agencies’ efforts to promote and protect competition in health care markets is commendable, it is also the case that the antitrust law has little to say about monopolies legally acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in hospital markets and a growing number of physician specialty markets, it is particularly important other measures that promote competition.”

-- Professor Thomas (Tim) Greaney, Testimony to the Committee of the Judiciary, House of Representatives, May 18, 2012

Or other public policies that are more regulatory in nature
Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets

A Report of the National Academy of Social Insurance
April, 2015
NASI Report Policy Options on a Continuum from Market-oriented to Classically Regulatory

• Encouraging market entry of competitors
  – Eliminate scope of practice restrictions, AWP laws, CON
  – Policies to support telehealth adoption, alternative sites of care

• Greater price transparency (and quality)
  – Two different purposes: 1) to shine a spotlight on the problem, 2) to facilitate consumer choice when significant out-of-pocket payment obligations
  – Collecting and reporting all-payer claims data (now made more difficult because of Supreme Court’s Gobeille ruling)

• Active purchasing by public payers
  – With hoped-for spillover to other product markets
Policy Options (cont.)

• Limiting anticompetitive health plan-provider contracting provisions
  – e.g., anti-tiering, all-or-none contracting, most favored nations clauses

• Harmonizing network-adequacy requirements with development of limited provider networks
  – While addressing out-of-network “surprise” bills

• Improved Antitrust Enforcement
  – Scrutiny of hospitals and insurers with market power
  – Active review of vertical mergers, based on recent evidence of anticompetitive effects
  – Conduct remedies and post-merger monitoring?
Policy Options (cont.)

• State-based oversight
  – Across the states doing this, there is significant variation in what state commissions are doing and whether they have regulatory authority

• Formal insurance rate review
  – Moving from “file and use” to “prior approval” and medical loss ratio requirements
  – Variations across states in which insurance products subject to review
  – Unsettled whether this approach creates necessary leverage for plans or whether also need direct authority over plan-provider (hospital) contracts, esp. re prices
Policy options (cont.)

• Limits on out-of-network billing as a way to constrain negotiating leverage between plans and providers

• Setting upper limits on permissible, negotiated rates
  – Or focus regulatory limits on health systems that exceed a threshold of consolidation

• Expanded use of all-payer or private payer rate setting, a la Maryland and West Virginia, respectively
NASI Did Not Include Payment Reform As One of the Options

• The greater concern is that some payment reforms would increase pricing power and price differentials
• “Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,” Berenson, Ginsburg, and Kemper. Health Affairs, April, 2010
• Indeed, policy analysts, such as Michael Porter, argue that “focused factories” receiving bundled episode payments for treatments and conditions are preferred over integrated systems receiving population-based payments, partly because of less concern about market power raising prices
High Prices Eat Low Service Use for Lunch

- Dartmouth and subsequent analyses suggest that efficient providers have service use profiles perhaps 20% lower than average; in Medicare, MedPAC finds a 30% spread across geographic areas between the 10th and 90th percentile if health status adjustments are included.
- But private insurance prices vary by far more than 20-30% -- perhaps 100% between the 10th and 90th percentile in many markets.
- Only through a pure “bending the cost curve” lens can one consider Shared Savings or Total Cost of Care contracting based on historical costs a win. These approaches basically accept and can even exacerbate wide price disparities between “haves” and “have-nots.”
How Payment Design Can Affect Prices in Commercial Market Products

• Essentially, whether or not providers’ historic costs are the basis for target spending
  – In calculating benchmarks for determining whether shared savings
  – In setting hospital global budgets a la Maryland, where there actually is substantial price variation by hospital, but much less so by patient and payer
  – In pricing a bundled episode

• Using historic costs without adjustments “bakes in” historic pricing differentials, but some approaches to updates can narrow differences over time
Options for Balancing Provider Specific, Historic v. Community Average Prices

• Medicare ACOs get an absolute dollar rather than a percentage trend update (so higher cost providers get a lower percentage update)

• Blend and transition benchmarks from historic toward the average -- but maybe not all the way
  – In Medicare IPPS, 4 yr. transitional blend from actual cost per case to national, standard cost per case
  – In Medicare Advantage, there are 4 different benchmarks based on level of per capita spending in traditional Medicare
  – All-payer rate setting states in ‘80s had transitional blends

• Can vary shared savings percentages in relation to the level of historic, baseline spending
Classification of State Policies Addressing Provider Market Power

(Catalyst for Payment Reform, for NASI)

The report produced a catalogue of laws to enhance market competition or substitute for it

• Antitrust related laws
• Laws and regulations:
  – encouraging transparency on quality and price
  – encouraging competitive behavior in health plan contracting
  – implementing the monitoring or regulating of prices
  – around the development of ACOs
  – expanding the authority of Departments of Insurance
  – facilitating or reducing barriers for new entrants to the market
Examples of State Actions to Address Consolidation and Pricing

• CA prevents providers’ ability to suppress price information

• MA has created the Health Policy Commission which among other things conducts a “cost and market impact review” to monitor material changes by provider organizations

• MA bans carriers from entering contracts that limited tiered networks or guarantees a provider’s participation

• MI (and other states) explicitly bar insurers from using “most favored nation” clauses in provider contracts
State Examples (cont.)

• RI Office of the Insurance Commissioner has been granted broad authority to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability, and giving them the ability to review and approve payer-provider contracts.

• Texas defines a “health care collaborative” (ACO) and requires them to obtain a certificate of authority from the DOI and AG concurrently. The latter reviews whether the ACO is likely to reduce competition and whether it should be permitted.
Some Useful Papers and Reports

- Murray and Berenson. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* The Urban Institute, Washington, D.C., November, 2015. Available at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000516-Hospital-Rate-Setting-Revisited.pdf
THANK YOU
Up Next
Panel: Meeting the Health Care Cost Growth Benchmark

Annual Health Care Cost Trends Hearing

CTH 2016
Panel: Meeting the Health Care Cost Growth Benchmark

Panelists

Atrius Health
Baystate Health
Blue Cross Blue Shield of MA
Community Care Cooperative
Harvard Pilgrim Health Care

Dr. Steven Strongwater, President and CEO
Dr. Mark Keroack, President and CEO
Mr. Andrew Dreyfus, President and CEO
Ms. Christina Severin, President and CEO
Mr. Eric Schultz, President and CEO

Focus Areas

1. Meeting the Goals of Chapter 224
2. Adoption of Alternative Payment Methods
3. Impact of Pharmaceutical and Medical Device Pricing Trends
4. Out-of-Network Billing
Up Next
Reactor Panel:
Employer Perspective

Annual Health Care Cost Trends Hearing

CTH 2016
Reactor Panel: Employer Perspectives

Panelists

Northeast Business Group on Health
Ms. Laurel Pickering, President and CEO
Onyx Specialty Paper
Ms. Patricia Begrowicz

Focus Areas

1. Role of Employers in Promoting Value-Based Health Care
2. Plan and Benefit Design Strategies
3. Employee Engagement
4. Health Insurance Premium Trends
Up Next
Presentation by the Office of the Attorney General

Annual Health Care Cost Trends Hearing

CTH 2016
Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

October 17, 2016

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108
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

© 2016 Massachusetts Attorney General's Office
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.
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?
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)
## Other Examples of Differences in Hospital Mix Across Pairs of Similarly Situated Employer Groups

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

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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?
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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Relative Efficiency</th>
<th>Traditional Monthly Premium</th>
<th>Differentiated Monthly Premium</th>
<th>Exemplar Employer Contribution (set at 80% of Prov. A premium)</th>
<th>Exemplar Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>0.88</td>
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<td>$514</td>
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<td>0.96</td>
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<td>$566</td>
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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.
Up Next
Panel: Evolving Provider Market

Annual Health Care Cost Trends Hearing

CTH 2016
Panel: The Evolving Provider Market

Panelists

Central Massachusetts IPA
Ms. Gail Sillman, Chief Executive Officer

Lahey Health
Dr. Howard Grant, President and CEO

NEQCA
Dr. Joseph Frolkis, President and CEO

South Shore Health System
Dr. Gene Green, President and CEO

Tufts Health Plan
Mr. Thomas Croswell, President and CEO

Focus Areas

1. Continued Provider Consolidation
2. Shift in Care from Inpatient to Outpatient Settings
3. Physician Recruitment and Employment Trends
4. Future Role for Community Hospitals and Independent Physician Practices
5. Provider Price Variation
October 18, 2016

Annual Health Care Cost Trends Hearing

CTH 2016
Up Next
Presentation by the Office of the Attorney General

Annual Health Care Cost Trends Hearing

CTH 2016
Examination of Health Care Cost Trends and Cost Drivers
Pursuant to G.L. c. 12C, § 17

October 18, 2016

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA  02108
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 prescription drug spending.
- Examined commercial spending under the pharmacy benefit by five health plans – four regional and one national – representing 75% of the Massachusetts commercial market.
Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?
### Annual Increase in Commercial Drug Spending Net of Rebates (PMPM) 2013-15

#### Annual Pharmaceutical Spending Trend (Per Member Per Month) 2013-2015

<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Pre-Rebate</td>
<td>Net-Rebate</td>
</tr>
<tr>
<td>Plan 1</td>
<td>14.3%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Plan 2</td>
<td>11.0%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Plan 3</td>
<td>10.2%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Plan 4</td>
<td>21.1%</td>
<td>19.9%</td>
</tr>
<tr>
<td>Plan 5</td>
<td>13.4%</td>
<td>13.1%</td>
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<tr>
<td>Average</td>
<td>14.6%</td>
<td>13.7%</td>
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#### Reporting Entity

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<tr>
<td>HPC ('13-'14)</td>
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<td>CHIA ('14-'15)</td>
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<td>8.5%</td>
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<tr>
<td>IMS</td>
<td>13.1%</td>
<td>N/A</td>
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### Annual Increase in Commercial Specialty Spending Net of Rebates (PMPM) 2013-15

#### Annual Trend for Spending on Specialty Drugs (Per Member Per Month) 2013-2015

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Rebate</td>
<td>Net-Rebate</td>
</tr>
<tr>
<td>Plan 1</td>
<td>32.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>Plan 2</td>
<td>30.4%</td>
<td>30.5%</td>
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<tr>
<td>Plan 3</td>
<td>33.4%</td>
<td>N/A</td>
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<tr>
<td>Plan 4</td>
<td>45.0%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Plan 5</td>
<td>36.3%</td>
<td>36.2%</td>
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<tr>
<td>Average (Plans 2, 4 and 5)</td>
<td>38.0%</td>
<td>38.3%</td>
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<table>
<thead>
<tr>
<th>Reporting Entity</th>
<th>Pre-Rebate</th>
<th>Net-Rebate</th>
<th>Pre-Rebate</th>
<th>Net-Rebate</th>
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</thead>
<tbody>
<tr>
<td>IMS</td>
<td>26.5%</td>
<td>N/A</td>
<td>21.5%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?
# Health Plans Pay for Specialty Drugs in a Variety of Ways

<table>
<thead>
<tr>
<th>Plan</th>
<th>PBM for discounts</th>
<th>Manufacturers for discounts</th>
<th>Pharmacy for discounts</th>
<th>PBM for rebates</th>
<th>Manufacturer for rebates</th>
<th>PBM for up-front price, with rebate guarantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan A</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Plan B</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan C</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Plan D</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Plan E</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?
Steady, Substantial Price Increases and Minimal Differences in Prices for Multiple Sclerosis Drugs Across Health Plans
Steady, Substantial Price Increases and Minimal Differences in Prices (Low CVs) for Multiple Sclerosis Drugs Across Health Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Average Annual Growth Rate in Net Prices for 10 MS Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan I</td>
<td>12.1%</td>
</tr>
<tr>
<td>Plan II</td>
<td>11.6%</td>
</tr>
<tr>
<td>Plan III</td>
<td>15.0%</td>
</tr>
<tr>
<td>Plan IV</td>
<td>11.7%</td>
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<tr>
<td>Plan V</td>
<td>10.2%</td>
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</table>

<table>
<thead>
<tr>
<th>Coefficient of Variation Across Plans’ MS Prices: 2011-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Aubagio</td>
</tr>
<tr>
<td>Avonex</td>
</tr>
<tr>
<td>Betaseron</td>
</tr>
<tr>
<td>Copaxone 20 mg</td>
</tr>
<tr>
<td>Copaxone 40 mg</td>
</tr>
<tr>
<td>Gilenya</td>
</tr>
<tr>
<td>Glatopa</td>
</tr>
<tr>
<td>Plegridy</td>
</tr>
<tr>
<td>Rebif</td>
</tr>
<tr>
<td>Tecfidera</td>
</tr>
</tbody>
</table>

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Little Variation in Relative Spending on Multiple Sclerosis Drugs Studied

<table>
<thead>
<tr>
<th>Share of average annual net cost</th>
<th>Proportion of Plan Spending on Subject MS Drugs from 2011-2015 Broken Out By Each Subject Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan I</td>
</tr>
<tr>
<td>100%</td>
<td>1.9%</td>
</tr>
<tr>
<td>90%</td>
<td>9.6%</td>
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<tr>
<td>80%</td>
<td>12.1%</td>
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<tr>
<td>70%</td>
<td>5.8%</td>
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<tr>
<td>60%</td>
<td>10.9%</td>
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<tr>
<td>50%</td>
<td>15.3%</td>
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<tr>
<td>40%</td>
<td>36.6%</td>
</tr>
<tr>
<td>30%</td>
<td>7.5%</td>
</tr>
<tr>
<td>20%</td>
<td>9.7%</td>
</tr>
<tr>
<td>10%</td>
<td>3.8%</td>
</tr>
<tr>
<td>0%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>
Impact of Single Generic Alternative on Multiple Sclerosis Drug Spending is Unclear

Copaxone and Glatopa Total Monthly Prescriptions – All Plans

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Recommendations

• To facilitate understanding of actual spending on pharmaceuticals, require reporting of aggregated, standardized information on drug rebates.

• Continue fostering competition by promoting the availability of generic and biosimilar drugs.

• Improve measurement and transparency of the comparative efficacy of different drugs that treat the same disease.
  – Where different drugs are demonstrated to be similarly effective, consider broader implementation of strategies that spur competition on behalf of consumers (e.g., formularies, reference pricing).
  – Where access to all drugs in a therapeutic class is strongly valued (i) consider enhancing patient value by relying on comparative efficacy to encourage research, development, and spending on the highest value drugs; and (ii) explore innovative reimbursement approaches (e.g., outcomes-based contracts).
Social Determinants of Health: Opportunities and Challenges
MA Annual Cost Trends Hearing
Oct 18, 2016

Lauren A. Taylor, MDiv, MPH
@LaurenTaylorMPH, ltaylor@hbs.edu
Goals for Today

**Overall**
“The annual health care cost trends hearing is a public examination into the drivers of health care costs as well as the engagement of experts and witnesses to identify particular challenges and opportunities within the Commonwealth's health care system.”

**This 40min**
1. A Driver – Unmet Social Need
2. An Opportunity – Social Service Investment
3. Two Challenges – Governance and Contracting
Health Expenditures as a % of GDP, 2009*

*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.
Total Expenditures as a %GDP

*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.
METHOD: Multivariable regression using OECD pooled data from 1995-2007 on 29 countries and 5 health outcomes.

FINDING: The ratio of social to health spending was significantly associated with better health outcomes: less infant, mortality, less premature death, longer life, expectancy and fewer low birth weight babies.

NOTE: This remained true even when the US was excluded from the analysis.
Ratio of social-to-health care spending*  

*Medicare and Medicaid spending; Data from Bradley et al, Health Affairs, May 2016.
METHOD: Multivariable regression using state-level repeated measures data from 2000-2009 with regional and time fixed effects.

FINDING: The lagged ratio of social to health spending was significantly associated with better health outcomes: adults who were obese; had asthma; reported fourteen or more mentally unhealthy days or fourteen or more days of activity limitations in the past thirty days; and had lower mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes.
Which social services produce better health and save dollars?
National Tradeoffs

$337 billion public dollars that IOM estimates is wasted in US health care (2012)

$85b on education
$37b on child health
$23b on infrastructure
$20b on job training
$168b debt reduction

Some Evidence of Crowd Out

Figure 1.1: State budgets for health care coverage and other priorities, FY2004-FY2014
Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014

- $2.8B (+21%)
- $1.4B (-7%)

GIC, MassHealth, & Other
Mental Health
Public Health
Education
Human Services
Infrastructure, Housing & Economic Development
Law & Public Safety
Local Aid

NOTE: Figures all adjusted for Gross Domestic Product (GDP) growth; GIC = Group Insurance Commission
SOURCE: Massachusetts Budget and Policy Center
Innovative Medicaid Redesigns
PORTLAND, Ore. — Five major hospitals in Portland, Oregon, and a nonprofit health care plan said Friday they will donate a combined $21.5 million toward the construction of nearly 400 housing units for the city’s burgeoning homeless and low-income population — a move hailed by national housing advocates as the largest private investment of its kind in the nation.

The money from the private health care providers will be part of a larger $69 million capital construction plan that comes as the booming Pacific Northwest city struggles with a seemingly intractable homeless problem that has become more visible in the past few years and poses a political quagmire for local leaders.

Earlier this month, hundreds of people were evicted from an informal tent camp on a nature trail on the city's east side, and the city has fielded thousands of complaints on a hotline for residents as leaders debate...
Evidence Exists for Various Integration Models

Traditional Health Care Sector

- Community Benefit Grants
- Programmatic Partnership
- Offering Individual Social Services
- Strategic Investments
- Pooled Health and Social Services Budgets
Key Governance Question

Healthcare

- Skilled Nursing
- Job Training
- Home Health
- (etc)
- Housing
- Rehab Centers

Rehab Centers

- Housing
- Job Training
- Home Health
- (etc)
- Health care
Health + Social Contracting Challenges

How to provide social services – make in-house or buy from community?

How to vet potential partner organizations?

How to share information with partner organizations?
Look forward to learning from you.

Follow up with me:
@LaurenTaylorMPH
ltaylor@hbs.edu
Up Next
Panel: Strategies to Address Social and Behavioral Health Needs

Annual Health Care Cost Trends Hearing

CTH 2016
## Panel: Strategies to Address Social and Behavioral Health Needs

### Panelists

<table>
<thead>
<tr>
<th>Organization</th>
<th>Panelist Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Medical Center</td>
<td>Ms. Kate Walsh, President and CEO</td>
</tr>
<tr>
<td>Commonwealth Care Alliance</td>
<td>Dr. Toyin Ajayi, Chief Medical Officer</td>
</tr>
<tr>
<td>Holyoke Medical Center</td>
<td>Mr. Spiros Hatiras, President and CEO</td>
</tr>
<tr>
<td>Massachusetts General Hospital</td>
<td>Dr. Elsie Taveras, Division of General Pediatrics</td>
</tr>
</tbody>
</table>

### Focus Areas

1. Efforts to Address Social Determinants of Health
2. Efforts to Integrate Behavioral Health
3. Alternative Payment Models to Support Innovative Care Models
4. Partnership Models between Health Care Organizations and Community Agencies
Up Next
Reactor Panel: Consumer Perspective

Annual Health Care Cost Trends Hearing

CTH 2016
Reactor Panel: Consumer Perspective

Panelists

Community Catalyst
Health Care For All
Patient Family Advocate

Ms. Alice Dembner, Director, SUD Project
Mr. Brian Rosman, Research Director
Ms. Alexis Snyder

Focus Areas

1. Role of Consumers in Promoting Value-Based Health Care
2. Importance of Social Determinants of Health
3. Efforts to Engage Patients and Families in Health Care System Transformation
4. Impact of Pharmacy Costs on Consumers and Patient Access
Up Next
Panel: Strategies to Address Pharmaceutical Spending Growth

Annual Health Care Cost Trends Hearing

CTH 2016
Strategies to Address Pharmacy Cost – Health Care Providers

Currently Implementing

1. Implementing programs or strategies to improve medication adherence/compliance

2. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

3. Implementing internal “best practices” such as clinical protocols or guidelines for prescribing of high-cost drugs
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Strengthening utilization management or prior authorization protocols</td>
<td>100%</td>
</tr>
<tr>
<td>Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs</td>
<td>91%</td>
</tr>
<tr>
<td>Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers</td>
<td>91%</td>
</tr>
<tr>
<td>Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends</td>
<td>73%</td>
</tr>
<tr>
<td>Implementing programs or strategies to improve medication adherence/compliance</td>
<td>73%</td>
</tr>
<tr>
<td>Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)</td>
<td>73%</td>
</tr>
<tr>
<td>Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending</td>
<td>73%</td>
</tr>
<tr>
<td>Pursuing exclusive contracting with pharmaceutical manufacturers</td>
<td>64%</td>
</tr>
<tr>
<td>Risk-based or Performance-based Contracting</td>
<td>45%</td>
</tr>
<tr>
<td>Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit</td>
<td>27%</td>
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<tr>
<td>Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts</td>
<td>27%</td>
</tr>
</tbody>
</table>
Panel: Strategies to Address Pharmaceutical Spending Growth

Panelists:

- Dana-Farber Cancer Institute
- Harvard Pilgrim Health Care
- Partners HealthCare System
- PhRMA

- Dr. Deborah Schrag, Surgical Oncology Chair, Harvard Pilgrim Health Care
- Dr. Rick Weisblatt, Chief of Innovation and Strategy, Partners HealthCare System
- Dr. Gregg Meyer, Chief Clinical Officer, Partners HealthCare System
- Ms. Lisa Joldersma, VP, Policy and Research, PhRMA

Focus Areas:

1. Impact of Rising Pharmaceutical Costs on Payers, Providers, and Patients
2. Innovative Strategies to Mitigate Pharmaceutical Spending Trends
3. Transparency of Pharmaceutical Prices and Spending Trends Net of Rebates/Discounts
Up Next
Public Testimony

Annual Health Care Cost Trends Hearing

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Annual Health Care Cost Trends Hearing

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