Commonwealth of Massachusetts

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Recommendations of the Special Commission on Provider Price Reform

November 9, 2011

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Commissioner
Division of Health Care Finance and Policy

Jay Gonzalez, Co-Chair
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Executive Office of Administration and Finance

Members of the Special Commission on Provider Price Reform

Member	Title
Ex Officio Members	
Jay Gonzalez	Secretary, Executive Office of Administration and Finance (co-chair)
Seena Perumal Carrington	Acting Commissioner, Division of Health Care Finance and Policy (co-chair) (June – August 2011)
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Legislative Appointments	
Richard T. Moore Appointee of the Senate President	Senator, Massachusetts Senate Chair of Joint Committee on Health Care Financing
Steven M. Walsh Appointee of the Speaker of the House	Representative, Massachusetts House of Representatives House Chair of Joint Committee on Health Care Financing
Gubernatorial Appointments	
Amitabh Chandra, PhD Representing a health economist or expert in the area of payment methodology	Economist and Professor of Public Policy, Harvard Kennedy School of Government
Patrick Gilligan Representing Blue Cross and Blue Shield of Massachusetts, Inc.	Senior Vice President for Health Care Services, Blue Cross Blue Shield of Massachusetts
H. Eugene Lindsey, MD Representing the Massachusetts Medical Society	President and CEO, Atrius Health
Eric Linzer Representing the Massachusetts Association of Health Plans, Inc.	Senior Vice President, Massachusetts Association of Health Plans
Lynn Nicholas, FACHE Representing the Massachusetts Hospital Association, Inc.	President and CEO, Massachusetts Hospital Association

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Executive Summary

Section 67 of Chapter 288 of the Acts of 2010, *An Act to Promote Costs Containment, Transparency, and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses,* mandated the creation of a Special Commission on Provider Price Reform to "investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers."[1] Section 67 established three responsibilities for the Special Commission: (1) to examine policies aimed at enhancing competition, fairness and cost effectiveness in the health care market; (2) to examine provider variation in relative prices, costs, volume of care, and correlations between price and quality, patient acuity, payer mix, and the provision of unique services; and (3) to file a report of its findings and recommendations

The statute designated three categories of appointments to the Special Commission: three ex officio members, one member to be appointed by the Senate President, one member to be appointed by the Speaker of the House, and five members to be appointed by the Governor.

The Special Commission met on seven occasions between June and November 2011. To guide the development of recommendations regarding reducing the variation in provider prices, the Special Commission adopted the following set of principles:

- The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.
- Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.
- Provider prices may vary.
- Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.
- When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.
- Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.
- Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.
- Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
- Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.

1 The full text of Section 67 is contained in Appendix A.

To aid its examination and recommendations, the Special Commission conducted two rounds of stakeholder engagement. During this time, the following organizations and constituents provided feedback: the Massachusetts League of Community Health Centers, the Massachusetts Council of Community Hospitals, Health Care For All, the Massachusetts Association of Health Plans, the Massachusetts Hospital Association, the Massachusetts Coalition of Nurse Practitioners, the Massachusetts Medical Society, and Taft-Hartley and self-insured employer plans. In addition, the Commission consulted the following state agencies: the Attorney General's Office, the Health Care Quality and Cost Council, MassHealth, the Commonwealth Health Insurance Connector, and the Division of Health Care Finance and Policy.

After the Special Commission reviewed analyses on the extent and reasons for price variation, considered input from key stakeholders, and assessed and discussed strategies to reduce price disparities, the Special Commission arrived at the following six recommendations:[2]

1. Act upon the recommendations of the Special Commission on the Health Care Payment System to change the way we pay for and deliver health care services to improve the quality of care and reduce costs.
2. Increase transparency related to price variation.
3. Ensure competitive market behavior.
4. Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions.
5. Research acceptable and unacceptable factors for variation and then determine how they could be applied to reduce unacceptable variation in provider prices.
6. Establish a short-term process to ensure that higher prices more closely correlate to quality and thereby reduce costs.

2 For more detailed explanations of the recommendations, please refer to Chapter 4 of this report.

Chapter 1: Provider Price Variation

Massachusetts leads the nation in health care delivery, boasting a system of highly skilled providers and a generally healthy population that enjoys near universal insurance coverage due to Massachusetts' historic health care reform initiative implemented in 2006. However, the Massachusetts health care system is costly as Massachusetts has had the highest rate of spending per resident in the nation since 1993[3], and in recent years, the growth of Massachusetts' private insurance market spending has exceeded Massachusetts per capita gross domestic product (GDP) growth.[4] The degree to which price variation contributes to this growth is not currently known, but a recent study published by the Division of Health Care Finance and Policy (DHCFP) indicated that a reduction in price variation in the private payer market would generate health care cost savings.[5]

In a recent report, the Attorney General Office's (AGO) identified a wide variation in the prices that health insurers pay to providers for the same services.[6] The AGO also found that price variation is not correlated to quality of care delivered, the sickness of the population served or complexity of the services provided, the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or whether a provider is an academic teaching or research facility.[7] Moreover, price variation is not adequately explained by differences in hospital costs of delivering similar services at similar facilities.[8] Rather, the AGO found that provider price variation is correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.[9] In addition to the AGO's findings that provider prices vary widely, DHCFP has found that provider price increases have been the primary driver of rising private market health care spending in Massachusetts.[10] The Special Commission on Provider Price Reform examined price variation to determine what might be done to mitigate its impact on health care spending in Massachusetts.

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3 Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. *Available at:* https://www.cms.gov/NationalHealthExpendData/downloads/res-us.pdf (last accessed 11/3/2011).

4 Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011, Mathematica Policy Research analysis of private, Medicare, and MassHealth claims for Massachusetts residents. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 11/4/2011). Health care spending estimates include patient cost sharing. *See also* U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product by State. *Available at:* http://www.bea.gov/scb/pdf/2010/12%20December/1210_gdp_state-text.pdf (last accessed 11/4/2011). Between 2008 and 2009, health care spending in the private insurance market grew 10.3%, while the Massachusetts per capita GDP decreased by 1.6%.

5 Division of Health Care Finance and Policy 2011 Cost Trends Report, Price Variation in Health Care Services, May 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report.pdf (last accessed 11/4/2011). Based on an examination of a small sample of Diagnosis Related Groups and CPT codes, DHCFP found that if private payer prices among hospital inpatient services and physician and professional services were narrowed to reflect a range spanning the existing 20th percentile to 80th percentile of payments, the potential total savings for these two groups of services could approximate $267 million.

6 Attorney General's Office 2010 Cost Trends Report, Examination of Cost Trends and Cost Drivers, March 2010. *Available at*: http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf (last accessed 11/4/2011).

7 *Id*.

8 *Id*.

9 *Id*.

10 Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 11/4/2011).

A. Section 67 Considerations:

Section 67 required that the Special Commission examine the influence of various factors on provider prices. Specifically, the Special Commission was required to examine:

(i) the variation in relative prices paid to providers within similar provider groups;

(ii) the variation in costs of providers for services of comparable acuity, quality and complexity;

(iii) the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses;

(iv) the correlation between price paid to providers and

(1) the quality of care,

(2) the acuity of the patient population,

(3) the provider's payer mix,

(4) the provision of unique services, including specialty teaching services and community services, and

(5) operational costs, including labor costs;

(v) the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and

(vi) policies to promote the use of providers with low health status adjusted total medical expenses.

B. Examination of Price Variation and Consideration of Factors

The Commission reviewed analyses of relative prices and payments paid by private health plans to hospitals and physician groups within payer networks, which identified significant variation. The data are summarized in the tables below.

Table 1. Summary of Hospital Relative Price/Payment Variation:

Payer	Year	Variation Within Network	Variation, excluding specialty	Variation, excluding specialty and islands
BCBS (Inpatient)	2010	165%	110%	101%
BCBS (Outpatient)	2010	222%	222%	147%
THP (Inpatient)	2010	955%	932%	600%
THP (Outpatient)	2010	268%	266%	168%
HPHC (Blended)	2010	389%	389%	267%

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). *Available at*: http://www.mass.gov/dhcfp/costtrends (last accessed 11/4/2011). HPHC reported blended inpatient and outpatient data. Specialty hospitals include Children's Hospital Boston, Dana Farber Cancer Institute, Massachusetts Eye and Ear Infirmary, and New England Baptist. Island hospitals include Martha's Vineyard Hospital and Nantucket Cottage Hospital.

Across insurer and provider networks, variation in provider prices ranged from a low of 165% for inpatient hospital services in the Blue Cross Blue Shield of Massachusetts network to a high of 955% within the Tufts Health Plan network. After excluding specialty hospitals and hospitals operating on Martha's Vineyard and Nantucket islands from the price variation analysis, provider prices ranged from 101% for inpatient hospitals services within the Blue Cross Blue Shield of Massachusetts network to 600% for inpatient hospital services across the Tufts Health Plan network.

Table 2. Summary of Physician Group Relative Price/Payment Variation:

Payer	Year	Variation Within Network	Variation, excluding pediatrics
BCBS	2008	225%	80%
THP	2009	177%	56%
HPHC	2010	184%	106%

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). *Available at:* http://www.mass.gov/dhcfp/costtrends (last accessed 11/4/2011). Pediatrics include Pediatric Physicians' Organization at Children's.

Across physician groups, variation in provider prices ranged from 177% within the Tufts Health Plan network to 225% within the Blue Cross Blue Shield of Massachusetts network. After excluding pediatric providers from the price variation analysis, provider price variation ranged from 56% within the Tufts Health Plan network to 106% within the Harvard Pilgrim Health Care network.

As required under Section 67, the Special Commission examined the correlation between relative prices and various factors. As indicated below, there were some statistically significant, although weak, correlations found for several of these factors for different payers. While the correlation and subsequent stratification analyses included all sixty-five acute care hospitals located in Massachusetts, the likelihood that analyses would result in a statistically significant relationship may have been limited by the smaller number of observations. The R-squared values illustrated in *Table 3* indicate the proportion of price variation that each of the individual factors can explain.

Table 3. Price Variation Analysis: Summary of Findings

Correlation Analysis	Payer	R-squared*	Correlation Strength
Quality	No statistically significant relationship observed		
Acuity (inpatient only)	BCBS inpatient	0.2307	Weak
Payer Mix / Disproportionate Share Status	BCBS inpatient	0.1236	Weak
	BCBS outpatient	0.1324	Weak
	THP inpatient	0.2307	Weak
	THP outpatient	0.0999	Weak
Provision of Specialty Services	BCBS inpatient	0.1967	Weak
	THP inpatient	0.2050	Weak
Provision of Community Services	No statistically significant relationship observed		
Costs per CMAD (inpatient only)	BCBS inpatient	0.1789	Weak
	THP inpatient	0.1572	Weak
Teaching Status	BCBS inpatient	0.1809	Weak
	THP inpatient	0.1364	Weak
Volume (inpatient only)	BCBS inpatient	0.1415	Weak
	THP inpatient	0.1966	Weak

*Statistical significance is calculated at p-value <0.05

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). *Available at:* http://www.mass.gov/dhcfp/costtrends (last accessed 11/4/2011).

In addition, the Commission reviewed the outcome of regression models to determine whether selected factors could predict provider prices. The factors included teaching status[11], percent of public payer mix, the payer's casemix index at the hospital, and the inpatient cost per casemix-adjusted discharge (CMAD). As seen in *Table 4*, among the selected factors, public payer mix seems to be the common predictor for provider prices as it was statistically significant in three out of four models. This analysis indicates that a higher public payer mix was associated with lower private payer prices. The Blue Cross Blue Shield of Massachusetts inpatient model, which used casemix, public payer mix, and inpatient costs to determine provider prices, was the most predictive model, in which 60% of the price variation in the network's provider prices could be explained by the selected factors.

Table 4. Regression Analyses Parameter Estimates for Statistically Significant Variables

	R2 (Adj.R2)	Model Intercept	Teaching Status	Public Payer Mix	Case mix Index	Inpatient Costs per CMAD (per $1000)
BCBS Inpatient (2009)**	.6281 (.6010)	0.4265	0.0126	-.4413*	.4015**	0.0468**
BCBS Outpatient (2009)*	.1683 (.1392)	1.4064	0.1348	-.8361*	N/A	N/A
THP Inpatient (2009)**	.3651 (.3189)	0.8732	0.1615	-1.030*	-.0327	0.0498*
THP Outpatient (2009)*	.1161 (.0851)	1.3677	0.1421	-.8052	N/A	N/A
HPHC Blended (2009)*	.1470 (.1171)	1.2883	0.0952	-.7315*	N/A	N/A

* Indicates statistical significance at p-value <0.05, ** at p <.0001

SOURCE: Payer data submitted pursuant to M.G.L. c. 118G, § 6½(b). *Available at:* http://www.mass.gov/dhcfp/costtrends (last accessed 11/4/2011). Data regarding teaching status, public payer mix, provision of specialty services, casemix, inpatient cost per CMAD, and discharges from 2009 DHCFP-403 hospital cost reports. N=60 for all models. Hospitals with less than 40 beds were excluded from the analysis.

11 Teaching status was a yes/no variable. A teaching hospital was defined as a hospital with at least 25 full-time equivalent residents per one hundred inpatient beds.

C. Increase in Provider Prices Is Primary Driver of Rising Private Market Health Care Spending in Massachusetts

In addition to price variation analyses, DHCFP presented data to the Commission to facilitate understanding of existing provider price variation in the context of private market spending within the Massachusetts health care delivery system. DHCFP presented data that indicated that overall health care spending in Massachusetts is on the rise. From 1991 to 2000, the health care expenditure growth rate in Massachusetts was 5.0% compared with 4.8% for the national average.[12] From 2000 to 2004, the health care expenditure growth rate for Massachusetts was 7.4% compared with 6.9% for the national average.[13] Based on this trend, health care spending per capita in Massachusetts is projected to increase by approximately 70% from $10,262 in 2010 to $17,872 in 2020.[14]

In combination with the overall health care spending analyses, DHCFP presented data that indicated that spending growth is greatest in the private health insurance market while the largest components of private market spending are growing fastest. Specifically, hospital inpatient and outpatient care and physician and other professional services, together representing 72% of total 2009 private health care spending, increased by 5.5%, 8.8%, and 7.7% respectively from 2007 to 2009.[15]

DHCFP also presented to the Commission findings that provider price increases have been the primary driver of rising overall health care costs in the private insurance market in Massachusetts. Recent reports from DHCFP below highlight the extent to which provider prices contribute to the rise in Massachusetts private market health care costs. For the largest components of health spending, inpatient and outpatient hospital care and physician and other professional services, pure price growth drove almost all of the increase in health care spending from 2007 to 2009.

12 Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. *Available at:* https://www.cms.gov/NationalHealthExpendData/downloads/res-us.pdf (last accessed 11/3/2011). Projections by the Division of Health Care Finance and Policy.

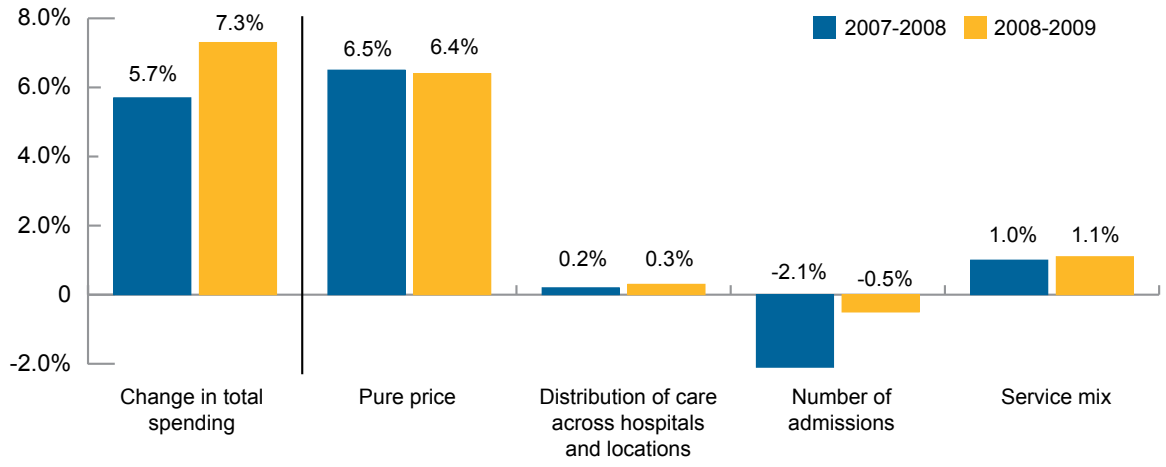
13 Id.

14 Id.

15 Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011, Mathematica Policy Research analysis of private claims data for Massachusetts residents in insured and self-insured plans. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 11/4/2011). Analyses contain data from the five largest carriers in Massachusetts, representing the costs of approximately 43% of all statewide residents.

For hospital inpatient services, price growth was the dominant component of the increase in overall spending from 2007 to 2009, as illustrated below.

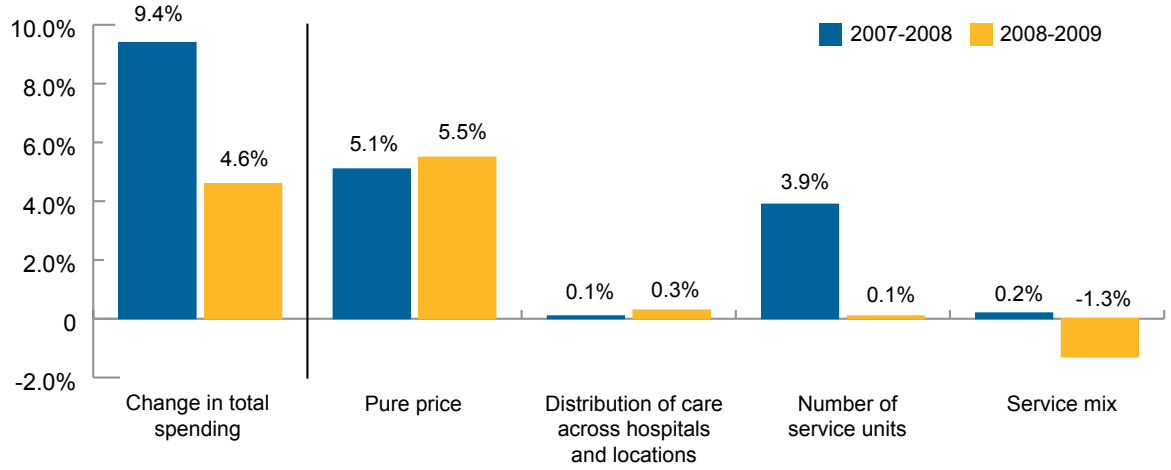
Figure 1. Components of Change in Spending for Privately Insured Hospital Inpatient Care



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 11/4/2011).

For hospital outpatient services, price growth was the single largest component of the change in spending from 2007 to 2009.

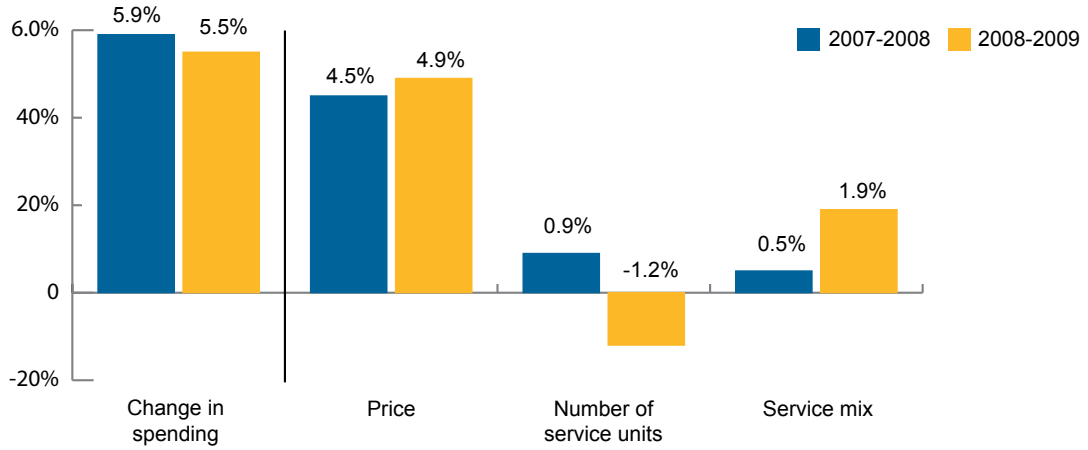
Figure 2. Components of Change in Total Spending for Privately Insured Hospital Outpatient Care



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report, *Massachusetts Health Care Cost Trends: Trends in Health Expenditures*, June 2011. *Available at:* http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf (last accessed 11/4/2011).

For physician and other professional services, price growth significantly influenced the overall change in spending from 2007 to 2009.

Figure 3. Components of Change in Total Spending for Privately Insured Physician and Other Professional Services



SOURCE: Division of Health Care Finance and Policy 2011 Cost Trends Report**,** *Massachusetts Health Care Cost Trends: Trends in Health Expenditures,* June 2011**.** *Available at: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/health_expenditures_report.pdf last accessed 11/4/2011).* DHCFP could not examine the pure price for physician and other professional services because DHCFP did not know the identity of all of the providers and thus was unable to separate the effect of changes in market share of higher or lower price providers. Price consists of the effect of pure price and the effect of changes in market share of higher or lower average price..

These analytics provided the Commission with a common foundation for understanding existing provider price variation in the context of private market spending within the Massachusetts health care delivery system and informed the Commission's subsequent discussions regarding possible solutions.

Chapter 2: Principles for Provider Price Reform and Strategies for Consideration

The Special Commission developed a set of principles that were subsequently adapted to reflect feedback from numerous stakeholder groups. These principles underlie its recommendations for provider price reform and the reduction of variation in provider prices. The principles are:

- The data needed to understand provider prices, the variation in prices, and the underlying factors influencing prices should be made available to support on-going provider price reform and monitoring.
- Factors which account for variation in provider prices should be analyzed using sound methodological tools. Public discussion regarding interpretations of such analyses should be promoted.
- Provider prices may vary.
- Prices and any factors for variation should be transparent and communicated in a manner easily understood by consumers and purchasers.
- When market processes result in prices that contribute to increasing health care spending, state government should take appropriate steps that will address the unjustified variation in provider prices.
- Unjustified variation in provider prices should be adjusted responsibly, and changes should be continually evaluated for intended and unintended consequences.
- Any strategy to reduce the variation in provider prices must result in containing health care costs, and maintaining or improving quality and access.
- Strategies to reduce the variation in provider prices must take into account current and any future payment methodologies.
- Any strategy to reduce the variation in provider prices for a particular cohort of providers should consider all Massachusetts providers within that group.

Special Commission Evaluation of Strategies

Section 67 directed the Special Commission to examine policies aimed at enhancing competition, fairness and cost-effectiveness in the health care market though the reduction of reimbursement disparities. The Special Commission considered eight strategies:

1. Price Transparency

The price transparency strategy requires the disclosure of prices in a manner that enables health care providers, payers, employers, and patients to make more informed and cost efficient health care decisions. Massachusetts has already implemented certain transparency initiatives. Among the initiatives, the Health Care Quality and Cost Council provides consumers with *MyHealthCareOptions*, a website that allows the user to search and compare the price and quality of providers relative to each other and to a statewide average.[16] The results, however, do not indicate price based on a specific payer. User traffic totals about 75 visitors per day, and each visitor spends slightly over two minutes on the website. As another initiative to promote transparency, Chapter 305 of the Acts of 2008 requires DHCFP to hold annual hearings concerning health care provider and payer costs and cost trends. Furthermore, Chapter 288 of the Acts of 2010 contains a number of initiatives intended to improve transparency, including the requirement that DHCFP collect total medical expense (TME) and relative price data and that health plans post such data publicly.

2. Market Power Intervention

The market power intervention strategy mitigates the competitive advantage of large provider systems through monitoring provider negotiating and contracting practices, applying closer anti-trust scrutiny to negotiations between payers and providers, and/or implementing legislation to limit future market consolidation. Current policy in Massachusetts implemented through Chapter 288 of the Acts of 2010 prohibits providers from utilizing system affiliations to achieve a guaranteed right of participation in a tiered or select network plan; uniform placement in the same tier of a tiered network plan; or all or nothing inclusion in a select network plan.

The Federal Trade Commission (FTC) has taken action in the health care sectors of other states to prevent hospital mergers that would effectively decrease competition and raise overall prices without an obvious improvement in quality.[17] However, the FTC reported only one antitrust action for general acute care hospitals during 2010 among approximately 89 hospital mergers and acquisitions involving 227 hospitals that occurred in 2010.

16 MyHealthCareOptions website can be accessed at http://hcqcc.hcf.state.ma.us (last accessed 11/7/2011).

17 U.S Federal Trade Commission, Health Care Division, "Overview of FTC Antitrust Actions in Health Services and Products," March 2011. A*vailable at:* www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf (last accessed 11/4/2011). A 2010 hospital merger in Ohio was delayed by the FTC because of a preliminary finding that the merger would "reduce competition and allow [the company] to raise prices for general acute-care and inpatient obstetrical services. While the merger was completed before the complaint was filed with the FTC, the FTC ordered the merged hospitals to operate and negotiate as separate entities pending a final determination. Id. In 2008, the Virginia Attorney General joined with the FTC in securing an injunction against the merger of a hospital into a larger hospital system in the state. In its complaint, the FTC noted that the merged hospital system would control 73% of the licensed hospital beds in Northern Virginia. Id. In 2007, the FTC found that, after a merger of three Illinois hospitals, the result was "price increases for all three hospitals that were significantly higher than price increases for other comparable hospitals, forcing payers to accept the increases or lose the three hospitals from their networks." The FTC ordered the three hospitals to negotiate and contract separately from one another. *Id*.

3. Consumer Incentives

The consumer incentives strategy incentivizes patient choice in selecting cost-effective providers. This strategy is sometimes referred to as "value-based benefit design" or "value-based insurance design." Under this strategy, payers could continue to develop tiered and/or select network plans with reduced premiums or reduced cost-sharing. Additional actions could include: increasing required premium differentials between traditional network benefit programs and tiered/select network programs; specifying cost-sharing differentials between providers in and out of select network products and between tiered network products; limiting the ability of providers to opt out of tiered network products; and specifying criteria that insurers must use to determine providers' eligibility for the select network.

The Massachusetts Legislature has already mandated that health plans offer products that employ health benefit designs to engage patients more fully in choosing lower-cost providers. Section 32 of Chapter 288 of the Acts of 2010 requires carriers that cover more than 5,000 eligible individuals, employees, and dependents in the individual and small group market to offer a select or tiered network product to eligible individuals and small employers in at least one geographic area. The select or tiered product must cost at least 12% less than the carrier's most actuarially similar non-select/non-tiered network product. As a result of this offering, Blue Cross Blue Shield of Massachusetts has reported significant enrollment growth since introducing its product in early 2011, and other commercial insurers have reported notable employer interest in products introduced July 1, 2011. Additionally, 31% of state employees, up from 19%, opted into tiered and select network products following the announcement of a three month premium holiday for individuals enrolled in products through the Group Insurance Commission.

The consumer incentives strategy has also proven to be effective in producing cost savings. Savings associated with the Group Insurance Commission's (GIC) increased enrollment in tiered and select network products are estimated to be $30 million over the next year. During open enrollment in 2011, 31% of state employees, up from 19%, opted into tiered and select network products following the announcement of a three month premium holiday for individuals in those less expensive, limited network plans. In addition, a recent report by a health plan to the Institute of Medicine detailed significant savings from tiered networks, though it is not clear whether the savings were due to lower prices or shifting utilization to lower cost providers.

There is strong anecdotal evidence that providers do take notice of benefit plan designs that provide incentives for patients to choose certain providers and that such products have an impact on providers. After the Maine state employee benefits plan adopted a co-pay differential that favored hospitals reporting quality data to the Leapfrog Group, 100 percent of hospitals began reporting such data. Additionally, the Buyers Health Care Action Group in Minnesota reported that the use of differential employee health insurance contributions based on provider cost and quality led providers to view the initiative as an opportunity to strengthen their credentials in direct employer contracting and improve coordination and joint decision making among system hospitals and physicians.[18] This may suggest that providers would be encouraged to lower prices to participate in tiered and select network plans if patients prefer to enroll in those products over higher cost products.

18 J Christianson, R Feldman, J P Weiner, and P Drury, "Early experience with a new model of employer group purchasing in Minnesota", Health Affairs, 18, no.6 (1999):100-114. *Available at:* http://content.healthaffairs.org/content/18/6/100.full.pdf (last accessed 11/4/2011).

4. Benchmarks for Variation

The benchmarks for variation strategy limits the amount of variation that an individual payer permits for a given service or market basket of services across the payer's network. Permissible price variation could be defined in terms of the percentage variation from high to low or around a baseline within a payer's network. Individual providers and payers could then negotiate within the pre-defined limits, and contracts and payment practices could be monitored to ensure compliance.

Limits on price variation are not currently in place in any state, therefore this strategy has not been evaluated.

5. Acceptable Factors for Variation

The acceptable factors for variation strategy identifies the variables that reasonably contribute to price variation. This method could prohibit variation in price due to any other reason. A similar strategy is employed by Medicare through Medicare's Inpatient Prospective Payment System that uses a base Diagnosis Related Group (DRG) rate with adjustments for specific factors. The base rate reflects the national average inpatient cost per discharge from a prior period, trended forward to the rate period using annual update factors. Specific adjustment factors include: geographic adjustments, including wage area and capital factors; DRG weights to reflect case intensity; medical education; disproportionate share status; and high cost outlier that is case-specific.

DHCFP's 2011 health care cost trends analysis found that the variation associated with these factors results in a range in Medicare prices that is similar in breadth to variation in private payer prices. The analysis, however, resulted in a different ranking of hospital prices. Unlike private payer variation, variation in Medicare prices is completely transparent and subject to public scrutiny, resulting in more system accountability.

6. Price or Price Growth Thresholds

The price or price growth thresholds strategy establishes a ceiling on the allowable price for any given service or aggregation of services, or sets an allowable threshold for price increases.

Price or price growth thresholds do not appear to be in place in any state. Massachusetts implemented hospital charge thresholds for two years as a small component of the deregulation of acute hospitals in Massachusetts through Chapter 495 of the Acts of 1991. The impact of this strategy has not been evaluated.

7. Reference Pricing

The reference pricing strategy requires all providers or all insurers to charge or pay the benchmark price or within a percentage threshold of the benchmark price. Price for a given health product or service is based on an established, published external source. Implementation can apply to a broad range of health services or be targeted towards those services with strong evidence of clinical equivalence across providers. The focus of the reference pricing strategy could be on high cost or high volume services. Reference benchmarks could be obtained from a variety of sources, including Medicare or existing market data. Reference pricing could include acceptable ranges of variation from the external source to be set through negotiation.

The RAND Corporation modeled a scenario in which academic medical centers were subject to reference pricing and consumer purchasing engagement. Payment would be based on community hospital rates, and consumers may opt to pay the difference for care at an academic medical center. This model assumed a phased implementation. Under the upper bound scenario, 97% of DRGs were subject to reference pricing. The model concluded that reference pricing could save up to $8.6 billion (1.3%) between 2010 and 2020. Savings to private insurers could total as much as $8.8 billion. Consumers, however, would spend an additional $2.9 billion as a result of increased co-payments for services at academic medical centers. Under a more conservative model in which only maternity services were subject to reference pricing, total savings over ten years were $526 million. Maternity services were chosen for the simulation because they account for approximately 15% of hospital discharges.

8. Rate Setting

The rate setting strategy establishes a schedule of health care service prices that must be charged by providers or paid by payers. Rate setting has typically been applied to inpatient services only, but rates could be set for all services which are subject to negotiation. Rate setting methodology could be based on the methodology of other payers, such as the Medicare Inpatient Prospective Payment System, which pays most acute hospitals in the nation a fixed base amount with additional payments in the form of factors that adjust for regional differences in costs and patient severity. Rates could also be set on a per-diem basis, unit cost, or global payment or other alternative payment level to account for factors that contribute to cost, quality, or outcomes.

Rate setting was a popular strategy to control costs in the 1970s with 30 states adopting some form of rate setting. Rate setting fell out of favor in the 1980s, and hospitals rates were deregulated in many states during the rise of the managed care model. Five states, including Massachusetts, had substantial experience with rate setting. Today, Maryland and West Virginia are the only states that continue to set hospital rates.

Massachusetts: Massachusetts set hospital rates for the 16-year period between 1975 and 1991 through an independent commission. The Commission set per-diem rates for Medicaid and established controls for hospital charges. In Massachusetts, rate setting ended after a period of unlimited discounting authority was given to HMOs to encourage their growth in the marketplace. During the period of rate setting in Massachusetts, hospital costs were nearly 2 percent below national rates, but after 1991, costs increased at the same rate as the nation. Price variation existed in Massachusetts during the time period of rate setting as HMOs were not subject to rate setting and were allowed to negotiate lower prices.

Maryland: Maryland has a long history with hospital rate setting. In 1974, commercial payer rates were established for hospitals and in 1977 federal waivers were obtained to apply the same rates to Medicare and Medicaid payments. Maryland's rate setting involves a service-specific rate (e.g., ICU per diems) and accounts for cost and a margin for profitability. Under this system, hospital revenue is controlled through imposing per-encounter limits though hospital revenue is later adjusted based on performance. This dual approach aligns the motivation of both payers and providers into controlling utilization. Maryland's rate system also receives periodic adjustment for inflation and has uncompensated care built into all payers' rates equally.

Rate setting in Maryland has been successful in controlling price variation as well as cost growth. The cost of a hospital admission in Maryland fell from 26 percent above the national average in 1975 to 2 percent below the national average in 2007. One researcher calculated that if costs had risen at the same rate as the nation, health care costs in Maryland would have been $40 billion more. On the other hand, if the national average cost slowed to match that of Maryland's, health care costs would have decreased by $1.8 trillion.

West Virginia: West Virginia has also experienced a control of cost growth similar to Maryland. West Virginia has been regulating hospital prices since 1985 by setting revenue limits for commercial payers and implementing price growth thresholds on rate increases. West Virginia sets rates by calculating the average charge for commercial payers by analyzing prior year's hospital expense, revenue, and utilization data.

The RAND Corporation modeled a scenario which implemented rate regulation for routine community care at academic medical centers and highly reimbursed community hospitals. The model limited payment for non-tertiary care to the average community hospital rate. The model concluded that non-tertiary rate regulation could save as much as $18 billion, or a 2.7% decline in spending, over ten years. This assumed that 97% of DRGs were covered by rate regulation. Under a more conservative model, assuming only maternity services were subject to rate regulation, ten year savings would be $1.4 billion, or 0.2% of total spending. Maternity services were chosen for the simulation because they account for approximately 15% of hospital discharges.

Chapter 3: Feedback from Massachusetts Stakeholders

The Special Commission was committed to engaging experts and stakeholders by soliciting their expertise and opinions regarding a) the incidence and effect of provider price variation, b) the draft principles for provider price reform created by the Special Commission, and c) options for reducing provider price variation and their likely impact.

DHCFP selected the firm Bailit Health Purchasing (Bailit) to assist the agency in responding to the requirements of Section 67, including stakeholder engagement.

Section 67 specified that as part of its investigation into reimbursement disparities, the Special Commission was to consult with "the Attorney General, the Health Care Quality and Cost Council, the Division of Health Care Finance and Policy, health care economists, and other individuals or organizations with expertise in state and federal health care payment methodologies and reforms." The statute specified that the Commission consider the research and data that resulted from these meetings when making final recommendations.

In order to meet this statutory requirement, the Special Commission engaged in the following:

- The Special Commission reviewed a presentation by the Attorney General's staff covering the AGO's findings on health care costs trends and drivers, including of the extent to which variation exists in commercial prices paid by insurers to providers;
- Bailit collected feedback from the Health Care Quality and Cost Council; and
- DHCFP conducted analysis and presented to the Special Commission its findings on the correlations between price paid to providers and key factors that may explain price variation.

Additionally, Section 67 specified that the Special Commission meet with parties that would likely be affected by the Special Commission's recommendations including, at a minimum, "the office of Medicaid, the Division of Health Care Finance and Policy, the Commonwealth Health Insurance Connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., one or more academic medical centers, one or more hospitals with a high proportion of public payors, one or more Taft-Hartley plans, one or more self-insured plans with membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers."

On behalf of the Special Commission, Bailit convened meetings with each of the following nine stakeholder entities. Most of the entities participated in two rounds of stakeholder engagement:

- Massachusetts League of Community Health Centers, the Massachusetts Council of Community Hospitals, Health Care For All, the Massachusetts Association of Health Plans, the Massachusetts Hospital Association, the Massachusetts Coalition of Nurse Practitioners, the Massachusetts Medical Society, and Taft-Hartley and self-insured employer purchasers.

Additional meetings were conducted with the Commonwealth Health Insurance Connector, and with the Department of Mental Health and the Office of Medicaid. For some meetings, staff from the Division of Health Care Finance and Policy and the Executive Office for Administration and Finance participated. Bailit reported summaries of the stakeholder meetings to the Special Commission, which can be found in Appendix E.

During meetings with Bailit, stakeholders provided a wide range of feedback. While most stakeholders agreed that price variation was a problem, stakeholders disagreed on the extent to which it was a problem, the perceived reasons for its occurrence, and the strategies contemplated by Special Commission members to reduce it. The major themes from stakeholder feedback are presented below, organized in the context of the following three questions that were posed to stakeholders:

1. To what extent is price variation a problem in health care (and why);
2. What are the drivers of price variation in health care;
3. Which of the Commission-reviewed strategies to reduce provider price variation would you recommend?

1. To what extent is price variation a problem in health care (and why)?

The majority of interviewed stakeholder representatives shared the opinion that provider price variation is a problem. Some health plan representatives thought price variation had contributed to medical cost inflation and the destabilization of community hospitals. Physician representatives agreed that price variation is a problem and noted that some price variation in the health care market is acceptable, such as variation that results from teaching and research costs, and variation that reflects higher quality. Community health center representatives stated that the effects of price variation have significantly impeded their ability to attract and retain physicians.

Hospital representatives differed from most other stakeholders when they stated that the significance of unit prices was being greatly exaggerated and that the Special Commission's work should be focused on a broader set of issues that impact rising premiums. These hospital representatives expressed the view that price variation exists in most other markets and is acceptable in the health care market. These representatives felt that prices and price variation were not worthy of Commission attention relative to other concerns. The Massachusetts Hospital Association and the member hospitals it had gathered felt that other issues more profoundly influence commercial insurance premium growth, including underpayment by public payers (identified as the leading issue), overcapacity of inpatient beds and subspecialist physicians, and fee-for-service payment.

Other stakeholders representing consumers, large employers, and Taft-Hartley plans understood price variation was problematic but had little to no perspective on the extent to which price variation is a problem.

2. What are the drivers of price variation in health care?

Many of the stakeholders pointed to market power as the main driver of price variation. Community health center representatives noted that current provider consolidation activity is exacerbating price variation. Physician and nurse practitioner representatives added that historical pricing policies have influenced price variation. Hospital representatives, on the other hand, viewed public-payer underpayment as the main cause of price variation. These representatives shared the belief that Medicare and Medicaid pay hospitals at rates below the cost of services and therefore hospitals must demand higher reimbursement dollars from commercial payers to account for the difference between their incurred costs and public payer reimbursement.

3 Which of the Commission-reviewed strategies to reduce provider price variation would you recommend?

After the Special Commission met to discuss strategies, Bailit solicited the stakeholders during a second round of meetings for feedback on the eight options the Special Commission discussed. This stakeholder feedback was presented to the Special Commission prior to the meetings in which the Commissioners assessed the merits of the strategy options and deliberated upon their recommendations.

While the majority of stakeholders agreed to support the strategies of price transparency, consumer incentives in the form of tiered and narrow networks, and applying acceptable factors for variation, stakeholders still voiced some concerns with each of these three strategies, and were not in agreement regarding implementation considerations.

The following text summarizes the stakeholder feedback regarding the eight strategy options: [19]

Community health centers: Community health centers supported acceptable factors for variation, price or price growth threshold, and benchmarks for variation. They believed that acceptable factors for variation should only include quality, case mix, and socio-economic patient population status. They agreed with capping the prices of the highest priced providers or lowering the rates of increase in a regulatory fashion, or regulating the extent to which insurers can vary their rates by provider.

Consumer advocates: The consumer advocates, who were largely but not wholly staff of Health Care for All, met with Bailit prior to the Special Commission's review of strategy options to reduce provider price variation and reacted mostly to the principles for provider price reform. They supported making price more transparent and recommended that a consumer-friendly way of providing this information is necessary. They also thought that any forthcoming recommendations from the Special Commission must also address disparities in payment across service type and specialty for mental health and substance abuse services relative to other services. The consumer advocates also recommended that the Commissioners adopt the consideration of consumer impact as a principle.

Health plans: Health plan representatives offered a few suggestions for decreasing price variation, including prohibiting physicians who do not practice on a hospital campus from billing under the same tax identification number as physicians who practice on a hospital campus to receive identical rates, setting global payment or other alternative payment rates at payer network averages, limiting hospital charges for various services, and modifying regulations that permit providers to not participate in the new limited and tiered network insurance products.

Hospitals: Hospital representatives agreed with some reservations to support increased price transparency and continued use of consumer incentives through tiered and select network insurance products. Hospitals urged the Special Commission to refrain from focusing on strategies that might be broadly construed as rate setting and focus more on market-based efforts such as transparency of price, quality and consumer insurance product restrictions, and tiered networks. They also advocated for the Special Commission to consider a strategy that considers reducing provider total medical expense trend as a goal to reduce health insurance premiums. The Massachusetts Council of Community Hospitals representative asserted that when the state pressures insurers to reduce their premium growth, insurers turn principally to hospitals, rather than physicians, to reduce price growth. Any premium rate impacts, therefore, would have a greater adverse effect on community hospitals than teaching hospitals since larger teaching hospitals with more market leverage would have more resources to negotiate against insurer-driven reductions in price growth. The representative urged the Special Commission to protect community hospitals from adverse effects of premium growth reduction in exchange for holding hospitals more accountable for performance.

19 See Chapter 2 for a discussion of the eight strategy options.

Nurse practitioners: The Massachusetts Coalition of Nurse Practitioners representatives supported price transparency and acceptable factors for variation. They recommended measuring and adding transparency to “value”, which was defined as a measure of patient outcomes per dollar expended. They asserted that government should have a role in deciding which factors for variation should be acceptable and recommended that the type of license a provider holds should not be an acceptable factor for rate variation.

Physicians: The physician representatives were not of one mind when recommending potential strategies to reduce provider price variation. For the most part, physicians supported three strategies: price transparency, benchmarks for variation, and acceptable factors for variation. With respect to price transparency, the representatives asserted that coupled with quality transparency, this option is a necessary step to influence market behavior, but insufficient as a standalone option. The representatives viewed benchmarks for variation favorably so long as great care is taken when developing the methodology, including consideration of special services and geographic differences in labor costs. Lastly, a majority of the representatives found acceptable factors for variation to be an attractive option to reduce provider price disparity. They expressed concern about implementation and possible unintended consequences of establishing acceptable factors for variation, but felt that if there was a consensus set of factors that included quality, language, and psychosocial patient characteristics, at a minimum, the strategy would likely be effective.

Chapter 4: Recommendations for Reducing Provider Price Variation

To enhance competition, fairness, and cost-effectiveness in the health care market through the reduction of reimbursement disparities, the Special Commission proposes the following group of complementary recommendations. These recommendations are consistent with the principles for provider price reform adopted by the Commission.[20]

The Special Commission recognized that strategies to address provider price reform cannot be implemented in isolation. Price is only one component of a broader approach to cost containment and delivery system redesign. Accordingly, and consistent with the Commission's statutory mandate, the Commission considered the recommendations of the Special Commission on the Health Care Payment System [21] and discussed price variation in the context of the broader goals of cost containment and quality improvement. The final recommendations of the Special Commission speak to these broader themes and endorse the need for a comprehensive approach to cost containment and delivery system redesign.

Recommendation #1: Act upon the recommendations of the Special Commission on the Health Care Payment System to change the way we pay for and deliver health care services to improve the quality of care and reduce costs

Consistent with Section 67, the Special Commission considered the recommendations of the Special Commission on the Health Care Payment System, as created under Section 44 of Chapter 305 of the Acts of 2008. The Special Commission supports the prior Special Commission's recommendation that price reform simultaneously addresses both price and volume. Specifically, the Special Commission on Provider Price Reform found that efforts to reduce price disparities without accompanying efforts to reduce total cost growth would not fully realize cost containment.

In addition, the Special Commission supported the notion of setting milestones for growth in the adoption of global payments or other alternative payments and cost containment benchmarks, allowing for potential state action if those milestones are not met, as recommended by the Special Commission on the Health Care Payment System.

The Commissioners noted during deliberations that the proposed strategies to mitigate provider price variation should not be implemented in isolation, as they do not address increasing health care costs in a comprehensive manner. Notably, a focus on price variation alone would not address other cost sources such as service mix and service volume changes.

In addition to the recommended strategies to reduce provider price variation, the Commissioners expressed support for complementary strategies that address cost directly. Such strategies include additional oversight and analysis of total medical expenditures, efforts to define and implement alternative payment methodologies (such as global payment), creation of more integrated health care delivery systems, and additional research, oversight, and regulation with respect to the implementation of these strategies. The Commissioners believe that strategies to reduce price variation will be more effective if implemented in unison with these broader strategies to address other elements of cost containment.

20 See Chapter 2 for the list of principles.

21 The Special Commission on the Health Care Payment System was created under Section 44 of Chapter 305 of the Acts of 2008, and issued its final report on July 16, 2009. *Available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf (last accessed 11/7/2011).

Recommendation #2: Increase transparency related to price variation

The Special Commission found that information about health care prices, products, and quality is essential to better inform the decision-making of payers, providers, and individuals who are able to access and use these data. The Commission recognized the gains made in transparency over the past several years, including the creation of the MyHealthCareOptions website under the direction of the Massachusetts Health Care Quality and Cost Council.[22]

The Special Commission recommends that transparency efforts be expanded not only for consumers, but also providers and purchasers, and that it include the following components:

- **Provider-specific price data for providers and for employers and other purchasers.** While initial cost containment efforts within the state have focused on transparency for consumers, providers and purchasers also seek such information. Providers, particularly those operating under global payment or other alternative payment arrangements incorporating shared savings or shared risk, need accurate, valid and reliable information on price and quality measures for quality improvement and to inform referral decisions. As more providers transition from fee-for-service systems to systems of global payment or other alternative payment, provider access to transparent price information is essential to ensure that global payment or other alternative payment systems incorporate methods that will promote high quality and cost efficiency and enhance shared decision making between patients and their physicians. Large health insurance purchasers, such as large employers, would also benefit from having access to such information. The Special Commission recommends that insurers, including their subcontracted managed behavioral health organizations and pharmacy benefit management organizations, make price information available in a format that is easily accessible and comprehensible to providers, purchasers, and employers for the most common referral or prescribed services, as defined by the Division of Health Care Finance and Policy (DHCFP).
- **Real-time expected out-of-pocket costs for the most common health care services**. While MyHealthCareOptions provides comparative price information to consumers, the information uses historical claims data in a range format, and does not reflect what a consumer would pay under his or her benefit plan (e.g., based on specific deductible requirements). The Special Commission recommends that insurers be required to provide real-time calculations of expected member out-of-pocket costs for a group of common health care services and associated quality information. The estimates should be based on: a) provider-specific prices, b) coverage product-specific cost sharing requirements, and c) provider-specific quality measures (where available).

  While insurers would independently develop and implement these calculators and should be afforded flexibility in doing so, the Special Commission recommends that insurers use a uniform set of information and health care services that the state would define, in consultation with insurers consumers, providers and employers and in reference to appropriate nationally recognized measure sets. Implementation should be in accordance with a timeline established by the Division of Health Care Finance and Policy that recognizes the required level of effort for insurer implementation. In addition, the Special Commission recommends that the state prohibit provider-insurer contract language that would prevent the disclosure of required price information to consumers including but not limited to the price quote for out-of-pocket expenditures.

22 MyHealthCareOptions website can be accessed at http://hcqcc.hcf.state.ma.us (last accessed 11/7/2011).

- **Methodology for the categorization of providers into tiered and select network products.** After considering the growing number of tiered network and select network insurance products and in recognition of their growing enrollment, the Special Commission recommends that insurers and government purchasers disclose the methodology used to assign providers to tiers and select networks. Methodological information should be disclosed to the public on each insurer's website and should provide sufficient detail to be meaningful to providers, purchasers, and consumers. The detailed data that is on the website should be regulated in order to ensure that it is easily understood and useful for consumers.

  The Special Commission recognizes that Sections 32 and 33 require that such information shall be reported for individual and small group market products required by law[23], but recommends that the requirement be extended to large group products. Furthermore, the Special Commission recommends that the state[24] specify in greater detail the information that must be disclosed, including, for example, the measures insurers use to distinguish providers by tier.
- **Access to the All-Payer Claims Database.** DHCFP is currently in the process of developing an All-Payer Claims Database (APCD), pursuant to M.G.L. c. 118G §6. The Special Commission recommends that the state make the APCD accessible to consumers, purchasers, providers, insurers, and researchers both for standardized queries and in support of research to analyze price variation consistent with the provisions of the Data Release regulations, 114.5 CMR 22.00 et seq. Such disclosure should carefully guard protected health information (PHI), consistent with the Health Insurance Portability and Accountability Act (HIPAA). In addition, the Special Commission recommends including third-party administrators that process claims for self-insuring employers among the entities required to submit claims data to the APCD, consistent with the filing requirements for insurers serving fully-insured employers and individuals, to the extent it is legally feasible to do so.

In order to ensure that price transparency does not have the unintended consequence of raising provider prices, the Special Commission recommends that as part of its Chapter 305 annual cost hearings the Division of Health Care Finance and Policy assess the impact of price transparency on prices.

23 "Carriers shall provide information on their websites about any tiered or selective plan, including, but not limited to, the providers participating in the plan, the selection criteria for those providers and if applicable, the tier in which each provider is classified.

24 In recognition of existing requirements created by Chapter 288 of the Acts of 2010 in Sections 32(b) and 33(c) and in Section 38, the Special Commission recommends that the Division of Insurance and Department of Public Health be involved and that the work be completed in a timely manner.

Recommendation #3: Ensure competitive market behavior

In order to ensure a competitive marketplace, the Special Commission recommends the following two actions:

A. Prioritize oversight of competition in the health care market

The Special Commission believes that during a period of rapid reorganization of the health care delivery system, it is essential that the Attorney General's Office (AGO), the Departments of Public Health and Mental Health (DPH and DMH), DHCFP, and the Division of Insurance (DOI), continue to use their authority to address market behavior that is likely to cause health care spending to rise.

As the Commonwealth moves to payment and delivery reform the attorney general should also review and monitor consolidation and remedy any anti-competitive behavior. The Commonwealth should evaluate whether the AGO has sufficient authority to effectively do so.

The executive branch agencies with regulatory oversight of provider and insurer markets should submit specific recommendations to the Legislature on strategies to strengthen oversight effectiveness.

B. Prohibit non-competitive provider contracting practices

The Special Commission found that two provider contracting practices described by commercial insurers have contributed inappropriately to price variation. The Special Commission therefore recommends the prohibition of the following contract practices:

- any contracting practices that require insurers to contract with all provider locations for a multi-location provider, rather than contracting only with the individual provider locations with which an insurer may wish to contract;
- any contracting practices that require payers to pay the same or similar prices to all provider locations for a multi-location health care provider where geographic differences in the provider's site do not support charging the same or similar prices;

The Special Commission recognizes that in order to more effectively integrate care delivery and manage costs under alternative payment methodologies (including risk-bearing contracts), it may be necessary to specify provider networks in contract. Accordingly, the recommended prohibitions listed above may not apply to alternative payment arrangements and should be reevaluated as the market moves in this direction.

Recommendation #4: Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions

The Special Commission endorses the actions taken by the legislature through Section 32 of Chapter 288 of the Acts of 2010 (Section 32) to require insurers to offer tiered or select network products to the individual and small group market. The Commission believes that increased enrollment in such products has the potential to create market incentives to reduce price disparities. Recognizing that many of these new products were introduced in July 2011, the Special Commission recommends that the impact of the introduction of tiered and select network products be studied and evaluated.

Specifically, the Special Commission recommends that the Division of Insurance, in collaboration with the Division of Health Care Finance and Policy, evaluate and publish reports on the impact of Section 32, expanding upon the scope of analysis prescribed by Sections 32(g) and 33(g) of Chapter 288. The Special Commission also recommends that the analysis include the examination of the impact of products sold to the large group insured and self-insured markets, and government payer products. The analysis should assess the techniques insurers use to create networks for such products, the impact, if any, of the statutory option for providers to opt out of such tiered network products on insurers ability to create such products and on the effectiveness of such products, and the extent to which insurers consider provider clinical quality, quality of service, efficiency, price, and any other variables. The analysis should also include a review of the impact of such products on:

- provider prices and price variation;
- total medical expense and premium trend;
- quality of care (including consumer satisfaction, and care continuity);
- enrollment volume, case mix, health status, and market share;
- over and under-utilization;
- consumer financial impact, specifically for low-income populations and for patients with high medical expense; and
- access to care, including changes in care-seeking behavior among patients (e.g. with respect to site of care).

Recommendation #5: Research acceptable and unacceptable factors for variation and then determine how they could be applied to reduce unacceptable variation in provider prices

The Special Commission agreed that both acceptable and unacceptable factors for variation exist in prices among providers. For example, quality, stand-by services, care coordination, and community-based services provided by allied health professionals may be among the acceptable factors for variation. Market power and advertising expenditures may be among the unacceptable factors.

The Special Commission recommends that an independent body conduct a rigorous analysis to identify the acceptable and unacceptable factors for price variation in physician, hospital, diagnostic testing, and ancillary services. The majority of the group should comprise experts in health care economics and provider payments, while a minority of the group should represent stakeholders such as payers, purchasers, and providers. The analysis should take into account updated cost reporting reported to the Division of Health Care Finance and Quality. At a minimum, the analysis should consider the following as possible acceptable or unacceptable factors:

- quality;
- medical education;
- stand-by service capacity;
- emergency service capacity;
- special services provided by disproportionate share hospitals and other providers serving underserved or unique populations;
- market share;
- location;
- research;
- costs ;[25]
- care coordination;
- community-based services provided by allied health professionals; and
- use of and continued advancement of medical technology and pharmacology.

The Special Commission recommends that the following steps be taken after acceptable factors for variation are identified to reduce variation and slow premium growth:

- The expert body should seek to quantify the maximum reasonable adjustment to a commercial insurer's median rate for individual or groupings of services for each acceptable factor.
- If the expert body is able to successfully complete the quantification of the maximum reasonable adjustments referenced above, it should recommend steps to be taken to implement acceptable factors for variation as a strategy for the state to reduce variation.

25 The Commission recognized that there is a complex relationship between costs and prices. While costs may influence prices, so too can prices influence costs.

Recommendation #6: Establish a short-term process to ensure that higher prices more closely correlate to quality and thereby reduce costs

The Special Commission found that while the prior five recommendations may in time contribute to a reduction in price variation, additional measured steps are required to ensure that such reduction in price variation is achieved in the short term.

As a result, the Special Commission recommends that providers and insurers work together and assume joint responsibility for reducing unjustified price variation in a manner that will also reduce cost growth. In the event, however, that (a) a provider requests a price for a particular inpatient or outpatient service that exceeds the market-based plan median and (b) the insurer rejects the requested price based on its determination that the higher price for such services is not justified, then the provider shall either: accept the lower of (i) the market-based median price for such service or (ii) the price they received for such service from the insurer in their preceding contract, or submit its request to an independent panel supported by evidence that the higher price requested is justified based on the quality of the service it provides. The independent panel, which shall be staffed by the Division of Health Care Finance and Policy, shall determine whether the requested price is justified based on the demonstrated quality of the service or not. If the panel determines it is justified, then the insurer shall accept the requested price. If the panel determines it is not justified, then the price shall be the lower of (i) the market-based plan median price for such service or (ii) the price they received for such service from the insurer in their preceding contract.

This recommended process is written to apply to fee-for-service arrangements. A similar process should be developed and applied by the independent panel for global payments or other alternative payments.

Two years after the implementation of this requirement, and each year thereafter, the Division of Health Care Finance and Policy should report to the Legislature regarding the effect of these requirements in order to facilitate legislative consideration of modification or termination of this approach. The Legislature and the Division should terminate implementation of this recommendation once it is determined that the price variation in the market sufficiently reflects meaningful differences in quality (or other acceptable factors for variation successfully identified by the expert body described above).