COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

2014 HEALTH CARE COST TRENDS HEARING

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

OCTOBER 6, 2014

Presentation

Center for Health Information and Analysis

LEVEL AND TREND

MAKING SENSE OF THE PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

Áron Boros| *Executive Director*

October 6, 2014 Cost Trends Hearings

CHIA.

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TOTAL HEALTH CARE EXPENDITURES

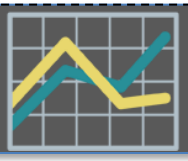
Level

Highest

Compared to other states

CMS, 2009 data

Trend



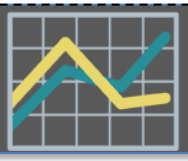
Favorable

Compared to benchmark, economic growth, national trends

CHIA, Prelim. 2012-2013

Public Payers

Level



Trend

High — Medicare — **Low**

c.f. other states — like other states

Low — Medicaid — **Higher**

c.f. 2005, inflation adjusted — +3.3% per member

CMS, 2009 data
Blue Cross Blue Shield Foundation

CMS, CHIA (MassHealth)

ALTERNATIVE PAYMENT METHODOLOGIES

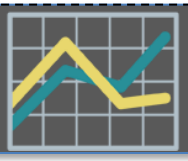
Level

High

c.f. other states

Catalyst for Payment Reform

Trend



Flat

CHIA, 2012-2013

PREMIUMS

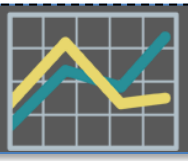
Level

High*

c.f. other states

MEPS 2013 data

Trend



Flat

and no buy-down

CHIA, 2012-2013

DATA CHALLENGES

- Standardization
- Adjustments and Estimates
- Timing
- Gaps

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Presentation

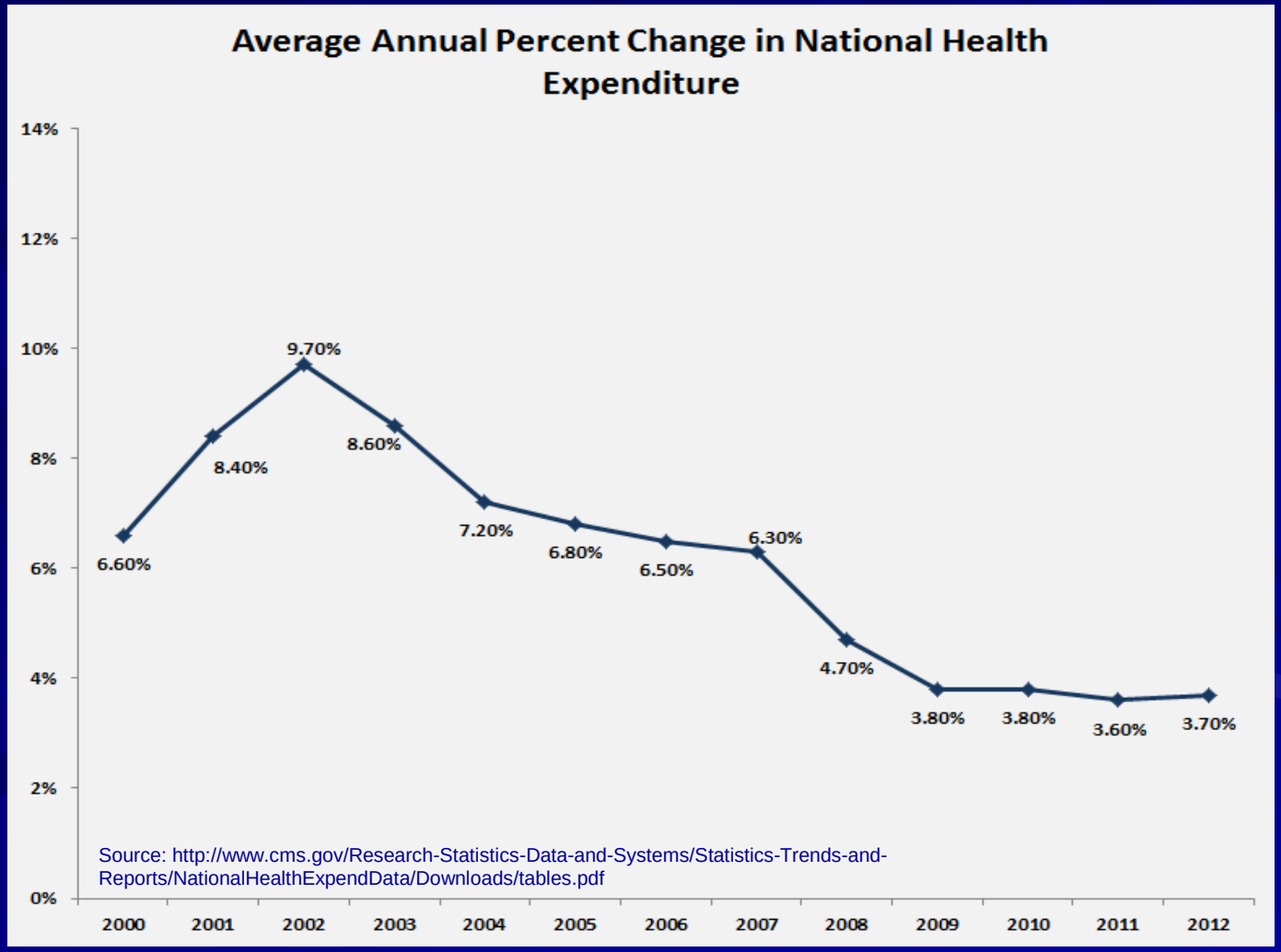
Dr. Michael Chernew

Perspectives on Spending Growth

Michael Chernew

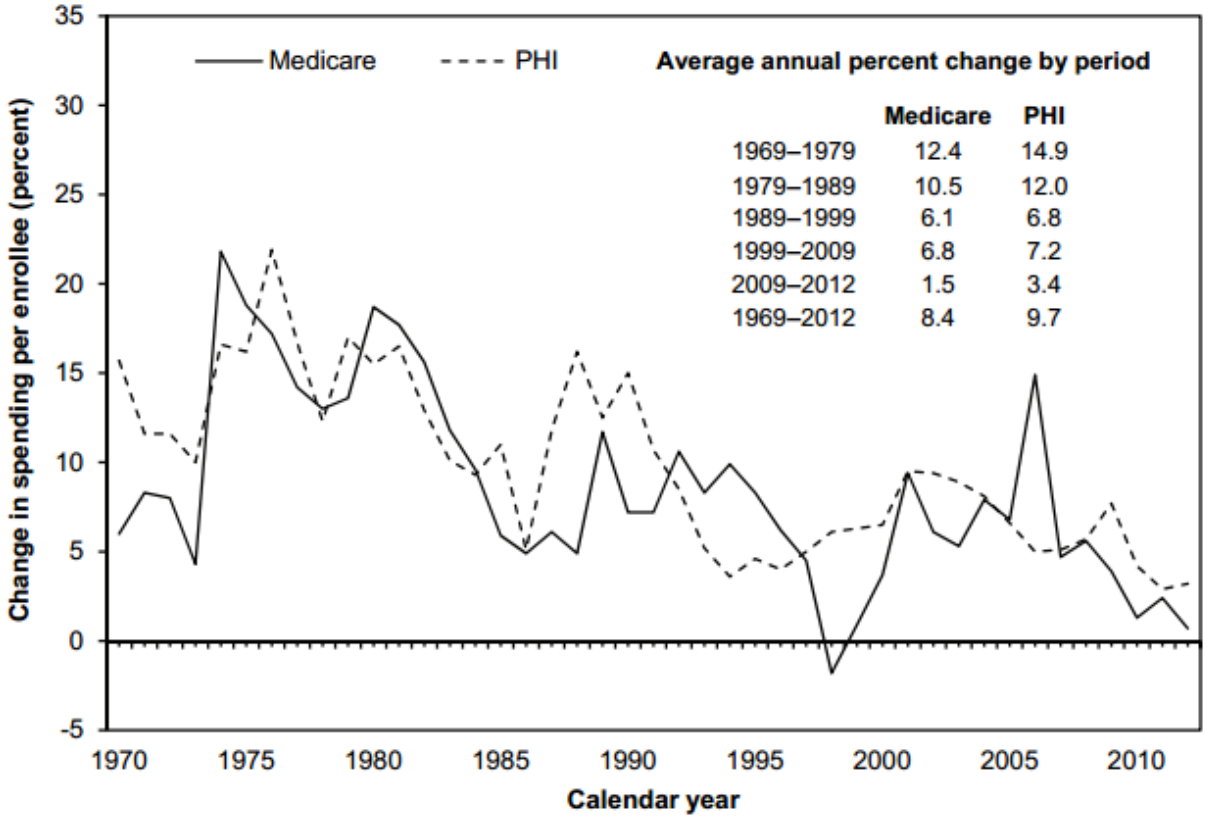
Oct. 6, 2014

Health Care Spending Growth has Slowed Dramatically



Slowdown Common Across Payers

Chart 1-7. Changes in spending per enrollee, Medicare and private health insurance



	Medicare	PHI
1969–1979	12.4	14.9
1979–1989	10.5	12.0
1989–1999	6.1	6.8
1999–2009	6.8	7.2
2009–2012	1.5	3.4
1969–2012	8.4	9.7

Note: PHI (private health insurance). Medicare expenditures include both fee-for-service and private plans.

Source: CMS Office of the Actuary, National Health Expenditure Accounts 2014.

Excess Spending Growth

	1960-1970	1970-1980	1980-1990	1990-2000	2000-2010	2010-2012
Average annual growth in per capita health expenditures	9.2%	12.0%	9.9%	5.5%	5.6%	3.0%
Average annual growth in per capita GDP	5.8%	9.3%	6.6%	4.5%	2.9%	3.5%
Excess growth in health expenditures	**3.4%**	**2.7%**	**3.3%**	**1.0%**	**2.7%**	**-0.5%**

In current dollars
Source: Spending and population data obtained from Centers for Medicare & Medicaid Services National Health Expenditures Data, 2013

Spending Growth Remains Low

- Nationally
  - 3.6% (vs 3.7% in 2012)
  - vs. 2.3% in MA 
- Per enrollee spending growth projected for 2014:
  - Medicare: +0.8%
  - Medicaid: -0.6%
  - Commercial Spending: +2.9%

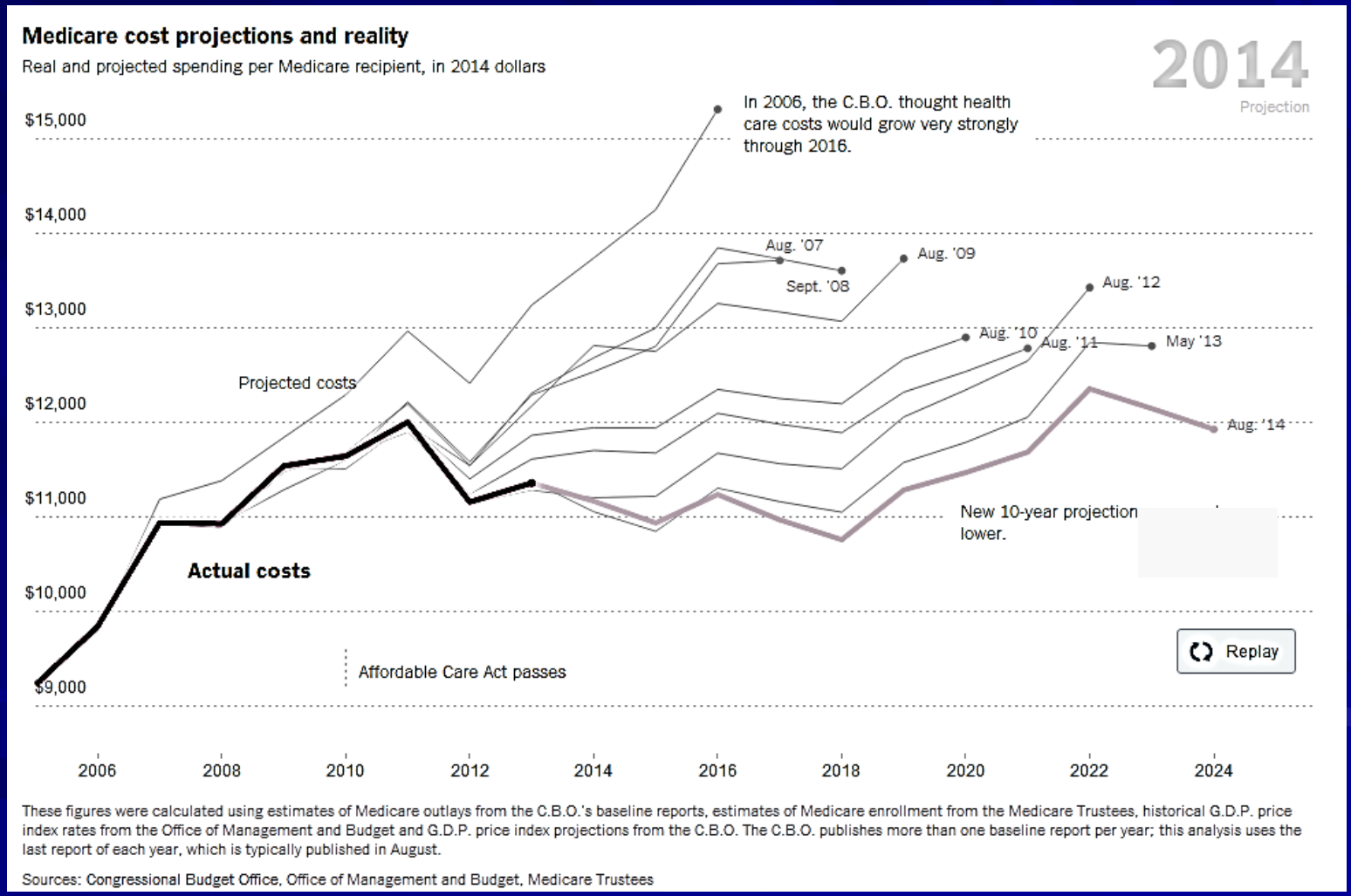
Source: Sisko, Andrea M., et al. "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy."*Health Affairs* (2014): 10-1377.

CBO Projections per Beneficiary

- From 2015-2029 the rate of growth in costs per beneficiary is projected to exceed the rate of growth in per capita GDP by an average of:
  - Medicare: 0.6 percent per year
  - Medicaid: 1.5 percent per year

Source: http://www.cbo.gov/publication/45543

But Projections Have Been Falling



Two Questions

- What caused the spending slowdown?
- Will the slowdown persist?

It’s harder to look forward than backward

Why might spending growth slow?

- Direct recession effects
  - Job loss
  - Reductions in benefit generosity
- Indirect recession effects
  - Stock market drop
  - Job insecurity
- Structural change (temporary and permanent)
  - Culture
  - Technology

Why Slowdown Was Not Simply Due to the Recession?

- Started before the recession (Cutler 2012)
- Affected populations not as strongly impacted by the recession (Ryu et al.)
  - Privately insured
    - HOLDING BENEFIT GENEROSITY CONSTANT
    - Medicare
- Observed change in technology introduction (Cutler 2012)

Cutler, David M., and Nikhil R. Sahni. *Health Affairs* 32.5 (2013): 841-850.

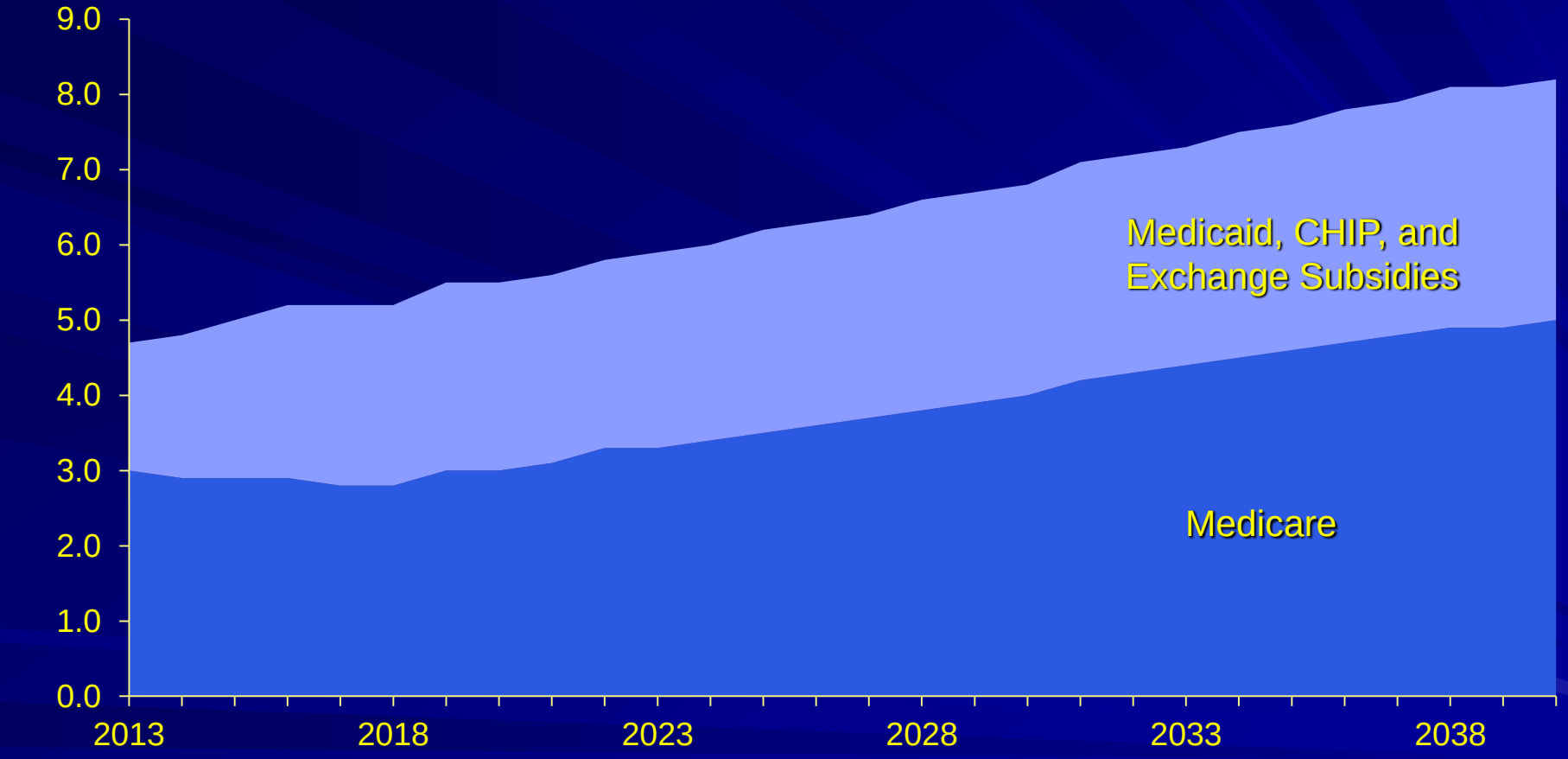
Slowdown may not continue

- One time factors may not repeat
  - Patent expirations
- Technology may rebound
  - Sovaldi
- Provider cost control efforts could weaken
  - Slowdown in spending in the 1990s in subsequent rebound reflected a relaxation of efforts to control spending

➔ We must continue to strive for efficiency

Pressure from Public Payers to Continue

Federal Spending on Health as % of GDP



Source: Congressional Budget Office. The 2013 Long-Term Budget Outlook. https://www.cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO-1Column_0.pdf

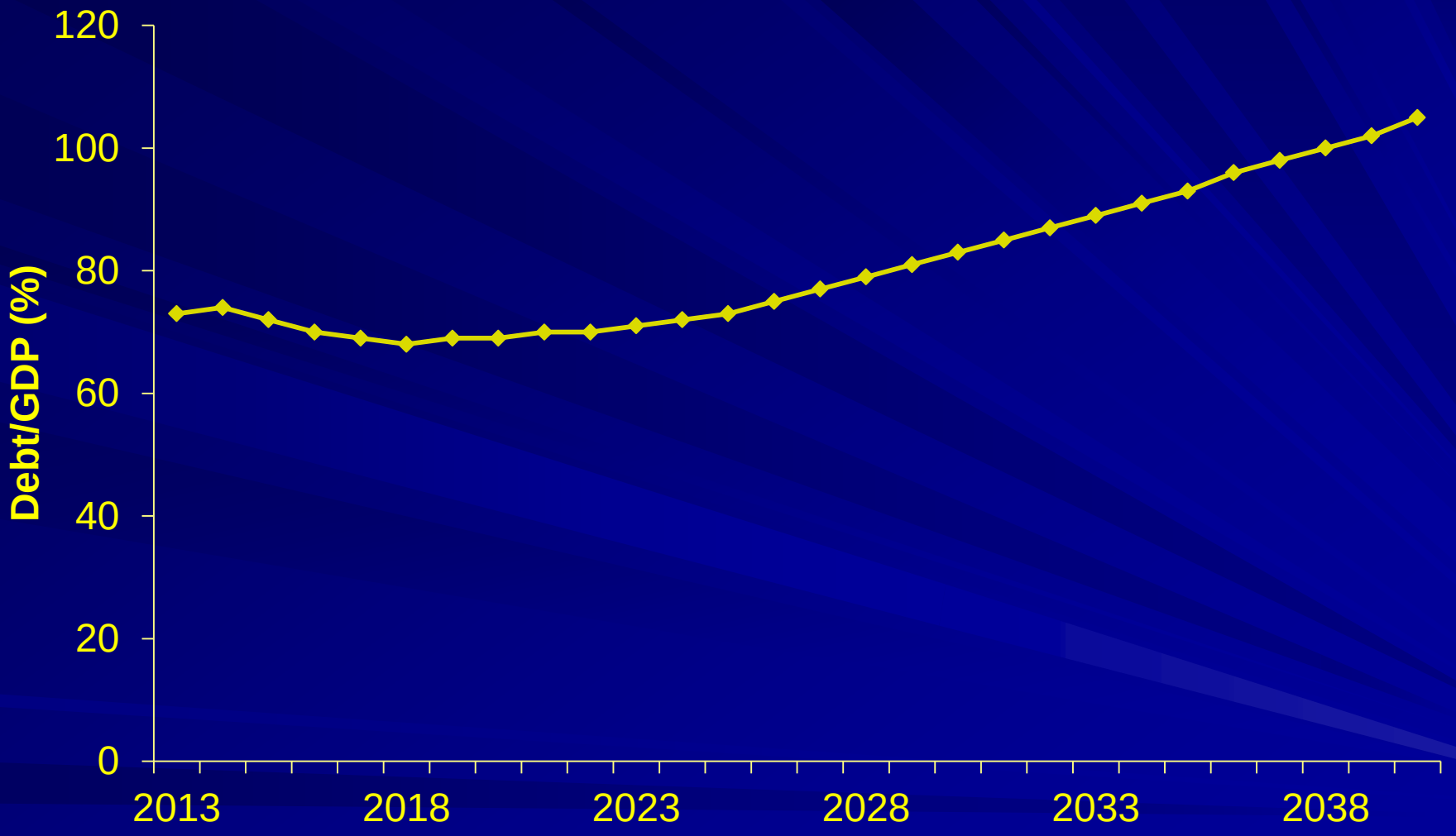
Medicare's Challenge

Excess spending growth per beneficiary (percentage points)	Medicare share of GDP in 2035 (%)
2	7.9
1	6.4
0.5	5.7
0	5.1

Share in 2013 projected to be 3.7 percent. To remain at 3.7 percent of GDP in 2035, Medicare needs to grow at a rate of 1.5 percentage points below GDP. Faster GDP growth would imply slightly lower Medicare shares for any amount of excess spending growth.

SOURCE Congressional Budget Office; see note 15 in text. Congressional Budget Office. Long-term budget outlook 2012. Washington (DC): CBO; 2012.

Our Debt is Unsustainable

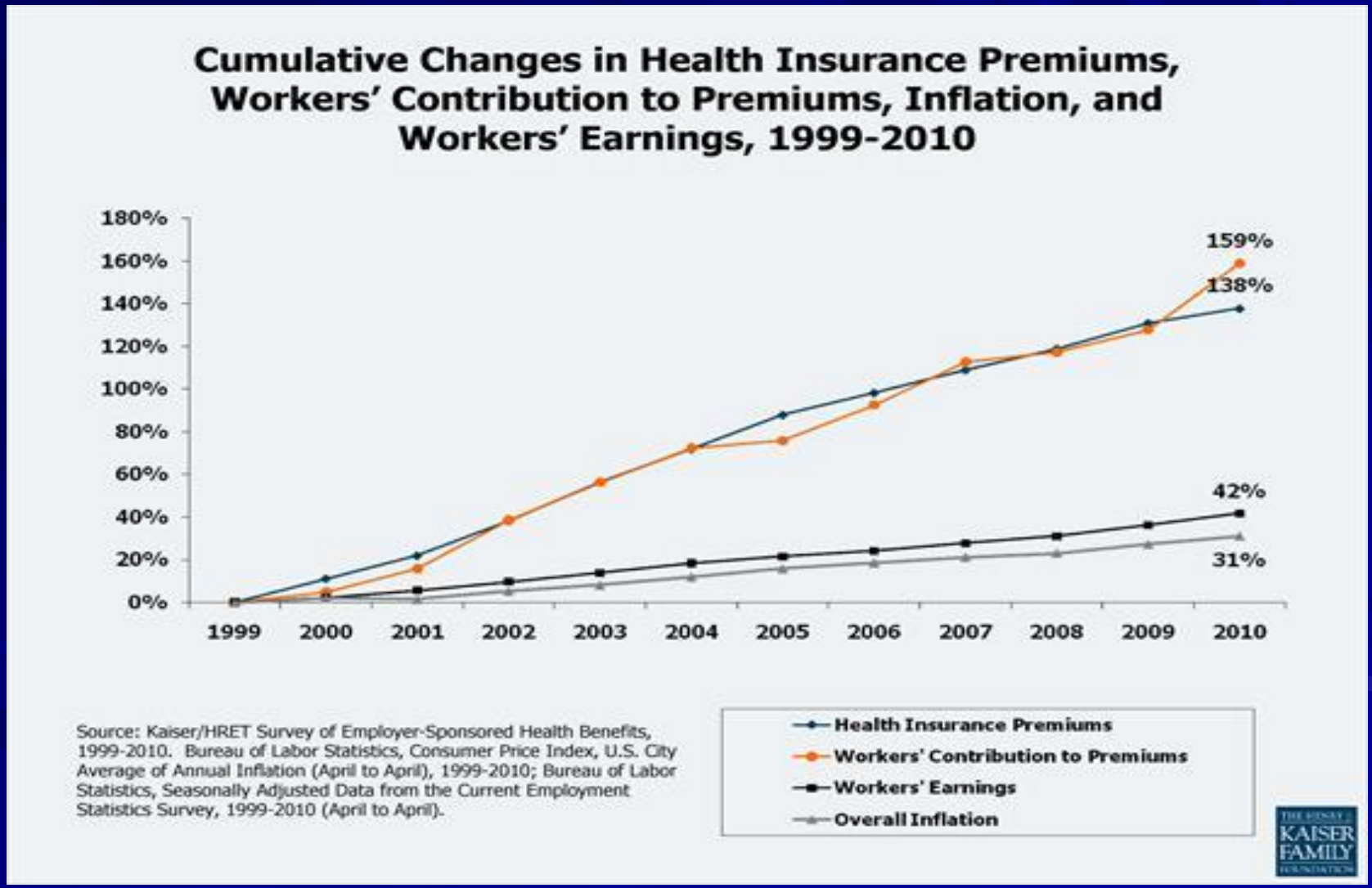


Source: Congressional Budget Office. The 2013 Long-Term Budget Outlook.
https://www.cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO-1Column_0.pdf

This policy debate is less about health and more about taxes

Pressure from Private Payers to Continue

Private Health Care Spending is not Sustainable



Benefit Design Options

- Higher co-premiums / premium support
- Higher copays, co-insurance or deductibles
  - Reforming Medicare supplemental market
- Reference pricing
- Tiered networks
- Value Based Insurance Design (VBID)

Private Payment Reform

- Global payment models
  - Alternative Quality Contract
- Insurer / provider partnerships
  - Aetna
- Medical home based models
  - Carefirst

Basic Features

- Transfer risk to providers
  - But built on FFS chassis
  - Primary care focused
- Include P4P
- Data support
- Assignment rules
  - Beneficiary designated (AQC)
  - Payer assigned
    - ACO attribution
    - Episode attribution (Arkansas)

Payment Reform Summary

- Can slow spending
  - Providers capture efficiencies
  - Payers only capture savings if they lower payment rates

  ➔Discipline in global rates is key
    - ➔Fragmentation requires attention to market failures
    - ➔Bigger can be better with the right rules

Summary

- Delivery system is key to success
  - Incentivize efficient practice
  - Focus on accountability for person level spending (Total Medical Expense)
  - Focus on trajectory (vs. level)
- Be aware of spillovers
  - Free riders / general equilibrium effects
  - Connections between services

END

PANEL 1

MEETING THE COST GROWTH BENCHMARK

PRESENTATION

ALAN WEIL

Massachusetts Health Policy Commission
2014 Cost Trends Hearing

October 6, 2014

Alan Weil
Editor-in-Chief
Health Affairs

HealthAffairs

Outline

- What are leading State Medicaid programs trying to achieve?
- What methods are they using?
- Massachusetts context

Leading Goals

- Health System Integration
- Health/Social Integration
- High Cost/Complex Patient Focus
- Enhance Primary Care Capacity
- Build Community Capacity

Methods

- Consolidated Payment
- Multi-payer Initiatives
- Data Analytics
- Targeted Funding Streams
- Workforce

Massachusetts Context

- **Private sector went first**

$$PopulationHealth \neq \sum_{n=1}^{\infty} ACOs$$

- **Redeployed institutional funds**
- **Governance attributes**

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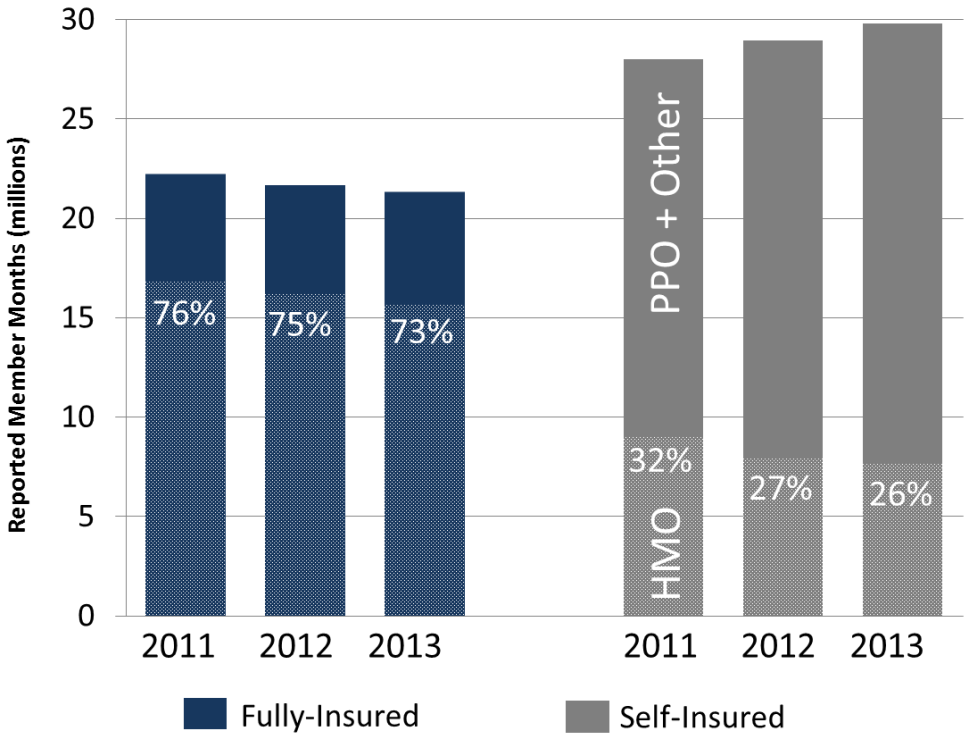
HealthAffairs

Panel 2

Alternative Payment Methods

Two related trends affect the commercial market



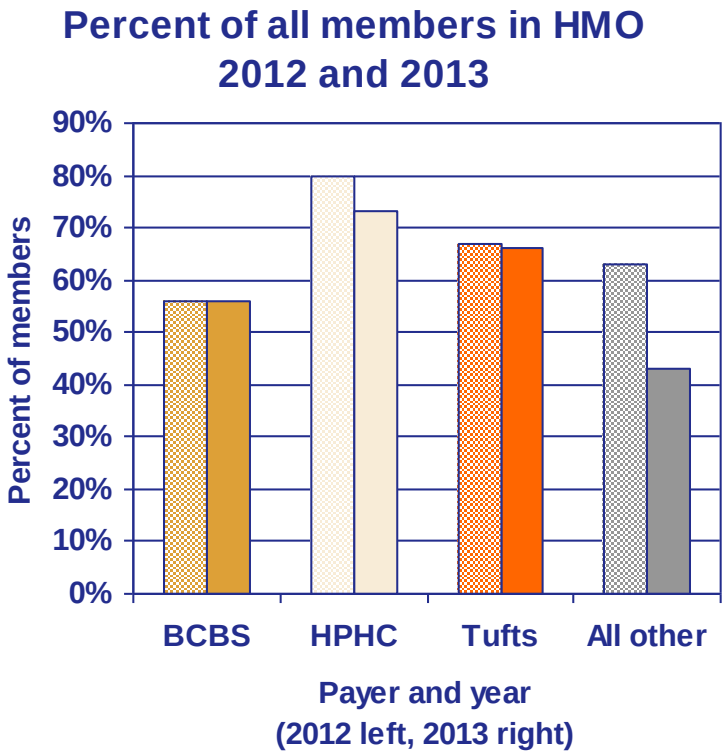
Declining enrollment in fully-insured plans and in HMOs.

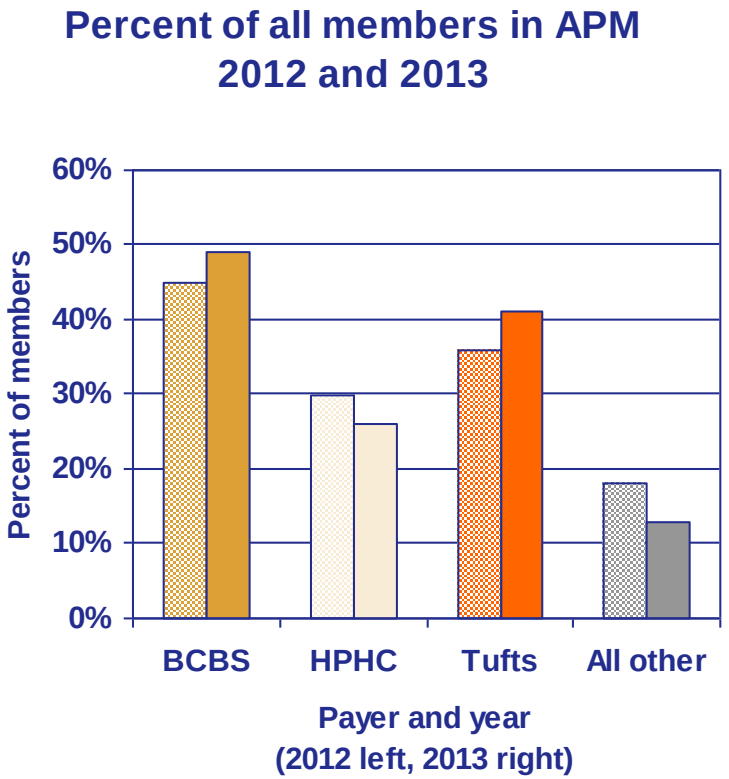
In today's market, APMs are mainly used within HMO-type plans.

Total HMO Membership in Massachusetts			Change Over Time	
2011	2012	2013	2011-2012	2012-2013
51.5%	47.5%	45.7%	-4.0pp	-1.8pp

Source: Center for Health Information and Analysis.

All major payers show declining HMO membership and slow or negative growth in percentage of members covered by APMs.





Many providers testified that standardizing APM elements would improve efficiency, but some payers prioritized flexibility. Operational challenges remain.

Risk Adjustment	▪ Standardization eliminates uncertainty, simplifies administration, aids in comparisons. ▪ Flexibility accounts for differences among providers. ▪ Providers see socioeconomic factors and behavioral health missing in adjustment methodologies. Payers tend to find methodologies sufficient.
Data and Quality Metrics	▪ Providers seek real-time data on financial, administrative, and clinical metrics. ▪ Many varying quality measures increase administrative burden, but allow for tailoring to providers' improvement needs and specific populations served. ▪ Many providers lack systems to share quality information with each other, and payers have not always been able to bridge the gap.
Patient Attribution	▪ A working group, consisting of payers and providers, is developing a standardized PPO attribution methodology. ▪ Many providers question the value in holding PCPs responsible for patient costs absent referral management. ▪ Providers are also concerned about the accuracy of attribution methods that rely on claims history, not patients' choice of provider.

Source: Pre-Filed Testimony, Sept. 2014.

Public Testimony

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

OCTOBER 7, 2014

PRESENTATION

OFFICE OF THE ATTORNEY GENERAL

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

OFFICE OF ATTORNEY GENERAL
MARTHA COAKLEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

Examination Focus

1. Are consumer-driven health insurance products lowering costs?
2. What is the behavioral health reimbursement landscape?

Preliminary Findings

I. Impact of Tiered Network Products on Costs

Plan Design
Membership
Utilization Case Study

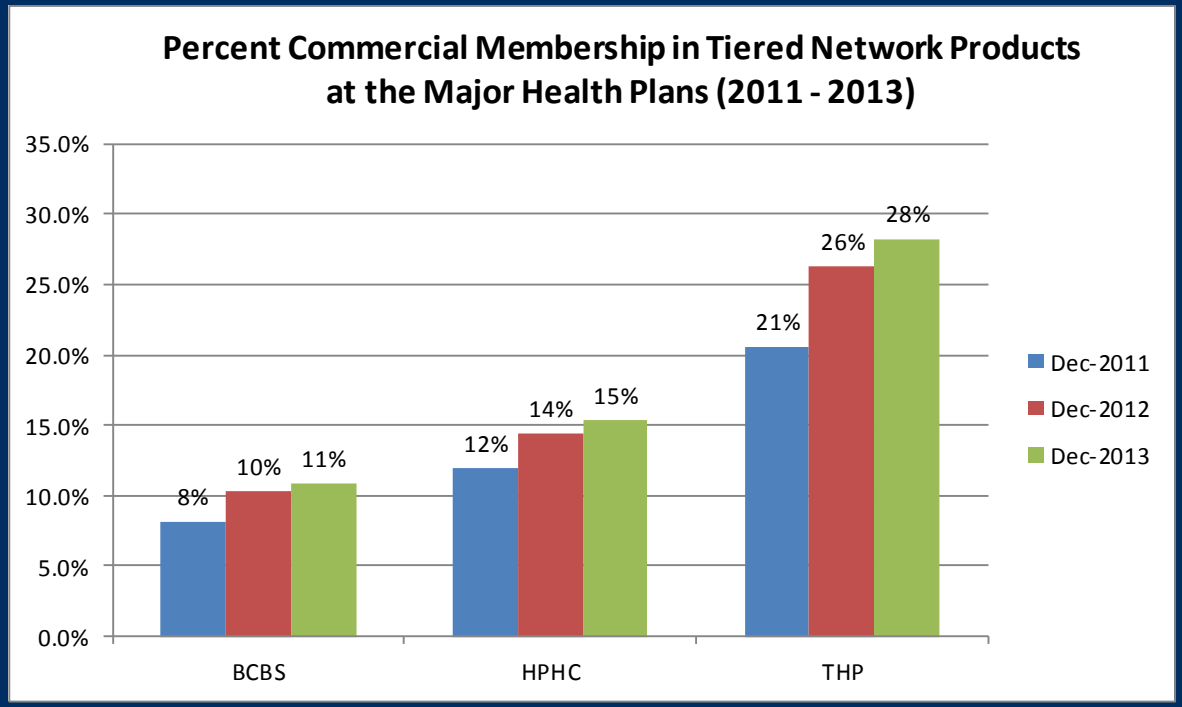
Tiered Network Plan Designs

- Designed to shift health care volume to efficient providers.
- Efficient providers provide health care at low cost and high quality ("Tier 1").
- Tiered network plan designs are developed to encourage members to use Tier 1 (and sometimes Tier 2) providers.

Current Tiered Network Plan Offerings

- Inpatient copay differentials span $250 - $1000 between tiers, which may result in incentives of various strength to obtain care at high value facilities.
- Customized tiering methodologies result in conflicting tiers and competing incentives for members within and across carriers.

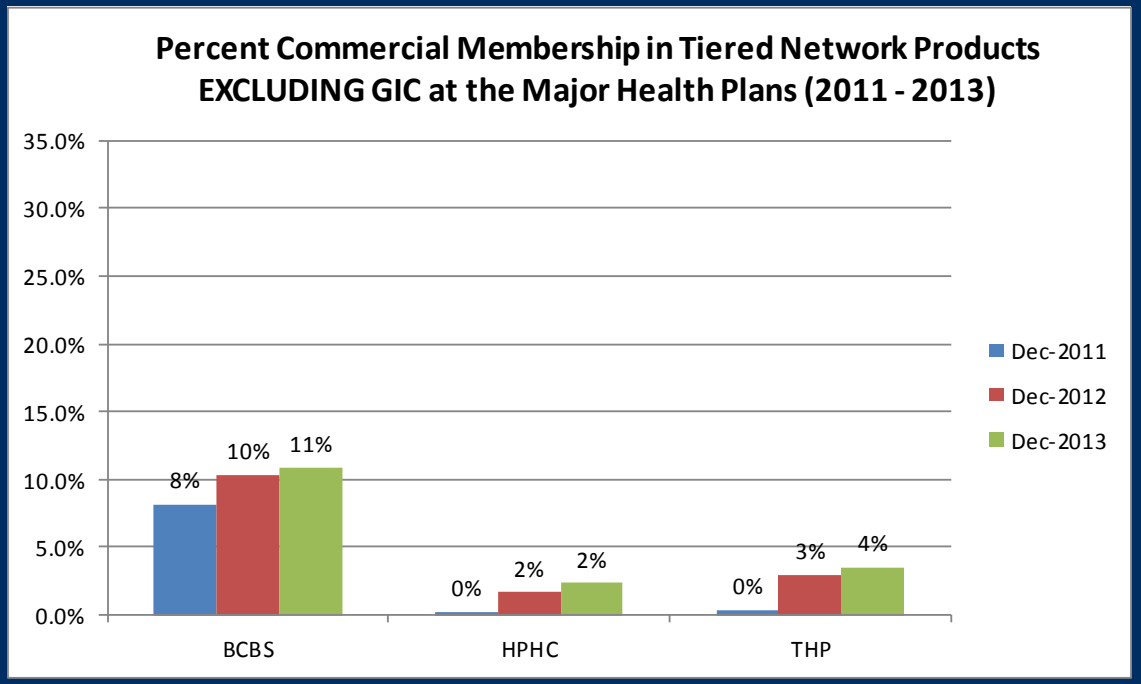
Overall Membership Growth in Tiered Network Products



Notes:

1. Tiered network membership reflects membership of Massachusetts residents in products that, in a given year, included financial incentives for hospital services (e.g., lower copayment or deductibles) for members to obtain in-network health care services from providers that are most cost effective.
2. BCBS data reflects enrollment in Blue Options and Hospital Choice Cost Sharing.
3. HPHC data reflects enrollment in Tiered Choice Net, GIC Independence, GIC Primary Choice (limited and tiered network) and Hospital Prefer to the extent the product was in place in a given year (e.g., HPHC introduced Hospital Prefer in 2012).
4. THP data reflects enrollment in Your Choice, GIC Navigator and GIC Spirit (limited and tiered network).

Low Membership in Non-GIC Tiered Network Products



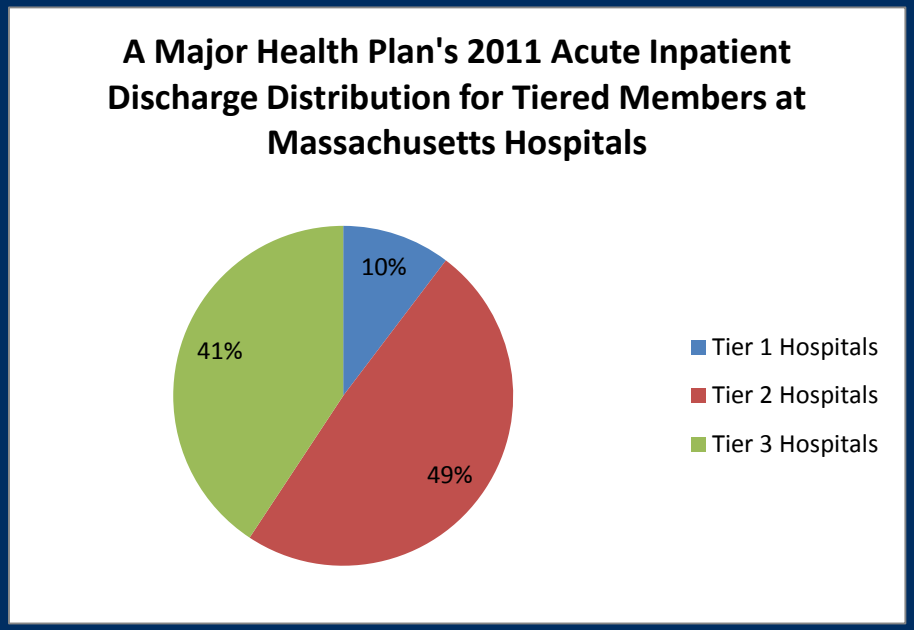
Notes:

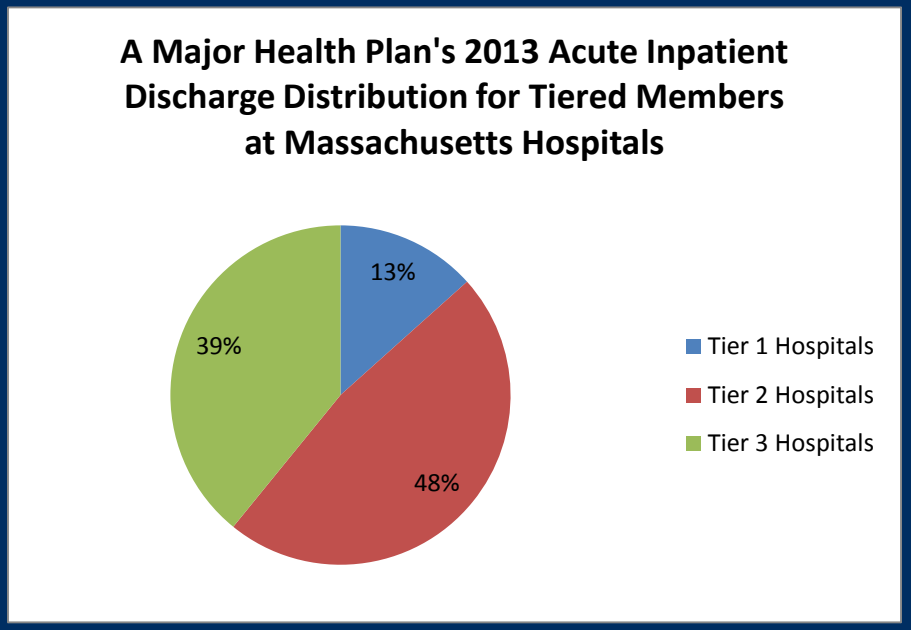
1. BCBS data reflects enrollment in Blue Options and Hospital Choice Cost Sharing.
2. HPHC data reflects enrollment in Tiered Choice Net and Hospital Prefer to the extent the product was in place in a given year (e.g., HPHC introduced Hospital Prefer in 2012).
3. THP data reflects enrollment in Your Choice.

Tiered Network Utilization Case Study

A Major Health Plan's Tiered Network Offering Member Cost Sharing by Tier			
Service	**Copay**		
	Tier 1	**Tier 2**	**Tier 3**
Primary Care	$20	$20	$20
Specialist	$20	$35	$45
Inpatient Hospital	$250	$500	$750
Outpatient Surgery	$150	$150	$150
High Tech Imaging	$100	$100	$100
ED Room	$100	$100	$100

Case Study: Small Shift in Inpatient Utilization to Tier 1 Facilities

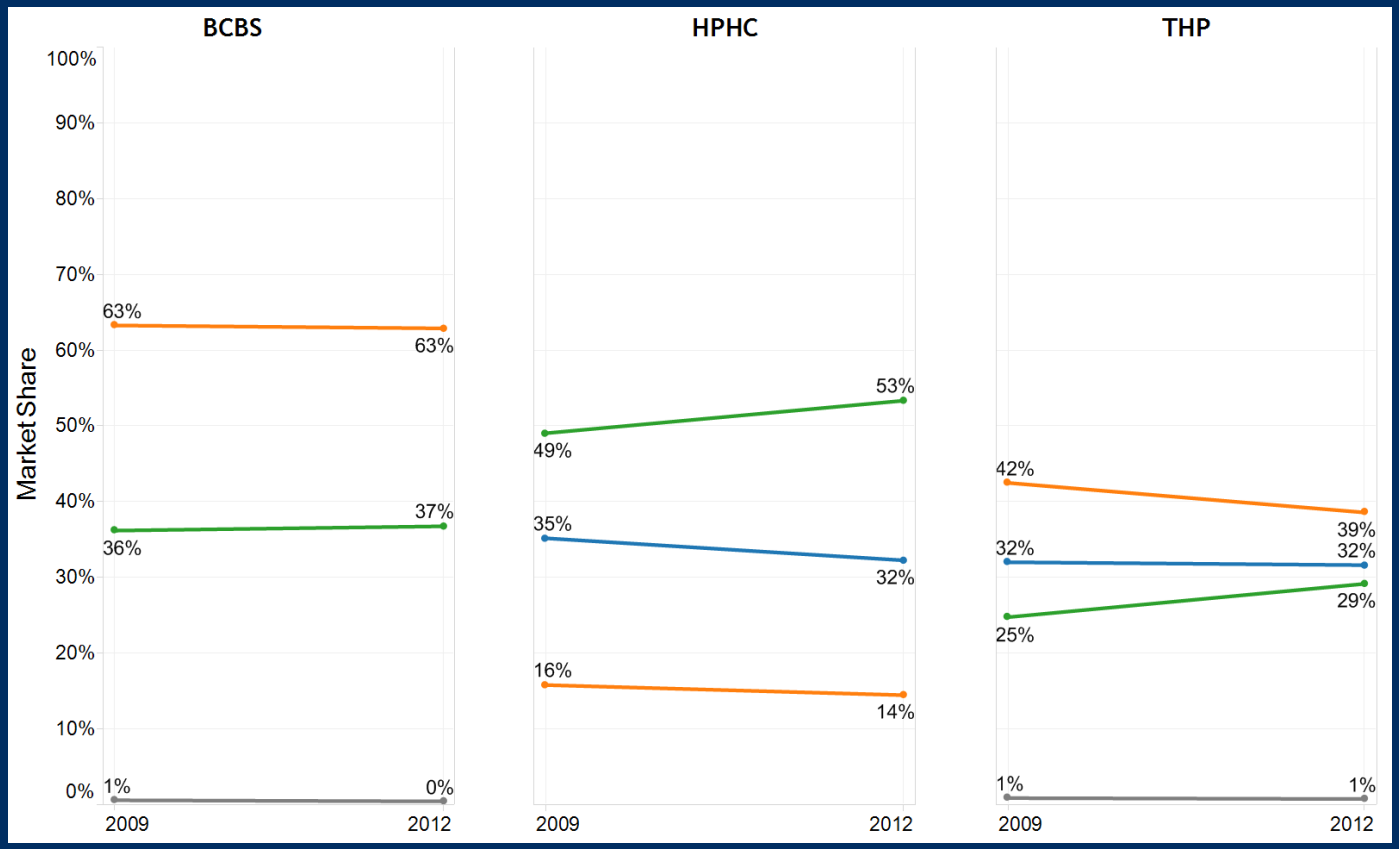




Note:
1. Data reported as visits assumed to equal discharges.

Case Study Results in Context of Total Inpatient Market Share for Tiered and Non-Tiered Plans

2009-2012 Market Share Distribution of Inpatient Discharges By Tier For Major Commercial Health Plans Across All Products



Notes:

1. BCBS hospital tiering based on 2014 Hospital Cost Choice plan.
2. HPHC hospital tiering based on FY2015 GIC Independence plan.
3. THP hospital tiering based on FY2015 GIC Navigator plan.

Areas of Further Exploration on Product Design

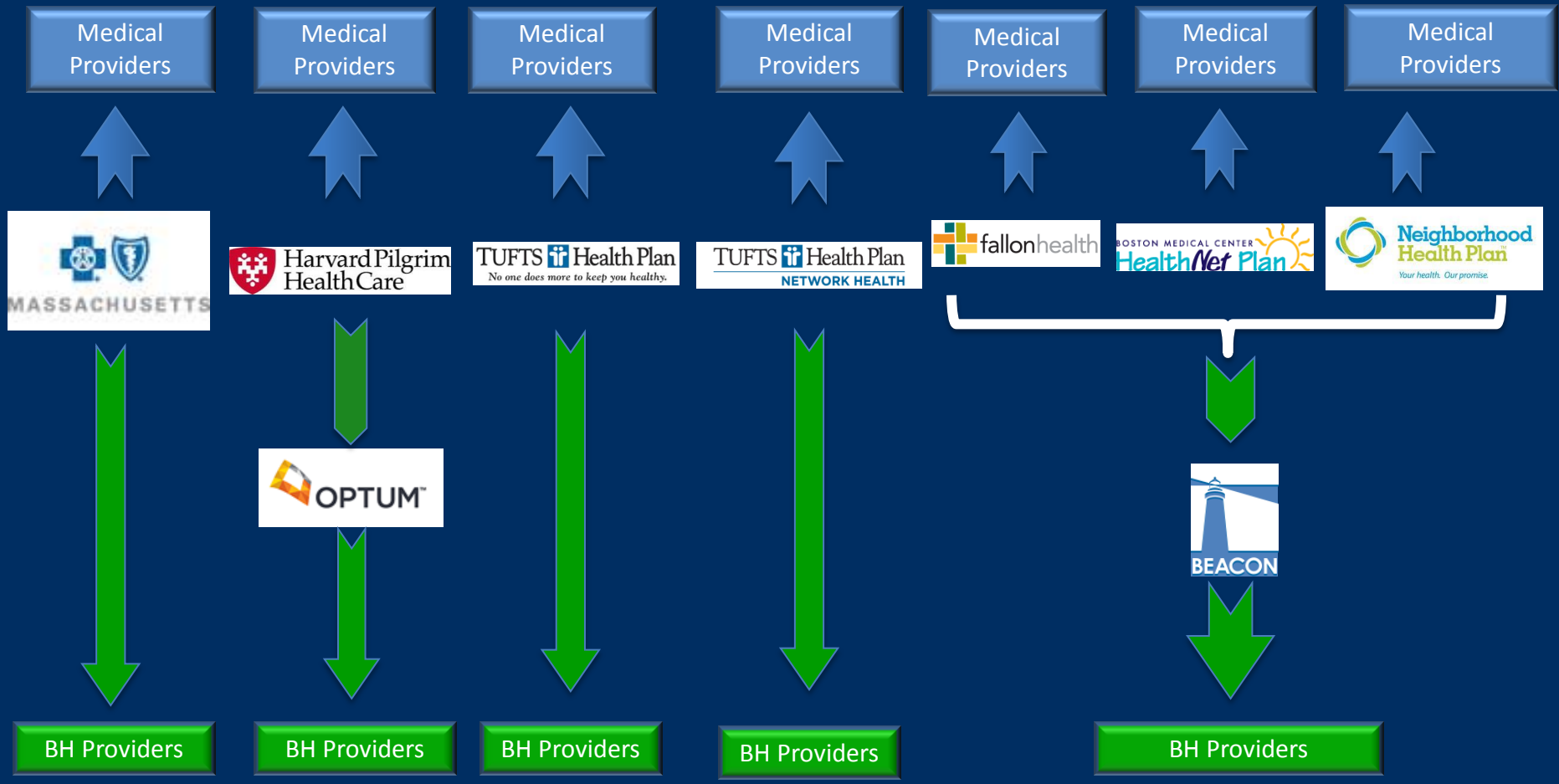
- Continued examination of impact of tiered networks on provider market share.
- Utilization trends for members before and after enrollment in a tiered network product.
- Impact of various cost share differentials on member utilization (e.g., $250 copay differential between tiers vs. $1000).
- Cost impact of other product design initiatives (e.g., limited networks, high cost sharing products).

II. Behavioral Health Reimbursement Landscape

Major Players
Reported Behavioral Health Spending

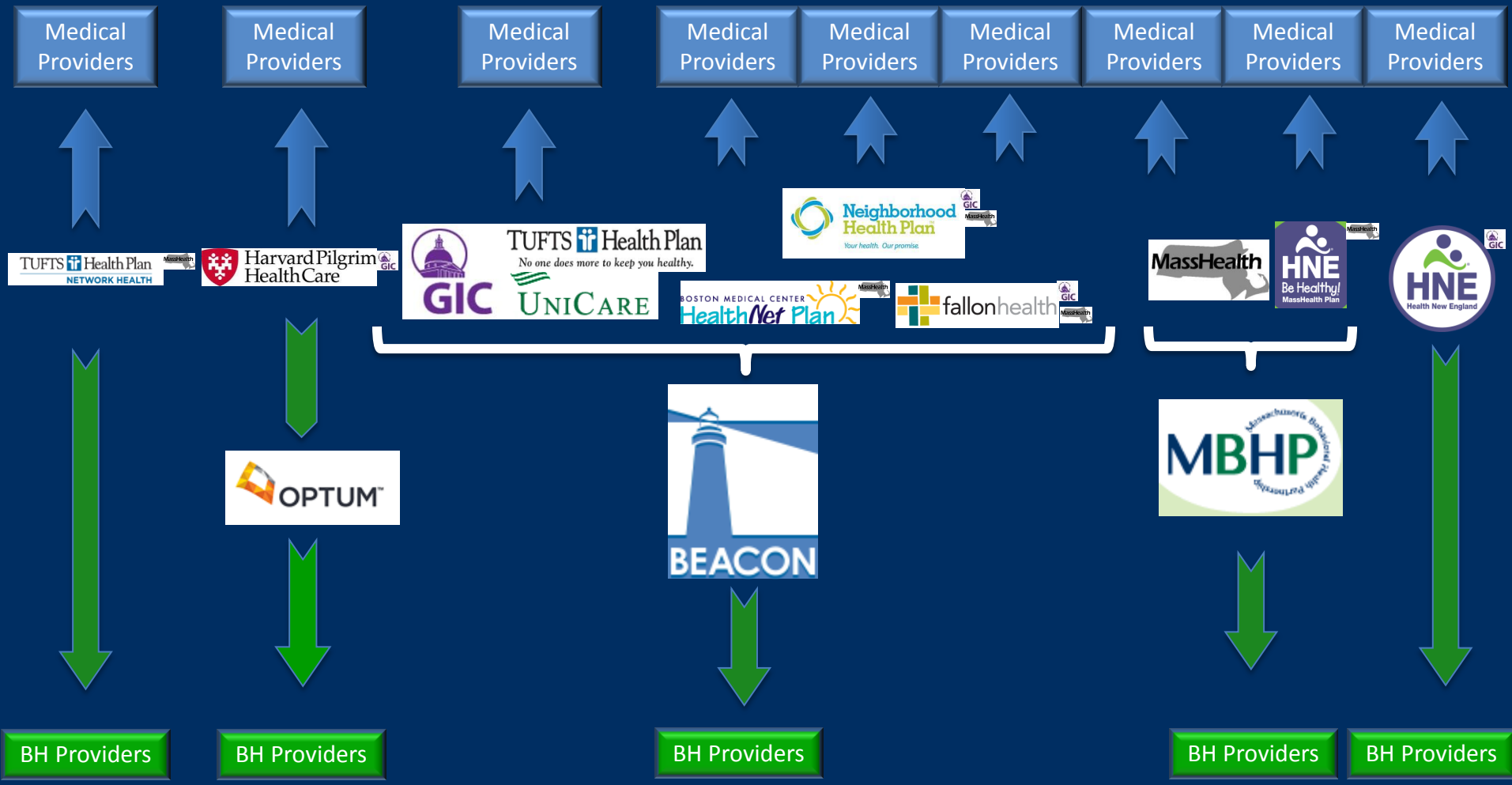
Behavioral Health Management Players

Commercial



Behavioral Health Management Players

Commonwealth-Sponsored Plans



Fragmented Behavioral Health Benefit Administration and Financial Risk - Commercial

Carrier	BH Administrative Responsibility		BH Primary* Financial Risk Responsibility			
	HMO	*PPO/Indemnity*	*HMO*		*PPO/Indemnity*	
			FI	**SI**	**FI**	**SI**
Blue Cross Blue Shield Massachusetts	Blue Cross Blue Shield Massachusetts	Blue Cross Blue Shield Massachusetts	Blue Cross Blue Shield Massachusetts Risk Bearing Provider Organizations	Plan Sponsor	Blue Cross Blue Shield Massachusetts	Plan Sponsor
Harvard Pilgrim Health Care	OPTUM	OPTUM	OPTUM	Plan Sponsor	OPTUM	Plan Sponsor
Tufts Health Plan — No one does more to keep you healthy.	Tufts Health Plan	Tufts Health Plan	Tufts Health Plan Designated Facilities	Plan Sponsor	Tufts Health Plan	Plan Sponsor
fallonhealth	BEACON	BEACON	BEACON	Plan Sponsor	BEACON	Plan Sponsor

Fragmented Behavioral Health Benefit Administration and Financial Risk – Medicaid MCOs and MassHealth

Carrier	BH Administrative Responsibility		BH Primary* Financial Risk Responsibility	
	Commercial	*Government*	*Commercial*	*Government*
Neighborhood Health Plan	BEACON	BEACON	BEACON	BEACON
Boston Medical Center HealthNet Plan	BEACON	BEACON	BEACON	BEACON
Tufts Health Plan Network Health	Tufts Health Plan Network Health	Tufts Health Plan Network Health	Tufts Health Plan Network Health	Tufts Health Plan Network Health
fallonhealth	BEACON	BEACON	BEACON Plan Sponsor	BEACON fallonhealth
MassHealth	N/A	MBHP	N/A	MBHP

Snapshot of a Consumer's Experience in a Fragmented System

55 year old man with high cholesterol, high blood pressure and chronic depression.

Employer-Sponsored Health Plan

Behavioral Health Manager

Pharmacy Benefit Manager

PCP manages high cholesterol and high blood pressure and prescribes ACE-inhibitors and Beta-blockers.

Blood pressure and cholesterol medication supplies are low. PBM leaves phone message reminder. Worsening depression makes patient non-responsive.

Psych Unit adjusts anti-depressants.

PCP continues to manage high cholesterol and high blood pressure.

Stable Condition → ***Depression Worsens*** → ***Discharge***

Psychiatrist manages chronic depression and prescribes anti-depressants.

As condition worsens and suicidal ideations surface, patient presents at ED and MBHO coordinates admission to Inpatient Psych Unit.

Internist consult in Psych Unit addresses ACE-inhibitor and Beta-blocker use.

Psychiatrist continues to manage chronic depression.

Snapshot of a Consumer's Experience in a Fragmented System

55 year old overweight man with diabetes, schizophrenia, and alcoholism

Medicaid MCO Health Plan

Behavioral Health Manager

PCP

Gastroenterologist (primary)

Psychiatrist #2 (Psych Unit)

BH case manager

Psychiatrist (primary)

Health Plan case manager for prescriptions

Therapist #2 (Psych Unit)

Gastroenterologist (Hospital #2)

Stable Condition → *Schizophrenia Worsens* → *Discharge*

Therapist (primary)

Endocrinologist (primary)

Sobriety counselor

Hospital #1 ED transfer to Hospital #2 Inpatient Psych Unit

Internist (Hospital #2)

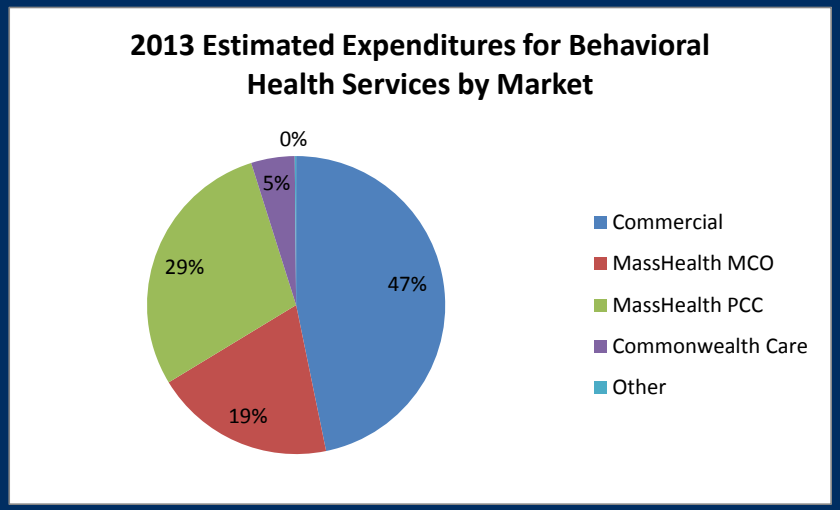
Endocrinologist (Hospital #2)

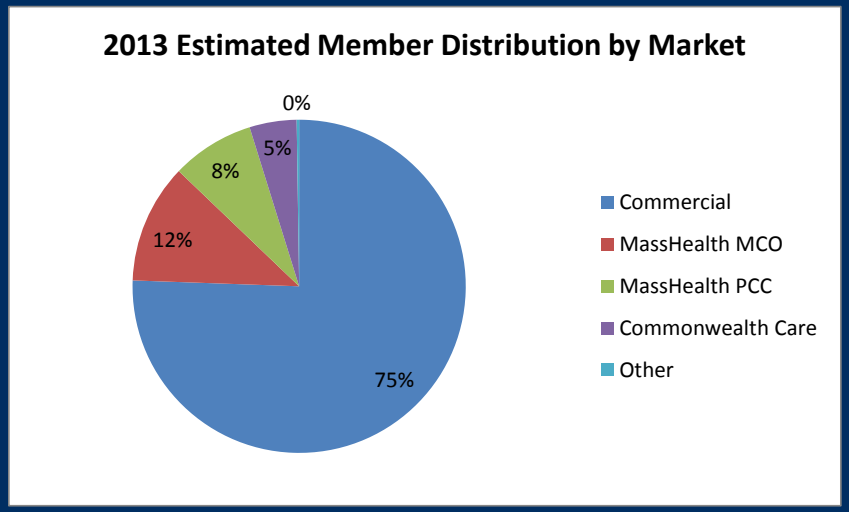
Halfway House

Reported Behavioral Health Expenditures Lack Consistent Definitions

- There is no consistent definition of behavioral health.
- There is no consistent way of reporting behavioral health spending.
- It is difficult to compare behavioral health spending across entities due to differing definitions and methodologies.

Reported Expenditures on Behavioral Health Services for Massachusetts Insured Population

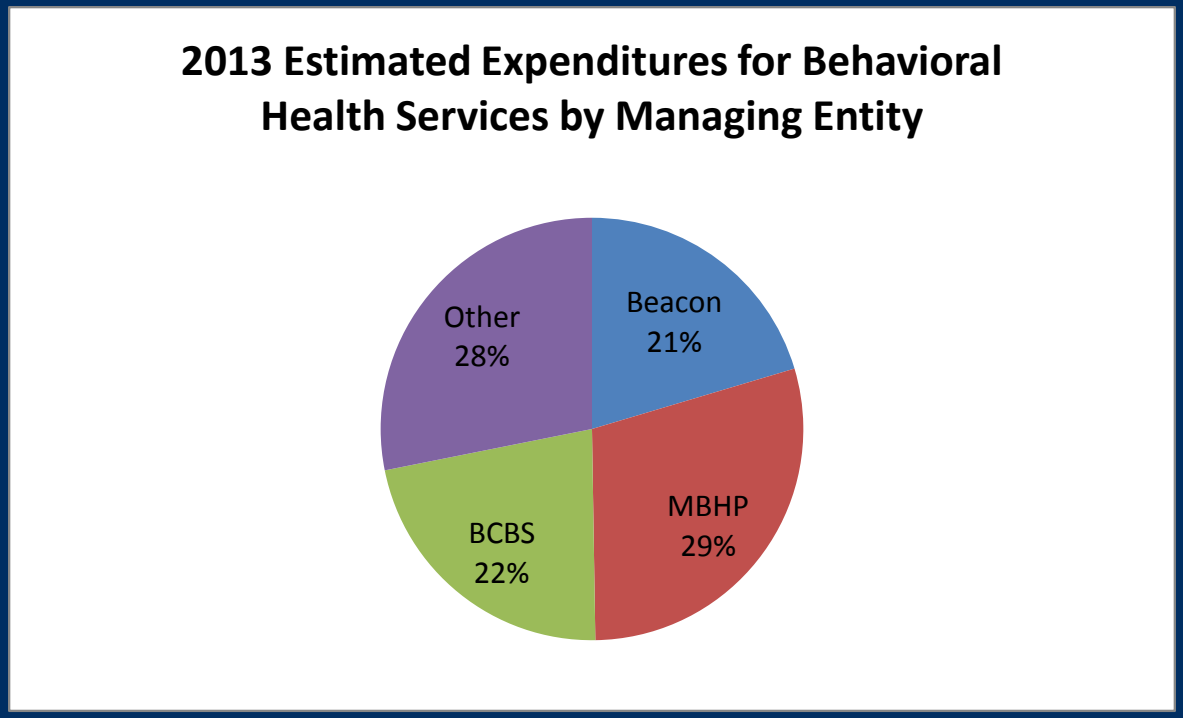




Note:

1. Medicare, dual eligible, VA populations excluded from analysis.
2. MassHealth FFS, Premium Assistance and Senior Care Options populations excluded from analysis. FFS includes people with other coverage (employer-sponsored or Medicare) as primary coverage, seniors not enrolled in SCO, and people who are institutionalized.
3. MassHealth PCC PMPM reflects average that includes children in DCF or DYF custody whose behavioral health benefits are administered by MBHP through MBHP's contract with MassHealth.

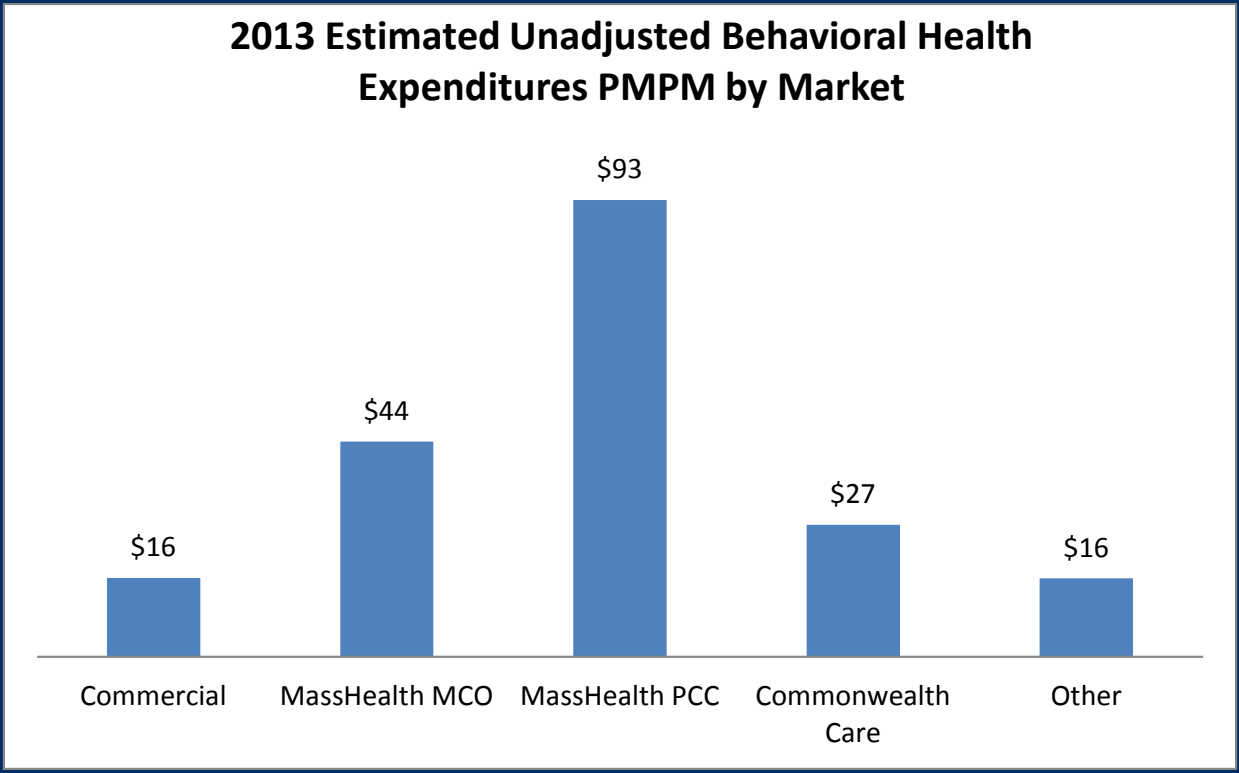
Reported Expenditures on Behavioral Health Services Broken Out by Entity Managing Expenses



Note:

1. GIC entered into contract with Beacon for Beacon to manage behavioral health expenses for GIC's THP and Unicare members as of July 1, 2013. This chart assumes movement of THP and Unicare GIC members to Beacon occurred in January 2013.

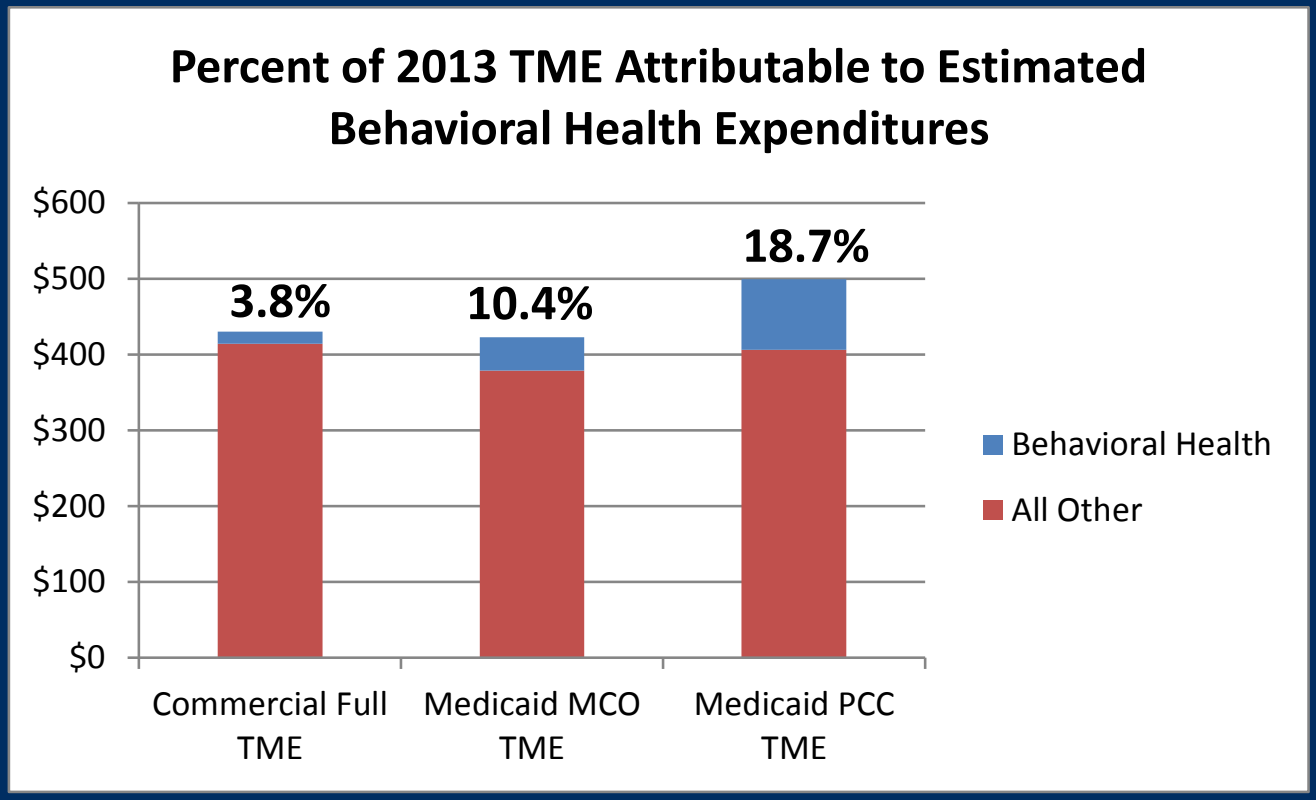
Managed Medicaid Patients Have Highest Estimated PMPM Behavioral Health Expenses



Note:

1. Not adjusted for differences health status.

Larger Portion of TME Attributable to Behavioral Health Services for Managed Medicaid Patients



Areas of Further Exploration in Behavioral Health

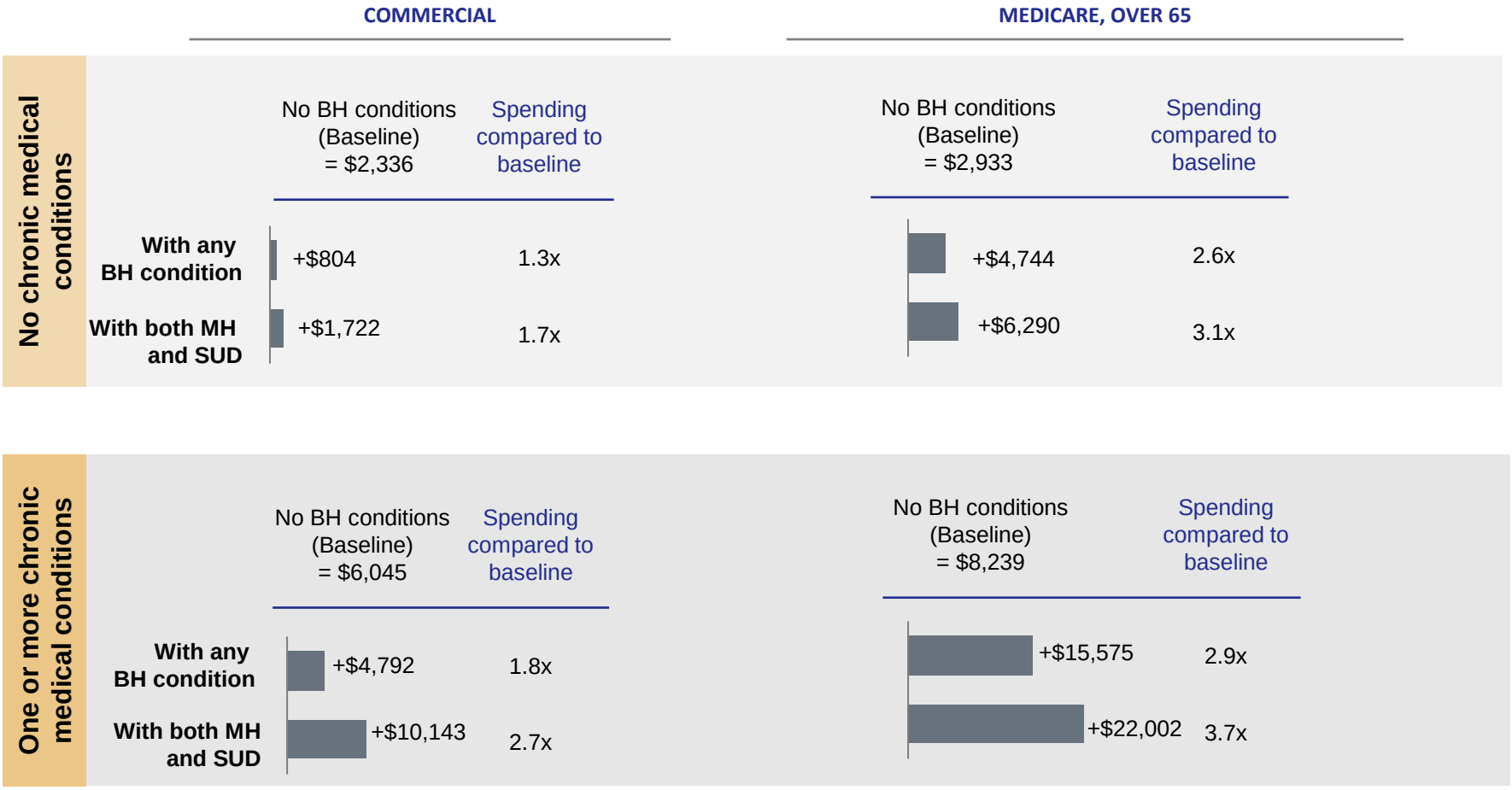
- Continued examination of behavioral health spending levels and trends.
- Behavioral health provider payment arrangements and payment levels within and across payers.
- Structural components and financial performance of health plan and MBHO risk arrangements.

Panel 3

Challenges and Opportunities to Coordinating Care: Behavioral Health

For patients with behavioral health conditions, spending is higher for other medical conditions, suggesting the potential value of integration.

Per person claims-based medical expenditures on non-behavioral health conditions based on presence of behavioral health (BH) comorbidity†, 2012 (Commercial) and 2011 (Medicare)*



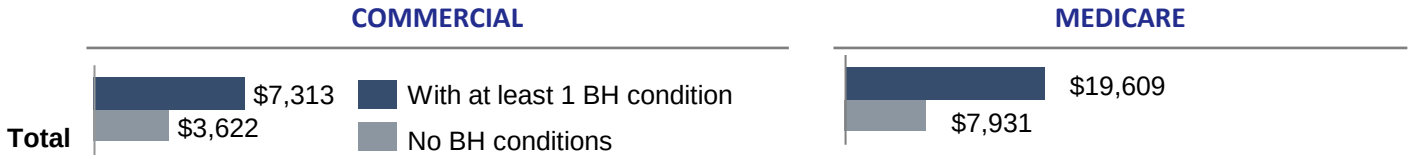
* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software. Expenditures for non-behavioral health conditions were identified using Optum ETG episode grouper. Additional detail is available in a technical appendix.

Higher spending for people with behavioral health conditions is concentrated in inpatient and ED spending.

SPENDING BY CATEGORY OF SERVICE FOR PATIENTS WITH AND WITHOUT BEHAVIORAL HEALTH CONDITIONS

Claims-based medical expenditures by category of service†, for people with and without behavioral health (BH) conditions‡, 2011*



Category of Service	Spending per person per category	% difference between people with and without BH conditions	Spending per person per category	% difference between people with and without BH conditions
ED	$291 / $122	+140%	$419 / $131	+220%
Inpatient	$2,245 / $1,000	+125%	$8,496 / $2,810	+202%
Outpatient	$926 / $515	+80%	$1,635 / $1,086	+51%
Long-Term Care and Home Health	$66 / $17	+279%	$4,715 / $1,191	+296%
Lab and X-ray	$782 / $524	+49%	$828 / $668	+24%
Professional[1]	$3,003 / $1,444	+108%	$3,516 / $2,045	+72%

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† For detailed definitions of categories of service, see CHIA and HPC publication, "Massachusetts Commercial Medical Care Spending: Findings from the All-Payer Claims Database." Lab/x-ray category includes professional services associated with laboratory and imaging.

‡ Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software

Market participants identified persistent challenges to behavioral health care and integration.

- Delivery system issues
  - Insufficient resources to meet patient needs
    - Including beds, providers, community resources and services
- Payment issues
  - Standard fee-for-service payment models
    - Separate co-payments for BH and medical visits
    - Rules against same day-billing
- BH carve-outs – advantages/ disadvantages
- Data limitations
- Need for culture change - more collaboration, less stigma
- The special needs of the population
  - For some, poverty, lack of stable housing, and other basic needs impedes treatment and recovery
  - Low levels of social support
  - Difficulty with self-care and follow-up
  - Frequent co-occurring conditions – multiple BH conditions or BH and medical conditions

Source: Pre-Filed Testimony, Sept. 2014.

Panel 4

Challenges and Opportunities to Coordinating Care: Post-Acute Care

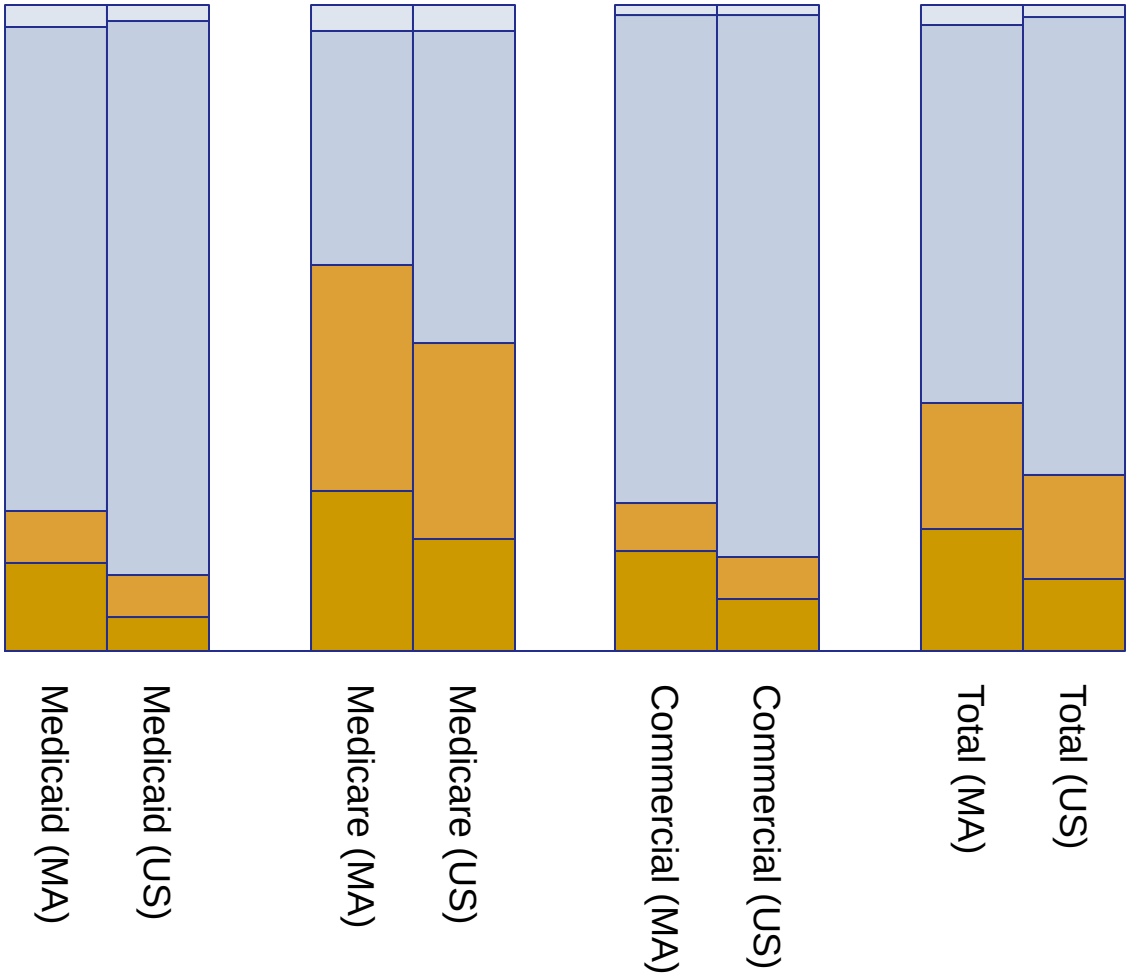
Compared to the average U.S. patient, Massachusetts patients are more likely to be discharged to post-acute care after a hospitalization.

- Adjusting for patients' demographic and clinical characteristics and for the type and intensity of inpatient care delivered, we estimate that Massachusetts hospitals are **2.1 times as likely to discharge patients to either skilled nursing facilities or home health agencies** relative to the national average, based on 2011 data
- Rates of discharge to post-acute care vary widely across Massachusetts hospitals

Notes: Relative probabilities of discharge to post-acute care and of choice of post-acute care setting were estimated using a logistic regression model that adjusted for: age, sex, payer, income, length of stay, DRG, patient comorbidities, APR-DRG illness severity score, and APR-DRG risk of mortality score using a 2011 national inpatient sample from the Healthcare Cost and Utilization Project.

Home health use drives higher rate of post-acute care in Massachusetts.

HCUP Massachusetts and U.S. discharge destination by payer, all discharges
Percent of discharges, 2011



Among all payers, the share of patients in MA who are discharged with home health is greater than the national average (19% in MA versus 11% in U.S.).

Other
Routine - No Post-Acute Care
Institutional
Home Health Care

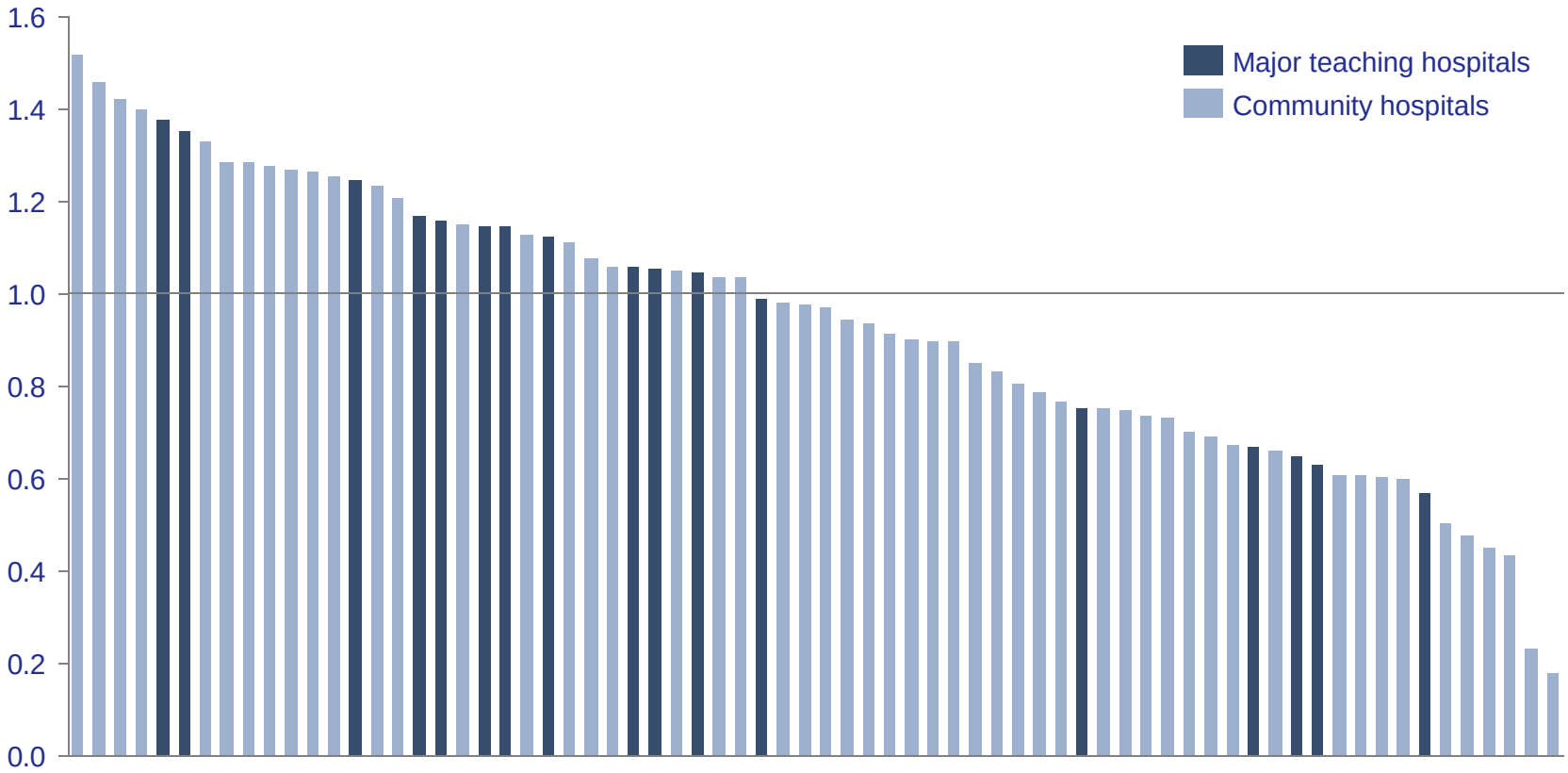
*Institutional includes skilled nursing facility, short-term hospital, intermediate care facility, another type of facility including inpatient rehabilitation facility and long-term care hospital.
**Other includes against medical advice, died, alive destination unknown, not recorded.

Source: Health Care Cost and Utilization Project; Census Bureau; HPC analysis.

Massachusetts hospitals vary widely in their rate of post-acute care use.

RATES OF DISCHARGE TO POST-ACUTE CARE

Adjusted rate of discharge to skilled nursing facilities and home health versus routine discharge, 2012*



* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the state volume-weighted average rate equal to 1.0.

† Discharge to nursing facility as a proportion of total discharges to either nursing facility or home health.

Source: Massachusetts Health Data Consortium, 2012; HPC analysis.

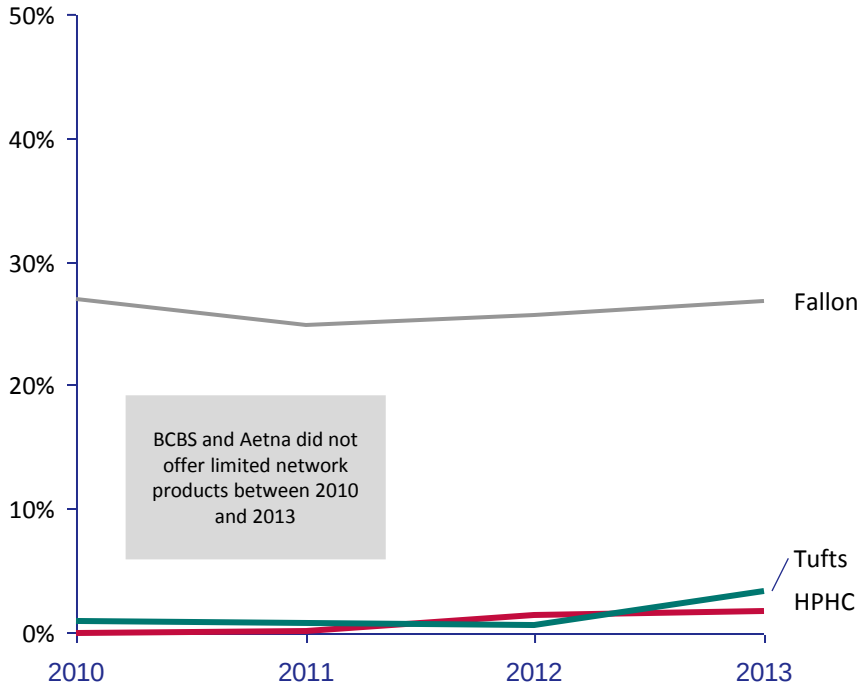
PANEL 5

PROMOTING A VALUE BASED MARKET: INSURANCE MARKET TRENDS

Value-oriented insurance products are slowly gaining ground.

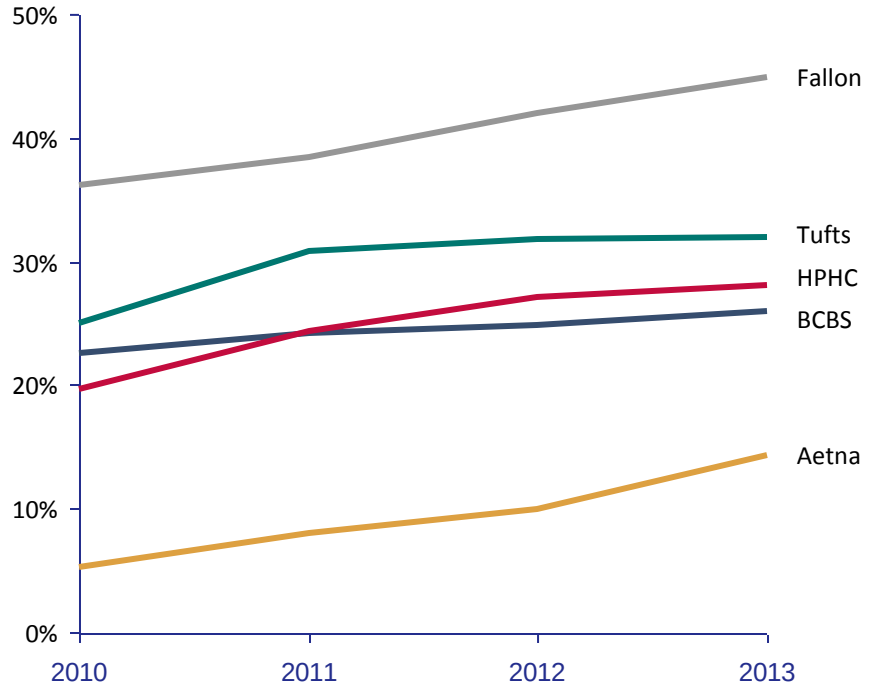
LIMITED NETWORK PRODUCTS

Enrollment in limited network products as % of total Commercial enrollment, 2010-2013



HIGH COST-SHARING PLANS

Enrollment in high cost-sharing plans as % of total Commercial enrollment, 2010-2013



Payers	BCBS	HPHC	Tufts	Aetna	Fallon
Total Commercial Enrollment 2013 (M)	1.45M	0.61M	0.34M	0.18M	0.13M

Note: Enrollment in Tufts Health Plan limited network products does not include enrollment in Commercial GIC limited network products
Source: Pre-filed Testimony, Sept. 2014.

The Group Insurance Commission offers state employees a range of insurance choices (including limited network plans) and information on premiums and coverage.

STATE EMPLOYEE HEALTH PLAN RATES

GIC PLAN RATES EFFECTIVE JULY 1, 2014

Compare the rates of these plans with the other options and see how much you will save every month!

		For Employees Hired *Before July 1, 2003*		For Employees Hired *On or After July 1, 2003*	
		20%		25%	
		Employee Pays Monthly		*Employee Pays Monthly*	
BASIC LIFE INSURANCE ONLY $5,000 Coverage		$1.26		$1.58	
HEALTH PLAN (Premium includes Basic Life Insurance)	**PLAN TYPE**	**INDIVIDUAL**	**FAMILY**	**INDIVIDUAL**	**FAMILY**
Fallon Health Direct Care ✓	HMO	$97.52	$232.28	$121.90	$290.35
Fallon Health Select Care	HMO	123.85	295.47	154.82	369.34
Harvard Pilgrim Independence Plan	PPO	137.94	334.77	172.43	418.46
Harvard Pilgrim Primary Choice Plan ✓	HMO	110.60	268.06	138.26	335.09
Health New England ✓	HMO	97.25	239.25	121.57	299.07
NHP Care (Neighborhood Health Plan) ✓	HMO	93.97	246.95	117.47	308.69
Tufts Health Plan Navigator	PPO	124.74	299.59	155.93	374.49
Tufts Health Plan Spirit ✓	EPO (HMO-type)	100.94	241.50	126.18	301.88
UniCare State Indemnity Plan/ Basic *with CIC** *(Comprehensive)*	Indemnity	221.55	514.95	266.39	619.20
UniCare State Indemnity Plan/ Basic *without CIC* *(Non-Comprehensive)*	Indemnity	179.31	416.97	224.15	521.22
UniCare State Indemnity Plan/ Community Choice ✓	PPO-type	92.23	219.58	115.30	274.49
UniCare State Indemnity Plan/PLUS	PPO-type	132.12	313.55	165.15	391.94

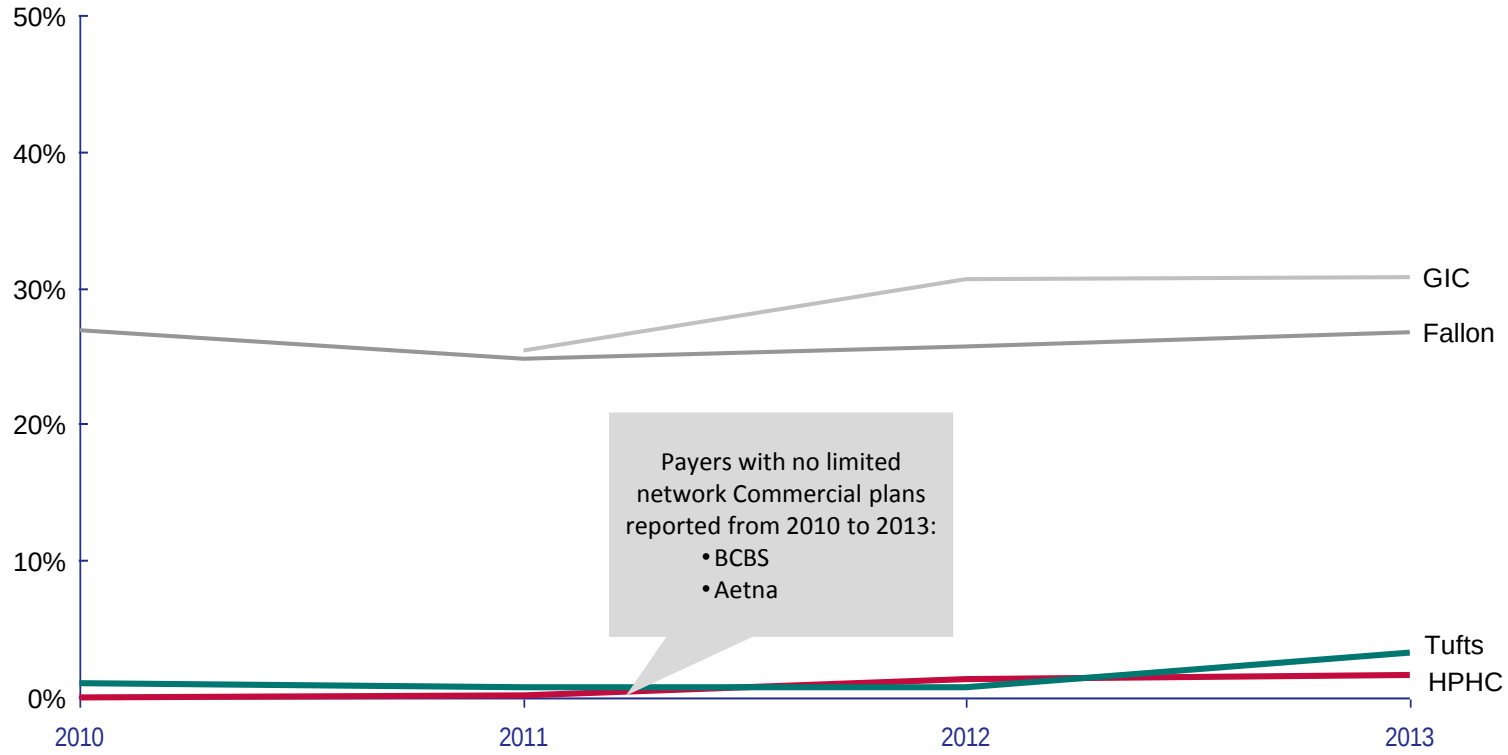
* CIC is an enrollee-pay-all benefit.

Note: Coverage information not shown.
Source: Group Insurance Commission

Although market-wide enrollment is narrow networks is low, narrow networks have 30 percent of the market among GIC members.

GIC MEMBERS ARE ABLE TO COMPARE PRODUCTS, AND 30 PERCENT CHOSE A LIMITED NETWORK PLAN

Enrollment in limited network products as % of total Commercial enrollment, 2010-2013



	BCBS	HPHC	Tufts	Aetna	Fallon	GIC
Total Commercial Enrollment 2013 (M)	1.45M	0.61M	0.34M	0.18M	0.13M	0.11M

Note: The GIC administers health benefits for state employees. It offers a choice of plans from multiple payers.

Source: Pre-filed Testimony, Sept. 2014, and GIC enrollment data.

Payers and providers stated they were complying with price transparency requirements and cited several challenges.

Experience

- Payers reported telephone and web access to price information within 48 hours.
- Providers reported a range of processes to provide price information.
- Commonly requested procedures:
  - Lab tests and imaging,
  - Mammography,
  - Pregnancy-related procedures,
  - Psychiatric evaluation / psychotherapy
  - Shoulder and knee arthroscopies
  - Colonoscopies
  - Dermatology procedures,
  - Gastric bypass,
  - Initial office visits,
  - Joint replacement
- Aetna stated that, in 2011, 60% of members requesting price information chose lower cost providers, saving on average $612 on allowed expenses and $170 on out-of-pocket costs.

Challenges

- Pricing transparency is only possible for services that are anticipated and well-defined.
- Even for these services, prices may vary unpredictably.
- Changing clinical circumstances may lead to changes in services required.
- Price transparency requires communication between payers and providers regarding the exact nature of services planned (CPT codes).
- Price transparency also requires patients' understanding precisely what services are planned.

Source: Pre-Filed Testimony, Sept. 2014.

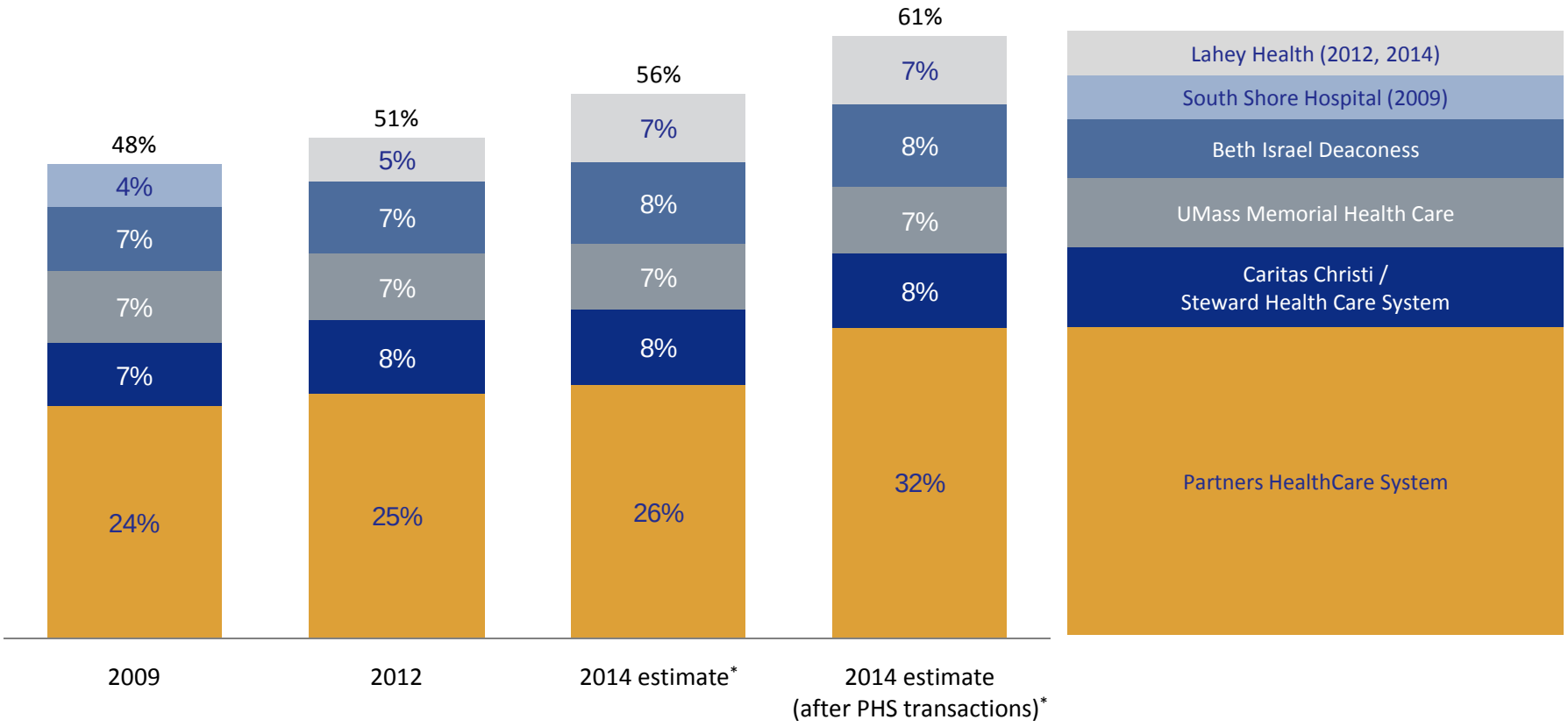
PANEL 6

PROMOTING A VALUE BASED MARKET: PROVIDER MARKET TRENDS

Inpatient concentration has increased since 2009.

CONCENTRATION OF COMMERCIAL INPATIENT CARE IN MASSACHUSETTS

Share of commercial inpatient discharges held by five highest-volume systems, 2009-2012



* 2014 data not yet available. Based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data

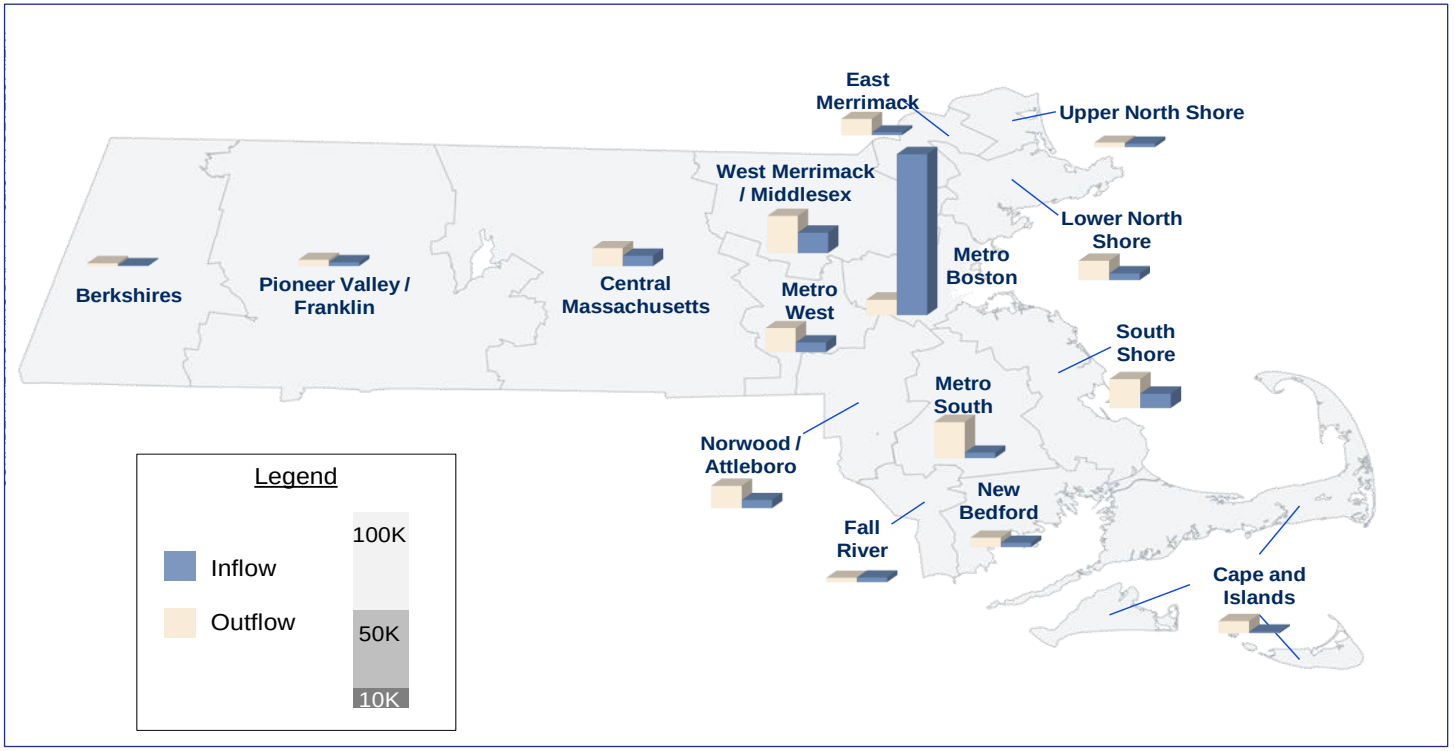
† Includes South Shore Hospital and Hallmark Health hospitals within Partners HealthCare System

Source: Center for Health Information and Analysis; HPC analysis

Many Massachusetts residents leave their home region to seek inpatient care in metro Boston.

Discharge flows in and out of Massachusetts regions, for Massachusetts residents only

Number of discharges for non-transfer volume, 2012

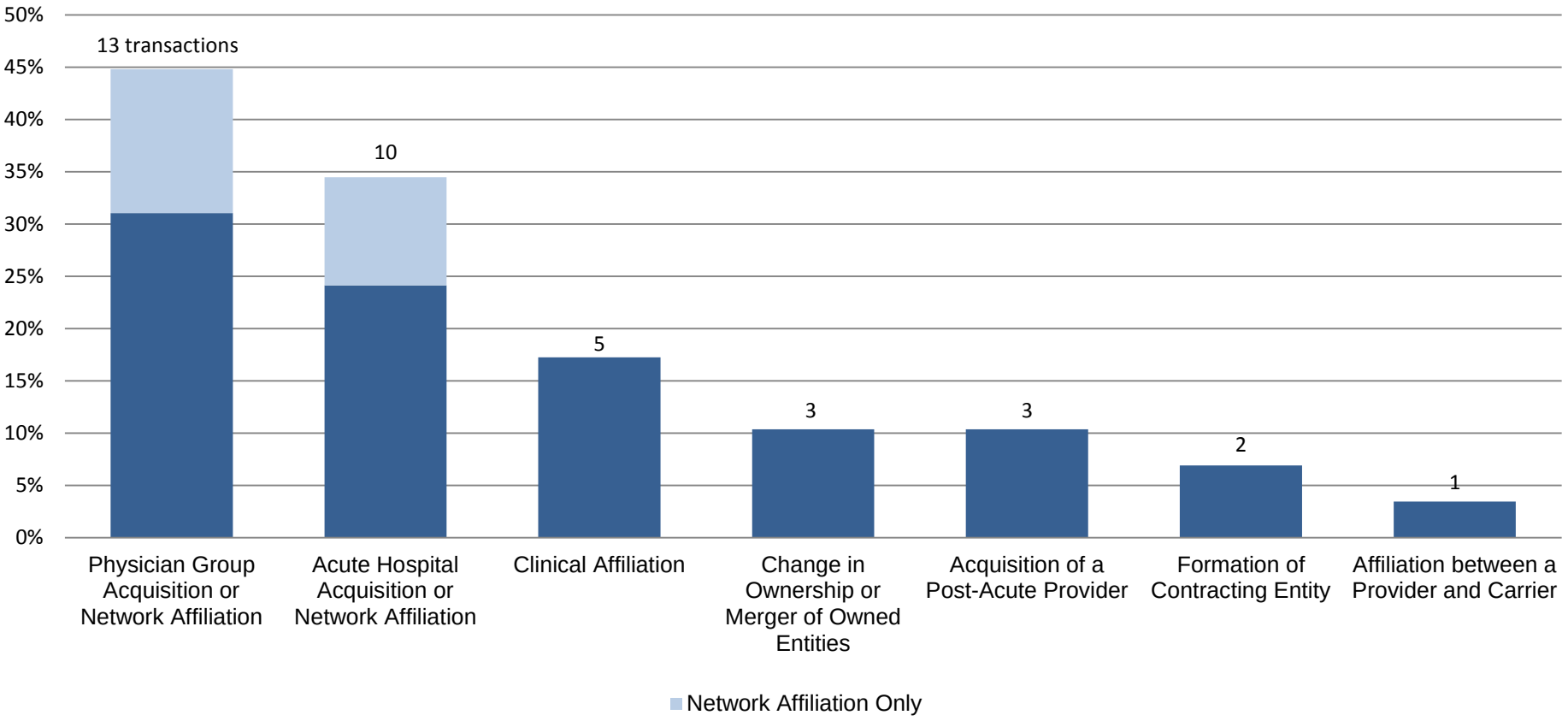


Inflow: Discharges at hospitals in region for patients who reside outside of region.
Outflow: Discharges at hospitals outside of region for patients who reside in region.

Source: Center for Health Information and Analysis; HPC Analysis.

The provider market is dynamic.
Not all models of integration and care coordination require corporate ownership.

Noticed Transactions by Type
April 2013 to Present



Percentages sum to more than 100% as some transactions are more than one type

Source: Material change notices received by HPC, April 2013-present. Represents 29 separate transactions.

PUBLIC TESTIMONY

2014 Health Care Cost Trends Hearing