# 2015 COST TRENDS REPORT


Massachusetts Health Policy Commission

# Key statistics from the 2015 Cost Trends Report

## 2015 HPC Key Findings

**$19,300**
annual health insurance premium plus cost-sharing for typical family

**1.0%**
rate of growth of commercial spending on physician and hospital services

**4.8%** rate of growth of THCE

**1.6%** percentage points due to drug spending

**3.2%** percentage points due to MassHealth (2.5 excluding drugs)

**74%**
percent of PCPs affiliated with one of the 8 largest provider systems

**$6,300**
difference in spending between Mass General and Mt. Auburn for a low-risk pregnancy

**56%**
difference in price of colonoscopy between hospital outpatient department and community setting

**~0**
change in statewide rate of discharge to institutional post-acute care, 2010-2014

**24%** statewide growth in ED visits with a primary behavioral health diagnosis, 2010-2014

**~50%** growth in behavioral health ED visits in New Bedford and Fall River

**68%**
share of HMO lives covered by alternative payment models, 2014

**2%**
share of PPO lives covered by alternative payment models, 2014

**49/57**
number of hospitals that decreased their rate of discharge to institutional post-acute care after joint replacement surgery, 2010-2014

# Legislative mandate for HPC's annual cost trends report

## Section 8g of Chapter 224 of the Acts of 2012

The commission shall compile an **annual report concerning spending trends and underlying factors**, along with any **recommendations for strategies to increase the efficiency of the health care system**. The report shall be based on the commission's analysis of information provided at the **hearings** by providers, provider organizations and insurers, **registration data** collected under section 11, **data collected by the Center for Health Information and Analysis** under sections 8, 9 and 10 of chapter 12C and **any other information the commission considers necessary to fulfill its duties under this section**, as further defined in regulations promulgated by the commission. The report shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include **any legislative language necessary to implement the recommendations**.

**Required outputs**

- **Annual report concerning spending trends and underlying factors**
- **Recommendations for strategies to increase efficiency**
- **Legislative language necessary to implement recommendations**

**Data inputs**

- **Hearings**
- **Registration data**
- **CHIA data**
- **Any other information necessary to fulfill duties**

# Agenda

- **HPC Presentation**
  - Select findings concerning spending trends and underlying factors from the 2015 Cost Trends Report
- Board Discussion
  - Significance of findings
  - Recommendations for inclusion in the final report

# Presentation themes and potential areas for recommendations

## Themes

### Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

### Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
- Primary care access

### Progress in aligning incentives

- APMs
- Demand-side incentives

## Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
- Supporting efficient, high-quality care
- Advancing alternative payment methods, cultivating alignment
- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure

# Select findings from the 2015 Cost Trends Report

## Overview of spending and the delivery system

- 2014 spending growth
- Prescription drug spending
- Hospital outpatient spending
- Trends in provider markets

## Opportunities to improve quality & efficiency

## Progress in aligning incentives

# Background

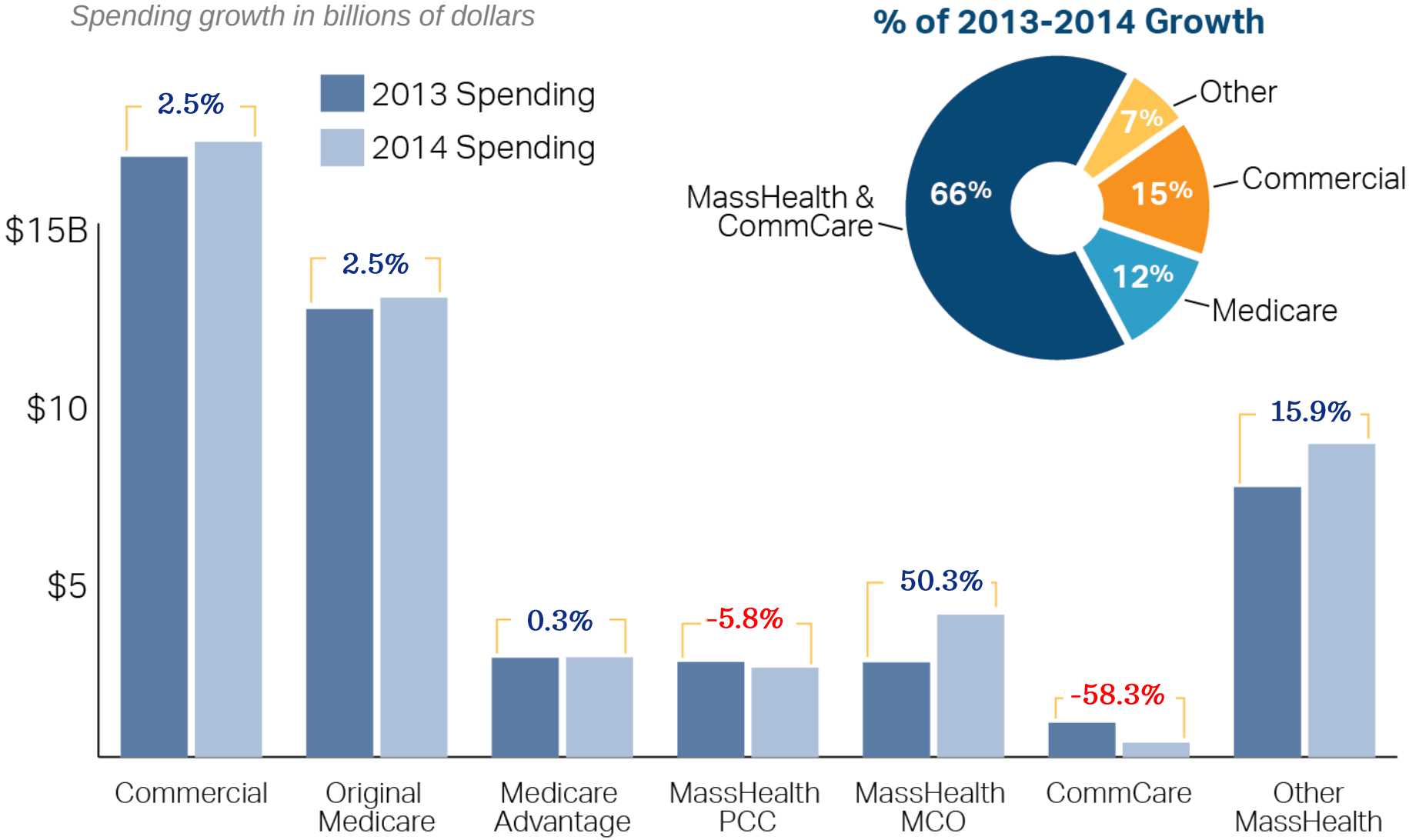
- Between 2013 and 2014, health care spending per resident (THCE) grew **4.8%**, exceeding the health care cost benchmark established by the HPC by 1.2 percentage points. In 2014, THCE in Massachusetts was $54 billion or **$8,010 per resident**.

- In 2014, commercial cost of health insurance coverage increased by **2.6%**, for both fully-insured premiums (+1.6%) and self-insured premium equivalents (+3.4%), while benefit levels remained constant.

- The final analysis of 2012- 2013 found that THCE grew 2.4%, or 1.2 percentage points below the 3.6% benchmark, and below comparable national averages.

# MassHealth accounted for two-thirds of the 2013-2014 spending growth

*Spending growth in billions of dollars*





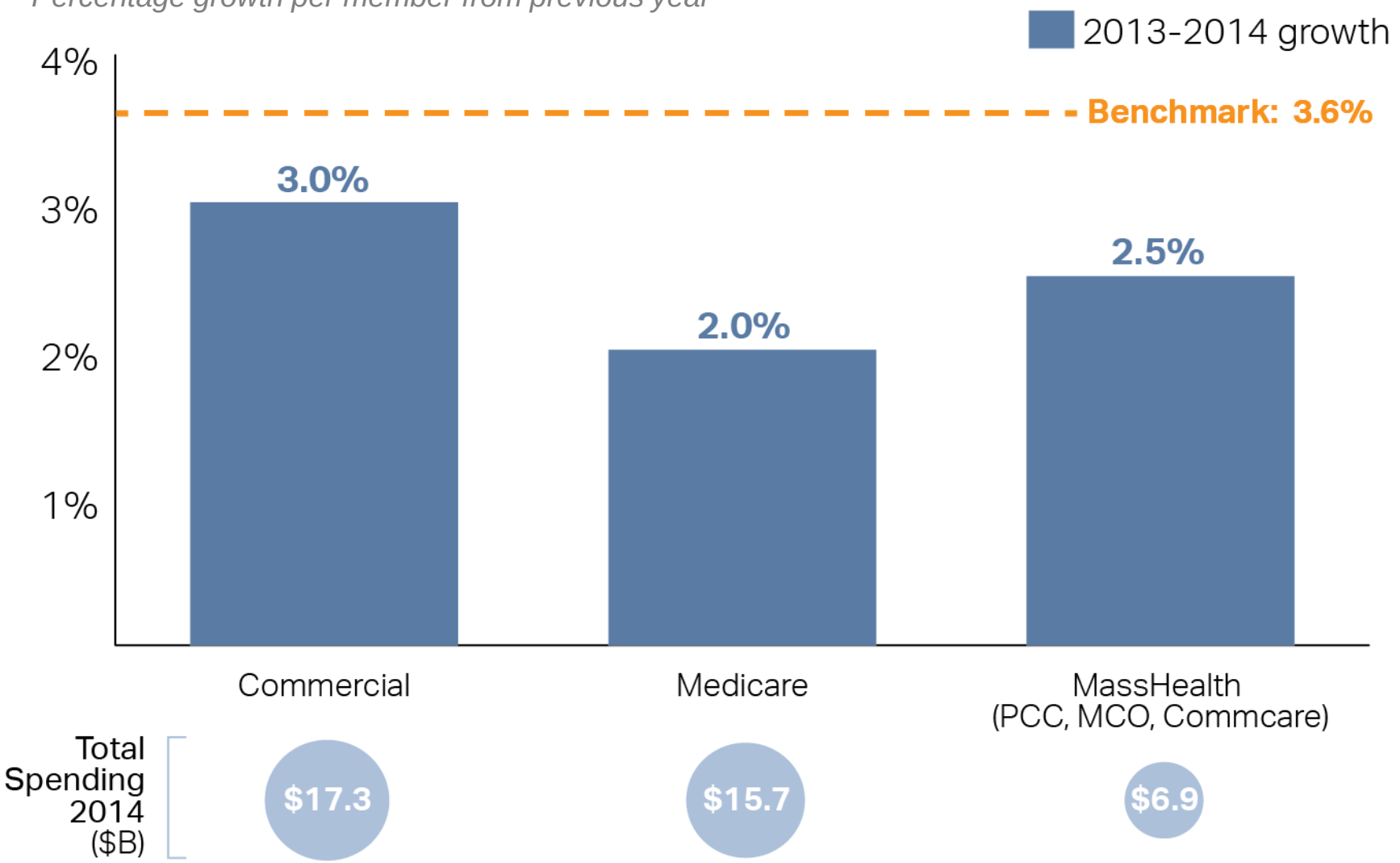


Note: Commercial spending includes reported full and partial claims data for residents insured by in-state carriers. About 600,000 residents with commercial insurance via out-of-state carriers are excluded . VA and some other minor payers not included in figure. MassHealth spending include all spending by EOHHS agencies on behalf of MassHealth members, including pass-through claims for DMH and DDS services, supplemental payments to hospitals, etc.

Source: Center for Health Information and Analysis, Total Health Care Expenditures

# *Per enrollee*, all categories of spending grew at rates below the benchmark

*Percentage growth per member from previous year*

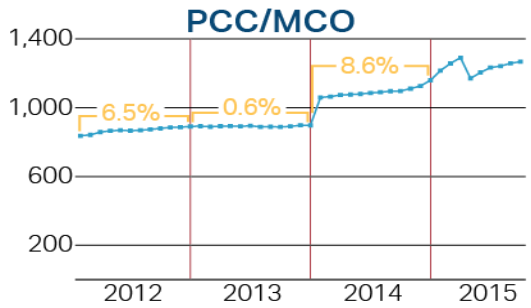


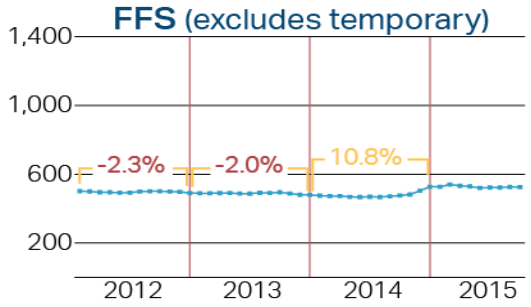

Note: MassHealth FFS not shown due to considerable enrollee flux in 2014 combined with the fact that much FFS spending is for individuals primarily covered (and already included) in the Commercial or Medicare populations

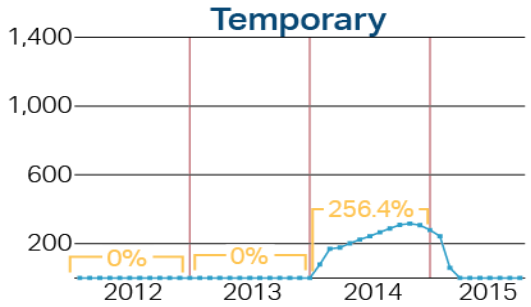
Source: Center for Health Information and Analysis, Total Health Care Expenditures

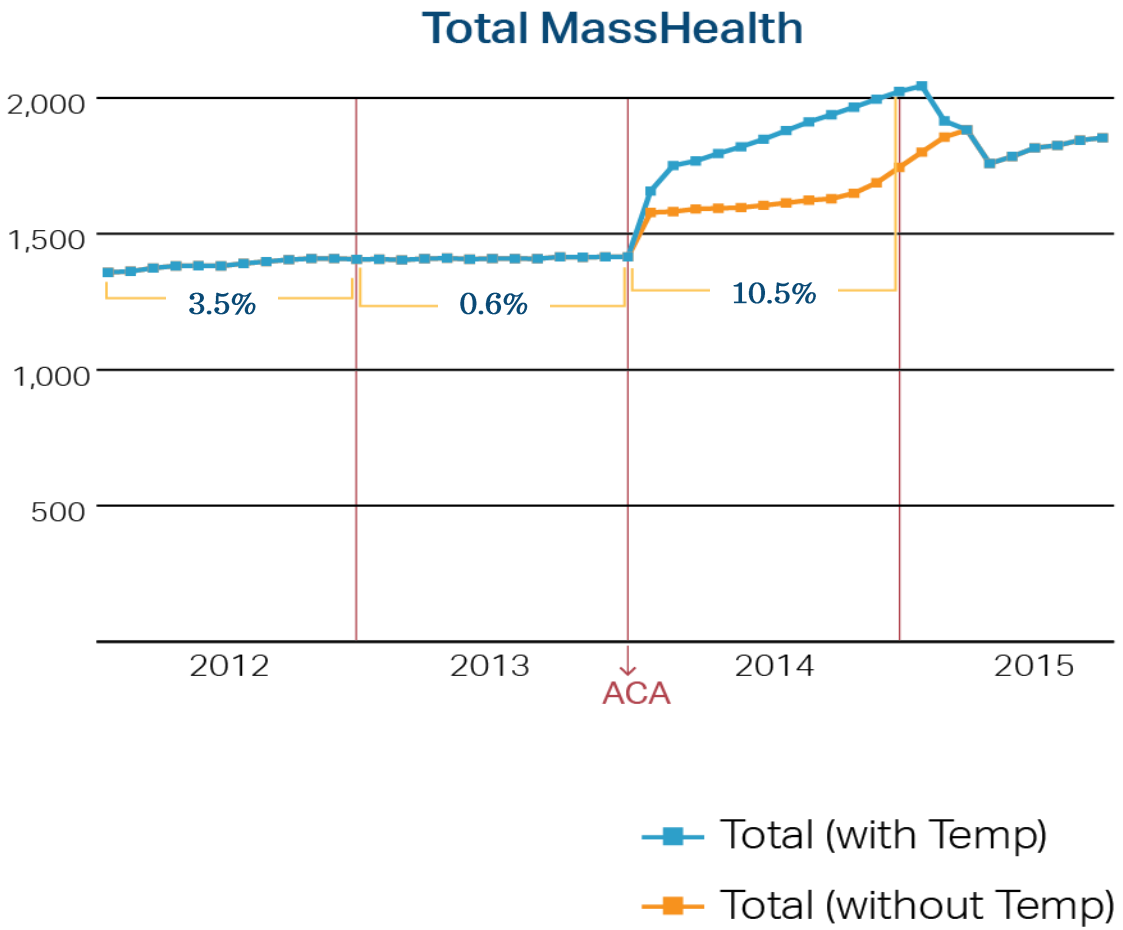
# Baseline trends, the ACA, and a temporary program for 2014 Connector applicants all contributed to significant MassHealth enrollment growth

*Enrollment (thousands)*



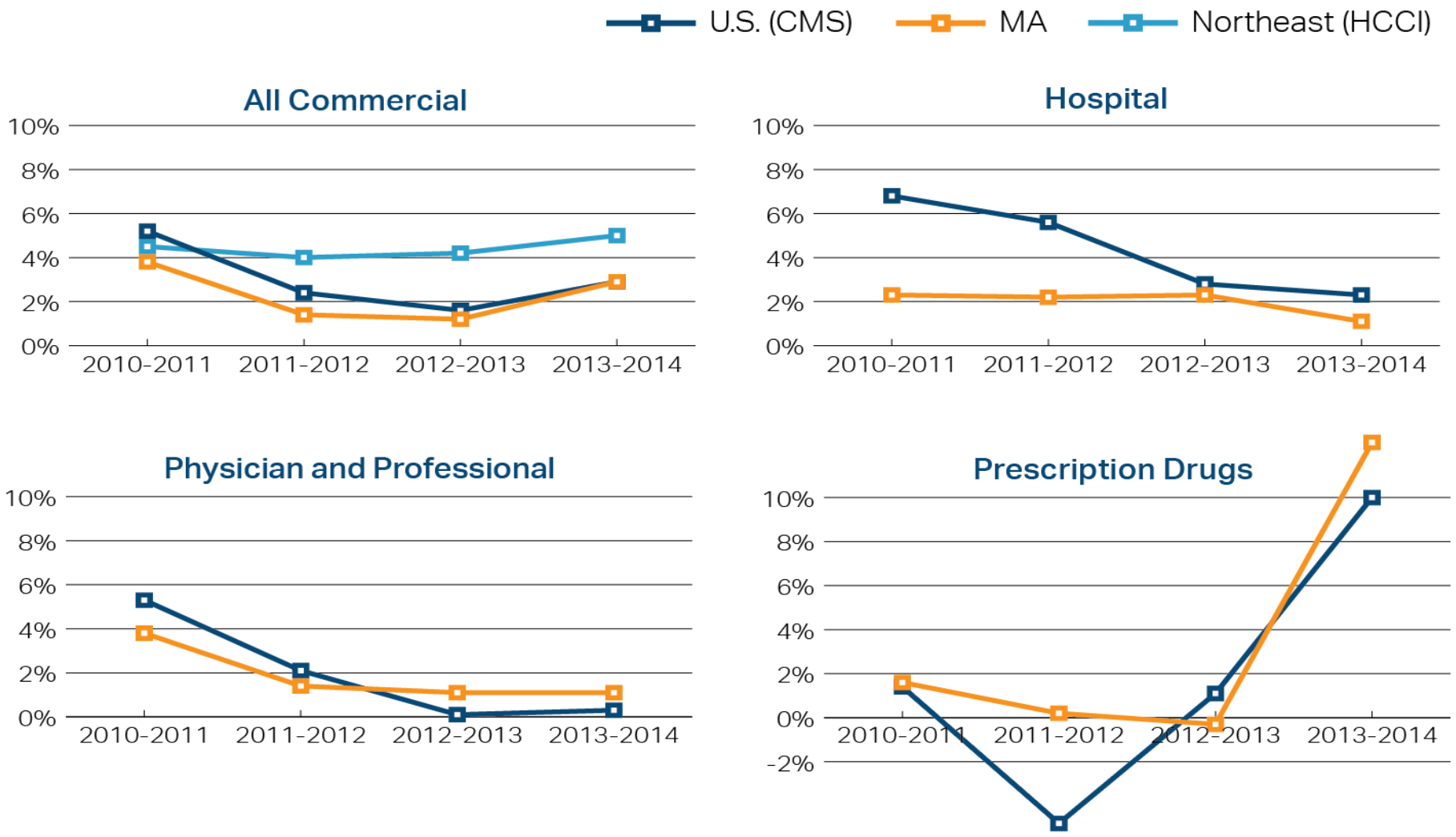




Note: The MassHealth Enrollment Snapshot and THCE define MassHealth enrollment differently. Approximately 2.4 million members months for individuals enrolled in the Health Safety Net, Children's Medical Security Plan, and DMH-only as well as CommCare-unenrolled are included in THCE but not the Enrollment Snapshot

Source: Center for Health Information and Analysis, Enrollment Snapshot

# Commercial spending growth remained low in each category of spending with the exception of prescription drugs

*Annual spending growth per member*

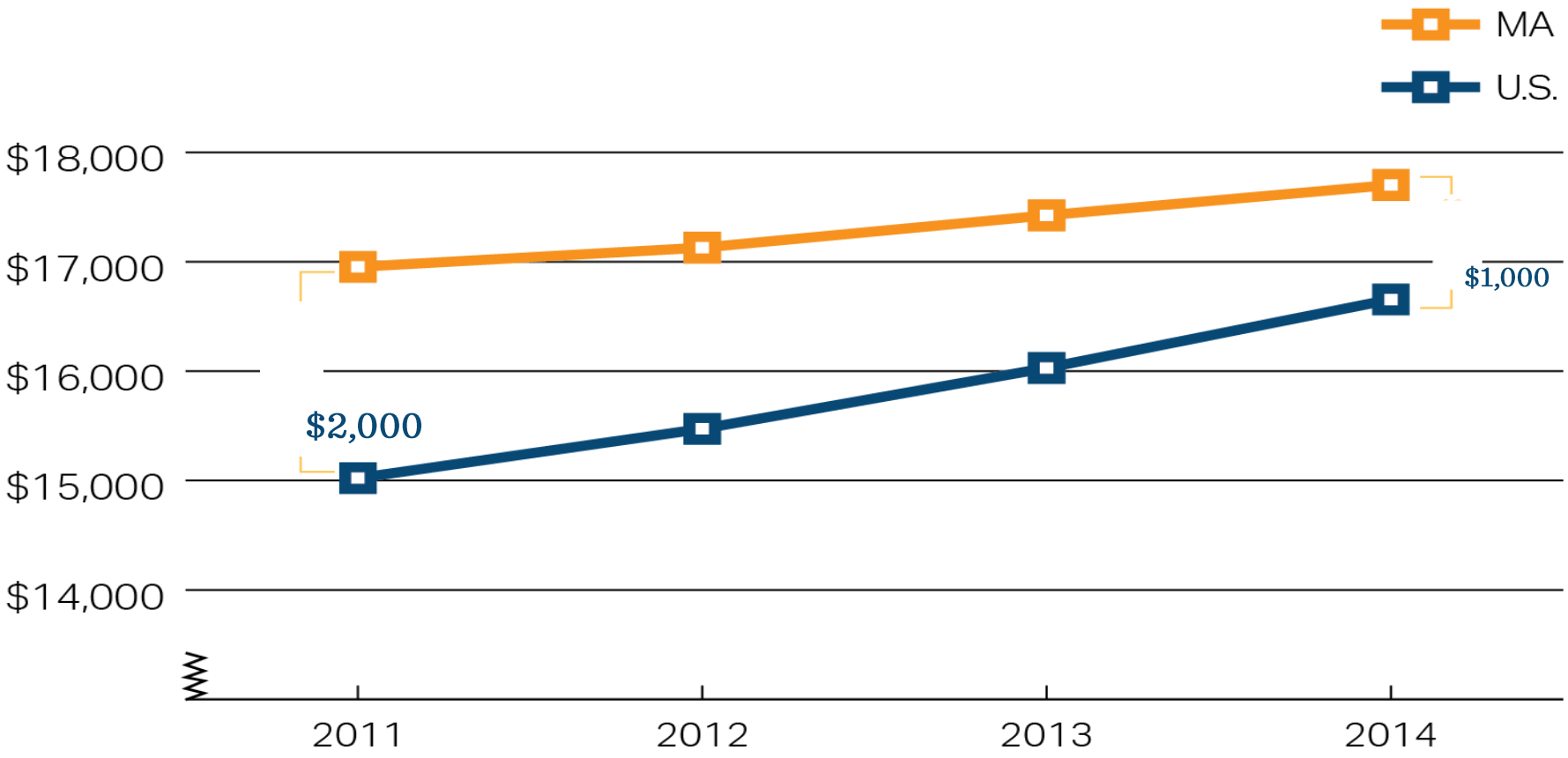



Note: Massachusetts data are for full-claims only. Drug spending figures do not account for manufacturer rebates, which affect spending level and growth

Source: U.S. Center for Medicare and Medicaid Services and Massachusetts Center for Health Information and Analysis

# As a result of continued slow commercial spending growth, Massachusetts is closing the (family) premium gap with the rest of the US

*Annual family premiums in nominal dollars, does not include cost-sharing*




Note: Data include premiums for employer-sponsored private health insurance and account for both employer and employee contributions. Figures do not include cost-sharing

Source: Agency for Healthcare Quality and Research, Medical Expenditure Panel Survey

# While premiums grew slowly, health care is still unaffordable for many

## Family employer health insurance premiums plus cost-sharing in 2014 ($19,300) were:

- Greater than the annual full-time earnings of a minimum wage worker in Massachusetts ($16,640)
- 40% of the annual income of a family of four living at twice (200%) the federal poverty level

## Cost sharing in 2015 grew faster than premiums

- Cost-sharing (copayments and deductibles) increased 4.9% overall in 2014
- The increase was slightly higher in the individual (5.0%) and self-insured (6.5%) markets

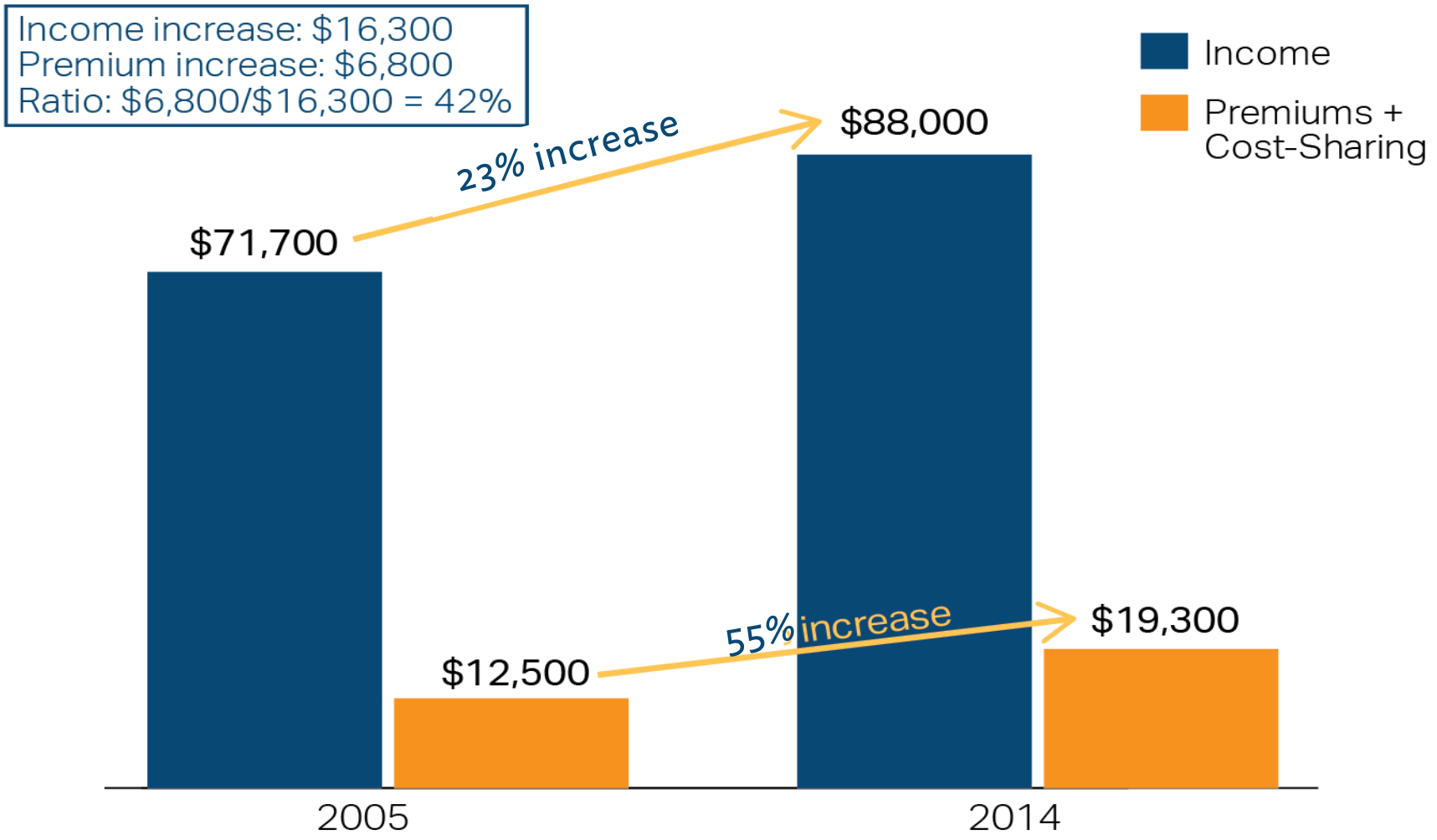
## For many, out of pocket spending and medical debt were a burden

- 19% of residents paid more than $3,000 out of pocket for health care in 2014
- 17% of residents were paying off old medical bills: 9% of those owed more than $8,000
- 16.9% residents reported an unmet need for health care due to costs

Sources: Medical Expenditure Panel Survey, Center for Health Information and Analysis (Annual Report on the Performance of the Health Care System and Massachusetts Health Insurance Survey, 2014 and 2015)

# Increases in health insurance premiums have outpaced income gains, consuming over 40% of family income growth since 2005

*Dollars in year shown*




Note: Data are in nominal dollars. Includes cost-sharing

Source: American Community Survey (income data) , Agency for Healthcare Research and Quality (premiums) , and Center for Health Information and Analysis (cost-sharing)

# Massachusetts health care spending growth in 2014

## Summary

- MassHealth spending increased by 13% and accounted for two-thirds of the 4.8%; enrollment was an important driver
  - ACA (permanent) and operational difficulties at the Connector (temporary)
- *Per-capita* spending growth for each payer category remained below the benchmark
- Commercial hospital and physician spending grew 1% per capita
- The gap between Massachusetts family premiums and the U.S. average dropped from $2,000 in 2011 to $1,000 in 2014, yet affordability problems remain for many
- While commercial spending growth was relatively low overall, there were increases in prescription drugs, outpatient spending, and prices

# Prescription drug spending

## Background

- Prescription drug spending increased by 13% per capita in 2014. This category of service, across all payers including MassHealth, accounted for 1.6 percentage points of the 4.8% growth in THCE
  - Prescription drug spending accounted for 13.5% of THCE in 2014
  - Trends in Massachusetts mirror U.S. growth of 12% per capita between 2013 and 2014, after a decade of relatively low growth
  - Drug spending numbers do not include manufacturer rebates

- Many similar factors drive drug spending in Massachusetts as in the U.S. overall
  - Drug prices have a national nature through pharmacy benefit management companies (PBMs), although private payers can also negotiate independently with drug manufacturers for additional rebates
  - Distribution of prescriptions by payer is similar in Massachusetts and the U.S.

Notes: THCE: total health care expenditures.

# Drivers of national pharmaceutical spending in 2014

## 1 New high-cost drugs

Sofosbuvir (Sovaldi) and other HCV drugs entered the market late 2013 and early 2014 at extremely high prices, e.g. $84,000 (list price) for 12-week treatment with Sofosbuvir

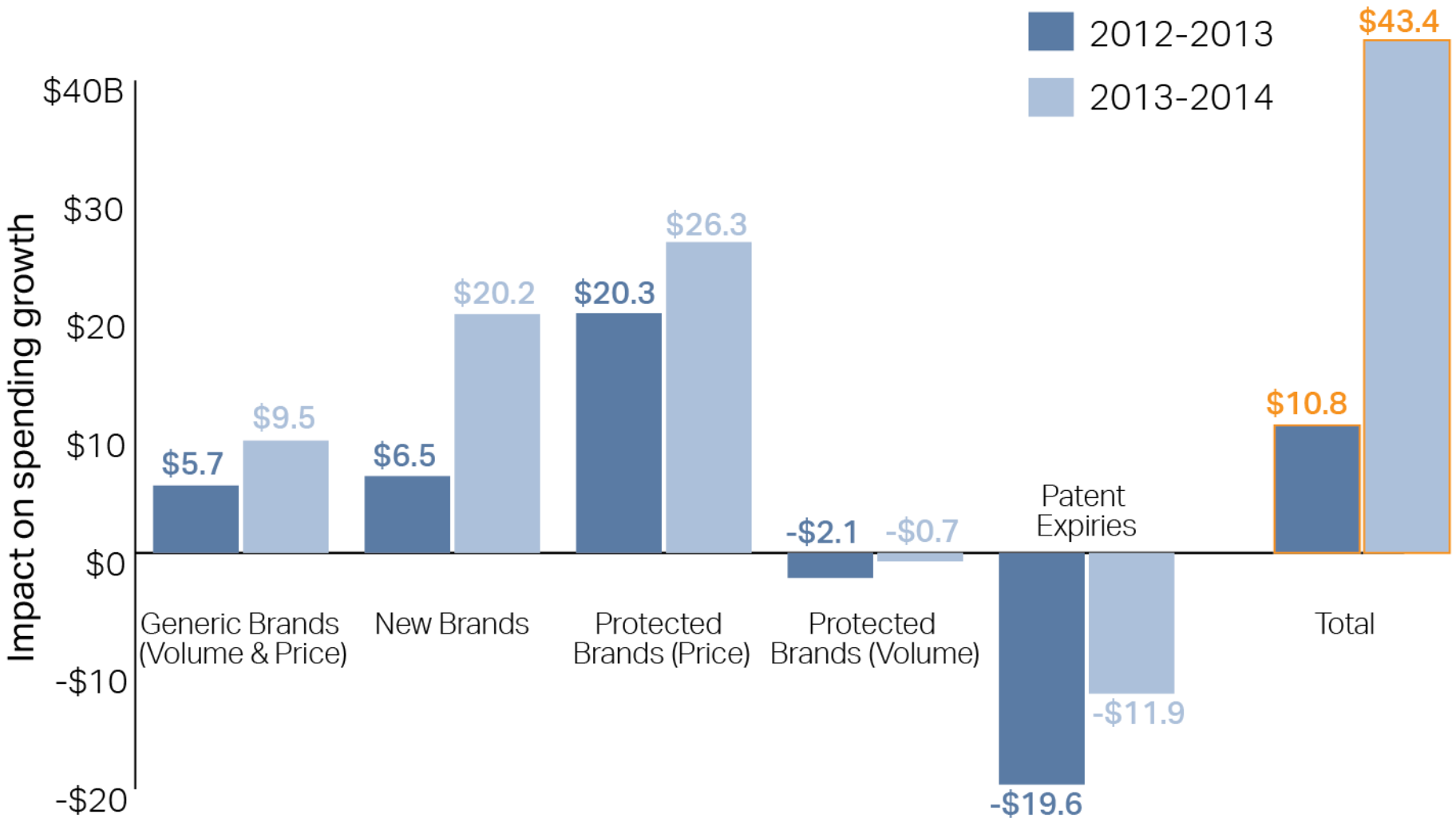
## 2 Large drug price increases

While price increases for brand-name drugs have the greatest impact on total spending, increases for some generics also impact spending and access

## 3 Low rate of patent expirations

# Many factors led to increased nationwide drug spending in 2014

*Components of U.S. spending growth for pharmacy and non-pharmacy drugs*

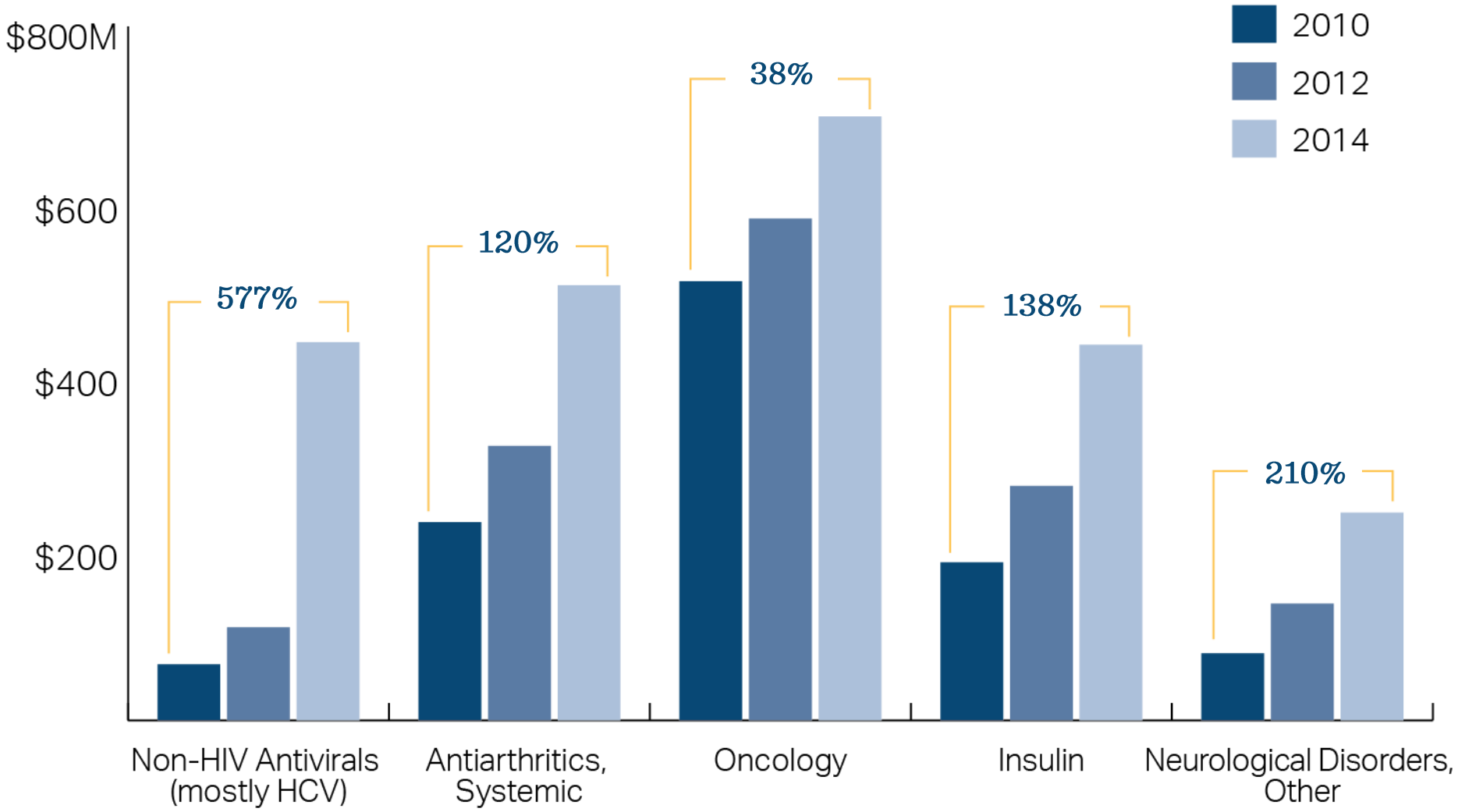



Note: Adjusted for rebates and discounts, protected brand price grew $11.8B in 2013 and $10.3B in 2014

Source: IMS, "Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014," April 2015

# In Massachusetts, growth in drug spending was driven by hepatitis C drugs, but many other drug classes also had large spending increases

*Annual spending for 5 drug classes with highest contribution to growth in 2014, millions of dollars*




Note: Drug spending figures do not account for manufacturer rebates, which could affect both level and trend of spending

Source: Data from IMS Health Incorporated

# Background

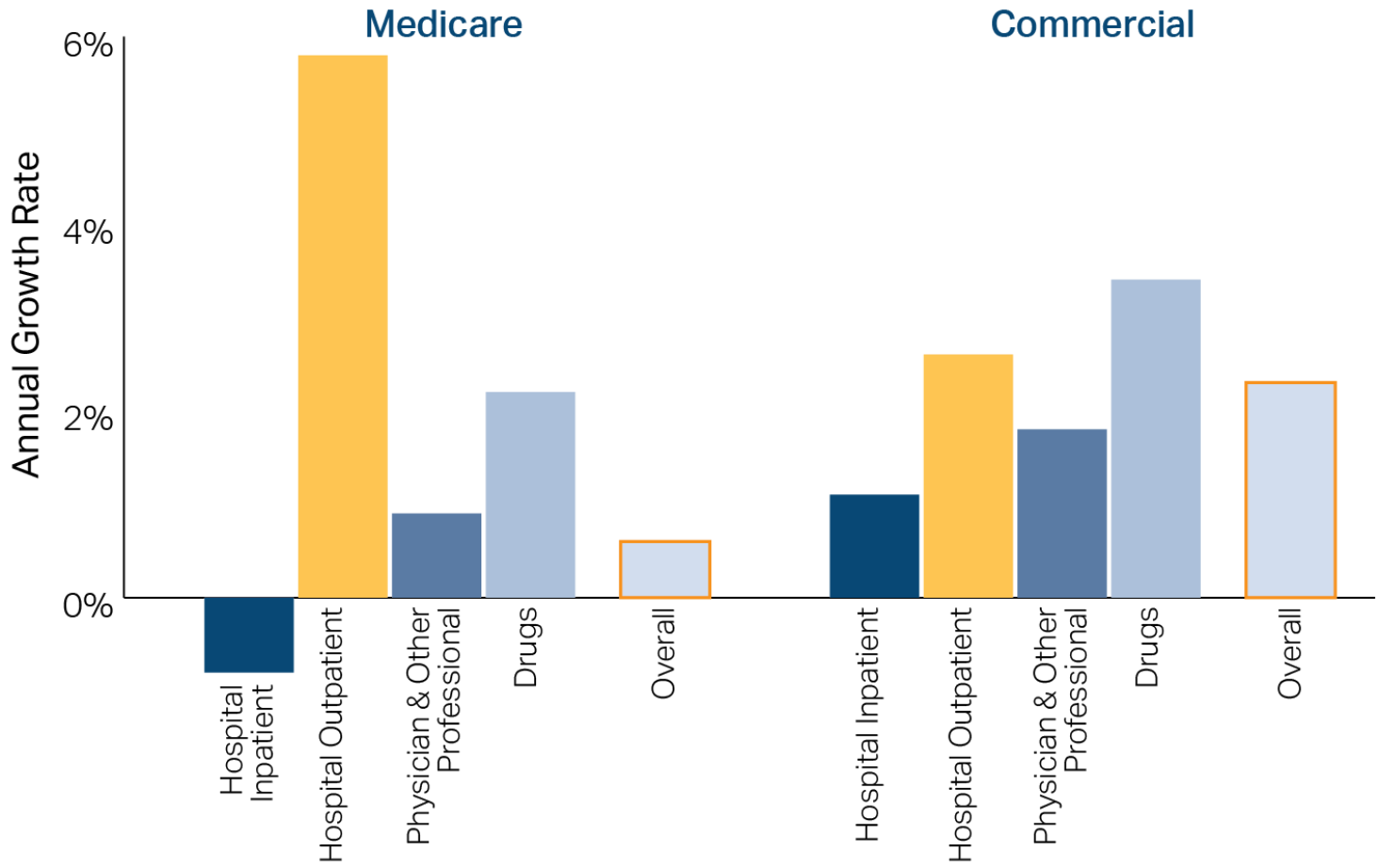
- Between 2010 and 2014, hospital outpatient spending had one of the fastest annual growth rates, for both Medicare (6%) and commercial (3%)
- In 2014, outpatient spending represented 24% of commercial spending and 15% of Medicare spending
- Our analysis compares trends in:
  - Hospital inpatient
  - Hospital outpatient
  - Community settings (non-hospital settings, primarily physician offices and freestanding facilities)

# Some services have shifted from inpatient to outpatient, while others have shifted from the community to outpatient


Prices for the same service in hospital outpatient departments are typically higher than in community settings because outpatient services charge both a professional fee and a facility fee

# Hospital outpatient spending in Massachusetts has consistently high annual growth

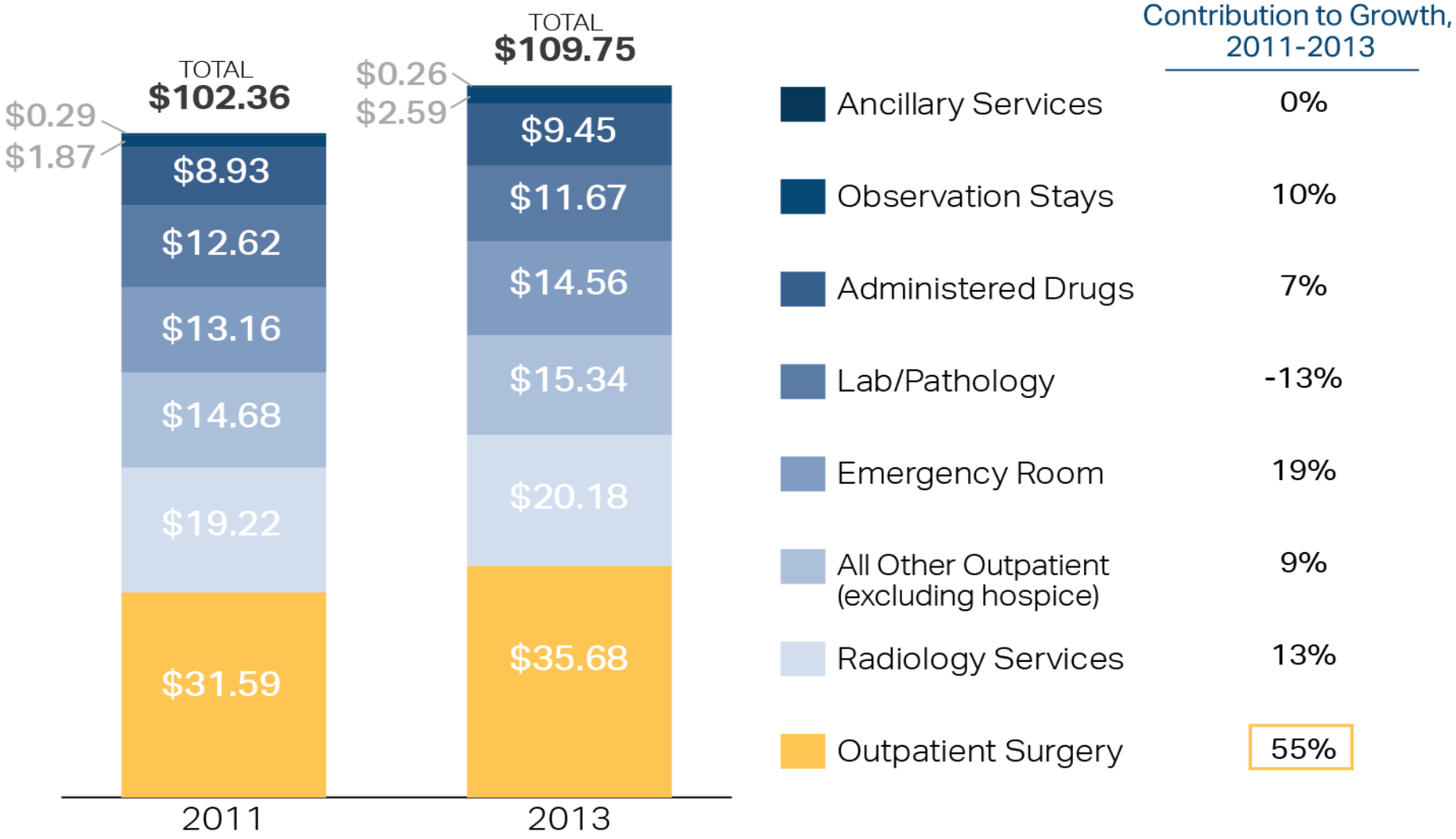
*Average annual growth rate in spending, 2010-2014, by category*




Source: Medicare Fee For Service spending data from the Center for Medicare and Medicaid Services and Commercial full-claims spending data from the Center for Health Information and Analysis and Kaiser Family Foundation, 2013

# Among commercial payers, hospital outpatient spending growth has been driven by outpatient surgery

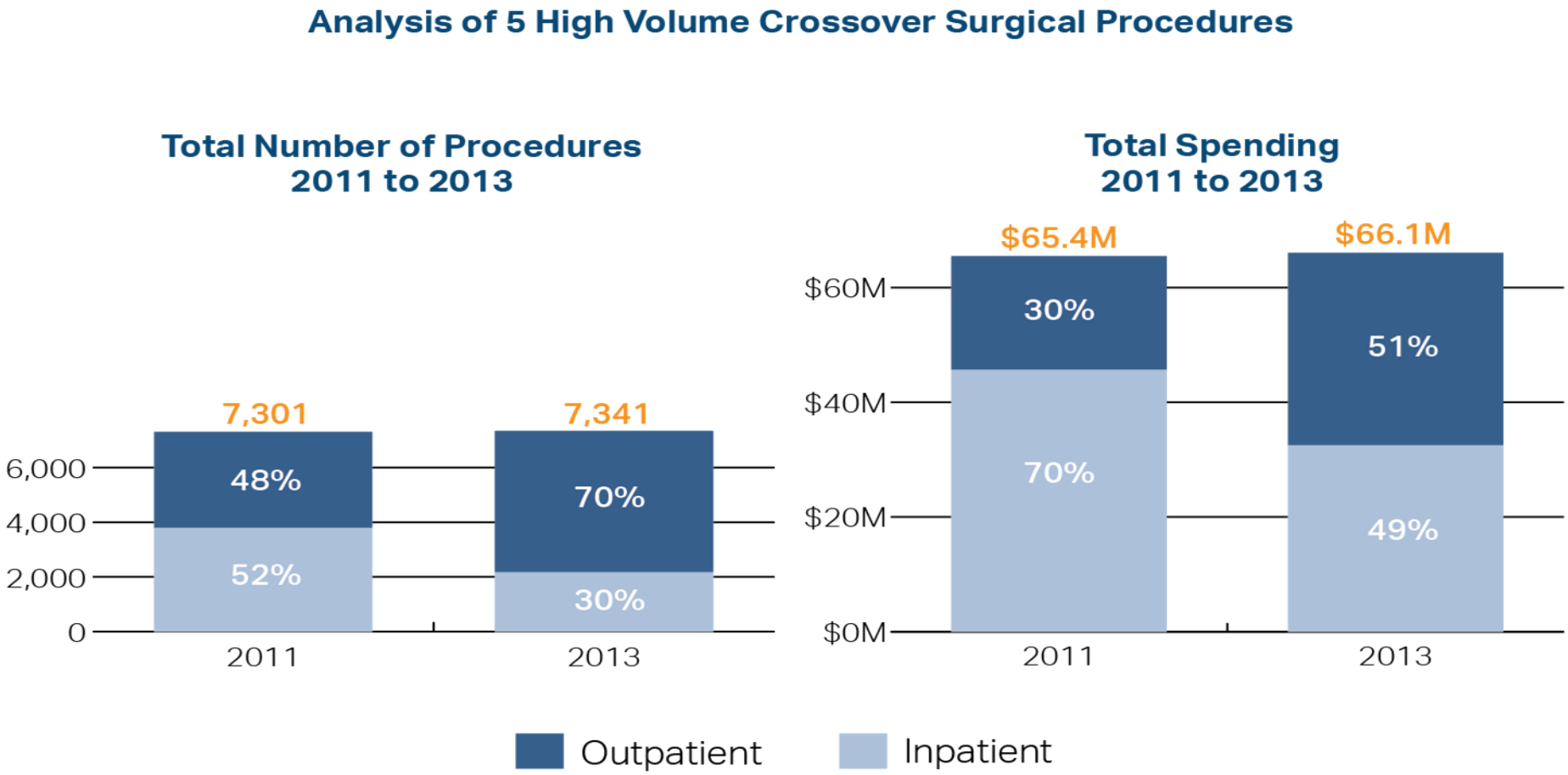
*Per member per month spending*




Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

# Changes in site of care: Procedures are shifting from hospital inpatient to hospital outpatient

*Volume and spending for laparoscopic cholecystectomy, laparoscopic appendectomy, arthrodesis, laparoscopic total hysterectomy, and laparoscopic vaginal hysterectomy, 2011 and 2013.*

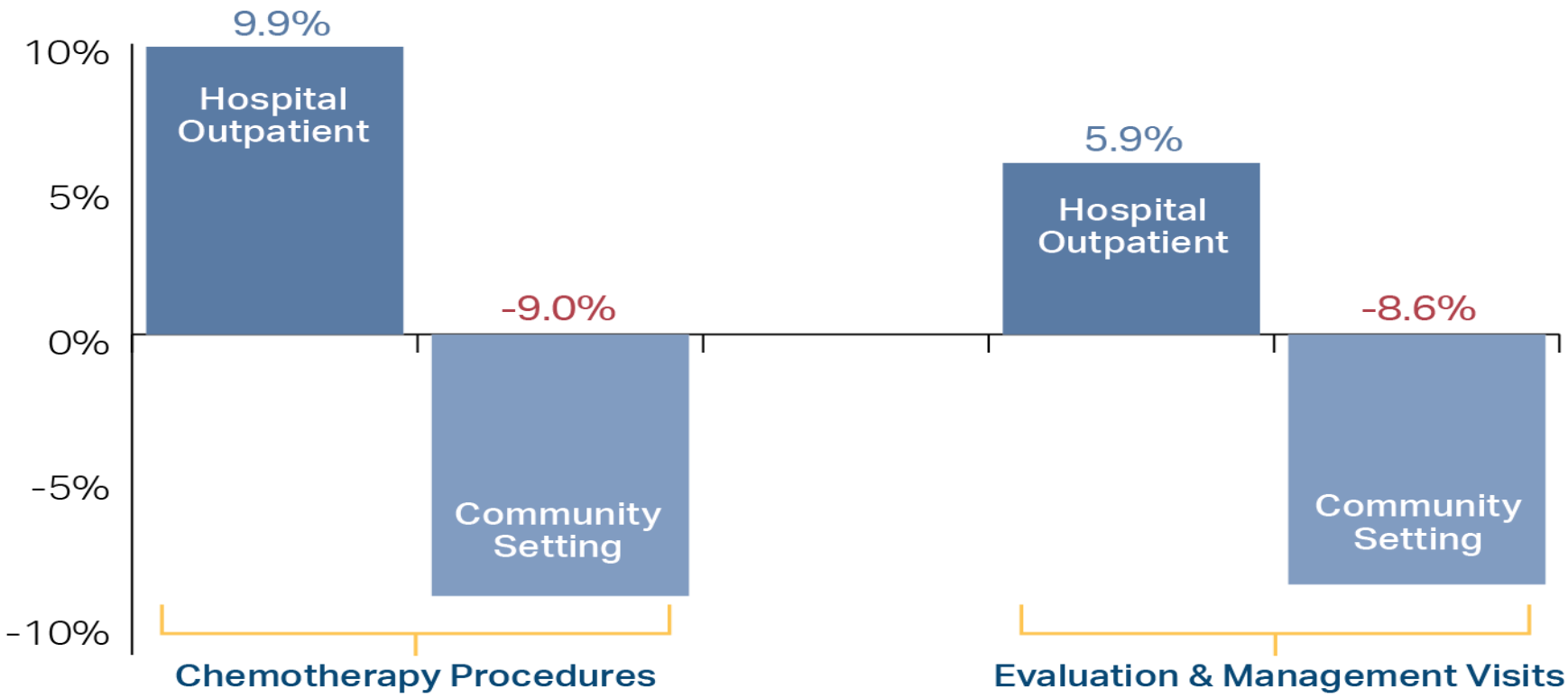



Note: The five major cross-over procedures were identified as the highest-volume procedures billed by surgeons in 2013 where at least 10 percent of the surgeries occurred at an inpatient hospital and at least 10 percent occurred in an outpatient setting. Total spending includes insurer and enrollee payments for the facility portion of the surgical procedure. Commercial FFS spending does not include capitated payments. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

# Changes in site of care: Chemotherapy and E&M visits are shifting from community settings to hospital outpatient departments

*Change in number of procedures per 1,000 member months, 2011 - 2013*



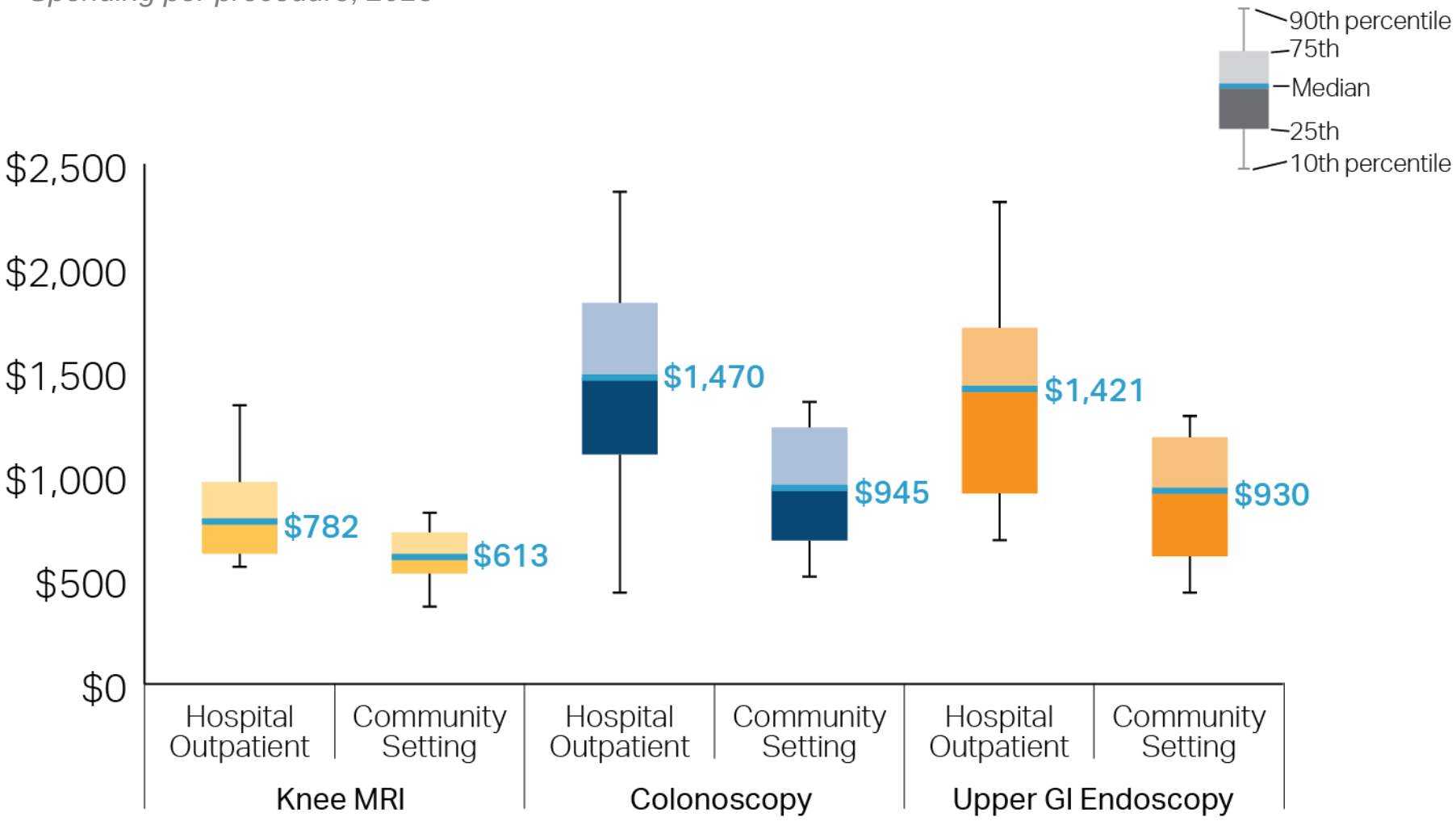

Outpatient prices are typically higher than in community settings:
for example, $298 vs $177 per procedure for chemotherapy administration in 2013*

Note: * Median price. Procedures with a missing site of service or non-community non-hospital outpatient site were excluded. Spending includes insurer and enrollee payments for both the facility and professional portion of the covered medical service, on all claim lines for the same patient on the same date with the same CPT procedure code. Commercial FFS spending does not include capitated payments. Community setting includes office, independent lab, urgent care, ambulatory surgical center, independent clinic, FQHC, public health clinic, walk-in retail health clinic, or rural health clinic. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

# For common standard imaging and diagnostic procedures, hospital outpatient departments are more costly than community settings

*Spending per procedure, 2013*

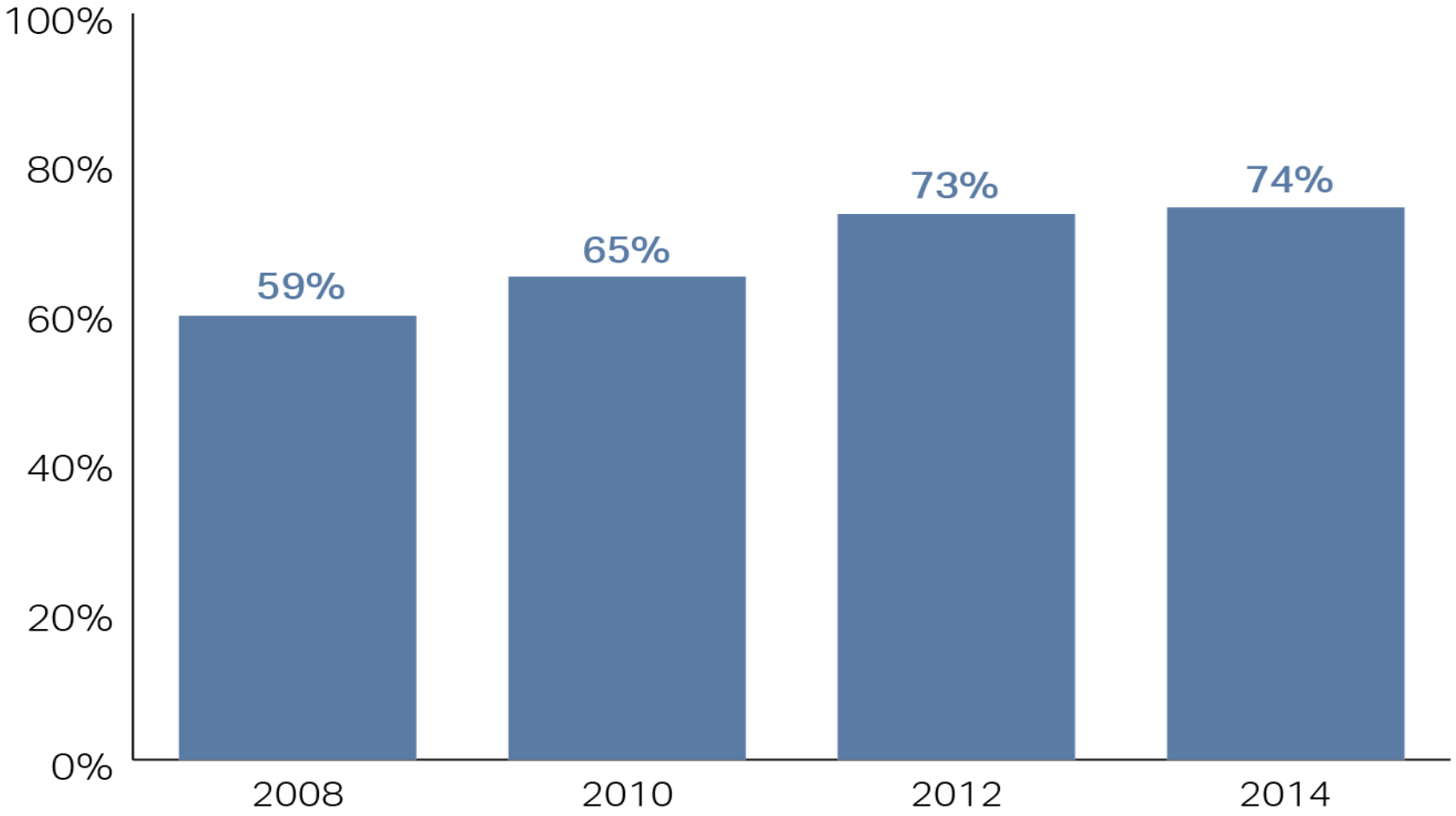



Note: Procedures with a missing site of service or non-community non-hospital outpatient site were excluded. Spending includes insurer and enrollee payments for both the facility and professional portion of the covered medical service, on all claim lines for the same patient on the same date with the same procedure code. Commercial FFS spending does not include capitated payments. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

# PCP affiliations with the 8 largest provider systems have increased in recent years

*Percentage of PCPs affiliated with one of the eight largest provider systems, 2008 - 2014*




Note: Reflects PCPs associated with Partners Community Health Care, Beth Israel Deaconess Care Organization, Steward Health Care Network, New England Quality Care Alliance, Atrius Health, UMass Memorial Health Care, Baycare Health Partners, and Lahey Health System

Source: HPC analysis of data from Massachusetts Health Quality Partners

# Drug spending, outpatient spending, and trends in provider markets

## Summary

### Drug spending

- In 2014, prescription drug spending increased by 13% per capita in 2014, accounting for 1.6% of the 4.8% growth in THCE per capita
- The 2014 spike was driven by both new high-cost drugs (including hepatitis C drugs), price increases, and a low rate of patent expirations; many trends point towards ongoing increases

### Hospital outpatient spending

- Hospital outpatient spending is the fastest-growing category of care aside from the recent spike in prescription drug spending
- Some services (e.g. surgery) have shifted to outpatient departments from inpatient departments while others have shifted from community settings.
- 56% difference in median price of colonoscopy between hospital outpatient department and community setting

### Provider market trends

- One driver of the shift from physician offices to outpatient departments may be the increasing share of physicians affiliated with large systems and the relicensing of physician offices as hospital outpatient departments

# Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

**Opportunities to improve quality & efficiency**


Progress in aligning incentives

- Variation in prices and spending among providers
- Avoidable hospital use
- Post-acute care
- Access to primary care

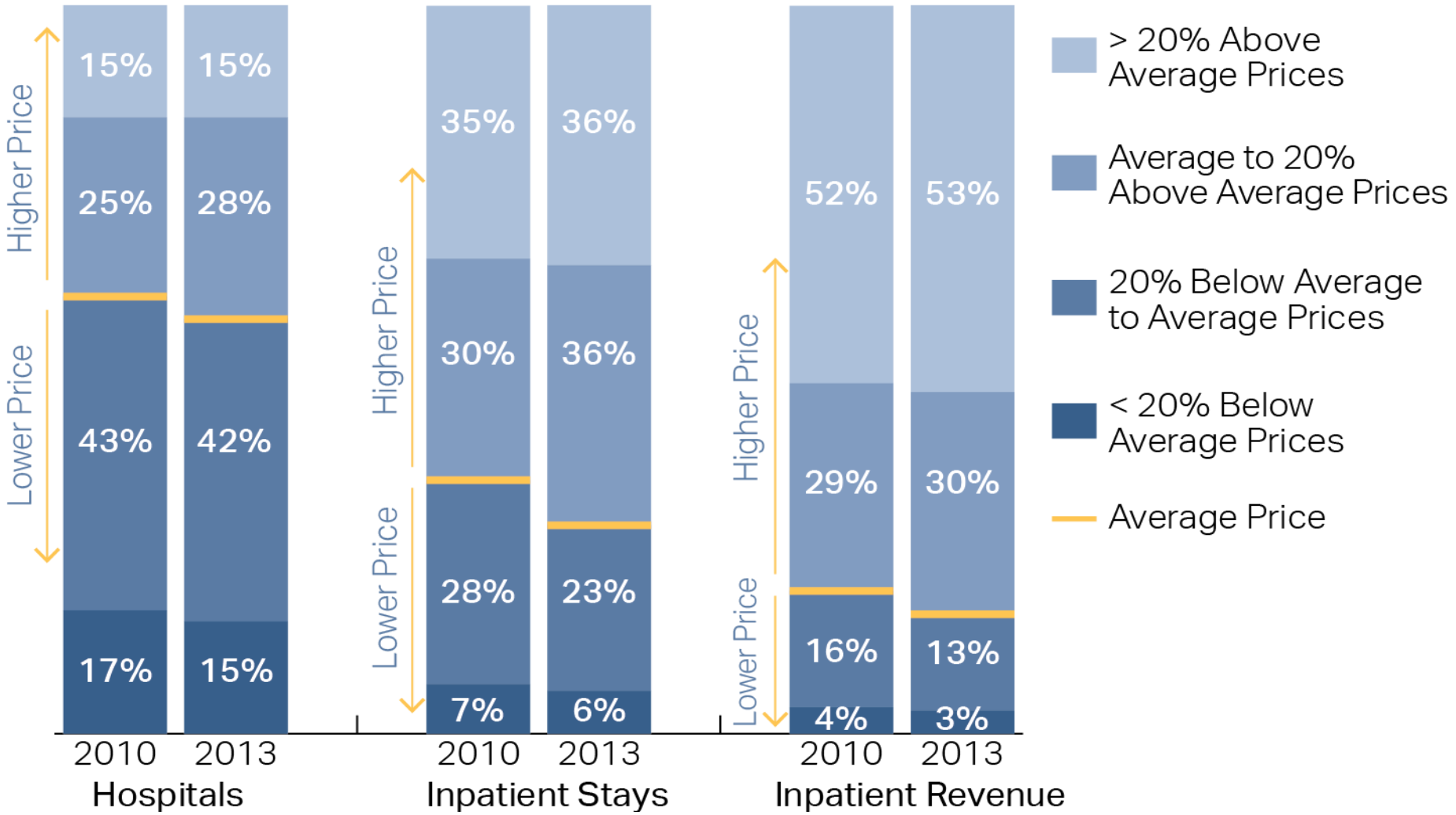
# Variation in prices and spending among providers

## Background

- Prices vary significantly among providers in Massachusetts and, in general, this variation is not related to quality
- Price variation, combined with increasing concentration of volume in high-cost providers, leads to higher spending
- In 2015 testimony, payers cited higher prices as the driver of spending growth
- Childbirth is the most common commercial inpatient procedure, accounting for one in six commercial hospital discharges

# Higher-priced hospitals continue to receive a disproportionately high share of both inpatient admissions and inpatient revenue

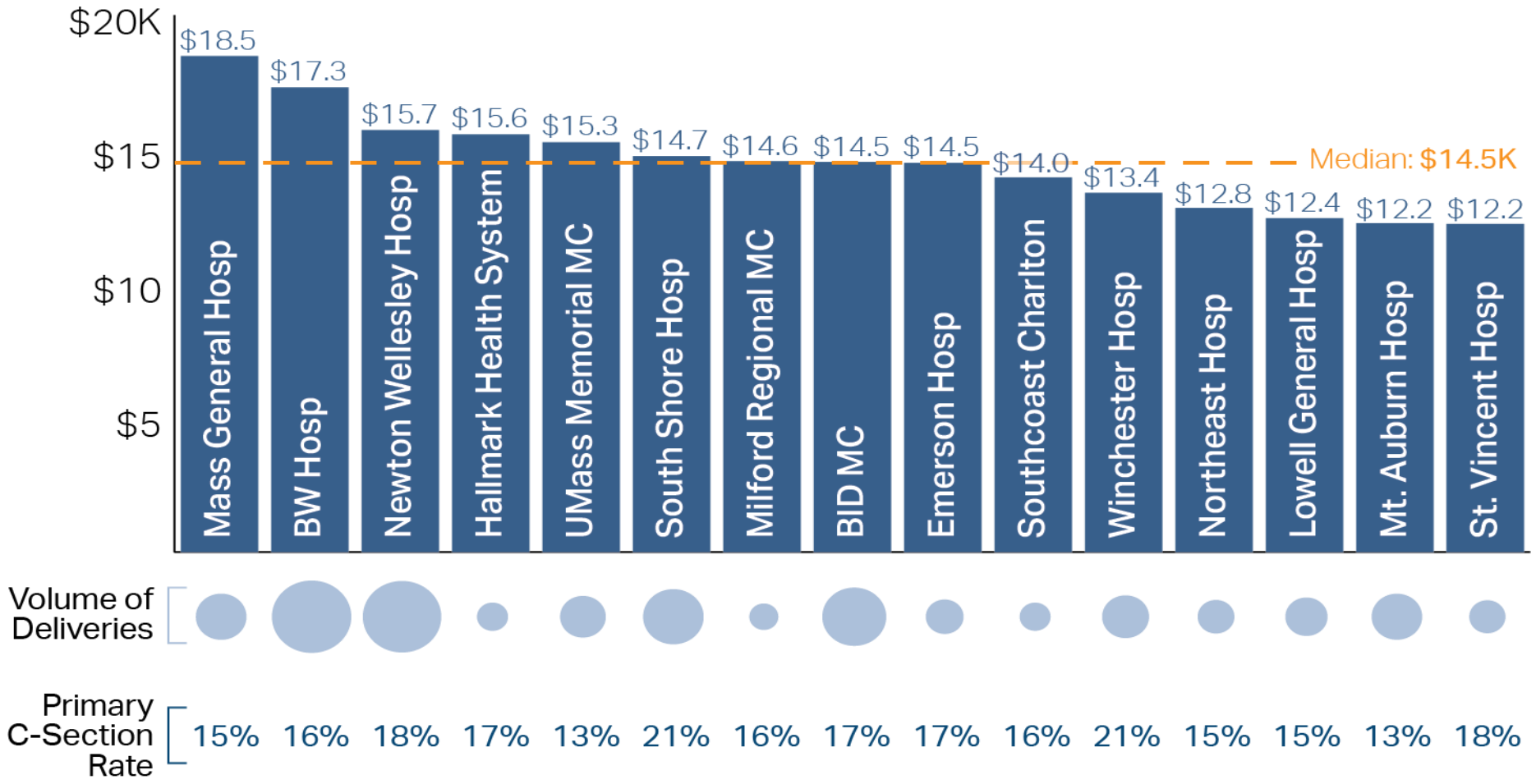
*Inpatient spending, volume and prices for Blue Cross Blue Shield enrollees*




Source: Center for Health Information and Analysis. Relative Price Data. Non-public file

# Episode spending for low-risk pregnancies varied considerably among hospitals, with volume concentrated in higher-cost hospitals

*Average total payment per pregnancy episode ($K), by hospital*




Note: Displayed are the 15 hospitals with the highest volume, which accounted for 78% of deliveries. Spending includes both vaginal deliveries and C-sections. Spending data include low-risk, commercial deliveries only, while C-section rates include all payers

Source: HPC Analysis of All-Payer Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011- 2012, HPC analysis of CHIA hospital discharge database, 2014

# Variation in prices and spending among providers

## Summary

- Price variation is not decreasing nor is it self-correcting
- Inpatient stays remain concentrated in high-priced hospitals
- For low-risk pregnancies, spending for an episode of care varied from $12,200 at the least expensive hospital to $18,500 at the most expensive hospital, with variation largely driven by the price of the procedure

# Avoidable hospital use / post-acute care

## Background

- Hospital and post-acute care (PAC) use is higher in MA than in the U.S. overall
- Avoidable ED visits make up about half of all ED visits
- Hospitals vary in discharge practice patterns
  - While the "right" level of PAC use is not clear, higher use of institutional settings shows need for focus on optimizing care delivery

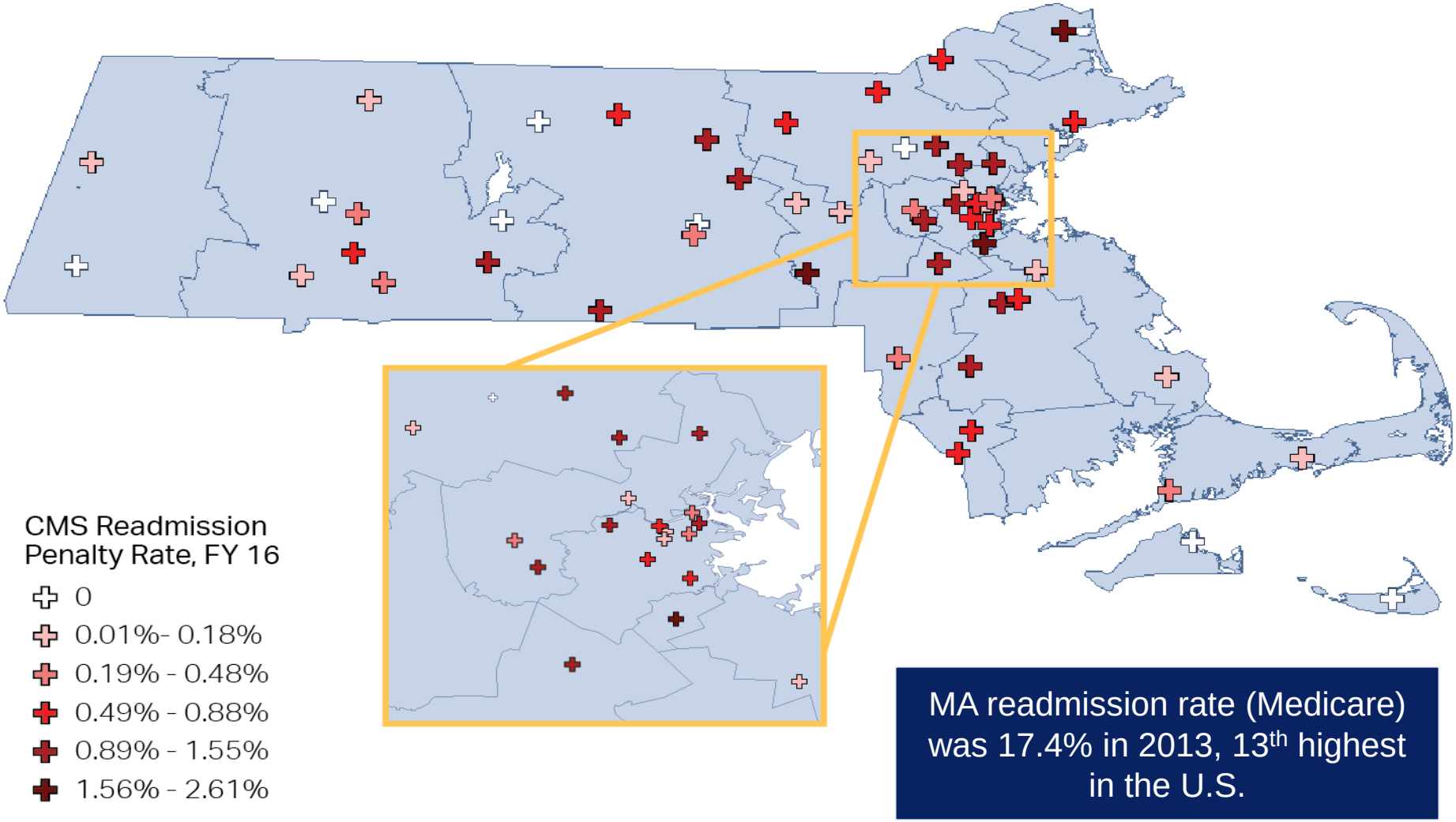
Hospital utilization in Massachusetts and the U.S., 2013 (visits per 1,000 residents)

| | MA | U.S. | DIFFERENCE (%) | RANK (1=BEST) |
|---|---|---|---|---|
| Inpatient Admissions | 118 | 106 | 11.3 | 36 |
| Outpatient Visits | 3,302 | 2,145 | 53.9 | 47 |
| ED Visits | 481 | 423 | 13.7 | 29 |

Source: HPC Cost Trends Report, 2014; Kaiser Family Foundation, accessed 2015

# Medicare will penalize most hospitals in Massachusetts in FY 2016 for high readmission rates

*CMS' FY 2016 Assessment Rate*

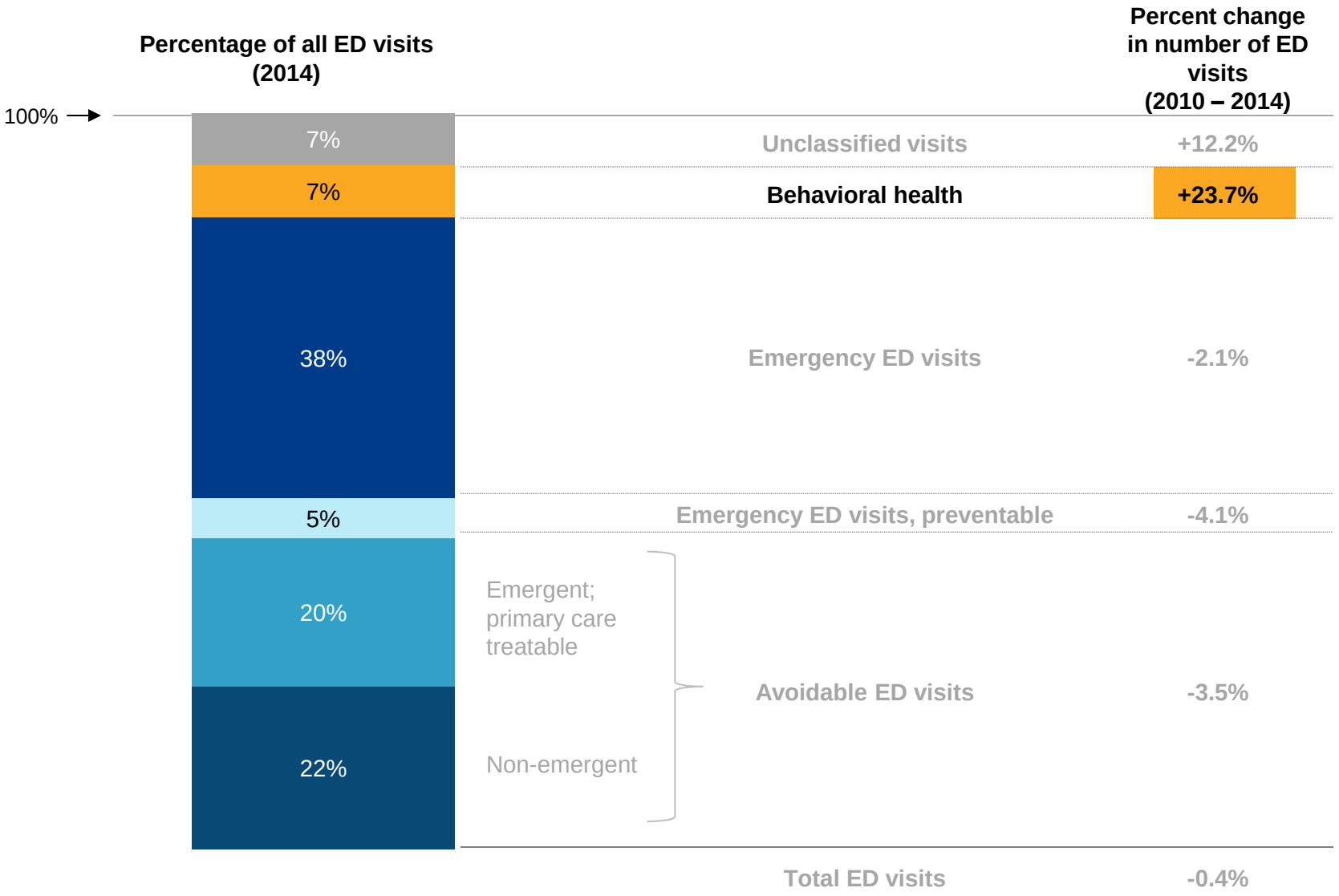



MA readmission rate (Medicare) was 17.4% in 2013, 13th highest in the U.S.

Note: Excludes Specialty and VA Hospitals

Source: Kaiser Family Foundation analysis of Centers for Medicare and Medicaid data, Institute of Medicine analysis of Centers for Medicare and Medicaid data

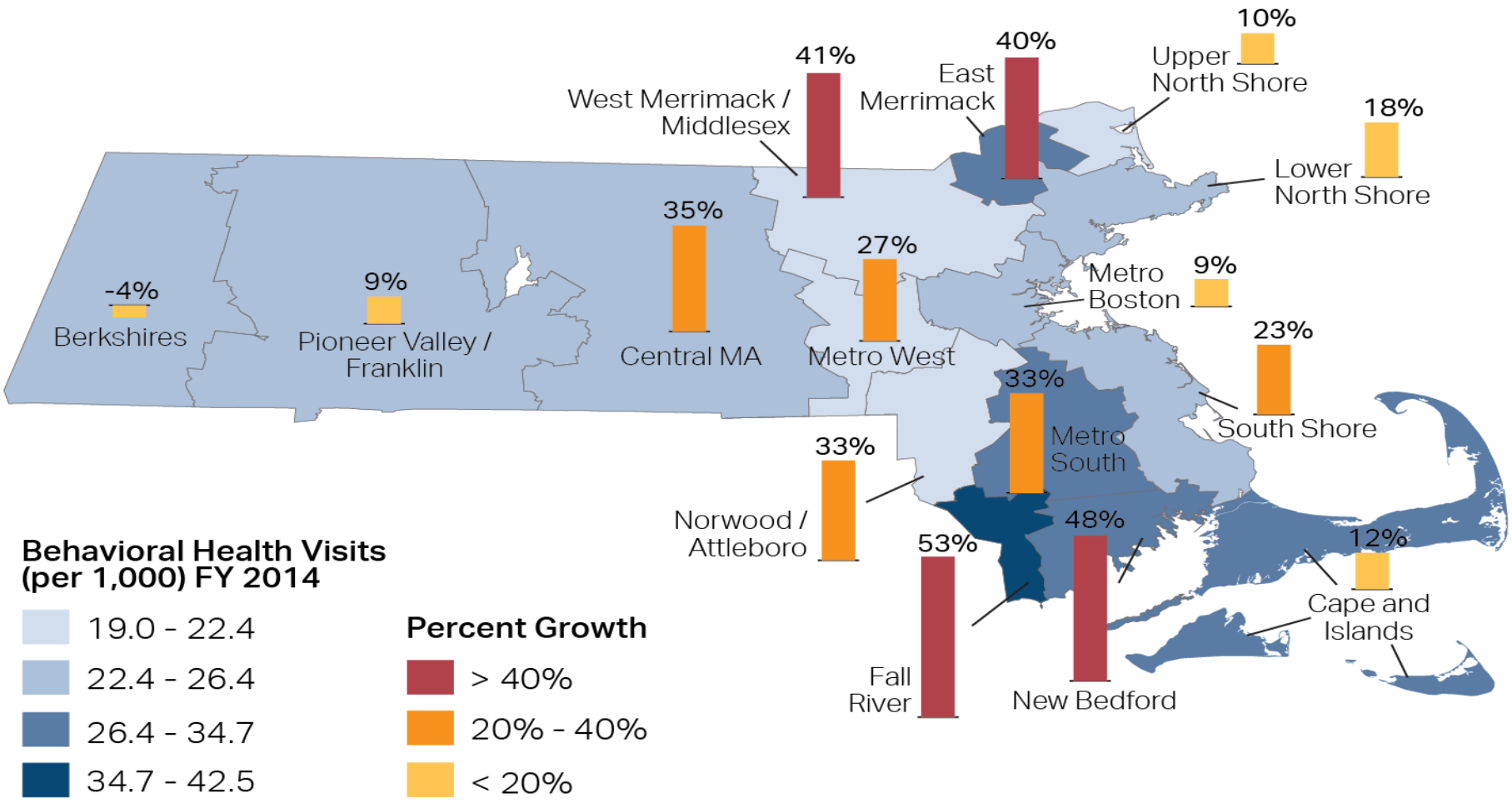
# Primary behavioral health ED visits grew significantly between 2010 and 2014




Note: Definition for avoidable ED visits based on NYU Billings Algorithm

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2014

# ED visits with a primary diagnosis of behavioral health increased sharply in a few regions between 2010 and 2014




Note: Behavioral health includes mental health and substance use disorder. All conditions are based on primary diagnosis. All rates are adjusted for age and sex

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis case mix ED database, FY2010-FY2014

# The rate of use of institutional post-acute care was roughly constant from 2010-2014, though joint replacement has been shifting to home health

| Probability of discharge, all DRGs, 2010-2014 | | | | |
|---|---|---|---|---|
| | 2010 | 2012 | 2014 | Change (percentage point) 2010-2014 |
| Routine | 58.5% | 58.9% | 57.4% | -1.1% |
| All PAC | 41.3% | 41.1% | 42.5% | 1.2% |
| *Home Health* | 20.9% | 21.2% | 21.7% | 0.8% |
| *Institutional PAC* | 20.3% | 19.7% | 20.8% | 0.5% |

| Probability of discharge, after joint replacement surgery (DRG 470), 2010-2014 | | | | |
|---|---|---|---|---|
| | 2010 | 2012 | 2014 | Change (percentage point) 2010-2014 |
| Routine | 3.8% | 3.5% | 4.7% | 0.9% |
| All PAC | 96.1% | 96.5% | 95.2% | -0.9% |
| *Home Health* | 41.5% | 46.7% | 51.0% | 9.5% |
| *Institutional PAC* | 54.6% | 49.8% | 44.2% | -10.4% |

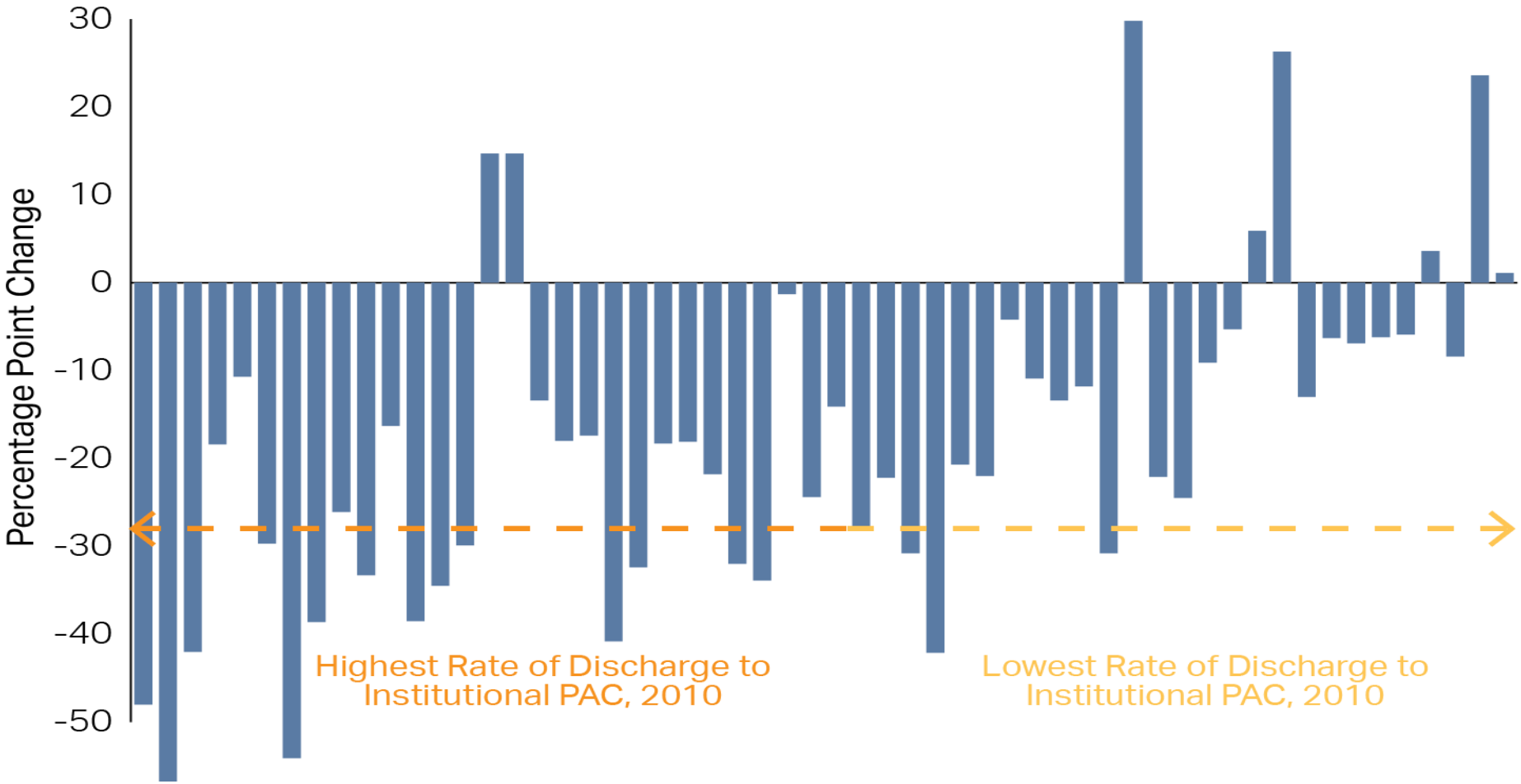
In 2012, 20% of MA patients were discharged to institutional PAC following an inpatient stay, compared to 17% to the U.S.

Note: All DRG analysis was adjusted for changes in case mix overtime

Source: HPC Analysis of Massachusetts Health Data Consortium inpatient discharge database, 2010-2014 and Healthcare Cost and Utilization Project (HCUP), 2012

# For total joint replacement, 49 of 57 hospitals reduced use of institutional post-acute care between 2010 and 2014

*Percentage point change in probability of discharge to institutional PAC, following joint replacement surgery, by hospital, 2010-2014*




Note: Adjusted for age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Sample includes only adult patients who were discharged to routine care or some form of PAC. Specialty hospitals, except New England Baptist, were excluded

Source: HPC Analysis of Massachusetts Health Data Consortium, inpatient discharge database, 2010-2014

## Summary

- Readmission rates improved slightly, but Medicare readmission rates remained worse than the national average, leading to high hospital penalties
- While overall ED use declined between 2010 and 2014, visits associated with a behavioral health diagnosis increased sharply
- Relative to the U.S., Massachusetts continued to use post-acute care at a high rate, but there were declines in institutional post-acute care use after total joint replacement

# Access to primary care

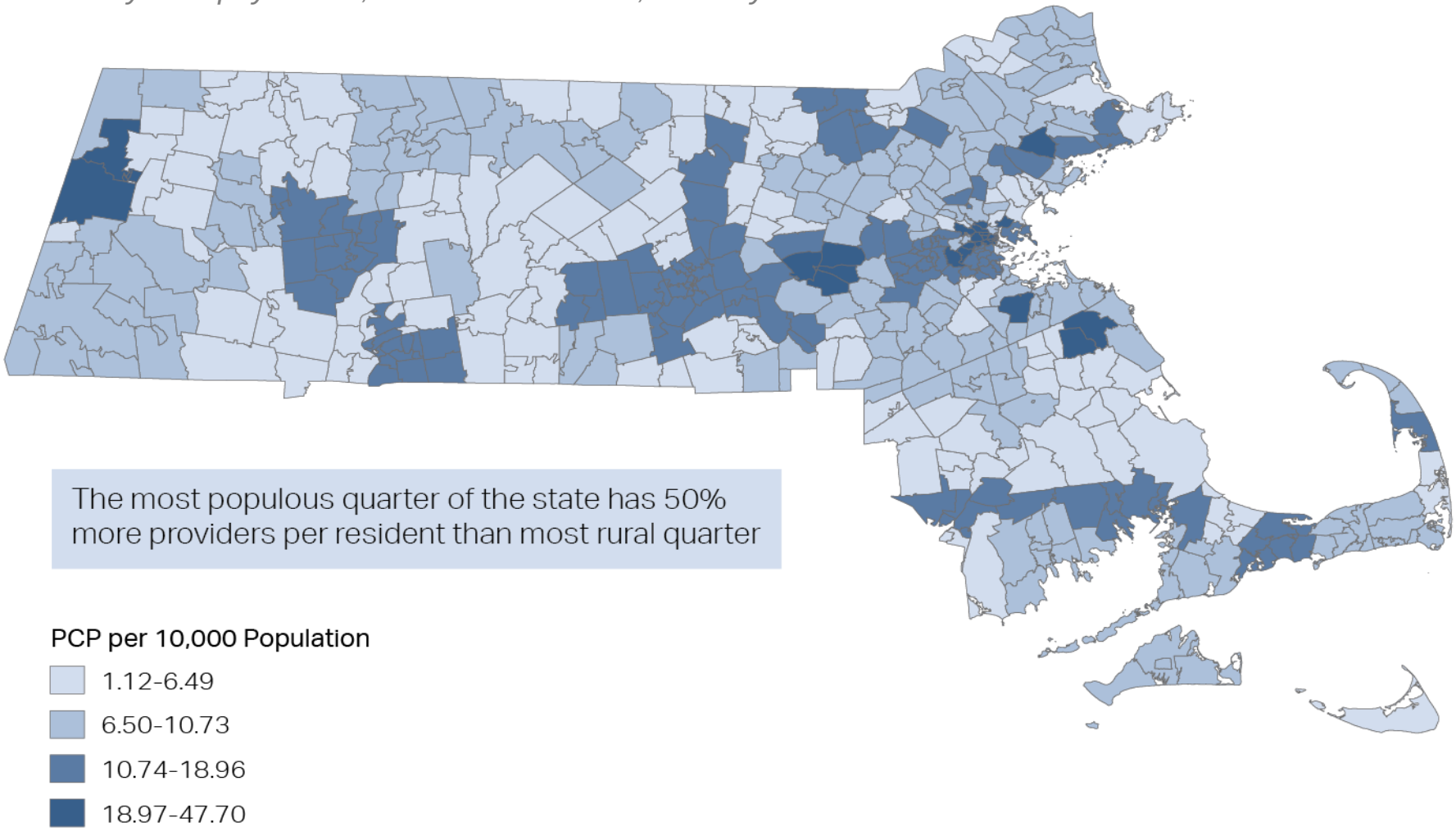
## Background

- While Massachusetts has a large number of primary care physicians, 500,000 residents live in a federally-designated primary care professional shortage area
- Primary Care Nurse Practitioners (NPs) provide care at comparable quality at lower cost than physicians, and are more likely to practice in rural areas and to serve Medicaid patients
- Scope-of-practice restrictions are anti-competitive, hinder NP cost-effectiveness, add layers of unnecessary bureaucracy and can disrupt care
- Research has linked removal of such restrictions to greater NP supply and improved access to primary care

Source: Health Resources and Services Agency, Designated HPSA statistics, 2015

# There is substantial variation in primary care providers per resident across Massachusetts

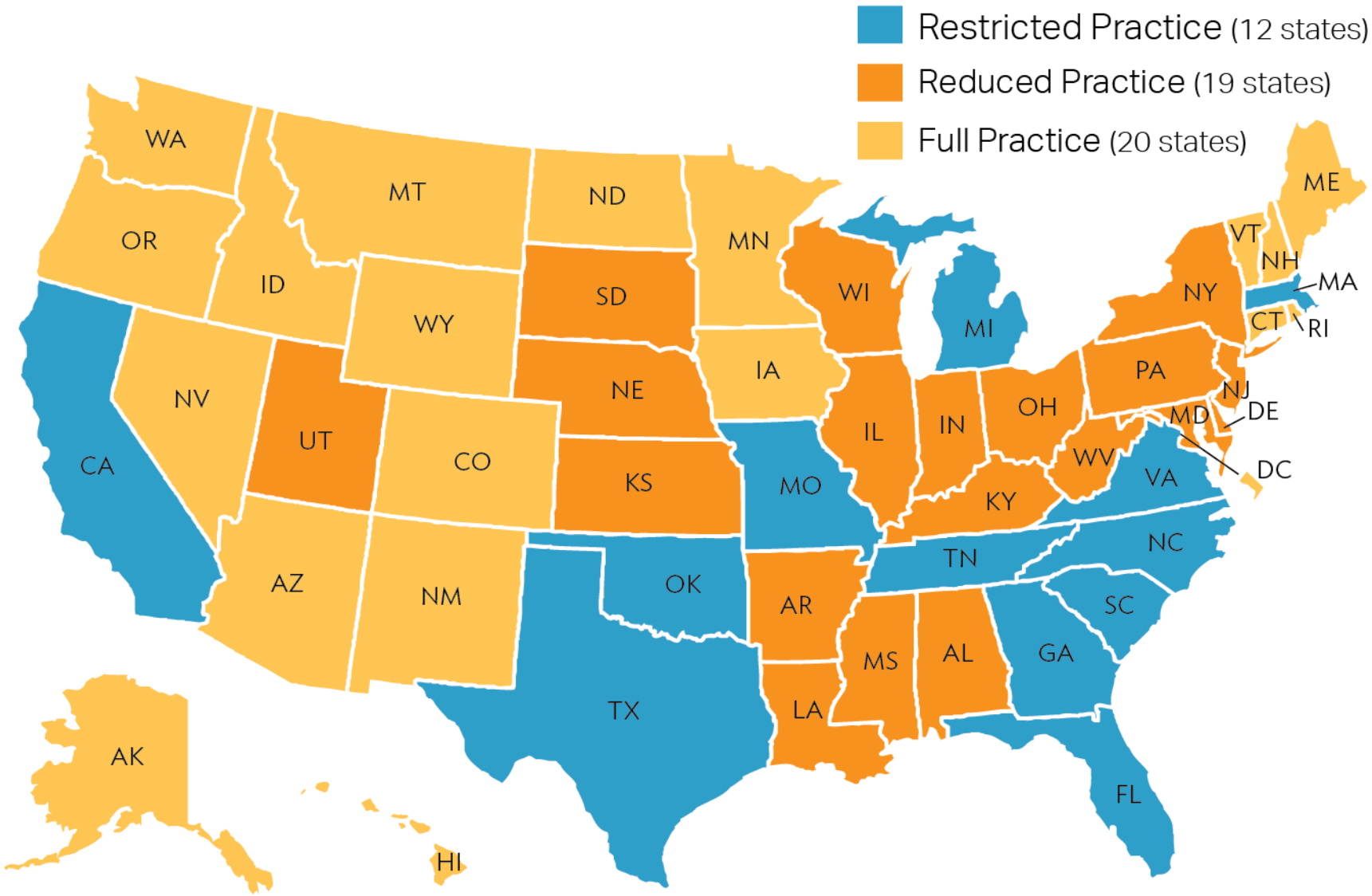
*Primary care physicians, Nurse Practitioners, and Physician Assistants*




Note: Massachusetts is divided into 158 regions called Primary Care Service Areas (PCSAs). These areas were developed by researchers associated with the Dartmouth Atlas and represent a geographic approximation of patients' travel patterns to obtain to primary care services. According to common practice, Nurse Practitioners and Physician Assistants weighted as equivalent to .75 relative to a physician. See technical appendix

Source: SK&A Office Based Physician Database, September 30, 2015 and Massachusetts Department of Public Health: Health Care Workforce Center

# Massachusetts is one of the 12 most restrictive states for Nurse Practitioners, due to required physician supervision for prescribing drugs




Source: American Association of Nurse Practitioners, 2014

# Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

Opportunities to improve quality & efficiency

## Progress in aligning incentives


Alternative payment methods

Demand-side incentives

# Alternative payment methods (APMs)

## Background

- Alternative payment methods offer incentives that support value and reward high-quality care
- In 2013, overall commercial APM coverage was 61% in HMOs, with high variation in rates by payer; only ~1% in PPOs
- To advance APMs, payer/provider coalition developed attribution method in 2014

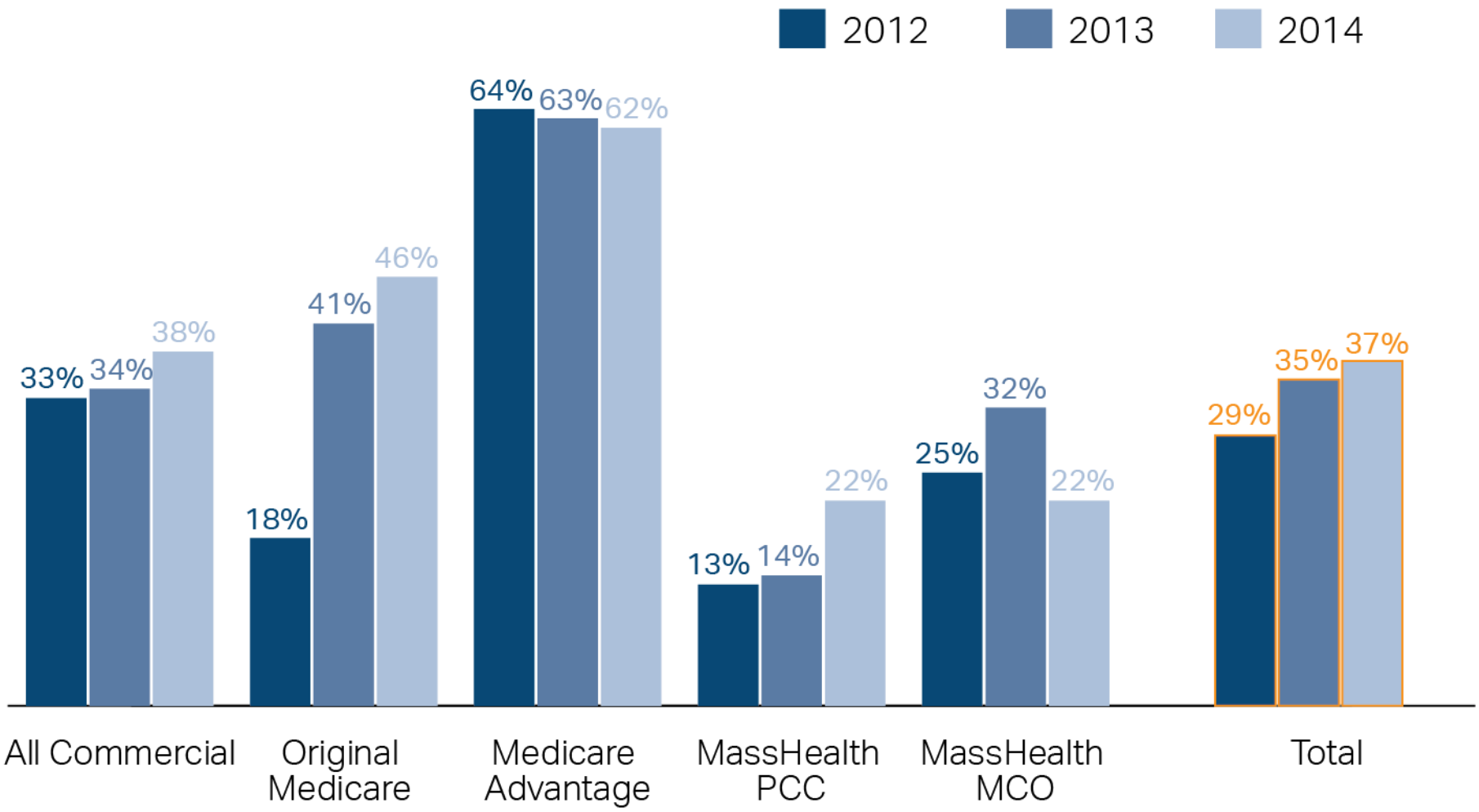
### Recommendations in 2014 Cost Trends Report

- *APMs in HMO.* Each payer should use APMs for 60% of HMO lives in 2016
- *APMs in PPO.* Market should begin introducing APMs into PPOs in 2016, with goal of reaching one third of PPO lives in that year
- *Alignment*
- *BH.* APMs should include BH when possible
- *MassHealth.* MassHealth should continue progress towards at-scale care delivery and payment system reforms
- *Bundled payment*

Source: HPC Cost Trends Report, 2014

# Statewide, the rate of APM coverage increased 8 percentage points between 2012 and 2014, with differences among payers

*Percentage of covered lives in APMs across all payers*




Note: See APM technical notes

Source: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other publicly-available Centers for Medicare & Medicaid Services data; MassHealth personal communication

# Very little progress yet in PPO, although recent announcement from payer/provider coalition is promising

| | HMO members as percent of all members | Percent of HMO members covered by APMs | PPO members as percent of all members | Percent of PPO members covered by APMs | Percent of all members covered by APMs |
|---|---|---|---|---|---|
| BCBS | 53% | * 91% | 47% | 0% | 48% |
| HPHC HPI | 71% | * 65% | 27% | 0% | 46% |
| Tufts/ Network | 67% | * 60% | 33% | 11% | 43% |
| Other | 40% | 33% | 47% | 2% | 15% |
| **Total** | **55%** | **68%** | **42%** | **2%** | **37%** |

* Met HMO coverage goal from 2014 Cost Trends Report

Source: CHIA 2015 Annual Report, and HPC analysis of CHIA 2015 Annual Report APM data book

# Alternative payment methods (APMs)

## Summary

- *APMs in HMO.* Three large commercial payers attained better than 60% coverage in 2014
- *APMs in PPO.* BCBS and four providers committed to extending APMs to PPO in 2016
- *BH.* More payers are including behavioral health spending in APM contracts
- *MassHealth.* MassHealth is engaged in an extensive stakeholder process to establish a strategy for at-scale care delivery/payment system reform – significant progress anticipated in 2016
- *Alignment.* At the hearings, providers continued to emphasize the need for progress, especially around risk adjustment and quality measurement
- *Bundled payment.* Limited offerings from payers. Mandatory bundled payments for select episodes from Medicare. Some use within provider systems.

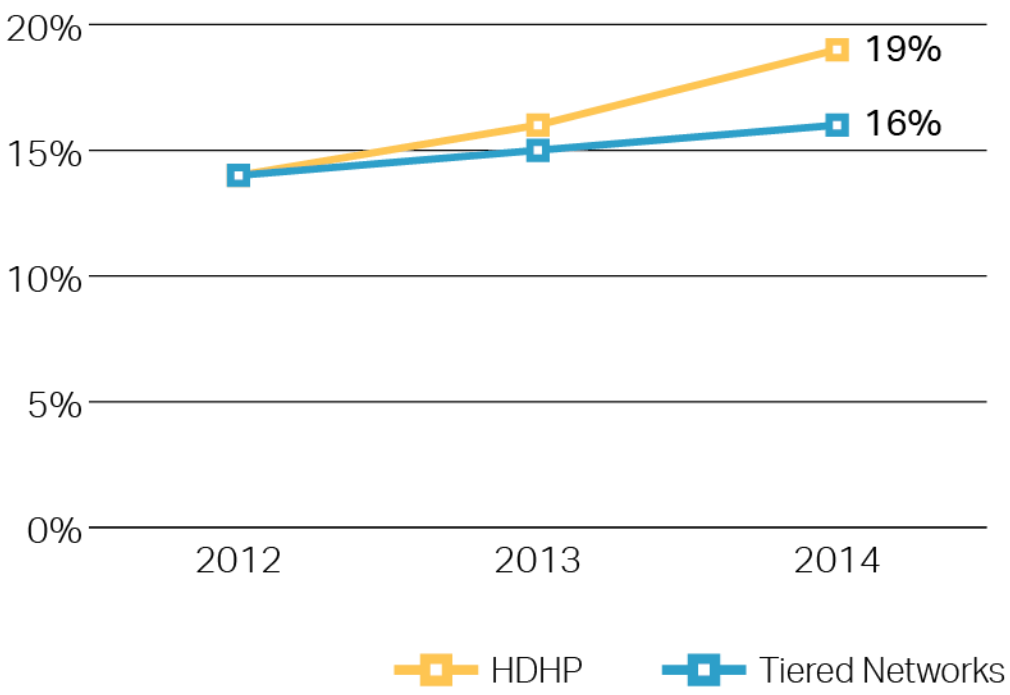
# Demand-side incentives

## Background

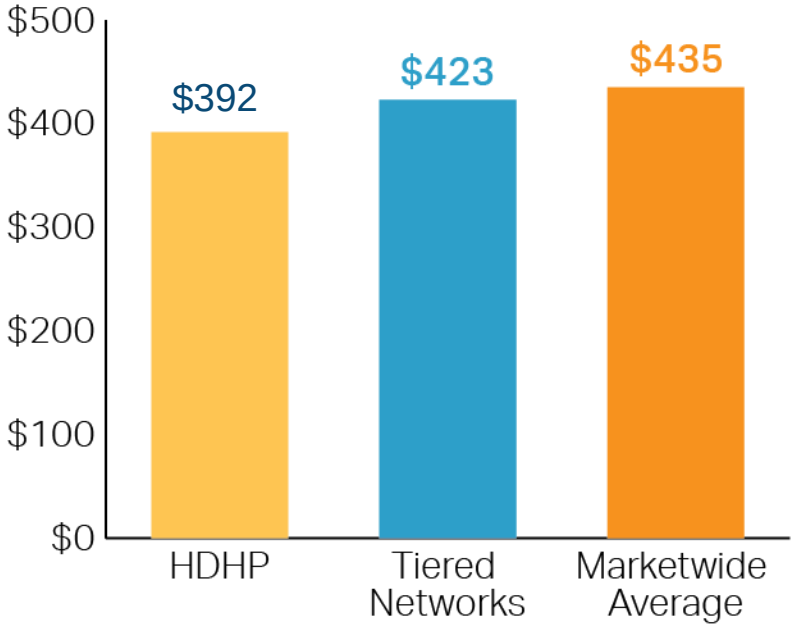
- Demand-side incentives complement supply-side incentives (APMs) by driving volume to high-value providers, products, and services
- Demand-side incentives may target employers or consumers
- Opportunities for demand-side incentives:
  - Choice of insurance plan
  - Choice of primary care provider
  - Choice of provider and care setting at the time of service use
- Tiered network plans identify high-value providers
  - Consumers pay less out-of-pocket when high-value providers are used
  - Premiums are also lower

# Tiered network product growth is being outpaced by high deductible health plans

## Uptake of Tiered Network and High Deductible Health Plans




## 2014 Monthly Premium, Per Person




Note: Premiums are for fully-insured products, net of medical loss ratio rebates and scaled to account for carved-out benefits. Cost-sharing is not included

Source: Center for Health Information and Analysis Enrollment and Source of funds data book released with the September 2015 Annual Report

## Summary

- Efficacy of demand-side incentives and consumer engagement can be enhanced with:
  - Continued improvement in the transparency of price and quality information, that is accessible, understandable, and actionable by a wide range of consumers for a wide range of health care services and settings
  - Additional mechanisms for rewarding value
    - Cash back incentives
    - Incentives for choosing an efficient PCP or system
  - Larger cost differentials between tiers for tiered products
  - Opportunities for firms to offer multiple products, comparative information, and “defined contribution”
  - Reduced administrative complexity for firms and consumers

# Future outlook – 2015 and beyond

- Reasons for concern
  - 6.3% premium growth in January 2016 in Massachusetts merged market
  - Higher U.S. spending growth through September, 2015
    - 5-6% overall; 8-9% for prescription drugs
  - Ongoing market consolidation
  - Continued high rates of readmissions, ED use, and PAC
- Reasons for optimism
  - Low rate of growth in hospital and physician services
  - Connector website is well-functioning and MassHealth enrollment growth has stabilized
  - Spread of APMs (PPO, MassHealth) may enhance providers' incentives to contain costs and improve quality

Source: Altarum Institute, Massachusetts Division of Insurance, Center for Health Information and Analysis

# Agenda

- HPC Presentation
  - Select findings concerning spending trends and underlying factors from the 2015 Cost Trends Report
- **Board Discussion**
  - Significance of findings
  - Recommendations for inclusion in the final report

# Presentation themes and potential areas for recommendations

## Themes

### Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

### Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
- Primary care access

### Progress in aligning incentives

- APMs
- Demand-side incentives

## Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
- Supporting efficient, high-quality care
- Advancing alternative payment methods, cultivating alignment
- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure