

# *Examination of Health Care Cost Trends and Cost Drivers*

*Pursuant to G.L. c. 12C, § 17*

*Report for Annual Public Hearing Under G.L. c. 6D, § 8*



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## EXECUTIVE SUMMARY

This report by the Office of the Attorney General (“AGO”) under its cost containment subpoena authority<sup>1</sup> focuses on health care spending trends that differentially impact certain communities.

The most recent data show that overall health care cost growth in the Commonwealth has remained steady, with growth in total health care expenditures at 4.1% in 2014-2015 compared to 4.2% in 2013-2014.<sup>2</sup> While still exceeding the statewide cost growth benchmark and the rate of medical inflation,<sup>3</sup> the recent growth rate is slower than in years past, and represents modest progress toward curbing the rising health care costs that burden many Massachusetts families and businesses.

At the same time, the overall rate of health care cost growth obscures several realities in our health care market. First, the recent flattening of statewide health care cost growth has not been shared equally by all across the market. Premiums for certain market segments continue to rise steeply,<sup>4</sup> with over 10% annual increases reported for certain industries.<sup>5</sup> Second, health insurance benefits continue to erode for many consumers, placing increasing strain on those facing rising out-of-pocket expenses.<sup>6</sup> In 2015, 1 in 5 adults with health insurance in Massachusetts reported having an unmet health need in the past year due to costs, 1 in 6 reported having difficulty paying their medical bills, and 1 in 5 reported having medical debt.<sup>7</sup> Third, the overall rate of growth does not answer whether the health insurance market is functioning effectively and fairly. Health insurance is fundamentally a social compact to share the financial risk of getting sick across everyone, healthy and sick alike. This social compact should result in spending more health care resources on those with the greatest health need.

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- 1 This report relies on information obtained through civil investigative demands issued to Massachusetts health insurers pursuant to MASS. GEN. LAWS ch. 12C, § 17 (2012). We reviewed detailed information on health care premiums, prices, utilization, and spending and consulted with health care experts, market participants, consumer advocates, and other key stakeholders. To assist in its review, the AGO engaged experts with extensive experience in actuarial sciences and financial analysis, clinical quality evaluation and population health management, and insurer-provider contracting.
  - 2 CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASS. HEALTH CARE SYSTEM ANNUAL REPORT SEPTEMBER 2016 at 12 (Sept. 2016) [HEREINAFTER 2016 CHIA ANNUAL REPORT], available at <http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report.pdf>.
  - 3 The statewide cost growth benchmark was 3.6% in 2014-2015; see also BUREAU OF LABOR STATISTICS, DATABASES, TABLES & CALCULATORS BY SUBJECT, available at [http://data.bls.gov/timeseries/CUUR0000SAM?output\\_view=pct\\_12mths](http://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths) (average annual growth in medical inflation was 2.4% in 2014 and 2.6% in 2015).
  - 4 For example, in the small group market, premiums increased by an average of 6.1% in 2015 and 6.7% in the first half of 2016 as reported by payers to the Massachusetts Division of Insurance.
  - 5 Employers and employees in certain industries are facing annual premium increases in the high single-digits, with some small businesses reporting an average 11% increase in premiums in 2016. See RETAILERS ASS'N OF MASS., ON 10 YEAR ANNIVERSARY OF ROMNEYS CARE, SMALL RETAILERS HIT WITH 11% HEALTH INSURANCE HIKES (Mar. 29, 2016) [HEREINAFTER RETAILERS ASS'N OF MASS.], available at <https://retailersma.org/sites/default/files/2016RAMHealthInsuranceSurvey%2610YearRomneyCareAnniversary.pdf>.
  - 6 See 2016 CHIA ANNUAL REPORT, *supra* note 2, at 42 (describing how average cost sharing for commercial members increased by 4.4% from 2014 to 2015, to an average of \$567 per member per year).
  - 7 Sharon K. Long et al., *Massachusetts Health Reform at Ten Years: Great Progress, But Coverage Gaps Remain*, 35(9) HEALTH AFFAIRS 1633, 1634-35 (Sept. 2016) (surveying persisting gaps in access and affordability in Massachusetts, despite high rates of insurance coverage).

In this examination, we look behind the reported trends and averages to understand whether we are investing more of our commercial health care dollars in communities with the greatest health need. In 2011, this office launched a study of medical spending by ZIP code to understand whether there were differences in how much we spend on patients depending on the income level of their community. We found that, in the commercial insurance market, we spent more on the health care of higher income communities in ways that were not explained by health need. In this report, we build upon this prior work using the latest Massachusetts data and recent national research to examine how spending patterns in the commercial insurance market continue to track community income rather than health need. We note that there are many factors that likely explain these spending differences, including variation in the prices of health care providers used by different communities and structural and socioeconomic barriers that make it more difficult for lower income residents to access health care.

To better understand the role of provider price variation and consumer choice of provider in driving spending differences within and between groups, we examined data on the hospitals used by employees of hundreds of Massachusetts employers. We looked at employer groups of similar size, located in the same part of the state, and insured through the same payer to illustrate how members' provider choices can lead to very different health care costs for otherwise similarly situated groups. Where premiums do not reflect the different costs associated with different provider choices, employers and consumers lack the incentives to shop for more efficient care that other market-based systems rely on to drive value.

This report is organized into three sections. Section I documents how commercial health care dollars are being distributed across communities of different levels of income. Section II uses data from employer groups to illustrate spending differences driven by the mix of low and high priced providers used by employees, and the resulting cross-subsidies within and between employer groups. Section III offers recommendations for monitoring the relationship between spending patterns and health burden across different communities and sharpening available tools to reward higher value health care choices.

The key findings of our examination are the following:

1. In the commercial insurance market, we spend more on the health care of residents of higher income communities relative to their health burden than residents of lower income communities. This data is adjusted for health status, meaning the higher spending on affluent communities is not explained by greater health need.
2. Substantial spending differences exist within and between employer groups, and these differences are driven in part by members' provider choices.
3. Premiums as currently structured socialize not only the financial risk of getting sick, but also the higher costs of some members' use of high-priced providers. Socializing the costs of members' provider preferences dulls their incentives to seek out high quality, lower cost care – incentives that market-based systems rely on to drive value.

The Office of the Attorney General looks forward to continued collaboration with the Legislature, sister agencies, health care market participants, and all stakeholders in promoting the affordability and accessibility of health care for all Massachusetts residents.

# I. IN THE COMMERCIAL INSURANCE MARKET, HEALTH CARE SPENDING RELATIVE TO HEALTH BURDEN CONTINUES TO BE HIGHER FOR PATIENTS FROM HIGHER INCOME COMMUNITIES THAN FOR PATIENTS FROM LOWER INCOME COMMUNITIES

Health insurance, at its core, is a social compact that is designed to socialize the risk of getting sick across a population of people. Cross-subsidies between the healthy and the sick serve a social good and should result in spending more health care dollars on those with the highest health needs. However, analysis of commercial health care spending patterns in Massachusetts demonstrates that there is a second type of subsidization taking place – one which is less desirable and which appears to be concentrating health care dollars on residents of higher income communities in ways that are not explained by health need.

This office and other state agencies have documented the fact that the Massachusetts health care market features wide payment differentials that are not explained by quality, patient complexity, or other common measures of consumer value.<sup>8</sup> As the market transitions to alternative payment arrangements, these historic rate differentials are being “baked” into new global payment systems such that providers with fee-for-service rates that were significantly higher than those of competitors providing similar quality and complexity of services get higher annual budgets to spend on patient care going forward.<sup>9</sup> Consequently, when a patient switches to a doctor that is affiliated with a different provider system, the amount allocated to his or her care may increase or decrease significantly merely because he or she has changed

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8 See, e.g., CTR. FOR HEALTH INFO. & ANALYSIS, RELATIVE PRICE: HEALTH CARE PROVIDER PRICE VARIATION IN THE MASS. COMMERCIAL MARKET (Feb. 2016), available at <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>; HEALTH POLICY COMM'N, MASS., 2015 COST TRENDS REPORT: PROVIDER PRICE VARIATION (Jan. 2016), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Sept. 18, 2015) [HEREINAFTER AGO 2015 REPORT], available at <http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf>; CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASS. HEALTH CARE SYSTEM SERIES: PROVIDER PRICE VARIATION IN THE MASS. HEALTH CARE MARKET (CY 2013 DATA) (Feb. 2015), available at <http://www.chiamass.gov/assets/Uploads/relative-price-brief-2013.pdf>; CTR. FOR HEALTH INFO. & ANALYSIS, POLICY BRIEF: PROVIDER PRICE VARIATION FOR MAMMOGRAPHY SERVICES IN THE COMMERCIAL MARKET (Oct. 2014), available at <http://www.chiamass.gov/assets/docs/r/pubs/14/rp-mammography-policy-brief.pdf>; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Apr. 24, 2013), available at <http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>; CTR. FOR HEALTH INFO. & ANALYSIS, HEALTH CARE PROVIDER PRICE VARIATION IN THE MASS. COMMERCIAL MARKET- BASELINE REPORT (Nov. 2012), available at <http://www.chiamass.gov/assets/docs/cost-trend-docs/cost-trends-docs-2012/price-variation-report-11-2012.pdf>; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (June 22, 2011) [HEREINAFTER AGO 2011 REPORT], available at <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>; DIVISION OF HEALTH CARE FINANCE AND POLICY, MASS. HEALTH CARE COST TRENDS: PRICE VARIATION IN HEALTH CARE SERVICES (June 3, 2011); OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Mar. 16, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>.

9 AGO 2015 REPORT, *supra* note 8, at 17-18

providers. Further, because providers are located in specific geographies and serve their local populations,<sup>10</sup> more health care resources may be accessible to residents of communities where the local providers have more favorable payment rates and can spend more on services regardless of patient need.

A recent study has shown that as a nation we spend more dollars on health care for wealthier Americans than for those in low or middle income communities.<sup>11</sup> The study “Health Spending for Low-, Middle-, and High-Income Americans, 1963-2012,” published in August of this year, complements work that this office launched in 2011 to understand the relationship between health care spending and income. Like our analysis in 2011, the August 2016 study compares health care spending data and income data to assess if any patterns emerge. The study examines patients nationwide and relies on survey data of health expenditures and health status. It found that the slowdown in spending growth from 2004-2013 masked troubling spending disparities. Notably, “[s]lower spending growth (at least through 2012) was concentrated among poor and middle-income Americans, leading to a growing disparity in health expenditures across income groups.”<sup>12</sup>

This observed higher spending on wealthier communities is not explained by greater health need in those populations. In fact, residents in wealthier communities tend, on average, to be healthier. Market participants, including payers, measure the healthiness of patients by calculating health risk scores, which measure a patient’s illness burden and predicted health care resource use based on differences in patient characteristics and historic claims experience.

Here in Massachusetts, as the chart below demonstrates, across all three major commercial payers, the average health risk score for members in lower income communities (communities with average annual income of approximately \$35,000) is significantly higher than that of members who reside in the state’s highest-income communities (where annual incomes average about \$112,000). Simply put, wealthier communities are healthier. But despite their lower health burden, the August 2016 study shows that we continue to spend more health care dollars in higher income communities across the nation.

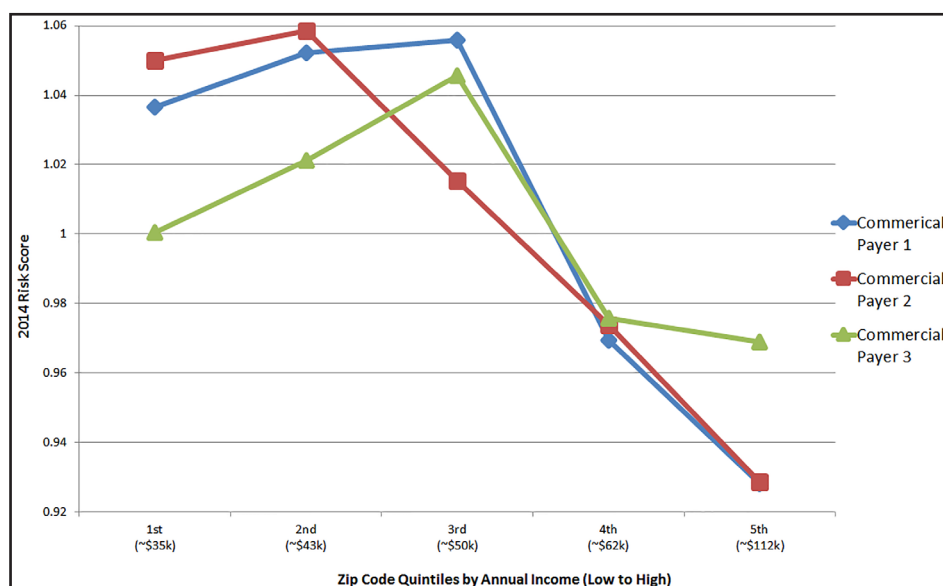
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10 See HEALTH POLICY COMM’N, MASS., COMMUNITY HOSPITALS AT A CROSSROADS: FINDINGS FROM AN EXAMINATION OF THE MASS. HEALTH CARE SYSTEM at 23 (Mar. 2016), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf> (finding that 45% of patients living close to a community hospital choose that hospital for their inpatient care, with even more residents in isolated geographies like the Cape and Islands relying on their local community hospitals).

11 Samuel L. Dickman et al., *Health Spending for Low-, Middle-, and High-Income Americans, 1963-2012*, 35(7) HEALTH AFFAIRS 1189 (Aug. 2016).

12 *Id.* at 1194.



Health Risk Scores for Low and High Income Communities<sup>13</sup>

## Notes:

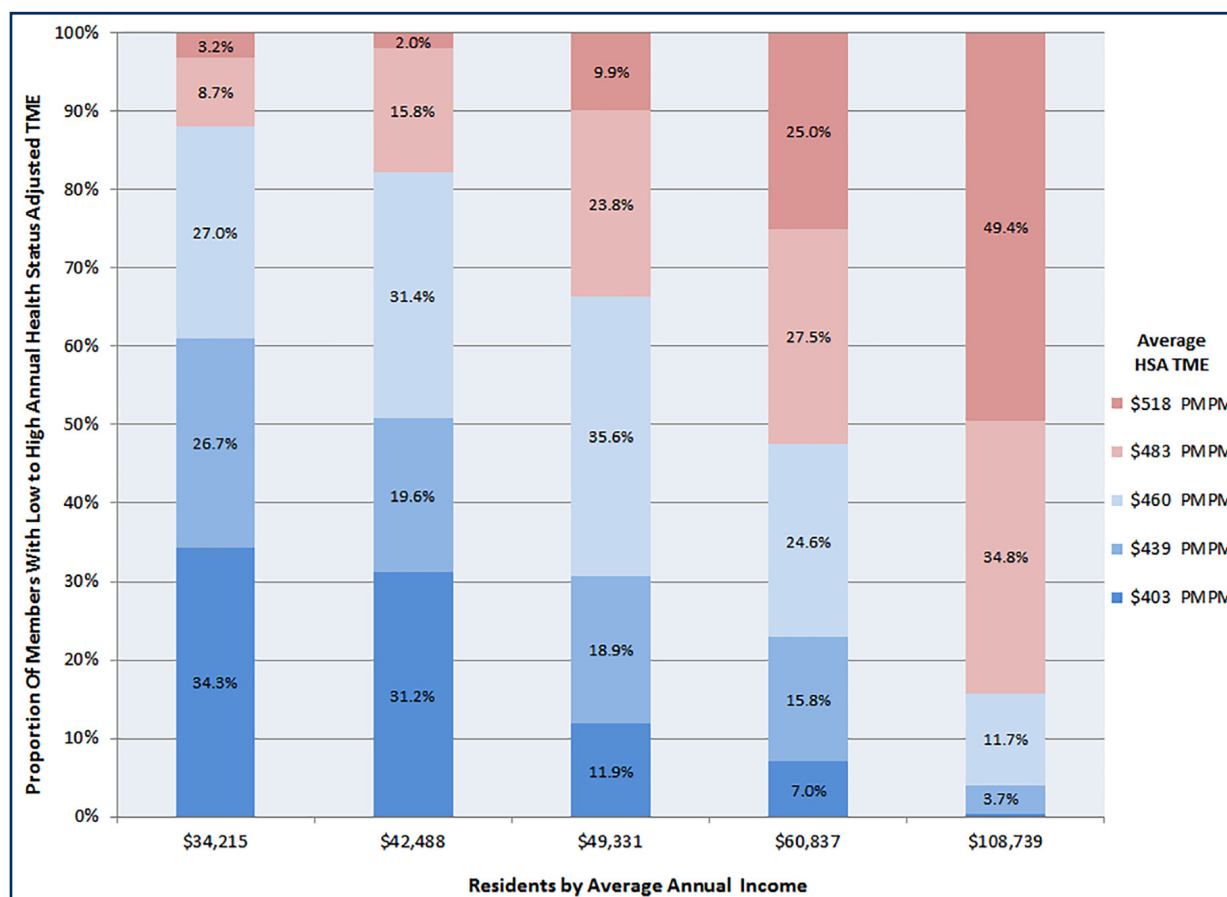
1. Risk scores and income levels shown are for commercial members.
2. Risk scores are normalized by payer.
3. The average income quintiles do not correspond to the same dollar amount across payers; e.g., the average income for Quintile 1 was \$34,215 for Commercial Payer 1, \$35,613 for Commercial Payer 2, and \$34,877 for Commercial Payer 3.

Unsurprisingly, when the national spending data is adjusted to account for health status, the findings are compounded: the spending disparity by income widens.<sup>14</sup> This is consistent with our Cost Trends Report published in 2011. That report first documented a pattern in commercial spending differentials by income that were unexplained by health burden. Specifically, we compared health status adjusted total medical expenditures (“TME”) by ZIP code with data on income by ZIP code to explore whether any spending patterns emerged. Like the authors of the August 2016 study, we found that health status adjusted total medical spending was on average higher for the care of members residing in higher income communities.<sup>15</sup>

This year, we updated our 2011 analysis with the most recently available TME and income data to see whether the pattern we previously uncovered has changed. It has not. We continue to observe greater spending on residents of wealthier communities in ways unexplained by their health burden.

- 13 We obtained data from the Internal Revenue Service, Statistics of Income Division showing 2013 adjusted gross income per Massachusetts federal income tax filer for the approximately 675 ZIP codes in Massachusetts. We grouped the ZIP codes into quintiles of equal size (i.e., 20% of ZIP codes in each cohort) from low income to high income, while excluding certain outlier ZIP codes to increase the reliability of the results. The ZIP codes excluded were the top and bottom 10 ZIP codes by average income and those with less than 1,000 member months for the payer studied. We then obtained data from each major commercial payer on their members’ 2014 risk scores by ZIP code. Using that data, we calculated the payer’s average risk score for each ZIP code quintile, weighted by the payer’s membership in each ZIP code.
- 14 Dickman, *supra* note 11, at 1192, Ex. 2 (illustrating medical spending per capita by income quintile, adjusted for age, health status, and inflation).
- 15 AGO 2011 REPORT, *supra* note 8, at 27. TME is the total dollar amount spent on the care of a health plan member and includes both the amount spent by the health insurer and any amounts, such as copayments and deductibles, paid by the member. The AGO 2011 Report studied the relationship between TME and resident income for each of the three major health insurers by comparing 2009 health status adjusted TME for all members (HMO, POS, PPO, and indemnity) in a ZIP code with 2007 incomes as reported by all federal income tax filers in that ZIP code. *Id.* at 27-28.

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



**Notes:**

1. Chart reflects per member per month ("PMPM") 2014 health status adjusted TME of one major payer's commercial members (HMO, POS, PPO, and indemnity) reported by Massachusetts ZIP code.
2. Income data is from the Internal Revenue Service, Statistics of Income Division, and reflects 2013 adjusted gross income per Massachusetts federal income tax filer, weighted by one major payer's 2014 commercial membership for each Massachusetts ZIP code.

The chart above shows, for one major payer, the proportion of members in each income quintile who fall into one of five health care spending quintiles, adjusted for health status. Although data from one payer is reflected here, we conducted this same analysis for all three major commercial payers and found the same pattern. Notably, the darkest red bars at the top of the chart represent those members with the highest health-status adjusted TME. These are individuals to whom we devote the most health care resources relative to their health need. If we compare the right- and left-most columns in the chart, we see that in the highest income communities, almost half of members fall into the highest spending quintile, while in the lowest income communities, only 3.2% of members are in the highest spending quintile. By contrast, 34.3% of members in the lowest income communities are individuals in the lowest TME quintile.

This difference in risk-adjusted spending by income is not explained by health need and does not advance the social goal of spending more on communities with higher health burdens.

Further, to the extent the additional spending on residents of higher income communities, unrelated to health need, is spread through a larger risk pool (e.g., like the merged market or a large employer group like the Group Insurance Commission (“GIC”)), all members of that risk pool, including those from lower income communities, end up paying for that additional spending.

A variety of market and socio-economic factors likely contribute to these spending differentials by income. One factor, described above, is that prices for comparable services vary widely in Massachusetts (both fee-for-service prices and global budget payments). To the extent affluent residents use higher priced providers more often than lower-income residents do, more is spent on their health care because the services they receive are costlier. Structural barriers that disproportionately affect people from lower income communities may also explain these spending differentials. Challenges in accessing transportation and paid sick leave,<sup>16</sup> as well as linguistic and other social barriers that are more prevalent in lower-income communities,<sup>17</sup> can constrain people’s access to health care services, thereby resulting in lower levels of spending. Similarly, benefit design and the trend toward high deductible health plans and increased consumer cost sharing also impact the rate at which members access care.<sup>18</sup> It is well documented that lower income families enrolled in high deductible health plans are more likely than higher income families to delay or forgo seeking health care services.<sup>19</sup>

More work is needed to gain a deeper understanding of these and other drivers of spending differentials by income in our state. To advance one aspect of this work, the next section of this report examines spending differentials driven by member use of higher versus lower cost providers, which is embedded in the spending differentials by income documented in Section I.

- 16 See, e.g., Samina T. Syed et al. *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38(5) JOURNAL OF COMMUNITY HEALTH 976 (Oct. 2013) (surveying studies on transportation barriers to health care access); LeAnne DeRigne et al., *Workers Without Paid Sick Leave Less Likely to Take Time Off for Illness or Injury Compared to Those With Paid Sick Leave*, 35(3) HEALTH AFFAIRS 520, 522 (Mar. 2016) (finding based on a study of National Health Interview Survey data that “[n]early 65 percent of families with incomes below \$35,000 had no paid sick leave, compared to 25 percent of families who earned more than \$100,000 a year” and concluding that “[t]his disparity left the most economically vulnerable without the protective benefit of paid sick leave”). We note that we studied the latest available TME data, from 2014, which would not reflect any change in health care access and related spending made possible by Massachusetts’s landmark 2015 Earned Sick Time Law, which entitles Massachusetts employees to earn up to 40 hours per year of sick leave. MASS. GEN. LAWS ch. 149, § 148C (2015). Over time, more widely available paid sick leave may help to alleviate one barrier to accessing health care services that many Massachusetts employees have historically faced.
- 17 See KAISER COMMISSION ON MEDICAID AND THE UNINSURED, OVERVIEW OF HEALTH COVERAGE FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY at 2-3, Fig. 4 (Aug. 2012) available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8343.pdf> (noting that nationwide 34% of individuals with limited English proficiency have family income below the federal poverty level, compared to 22% of English proficient individuals, and finding that individuals with limited English proficiency often face multiple barriers to accessing health insurance and health care).
- 18 Roughly one million Massachusetts members were enrolled in high deductible health plans in 2015, reflecting about 21% of the insured population, up from 19% of the insured population in 2014. 2016 CHIA ANNUAL REPORT, *supra* note 2, at 35-36. Some have pointed to health savings accounts (HSAs) as alleviating the burden on consumers presented by high deductible health plans. We agree that more work is needed to understand how high deductible health plans are being offered, including the extent to which they are offered in conjunction with an adequately funded HSA or health reimbursement arrangement (HRA). The latest information for Massachusetts indicates the number of employers offering high deductible health plans exceeds those who offer an HSA or HRA. See CTR. FOR HEALTH INFO. & ANALYSIS, MASS. EMPLOYER SURVEY: 2014 SUMMARY OF RESULTS at 9 (Oct. 2014), available at <http://www.chiamass.gov/assets/docs/r/pubs/14/2014-employer-survey-summary-results.pdf>.
- 19 See Jeffrey T. Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170(21) J. AM. MED. ASS’N INTERNAL MED. 1918 (Nov. 2010).

## II. HIGHER HEALTH CARE SPENDING AND ASSOCIATED CROSS-SUBSIDIES DRIVEN BY DIFFERENTIAL USE OF LOW AND HIGH PRICED PROVIDERS IN THE SMALL AND LARGE GROUP MARKETS

This section takes a closer look at how residents use and pay for health care in Massachusetts to gain a deeper understanding of some of the factors contributing to the spending differentials by income documented in the previous section, and to explore how current approaches to paying for health care diminish and even eliminate incentives for consumers to seek out high quality, lower cost care. We begin by examining data on the provider use patterns of several hundred small and mid-size employer groups to shed light on the extent of differential use of low and high priced providers among real-world employers. We then study how premiums are set in different market segments (the large group market and the merged market of individuals and small groups) to show how the added costs associated with use of higher priced providers are being spread across all members in each of those markets. Where the underlying provider price differentials are not explained by quality, patient complexity, or other common measures of consumer value, the sharing across all members of the costs associated with some members' preference for high priced providers raises important questions about the extent to which current approaches to setting premiums are muting the kinds of consumer incentives to seek out high quality, lower cost care that market-based systems rely on to drive value.

### A. Differential Hospital Use Among Small Group Employers

To study examples of differential provider use among Massachusetts residents, our office reviewed hospital claims data for approximately 240 small and mid-size employer groups across four major payers. We focused on small and mid-size employers because they have emphasized their need for premium relief,<sup>20</sup> and so present an important market segment in which to better understand spending patterns that underlie premium growth. We examined the mix of hospitals used by each employer group, the relative price of each hospital, and determined the average price for the mix of hospitals used by members in each group (which we call the “Group Hospital Price”). We observed significant variation in the mix of hospitals used by employer groups located in the same geography and insured through the same payer. The following chart presents examples of the observed range in Group Hospital Price among pairs of small employer groups, where each pair has the same payer, a similar number of employees, and is located in the same region of Massachusetts.<sup>21</sup>

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20 See RETAILERS ASS'N OF MASS., *supra* note 5 (noting that retailers in Massachusetts experienced an 11% increase in premiums in 2016, “far exceeding the state healthcare growth target of 3.6%, as well as the increases seen by large employers and taxpayer funded consumers, the inflation rate, and the sales growth of Main Street Massachusetts employers”).

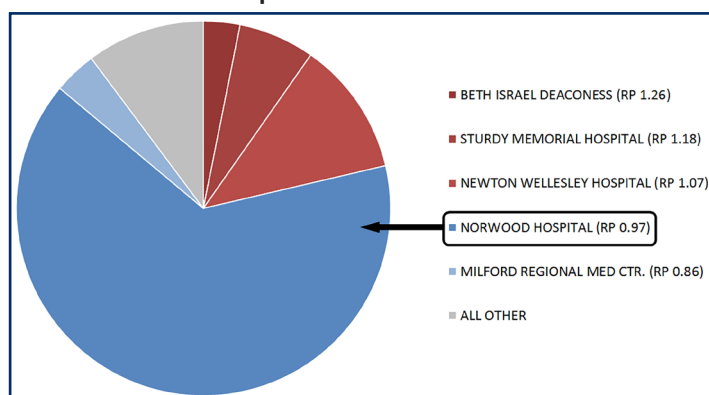
21 In the small group market, premium rating regions are prescribed by state regulation. 211 C.M.R. § 66.08 2(b). These regions are generally known as Boston, Cape/Islands, Central, Metrowest, Northeast, Southeast, and West.

For the first example below, Employer A and Employer B are a pair of employer groups who are both located in the Metrowest region of Massachusetts and purchase health insurance in the small group market through the same payer. Employer A's employees use a mix of hospitals with an average relative price of 1.03, while Employer B's employees use a mix of hospitals whose relative prices average 1.20. The pie charts, which show the top five hospitals used by each employer group based on 2014 claims revenue, illustrate how a different mix of hospitals used by these two employer groups drives their different Group Hospital Prices. However, premiums for the two groups do not differ based on the provider choices of their employees.

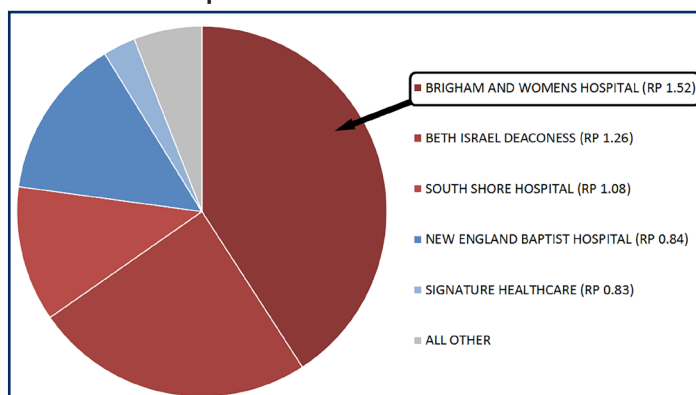
### Variation in Group Hospital Price Across Pairs of Similarly Situated Employer Groups

	Employer Group 1	Group Hospital Price	Employer Group 2	Group Hospital Price	Difference in Group Hospital Price
<b>Exemplar 1: Metrowest Region</b>	Employer A	1.03	Employer B	1.20	16.5%

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



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



	Employer Group 1	Group Hospital Price	Employer Group 2	Group Hospital Price	Difference in Group Hospital Price
<b>Exemplar 2: Boston Region</b>	Employer C	1.07	Employer D	1.22	14.0%
<b>Exemplar 3: Cape/Islands Region</b>	Employer E	1.25	Employer F	1.38	10.4%
<b>Exemplar 4: Central Region</b>	Employer G	1.03	Employer H	1.26	22.3%
<b>Exemplar 5: Northeast Region</b>	Employer I	0.84	Employer J	1.09	29.8%
<b>Exemplar 6: Southeast Region</b>	Employer K	0.93	Employer L	1.18	26.9%
<b>Exemplar 7: West Region</b>	Employer M	0.91	Employer N	1.32	45.1%

Note: The "Group Hospital Price" is a weighted average hospital relative price calculated from 2014 inpatient and outpatient hospital claims for each employer group.

The size of spending differentials that can be driven by the above differences in hospital mix are substantial. Consider, for example, an employer group with 30 employees, and suppose that the employees in this group use the same distribution of hospitals as Employer A above – with a Group Hospital Price of 1.03 – and incur \$200,000 in hospital spending annually (an amount in the range of what we observed for groups this size). If these members changed their hospital use to instead reflect the mix of hospitals used by Employer B – with a Group Hospital Price of 1.20 – then the hospital spending associated with those members would increase to \$233,000 per year. Put another way, this change in choice of hospitals would increase spending by \$33,000 each year, a 16.5% increase for this small employer group, with no increase in utilization or change in the types of hospital services members received.

Spending differentials driven by choice of provider system also exist under global payment arrangements. For example, consider an employee enrolled in an HMO or POS plan offered by a payer that has implemented global risk contracts to pay for the care of its members. Through our confidential subpoena authority, we are able to review those risk contracts and determine the effective dollars allocated for the care of members who select primary care providers (PCPs) at different provider systems.<sup>22</sup> Based on our review of 2013 contracts for a major payer, if the employee selects a provider in the most well-resourced system in the payer's network, approximately 13% more dollars (or about \$750 per person per year) will be allocated for the employee's care than if that same employee chose a PCP affiliated with another large provider system with a budget in the mid-range for that payer. Much like the increase in spending that accompanies a switch to a higher-priced hospital, switching one's PCP from a system that has a lower global budget to one that has a higher global budget will increase overall levels of spending.

## **B. Cross-Subsidization of the Costs of Provider Choice Across All Market Segments**

In this section, we turn to the question of how employers and employees are paying for the increased costs of using higher priced providers. In both the large group and merged markets, member premiums generally do not reflect whether the member uses providers that are high quality and lower cost, whom we call “efficient” or “high value” providers. In any fully or self-insured risk pool where a consumer's share of premiums does not account for provider efficiency, consumers' premiums will not only socialize the costs associated with the diverse health profile of the pool, but will also result in members who use higher value providers subsidizing the choices of those who use lower value providers. This approach, in effect, financially penalizes consumers who seek out high quality, lower cost care. This is contrary to the premise of a market-based system, which relies on financial rewards for consumers who seek out more efficient care delivery to drive overall value in the system.

The remainder of this section explores how premiums are being set in the large group and small group markets, highlights cross-subsidies that are present in both markets, and models a novel approach to developing premiums that seeks to untangle cross-subsidies related to provider choice.

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<sup>22</sup> See AGO 2015 REPORT, *supra* note 8, at 17-18.



## 1. Large group market

In the large group market, payers and employers have flexibility in setting premiums that are responsive to member provider choices. Premiums for these large employer groups are either fully or partially experience rated, meaning that premiums reflect a prediction of a group's future medical costs based on its past claims experience. Large employers will therefore see direct savings in their premiums if their employees choose more efficient providers.<sup>23</sup> As one example of the scope of premium savings available to large employer groups who use more efficient providers, our office presented findings earlier this year showing a 20% difference in the total cost of care associated with the most and least efficient provider groups in one major payer's network of large Boston-area provider groups.<sup>24</sup>

Apart from some limited implementation of narrow network products, payers and employers have not generally pursued strategies to offer their members premium-based savings to seek out higher value providers. We learned through our examination that a couple of payers have internally explored approaches to developing premiums that would take into account member choice of higher versus lower cost providers, and would not necessarily be tied to a narrow network product. Those explorations recognize that a member's selection of provider meaningfully impacts overall spending, and that premiums can be differentiated in ways that do not require limiting members to just one or a few provider systems. We understand that at least one reason such explorations have stalled is uncertainty about sufficient interest from employers in purchasing such products. We present below a basic model for how premiums can be developed based on provider efficiency, to provide an example of how cross-subsidies that penalize consumers who choose higher value providers can be untangled.<sup>25</sup> We caveat that further exploration of such an approach will depend on employer interest in pursuing premium-based incentives (also called incentives at the "point-of-enrollment," in comparison to incentives through co-payments or deductibles at the "point-of-service") to encourage employees to seek out higher value care, and reallocate the additional cost of obtaining care at less efficient providers to the employees who make that choice.

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23 Self-insured employers will see these savings even more directly, in the form of direct reductions in claims costs, as they determine their employees' health benefits and do not rely on payers to set premiums or bear the risk of changes in their claims costs.

24 See HEALTH POLICY COMM'N, MASS., PROVIDER PRICE VARIATION: STAKEHOLDER DISCUSSION SERIES SUMMARY REPORT at 5 (2016) [HEREINAFTER STAKEHOLDER DISCUSSION SERIES SUMMARY REPORT], available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-ppv-summary-report.pdf>. This 20% differential reflects a comparison of provider groups in the Boston area; savings may be even more pronounced for larger employers in statewide shared risk pools, such as the GIC, where members may seek care from the full range of providers across the state.

25 Our office first introduced the idea of a tiered premium product design in our 2015 Cost Trends Report. AGO 2015 REPORT, *supra* note 8, at 11. At the invitation of the Health Policy Commission ("HPC"), our office presented an early version of this model at the March 30, 2016 HPC forum on demand-side approaches to provider price variation. See STAKEHOLDER DISCUSSION SERIES SUMMARY REPORT, *supra* note 24, at 5.

The following chart reflects a hypothetical health insurance product in which members who choose a PCP group with more efficient health status adjusted TME pay a lower premium. This product continues to socialize health risk without subsidizing the inefficient choices of some members.<sup>26</sup> Members' HMO or POS product design would not change<sup>27</sup>: as is currently the case, with a referral, members would be able to get care outside of their PCP's affiliated system. The chart illustrates the premium differential such a model would yield for a member choosing between eight major eastern Massachusetts provider systems for primary care. When combined with a defined employer contribution (in the columns on the right in the table),<sup>28</sup> the difference between premiums could translate into substantial savings for employees as well as encourage providers to compete on efficiency. Where employees do not wish to change providers, this approach retains the advantage of allowing members their choice of provider, while addressing the undesirable cross-subsidies outlined above by not penalizing members for selecting higher value providers.

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- 26 While traditional premiums socialize costs associated with health status as well as with provider selection, the relative efficiency score shown in the chart below measures the provider group's efficiency while controlling for health status. This means that the total medical spending attributable to a member with a PCP at Provider A is 12% less than the total medical spending attributable to a member with a PCP at Provider E, and this difference cannot be explained by one member being older or sicker than the other.
- 27 This model, similar to initial approaches to global payments, focuses on HMO/POS products. Also like global payments, it is possible to explore expanding this model to PPO products via members' physician selection. Reports indicate that about 88% of adults in Massachusetts identify as having a "personal health care provider." MASS. DEP'T OF PUBLIC HEALTH, HEALTH SURVEY PROGRAM, A PROFILE OF HEALTH AMONG MASS. ADULTS, 2011: RESULTS FROM THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM at 35, Table 2.2 (Jan. 2013), available at <http://www.mass.gov/eohhs/docs/dph/behavioral-risk/report-2011.pdf>.
- 28 For illustrative purposes, the employer contribution level in this model is set at 80% of Provider A's premium, but could easily be adjusted from employer to employer based on their needs.



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

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

## Notes:

1. Each provider group's "Relative Efficiency" is calculated based on the group's 2014 health status adjusted HMO/POS TME compared to the weighted average 2014 health status adjusted HMO/POS TME across Providers A-H. Data on each group's TME for PPO members was unavailable (notably, there can be variation between a provider group's HMO/POS payment rates and its PPO payment rates; in such cases, the group's total spending on PPO members would expectedly be different than its total spending on HMO/POS members). This model neither measures nor reflects provider groups' efficiency in caring for their PPO members.
2. The "Traditional Monthly Premium" is a premium for a hypothetical employer group, calculated using 2014 TME, that is not differentiated based on provider efficiency.
3. The "Differentiated Monthly Premium" is a premium for the same employer group that is differentiated based on provider efficiency. This premium is calculated by multiplying the Traditional Monthly Premium by the Relative Efficiency score of the provider group selected by the member.

Adopting a product design like this, which pays close attention to financial incentives for consumers at the point-of-enrollment, has several advantages over existing efforts in Massachusetts that reward consumers at the point-of-service for choosing higher value providers. As documented in our 2015 Cost Trends Report, a weakness of point-of-service approaches is that they can include unrealistic expectations regarding when and how often consumers are able to consider financial tradeoffs related to their health care options.<sup>29</sup> Incentives at the point-of-enrollment would simplify the consumer's cost and quality calculus to once a year; move that calculus to an earlier, less sensitive point in time (rather than after the consumer is already in need of medical care); and focus on a single decision of PCP group affiliation, instead of expecting consumers to assess and reassess the efficiency of specific provider types each time they need a different type of service. Incentives through premiums are also more comprehensive, considering efficiency across the entire continuum of care as opposed to for a subset of services, and are thus more harmonious with the trend toward global and other risk-based forms of payment. Simply put, these incentives better match the reality of how Massachusetts consumers today are being cared for by integrated, at-risk provider systems seeking to maximize continuity of care and a seamless patient

<sup>29</sup> AGO 2015 REPORT, *supra* note 8, at 11-12.

experience.<sup>30</sup> Premium-based incentives have the added benefit of fostering a range of other positive market developments, such as encouraging competition on the basis of provider efficiency and increasing how desirable it becomes to affiliate with high quality, lower cost providers.

Finally, consumer protections built into our health insurance system to shield consumers who face serious health problems from incurring devastating costs also suggest the merits of point-of-enrollment incentives.<sup>31</sup> Consistent with conventional wisdom that a small percentage of high-cost patients account for the vast majority of health care spending, we found that 77% of 2014 health care claims across the three major commercial payers were attributable to only 19% of members. At the same time, in this state<sup>32</sup> and across the nation,<sup>33</sup> limits are set on the out-of-pocket expenses – deductibles, copayments, and coinsurance – that members may face in a given year. In 2016, these limits are set at \$6,850 per member and rightly protect consumers from facing extreme, unexpected costs from medical care. These limits also mean that for more than three-quarters of health care spending, point-of-service incentives are an ineffective means of engaging patients. Under point-of-service approaches, the high-cost patients who account for the vast majority of spending are certain to reach their out-of-pocket maximum irrespective of how prudently they shop for care, and thus they receive no economic reward for seeking out higher value care. Put another way, point-of-service approaches can at most affect the one-quarter of spending not attributable to high-cost patients, and thus have limited potential to drive value-based decision-making across most categories of spending. To engage all consumers, it is worth considering alternative benefit designs that use premiums as the lever for incentives and rewards.

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30 *Id.* at 11 (explaining that most PCPs are affiliated with a broader system within which they coordinate patient care; where there is variation in the efficiency of specific provider types within the same care system, it may be unrealistic to expect consumers to seek care outside their “home” system, especially if their actions contradict their PCP’s recommendation and PCPs under global budgets are being encouraged to manage the entire continuum of care with their affiliates).

31 See, e.g., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, RESEARCH IN ACTION: THE HIGH CONCENTRATION OF U.S. HEALTH CARE EXPENDITURES (June 2006), available at <http://archive.ahrq.gov/research/findings/factsheets/costs/expriach/pendria.pdf>.

32 As of 2009, Massachusetts regulations prohibited payers from offering insurance products that exceeded an out-of-pocket maximum of \$5,000 per member. 956 C.M.R. § 5.03(1)(d). In 2014, the out-of-pocket maximum was increased to align with federal requirements under the ACA.

33 Under the ACA, all non-grandfathered health plans may not exceed an out-of-pocket maximum of \$6,850 per member in 2016. DEP’T OF HEALTH AND HUMAN SERVICES, PATIENT PROTECTION AND AFFORDABLE CARE ACT; HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2016: FINAL RULE, 80 Fed. Reg. 10,750, 10,825 (Feb. 27, 2015), available at <https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

## 2. Small group market

There are currently challenges unique to the small group market in exploring efforts to untangle cross-subsidies in premiums related to provider choice. We studied two such challenges over the course of our examination, which we document below. We then turn to the final section of this report, which offers a few recommendations on the broad topics studied.

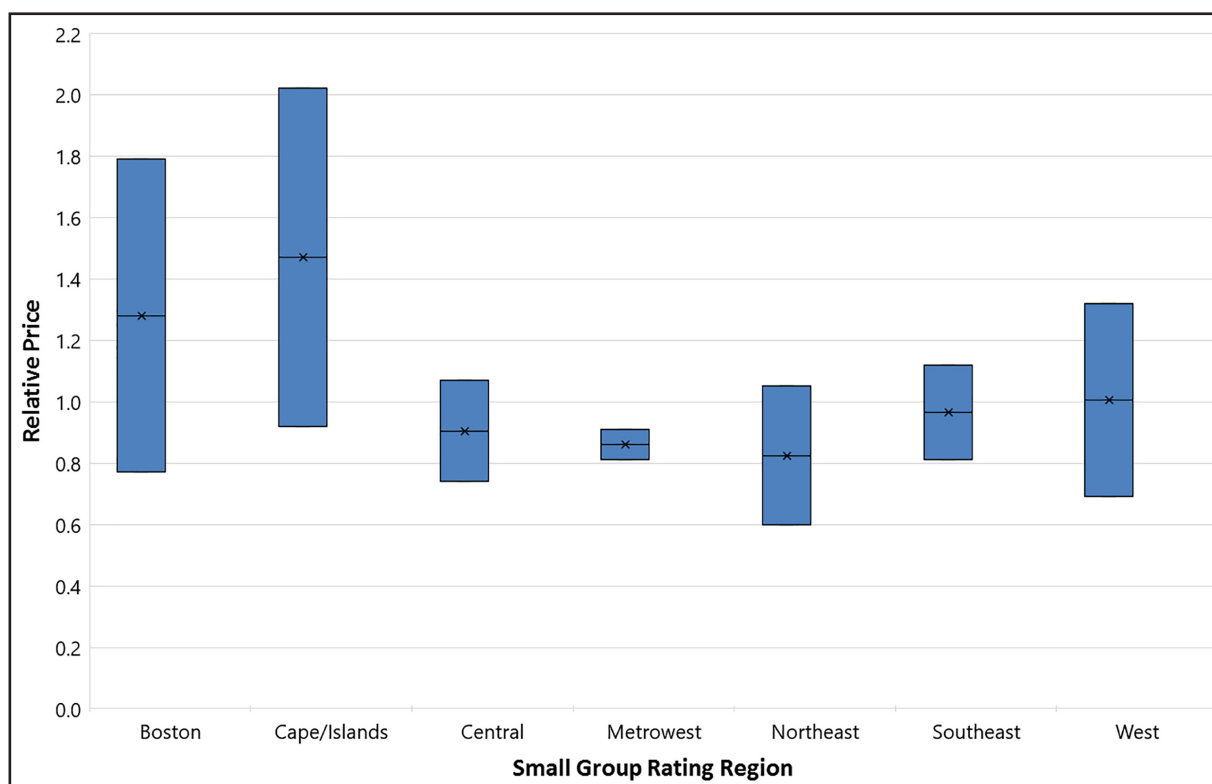
One challenge in the small group market is finding space within current rating rules for untangling these cross-subsidies related to provider choice – and unrelated to health risk – that have been uncovered since Massachusetts initially pioneered beneficial community rating principles that prohibited rating based on health status. The main approach that would currently be available to address such cross-subsidies would be to use area rating factors to account for provider efficiency.<sup>34</sup> However, as documented below, these area rating factors – based on geography – are not an effective proxy for provider efficiency.

An area rating factor is a factor available for adjusting small group rates to account for geographic differences in health care costs. By regulation, payers may apply area rating factors by seven geographic groupings based on the first three digits of the ZIP code where the employer is located. These rating factors are a poor proxy for provider efficiency because there is significant variation in efficiency among providers *within* each of the seven regions, and employer groups in the same region may use a very different mix of providers.

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34 The ACA permits payers to apply only four rating factors in the small group market: rate basis type (i.e., individual or family), geographic rating area, age of enrollees, and tobacco use. The Centers for Medicare and Medicaid Services (CMS) has allowed Massachusetts to gradually phase out its practice of rating based on industry and employer size in the small group. These transitional rating factors may be applied through 2017. See Letter from Kevin Counihan, Director, Center for Consumer Information and Insurance Oversight, Marketplace Chief Executive Officer, Centers for Medicare and Medicaid Services, to Louis Gutierrez, Executive Director, Commonwealth Health Insurance Connector Authority (June 16, 2015), available at <http://www.mass.gov/governor/docs/news/mahealthconnector.pdf>.

### Significant Variation in Hospital Relative Price Within Each Small Group Rating Region



#### Notes:

1. Chart reflects blended hospital inpatient and outpatient relative price for one major payer for all hospitals located within each of the seven small group rating regions.
2. The rating regions are defined by the following 3-digit ZIP codes: Boston (021-022, 024), Cape/Islands (025-026), Central (014-016), Metrowest (017, 020), Northeast (018-019), Southeast (023, 027), and West (010-013). 211 C.M.R. § 66.08 2(b).

The chart above shows the range in relative prices among hospitals located in each of the seven small group rating regions. For this payer, all small employers located in the Boston region receive an identical area rating factor of 1.014, meaning that the premiums for all small employers in this region are adjusted upwards by 1.014 regardless of whether the group uses Boston providers on the higher or lower end of the relative price spectrum (or whether the members live and seek care outside of the Boston region).

Another challenge for those seeking to link premiums and provider efficiency in the small group market is the ACA's Risk Adjustment program.<sup>35</sup> Risk Adjustment is a permanent program designed to stabilize premiums in the merged market by transferring money from payers with low-risk members to payers with high-risk members, thereby removing the incentive for payers to “cherry-pick” healthier members. In Massachusetts, however, the need for such stabilization with the

<sup>35</sup> Starting in 2014, Massachusetts was the only state to administer its own Risk Adjustment program, which was run through the Commonwealth Health Insurance Connector Authority (“Connector”). In December 2015, the Connector opted not to seek federal permission to continue operating a state-run program, so starting with plan year 2017, the Risk Adjustment process for Massachusetts will be run by the federal government.

rollout of the ACA was limited, as the state had already introduced guaranteed issue, adjusted community rating, and nearly-universal coverage to our health insurance market. The Risk Adjustment program in its current form creates challenges in Massachusetts for payers seeking to use product design as a cost containment tool in the small group market. Risk adjustment transfers, calculated by multiplying each plan's average risk score by the statewide average premium, are intended to redistribute funds from payers with lower-risk members to payers with higher-risk members.<sup>36</sup> The use of the statewide average premium in the transfer calculation serves as a disincentive for smaller plans and new entrants to offer plans with lower premiums, since their Risk Adjustment obligation if they attract lower risk members will be calculated based on a higher statewide average premium.<sup>37</sup> Furthermore, the Risk Adjustment program leads to pricing instability because the transfer amounts are unknown to payers during rate setting and are not calculated or assessed until long after the claims year is over.<sup>38</sup> This issue merits close scrutiny from the Massachusetts Division of Insurance, the Connector, and policymakers as the Commonwealth seeks to promote stable insurance markets that encourage innovation based on value.

In all market segments, cross-subsidies related to provider choice work against the incentives and transparency needed for market forces to drive value in health care. Employers do not have strong incentives to encourage their employees to seek out efficient providers. In the small group market, employer groups pay premiums that are not adjusted for provider efficiency and at best reflect area adjustments that fail to account for the wide range of provider price variation within the rating regions. In the larger market segments, payers and employers in practice do not adjust group premiums to reflect the efficiency of the providers selected. Furthermore, employers of all sizes lack clear and timely data on the providers selected by their employees, the relative prices and efficiency of those providers, and the impact of those choices on premiums. In a market characterized by significant differences in provider efficiency, greater innovation is needed in improved transparency and incentives for employers and individuals to identify and choose high value care.

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36 In September 2016, CMS proposed changes to the federal Risk Adjustment program intended to improve the accuracy of risk adjustment transfers by introducing factors to reflect partial-year enrollment and include pharmacy data in the calculation of member risk scores. DEP'T OF HEALTH AND HUMAN SERVICES, PATIENT PROTECTION AND AFFORDABLE CARE ACT; HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2018: PROPOSED RULE, 81 Fed. Reg. 61,455, 61,466-89 (Sept. 6, 2016), available at <https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-20896.pdf>.

37 See CONSUMERS FOR HEALTH OPTIONS, INSURANCE COVERAGE IN EXCHANGES IN STATES ("CHOICES"), TECHNICAL ISSUES WITH ACA RISK ADJUSTMENT AND RISK CORRIDOR PROGRAMS, AND FINANCIAL IMPACT ON NEW, FAST-GROWING, AND EFFICIENT HEALTH PLANS at 9 (Nov. 4, 2015) (prepared by CHOICES with technical assistance provided by Leavitt Partners and by Richard S. Foster, FSA, MAAA (CMS Chief Actuary, 1995-2012)).

38 See *id.* at 2.

### III. RECOMMENDATIONS

This report documented how certain populations are disproportionately burdened by the cost of payment and spending differentials not explained by quality or patient health burden. We explored how the socialization of these payment disparities may contribute to a continuing and distressing pattern in our commercial insurance market of spending more on the care of residents of affluent communities than residents of lower income communities, in ways unexplained by health need. These spending patterns and cross-subsidies are in tension with a number of the Commonwealth's health care reform goals, and may make market reforms aimed at rewarding high-value consumer and employer choices all the more urgent. The following recommendations aim to sharpen our tools for considering and responding to spending patterns that are linked to income rather than health need, and the cross-subsidies that have become barriers to meaningful rewards for consumers who make higher-value choices. Specifically, we recommend:

#### **A. Standard Monitoring of the Relationship Between Health Care Spending and Health Burden in the Commonwealth**

The fact that commercial health care dollars continue to be concentrated in higher income communities in ways unexplained by health burden raises important questions about how health care resources are being distributed across the state. We recommend regular monitoring and analysis of patterns in the distribution of health care dollars across Massachusetts communities to deepen our understanding of the impact of market factors (like price disparities) and socioeconomic factors (like inadequate access to transportation) on how health care is being accessed and paid for in this state. Such monitoring could include:

1. Closely tracking the allocation of health care dollars under global budgets to understand if these arrangements are being implemented in a way that distributes greater resources to the populations most in need of health care services, or if resources flow to higher income communities or other populations by virtue of residents' provider group selection (or for other reasons).
2. Monitoring the impact of plan design on access to health care services and the prevalence of different plan designs (such as high deductible health plans and the associated availability of HSAs and HRAs) among higher versus lower income populations.
3. Examining whether higher health care spending on higher income, healthier communities is contributing to income-based disparities in health outcomes. We recommend renewed investment in public health data collection to help track socioeconomic disparities in health care and identify priority areas for community-based interventions.

## **B. Sharpening Available Tools to Reward More Efficient Health Care Delivery**

The health care sector in the United States is built upon a private market system, which means a well-functioning market is foundational to making health care more affordable. Lack of transparency, payments not tied to value, product designs that dull or eliminate the incentives for employers and consumers to be effective shoppers, and other forms of market dysfunction undermine healthy competition that is needed to drive value. There are a number of efforts the Commonwealth can continue developing to engage all market participants around a value-based health care system that rewards high quality, cost effective performance. These include:

1. Exploring product designs that offer consumer incentives at the point-of-enrollment, with premium differentials that better reflect the true financial benefit that flows from consumers who select high value providers.
2. Leveraging state agencies like the GIC and the Connector to pilot such efforts, which build upon these agencies' past leadership piloting tiered network products and implementing novel consumer incentives. This includes considering any necessary statutory or regulatory updates to facilitate innovation, such as exploring rating by provider selection in the small group market, or facilitating the GIC's ability to pilot alternative member contributions at the point-of-enrollment.
3. Engaging the employer community to demand timely and easily compared information on the cost and quality of different insurance plans and provider systems combined with information on how provider mix and utilization is impacting their health care costs, to facilitate higher value choices.
4. Evaluating provider performance under the statewide cost growth benchmark in ways that take into account differences in provider efficiency, such that more efficient providers are given more room to grow under the benchmark than less efficient providers.

The Office of the Attorney General looks forward to continued collaboration with the Legislature, sister agencies, health care market participants, and other stakeholders in advancing health care reform efforts in this state, including the opportunity to work with the newly created Special Commission on Provider Price Variation to consider ways in which its work might address some of the broad issues documented in this report.

## ACKNOWLEDGMENTS

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