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

October 11, 2018

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Executive Summary

This is the Office of the Attorney General's ("AGO") 2018 report of its examination[1] of health care cost trends conducted pursuant to Section 17 of Chapter 12C of the Massachusetts General Laws.

Prior AGO cost trends reports have documented inefficiencies in the distribution of health care dollars. Two of those key findings have been that there is (1) significant price variation among hospitals and physicians that is unrelated to quality[2] and (2) significantly higher per capita spending on commercially insured people in more affluent communities as compared to less affluent ones despite the higher sickness burden found in less affluent communities.[3] In this report, we examine the different ways commercial insurance companies pay health care providers for services and assess how these differences contribute to market inefficiencies.

While total health care expenditures in Massachusetts grew only 1.6% in 2017—substantially below the state cost growth benchmark of 3.6%—consumers' exposure to health care costs rose at a much higher rate.[4] On average, fully-insured commercial premiums increased 4.9% in 2017 to $483 per month, with premiums for small employer groups increasing even more (6.9%).[5] Enrollment in high deductible plans is also increasing in Massachusetts (from 20.9% in 2015 up to 28.2% in 2017),[6] exposing consumers to high out-of-pocket costs and increasing their need to shop effectively for high value health care services. Consumers and employers rely on state health care reform initiatives like alternative payment methods and price transparency to curb health care cost increases and to help manage their increased financial exposure. This report examines the underlying complexity and variation in health care payment arrangements and considers how they may increase administrative costs and impair the ability of consumers, employers, and referring providers to shop for the most cost-effective care.

Payments between payers and providers are based on complex contracts that detail how all health care services will be reimbursed. Commercial insurers negotiate these multi-year contracts with providers to establish a mutual understanding of how and how much providers will be paid for delivering health care services to their members. As we describe in detail below, these contracts use a wide range of methods for calculating the ultimate payment rates for a vast array of services. This variability and complexity in how health care services are reimbursed add significant costs to the health care market and make price comparisons more difficult for market participants.

1 This report relies on information obtained through civil investigative demands issued to Massachusetts health insurers pursuant to Mass. Gen. Laws c. 12C, § 17. We reviewed detailed information on health care contracting, prices, utilization, claims, 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 OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Mar. 16, 2010), *available at* https://www.mass.gov/files/documents/2016/08/vn/2010-hcctd-full.pdf; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (June 22, 2011) [HEREINAFTER AGO 2011 REPORT], *available at* https://www.mass.gov/files/documents/2016/08/uy/2011-hcctd-full.pdf; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Apr. 24, 2013) [HEREINAFTER AGO 2013 REPORT], *available at* https://www.mass.gov/files/documents/2016/08/xc/2013-hcctd.pdf; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Sep. 18, 2015), *available at* https://www.mass.gov/files/documents/2018/05/04/cost-containment-5-report.pdf.

3 AGO 2011 REPORT, *supra* note 2; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Oct. 13, 2016), *available at* https://www.mass.gov/files/documents/2016/10/ts/cc-market-101316.pdf.

4 CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASS. HEALTH CARE SYSTEM ANNUAL REPORT SEPTEMBER 2018 at 7 (Sept. 2018) [HEREINAFTER 2018 CHIA ANNUAL REPORT], *available at* http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf.

5 *Id.* at 8.

6 *Id.* at 65.

This report is organized into three sections. Section 1 documents the variation and complexity in health care payment practices associated with hospital outpatient services (Section 1.A), hospital inpatient services (Section 1.B), and risk contracts (Section 1.C). To illustrate this variation and complexity, the report includes examples related to payment for hospital observation services (Section 1.A.ii) and obstetrics services (Section 1.B.ii). Section 2 reports on the implications of this complexity, highlighting the increased administrative costs (Section 2.A.) and the impact on price transparency (Section 2.B). Finally, Section 3 summarizes our recommendations.

Our principal findings are as follows:

1. Commercial health care fee-for-service payments are determined using complex and varied methods with little consistency across payers, providers, or insurance products.
    a. Hospital outpatient payment methods are particularly complex and varied, with the largest payers using different approaches to fee schedules and other forms of payment.
    b. Hospital inpatient payment methods are somewhat more consistent across the largest payers as the market has moved towards adopting DRG-based payment methods,[7] but significant variation remains across smaller payers.
2. Risk contracts are also complex and vary from payer to payer, adding another layer of complexity on top of the fee-for-service framework that underlies alternative payment methods.
3. The complex and varied payment system generates additional administrative costs that do not appear to add value to patient care, patient experience, or patient or provider engagement. It also serves as an obstacle to price transparency for consumers, employers, policymakers and providers.

Based on these findings, we make the following principal recommendations to policymakers, payers, providers, and consumer advocates:

1. Study further the administrative costs associated with the current complex and varied approaches to payment with the goal of identifying waste and achieving savings.
2. Reduce complexity and explore increased standardization where appropriate in the methods for determining health care payment rates.
3. Establish real-time, service-level price transparency for employers, consumers, policymakers, and providers.

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

7 A diagnosis related group or "DRG" is a methodology used to determine payment rates for hospital admissions. *See infra* at page 7.

I. There Are Complex and Varied Methods for Determining Commercial Health Care Payment Rates.

As part of our examination, we reviewed commercial payer contracts for the hospitals affiliated with the largest Massachusetts hospital systems.[8] As detailed below, our examination found variation in commercial payment practices across payers, insurance products, and providers for hospital outpatient services, hospital inpatient services, and risk contracts.

a. Hospital Outpatient Payment Methods Are Particularly Complex and Varied.

Hospital outpatient services account for 63% of Massachusetts hospital commercial revenue on average across all payers.[9] Hospital outpatient services account for an even higher percentage of commercial revenue for Massachusetts community hospitals. From the largest Massachusetts commercial payer, on average 74% of community hospital commercial revenue is for outpatient services, with specific hospitals ranging from 49% to 98% outpatient revenue.[10] Hospital outpatient spending is one of the service categories with the highest recent growth in total health care expenditures (4.8% growth in hospital outpatient spending as compared to growth in overall total health care expenditures of 1.6% in 2017).[11] Due to its increasing volume and significance as a health care cost driver, hospital outpatient spending should be a priority area for cost containment and transparency efforts.

i. Hospital Outpatient Fee Schedules Vary in Structure Across Payers.

The three largest commercial payers in Massachusetts typically use fee schedules as the basis for negotiating and establishing contractually agreed upon payment rates for hospital outpatient services. A fee schedule is a detailed listing of hospital outpatient services and the corresponding "list" prices payers have established. While the list of services and the codes used are generally the same across payers, the underlying base fees each commercial insurer establishes are unique to each insurer. Each provider then typically negotiates "multipliers" that are used to inflate those base fees for groups of services. For example, the parties may negotiate a multiplier of 1.2 for a certain set of hospital outpatient services, which means that the provider would receive 120% of the prices reflected in the payer's fee schedule for the specified range of services.

8 This examination included data from payers pertaining to their contracts with Beth Israel Deaconess Care Organization, Lahey Health System, Partners HealthCare System, Steward Health Care System, UMass Memorial Health Care, and Wellforce. Our examination did not address reimbursement for behavioral health services or pharmaceuticals, as the AGO has previously documented the complex reimbursement arrangements governing these areas. *See* OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (June 30, 2015), *available at* https://www.mass.gov/files/documents/2016/08/qz/hc-ct-cd-06-2015.pdf; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Oct. 7, 2016), *available at* https://www.mass.gov/files/documents/2016/10/wk/cc-pharma-100716.pdf.

9 Based on a simple unweighted average of payer inpatient/outpatient commercial revenue reported by the Center for Health Information and Analysis. CTR. FOR HEALTH INFO. & ANALYSIS, RELATIVE PRICE PROVIDER PRICE VARIATION IN THE MASS. COMMERCIAL MARKET DATABOOK (Apr. 2018), *available at* http://www.chiamass.gov/assets/docs/r/pubs/18/Relative-Price-Databook-2018.xlsx.

10 *Id.*

11 2018 CHIA ANNUAL REPORT, *supra* note 4, at 18.

A different multiplier (e.g. 1.4 or 140% of the base fee schedule) could be negotiated for a different set of services.

In our examination of how Massachusetts payers pay for hospital outpatient services, we found significant differences in the way the largest three payers establish and use base fee schedules.

Different Approaches to Hospital Outpatient Fee Schedules

	Payer 1	Payer 2	Payer 3
Number of outpatient billing service categories	17	12	4
Rate multipliers negotiated by outpatient billing service category?	Yes	Yes	No

Note:

1. Data is based upon an analysis of the contracts between the three largest Massachusetts payers and the six largest Massachusetts hospital systems.

As illustrated in the chart above, two of the three major commercial payers use fee schedules with different service category groupings of hospital outpatient services for purposes of negotiating multipliers. These groupings are not defined consistently across the two payers. For example, one payer negotiates a single multiplier for radiology services while the other payer negotiates two multipliers—one for general radiology and one for high tech radiology and sometimes yet a third category for "imaging agents." One payer divides its hospital outpatient fee schedule into seventeen groups of services while another payer uses twelve. This means there may be seventeen different multipliers for different hospital outpatient services for one payer and twelve multipliers for different hospital outpatient services for the other payer.

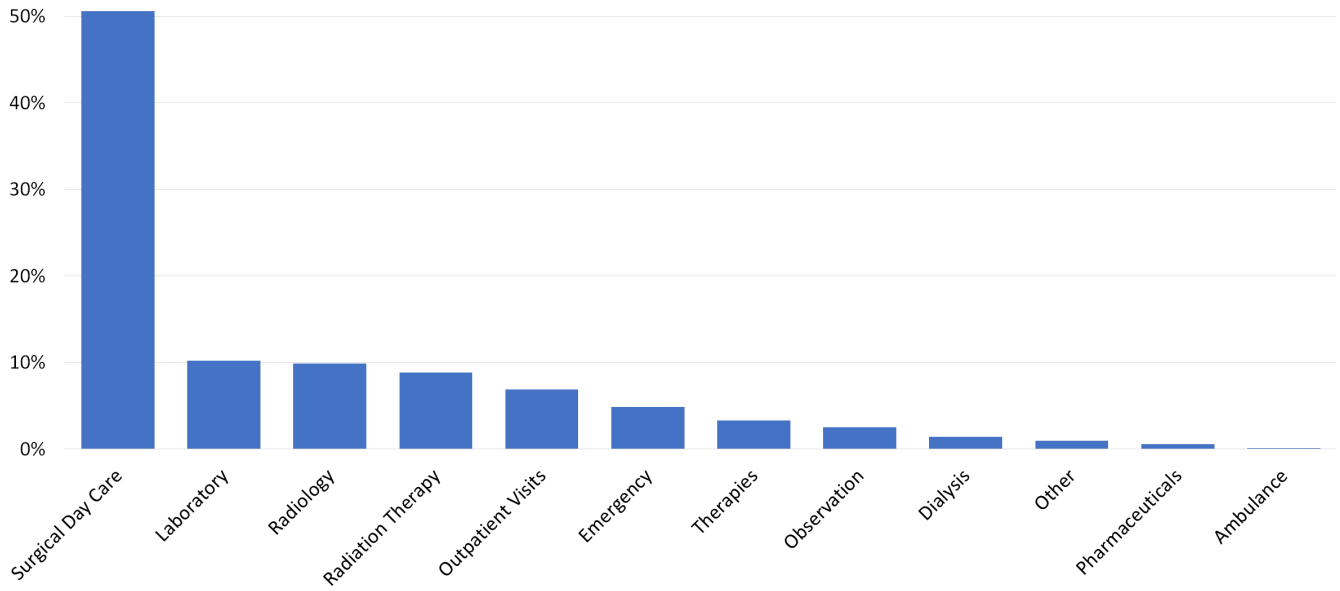
The third payer has four different service categories of hospital outpatient rates but does not use these categories as a basis for negotiating multipliers. Instead, this payer starts with a fee schedule for each hospital. It then negotiates an aggregate rate increase for that hospital's outpatient services over the prior year, which is then realized through changes to the hospital-specific fee schedule. This approach does not use negotiated "multipliers" for particular groups of services.

Adding to the complexity of service-specific multipliers, outpatient multipliers also often vary by insurance product, with different rates for health maintenance organization ("HMO") and preferred provider organization ("PPO") products. Further, some commercial payers have rates for certain hospitals that vary within products, with up to four different HMO prices for the same services and up to six different PPO prices. These different rates within a single product category (such as within a payer's PPO offerings) are differentiated based on factors such as the member's employer group or primary care provider. These rates can vary significantly: for one hospital system, PPO prices for the exact same services varied by up to 57% depending on the member's employer.

Equally important, billing requirements also vary significantly across payers and providers. Coding and authorization requirements, as well as documentation requirements for determination of medical necessity, vary significantly between commercial plans and sometimes across products within a plan. In addition, some providers are paid supplemental payments on top of their fee-based payments that are calculated without respect to claims-based billing.

The result of this approach to establishing hospital outpatient prices by service category is that a hospital may be much less expensive than average for one type of service but much more expensive than average for another type of service. To illustrate this variation, we examined three hospital outpatient services: surgical day care, laboratory, and radiology services. As reflected in the chart below, these services account for substantial hospital outpatient spending.

Outpatient Total Medical Expenses by Service Category for One Massachusetts Payer (2017)

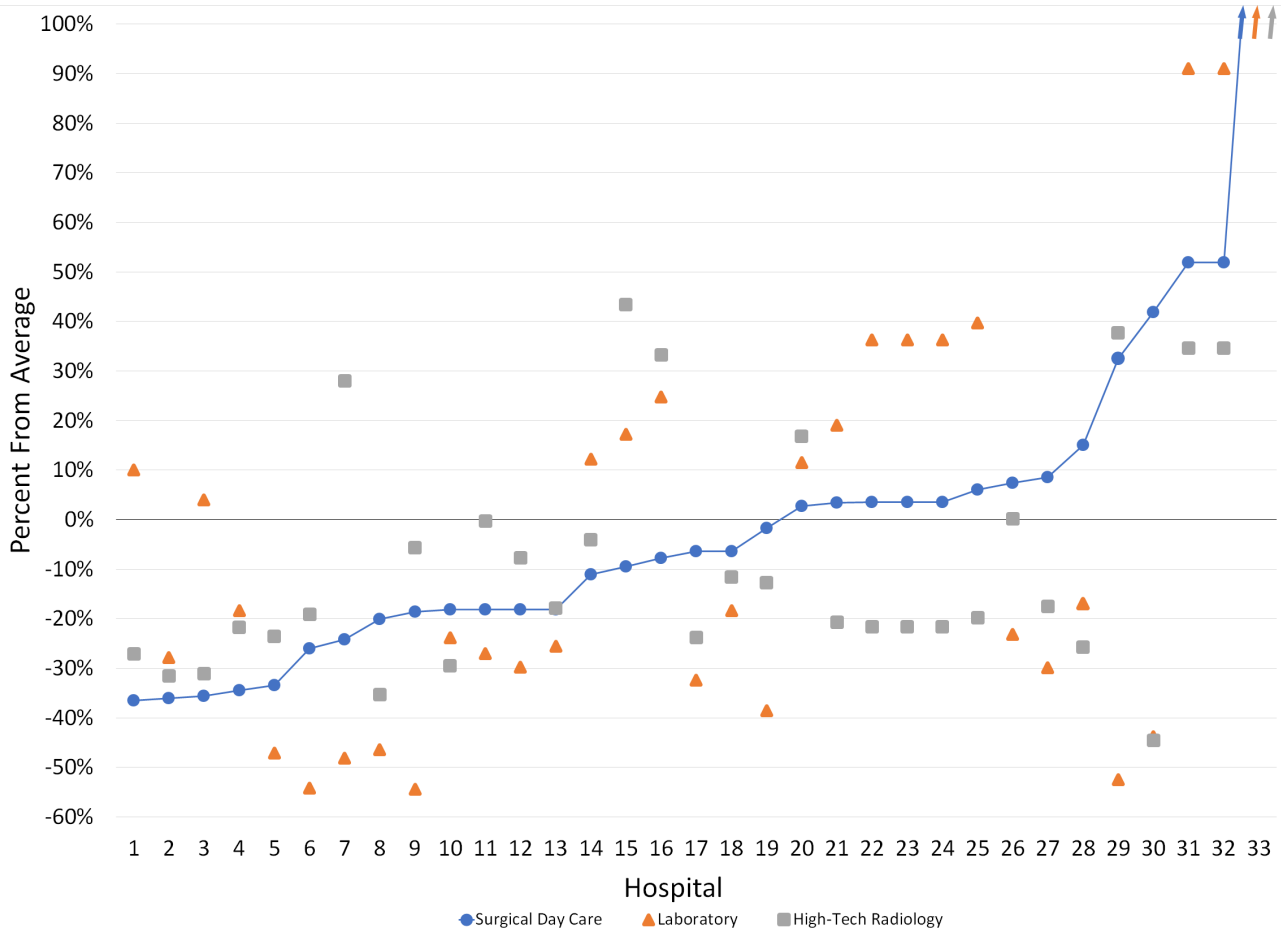


Notes:

1. Data is based on 2017 risk settlements from one payer for three large Massachusetts physician groups for an attributed population of approximately 80,000 members.
2. Data excludes behavioral health spending.

The use of multiple service categories with different negotiated multipliers within a single payer means that different services within a single hospital may vary in relative price. The chart below depicts the hospital outpatient fee schedule multipliers applicable to surgical day care, laboratory, and high-tech radiology for one product offered by one large Massachusetts payer for the Massachusetts hospitals that contract through the six largest Massachusetts hospital systems. Each number on the horizontal axis represents a different hospital, with three corresponding points plotted on the chart to represent the hospital's negotiated multipliers for each service as compared to the average multiplier for the service across this set of hospitals.

Hospital Rate Multipliers for Three Outpatient Services for One Massachusetts Payer (2018)



Notes:

1. Includes hospitals that contract through the six largest Massachusetts hospital systems but excludes hospitals that are not paid based on a fee schedule for these services.
2. The average reflected in this chart is the unweighted average multiplier for the specific service category for this set of hospitals.
3. Where a contract included negotiated multipliers for ambulatory surgery centers owned by the hospital system, those ambulatory surgery centers are included as one hospital in the chart above.
4. The multipliers for hospital 33 exceed 100% above average (Surgical Day Care 149%, Laboratory 229%, High-Tech Radiology 267%).

In the chart, the hospitals are organized in order of their multiplier for surgical day care (the blue circles), and this chart shows that other multipliers (laboratory as represented by orange triangles and high-tech radiology as represented by gray squares) often do not align with the surgical day care price.

Our examination showed that it is difficult for a patient, employer, or referring provider to identify consistently the best value for a particular health care service. For example, a hospital that is a good value for outpatient surgery may not be a good value for radiology (like hospital 7 in the chart above). While some hospitals are very expensive for almost everything, or very low-cost for almost everything, this was the exception. We found that significant differences in payment rates across services existed at most hospitals.

ii. Hospital Outpatient Payment Complexity Extends Beyond Fee Schedules and Billing Categories: Observation Services Case Study.

There are exceptions to the general rule that hospital outpatient services are reimbursed according to a fee schedule. Negotiated approaches to payment for hospital outpatient services that do not fall within the typical fee schedules are complicated and inconsistent across payers. To illustrate how payment rates are calculated for services that fall within these exceptions, we examined the different approaches to reimbursing hospitals for "observation" services. Observation services are short-term treatments and assessments used to determine whether a patient needs to be admitted for inpatient care or can be discharged.

We found significant variation within and across the largest Massachusetts payers in the way this service is reimbursed. One insurer pays for observation services based on time increments but does not have standardized increments. Instead, this payer breaks out time increments for purposes of billing in six different ways across its contracts with different hospitals. Another payer uses a base rate for each hour of observation with a negotiated multiplier. The third payer uses an all-inclusive rate for 24 hours of observation. In addition, each of these rates generally varies by insurance product (e.g., HMO or PPO).

The result of this structural complexity is that it is very difficult (1) to predict which hospitals are competitively priced or are likely to be a good value within any particular payer and (2) to assess value across payers without detailed case-specific information. Due to these different payment approaches, one cannot determine in advance whether certain hospitals are more expensive as compared to others for observation services, since the ultimate price will vary significantly based on the length of treatment and the applicable payment method.

b. Hospital Inpatient Payment Methods Are Somewhat More Standardized Across the Three Largest Payers, But Variation Exists Across the State.

For hospital inpatient services, payments are somewhat more standardized across the three major commercial payers in Massachusetts, but variation exists across the state. As summarized below, Massachusetts payers typically use some combination of four different methods for calculating hospital inpatient payment rates: diagnosis related groups ("DRGs"), case rates, per diems, and percent of charges (also called "payment on account factor").

A DRG is a methodology used to determine payment rates for hospital admissions. Medicare implemented DRG-based payments in 1981, and commercial insurers have slowly adopted this prospective payment method as an alternative to other retrospective methods of payment. Under a DRG methodology, a base rate of payment is prospectively negotiated between each insurer and hospital, and this base rate drives the total payment level for each admission. Upon each hospital discharge, all of the diagnoses, procedures, complications and co-morbidities, and other patient characteristics are coded and grouped using the software each payer uses to assign DRGs, called "groupers." Each assigned DRG is then associated

with payer-specific severity weights known as "case weights." The prospectively negotiated base rate is then multiplied by the case weight associated with the assigned DRG. The number and types of DRGs vary across groupers, and the case weights associated with each grouper can vary as well. Payers may use one or more DRG groupers, such as those developed by CMS for Medicare patients, or they may use other groupers developed for commercial or non-commercial populations. Payers may develop their own proprietary case weight systems or use commercial case weights or case weights derived from Medicare or Medicaid.

Case rates are similar to DRGs as they are negotiated prospectively for certain specific categories of care, such as joint replacements, cardiac services, obstetrics and transplants. Unlike DRGs, case rates are not adjusted for severity and generally are accompanied by negotiated outlier[12] calculations that are not consistent with DRG methods of adjusting for outliers.

Per diem payments are negotiated rates paid retrospectively based on the number of days a patient stayed in the hospital.

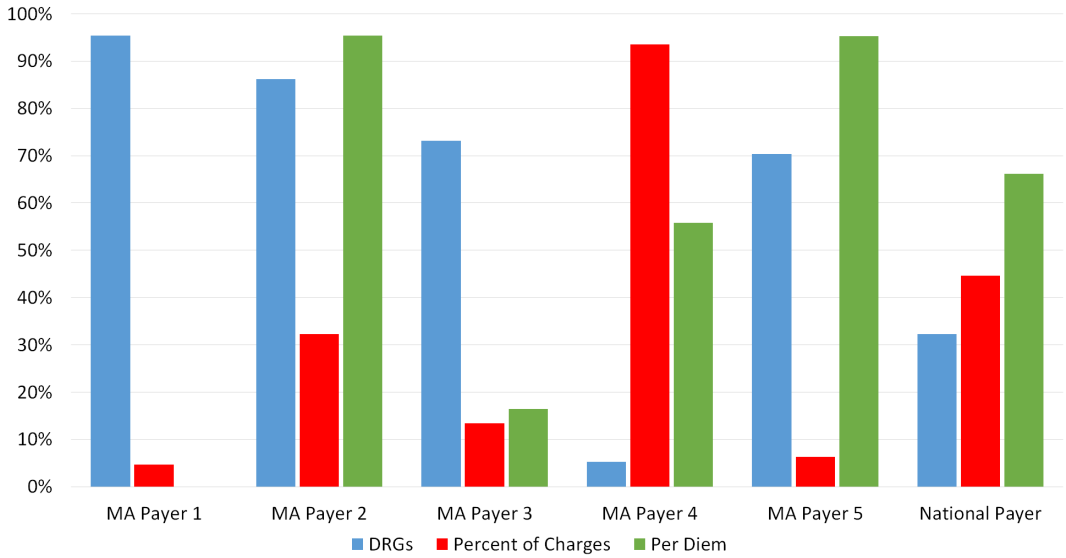
Percent of charges is a payment method in which a hospital is paid a negotiated discount off the hospital's pricing list (called the hospital's chargemaster).

i. The Three Largest Massachusetts Payers Use Principally DRGs for Hospital Inpatient Payment; Other Payers Use Per Diems and "Percent of Charges" Arrangements.

As reflected in the chart below, the three largest Massachusetts payers (MA Payer 1, 2, and 3) use principally DRGs (blue bar) for hospital inpatient payment across their Massachusetts hospital contracts. However, many payers use a combination of DRGs, per diems (green bar), and percent of charges (red bar) for payment for different services sometimes at the same hospital. Data from two smaller Massachusetts plans (MA Payer 4 and 5 in the chart below) and a national plan showed that adoption of DRGs was more limited outside of the largest three payers. For instance, one small Massachusetts plan pays over 90% of Massachusetts hospitals, at least in part, on a percent of charges basis. Another small plan uses per diems in over 90% of its Massachusetts hospital contracts. The national payer reported using all three methods across a significant percentage of its Massachusetts hospital contracts. Where different payment methods are used for the same services, it is difficult for a market participant to accurately assess relative value across health plans or even between provider options within a health plan.

12 An outlier is a particularly complex case that may trigger additional payments.

Percent of Payers' Massachusetts Hospital Contracts that Use DRG, Percent of Charges, and Per Diem for Inpatient Payment



Notes:

1. Data reported by payers for contracts in effect in May 2018 with Massachusetts acute care hospitals for commercial business.
2. Data excludes payment methods for behavioral health services.
3. A payer's reported use of these payment methods may add up to over 100% where the payer uses multiple methods to pay some hospitals.
4. Most payers surveyed also reported using case rates to pay for at least some types of hospital inpatient services.

Increased administrative resources are required for hospitals to maintain systems that simultaneously accommodate DRG-based payments, per diem payments, and condition-specific case rates. Each of these inpatient payment methods comes with its own set of payment rules, contractually negotiated specifications, and payment policies and procedures. The complexity of these systems not only leads to increased resource needs to adjudicate multiple systems, but also can lead to difficulty complying with billing specifications, resulting in claims denials, appeals, and additional work and costs associated with this appeal process.

Administrative complexity is also costly for providers where insurers may use the same method of payment but have different ways of administering that particular method of payment. For instance, while many insurers use DRGs for inpatient payments, each has its own contractual specifications and billing requirements. Several Massachusetts insurers use different DRG groupers or different versions of a particular grouper. In addition, each insurer uses its own set of case weights. All of these potential variations in the way DRGs are administered require providers to maintain multiple DRG billing systems and devote incremental resources to complying with variations in billing and contractual requirements. While the three largest Massachusetts payers reported high rates of DRG adoption, they reported using different DRG grouper versions and case weights (some proprietary, some derived from Medicare). These plan-specific grouping, coding, and severity adjustment systems introduce substantial administrative complexity.

ii. Payment Methods for Obstetrics Illustrate the Lack of Standardization Within and Across Payers.

To illustrate inpatient billing and insurance-related complexity, we conducted a case study of the three largest payers' approaches to payment for obstetrics services. In this study we observed multiple approaches to payment for obstetrics including global case rates, per diems, and DRGs. We found that among the three largest insurers in Massachusetts, all three payment methods were used across their networks. That is, a single hospital is sometimes paid on a per diem by one insurer, global case rates for another insurer, and DRGs for another insurer. In addition, we also observed rate variation by product (e.g., HMO or PPO) as well as by product segment (e.g., by the member's primary care provider or employer).

As reflected in the chart below, we observed substantial variation in the billing specifications for global case rates, per diems, and DRGs for obstetrics services. Not only did we see the same obstetrics services paid for in three distinct payment methods, but each of the payment methods lacked standard billing specifications within and across payers. For instance, we observed different categorizations of the services to be included in the global case rates, with some payers offering just two categories of rates (one for vaginal delivery and one for caesarian delivery) and others breaking out four categories based on whether the delivery had complications and whether care for the healthy newborn is included. We also observed variation across provider contracts regarding the specifications of outlier payments and in when an outlier payment is triggered (e.g., Day 5 versus Day 6).

We found the per diem rates used across the plans for obstetrics services to be generally comparable to one another in structure: a negotiated rate multiplied by the number of days of the admission. Rates are generally set with one rate for the first day of the admission and a second rate for subsequent days. However, rates varied by and within products. Some hospitals had more than one HMO rate while others had just one.

We also observed variation in the administration of DRGs for obstetrics services (such as grouper type and version, case weights, and variation across products). DRG rates are more likely to be predictable and comparable across plans if case weights, DRG groupers, and product structure are standardized.

Variation in Obstetrics Payment Methods

	Global Case Rates	Per Diems	DRGs
Standardized Service Categories?	No	N/A	No
Standardized Outlier Definition?	No	N/A	No
Standardized Base Payment Structure?	No	Yes	Yes
Standardized Rates Across Products and Product Segments?	No	No	No

Note:

1. Data is based upon an analysis of the contracts between the three largest Massachusetts payers and the six largest Massachusetts hospital systems.

Our study of obstetrics services is just one example of variation in hospital inpatient payment methods. We found significant variation within and across payers for other hospital inpatient services similar to the variation observed in obstetrics. In particular, we found variation in payment methods for cardiac services, bariatric surgery, transplants, joint replacement, and vascular surgery. We also observed, outside of obstetrics services, that hospital inpatient payment methods may vary based on individualized exceptions or nuances that augment payment structures due to contractual variation in payment specifications. These contractual variations in payment approaches present significant complexity with regard to how a service is defined, how outliers are defined and paid for, and whether services are eligible for additional payments for certain implantable devices or high-cost drugs.

c. Risk Contracts Vary Significantly Across Payers and Providers.

Risk contracts are intended to incent providers to deliver higher-value care. Under a risk arrangement, insurers and providers negotiate a monthly budget for a covered population, and the providers are rewarded at the end of the year if they spend below their negotiated budget or penalized if they spend more than that budget. In addition to this efficiency incentive, most of these arrangements also include certain quality and patient satisfaction bonuses.

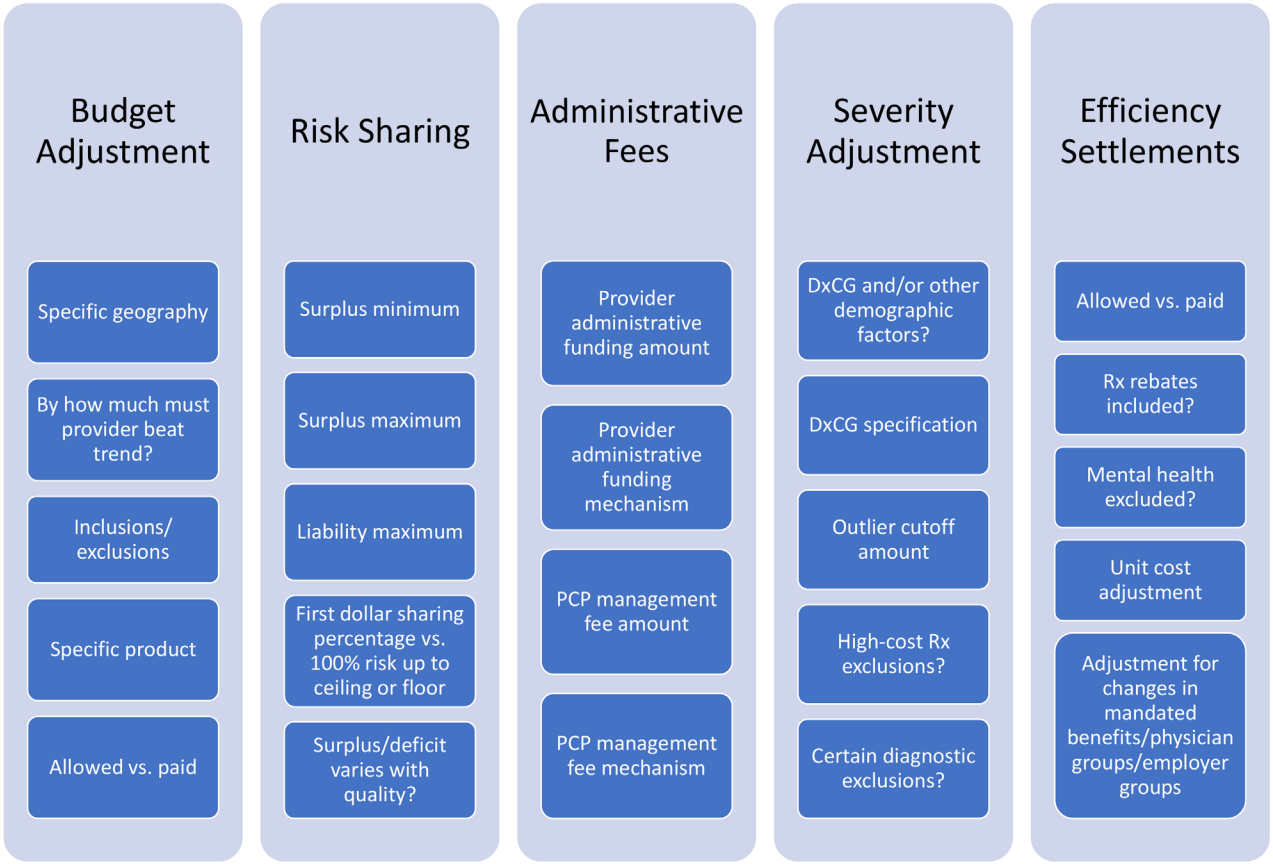
Our examination found that risk contracts vary in significant ways, with many contracts significantly capping or limiting efficiency risk exposure and bonus opportunities. We observed certain products and plans that had significant opportunities for rewards and bonuses, while others had very limited opportunity. Our study found, for instance, that the incentive and surplus opportunity in PPO arrangements are often significantly less than in HMO products.

Such variation across plans and products limits providers' incentives to invest in systems and services that could reduce healthcare costs over time because patients move from one plan to another. If patients move from a plan with attractive risk terms and budgets to a different insurer or product that has less attractive risk terms and budgets (or to a fee-for-service product with no provider risk), a provider is less likely to invest in cost-reducing initiatives. Without alignment among insurers on how

budgets are set and the level of provider risk and opportunity, when patients migrate between plans, the incentives can shift significantly for providers. To illustrate the migration of members among plans, we looked at member persistency for a large Massachusetts plan and found that year over year approximately 5-15% of members did not stay in the same product, either leaving for a different payer or for a different product within the same payer. This means that over a five-year period, as much as 20-50% of membership can move to another plan or product, significantly altering a provider's attributed population and reward potential.

Furthermore, like the fee-for-service framework these risk arrangements are layered over, alternative payment methods are highly variable with virtually no standard approach to the complex budget and expense calculations, settlement processes, and other administrative and contractual specifications that define these arrangements. Below is a list of the key terms that define a provider's resources and efficiency incentives under risk contracts where we observed variation across contracts.

Key Areas of Variation Across Risk Terms



Notes:
1. Data is based upon an analysis of the contracts and risk settlements between the three largest Massachusetts payers and the six largest Massachusetts hospital systems.
2. This chart does not include terms related to quality.

These terms illustrate areas where risk contracts are not comparable to one another across payers or providers, leading to very different actual risk and incentive exposure for providers who participate in risk contracts. For example, our examination found variation in the liability maximums that govern risk sharing across different risk contracts. The liability maximum is a cap on the provider's losses if the provider spends more than the negotiated budget to care for an attributed population. For one payer, we found physician liability maximums ranging from $5.87 up to $25 per member per month across large Massachusetts provider groups. In previous examinations, we also noted significant differences in the negotiated budgets between providers.[13]

Risk settlements are complicated processes that take up to a year to complete after the end of the contract risk period. Auditing, confirming, and interpreting these risk provisions, adjustments, and appeals requires significant resources from providers and insurers. The complexity of these arrangements means insurers and providers must devote additional resources to negotiating and administering these unique and varied arrangements.

13 *See* AGO 2013 REPORT, *supra* note 2; OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (Sep. 18, 2015), *available at* https://www.mass.gov/files/documents/2018/05/04/cost-containment-5-report.pdf.

II. The Complex and Varied Payment System Has Significant Implications for the Commonwealth's Health Care Cost Containment Goals.

a. Administrative Complexity Adds Substantial Costs to the Health Care System.

Administering a complicated and varied set of health care payment methods is expensive. Although there have not been published studies of this cost in Massachusetts, one important study estimated that administrative costs represented between $107 billion and $389 billion nationally in wasteful spending in 2011.[14] This study concluded that "[r]educing waste is by far the largest, most humane, and smartest opportunity for evolving an affordable health care system,"[15] finding that of the six "wedges" of waste in the U.S. health care system, the largest is administrative complexity—the waste driven by inefficiency in how the health care system is administered.[16]

More recent national studies have similarly documented the continued high cost of administrative complexity in our health care system. A study comparing administrative costs of hospitals in eight nations found that in the United States administrative costs account for 25.3% of hospital expenditures, the highest percent of the eight nations.[17] Administrative costs are a major driver behind the difference in overall health care cost between the US and other countries.[18] In fact, reducing US spending for hospital administration to that of Canada would have saved approximately $158 billion in 2011 dollars.[19] Likewise, another study looking at administrative costs in a multisite, multispecialty medical group found that for every ten physicians, there were almost seven full-time equivalent employees engaged in billing and insurance-related ("BIR") activities.[20] Approximately 62% of administrative costs can be attributed to BIR activities.[21] Not only is the cost attributable to BIR activities high, but it appears to be growing. A national study found that in 2009 costs associated with BIR activities represented 14.4% of total health expenditures, and by 2012 such costs represented 16.8%.[22]

14 Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307(14) JAMA 1513, 1515 (Apr. 2012).

15 *Id.*

16 *Id.*

17 David U. Himmelstein et al., *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far*, 33:9 HEALTH AFFAIRS 1586, 1589 (Sep. 2014). *See also* David M. Cutler, *Reducing Health Care Costs: Decreasing Administrative Spending*, Testimony for Senate Committee on Health, Education, Labor and Pensions (Jul. 31 2018) (stating that "[t]he typical hospital spends nearly 10 cents out of every dollar collected collecting that dollar; the typical physician's office spends even more").

18 Himmelstein, *supra* note 17, at 1593.

19 *Id.*

20 Julie Ann Sakowski et al., *Peering Into the Black Box: Billing and Insurance Activities in a Medical Group*, 28:4 HEALTH AFFAIRS 544, 547 (May 14, 2009), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.28.4.w544.

21 Philip Tseng et al., *Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System*, 319(7) JAMA 691, 692 (Feb. 2018).

22 Elsa Pearson, *How much is too much? What does the US actually spend on health care administration?*, The Incidental Economist (Apr. 4, 2018), *available at* https://theincidentaleconomist.com/wordpress/how-much-is-too-much-what-does-the-us-actually-spend-on-health-care-administration/.

There is no evidence that these higher administrative costs translate to higher-value care. While one could imagine a scenario in which more administration would reduce overall costs by eliminating other waste or increasing efficiency, data suggest the opposite. As reported, the eight-nation study found that "total hospital costs were highest in the nations that had the highest hospital administrative costs."[23] This study is consistent with our finding that providers are paid in different, idiosyncratic ways by the different plans with whom they contract. We did not identify evidence that this kind of administrative complexity and its associated costs are bringing value to patients, plan sponsors, or insurers.

b. The Complex Payment System Serves as a Barrier to Actionable Price Transparency.

Our findings on the variation and complexity of payment methods also have implications for health care price transparency and market-driven cost containment initiatives. We found a wide range of payment methods in use across Massachusetts payers and providers for determining the rates paid for hospital inpatient and outpatient services. As described above, payment rates for certain services may be determined on a per diem basis for one insurer and a DRG basis for another insurer, with rates that further vary depending on whether the patient has an HMO or PPO product. This individualized approach to payment arrangements makes "apples to apples" price comparisons difficult for market participants like consumers, employers, and providers who want to identify high value health care services and products.

The difficulty of making actionable price comparisons is easiest to model for outpatient services. We found that outpatient fee schedules are generally subdivided into varying service groupings for purposes of negotiating prices. Price negotiations at the service group level result in variation in relative prices for services within the same hospital that raises questions about the appropriateness of using aggregated hospital prices for purposes of comparing outpatient service prices among hospitals.

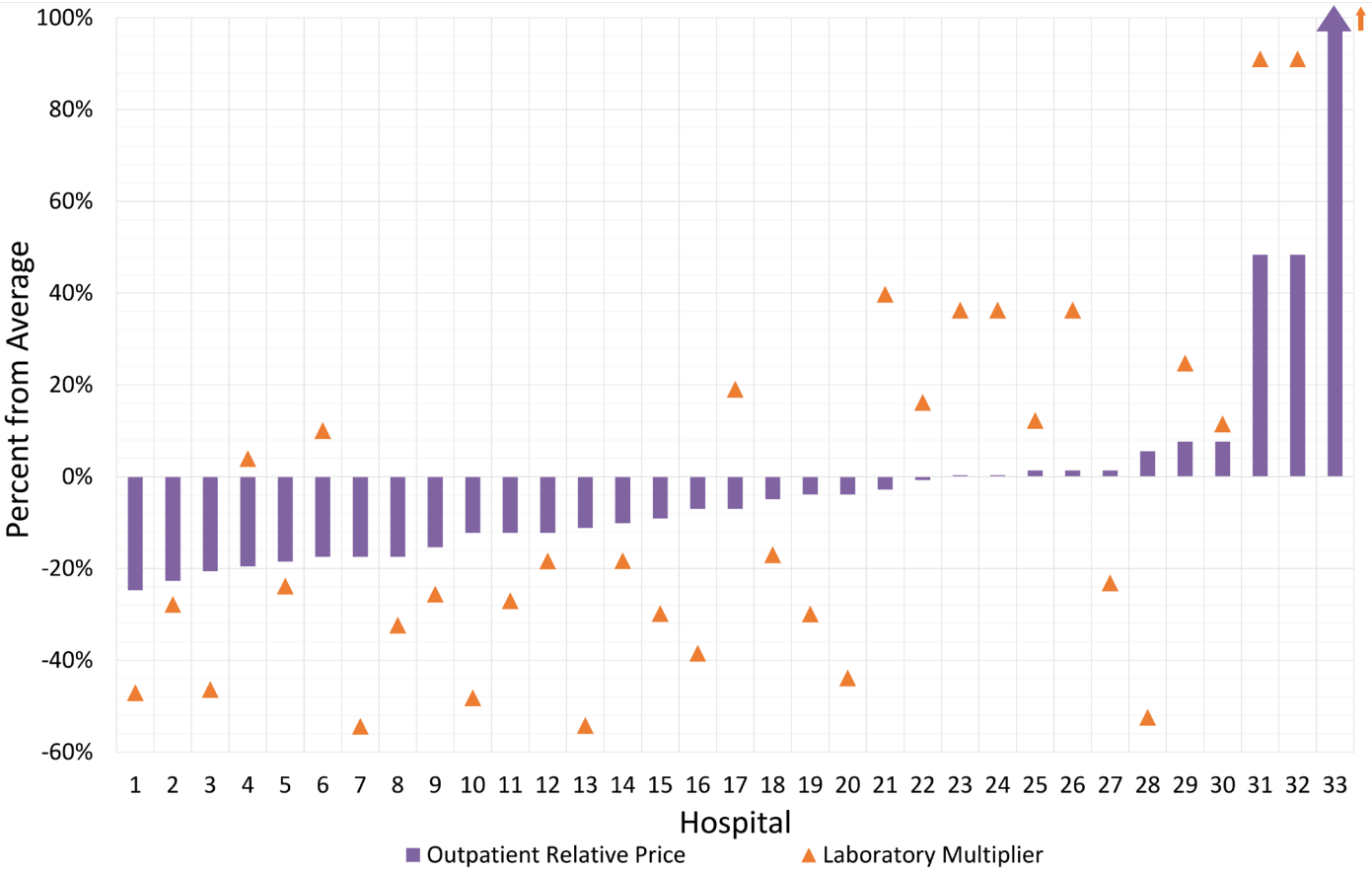
For example, the existence of intra-hospital price differences by service means that aggregate relativity indices like Relative Price[24] mask the fact that one hospital may be high-priced for some services and lower-priced for others. This adds a hidden level of complexity to discussions of provider relative price and means that aggregate measures—while valuable for analysis of the health care market and overall relativities in price—are not well tailored to capture variation in prices for specific services. The chart below shows the most recent outpatient Relative Price index for one payer mapped against the current laboratory multipliers in effect for the same set of hospitals for the same payer.[25]

23 Himmelstein, *supra* note 17 at 1592.

24 *See* CTR. FOR HEALTH INFO. & ANALYSIS, RELATIVE PRICE PROVIDER PRICE VARIATION IN THE MASS. COMMERCIAL MARKET (Apr. 2018), *available at* http://www.chiamass.gov/assets/docs/r/pubs/18/Relative-Price-Report-2018.pdf.

25 We performed the same analysis for surgical day care and radiology multipliers and found similar results.

Hospital Outpatient Relative Price Compared to Multipliers for Laboratory Services for One Massachusetts Payer



Notes:

1. Includes hospitals that contract through the six largest Massachusetts hospital systems but excludes hospitals that are not paid based on a fee schedule for these services.
2. Outpatient Relative Price is the 2016 payer-specific Relative Price for HMO and POS products as reported by the Center for Health Information and Analysis.
3. The average Outpatient Relative Price in this chart is the unweighted average Outpatient Relative Price for this set of hospitals.
4. The average Laboratory Multiplier in this chart is the payer's unweighted average Laboratory Multiplier for this set of hospitals.
5. Where a contract included negotiated multipliers for ambulatory surgery centers owned by the hospital system, those ambulatory surgery centers are included as one hospital in the chart above.
6. The Laboratory Multiplier and Outpatient Relative Price for hospital 33 exceed 100% above average (Outpatient Relative Price 149% and Laboratory Multiplier 230%).

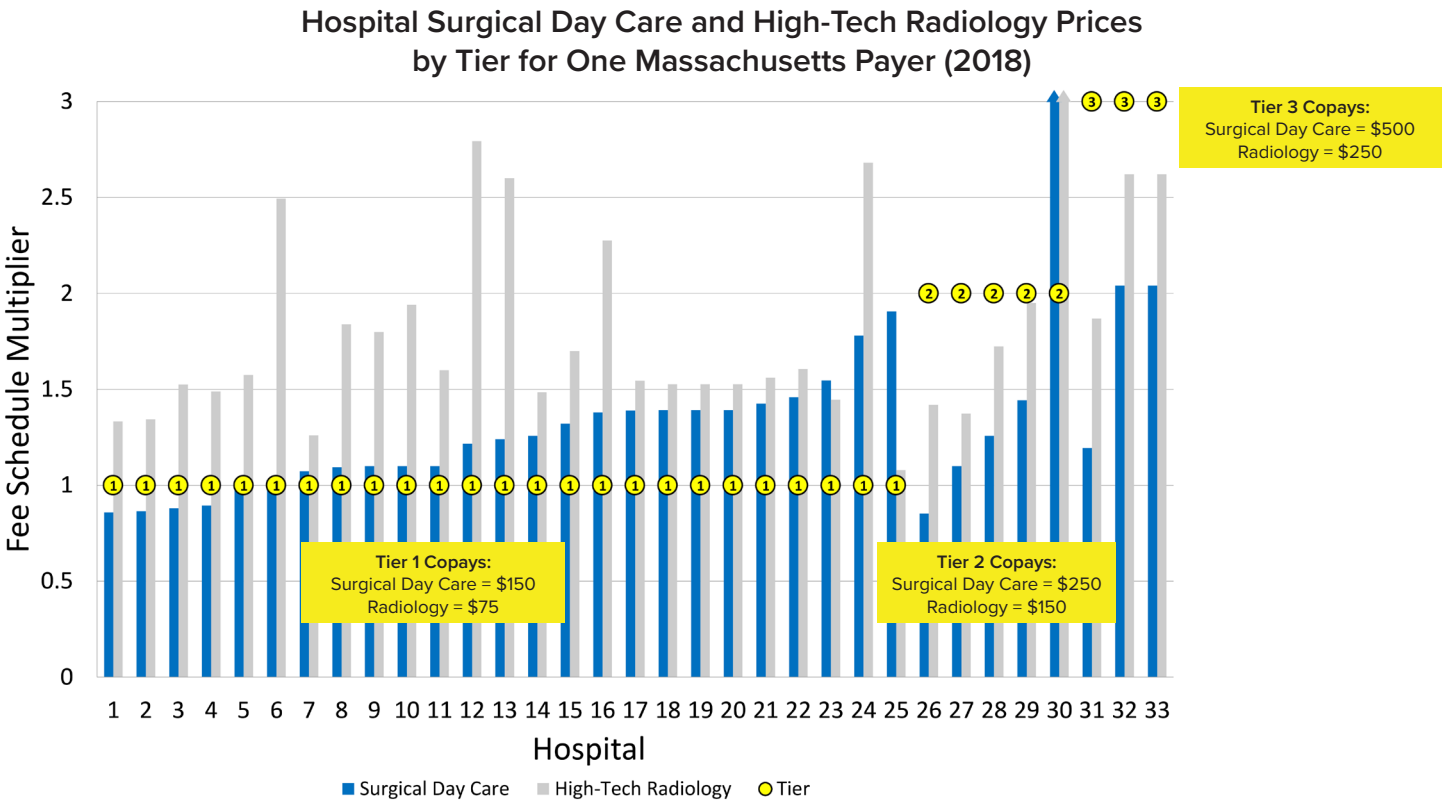
The existence of intra-hospital price variation creates barriers for purchasers seeking to shop for value. Massachusetts law requires payers to maintain online pricing tools that consumers can use to look up price estimates for specific services.[26] Although these online tools should provide consumers with reasonable estimates of the price of services notwithstanding this administrative complexity, reported consumer use of such tools is limited. In FY2016, Massachusetts hospitals reported over 800,000 discharges and over 15,000,000 hospital outpatient visits.

26 Mass. Gen. Laws c. 32A, § 27.

Yet, the largest three Massachusetts payers reported a combined total of only 103,283 hits in 2016 and 93,297 hits in 2017 on their price transparency online tools.[27] Furthermore, such tools are not available to other purchasers, such as employers, who may seek information on comparative costs for particular services when making plan and product selections that will shape the health care options available to their employees.

For most consumers, shopping for health care services is driven by their plan design and out-of-pocket cost exposure. Tiered network products are intended to incentivize consumers to select higher-value providers by offering lower cost sharing when a consumer chooses a provider with a preferred tier classification. However, as the graph below indicates, we found that tier placement is not consistently predictive of actual hospital outpatient pricing, leading consumers to, in some cases, pay higher co-payments when they receive lower-cost services.

27 *See* HEALTH POLICY COMM'N, MASS EXEC. OFFICE FOR ADMIN. & FINANCE, 2014 HEALTH CARE COST TRENDS HEARING, PRE-FILED TESTIMONY [HEREINAFTER HPC PRE-FILED TESTIMONY]: Blue Cross Blue Shield (2017), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/2017/2017-pre-filed-testimony-questions-bcbsma.pdf; HPC PRE-FILED TESTIMONY: Tufts Health Plan (2017), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/2017/2017-pre-filed-testimony-tufts-health-plan.pdf; HPC PRE-FILED TESTIMONY: Harvard Pilgrim Health Care (2017), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/2017/2017-pre-filed-testimony-questions-harvard-pilgrim.pdf; HPC PRE-FILED TESTIMONY: Blue Cross Blue Shield (2018), *available at* https://www.mass.gov/files/documents/2018/09/17/BCBSMA%20-%202018%20Pre-Filed%20Testimony%20Questions%20-%20Payers.pdf; HPC PRE-FILED TESTIMONY: Tufts Health Plan (2018), *available at* https://www.mass.gov/files/documents/2018/09/17/Tufts%20Health%20Plan%20-%202018%20Pre-Filed%20Testimony%20Questions%20-%20Payers.pdf; HPC PRE-FILED TESTIMONY: Harvard Pilgrim Health Care (2018), *available at* https://www.mass.gov/files/documents/2018/09/17/Harvard%20Pilgrim%20-%202018%20Pre-Filed%20Testimony%20Questions%20-%20Payers.pdf. These payers also reported a total of 2,163 consumer price inquiries in person or over the phone in 2016 and 2,989 such inquiries in 2017. *Id.*



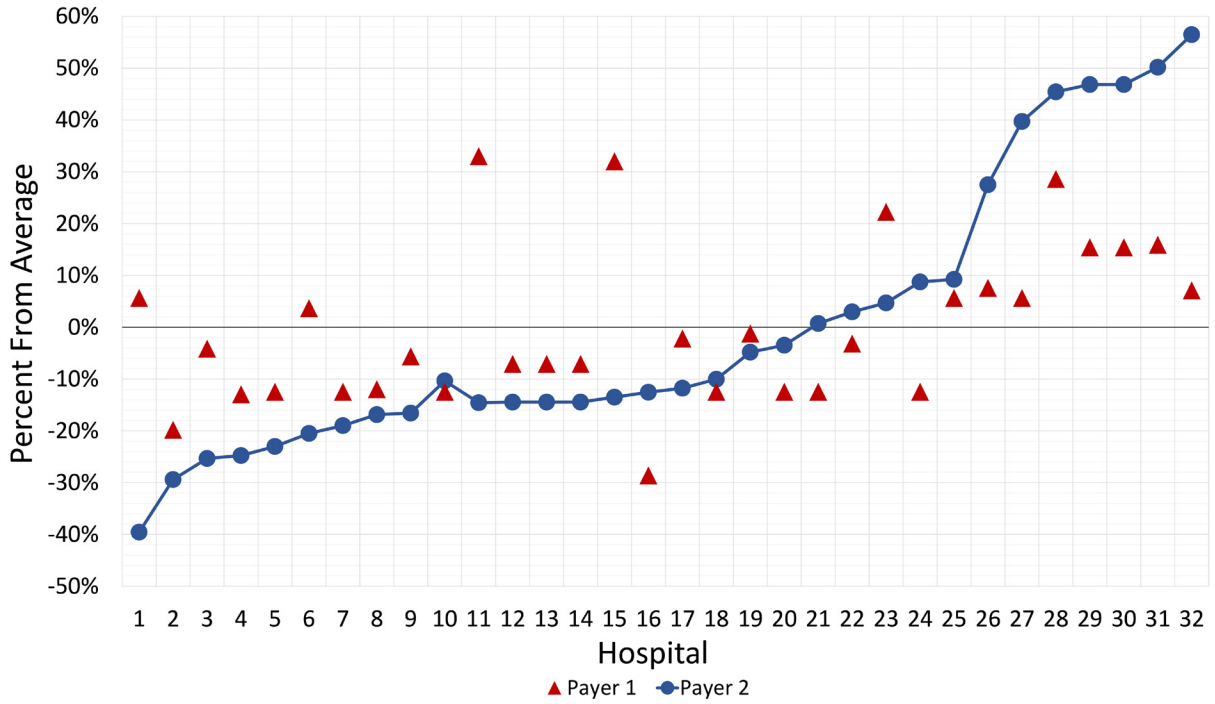
Notes:

1. Includes hospitals that contract through the six largest Massachusetts hospital systems but excludes hospitals that are not paid based on a fee schedule for these services.
2. Where a contract included negotiated multipliers for ambulatory surgery centers owned by the hospital system, those ambulatory surgery centers are included as one hospital in the chart above.
3. The multipliers for hospital 30 exceed three (Surgical Day Care 3.342 and High-Tech Radiology 7.158).

In the graph above, each pair of blue and gray bars represents a hospital's prices for surgical day care and high-tech radiology for one large Massachusetts payer. The hospitals are organized in the graph based on their co-payment tiering level (depicted in yellow) for both surgical day care and radiology services. This chart demonstrates that preferred tiered status with a lower co-pay does not always identify lower-cost options.

Service level price transparency is also necessary for health care providers so that they can make high value referrals for their patients. Providers need to know the relative prices of different services at different sites of care so they can refer patients to high value specialists to contain overall costs, perform on risk contracts, and guide patients—who are increasingly likely to be in a high deductible plan—to affordable options. Hospital outpatient rate variation between payers and across service categories creates barriers for physicians seeking to make efficient referrals. For example, one payer may have negotiated multipliers with a hospital such that it is less expensive for surgical day care but more expensive for radiology, but another payer's negotiation may have yielded the opposite result. The following chart shows multiplier rates for two Massachusetts payers for high-tech radiology, showing that identifying a low-cost referral for a particular service may not be possible without detailed information by payer.

Hospital High-Tech Radiology Prices for Two Massachusetts Payers (2018)



Notes:

1. Includes hospitals that contract through the six largest Massachusetts hospital systems but excludes hospitals that are not paid based on a fee schedule for these services.
2. This chart includes the multipliers used to determine prices for High-Tech Radiology services for two payers. For one payer, the chart includes a negotiated multiplier specific to High-Tech Radiology services. For the other payer, the chart includes a negotiated multiplier for all radiology services (which includes High-Tech Radiology).
3. The averages reflected in this chart are calculated separately for each payer and are based on the payer's unweighted average High-Tech Radiology Multiplier for this set of hospitals.
4. This chart excludes one hospital that is included in the other charts in this report because one of these payers reimburses that hospital on a percent of charges basis for these services.
5. Where a contract included negotiated multipliers for ambulatory surgery centers owned by the hospital system, those ambulatory surgery centers are included as one hospital in the chart above.

This analysis was possible only where comparable outpatient service categories were used by multiple payers for negotiating multipliers to their fee schedules. As discussed in Section 1.A, the largest Massachusetts payers use different service groupings for negotiating outpatient prices, which results in cross-payer price differences that cannot be modeled with a single multiplier. This variation contributes to the challenge for market participants like providers and employers who must assess prices across payers.

III. RECOMMENDATIONS.

This report documents how commercial health care payment rates are determined using complex and varied methods with little consistency across payers, providers, or insurance products. The variation is particularly notable across hospital outpatient services, but we also found variation in how hospital inpatient services are reimbursed. Risk contracts add yet another layer of complexity on top of the intricate and opaque fee-for-service foundation that determines the provider's budget and performance. This complexity and variation create administrative costs and are in tension with the actionable price transparency required to drive market-based solutions.

Based on these findings, we recommend that all stakeholders, including payers, providers, consumer advocates, and policymakers:

1. Study further the administrative costs associated with current approaches to reimbursement that vary significantly between insurers, insurance products, market-segments within insurance products, and providers. These costs remain hidden in part because payers and providers are not required to report or even track how much of their annual operating expenses are used to administer provider reimbursement contracts. A working group with representation from providers, payers, and consumer advocates could determine a consistent way to report on these costs with the goal of developing strategies to reduce them.
2. Reduce complexity and explore increased standardization where appropriate in the methods for determining fee-for-service payments and the key terms that govern risk contracts. Simplifying these complicated provisions would require engagement from providers and payers and may require a legislative catalyst to facilitate changes to historic approaches to payment.
3. Establish real-time, service-level price transparency for employers, consumers, policymakers, and providers. Through the work of the legislature, other agencies, and health care stakeholders, Massachusetts has strong public reporting on overall measures of provider price variation. For example, Relative Price data published through the Center for Health Information and Analysis (CHIA) provides critical insight into aggregate price differences in the market. However, such aggregate metrics are not well tailored to capture variation in prices for specific services or provide real-time information needed for employers or consumers to shop for plans or procedures or for providers to assess the value of a particular referral. While current transparency initiatives such as CHIA's release of 2016 service-specific price data[28] are significant steps in the right direction, a simpler underlying approach to payment would allow for new transparency initiatives that would enable purchasers and providers to compare options for specific services.

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

28 CTR. FOR HEALTH INFO. & ANALYSIS, BULK RELEASE OF PROCEDURE PRICE DATA 2018 (Jul. 20, 2018), *available at* http://www.chiamass.gov/transparency-initiatives.

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