2021 ANNUAL HEALTH CARE COST TRENDS REPORT

EXECUTIVE SUMMARY

MASSACHUSETTS
HEALTH POLICY COMMISSION

SEPTEMBER 2021

EXECUTIVE SUMMARY

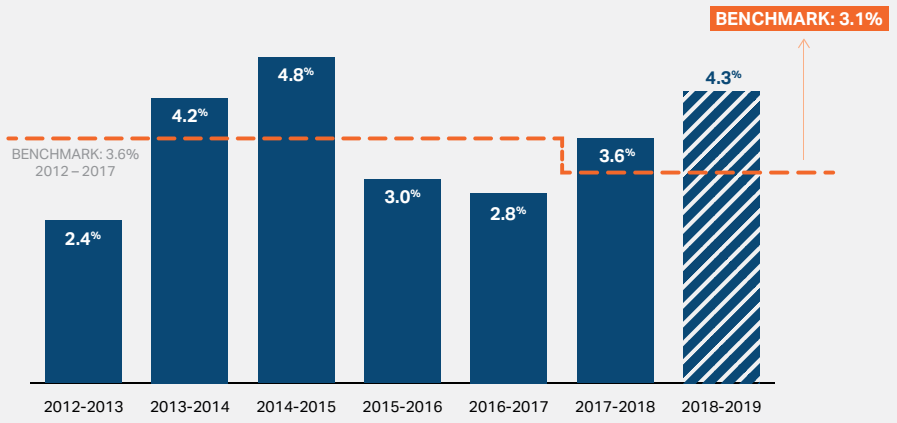
Massachusetts has long sought to foster a health care system that is affordable, high quality, and accessible for all. While the Commonwealth has been a leader in health care coverage and innovation, cost containment, affordability, and health equity have continued to be challenges.

In an effort to restrain rapidly increasing health care costs, the Legislature passed comprehensive health care reform in 2012 and set a first-in-the-nation, statewide target for sustainable growth in total health care spending (3.6 percent for the first five years, lowered to 3.1 percent in 2018). The same legislation established the Health Policy Commission (HPC) to help monitor and guide this ambitious effort. In the years since, the HPC has reported progress towards health care cost containment in the Commonwealth on an annual basis. Since the benchmark was established, the state's health care spending has grown at an average annual rate of 3.59 percent. In the most recent data, from 2018 to 2019, the state's preliminary health care spending growth was 4.3 percent, exceeding the benchmark target of 3.1 percent set by the HPC. Despite exceeding the benchmark, Massachusetts total health care spending growth (including both public and private payers) has remained at or below national growth rates for ten consecutive years, a reversal from trends prior to the passage of the 2012 legislation and the creation of the HPC.

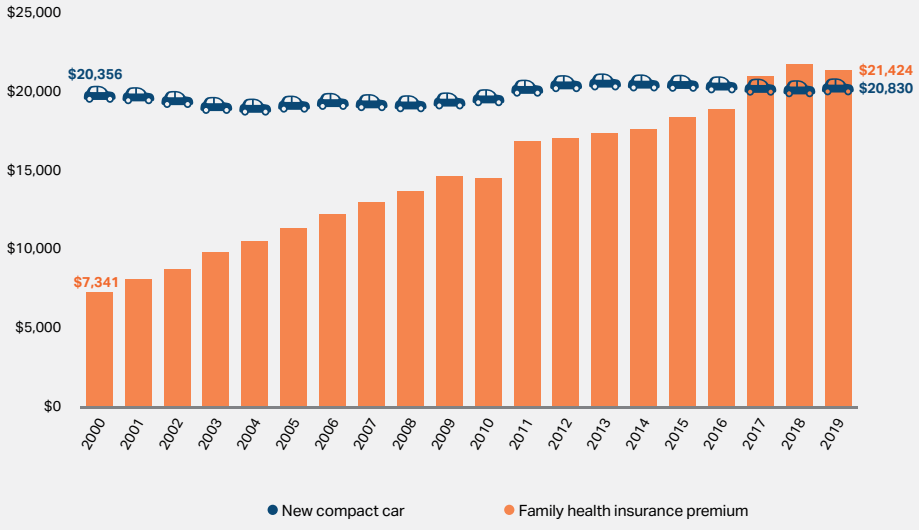
In this annual report, the HPC presents new research to enhance the collective understanding of health care spending trends and cost drivers in the Commonwealth and evaluates the state's progress in meeting several cost containment, care delivery, and payment system goals set by the Commonwealth and the HPC. This year's report focuses on insights from the health care system before the Coronavirus Disease 2019 (COVID-19) pandemic, which has left a deep impact on Massachusetts and its health care system. Learning from the pandemic is critical, and the HPC is currently undertaking a separate analysis of the impact of COVID-19 on the health care system.

Based on findings from this and other HPC research and programs, the report includes five policy recommendations for lawmakers, providers, payers, employers, and other health care market participants to create a more affordable and accessible high-quality health care system. These recommendations include specific steps the Commonwealth must take to address the intersecting challenges of **cost containment, affordability, and health equity** — the seriousness and urgency of which were underscored both by the pandemic and recent spending trends — to improve outcomes and lower costs for all.

Annual growth in total health care expenditures per capita in Massachusetts



Average total cost for Massachusetts family health insurance premiums and national cost of a new compact car



KEY FINDINGS

KEY DRIVERS OF SPENDING GROWTH LEADING TO MASSACHUSETTS EXCEEDING THE BENCHMARK

- Total health care spending per capita grew 4.3% in 2019 and 3.6% in 2018 (after revision), exceeding the benchmark rate of 3.1% in those years. Health care spending per enrollee grew 4.1% for those with commercial coverage.
- In recent years, commercial spending growth has been driven mostly by growth in prices, although growth in utilization has also contributed.
- Overall, hospital spending (inpatient and outpatient) in Massachusetts comprised 43% of total spending in 2019, but accounted for 54% of spending growth. Hospital outpatient was the category of service with the largest spending growth in 2019, increasing 7.6% from 2018 to 2019.
- In addition to growing prices, the number of hospital outpatient visits grew by 3.7% in 2019, including a substantial shift in visits from community hospitals to academic medical centers (AMCs).
- Hospital outpatient prices among hospitals ranged from being on par with Medicare prices to nearly triple Medicare prices, with the highest prices generally found at AMCs.
- Hospital outpatient spending in Massachusetts is far higher than the U.S. average: the number of visits per capita is 40% higher in Massachusetts than in the U.S. overall, and Medicare spending per enrollee on hospital outpatient care is 29% above the U.S. average.

THE HIGH COST OF CARE LEADS RESIDENTS WITH LOWER INCOME TO AVOID CARE AND FACE INCREASING MEDICAL DEBT.

- Massachusetts residents living in lower-income areas had higher proportions of spending for emergency care, inpatient use and prescription drugs, while residents living in higher-income areas had higher proportions of spending for professional services and hospital outpatient care.
- 59% of commercially-insured residents with lower incomes experienced an affordability issue (e.g., problems paying medical bills and unmet health care needs) compared to 38% of commercially-insured residents with higher incomes. For those who experienced problems paying family medical bills, medical tests and surgical procedures were the most common source of those bills.
- Residents with lower incomes were much more likely to go without needed care and prescription drugs because of cost, and those with high deductible health plans were twice as likely to do so compared to those with conventional plans.
- Residents with lower incomes reported that a key factor in going without care was that cost-sharing was unaffordable. Another reported factor was uncertainty that care would be covered, which can affect the choice to seek needed care and even lead to choosing higher-cost settings of care (e.g., the ED over an urgent care center).

TRENDS IN USE OF HOSPITAL CARE

- The average commercial payment (excluding professional fees) per inpatient hospital stay rose from $15,100 in 2013 to $20,900 in 2019, or an average 5.5% per year.
- Between 2010 and 2019, the share of total commercial discharges and newborn deliveries that took place at community hospitals continued to decline. In 2019, while community hospitals accounted for 52.4% of all hospital stays, they accounted for 49.7% of newborn stays and 44.7% of commercially-insured stays.
- In Massachusetts, inpatient and outpatient hospital care is increasingly provided by a few large provider systems. Beth Israel Lahey Health and Mass General Brigham together provide 41% of hospital-based care, with other to systems representing far smaller shares.

VARIATION AND GROWTH IN PRICES OF CARE

- From 2016 to 2018, prices for common procedures and services grew by an average 4.4% in physician offices, 6.1% in hospital outpatient departments (HOPDs) and 9.0% in hospital inpatient settings. Many individual services saw price increases of more than 20%.
- Prices at HOPDs for common procedures and labs were often double the amount paid for the same services performed in physician offices.
- Prices for common HOPD services such as mammography, GI endoscopy and colonoscopy tended to vary substantially by hospital, in some cases by a factor of more than two, with the highest prices generally occurring at AMCs and geographically isolated hospitals (e.g. Cape Cod).
- Payments for cesarean section deliveries varied from $15,600 (Mount Auburn) to $24,000 (Massachusetts General) in 2018. For major joint replacement, payments varied from $22,000 (Lowell General) to $42,000 (Massachusetts General).

VARIATION BY PROVIDER ORGANIZATION

- Patients attributed to Mass General Brigham (MGB) had the highest unadjusted ($6,506) and adjusted ($6,131) medical claims spending in 2018, which were 49% and 30% higher than the lowest spending organizations based on unadjusted (Reliant, $4,352) or adjusted spending (Atrius, $4,709), respectively.
- Among broad categories of spending, hospital outpatient spending varies the most by provider organization. Per member per year (PMPY) spending for hospital outpatient services was highest for patients attributed to MGB ($2,481), 43% above the average ($1,737) and double that of patients attributed to Atrius ($1,176).
- Patients attributed to Boston Medical Center providers had the highest rate of ED utilization (298 visits per 1,000 patients per year) and potentially avoidable ED visits (92), which was 68% more ED visits (178) and 144% more potentially avoidable ED visits (38) than patients attributed to Atrius providers.
- A study of seven low value care services identified more than 130,000 instances of low value care provided to over 80,000 patients in 2018. Rates of low value care generally varied two-fold or more across provider organizations.

POLICY RECOMMENDATIONS

As the Commonwealth approaches the ten year anniversary of this nation-leading effort, it is critical that lawmakers take action this session to strengthen and enhance the state's strategy for addressing the intersecting challenges of **cost containment, affordability, and health equity** to improve outcomes and lower costs for all. With that opportunity in mind, the HPC recommends the Commonwealth take the following immediate actions:

1. STRENGTHEN ACCOUNTABILITY FOR EXCESSIVE SPENDING. Recognizing that statewide spending growth has exceeded the benchmark, the Commonwealth should strengthen the mechanisms for holding providers, payers, and other health care actors responsible for spending performance. The Legislature should take action to improve the annual performance improvement plan (PIP) process by allowing the Center for Health Information and Analysis (CHIA) to use metrics other than health status adjusted total medical expense growth to identify entities contributing to concerning spending. These measures should hold providers accountable for spending for all of their patients (not only their primary care patients), should include a broader range of provider types than primary care groups (e.g., hospitals), and should address the impact of medical coding efforts which can both increase spending and mask spending increases in health status adjusted measures. The PIPs process can be further strengthened by increasing financial penalties for above-benchmark spending or non-compliance. Finally, the Legislature should consider additional tools that ensure that the benchmark reflects and responds to underlying variation in the relative level of provider prices.

2. CONSTRAIN EXCESSIVE PROVIDER PRICES. Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices for Massachusetts providers (without commensurate differences in quality) continues to divert resources away from smaller, less competitive community providers toward generally larger and more well-resourced systems. For example, shifts in volume from lower-priced to higher-priced hospitals, combined with commercial price levels which can be three times as high as Medicare prices, were a key reason Massachusetts failed to meet the benchmark in 2018 and 2019. Many market initiatives have attempted to address these pricing failures (e.g., tiered and narrow network products, price transparency, risk contracting), but have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider prices. Accordingly, the HPC recommends the following actions:

A. Establish Price Caps for the Highest-Priced Providers in Massachusetts. The Legislature should take action to cap prices for the highest-priced providers (i.e., limiting the highest, service-specific commercial prices with the greatest impact on spending) and limit price growth (e.g., limiting annual service-, insurer-, and provider-specific price growth). Such price caps, targeted specifically at the highest-priced providers in Massachusetts, would be an important complement to the health care cost growth benchmark, which is not designed to directly address prices. Such caps would reduce unwarranted price variation and promote equity by ensuring that future price increases can accrue appropriately to lower-priced providers, including many community hospitals and other providers that care for populations facing the greatest health inequities, ensuring the viability of these critical resources.

B. Limit Facility Fees. In many cases, the same services can be provided in both hospital outpatient departments and non-hospital settings such as physician offices. Nevertheless, Massachusetts residents disproportionately use hospital outpatient settings, on average, utilizing hospital outpatient services 40 percent more than residents of other states do. Prices and patient cost-sharing are generally substantially higher at hospital outpatient sites due to the addition of hospital "facility

fees." In many cases, patients may not realize that pricing can be substantially higher at some sites (those licensed as hospital outpatient departments), unknowingly facing higher costs as a result. In order to improve market functioning and consumer protections, policymakers should take action to require site-neutral payments for certain common ambulatory services (e.g., basic office visits) and limit the cases in which both newly-licensed and existing sites can bill as hospital outpatient departments. Additionally, outpatient sites that charge facility fees should be required to conspicuously and clearly disclose this fact to patients, prior to delivering care.

C. Enhance Scrutiny and Monitoring of Provider Expansions and Ambulatory Care. Recognizing that the cost of care can vary substantially among different providers, with significant implications for health equity and affordability, the Commonwealth should continue to closely examine the impact of plans for major expansions of services or new facilities, particularly for higher-priced providers. These examinations should evaluate the impact on health care costs, quality, access, and market competition, and ensure that any such expansions are well informed by health equity considerations and aligned with community need. In addition, given the particular importance of outpatient care in driving spending and utilization trends and the likelihood of ambulatory and hospital outpatient care expansions, the Commonwealth should improve data collection on ambulatory care across different sites and settings, including urgent care, hospital main campus and off-campus sites, and non-hospital-licensed ambulatory sites. Enhanced data will better enable the HPC and others to analyze the impact of shifts in patient care between lower- and higher-priced sites on health care costs, quality, and access, particularly for underserved populations.

D. Adopt Default Out-of-Network Payment Rate. As a constraint on the spending and market impact of excessive prices charged by out-of-network providers, the Legislature should enact the default out-of-network payment rate for "surprise billing" situations recommended by the Executive Office of Health and Human Services in its Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations.

3. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY. As both health insurance premiums and consumer cost-sharing growth continued to outpace increases in total claims spending, wage growth, and inflation between 2017 and 2019, the Commonwealth should require greater accountability of health plans for delivering value for consumers and ensure that any savings that accrue to health plans (e.g., from provider price caps as described above) are passed along to consumers.

A. Set New Affordability Targets and Affordability Standards. To both complement and bolster the health care cost growth benchmark, the Commonwealth should set measurable goals that target affordability of care for Massachusetts residents. This measurement strategy should identify and track improvement on indicators of affordability, including measures that capture the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors. Such targets should inform the development of new health plan affordability standards which prioritize the public's interest in equitable access to quality care.

B. Improve Health Plan Rate Approval Process. The Legislature should require that the health plan affordability standards discussed above be a key factor in the Division of Insurance's review and approval of health plan rate filings. In addition, there should be greater transparency and public participation in the rate approval process by including, at a minimum, a public comment period, and written justifications for approvals of rate increases.

C. Reduce Administrative Complexity. Administrative complexity that does not add value permeates the Massachusetts health care system, from the wide array of plan options that are not easily comparable for consumers and employers, to differing rules for claims submission and prior authorization which consume significant provider time and divert attention away from patient care, to non-standard alternative payment method (APM) contract terms which may ultimately undermine efforts to shift away from the historic fee-for-service pricing model. This lack of standardization across health plans creates unnecessary costs for all health care actors and for the Massachusetts residents and businesses and their employees who pay for this complexity in the form of higher premiums, cost-sharing, and confusion in navigating the health care system. The Legislature should require greater cross-payer standardization of policies, programs, and processes to reduce administrative complexity, enhance affordability, and improve equity.

D. Improve Benefit Design and Cost-Sharing. As the number of Massachusetts consumers with high-deductible health plans has sharply increased, the HPC has documented increasing challenges to affordability, equitable access, and experience of care, particularly for employees with lower incomes. Even in traditional health plans, cost-sharing can disproportionately impact individuals with lower income. Health plans should

work with employers to develop alternatives to high-deductible health plans and other benefit designs that can impede access and perpetuate inequities. In particular, to put equity at the forefront, health plans and employers should revise plan designs that require set contributions for all members regardless of income and all medical services regardless of value (such as by waiving co-payments or deductibles for high-value medical care) and by structuring premium contributions to reflect different employee wage levels.

E. Alternative Payment Methods (APMs). Health plans should continue to promote the increased adoption and effectiveness of APMs, especially in the commercial market where expansion has stalled (e.g., increased use of primary care capitation, APMs for preferred provider organization (PPO) populations, episode bundles, and two-sided risk models).

4. ADVANCE HEALTH EQUITY FOR ALL. The Commonwealth and all actors in the health care system should be held accountable in efforts to achieve health equity for all.

A. Set New Health Equity Targets. To ensure that all residents of the Commonwealth have the opportunity to attain their full health potential without being disadvantaged from achieving that potential because of socioeconomic status or socially-assigned circumstance (e.g., race, ethnicity, language, disability status, sexual orientation, and gender identity), the Commonwealth should set measurable goals to advance health equity. Such goals should focus on eliminating disparities that manifest in both health and health care and be developed through a collaborative approach that is guided by the perspectives of individuals and communities most affected by these disparities.

B. Address Social Determinants of Health. The Commonwealth should continue to examine and address the social determinants of health (SDOH) that can lead to poor health outcomes for individuals and communities. Policymakers should consider making investments in affordable housing, food security, transportation systems, and other community resources. Health care providers, as anchor institutions, can play a critical role in supporting community-led efforts to improve these and other SDOH. At the same time, providers should enhance their efforts to address the health-related social needs of individual patients through collaborative relationships with community-based social service agencies to ensure a holistic response to patients' medical, behavioral, and social needs. Payers and providers should continue to offer and adopt APMs that enable the investments in care coordination, integrated technology, and performance measurement that support such relationships.

C. Improve Data Collection. Data collection improvement is a critical and fundamental first step in the work to dismantle racism and other long-standing inequities that, in the context of the health care delivery system, result in profound disparities, such as maternal health outcomes for people of color. Collaboration among all stakeholders, including policymakers, providers, and payers, is foundational to ensure the collection of reliable patient data on race, ethnicity, language, disability status, sexual orientation, and gender identity to inform the integration of equity considerations into quality improvement, cost-control, and affordability efforts.

5. IMPLEMENT TARGETED STRATEGIES AND POLICIES. To further advance cost containment, affordability, and health equity, the Commonwealth should adopt the following additional strategies and policies.

A. Examine Increases in Medical Coding Intensity and Improve Patient Risk Adjustment. The HPC and other researchers have documented that recent increases in patient risk scores and acuity are better explained by changes in payer and provider documentation and coding behavior than by changes in actual patient health status. While there are benefits to more complete and accurate coding, increased coding intensity impairs accurate performance measurement, absorbs and attracts resources and personnel, and has resulted in millions in additional spending for Massachusetts payers, employers, and residents. The Commonwealth should continue to investigate medical coding and risk adjustment trends and incentives and take action to mitigate the impact of changes in clinical documentation practices on spending and performance measurement. Specific areas of action should include adoption of risk adjustment methods for accountability and payment purposes that are not based primarily on patient diagnoses or severity, more frequent updates to clinical classification software to better align payments with actual resource use, mechanisms to offset coding-related spending impacts, and continued development of alternative risk adjustment methods and performance metrics less sensitive to coding-based acuity.

B. Reduce Pharmaceutical Drug Spending, Align Pricing with Value, and Improve Affordability. The Commonwealth should take action to reduce drug spending growth and improve affordability for patients. High-cost specialty drugs represent an increasing share of drug spending, and the large number of

new specialty drugs expected to enter the market over the next decade brings not only the promise of improvement to patients' lives but also significant concerns about the impact on health care spending. Recent discussions about the clinical benefits of newly-approved high-cost medications have also underscored the need for greater focus on value to ensure that drug costs are aligned with the benefits such drugs provide to patients and society. Massachusetts should build on its current successful initiatives to reduce drug spending growth. For example, MassHealth continues to demonstrate the ability to reduce pharmacy costs without restricting consumer access. This is one model that should be replicated by authorizing the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts. The state should further increase oversight and transparency for the full drug distribution chain, including of pharmacy benefit managers' (PBMs) purchasing and pricing practices. Payers and providers should pursue strategies to maximize value and enhance access by using risk-based contracts and value-based benchmarks when negotiating prices, distributing clinical decision tools, monitoring prescribing patterns, and developing plan designs that minimize financial barriers to high-value drugs.

C. Improve Primary and Behavioral Health Care. There is considerable evidence that health care delivery systems oriented toward primary care tend to have lower costs, higher quality, and a more equitable distribution of health care resources. Better management of behavioral health conditions has also been found to lower overall health care spending and improve quality of life. The ongoing novel coronavirus pandemic (COVID-19) has underscored the importance of equitable access to both types of care. Specific areas of focus should include:

i. Focus Investment in Primary Care and Behavioral Health Care. Payers and providers should increase spending devoted to primary care and behavioral health while adhering to the Commonwealth's total health care cost growth benchmark. These spending increases should prioritize non-claims-based spending such as capitation, infrastructure, and workforce investments. CHIA and the HPC should continue to track and report on primary care and behavioral health care spending trends annually and hold entities accountable for meeting improvement targets if they fall short of established targets.

ii. Improve Access to Behavioral Health Services. In response to increased need for behavioral health services as a result of the pandemic — in particular among children, young adults, and people of color — payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations. This must include a redoubling of the Commonwealth's efforts to provide resources and support to individuals and families suffering from the effects of the opioid epidemic, notably Black men, a population that has recently experienced a significant increase in overdoses. The Commonwealth can advance these goals and additional efforts to increase needed access to behavioral health care by implementing the Executive Office of Health and Human Services' Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it.

D. Support Efforts to Reduce Low-Value Care. HPC research shows that Massachusetts residents continue to receive a significant amount of care that does not provide value, and the provision of such care by provider organizations varies widely. The Commonwealth should act to reduce the incidence of low-value care. Toward this end, payers, providers, and purchasers should convene to develop strategies, incentives, and action steps to eliminate low-value care. Employers can also play a role in assisting employees and their families in accessing information useful in making high-value treatment decisions.

THE IMPACT OF COVID-19

This report is issued in the context of the ongoing response to COVID-19, which has indelibly changed the lives of Massachusetts residents and the health care system that serves them. As vaccine administration efforts and the response to new variants continue, recovery for residents, the health care system, and health care workers will be a long-term process. To help guide this recovery, policymakers, health care leaders, and community partners should look to lessons from the pandemic to inform opportunities for rebuilding sustainable, resilient, and equitable systems of care. In this context, the Legislature has charged the HPC with studying the impact of COVID-19 on the health care delivery system. An Interim Report was released in April 2021, and a Final Report from the HPC is due in 2022. While many of the topics will be more fully examined in the Final Report, the HPC recommends that the Commonwealth take immediate steps to sustain the successful innovations made during the pandemic including, for example, expanded access to telehealth, workforce flexibilities, and innovative care models. The HPC stands ready to support these efforts with data insights and independent policy leadership.