2022 HEALTH CARE COST TRENDS REPORT

POLICY RECOMMENDATIONS

MASSACHUSETTS
HEALTH POLICY COMMISSION

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This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and extensive variation in provider prices that is unrelated to value,
- Increased market consolidation and shift in volume to high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the Commonwealth's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

This year presents an opportunity to reflect on ten years of Massachusetts experience, data, and evidence, to chart a bold path forward for the next decade. The six policy recommendations below reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 **prioritizes improving state oversight and accountability** in the following areas:

1. TARGET ABOVE BENCHMARK SPENDING GROWTH. The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

2. CONSTRAIN EXCESSIVE PROVIDER AND PHARMACEUTICAL PRICES. The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

3. LIMIT INCREASES IN HEALTH INSURANCE PREMIUMS AND COST-SHARING. The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

2022 POLICY RECOMMENDATIONS

1. STRENGTHEN ACCOUNTABILITY FOR THE HEALTH CARE COST GROWTH BENCHMARK. As recommended in past years, the Commonwealth should strengthen the mechanisms for holding providers, payers, and other health care actors responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark. The HPC can take a range of factors into account in determining whether to require a Performance Improvement Plan (PIP) from a payer or provider referred to it by the Center for Health Information and Analysis (CHIA). However, the PIP statute requires that CHIA base its referrals on growth in health

status adjusted total medical expenses (HSA TME), a metric that is limited to spending for providers' primary care patients, that is heavily influenced by medical coding efforts, and that overlooks the significant variation in baseline spending levels among entities.

A. **Improve Metrics and Referral Standards for Monitoring Health Care Entity Spending.** The Legislature should take action to increase accountability through the annual PIP process by allowing CHIA to use metrics in addition to growth in HSA TME to identify and refer entities to the HPC for review and consideration for a PIP. These metrics should take baseline spending levels into account in addition to growth, hold providers accountable for spending for all of their patients (not only their primary care patients), include providers in addition to primary care groups (e.g., hospitals), and address the impact of medical coding efforts which can both increase spending and mask spending increases in health status adjusted measures. The measures and referral standards should also be expanded to allow the PIPs process to account for persistent variation in negotiated provider prices for the same types of services, which primarily reflects differences in size and bargaining leverage between different providers, rather than differences in quality of other indicia of value. Additionally, accountability should be extended to other market participants that contribute to health care spending growth (e.g., pharmaceutical benefit managers and manufacturers).

B. **Strengthen Enforcement Tools in PIPs Process.** The PIP process should also be strengthened, including by allowing HPC to set savings expectations, to identify the types of strategies that should be included in a PIP, and giving the HPC greater oversight tools to ensure that any PIP results in meaningful improvement. The Legislature should also take action to deter excessive spending by allowing the HPC to apply tougher, escalating financial penalties for above-benchmark spending or non-compliance, similar to efforts in other states with health care growth targets.

These collective fixes to the benchmark and its accountability mechanisms are critically necessary to establish a more effective process to constrain excessive spending and reduce unwarranted variation in 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 and/or unaffiliated community providers, many of which serve vulnerable patient populations, and toward generally larger and more well-resourced systems. For example, shifts in volume 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 high, variable, and non-transparent provider prices (e.g., tiered and narrow network products, price transparency efforts, risk contracting), but these efforts 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 and those services and provider types for which competitive forces are not likely to meaningfully constrain prices—would be an important complement to the health care cost growth benchmark. 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, utilizing hospital outpatient services on average, 40 percent more than residents of other states. 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), and face 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, and payers and providers should include the location where the visit occurred on claims submitted to payers and reported to the Commonwealth's all-payer claims database.

C. Enhance Scrutiny and Monitoring of Provider Expansions. Recognizing that the cost of care can vary substantially among different providers with significant implications for health equity and affordability, the Commonwealth should strengthen its examinations of plans for major expansions of services or new facilities, particularly for higher-priced providers and at hospitals and other higher-priced sites of care. Such examinations, which could be conducted by the HPC and incorporated into the state's existing determination of need process in lieu of the current independent cost analysis, should assess the impact of proposed expansions and new facilities on health care costs, quality, access, and market competition, and ensure that any such proposals are well informed by health equity considerations and aligned with community need. In addition, given the extent to which many such expansions focus on ambulatory care and the particular importance of hospital outpatient care in driving spending and utilization trends, the Commonwealth should improve data collection on outpatient and ambulatory care across different sites and settings, including hospital main campus and off-campus sites such as ambulatory surgery centers, and non-hospital-licensed ambulatory sites, such as urgent care centers. More accurate data, identifying the location at which services were rendered, will better enable the HPC and others to analyze the impact of outpatient and ambulatory care proposals 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. Broader application of out-of-network default rates should also be explored as an approach to reduce unwarranted price variation across providers and settings.

3. ENHANCE OVERSIGHT OF PHARMACEUTICAL SPENDING. As drug spending continues to grow in Massachusetts, patients are acutely feeling rising out-of-pocket costs and other barriers to access in their insurance plan design. Accordingly, the HPC recommends the following actions:

A. Enhance Transparency and Data Collection. The Commonwealth should take action to increase both transparency of drug price growth and spending and oversight of the key stakeholders responsible for setting drug prices and establishing the policies and financial incentives that influence how patients access critical medications. The Commonwealth should authorize CHIA to collect data on pharmaceuticals from payers and pharmacy benefit managers (PBMs), including the average cost of pharmaceuticals after all discounts and rebates, markups, price increases, and launch prices of new drugs, as well as the cost of drugs administered in in provider offices and hospital outpatient departments.

B. PBM Oversight. The state should also require licensure of PBMs in order to monitor their business practices with pharmacies and health plans, and their impact on patients.

C. Expand Drug Pricing Reviews. Commonwealth should build on MassHealth's successful process by expanding the HPC's drug pricing review authority in order to strengthen commercial price negotiations by transparently reporting on drugs that are contributing most to commercial spending growth in Massachusetts.

D. Limit Out-of-Pocket Costs on High-Value Drugs. Finally, the Commonwealth should cap monthly out-of-pocket costs for high value prescription drugs that are widely recognized to improve health outcomes for patients with no or minimal impact on health care spending.

4. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY. As both health insurance premiums and the use of higher deductibles increase, further squeezing families in Massachusetts, the Commonwealth should require greater accountability of health plans for delivering value to consumers and ensuring that any savings that accrue to health plans (e.g., from provider price caps as described above or reduced use of high-cost care) 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 (DOI) 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, as in DOI's proposed regulation.

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 by consumers and employers, to non-standard contract terms and differing rules for claims submission, provider credentialing, and prior authorization which consume significant provider time and resources. 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. Evidence suggests that this complexity poses particular challenges for patients with fewer resources. 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 (HDHPs) 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 non-HDHPs, 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 hold total spending in check without impeding access and perpetuating inequities. To put equity at the forefront, health plans and employers should revise plan designs that impose equivalent cost sharing for medical services regardless of value (such as by waiving co-payments or deductibles for high-value medical care) and adjust 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 (e.g., increased use of primary care capitation, APMs for preferred provider organization (PPO) populations, episode bundles, and two-sided risk models), especially in the commercial market where expansion has stalled). They should also ensure that APM payment formulas reward efficient, patient-centered care rather than coding efforts.

5. ADVANCE HEALTH EQUITY FOR ALL. Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery and the impact of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

A. **Set and Report on Health Equity Targets.** The Commonwealth should undertake a coordinated effort across state agencies and sectors to identify a list of high-priority areas of documented disparities in health outcomes that are rooted in inequities, set measurable goals for improvement, and report annually on progress. Such goals should 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.** Recognizing that success in achieving health equity targets will be difficult to achieve without addressing inequities in the social determinants of health, policymakers must continue to prioritize investments in affordable housing, improved food and 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 social determinants.

C. **Use Payer-Provider Contracts to Advance Health Equity.** Payers and providers should accelerate efforts to reduce health inequities among their members/patient populations by introducing health equity accountability into their provider contracts, including alternative payment model (APM) contracts. Provider contracts offer the opportunity to embed equity principles and enforce accountability (e.g., by requiring stratification of performance data by race/ethnicity). At the same time, APMs can align incentives to motivate investments in services and infrastructure (e.g., care coordination, integrated technology, and performance reporting) aimed at addressing inequities within patient populations.

D. **Improve Data Collection.** To implement these health equity goals, policymakers, providers, and payers should commit to collection of reliable, standardized patient data on race, ethnicity, language, disability status, sexual orientation, gender identity, and sex to inform the integration of equity considerations into quality improvement, cost-control, and affordability initiatives. These efforts would be accelerated by the adoption of the data standards recommended by the Health Equity Data Standards Technical Advisory Group of the EOHHS Quality Measurement Alignment Taskforce.

6. 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. 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 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 the recent increased need for behavioral health services— 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 experienced a significant increase in overdoses since 2020. The Commonwealth can advance these goals 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, including increasing inpatient beds for behavioral health patients (including pediatric patients), investing in community-based alternatives to the emergency department, and increasing the behavioral health workforce, particularly providers who can support their communities' needs with linguistically and culturally relevant care.

B. 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. This conclusion was bolstered by the finding that risk scores fell in 2020 — during a global pandemic that reduced overall life expectancy in the US — not because patients were less sick but because a reduced number of patient encounters with the medical system created fewer opportunities to document patient diagnoses. While there may be some benefits to more complete and accurate coding, efforts aimed toward increasing revenue through increased coding intensity impair performance measurement, absorb clinical and administrative personnel (for those providers able to devote such resources), and have resulted in millions in additional spending for Massachusetts payers, employers, and residents. The Commonwealth should 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, which reduces the return on investment from coding efforts; more frequent updates to clinical classification software to better align payments with actual resource use; and continued development of alternative risk adjustment methods and performance metrics that are less sensitive to coding-based acuity and that reward providers for caring for vulnerable populations facing barriers to care.

C. Support Efforts to Reduce Low-Value Care. HPC research shows that Massachusetts residents receive a significant amount of care that does not provide value, and that the provision of such care by provider organizations varies widely. While the incidence of low-value care decreased during the pandemic, the Commonwealth should act to sustain the reduction. Toward this end, payers, providers, and purchasers should convene to develop strategies, incentives, and action steps to eliminate low value care. Government regulations and internal provider policies should be reviewed and updated in order to reflect evolving clinical standards and to ensure that, at a minimum, they do not require or encourage low value care. Employers can also play a role in assisting employees and their families in accessing information useful towards making high-value treatment decisions.

The HPC stands ready to support these efforts with data insights and independent policy leadership.

THE IMPACT OF COVID-19

This report is issued in the context of the evolving response to the COVID-19 pandemic, which has indelibly changed the lives of Massachusetts residents and the health care system that serves them. Vaccine administration and other public health measures continue, and 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 Impact Report was released in April 2021, with additional reports to be released in 2023. While many of the topics will be more fully examined in these upcoming publications, the HPC recommends that the Commonwealth take immediate steps to sustain the successful innovations made during the pandemic including the following as primary examples.

A. Maintain Access to Telehealth. Telehealth expanded greatly during the COVID-19 pandemic, aided by emergency regulatory action and quick adoption by providers and payers. Telehealth expansion aided in maintaining access to behavioral health psychotherapy services and may also have helped prevent avoidable ED visits. While the HPC will make further recommendations in an upcoming legislatively mandated report on telehealth, the HPC recommends that payers, providers, and employers continue to make telehealth services available to their members regardless of geography, income, or language. State policy should continue to enable access to telehealth services, including across state lines when this would benefit patients, and to encourage payment policies that support cost-effective use of telehealth that ultimately increases patient access to care while reducing both financial and non-financial costs to patients.

B. Move Care into High Value, Low-cost Settings. Early HPC findings indicate that decreases in potentially avoidable emergency department visits are partially explained by patients seeking care through telehealth and urgent care centers. The HPC will continue to monitor trends in use across a range of high value, low-cost care settings (including, for example, birth centers) to understand the impact of these alternatives on equity in access and health care spending (this was also noted in Recommendation 2C: Enhance Scrutiny and Monitoring of Provider Expansions).

C. Support and Strengthen the Health Care Workforce. After more than two years of COVID-19-era care, which exhausted and strained the health care workforce, providers and workers continue to experience significant challenges in their ability to care for patients. High rates of turnover and shortage have led to critical disruptions and backlogs across the health care system. The HPC will be releasing a legislatively mandated report on the Commonwealth's health care workforce in the coming months that examines policy priorities to boost retention and workforce resilience, including improving the transition from training to employment, such as expanding health care apprenticeship and other programs that remove financial barriers to training and allow trainees to move smoothly into employment and funding practices such as mentorship and shadowing for new entrants.