MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC 2021 Policy Recommendation #2: Constrain Excessive Provider Prices

October 6, 2021

HPC 2021 Policy Recommendations

AREAS OF FOCUS

1	2	3	4	5
Strengthen Accountability for Excessive Spending	**Constrain Excessive Provider Prices**	Make Health Plans Accountable for Affordability	Advance Health Equity for All	Implement Targeted Strategies and Policies

2 Constrain Excessive Provider Prices. Since prices continue to be a primary driver of health care spending growth in Massachusetts and divert resources away from smaller, community providers, the HPC recommends the following actions:

a. **Establish Price Caps for the Highest Priced Providers in Massachusetts.** As a complement to the statewide benchmark, 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) to reduce unwarranted price variation and promote equity.

Recommendation 2: Constraining Excessive Provider Prices

1. Hospital Prices as Key Cost Driver
2. Activity in Rhode Island and Other States
3. Constraining Prices in Massachusetts
4. Next Steps

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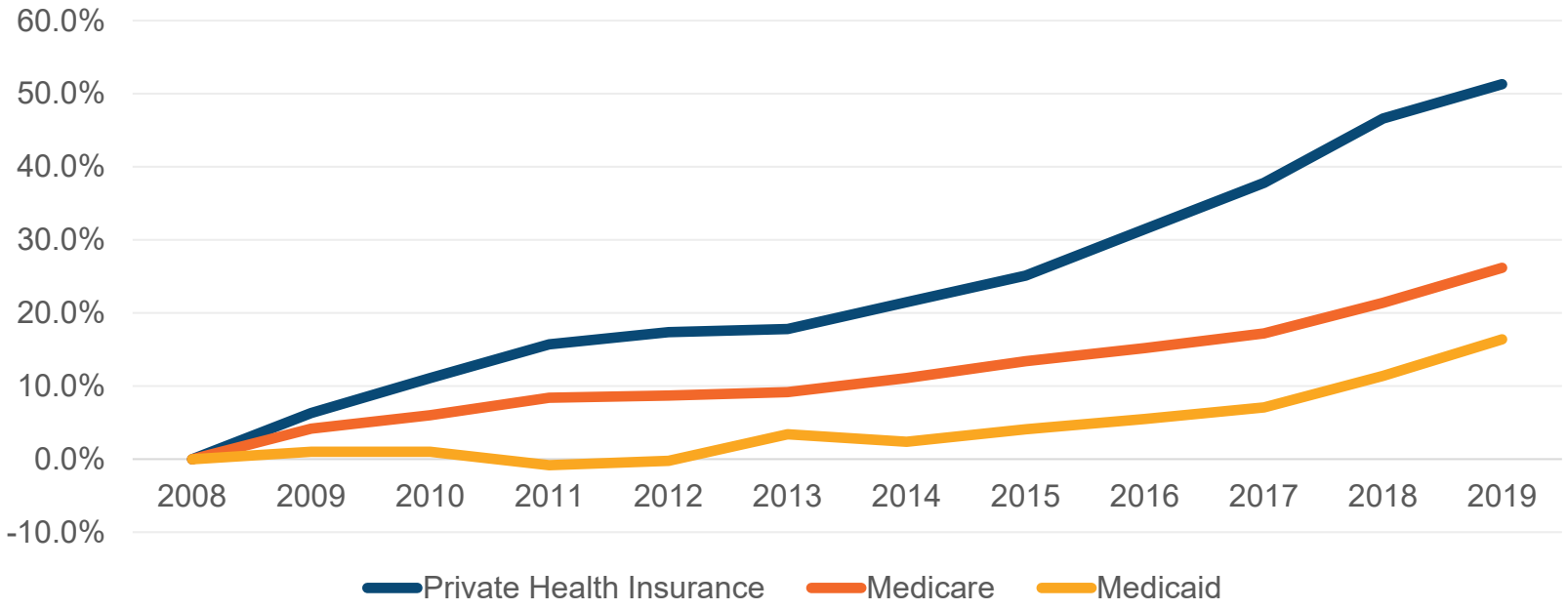
Private health insurance spending is growing faster than Medicare and Medicaid, largely due to price increases.

Cumulative growth in spending per enrollee by type of coverage since 2008; National Health Expenditures



- Commercial spending per hospital stay grew 14% from 2015 to 2018 compared to 6% for Medicare.
- Commercial spending growth per hospital stay is mostly driven by **facility spending** growth.
  - Inpatient: facility prices grew 42%; physician prices grew 18% (2007-2014)
  - Outpatient: facility prices grew 25%; physician prices grew 6% (2007-2014)

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Cooper, Z., Craig, S., Gaynor, M., Harish, N. J., Krumholz, H. M., & Van Reenen, J. (2019). Hospital prices grew substantially faster than physician prices for hospital-based care in 2007–14. Health Affairs, 38(2), 184-189; Peterson-KFF Health System Tracker: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start

There are increasing calls for constraining provider prices from the policy and academic community.

"While the United States will likely continue to rely largely on markets to allocate health-care resources, overall market forces have not been sufficient to contain commercial provider prices."

- Chernew ME, Dafny LS, Pany MJ. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market." The Hamilton Project, March 2020

The Hamilton Project's Proposed Approach

Three-pronged approach

- Set **rate caps** to limit prices for health care services *at the very top of the commercial price distribution*
  - Propose setting the cap at five times the 20th percentile of the market's truncated commercial price distribution
- Annual **price growth caps** specific to each insurer-provider-service combination to reduce (but not eliminate) price growth and provider price variation
- Flexible **government oversight** to address potential evasion

Committee for a Responsible Federal Budget: Estimates a commercial hospital price cap at 200% of Medicare rates would reduce commercial premiums by $889B (6%) and cost-sharing by $99 billion nationally (2%) over 10 years.

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Chernew, Dafny, Pany. The Hamilton Project proposal: Chernew ME, Dafny LS, Pany MJ. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market." The Hamilton Project, March 202. Available at: https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf. Committee for a Responsible Federal Budget. Health Savers Initiative: Capping Hospital Prices. Available at: Final_Capping Hospital Prices_022221 (crfb.org)

Rhode Island was the first state to cap hospital prices (excluding Maryland), but many states have now followed their lead.

Montana (2016)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services (*average price of all services at hospital*): Payments limited to **234%** of Medicare rates ▪ State was able to secure all major hospitals in network, due partly to public pressure from workers and unions
Oregon (2019)	▪ **Cap on state employee health plan payments** for inpatient and outpatient hospital services (*for each service individually*): in-network services limited to **200%** of Medicare rates and out-of-network services limited to **185%** of Medicare rates
Washington (2019) Colorado (2021) Nevada (2021)	▪ Created **public options** using public-private partnerships, with plans offered through private companies (like Medicare Advantage and Medicaid MCOs) ▪ WA capped provider payments at **160%** of Medicare rates ▪ In CO, rates can't be lower than **155%** of Medicare, but the insurance commission can mandate lower rates if insurers fail to meet the premium target ▪ All three states set provider participation requirements
Delaware (2021)	▪ Department of Insurance set a **target for commercial payer aggregate unit price growth** for non-professional services (inpatient, outpatient, and other medical services) of inflation (core CPI) plus 1 percentage point ▪ Progress on achieving the target will inform, but not determine, DOI's rate review decisions

Sources: https://www.crfb.org/sites/default/files/HSI_CappingHospitalPrices.pdf; Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience – The National Academy for State Health Policy (nashp.org); States' Role in Combatting High Health Care Prices | Commonwealth Fund; How a public option for health insurance works in Colorado, Nevada, and Washington – Vox; Delaware-Health-Care-Affordability-Standards-Report-Final-03042021.pdf; Oregon Educators Benefit Board

Notes: Maryland's longstanding All-Payer Rate System is a different model, but also serves to restrain hospital prices. See Rates (maryland.gov)

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Rhode Island's Affordability Standards

- In 2009, the Rhode Island Legislature passed a package of Affordability Standards including mandated increases in the percentage of overall spending devoted to primary care and constraints on hospital price growth.
- **Hospital inpatient and outpatient price growth** from year to year was limited to Medicare's hospital update factor (later switched to CPI-U) plus one percentage point (e.g., 2.7% in 2017-8).
- Growth is measured as a given payer's **aggregate price increases** (inpatient and outpatient combined) for a given hospital.
- The limit is enforced by the Office of the Health Insurance Commissioner via the rate review process.

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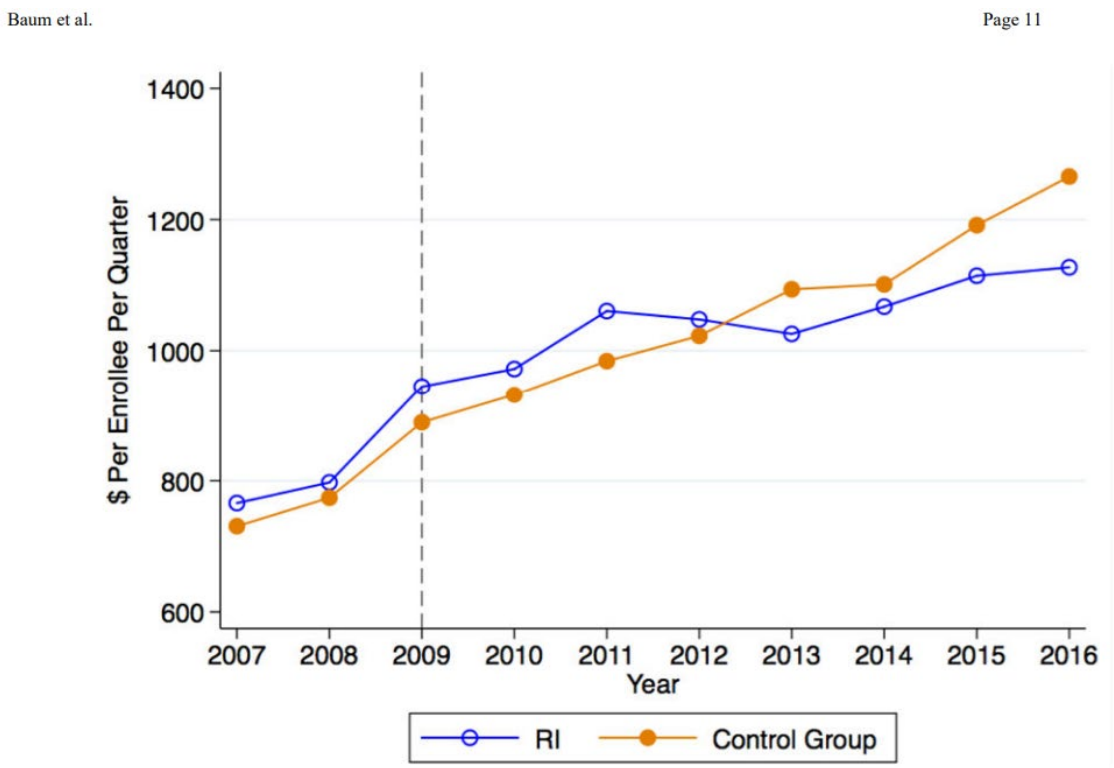
Notes: http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php

Rhode Island's reforms dramatically reduced spending.



- Rhode Island's spending was initially above control states.
- Spending growth declined in Rhode Island starting in 2012; spending was **15%** below control states by 2016.
- Most of the savings came via a reduction in **spending per hospital inpatient visit.**
- Cost-sharing also dropped markedly.
- Quality of care was unchanged.

"Rhode Island's experience thus suggests that mandated price control measures may effectively leverage state regulatory power to reduce healthcare costs, particularly in areas where the market power of providers is greater than insurers."
– Baum et al. Health Affairs, 2019

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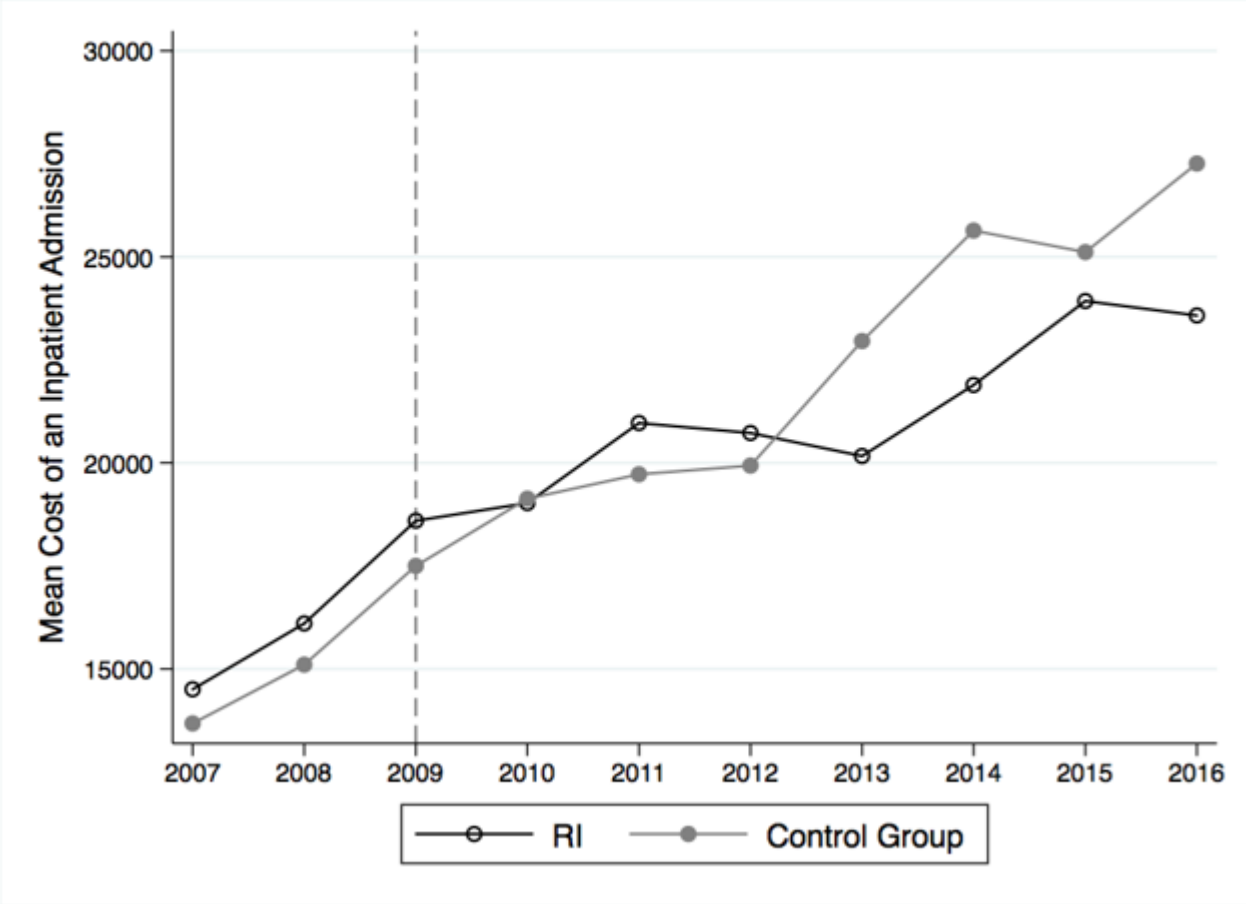
Source: Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. Health Affairs, 38(2), 237-245.

Following reform, spending per hospital visit in RI decreased significantly.

Exhibit A9. Unadjusted Spend per Inpatient Admission in the Rhode Island Cohort and the Control Group Cohort



Source: Baum, A., Song, Z., Landon, B. E., Phillips, R. S., Bitton, A., & Basu, S. (2019). Health care spending slowed after Rhode Island applied affordability standards to commercial insurers. Health Affairs, 38(2), 237-245.

Prices (particularly hospital prices), are also the major driver of commercial spending growth in Massachusetts.

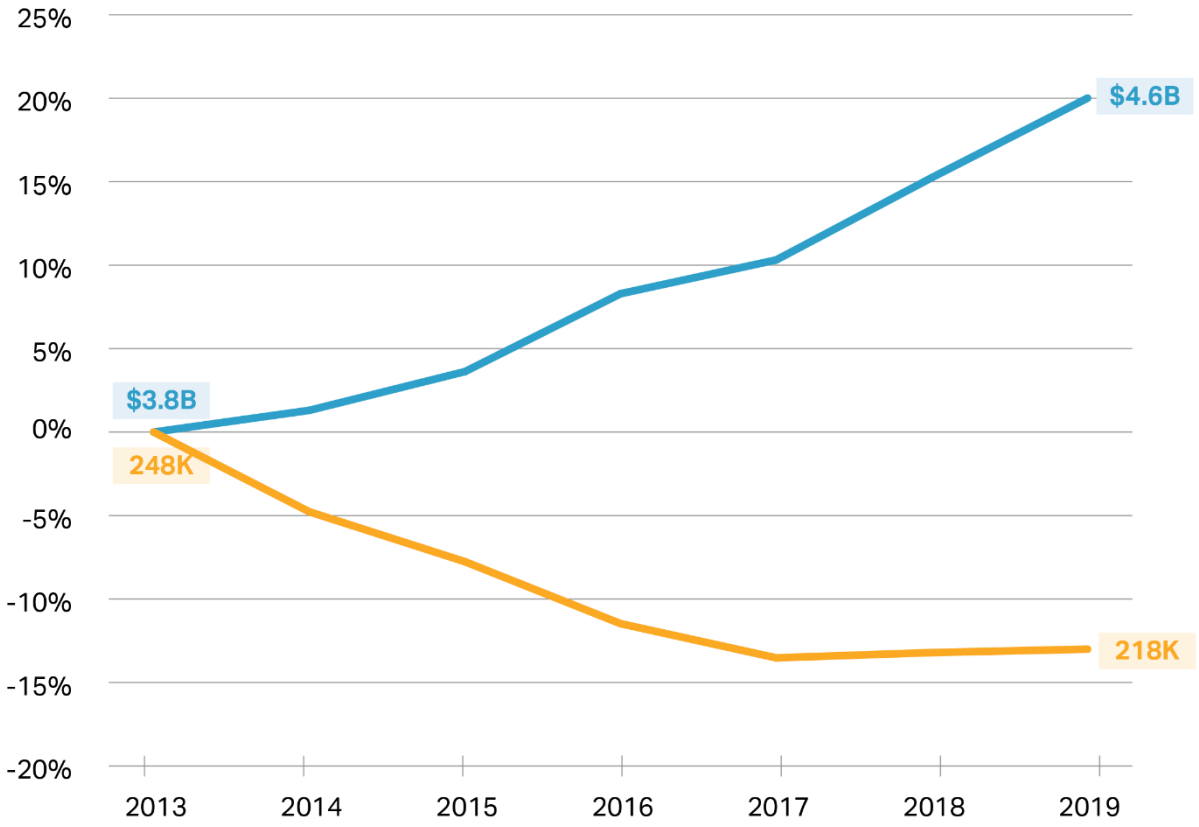
- **Massachusetts price growth overall**
  - BCBS, Tufts and HPHC all reported annual prices grew from 2015-2018 **more than twice** the rate of utilization.
  - The Health Care Cost Institute found that Massachusetts commercial health care prices grew **15.6%** from 2014-2018 while utilization grew **7.0%.**

- **Massachusetts price growth by category, 2016-8 (2021 Cost Trends Report)**
  - Hospital inpatient services: **9.1%**
  - Hospital outpatient services: **6.6%**
  - Office-based services: **4.4%**

Source: HCCI 2018 Health Care Cost and Utilizaton Report. Available at: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report Massachusetts Health Policy Commission. 2021 Cost Trends Report. Sept. 2021. Available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download

Commercial inpatient spending on hospital stays grew 20% even as volume declined 13% from 2013 to 2019.

Cumulative change in commercial inpatient hospital volume and spending per-enrollee (percentages) and absolute, 2013 – 2019



Spending per commercial discharge grew **38%** (5.5% annually), from **$15,100 to $20,900,** from 2013 to 2019

5.5% growth in price per discharge has been divided roughly evenly between **price increases** and **acuity increases.**

Notes: Data points indicate % growth from previous year (2013=0). Volume data correspond to fiscal years while spending data are calendar years.

Sources: CHIA Hospital Inpatient Discharge Data, 2013-2018. Commercial full-claims TME from CHIA Annual Report TME Databooks. 2019 Annual report (for 2017-8 growth and 2016-7 growth), 2018 Annual Report (for 2015-6), 2017 annual report (for 2014-2015) and 2016 Annual Report (for 2013-4 growth).

How do hospital price increases in Massachusetts compare to Rhode Island's growth cap?

- Rhode Island limit on payer-hospital level (inpatient and outpatient combined) facility price growth from 2017-8: **2.7%**

For comparison:

- Massachusetts aggregate **hospital inpatient** price growth 2017-2018:
  - Facility and professional combined: **4.2%** growth
  - Facility only: **4.5%** growth

- Massachusetts aggregate **hospital outpatient** (HOPD) price growth 2017-2018:
  - Facility and professional combined: **2.9%** growth
  - Facility only: **3.2%** growth

Note: these are retrospective price growth estimates versus prospective rate increases

Notes: RI allowed amount of price growth can be found here:http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php.
Inpatient payment growth includes both facility and professional claims for an inpatient stay. Inpatient stays were identified by MS-DRG. Hospital outpatient price growth is computed at the level of the procedure code encounter. Encounters are defined as the same person, same date of service, same procedure code. Overall average percent price growth for inpatient and HOPD was weighted by 2018 aggregate spending for the procedure code in the respective setting. This methodology is available in more detail in the 2021 Cost Trends Report.
Sources: HPC analysis of CHIA's All-Payer Claims Database v8.0

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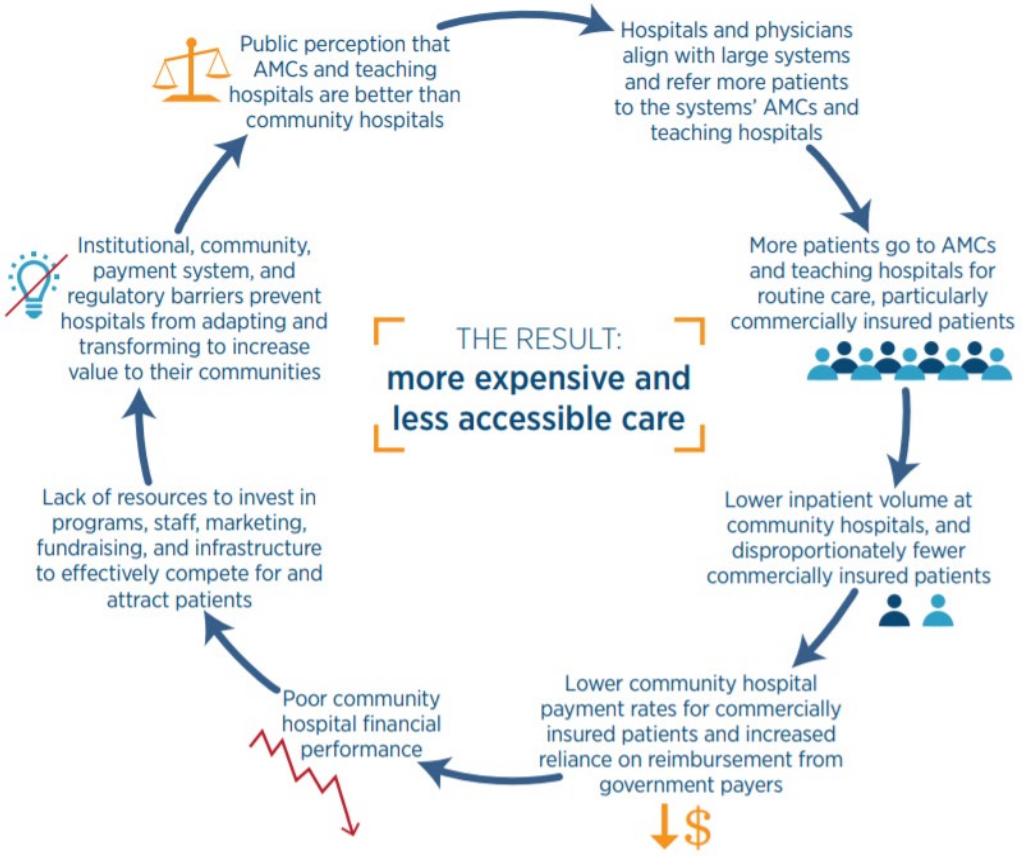
Limits on high price levels are needed as well.

"Capping prices [levels] can reduce the impact of provider market power while allowing prices to remain flexible beneath the cap. Capping price growth ensures that prices can rise to reflect a changing economy, but not at runaway speed."

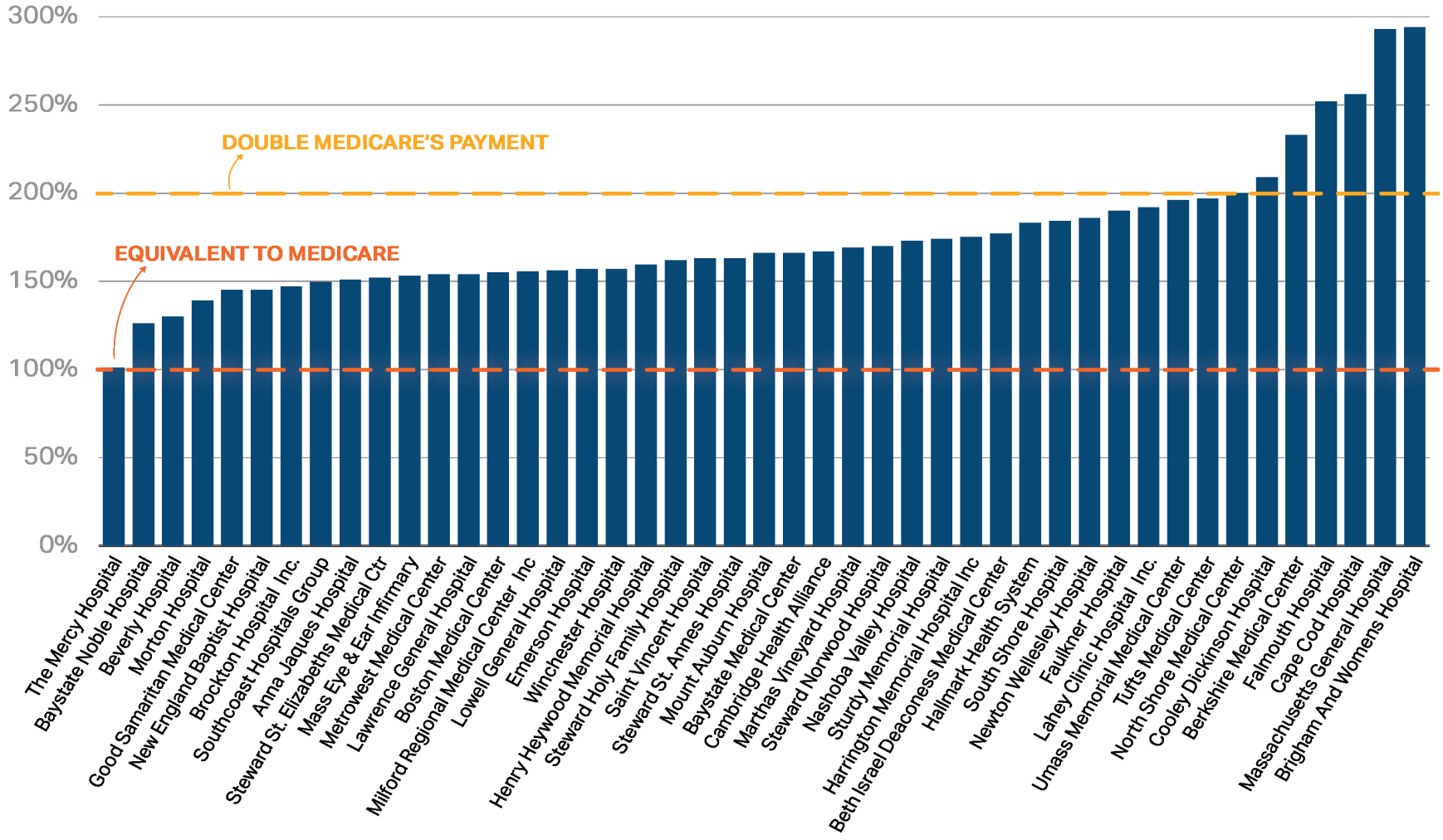
- Chernew ME, Dafny LS, Pany MJ. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market.

- **Price growth caps** are important to reduce health care spending growth, but do not address unwarranted price variation and could perpetuate a cycle that disadvantages many community hospitals.
- **Price level caps** would affect only the highest priced providers and could help mitigate these disparities.



Hospital outpatient prices vary nearly threefold by hospital.

Aggregate commercial hospital outpatient payments to hospital relative to what they would have received from Medicare, 2016-2018



Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate spending from 2016-2018. Analysis based on commercial claims-level data contributed by self-insured employers and private health plans. Authors simulated Medicare payments using 3M software that applied Medicare payment rules to claims data. Data based on more than 100,000 services provided in MA hospitals. Hospitals excluded from figure if fewer than 250 services.

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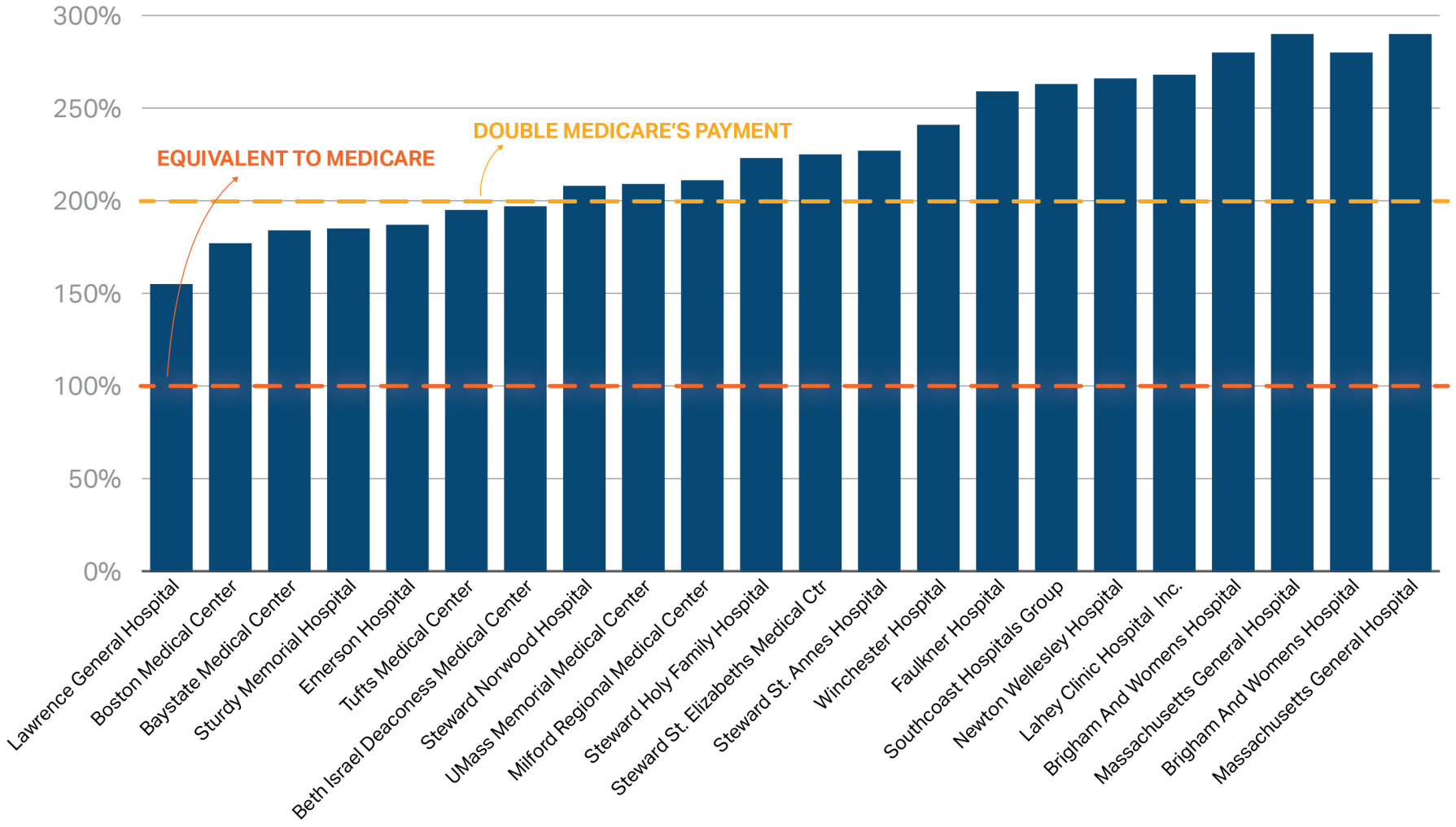
Hospital inpatient prices vary twofold by hospital.

Aggregate commercial hospital inpatient payments to hospital relative to what they would have received from Medicare, 2016-2018



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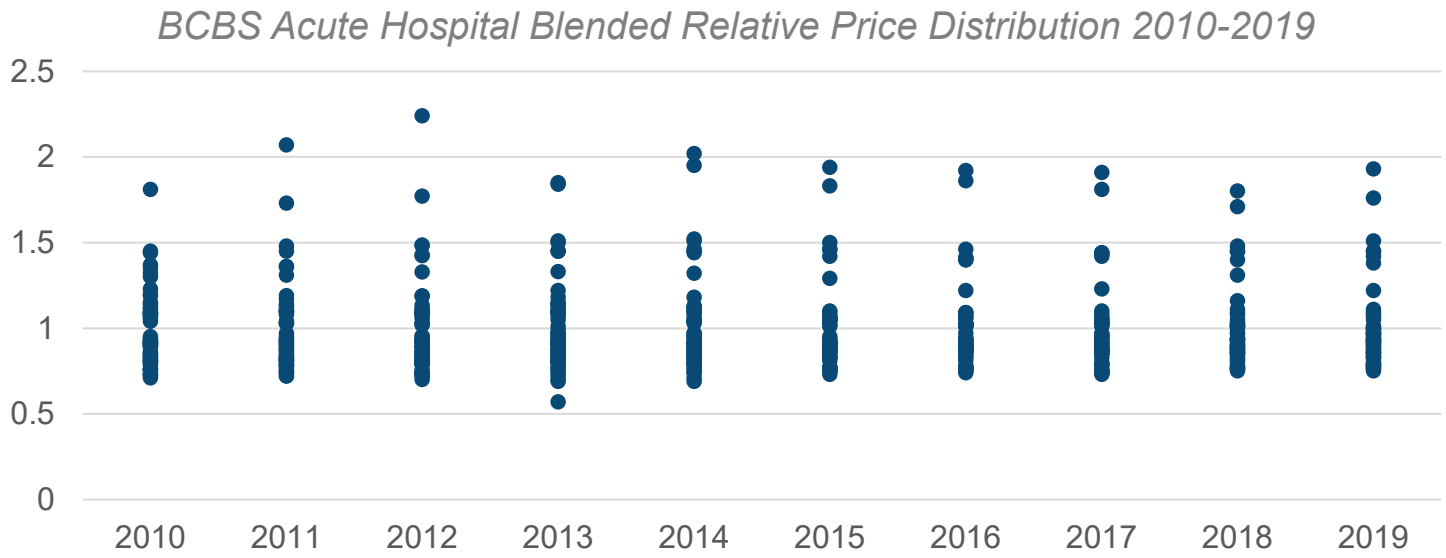
Price variation has persisted; volume and spending at high-priced providers is growing.

- The extent of price variation has not significantly diminished over time.

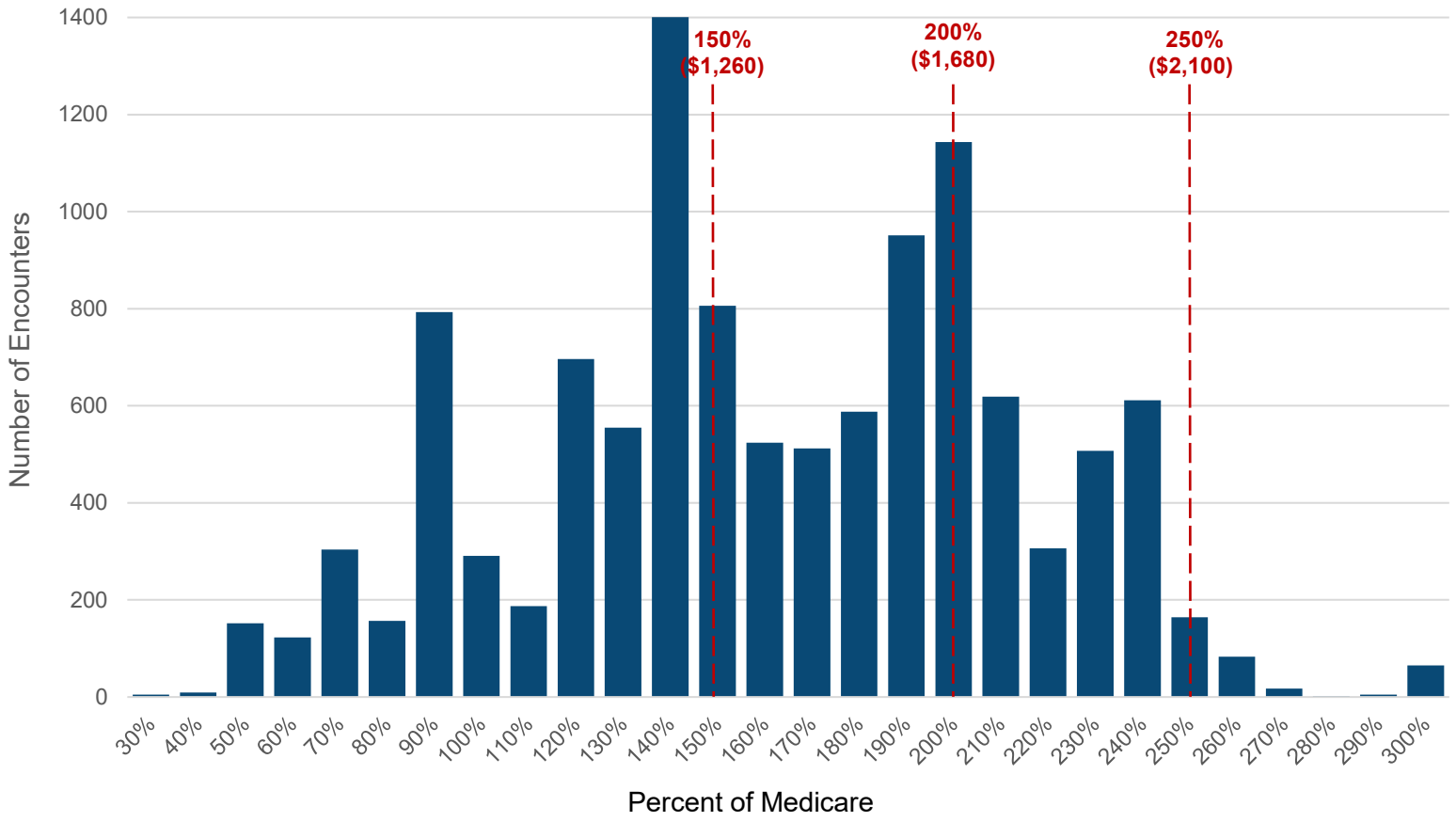


- The volume at high priced providers is growing:
  - The percentage of discharges from hospitals with prices 20% above average **grew from 23.8% in 2015 to 27.6% in 2019**.
  - The percentage of payments to hospitals in the top price quartile **grew from 51.9% in 2015 to 54.3% in 2019**

Sources: HPC analysis of data provided by the Center for Health Information and Analysis: Relative Price.

There was wide variation in colonoscopy payments in 2018, with many prices far above 200% of Medicare.

Facility price per colonoscopy encounter in Massachusetts, 2018



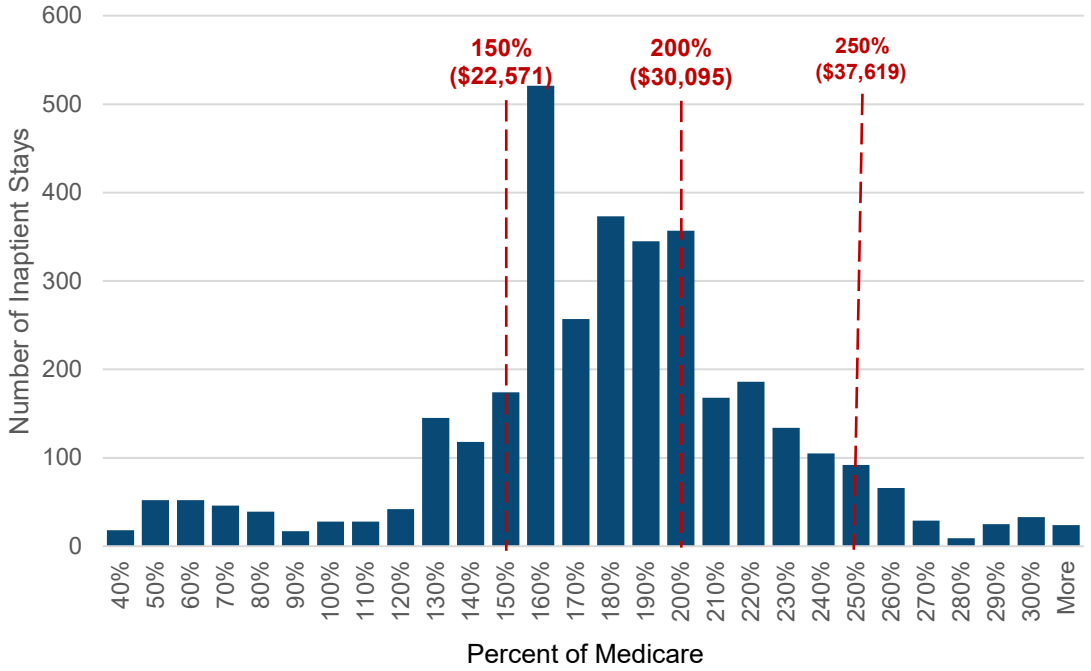
- 21.7% of encounters were paid **more than 200% of Medicare's rates**.
- Spending for these services would be **reduced by 4.8%** if prices were limited to 200% of Medicare.

Notes: The prices examined are for diagnostic colonoscopy CPT 45378. The Medicare prices represent the payment for Suffolk county. Prices are shown as percent of Medicare payment.

Sources: HPC analysis of CHIA's All-Payer Claims Database v8.0; Medicare data

There was also wide price variation for hip and knee inpatient procedures.

Facility spending per major joint replacement (DRG 470) in Massachusetts relative to Medicare base rate, 2018



- Using Medicare's base rate as a comparison (**excluding** DSH and teaching add-ons):
  - 25% of encounters were paid more than 200% of Medicare's rates.
  - Spending would be reduced by 4.8% if prices were limited to 200% of Medicare.
- Using Medicare's hospital specific rates as a comparison (**including** DSH and teaching):
  - 12% of encounters were paid more than 200% of Medicare rates.
  - Spending would be reduced by 1.7% if prices were limited to 200% of Medicare.

Notes: HPC created inpatient stay episodes and assigned an MS-DRG to each episode. All facility payments associated with an inpatient stay for MS-DRG 470 were included in the facility spending for a given service. Spending is shown as a percent of Medicare's base rate.

Sources: HPC analysis of CHIA's All-Payer Claims Database v8.0; Medicare data

Options for Setting Price Benchmarks

- The Hamilton Project's Proposed Approach uses a benchmark based on **private rates** (5 times the 20th percentile of the distribution* of private prices).
  - A private rate-based benchmark would be more influenced by local market conditions
- Many states use **Medicare-based benchmarks.**
  - Medicare hospital payments are designed to be consistent with an efficient hospital's costs.
    - For efficient hospitals in 2019, Medicare paid 1% below their cost
    - For other hospitals in 2019, Medicare paid 7% below their cost

Thus, a payment benchmark of 200% of Medicare is providing a 90+% markup over cost for an average hospital.

  - Medicare spending growth is consistent with the Massachusetts benchmark.
  - In Massachusetts, from 2016 to 2019:
    - Commercial spending per enrollee grew **3.7%** per year
    - Medicare spending per enrollee grew **2.4%**

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MedPAC report to the Congress, March 2021.
*In some cases, the distribution would first be truncated to remove high-cost outliers.

Next Steps

1. Further research and development of spending measures that are less influenced by changes in coding intensity, and further documentation of coding trends.

2. Further exploration of the implications of different price benchmarks, including both savings estimates and distributional impacts (which providers, impacts on health equity).

3. Further research on how to implement growth and level price caps (e.g., different levels of aggregation – hospital-wide average or service-specific).