

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 17, 2019

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EXECUTIVE SUMMARY

This is the Office of the Attorney General’s (“AGO”) report of its 2019 examination of health care cost trends conducted pursuant to Section 17 of Chapter 12C of the Massachusetts General Laws.

Prior AGO cost trends reports have highlighted the successes and challenges associated with health care cost containment initiatives. In our earlier reports, the AGO documented significant price variation among Health Care Providers that is unrelated to the quality of care provided. Most recently, the AGO examined the complexity and variation in payment methods between health insurers (“payers”) and providers and reported how this complexity adds costs to the health care system and hinders the ability of consumers and employers to shop for the most cost-effective care. This year, we analyzed changes in patient expenditures at Lower-Priced Hospitals compared with Higher-Priced Hospitals. We also examined the impact of two cost containment initiatives—online consumer Cost Estimators and Alternative Payment Arrangements.

Although the increase in total health care expenditures in Massachusetts was equal to the cost growth benchmark¹ of 3.1% in 2018, consumers were responsible for a growing share of health care costs.² On average, fully-insured commercial premiums paid by consumers and their employers increased by 5.6% in 2018 to \$509 per month.³ Enrollment in High-Deductible Plans continues to increase in Massachusetts (from 24.5% in 2016 up to 31.5% in 2018),⁴ exposing consumers to higher out-of-pocket costs. Massachusetts working-class families with employer-sponsored insurance contributed nearly a third of their income to health care expenses.⁵ In 2017, more than 1 in 4 residents of Massachusetts reported an unmet need for medical or dental care in the previous year due to an inability or unwillingness to pay the cost.⁶

One way policymakers have hoped to slow rising health care costs is to shift care to higher-value (high-quality, lower-price) care settings. In this report, we compare the share of expenditures at Lower-Priced Hospitals with that of Higher-Priced Hospitals in 2014 and 2018 for patients in certain Provider Organizations. The report then examines two cost containment initiatives that have sought to incent patients and providers to select high-quality, lower-price providers. We examine Massachusetts health insurers’ online Cost Estimators and consider whether they have been successful cost containment tools. We also examine Alternative Payment Arrangements and consider whether the complexity and costs associated with these arrangements hinder the provider incentives designed to encourage effective Population Health Management.

This report is organized in four sections. Section I reports on the results of our examination of the change in the share of spending at Lower-Priced Hospitals compared to Higher-Priced Hospitals. Section II presents the results of our examination of health care payers’ Cost Estimator tools. This section reviews the overall use of these tools as well as the tools’ functionality and accessibility, the most frequent users and most frequently searched services. Section III reports on our examination of Alternative Payment Arrangements. This section details changes in patient enrollment across payers and insurance products, as well as the methods payers use to assign patients with a Preferred Provider Organization plan to a provider for Alternative Payment Arrangements. Finally, the report concludes with our recommendations.

¹ Chapter 224 of the Acts of 2012 created the health care cost growth benchmark, which is a statewide target for the annual rate of growth of total health care expenditures. The benchmark target is established by the HPC in accordance with M.G.L. ch. 6D, § 9.

² See CTR. FOR HEALTH INFO. & ANALYSIS, PERFORMANCE OF THE MASS. HEALTH CARE SYSTEM ANNUAL REPORT OCTOBER 2019 at 7, (Oct. 2019) (Hereinafter 2019 CHIA ANNUAL REPORT), available at <http://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report.pdf>.

³ *Id.* at 53.

⁴ *Id.* at 49.

⁵ See MASS. HEALTH POLICY COMM’N, 2018 ANNUAL HEALTH CARE COST TRENDS REPORT at 3, (Feb. 2019), available at <https://www.mass.gov/files/documents/2019/02/20/2018%20Cost%20Trends%20Report.pdf>.

⁶ See CTR. FOR HEALTH INFO. & ANALYSIS, FINDINGS FROM THE 2017 MASS. HEALTH INSURANCE SURVEY DECEMBER 2017 at 44, (Dec. 2017) available at <http://www.chiamass.gov/assets/docs/r/survey/mhis-2017/2017-MHIS-Report.pdf>.

Our principal findings are as follows:

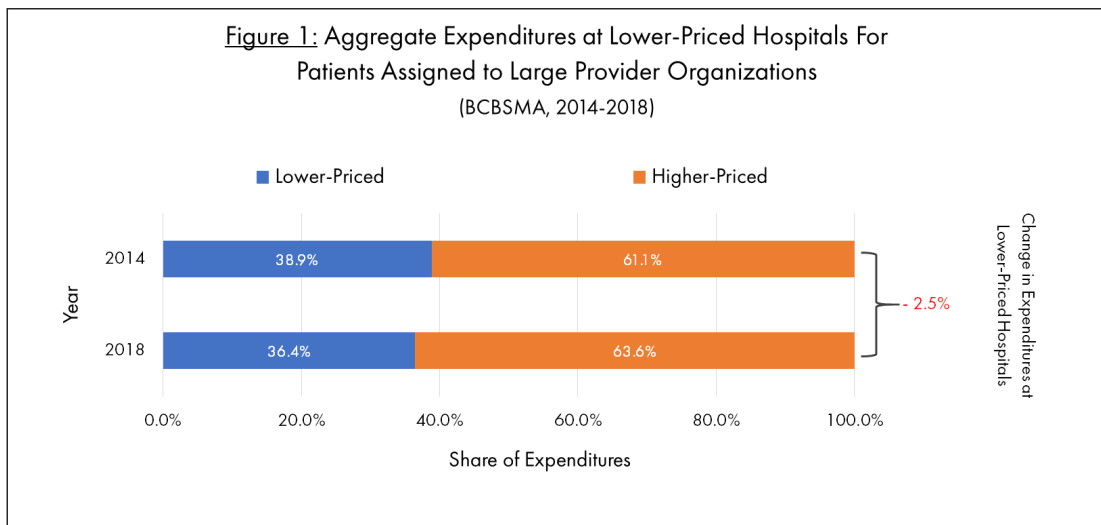
1. Patient expenditures at Lower-Priced Hospitals have decreased over time and vary across provider organizations.
2. Online Cost Estimators have had a limited impact on patient selection of high-value health care options.
 - a. Massachusetts payers have developed useful Cost Estimator tools; however, the tools do not capture alternative payments.
 - b. Overall use of online Cost Estimators is very low, with some payers experiencing a modest increase in use from 2017 to 2018. Women and young adults (ages 26-34) were the most frequent tool users. Patients in High-Deductible Plans were more likely to use the tool. Imaging services and women's health services, along with behavioral health services (when available), were among the top-searched services.
 - c. Very few consumers who use Cost Estimators seek to hold their payers to the cost estimates they receive.
 - d. Payers have tried different strategies to encourage use of the Cost Estimators, although most payers do not track whether members who use the tools are more likely to select higher-value health care options.
3. Patient movement across payers and products is significant and limits the ability of providers to measure their own performance under an Alternative Payment Arrangement.
4. The methods payers use to assign ("attribute") patients with PPO plans to providers for the purpose of Alternative Payment Arrangements is complex and may serve as a barrier to incenting providers to effectively manage and care for their patient population.

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

1. Temper expectations that consumer-driven health care price transparency tools will reduce overall health care cost growth.
2. Closely review incentives for health care providers to direct patients to lower-cost health care settings.
3. Recognize that providers' incentives to manage their patient populations are significantly hampered by the frequency with which patients switch health plans.
4. Standardize the methods used to attribute patients to providers under Alternative Payment Arrangements.

I. PATIENT EXPENDITURES AT LOWER-PRICED HOSPITALS HAVE DECREASED OVER TIME AND VARY ACROSS PROVIDER ORGANIZATIONS.

In this section, we report on our examination of the share of expenditures for inpatient medical-surgery services in 2014 and 2018 at Lower-Priced Hospitals compared with Higher-Priced Hospitals.⁷ We examined expenditures for HMO patients assigned to eight large Provider Organizations⁸ for the largest Massachusetts payer, Blue Cross Blue Shield of Massachusetts (“BCBSMA”).⁹ We reviewed expenditures over time to identify any correlation between changes in the share of patient expenditures at Lower-Priced Hospitals with the roll-out of consumer and provider-facing cost containment initiatives since 2014. Across eight large Provider Organizations, we found that the share of inpatient spending at Lower-Priced Hospitals decreased by 2.5% from 2014 to 2018, as shown in Figure 1 below.



Notes:

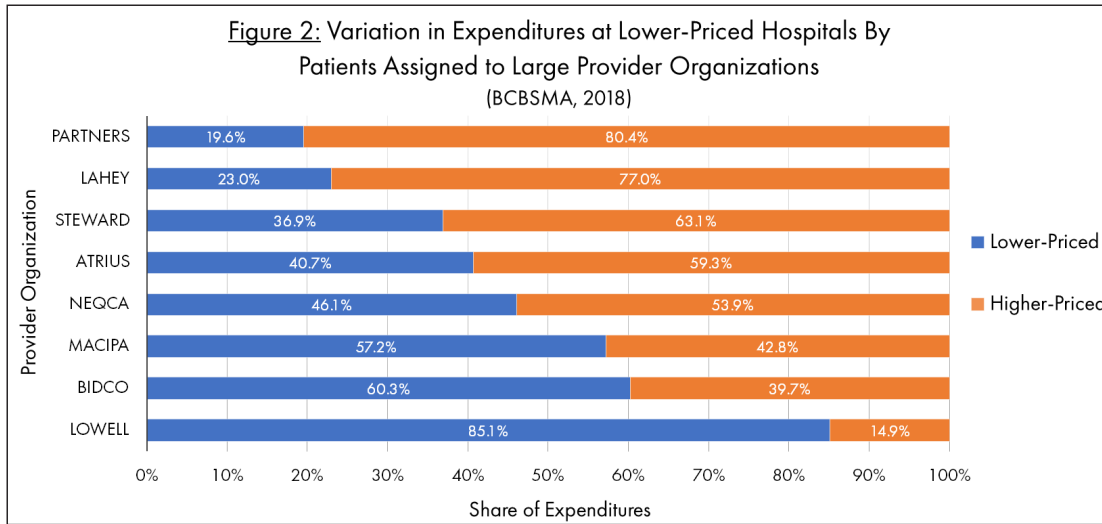
1. A “Lower-Priced Hospital” is defined as a community hospital with a CHIA Relative Price (2017) of 1.0 or lower, or an Academic Medical Center with a relative price of 1.2 or below. A “Higher-Priced Hospital” is defined as a community hospital or Academic Medical Center with relative pricing above the specified thresholds.
2. The Provider Organizations are: Atrius Health (“Atrius”), Beth Israel Deaconess Care Organization (“BIDCO”), Steward Health Care Network, (“Steward”), New England Quality Care Alliance (“NEQCA”), Partners HealthCare System (“Partners”), Mount Auburn Cambridge Independent Practice Association (“MACIPA”), Lahey Health System (“Lahey”) and Lowell General Physician Hospital Organization (“Lowell”).
3. Data reflect inpatient HMO medical-surgery expenditures.
4. Data for Partners, BIDCO, Lahey and Lowell Health Systems are from 2015 and 2018. Data for remaining organizations are from 2014 and 2018.

⁷ A “Lower-Priced Hospital” is defined as a community hospital with a Center for Health Information and Analysis (“CHIA”) Relative Price (2017) of 1.0 or lower, or an Academic Medical Center with a relative price of 1.2 or below. A “Higher-Priced Hospital” is defined as a community hospital or Academic Medical Center with relative pricing above the specified thresholds.

⁸ A “Provider Organization” is any organized group of providers that contracts with carriers for payment for health care services.

⁹ BCBSMA is the largest payer in the MA market so our analysis of its inpatient expenditures across 8 large Provider Organizations serves as an important case study. We also conducted a similar expenditure analysis using Harvard Pilgrim Health Care (“HPHC”) data and found similar aggregate level results. However, HPHC data was not directly comparable to BCBSMA data and so we do not report it.

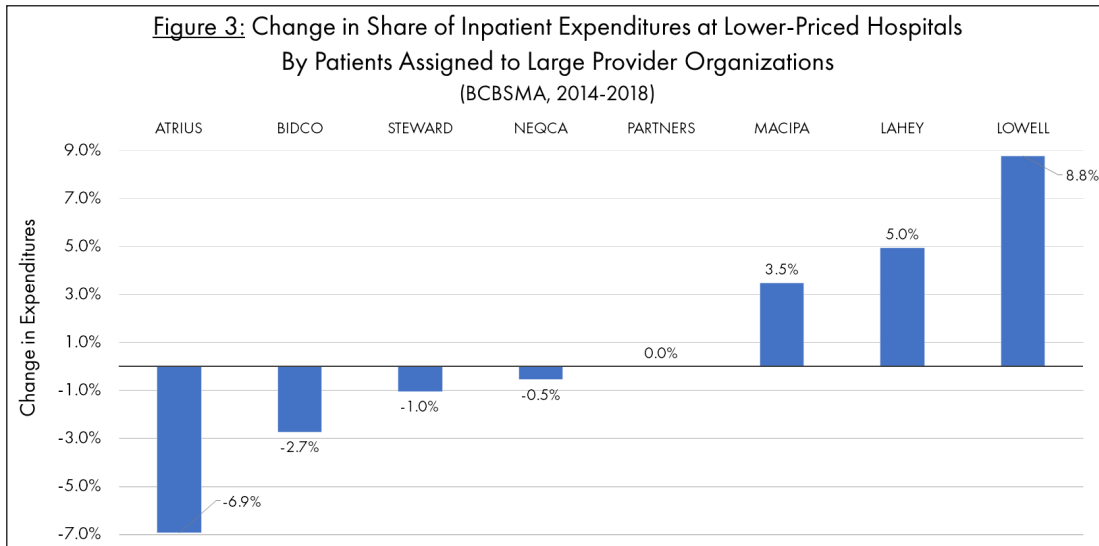
Below, Figure 2 shows the expenditures at Lower-Priced Hospitals compared with Higher-Priced Hospitals across eight Provider Organizations in 2018. As shown below, we found that the share of inpatient expenditures at Lower-Priced Hospitals varies substantially across the Provider Organizations patients are assigned to.



Notes:

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3. Data reflect inpatient HMO medical-surgery expenditures.

In Figure 3, we display the change in spending at Lower-Priced Hospitals from 2014 to 2018 by Provider Organization. Together, Figures 2 and 3 show that the Provider Organizations with a high proportion of expenditures at Lower-Priced Hospitals in 2014 also often had a greater increase in the proportion of expenditures at Lower-Priced Hospitals from 2014 to 2018. In other words, organizations where patients frequently chose a Lower-Priced Hospital at the beginning of the period were also often most successful at increasing the selection of efficient hospitals over the period.



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2. The Provider Organizations are: Atrius Health ("Atrius"), Beth Israel Deaconess Care Organization ("BIDCO"), Steward Health Care Network, ("Steward"), New England Quality Care Alliance ("NEQCA"), Partners HealthCare System ("Partners"), Mount Auburn Cambridge Independent Practice Association ("MACIPA"), Lahey Health System ("Lahey") and Lowell General Physician Hospital Organization ("Lowell").
3. Data reflect inpatient HMO medical-surgery expenditures.
4. Data for Partners, BIDCO, Lahey and Lowell Health Systems are from 2015 and 2018. Data for remaining organizations are from 2014 and 2018.

In five out of the eight Provider Organizations studied, the share of expenditures at Lower-Priced Hospitals either remained essentially the same or decreased. Only three Provider Organizations increased the proportion of hospital expenditures at Lower-Priced Hospitals between 2014 and 2018. Expenditures at Lower-Priced Hospitals was not uniform, with variation in the change in the share of expenditures at Lower-Priced Hospitals ranging from negative 6.9% to positive 8.8%. These data suggest that cost containment initiatives that have been implemented since 2014 have not uniformly led patients to move their care to Lower-Priced Hospitals. Instead, we observed varied results, with some Provider Organizations succeeding in moving patient expenditures to Lower-Priced Hospitals while others did not.

Although the patient expenditure data do not explain the causes of any shift toward or away from Lower-Priced Hospitals, we noted that the composition of some of these Provider Organizations changed during the period we examined, and those changes may have influenced the data. For example, the share of patient expenditures for Lowell General PHO at Lower-Priced Hospitals increased significantly from 2014-2018. This change correlated with Lowell's affiliation with Tufts Medical Center under a new parent organization, Wellforce, in October 2014.¹⁰ The data reflect a significant increase in the use of Tufts Medical Center, a Lower-Priced Hospital, for Lowell patients after the change in affiliation. Likewise, the affiliation between Winchester Hospital and Lahey Health System in 2014 may explain, in part, the increase in expenditures at Lower-Priced Hospitals for Lahey-affiliated patients.¹¹

In 2019, the Health Policy Commission ("HPC") analyzed patient discharge data to report on the volume of care provided at the larger and generally higher-priced Provider Organizations compared with smaller, generally lower-priced community hospitals.¹² Consistent with our examination, the HPC found that care is concentrated in the largest systems, in part because as hospitals and physicians continue to consolidate and/or align with large systems, they then refer more patients to the system's hospitals.¹³

Most patients consult with their Primary Care Physician or Provider ("PCP") to determine which health care services to obtain and where to receive treatment.¹⁴ So, it is expected that patients are likely to seek care within their PCP's system given that most PCPs have some affiliation with a broader network of providers with which they coordinate care and refer patients. However, there is wide variation in health care cost efficiency across Provider Organizations. Therefore, a cost containment solution that provides consumers with price transparency at the point-of-enrollment (when consumers select their PCP) and financially incents consumers to select a PCP affiliated with a lower-cost system, rather than transparency at the point-of-service, may better contain costs.¹⁵

10 Priyanka Dayal McClusky, *Deal completed, Tufts, Lowell General look to expand*, BOSTON GLOBE (Oct. 2014), available at <https://www.bostonglobe.com/business/2014/10/22/merger-completed-tufts-lowell-general-network-looks-expand/J3AnPtWYx0kcDfInyWTf5L/story.html>.

11 Beth Israel Lahey Hospital, *Winchester Hospital Affiliation with Lahey Health Yields \$13.8 Million in Savings and Increased Volume*, (June 30, 2016), available at <https://www.winchesterhospital.org/about-us/news--media/in-the-news/supporting-winchester-hospital/winchester-hospital-affiliation-with-lahey-health-yields-13-8-million-in-savings-and-increased-volume>.

12 MASS. HEALTH POLICY COMM'N BOARD MEETING at 15-17 (Sept. 11, 2019), available at https://www.mass.gov/files/documents/2019/09/11/20190911_Presentation_vFinal%20to%20post_0.pdf.

13 *Id.*

14 See OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 11-12, (Sept. 18, 2015), (Hereinafter, 2015 AGO COST TRENDS REPORT) available at <https://www.mass.gov/files/documents/2016/09/va/cctcd5.pdf>; See also, See OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 12-13, (Oct. 13, 2016), (Hereinafter 2016 AGO COST TRENDS REPORT) available at <https://www.mass.gov/files/documents/2016/10/ts/cc-market-101316.pdf>.

15 2015 AGO COST TRENDS REPORT at 11.

II. ONLINE COST ESTIMATORS HAVE HAD A LIMITED IMPACT ON PATIENT SELECTION OF HIGH-VALUE CARE.

We examined the online Cost Estimators of six health care payers—the three largest payers in Massachusetts, one national payer, and two smaller Massachusetts payers.¹⁶ To conduct our analysis, we obtained data reflecting patient use of payers’ online tools from 2016 to 2018, as well as data on tool features, functionality, payer marketing of the tools and associated incentive programs.

This section presents the results of our examination. Subsection A provides an overview of the development and current state of payer Cost Estimator tools. Subsection B reports on patient use of online Cost Estimators, including patients most likely to search and the services they most often search for. Subsection C summarizes the data showing the number of patients who have sought to enforce cost estimates. Subsection D reports on payers’ use of incentive programs to encourage patients to use Cost Estimator tools and to select high-value care options.

A. Massachusetts Payers Have Developed Useful Cost Estimator Tools; However, Payer Tools Do Not Capture Alternative Payments.

In 2012, the Commonwealth enacted Chapter 224, An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. As reflected in the law’s title, price transparency was a central component in this effort to contain the growth of health care costs.¹⁷ With Chapter 224, Massachusetts became the first state in the nation to require that payers establish toll-free telephone numbers and websites for patients to access real-time cost estimates for procedures and services at various sites of care.¹⁸ In coordination with the Division of Insurance, all Massachusetts payers, including the six payers we examined, launched online Cost Estimator tools, with the earliest tool being launched in 2012.¹⁹

In 2015, Health Care for All assessed the three largest payers’ tools, reviewing the accessibility and functionality of each tool.²⁰ The Pioneer Institute followed with its own review in 2017.²¹ At least two studies from outside Massachusetts have examined the use and impact of Cost Estimator tools, finding that offering such a tool is not associated with lower health care spending.²² Another study reviewed trends in the patient use of a national insurer’s Cost Estimator outside Massachusetts, concluding that use was low, among other findings.²³ In this context, we sought to assess the specific impact of Cost Estimator tools on consumer choices and health care costs in the Commonwealth.

¹⁶ We also conducted transcribed interviews with four of the six payers: three large Massachusetts payers and one national payer.

¹⁷ See 2012 Mass. Acts ch. 224.

¹⁸ The Center for Health Information and Analysis operates a separate website, Massachusetts Compare Care, which provides the average cost estimate for certain health care services and directs patients to their payer’s cost estimators. See Mass. Gen. Laws ch. 12C, § 20 (requiring CHIA “maintain a consumer health information website” with “information comparing the quality, price and cost of health care services”); See also MASS COMPARECARE available at <https://masscomparecare.gov/>.

¹⁹ “Cost Estimators” are also commonly referred to as price transparency tools.

²⁰ See HEALTH CARE FOR ALL, CONSUMER COST TRANSPARENCY REPORT CARD at 2, (2015) (Hereinafter 2015 HCFA REPORT CARD) available at https://www.hcfama.org/sites/default/files/consumer_cost_estimation_report_card.pdf.

²¹ See Barbara Anthony et al., *MA Health Insurers Have Improved Their Consumer Price Transparency Efforts, But Significant Work Remains*, (April 2018), Pioneer Institute, available at <http://www1.prweb.com/prfiles/2018/04/18/15423055/CarrierSurveyWP.pdf>.

²² See Sunita Desai et al., *Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, 36(8), (Aug. 2017) *Health Affairs*, available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1636>. See also Sunita Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, (May 2016) *JAMA*, available at <https://jamanetwork.com/journals/jama/fullarticle/2518264>.

²³ A. Sinaiko and M. Rosenthal, *Examining A Health Care Price Transparency Tool: Who Uses It, And How They Shop for Care*, 35(4) (April 2016), *Health Affairs*, (Hereinafter Sinaiko et al., *Price Transparency Tool*) available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0746>.

Our examination found that, consistent with Chapter 224, the payers operate consumer-facing online tools that generate cost estimates according to each member's health plan.²⁴ After logging into the tool, a patient can view the estimated cost of each service included in the tool based on his or her deductible, out-of-pocket maximum, and other cost-sharing conditions personalized to the patient's plan.

The payers' Cost Estimator tools share common design and functionality features. Three payers use the same vendor to develop and manage their online tools. The Cost Estimators each allow patients to search for care by procedure, facility, provider, and location. Most tools include a search bar or drop-down menu that auto-fills services and procedures as members search for care, and some tools include links to popular Shoppable Services.²⁵ None of the payer tools fully integrate pharmacy prices²⁶ and three of the six tools are available through a mobile application. Some payers offer incentive programs through their Cost Estimators, which provide reduced cost-sharing or cash incentives to encourage patients to choose lower-price, high-value options.

Most payers generate the cost estimates using historical claims data ranging from 12 to 36 months in the past. One national payer uses current contracted rates to generate cost estimates. The payers refresh the data underlying the estimates at differing intervals. One payer refreshes its historical claims data on a monthly basis. Two payers refresh their historical claims data bi-annually, and two payers refresh their historical claims data annually.²⁷

None of the payers include non-claims-based payments in their Cost Estimators. Non-claims-based payments are quality and efficiency bonuses paid out to providers by payers associated with Alternative Payment Arrangements.²⁸ These bonuses are most often paid after care is provided to patients and after patients and payers are billed for their care using a fee-for-service framework. Given the retrospective nature of most of these bonuses, they do not directly impact consumers' cost liability or the accuracy of cost estimates from the consumers' perspective. However, these payments account for a significant amount of health care costs that impact the Commonwealth and yet are not reflected in payer Cost Estimators. Moreover, Chapter 224 requires commercial payers to reduce the use of fee-for-service payment mechanisms "to the maximum extent feasible."²⁹ If the market shifts towards value-based payment models that are not based on an underlying fee-for-service framework, historical fee-for-service claims data will have little relevance to the actual price differences among providers and services. As such, the Cost Estimators, as currently constructed, are incompatible with a shift towards Full Capitation.³⁰

Of the tools examined, only one provides cost information in a language other than English.³¹ One payer provides members with the option to request a written estimate in another language, but this function is not embedded in the Cost Estimator. Enhanced language features have not been implemented into most tools since they were first evaluated in 2015, highlighting an opportunity for increased innovation.³²

24 See Mass. Gen. Laws ch. 32A, § 27 (2014).

25 Shoppable health care services are services offered by multiple providers that can be scheduled in advance by the patient

26 Five payers directed members to a PBM-run online tool, and one payer provides pharmacy price estimates in a separate online tool.

27 We did not examine the accuracy of the tools' cost estimates, but we obtained information about cost estimation grievances for each payer. See following Section II, subsection D for more information.

28 An "Alternative Payment Arrangement" or "Risk Arrangement" is an agreement between a payer and provider that gives financial incentives to the provider to provide efficient, coordinated care in order to contain overall health care costs and improve health quality.

29 2012 Mass. Acts ch. 224, § 280(c).

30 Full capitation payments are fixed, pre-arranged payments health plans make to provider organizations based on a per-member per month or per capita budget to cover all care delivered to the members covered by the arrangement.

31 This payer provides cost information in English and Spanish.

32 See 2015 HCFA REPORT CARD at 1, 2.

An important feature embedded within some of the payer tools that we examined is provider directories. Provider directories provide consumers with contact information and other details about providers in their network, including information about which providers are currently accepting new patients.³³ This feature supports increased access to health care services for patients while further incenting tool use. For instance, when interviewed, payers reported that many consumers who accessed their websites did so to find a particular doctor for a particular service and now—through provider directory integration—they have the ability to simultaneously compare prices across providers.³⁴ Additionally, for most payers, members access their Cost Estimator tool through their personal portal, which often includes the members' personal health records, health plan specifications, and individualized cost information. The integration of these features is an example of how payer tools can help consumers obtain multiple aspects of information across the fragmented health care system as they seek to understand, access and pay for their health care.

B. Consumer Use of Payers' Cost Estimator Tools is Limited and Varies by Age, Gender, Income and Plan Type.

As part of our examination, we evaluated payer Cost Estimator tool user demographics, including by gender, age and plan type. This comprehensive assessment of tool user demographics across six payers is the first of its kind to our knowledge.

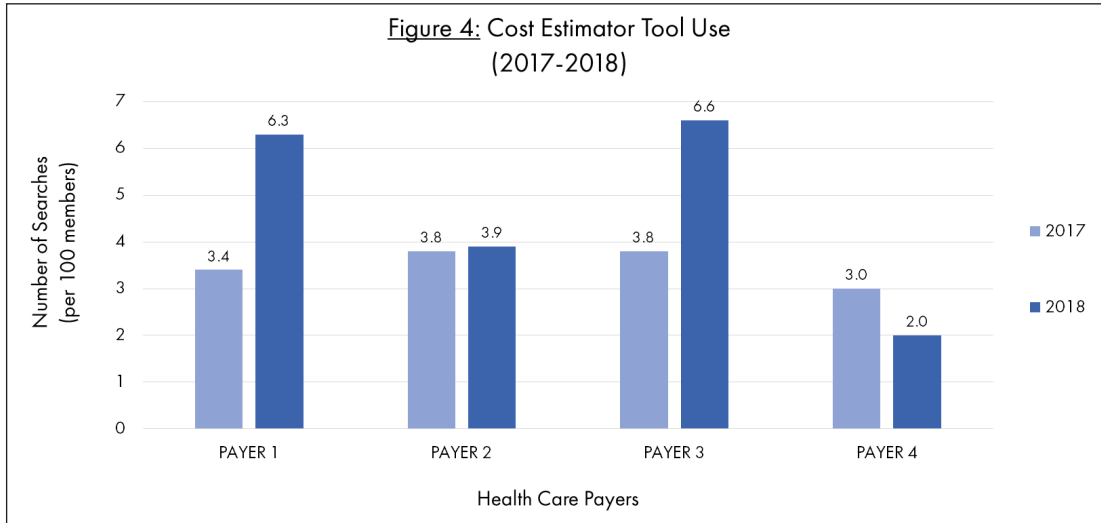
We made five important findings in our analysis of patient use of Cost Estimator tools: (1) overall, few patients use the online Cost Estimators; (2) women and young adults are the most frequent users; (3) members enrolled in High-Deductible Plans are more likely to use the Cost Estimator tools; (4) patients most frequently searched for imaging services; (5) behavioral health services are among the most frequently searched services when they are available on the search tool.

³³ We did not assess the accuracy of the provider directories available through payer Cost Estimator tools.

³⁴ Although provider directories do not require login credentials or membership with a payer to access, when consumers search in the embedded provider directories, they are encouraged to login to access estimator tools.

1. Few Patients Use Payers' Online Cost Estimators

Although Massachusetts payers provide consumer-facing Cost Estimators, very few patients use these tools. In 2017 and 2018, the number of searches per 100 members ranged from 2.0 to 6.6 in either year.³⁵ As indicated in Figure 4, of the four payers with data for both years, two small payers reported an increase in the use of their Cost Estimator between 2017 and 2018, one payer reported a reduction in use, and one payer found no change in use.³⁶



Notes:

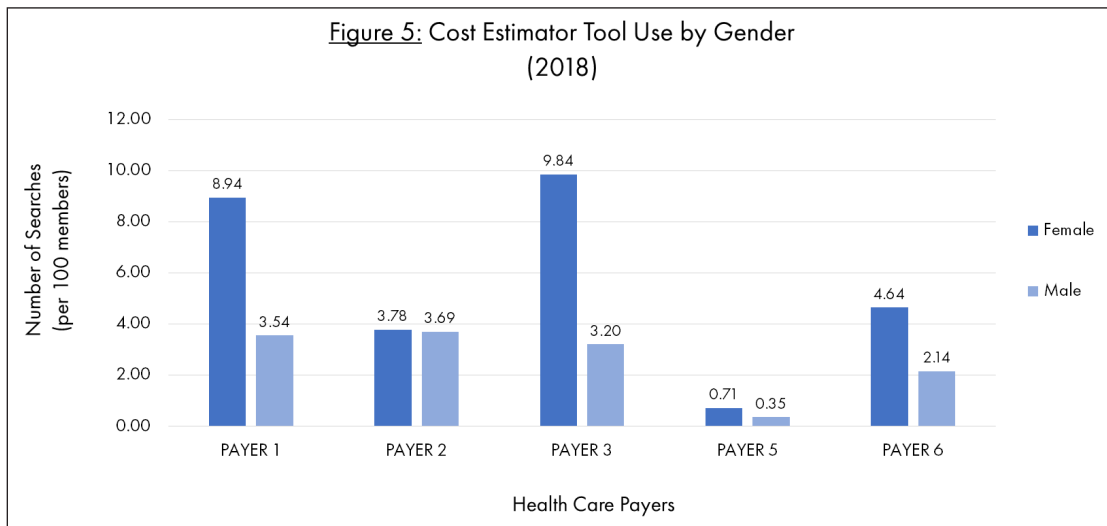
1. Data are based on 2017 and 2018 searches generated by members enrolled in Massachusetts-based commercial plans as reported by payers; one payer included searches generated by members enrolled in Massachusetts, Rhode Island and New Hampshire-based plans.
2. Payer commercial enrollment data are based on CHIA's Feb. 2019 Enrollment Trend Report.
3. Data reflect the number of searches per 100 members.
4. PAYER 1 provided 2017 data only for the months of Aug. to Dec., which were annualized.

35 In advance of the 2019 Annual Cost Trends Hearing, payers submitted written pre-filed testimony ("PFT") regarding the aggregate number of price inquiries generated using their online Cost Estimator tools. Due to differences in the requested data metrics, some payers' PFT submissions are not comparable to data obtained by the AGO for this examination. See TESTIMONY FOR THE 2019 HEALTH CARE COST TRENDS HEARING (2019) available at <https://www.mass.gov/info-details/testimony-for-the-2019-health-care-cost-trends-hearing#pre-filed-testimony-overview->

36 Two payers did not provide tool use data for 2017.

2. Women and Young Adults (Ages 26-34) Are the Most Frequent Cost Estimator Tool Users

To better understand who is most likely to use online Cost Estimators, we examined the demographic data associated with member searches. As illustrated in Figure 5, we found that, for most payers, female members generated more searches using Cost Estimator tools than male members in 2018. One payer—the only payer to highlight a category of men’s health services in its tool—reported that men and women searched the Cost Estimators at similar rates. This finding aligns with studies that have found that women use more health care services and spend more on services and procedures over their lifetimes than men.³⁷ Women also make a majority of the health care decisions for their children.³⁸



Notes:

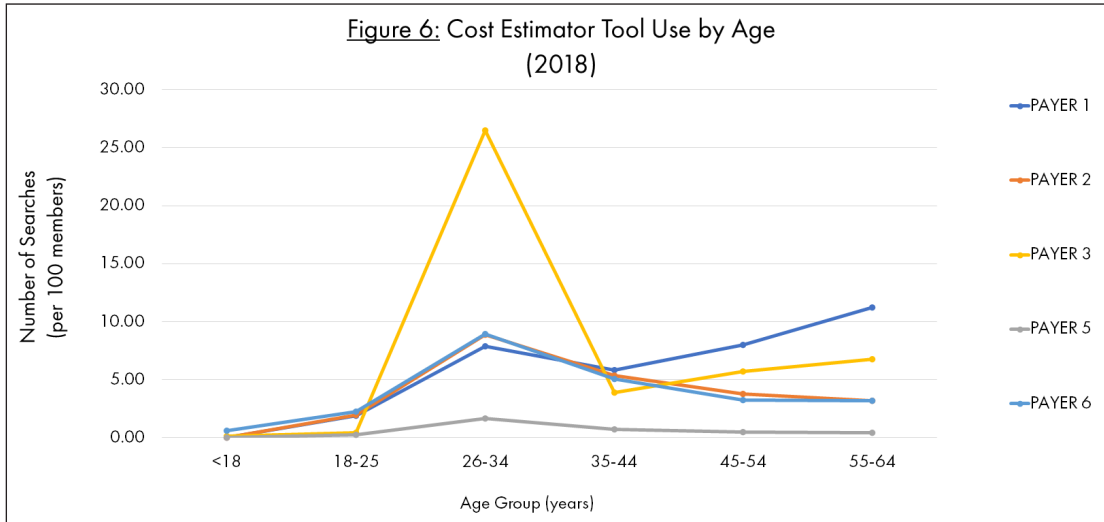
1. Data are based on 2017 and 2018 searches generated by members enrolled in Massachusetts-based commercial plans as reported by payers; one payer included searches generated by members enrolled in Massachusetts, Rhode Island and New Hampshire-based plans.
2. Payer commercial enrollment data are based on CHIA’s Feb. 2019 Enrollment Trend Report.
3. Data reflect the number of searches per 100 members.
4. PAYER 4 did not provide this data.
5. PAYER 5 provided 2018 data only for the months of May to Dec., which were annualized.

We also found that for most payers, members between the ages of 26-34 were the most frequent users of Cost Estimator tools compared to other age groups in 2018. One small payer reported that members between the ages of 55-64 most frequently used the Cost Estimator in 2018. See Figure 6. Similarly, most payers reported that members aged 55-64 generated the second-highest number of searches using the tool. Across four payers, we found that adults below the age of 25 generated the least number of searches in 2018.

³⁷ See US DEPT OF LABOR, EMPLOYEE BENEFITS SECURITY ADMINISTRATION; GENERAL FACTS ON WOMEN AND JOB BASED HEALTH, [Hereinafter, DOL EBSA GENERAL FACTS] available at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/women-and-job-based-health.pdf>. See also, KD Bertakis et al., *Gender Differences in the Utilization of Health Care Services*, 49(2) NCBI. (Feb 2000), available at <https://www.ncbi.nlm.nih.gov/pubmed/10718692>.

³⁸ See DOL EBSA GENERAL FACTS.

The published literature shows that patient health care expenditures increase with age. For example, a 2016 analysis of nationwide claims data found that individuals above the age of 55 accounted for over 55% of total health care spending.³⁹ Even though this might provide older patients with greater reason to use the tools, our examination found that Cost Estimator tool use among older patients was lower than use by younger patients among five of the six payers examined.

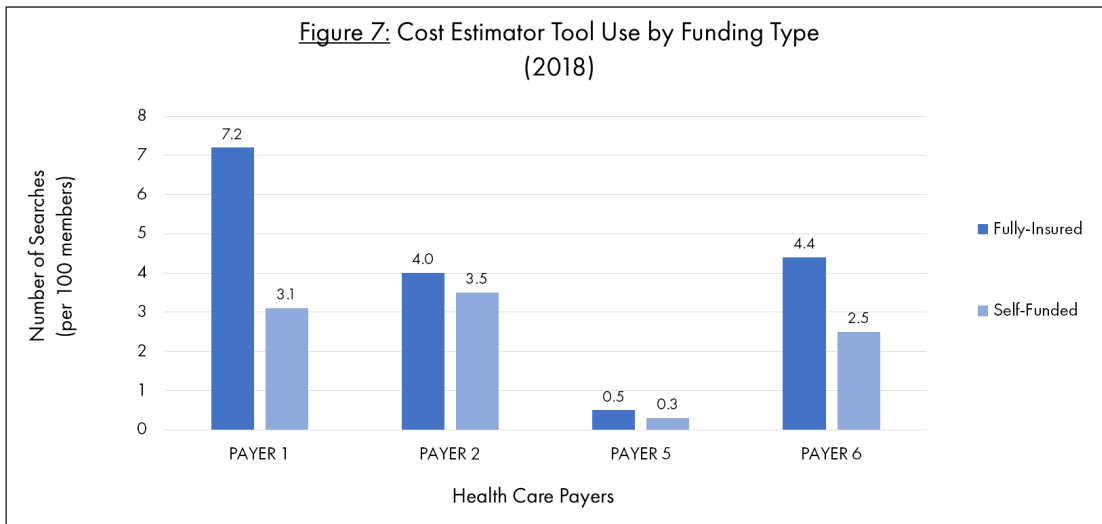


Notes:

1. Data are based on 2017 and 2018 searches generated by members enrolled in Massachusetts-based commercial plans as reported by payers; one payer included searches generated by members enrolled in Massachusetts, Rhode Island and New Hampshire-based plans.
2. Payer commercial enrollment data are based on CHIA's Feb. 2019 Enrollment Trend Report.
3. Data reflect the number of searches per 100 members.
4. PAYER 3 reported a large number of searches generated by 26-34 year-olds, in part due to searches generated by the payer's own employees.
5. PAYER 4 did not provide this data.
6. PAYER 5 provided 2018 data only for the months of May to Dec., which were annualized.

³⁹ Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; see Bradley Sawyer and Gary Claxton, *How do health expenditures vary across the population?* KAISER FAMILY FOUNDATION, (Jan. 16, 2019), available at <https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/>.

Figure 7 below shows that use of payers’ Cost Estimator tools varied between members with fully-insured and self-funded plan types. Whether a member is enrolled in a self-funded plan or a fully-insured plan, there is an incentive to encourage patients to select high-value care options. Self-funded employers, who are responsible for paying employees’ medical claims, are exposed to greater risk than fully-insured employers. As a result, employers offering self-funded plans may be more likely to encourage employees to use Cost Estimator tools to select lower-cost care options. At the same time, payers offering fully-insured plans are responsible for paying their members’ health plan premiums and may be more likely to encourage their members to use Cost Estimators in an effort to hold down premium increases. Payers are also more likely to encourage their employer customers (who purchase health coverage for their employees and negotiate with payers over premium levels) to encourage their employees to use the tools. We found that across four payers, members in fully-insured plans used Cost Estimators more frequently in 2018 than members with self-funded plans. Our review of payer Cost Estimator tool use according to plan funding type is the first of its kind to our knowledge.



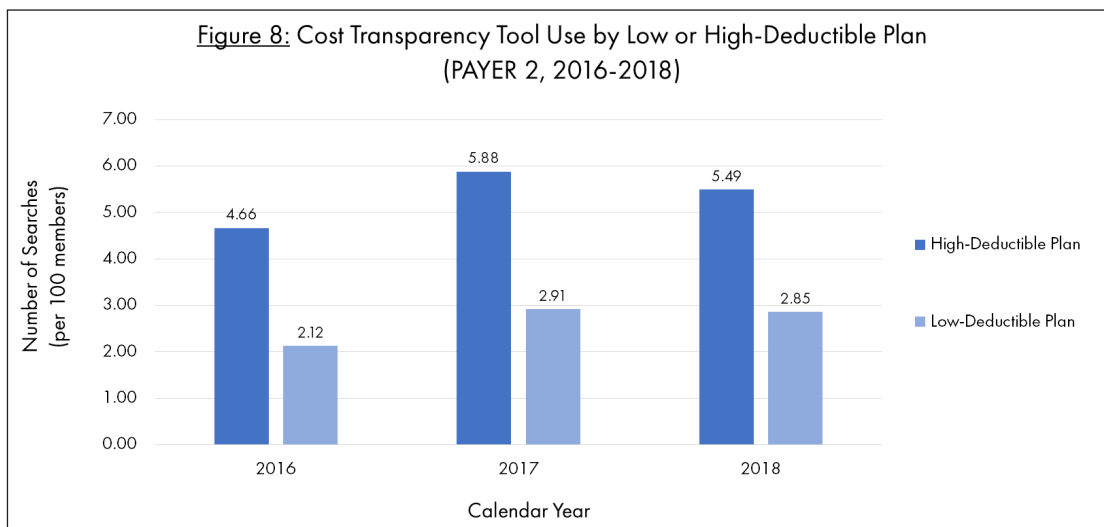
Notes:

1. Data are based on 2017 and 2018 searches generated by members enrolled in Massachusetts-based commercial plans as reported by payers; one payer included searches generated by members enrolled in Massachusetts, Rhode Island and New Hampshire-based plans.
2. Payer commercial enrollment data are based on CHIA’s Feb. 2019 Enrollment Trend Report.
3. Data reflect the number of searches per 100 members.
4. PAYER 3 has a small self-funded population and was excluded from analysis.
5. PAYER 4 did not provide this data.
6. PAYER 5 provided 2018 data only for the months of May to Dec., which were annualized.

3. The Amount of a Consumer’s Deductible Has a Limited Impact on Selection of Lower-Price, High-Value Care

We examined one Massachusetts payer’s Cost Estimator tool use by patients with Low and High-Deductible Plans.⁴⁰ In a High-Deductible Plan, consumers pay a lower monthly premium but are required to pay more out-of-pocket before reaching their deductible. High-Deductible Plans are favored by some who believe that requiring patients to pay out-of-pocket for some amount of health care services will encourage patients to seek higher-value options. In 2018, over 1.2 million Massachusetts consumers were enrolled in High-Deductible Plans.⁴¹ Notably, High-Deductible Plan enrollees were more likely to receive their coverage through fully-insured employers in 2018, suggesting that employers may offer these plans in an effort to reduce premium costs.⁴²

We found that members enrolled in High-Deductible Plans in 2016, 2017 and 2018 used the Cost Estimator more frequently than members with Low-Deductible Plans. Members in High-Deductible Plans generated nearly two times as many searches as Low-Deductible members on this payer’s Cost Estimator, despite only accounting for 33% of this payer’s enrollment. See Figure 8 below. Our review of payer Cost Estimator tool use by High-Deductible Plan enrollment is the first of its kind in the Commonwealth to our knowledge. Still, this finding is consistent with another study, which examined one national payer’s Cost Estimator tool and identified higher rates of tool use among members with High-Deductible Plans.⁴³



Notes:

1. Data are based on 2017 and 2018 searches generated by members enrolled in Massachusetts-based commercial plans as reported by payers.
2. Plans were classified as High-Deductible Plans if the individual policy deductible was greater than or equal to the qualifying IRS threshold set at \$1,300 in 2016 and 2017, and \$1,350 in 2018. Plans below these thresholds were classified as Low-Deductible Plans.

40 High-Deductible Plans are defined by IRS individual plan deductible threshold. Plans were classified as High-Deductible Plans if the individual policy deductible was greater than or equal to the qualifying IRS threshold set at \$1,300 in 2016 and 2017, and \$1,350 in 2018. Plans below these thresholds were classified as Low-Deductible Plans.

41 See 2019 CHIA ANNUAL REPORT at 49.

42 See 2019 CHIA ANNUAL REPORT at 45 and 48.

43 See eg., Sinaiko et al., *Price Transparency Tool*.

Although consumers enrolled in High-Deductible Plans were more likely to use the tool, the opportunity for Cost Estimators to reduce spending among even this group of patients is limited. Past AGO Cost Trends reports have found that High-Deductible Plans have a limited impact on consumers’ selection of care once they meet their deductible.⁴⁴ Consumers receive no economic reward for selecting a high-value care option once their deductible and out-of-pocket maximum are met because they have no remaining cost-sharing responsibilities. Higher-cost patients with chronic illnesses are certain to reach their out-of-pocket maximum irrespective of how prudently they shop for care. In 2016, the AGO reported that 77% of health care claims across three major commercial payers were attributable to only 19% of members in 2014.⁴⁵ Thus, the small share of patients who account for the vast majority of health care spending are likely not adequately incented by their deductibles to use Cost Estimator tools to select high-value care options.

4. There is Substantial Variation in the Number and Type of Searchable Services Available Across Payers’ Cost Estimators

As part of our assessment, we reviewed the health care services and procedures available to members on payers’ Cost Estimators. As detailed in Figure 9, our analysis found that the number of searchable services and procedures varied significantly, ranging from 105 to 1,625. We found that imaging services—predominantly MRI, X-Ray and mammography exams—were the most frequently searched services in 2018, followed by physician office visits, pregnancy and childbirth procedures, colonoscopies, and elective surgeries.

Figure 9: Total Number of Searchable Services & Most Frequently Searched Services (2018)						
	PAYER 1 (245 services)	PAYER 2 (1625 services)	PAYER 3 (105 services)	PAYER 4 (800 services)	PAYER 5 (770 services)	PAYER 6 (302 services)
1	Imaging (MRI, Mammography)	Physician Office Visits	Imaging (MRI, X-Ray)	Imaging (MRI, Ultrasound)	Imaging (MRI, X-Ray)	Imaging (MRI, X-Ray)
2	Colonoscopy	Imaging (MRI, X-Ray)	Clinical Pathology	Specialist Office Visits	Clinical Pathology	Pregnancy & Childbirth
3	Physician Office Visits	Behavioral Health	Colonoscopy	Physician Office Visits	Pregnancy & Childbirth	Colonoscopy
4	Elective Surgery (Orthopedic)	Pregnancy & Childbirth	Elective Surgery (Bariatric)	Colonoscopy	Elective Surgery (Gastrointestinal)	Physician Office Visits
5	Pregnancy & Childbirth	Chiropractic Visits	Pregnancy & Childbirth	Behavioral Health	Preventive Care	Elective Surgery (Bariatric)

Notes:

1. Data on most frequently searched services are based on 2018 search data obtained from payers.
2. Data include member searches that did not generate links to searchable service in the tool or produced a “null” or “error” message.
3. Two payers provided searches grouped according to CPT code, and four payers provided unique searches that were then grouped by the AGO according to service line or type of service. When applicable, unique searches were grouped using a CPT clustering map.

44 See 2016 AGO COST TRENDS REPORT at 11.

45 *Id.* at 14.

The type and number of searchable services available may affect which patients are likely to use these tools and how frequently they use them. For example, the data show that female consumers were more likely to use the Cost Estimators. As mentioned earlier, this may be because the tools include a wide array of searchable services related to women’s health like pregnancy and childbirth, mammography, and other obstetric and gynecological services. Our examination found that the one payer Cost Estimator tool that specifically linked to a distinct category of men’s health services had similar rates of tool use by men and women.

5. Behavioral Health Services are Among the Top Searched Services When Included in the Cost Estimator Tools

Only three of the six payers’ online Cost Estimators included behavioral health services in 2018. Of the three, two of the tools fully embedded behavioral health directories and services in the tool, while member searches for behavioral health services in the third tool connected members to the provider directory but did not generate cost estimates. For the three Cost Estimator tools that include behavioral health services, searches for behavioral health services were among the services most frequently searched in 2017 and 2018. Behavioral health care services ranked in the top five most searched services for two payers and top ten for the other.

Given that most payers have embedded provider directories within their Cost Estimator tools, we suspect that the volume of behavioral health care searches on these Cost Estimators may be a result of consumers attempting to find a behavioral health provider, rather than price information. For example, one payer stated that it embedded its behavioral health provider directory into the tool due to consumer interest. Another payer chose to include behavioral health services in the tool to provide members with access to provider availability, even though the tool did not show cost estimates for these services. This is consistent with the documented demand for behavioral health services, as well as the limited access to these services across the Commonwealth.⁴⁶ As such, the frequency of behavioral health related searches may relate as much or more to demand for information about provider availability and access to care, as it does to consumer price sensitivity in 2017 and 2018. We also found that the one Cost Estimator tool that generated the most behavioral health searches was the only tool that specifically linked to this service category on the tool homepage.

C. Payers Have Tried Different Strategies to Encourage Use of the Cost Estimators Without Significant Success.

Some payers offer innovative programs through their online Cost Estimator to encourage members to select lower-cost services. These programs incent patients by reducing their cost sharing responsibility or offering a cash reward—either where members select lower-priced providers for certain health care services, or where members simply use the tool and receive a cost estimate. Some incentive programs are embedded in the Cost Estimator tools and others are not.

46 In 2015, the AGO found that the fragmented administration of behavioral health benefits and the lack of necessary data limit efforts to promote access to behavioral health care. Even so, the Commonwealth and other stakeholders have taken steps to address structural barriers that limit access to these crucial services, including inaccuracies in provider directories. See e.g., OFF. OF ATT’Y GEN., PRESS RELEASE: AETNA AGREES TO MAKE SUBSTANTIAL IMPROVEMENTS TO BEHAVIORAL HEALTH CARE ACCESS (Dec. 12, 2018), available at <https://www.mass.gov/news/aetna-agrees-to-make-substantial-improvements-to-behavioral-health-care-access>; see also, MASS. DIV. OF INS., SUMMARY REPORT: MARKET CONDUCT EXAM REVIEWING HEALTH INSURANCE CARRIERS’ PROVIDER DIRECTORY INFORMATION at 3, (June 2018), available at https://www.mass.gov/files/documents/2018/06/15/Provider%20Information%20Report_06122018.pdf.

Four of the six payers we examined have incentive programs associated with their tools that began in 2018 or earlier, and one began its incentive program in June 2019. Although promising, we found that incentive programs are not widely available to all members and where they are available, incentives are limited to several services or procedures. See Figure 10 below. In some instances, the incentive programs are available only to fully-insured members. In many cases, employers decide whether to offer an incentive program to their employees and employer adoption has been limited.

Through these incentive programs, three payers tracked which members chose a lower-priced health care option in 2018 after using the Cost Estimator. These payers found that between 2% and 28% of members who were offered an incentive were rewarded for selecting a lower-priced care option. See Figure 10.

Figure 10: Incentive Programs (2018)				
	PAYER 1	PAYER 2	PAYER 3	PAYER 4
Cash Incentives Offered	\$25-\$500 per service	Up to \$250 per year	\$25-500 per service	Approx. \$20-\$50
Number of Searchable Services Tied to Incentives	42	22	62	All services
Reported Conversion Rate	2%	14%	28%	N/A

Notes:

1. The conversion rate as defined by PAYERS 1-3, is equal to the number of incentives paid divided by the total count of phone inquiries and web searches by members and agents.
2. Employers enrolled in PAYER 4's program are able to select the amount of cash offered to members.
3. PAYER 5 did not offer an incentive program associated with its Cost Estimator in 2018.
4. PAYER 6 did not report offering an incentive program in 2018 but announced the launch of its incentive program in June 2019.

Apart from the incentive programs, most payers do not track whether members who use online Cost Estimator tools then select high-value care options. A lack of investment in monitoring and capturing the impact of the Cost Estimators may indicate that payers have not found value in these tools to drive patients to select higher-value providers and sites of care. At least one large employer group has requested data from one payer, suggesting employers may be interested in the potential for the Cost Estimator tools to impact costs.

D. Very Few Consumers Who Use Cost Estimators Seek to Hold Their Payers to the Cost Estimates They Receive.

Under Chapter 224, cost estimates from the online tools are binding and must account for the costs of the entire procedure—including any facility fees, copayment, deductible, co-insurance or any other out-of-pocket amount.⁴⁷ Consumers can appeal if they are charged more than the estimate they received using the online tool. We did not examine the accuracy of the tools' cost estimates, but we requested information about cost estimation grievances and appeals for each payer.

⁴⁷ See Mass. Gen. Laws ch. 32A, § 27 (2014).

None of the payers had dedicated procedures to monitor these types of grievances, and as a result, two payers did not have any means of identifying such grievances. For payers from which we obtained data, very few members took advantage of this consumer protection.⁴⁸ Three received only a few cost estimate grievances, and one did not receive any grievances related to cost estimates. Together, the six payers examined reported receiving a total of 18 grievances between 2016 and 2018. Few of these cases resulted in a claim adjustment. For the payer with the most complaints (12), only one grievance led to a claim adjustment.

None of the online Cost Estimator tools reference the legal requirement that estimates are binding, nor the associated consumer protection. Indeed, most of the Cost Estimators have a disclaimer stating that cost estimates provided through the tool may not be accurate or up-to-date. Consumers using these tools are likely unaware that online cost estimates are binding. These disclaimers, as well as a general lack of awareness regarding the state mandate, may explain why so few consumers appeal bills that do not reflect cost estimates.

⁴⁸ Four payers reported sorting through all member grievances and appeals in order to identify complaints regarding online binding estimates. As a result, these payers were unable to confirm whether they captured all grievances associated with the Cost Estimator tools in 2016-2018.

III. PATIENT MOVEMENT ACROSS PAYERS AND PRODUCTS IS SIGNIFICANT AND LIMITS THE ABILITY OF PROVIDERS TO MEASURE ALTERNATIVE PAYMENT ARRANGEMENT PERFORMANCE.

This section reports on our analysis of two issues related to Alternative Payment Arrangements. An Alternative Payment Arrangement or Model (“APM”) is a payment approach that gives providers added financial incentives to provide high-quality, cost-effective care. In 2018, 40%⁴⁹ of commercially insured patients in Massachusetts were cared for as part of an APM.⁵⁰

First, as described below in subsection A, we analyzed patient movement across payers and insurance products over a two-year period. Second, in subsection B, we describe our analysis of the methods payers use to assign patients who are in Preferred Provider Organization (“PPO”) health plans to providers for the purpose of APMs. Both patient movement across payers and variation in how PPO patients are assigned to providers may obscure providers’ ability to measure their performance in Population Health Management.⁵¹

A. Many Patients Switched Payers and Products Over a Two-Year Period.

Prior AGO Cost Trends Reports documented the challenges with provider-oriented cost containment initiatives, including those that try to change the way providers are paid.⁵² APMs are intended to give providers incentives to deliver high-value care by financially rewarding them for efficiently caring for their attributed patient population, rather than giving them volume-based fee-for-service payments.⁵³ This section examines the rate at which patients switch from one payer or product to another. Changes in patient enrollment may impact provider incentives to invest in Population Health because different payers and products include different incentives in their APMs.

To measure the rate of patient persistence within a payer or product, we reviewed member roster data from three Massachusetts payers associated with twelve large registered Provider Organizations⁵⁴ for the 24-month period from January 2017 through December 2018. We measured persistency, defined as the continued assignment each month of a commercial member to the same payer and product in which the member was enrolled in January 2017. Persistency rate therefore represents the proportion of individual commercial members for a payer and product in a given month that were associated with that payer and provider in January 2017.

Under a risk arrangement, insurers and providers negotiate a monthly budget for a covered population, and providers receive additional payments at the end of the year if the total expenditures

49 See 2019 CHIA ANNUAL REPORT at 31.

50 Although APMs are widely adopted, the level of risk varies greatly across arrangements. In full and partial APMs, providers will share (either fully or partially) in any budget surplus or deficit. In “upside only” arrangements, providers may share in any budget surplus, but are not at risk for any portion of a budget deficit. For more information, see OFF. OF ATT’Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 20 (April 24, 2013) (Hereinafter, 2013 AGO COST TRENDS REPORT) available at <https://www.mass.gov/files/documents/2016/08/xc/2013-hccid.pdf>.

51 Under an Alternative Payment Arrangement, “Population Health Management” is a system or network-wide approach to improving the overall health outcomes of a group of individuals as defined by the payment arrangement.

52 See OFF. OF ATT’Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 11 (Oct. 11, 2018), (Hereinafter 2018 AGO COST TRENDS REPORT) available at <https://www.mass.gov/files/documents/2018/10/11/AGO%20Cost%20Trends%20Report%202018.pdf>. See also 2016 AGO COST TRENDS REPORT.

53 See 2013 AGO COST TRENDS REPORT at 48.

54 Atrius, BIDCO, BMC, Baystate, LCPN, Lowell, MACIPA, NEQCA, Partners, Reliant, Steward, and UMass. We obtained data at the member per month level.

for patients in their covered population are less than the budget for their population for the year.⁵⁵ Conversely, providers are financially penalized if the total expenditures for their patients are more than the budget.⁵⁶ Most risk arrangements also include certain quality and patient satisfaction bonuses.⁵⁷ In a risk arrangement, the provider's financial incentives for each health plan are product-specific and are directly tied to the patients in the covered population and to the Provider Organization's physicians.⁵⁸ Because these terms are negotiated on a product-specific basis (i.e. HMO versus PPO, or fully-insured versus self-funded), the financial incentives associated across products and payers vary significantly.⁵⁹

When patients move from one payer or product to another, the financial incentives that apply to providers' management of their care change. The care plan for any particular patient may result in different financial rewards to the provider after the patient switches plans. Providers cannot be certain that they will receive the financial benefits from Population Health investments when patients move between products and plans. In other words, providers cannot count on obtaining the benefits of Population Health investments in any predictable way if patients move between products and plans with very different payment incentive structures. When patients switch payers, they may also move to a plan that is based on fee-for-service payments entirely with no provider risk at all.

As illustrated in Figure 11 below, we found substantial member movement among payers and products. For two of the three payers that we examined, 43% of members moved either out of their health plan or out of their product over the two-year period. One payer experienced a much higher attrition rate, with 56% of its members leaving their plan or product over the two-year period. Most patients who switched payers or products did so in January and July, months in which most policies renew.

These data show only the rate at which patients switched payers or health plan products, not changes in patients' relationships with their providers. However, a study conducted in Massachusetts found that switching payers is associated with a change in provider selection.⁶⁰ It also found that patients who switched payers had higher rates of new physician visits, which may indicate a change in primary care provider—and in turn could present a further barrier to effective Population Health Management.

55 For more information, See 2013 AGO COST TRENDS REPORT; See also, 2018 AGO COST TRENDS REPORT.

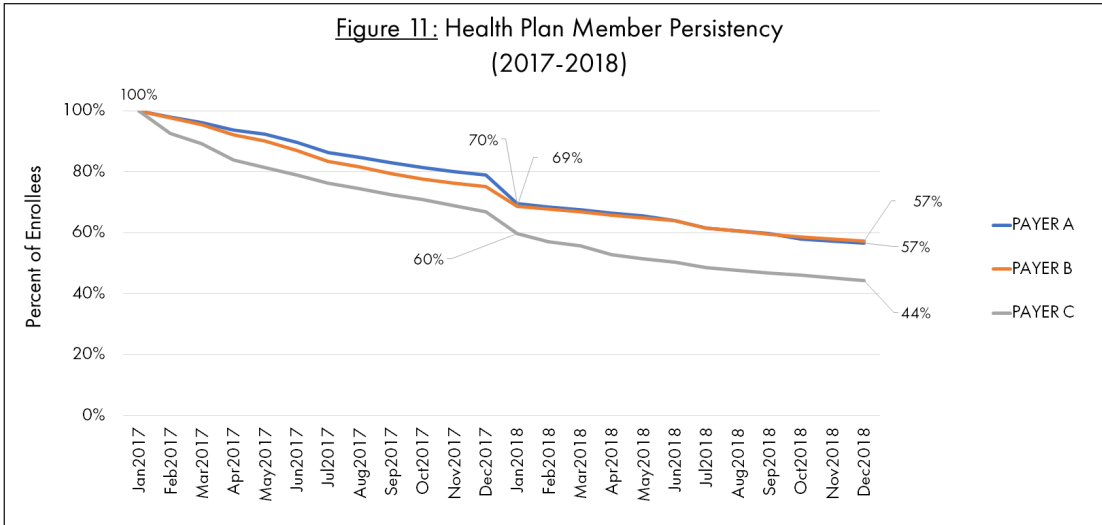
56 2018 AGO COST TRENDS REPORT at 11.

57 *Id.*

58 *Id.* at 12.

59 Risk contracts are complex and vary significantly from payer to payer, with many contracts significantly capping or limiting efficiency risk exposure and bonus opportunities. Risk contract variation extends to certain products within a single payer, wherein there is substantial opportunity for rewards and bonuses, in one product, while others have very limited opportunity. See 2018 AGO COST TRENDS REPORT at 11.

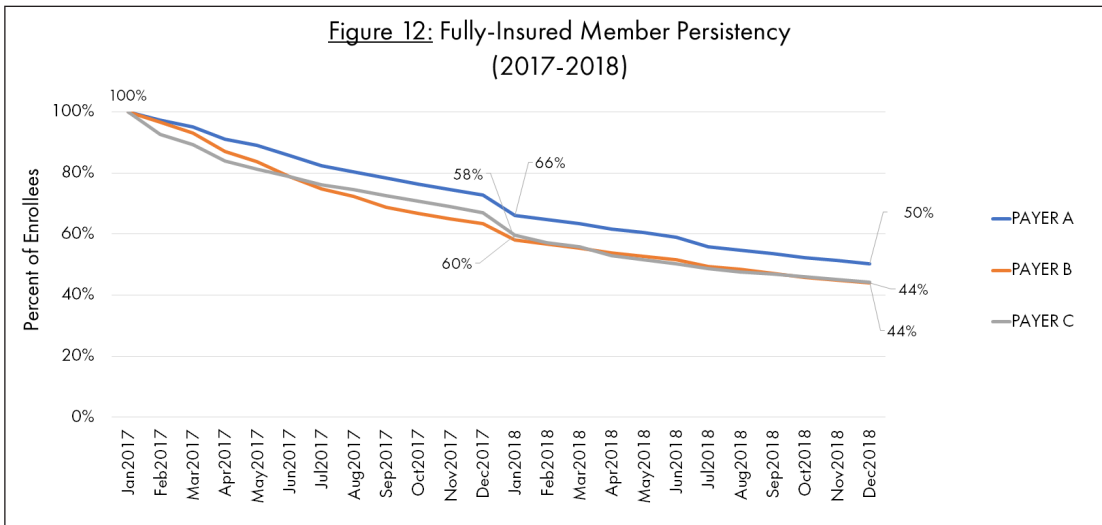
60 M. Barnett et al., *Insurance Transitions and Changes in Physician and Emergency Department Utilization: An Observational Study*, 32(10) (October 2017), JOURNAL OF GENERAL INTERNAL MEDICINE, available at <https://link.springer.com/article/10.1007/s11606-017-4072-4>.



Notes:

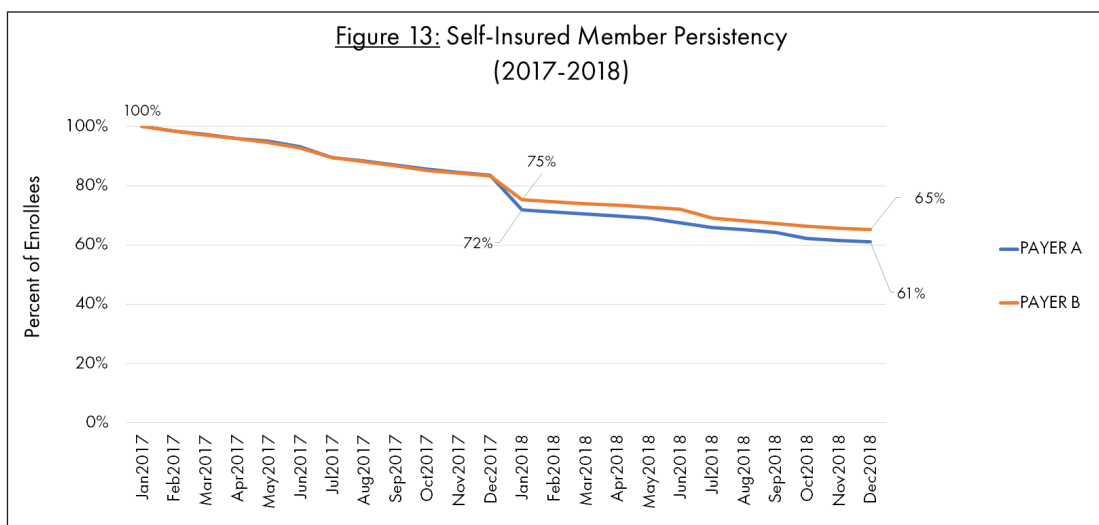
1. Data are based on member roster data from Jan. 2017-Dec. 2018 as obtained from the payers.
2. Member data are of commercial members associated with twelve large Provider Organizations.
3. The month of Jan. 2017 was used as a baseline. Data for Jan. 2019 is not included and therefore, persistency rates are based on a 23-month period.
4. Persistency rate represents the proportion of individual commercial members for a payer and product in a given month that were associated with that payer and provider in Jan. 2017.

We also analyzed member persistency rates broken out by insurance funding type. As shown in Figures 12 and 13, we found more movement for members in fully-insured plans than self-funded plans. This finding is consistent with a published study, which found that members enrolled in fully-insured plans were more likely to switch payers than members in self-funded plans.⁶¹ We also examined HMO and PPO attrition rates (data not shown) and did not find a substantial difference between member persistency rates within HMO and PPO products.



Notes:

1. Data are based on member roster data from Jan. 2017-Dec. 2018 as obtained from the payers.
2. Member data reflect members associated with twelve large Provider Organizations.
3. The month of Jan. 2017 was used as a baseline. Data for Jan. 2019 is not included and therefore, persistency rates are based on a 23-month period.
4. Persistency rate represents the proportion of individual commercial members for a payer and product



in a given month that were associated with that payer and provider in Jan. 2017.

Notes:

1. Data are based on member roster data from Jan. 2017-Dec. 2018 as obtained by the payers.
2. Member data reflect members associated with twelve large Provider Organizations.
3. The month of Jan. 2017 was used as a baseline. Data for Jan. 2019 is not included and therefore, persistency rates are based on a 23-month period.
4. Persistency rate represents the proportion of individual commercial members for a payer and product in a given month that were associated with that payer and provider in Jan. 2017.
5. PAYER C has a small self-funded population and was excluded from analysis.

These changes in patient enrollment across payers and plans may hinder providers' ability to determine whether investments they made under APMs for their specific patient population have been successful. The inability to measure the impact of APM investment over time likely limits the impact of provider incentives under risk arrangements.

B. Alternative Payment Arrangement Attribution Methods of Assigning Patients to Providers Are Complex and Varied.

As part of our examination, we reviewed the different ways the three largest Massachusetts payers assign (or "attribute") their PPO members to providers for the purpose of APMs. Unlike in an HMO, patients in PPO plans do not need to select a Primary Care Provider who is responsible for their care. More than a third of Massachusetts residents who have commercial insurance are enrolled in a PPO,⁶² and 18% of consumers in PPO plans are part of an APM.⁶³ So it is important to understand how PPO patients are assigned to a provider's covered population. The process a payer uses to assign a PPO patient to a provider or Provider Organization's covered population for purposes of a Risk Arrangement is called "attribution."

As illustrated in Figure 14, these payers use different and complex processes to attribute PPO members to responsible providers. Because PPO members are allowed to visit any in-network physician or healthcare provider without a referral from a Primary Care Provider, payers must look to the members' histories (usually reflected in the claims data) to determine who is the best provider to be

⁶² See 2019 CHIA ANNUAL REPORT at 43.

⁶³ See CTR. FOR HEALTH INFO. & ANALYSIS, 2019 REPORT ON THE PERFORMANCE OF THE MASS. HEALTH CARE SYSTEM: 2019 ANNUAL REPORT TME APM DATA SET.xls, available at <http://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report-Databooks.zip>.

responsible for that patient. The payers attribute members to different types of providers and use the claims data in different ways to determine which provider is the right one to attribute the patient to.

One payer attributes patients to Primary Care Physicians only, while another payer attributes members to specialists also. One payer attributes patients to nurse practitioners and physician assistants, as well as physicians. Some payers only assign patients who are Massachusetts residents and one payer considers only outpatient claims originating in Massachusetts for purposes of attribution. One payer excludes all inpatient and outpatient behavioral health claims from attribution. All payers attribute patients retrospectively, so providers may not know which patients they are responsible for until after they have cared for them. A patient may be attributed to a provider who cared for the patient only for one visit as long as 27 months ago—demonstrating the fragile link between an attributed patient and “his or her” provider.

Figure 14: Member Attribution Methodologies for PPO Patients (2018)

	PAYER A	PAYER B	PAYER D
Providers Eligible for Attribution	<ul style="list-style-type: none"> Primary Care Physicians (“PCPs”) Specialty Care Physicians (“SCPs”) 	<ul style="list-style-type: none"> PCPs Double-Boarded Physicians (i.e. PCP/SCP combination) 	<ul style="list-style-type: none"> PCPs Nurse Practitioners (“NPs”) Physician Assistants (“PAs”)
Attribution Lookback Period	18-27 months*	24 months	24 months
Member-Driven Provider Selection	Yes	No	Yes (ability to opt out)
Attribution Criteria and Methodology	<ul style="list-style-type: none"> Member selection of PCP Well-visit in previous 24 mos. Evaluation and Management visit (“E&M”) in previous 24 mos. Prescription (“Rx”) from a PCP in previous 24 mos. Well-visit with certain SCPs in previous 24 mos.* E&M visit with certain SCPs in previous 24 mos.* Rx from certain SCPs in previous 24 mos.* 	<ul style="list-style-type: none"> PCP visit in previous 24 mos. Rx in previous 24 mos. 	<ul style="list-style-type: none"> Member selection of PCP, NP, PA At least 1 well-visit in previous 12-24 mos. (if multiple, most recent visit) At least 1 E&M visit in 12-24 mos. (if multiple, most recent visit) 3 or more Rx from a PCP in previous 12-24 mos. (if multiple, most prescriptions; if tied, most recent)
Attribution Exclusions or Limitations		<ul style="list-style-type: none"> All hospital IP, OP and Behavioral Health claims are excluded 	<ul style="list-style-type: none"> Patient must be MA Resident OP claims must be in MA

Notes:

1. Data are based on member attrition methodology as reported by payers.

2. *PAYER A reported that some providers reference an 18 or 27-month period, rather than a 24-month period.
3. *PAYER A reported that some providers exclude SCP claims for attribution.

Even if a provider is consistently managing his or her patient population, the variability among payers' attribution methods and the lack of member persistency across payers suggest considerable unpredictability in how the provider will be "scored" under different APMs. For example, a provider could be held "responsible" for the health outcomes and expenditures associated with a patient he or she has rarely seen, and whose care he or she has had no meaningful opportunity to manage. Similarly, a provider could "earn" financial incentive payments or penalties based on a contract with a payer that has only covered a portion of his or her patient panel for a short time.

Our interviews with payers showed that the complexity of attribution methods and patient movement in and out of health plans add layers of complexity to the reconciliation process associated with APMs.⁶⁴ To reconcile their Risk Arrangements, payers and providers frequently review, verify and communicate member rosters and claims data with each other to ensure that each can identify attributed populations. The retroactive accountability for a constantly changing population is a complex process that requires centralized resources to manage. Both providers and payers employ staff and systems to identify and account for the variability and fluctuation. This finding is consistent with a recently published study which found that administrative complexity was associated with the greatest contribution to wasteful health care spending.⁶⁵ In 2018, the AGO reported on the administrative complexity and costs associated with varied payment methods.⁶⁶ Similar to our 2018 examination, we did not identify evidence that this kind of administrative complexity adds value for patients, providers, or payers.

64 We interviewed four payers: three large Massachusetts payers and one national payer.

65 See William H Shrank et al., *Waste in the Health Care System, Estimated Costs and Potential for Savings*, (Oct. 7, 2019) JAMA, available at <https://jamanetwork.com/journals/jama/fullarticle/2752664>.

66 See e.g., 2018 AGO COST TRENDS REPORT.

CONCLUSIONS AND RECOMMENDATIONS

Our 2019 cost trends examination explored the impact certain cost containment initiatives have had in shifting health care spending to higher-value providers. We examined online Cost Estimators and Alternative Payment Arrangements and found that neither has substantially influenced consumers and providers to select higher-value care settings.

First, we analyzed expenditures at Lower-Priced Hospitals among patients assigned to certain Provider Organizations. We found that expenditures at Lower-Priced Hospitals have decreased over the last few years and that the share of inpatient expenditures at Lower-Priced Hospitals (compared to Higher-Priced Hospitals) varies substantially across Provider Organizations. We observed that a Provider Organization's affiliation with Lower-Priced Hospitals was associated with an increased share of expenditures at lower-cost settings. With increased provider consolidation and affiliation in the health care sector, more physicians are incented to refer patients to in-system providers, whether they are high or low-cost. Also, since most consumers are likely to choose their care options based on their PCP's advice, it is unrealistic to expect consumers to consistently or meaningfully seek care outside of their PCP's system, unless they are advised to by their PCPs.

Second, with the Cost Estimators, we found that payers have developed online tools that play an important role in improving consumer access to meaningful and individualized health information. And, although we found that few consumers are using these tools or holding payers to the cost estimates the tools provide, we documented key demographics and market segments that were more likely to use payer tools. We also identified the most searched services, including imaging, office visits, and behavioral health. These findings suggest an opportunity for payers and employers to engage in a thoughtful strategy to promote increased use of online Cost Estimators.

We also found that consumers enrolled in High-Deductible Plans were more likely to use online Cost Estimators, suggesting that financial exposure may influence some consumers to use the tools. However, there is still limited potential to lower health care expenditures overall through High-Deductible Plans for a few reasons. First, even patients in High-Deductible Plans do not have a financial incentive to select a high-value provider once their deductibles are met. Moreover, the patients with the highest health burdens (whose health care costs the most) know that they are sure to meet their deductibles and, therefore, have limited financial incentive to shop for lower-priced care options. Despite these limitations in the ability of the Cost Estimators to contain costs overall, these tools provide important information for consumers as they navigate our fragmented health care system to understand, access and pay for their care.

Finally, our examination showed that providers' incentives to invest in Population Health are limited because patients frequently change health plans. When a patient changes his or her insurer or product type, the patient becomes associated with a different payment arrangement that has different financial incentives. As the incentives shift with patient movement, a provider may lose the financial incentive to invest in Population Health as applied to that provider's patient panel. Significant patient movement across plans and products also hinders providers' ability to determine whether investments made in their patient population have been successful. We also found that the methods for attributing PPO patients to providers under Risk Arrangements are complex and varied—so providers may not know which patients they are responsible for until after they have cared for them.

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

1. Temper expectations that consumer-driven health care price transparency tools will reduce overall health care cost growth.

- a. Any effective cost containment strategy aimed at consumers should acknowledge the reality that patients are likely to choose their care based on their PCP's advice. Thus, policymakers should consider price transparency tools at the point-of-enrollment that enable and incentivize consumers to select a PCP that is affiliated with a lower-cost system, rather than price transparency at the point-of-service.
 - b. Payer Cost Estimator tools play a vital role in educating and empowering consumers to better navigate a complex health care system. Payers should enhance their Cost Estimator tools to: (i) focus on Shoppable Services such as imaging, physician office visits, and elective surgeries, (ii) expand access for non-English speakers, (iii) fully integrate pharmacy and behavioral health services, and (iv) advise consumers on tool homepages that estimates are binding. Information about payment grievance and appeal processes should be included as well.
 - c. Payers should expand to all members, incentive programs that share cost savings with consumers by offering cash rewards or other financial incentives to consumers who select lower-cost providers for certain services. Payers should also explore innovative ways to measure Cost Estimator impact on consumer selection of care.
2. Closely review incentives for health care providers to direct patients to lower-cost health care settings. For example, Alternative Payment Arrangements would likely have a greater impact on shifting care to lower-cost settings if providers took on sufficient downside risk if their patient population received care at higher-priced hospitals. Stakeholders should consider implementing common approaches to risk contracting terms, such as an approach across payers and providers, to set risk budget levels. This would better ensure that all providers face true risk of financial loss resulting from poor care management. As health care providers and payers continue to consolidate or affiliate, further study of how system and network composition impacts patient referral and selection of higher-value care settings is warranted. A working group with representation from providers, payers, and consumer advocates could develop strategies to support efforts to direct patients to higher-value care settings, in order to contain overall health care costs in the Commonwealth.
 3. Recognize that providers' incentives to manage their patient populations are significantly hampered by the frequency with which patients switch health plans. Stakeholders should explore opportunities to align risk contracting terms so that, even when patients switch health plans, provider incentives to manage their patient populations remain consistent. Both providers and payers incur substantial staff and systems costs to identify and account for the impact of Population Health complexity and variation. Further study on the aggregate costs and benefits associated with Alternative Payment Arrangement complexity and variation is warranted, particularly because of the significant patient movement across health plans. Common metrics for measuring quality and efficiency in care management could lead to more predictable outcomes and better management practices across the health care system.
 4. Standardize the methods used to attribute patients to providers under Alternative Payment Arrangements. The variation in payers' attribution methods and significant patient movement across payers create uncertainty in how providers are measured under Alternative Payment Arrangements. Common methods for attributing patients to providers could reduce administrative burden and costs and lead to better management practices.

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

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