MASSACHUSETTS
HEALTH POLICY COMMISSION

Annual Health Care
Cost Trends Report

CTR 2016

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Section I: Introduction

Consistent with the statutory mandate of the Massachusetts Health Policy Commission (HPC), the 2016 Cost Trends Report presents an overview of health care spending and delivery trends in Massachusetts, evaluates progress in key areas, and makes recommendations for strategies to increase quality and efficiency in the Commonwealth.

HPC reports have identified four areas of opportunity: fostering a value-based market; promoting an efficient, high-quality healthcare delivery system; advancing aligned and effective financial incentives; and enhancing data and measurement for transparency and accountability.

The HPC continues to emphasize these opportunities in its analysis, recommendations, and strategic priorities.

This Executive Summary presents a concise overview of the findings and recommendations detailed in this report.

FINDINGS

TRENDS IN SPENDING AND THE DELIVERY SYSTEM

Trends in spending

- Massachusetts exceeded the benchmark in 2015 for the second year in a row, with growth in total health care expenditures (THCE) of 4.1 percent, similar to growth from 2013 to 2014 (4.2 percent).
- Contributors to growth exceeding the benchmark included prescription drug spending across all sectors (accounting for roughly a third of per capita spending growth for the second year in a row), hospital spending, enrollment changes, and spending on long-term services and supports.
- Even with several years of commercial and Medicare growth rates below national trends, Massachusetts continues to be a high cost health care state. Massachusetts commercial health care spending is roughly 6-9 percent higher than the national average, with premium costs among the highest in the nation.
- These costs disproportionately impact low-to-middle income residents and result in persistent health care affordability concerns for individuals, families, employers, and government in Massachusetts.
    - Massachusetts' level of household health care spending relative to average statewide household income is comparable to national standards, but low and middle income households bear a very high burden of spending, as premiums and out-of-pocket spending do not vary significantly by income. The roughly $20,000 premium and cost sharing total for family coverage amounts to 30 percent of household income for family of three living at three times the federal poverty level.
    - Recent information suggests rising premium costs in 2016 and beyond. After 12 quarters of growth below 4 percent, the Division of Insurance (DOI) reported base rate increases in the small group and individual markets in Massachusetts of between 5.4 and 8.3 percent from the end of 2015 through the first quarter of 2017.
- Hospital care accounts for a substantial share of total health care spending – and the rate of growth in hospital spending is increasing. Spending in this category accounted for 41 percent of total commercial spending growth in 2015, up from 18 percent in 2014.

Trends in provider markets

- Analysis of the Registration of Provider Organizations (RPO) dataset, a first-in-the-nation initiative, shows key features of the eight largest provider systems in the Commonwealth (representing about 85 percent of physicians practicing in Massachusetts), including

practices regarding direct employment of physicians, geographic reach, and organizational structure and corporate complexity.

- The majority of care in the Commonwealth is now provided by a relatively small number of large provider systems. In 2015, the five largest health systems in the state accounted for 59.9 percent of hospital discharges for commercially insured patients, an increase from 54.6 percent in 2012.
- The number of new urgent care centers entering the market in Massachusetts has grown significantly in recent years, from 8 in 2010 to 90 in 2016.

Prescription drugs

- While moderating somewhat in 2015, prescription drug spending continues to grow more rapidly than any other commercial category of service. Continued growth is projected.
- Drug spending has grown faster than overall commercial trends in the past three years and now accounts for more than 20 percent of commercial spending in Massachusetts when including medical drugs.
- Generic drugs represent an increasing share of the drug claims prescribed in Massachusetts (82 percent in 2012 to 84 percent in 2014), yet account for a decreasing proportion of the drug spending in the state (30 percent to 27 percent from 2012 to 2014).
- While total commercial drug spending has grown significantly in Massachusetts from 2012 to 2014, out-of-pocket spending decreased 9 percent, from $219 to $198 per member per year.
- A key factor in lower out-of-pocket spending on prescription drugs has been the Affordable Care Act's (ACA) mandate of zero cost sharing for certain preventative drugs, including contraception. The percentage of prescription drug claims with no cost sharing among women increased dramatically between 2012 and 2014, from 3.2 percent to 13.4 percent.
- Commercial spending on Mylan's EpiPen in Massachusetts jumped over $100 per claim in two years, from $244 in 2012 to $362 in 2014.
- Transparency on pricing trends, rebates, discounts, and pharmaceutical benefit managers is lacking.

CARE DELIVERY PERFORMANCE: OPPORTUNITIES TO IMPROVE QUALITY AND EFFICIENCY

Hospital utilization

- Hospital use declined in Massachusetts from 2010 to 2014; emergency department (ED) and hospital outpatient visits declined by 2 percent, and inpatient discharges declined by 11 percent. However, Massachusetts continues to use hospitals at a higher rate than national averages. Compared to the U.S., in 2014 Massachusetts hospital utilization rates were 50 percent higher for hospital outpatient visits, 10 percent higher for ED visits, and 8 percent higher for inpatient discharges.
- While hospital use has steadily declined in Massachusetts in recent years, in 2015 inpatient discharges increased by almost 2 percent. This growth was entirely due to increases in discharges by patients ages 65 and older.
- Massachusetts did not make progress in reaching the HPC target of a 20 percent reduction in all-cause, all-payer 30-day hospital readmissions relative to the 2013 level. The statewide all-payer readmission rate remained unchanged from 2013 to 2014 at 15.3 percent and increased to 15.8 percent in 2015.
- Inpatient care that could safely and effectively be provided in community hospitals is increasingly being provided by teaching hospitals. However, the trend is not universal. For example, at Winchester Hospital, following acquisition by the Lahey Health System in 2014, the volume of community appropriate discharges increased while community appropriate discharges decreased at Lahey Hospital and Medical Center, the system's anchor teaching hospital.
- Despite declines in overall ED utilization, the share of visits considered avoidable has remained relatively unchanged since 2011 (42 percent of all visits).
- The number of behavioral health-related ED (including opioid-related ED use) visits per Massachusetts resident has grown steadily, increasing 13 percent from 2011 to 2015.
    - ED "boarding" disproportionately impacts behavioral health patients and rates of behavioral-health related ED "boarding" are increasing. In 2015 almost a quarter of all ED patients with a primary behavioral health-related condition had a length of

stay in the ED of more than 12 hours, compared to only 1 percent of patients without a primary behavioral health-related condition.

Post-Acute Care

- Massachusetts continues to discharge patients to institutional post-acute care (PAC) settings (SNFs, IRFs, LTCHs) at a higher rate than the U.S. average, with 21.8 percent of patients in Massachusetts discharged to institutional care in 2013 compared to 17.1 percent in the U.S. overall.
- Adjusting for changes in patient acuity, institutional discharges remained relatively constant between 2010 and 2015, while discharges to home health increased somewhat over the same period.
- Rates of discharge to PAC following joint replacements have declined substantially in Massachusetts, but remain far higher than in the U.S. overall. In 2013, just 3.5 percent of Medicare joint replacements were discharged to home compared to 20.4 percent nationally.

Primary care provider group spending

- Total medical expenses (TME) per patient for the 10 largest provider groups have generally converged between 2012 and 2015, with the exception of Partners which has remained high at 7 percent above the next-highest group.
- Across all groups, health status adjusted TME grew 0.4 percent annually between 2012 and 2015, while unadjusted TME grew 3.5 percent annually, as members were reported to be roughly 3 percent sicker each year on average.
- Higher adoption of APMs is associated with lower TME growth in the subsequent year(s). Those with lower rates of APM adoption in 2013 had spending growth more than double groups with higher rates of APM adoption.
- Rates of non-recommended care, defined as services the medical community agrees provide few benefits to patients, vary in Massachusetts by provider group and by geographic region.

PROGRESS IN ALIGNING INCENTIVES FOR EFFICIENT AND HIGH QUALITY CARE

Alternative payment methods (APMs)

- Progress stalled in 2015 among both commercial and public payers in expanding use of APMs. However, there are several potentially promising developments for 2016 and beyond:
  - Expansion of APMs into commercial preferred provider organization (PPO) products, with the three largest commercial insurers reporting growth in the numbers of PPO members in global budget contracts in 2016; and expansion of quality and risk-based payments in Medicare with implementation of Medicare Access and CHIP Reauthorization Act (MACRA), adoption of the Next Generation ACO program with higher levels of downside risk than in previous ACO options, and introduction of new bundled payment initiatives.
  - Comprehensive payment and delivery system initiatives in MassHealth, with the launch of its global-budget based ACO program in 2016 as a pilot and full program in 2017.

Demand-side incentives

- Adoption of tiered network plans was unchanged from 2014 to 2015 (16 percent) and use of limited network plans grew slightly but remained low (3.0 percent to 3.2 percent).
- Fully-insured health insurance premiums varied by market segment, with premiums paid by members of the Group Insurance Commission (GIC) and those obtaining insurance through the Connector lower than those who obtain insurance in group markets. Connector premiums in the individual market were below the national average, unlike those in the small group market, which were above national averages.
- Smaller businesses pay higher broker fees and administrative costs for their insurance coverage than do larger businesses, and most do not offer employees a choice of insurance plan (unlike larger businesses). Surveyed small employers stated they were unaware of the Connector and that they don't have enough employees to offer plan choice.

RECOMMENDATIONS

In light of these findings, as well as the HPC's other analytic and policy work throughout the year, the HPC makes the following recommendations to advance the goal of better care and better health at a lower cost for the people of the Commonwealth.

RECOMMENDATIONS TO FOSTER A VALUE-BASED MARKET

1. **Health Care Equity and Affordability:** The Commonwealth should examine how health care costs are differentially allocated to individuals, families, and businesses across Massachusetts, and should further consider opportunities to promote equity and affordability, including tracking and monitoring differences in health care spending, insurance costs, and member cost-sharing across a range of characteristics (e.g., socio-economic profile, employer size and industry, health status, etc.).
2. **Prescription Drug Spending:** The Commonwealth should take action to reduce increases in drug spending including by enhancing the transparency of drug prices and spending, and payers and providers should consider further opportunities to maximize value.
3. **Out-of-Network Billing:** Efforts to address out-of-network billing issues continue to gain momentum across the nation. Massachusetts has not taken comprehensive action on this issue. The Commonwealth should implement safeguards for consumers and improve market functioning related to out-of-network billing by enhancing out-of-network billing protections and establishing reasonable reimbursement for services.
4. **Provider Price Variation:** Extensive variation in prices paid to health care providers for the same sets of services is a persistent issue in the Commonwealth, driving increased health care spending and perpetuating inequities in health care resources. The Commonwealth should take action to reduce unwarranted variation in provider prices by continuing to monitor and analyze price variation, including by factors identified as "warranted" and "unwarranted".
5. **Facility Fees:** The Commonwealth should take action to limit newly-licensed and existing sites that can bill as hospital outpatient departments and equalize payments for select services for similar patients between hospital outpatient departments and physician offices.
6. **Community-Appropriate Care:** The Commonwealth, payers, and providers should work to redirect community-appropriate care to high value, community settings.

RECOMMENDATIONS TO PROMOTE AN EFFICIENT, HIGH-QUALITY HEALTH CARE DELIVERY SYSTEM

7. **Unnecessary Hospital Use and Other Institutional Care:** The Commonwealth should continue to focus on strengthening partnerships between the health care delivery system and community-based organizations in order to reduce the unnecessary utilization of institutional care, including hospital readmissions, behavioral health-related ED visits, and institutional post-acute care.
8. **Substance Use Disorder Treatment:** The Commonwealth, payers, and providers should continue to improve treatment of substance use disorder, particularly including opioid use disorder.
9. **Adherence to Evidence-Based Care:** The Commonwealth, payers, and providers should work to focus on the highest possible adherence to evidence-based care, including putting systems in place to track and reduce the provision of non-recommended care.

RECOMMENDATIONS TO ADVANCE ALIGNED AND EFFECTIVE INCENTIVES

10. **Adoption of Alternative Payment Methods (APMs):** Payers and providers should continue to focus on increasing the adoption of alternative payment methods (APMs). The Commonwealth should set APM adoption targets for HMO and PPO patients, and MassHealth members.
11. **Alignment and Improvement of APMs:** Payers should align and improve features of APMs in order to increase their effectiveness in promoting high quality, efficient care, including through improving quality measurement, reducing disparities in spending levels, inclusion of behavioral health, and adopting HPC's ACO certification standards.

12 **Demand-Side Incentives:** Payers and employers should continue to enhance strategies that empower consumers to make high-value choices, including increasing the transparency of comparative prices and quality to enhance the selection of value-based providers.

RECOMMENDATIONS TO ENHANCE DATA AND MEASUREMENT FOR TRANSPARENCY AND ACCOUNTABILITY

13 **Data and Measurement:** Center of Health Information and Analysis (CHIA) should continue to improve and document its data resources and develop key spending measures on drug rebates, Total Medical Expenditures (TME) for PPO populations, provider-level measures of spending growth, and ambulatory quality measures. CHIA should also evaluate the impact on the All-Payer Claims Database (APCD) of the expected loss of data due to the Gobielle decision.