MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

October 10, 2013

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

re: Annual Cost Trends Hearings

Dear Director Seltz:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 16 health plans providing coverage to approximately 2.5 million Massachusetts residents, I am writing to offer written comments on the Health Policy Commission's 2013 annual cost trends hearings. Our comments focus on issues related to provider consolidations and the discussion concerning the relationship between alternative payment methods and the increase in self-insured coverage and PPO plans.

Provider Consolidation

Keeping health care affordable is ***the*** challenge facing all of us in the health care system. MAHP and its member plans have been strong proponents of the cost trends hearings as they are essential to shining a spotlight on underlying health care costs and holding the entire system accountable. As health insurance premiums and medical costs are inextricably linked, dealing with the underlying cost of care is essential to making health care affordable for employers and consumers and meeting the cost benchmarks included in the Payment Reform Law (Chapter 224 of the Acts of 2012).

Over the last three years, more than a half dozen state government reports, including landmark reports by the Attorney General, have shown that increases in the prices doctors and hospitals charge for medical services, not how much care patients use or the quality of care they receive, remains the major factor for rising health care costs. Increased consolidation among doctors and hospitals may lead to increases in provider prices, pushing premiums higher and leaving Massachusetts consumers and employers with fewer choices.

Some have suggested that the wave of mergers, acquisitions and clinical affiliations among hospitals, physicians and other providers is necessary and will result in better integration and improved quality for patients. However, the evidence has shown that costs increase when providers consolidate. At the national level, there is a growing body of research among policy experts that suggests that the growing movement by providers towards greater consolidation may not, in fact, lead to better care and lower prices. Instead, researchers have determined the opposite, concluding provider consolidation merely leads to enhanced bargaining power with no notable improvement in quality of care for patients.

Recent state reports have examined where individuals are receiving care, the significant changes taking place in the marketplace, and the impact these changes can have on the cost of care. As the Center for Health Information and Analysis' 2013 *Annual Report on the Massachusetts Health Care Market* highlighted, in 2011 and 2012 roughly 80 percent of commercial health care spending for acute hospitals and physicians was concentrated in high-cost providers.

The Attorney General's April 2013 *Examination of Health Care Cost Trends and Cost Drivers* report noted, "Providers are aligning in ways that are not explained by care coordination or risk contracting requirements, though those reasons are often cited. Provider consolidation and alignments have significant market implications that should be measured and monitored, particularly where consolidation may reduce access to lower-cost options for consumers and undermine efforts to promote value-based decisions by purchasers."

Further, a great deal of provider consolidation has been occurring at the so-called "vertical" level. In such situations, hospitals employ, acquire, or effectively control previously independent physicians or physician practices. Some of this consolidation, however, holds the prospect of harm to employers and consumers similar to the results when previously competing hospitals merge with each other. For example, if such vertical integration reduces competition among hospitals because the relevant physicians will now only refer to one hospital, consumers may suffer harm. Similarly, if previously competing physicians are consolidated so that there is no, or less, competition among these physicians, costs will rise and consumers and employers will be harmed.

The creation of the Health Policy Commission provides an opportunity for the state to take a closer look at provider consolidation. Sufficient checks are necessary to ensure that changes in the health care system truly benefit employers and consumers. As the Commission examines these changes, we would like to offer a series of standards designed to ensure that there is increased oversight and information on proposed mergers, acquisitions and clinical affiliations, and that employers and consumers ultimately benefit from these changes. As it examines provider consolidations, the Commission should adopt the following criteria:

1. Employers, Consumers & Patients Should Benefit Through Lower Health Care Costs, Clinical Integration and Improved Quality;
2. All Proposals Should be Transparent; and
3. All Entities that Merge, Affiliate or Consolidate Should be Subject to Regular Monitoring & Annual Reporting.

Further, the Attorney General and the Health Policy Commission should have greater authority to prohibit consolidations, mergers or affiliations that either entity determines could adversely affect competition or increase costs for employers and consumers. MAHP's Principles for Provider Consolidation are enclosed with our testimony.

The provider consolidation taking place today will reshape the health care system for years to come. The goal of any provider consolidation should be greater efficiency and improved care, not enhanced bargaining power. Ultimately, provider consolidations should benefit employers and consumers through lower costs. Further, the combined entities should be expected to truly function as a system, resulting in clinical integration and better delivery performance. A system of continued accountability is necessary to ensure that we are getting a better health care system, not one that continues to be simply too expensive. This will require ongoing monitoring of consolidated entities to ensure that they in fact work towards real cost containment, coordination and integration.

Alternative Payment Methods and Self-Insured Coverage & PPO Plans

Chapter 224 made the movement to alternative payment methods voluntary in the commercial market, so that the market could continue to innovate and develop other mechanisms to lower costs for employers and consumers, such as tiered and limited network products. The law recognized that employers' needs vary and it is important that they have a wide array of product options in deciding the coverage that best meets their employees' needs. Employer and consumer choice has been a driving factor in the enrollment increase in PPO plans and self-insured coverage.

Among the reasons for the increase in PPO membership is that these plans allow employers to offer their employees more choices in benefit packages. This is particularly useful when a few employees may be located in other states or for dependents that may live in other states and cannot use the Massachusetts network. Further, for individuals who want broad access to providers, PPOs provide greater choice compared to closed network (e.g., HMO) options. Similarly, self-insured coverage provides employers with greater flexibility and choice in benefit design. Additionally, some employers self-insure to avoid covering certain mandated benefits or to place limits on them.

Meanwhile, health plans and providers are beginning to develop new financial arrangements that take into account consumer and employer choice, with health plans reviewing efforts to expand alternative payment arrangements to include PPO membership. For example, Chapter 224 required that health plans attribute every member to a PCP to the maximum extent feasible. Health plans are developing processes so that patients in different product types, including PPOs, and various funding arrangements, such as alternative payment methods, can be attributed to a PCP. This includes enhancing reporting, business processes and systems capabilities to support new models for all product types and various payment arrangements, although it may require several years of data to test the persistency of the patient PCP relationships before fully adopting risk-type models across patient populations regardless of the type of health plan design. These attribution methodologies highlight that the growth in PPO plans is not incompatible with the goal of expanding the use of alternative payment methodologies.

Moving the delivery system toward alternative payment arrangements, regardless of whether a member is in a PPO or HMO or in a fully-insured or self-insured product, will require significant change. The spectrum of provider readiness varies widely and one size doesn't fit all. Every provider group is unique in its support needs for practice transformation. Despite comments during the hearings to the contrary, health plans have undertaken a number of initiatives that support providers in alternative payment arrangements including making detailed reporting of cost and quality results, customized analytics, and clinical consultation available to providers.

Recognizing the variation in readiness, health plans take a measured approach in determining the appropriate payment methods to use with providers at varying places on the spectrum. Health plans routinely examine the competencies and structures of the provider group, such as the provider's size and membership, degree of alignment between hospitals and physicians, level of clinical integration, and financial strength.

Further, health plans typically include a number of protections designed to hold providers harmless for insurance risk. For example, budget targets are severity adjusted to reflect the underlying health of the provider's patient population, caps on potential provider deficits are included to protect against catastrophic consequences stemming from medical cost charges that may not be within their control, and other strategies that share performance risk with providers while the health plan retains insurance

risk (those costs that a provider would have no reasonable ability to manage effectively). We would urge that any commentary on the level and type of risk that providers may be assuming that the Commission may include in its final report recognize this distinction.

We appreciate the opportunity to offer our comments and we look forward to the Commission's final report.

Sincerely,

Lora Pellegrini
President & CEO

cc: Stuart Altman, Ph.D., Chairman, Health Policy Commission
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Veronica Turner, Executive Vice President, 1199SEIU
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MAHP Principles on Provider Consolidations

Employers, Consumers & Patients Should Benefit Through Lower Health Care Costs, Clinical Integration and Improve Quality

- In their notice of material change, providers should provide the following information on their costs:
  - Current Total Medical Expense (TME) & Anticipated Changes in TME.
  - Current Relative Price (RP) & Anticipated Changes in RP.
  - Current Contract Prices & Any Proposed Changes in Contracting Practices.
- To promote clinical integration and improve quality, providers should include in their material change notices the structures they expect to put in place to:
  - Enhance quality as measured against nationally recognized measures.
  - Improve efficiency.
  - Coordinate services across facilities.
  - Direct care to the most appropriate and lowest-cost setting.
  - Enable all providers and facilities within a system to access clinical records.
  - Avoid duplication of services.

All Proposals Should be Transparent

- The Health Policy Commission staff should issue a report on the application of all entities that file notice seeking to consolidate, merge or affiliate, including the rationale for whether or not to conduct a cost & market impact review.

All Entities that Merge, Affiliate or Consolidate Should be Subject to Regular Monitoring & Annual Reporting

Annual Reporting:

- Entities that consolidate, merge or affiliate should report annually to the Health Policy Commission comparing the anticipated benefits and the actual results of proposed changes in costs and clinical integration efforts including:
  - Changes in TME, Relative Price & Contract Prices.
  - Changes in referral patterns, including efforts to coordinate care across facilities and avoid duplication, whether care is being directed to high-cost settings, and measures that have been undertaken to direct care to the most appropriate & lowest-cost setting.
  - Changes in patient volume and payer mix.

Oversight at the Annual Cost Trend Hearings:

- As part of it annual cost trends report & public hearings, the Health Policy Commission should examine
  - Whether the actual results align with the anticipated benefits of entities that had proposed consolidating, merging or affiliating.
  - The impact of the proposed change on access to lower-cost providers & the statewide cost benchmark.
  - Data should be utilized from existing databases, including the Center for Health Information & Analysis.

Ensuring Accountability:

- Entities that consolidate, merge or affiliate that fail to realize the anticipated benefits should be subject to a cost and market impact review with a referral to the Attorney General's office for review.

Enhance the Authority of the Attorney General and Health Policy Commission

- The current market impact review process should be strengthened by providing the Attorney General and the Health Policy Commission with the clear authority to prohibit consolidations, mergers or affiliations that either entity determines could adversely affect competition or increase costs for employers and consumers.