MASSACHUSETTS
HEALTH POLICY COMMISSION

Provider Price Variation Stakeholder Discussion Series

March 30, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Overview of Provider Price Variation Discussion Sessions**
- HPC Staff Presentation: Demand-Side Incentives
- Office of the Attorney General Presentation: A More Effective Approach to “Consumerism” in Health Care: Premiums Based on Value
- Discussion
- Schedule of Next Meeting (April 13, 2016)

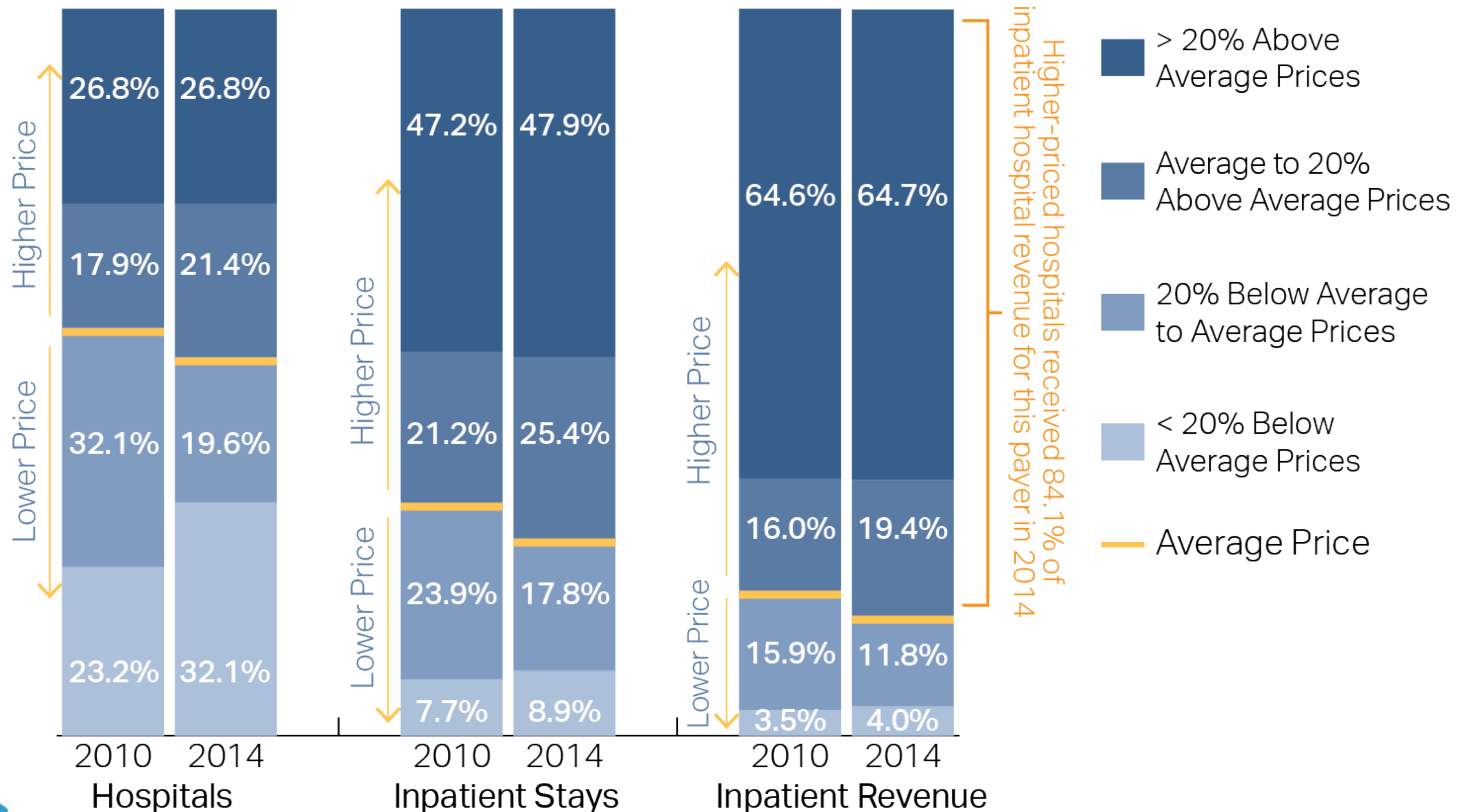
Key findings from HPC 2015 Special Report on Provider Price Variation

- Provider prices vary extensively for the same sets of services.
- Provider price variation has not diminished over time.
- Market leverage continues to be a significant driver of higher prices; higher hospital prices are not generally associated with higher quality or other value-based factors that provide benefit to the Commonwealth.
- While some variation in prices may be warranted to support activities that provide value to the Commonwealth (e.g. physician training), unwarranted variation in prices combined with the large share of volume at higher-priced providers results in increased health care spending and creates inequities in the distribution of health care resources.
- Other states have also found unwarranted variation in provider prices; however, in one state that limits hospital price variation to value-based factors, hospital prices for specific services vary less than in Massachusetts.
- Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue.

Multiple state agencies have documented extensive, unwarranted variation in hospital and physician prices in Massachusetts since 2010

- Multiple state agencies have found significant price variation among health care providers in the Commonwealth:
  - The Office of the Attorney General in 2010, 2011, 2013, and 2015
  - The Special Commission on Provider Price Reform in 2011
  - The Division of Health Care Finance and Policy in 2011 and the Center for Health Information and Analysis (CHIA) in 2012, 2013, and 2015
- In addition to variation in fee-for-service prices, multiple reports have documented extensive variation in prices paid under alternative payment methods, specifically global budget arrangements.
- Variation has not generally be found to be explained by differences in quality, patient acuity, or other common measures of value. Rather, past reports have found that higher prices are associated with market leverage.
- Previous reports have documented that hospital prices vary considerably not only across all Massachusetts hospitals, but also within hospital cohorts (AMC, teaching, community, community-DSH).

Higher healthcare spending is driven by both the higher prices some providers receive and the large volume at these higher-priced providers



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The HPC found that a substantial portion of hospital price variation is associated with market structure, and not with quality

Factors associated with higher commercial prices (Holding all other factors equal)
Less competition
Larger system size (above a certain size)
Corporate affiliations with certain systems
Provision of higher-intensity (tertiary) services
Status as a teaching hospital

Factors associated with lower commercial prices (Holding all other factors equal)
More Medicare patients
More Medicaid patients
Corporate affiliations with certain systems

Factors not generally associated with commercial prices (Holding all other factors equal)
Quality
Mean income in the hospital's service area

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Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue

Existing policy initiatives were not designed to directly reduce unwarranted price variation. For example:

- The benchmark focuses on year-over-year growth, not the allocation of resources within the system;
- Alternative payment methods are not likely to reduce price variation so long as global budgets are based on providers' historic spending levels.

The need for action is reinforced by the extent of the price variation in the market. Price variation is extensive enough that it would take 16-19 years for some lower-priced hospitals in the three major commercial payer networks to reach the 2013 price level of the 75th percentile, even if they received annual 3.6% rate increases.

Stakeholder Discussions of Provider Price Variation

WHO	**HPC Commissioners**, HPC staff, key stakeholders including HPC Advisory Council members, expert speakers, and representatives of sister agencies (AGO, CHIA). HPC will invite legislators and legislative staff to attend. Members of the public are welcome.
WHEN	**Three meetings** are scheduled to take place through the end of May 2016. Each meeting is expected to last two hours. The next meeting will take place on April 13, 2016.
WHAT	As stated in the HPC's Special Report on price variation, **policy action is required** to address unwarranted price variation and its impact on overall spending and the sustainability of lower-priced providers. These discussions provide an opportunity for Commissioners and stakeholders to engage in a discussion regarding the potential for specific, **data-driven policy approaches to reduce unwarranted price variation** without increasing overall healthcare spending. The HPC anticipates presenting analyses and inviting expert speakers to introduce certain policy options
GOAL	At the conclusion of the process, a **Summary Report** of the discussions will be presented at a full Board meeting. The Board may take the opportunity to discuss potential policy options, make recommendations, or identify new analyses necessary to support future policy development.

Topics: Meeting 1 – Demand-Side Incentives

Discussion of proposed policies to encourage consumers to use high-value providers for their care, e.g.:

- Using insurance design to encourage consumers to use high-value providers
  - Tiered and limited network plans
  - Reduced premiums for choosing high-value primary care providers (PCPs)
  - Encouraging enrollment in value-based plans, e.g., defined employer contributions, active re-enrollment and/or premium holidays

- Encouraging consumer shopping for services
  - Reference pricing
  - Cash-back rebates and other consumer choice interventions
  - Price and quality transparency

Presenters:

HPC staff and the Office of the Attorney General

Topics: Meetings 2 and 3

Meeting 2: Supply-Side Policy Options

Anticipated Presenters: HPC staff and Hoangmai Pham, MD, MPH, Chief Innovation Officer for the Center for Medicare and Medicaid Innovation

Meeting 3: Direct Limits on Variation

Anticipated Presenters: HPC staff and Joshua Sharfstein, MD, former Secretary of Maryland Department of Health and Mental Hygiene, currently professor and associate dean of the Johns Hopkins University Bloomberg School of Public Health

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Demand-side incentives for reducing unwarranted price variation

Demand-side incentives in health care encourage purchasers of coverage and services (i.e. individuals and employers) to make higher-value choices

- **Demand-side incentives can result in cost savings**
  - For individuals through lower premiums and out-of-pocket costs
  - For employers and insurers though lower premiums and higher-value spending

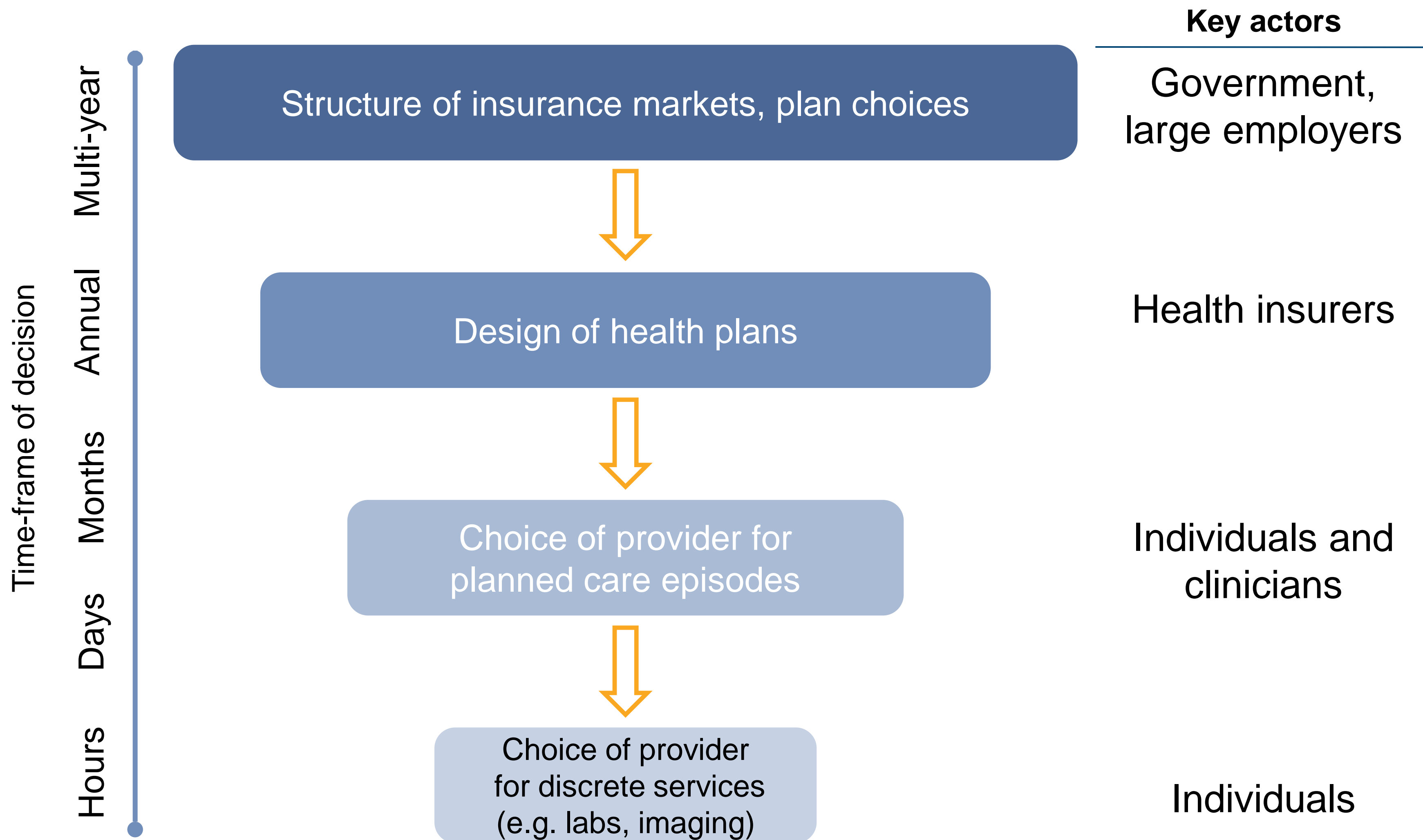
- **Demand-side incentives can reduce unwarranted price variation**
  - By encouraging patients to use higher-value (e.g. lower-priced, high quality) providers, demand-side incentives can incentivize higher-priced providers to lower prices

Limitations of demand-side incentives

- Demand-side incentives tend to play a smaller role in health care than in other markets, e.g.:
  - Insurance and subsidies limit consumer exposure to the cost of care, which tends to reduce consumer incentives to shop for less expensive care
  - Consumers are unlikely to know what health care services they need and often depend on providers to make care decisions
  - It is often difficult to determine the quality of a service or differences in services between providers; as a result, consumers sometimes use price as a proxy for quality, assuming that higher prices are associated with higher quality*
  - Consumers may consider health to be so important that they are less likely to consider cost in making health care decisions
- Demand-side incentives may not work for all types of care. They tend to work best for:
  - Planned episodes of care
  - Situations where quality is more transparent or services are more standardized
- Demand-side incentives may create financial burdens for some consumers

* These findings are partly informed by a series of focus groups conducted for the HPC by Amy Lischko et al, as described in "Community Hospitals at a Crossroads," Health Policy Commission, March, 2016

Where can demand-side incentives be applied in health care?



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Key demand-side policy options

Strategy 1:

Using insurance design to encourage consumers to use high-value providers

- Tiered and limited network plans
- Reduced premiums for choosing high-value primary care providers (PCPs)
- Encouraging enrollment in value-based plans, e.g., defined employer contributions, active re-enrollment and/or premium holidays

Strategy 2:

Encouraging consumer shopping for services

- Reference pricing
- Cash-back rebates and other consumer choice interventions
- Price and quality transparency

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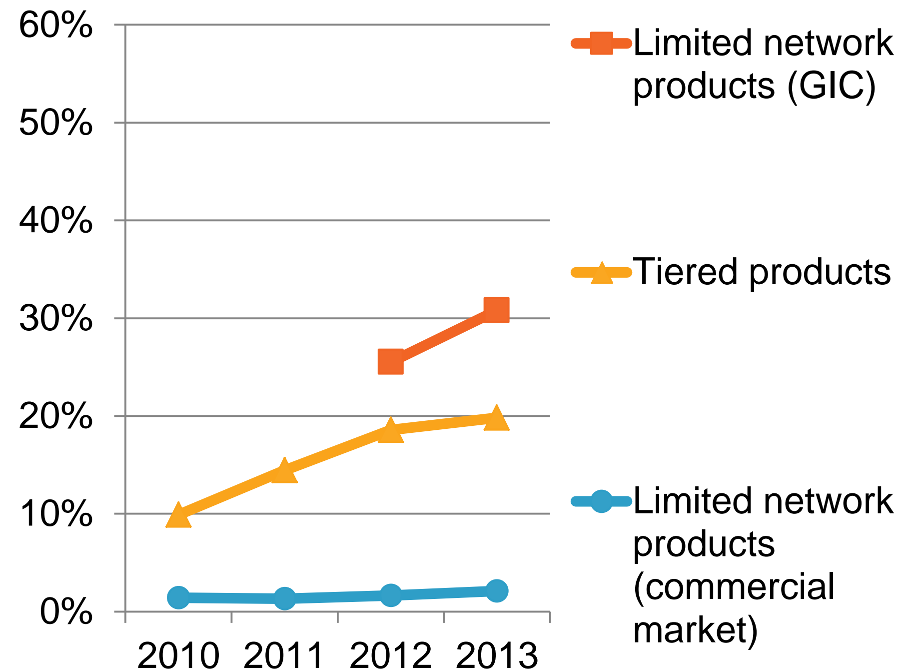
Tiered and limited network plans: Opportunity

- Uptake of tiered and limited network plans in Massachusetts remains low
- But evidence suggests these plans can shift care to higher-value providers and reduce spending without reducing quality of care.
  - Limited network plans in the GIC were associated with 36% lower costs with no reduction in quality of care
- If tiered network coverage comprised 50% of the market instead of 16%:
  - Premium spending would be ~3.5% lower
  - ~1.5% of volume would shift from higher to lower-priced hospitals



Tiered and limited network data are from Massachusetts commercial payers as reported in pre-filed testimony in 2014 to the Attorney General's Office and reported in the Health Policy Commission's 2014 Annual Cost Trends Report

Frank, Matthew B., et al. "The impact of a tiered network on hospital choice." *Health services research* 50.5 (2015): 1628-1648

Gruber, Jonathan, and Robin McKnight. *Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees.* No. w20462. National Bureau of Economic Research, 2014.

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Tiered and limited network plans: Considerations and limitations

- Tiered and limited networks can be complex for employers, consumers and providers to navigate; transparency is critical
- Employers may be concerned about employee preference for broad networks
- Tiered and limited networks may work in tension with ACOs and care coordination
- "Tiering" requires that differences in cost-sharing be significant enough to change consumer behavior

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Key demand-side policy options

Strategy 1:

Using insurance design to encourage consumers to use high-value providers

- Tiered and limited network plans
- **Reduced premiums for choosing high-value primary care providers (PCPs)**
  - **Presentation by the Office of the Attorney General**
- Encouraging enrollment in value-based plans, e.g., defined employer contributions, active re-enrollment and/or premium holidays

Strategy 2:

Encouraging consumer shopping for services

- Reference pricing
- Cash-back rebates and other consumer choice interventions
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Key demand-side policy options

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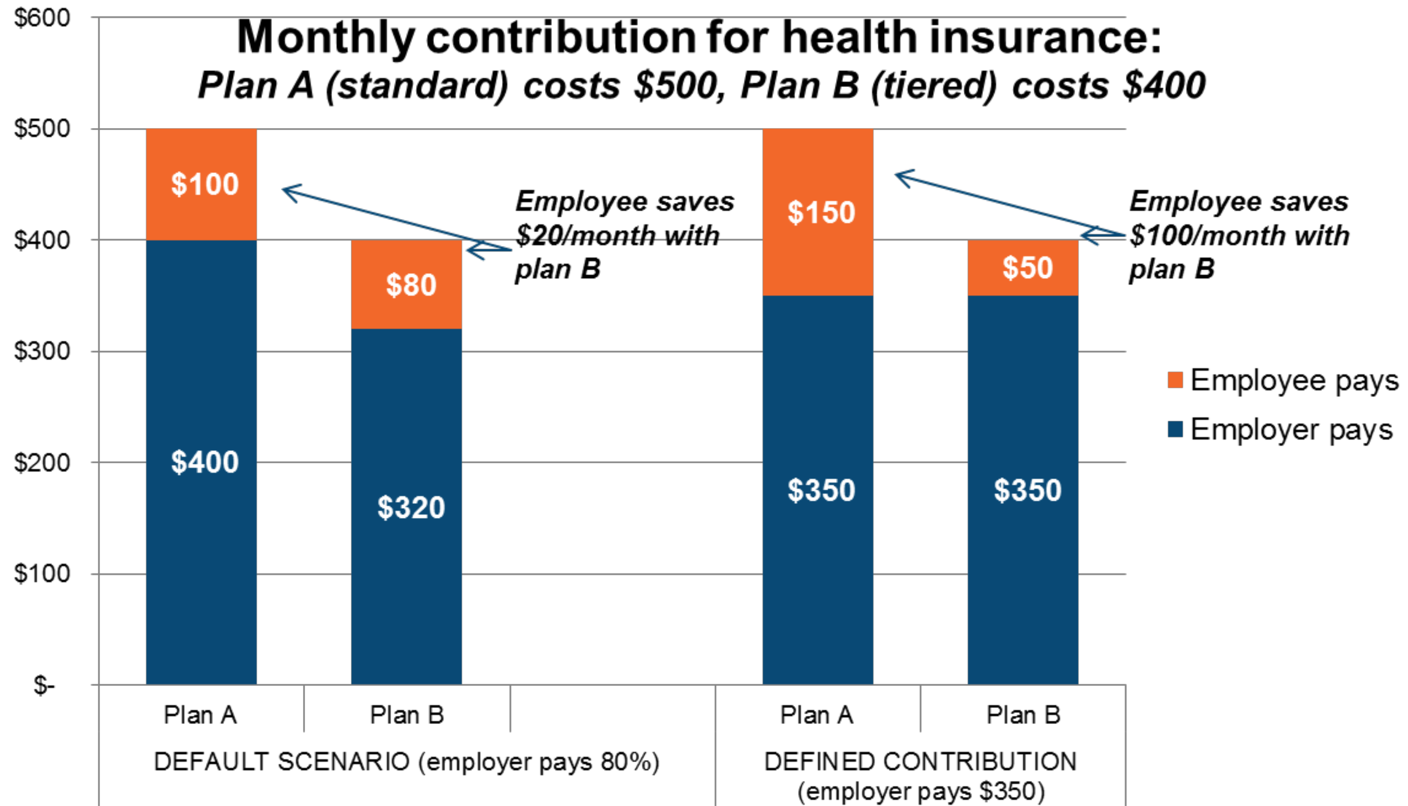
Defined employer premium contributions: Opportunity



- Research literature suggests ~5% lower total spending under a defined contribution strategy
- ACA exchanges (including MA Health Connector) use this strategy and tend to have a higher proportion of enrollees in limited and tiered network plans

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see Congressional Budget Office, "Key issues in analyzing major health insurance proposals," 2008

Employer defined contribution plans: Considerations and limitations

Employers may feel a defined contribution strategy allows for better long-run control of spending

However, some enrollees may pay significantly more under this arrangement

Plans should be substantially the same with respect to benefits, actuarial value

Other mechanisms (e.g. premium holidays, active re-enrollment) may also encourage enrollment in value-based plans

Key demand-side policy options

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Strategy 2:

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- **Reference pricing**
- Cash-back rebates and other consumer choice interventions
- Price and quality transparency

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Reference pricing: Opportunity

- A **reference price** is a set price for a procedure or service above which the payer (or self-insured employer) will not pay
- Consumers who seek care from providers with rates above the reference price pay the difference between the provider's rate and the reference price. This means that:
  - Patients are incentivized to be aware of provider prices and "shop" for health care services
  - Providers are incentivized to offer services at the reference price
- Some reference pricing initiatives (e.g. CalPERS) have shown very promising results in reducing spending, reducing price variation, and shifting care to higher-value settings

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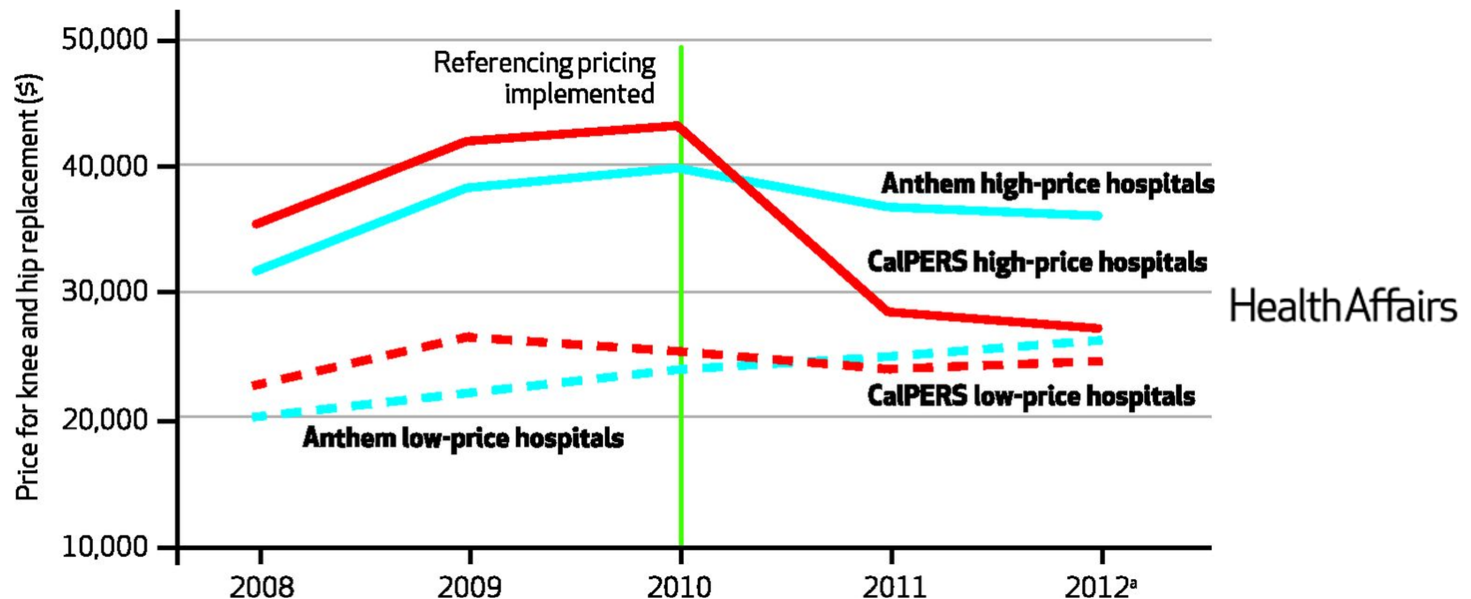
Reference pricing: CalPERS example

California's public employee retirement system (CalPERS) initially saw 5-fold variation in prices paid for knee and hip replacements. They identified 41 preferred hospitals and set a maximum price paid ($30,000); enrollees paid full cost above that set price



Results

- Patients chose care in lower cost facilities: ~30% switched to lower-priced facilities
- Prices declined ~34% at higher-priced facilities
- No evidence of reduced quality
- No evidence of cost-shifting to consumers

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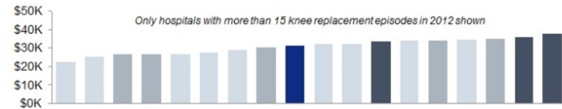
James C. Robinson, and Timothy T. Brown Health Aff 2013;32:1392-1397 ©2013 by Project HOPE - The People-to-People Health Foundation, Inc.

Reference pricing: Opportunities in Massachusetts

Knee Replacement

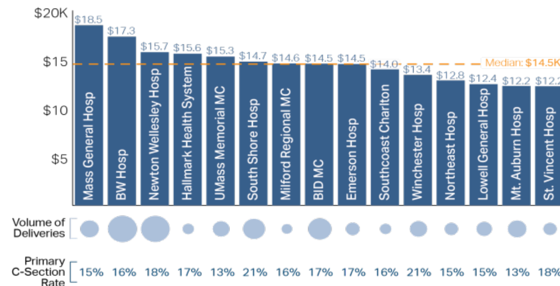
*Average total spending per episode of knee replacement, by hospital**

	Average spending per knee replacement episode	Percent difference compared to NE Baptist	
NE Baptist	$31.3K	-	Reference Hospital
AMC	$36.1K	15%	
Affiliated	$29.8K	-5%	Non-AMC hospitals
Unaffiliated	$28.6K	-9%	



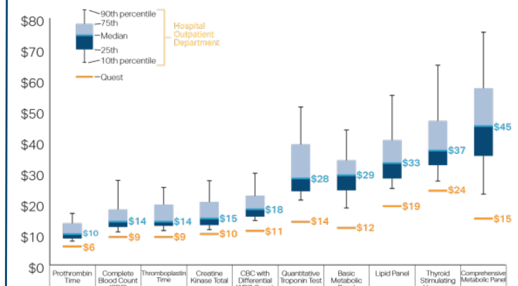
- Savings to the payer would be ~5% if New England Baptist price was set as the reference price
- No significant quality differences observed among hospitals

Maternity



- Payer savings would be 17% if Mount Auburn's price were set as the reference price
- Maternity care represents 1 in 6 commercial inpatient discharges and is 3.5% of all commercial spending

Lab Tests



- Payer spending on lab tests would be reduced by ~50% if Quest price were set as the reference price

System savings would be less to the extent that patients paid out of pocket to use higher-priced providers

Knee Replacement: *only hospitals with greater than 15 discharges are displayed as bars; average payment shown in table includes all hospitals studied
Source: HPC Analysis of All-Payer Claims Database, 2012
Maternity: Health Policy Commission. 2015 Cost Trends Report. Boston (MA): Health Policy Commission. 2016 Jan 20.
Lab Tests: Calculations are hospital outpatient averages for each lab test. Observations only include acute care hospitals inside the 10th and 90th percentile
Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health).

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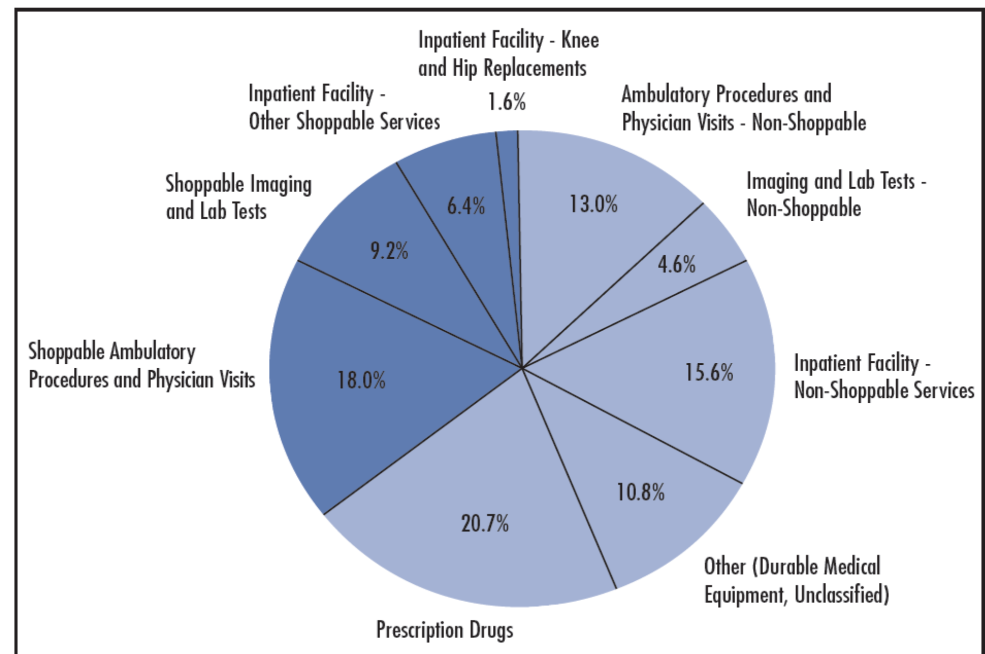
Reference pricing: Considerations and limitations

- Reference pricing is only appropriate for "shoppable" services, which account for about a third of total spending
- Reference pricing can be costly to implement due to the need to:
  - Carefully set a price appropriate to the market
  - Thoroughly communicate to all enrollees both the existence of the program and information on which providers they can use without extra cost-sharing
- Reference pricing may create financial burdens for some patients



Note: Shoppable services were identified in claims data based on the diagnosis-related group for inpatient facility stays or the Healthcare Common Procedure Coding System and Current Procedural Terminology codes for outpatient facility and professional services.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents

White, Chapin, and Megan Eguchi. *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle.* Research brief #18. Mathematica Policy Research, 2014.

Key demand-side policy options

Strategy 1:

Using insurance design to encourage consumers to use high-value providers

- Tiered and limited network plans
- Reduced premiums for choosing high-value primary care providers (PCPs)
- Encouraging enrollment in value-based plans, e.g., defined employer contributions, active re-enrollment and/or premium holidays

Strategy 2:

Encouraging consumer shopping for services

- Reference pricing
- **Cash-back rebates and other consumer choice interventions**
- Price and quality transparency

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Cash-back incentives and other consumer choice interventions: Opportunities and limitations

- Cash-back rebates provide consumers with direct payments when they utilize providers designated as “high-value” providers.
  - The payer may identify specific high-value providers that consumers can choose in order to qualify for the rebate payments
  - Typically, these are used for services that are highly standardized, such as imaging services (MRI etc.) or labs
- Other interventions can also seek to steer patients to low-cost, high-quality providers
  - Simply alerting consumers to the existence of high-value providers may encourage their use, especially where consumers receive assistance in scheduling appointments with these providers
- Like reference pricing, these incentives and interventions are limited to services that consumers can shop for well in advance, and where quality is more transparent or services are more standardized

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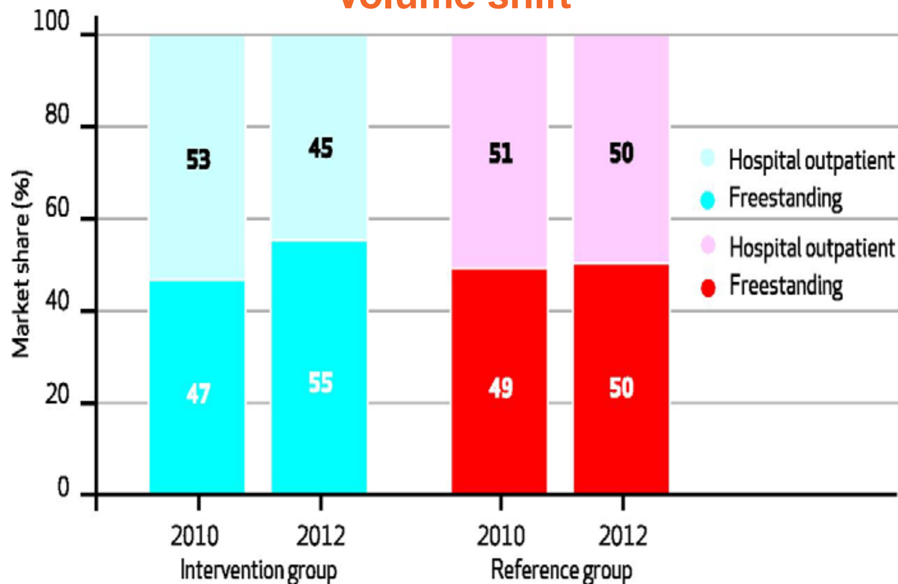
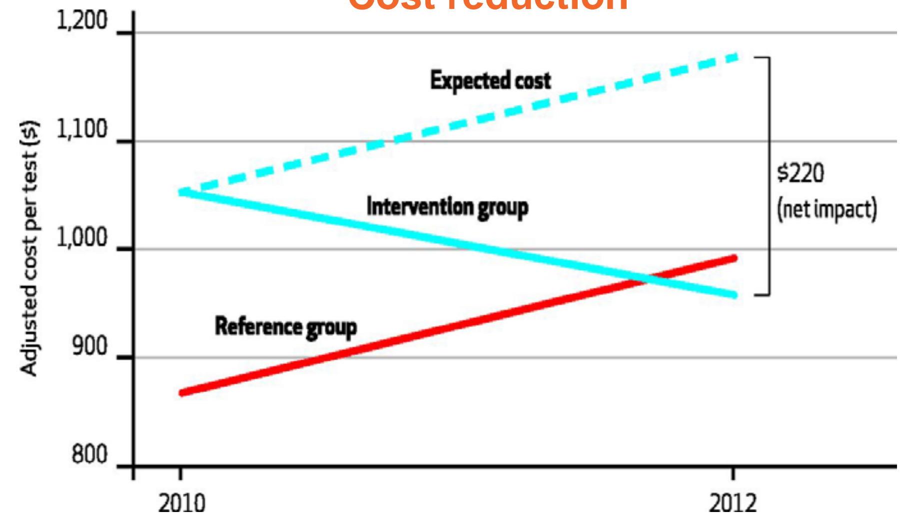
Consumer choice intervention: MRI example

- A specialty benefits management company implemented a voluntary, nationwide program
- Employees scheduled for an MRI were called by a benefits manager if there was a nearby alternative at lower cost and comparable or better quality
- The benefits manager rescheduled the appointment if the patient agreed

Volume shift



Cost reduction



Results

- Consumers who received calls spent 19% less on MRIs
- Hospital MRI prices dropped $360, freestanding site prices rose $85 (compared to controls)
- Several insurers in Massachusetts add cash-back incentives to augment this idea

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Sze-jung Wu et al. Health Aff 2014;33:1391-1398. ©2014 by Project HOPE - The People-to-People Health Foundation, Inc..

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Strategy 2:

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- Cash-back rebates and other consumer choice interventions
- **Price and quality transparency**

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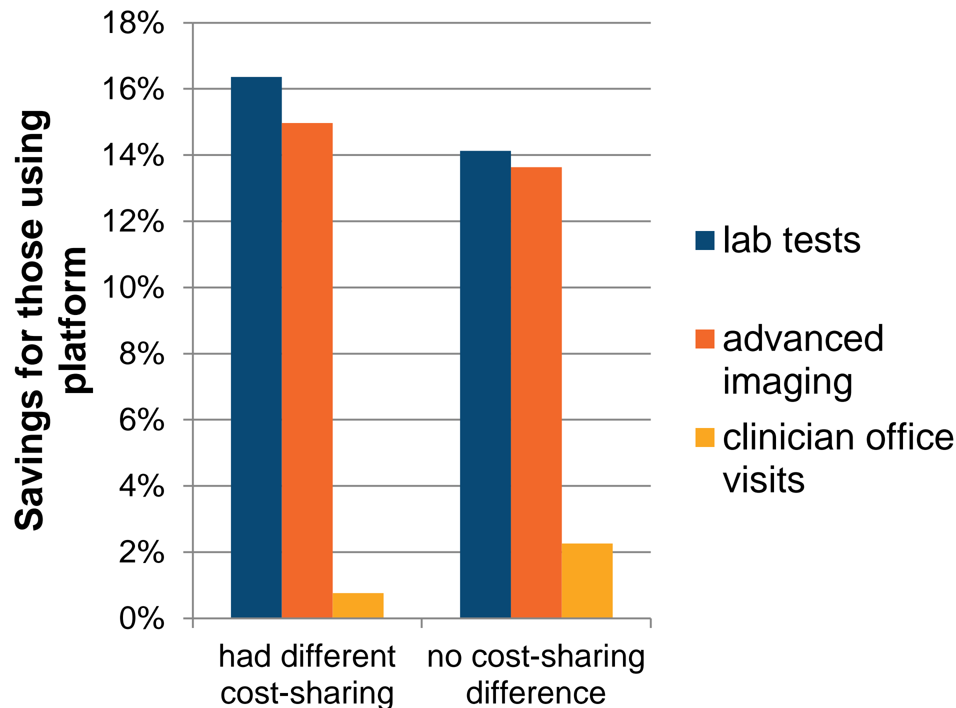
Price and quality transparency: Opportunities

- Price and quality transparency can facilitate consumer shopping:
  - Availability of price and quality information has led to lower spending among consumers who used a search tool (see next slide)
  - Clearer quality information presented alongside price information has been found to make consumers more likely to make high value choices (e.g. letting patients know if providers are rated as being responsive to patients' needs and whether providers use treatments "proven to get results.")
- Certain transparency requirements under existing Massachusetts law could consumer shopping:
  - Information on total medial expenses and relative prices for payers and providers
  - Health care providers are required give patients requested cost information within 2 business days
  - Payers are required to give patients requested cost information immediately
- Price and quality transparency are also necessary components of other demand-side incentives, such as reference pricing

Hibbard, JH, et al. (2012). An Experiment Shows That A Well-Designed Report On Costs and Quality Can Help Consumers Choose High-Value Health Care. *Health Affairs*, 31, 3: 560-568.; Whaley, C, et al. (2014). Association Between Availability of Health Services Prices and Payments for These Services. *JAMA*, 312, 16: 1670-1676; White, C, et al. (2014). Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending. *Westhealth Policy Center: Policy Analysis.*

Price transparency example: Introduction of searchable price platform



Percent who used search tool:

Labs: 5.9%

Imaging: 6.9%

Office visits: 26.8%

- A multi-state insurer used a vendor (Castlight) to allow employees to search price and quality information for certain services
- Few used the search tool, but those who did had lower spending than those who did not
- While the existence of a cost-sharing difference between using higher- or lower-cost providers yielded larger effects, those with no cost-sharing differential also spent less

Association Between Availability of Health Service Prices and Payments for These Services. JAMA. 2014;312(16):1670-1676. doi:10.1001/jama.2014.13373

Transparency: Considerations and limitations

- The Commonwealth faces implementation challenges around current transparency laws:
  - Many providers do not currently provide price information as required
  - Payer websites may not be comprehensive, and can be difficult for consumers to navigate
  - Few consumers may use transparency sites: fewer than 50 uses per 1,000 members for 3 largest insurer websites in Massachusetts
- Price information alone, without data on quality, may lead consumers to use high-priced providers under the assumption that their quality is superior
- Transparency, like reference pricing, is only helpful in encouraging use of high-value providers for those services for which consumers can shop ahead of time

Anthony, B & Haller, S. (August 2015). Bay State Specialists and Dentists Get Mixed Reviews on Price Transparency. *Pioneer Institute, Center for Health Care Solutions: Policy Brief.* White Paper No. 135.; Anthony, B & Haller, S. (2015). Mass Hospitals Weak on Price Transparency. *Pioneer Institute, Center for Health Care Solutions: Policy Brief*; Report Card on State Price Transparency Laws; Health Care for All. (2015). Consumer Cost Transparency Report Card, *available at*: https://www.hcfama.org/updates/hcfas-2015-consumer-cost-estimation-report-card; 2015 Cost Trends Hearing Pre-Filed Testimony; See description of focus groups conducted for the HPC by Amy Lischko et al., in "Community Hospitals at a Crossroads," Health Policy Commission, March, 2016.

Demand-side incentives summary

1. Use of demand-side incentives can increase the use of efficient plan designs, shift volume to higher-value providers and reduce spending and prices through competition
2. Encouraging examples exist, but thus far, they have been somewhat limited and applied to only a subset of shoppable conditions
3. Demand-side incentives can complement other policy options
4. Overall, demand-side incentives may support a more competitive, value-driven market place but likely will not fully address unwarranted price variation alone

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A More Effective Approach to "Consumerism" in Health Care: Premiums Based on Value

March 30, 2016

HEALTH CARE DIVISION
OFFICE OF ATTORNEY GENERAL MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

Health Care Costs Continue to Climb, Burdening Families and Businesses

Growth in Small Group Rates & Total Health Care Expenditures, 2013-2016

7%
6%
5%
4%
3%
2%
1%
0%

2013
2014
2015
2016 (Q1&Q2)

Growth in Small Group Rates (Weighted Average)
Growth in THCE

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Provider Prices Are the Biggest Driver of Rising Health Care Costs

Significant Growth in Medical Spending Is Due to Price Increases

% of Increase in Costs Due to Δ in Price v. Mix v. Utilization

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

UTILIZATION

PROVIDER MIX AND SERVICE MIX

UNIT PRICE

2005 2006 2007 2008 2009 2010

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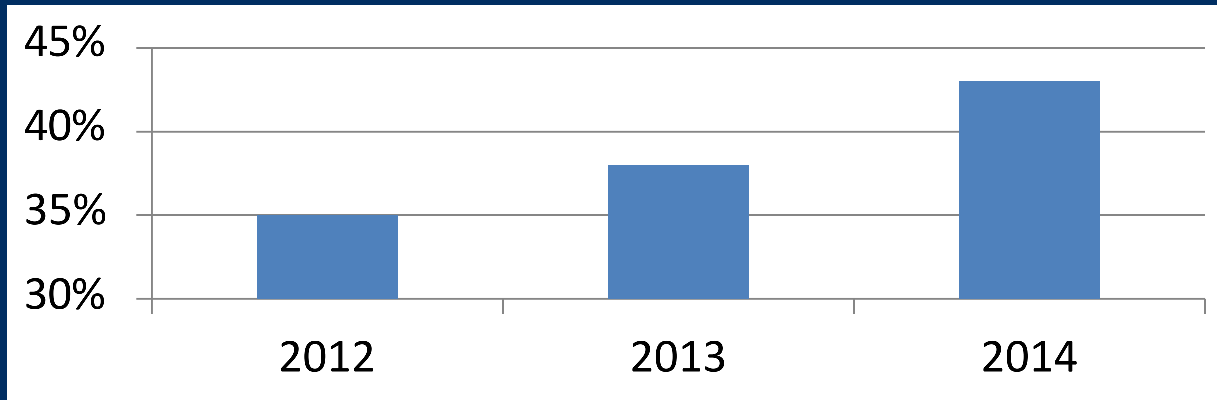
Responses to Date Have Been Regressive, Fragmented & Overly Complex

- Regressive: shifting costs onto consumers without attention to the underlying reasons costs are growing can discourage needed medical services.

High-Deductible Health Plan Membership, Small Group (CHIA, 2015)



- Fragmented and overly complex: current approaches to encouraging patients to choose high-value providers can include unrealistic expectations regarding health care decision-making.

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A Better Approach: Recognizing That Consumer Choice of A System of Care Better Aligns with Payment Reform and How Consumers Choose Health Care Providers

Variation in Provider Group Efficiency: Health Status Adjusted Budget for Care of HMO/POS Patients for a Major Insurer (2013)

Provider Group	2013 Risk Budget for Care of 35,000 Patients	2013 Savings as Compared to Least Efficient Provider Group
PCHI (Partners)	$220M	$0M
New England Quality Care Alliance	$220M	$0M
Atrius Health	$220M	$0M
South Shore PHO	$220M	$0M
Mount Auburn Cambridge IPA	$219M	$1M
Northeast PHO	$213M	$7M
Signature Healthcare	$209M	$11M
Lowell General PHO	$207M	$13M
Steward Health Care	$202M	$18M
Baycare Health Partners	$201M	$19M
Beth Israel Deaconess PO	$196M	$24M
Lahey Clinic	$194M	$26M
Accountable Care Assoc	$193M	$27M
BMC Management Svc	$192M	$28M
UMass Memorial Health Care	$186M	$34M
Cooley Dickinson PHO	$182M	$38M
Riverbend Medical Group	$161M	$59M

Y-axis: $150, $160, $170, $180, $190, $200, $210, $220

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What Would Premiums Look Like If They Reflected Provider Efficiency?

Tiering Premiums Based on Patient's Choice of PCP (Not a Limited Network Product) While Continuing to Socialize Health Risk

Provider Group	Current Approach (PMPM - Adult)	Health Status Adjusted Premium Relativity	New Approach (PMPM - Adult)
Provider A	$583.73	0.88	$514.00
Provider B	$583.73	0.93	$540.51
Provider C	$583.73	0.95	$553.30
Provider D	$583.73	0.97	$567.08
Provider E	$583.73	0.99	$580.02
Provider F	$583.73	1.00	$585.14
Provider G	$583.73	1.02	$595.20
Provider H	$583.73	1.06	$620.80

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AGENDA

- Overview of Provider Price Variation Discussion Sessions
- HPC Staff Presentation: Demand-Side Incentives
- Office of the Attorney General Presentation: A More Effective Approach to “Consumerism” in Health Care: Premiums Based on Value
- **Discussion**
- Schedule of Next Meeting (April 13, 2016)

Demand-side incentives overview

Strategy	Examples of Specific Options	Considerations
Using insurance design to encourage consumers to use high-value providers	▪ Tiered/ limited network plans ▪ Reduced premiums for choosing high-value PCPs ▪ Encouraging enrollment in value-based plans	▪ Tiered networks associated with savings and volume shifts to more efficient providers, but take-up is low: – Can be complex to navigate; transparency is critical – Employer concern about employee preference for broad networks ▪ Tiering requires differences in cost-sharing to be significant enough to change consumer behavior ▪ Defined contribution strategies can yield higher enrollment in these products and lower spending, but: – Some employees may pay significantly more – Plans should be similar in benefits, actuarial value
Encourage consumer shopping for services	▪ Reference pricing ▪ Cash-back rebates, other consumer choice incentives ▪ Price and quality transparency	▪ Evidence on reference pricing and choice incentives suggests savings, but policies only appropriate for "shoppable" care ▪ Reference pricing and choice incentives can be costly to implement (e.g., communication to enrollees) ▪ Reference pricing can create financial burden for some patients ▪ Transparency requirements have been challenging to implement, and have not yet engaged many consumers ▪ Price transparency without quality data may lead consumers to use higher-priced providers

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Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us