COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

2015 HEALTH CARE COST TRENDS HEARING

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

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Up Next: Presentation

Office of the Attorney General

#CTH15

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12, § 11N

October 6, 2015

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

Previous AGO Reports Identified Market Dysfunction

- Providers were paid widely different commercial prices that were not explained by differences in quality, complexity of services, or other common measures of consumer value.
- Price increases drove increases in health care spending from 2004 to 2008.
- Higher priced hospitals were gaining market share over lower priced hospitals.

2015 Examination

I. What progress has the Commonwealth made on initiatives to contain health care costs?

II. Has previously identified market dysfunction improved?

III. Recommendations to improve market operation.

Initiatives to Contain Health Care Costs

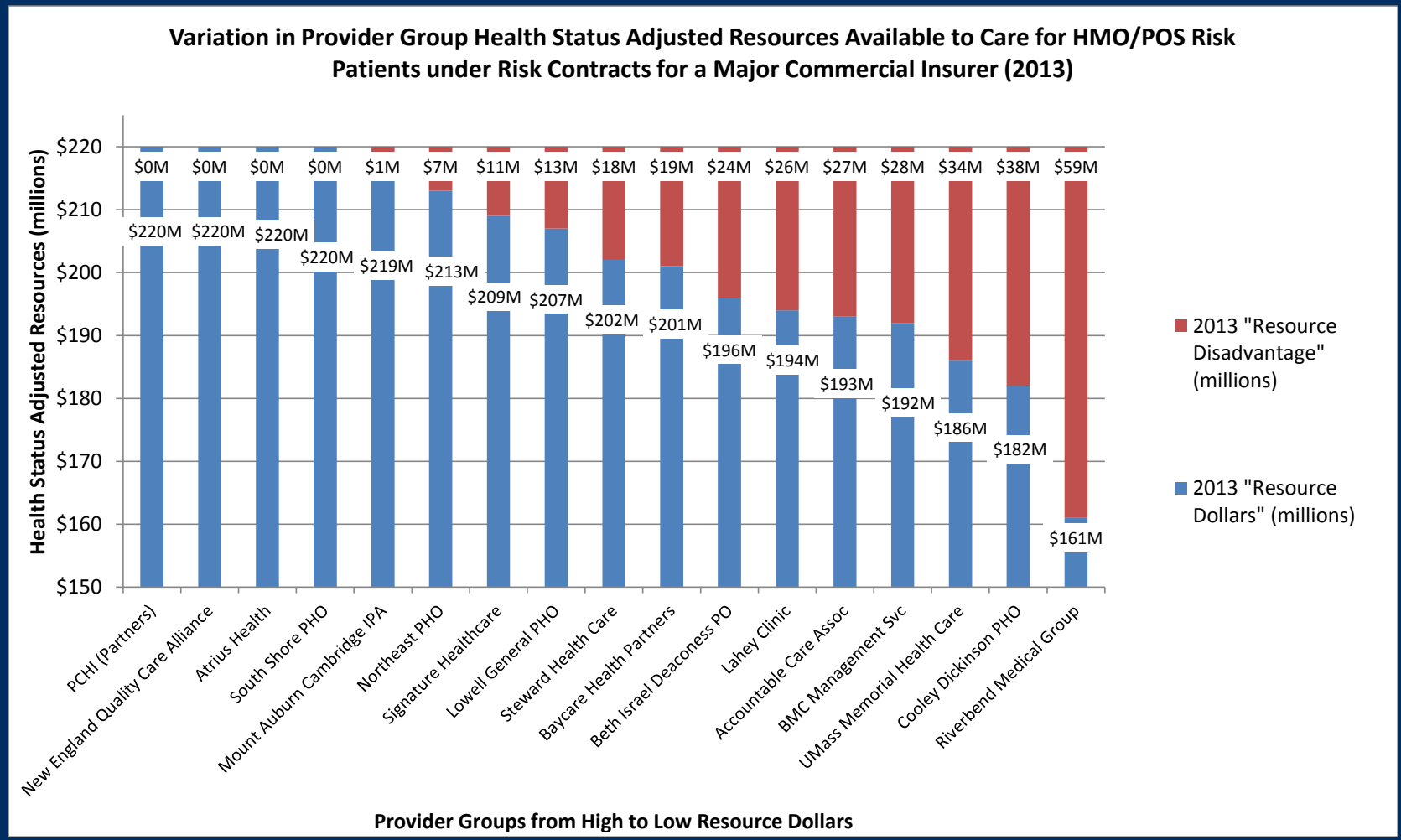
A. Consumer Directed Initiatives
   - Transparency for consumers in costs associated with health care services
   - Tiered network insurance products

B. Provider Oriented Initiatives
   - Global risk arrangements

Tiered Network Insurance Products Hold Promise, but Current Approaches Are Weakened by Mixed Incentives for Consumers

- Enrollment in tiered insurance products has increased, but has not resulted in an overall shift in inpatient volume away from higher priced providers.
- Tiered insurance products would benefit from further consideration of:
  - The scope of services and providers tiered
  - The size of cost share differentials between tiers
  - The transparency in methodology used to tier providers

Global Payment Arrangements Reflect Historic Payment Differentials, and Result in Widely Different Dollars Available to Care for Similar Patient Populations



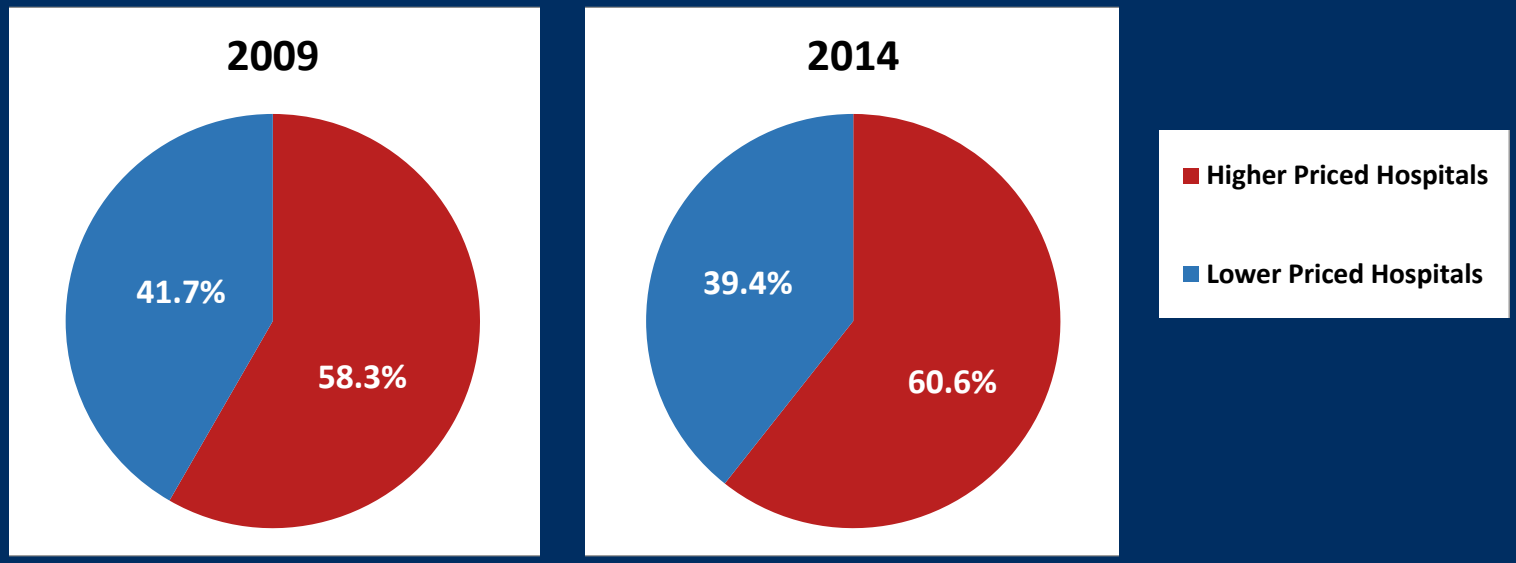
Price Variation Unexplained by Quality Persists, Contributing to Providers Having Different Levels of Resources to Carry Out Their Mission

Change in Extent of Price Variation by Hospital Peer Cohort from 2010 to 2013

	AMCs		Teaching Hospitals		Community Non-DSH		Community DSH	
	% Variation in 2013	Change in Variation Since 2010	% Variation in 2013	Change in Variation Since 2010	% Variation in 2013	Change in Variation Since 2010	% Variation in 2013	Change in Variation Since 2010
BCBS	66%	None	58%	Slight Decrease	225%	Moderate Increase	107%	Slight Increase
HPHC	43%	None	94%	Moderate Decrease	107%	Slight Decrease	144%	None
THP	95%	None	77%	Slight Decrease	109%	Slight Decrease	129%	None

Higher Priced Providers Continue to Draw Greater Patient Volume

Share of Total Commercial Discharges in Massachusetts by Higher Priced and Lower Priced Hospitals



Note:

1. Discharges exclude discharges for normal newborns and specialty services not fully captured by available discharge data.
2. Higher priced hospitals defined as hospitals with above average prices (relative prices above 1.0) for the largest commercial insurer in 2013.
3. Hospitals without a relative price for 2009 or 2014 were excluded from this analysis.

Projected Growth in Health Care Spending Underscores the Urgency of Addressing Market Dysfunction

- While data show that price increases have slowed, they have not slowed in a way that addresses price variation.
- Utilization and pharmacy trends are expected to increase, and are likely to consume most of the growth in medical trend "permitted" under the statewide cost growth benchmark.

If the Distribution of Price Increases Follows Historic Patterns, Price Disparities Will Only Persist or Worsen

Effect of Increased Pharmacy Trend and Illustrative Provider Contractual Increases on "Allowed" Commercial Unit Price Trend for All Other Providers and Services under State Cost Growth Benchmark

Unit Price Increase Negotiated for Providers Comprising One Third of Non-Pharmacy TME	Unit Price Increase Remaining Under Benchmark for All Other Non-Pharmacy Providers and Services
1.0%	0.7%
2.0%	0.2%
3.0%	-0.3%

	Estimated % Commercial TME in 2014	Estimated Commercial Expenses in 2014	Trend Assumptions for 2015		Benchmarked Commercial Expenses in 2015
			Utilization	Unit Price	
Prescription Drug Expenses	16.7%	$3.2 billion	12.5%		$3.6 billion
All Other Expenses	83.3%	$15.8 billion	1.0%	0.8%	$16.1 billion
Total Medical Expenses	100.0%	$18.9 billion	3.6% Benchmark		$19.6 billion

Recommendations

- Simplify and expand demand side efforts:
  - Require clear, easily compared information on the cost and quality of different insurance plans and provider systems for employers and consumers at the time of health insurance plan and PCP selection.
  - Simplify and strengthen how tiered networks are designed.
  - Promote consumer access to and understanding of health care cost and billing information.

Recommendations

- Consider ways to implement supply side incentives and penalties more evenly:
  - Monitor variation in health status adjusted global budgets.
  - Evaluate provider performance under the statewide cost growth benchmark in ways that take into account existing differences in provider efficiency.

Recommendations

- Monitor and address disparities in the distribution of health care resources:
  - Consider forms of directly regulating the level of variation in provider prices and/or medical spending.
  - Monitor income and health status adjusted medical spending by zip code on an annual basis.
  - Promote the development of population health status metrics that better account for socioeconomic risk factors.

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2015 HEALTH CARE COST TRENDS HEARING

Up Next: Presentation
Dr. Leemore Dafny

#CTH15

Healthcare Provider Consolidation: Facts and Myths

Leemore Dafny, Ph.D

2015 Massachusetts Cost Trends Hearing

October 6, 2015

NORTHWESTERN UNIVERSITY
Kellogg
School of Management

Competition is a bedrock of the U.S. vision for healthcare

- U.S. relies heavily on private markets to deliver, manage, and insure healthcare
  - The Affordable Care Act extended and expanded this approach
- For markets to achieve efficient outcomes, we need robust competition in all key healthcare sectors
- In general, robust competition requires many "small" buyers and sellers

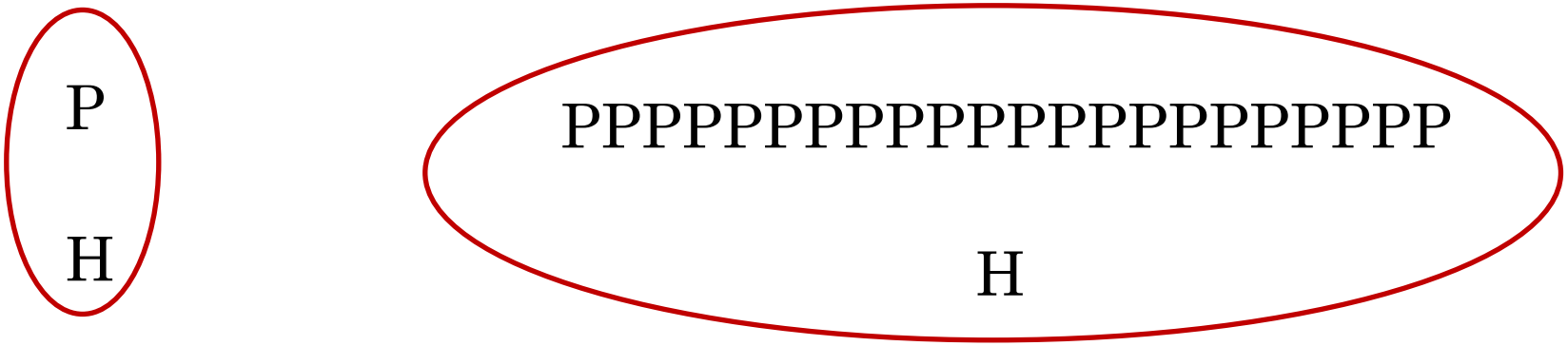
  → We've been seeing a lot of consolidation
- Goal today: what are the facts about consolidation and myths about antitrust enforcement?

Definitions

- Vertical chain of production is source of integration labels
  - **Horizontal**: combinations in the same product and geographic market and part of the value chain
  - **Vertical**: combinations up or down the value chain
  - **Lateral**: everything else

Non-horizontal

Hospital acquisition of physicians has vertical and horizontal components



The Facts

“Get your facts first, then you can distort them as you please.”

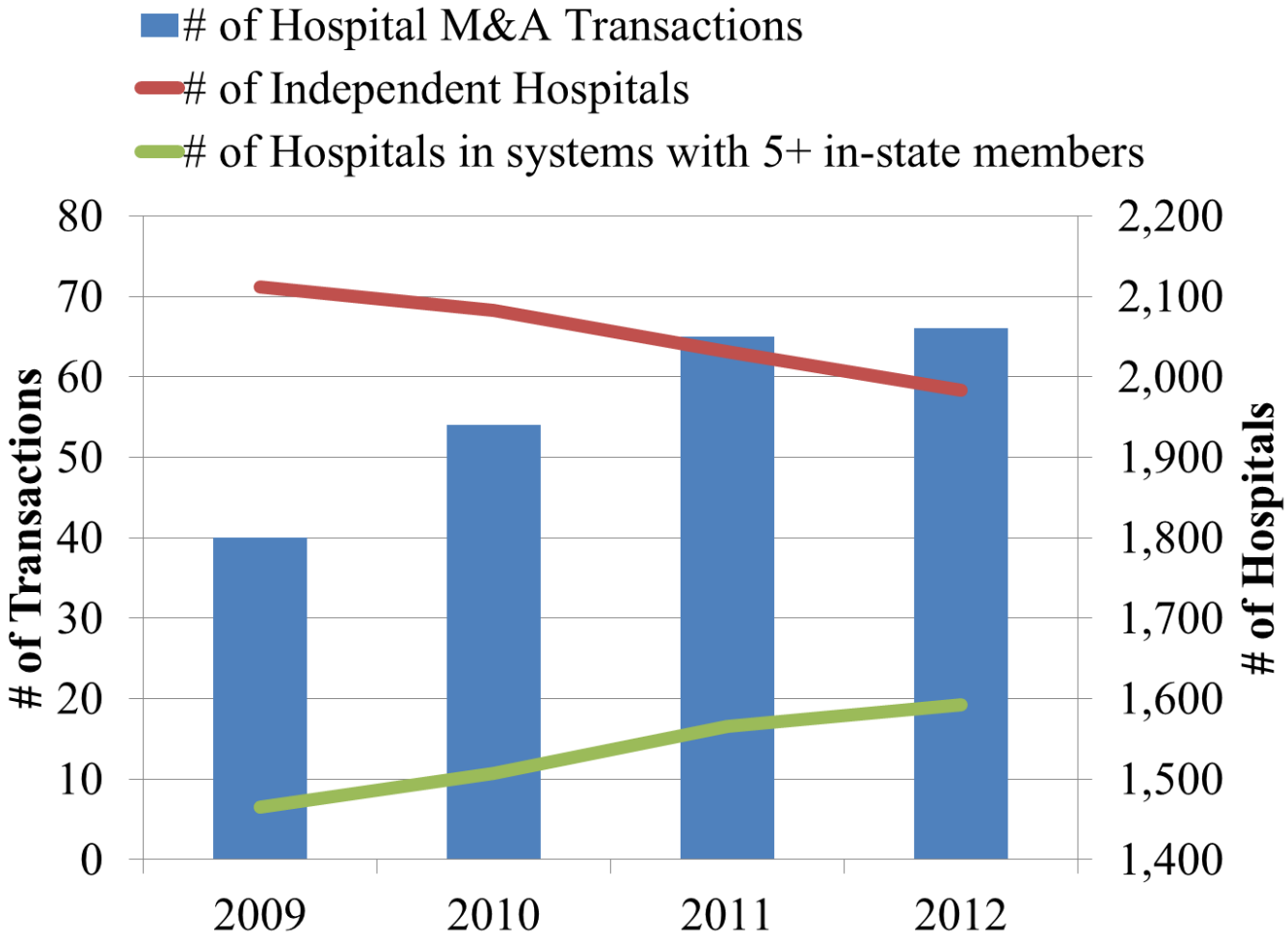
--Mark Twain

Horizontal consolidation is occurring among physicians and among hospitals

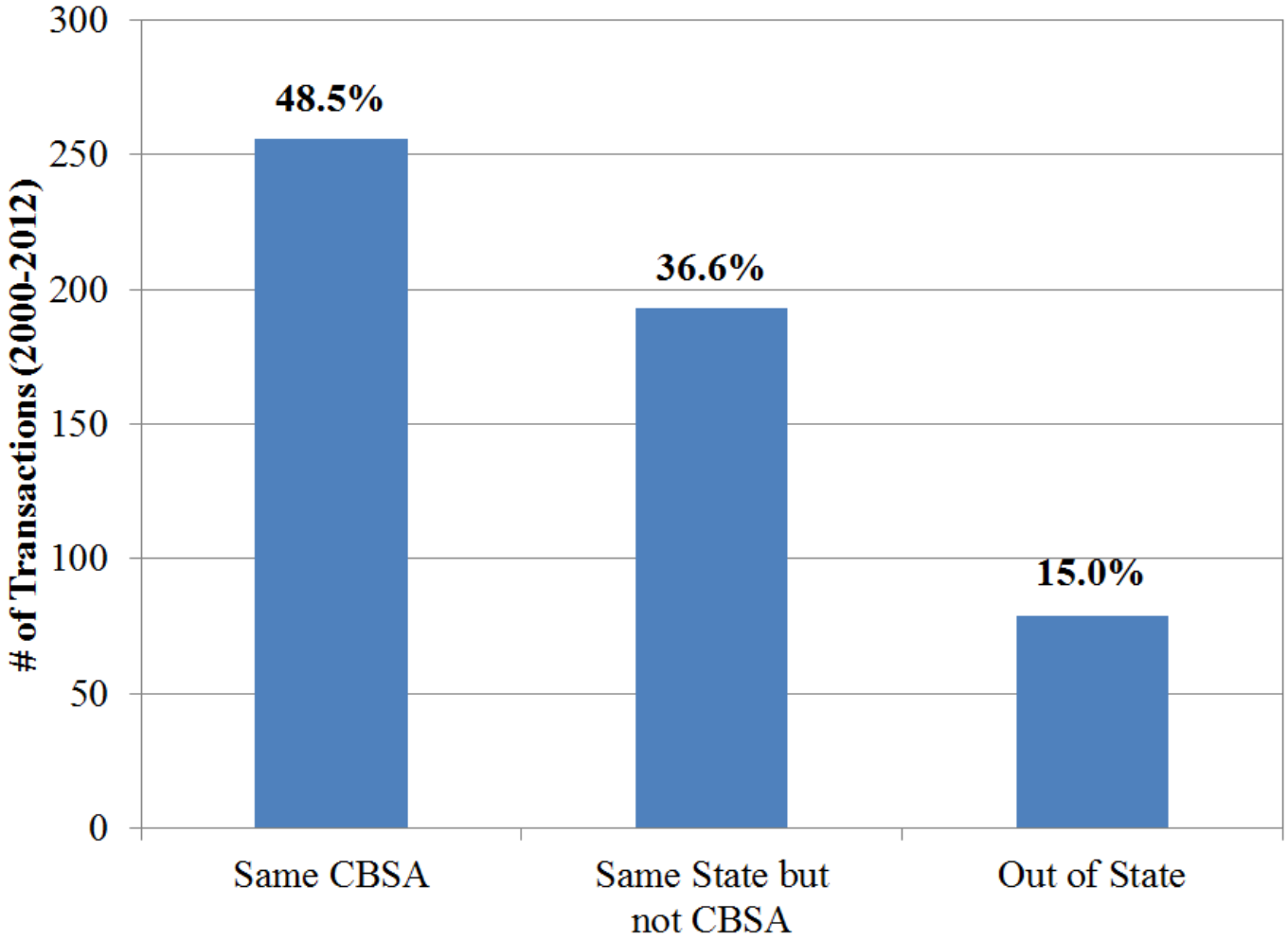
- Physician practices
  - Increase in mean practice size outside hospitals
  - Significant increase in hospital employment of MDs: 29% now employed by hospitals or hospital-owned practices (up from 16% in 2007)
- General acute care hospitals
  - Most MSAs are highly concentrated, and have become more so
  - 357 hospital transactions since 2010

Sources: American Medical Association, Gaynor (2015)

Hospital mergers are proceeding apace



Many hospital mergers do not have any traditional horizontal overlap



Notes: Based on 528 general acute care hospital mergers reported by Irving Levin over 2000-2012

Vertical integration trends

- Hospital-physician acquisitions and joint ventures
- Other cross-provider partnerships
  - DaVita and Healthcare Partners
- Provider-healthplan joint ventures
  - JVs: Anthem and Cedars-Sinai, UCLA, others in LA
- Provider-healthplan combinations
  - Highmark and West Penn Allegheny Health
  - Optum (United subsidiary) and Monarch HealthCare

So what? Bigger could be better

- Little evidence this is true for horizontal combinations
  - Mergers of competing hospitals lead to higher prices and (likely) lower quality (Gaynor and Town 2012)
  - Recent studies suggest consolidation may also raise price in outpatient settings
    - Physician services (e.g., Baker et al. 2013)
    - Dialysis (Cutler, Dafny and Ody working paper)

So what? Bigger could be better, *continued*

- Discouraging early evidence for integration of physicians with hospitals
  - Price and total spending increases in areas with increases in physician-hospital financial integration (Bundorf et al 2014)
  - Referral patterns shift toward acquiring hospital, and patients more likely to select high-cost, low-quality hospitals (Baker et al 2015)
  - Total risk-adjusted Medicare spending is higher for patients served by large hospital-based groups. No evidence of higher quality (McWilliams et al 2013)

So what? Bigger could be better, *continued*

- Recent evidence suggests cross-market mergers lead to higher hospital prices
  - Anecdotal
    - Community Tracking Study: *"Numerous participants in contract negotiations between health plans and hospitals noted that provider leverage depends on how big the hospital or hospital system is and how much of an insurer's patient volume it generates."*
  - Systematic
    - Hospitals joining systems with a member in same broad metro area raise price 4-7 percent (Cuellar and Gertler 2005)
    - Acquisition of indep hospitals by systems leads to higher prices even when other members are outside broad metro area (Lewis & Pflum 2014, 2015)
- But it is proceeding anyway

Why are cross-market mergers attracting little attention from antitrust enforcers?

- Clayton Act Sec 7 prohibits acquisitions where the effect "may be substantially to lessen competition, or to tend to create a monopoly"
- What to do about
  - Mergers that result in higher price due to greater ability to bear risk or improved bargaining skill
  - Mergers that result in higher spending due to changes in service mix
  - Mergers that enable exploitation of pre-existing market power
  - Mergers that bundle services in different patient and/or geographic markets

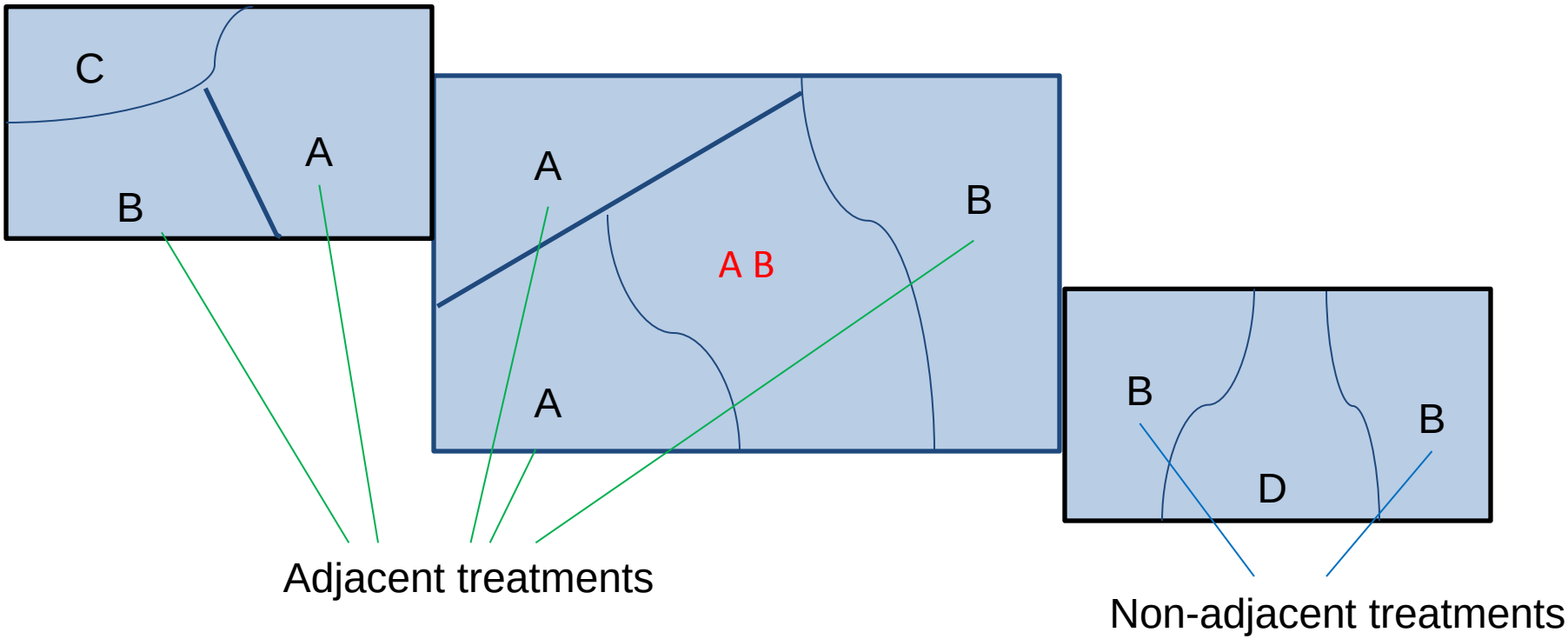
New research suggests enforcers might focus on a different market

- Focus to date: competition among hospitals for the same service
  - Under standard model only a merger of hospitals that compete for the same patients affects joint bargaining position and therefore the negotiated price with insurers
- Reality: customers purchase option to use a *bundle* of provider services from insurers
  - If same customer values both providers, the providers are substitutes vis a vis inclusion in the bundle
    - E.g. families who value both adult and pediatric hospitals
    - E.g. employer with employees in both relevant geo markets
- This **common customer effect** should be stronger for mergers in close proximity

Graphical depiction of new research design

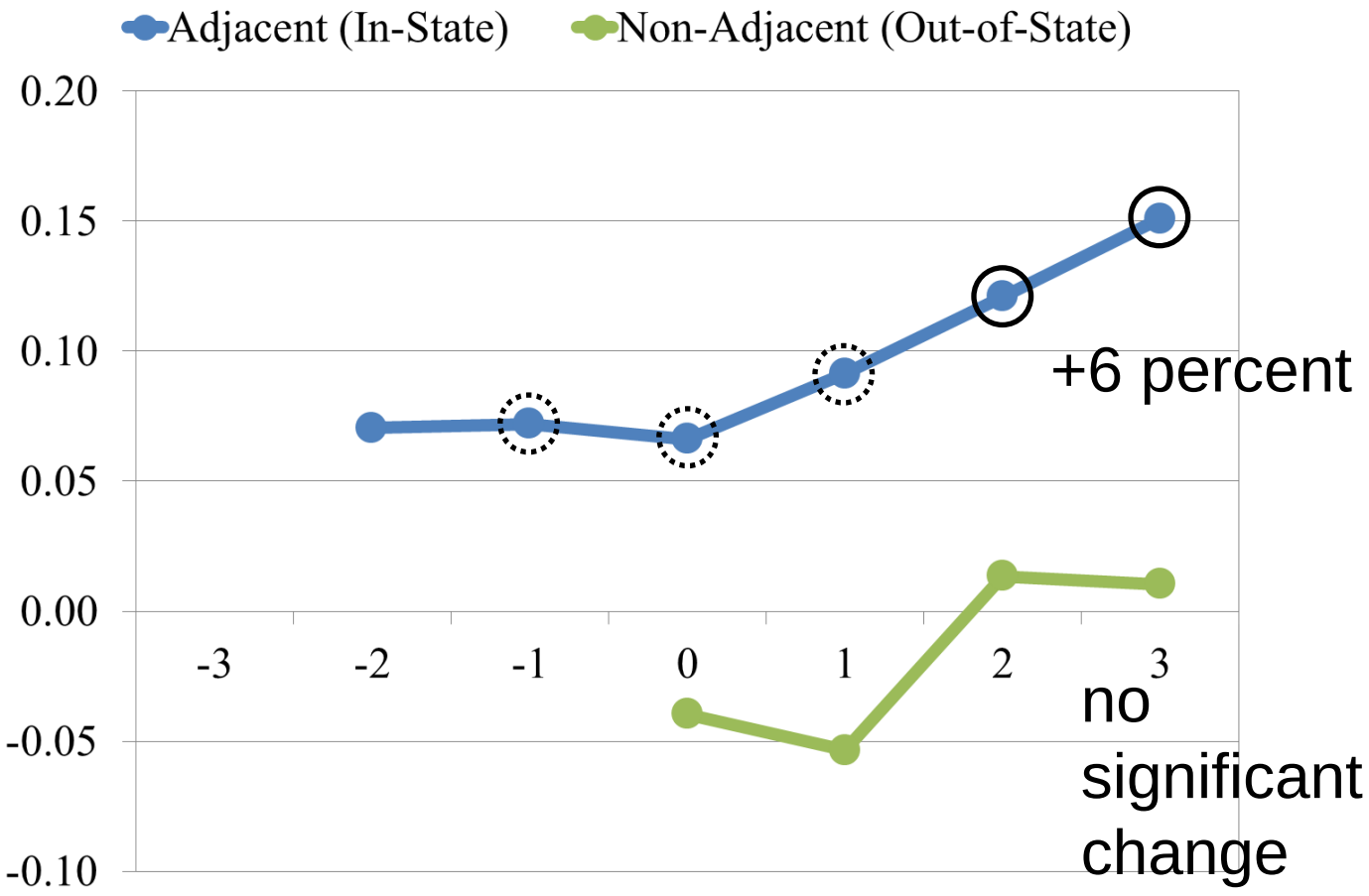
Consider two different types of "treatment hospitals"

Merger of System A and System B



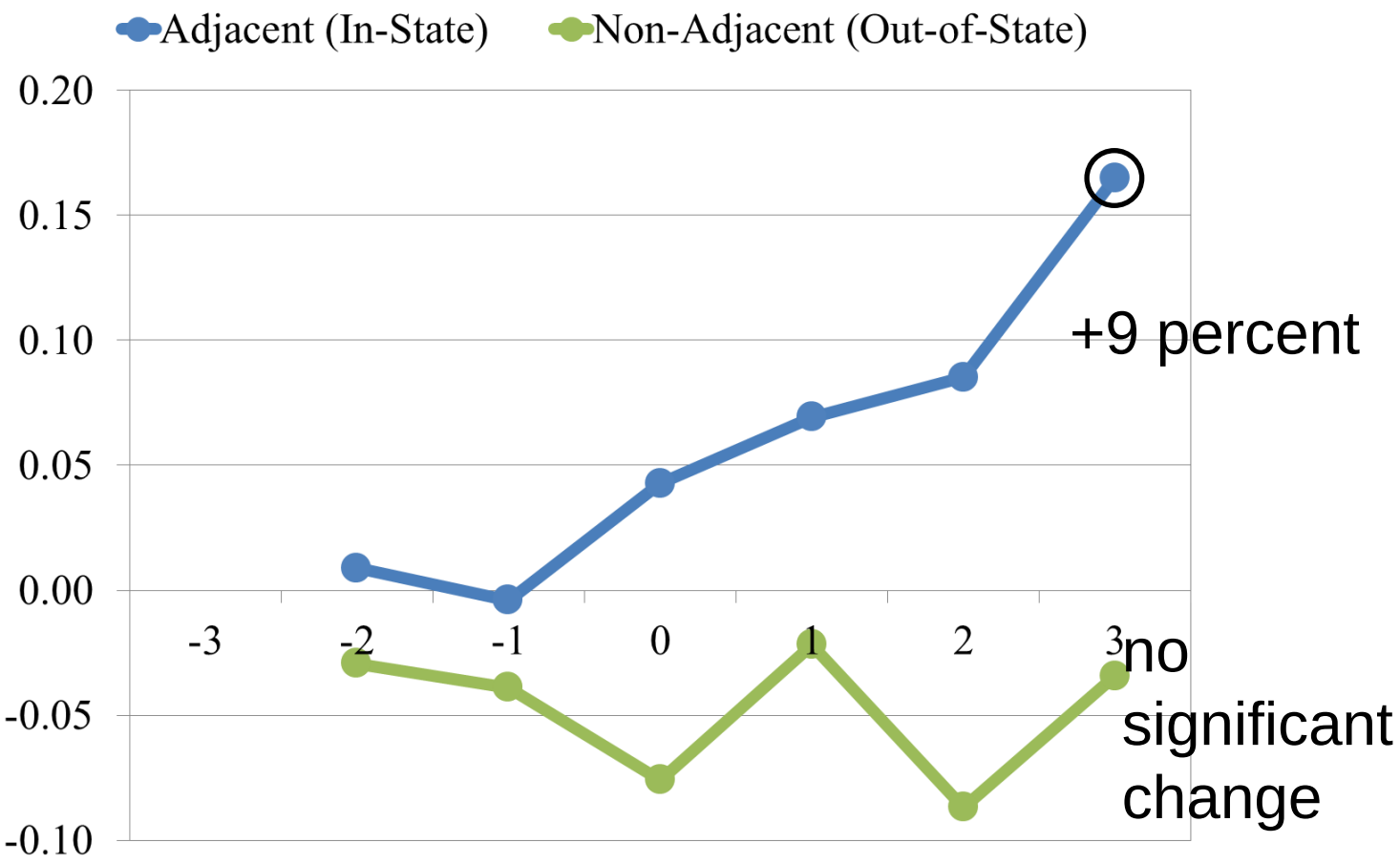
Notes: Each rectangle is a state; wavy lines signify within-state geo markets

Results: FTC Sample



p<0.05 p<0.01

Results: Broad Sample

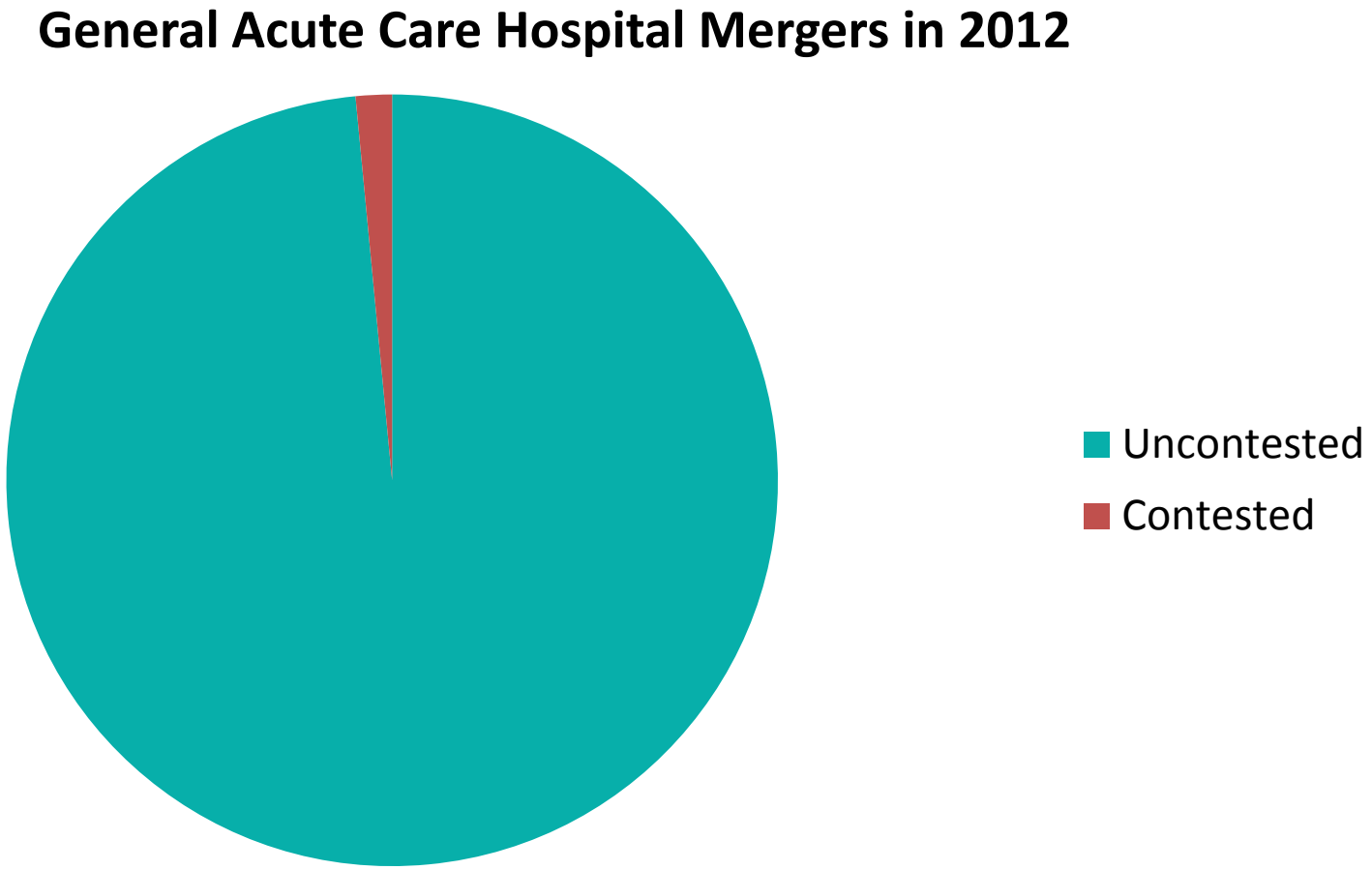


p<0.05 p<0.01

Cross-market mergers as potential target for antitrust enforcers

- New research suggests hospitals in different, nearby, markets can constrain one another's pricing because contracting with insurers occurs at broader geographic units than local hospital markets
- Enforcers may need to broaden criteria for deal investigations
  - But there must also be a limiting principle
  - And some of the estimated effect may be due to factors other than a "lessening of competition"

Myth #1: Antitrust enforcers block a lot of mergers



Myth #2: Antitrust enforcers will be able to ensure competitive markets

- Take a look around
- Antitrust agencies enforce the laws, and they are narrow
  - E.g. merger that facilitates exercise of pre-existing market power may not be construed as violation of Clayton Act
- They need evidence that something bad will happen, not evidence that something good is likely to happen
- They are saddled with legal precedents, including antiquated market definitions
- They avoid gray areas, and are deathly afraid of losing

→ We need industry leadership, and HPC-like entities to help

Myth #3: The ACA encourages provider consolidation

- Clinical integration $\not\rightarrow$ financial integration
- "We reject the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim [of the Shared Savings Program]."

  -Centers for Medicare and Medicaid Services, Final Rule,11/2011
- E.g., In recent merger case prosecuted by FTC, St. Luke's VP of Payer Relations, formerly of Advocate Health, testified that independent physicians could be financially incentivized to meet specific quality metrics
  - "Consolidation is not integration. Clinical integration requires meaningful data sharing, systems for effective handoffs, and streamlined care transitions. These processes can be achieved through other mechanisms," Tsai and Jha, *JAMA* 2014

- The ACA does not exempt organizations or collaborations from the antitrust laws

Myth #3: The ACA encourages provider consolidation, *continued*

- “In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment. But **the Clayton Act is in full force**, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment.”

  - St. Luke’s decision, Judge Winmill, 1/2014

- "I would prefer to reverse that order of events and instead consider any future proposed Partners' expansion only after Partners demonstrates an ability to contribute to health care cost containment in Massachusetts."

  – MA Attorney General Maura Healey, 1/2015

If traditional antitrust enforcement isn't enough, what can be done?

- Sunlight is the best disinfectant. Information can inspire alternatives to consolidation and/or mobilize opposition

- Regulation is an option
  - E.g., ban "facility based billing" for physicians recently/newly acquired by hospitals
  - Incentivize consumer choice of healthplans, e.g. via private or public exchanges

- Broader reading of antitrust laws may be possible

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Up Next: Panel Four
Provider Market Structure to Promote Value

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The HPC has tracked numerous changes to the Massachusetts provider market over the last two and a half years

Panel Four

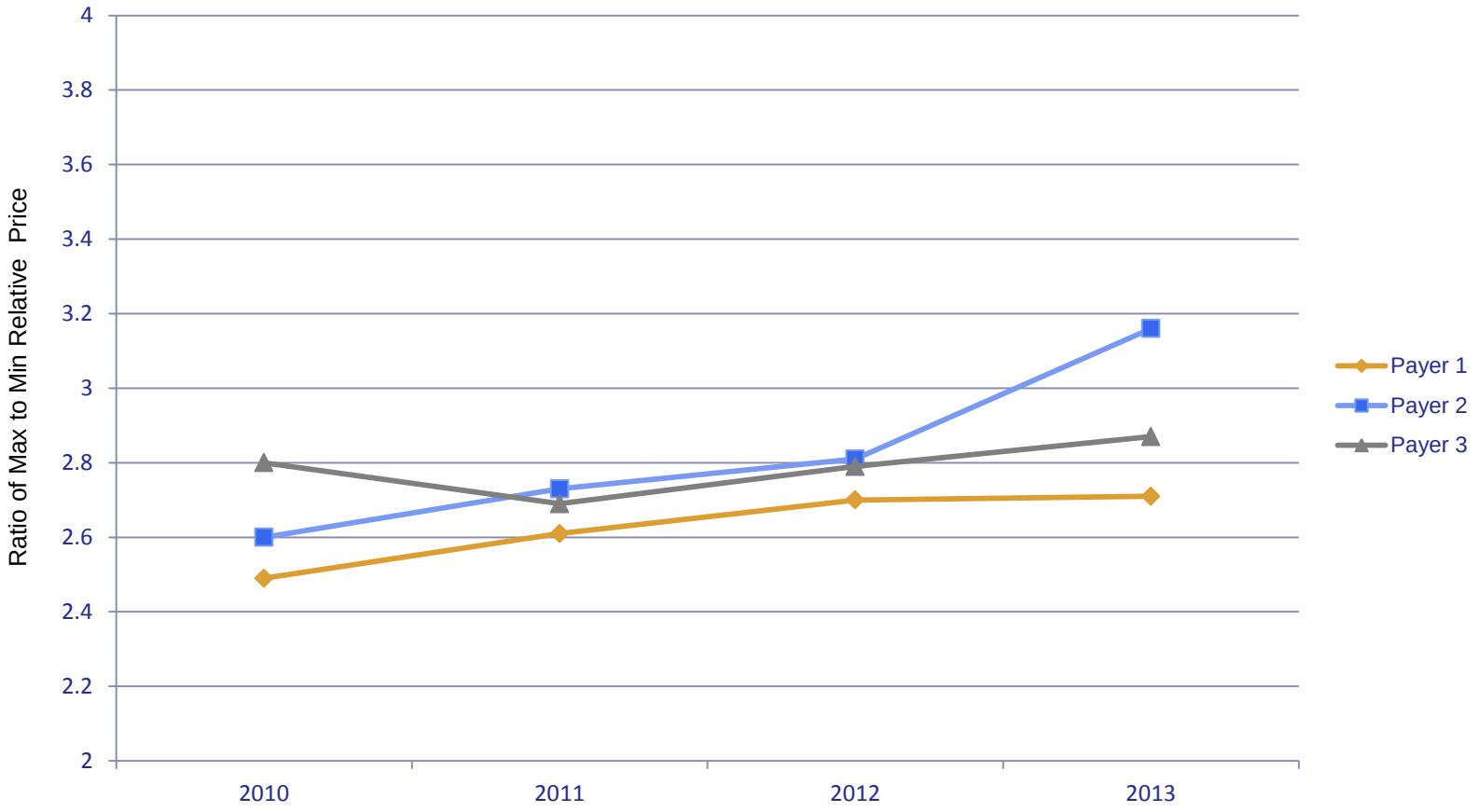
April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group merger, acquisition or network affiliation	12	26%
Clinical affiliation	10	21%
Acute hospital merger, acquisition or network affiliation	9	19%
Formation of a contracting entity	7	15%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	5	11%
Change in ownership or merger of corporately affiliated entities	3	6%
Affiliation between a provider and a carrier	1	2%

Across Top 3 commercial payers, extensive physician price variation persists

Panel Four

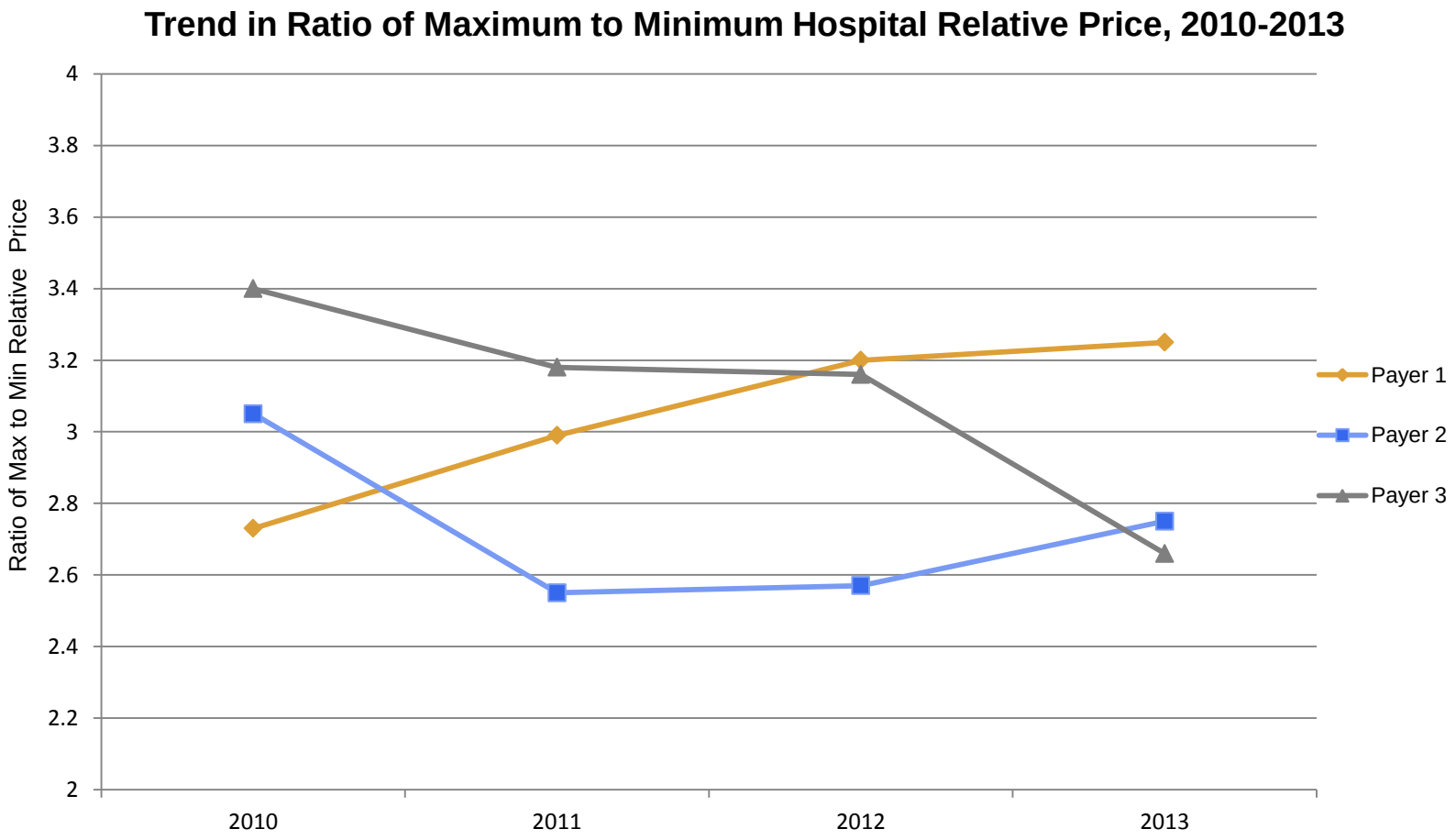
Trend in Ratio of Maximum to Minimum Physician Group Relative Price, 2009-2012



HPC analysis of CHIA relative price data for the three largest commercial payers

Across Top 3 commercial payers, extensive hospital price variation persists

Panel Four



HPC analysis of CHIA relative price data for the three largest commercial payers

HEALTH POLICY COMMISSION

Panel Four

PANELISTS

Mr. Jeffrey Hulburt, Interim President and CEO, Beth Israel Deaconess Care Organization
Ms. Dolores Mitchell, Executive Director, Group Insurance Commission
Dr. Howard Grant, President and CEO, Lahey Health
Dr. Michael Sheehy, Acting Chief Medical Officer, Reliant Medical Group
Dr. Eric Dickson, President and CEO, UMass Memorial Health Care

KEY FOCUS AREAS

1. Recent Changes to the Health Care Market
2. Provider Price Variation
3. Out-of-Network Charges
4. Facility Fees

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2015 HEALTH CARE COST TRENDS HEARING

Up Next: Panel Five
Transparency and Purchaser Incentives to Promote Value

#CTH15

Cost Transparency:
A Consumer Perspective

Amy Whitcomb Slemmer
Executive Director
Health Care For All

2015 Health Care Cost Trends Hearing

HEALTH CARE FOR ALL

Overview of Select Consumer Health Transparency Statutes

Requirements for CHIA

- Extensive specific requirements for consumer website

Requirements for Health Plans

Cost Sharing Toll-Free Number and Website

- All must offer a toll-free phone number and a website that allows consumers to obtain information on the estimated price for a proposed admission, procedure, or service.

Quality and Cost Information

- Health plans must fully disclose policies relating to in- and out-of-network cost sharing
- Health plans must make available current measures of providers' quality using the Standard Quality Measures Set.
- Health plans must make available relative provider prices and provider adjusted total medical expenses.
- Utilization review organizations must keep utilization review criteria on an easy-to-use public website. By October 1, 2015, health plans must do the same.

Requirements for Providers

- Must disclose the allowed amount of or charge for an admission, procedure, or service upon patient request.
- Must tell their insured patients about insurer's toll-free phone number/ website & give enough detailed information to use it.
- If referral made, relationship must be disclosed.

ACA Requirements

- Requires consumers have information on claims payment practices and claims denied, data on enrollment and disenrollment, and information on cost sharing and out of network coverage.
- Reporting includes measures that improve outcomes, prevent readmissions, reduce errors and promote health and wellness.

Sources: *Blue Cross Blue Shield of Massachusetts Foundation,* Summary of Chapter 224 of The Acts Of 2012
Kaiser Family Foundation, Health Insurance Transparency under the ACA

What Massachusetts consumers want:

- Information about health care costs
- Price and quality information that makes sense
- Relevant outcomes information
- Easy access for comparison shopping

Mass Insight, 2014

D. Schleifer,C.Hagelskamp and C. Rinehart, ***How Much Will It Cost? How Americans Use Prices In Health Care*** **(Public Agenda 2015)**

What consumers believe:

"…more care, newer care, and more costly care is **better care...**

- …high-quality care is necessarily expensive…
- low-cost care means needed care is being withheld, or is being provided by less competent professionals**.**

…In the absence of other usable signals of quality, consumers will rely on cost as a proxy."

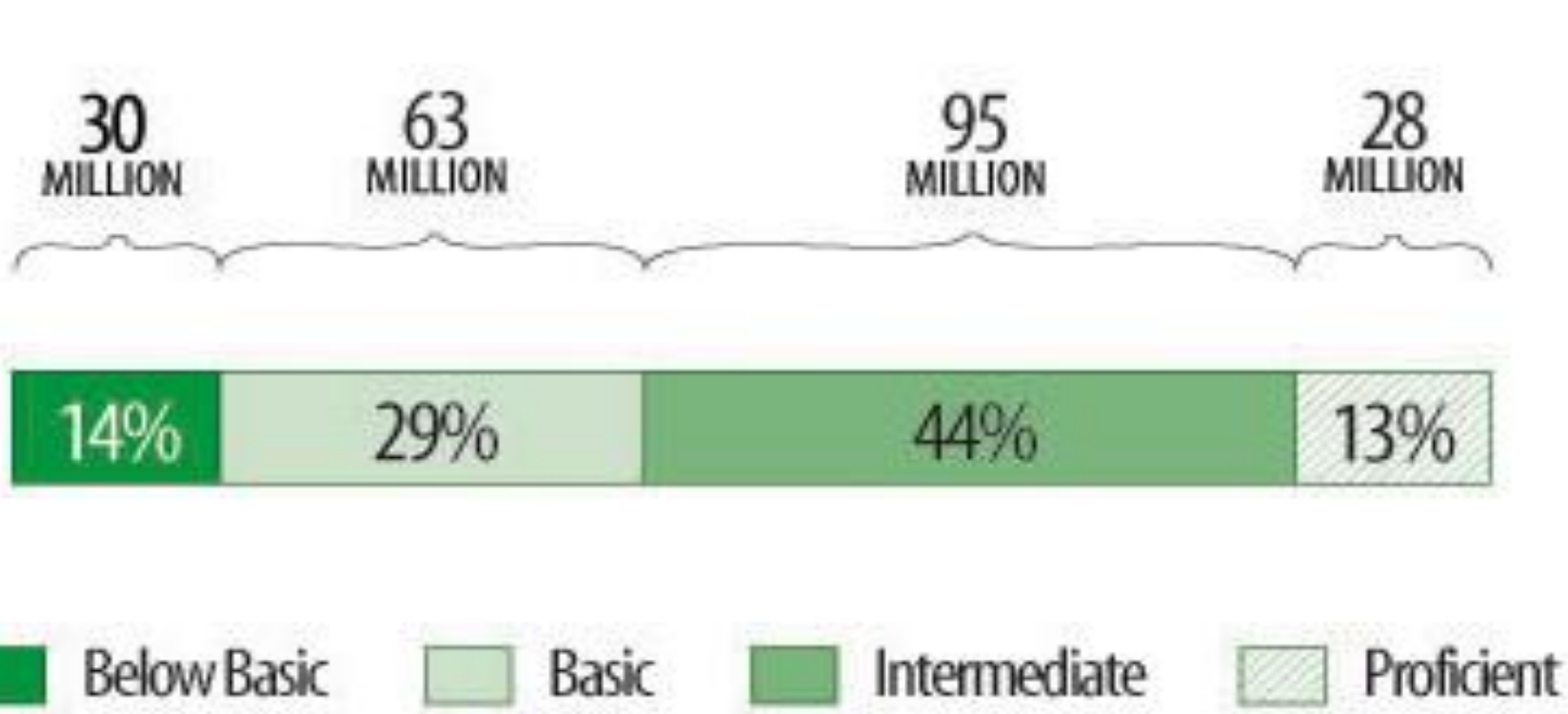
Consumers Union, Consumer Attitudes Towards Health Care Costs, Value and System Reforms: A Review of the Literature, October 2014

What consumers need:

- **Be aware** that the information exists
- **Know** how to interpret and use the information
- **Decide** that the information is valid and relevant
- **Use** the information to make choices

Hibbard JH and Sofaer S. Best Practices in Public Reporting –Learning Network tools. Rockville, MD: AHRQ Jun 2010. AHRQ Publication No. 10-0082-EF.

Impact on Use of Transparency Information: Low Health Literacy

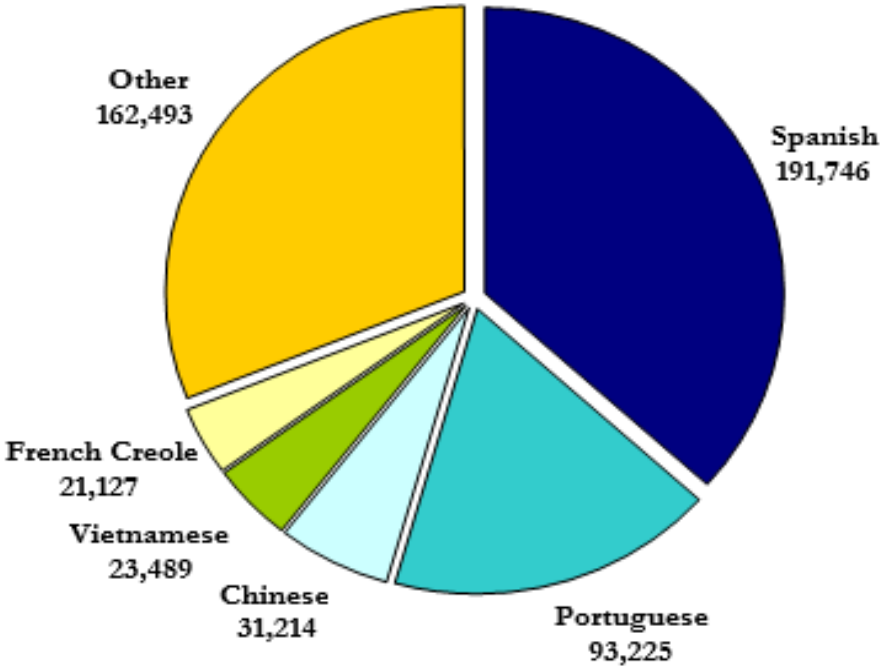


SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy

HEALTH CARE FOR ALL

Impact on Use of Transparency Information: Limited English Proficiency (LEP) in MA

Most Commonly Spoken Languages in Massachusetts LEP Population



Total Population 5 Years and Over: 6,087,734

Spoke Only English at Home: 4,841,697

Spoke a Language Other than English at Home: 1,246,037

Limited English Proficient Population (Spoke English Less than 'Very Well'): 523,294

Source: U.S. Census, American Community Survey, Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for the United States, April 2010 (Complete data included in virtual handout at masslegalservices.org)

Consumer cost transparency report card

A consumer-focused comparative assessment of the cost estimator tools of three leading Massachusetts health insurers

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Areas Evaluated

- Aid in Decision-Making
- Accessibility
- Comprehensiveness

WHAT IS YOUR
Health Literacy IQ?

AID IN DECISION-MAKING

	Blue Cross Blue Shield Massachusetts	Harvard Pilgrim Health Care	Tufts Health Plan
Can compare costs of multiple providers on one screen	**B** Compares overall procedure cost but not cost to patient.	**A**	**A**
Differentiation between total and out-of-pocket cost to consumer	**C** Shows the amount remaining in out-of-pocket maximum but not the estimated out-of-pocket cost.[1]	**A** Shows an equation of estimated price, price the plan pays, and remaining price the member pays.	**A** Shows an equation of estimated price, price the plan pays, and remaining price the member pays.
Costs totaled and presented in units meaningful to consumer (i.e. episodic, illness-based)	**D** Does not show estimated out-of-pocket cost.	**B** Provides an average annual cost of care for specific conditions, but unclear if medication costs are included.	**B** Provides an average annual cost of care for specific conditions, but unclear if medication costs are included.
Availability and presentation of provider quality information	**B** Quality information (CMS Hospital Compare) is available for hospitals; patient experience data available for some providers.	**C** Quality information (US HHS, Jan 2014) is available for hospitals only. Individual provider award is shown in some cases.	**C** Quality information (US HHS, Jan 2014) is available for hospitals only. Quality information shown is sometimes for a different procedure.
Can compare quality of multiple providers on one screen	**A** When quality information is available, it is shown using a star system.	**B** For hospitals, icons for quality are provided but a legend is not provided. For providers, awards received are listed.	**B** For hospitals, icons for quality are provided but a legend is not provided. For providers, awards received are listed.
Inclusion information about providers for decision-making (e.g., taking new patients, language spoken)	**A**	**B** Lists accepting new patients, specialties, and hospital affiliations. Does not list languages spoken or years in practice.	**B** Lists accepting new patients, specialties, and hospital affiliations. Does not list languages spoken or years in practice.
Members report of how likely they are to use the tool (1:Very unlikely - 5:Very likely)	**D** *Next time any health care is needed*: 1.7 *When a procedure is needed*: 2 *When choosing a provider*: 2	**B** *Next time any health care is needed*: 4 *When a procedure is needed*: 3.7 *When choosing a provider*: 3.7	**C** *Next time any health care is needed*: 2.6 *When a procedure is needed*: 3 *When choosing a provider*: 2.8
System Usability Score[2] (68 is average score for any system)	**D** 30.9	**C** 52	**B** 67.1
AVERAGE GRADE FOR THIS MEASURE	C	B-	B-

ACCESSIBILITY

	Blue Cross Blue Shield of Massachusetts	Harvard Pilgrim Health Care	Tufts Health Plan
Reference to the tool on pages of the home health plan website	**B** Listed in box titled "Find a Doctor" on home page, and in Cost & Quality Tools page.	**B** On public "For Members" page under "Cost & Quality" subheading (below the fold) is a link to public "Now iKnow" tool info page.	**B** Sub-item of "mytuftshealthplan.com" box (above the fold) is "EmpowerMe: Treatment Cost Estimator"
Clearly labeled link to tool on member portal homepage	**A** Listed under "I want to..." menu on member portal homepage	**A** Under first subheading "My Plan" is a link to the "Now iKnow" tool. Link is highlighted with "New" label.	**B** Listed under "What's New" (but link does not access tool) and under "Decision Tools" sidebars on member portal homepage
Accessibility on mobile devices	**B** Viewable but not fully optimized.	**A**	**A**
Member rating of how easy it was to find the tool	**B** Average rating of 3.9 (*"Neither difficult nor easy"*).	**C** Average rating of 3.0 (*"Somewhat difficult"*).	**A** Average rating of 4.5 (*"Somewhat easy"*).
Availability in other languages	**C** Only presented in English. Some elements display in Google translate.	**D** Only presented in English and does not display in Google translate.	**D** Only presented in English and does not display in Google translate.
Accessibility for users with disabilities	**D** Text is not resizable in browser. Tab navigation is not fully functional.	**C** Text is not resizable in browser. Can navigate using tabs.	**C** Text is not resizable in browser. Can navigate using tabs.
AVERAGE GRADE FOR THIS MEASURE	C	C	C+

HEALTH CARE FOR ALL

COMPREHENSIVENESS

Availability of cost information for:	Blue Cross Blue Shield of Massachusetts	Harvard Pilgrim Health Care	Tufts Health Plan
Both inpatient and outpatient services	**B** Inpatient procedures available, but not searchable with general names (i.e. "heart surgery" has no results).	**D** Cost information not available for inpatient procedures.	**D** Cost information not available for inpatient procedures.
Behavioral health services	**D** Not found.	**D** Providers listed but does not show costs.	**A** Yes, psychotherapy with behavior management.
Prescription drugs	**D** Not found.	**D** Not found.	**D** Not found.
AVERAGE GRADE FOR THIS MEASURE	D	D	C-

Health Care For All

Transparency Efforts Must:

- Raise awareness
- Be relevant
- Empower consumers to be engaged in treatment decision making
- Change behavior

D. Schleifer,C.Hagelskamp and C. Rinehart, ***How Much Will It Cost? How Americans Use Prices In Health Care*** **(Public Agenda 2015)**

Moving Forward

- Almost everyone has health coverage
- MA trying to lead on delivery reform
- Opportunity to engage consumers and support decision-making around quality of care
- The Commonwealth can be **the national trend-setter** to better inform the public about how to choose cost-effective care

HEALTH CARE FOR ALL

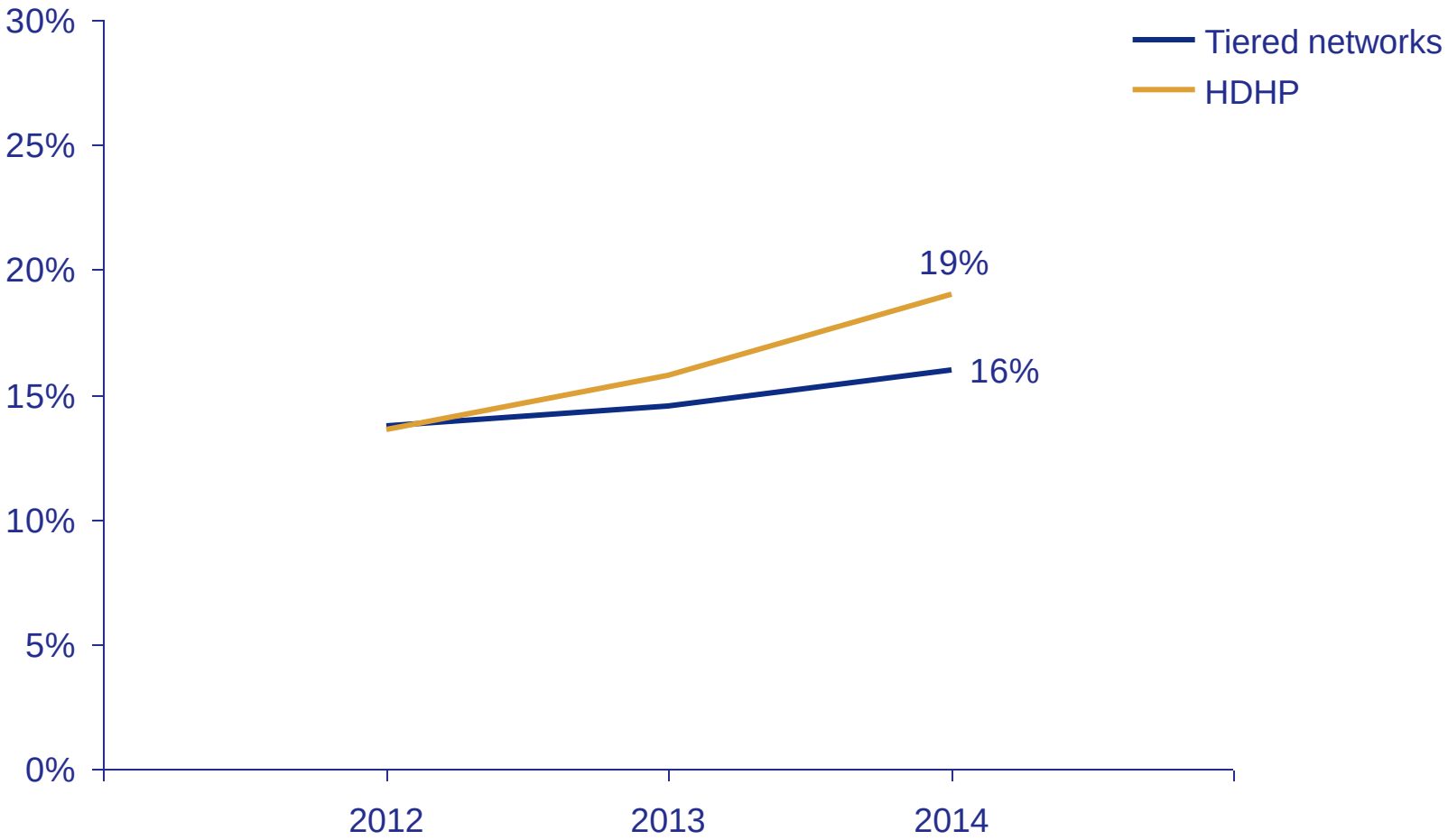
HPC Selected Findings:

High deductible health plans have overtaken tiered network products in popularity

Panel Five

Uptake of Tiered Network Products and High Deductible Health Plans

Proportion of insured individuals who have either tiered network products or high deductible health plans, 2010-2014



CHIA Annual Report, 2015

The top three commercial payers price transparency tools with basic elements

Panel Five

Components of each payer's price transparency tool

Checklist of components of each payer's price transparency tool, 2015

	Prices are provided for the following services					Other Information Provided		
	Diagnostics	Outpatient visits	Inpatient visits	Medical office visits	Behavioral health visits	Provides quality measures	Reflects actual provider contracted rates	Reflects benefits and deductible status
BCBS	✓	✓	✓	✓	✓	✓	✓	✓
HPHC	✓	✓	✓	✓	✓	✓	✓	✓
THP	✓	✓	X	✓	✓	✓	✓	✓
Cigna	✓	✓	✓	✓	X	✓	✓	✓
Aetna	✓	✓	✓	✓	X	✓	✓	✓
Fallon	✓	✓	✓	X	X	X	✓	✓
Health New England	✓	✓	✓	✓	X	X	✓	✓

Data gathered from pre-file testimony from BCBS, HPHC, THP, Cigna, Aetna, Fallon, Health New England

Top ten inquiries for the commonwealth commercial payers

Panel Five

Top ten inquiries for all the commercial payers, 2014

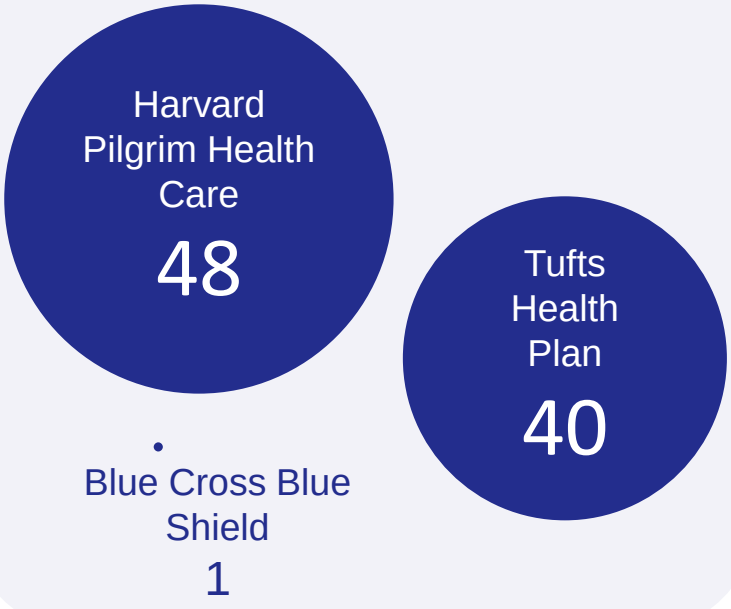
Top ten searches within each payer's price transparency tool, 2014

Top inquiries
MRI
Colonoscopy
Lab Tests
Pregnancy
Primary care for adults
Obstetrics and Gynecology
Mammogram
Dermatologist
Orthopedic surgeon
Physical Therapy

<50

the top three commercial payers lag in price inquiries

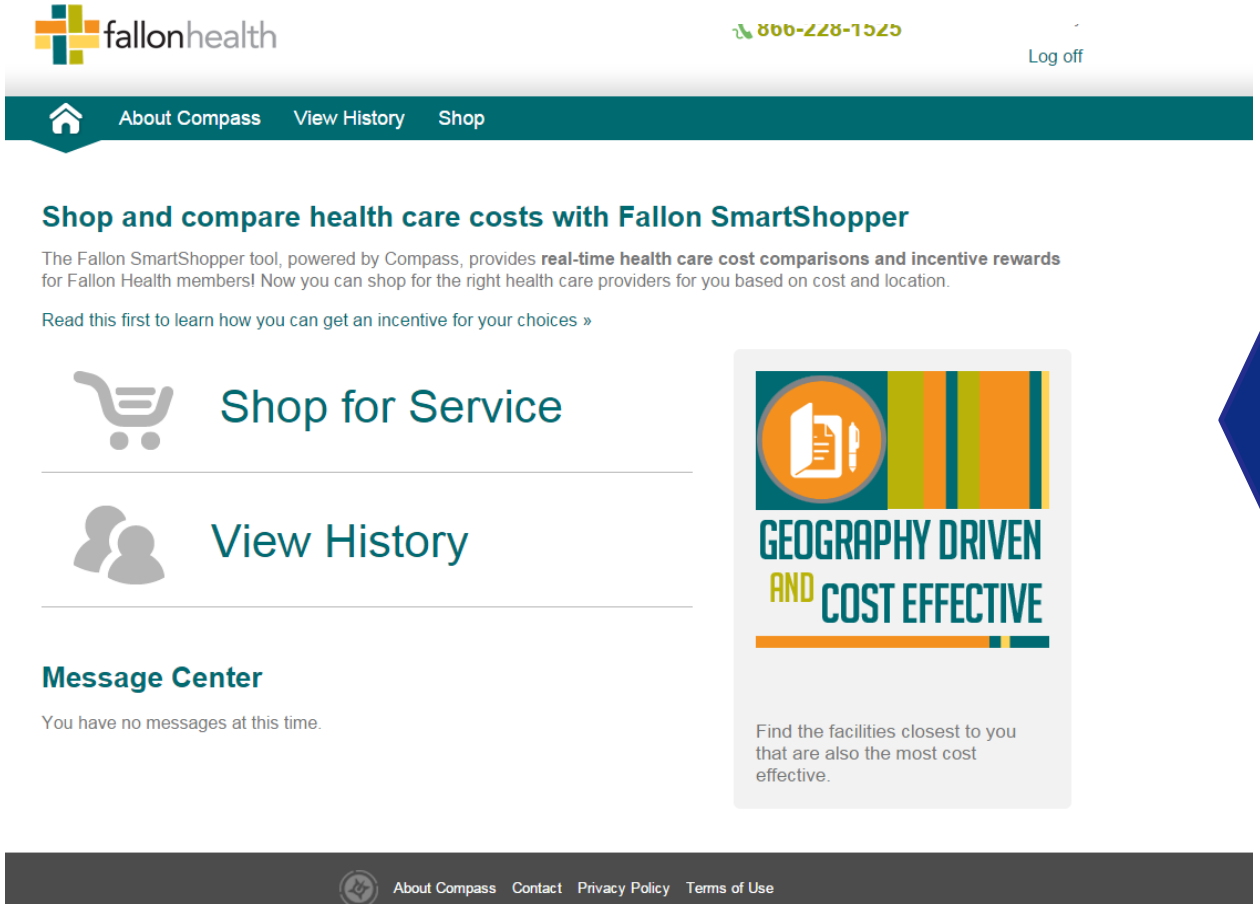
Data per 1,000 members



Data gathered from pre-filed testimony from BCBS, HPHC, and THP

Fallon's Smart Shopper Tool gives consumers an option of three tiers for a variety of services and procedures

Panel Five



If a consumer uses the Smart Shopper tool, they can receive a direct payment of between $25 and $500 depending on the service for choosing a high-value provider

Gives consumers an option of three tiers for a variety of services and procedures

If a consumer uses the Smart Shopper tool, they can receive a direct payment of between $25 and $500 depending on the service for choosing a high-value provider

A sample of consumer rewards under Fallon's Smart Shopper Tool shows that services and rewards vary based on the tier the provider has chosen.

Panel Five

Service or procedure	$$$	$$	$
Bariatric surgery (lap band)	$250	$100	$50
Bariatric surgery – laparoscopic gastric bypass	$500	$250	N/A
Bone density study	$50	$25	N/A
Bone imaging	$50	$25	N/A
Cardiac echocardiogram	$75	$50	$25
Carpal tunnel	$250	$100	$50
Cataract removal	$250	$100	$50
Colonoscopy	$150	$75	$50

$$$ largest incentive level
$$ middle incentive level
$ smallest incentive level

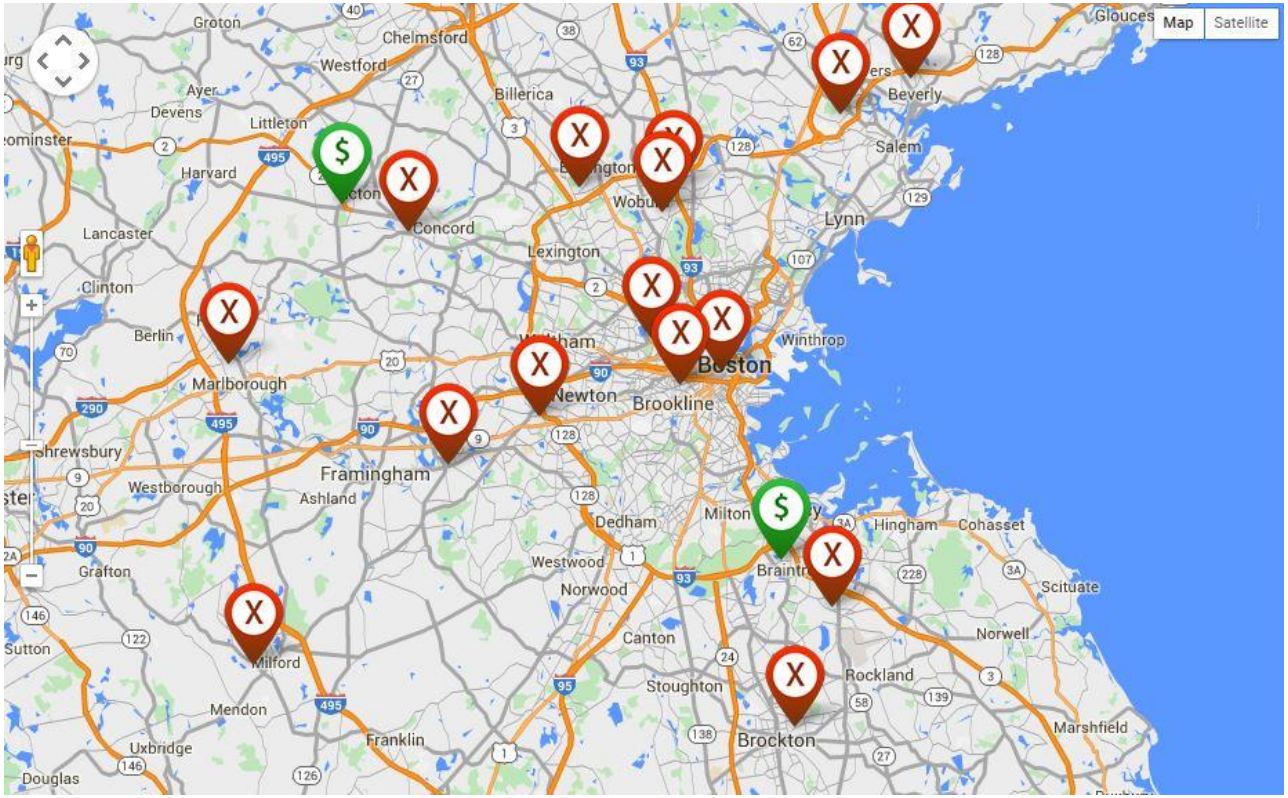
From Fallon's website: http://www.fchp.org/members/benefits-coverage/costs/smartshopper.aspx
Accessed: 9/29/15

There are 17 providers that offer a colonoscopy, consumers are financially incentivized to pick two of them

Panel Five

Map of providers for whom consumers offered incentives who offer a colonoscopy

Providers who offer a colonoscopy within the Metro Boston Area, $ is a provider that offers a cash reward for usage.



https://fallon.vitalssmartshopper.com/Login?ReturnUrl=%2F

Accessed: 9/30/15

Health Policy Commission received a $300K grant from the Robert Wood Johnson Foundation to identify effective incentives and policies to empower consumers and employers to lower health care costs

Overview of Grant

- HPC received **$298,417 grant** from the **Robert Wood Johnson Foundation** to study consumer perceptions of value over the next year; grant runs from October 2015 – September 2016
- Research will be conducted in close partnership with **Dr. Amy Lischko and Dr. Susan Koch-Weser** from Tufts University School of Medicine
- Grant will focus on understanding consumer perspective of value and how varied benefit designs and non-financial levers influence consumer decisions of setting of care
- Research will focus on community health systems versus academically affiliated systems for common, “shoppable” conditions such as births and uncomplicated joint replacements
- Will inform **benefit design** (e.g., narrow networks, tiered networks, etc.), employer **choice of health plans and incentives** (e.g., cash-back programs t), and **transparency** initiatives designed to support consumers in making value-based decisions.

Grant Supported by a Range of Stakeholders

Health Care For All

RAM

aim Associated Industries of Massachusetts 100 YRS

Tufts University School of Medicine

Commonwealth of Massachusetts Group Insurance Commission
Your Benefits Connection

Panel Five

PANELISTS

Mr. David Przesiek, Senior Vice President and Chief Sales Officer, Fallon Health Plan
Ms. Amy Whitcomb Slemmer, Executive Director, Health Care For All
Mr. David Shore, President, Massachusetts Association of Health Underwriters
Ms. Patricia Begrowicz, Owner, Onyx Specialty Papers, Inc.
Mr. John Jordan, Executive Vice President of Health Plans, Vitals

KEY FOCUS AREAS

1. Price Transparency Tools
2. Innovative Product Design
3. Engaging Employers and Employees

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

2015 HEALTH CARE COST TRENDS HEARING

Up Next: Panel Six
Meeting the Benchmark in 2015 and Beyond

#CTH15

Questions and Themes from the 2015 Cost Trends Hearing

Panel Six

Top Four Questions from the Hearing

1. What is the cost benefit of population health management? How do we measure effectiveness? At what pace should expect to see reductions in total medical expenses?
2. How should the state/market address persistent provider price variation?
3. How can we extend effective alternative payment methodologies?
4. How do we ensure that efficiency gains are passed along to consumers/purchasers?

Top Themes from the Hearing

- Pharmaceutical spending and the cost of innovation
- Need for greater transparency for consumers and policy-makers
- Behavioral health underpayment and lack of capacity
- Opportunity through team-based care models to address high-cost, high-risk patients
- Addressing ED utilization through expanded access (retail clinics, urgent care, after hours
- Demonstrating efficiencies from mergers and acquisitions
- Supporting consumer/employer decisions when selecting a health plan point or at point of service
- Payer/provider integration to allow for investments in technology and infrastructure

COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Panel Six

PANELISTS

Dr. Steven Strongwater, CEO, Atrius Health
Dr. Kevin Tabb, President and CEO, Beth Israel Deaconess Medical Center
Mr. Eric Schultz, President and CEO, Harvard Pilgrim Health Plan
Dr. David Torchiana, President and CEO, Partners HealthCare System
Ms. Ellen Zane
Chair, Wellforce; Vice Chair, Tufts Medical Center and Floating Hospital for Children; Chair, Minuteman Health

KEY FOCUS AREAS

1. Reflecting on Hearing Themes
2. Meeting the Goals of Chapter 224 Moving Forward