2019 HEALTH CARE COST TRENDS HEARING

OCTOBER 22

MASSACHUSETTS
HEALTH POLICY COMMISSION

#CTH19

2019 HEALTH CARE COST TRENDS HEARING

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Up Next

Presentation: Performance of the Massachusetts Health Care System
Mr. Ray Campbell, Executive Director
Center for Health Information and Analysis

Performance of the Massachusetts Health Care System

Annual Report
October 2019

CENTER FOR HEALTH INFORMATION AND ANALYSIS

CHIA.

Agenda

- Overview
- Total Health Care Expenditures
- Medicare Trends
- MassHealth Trends
- Private Commercial Insurance Trends

Overview

- Role of CHIA's *Annual Report*
- Publication Package
  - Executive Summary + Chartbook
  - Datasets
  - Technical Documentation
- Acknowledgements
  - Data submitters
  - CHIA's staff & actuaries

Total Health Care Expenditures (THCE)

$60.9B — Total Health Care Expenditures, 2018

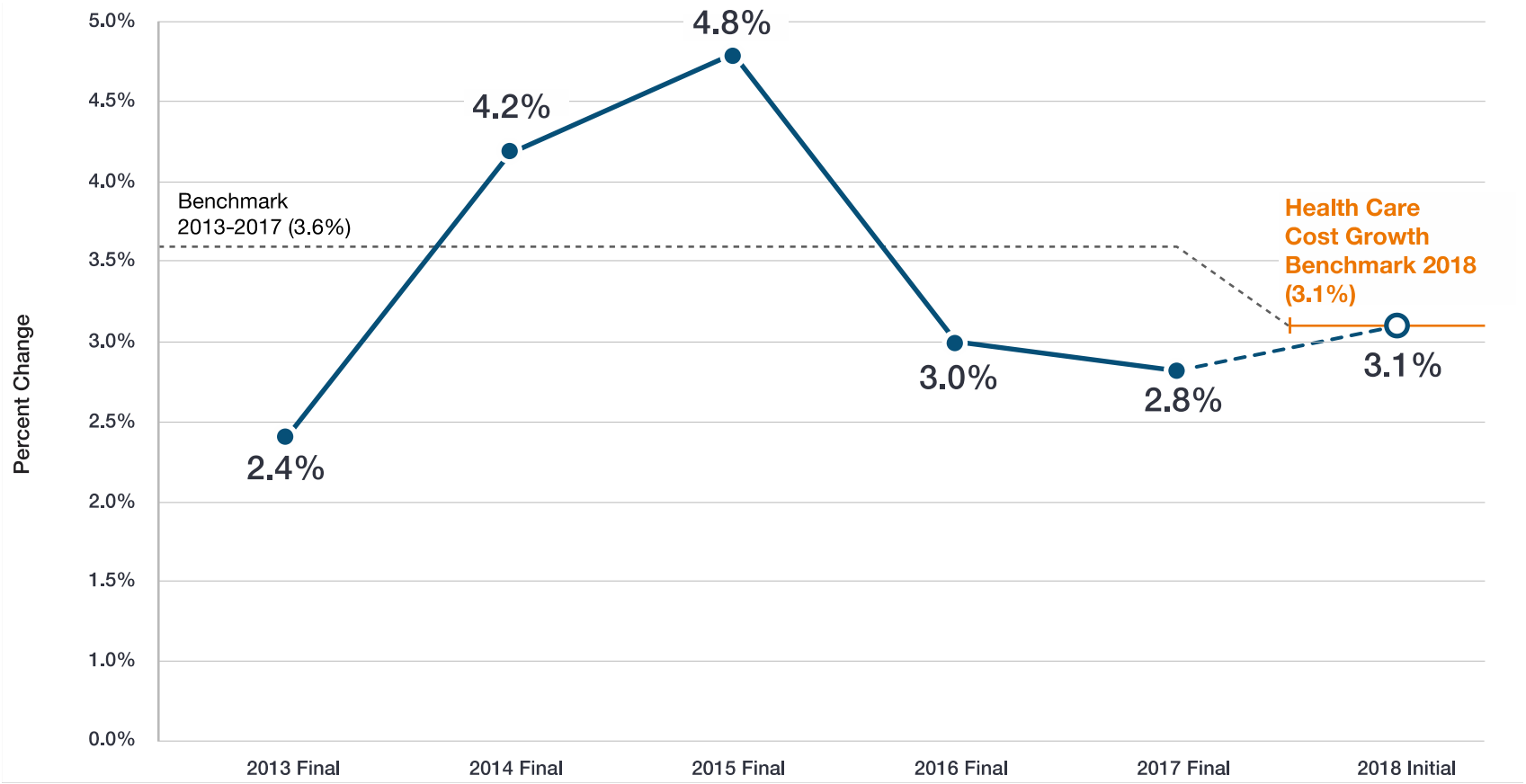
$8,827 — THCE per capita, 2018

3.1% — Growth rate per capita, 2018

For more information, see page 10 of CHIA's *Annual Report*

Total Health Care Expenditures

Trends, 2013-2018

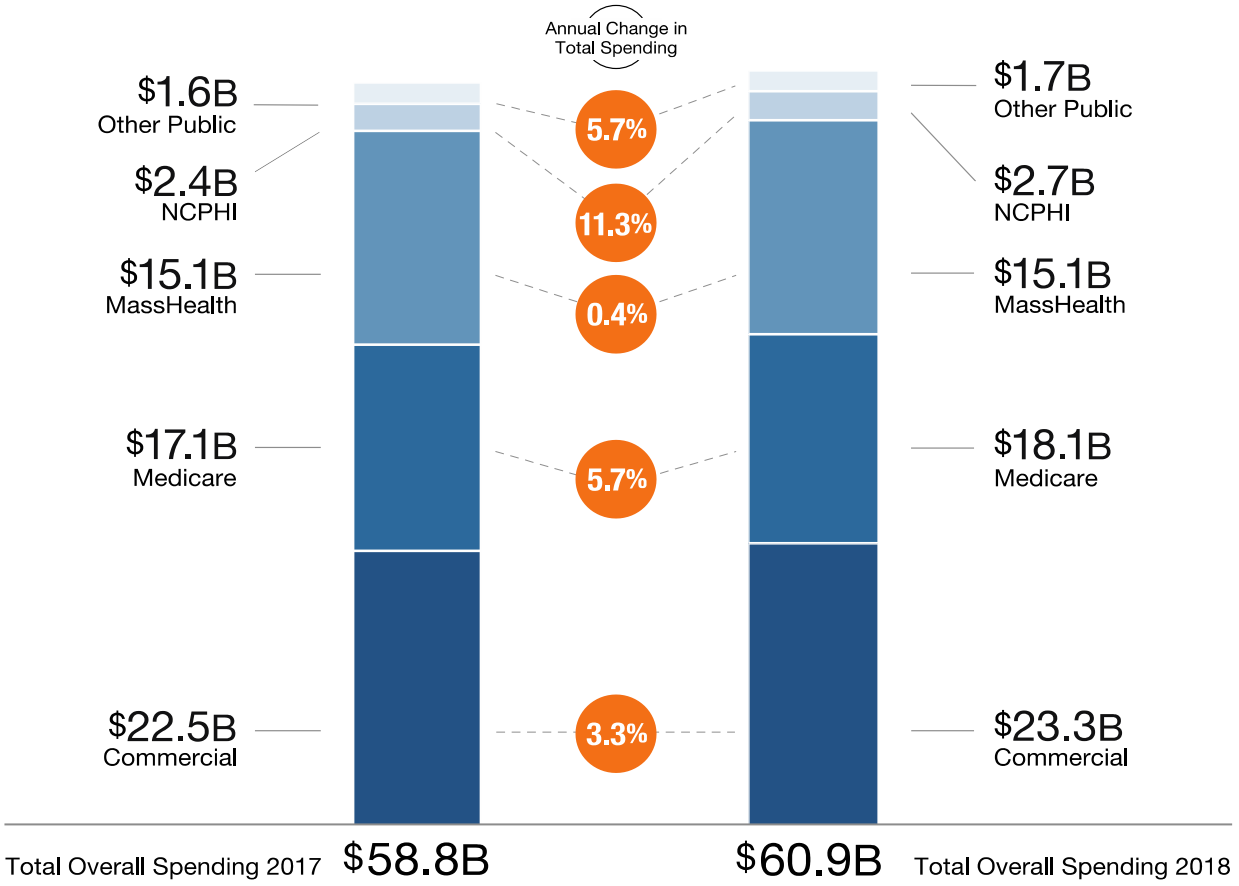


THCE growth per capita equaled the health care cost growth benchmark in 2018, after two years of trending below.

For more information, see page 21 of CHIA's *Annual Report*

Total Health Care Expenditures

Components, 2018

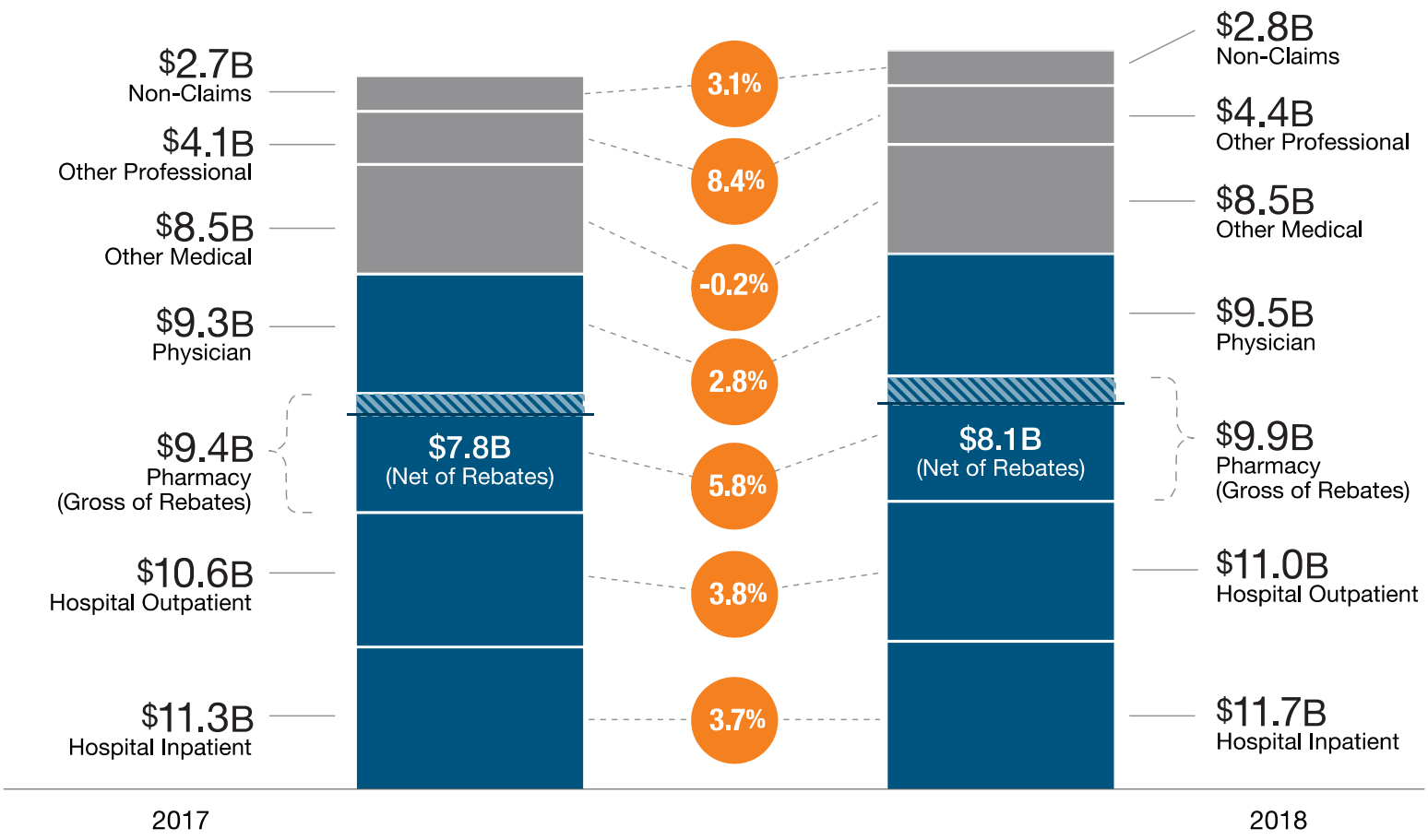


Medicare expenditures grew fastest among the largest components of THCE, though all other categories also accelerated from 2017, except for MassHealth.

For more information, see page 11 of CHIA's *Annual Report*

Total Health Care Expenditures

Spending by Service Category, 2017- 2018



After slower growth in 2017, expenditures accelerated across all service categories, with the exception of hospital outpatient expenses and non-claims.

For more information, see page 17 of CHIA's *Annual Report*

Total Health Care Expenditure Components

Medicare

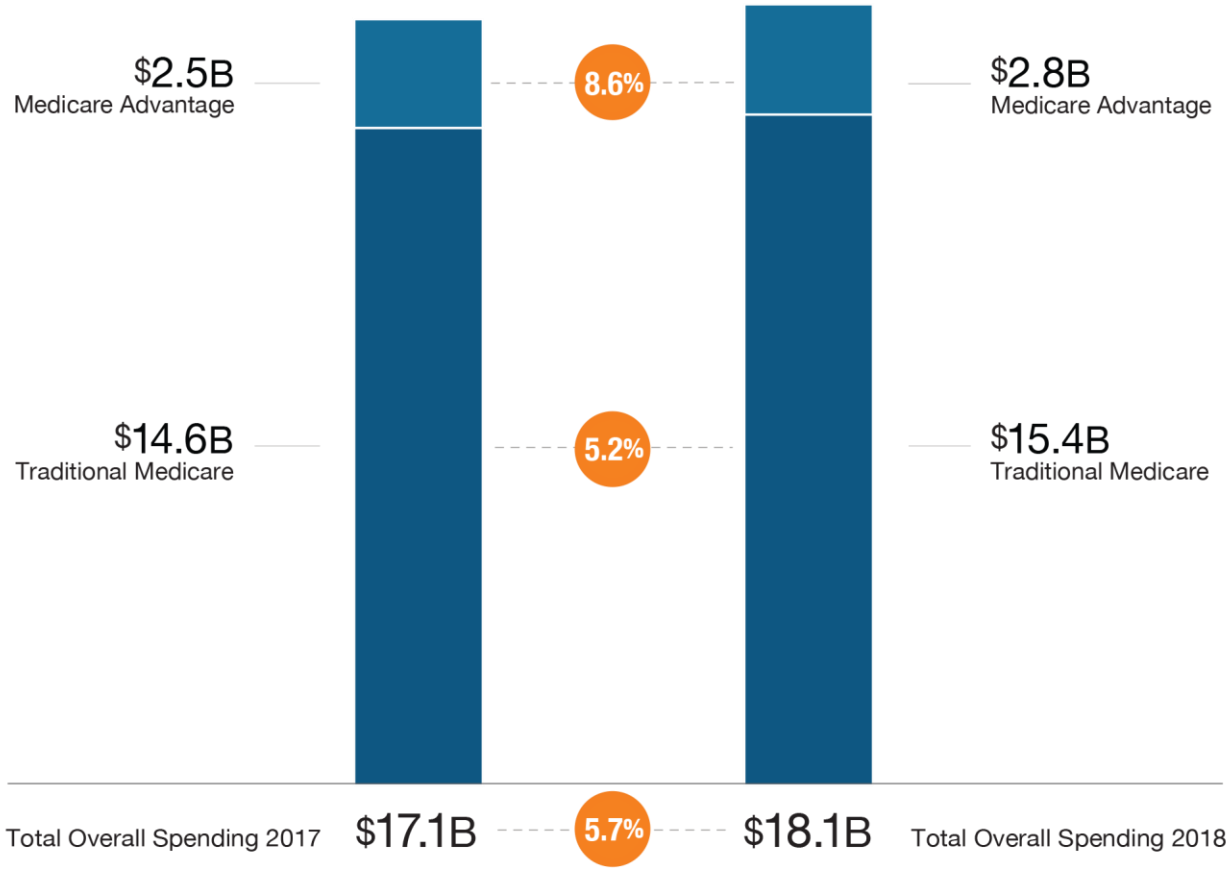
$18.1B Expenditures, 2018

5.7% Expenditures, 2017-2018

2.6% Beneficiaries, 2017-2018

Medicare

Spending by Program, 2017-2018



Expenditures grew faster for Medicare Advantage beneficiaries than traditional Medicare, in part due to increasing enrollment.

For more information, see page 13 of CHIA's *Annual Report*

Total Health Care Expenditure Components

MassHealth

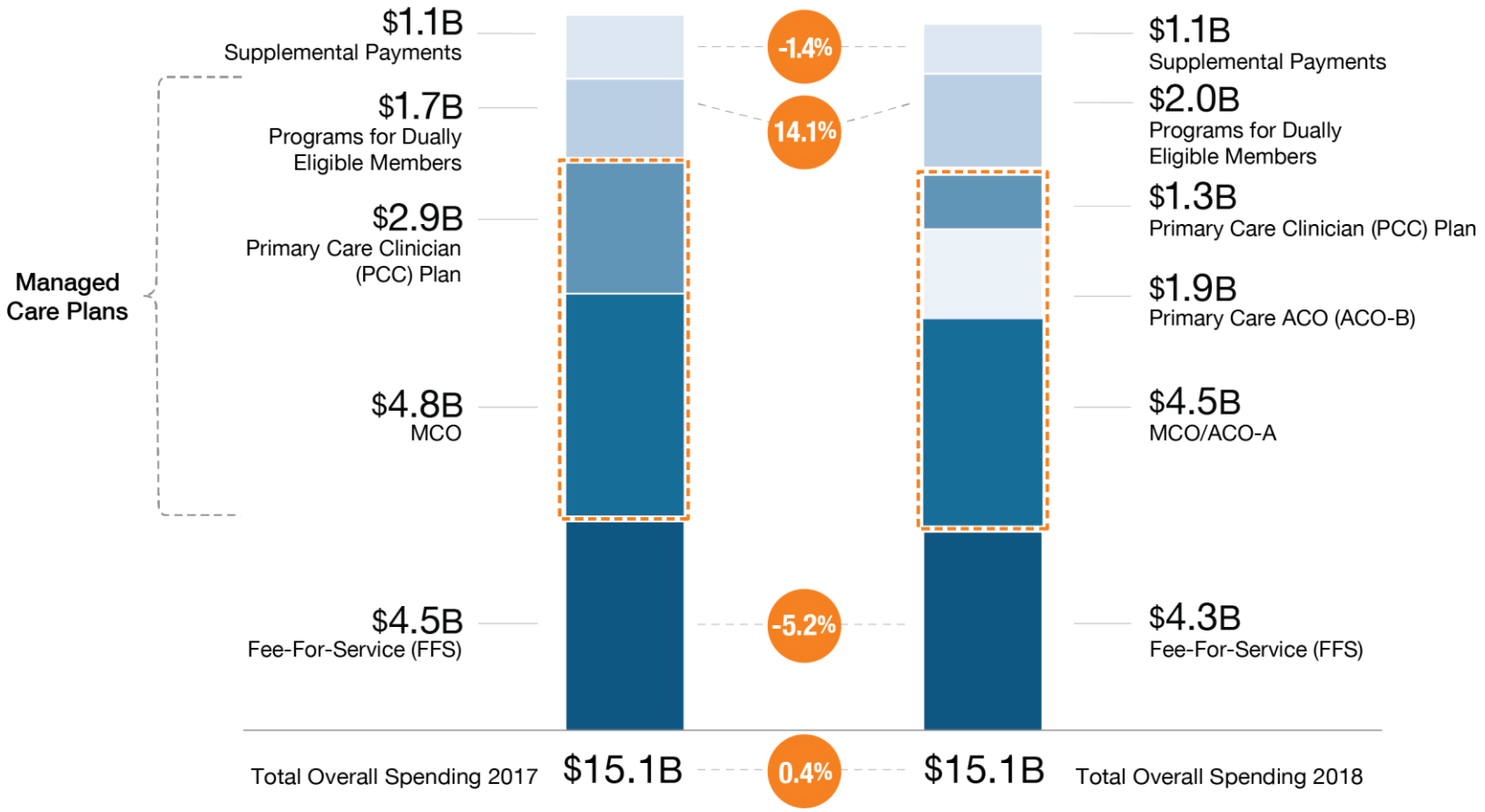
$15.1B Expenditures, 2018

0.4% Expenditures, 2017-2018

-4.4% Members, 2017-2018

MassHealth

Spending by Program, 2017-2018



2018 marked a transition year for MassHealth, as members shifted to new accountable care organizations.

For more information, see page 14 of CHIA's *Annual Report*

Commercial Insurance

$23.3B Expenditures, 2018

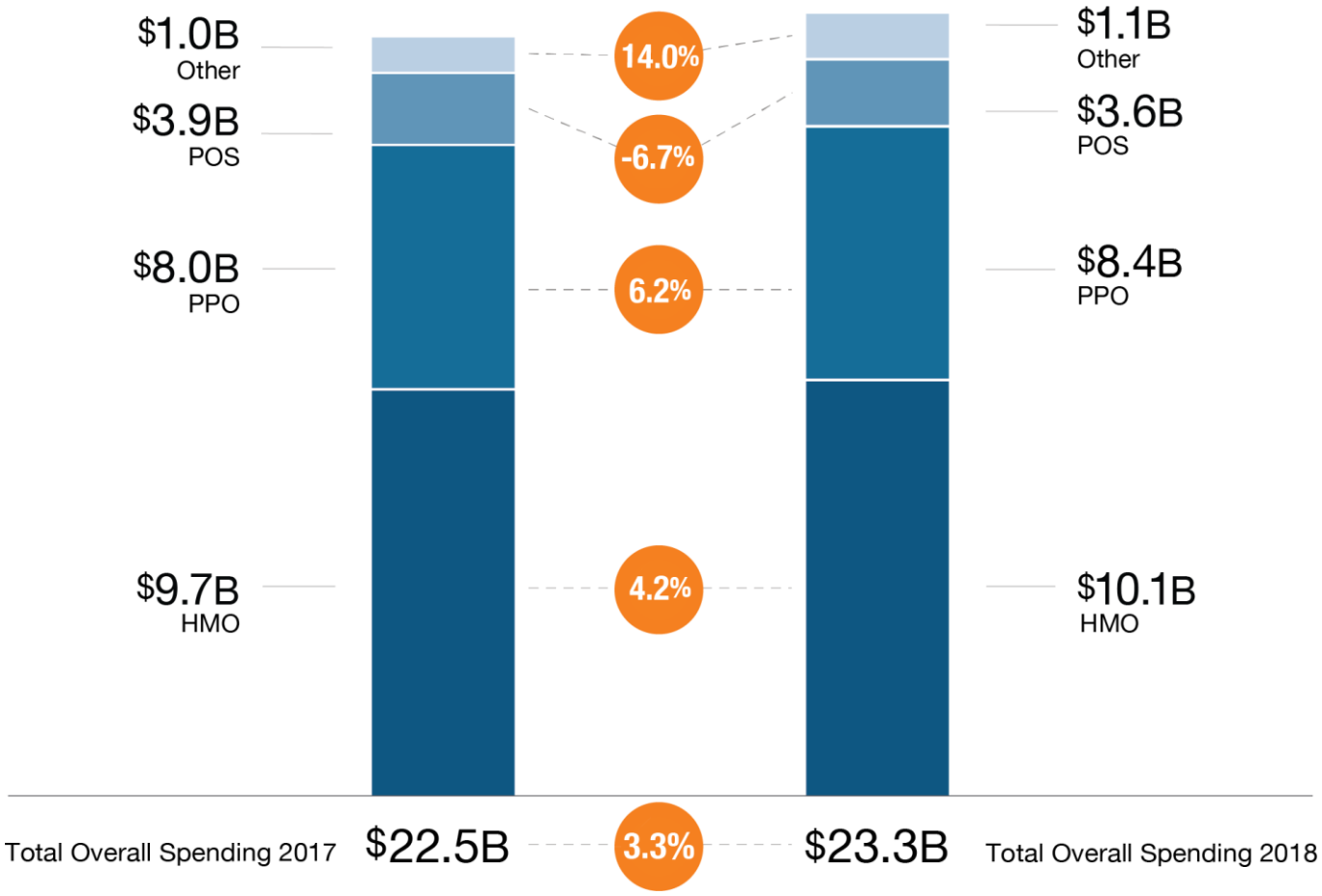
3.3% Expenditure, 2017-2018

-0.6% Member Months, 2017- 2018

For more information, see page 12 of CHIA's *Annual Report*

Commercial Insurance

Spending by Product Type, 2017-2018

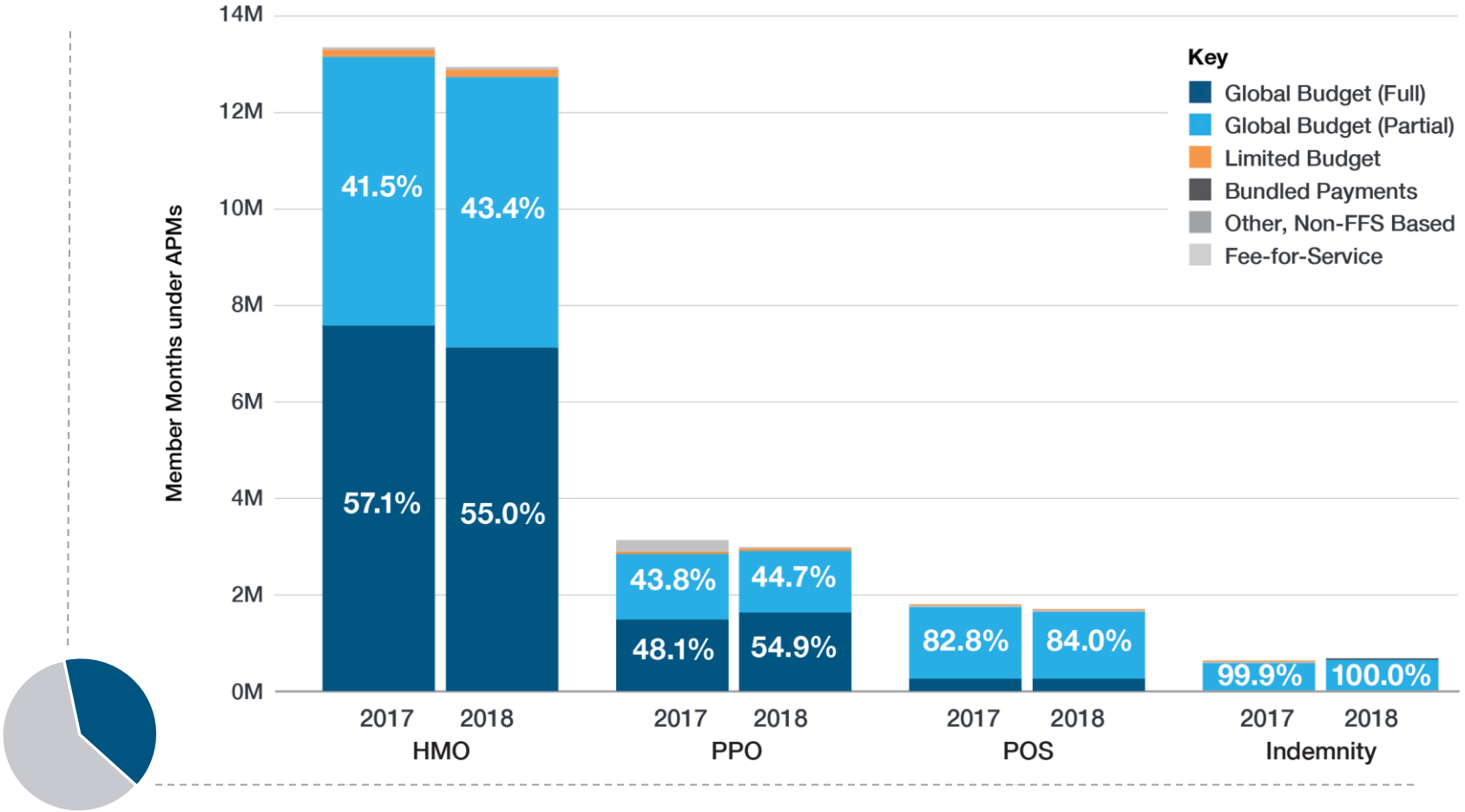


Expenditures increased for both HMO and PPO plans, though enrollment trends diverged.

For more information, see page 12 of CHIA's *Annual Report*

Commercial Insurance

Alternative Payment Methods, 2017-2018

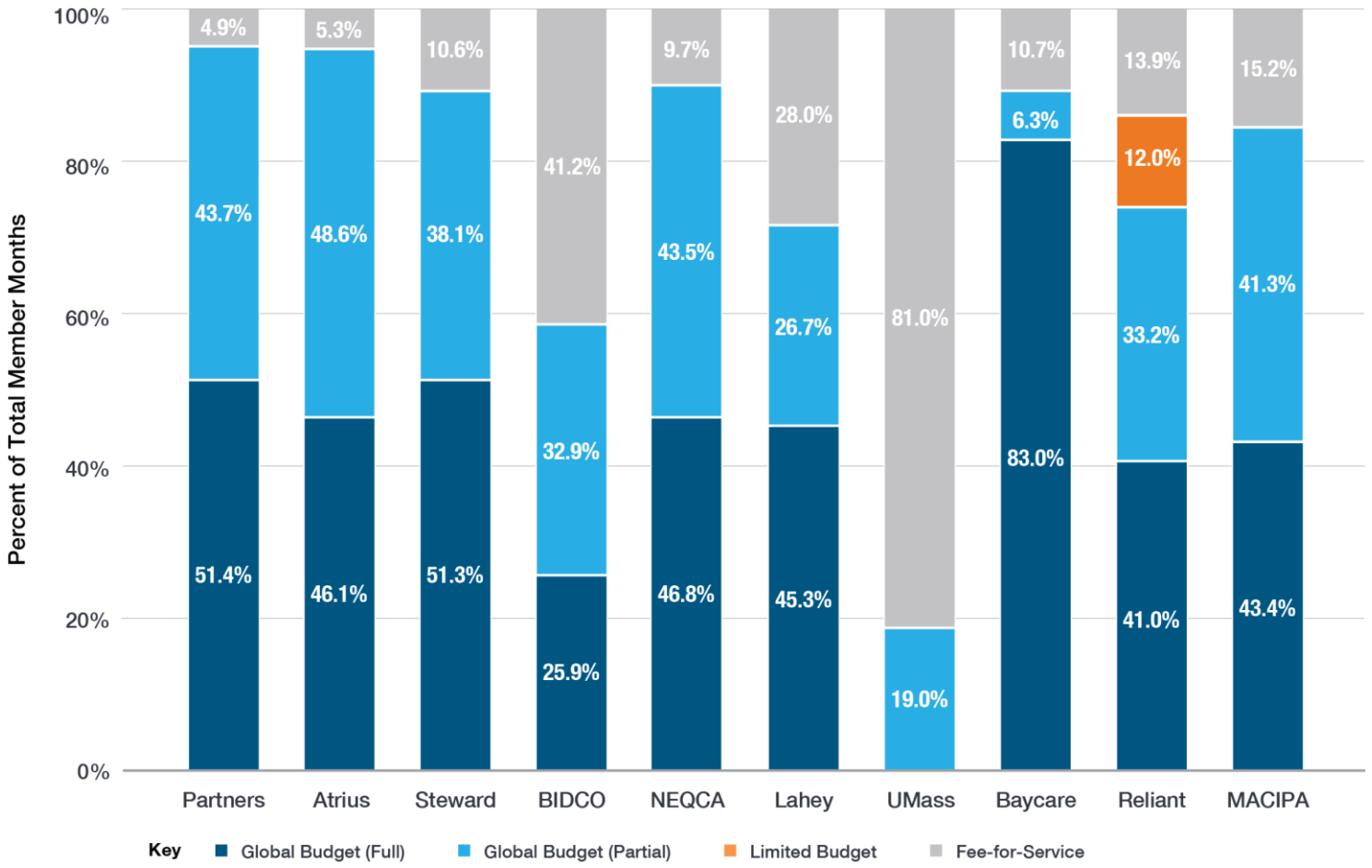


Global budgets inclusive of all services were the predominant APM among HMO and PPO products.

For more information, see page 32 of CHIA's *Annual Report*

Commercial Insurance

Alternative Payment Methods, 2018

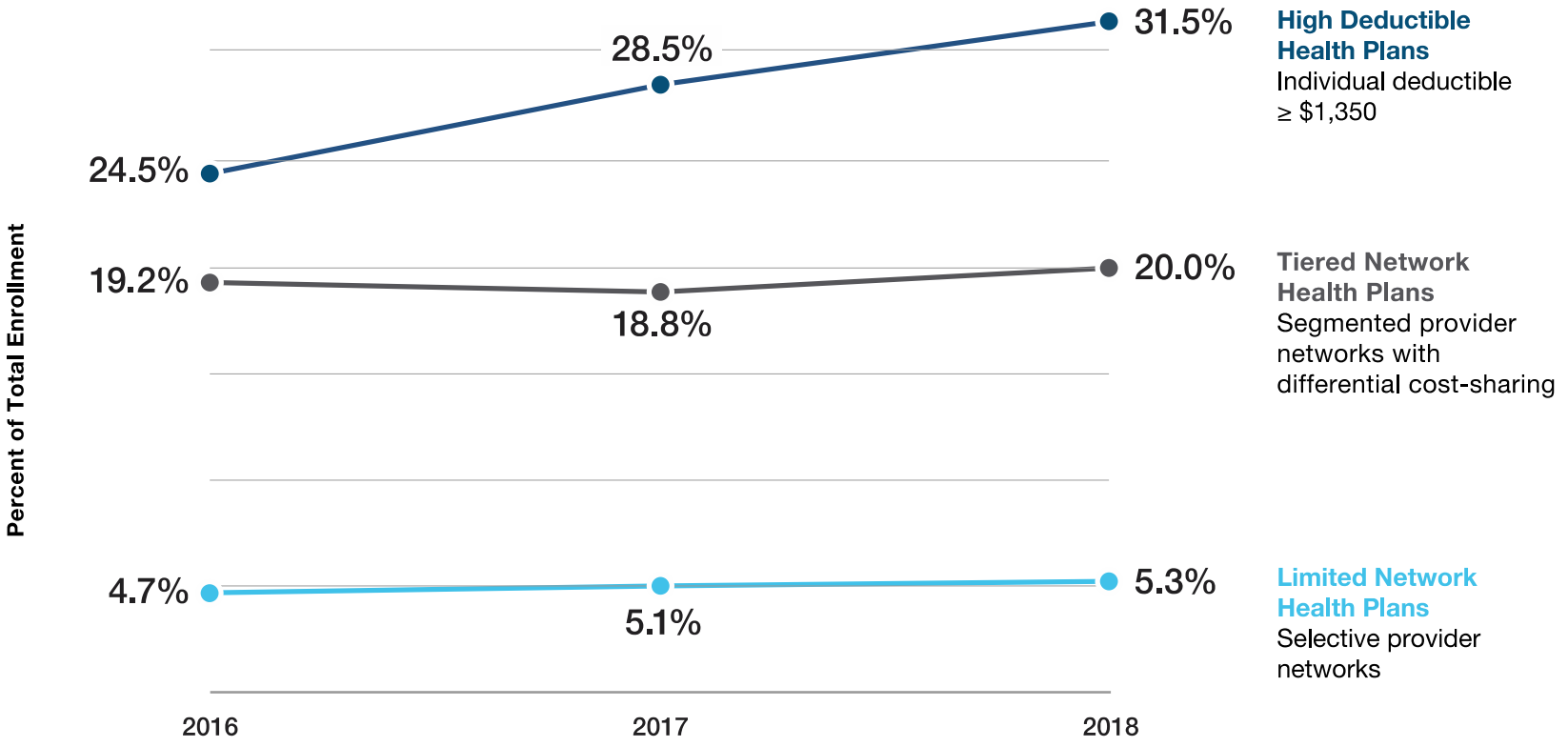


APM adoption varied among the largest provider organizations.

For more information, see page 35 of CHIA's *Annual Report*

Commercial Insurance

Benefit Design, 2016-2018

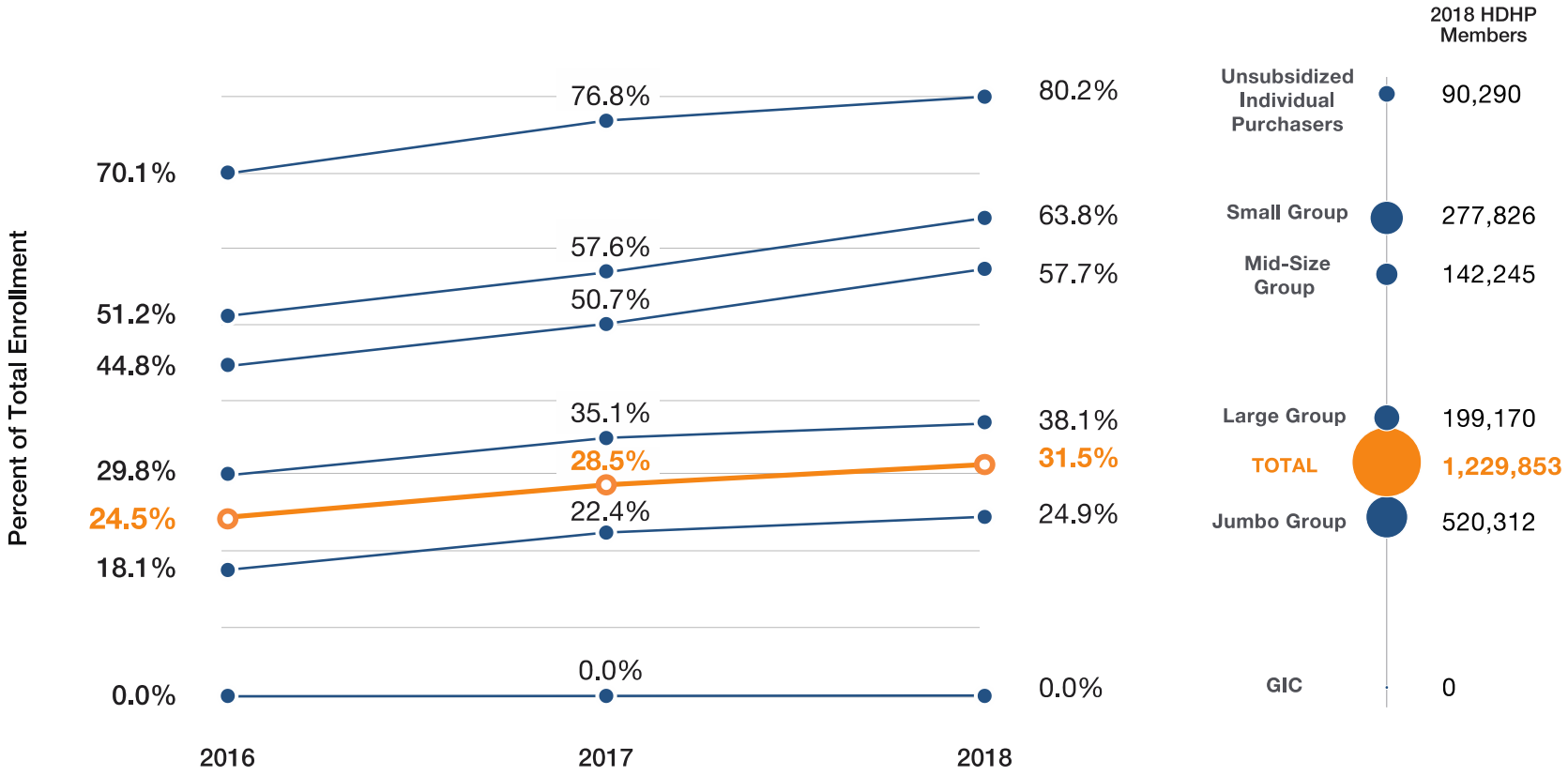


Enrollment in high deductible health plans continued to grow, while adoption of tiered and limited networks held steady.

For more information, see page 48 of CHIA's *Annual Report*

Commercial Insurance

High Deductible Health Plans by Market Sector, 2016-2018

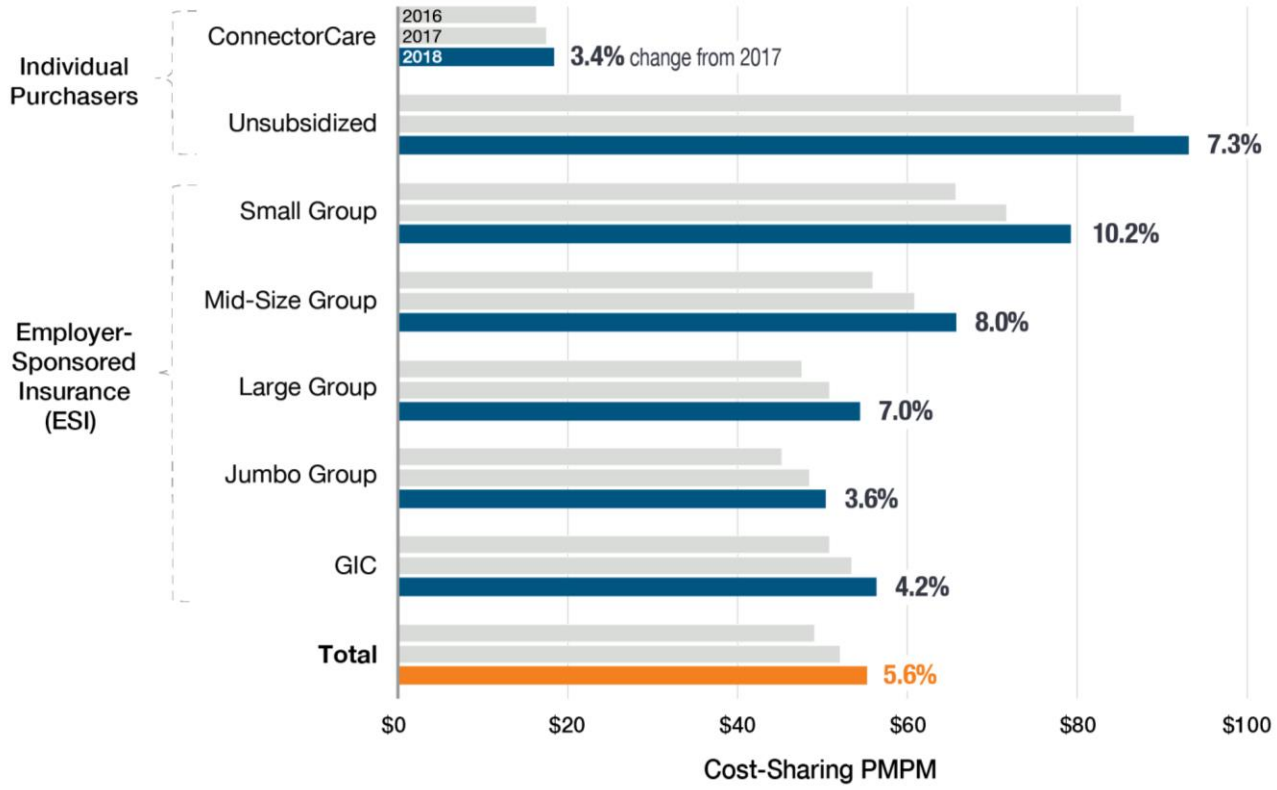


Nearly two-thirds of small group members and 80% of unsubsidized individuals were enrolled in high deductible health plans in 2018.

For more information, see page 49 of CHIA's *Annual Report*

Commercial Insurance

Cost-Sharing by Market Sector, 2016-2018



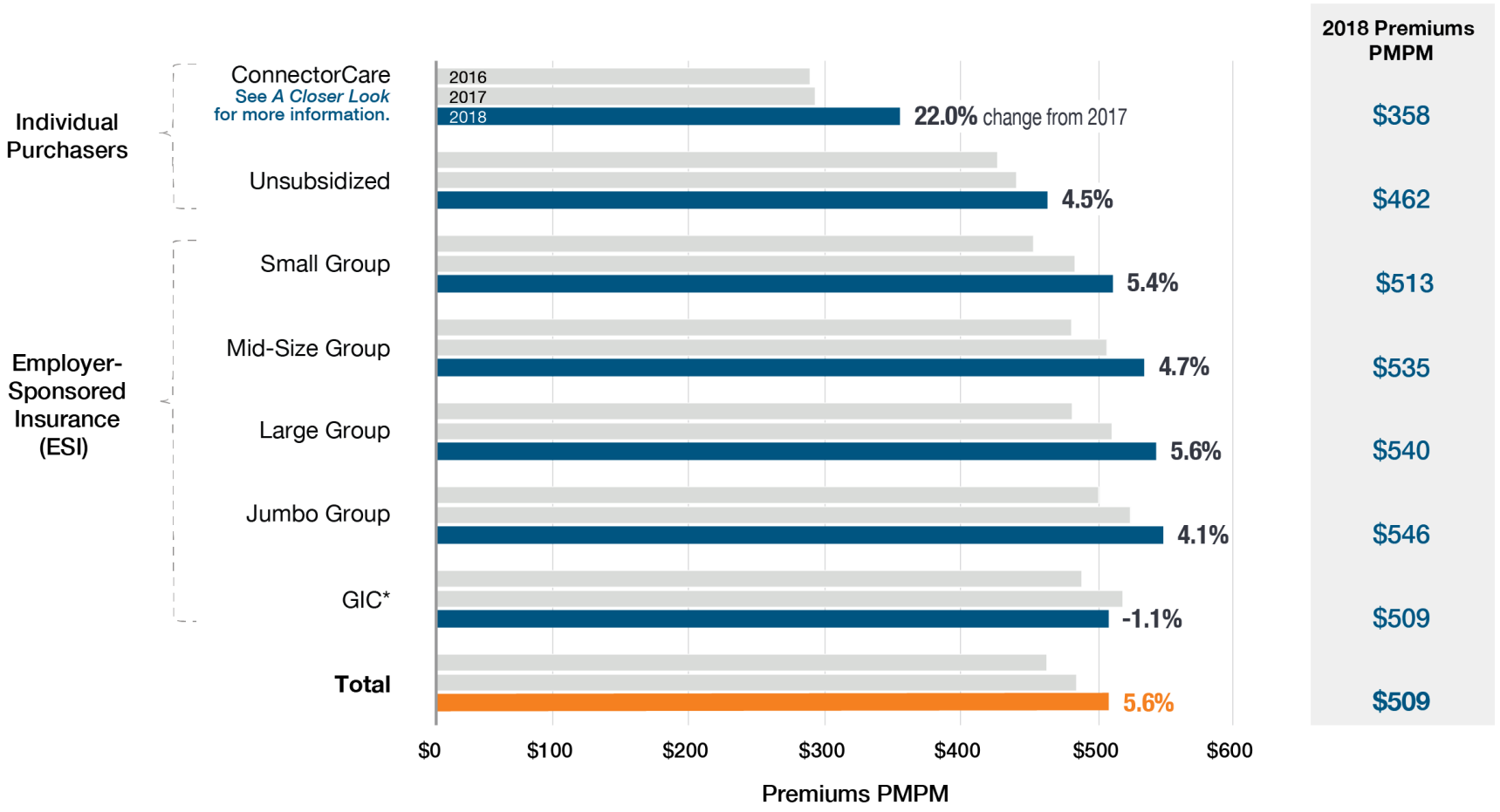
	2018 Member Cost-Sharing	
	PMPM	PMPY
ConnectorCare	$18	$218
Unsubsidized	$93	$1,115
Small Group	$79	$950
Mid-Size Group	$65	$784
Large Group	$54	$649
Jumbo Group	$50	$598
GIC	$55	$664
Total	$55	$658

Member cost-sharing was higher among unsubsidized individuals and members covered by smaller employers.

For more information, see page 67 of CHIA's *Annual Report*

Commercial Insurance

Fully-Insured Premiums by Market Sector, 2016-2018

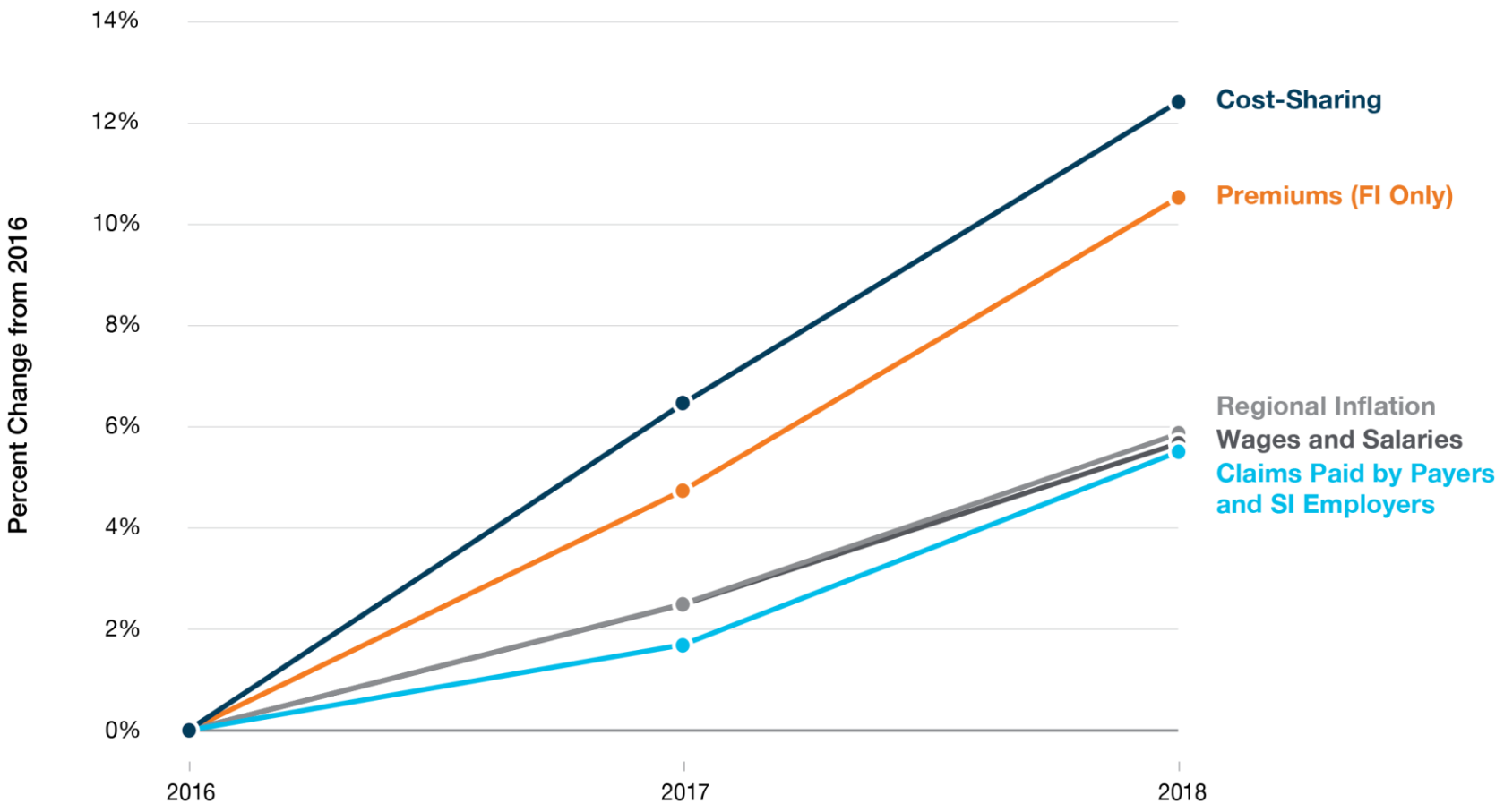


Fully-insured premiums increased 5.6% to $509 PMPM in 2018. Members covered through larger employers had higher premiums.

For more information, see page 53 of CHIA's *Annual Report*

Commercial Insurance

Affordability Trends, 2016-2018

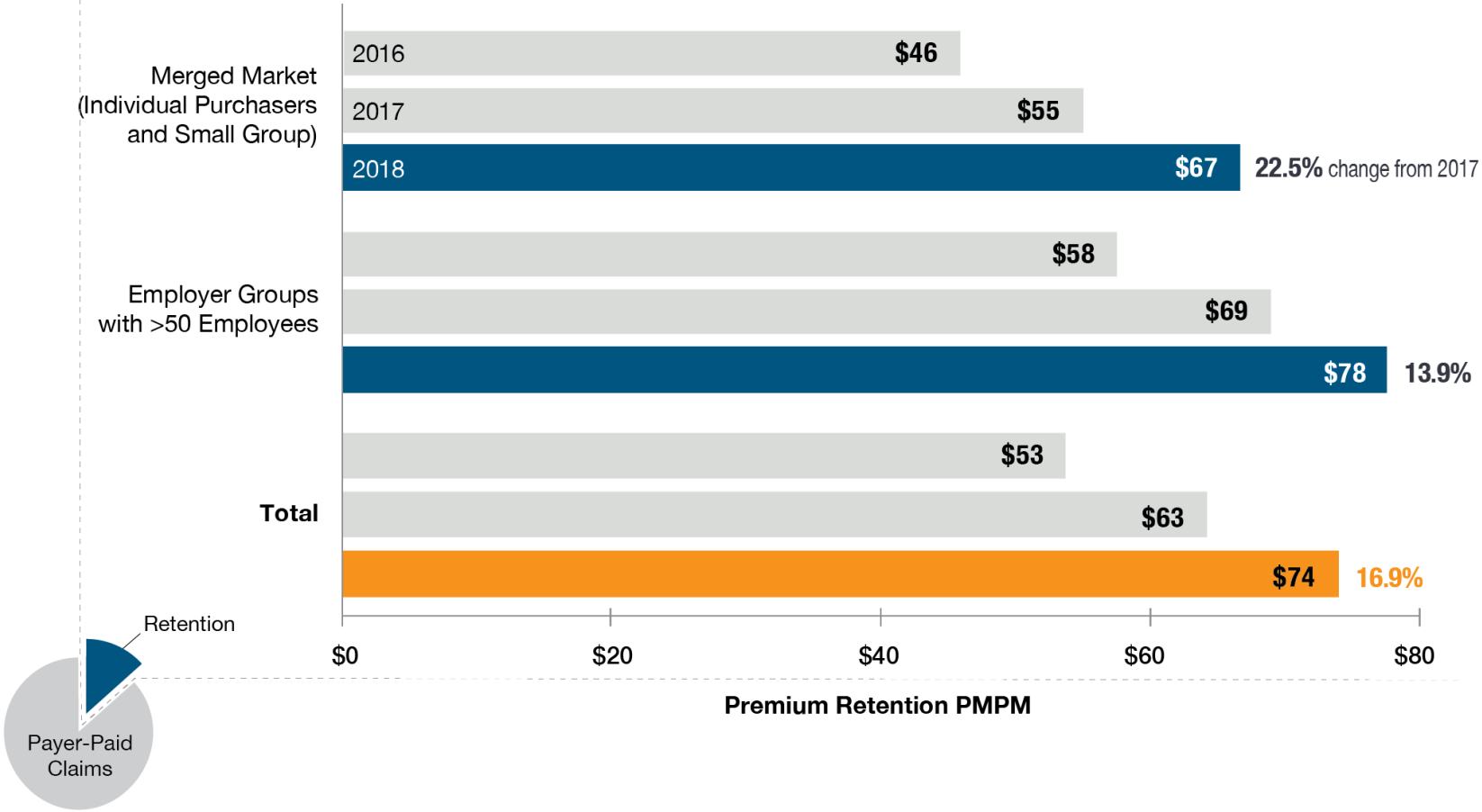


Member cost-sharing and premiums increased at a faster rate than wages and inflation between 2016 and 2018.

For more information, see page 49 of CHIA's *Annual Report*

Commercial Insurance

Fully-Insured Premium Retention by Market Segment, 2016-2018

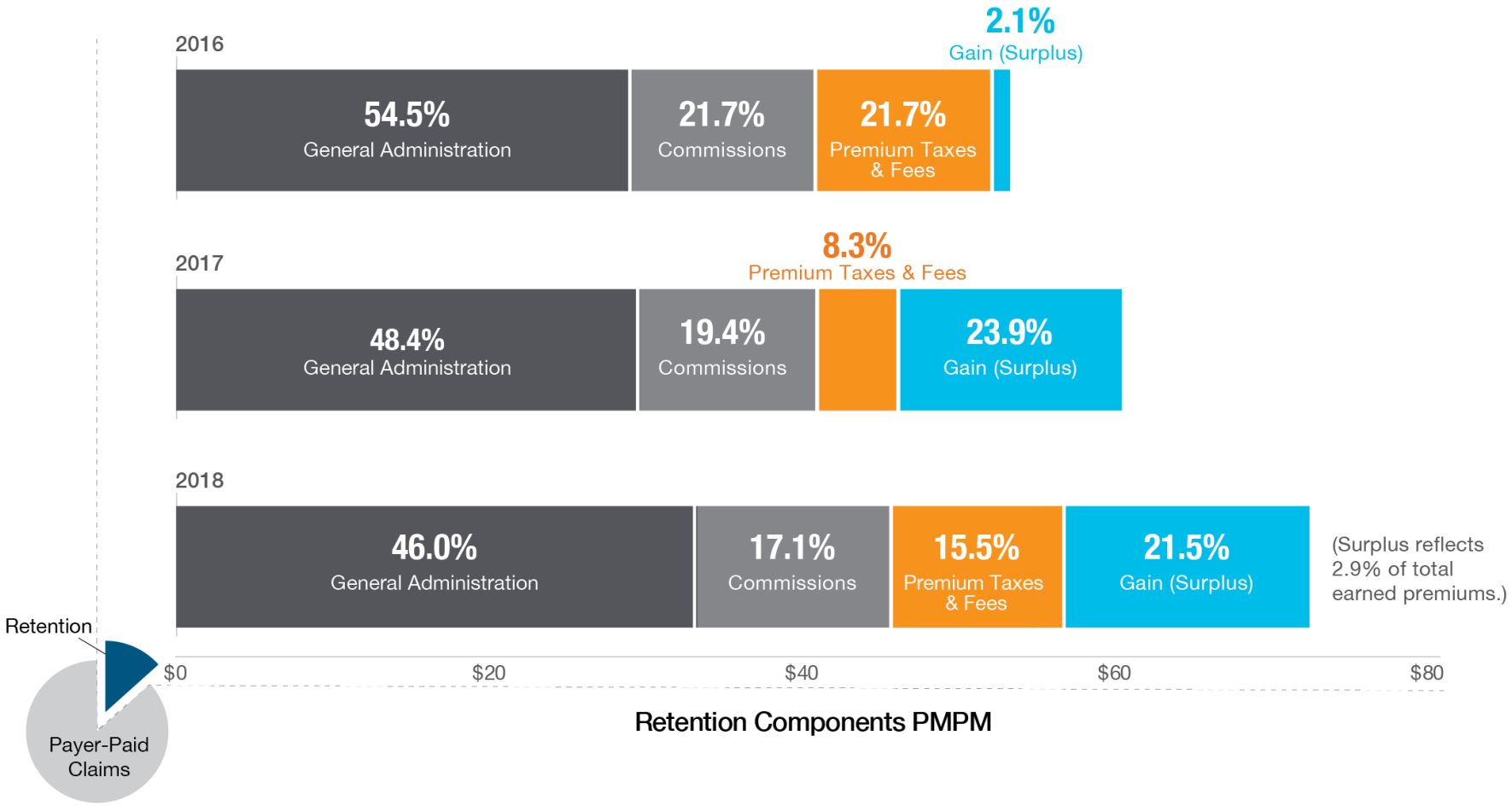


For the second year in a row, premium retention grew rapidly for both merged market and larger employer plans in 2018.

For more information, see page 78 of CHIA's *Annual Report*

Commercial Insurance

Components of Premium Retention (>50 Employees), 2016-2018



Payers reported more than one-fifth (21.5%) of premium retention as surplus in 2018. This gain represented 2.9% of total earned premiums.

For more information, see page 78 of CHIA's *Annual Report*

2019 HEALTH CARE COST TRENDS HEARING

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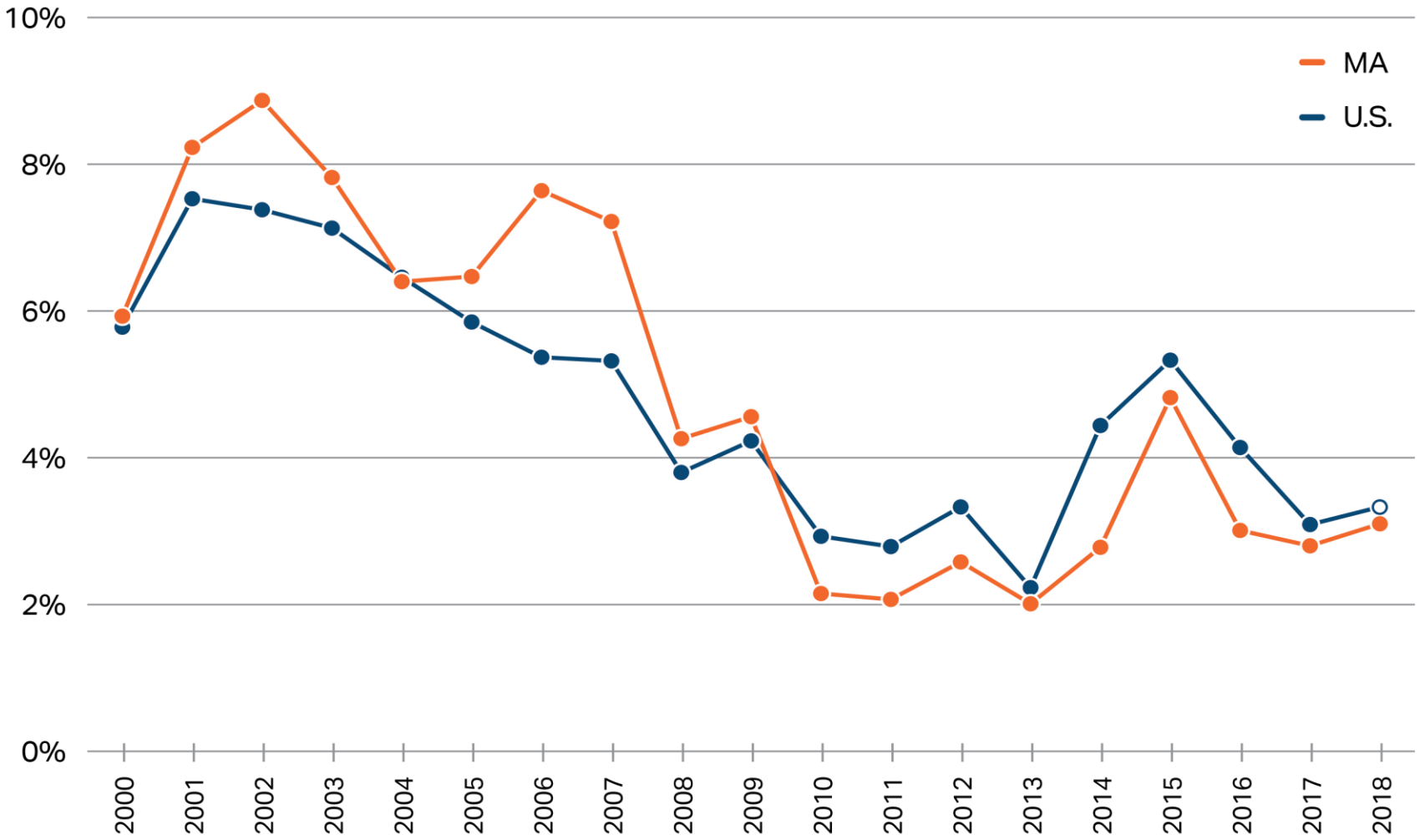
Up Next

Presentation: Health Care Spending Trends and Impact on Affordability
Dr. David Auerbach, Director of Research and Cost Trends
Health Policy Commission

Since 2009, total health care spending growth in Massachusetts has been below the national rate.

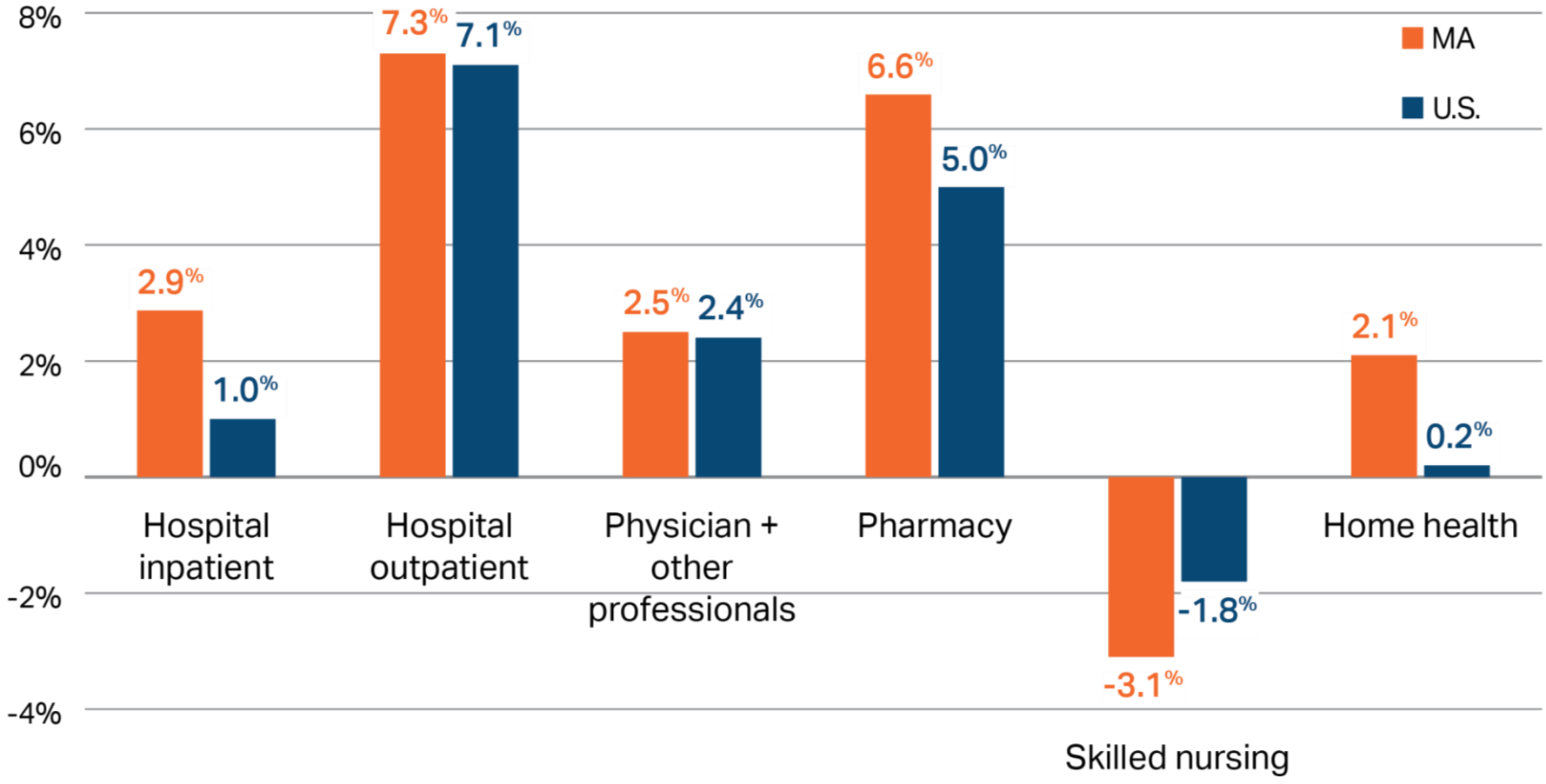
Annual growth in per capita health care spending, Massachusetts and the U.S., 2000-2018



Notes: U.S. data includes Massachusetts. U.S. data point for 2018 is partially projected. MA data point for 2018 is preliminary.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018); CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

Medicare spending growth in Massachusetts was above the national rate in 2018 in nearly all categories of care.

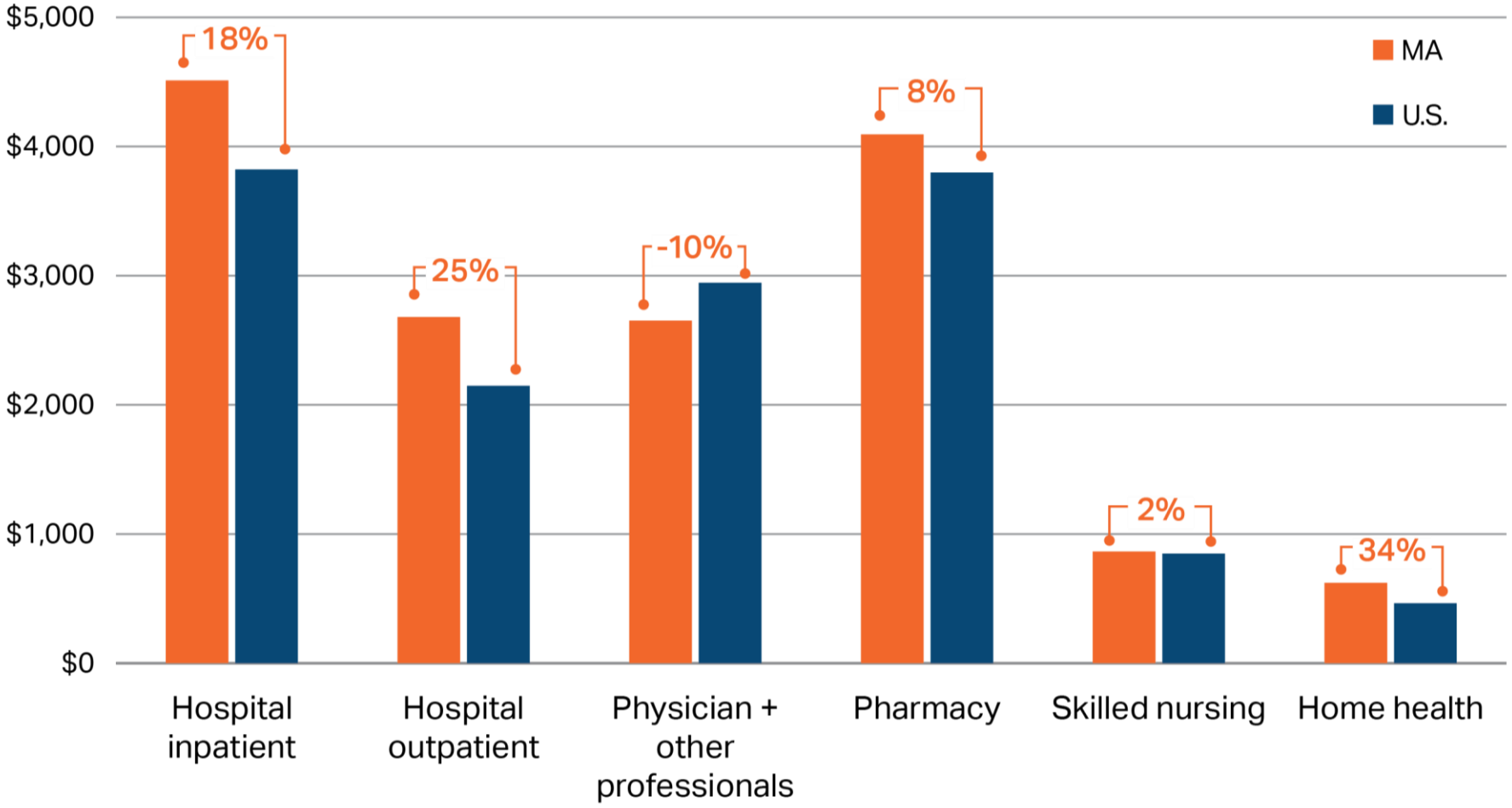
Medicare spending growth per Medicare beneficiary, Massachusetts and the U.S., 2017-2018



Notes: U.S. data includes Massachusetts. Growth in spending by service category reflects all Fee-For-Service Medicare beneficiaries. Prescription drug spending is calculated per enrollee in Medicare Part D. All other categories of spending reflect growth per beneficiary in either Part A or Part B.
Sources: Centers for Medicare and Medicaid Services, 2017-2018.

Spending levels in Massachusetts continue to be above the national average for Medicare beneficiaries in nearly all categories of care.

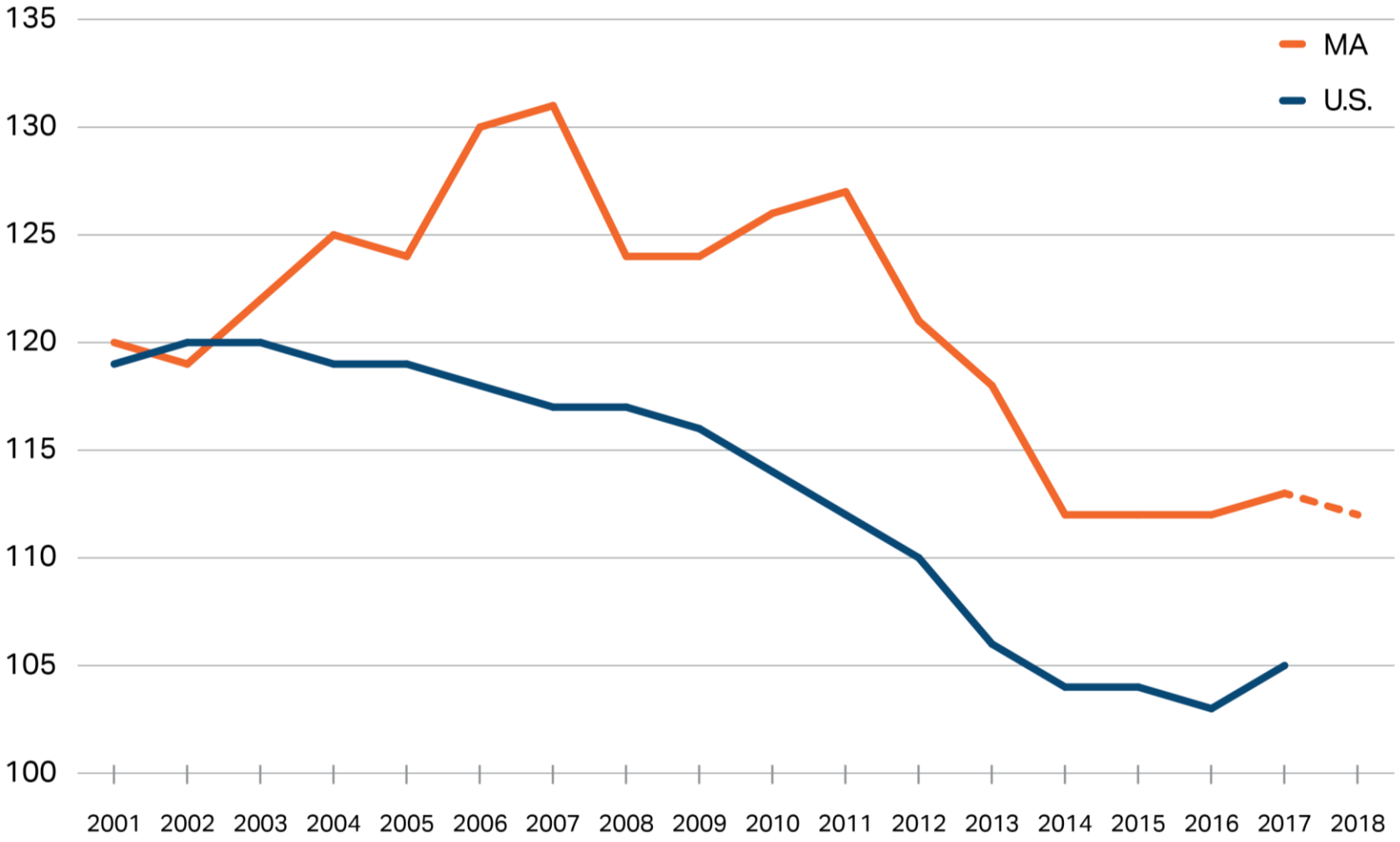
Medicare spending per Medicare beneficiary, Massachusetts and the U.S., 2018



Notes: U.S. data includes Massachusetts. Data reflects Fee-for-Service Medicare beneficiaries. Prescription drug spending is calculated per enrollee in Medicare Part D. All other categories of spending reflect growth per beneficiary in either Part A or Part B.
Sources: Centers for Medicare and Medicaid Services, 2018.

Massachusetts inpatient hospital admission rates show little change since 2014 and continue to exceed the U.S. average.

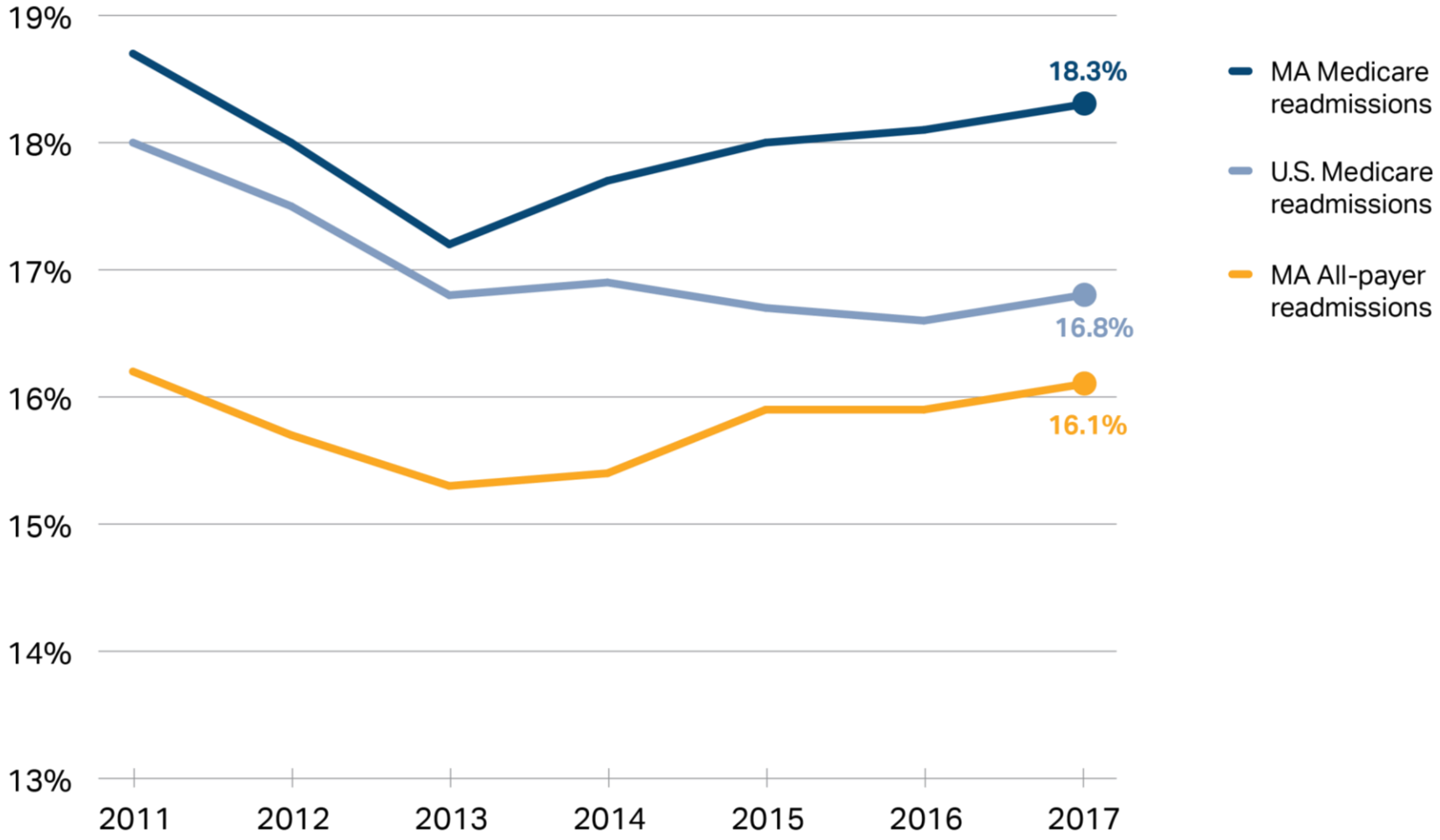
Inpatient hospital admission rate per 1,000 residents, Massachusetts and the U.S., 2001-2018



Notes: U.S. data includes Massachusetts.
Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2017), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2018).

Massachusetts readmission rates continue to increase and significantly exceed the U.S. average.

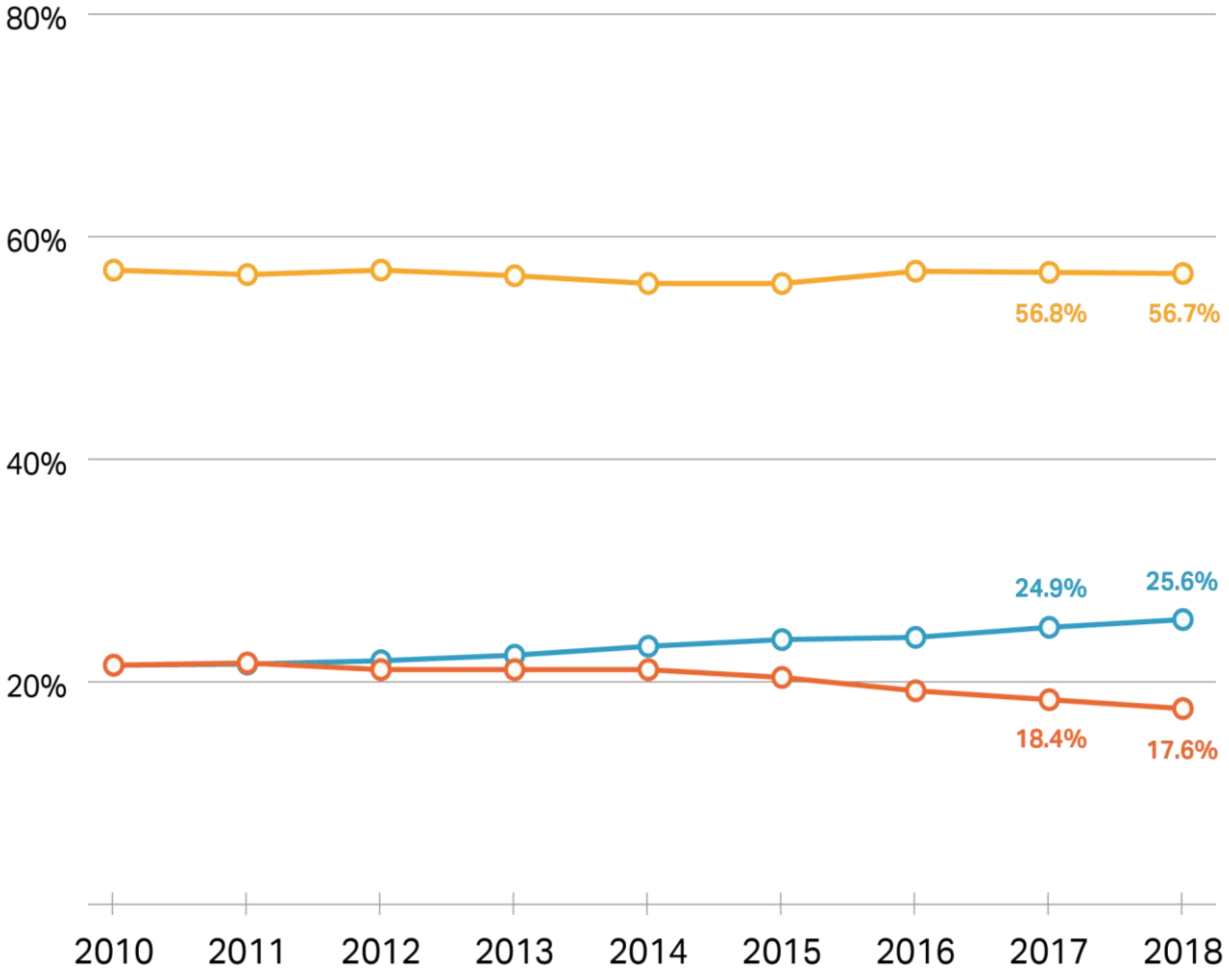
Thirty-day readmission rates, Massachusetts and the U.S., 2011-2017



Notes: Massachusetts Medicare and U.S. Medicare readmission rates are for Medicare beneficiaries aged 65 and over
Sources: Centers for Medicare and Medicaid Services (U.S. and Massachusetts Medicare Geographic Variation Public Use Files 2011-2017); Center for Health Information and Analysis (MA All-payer 2011-2018).

The rate of inpatient discharges to institutional post-acute care continued to decline, as care shifts to lower-cost settings.

Massachusetts discharge rates to post-acute care settings following an inpatient admission, 2010-2018

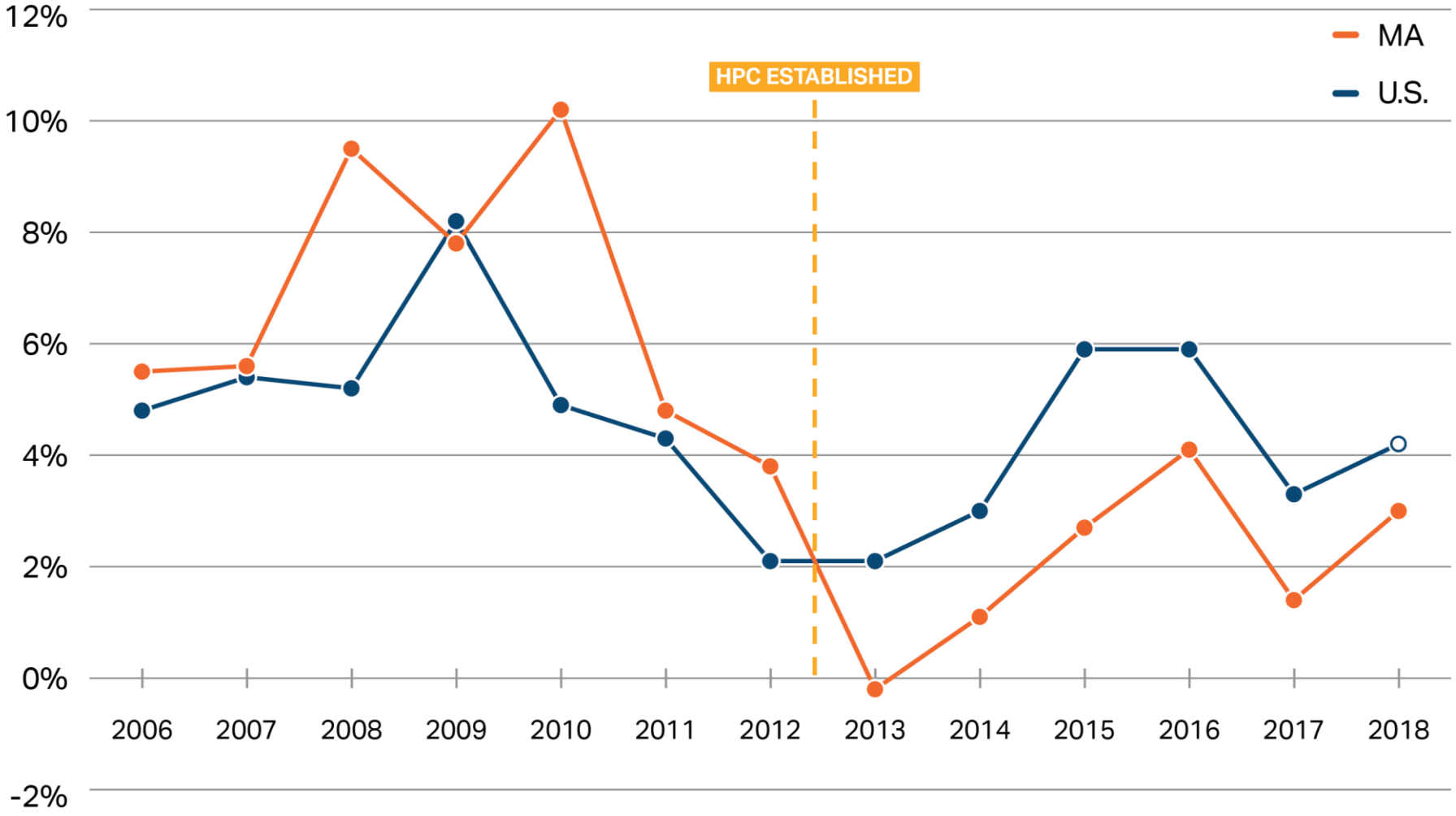


MA discharges to institutional care are closing the gap with the U.S., while the gap in rates of discharge to home health is large and growing.

Note: Out-of-state residents are excluded. Rates adjusted for age, sex, and changes in DRG mix. Several hospitals were excluded (UMass, Clinton, Cape Cod, Falmouth, Marlborough) due to coding irregularities in the data.
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2010-2018) and Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project.

Commercial spending growth in Massachusetts has been below the national rate every year since 2013.

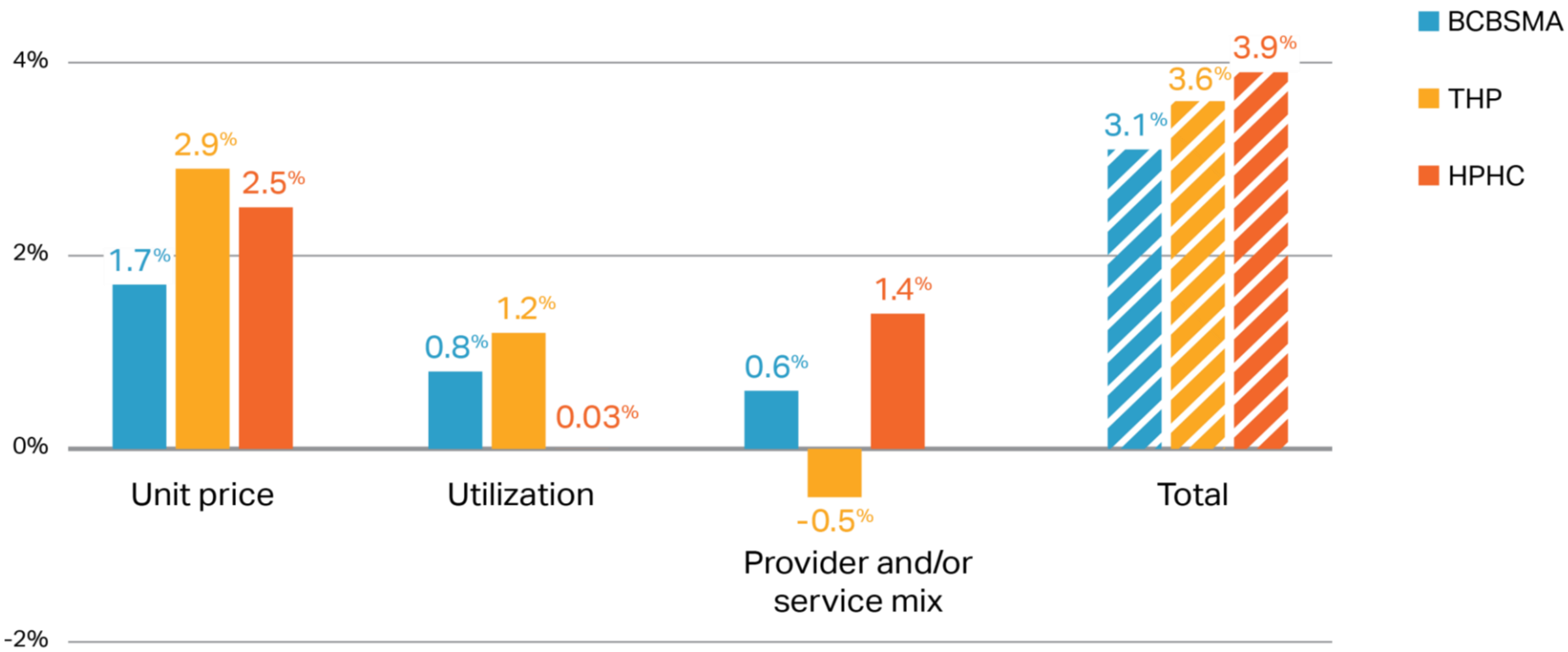
Annual growth in commercial medical spending per enrollee, Massachusetts and the U.S., 2006-2018



Notes: U.S. data includes Massachusetts. U.S. data point for 2018 is partially projected. MA data point for 2018 is preliminary.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018) ; CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

Unit price increases continued to drive most of the spending growth among Massachusetts' largest insurers over the past three years.

Average annual growth in spending by component for top three Massachusetts payers, 2016-2018

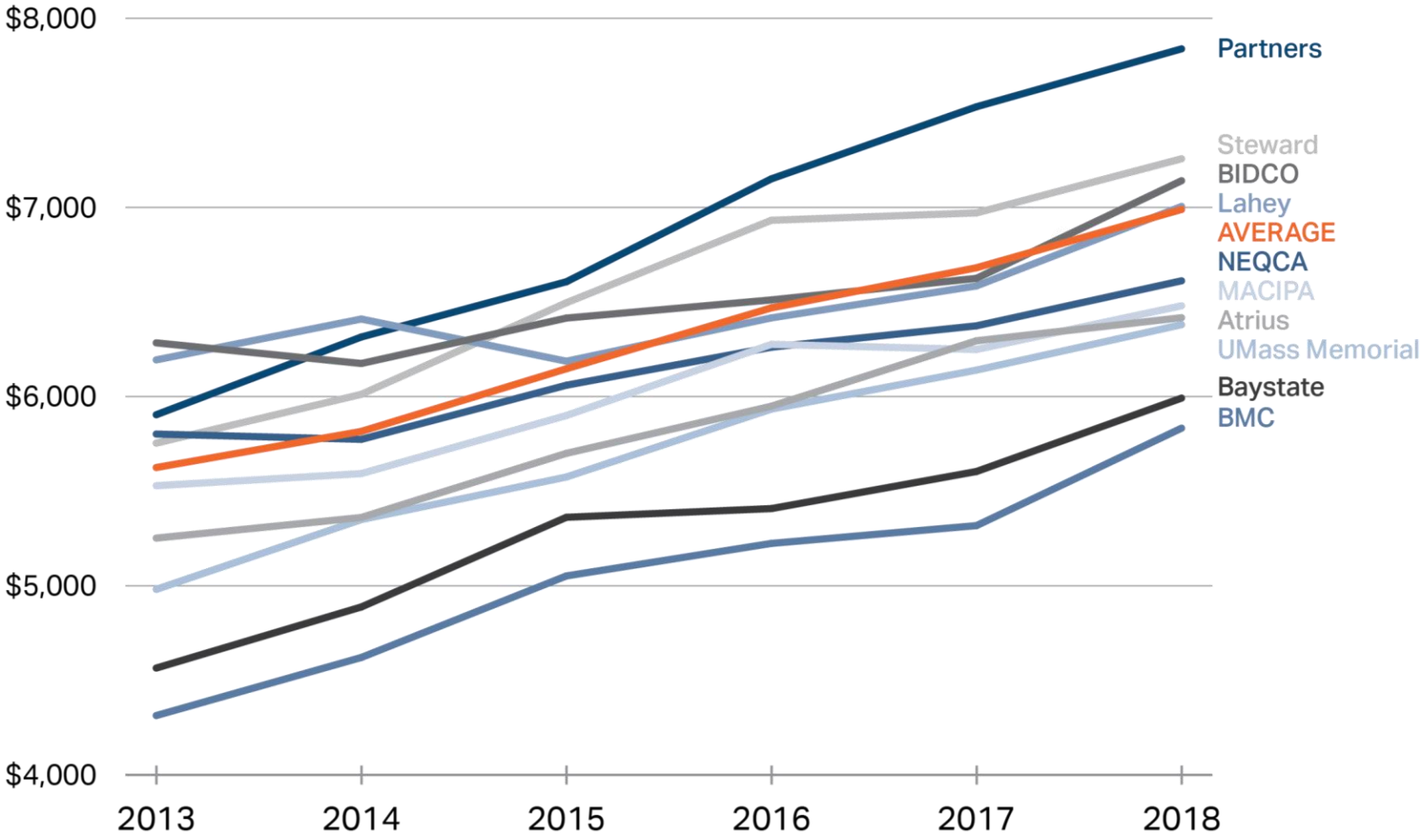


Notes: Average of medical expenditure trend by year 2016-2018. BCBSMA = Blue Cross Blue Shield of Massachusetts; THP = Tufts Health Plan; HPHC = Harvard Pilgrim Health Care.

Source: HPC analysis of Pre-Filed Testimony pursuant to the 2019 Annual Cost Trends Hearing

Annual commercial spending per member varies more than $2,000 by provider group; spending grew 24% on average from 2013 – 2018.

Total medical expenditures (unadjusted) per member by managing provider organization, 2013-2018

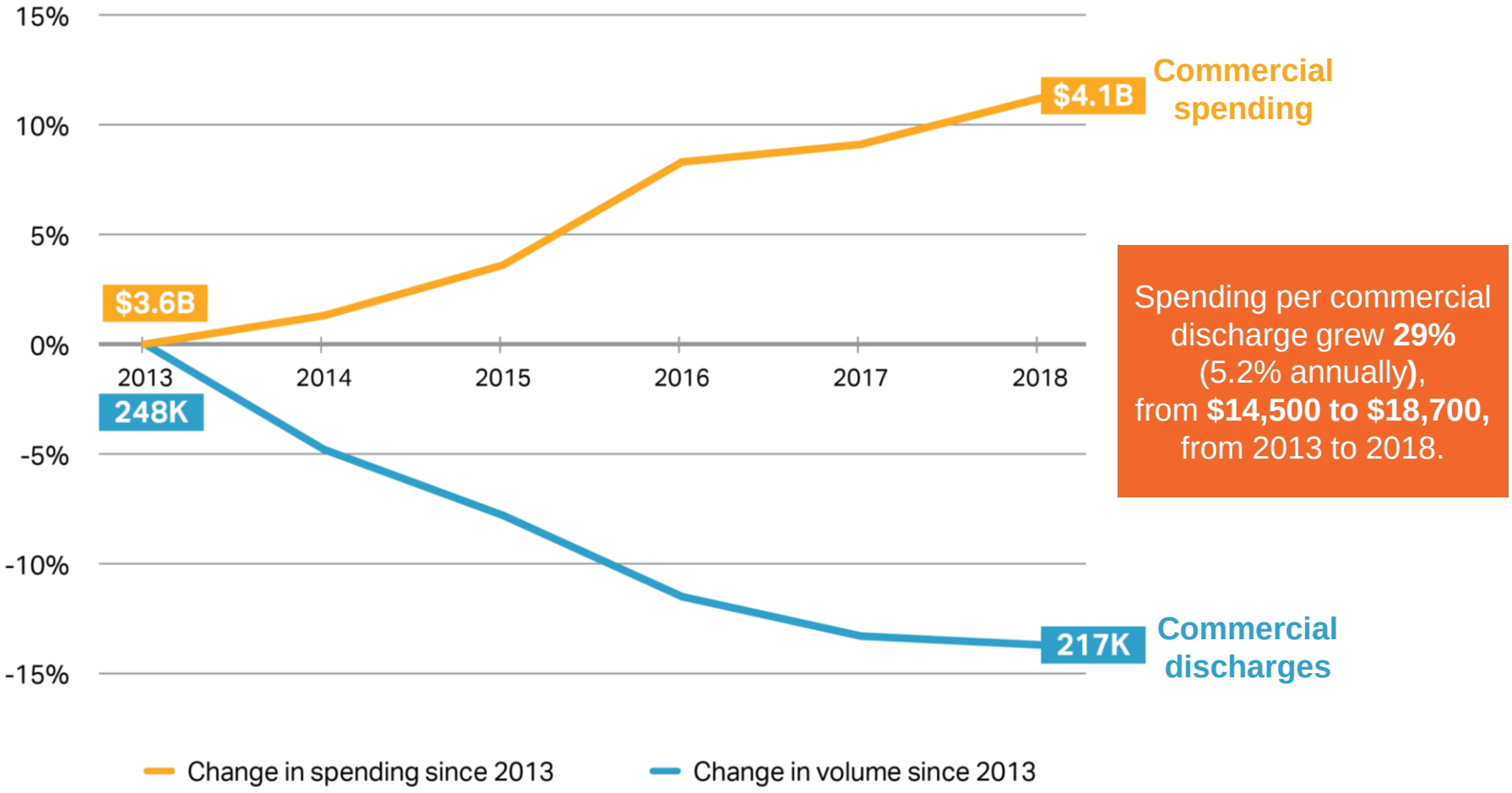


Notes: Analysis includes the ten largest provider groups and commercial spending for BCBSMA, Tufts, and HPHC members only. Members included are those in HMO or POS products which require choice of a primary care provider.

Source: HPC analysis of Center for Health Information and Analysis 2016-2019 Annual Reports, TME Databook

Commercial inpatient spending grew 11% even as volume fell 14% between 2013 and 2018.

Cumulative change in commercial inpatient hospital volume and spending per enrollee (percentages) and absolute, 2013-2018



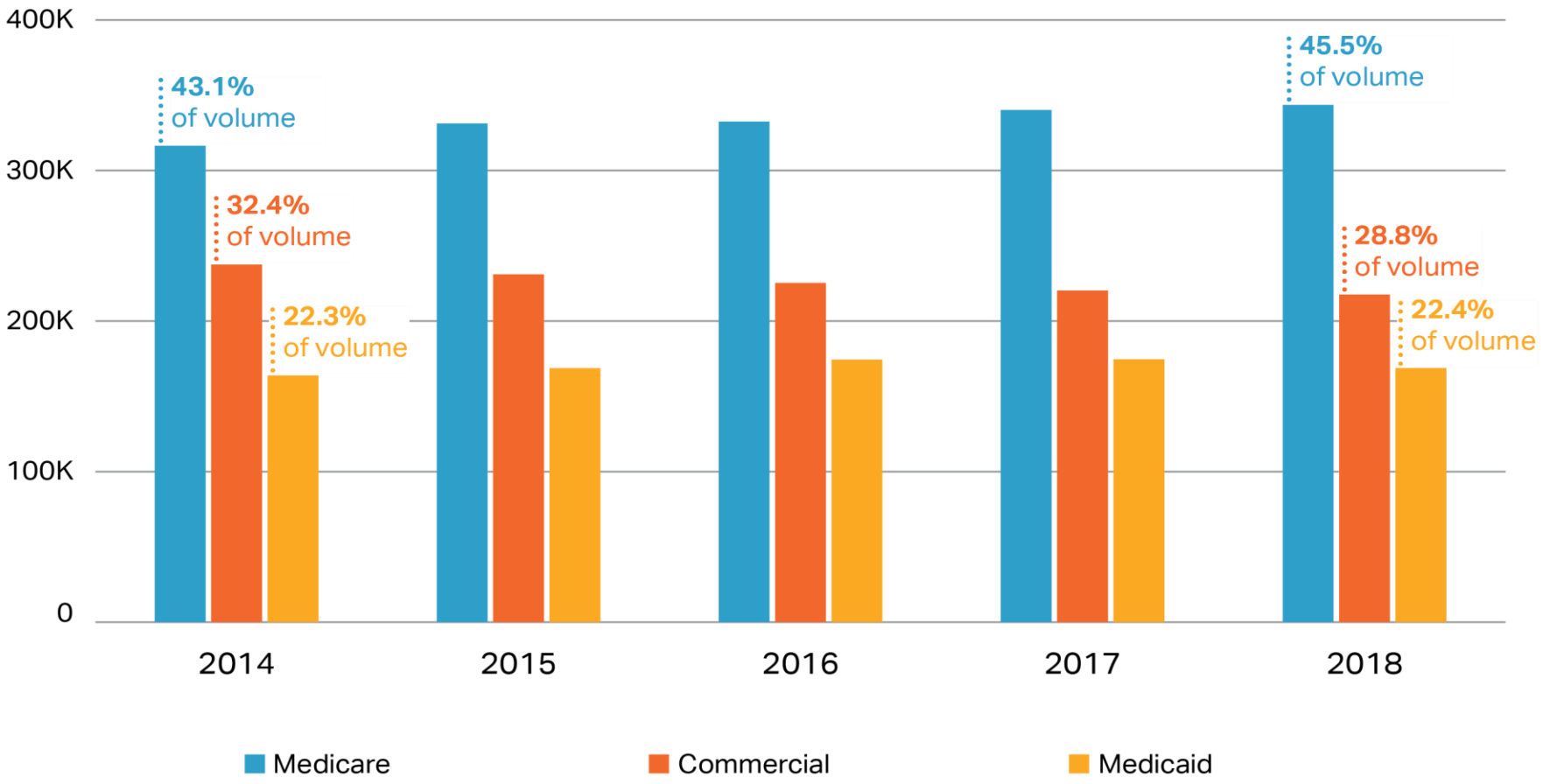
Spending per commercial discharge grew **29%** (5.2% annually), from **$14,500 to $18,700,** from 2013 to 2018.

Notes: Data points indicate % growth from previous year (2013=0). Volume data correspond to fiscal years while spending data are calendar years.

Sources: CHIA Hospital Inpatient Discharge Data, 2013-2018. Commercial full-claims TME from CHIA Annual Report TME Databooks. 2019 Annual report (for 2017-2018 growth and 2016-2017 growth), 2018 Annual Report (for 2015-2016), 2017 Annual Report (for 2014-2015) and 2016 Annual Report (for 2013-2014 growth).

Over the past five years, inpatient Medicare discharges have increased while commercial inpatient discharges have decreased.

Total inpatient hospital discharges by payer, Massachusetts, 2014-2018

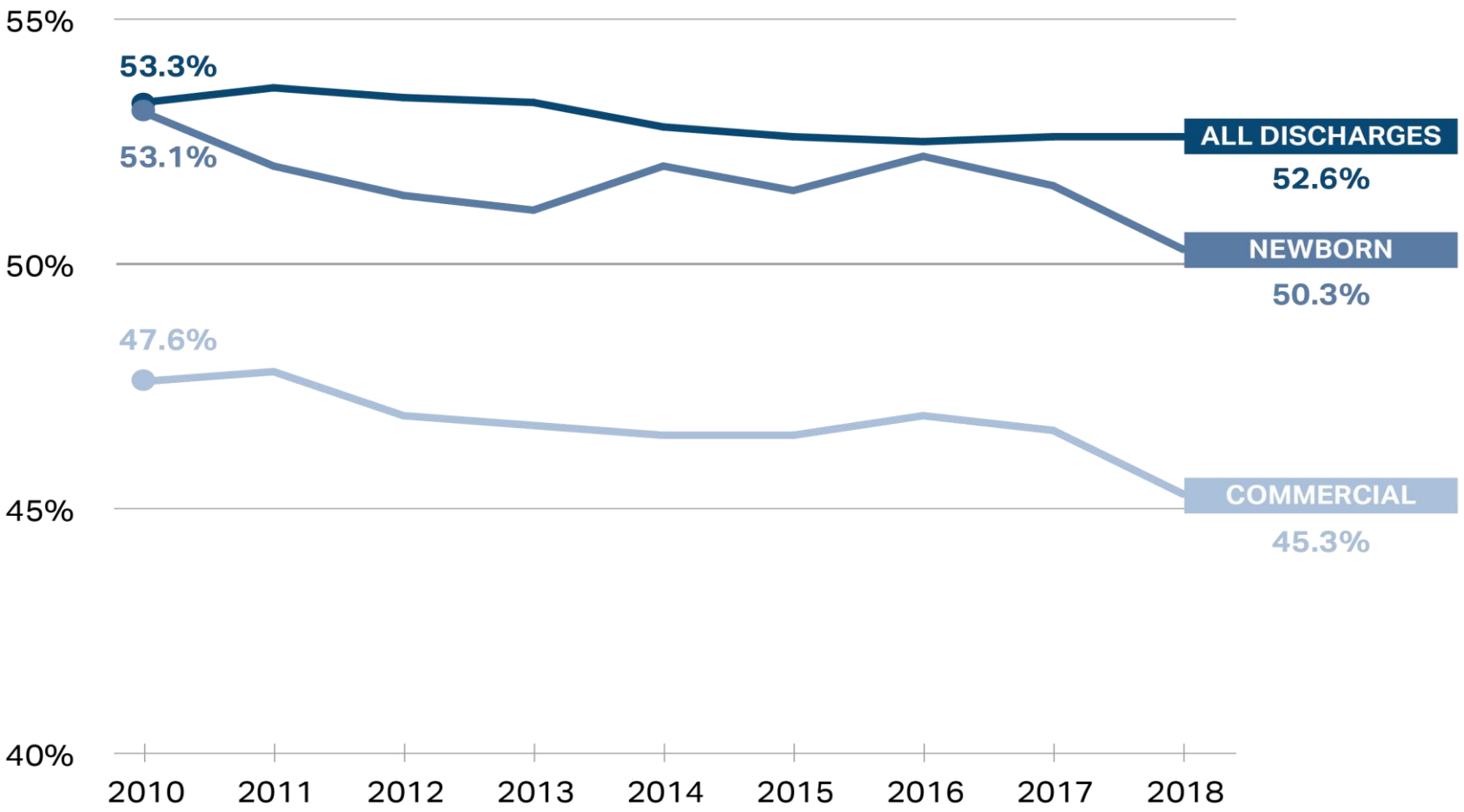


Notes: Out of state residents (~5% of discharges) are excluded from this analysis. Medicaid also includes "Low-margin government" discharges. All other payers (Other government, self/pay) are not illustrated, but accounted for in percentage calculations.

Sources: HPC analysis of Center for Health Information and Analysis Inpatient Discharge Database, 2014-2018.

Since 2010, the share of newborns and commercial discharges at community hospitals has declined, especially in the past two years.

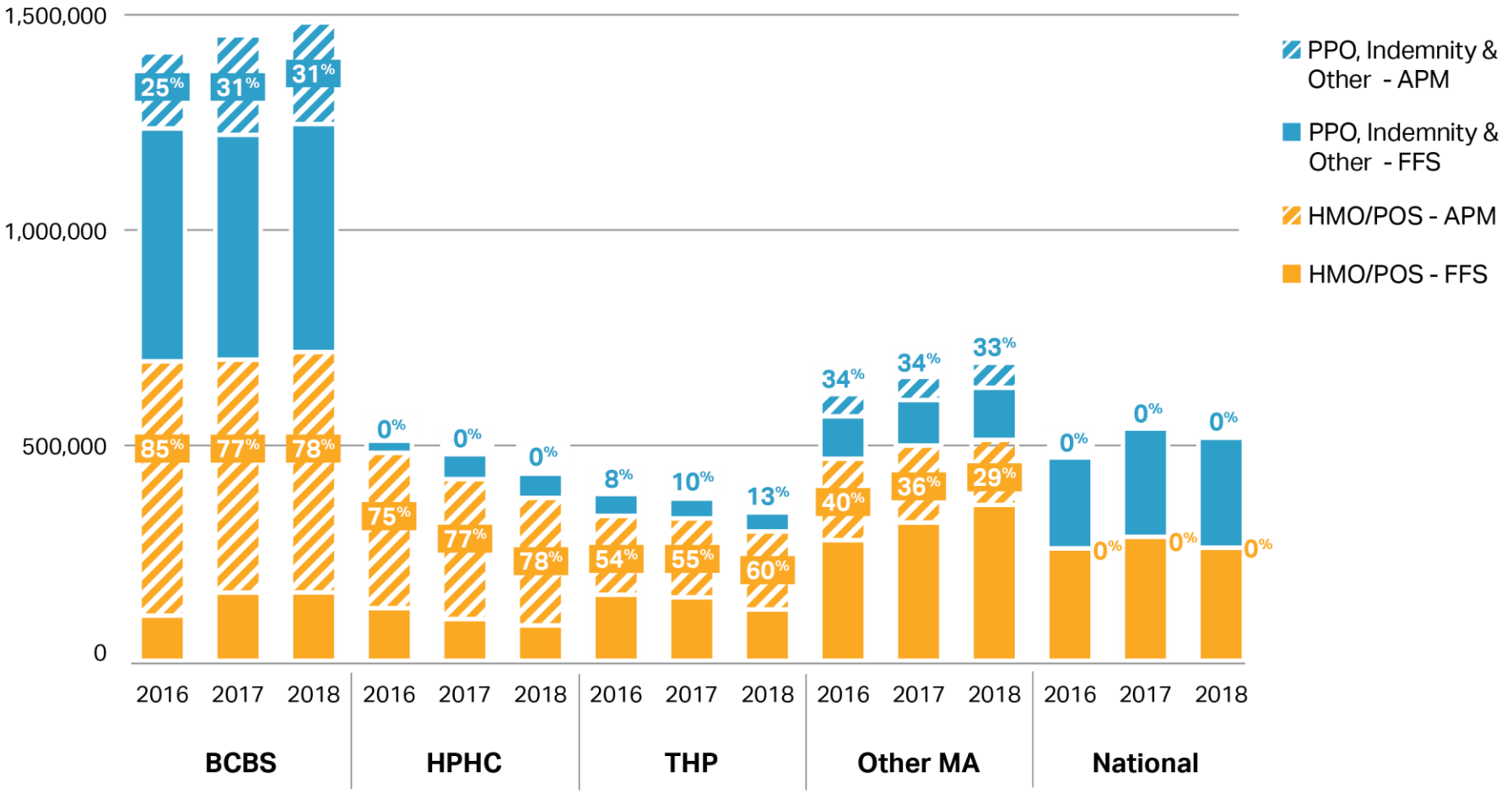
Massachusetts share of discharges in community hospitals, 2010-2018



Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs.
Sources: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database (2010-2018).

While overall APM adoption was stagnant in 2018, there is variation among Massachusetts insurers for their HMO and PPO members.

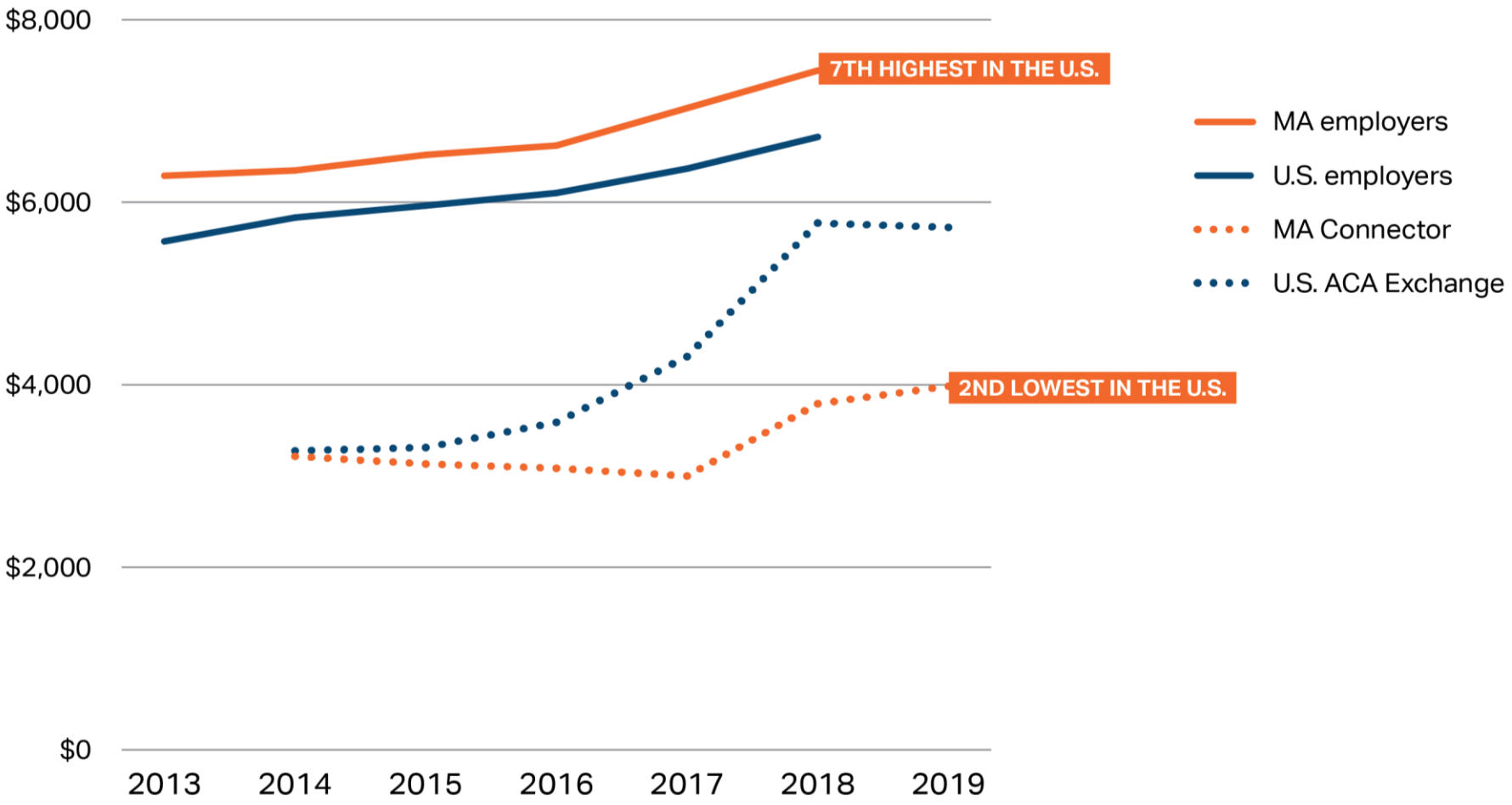
Commercial membership under alternative payment method (APM) and fee-for-service (FFS) contracts by payer, 2016-2018. Labels indicate percentage under an APM by product category.



Notes: Aetna was excluded from this analysis due to data anomalies. Other MA includes AllWays, Fallon, HNE, BMCHP, THPP, HPI, and Unicare. National payers includes United and Cigna.
Source: HPC analysis of Center for Health Information and Analysis Annual Report APM Databooks (2016-2018).

While Massachusetts has among the highest employer-sponsored insurance premiums, Connector premiums remain the second lowest in the U.S.

*Annual premium for **single** coverage in the employer market and average annual unsubsidized benchmark premium for a 40-year-old in the ACA Exchanges, Massachusetts and the U.S., 2013-2019*

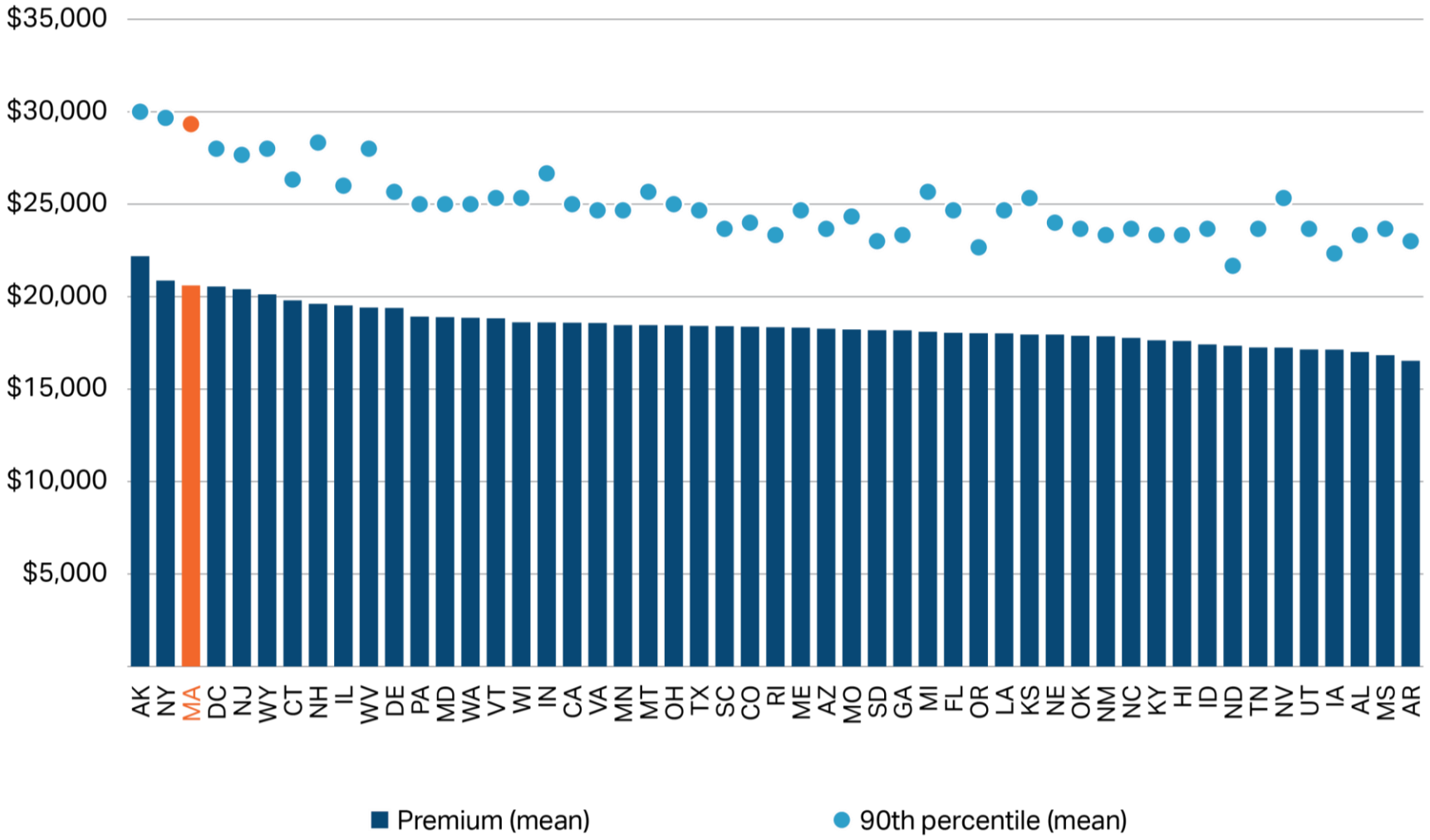


Notes: U.S. data includes Massachusetts. Employer premiums are averages based on a large sample of employers within each state. Exchange data represent the weighted average annual premium for the second-lowest silver (Benchmark) plan based on county-level data in each state. Exchange premiums grew in 2018 partly due to the discontinuation of cost-sharing reduction subsidies by the federal government.

Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov (marketplace premiums 2014-2019); Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), (commercial premiums 2013-2018).

Massachusetts has the 3rd highest average family premium in the U.S.; premiums exceed $30,000 for one in 10 Massachusetts residents.

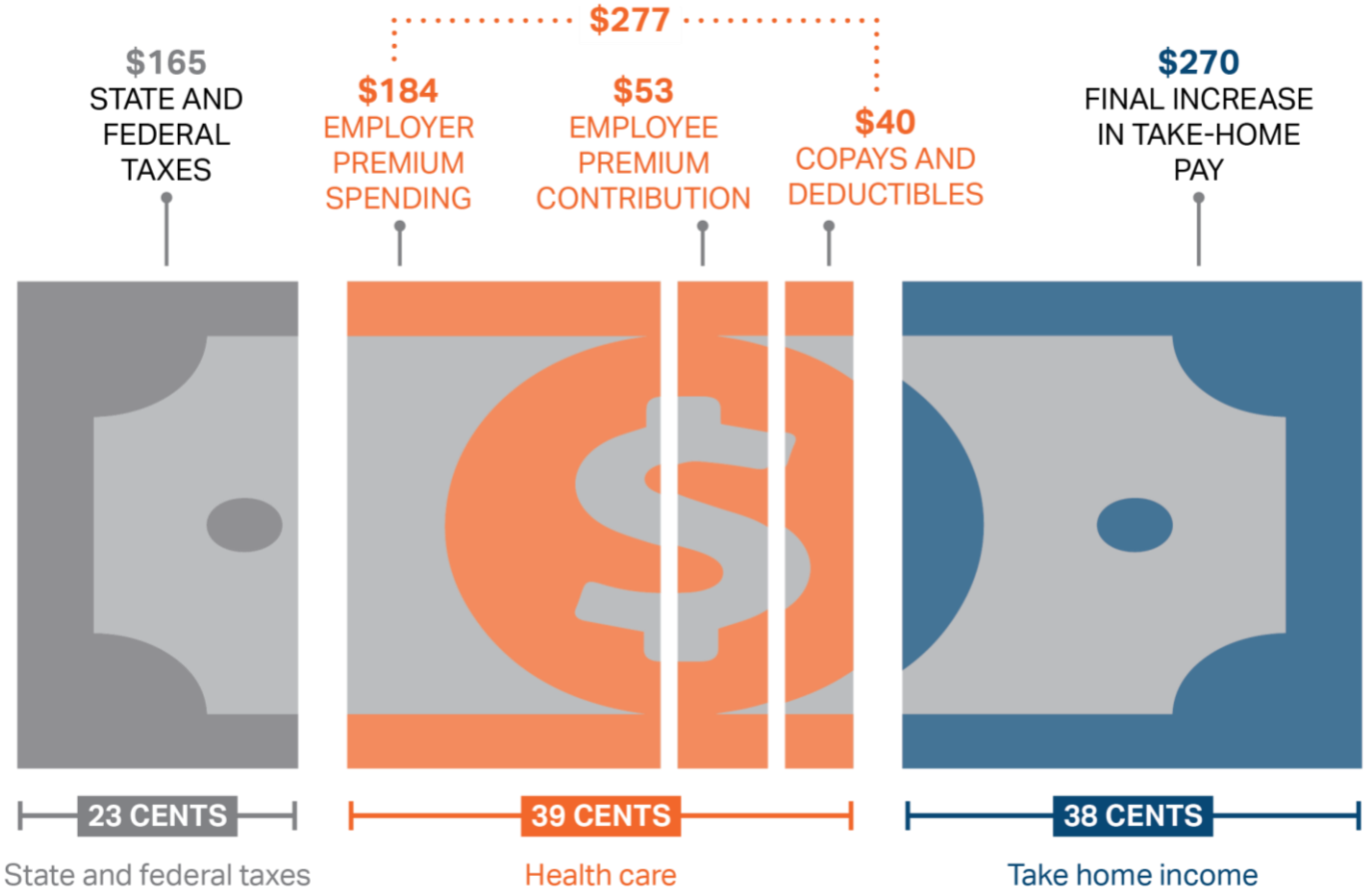
Average and 90th percentile of family premiums by state averaged across 2016-2018



Notes: Mean premiums and 90th percentile represent the three-year average from 2016 to 2018.
Source: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), 2016-2018

Nearly 40 cents of every additional dollar earned by Massachusetts families between 2016 and 2018 went to health care.

Allocation of the increase in monthly compensation between 2016 and 2018 for a median Massachusetts family with health insurance through an employer



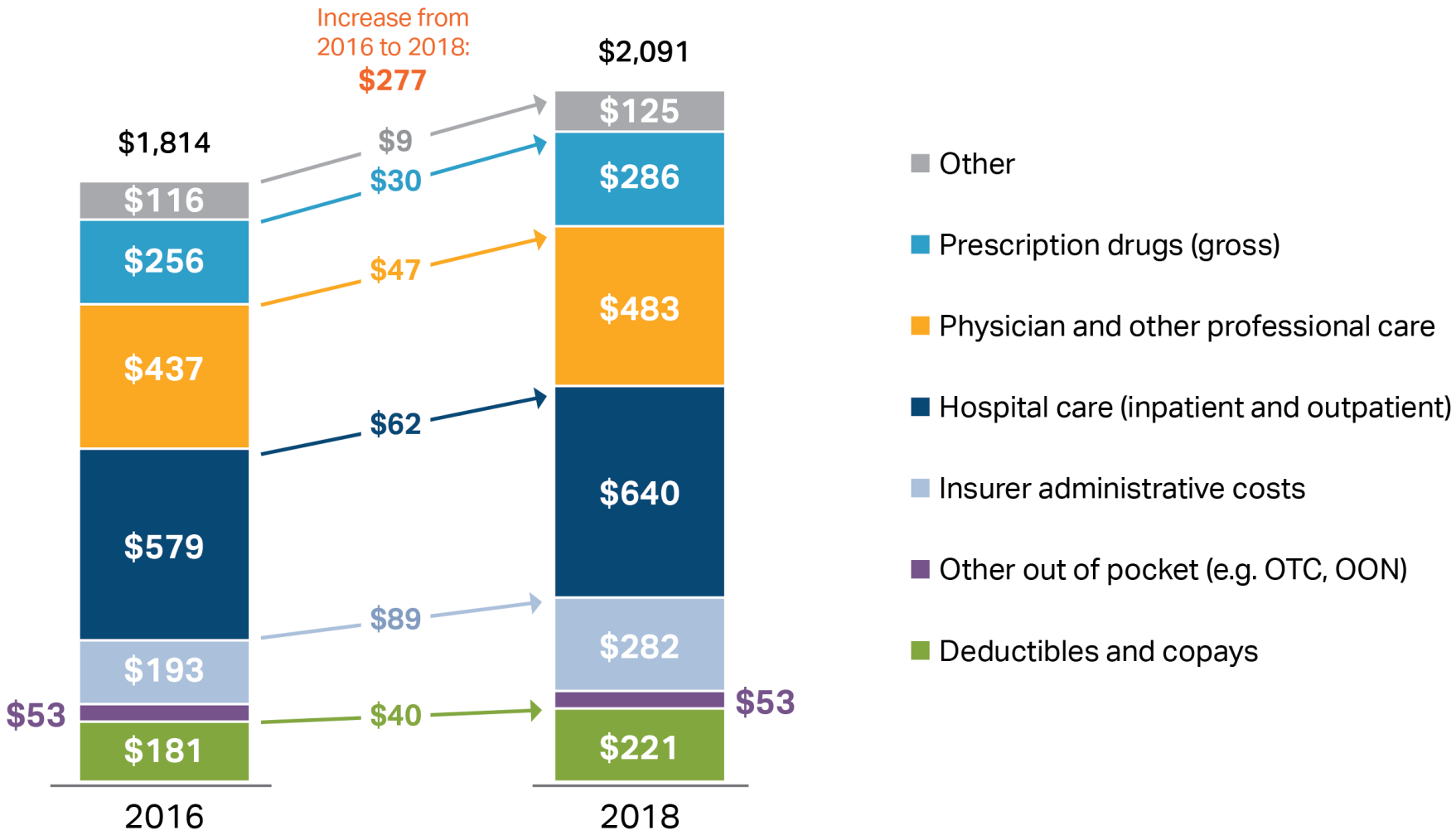
Notes: Data represent Massachusetts families who obtain private health insurance through an employer. Massachusetts median family income grew from $95,207 to $101,548 over the period while mean family employer-sponsored insurance premiums grew from $18,955 to $21,801. Compensation is defined as employer premium contributions plus income as recorded in the ACS and is considered earnings. All premium payments are assumed non-taxable. Tax figures include income, payroll, and state income tax.

Sources: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component (premiums) American Community Survey (ACS) 1-year files (income), and Center for Health Information and Analysis 2019 Annual Report (cost-sharing).

HPC

Health care spending for Massachusetts families with employer-sponsored coverage exceeded $2,000 *per month* in 2018.

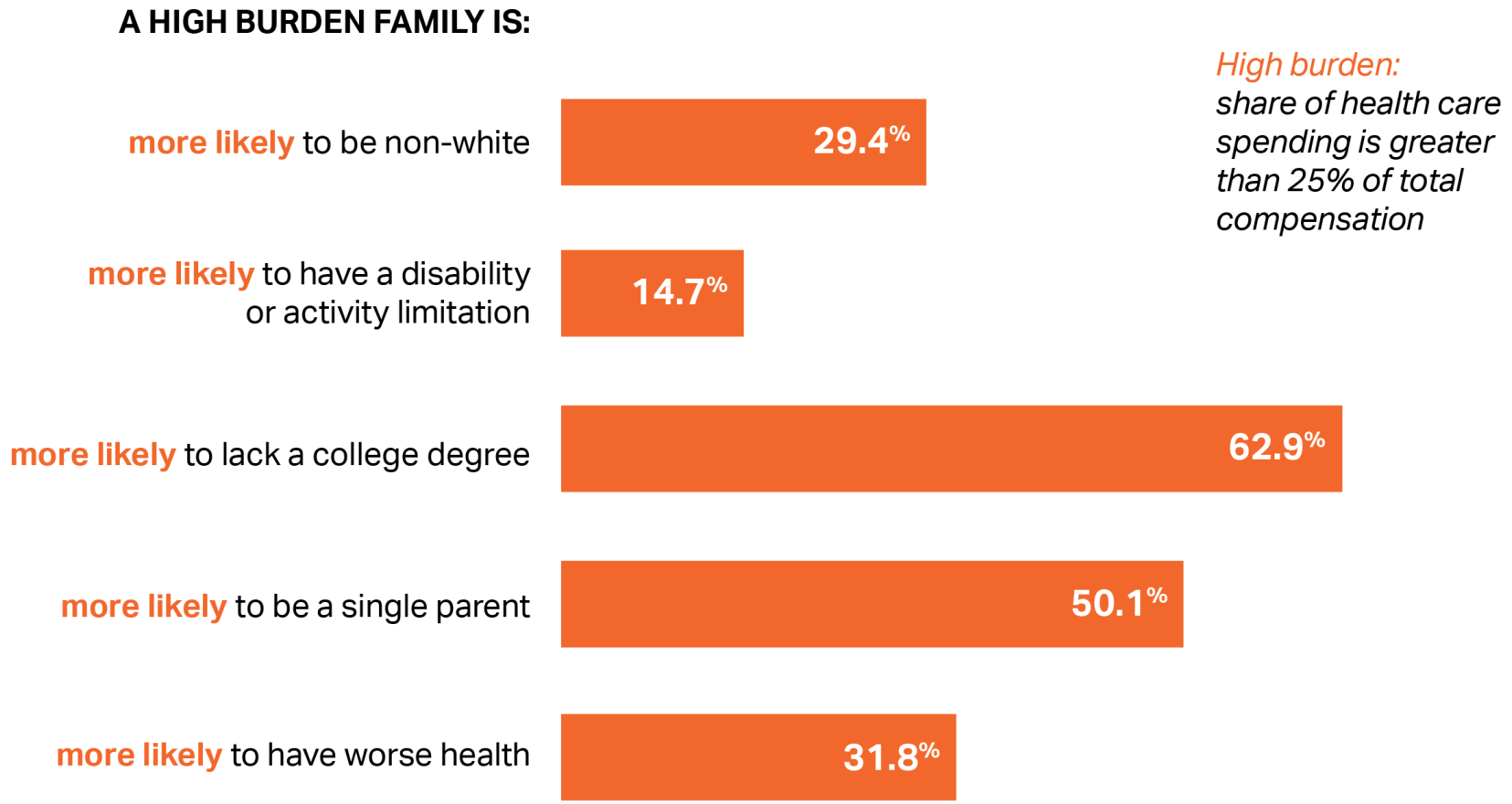
Monthly health care spending for an average Massachusetts family, by category, 2016 vs. 2018



Notes: Spending reflects members with employer-sponsored commercial coverage. Prescription drug spending does not account for rebates.
Source: HPC analysis of Center for Health Information and Analysis Annual Report, 2019, Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), 2016-2018, CPS Annual Social and Economic Supplement.

23% of Massachusetts middle-class families spend more than a quarter of all earnings on health care.

Characteristics of middle-class families with employer-sponsored health insurance that spend more than a quarter of earnings on health care (high burden families), 2016-2018 average



Notes: Estimates are a three-year average of middle class families from 2016-2018; middle class definition is based on General Social Survey (GSS) occupational prestige scores; "high burden" families are those whose total spending on healthcare (premiums, over-the-counter and other out-of-pocket spending) exceeds 25% of their total compensation. Premiums include employer and employee premium contributions and earnings (compensation) includes employer premium contribution. Disability or activity limitation was defined as difficulty walking or climbing stairs, dressing or bathing, hearing, seeing, or having a health problem or a disability which prevents work or limits the kind or amount of work they can perform. College degree was defined as having a B.A. or higher degree in the family. Single-parent families are those in families who did not report being in a married couple family (male or female reference person). Worse health was defined as those reporting a health status "poor," "fair" or "good."
Source: HPC's analysis of data from the CPS Annual Social and Economic Supplement (ASEC), 2016-8 and Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), 2016-2018 (premiums).

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Up Next

Presentation: Opportunities to Drive Value in Health Care
Dr. Meredith Rosenthal, Professor of Health Economics and Policy
Harvard T.H. Chan School of Public Health

Beyond shopping: How can price transparency improve value-based purchasing?

Anna D. Sinaiko, Pragya Kakani and Meredith Rosenthal

October 22, 2019

Can we spend less in health care without losing value?

Spending = Price x Quantity

Many policy strategies use price information to improve value

Target individuals:

- Decision support tools
- Benefit design

Target providers:

- Bundled payments
- Price regulation

Analysis of novel price dataset from Center for Health Information and Analysis (CHIA)

- Transparency a key strategy to reduce spending growth in MA
- CHIA has built both consumer-facing and “wholesale” price information assets
- Median fee-for-service prices for 291 outpatient services in Massachusetts during 2015
- Every insurer-provider-service paid price
  - N claims per price at least 15 (11 for maternity)
  - 8 commercial payers (75.4% commercial market)
  - 12,549 healthcare providers
- We use the wholesale data to examine variation in prices by geography, payer and provider

Measures of Price and Variation

- Service (e.g., CPT-code) level price
  - Analyzed variation using Coefficient of Variation
  - Compared acute hospital prices vs other providers

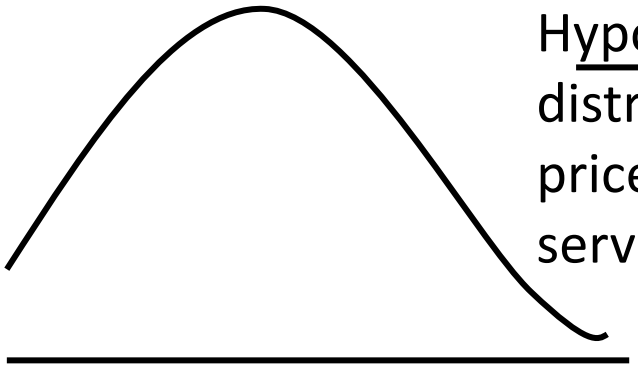
- Estimated ”implied price” for each provider

$$Implied\ Price_j = \frac{\sum_{s=1}^{S}\sum_{i=1}^{I} p_{isj} \times q_{isj}}{\sum_{s=1}^{S} \overline{p_s} \times q_{sj}}$$

Where *j* indexes the provider, *i* indexes the insurer, and *s* indexes medical services

- Aggregated by geography (HSA), and provider deciles

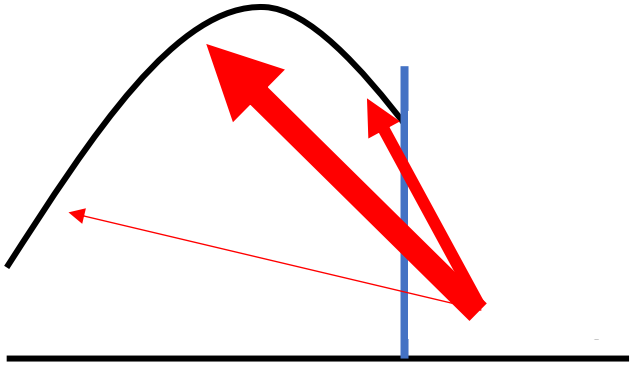
Two stylized policy simulations



Hypothetical distribution of paid prices for a medical service

1st percentile

99th percentile

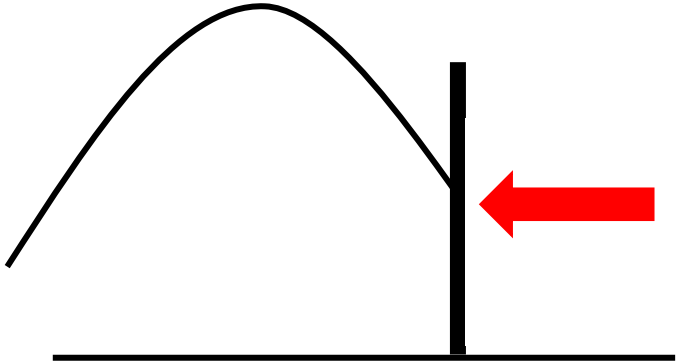


1st percentile

75th percentile

99th percentile

"Steering"



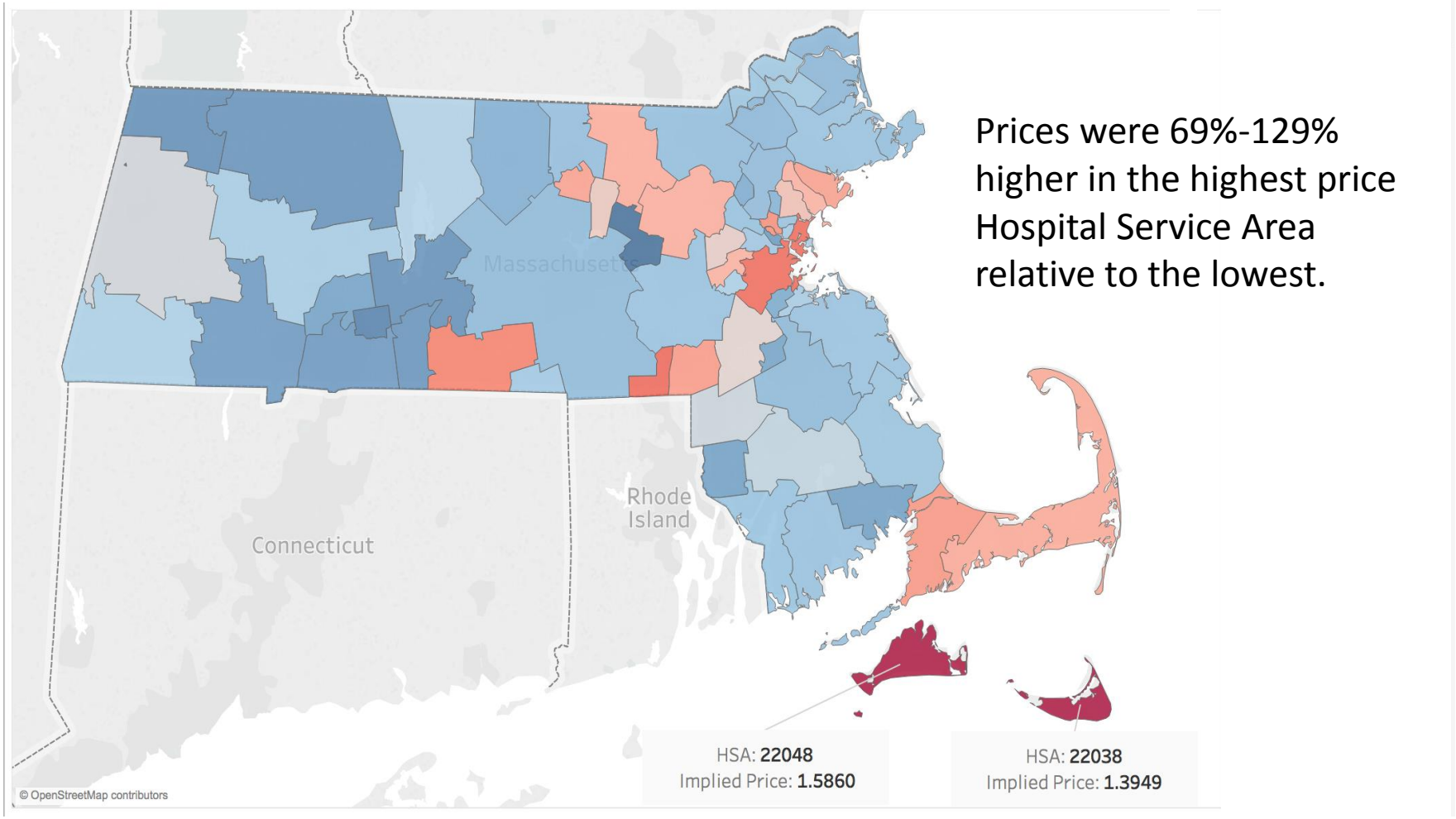
1st percentile

75th percentile

"State Price Ceiling"

Geographic Variation within state

Implied Price by Hospital Service Area

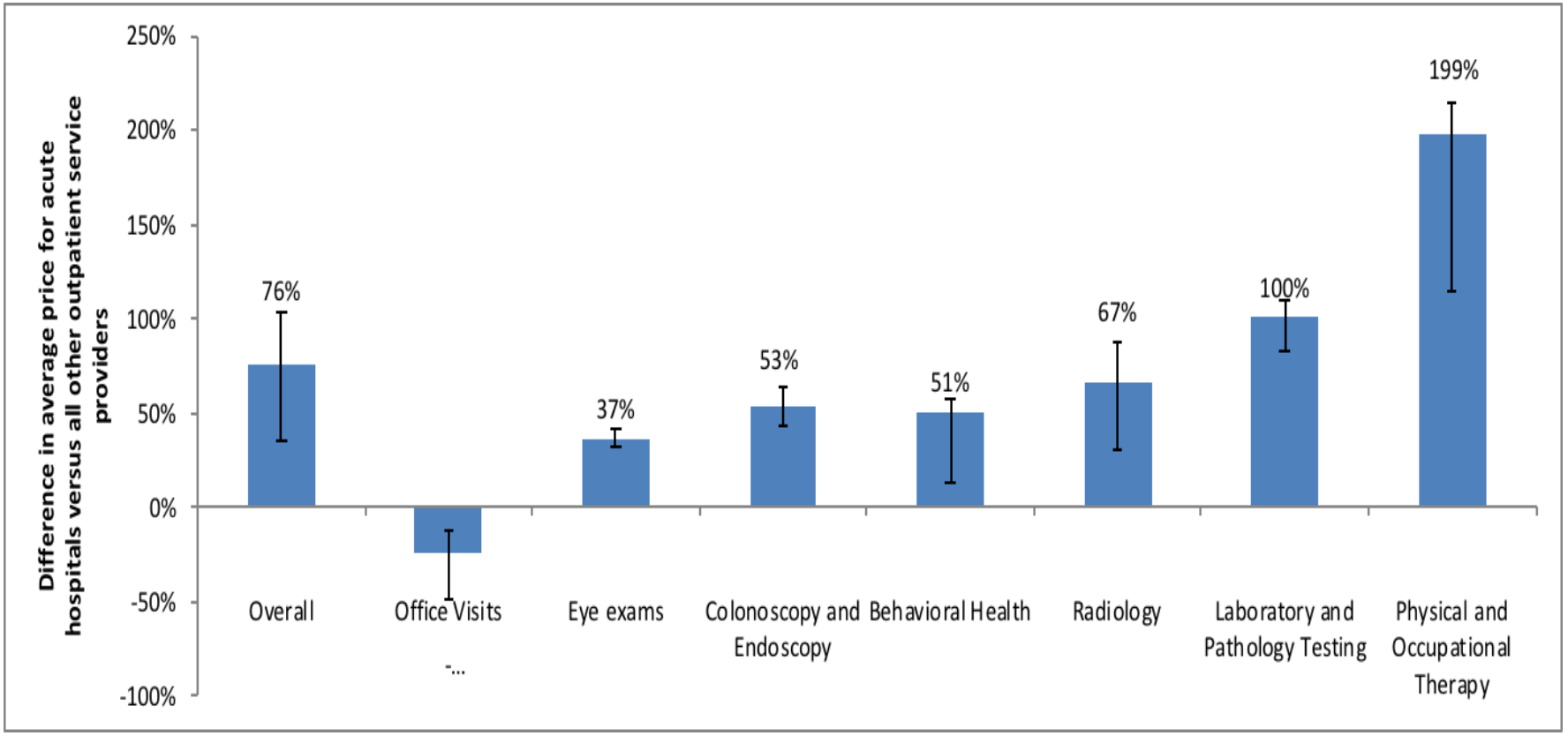


Prices were 69%-129% higher in the highest price Hospital Service Area relative to the lowest.

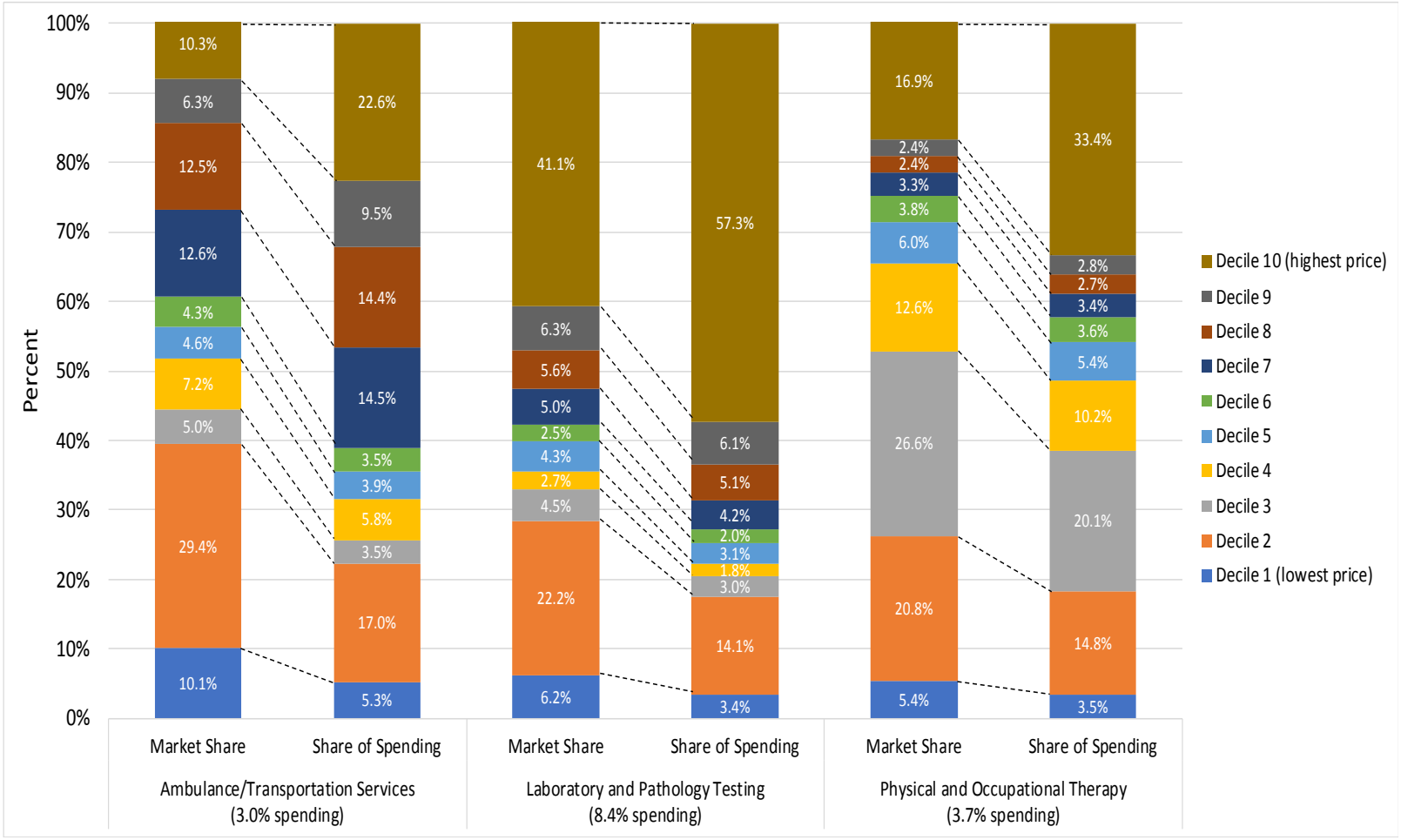
How much variation per service?

	Across Provider-insurer prices		Across Providers		Across Insurers	
	Mean provider-insurer price (SD)	Mean Coefficient of variation (SD)	N providers	Mean Coefficient of variation (SD)	N payers	Mean Coefficient of variation (SD)
Overall	177.68 (355.20)	0.50 (0.22)	12549	0.42 (0.22)	8	0.30 (0.51)
Service Line						
Ambulance/Transportation Services	654.15 (760.08)	0.79 (0.26)	255	0.75 (0.28)	8	0.34 (0.16)
Behavioral Health	88.62 (36.60)	0.35 (0.19)	7146	0.32 (0.21)	8	0.16 (0.11)
Colonoscopy and Endoscopy	2097.17 (888.71)	0.31 (0.05)	91	0.29 (0.04)	8	0.24 (0.11)
Emergency Department Visits	537.63 (351.89)	0.49 (0.10)	67	0.32 (0.07)	8	0.32 (0.07)
Eye exams	154.49 (86.59)	0.50 (0.07)	714	0.31 (0.06)	8	0.28 (0.04)
Laboratory and Pathology Testing	26.86 (26.89)	0.64 (0.12)	713	0.54 (0.11)	8	0.34 (0.13)
Maternity*	4132.35 (990.94)	0.24 (0.01)	99	0.20 (0.00)	4	0.16 (0.01)
Office Visits	164.81 (84.44)	0.38 (0.23)	4034	0.29 (0.17)	8	0.26 (0.35)
Physical and Occupational Therapy	42.96 (38.69)	0.70 (0.31)	1392	0.69 (0.36)	8	0.96 (1.89)
Radiology	471.11 (532.57)	0.42 (0.17)	518	0.34 (0.19)	8	0.22 (0.20)

Variation: Acute hospitals vs other providers



Variation: Implications for Spending Across 3 Service Types



Potential savings from "steering" and "price ceiling" stylized policies

Policy Simulation:	Steer patients to lower cost providers*	
	Savings as a percent of service catetory spending	Savings as percent of total spending
Overall		12.8%
By service line		
Ambulance/Transportation Services	23.4%	0.5%
Behavioral Health	7.3%	0.7%
Colonoscopy and Endoscopy	15.9%	0.5%
Emergency Department Visits	24.2%	0.5%
Eye exams	15.8%	0.6%
Laboratory and Pathology Testing	27.5%	1.3%
Maternity	1.7%	0.0%
Office Visits	9.2%	5.3%
Physical and Occupational Therapy	22.7%	1.1%
Radiology	21.0%	2.3%

Notes: *Simulation models shifting patients from providers paid prices above the 75th percentile price within HSA and within insurer to other providers. Only includes services rendered by at least 5 providers within HSA within insurer.

Limitations

- Outpatient service prices only here
- No data on quality
- Simulations don’t account for all considerations important for policy:
  - Incentives for innovation?
  - Network sufficiency

Policy Implications

- Transparency is not just for consumers – payers and regulators may be able to use price information more effectively: through steering tools and other policies
- For what services can we successfully steer patients?
  - PT/OT?
  - Outpatient Labs?
  - Ambulances?
- More analysis could increase our understanding of the price differences – and which ones are associated with the greatest opportunities to increase value

Additional questions and comments:

mrosenth@hsph.harvard.edu

2019 HEALTH CARE COST TRENDS HEARING

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Up Next

Witness Panel 1: Confronting Complexity in the Health Care System

Witness Panel 1

Confronting Complexity in the Health Care System

MASSACHUSETTS
HEALTH POLICY COMMISSION

Health system complexity has implications for cost, quality, and access.

Complexity is endemic to the US healthcare system.

- Insurance plans vary in their **benefit levels**, **coverage** for specific services or drugs, **provider network composition**, and **administrative requirements**.
- Administrative and even clinical tasks are **performed differently or redundantly** by different actors in the health care system.

- **Information-sharing and care coordination** across different providers and electronic health record systems can be challenging.

Navigating this complexity is costly. Many of those costs are reflected in high administrative spending, among other implications.

- Patients may experience challenges with **timely access** to services, **adherence** to treatment plans, **surprise bills**, and **out-of-pocket costs**.
- **Variation in the resources** needed to manage complexity can impact providers, employers, and consumers.

- Providers may experience **burnout** and recruiting difficulty.

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Administrative costs are a substantial share of national health care spending.

$496 billion

Nationally, **billing and insurance-related (BIR) activities** are estimated to account for 13-14% of health care spending.

$282 billion

Providers pay about 56% of these costs; public payer and private insurance companies pay the rest.

30%

When **non-BIR administrative costs** are included, administrative costs are estimated to reach close to 1/3 of national health care spending.

When examining private and public payer spending on administrative costs, **the U.S. had the highest level of administrative spending** of any OECD country.

HPC

Sources: Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, Center for American Progress (2019); Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, New England Journal of Medicine (2003); William H. Shrank et al., *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, JAMA (2019).

Administrative Spending in Massachusetts

- Applying national figures to Massachusetts, the HPC estimates that BIR activities cost **Massachusetts providers** approximately **$1.5 billion annually**.

  - **Physician practices** are estimated to spend **10% to 14% of revenue** on these activities, or **$600 – $840 million** per year.

  - **Hospitals** are estimated to spend **8% of revenue** on these activities, or **$768 million** per year.

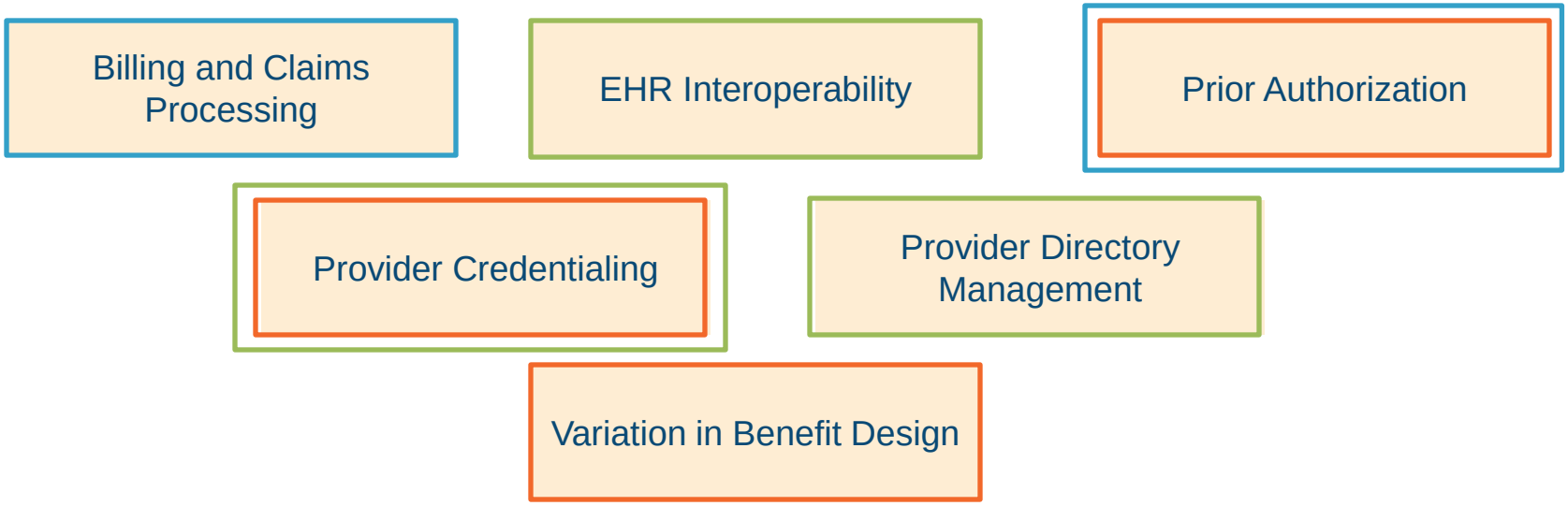
- CHIA estimates that **private payers in Massachusetts** spent approximately **$2.5 billion** on non-claims expenses in 2017.

  - These figures include areas that may constitute complexity without value as well as expenses like underwriting, rent, and salaries.
  - These figures do not include **carrier payments to providers**, a portion of which are also spent on administrative tasks.

- These estimates do not include the time and monetary costs borne by patients.

Sources: Sakowski 2009, Casalino 2009, Kahn 2010. Commercial revenue data is sourced from CHIA's 2017 Relative Price Databook.; Center for Health Information and Analysis. Performance of the Massachusetts Health Care System: Annual Report September 2018. http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf; Division of Insurance. Financial Summary of the 2017 Market for Health Insurance. https://www.mass.gov/files/documents/2018/09/28/2017%20Annual%20Comprehensive%20Financial%20Statement.pdf; Gorman Actuarial analysis of 2017 Federal MLR reports with Merged Market rebates from the MA MLR reports. Two carriers were excluded from the Federal MLR analysis due to data quality concerns

Payers and providers prioritize different areas of administrative complexity for greater alignment and simplification.



- The HPC's **Advisory Council** identified Prior Authorization, Provider Credentialing, and Variation in Benefit Design as top priority areas.
- Through pre-filed testimony, 29 surveyed **Providers** identified Billing and Claims Processing and Prior Authorization as top priority areas.
- Through pre-filed testimony, 12 surveyed **Payers** identified EHR Interoperability, Provider Credentialing and Provider Directory Management as top priority areas.

Source: HPC analysis of pre-filed testimony pursuant to the 2019 Annual Health Care Cost Trends Hearing. Available at https://www.mass.gov/info-details/testimony-for-the-2019-health-care-cost-trends-hearing

Levers for Reducing Administrative Complexity

Reduce Variation & Duplication

- Improve processes that require unnecessary repetition
- Standardize requirements and processes across organizations

Leverage Technology

- Reduce the use of faxing, phone, email
- Integrate forms, processes and systems into existing workflows
- Review existing IT systems against new technology

Eliminate Low-Value Tasks

- Identify tasks that are no longer achieving their intended purpose
- Determine whether task is valuable in all circumstances and consider differential application

Witness Panel 1: Confronting Complexity in the Health Care System

Witnesses

Dr. Michael Apkon, President and CEO	Tufts Medical Center
Cheryl Corman, Executive VP and Chief HR Officer	Middlesex Savings Bank
Dr. Alejandro J. Esparza-Perez, CMO	Holyoke Health Center
Amy Rosenthal, Executive Director	Health Care For All
David Segal, President and CEO	AllWays Health Partners

Goal

This panel will focus on the impact of administrative complexity on patients, employers, providers, and payers, as well as solutions for reducing complexity that does not provide value.

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Up Next

Witness Panel 2: Pharmaceutical Market Trends and Cost Drivers

Witness Panel 2

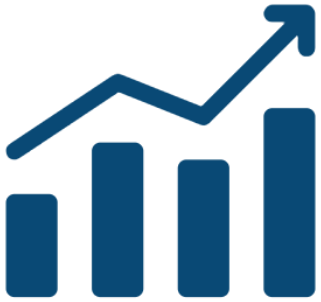
Pharmaceutical Market Trends and Cost Drivers

MASSACHUSETTS
HEALTH POLICY COMMISSION

There is a broad public consensus that further action is necessary to reduce prescription drug costs as more patients defer care due to cost.

6%

Estimated **average annual net drug spending growth** in the U.S., 2020 - 2024



Sources: Centers for Medicare and Medicaid Services, projected national health care expenditures per capita, Feb 2018 projections

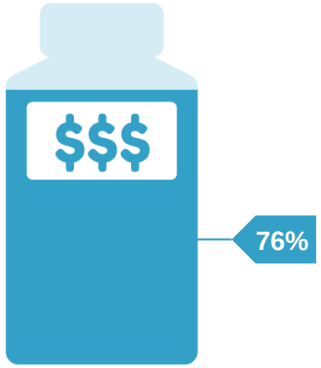
7 in 10

think "**lowering prescription drug costs for as many people as possible"** should be a top priority for Congress

Sources: Kirzinger A, Munana C, Fehr R, et al for the Kaiser Family Foundation. US Public's Perspective on Prescription Drug Costs. JAMA. 2019;322(15):1440

76%

Massachusetts residents think **the cost of prescription drugs is unreasonable**



1 in 4

Massachusetts residents **opted not to fill a prescription due to cost**

43% of those reported their condition worsened as a result

Source: Harrison E. "WBUR Poll: 76% of Mass. Residents Think Drug Prices Are Unreasonable." www.wbur.org. June 24, 2019.

Drug spending was identified as a main focus for cost containment by health plans and providers.

Strategies Used to Reduce Drug Spending

Value-based formulary design

Clinician education

Programs to encourage patient use of lower-cost alternatives

Recommended Policy Actions

- Increase **transparency from manufacturers** and **pharmacy benefit managers**
- Allow for more robust **price negotiation and controls**, reform manufacturer rebates
- Enhance **government oversight** and **monitoring of market tactics**
- **Flexibility in financing** to encourage value-based contracting
- Maximize **availability of biosimilars** and **generic specialty drugs**

Source: HPC analysis of pre-filed testimony pursuant to the 2019 Annual Health Care Cost Trends Hearing. Available at https://www.mass.gov/info-details/testimony-for-the-2019-health-care-cost-trends-hearing

Witness Panel 2: Pharmaceutical Market Trends and Cost Drivers

Witnesses

Dr. Troyen Brennan, Executive VP and CMO	CVS Health
Michael Carson, President and CEO	Harvard Pilgrim Health Care
Erin Mistry, Head of Value, Access, and HEOR	Syneos Health
Dr. David Twitchell, Chief Pharmacy Officer	Boston Medical Center Health System

Goal

The goal of this panel is to discuss emerging policies and strategies for payers, providers, manufacturers, and other stakeholders to address affordability of prescription drugs and promote value in pharmaceutical spending.

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2019 HEALTH CARE COST TRENDS HEARING

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Up Next
Public Testimony

PUBLIC TESTIMONY

MASSACHUSETTS
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2019 HEALTH CARE COST TRENDS HEARING

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Tomorrow:

Day Two of the Health Care Cost Trends Hearing

Hearing begins at 9:00 AM

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