2019 HEALTH CARE COST TRENDS HEARING

OCTOBER 22

#CTH19
2019 HEALTH CARE COST TRENDS HEARING

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
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)

<table>
<thead>
<tr>
<th>Total Health Care Expenditures, 2018</th>
<th>$60.9B</th>
</tr>
</thead>
<tbody>
<tr>
<td>THCE per capita, 2018</td>
<td>$8,827</td>
</tr>
<tr>
<td>Growth rate per capita, 2018</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

For more information, see page 10 of CHIA’s Annual Report
THCE growth per capita equaled the health care cost growth benchmark in 2018, after two years of trending below.
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
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

For more information, see page 14 of CHIA’s Annual Report
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
Expenditures increased for both HMO and PPO plans, though enrollment trends diverged.
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
APM adoption varied among the largest provider organizations.

For more information, see page 35 of CHIA’s Annual Report
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
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
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
Fully-insured premiums increased 5.6% to $509 PMPM in 2018. Members covered through larger employers had higher premiums.
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
Payers reported more than one-fifth (21.5%) of premium retention as surplus in 2018. This gain represented 2.9% of total earned premiums.
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
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Medicare (MA)</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient</td>
<td>2.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>7.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Physician + other</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>6.6%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Home health</td>
<td>2.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>-3.1%</td>
<td>-1.8%</td>
</tr>
</tbody>
</table>

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.
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

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.
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.

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

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.
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.

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).
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

<table>
<thead>
<tr>
<th>Category</th>
<th>2016</th>
<th>Increase from 2016 to 2018</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs (gross)</td>
<td>$1,814</td>
<td>$277</td>
<td>$2,091</td>
</tr>
<tr>
<td>Physician and other professional care</td>
<td>$116</td>
<td>$9</td>
<td>$125</td>
</tr>
<tr>
<td>Hospital care (inpatient and outpatient)</td>
<td>$256</td>
<td>$47</td>
<td>$286</td>
</tr>
<tr>
<td>Insurer administrative costs</td>
<td>$437</td>
<td>$62</td>
<td>$483</td>
</tr>
<tr>
<td>Other out of pocket (e.g. OTC, OON)</td>
<td>$579</td>
<td>$89</td>
<td>$640</td>
</tr>
<tr>
<td>Other</td>
<td>$193</td>
<td>$40</td>
<td>$282</td>
</tr>
<tr>
<td>Deductibles and copays</td>
<td>$181</td>
<td>$53</td>
<td>$221</td>
</tr>
</tbody>
</table>

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

A HIGH BURDEN FAMILY IS:

- more likely to be non-white: 29.4%
- more likely to have a disability or activity limitation: 14.7%
- more likely to lack a college degree: 62.9%
- more likely to be a single parent: 50.1%
- more likely to have worse health: 31.8%

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.”

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

\[
\text{Implied Price}_j = \frac{\sum_{s=1}^{S} \sum_{i=1}^{I} p_{isj} \times q_{isj}}{\sum_{s=1}^{S} \bar{p}_s \times q_{sj}}
\]

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"

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

Geographic Variation within state

Implied Price by Hospital Service Area
<table>
<thead>
<tr>
<th>Service Line</th>
<th>Across Provider-insurer prices</th>
<th>Across Providers</th>
<th>Across Insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean provider-insurer price (SD)</td>
<td>Mean Coefficient of variation (SD)</td>
<td>N providers</td>
</tr>
<tr>
<td>Overall</td>
<td>177.68 (355.20)</td>
<td>0.50 (0.22)</td>
<td>12549</td>
</tr>
<tr>
<td>Service Line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance/Transportation Services</td>
<td>654.15 (760.08)</td>
<td>0.79 (0.26)</td>
<td>255</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>88.62 (36.60)</td>
<td>0.35 (0.19)</td>
<td>7146</td>
</tr>
<tr>
<td>Colonoscopy and Endoscopy</td>
<td>2097.17 (888.71)</td>
<td>0.31 (0.05)</td>
<td>91</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>537.63 (351.89)</td>
<td>0.49 (0.10)</td>
<td>67</td>
</tr>
<tr>
<td>Eye exams</td>
<td>154.49 (86.59)</td>
<td>0.50 (0.07)</td>
<td>714</td>
</tr>
<tr>
<td>Laboratory and Pathology Testing</td>
<td>26.86 (26.89)</td>
<td>0.64 (0.12)</td>
<td>713</td>
</tr>
<tr>
<td>Maternity*</td>
<td>4132.35 (990.94)</td>
<td>0.24 (0.01)</td>
<td>99</td>
</tr>
<tr>
<td>Office Visits</td>
<td>164.81 (84.44)</td>
<td>0.38 (0.23)</td>
<td>4034</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>42.96 (38.69)</td>
<td>0.70 (0.31)</td>
<td>1392</td>
</tr>
<tr>
<td>Radiology</td>
<td>471.11 (532.57)</td>
<td>0.42 (0.17)</td>
<td>518</td>
</tr>
</tbody>
</table>
Variation: Acute hospitals vs other providers

<table>
<thead>
<tr>
<th>Service</th>
<th>Difference in Average Price (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>76%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>-77%</td>
</tr>
<tr>
<td>Eye exams</td>
<td>37%</td>
</tr>
<tr>
<td>Colonoscopy and Behavioral Health Endoscopy</td>
<td>53%</td>
</tr>
<tr>
<td>Radiology</td>
<td>51%</td>
</tr>
<tr>
<td>Laboratory and Pathology Testing</td>
<td>67%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>100%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>199%</td>
</tr>
</tbody>
</table>
Variation: Implications for Spending Across 3 Service Types

Decile 10 (highest price)  Decile 9  Decile 8  Decile 7  Decile 6  Decile 5  Decile 4  Decile 3  Decile 2  Decile 1 (lowest price)

<table>
<thead>
<tr>
<th>Market Share</th>
<th>Share of Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance/Transportation Services (3.0% spending)</td>
<td></td>
</tr>
<tr>
<td>Decile 10</td>
<td>10.3%</td>
</tr>
<tr>
<td>Decile 9</td>
<td>6.3%</td>
</tr>
<tr>
<td>Decile 8</td>
<td>2.4%</td>
</tr>
<tr>
<td>Decile 7</td>
<td>2.4%</td>
</tr>
<tr>
<td>Decile 6</td>
<td>3.3%</td>
</tr>
<tr>
<td>Decile 5</td>
<td>3.8%</td>
</tr>
<tr>
<td>Decile 4</td>
<td>6.0%</td>
</tr>
<tr>
<td>Decile 3</td>
<td>6.0%</td>
</tr>
<tr>
<td>Decile 2</td>
<td>2.7%</td>
</tr>
<tr>
<td>Decile 1</td>
<td>3.6%</td>
</tr>
<tr>
<td>Total</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Market Share</th>
<th>Share of Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory and Pathology Testing (8.4% spending)</td>
<td></td>
</tr>
<tr>
<td>Decile 10</td>
<td>10.1%</td>
</tr>
<tr>
<td>Decile 9</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 8</td>
<td>4.3%</td>
</tr>
<tr>
<td>Decile 7</td>
<td>4.3%</td>
</tr>
<tr>
<td>Decile 6</td>
<td>5.0%</td>
</tr>
<tr>
<td>Decile 5</td>
<td>5.1%</td>
</tr>
<tr>
<td>Decile 4</td>
<td>6.1%</td>
</tr>
<tr>
<td>Decile 3</td>
<td>6.1%</td>
</tr>
<tr>
<td>Decile 2</td>
<td>2.7%</td>
</tr>
<tr>
<td>Decile 1</td>
<td>14.8%</td>
</tr>
<tr>
<td>Total</td>
<td>22.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Market Share</th>
<th>Share of Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and Occupational Therapy (3.7% spending)</td>
<td></td>
</tr>
<tr>
<td>Decile 10</td>
<td>10.4%</td>
</tr>
<tr>
<td>Decile 9</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 8</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 7</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 6</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 5</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 4</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 3</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Decile 1</td>
<td>3.5%</td>
</tr>
<tr>
<td>Total</td>
<td>17.0%</td>
</tr>
</tbody>
</table>
Potential savings from “steering” and “price ceiling” stylized policies

<table>
<thead>
<tr>
<th>Policy Simulation:</th>
<th>Steer patients to lower cost providers*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Savings as a percent of service category spending</td>
</tr>
<tr>
<td>Overall</td>
<td>12.8%</td>
</tr>
<tr>
<td>By service line</td>
<td></td>
</tr>
<tr>
<td>Ambulance/Transportation Services</td>
<td>23.4%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>7.3%</td>
</tr>
<tr>
<td>Colonoscopy and Endoscopy</td>
<td>15.9%</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>24.2%</td>
</tr>
<tr>
<td>Eye exams</td>
<td>15.8%</td>
</tr>
<tr>
<td>Laboratory and Pathology Testing</td>
<td>27.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>1.7%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>9.2%</td>
</tr>
<tr>
<td>Physical and Occupational Therapy</td>
<td>22.7%</td>
</tr>
<tr>
<td>Radiology</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

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

Up Next
Witness Panel 1: Confronting Complexity in the Health Care System
Witness Panel 1
Confronting Complexity in the Health Care System
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.
Administrative costs are a substantial share of national health care spending.

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

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

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.

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.

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.

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.
2019 HEALTH CARE COST TRENDS HEARING

#CTH19

Up Next
Witness Panel 2: Pharmaceutical Market Trends and Cost Drivers
Witness Panel 2
Pharmaceutical Market Trends and Cost Drivers
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


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

<table>
<thead>
<tr>
<th>Strategies Used to Reduce Drug Spending</th>
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<tr>
<td>Value-based formulary design</td>
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<td>Clinician education</td>
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<td>Programs to encourage patient use of lower-cost alternatives</td>
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<th>Recommended Policy Actions</th>
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<tr>
<td>▪ Increase transparency from manufacturers and pharmacy benefit managers</td>
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<td>▪ Allow for more robust price negotiation and controls, reform manufacturer rebates</td>
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<tr>
<td>▪ Enhance government oversight and monitoring of market tactics</td>
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<td>▪ Flexibility in financing to encourage value-based contracting</td>
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<tr>
<td>▪ Maximize availability of biosimilars and generic specialty drugs</td>
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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.
PUBLIC TESTIMONY
Tomorrow:
Day Two of the Health Care Cost Trends Hearing
Hearing begins at 9:00 AM