

HEARING TO DETERMINE THE 2025

HEALTH CARE COST GROWTH BENCHMARK



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BENCHMARK MODIFICATION PROCESS
David Seltz, Executive Director, HPC

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012



An Act Improving the Quality of Health Care and **Reducing Costs** through Increased **Transparency, Efficiency, and Innovation.**

GOAL



Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION



A transparent, innovative, **and equitable** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

- The HPC sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a hard cap on spending growth or provider-specific prices** but is a measurable goal for moderating excessive health care spending growth and **advancing health care affordability**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans** (PIPs) and submit to public monitoring.
- A PIP of an individual provider or health plan may be required only after a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.

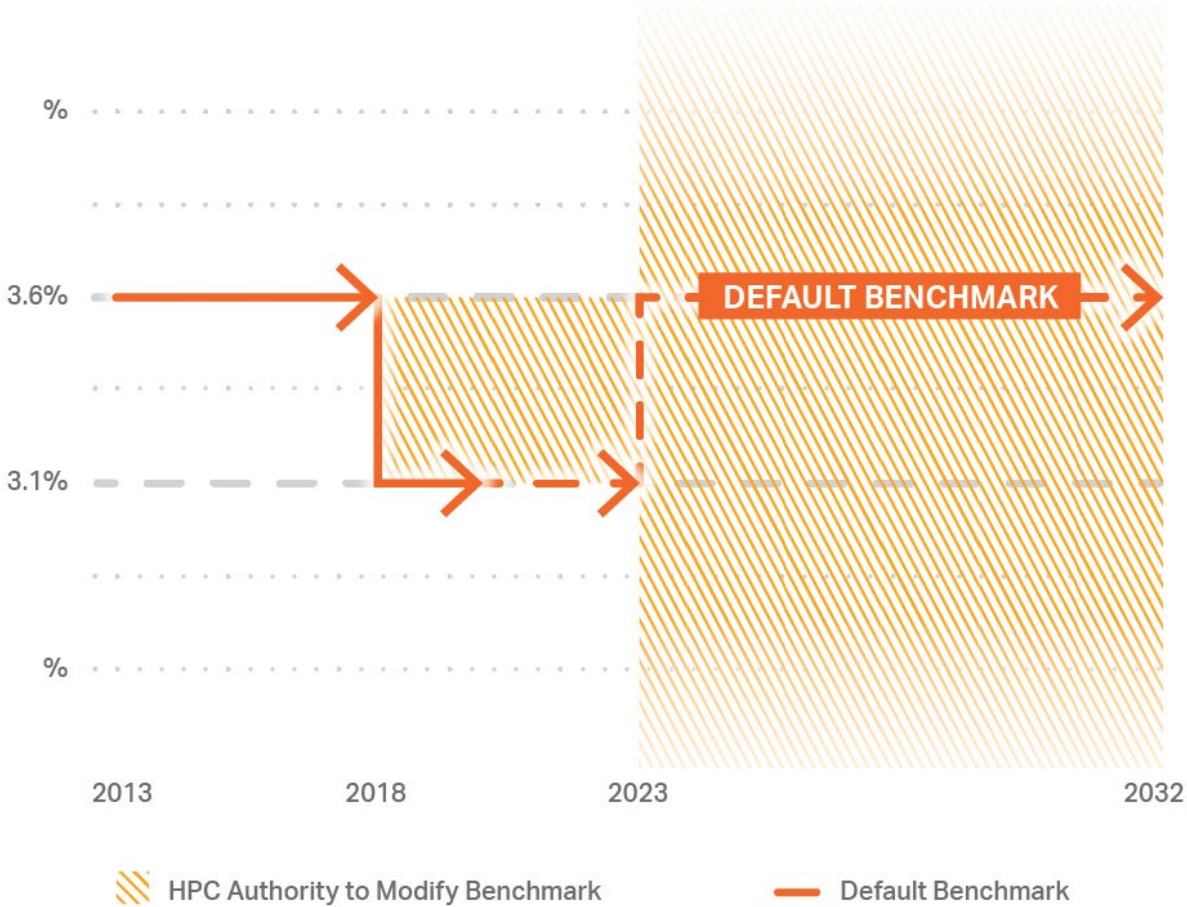
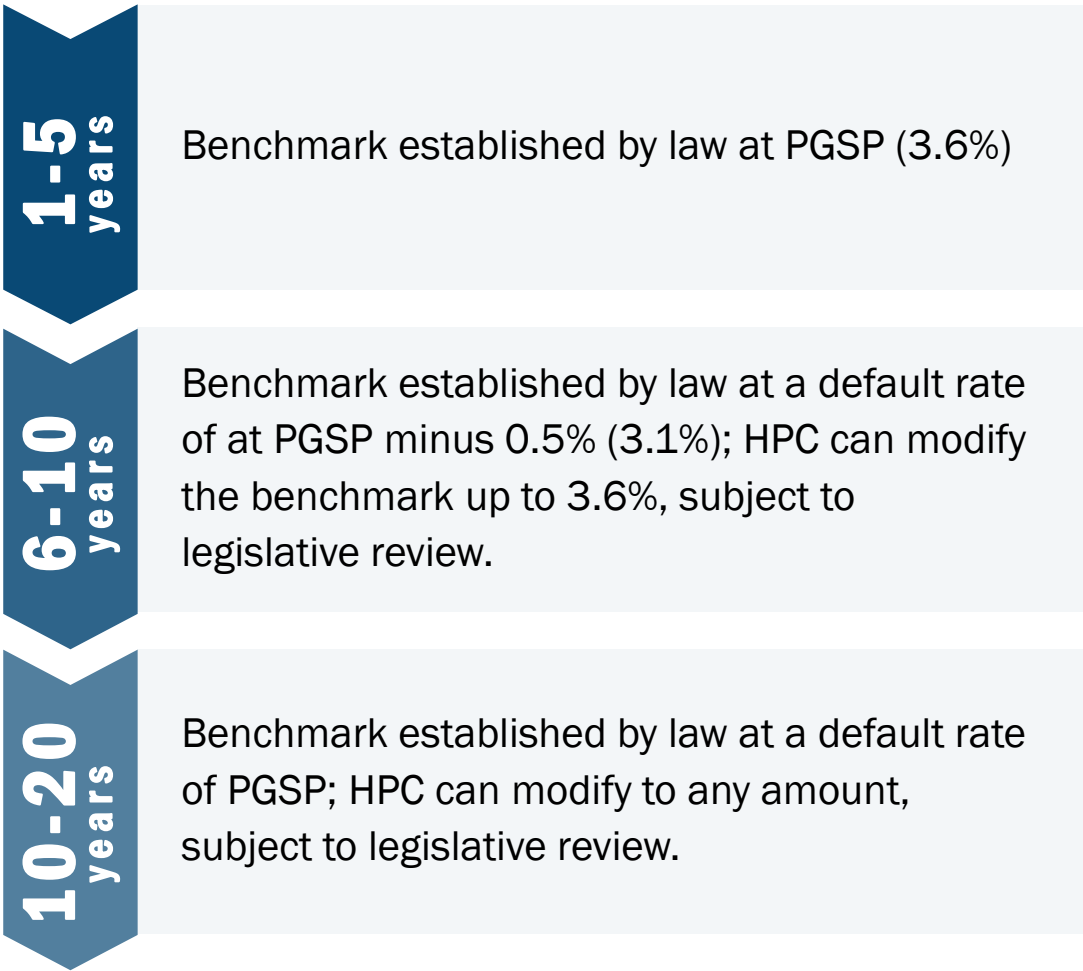
TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

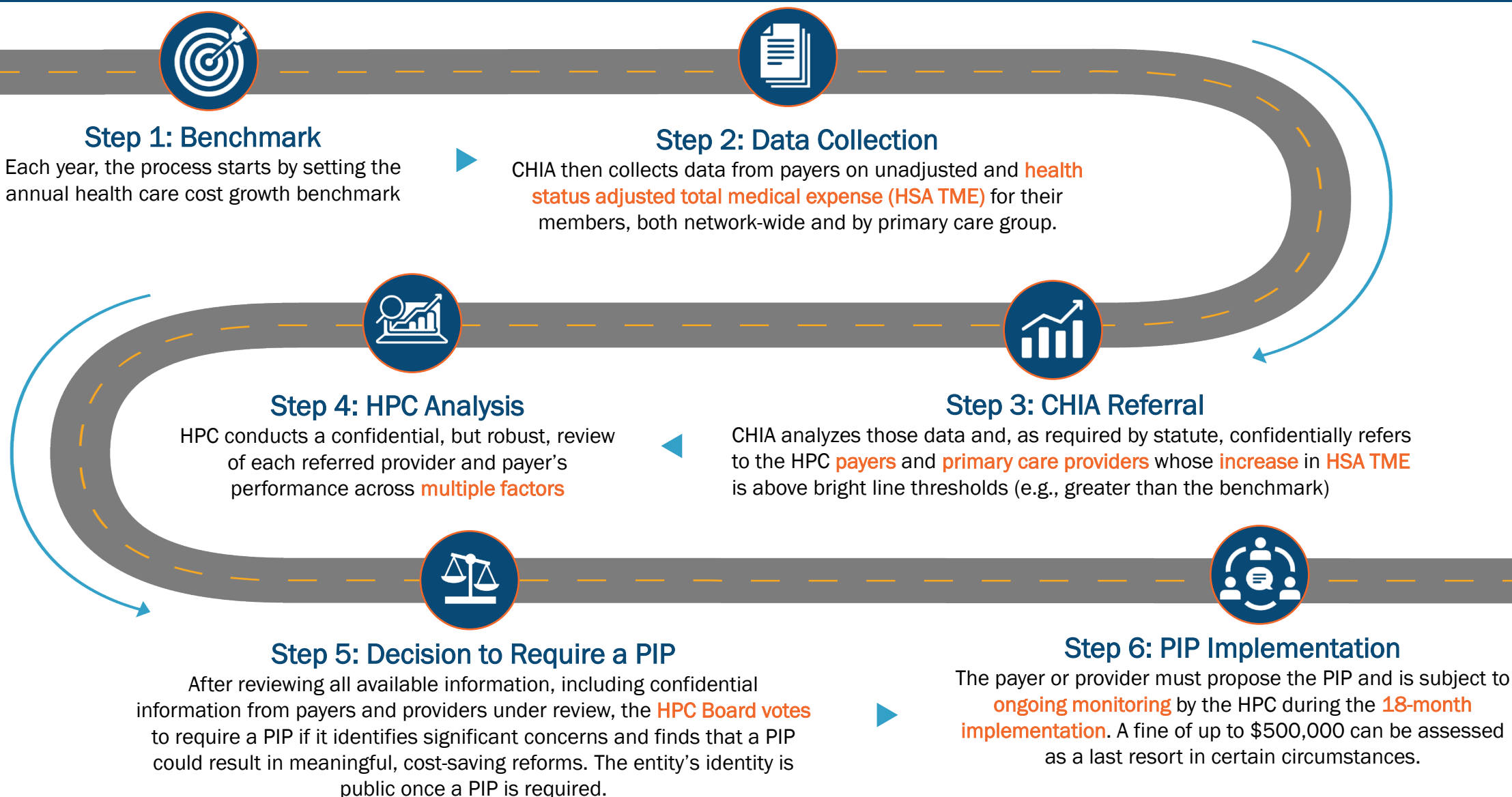
Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

The HPC’s authority to modify the benchmark is prescribed by law and subject to potential legislative review.



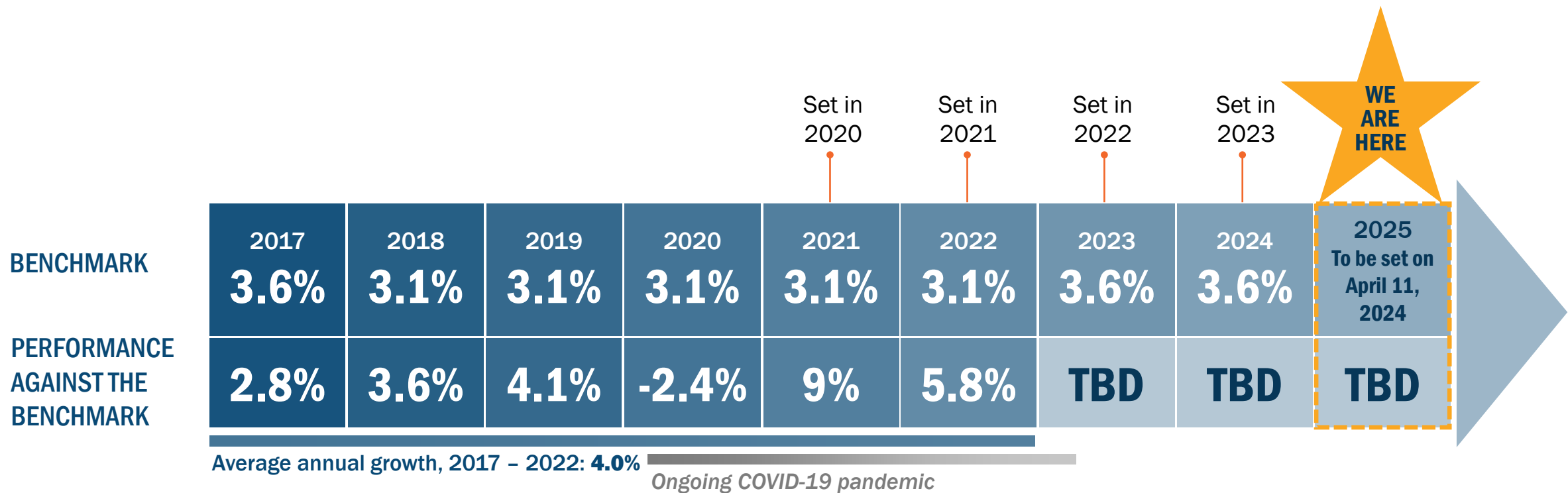
Accountability for the Health Care Cost Growth Benchmark: An Overview



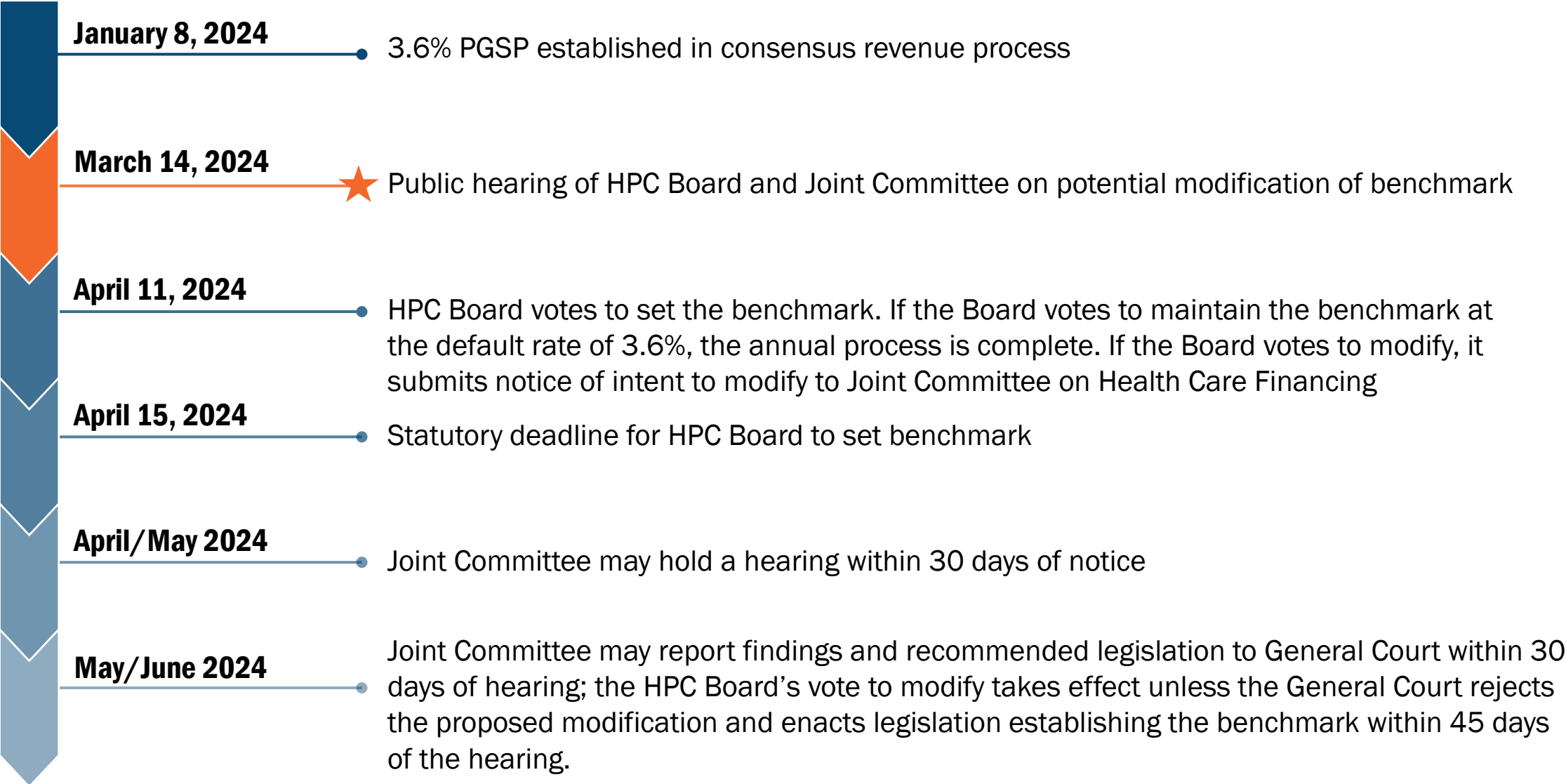
The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies **significant concerns** about the Entity’s costs and determines that a Performance Improvement Plan could result in **meaningful, cost-saving reforms**.

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity’s control; and
i	Any other factors the Commission considers relevant.

The health care cost growth benchmark is set prospectively for the upcoming calendar year, while actual performance is measured retrospectively.

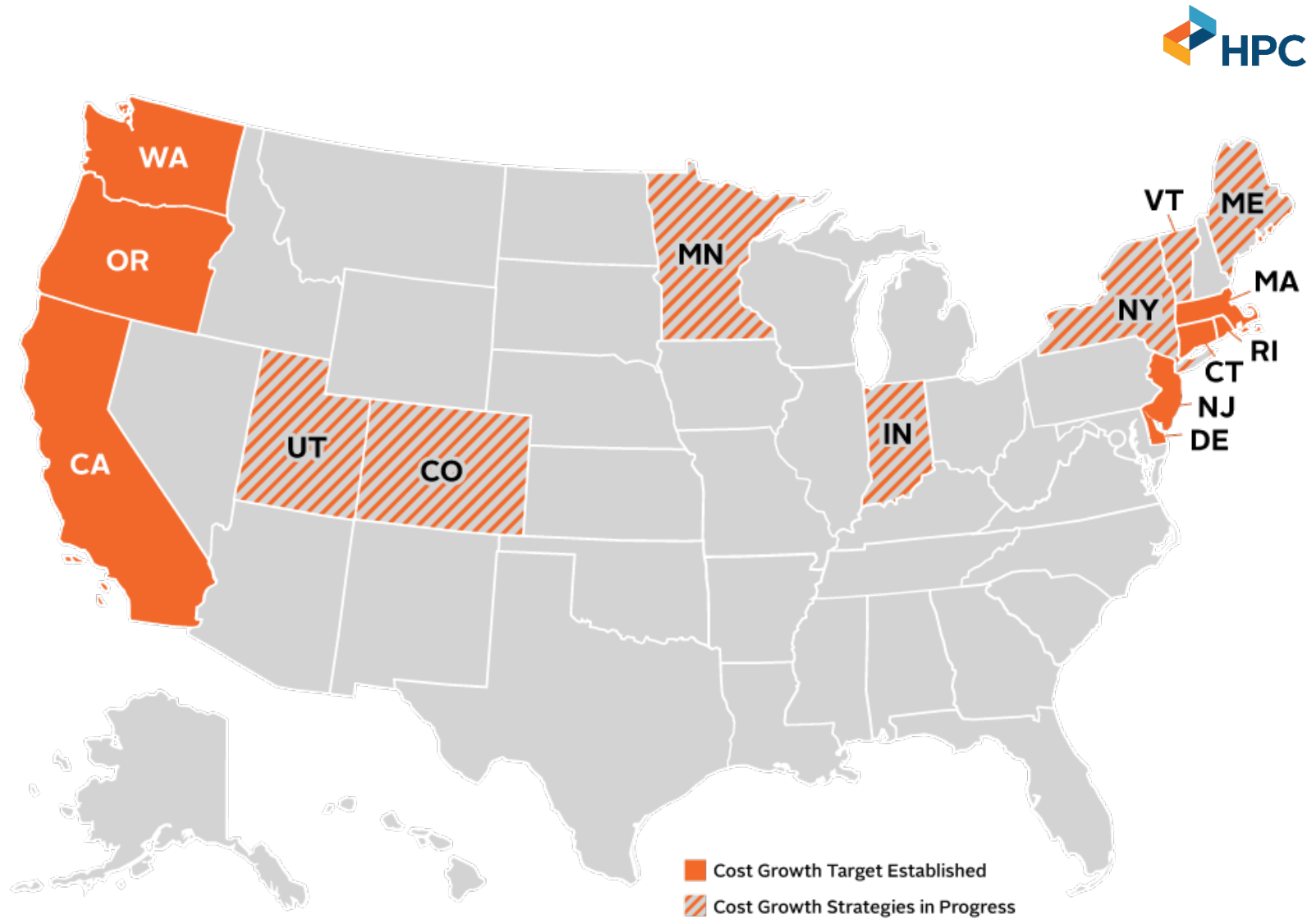


Benchmark Modification Process: 2024 Timeline



Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.

Many other states are going beyond the Massachusetts model and are adopting new strategies to promote transparency, oversight, and accountability.



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HEALTH CARE COST GROWTH BENCHMARK



**CENTER FOR HEALTH INFORMATION AND ANALYSIS (CHIA) ANNUAL REPORT
ON THE PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM**

Lauren Peters, Executive Director, CHIA

Performance of the Massachusetts Health Care System

Lauren Peters, Executive Director
Center for Health Information and Analysis

March 14, 2024

Total Health Care Expenditures 2021-2022

Overall THCE

+5.8% per resident

\$10,264 per resident

\$71.7 billion



MassHealth

+1.7% PMPM

+11.1% spending

+9.2% enrollment

Commercial

+4.1% PMPM

+0.7% spending

-3.2% enrollment

Medicare

+3.3% PMPM

+4.1% spending

+0.8% enrollment

Service Category Expenditures 2021-2022

Hospital Care

-1.4% Inpatient Spending
+5.0% Outpatient Spending
\$25.3 billion

Physician Services

-0.1% Spending
\$9.9 billion



Pharmacy

+8.8% Gross of Rebates
+8.3% Net of Rebates
\$10.1 billion (net of rebates)

Non-Claims

+23.3% Spending
\$3.7 billion
\$621.5 million in one-time
COVID-19 payments

Commercial Affordability Trends 2021-2022

+5.8% Premiums

Premiums for commercial members (fully-insured) rose to average \$595 PMPM in 2022.

31.2% Unmet Care

Among all **MA residents**, those who reported unmet health care needs in their family due to cost in 2021.



+6.0% Cost Sharing

\$61 PMPM in cost sharing (copays, coinsurance, and deductibles) for members with private commercial insurance.

42.4% High Deductible

Percentage of commercial members **enrolled in high deductible health plans** in 2022.

Acute Care Hospital Trends 2018-2023

5.5 Days

The **average length of stay** in acute hospitals in FFY2022, growing from 4.9 days in FFY2019.



1.6% Total Margin

Statewide **median total margin** across hospitals through June 2023.

-10% Discharges

Change in **hospital inpatient discharges** from FFY2019 to FFY2022.

0.2% Operating Margin

Statewide **median operating margin** across hospitals through June 2023.

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MASSACHUSETTS COST TRENDS: IMPACT ON AFFORDABILITY
Dr. David Auerbach, Senior Director of Research and Cost Trends, HPC
David Seltz, Executive Director, HPC

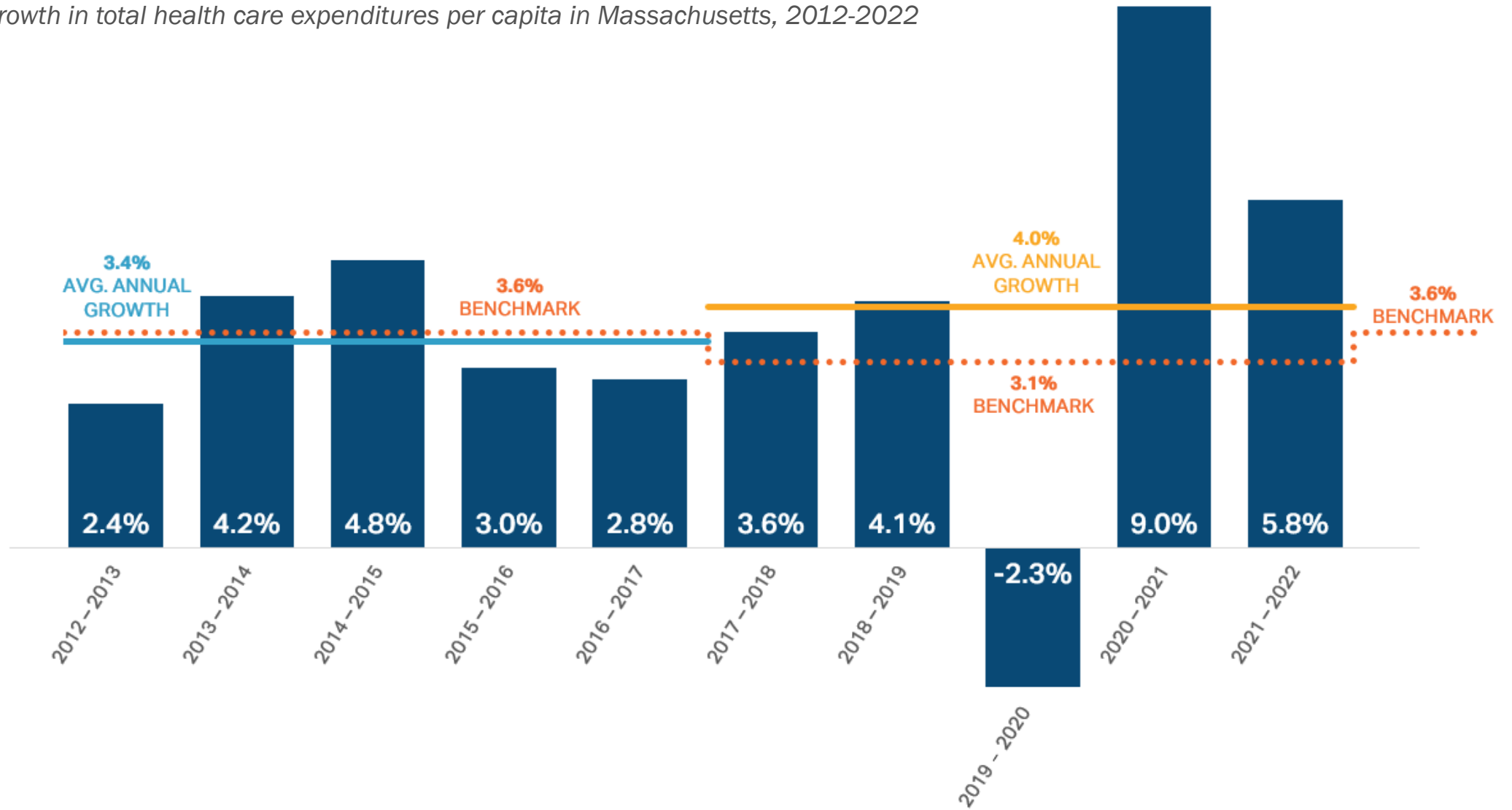
1. Recent Spending Trends

2. Implications of Recent Spending Growth for Affordability of Health Care

Health care spending growth in Massachusetts was below the benchmark from 2012 to 2017, but above from 2017 to 2022, on average.



Annual growth in total health care expenditures per capita in Massachusetts, 2012-2022

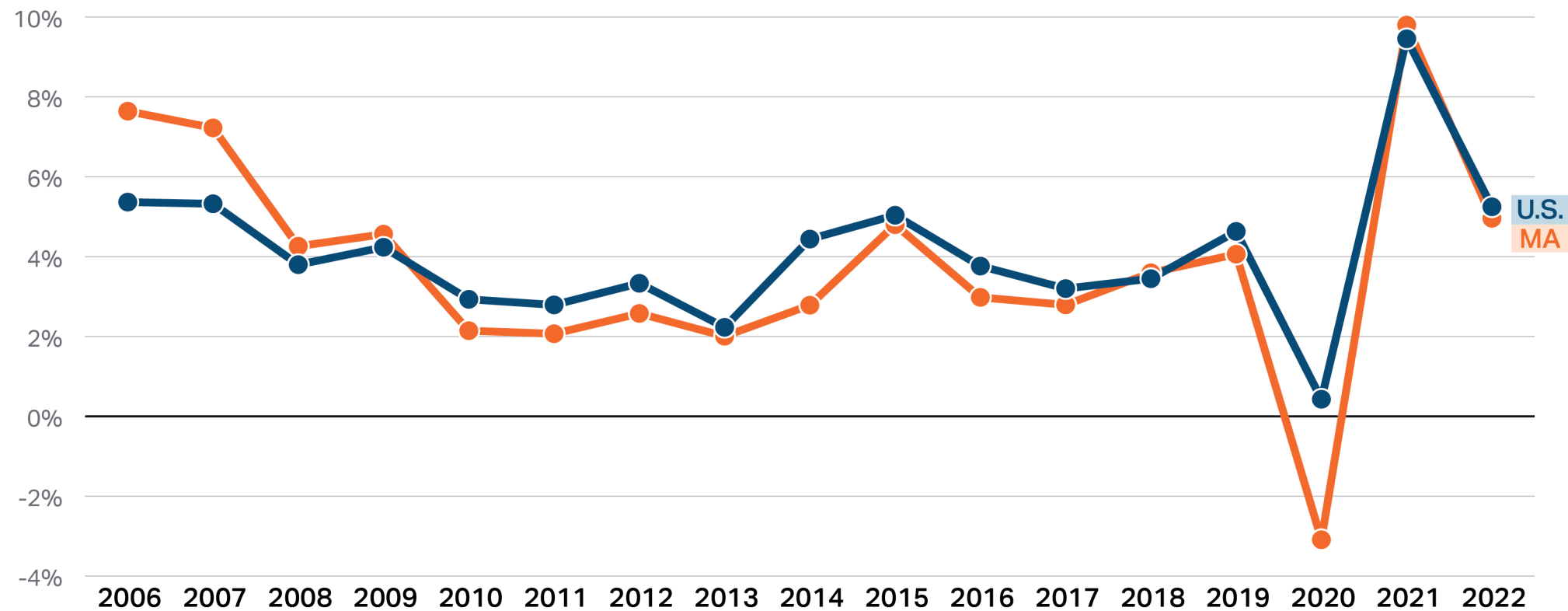


Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System 2013-2024.

Massachusetts' overall rate of spending growth had been slightly below the national rate in most years since 2010.



Annual growth in per capita health care spending from the previous year to the year shown, Massachusetts and the U.S., 2006-2022

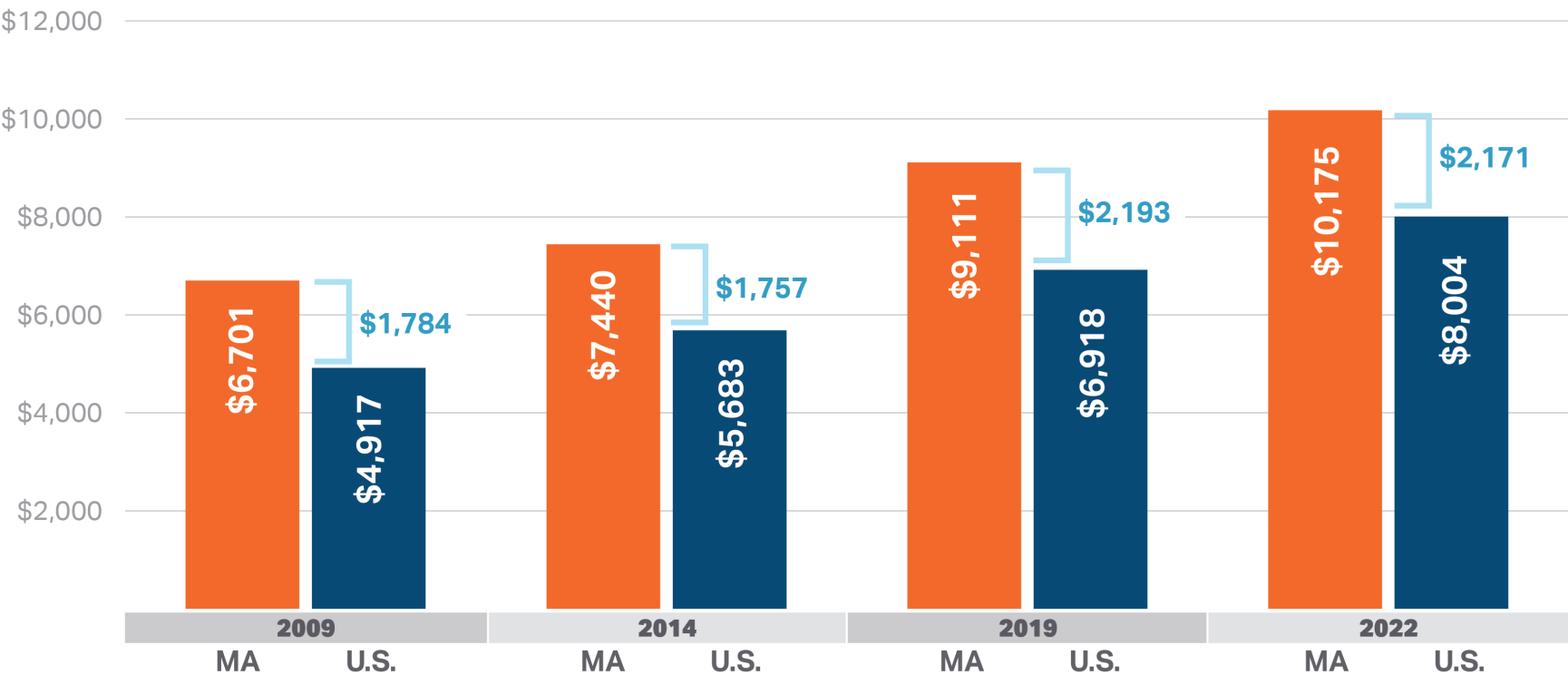


Notes: U.S. data includes Massachusetts. Massachusetts and U.S. data exclude federal and state supplemental COVID-19 relief funding.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2022 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, growth in Total Health Care Expenditures per capita, 2014-2022.

Despite a slightly slower growth rate since 2009, annual health care spending per person in Massachusetts exceeded the national average by more than \$2,000 in 2022.



Per capita total health care spending, Massachusetts and the U.S. 2009-2022



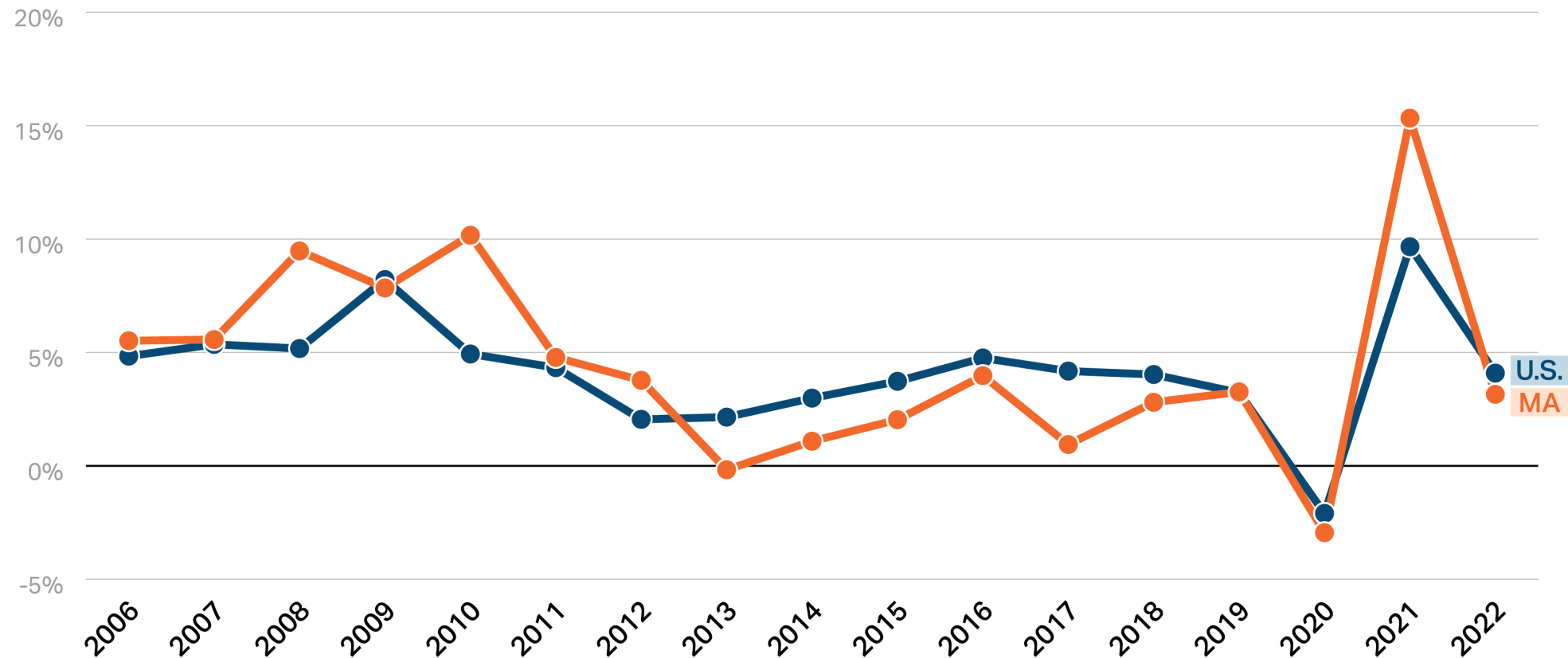
While the gap has closed on a percentage basis from 2009 (36%) to 2022 (27%), **the gap in spending per person has continued to increase** (from \$1,784 to \$2,171).

Notes: U.S. data includes Massachusetts. Massachusetts and U.S. data exclude federal and state COVID-19 relief funding.
Sources: MA 2019 and 2022 spending figures were calculated from Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System 2023-2024. 2009 and 2014 MA spending figures were calculated from Centers for Medicare and Medicaid Services (CMS) State Healthcare Expenditure Accounts. U.S. spending growth rates were calculated from CMS National Health Expenditures Accounts.

After several years of lower growth, commercial spending growth in Massachusetts outpaced the U.S. average from 2019 to 2022, 4.9% versus 3.8% annually.



Annual growth in per capita commercial health care spending, Massachusetts and the U.S., 2006-2022.

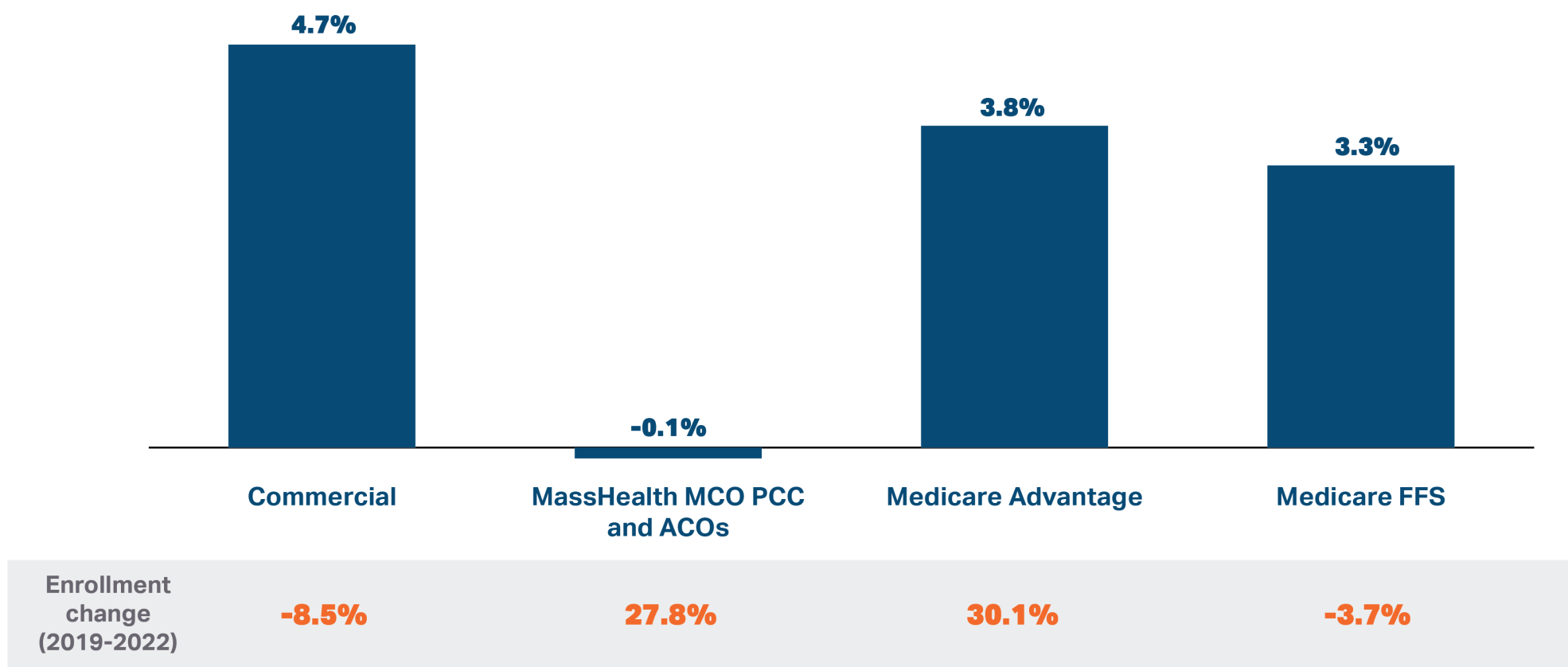


Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2022 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System 2014-2022.

Average commercial spending growth per enrollee from 2019 to 2022 exceeded growth for Medicare and MassHealth full coverage enrollees.



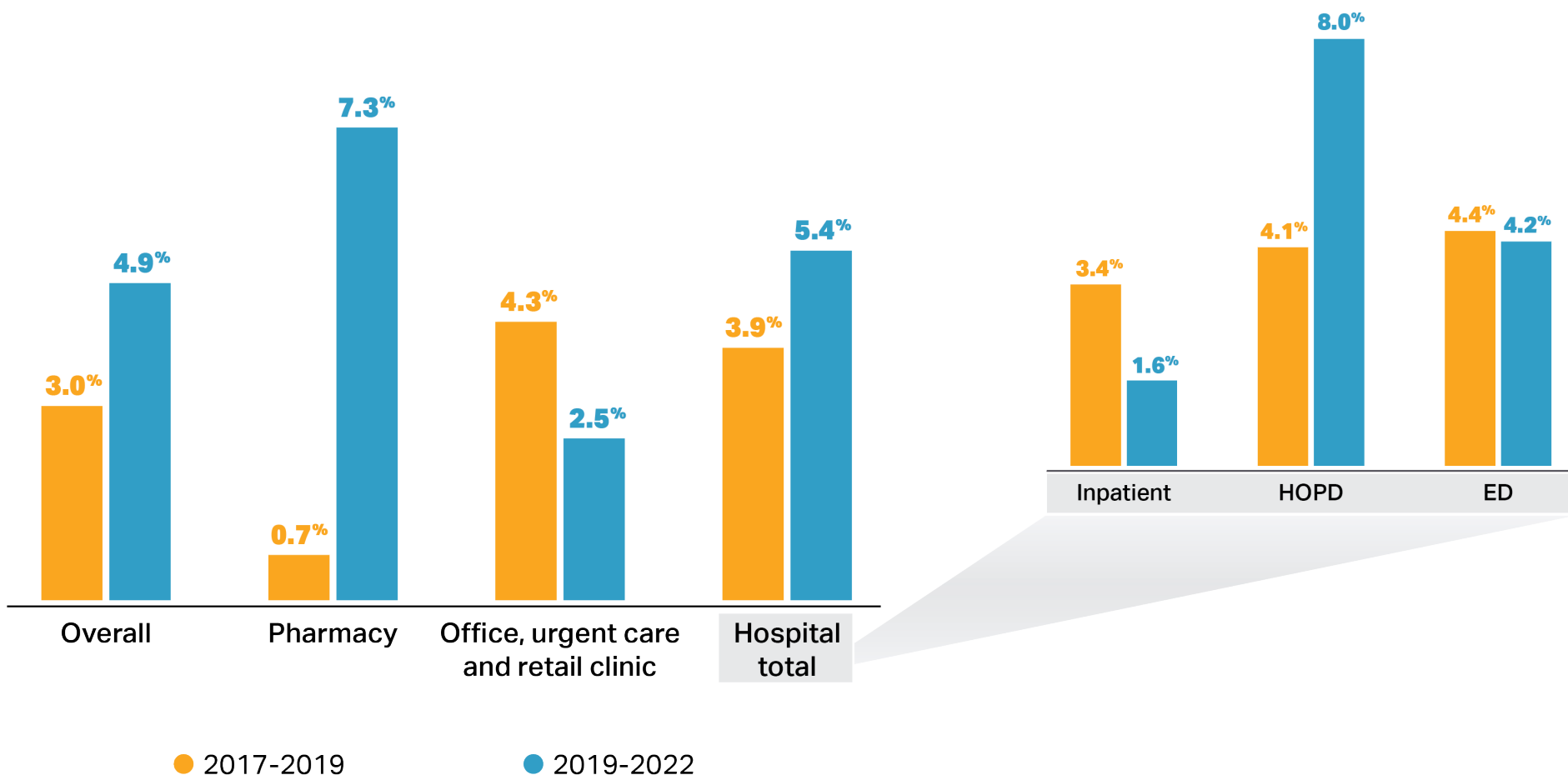
Average annual growth in spending per enrollee by market, 2019-2022, with total enrollment change



Notes: Commercial spending includes net cost of private health insurance and is net of prescription drug rebates. MassHealth includes only full coverage enrollees in the Primary Care Clinician (PCC), Accountable Care Organization (ACO-A, ACO-B), and Managed Care Organization (MCO) programs. Figures are not adjusted for changes in health status.
Sources: HPC analysis of Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2023-2024.

Accelerating growth in prescription drug spending and hospital outpatient spending drove faster commercial spending growth from 2019 to 2022.

Average annual growth in commercial spending per enrollee site of care, 2017-2019 vs 2019-2022



- Prescription drug spending **grew 10x faster** from 2019 to 2022 as it did from 2017 to 2019.
- Hospital spending patterns partly reflect **a shift of some surgeries from inpatient to outpatient** settings.

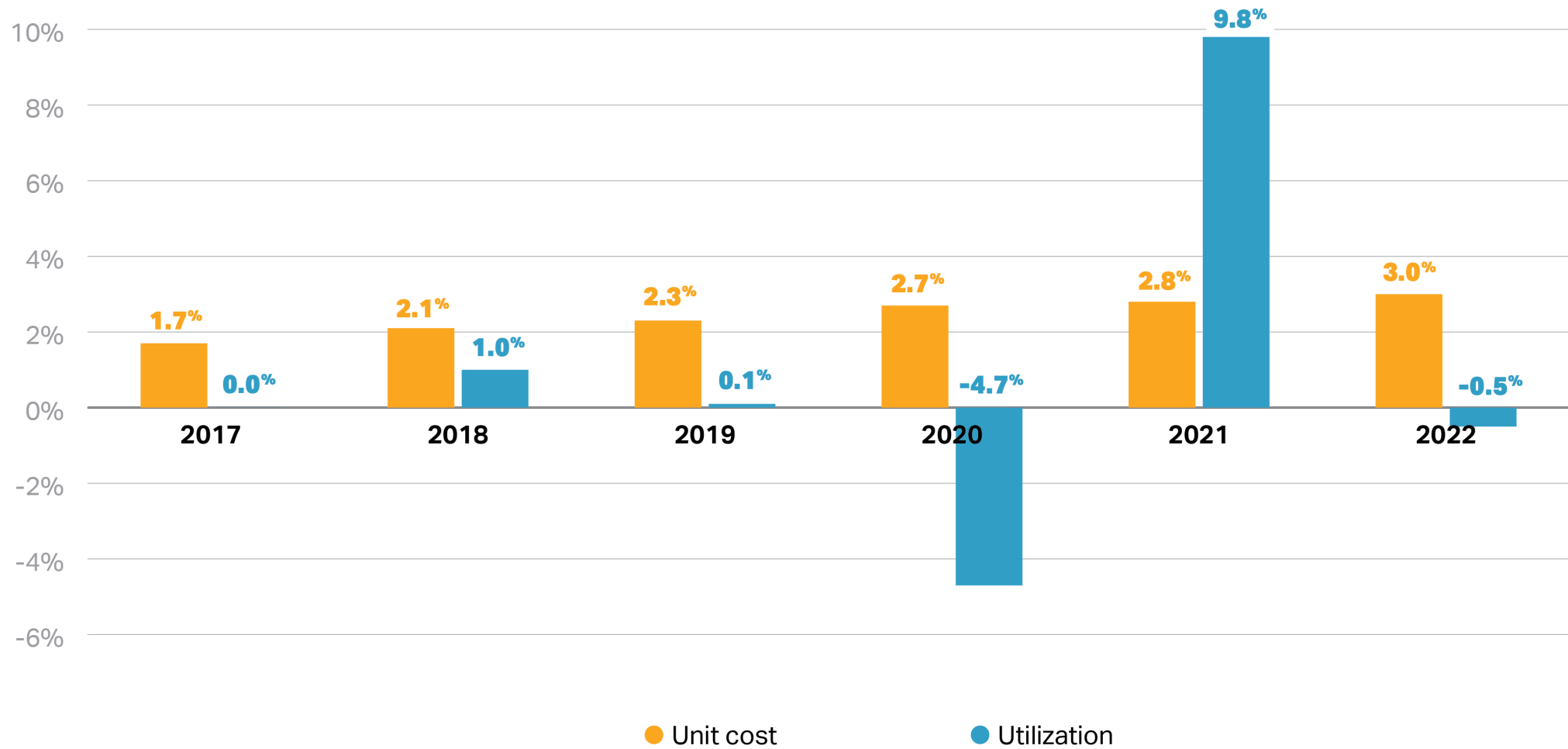
Notes: pharmacy spending is net of rebates.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2021 and V2022 (for hospital and office spending); Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System, 2019-2022 (for pharmacy and overall spending).

Commercial spending growth has increasingly been driven by growth in prices rather than utilization.



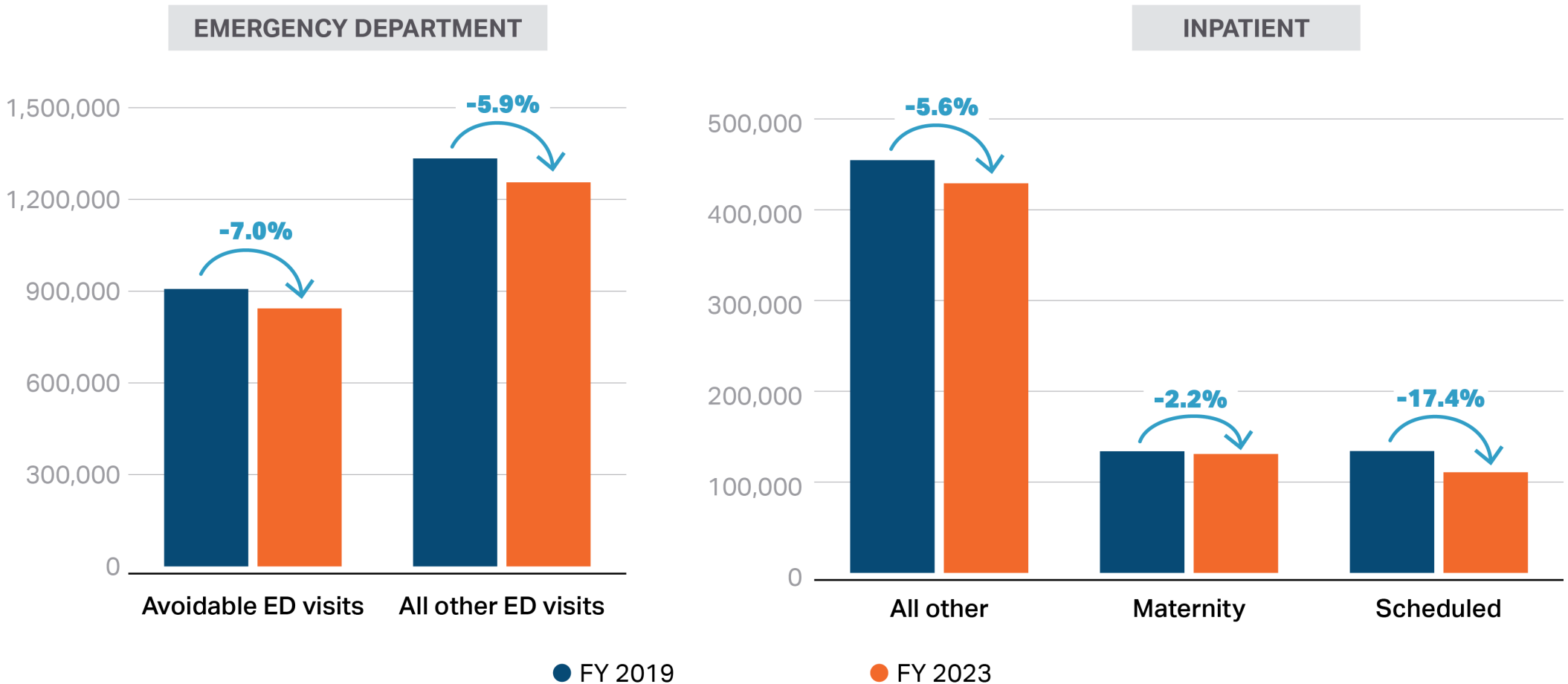
Payer-reported percent change in commercial unit costs (prices) and utilization for a large Massachusetts insurer from previous year to the year shown



Emergency department and hospital inpatient utilization are below pre-pandemic levels, down 6.3% and 7.2% respectively, from 2019 to 2023.



Number of ED visits and acute care hospital inpatient discharges by type, FY 2019 and FY 2023

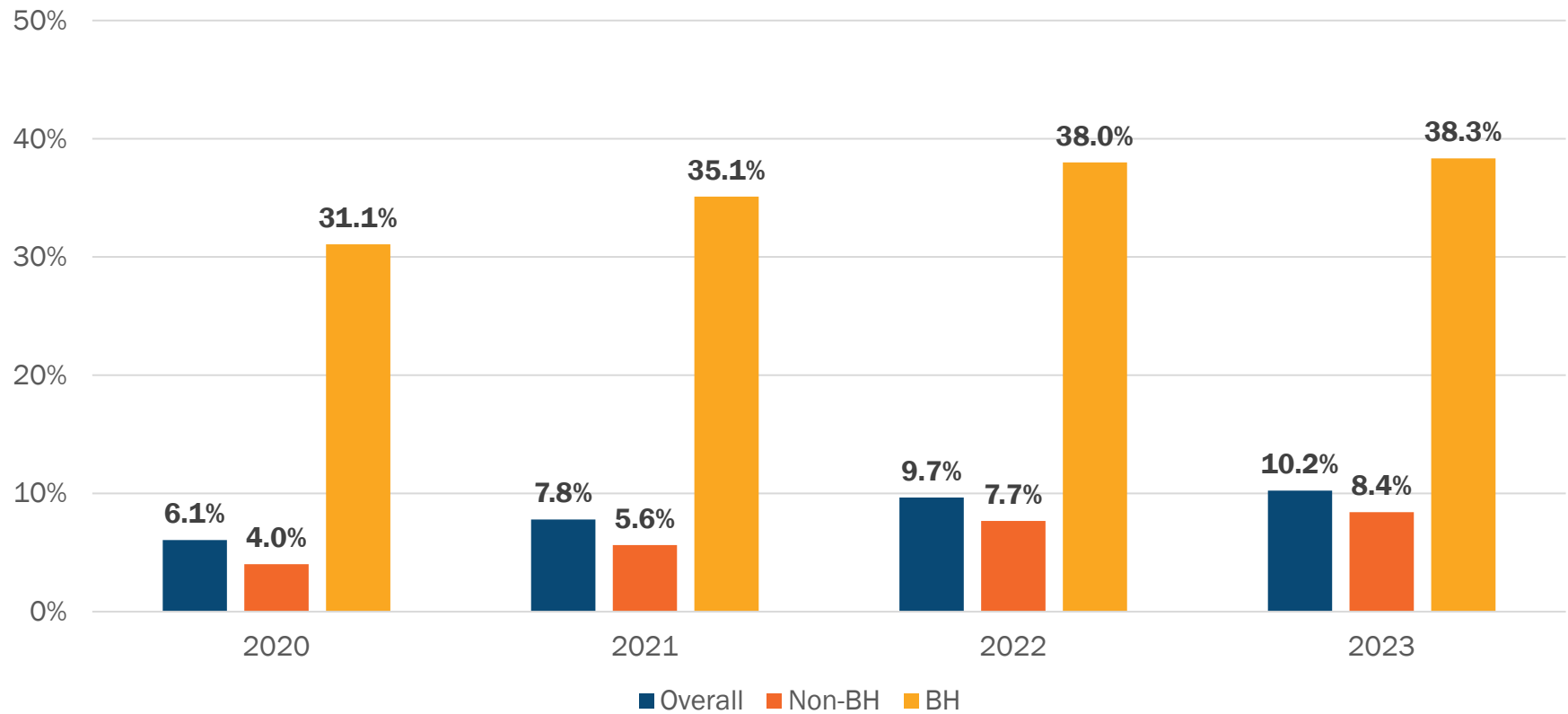


Notes: Excludes out-of-state residents. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into the following categories: Emergent - ED care needed and not avoidable; Emergent - ED care needed but avoidable; Emergent - primary care treatable; and Nonemergent - primary care treatable. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent - primary care treatable. Inpatient discharges were excluded if they were transfers, had a length of stay greater than 180 days, or rehabilitation. Two hospitals were excluded for the entire study period due to missing data for one or more quarters. Sources: HPC analysis of the Center for Health Information and Analysis Hospital Inpatient and Emergency Department Discharge database, FY2019 and FY2023, preliminary FY2023.

Between 2020 and 2023, the percentage of ED patients who boarded (stayed longer than 12 hours) increased from 6.1% to 10.2%.



Percent of ED visits that boarded (≥12 hours in ED) by type and fiscal year, 2020 to 2023



Notes: Emergency department visits identified using both emergency department and inpatient data. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Does not include visits that resulted in an observation stay. Visits at specialty hospitals and “hospital at home” programs are excluded, as well as visits at two hospitals with incomplete data during the study period. One additional hospital was excluded due to irregular length of stay data. Due to incomplete ED length of stay information in inpatient data, visits at the following hospitals were assumed to have boarded if they lasted more than one calendar day: UMass Memorial Medical Center – University Campus and Memorial Campuses, HealthAlliance Clinton Hospital, HealthAlliance Leominster Hospital, and Marlborough Hospital.

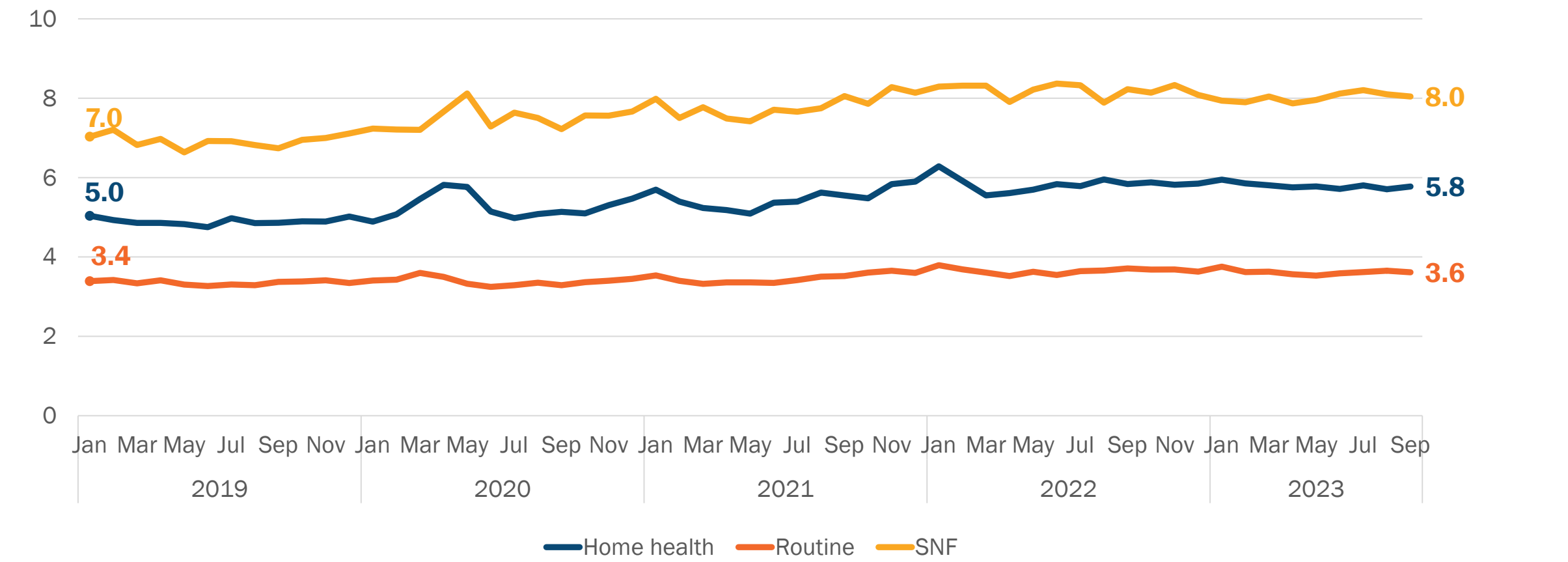
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Emergency Department Database (EDD) and Hospital Inpatient Discharge Database (HIDD), FY2020 to FY2023.

- These numbers include **patients who boarded in the ED prior to being admitted** to the same acute care hospital.
- CHIA’s EDD dashboard finds average wait time for “treat and release” in the ED **increased from 4.2 hours** in late 2018 to **5.5 hours** in mid-2023.

Average hospital length of stay has increased by roughly half a day since 2019, but the increase has been almost entirely for patients discharged to SNFs and home health care.



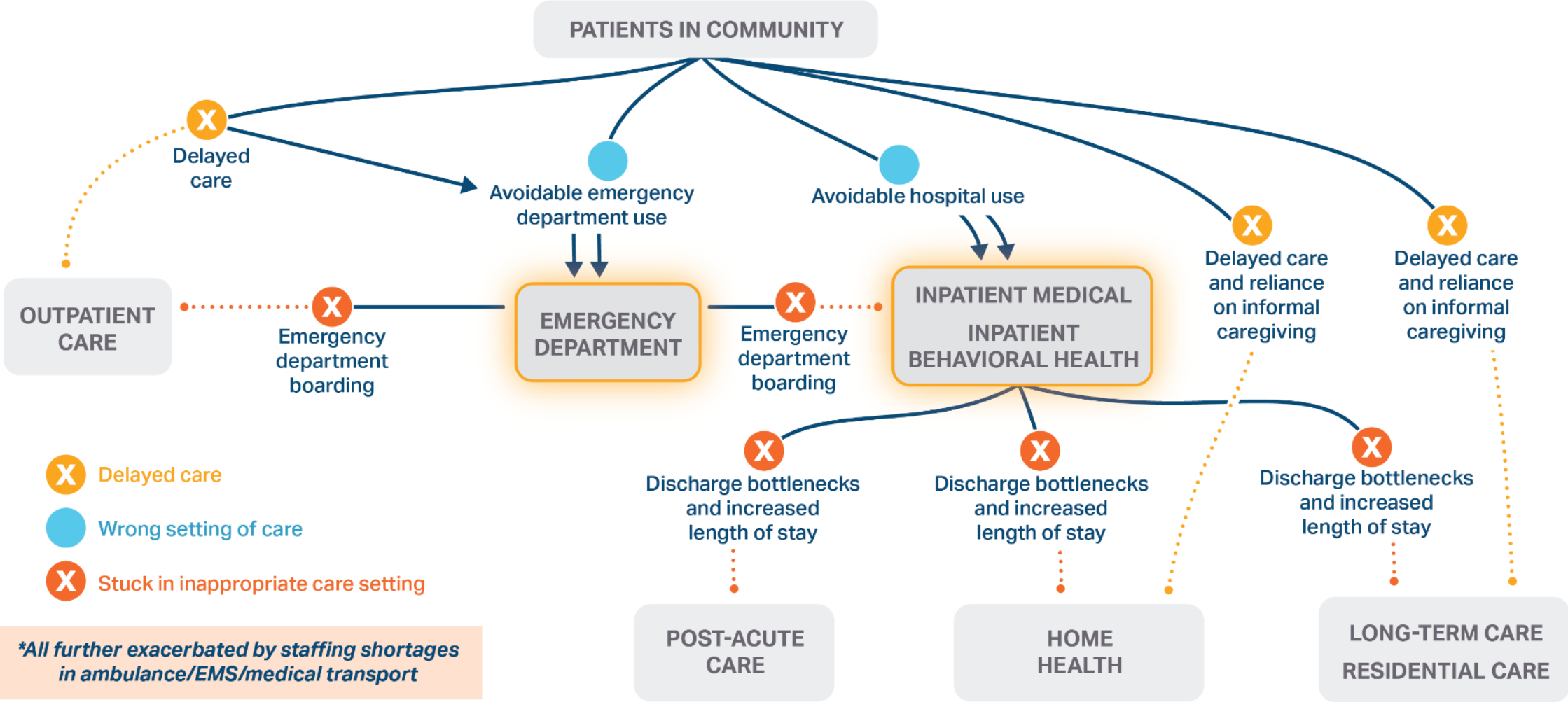
Average length of stay (days) for scheduled admissions and admissions from the ED (combined) by discharge disposition, January 2019 to September 2023



Notes: Based on patient discharge date and includes only admissions from the emergency department and scheduled admissions. COVID-related discharges are excluded. Excludes pediatric, maternity, BH, and rehabilitation admissions and admissions with length of stay greater than 180 days. Two hospitals were excluded for the entire study period due to missing data for one or more quarters.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2019 to FY2023, preliminary FY2023

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Workforce shortages throughout the health care continuum can contribute to delays in patient access to needed care and bottlenecks to timely transitions across care settings.

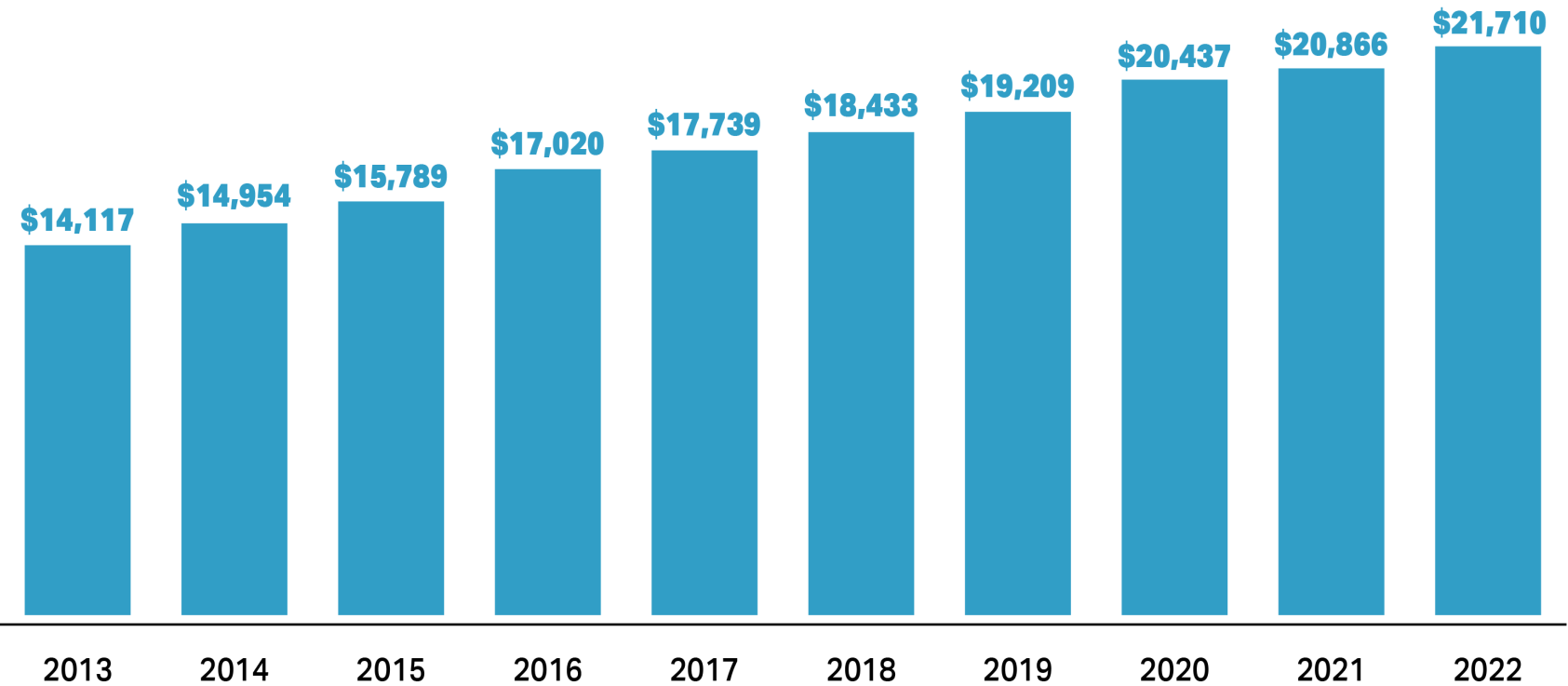


1 Massachusetts Health and Hospital Association. An Acute Crisis: How Workforce Shortages are Affecting Access & Costs. October 2022.
2 Lazar K. There's a new cause for Boston's ambulance delays: Hospital overcrowding. The Boston Globe. January 30, 2023. Available at: <https://www.bostonglobe.com/2023/01/30/metro/boston-ambulance-response-times-slow/>

Over the past ten years, the price paid per commercial hospital stay increased nearly 5% per year from 2013 to 2022, double the rate of inflation.



Average inpatient spending per commercial discharge, 2013-2022



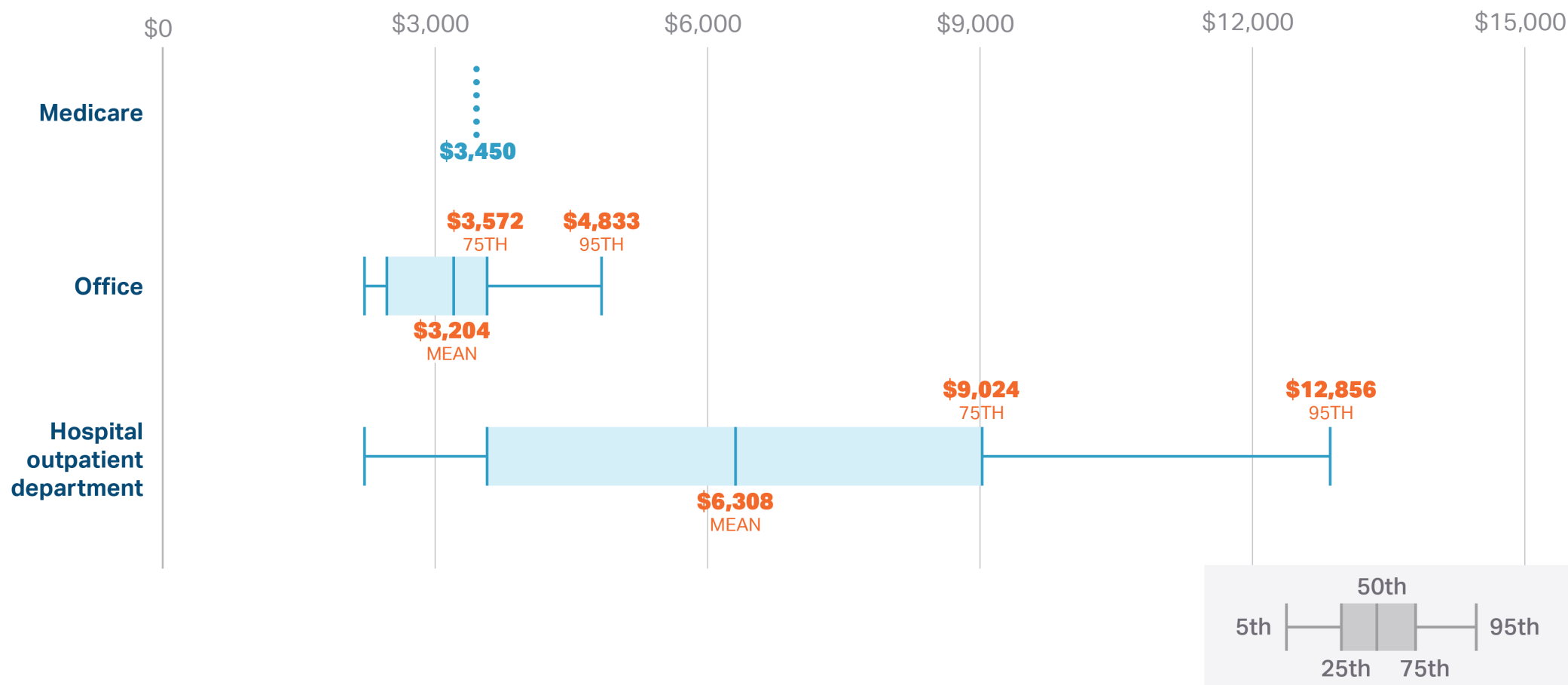
➤ The average price per discharge increased **54%** from 2013 to 2022 while inflation increased **25%**, in total.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge database, 2013-2022 and Annual reports, 2015-2024; Bureau of Labor Statistics, CPI-U for the greater Boston metro area. Inflation averaged 2.5% annually from 2013 to 2022.

Clinician-administered drugs are a significant driver of hospital outpatient spending growth. Prices are much higher than if the same drugs are provided in office settings.



Price distribution of Neulasta (which helps to reduce the chance of infection after receiving chemotherapy), by setting of care, 2021

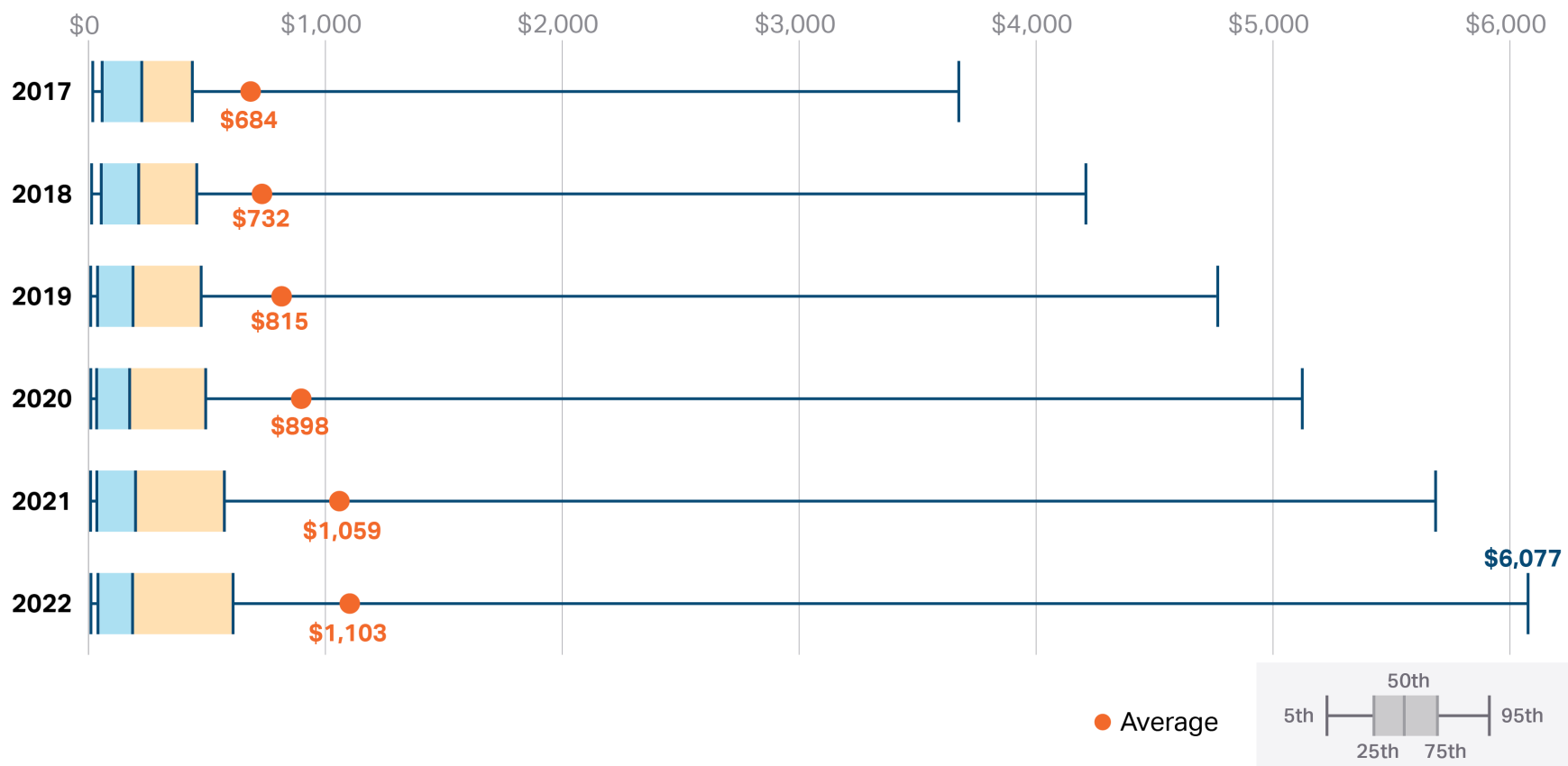


Notes: Neulasta can be given as an injection or as a patch applied to the skin, branded as Neulasta Onpro. This exhibit shows prices for Neulasta OnPro (identified using CPT code J2505).
Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, V2021, 2021. HPC analysis of information from the Centers for Medicare and Medicaid Services, ASP Drug Pricing Files (2020-2021).

Average commercial spending (gross) per branded prescription fill increased 10% per year since 2017, from \$684 to \$1,103, with 5% of prescriptions exceeding \$6,077 in 2022.



Gross spending distribution per branded prescription, 2017-2022



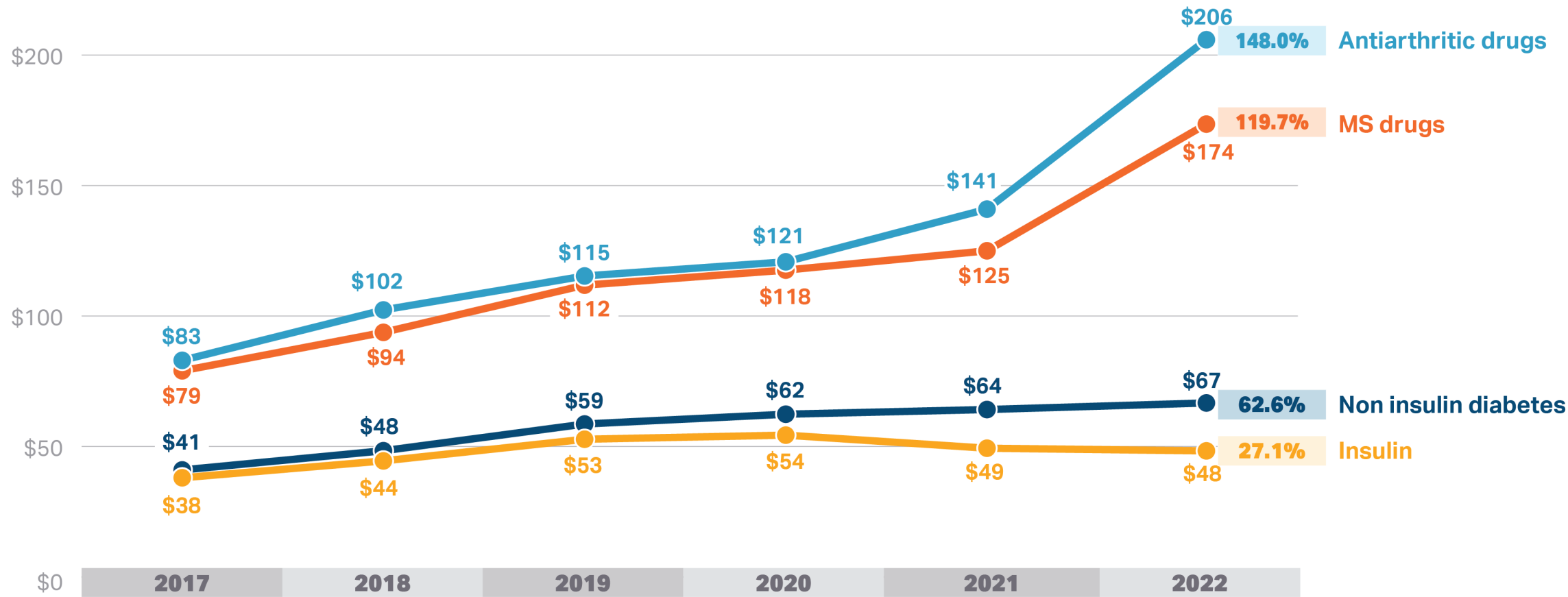
- Average **spending per branded prescription increased 61%** from 2017 to 2022.
- **The price of generic drugs has remained stable**, with an average spending of \$30 per prescription in 2017 and \$34 in 2022.

Notes: Claims with implausible spending and cost-sharing values were excluded. COVID-19 vaccines were excluded from analysis in 2021 and 2022.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims database, V2021 2017 and V2022 2018-2022.

Average out of pocket spending for a 30-day supply of prescription drugs for several common chronic conditions doubled from 2017 to 2022.



Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2017-2022

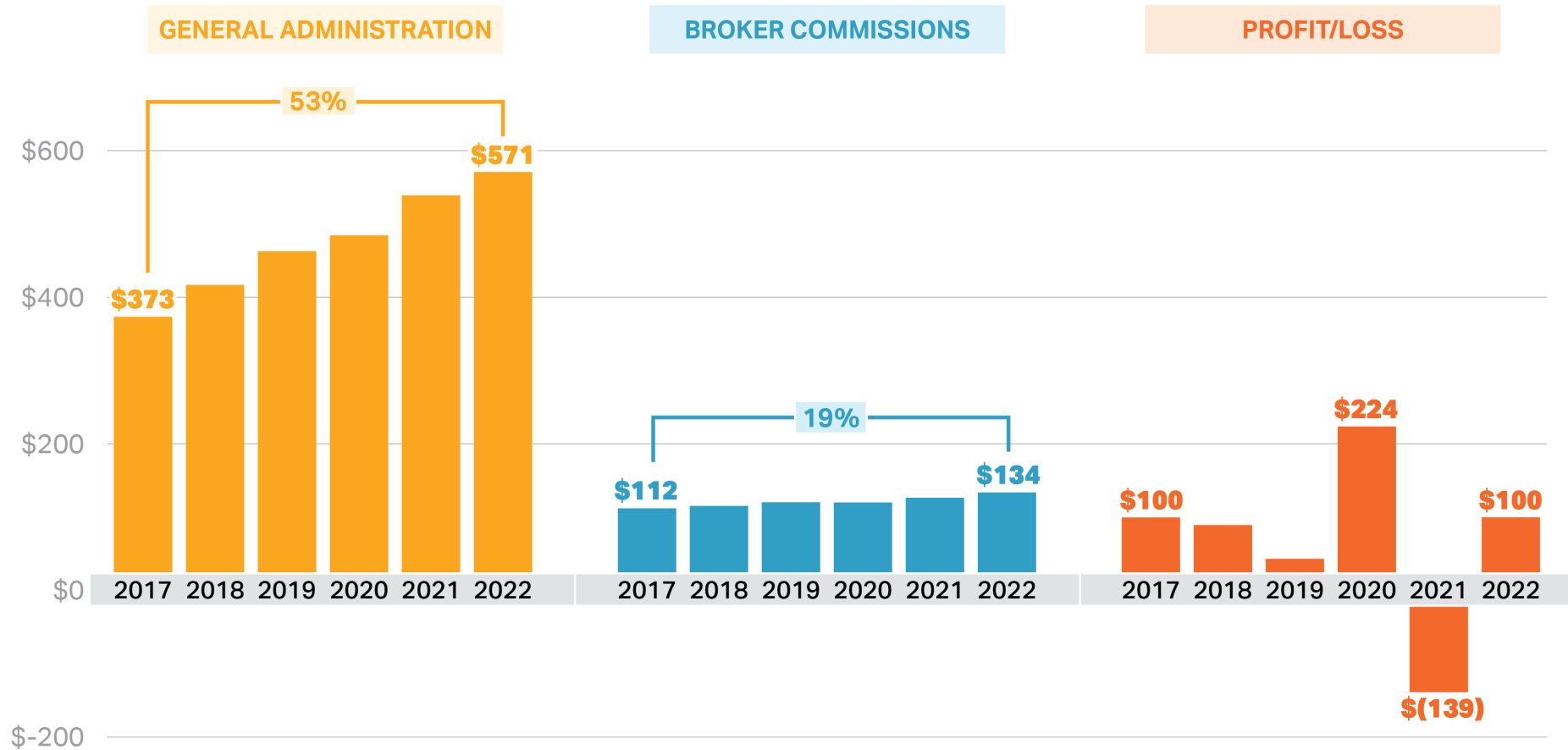


Notes: Drugs were identified based on lists or clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, American Diabetes Association, and National MS society. Clinician-administered drugs, which are typically covered under a plan's medical benefits, are excluded.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims database, 2017-2022.

Health insurer administrative costs have risen over 50% since 2017.



Payer non-medical expenses by category, per member per year, in the fully-insured market, 2017-2022

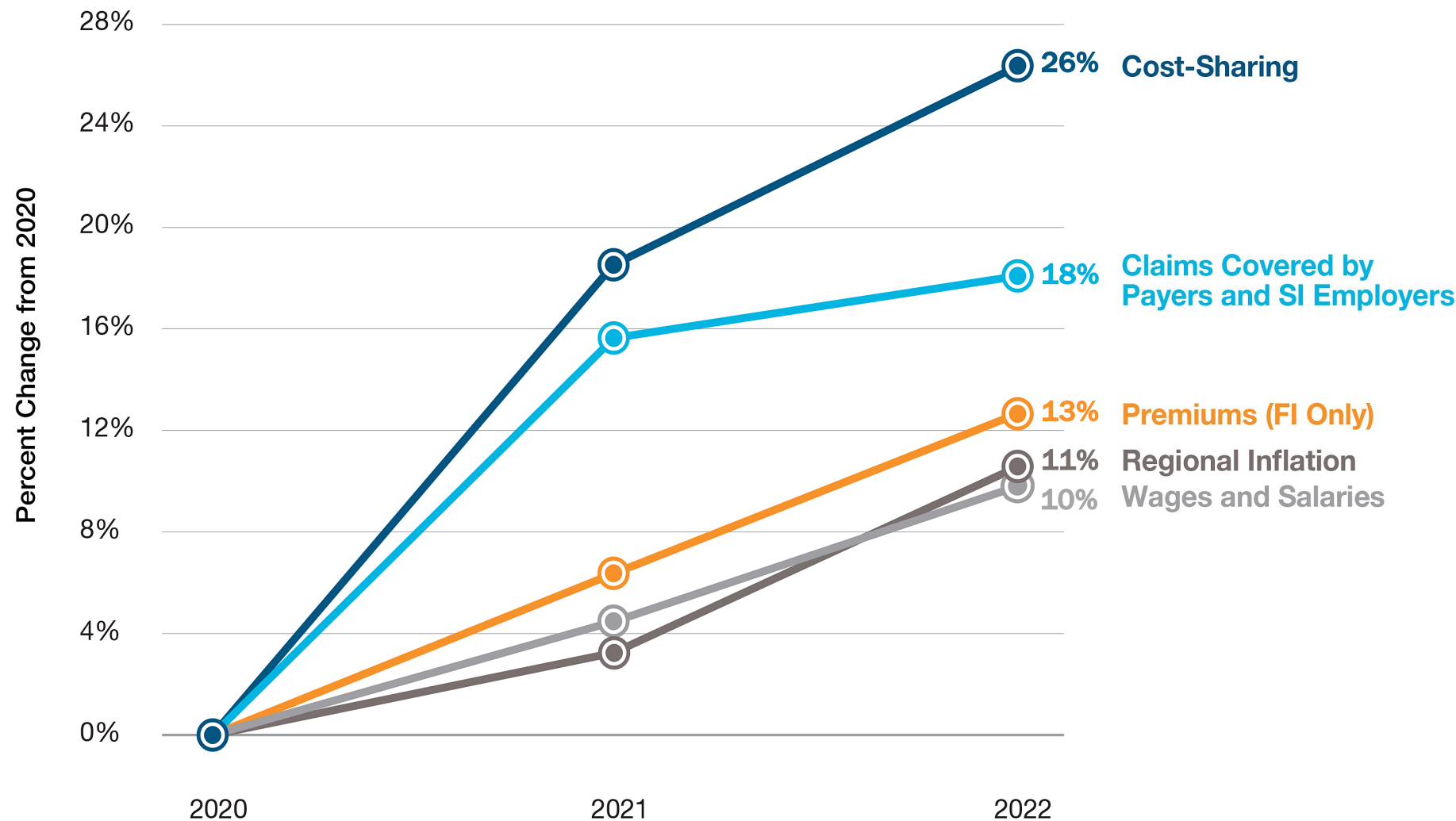


Notes: Data reflect the fully-insured market only. Exhibit does not show two other categories of non-medical expenses, which are federal and state taxes & fees and HCQI and fraud reduction expenses. Claims cost per member per year was \$6,264 in 2022. Insurer administrative spending in the merged market is subject to state administrative expense and medical loss ratio standards.
Sources: HPC analysis of Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2021-2024.

1. Recent Spending Trends

2. Implications of Recent Spending Growth for Affordability of Health Care

Between 2020 and 2022, growth in health insurance premiums and claims spending outpaced wages and inflation, with a 26% increase in cost-sharing.

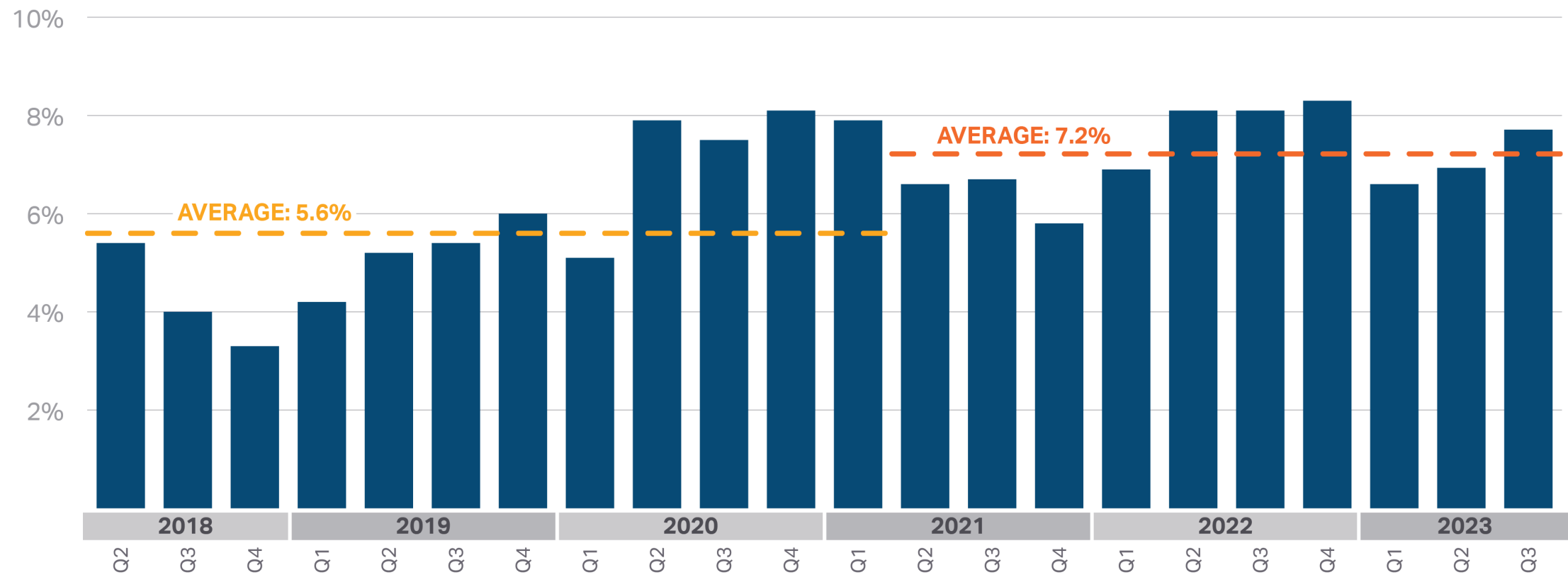


Sources: Center for Health Information and Analysis Annual Report on the Performance of the Massachusetts Health Care System, 2024.

Annual premium increases for companies with fewer than 50 employees and individuals purchasing their own insurance have averaged 6-8% in recent years.



Year-over-year approved enrollment-weighted average premium increases for the Massachusetts merged market, 2018-2023

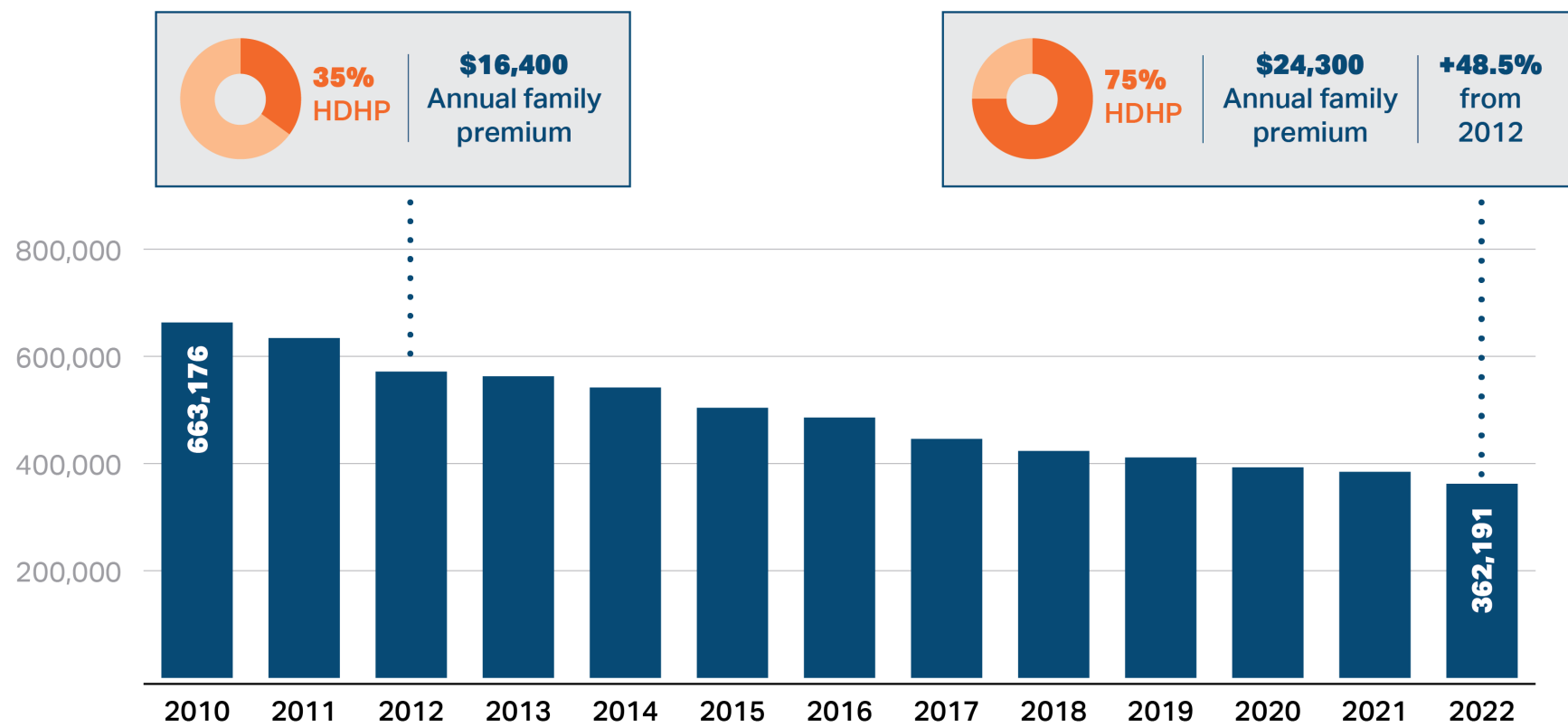


Notes: The Q1 2018 increase was 18% due to federal changes to cost sharing reduction subsidies in the Affordable Care Act exchanges. This data point was not shown in the figure.
Sources: Massachusetts Division of Insurance merged market quarterly rate increase data.

Enrollment in the small group market declined further in 2022, as premiums grew nearly 50% from 2012 to 2022 and 3 in 4 members are enrolled in high deductible health plans.



Small group (firms with between 1 and 50 employees) enrollment, percent of plans with HDHPs, and average family premiums

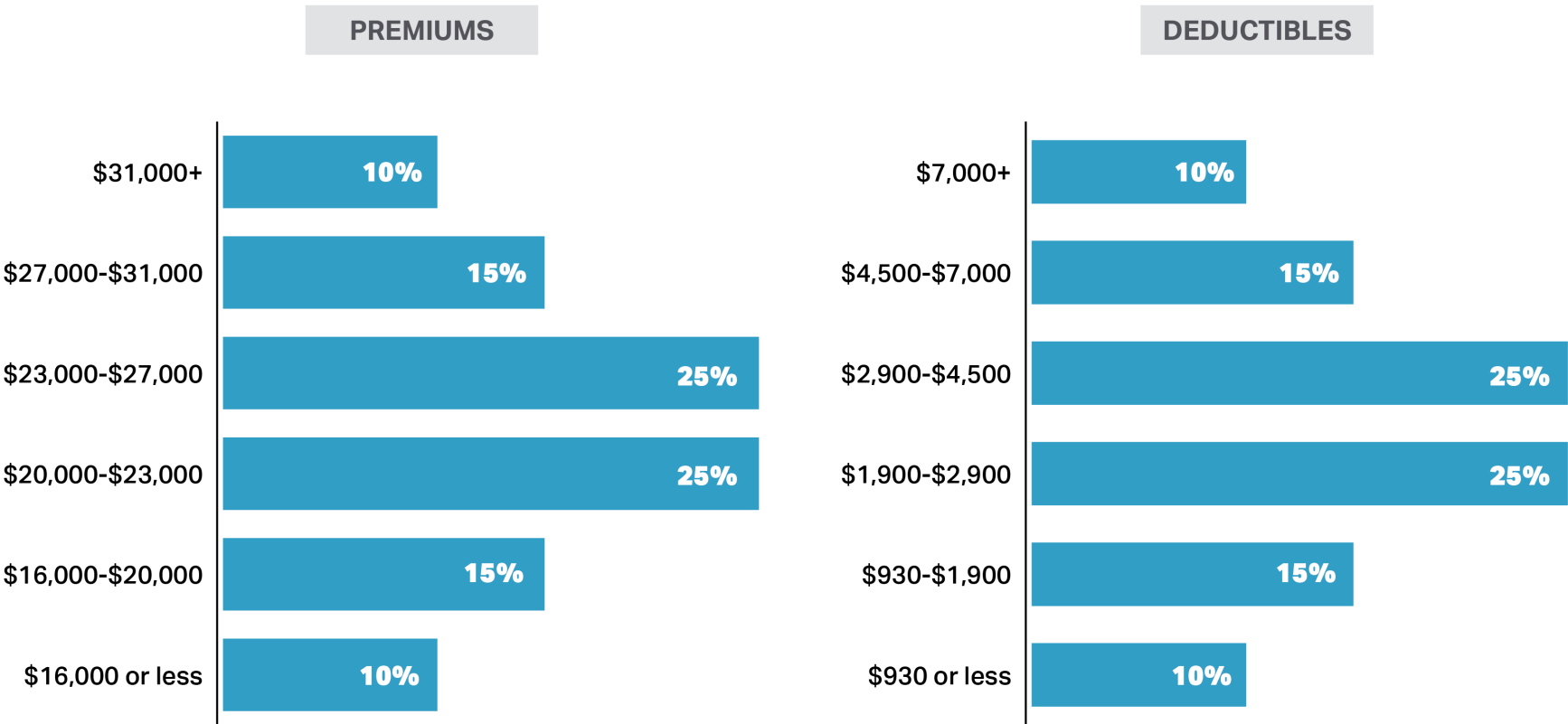


Notes: High Deductible plans are defined by the IRS as single/family plans with a deductible of more than \$1,200/\$2,400 in 2012 and of \$1,400/\$2,800 in 2022. Enrollment reflects membership in commercial carriers and health maintenance organizations.
Sources: Premium and HPHC data from Center for Health Information and Analysis (CHIA) Annual Reports. PMPM premium data from the CHIA Annual Reports were converted to family premiums using data from the Agency for Healthcare Resources and Quality (the MEPS-IC). Enrollment data from Massachusetts Division of Insurance, Individual/Small Group Membership Report, 2010-2022.

In 2022, half of commercially-insured residents faced total family premiums above \$23,000 and deductibles greater than \$2,900 per year.



Distribution of annual premiums (including employer and employee contribution) and deductibles for family coverage in Massachusetts, 2022



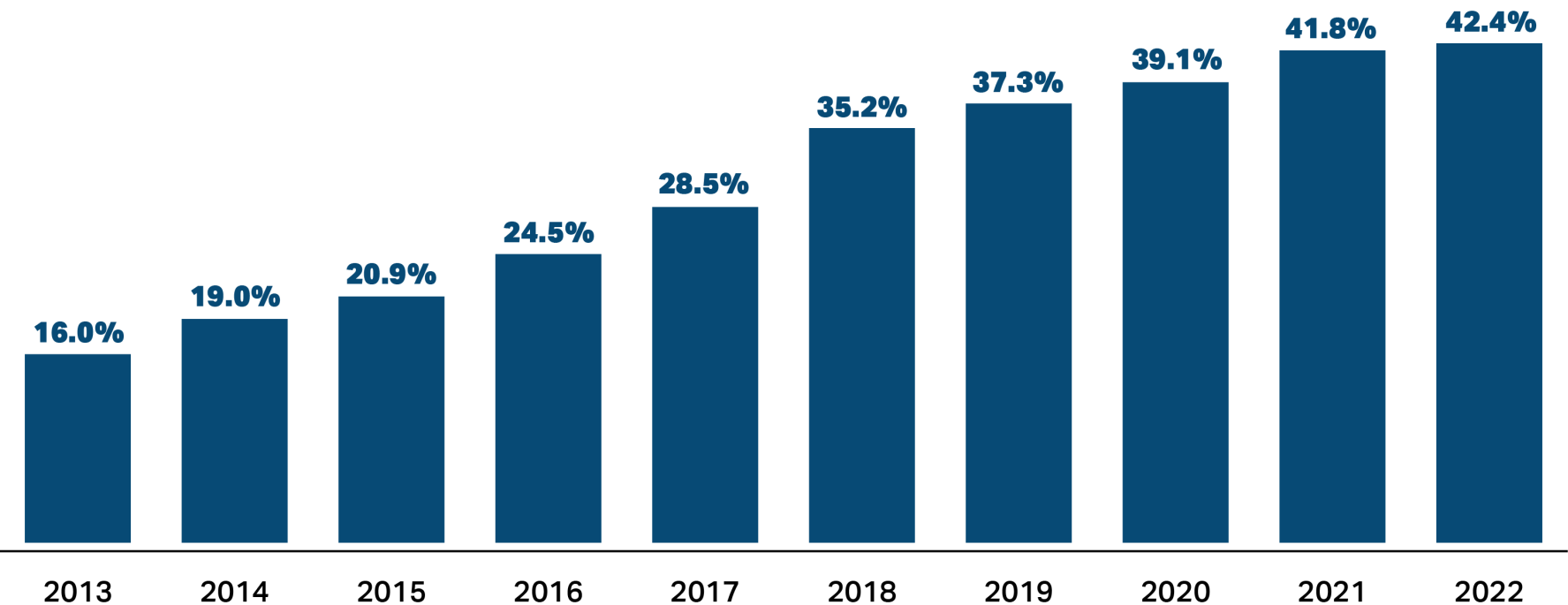
- In 2022, one in four commercially-insured residents faced total family premiums **above \$27,000** and deductibles **over \$4,500** per year.
- In 2017, the comparable premium and deductible amounts (75th percentile) were **\$24,000** and **\$3,800**, respectively.

Sources: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component, data for Massachusetts, 2017 and 2022.

The percentage of commercially-insured Massachusetts residents enrolled in high deductible plans has increased from 16% to 42% from 2013 to 2022.



Percentage of Massachusetts commercial enrollees with a high-deductible health plan, 2013-2022



➤ Adults with high deductible health plans are **twice as likely to go without needed health care** or prescription drugs because of cost.

Notes: High deductible plans are defined federally as a plan having a single/family deductible of \$1,250/\$2,500 in 2013-2014; \$1,300/\$2,600 in 2015-7; \$1,350/\$2,700 in 2018-9 and \$1,400/\$2,800 for 2020-22. GIC plans do not allow high deductibles.
Sources: Center for Health Information and Analysis, Annual Report on the Performance of the Massachusetts Health Care System, 2016-2024.

What is the impact of rapid premium and cost sharing growth on take-home pay?



A Massachusetts family with median income (**\$117,000**) and employer-sponsored family coverage receives a salary increase of **3%**.

How much of that raise goes into the family's pocket?

SCENARIO 1

3%

**increase in health insurance
premiums and cost sharing.**

SCENARIO 2

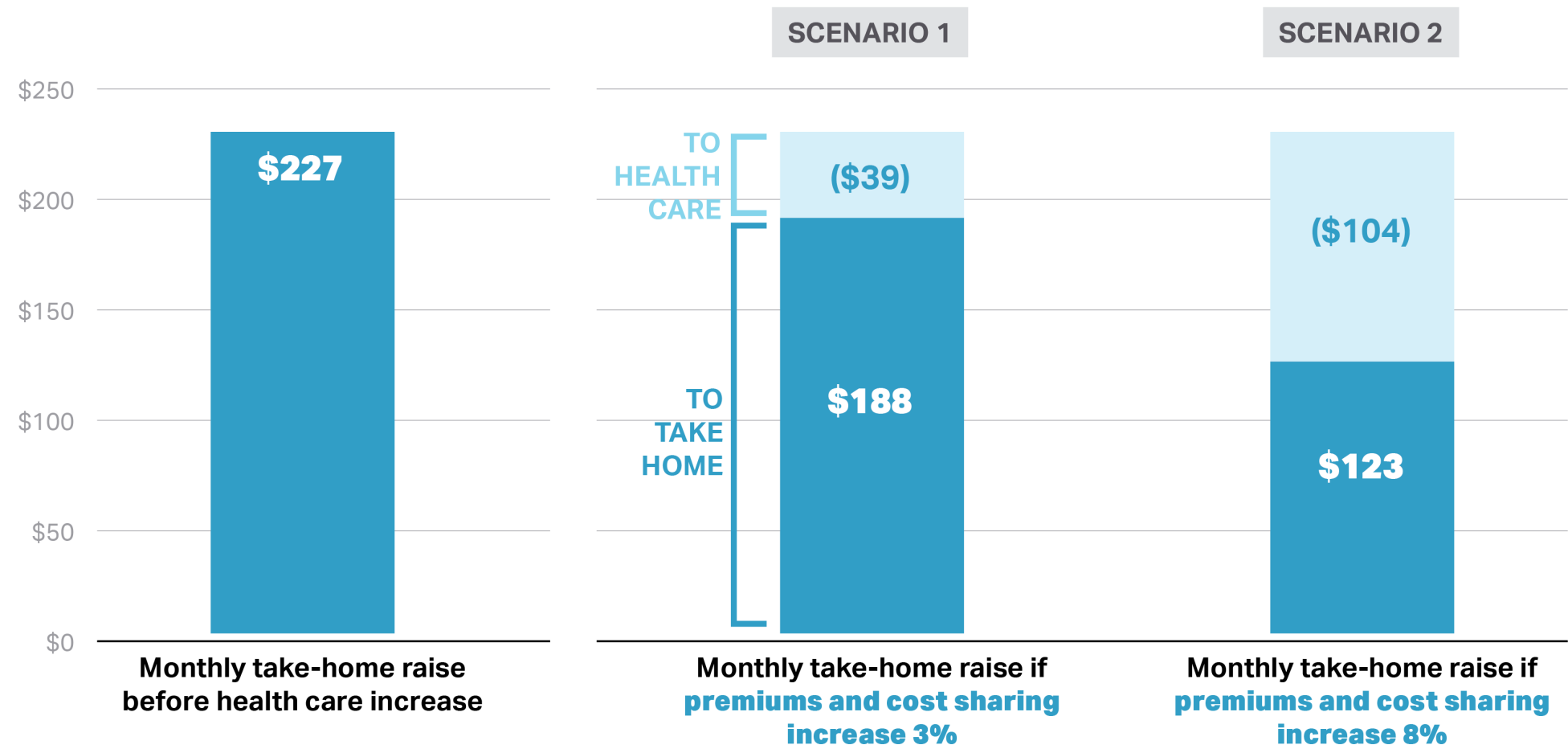
8%

**increase in health insurance
premiums and cost sharing.**

Nearly half of the salary increase is offset by the 8% increase in health insurance premiums and out of pocket costs, leaving just \$123 more per month in take-home pay.



Monthly increase in take-home pay for a worker with family coverage, \$117,000 income in 2021, with a 3% salary increase.



Notes: Modeling assumes that 1) 75% of employees in the firm take health care coverage offered by the hypothetical employer, 2) the employee faces a 20% average tax rate on salary and a 30% marginal tax rate on the salary increase, and 3) employer and employee premium contributions are not taxed but out of pocket spending is after-tax.

2023 Health Care Cost Trends Report Policy Recommendations



- 1 Modernize the Commonwealth's Benchmark Framework to Prioritize Health Care Affordability and Equity For All.
- 2 Constrain Excessive Provider Prices.
- 3 Enhance Oversight of Pharmaceutical Spending.
- 4 Make Health Plans Accountable For Affordability.
- 5 Advance Health Equity For All.
- 6 Reduce Administrative Complexity.
- 7 Strengthen Tools to Monitor the Provider Market and Align the Supply and Distribution of Services With Community Need.
- 8 Support and Invest in the Commonwealth's Health Care Workforce.
- 9 Strengthen Primary and Behavioral Health Care.

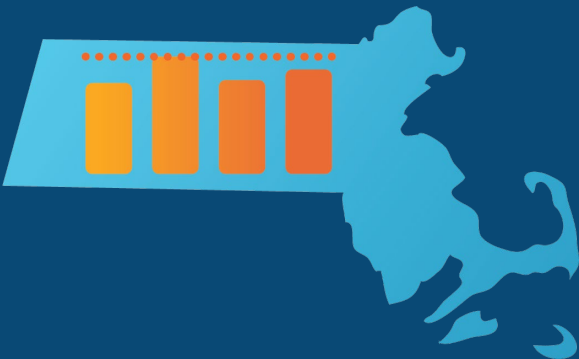
2023 Health Care Cost Trends Report Policy Recommendations

1

Modernize the Commonwealth's Benchmark Framework to Prioritize Health Care Affordability and Equity For All.

The Commonwealth should strengthen the accountability mechanisms of the benchmark such as by updating the metrics and referral standards used in performance improvement plan (PIP) process and enhance transparency and PIP enforcement tools. The state should also modernize its health care policy framework to promote affordability and equity including through the establishment of affordability and equity benchmarks.

- **Strengthen the Health Care Cost Growth Benchmark**
- **Establish New Affordability Benchmark(s)**
- **Establish New Health Equity Benchmark(s)**



Recommendation 1A: Strengthen the Health Care Cost Growth Benchmark



Strengthen the Health Care Cost Growth Benchmark



To improve the mechanisms to monitor health care spending performance, the Legislature should strengthen the existing health care cost growth benchmark framework by:

- **Directing CHIA to use metrics in addition to growth in health status adjusted total medical expense (HSA TME)** to refer entities to the HPC for review and a potential performance improvement plan (PIP). Such a change would enable CHIA to refer a broader range of entities that contribute to health care spending.
- **Directing CHIA to develop differential standards for referral to the HPC** that recognize that health care entities vary considerably in their baseline **spending levels, pricing levels, and populations served**, and that reflect that spending growth may be *more or less* concerning based on such factors.
- **Requiring that referrals of entities to the HPC for review and a potential PIP be made public.**
- **Strengthening the PIP process to** further deter excessive spending, including by allowing the HPC to apply escalating financial penalties for above-benchmark spending or non-compliance, similar to policies in other states.

Recommendation 1B and 1C: Establish New Affordability and Health Equity Benchmark(s)



Establish New Affordability and Equity Benchmarks



To advance health care affordability and health equity, the Commonwealth should complement and bolster the existing health care cost growth benchmark framework by:

- **Developing an accountability framework for affordability of care for Massachusetts residents.** As part of a strategy that tracks improvement on indicators of affordability, including the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors, an affordability index should be measured annually in a benchmark-like process.
- **Undertaking a coordinated effort across state agencies and sectors to identify high-priority areas of health inequities,** set measurable goals for improvement, develop a framework for accountability, and report annually on progress.

To enable public transparency and accountability, the state's performance on the affordability and health equity benchmark(s) should be incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing.