MASSACHUSETTS
HEALTH POLICY COMMISSION

October 17, 2016

Annual Health Care
Cost Trends Hearing

CTH 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by CHIA and the HPC

Annual Health Care Cost Trends Hearing

CTH 2016

CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

ANNUAL REPORT
SEPTEMBER 2016

CHIA.

2015
THCE
Growth

Factors
Underlying
Growth in THCE

KEY FINDINGS

Changes in the
Merged Market

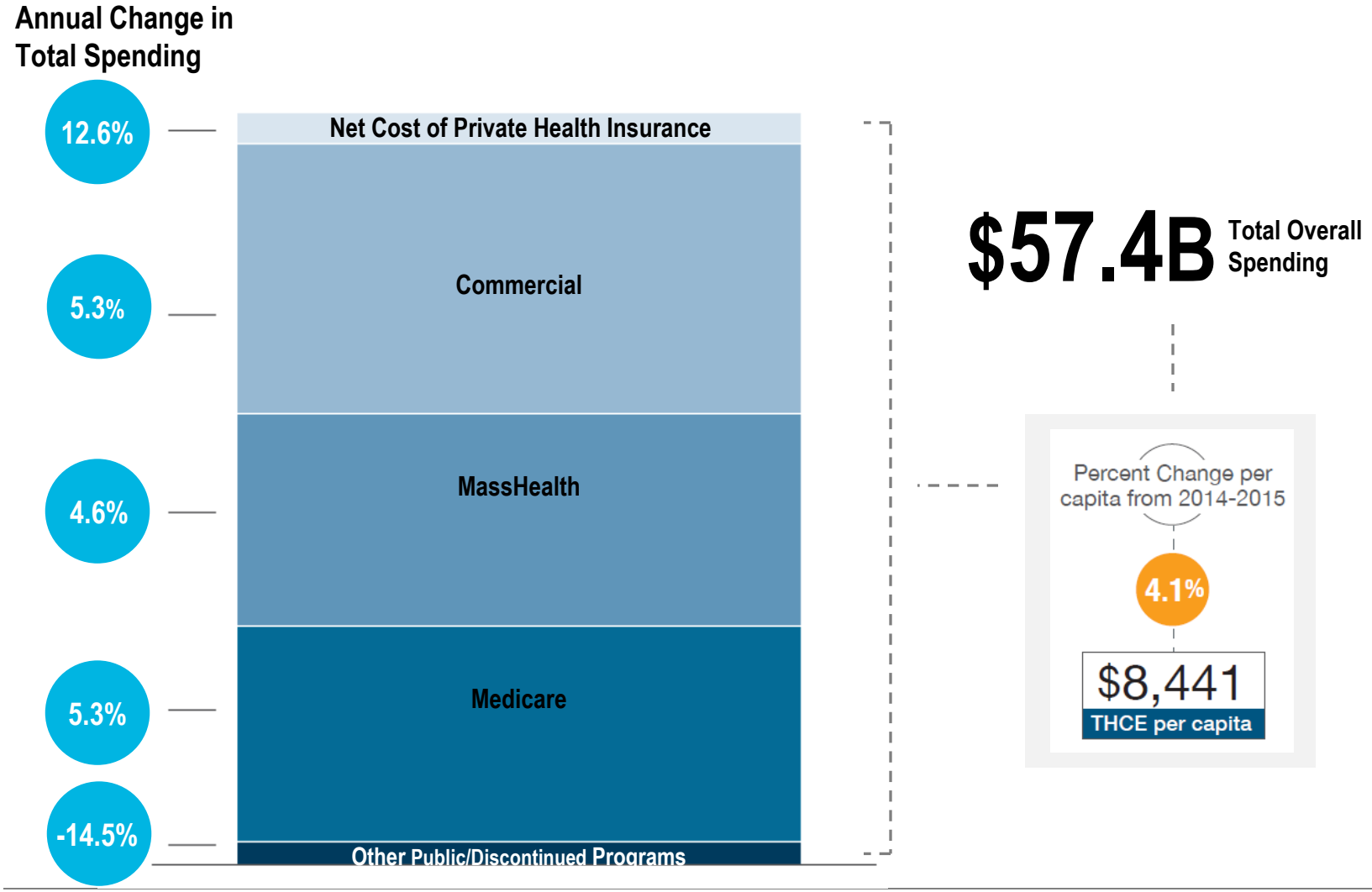
Member
Cost-Sharing

APM
Adoption

CHIA.

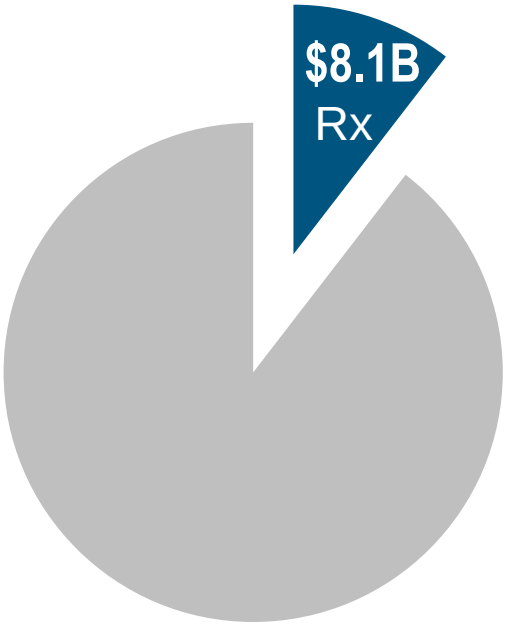
Total Health Care Expenditures grew by 4.1%, exceeding the 3.6% cost growth benchmark set by the Health Policy Commission.

2015 THCE Growth



CHIA

Payers reported prescription drug spending of $8.1 billion, representing 15% of THCE. Pharmacy spending accounted for 36% of the growth in THCE.



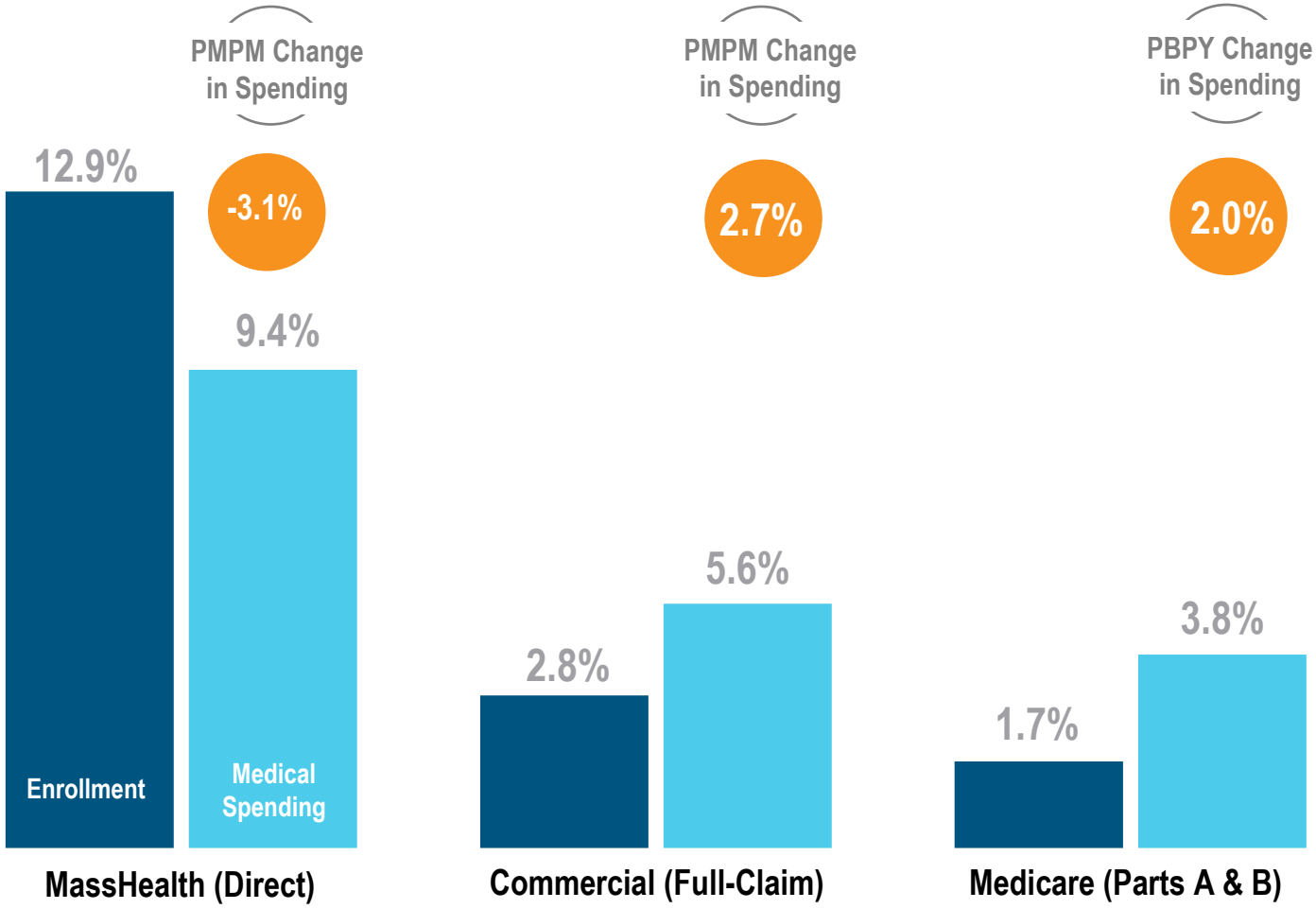
2015 THCE
($57.4B)

THCE GROWTH
($2.3B)

Note: Pharmacy data shown above excludes insurance categories for which pharmacy spending data is unavailable (e.g., HSN, VA, MSP).

Shifts in coverage contributed to an uptick in enrollment that drove growth in THCE. Comparing enrollment against medical spending reveals PMPM spending either declined or grew moderately for major coverage categories.

Factors Contributing to Growth

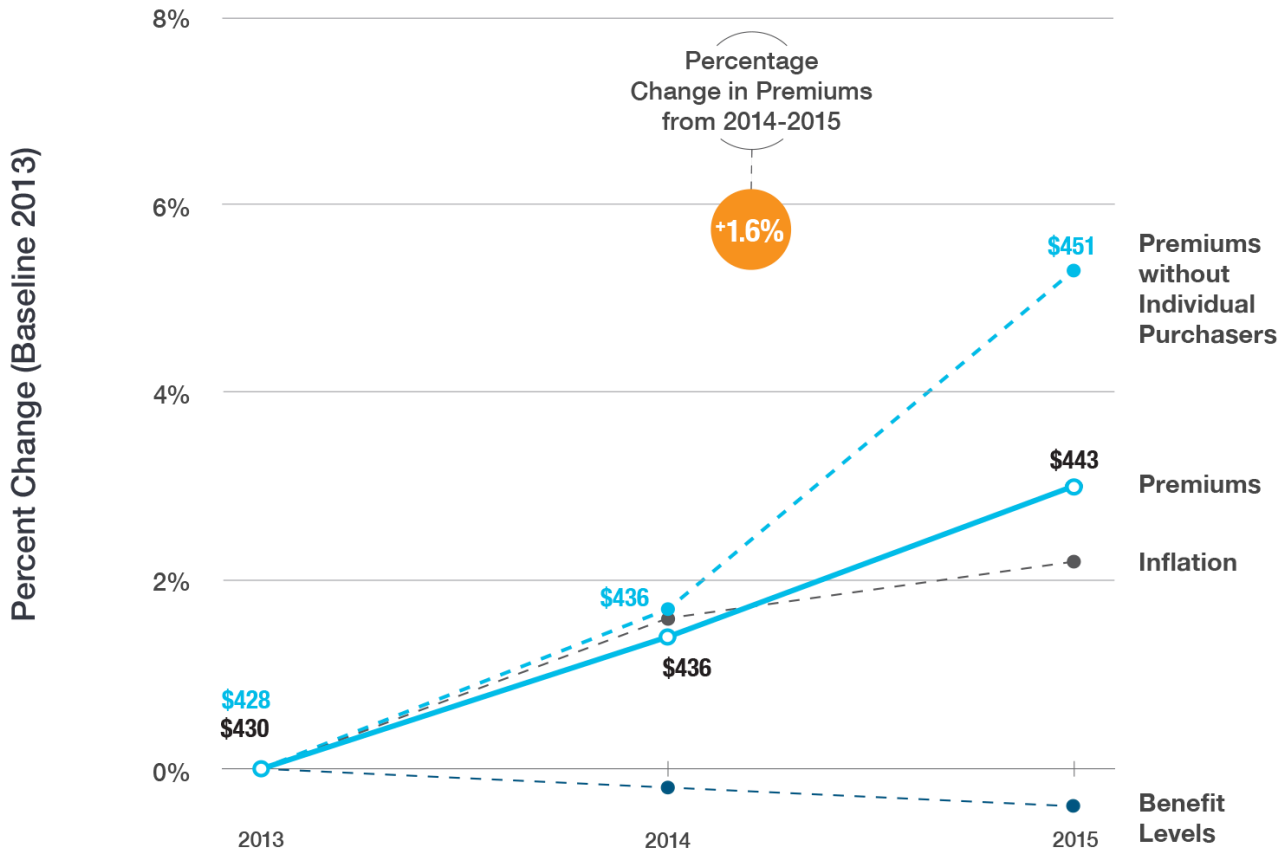


Individual enrollment in the commercial market more than doubled as new forms of subsidized and unsubsidized coverage became available. These members were associated with lower premiums, impacting the market as a whole.

Changes in the Merged Market

+90,000

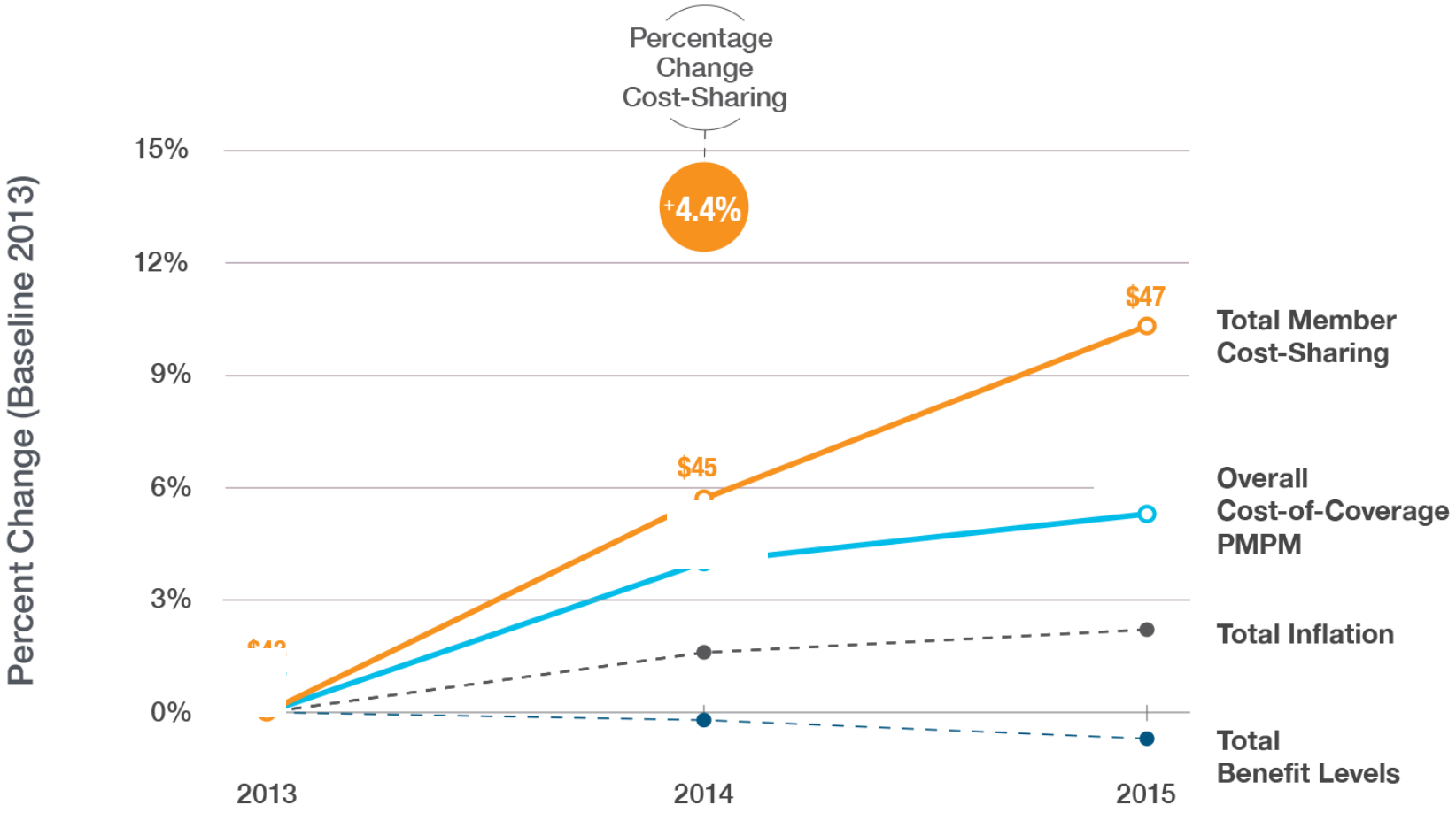
New Individual Purchasers



Member Cost-Sharing

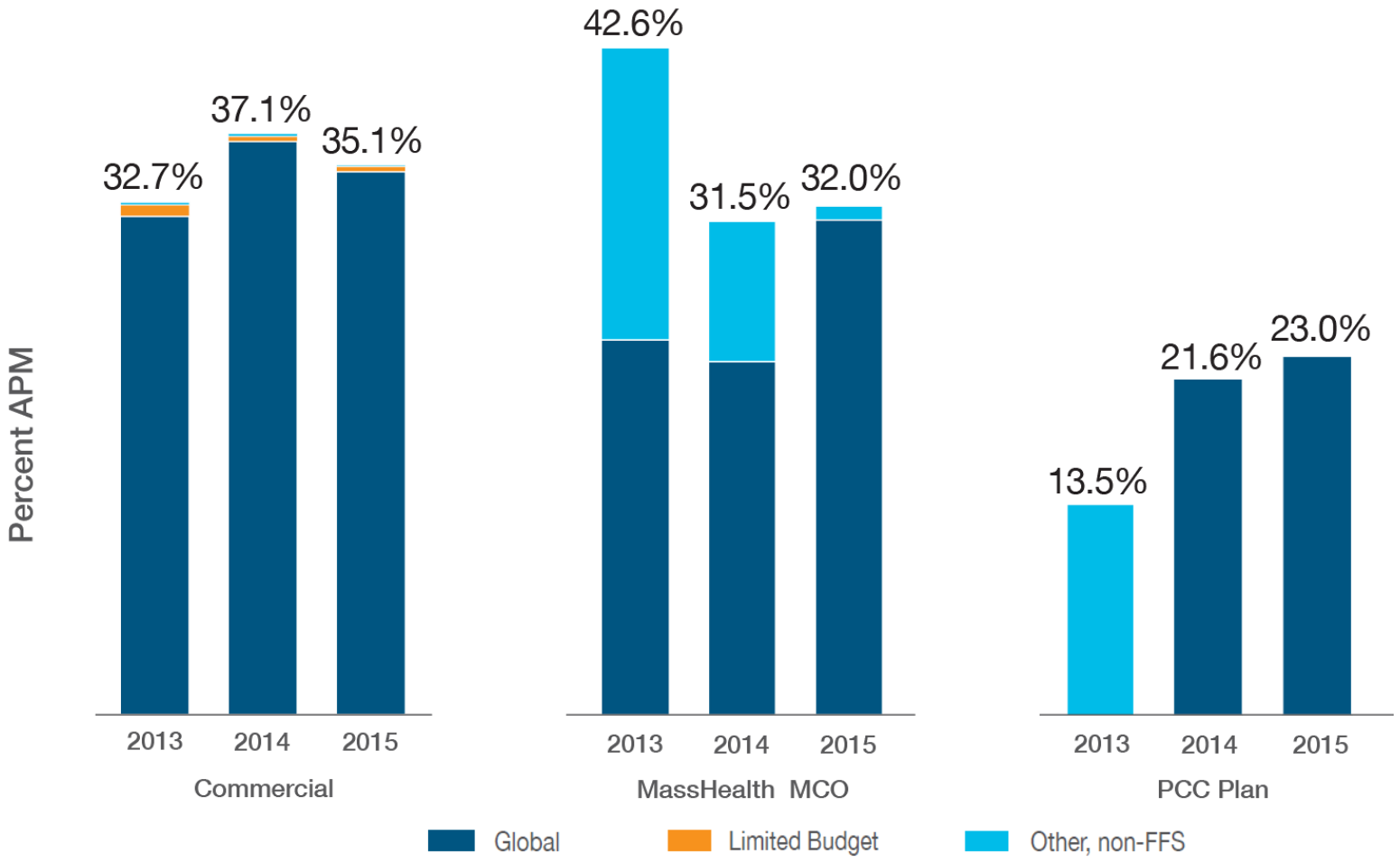
Private commercial member cost-sharing continues to increase faster than inflation, wage growth, and overall cost of insurance coverage.

One in five commercial members were enrolled in a high deductible health plan.



After several years of gains, the proportion of commercial members whose care was paid for through an alternative payment method fell by approximately two percentage points, to 35% of the market.

APM Adoption



THCE grew 4.1%, exceeding the benchmark (3.6%)

Pharmacy accounted for 36% of the growth in THCE

Shifts in enrollment increased overall spending, but PMPM spending only rose moderately

CONCLUSION

An influx of individual purchasers entered the private market into lower-premium plans, deflating overall market trends

Member cost-sharing outpaced the overall cost of insurance

One in five commercial members were enrolled in an HDHP

The proportion of commercial members whose care was paid for using APMs fell approximately 2 percentage points, to 35% of the market

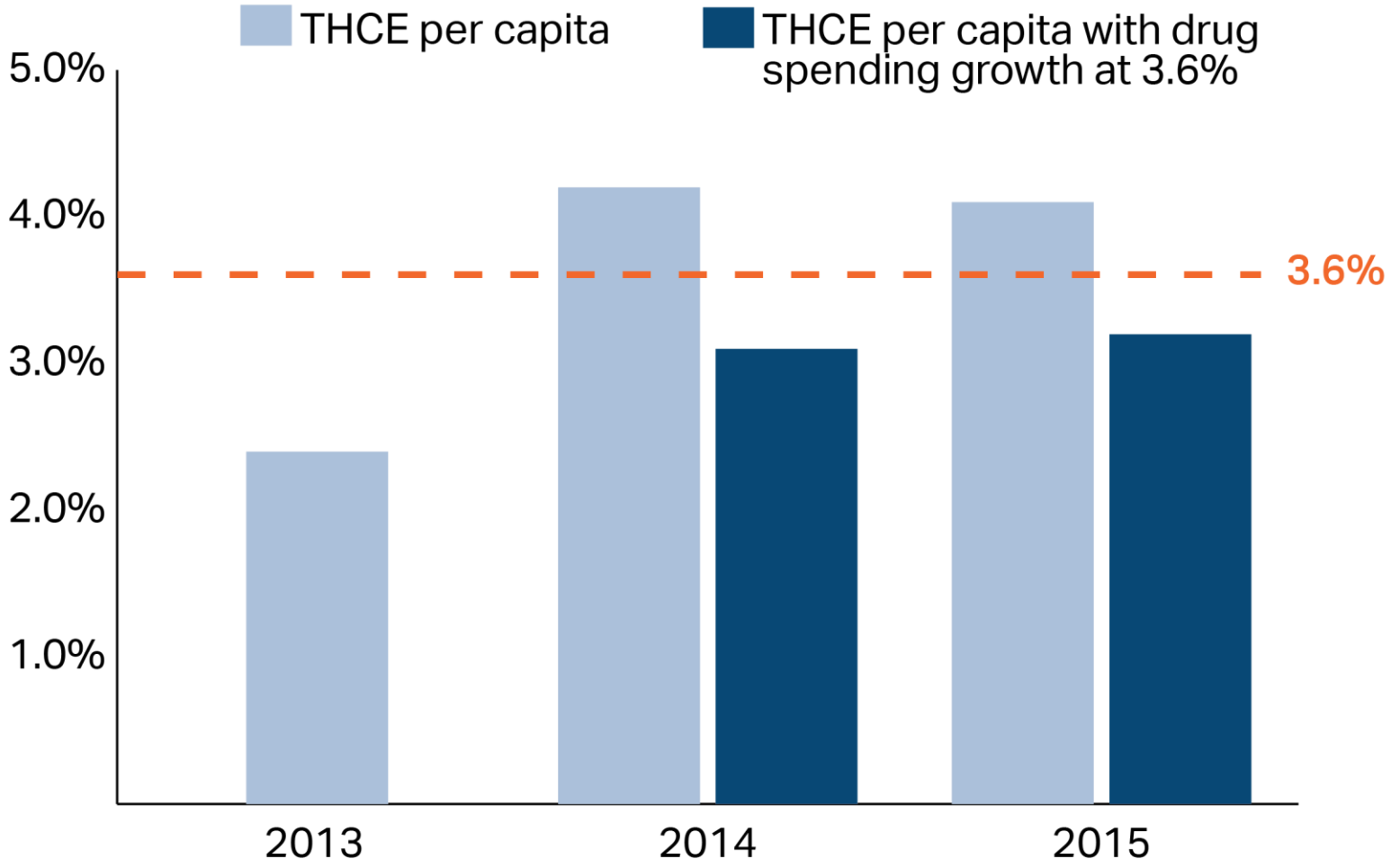
MASSACHUSETTS
HEALTH POLICY COMMISSION

Massachusetts health care spending and trends

October 17, 2016

Per-capita health care spending growth in Massachusetts has been generally in line with the benchmark

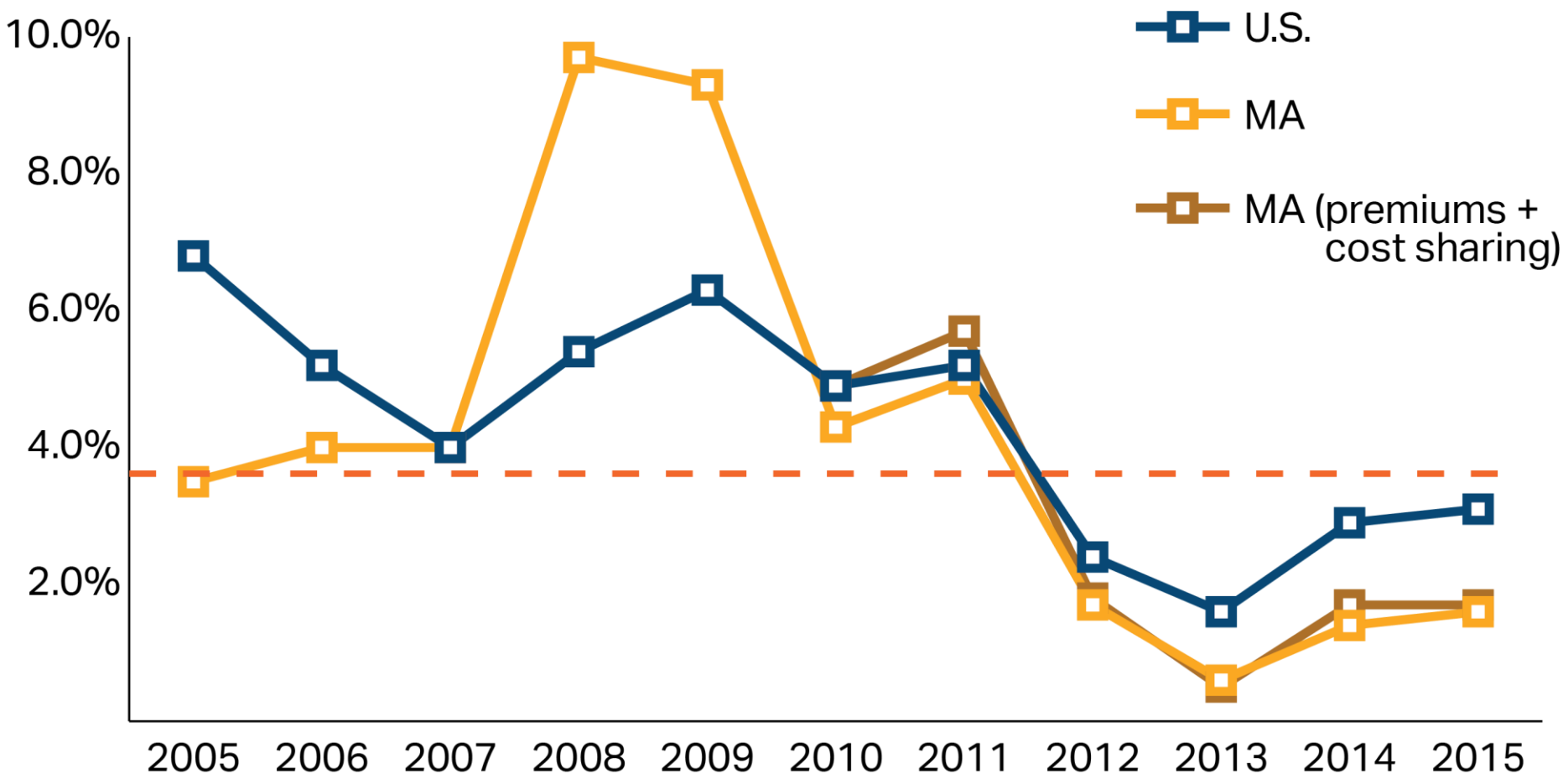
Annual growth in Total Health Care Expenditures per capita from previous year



Source: Massachusetts Center for Health Information and Analysis

Massachusetts commercial premium growth has been modest since 2012 compared to the U.S., even accounting for cost-sharing

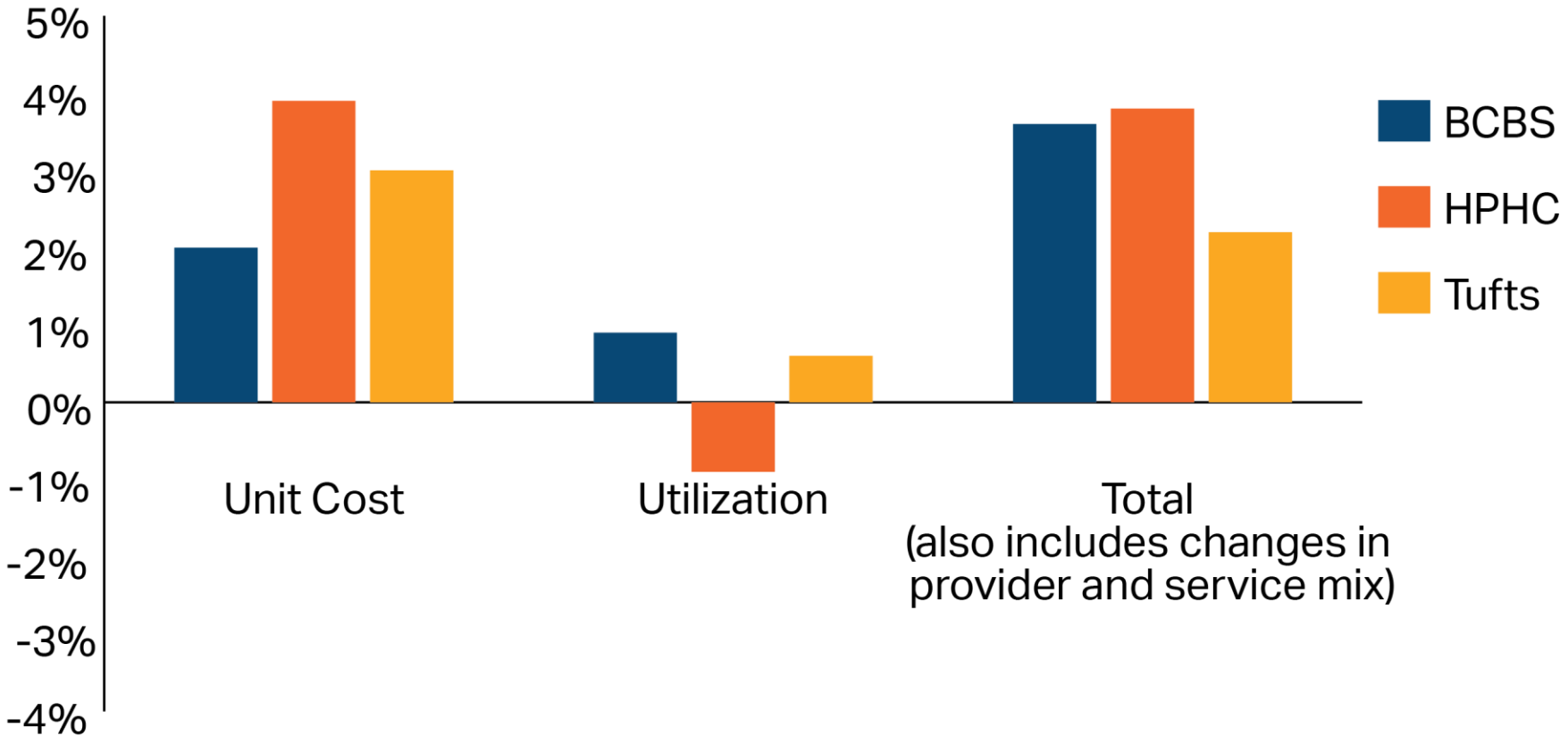
Annual growth in health insurance premium spending per enrollee from previous year



Sources: US data and MA data from 2005-2009: Centers for Medicare and Medicaid Services, State and National Health Expenditure Accounts, private health insurance expenditures and enrollment. MA 2009-2015: Massachusetts Center for Health Information and Analysis

Unit price growth continues to be the major driver of spending increases while utilization growth is flat, 2014-2015

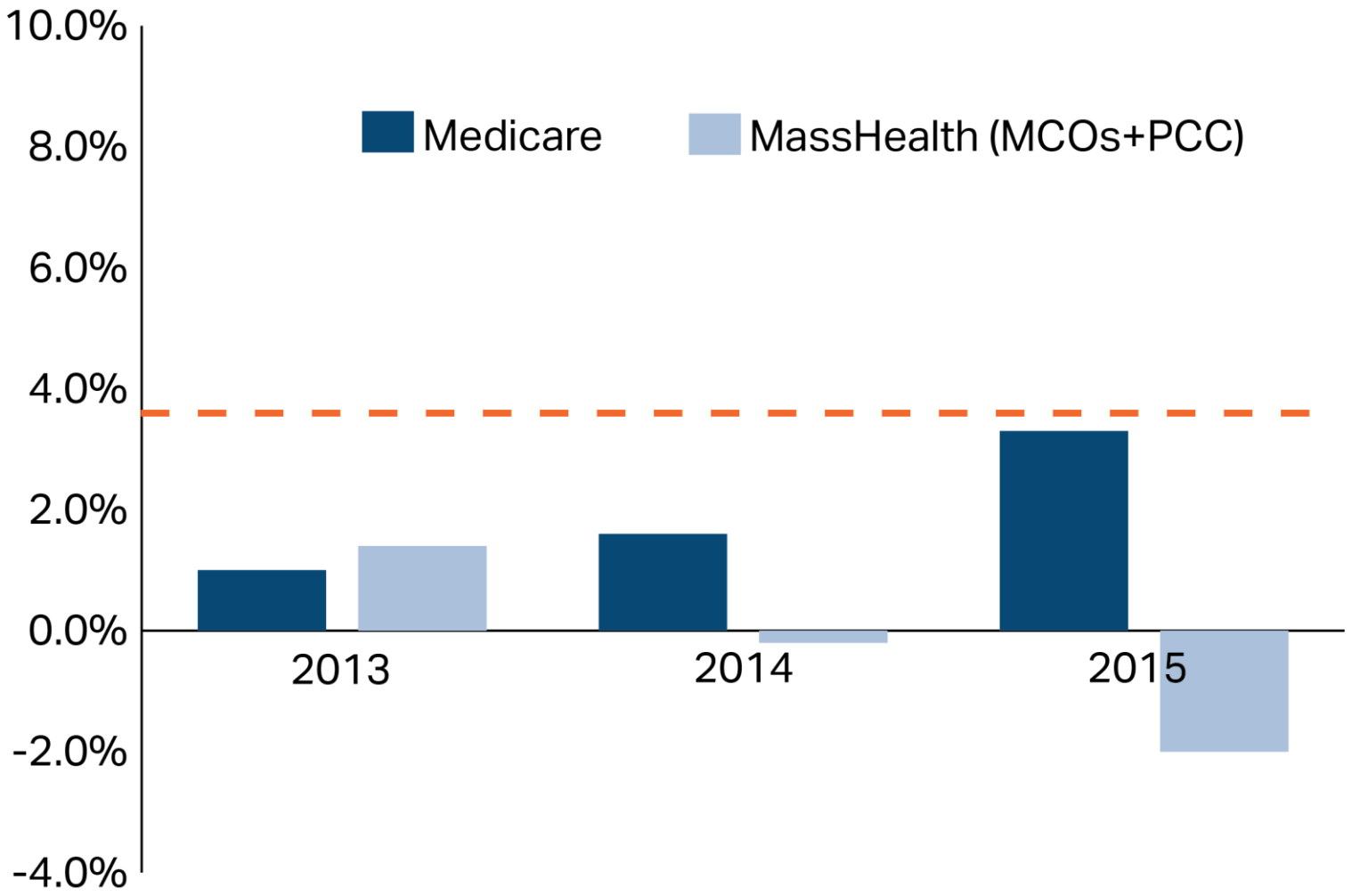
Annual growth in spending per enrollee due to each component



Source: Pre-filed testimony submitted by payers to the Health Policy Commission, 2016

Per-person spending growth in Medicare and MassHealth has also been modest

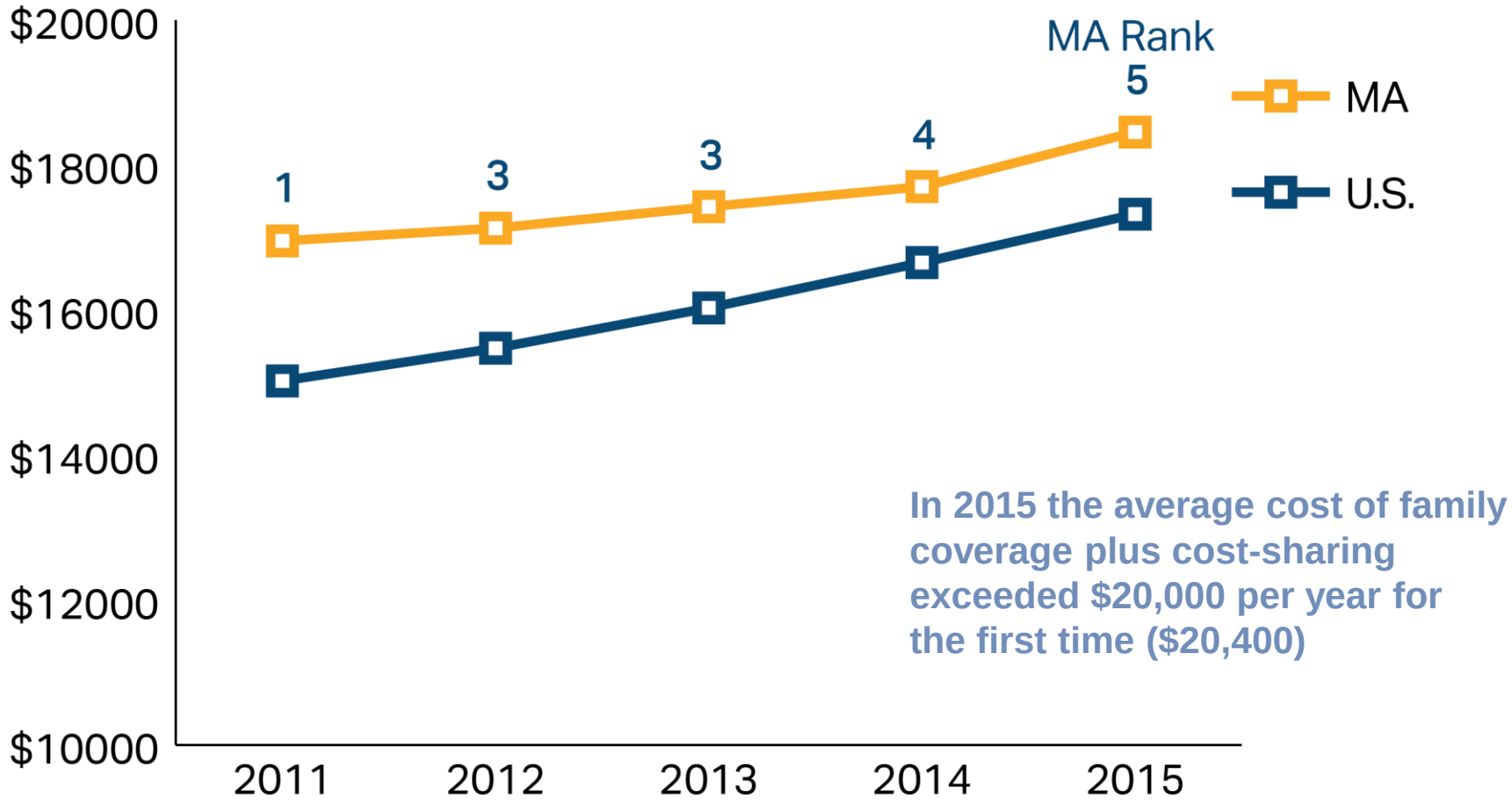
Annual per capita growth per enrollee from previous year



Source: Centers for Medicare and Medicaid Services (Medicare) and Center for Health Information and Analysis (MassHealth)

Massachusetts residents still pay among the highest health insurance premiums in the US

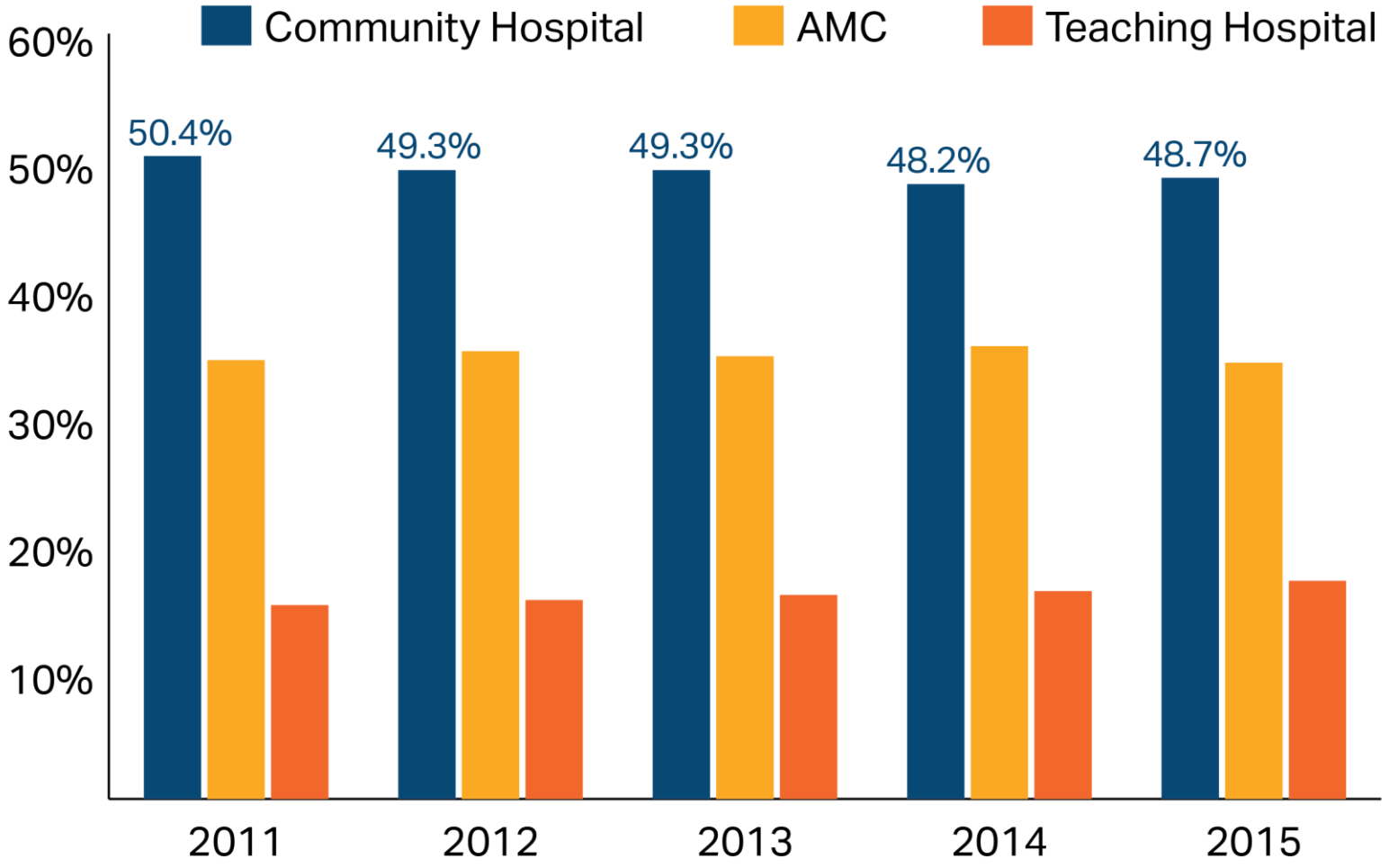
Annual premium for employer-based family health insurance, $



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component

The share of care that could be appropriately provided in a community hospital setting has not grown

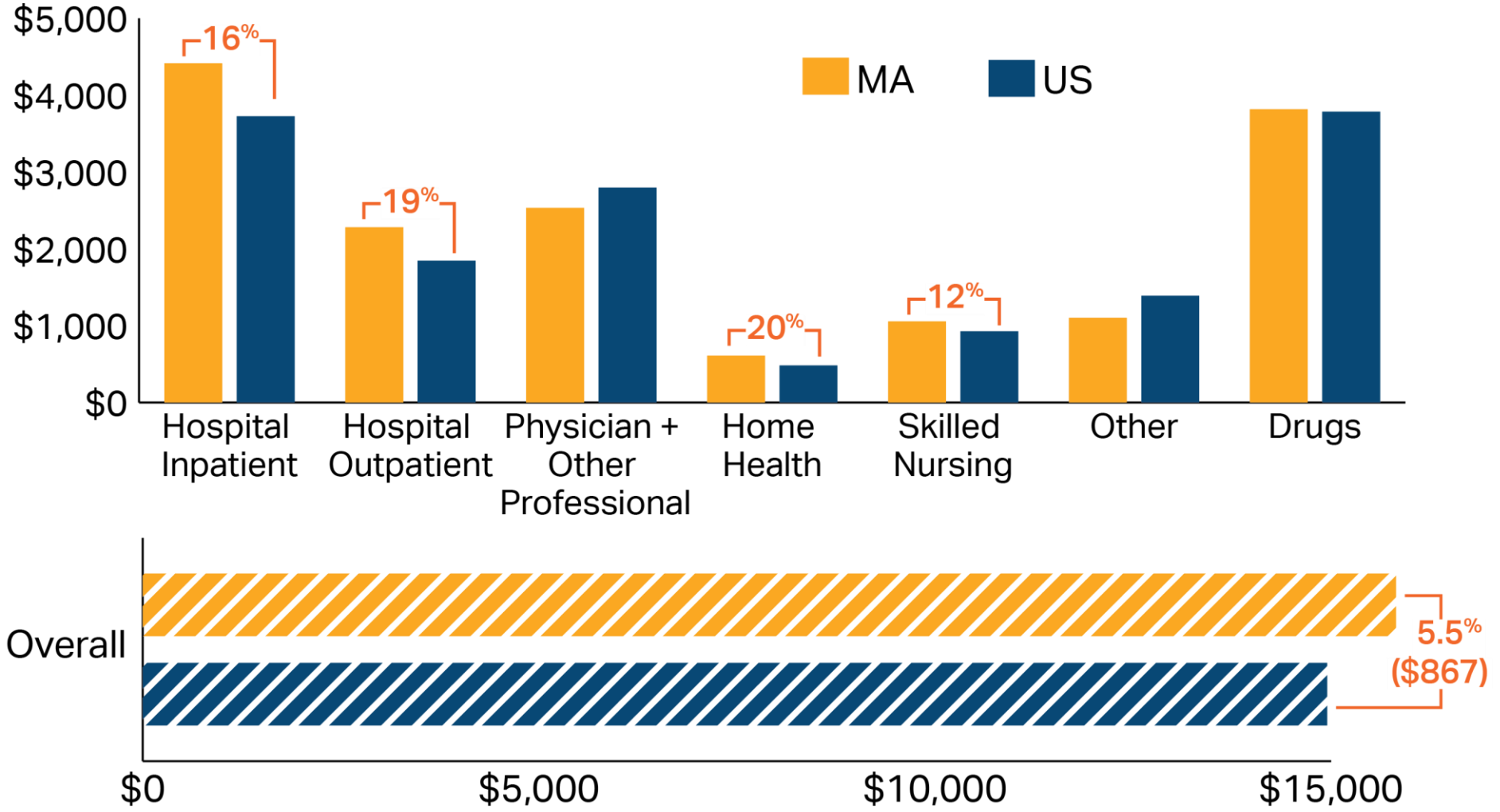
Percent of community-appropriate commercial discharges by hospital type



Discharge data from the Center for Health Information and Analysis

Massachusetts spends more per Medicare beneficiary than the rest of the U.S., particularly for inpatient and post-acute care

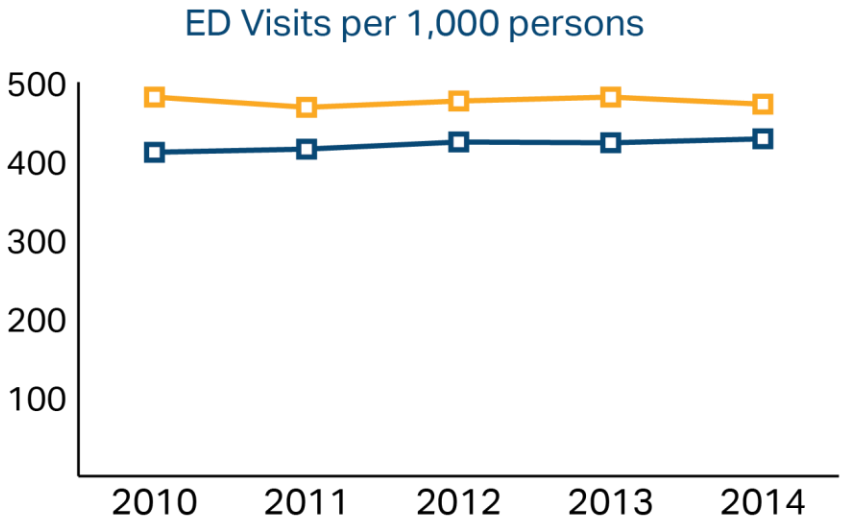
Annual spending per fee-for-service beneficiary, 2015

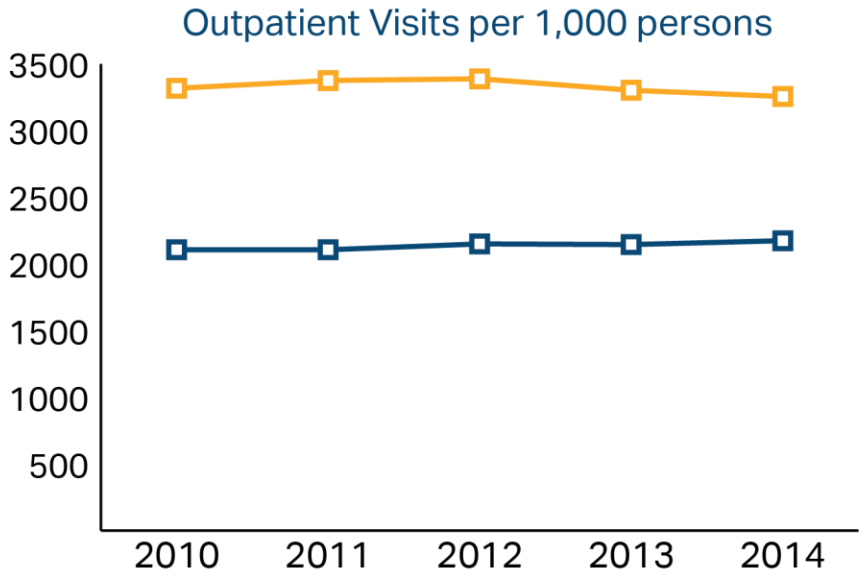


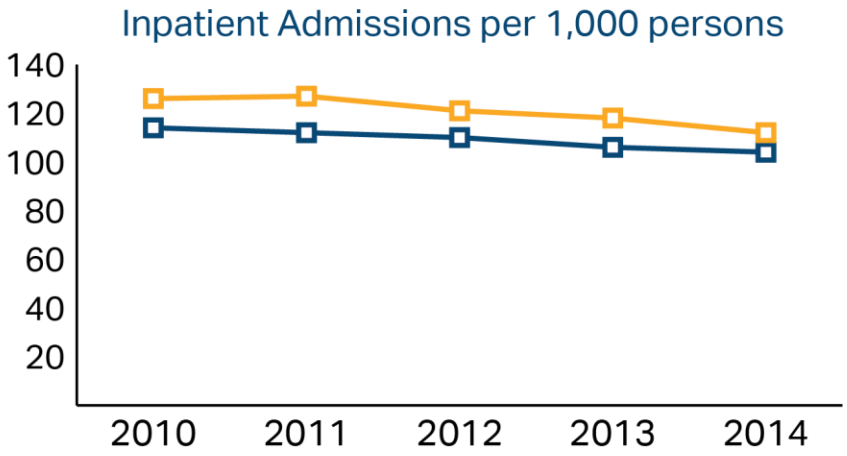
Source: Centers for Medicare and Medicaid Services

Though the gap has closed somewhat, Massachusetts continues to use hospital settings more intensively than the U.S.

Hospital Use in Massachusetts and the U.S., 2010-2014







Difference MA-US		
	2010	2014
Inpatient Admissions	11%	8%
Outpatient Visits	58%	50%
ED Visits	17%	10%

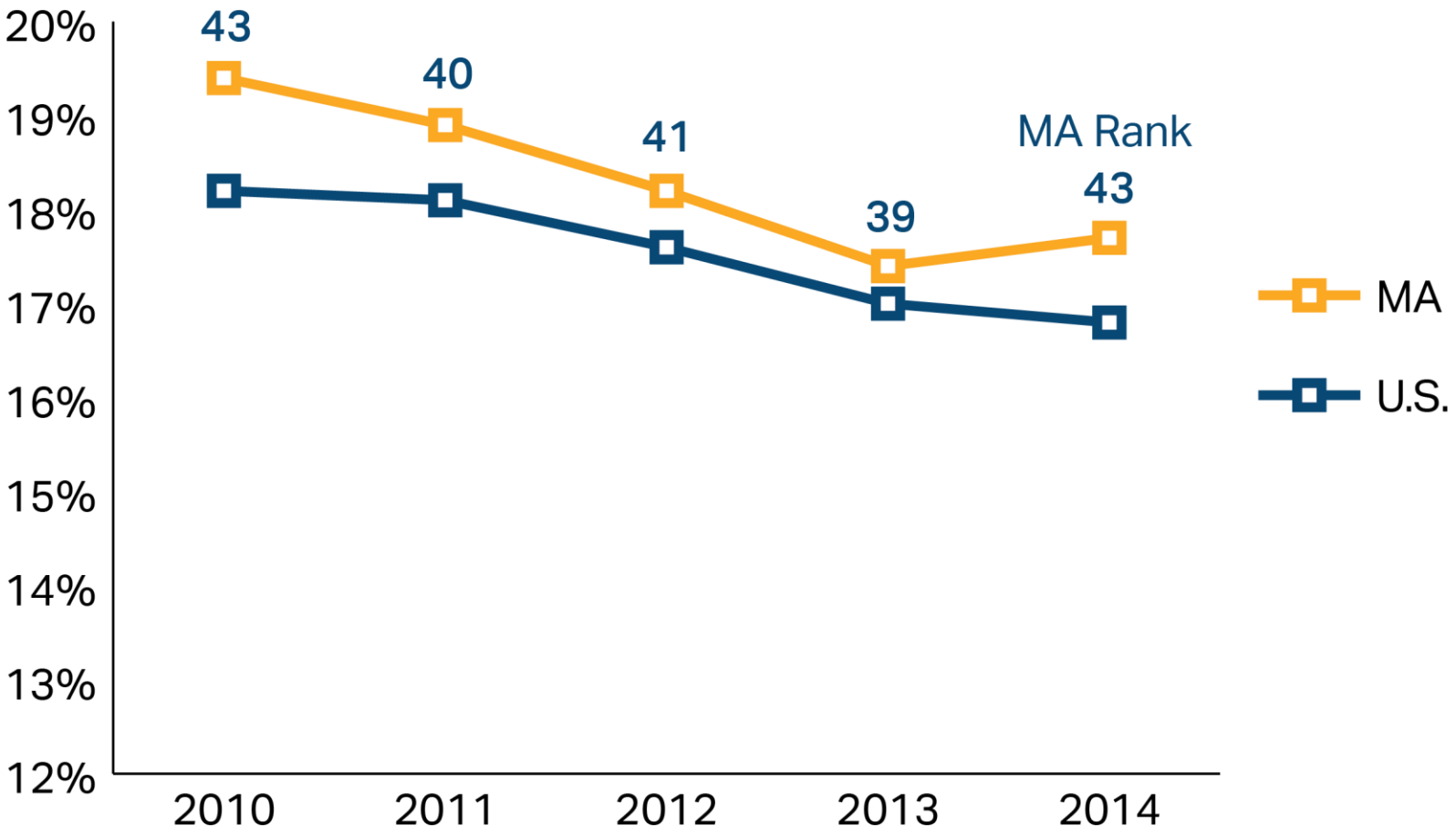
MA U.S.

HPC

Source: Kaiser Family Foundation analysis of American Hospital Association data

Medicare readmission rates have also declined but are higher than a majority of states

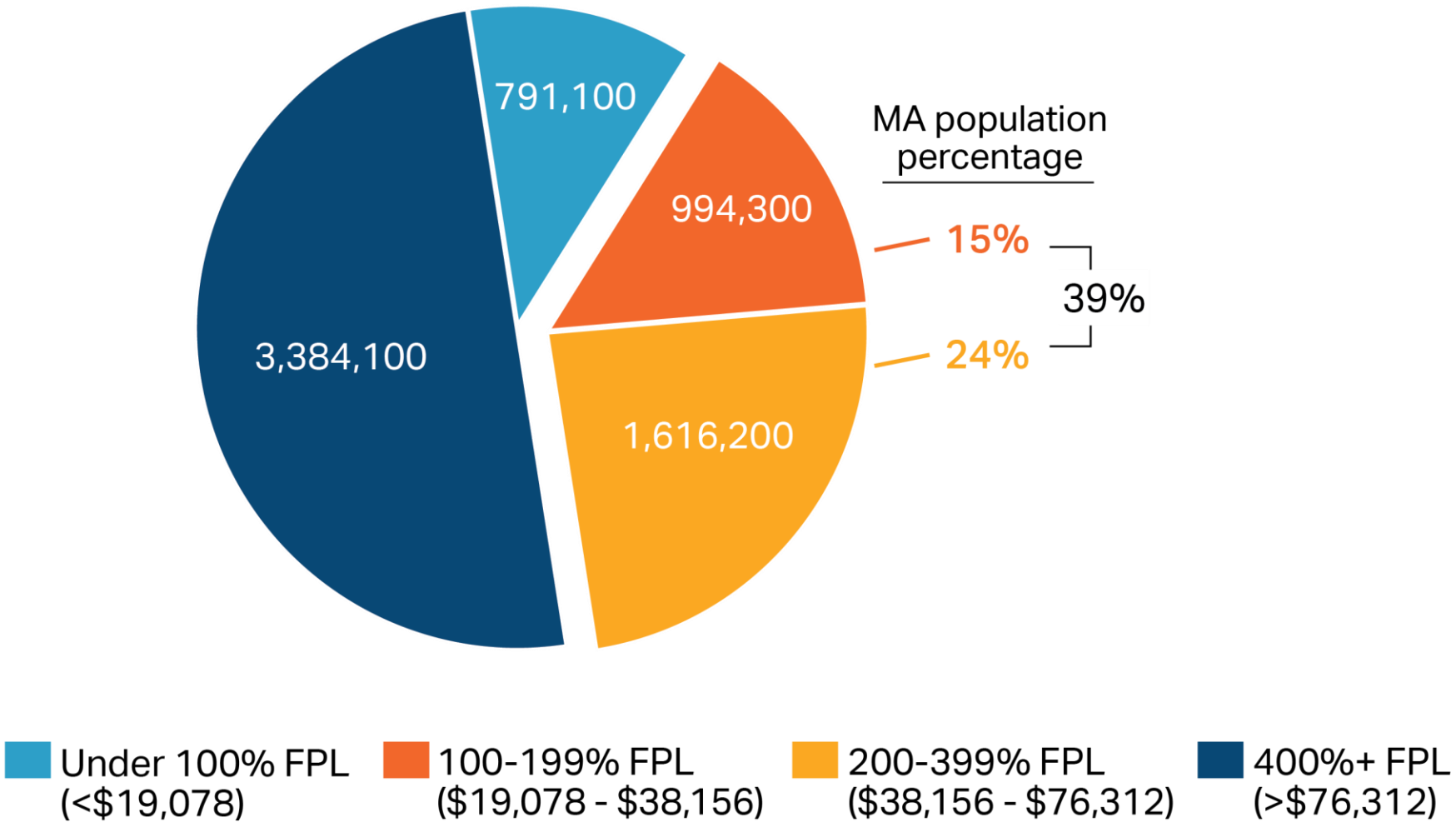
Percent of Medicare admissions that are readmissions



Source: Centers for Medicare and Medicaid Services

Although we are a high-income state, Massachusetts has a considerable portion of residents at middle-income levels

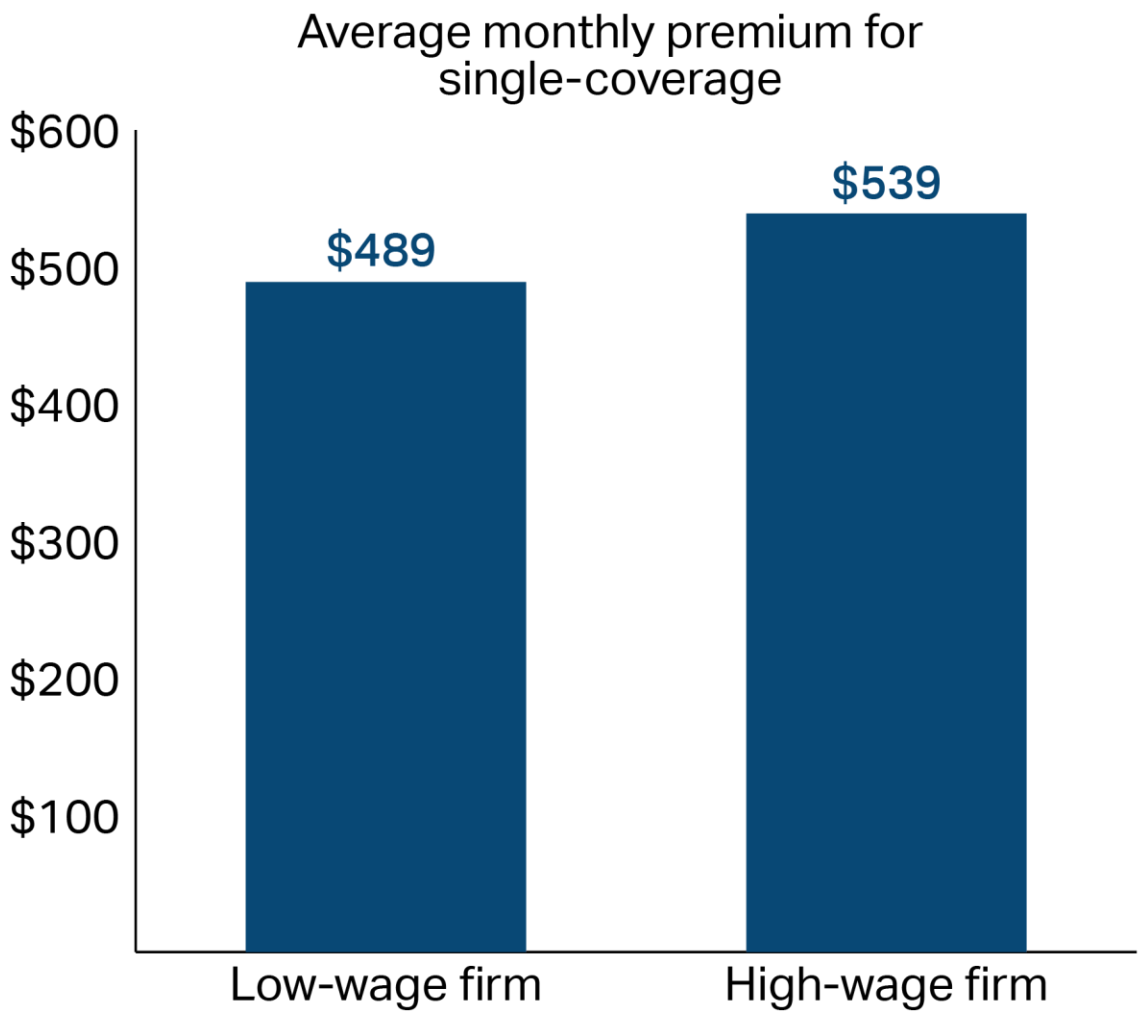
Number of state residents at each household income level, 2015



Source: Current Population Survey as reported by Kaiser Family Foundation. Dollar values are for a family of two adults and one child

Lower- and higher-income employees pay similar amounts in health insurance premiums

Per member per month premium spending for single coverage



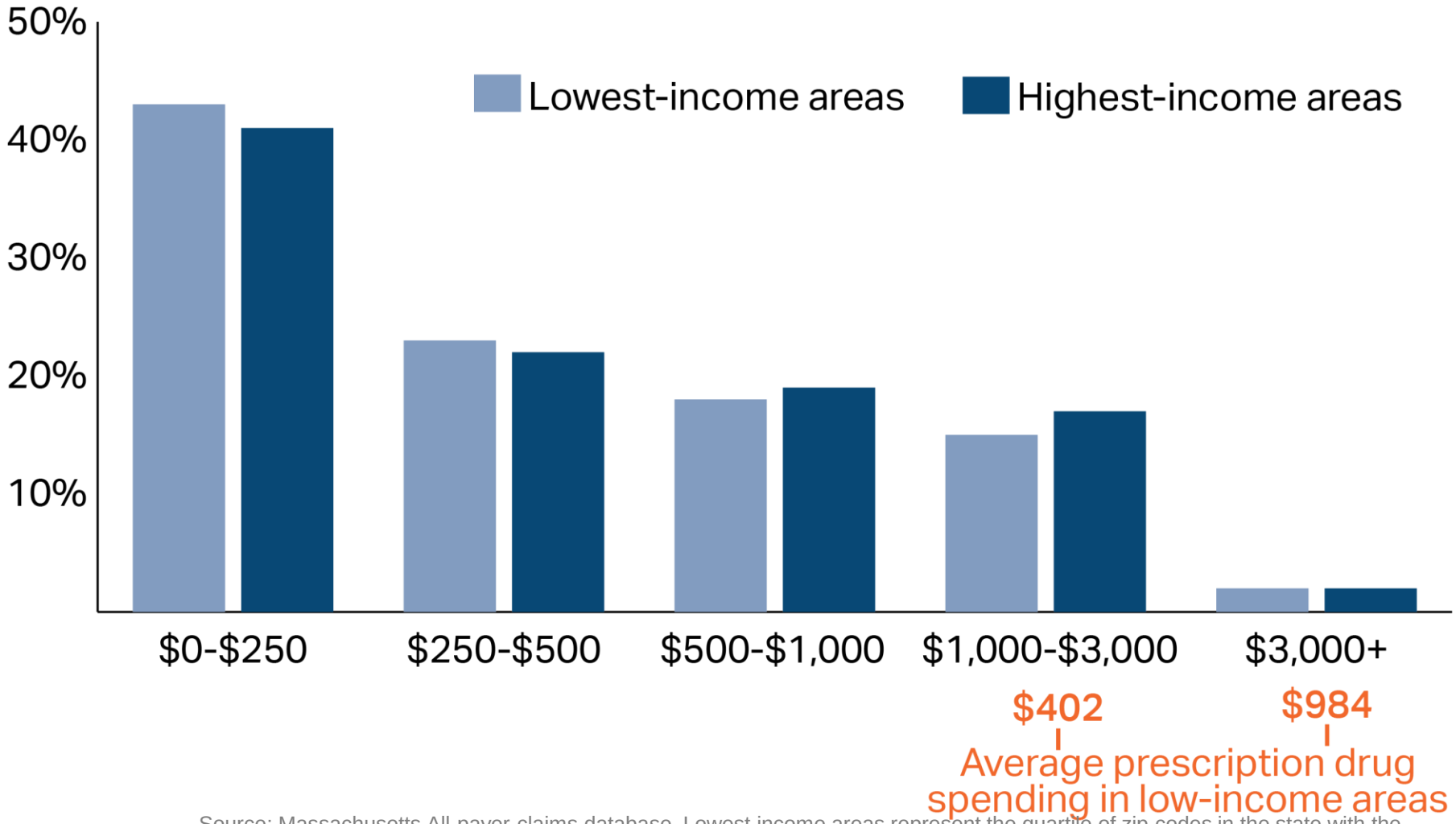
Low-wage firm: Most employees earn less than $25/hr

High-wage firm: 75% or more employees earn more than $25/hr

Source: Center for Health Information and Analysis, Massachusetts Employer Survey, 2014. Premiums include employee and employer contribution combined

Annual out of pocket spending is similar for individuals in low- and high-income areas of the state

% of residents, by income of region within Massachusetts, 2013

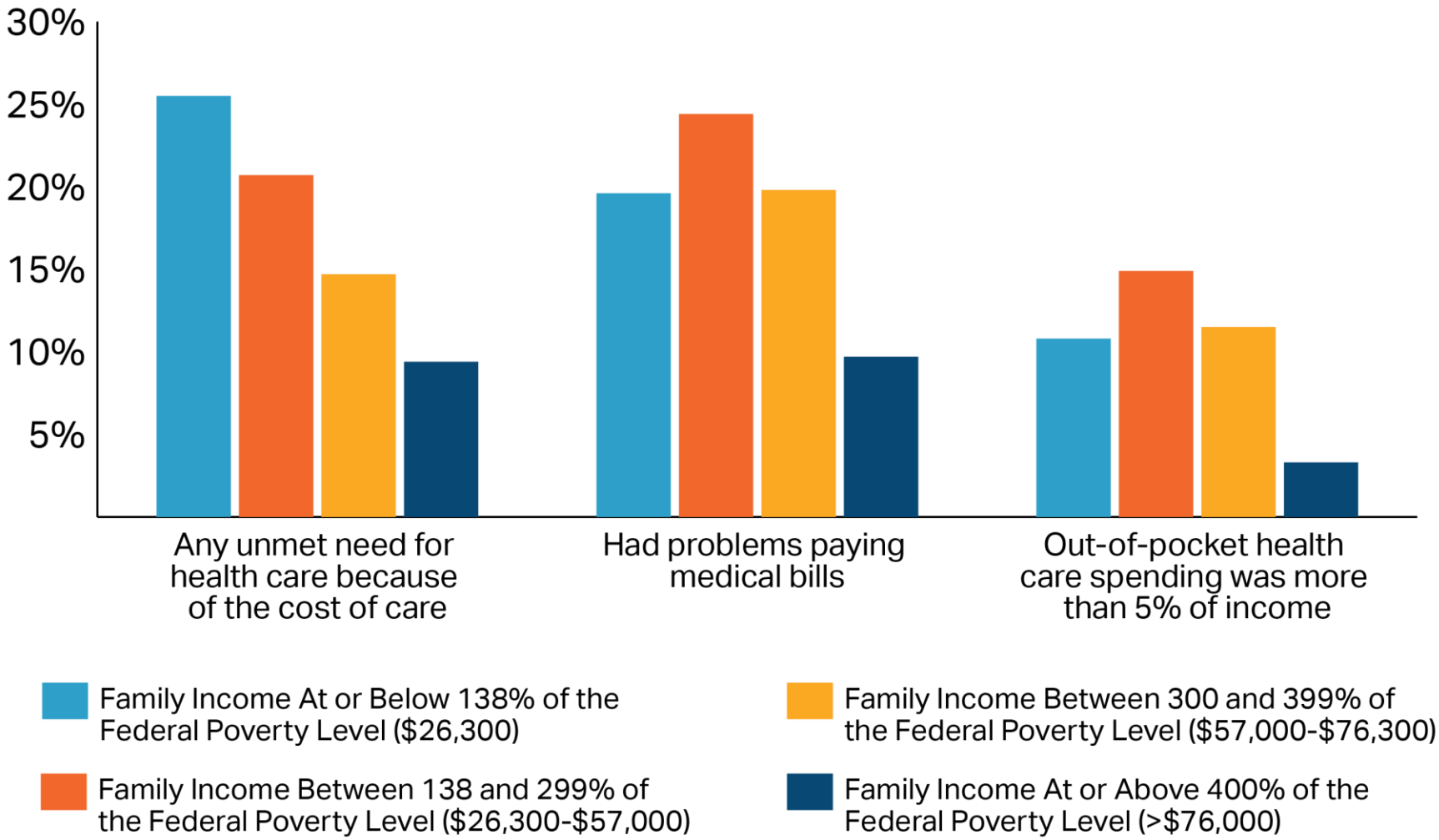


Source: Massachusetts All-payer claims database. Lowest income areas represent the quartile of zip codes in the state with the lowest median income. Spending includes only out of pocket spending within insurance benefits (e.g. copays and deductibles). Spending data is conditional on having non-zero spending.

HPC

Overall affordability of health care continues to be a challenge for many low and middle income residents

Percent of respondents saying they experienced the following in the past 12 months, by income



Source: Center for Health Information and Analysis, Massachusetts Health Interview Survey, 2015. Income ranges shown are for a family of two adults and one child. Out of pocket spending includes all health care spending including for non-covered services

Top areas of concern noted by payers and providers in 2016

PROVIDERS

Prescription drug costs (~50%)

Labor costs and wage pressure

Commercial payment rates for behavioral health

PAYERS

Prescription drug spending increases (100% of payers)

Most also noted lack of transparency in drug pricing

Provider consolidation and price variation

Source: pre-filed testimony submitted to the Health Policy Commission in advance of the 2016 Cost Trends Hearing

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by Dr. Robert Berenson

Annual Health Care
Cost Trends Hearing

CTH 2016

Provider Consolidation and Price Variation: A National Perspective

Robert A. Berenson, M.D.
Institute Fellow, The Urban Institute
rberenson@urban.org

Massachusetts Health Policy Commission
Cost Trends Hearing
Boston
17 October 2016

The Presentation Will:

- Establish the importance of prices as a primary driver of excessive spending
- Explore consolidation as one -- but not the only – reason for pricing power and price variations
- Review the evidence about the impact of consolidation on cost and quality
- Present an overview of policy options to address high and variable prices, with emphasis on states
- Discuss whether payment reform is part of the problem or part of the solution

Prices Are the Major Reason US Spending Exceeds the Rest of the World

- Whether as per capita spending or as percentage of GDP spent on health care
- "It's the prices, stupid: why the United States is so different from other countries." – Anderson et al., *Health Affairs*, 2003
- *Accounting for the Cost of Health Care in the United States* – McKinsey Global Institute, 2008

  "Input costs – including doctors' and nurses' salaries, drugs, and other medical supplies, and the profits of private participants in the system – explain the largest portion of additional spending… [the $650 billion extra the US spends compared to world norms]"

Trends in Payment to Cost Ratios

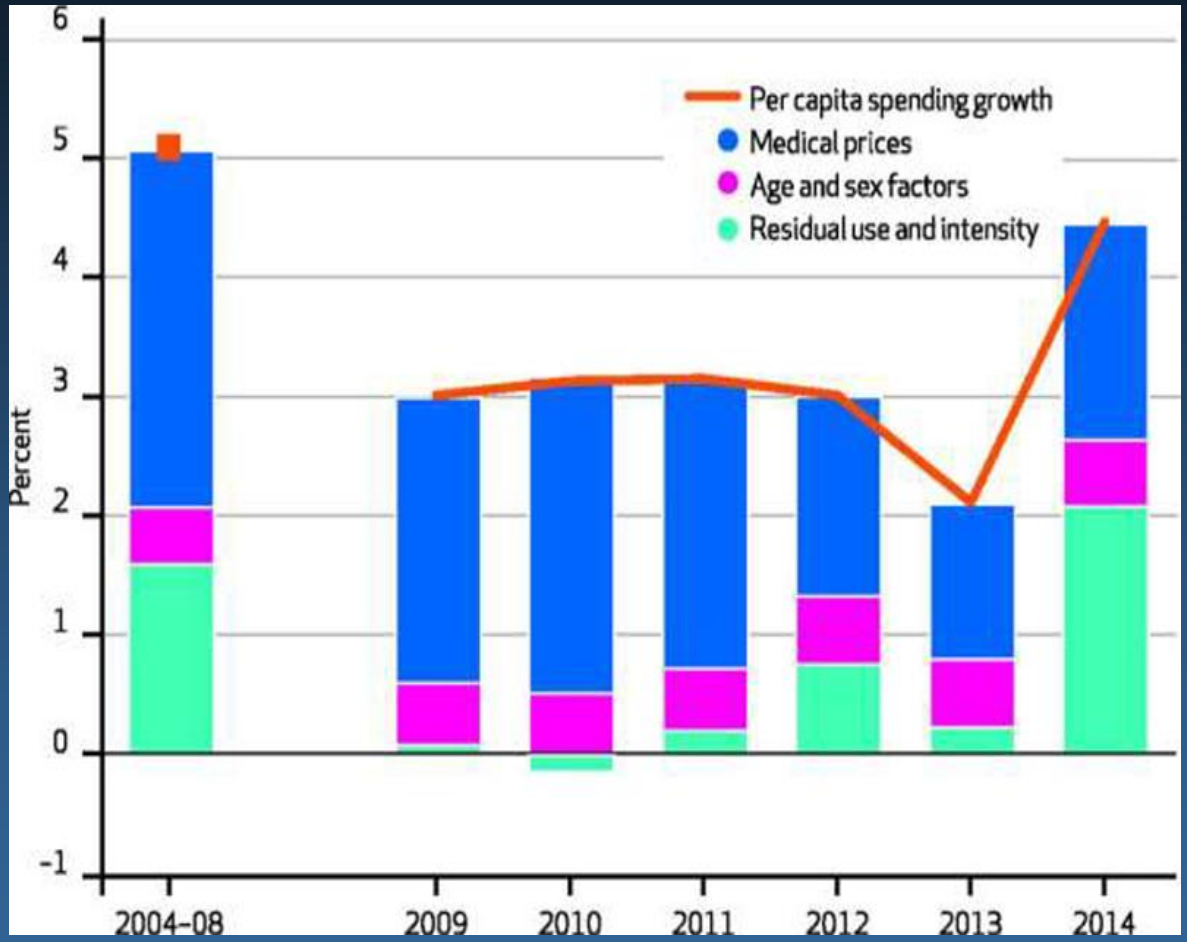
- Aggregate hospital payment-to-cost ratios for private payers increased from about 116% in 2000 to 144% in 2014 (was up to 149% in 2012 from 135% in 2011)

  AHA Annual Survey Data for Chart 4.6, for 2014, *AHA Trendwatch Chartbook,* 2016

- Some evidence of a slowdown in price increases in recent years, although some discrepancy in data sources used, i.e., whether Medicare Advantage is included
- "Medical Expenditure Panel Survey" data reveal that standardized private insurer payment rates in 2012 were approximately 75 percent greater than Medicare's – a sharp increase from the differential of approximately 10 percent in the period 1996-2001."

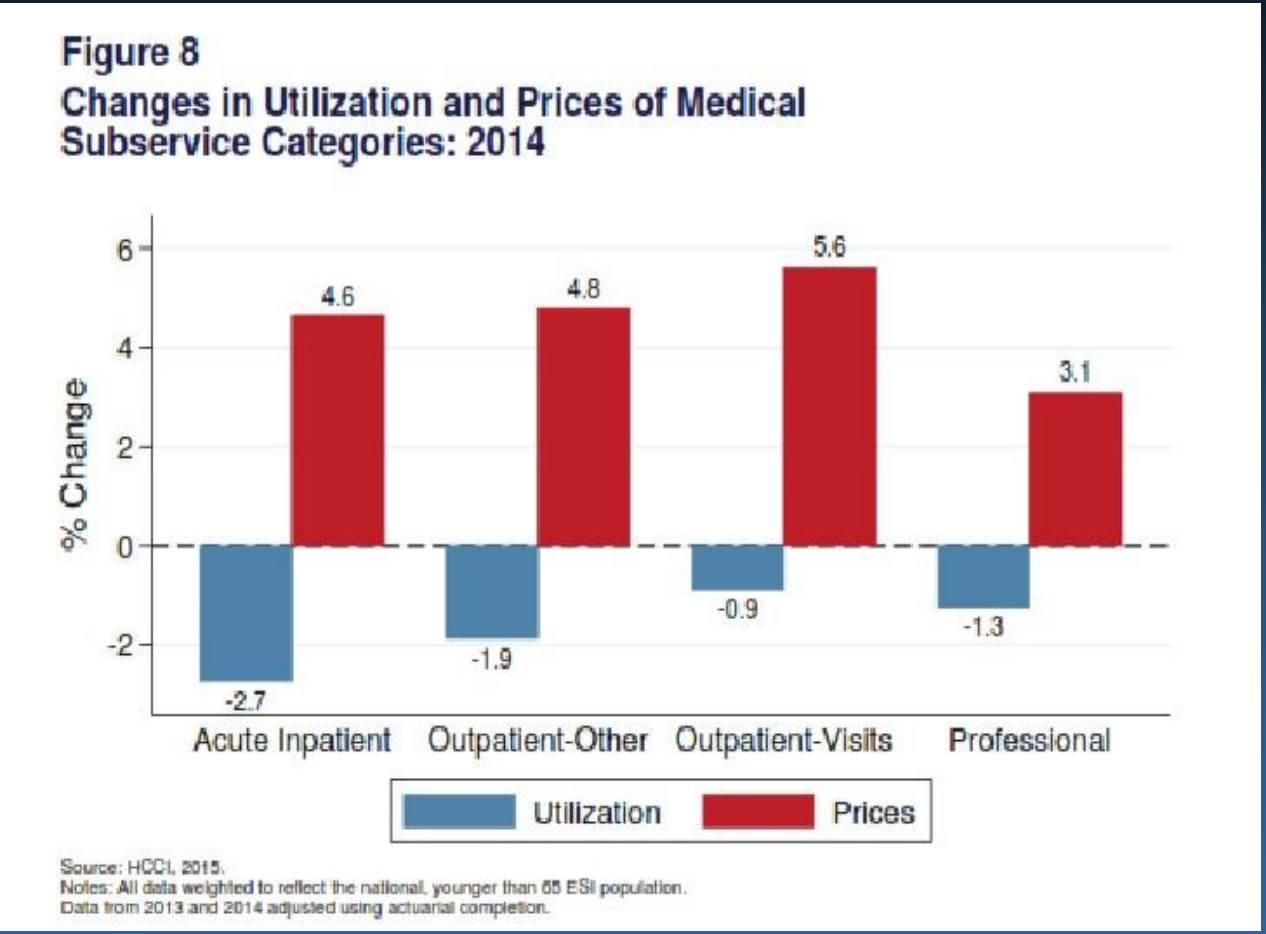
Selden et al., Health Affairs, Dec. 2015:2147

Factors Accounting for Growth in Per Capita National Health Expenditures, 04-14



Martin AB, Hartman M, Benson J, Catlin A; National Health Expenditure Accounts Team. "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending." *Health Aff (Millwood).* 2016 Jan; 35(1):150-60

Changes in Utilization and Prices of Medical Subservice Categories: 2014



"2014 Health Care Cost and Utilization Report." ***Health Care Cost Institute, Inc.,*** **Oct. 2015. Available online at: http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report**

The Price Variations Are Huge and Persistent

- Across 8 markets, from surveys, average inpatient rates ranged from 147% of Medicare in Miami to 210% in SF but ranged up to 500% for inpatient and 700% for outpatient care
- Within market variations were marked also – hospitals at the 25th percentile in LA County received 84% of Medicare payment levels while the 75th percentile got 184%

  Ginsburg. "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power." *Center for Studying Health System Change Research Brief No. 16,* 2010.
- From review of paid claims in 13 markets, the average highest priced hospital was paid 60% more than the lowest priced for inpatient services and >100% more for outpatient
- In 3 markets, the highest priced got >2X's lowest priced for inpatient care

  White, Bond, and Reschovsky. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." Center for Studying Health System Change Research Brief no. 27, 2013.
- MA Commission found hospital price variations consistent since 2010 and increased somewhat for physicians since 2009

“The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured”

Using HCCI data based supplied by Aetna, Humana, and UnitedHealth (27.6% of those with ESI), Cooper et al (Dec 2015) found:

- Per capita spending varies by a factor of 3 across 306 Hospital Referral Areas, with very weak correlation to Medicare per capita spending
- Variation in providers’ transaction prices is the primary driver of spending variation for privately insured
- Large dispersion of inpatient prices and for 7 homogeneous procedures, e.g., hospital prices for lower-limb MRI vary by a factor of 12 across US and on average two-fold within HRRs
- Hospital prices in “monopoly” markets are 15.3% higher than in markets with 4 or more hospitals

The Consolidation Frame

- Many frame the pricing power problem as consolidation, supported by evidence that finds that beyond a fairly low threshold, additional size does not improve quality or efficiency – but may actually make them worse
- But this frame:
  - ignores that there are high prices enjoyed by “must haves” as well in non-consolidated markets and which don’t do M&A
  - ignores the reality of “have-nots,” which are price takers and have relatively low payments, often below Medicare
  - points to antitrust policy as the prime antidote, rather than as just one tool to address pricing issues
  - and slides over strong views about the concept of ACOs as a community-based entity of some kind featuring collaboration rather than competition

Leverage Factors Unrelated to Concentration/Consolidation

- While concentration is the main story (and a major consideration re ACOs), other factors contribute to growing provider market power over prices and contract "terms and conditions"
  - Employer rejection of narrow networks
  - Reputation
  - Geography
  - Leveraging particular "monopoly" services – sometimes fostered by understandable regulatory exclusion of market competitors

Haves and Have-Nots

- While hospitals receive 175% of Medicare on average, anecdotally, it seems clear that many “haves” obtain >250% of Medicare, and as high as 500-600%
- But other hospitals accept even less than Medicare rates, because they have few commercially insured patients and are rarely if ever must haves in commercial insurance networks
- MedPAC finds that commercial insurance physician fees are at about 120-125% of Medicare overall but, anecdotally, in Miami, Las Vegas, and other places, physicians are “price takers,” accepting 60-70% of Medicare fee schedule rates, while in an unnamed mid-west city rates can be as high as 900%

The RWJF Synthesis Project

The Impact of Hospital Consolidation– Update, June 2012

Summary of key findings:

1. Hospital consolidation generally results in higher prices (with new evidence since 2012 confirming these findings)
2. Hospital *competition* improves quality of care
3. Physician-hospital consolidation has not led to either improved quality or reduced costs
4. Consolidation without integration does not improve performance
5. Consolidation between physicians and hospitals is fast increasing (although for various reasons, including to take advantage of FFS payment rules, not only to form ACOs able to receive population-based payments)

Why Antitrust Can't Be the Only or Even the Primary Policy Lever

- Many local markets can't readily support competition among major health care providers
- There are often justifiable, practical reasons for consolidations to take place, and some may improve quality and efficiency in particular situations -- but they can also lead to market power with increased prices as a derivative of the new, worthy arrangement
- The horse is out of the barn, after two major eras of hospital merger "mania"

"While the antitrust agencies' efforts to promote and protect competition in health care markets is commendable, it is also the case that the antitrust law has little to say about monopolies legally acquired, or in the case of consummated mergers, entities that are impractical to successfully unwind. Given the high level of concentration in hospital markets and a growing number of physician specialty markets, it is particularly important other measures that promote competition."

-- Professor Thomas (Tim) Greaney, Testimony to the Committee of the Judiciary, House of Representatives, May 18, 2012

Or other public policies that are more regulatory in nature

Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets

A Report of the National Academy of Social Insurance

April, 2015

NASI Report Policy Options on a Continuum from Market-oriented to Classically Regulatory

- Encouraging market entry of competitors
  - Eliminate scope of practice restrictions, AWP laws, CON
  - Policies to support telehealth adoption, alternative sites of care
- Greater price transparency (and quality)
  - Two different purposes: 1) to shine a spotlight on the problem, 2) to facilitate consumer choice when significant out-of-pocket payment obligations
  - Collecting and reporting all-payer claims data (now made more difficult because of Supreme Court's Gobeille ruling)
- Active purchasing by public payers
  - With hoped-for spillover to other product markets

Policy Options (cont.)

- Limiting anticompetitive health plan-provider contracting provisions
  - e.g., anti-tiering, all-or-none contracting, most favored nations clauses
- Harmonizing network-adequacy requirements with development of limited provider networks
  - While addressing out-of-network “surprise” bills
- Improved Antitrust Enforcement
  - Scrutiny of hospitals and insurers with market power
  - Active review of vertical mergers, based on recent evidence of anticompetitive effects
  - Conduct remedies and post-merger monitoring?

Policy Options (cont.)

- State-based oversight
  - Across the states doing this, there is significant variation in what state commissions are doing and whether they have regulatory authority
- Formal insurance rate review
  - Moving from “file and use” to “prior approval” and medical loss ratio requirements
  - Variations across states in which insurance products subject to review
  - Unsettled whether this approach creates necessary leverage for plans or whether also need direct authority over plan-provider (hospital) contracts, esp. re prices

Policy options (cont.)

- Limits on out-of-network billing as a way to constrain negotiating leverage between plans and providers
- Setting upper limits on permissible, negotiated rates
  - Or focus regulatory limits on health systems that exceed a threshold of consolidation
- Expanded use of all-payer or private payer rate setting, a la Maryland and West Virginia, respectively

NASI Did Not Include Payment Reform As One of the Options

- The greater concern is that some payment reforms would increase pricing power and price differentials
- "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform,"
  Berenson, Ginsburg, and Kemper. *Health Affairs,* April, 2010
- Indeed, policy analysts, such as Michael Porter, argue that "focused factories" receiving bundled episode payments for treatments and conditions are preferred over integrated systems receiving population-based payments, partly because of less concern about market power raising prices

High Prices Eat Low Service Use for Lunch

- Dartmouth and subsequent analyses suggest that efficient providers have service use profiles perhaps 20% lower than average; in Medicare, MedPAC finds a 30% spread across geographic areas between the 10th and 90th percentile if health status adjustments are included
- But private insurance prices vary by far more than 20-30% -- perhaps 100% between the 10th and 90th percentile in many markets
- Only through a pure "bending the cost curve" lens can one consider Shared Savings or Total Cost of Care contracting based on historical costs a win. These approaches basically accept and can even exacerbate wide price disparities between "haves" and "have-nots."

How Payment Design Can Affect Prices in Commercial Market Products

- Essentially, whether or not providers' historic costs are the basis for target spending
  - In calculating benchmarks for determining whether shared savings
  - In setting hospital global budgets a la Maryland, where there actually is substantial price variation by hospital, but much less so by patient and payer
  - In pricing a bundled episode
- Using historic costs without adjustments "bakes in" historic pricing differentials, but some approaches to updates can narrow differences over time

Options for Balancing Provider Specific, Historic v. Community Average Prices

- Medicare ACOs get an absolute dollar rather than a percentage trend update (so higher cost providers get a lower percentage update)
- Blend and transition benchmarks from historic toward the average -- but maybe not all the way
  - In Medicare IPPS, 4 yr. transitional blend from actual cost per case to national, standard cost per case
  - In Medicare Advantage, there are 4 different benchmarks based on level of per capita spending in traditional Medicare
  - All-payer rate setting states in ‘80s had transitional blends
- Can vary shared savings percentages in relation to the level of historic, baseline spending

Classification of State Policies Addressing Provider Market Power

(Catalyst for Payment Reform, for NASI)

The report produced a catalogue of laws to enhance market competition or substitute for it

- Antitrust related laws
- Laws and regulations:
  - encouraging transparency on quality and price
  - encouraging competitive behavior in health plan contracting
  - implementing the monitoring or regulating of prices
  - around the development of ACOs
  - expanding the authority of Departments of Insurance
  - facilitating or reducing barriers for new entrants to the market

Examples of State Actions to Address Consolidation and Pricing

- CA prevents providers' ability to suppress price information
- MA has created the Health Policy Commission which among other things conducts a "cost and market impact review" to monitor material changes by provider organizations
- MA bans carriers from entering contracts that limited tiered networks or guarantees a provider's participation
- MI (and other states) explicitly bar insurers from using "most favored nation" clauses in provider contracts

State Examples (cont.)

- RI Office of the Insurance Commissioner has been granted broad authority to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability, and giving them the ability to review and approve payer-provider contracts

- Texas defines a “health care collaborative” (ACO) and requires them to obtain a certificate of authority from the DOI and AG concurrently. The latter reviews whether the ACO is likely to reduce competition and whether it should be permitted

Some Useful Papers and Reports

- Gaynor and Town. *The impact of hospital consolidation—Update.* The Synthesis Project. Robert Wood Johnson Foundation, June, 2012. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261
- Office of the Health Insurance Commissioner State of Rhode Island. V*ariations in Hospital Payment Rates by Commercial Insurers in Rhode Island.* December, 19, 2012. Available at: http://www.ohic.ri.gov/documents/Hospital-Payment-Study-Final-General-Dec-2012.pdf
- Delbanco and Bazzaz. *State Policies on Provider Market Power.* National Academy of Social Insurance, Washington, D.C., July, 2014. Available at: https://www.nasi.org/sites/default/files/research/State_Policies_Provider_Market_Power.pdf
- NASI Panel on Pricing Power in Health Care Markets. *Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets- The Final Report.* National Academy of Social Insurance, Washington, D.C., April 2015. Available at: https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf
- Berenson. *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust.* Journal of Health Politics, Policy and Law, Vol 40, No. 4, June, 2015. Available at: http://jhppl.dukejournals.org/content/early/2015/06/09/03616878-3150026.abstract
- Murray and Berenson. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* The Urban Institute, Washington, D.C., November, 2015. Available at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000516-Hospital-Rate-Setting-Revisited.pdf
- Cooper et al. *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured.* The National Bureau of Economic Research, NBER Working Paper No. 21815, December, 2015. Available at: http://www.nber.org/papers/w21815

THANK YOU

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel: Meeting the Health Care Cost Growth Benchmark

Annual Health Care Cost Trends Hearing

CTH 2016

Panel: Meeting the Health Care Cost Growth Benchmark

Panelists

Atrius Health	Dr. Steven Strongwater, President and CEO
Baystate Health	Dr. Mark Keroack, President and CEO
Blue Cross Blue Shield of MA	Mr. Andrew Dreyfus, President and CEO
Community Care Cooperative	Ms. Christina Severin, President and CEO
Harvard Pilgrim Health Care	Mr. Eric Schultz, President and CEO

Focus Areas

1. Meeting the Goals of Chapter 224
2. Adoption of Alternative Payment Methods
3. Impact of Pharmaceutical and Medical Device Pricing Trends
4. Out-of-Network Billing

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Reactor Panel:
Employer Perspective

Annual Health Care
Cost Trends Hearing

CTH 2016

Reactor Panel: Employer Perspectives

Panelists

Northeast Business Group on Health	Ms. Laurel Pickering, President and CEO
Onyx Specialty Paper	Ms. Patricia Begrowicz

Focus Areas

1. Role of Employers in Promoting Value-Based Health Care
2. Plan and Benefit Design Strategies
3. Employee Engagement
4. Health Insurance Premium Trends

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by the
Office of the Attorney General

Annual Health Care
Cost Trends Hearing

CTH 2016

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

October 17, 2016

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

AGO Cost Trends Examinations

- Authority to conduct examinations:
  - G.L. c. 12, § 11N to monitor trends in the health care market.
  - G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued since 2010.
- This examination focuses on the distribution of health care spending in the commercial market.
- Examined commercial spending across communities of different income levels and across employer groups.

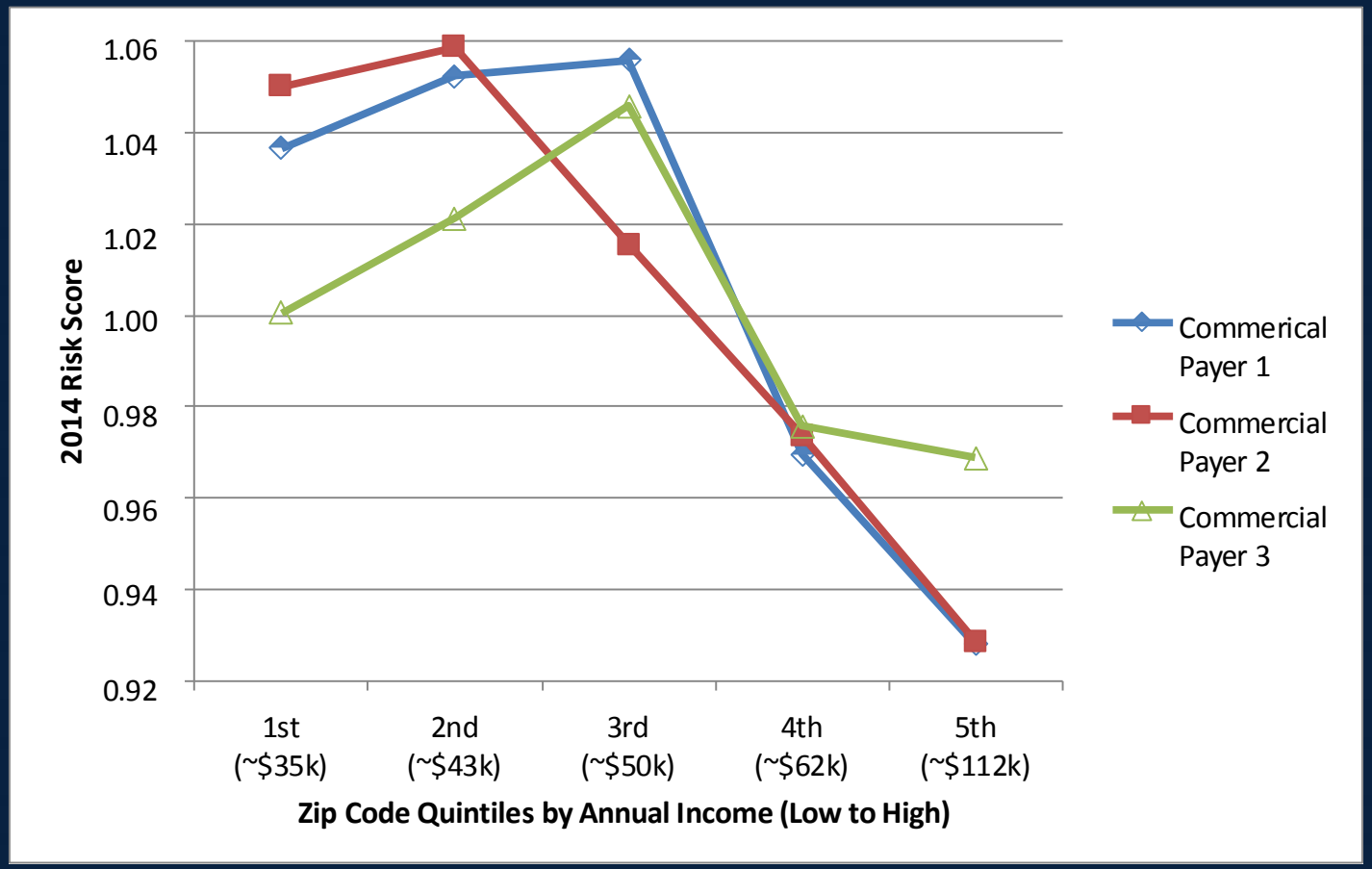
Questions Presented

I. How are commercial health care dollars being distributed across communities of different income levels relative to health need?

II. Are there spending differences attributable to members' provider choices within and between similarly situated employer groups?

III. Can approaches to setting premiums be improved to reward employers and consumers who seek out high quality, lower cost care?

Higher Income Communities Are Generally Healthier



We Continue to Spend More on Commercial Patients from Higher Income Communities Relative to Health Burden

Distribution of a Major Payer's Members by Income and Health Risk Adjusted Medical Spending (2014)

This Higher Spending on Higher Income Communities Is Likely Driven by a Number of Factors

- Lower-income communities may utilize less health care, notwithstanding health need, for a variety of reasons:
  - Lower income communities disproportionately experience structural barriers to accessing health care, like access to transportation and paid sick leave.
  - Changes in benefit design, like the trend toward high deductible health plans (HDHPs), can also disproportionately impact lower income communities. For example, lower income families enrolled in HDHPs are more likely than higher income families to delay or forgo care.
- On average, residents of lower and higher income communities may also use a different mix of health care providers. To the extent affluent communities use higher priced providers more often than lower-income communities, more is spent on their care because it is costlier.

Questions Presented

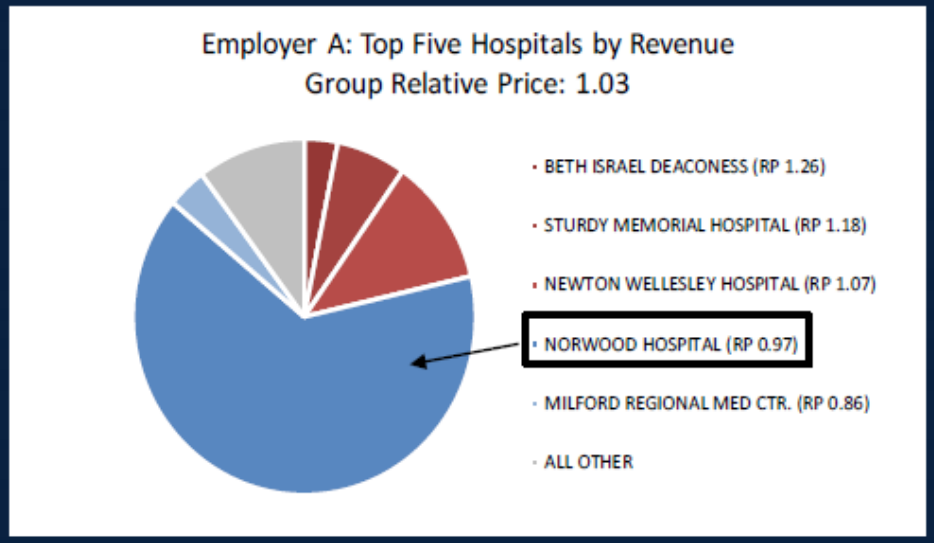
I. How are commercial health care dollars being distributed across communities of different income levels relative to health need?

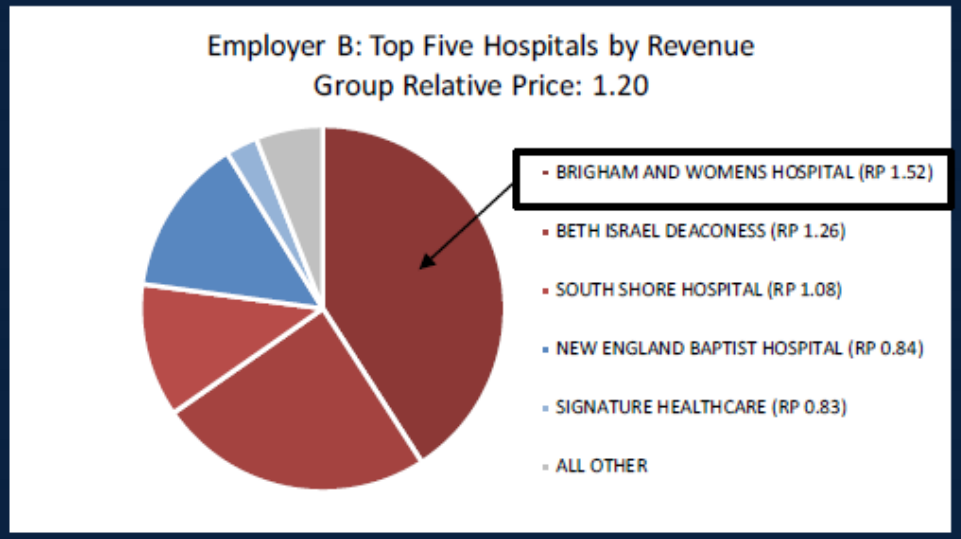
II. Are there spending differences attributable to members' provider choices within and between similarly situated employer groups?

III. Can approaches to setting premiums be improved to reward employers and consumers who seek out high quality, lower cost care?

Differences in the Mix of Hospitals Used by Two Similarly Situated Employer Groups

Top Five Hospitals Used by Two Small Employers Located in Metrowest, MA (By 2014 Claims Revenue)





Other Examples of Differences in Hospital Mix Across Pairs of Similarly Situated Employer Groups

	Employer 1	Average Price of Hospitals Used	Employer 2	Average Price of Hospitals Used	Difference in Avg Price of Hospitals Used
Metrowest Region	Employer A	1.03	Employer B	1.20	16.5%
Boston Region	Employer C	1.07	Employer D	1.22	14.0%
Cape/Islands Region	Employer E	1.25	Employer F	1.38	10.4%
Central Region	Employer G	1.03	Employer H	1.26	22.3%
Northeast Region	Employer I	0.84	Employer J	1.09	29.8%
Southeast Region	Employer K	0.93	Employer L	1.18	26.9%
West Region	Employer M	0.91	Employer N	1.32	45.1%

Questions Presented

I. How are commercial health care dollars being distributed across communities of different income levels relative to health need?

II. Are there spending differences attributable to members' provider choices within and between similarly situated employer groups?

III. Can approaches to setting premiums be improved to reward employers and consumers who seek out high quality, lower cost care?

Premiums Socialize the Costs of Provider Choice

- When premiums in a shared risk pool (like the merged market or a large employer like the GIC) do not account for provider efficiency, the risk pool socializes a number of costs.
  - The costs associated with the group's health needs, and
  - The costs associated with certain members' use of higher priced providers.

An Alternative Model: Premiums That Account for Provider Efficiency

Differentiating Premiums Based on Patient's Choice of PCP Group While Continuing to Socialize Health Risk

	Provider Relative Efficiency	Traditional Monthly Premium	Differentiated Monthly Premium	Exemplar Employer Contribution (set at 80% of Prov. A premium)	Exemplar Employee Contribution
Provider A	0.88	$584	$514	$411	$103
Provider B	0.92	$584	$537	$411	$126
Provider C	0.96	$584	$561	$411	$150
Provider D	0.97	$584	$566	$411	$155
Provider E	1.00	$584	$584	$411	$173
Provider F	1.00	$584	$584	$411	$173
Provider G	1.01	$584	$590	$411	$179
Provider H	1.06	$584	$619	$411	$208

Recommendations

- Monitor the relationship between health care spending and health burden:
  - Track the allocation of health care dollars under global budgets.
  - Monitor the impact of plan design on access to health care services across different communities.
  - Examine whether higher health care spending on more affluent communities is contributing to income-based disparities in health outcomes.

Recommendations

- Sharpen available tools to reward more efficient health care delivery:
  - Explore product designs that offer consumer incentives at the point-of-enrollment.
  - Engage the employer community to demand timely and easily compared information on the cost and quality of different insurance plans and provider systems.
  - Evaluate provider performance under the statewide cost growth benchmark in ways that take into account differences in provider efficiency.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel: Evolving Provider Market

Annual Health Care
Cost Trends Hearing

CTH 2016

Panel: The Evolving Provider Market

Panelists

Central Massachusetts IPA	Ms. Gail Sillman, Chief Executive Officer
Lahey Health	Dr. Howard Grant, President and CEO
NEQCA	Dr. Joseph Frolkis, President and CEO
South Shore Health System	Dr. Gene Green, President and CEO
Tufts Health Plan	Mr. Thomas Croswell, President and CEO

Focus Areas

1. Continued Provider Consolidation
2. Shift in Care from Inpatient to Outpatient Settings
3. Physician Recruitment and Employment Trends
4. Future Role for Community Hospitals and Independent Physician Practices
5. Provider Price Variation

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next
Public Testimony

Annual Health Care
Cost Trends Hearing

CTH 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

October 18, 2016

Annual Health Care
Cost Trends Hearing

CTH 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by the
Office of the Attorney General

Annual Health Care
Cost Trends Hearing

CTH 2016

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

October 18, 2016

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

AGO Cost Trends Examinations

- Authority to conduct examinations:
  - G.L. c. 12, § 11N to monitor trends in the health care market.
  - G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued since 2010.
- This examination focuses on prescription drug spending.
- Examined commercial spending under the pharmacy benefit by five health plans – four regional and one national – representing 75% of the Massachusetts commercial market.

Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?

Annual Increase in Commercial Drug Spending Net of Rebates (PMPM) 2013-15

Annual Pharmaceutical Spending Trend (Per Member Per Month) 2013-2015				
	2013-2014 Trend		2014-2015 Trend	
Plan	**Pre-Rebate**	**Net-Rebate**	**Pre-Rebate**	**Net-Rebate**
Plan 1	14.3%	12.9%	6.5%	4.5%
Plan 2	11.0%	11.7%	14.6%	15.3%
Plan 3	10.2%	9.0%	11.4%	9.3%
Plan 4	21.1%	19.9%	7.7%	3.3%
Plan 5	13.4%	13.1%	10.4%	8.4%
Average	14.6%	13.7%	8.2%	6.1%
Reporting Entity	**Pre-Rebate**	**Net-Rebate**	**Pre-Rebate**	**Net-Rebate**
HPC ('13-'14) CHIA ('14-'15)	12.5%	N/A	8.5%	N/A
IMS	13.1%	N/A	12.2%	8.5%

Annual Increase in Commercial Specialty Spending Net of Rebates (PMPM) 2013-15

Annual Trend for Spending on Specialty Drugs (Per Member Per Month) 2013-2015				
	2013-2014 Trend		2014-2015 Trend	
Plan	**Pre-Rebate**	**Net-Rebate**	**Pre-Rebate**	**Net-Rebate**
Plan 1	32.5%	N/A	29.9%	N/A
Plan 2	30.4%	30.5%	45.5%	45.7%
Plan 3	33.4%	N/A	23.5%	N/A
Plan 4	45.0%	46.4%	19.9%	17.3%
Plan 5	36.3%	36.2%	25.0%	18.0%
Average (Plans 2, 4 and 5)	38.0%	38.3%	26.1%	21.4%
Reporting Entity	**Pre-Rebate**	**Net-Rebate**	**Pre-Rebate**	**Net-Rebate**
IMS	26.5%	N/A	21.5%	N/A

Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?

Health Plans Pay for Specialty Drugs in a Variety of Ways

	For Specialty Pharmaceuticals, Health Plan Contracts Directly with:					
Plan	**PBM for discounts**	**Manufacturers for discounts**	**Pharmacy for discounts**	**PBM for rebates**	**Manufacturer for rebates**	**PBM for up-front price, with rebate guarantee**
Plan A	✓			✓		
Plan B			✓	✓		
Plan C			✓			✓
Plan D			✓		✓	
Plan E		✓			✓	

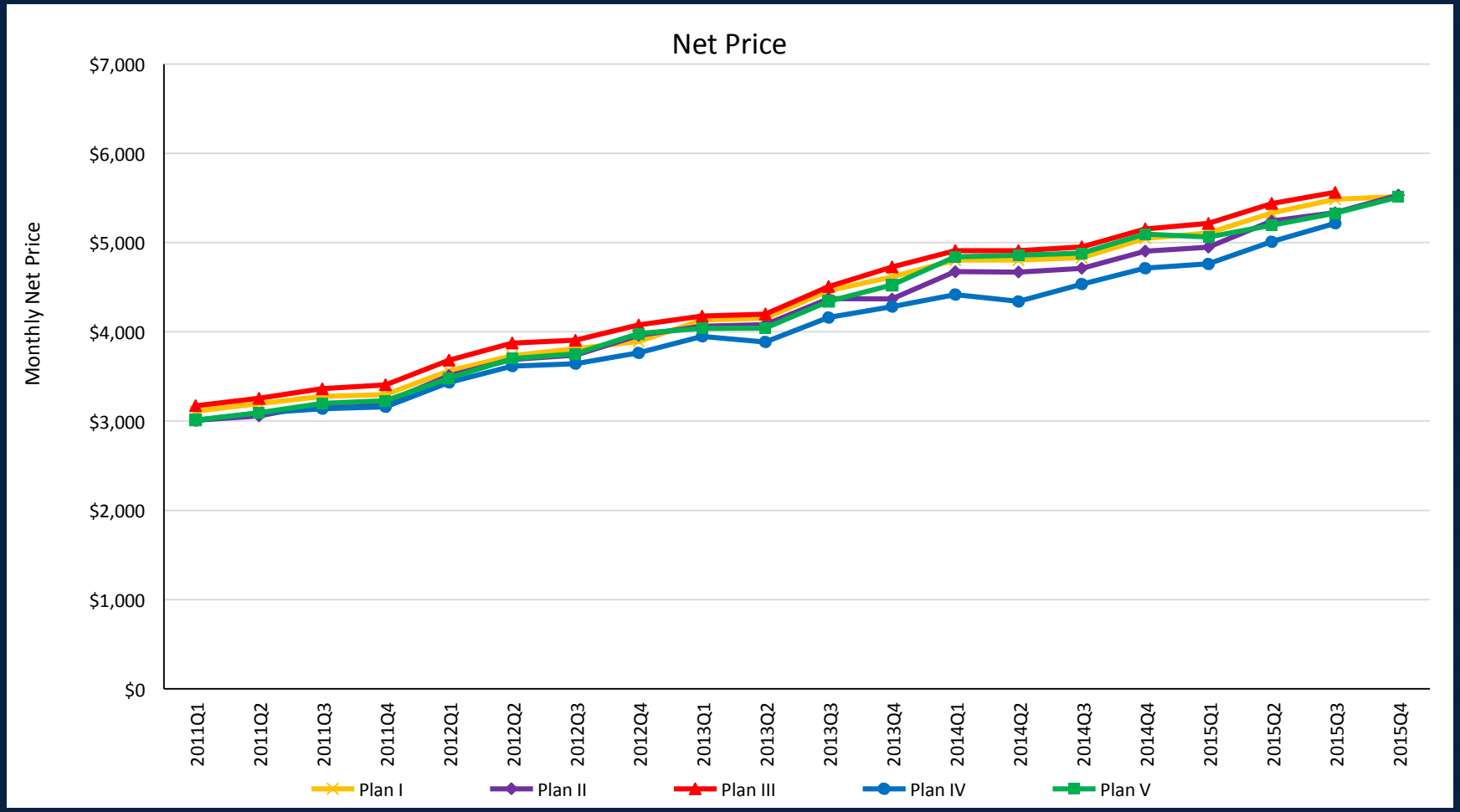
Questions Examined

I. What are overall trends in drug spending, accounting for discounts and rebates?

II. In the specialty space, what contractual arrangements do market participants use to attempt to manage spending?

III. Case study: How have those contracting approaches impacted drug prices in one high-cost specialty drug area (Multiple Sclerosis)?

Steady, Substantial Price Increases and Minimal Differences in Prices for Multiple Sclerosis Drugs Across Health Plans

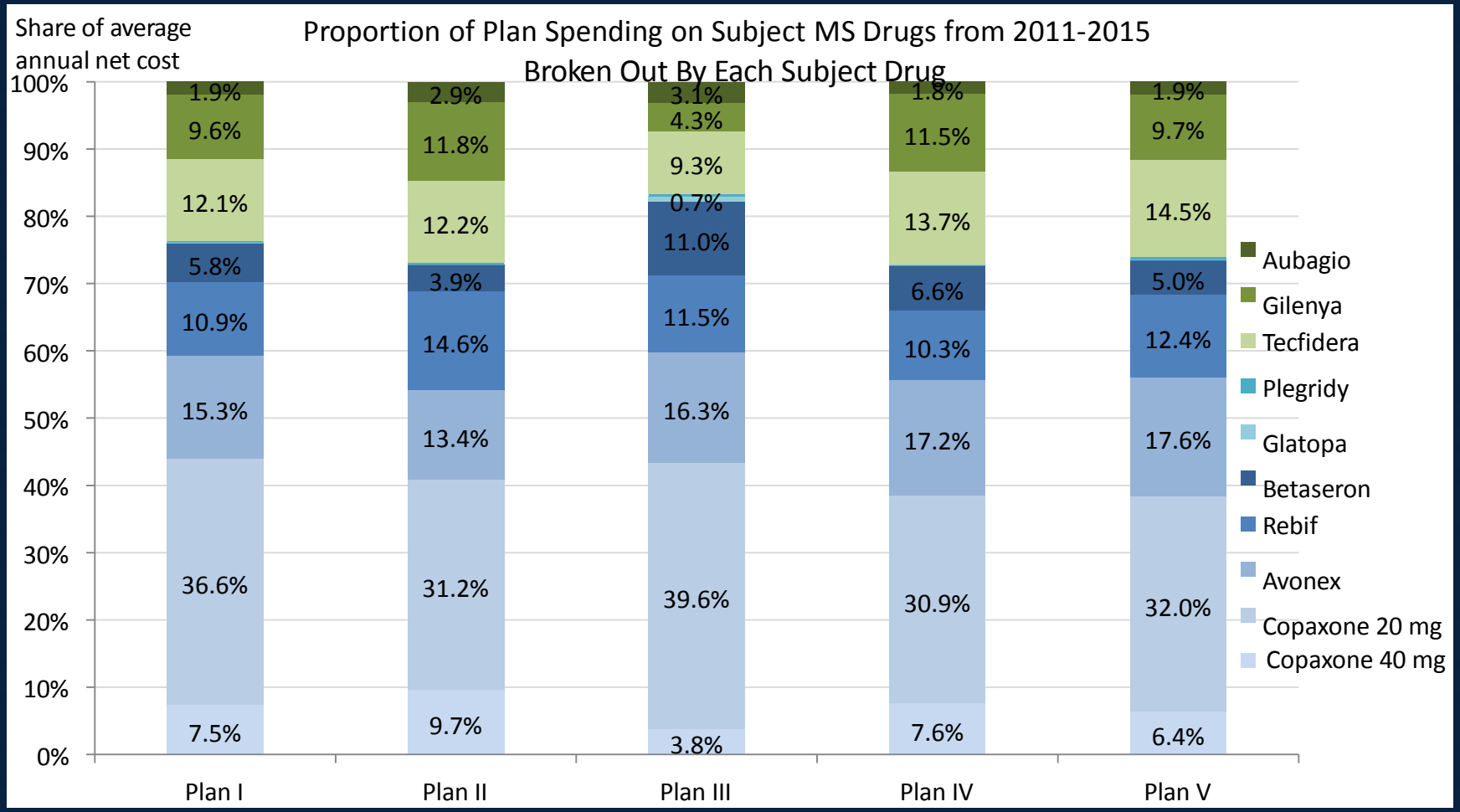


Steady, Substantial Price Increases and Minimal Differences in Prices (Low CVs) for Multiple Sclerosis Drugs Across Health Plans

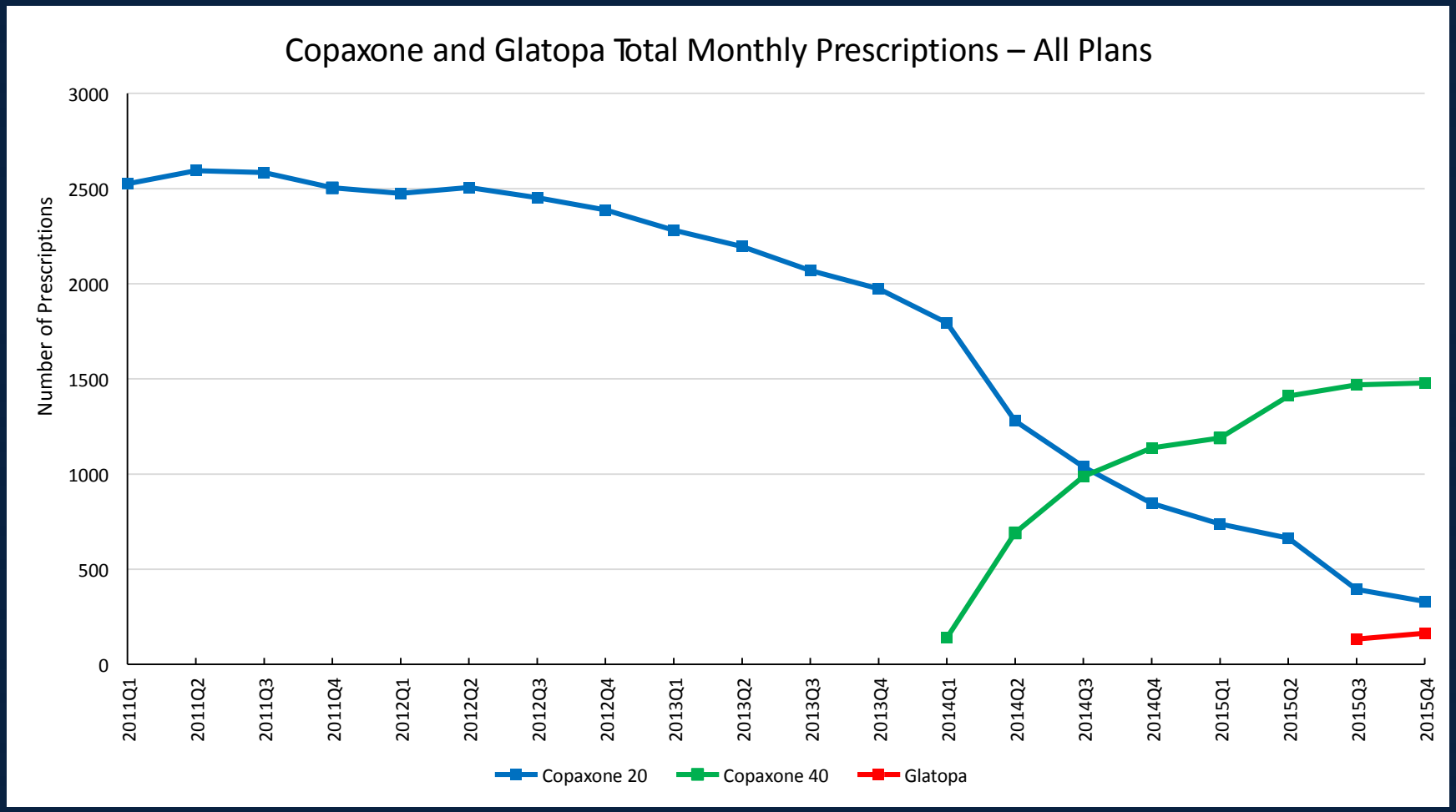
Plan	Average Annual Growth Rate in Net Prices for 10 MS Drugs
Plan I	12.1%
Plan II	11.6%
Plan III	15.0%
Plan IV	11.7%
Plan V	10.2%

Coefficient of Variation Across Plans' MS Prices: 2011-2015	
Drug	**Cross-Plan, Net-Rebate CV**
Aubagio	4.9%
Avonex	4.5%
Betaseron	5.2%
Copaxone 20 mg	1.9%
Copaxone 40 mg	4.8%
Gilenya	1.9%
Glatopa	3.7%
Plegridy	2.8%
Rebif	4.3%
Tecfidera	3.3%

Little Variation in Relative Spending on Multiple Sclerosis Drugs Studied



Impact of Single Generic Alternative on Multiple Sclerosis Drug Spending is Unclear



Recommendations

- To facilitate understanding of actual spending on pharmaceuticals, require reporting of aggregated, standardized information on drug rebates.
- Continue fostering competition by promoting the availability of generic and biosimilar drugs.
- Improve measurement and transparency of the comparative efficacy of different drugs that treat the same disease.
  - Where different drugs are demonstrated to be similarly effective, consider broader implementation of strategies that spur competition on behalf of consumers (e.g., formularies, reference pricing).
  - Where access to all drugs in a therapeutic class is strongly valued (i) consider enhancing patient value by relying on comparative efficacy to encourage research, development, and spending on the highest value drugs; and (ii) explore innovative reimbursement approaches (e.g., outcomes-based contracts).

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by Ms. Lauren Taylor

Annual Health Care
Cost Trends Hearing

CTH 2016

Social Determinants of Health: *Opportunities and Challenges*

MA Annual Cost Trends Hearing
Oct 18, 2016

Lauren A. Taylor, MDiv, MPH
@LaurenTaylorMPH, ltaylor@hbs.edu

Goals for Today

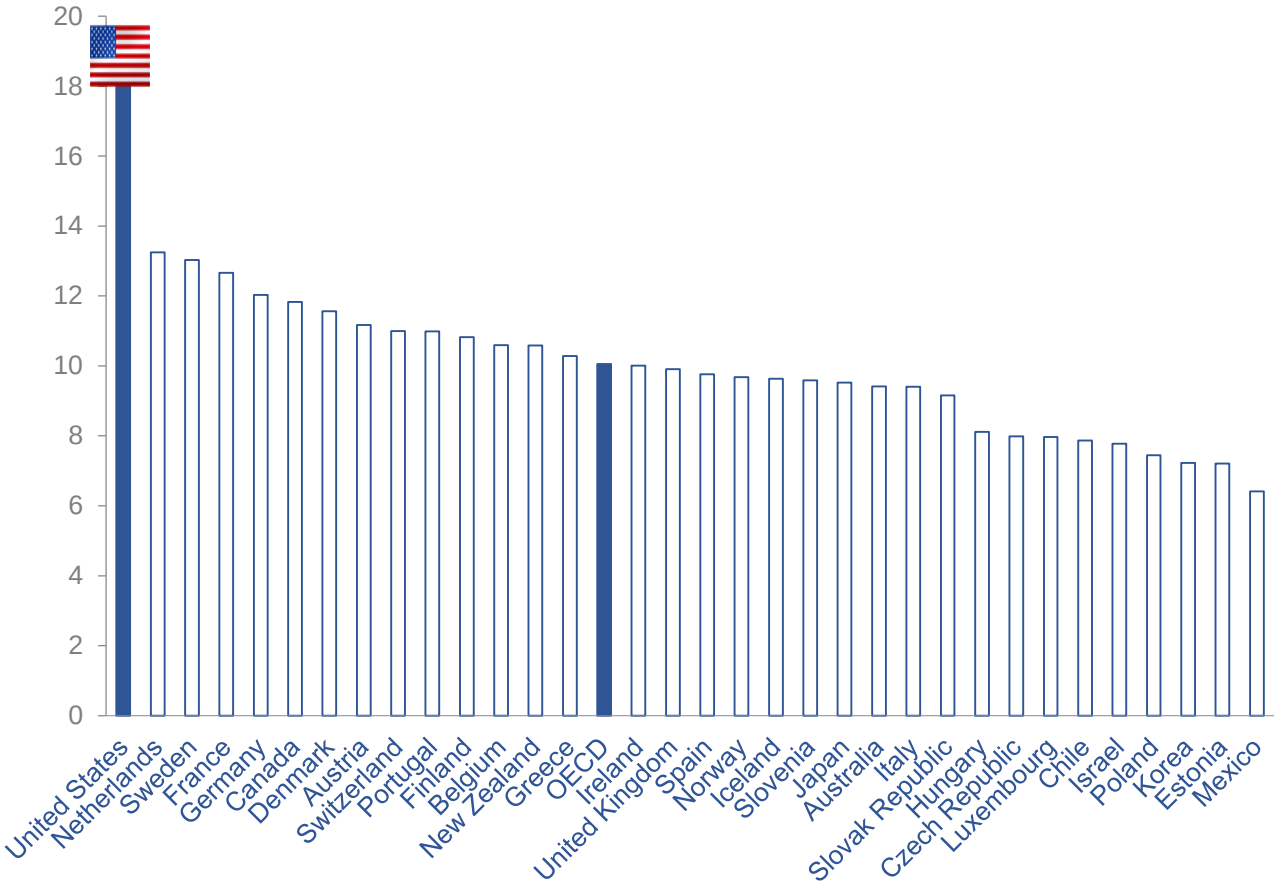
Overall

"The annual health care cost trends hearing is a public examination into the drivers of health care costs as well as the engagement of experts and witnesses to identify particular challenges and opportunities within the Commonwealth's health care system."

This 40min

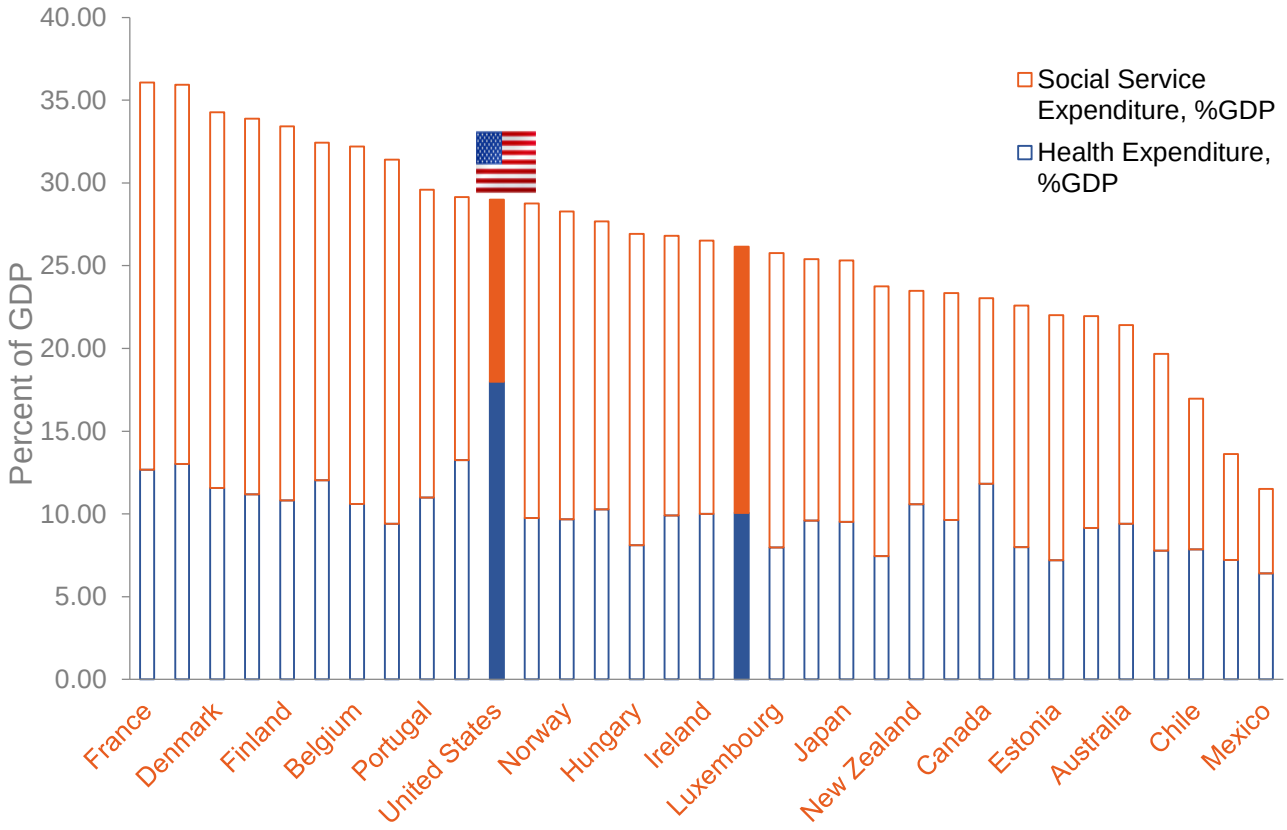
1. *A Driver – Unmet Social Need*
2. *An Opportunity – Social Service Investment*
3. *Two Challenges – Governance and Contracting*

Health Expenditures as a % of GDP, 2009*



*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.

Total Expenditures as a %GDP



*Turkey is missing data for 2009; Data from Bradley and Taylor, The American Health Care Paradox.

Original research

Health and social services expenditures: associations with health outcomes

Elizabeth H Bradley,[1] Benjamin R Elkins,[1] Jeph Herrin,[2] Brian Elbel[3]

[1]Yale School of Public Health, Division of Health Policy and Administration, and Global Health Leadership Institute, New Haven, Connecticut, USA
[2]Yale School of Medicine, Division of Cardiology, New Haven, Connecticut, USA
[3]New York University School of Medicine, Division of General Internal Medicine; New York University Wagner Graduate School of Public Service, New York, USA

Correspondence to
Dr Elizabeth H Bradley, Yale School of Public Health, Division of Health Policy and Administration, 60 College Street, New Haven, CT 06520, USA; elizabeth.bradley@yale.edu

Accepted 25 February 2011
Published Online First 29 March 2011

ABSTRACT

Objective: To examine variations in health service expenditures and social services expenditures across Organisation for Economic Co-operation and Development (OECD) countries and assess their association with five population-level health outcomes.

Design: A pooled, cross-sectional analysis using data from the 2009 release of the OECD Health Data 2009 Statistics and Indicators and OECD Social Expenditure Database.

Setting: OECD countries (n=30) from 1995 to 2005.

Main outcomes: Life expectancy at birth, infant mortality, low birth weight, maternal mortality and potential years of life lost.

Results: Health services expenditures adjusted for gross domestic product (GDP) per capita were significantly associated with better health outcomes in only two of five health indicators; social services expenditures adjusted for GDP were significantly associated with better health outcomes in three of five indicators. The ratio of social expenditures to health expenditures was significantly associated with better outcomes in infant mortality, life expectancy and increased potential life years lost, after adjusting for the level of health expenditures and GDP.

Conclusion: Attention to broader domains of social policy may be helpful in accomplishing improvements in health envisioned by advocates of healthcare reform.

Many countries are increasingly confronting issues of rising healthcare costs with limited improvement in health outcomes. The issue is particularly acute in the USA, which ranks highest among Organisation for Economic Co-operation and Development (OECD) countries in healthcare spending as a percentage of gross domestic product (GDP) while remaining among the lowest in key health indicators.[1–3] As an illustration, in 2005 the USA spent 16% of GDP on healthcare compared with an average of 9% spent by other OECD countries, and in 2006, the USA ranked 25th in life expectancy, 29th in infant mortality and 24th in maternal mortality among the 30 OECD countries.[4]

Previous efforts to understand the paradox of higher health care spending without necessarily better health outcomes have implicated over-reliance on private financing,[5 6] disparities in quality of care,[7 8] high medical prices[9] and too few primary care providers.[3 10–13] What has been less examined is the role of spending on social services, which may be productive for health. Social spending includes such investments as income supplements, housing, unemployment coverage and other social policy targets. Although health professionals have long recognised the importance of socio-economic, environmental and behavioural determinants of health, healthcare reforms have focused largely on spending for health services, with less attention focused on spending in potentially important social policy areas.

Accordingly, we sought to examine the associations between social expenditures and health expenditures, and a set of common health outcomes across the OECD countries. As a measure of relative investment, we also examined the ratio of social expenditures to health expenditures and its association with life expectancy, infant mortality, low birth weight, maternal mortality and potential life years lost using the OECD Health Data 2009 Statistics and Indicators and the OECD Social Expenditure database.[1 14] Findings from our analysis can contribute to the current debate in the USA and other countries about how best to direct limited resources to promote population health outcomes.

METHODS

Study design and sample

We conducted a pooled, cross-sectional analysis of OECD countries (n=30 countries) using data from the 2009 release of the

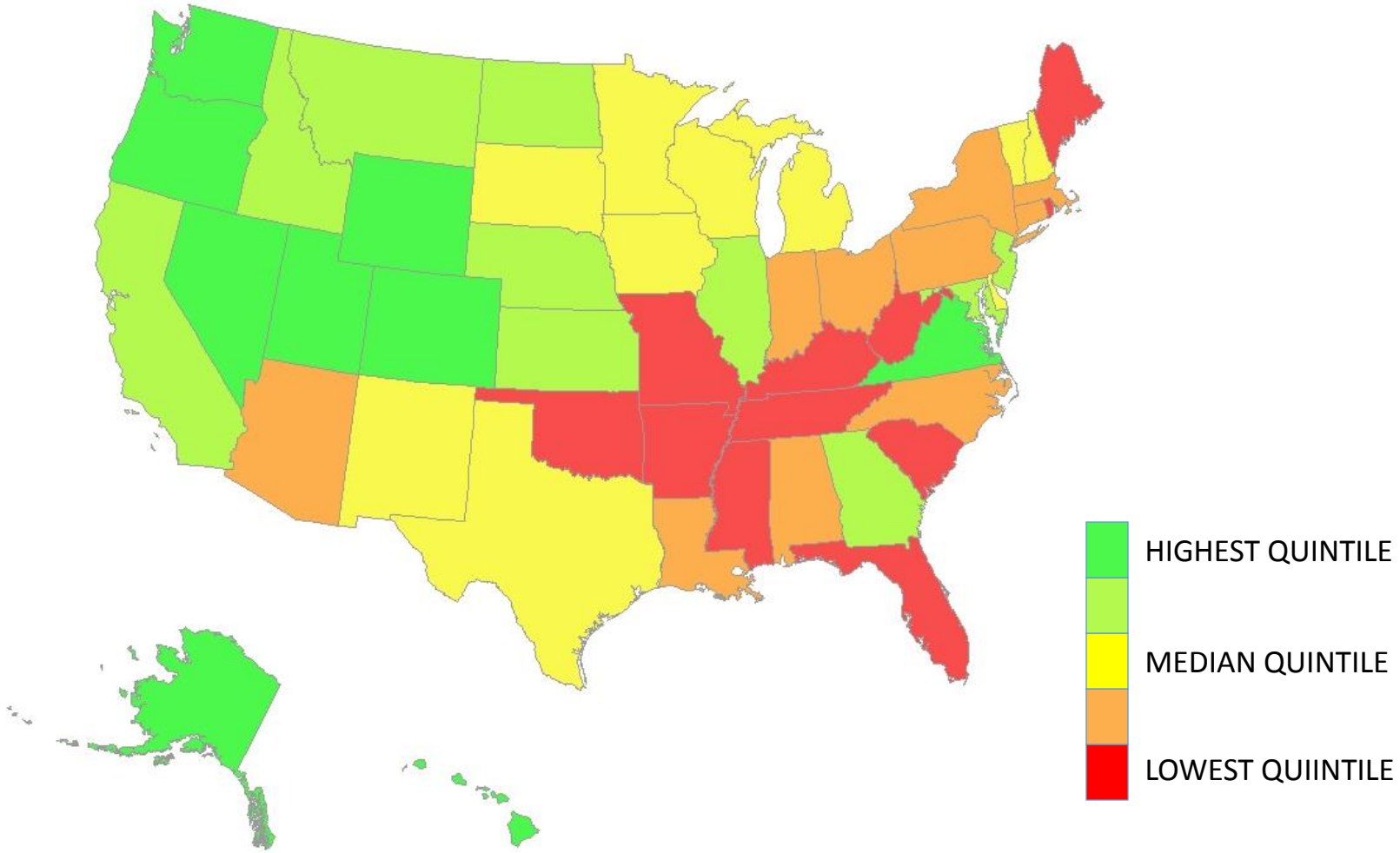
BMJ Qual Saf 2011;20:826–831. doi:10.1136/bmjqs.2010.043363

METHOD: Multivariable regression using OECD pooled data from 1995-2007 on 29 countries and 5 health outcomes.

FINDING: The ratio of social to health spending was significantly associated with better health outcomes: less infant, mortality, less premature death, longer life, expectancy and fewer low birth weight babies.

NOTE: This remained true even when the US was excluded from the analysis.

Ratio of social-to-health care spending*



*Medicare and Medicaid spending; Data from Bradley et al, Health Affairs, May 2016.

POPULATION HEALTH

By Elizabeth H. Bradley, Maureen Canavan, Erika Rogan, Kristina Talbert-Slagle, China Ndumele, Lauren Taylor, and Leslie A. Curry

DOI: 10.1377/hlthaff.2015.0814
HEALTH AFFAIRS 35,
NO. 5 (2016): 760–768

Variation In Health Outcomes: The Role Of Spending On Social Services, Public Health, And Health Care, 2000–09

Elizabeth H. Bradley (Elizabeth.Bradley@yale.edu) is the Brady-Johnson Professor of Grand Strategy and a professor of public health at the Yale School of Public Health, in New Haven, Connecticut.

Maureen Canavan is an associate research scientist in health policy and management at the Yale School of Public Health.

Erika Rogan is a doctoral candidate in health policy and management at the Yale School of Public Health.

Kristina Talbert-Slagle is a senior scientific officer and lecturer of health policy and management at the Yale School of Public Health.

China Ndumele is an assistant professor of health policy and management at the Yale School of Public Health.

Lauren Taylor is a doctoral student at the Harvard Business School, in Boston, Massachusetts.

Leslie A. Curry is a senior research scientist at the Yale School of Public Health.

ABSTRACT Although spending rates on health care and social services vary substantially across the states, little is known about the possible association between variation in state-level health outcomes and the allocation of state spending between health care and social services. To estimate that association, we used state-level repeated measures multivariable modeling for the period 2000–09, with region and time fixed effects adjusted for total spending and state demographic and economic characteristics and with one- and two-year lags. We found that states with a higher ratio of social to health spending (calculated as the sum of social service spending and public health spending divided by the sum of Medicare spending and Medicaid spending) had significantly better subsequent health outcomes for the following seven measures: adult obesity; asthma; mentally unhealthy days; days with activity limitations; and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes. Our study suggests that broadening the debate beyond what should be spent on health care to include what should be invested in health—not only in health care but also in social services and public health—is warranted.

The high cost of health care remains a pressing concern for state policy makers and taxpayers. During the period 1999–2009, health care costs increased faster than inflation,[1] and in many states Medicaid inflation-adjusted spending has had a compound annual growth rate of more than 5 percent since 2000.[2] Such increased spending may reflect greater insurance coverage and access to health care for the population. Nevertheless, greater investments in health care without equivalent economic and tax revenue growth may result in fewer resources for state-funded social services, such as housing, nutrition, and income support programs—which themselves may influence health outcomes in states.

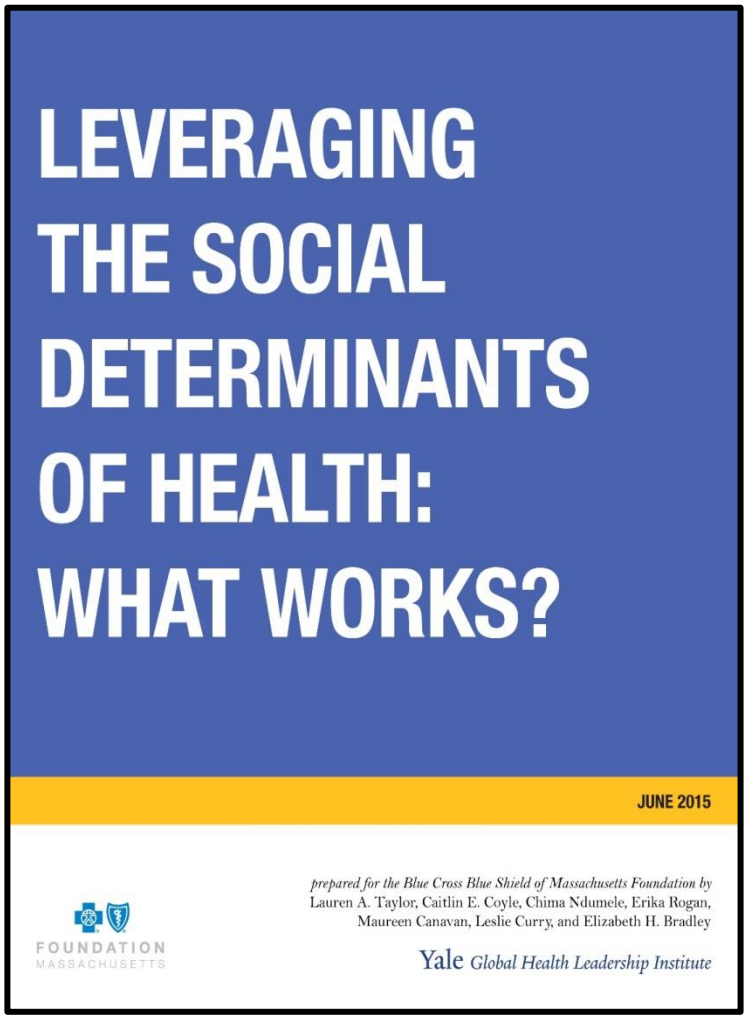
The potential for social services to be crowded out to some degree by rising health care costs is of particular concern given health policy makers' growing interest in the role of social determinants in influencing the health of individuals and populations. Extensive evidence demonstrates a clear relationship between a variety of social determinants and health outcomes.[3,4] Poor environmental conditions, low incomes, and inadequate education have consistently been associated with poorer health in a diverse set of populations. Taken together, social, behavioral, and environmental factors are estimated to contribute to more than 70 percent of some types of cancer cases, 80 percent of cases of heart disease, and 90 percent of cases of stroke.[3,4]

Furthermore, several studies have aimed to

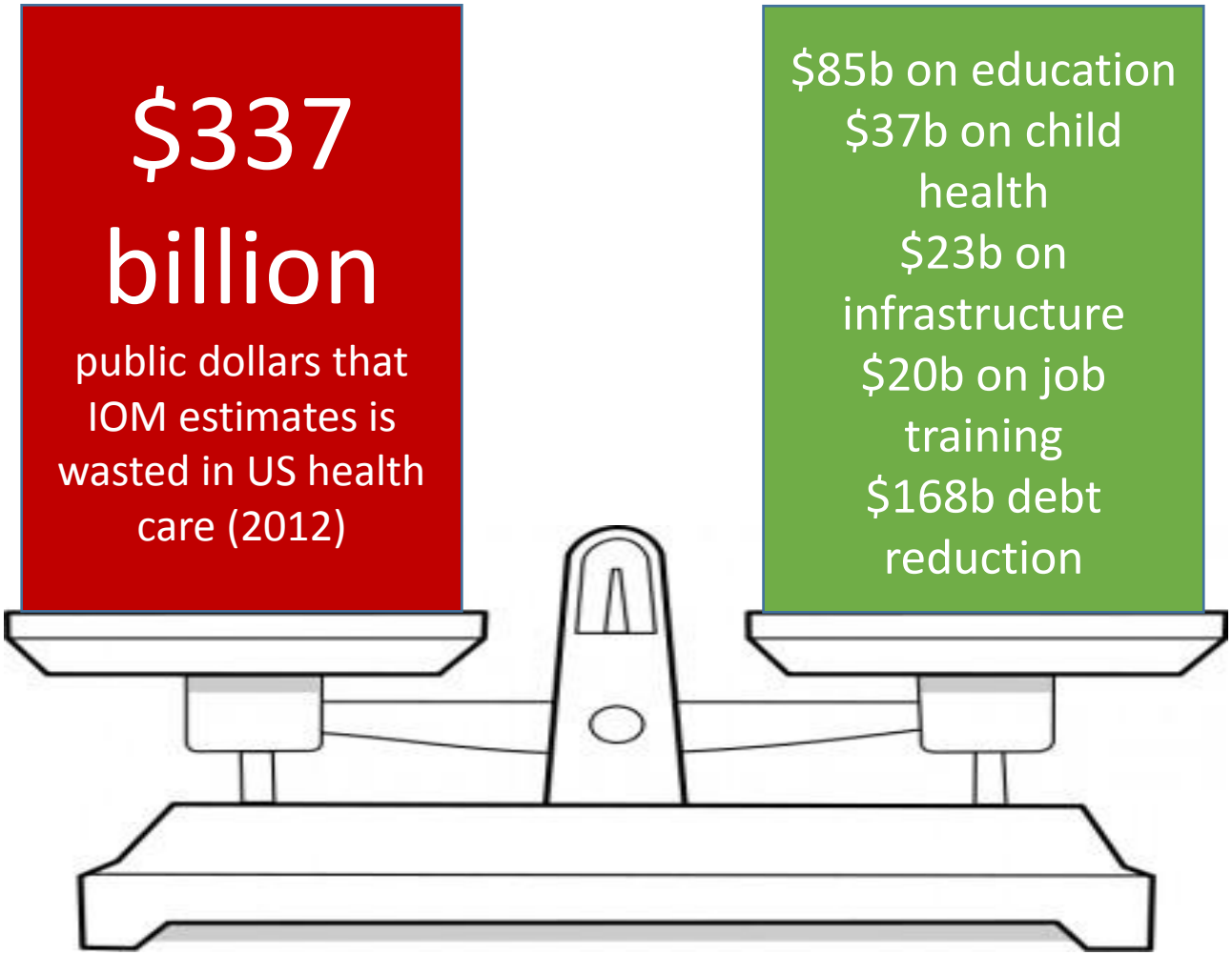
METHOD: Multivariable regression using state-level repeated measures data from 2000-2009 with regional and time fixed effects.

FINDING: The lagged ratio of social to health spending was significantly associated with better health outcomes: adults who were obese; had asthma; reported fourteen or more mentally unhealthy days or fourteen or more days of activity limitations in the past thirty days; and had lower mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes.

Which social services produce better health and save dollars?



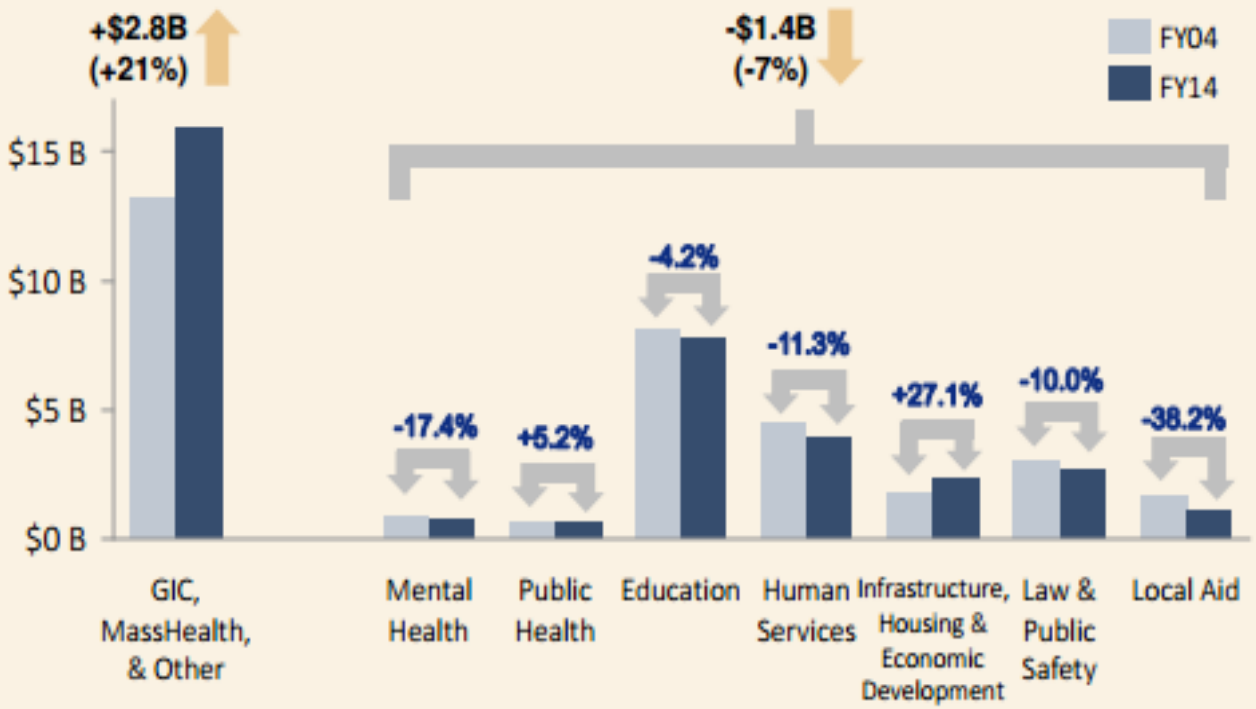
National Tradeoffs



Source: McCullough et al. A Health Care Dividend for America. American Journal of Preventative Medicine. 2012.

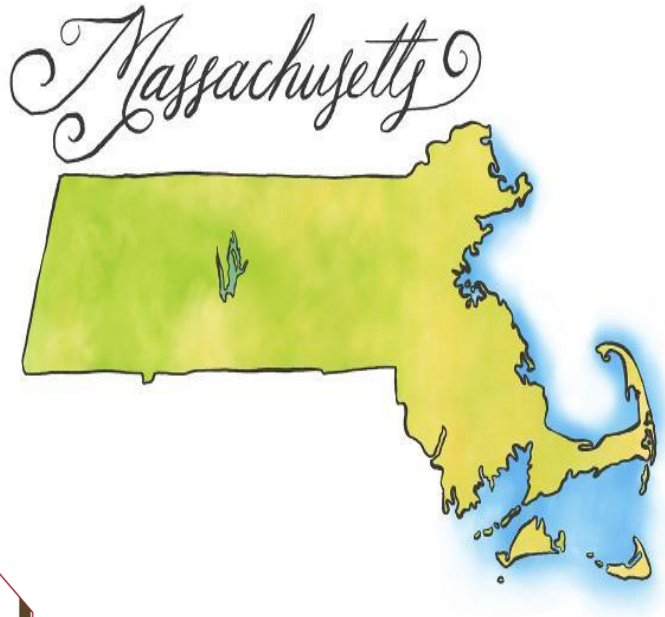
Some Evidence of Crowd Out

Figure 1.1: State budgets for health care coverage and other priorities, FY2004- FY2014
Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014



NOTE: Figures all adjusted for Gross Domestic Product (GDP) growth; GIC = Group Insurance Commission
SOURCE: Massachusetts Budget and Policy Center

Innovative Medicaid Redesigns



U.S.

6 Portland Health Providers Give $21.5M for Homeless Housing

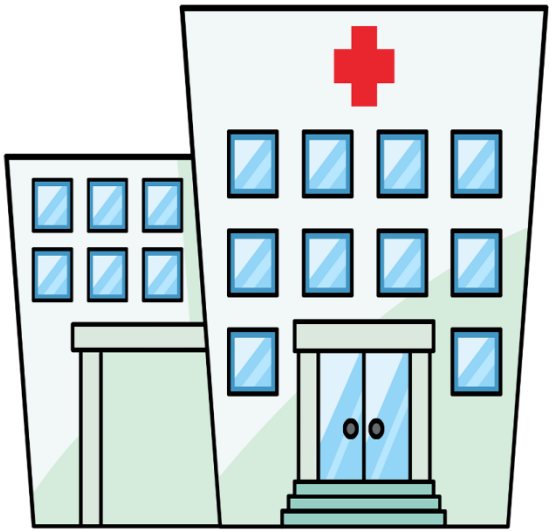
By THE ASSOCIATED PRESS SEPT. 23, 2016, 4:21 P.M. E.D.T.

PORTLAND, Ore. — Five major hospitals in Portland, Oregon, and a nonprofit health care plan said Friday they will donate a combined $21.5 million toward the construction of nearly 400 housing units for the city's burgeoning homeless and low-income population — a move hailed by national housing advocates as the largest private investment of its kind in the nation.

The money from the private health care providers will be part of a larger $69 million capital construction plan that comes as the booming Pacific Northwest city struggles with a seemingly intractable homeless problem that has become more visible in the past few years and poses a political quagmire for local leaders.

Earlier this month, hundreds of people were evicted from an informal tent camp on a nature trail on the city's east side, and the city has fielded thousands of complaints on a hotline for residents as leaders debate

Evidence Exists for Various Integration Models



Traditional Health Care Sector

Community Benefit Grants

Offering Individual Social Services

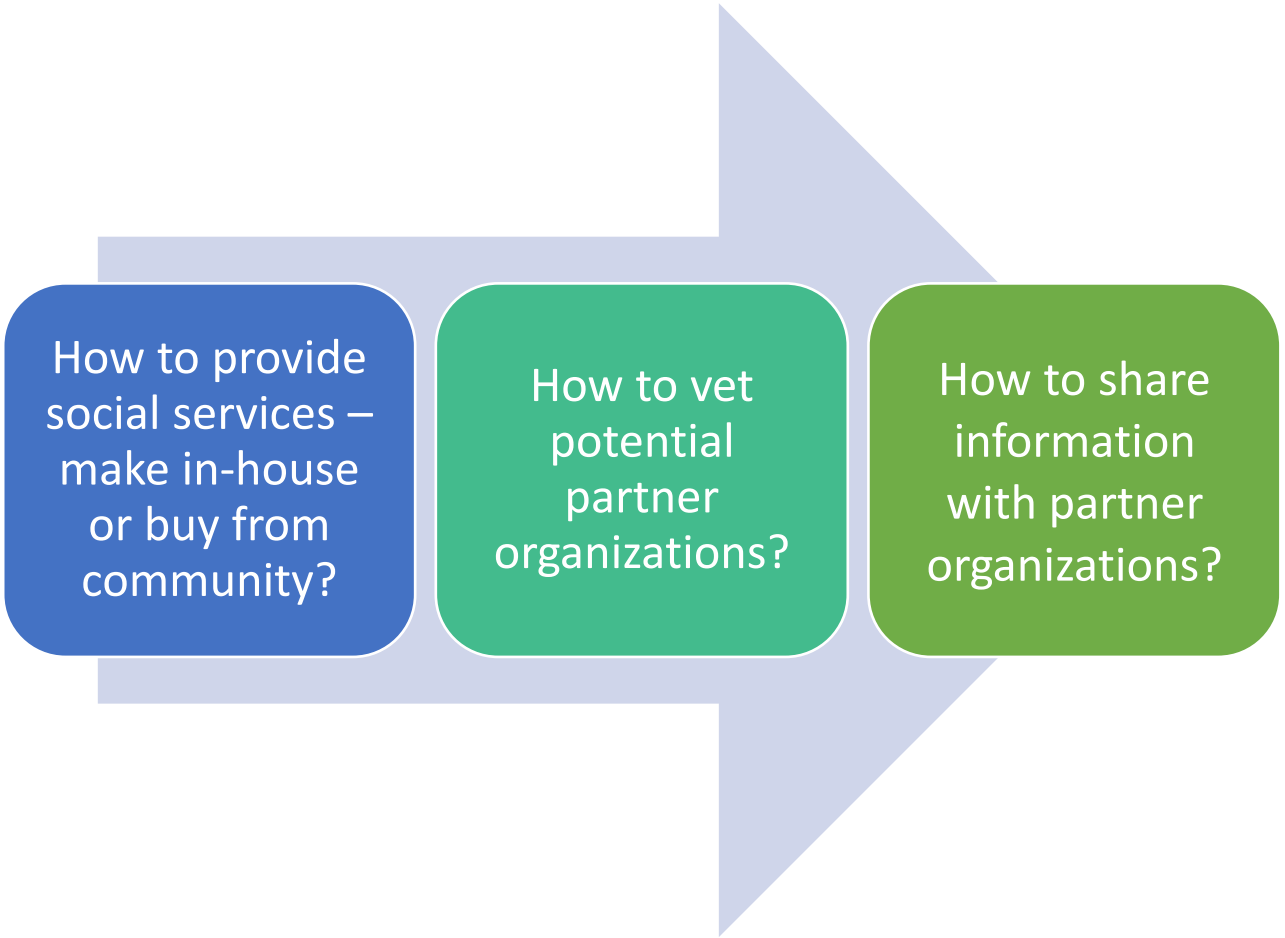
Programmatic Partnership

Strategic Investments

Pooled Health and Social Services Budgets

Key Governance Question

Health + Social Contracting Challenges



Look forward to learning from you.

Follow up with me:
@LaurenTaylorMPH
ltaylor@hbs.edu

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel: Strategies to Address Social and Behavioral Health Needs

Annual Health Care
Cost Trends Hearing

CTH
2016

Panel: Strategies to Address Social and Behavioral Health Needs

Panelists

Boston Medical Center	Ms. Kate Walsh, President and CEO
Commonwealth Care Alliance	Dr. Toyin Ajayi, Chief Medical Officer
Holyoke Medical Center	Mr. Spiros Hatiras, President and CEO
Massachusetts General Hospital	Dr. Elsie Taveras, Division of General Pediatrics

Focus Areas

1. Efforts to Address Social Determinants of Health
2. Efforts to Integrate Behavioral Health
3. Alternative Payment Models to Support Innovative Care Models
4. Partnership Models between Health Care Organizations and Community Agencies

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Reactor Panel:
Consumer Perspective

Annual Health Care
Cost Trends Hearing

CTH 2016

Reactor Panel: Consumer Perspective

Panelists

Community Catalyst	Ms. Alice Dembner, Director, SUD Project
Health Care For All	Mr. Brian Rosman, Research Director
Patient Family Advocate	Ms. Alexis Snyder

Focus Areas

1. Role of Consumers in Promoting Value-Based Health Care
2. Importance of Social Determinants of Health
3. Efforts to Engage Patients and Families in Health Care System Transformation
4. Impact of Pharmacy Costs on Consumers and Patient Access

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel: Strategies to Address Pharmaceutical Spending Growth

Annual Health Care
Cost Trends Hearing

CTH
2016

Strategies to Address Pharmacy Cost – Health Care Providers

Currently Implementing

1. Implementing programs or strategies to improve medication adherence/compliance

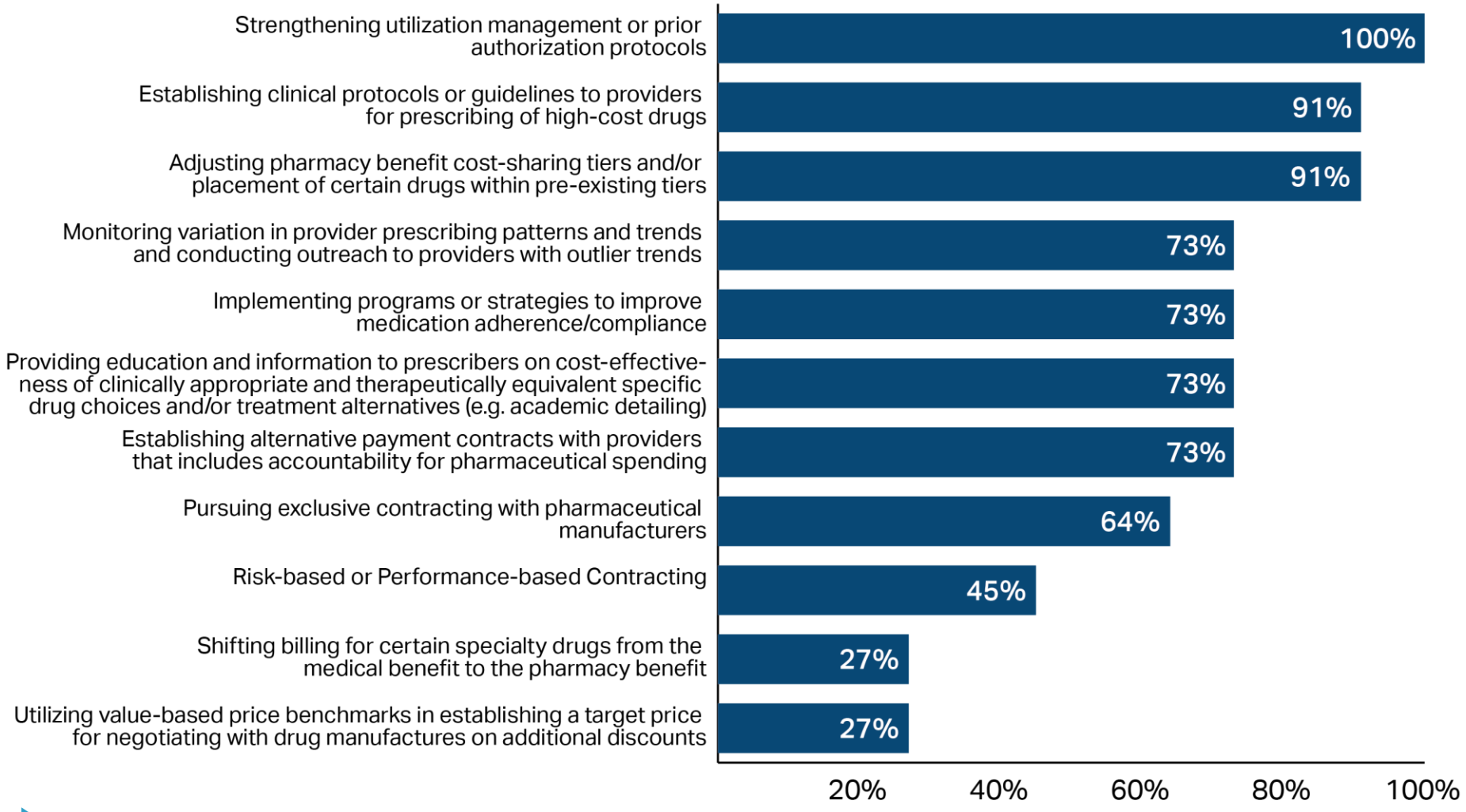
2. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

3. Implementing internal “best practices” such as clinical protocols or guidelines for prescribing of high-cost drugs

HPC

Strategies to Address Pharmacy Cost – Payers

Currently Implementing



HPC

Panel: Strategies to Address Pharmaceutical Spending Growth

Panelists

Dana-Farber Cancer Institute	Dr. Deborah Schrag, Surgical Oncology Chair,
Harvard Pilgrim Health Care	Dr. Rick Weisblatt, Chief of Innovation and Strategy
Partners HealthCare System	Dr. Gregg Meyer, Chief Clinical Officer
PhRMA	Ms. Lisa Joldersma, VP, Policy and Research

Focus Areas

1. Impact of Rising Pharmaceutical Costs on Payers, Providers, and Patients
2. Innovative Strategies to Mitigate Pharmaceutical Spending Trends
3. Transparency of Pharmaceutical Prices and Spending Trends Net of Rebates/Discounts

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next
Public Testimony

Annual Health Care
Cost Trends Hearing

CTH 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

Annual Health Care
Cost Trends Hearing

CTH 2016