



Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

Report for Annual Public Hearing

April 24, 2013

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

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This is the Office of the Attorney General’s (“AGO”) third report examining health care cost trends and cost drivers in Massachusetts. In our 2010 and 2011 Reports, the AGO identified market dysfunctions that have resulted in escalating health care costs that are not explained by the value of services provided. Since those Reports, health plans, providers, and purchasers have taken steps designed to lower costs, promote efficiency, and improve health care delivery in Massachusetts. Examples include efforts to promote tiered network products, global payment arrangements, and contractual provisions that reward quality. The legislature has also encouraged better market function by promoting transparency and establishing new infrastructure to measure and oversee these market changes.

This Report analyzes recent market developments, focusing on identifying significant trends that hold promise, or pose challenges, for the Commonwealth’s efforts to promote efficient and effective delivery of health care. We examine market developments and their implications for three categories of market participants: Purchasers (Part I of the Report), Health Plans (Part II), and Providers (Part III). The conduct and choices of these market participants directly impact health care spending levels in Massachusetts.

Our principal findings in each of these categories are:

I. Purchasers/Consumers¹

- A. Purchasers have increasingly moved to tiered and limited network products.
- B. Purchasers have increasingly moved to PPO products, including self-insured PPO products, and away from fully-insured HMO products.
- C. Purchasers have increasingly moved to high-deductible products (in general, defined in this Report as products with an annual individual deductible of \$1,000 or more).
- D. Purchaser enrollment trends have significant implications for health plans designing products and for providers managing risk contracts.

¹ In this Report, “purchasers” include employers (who purchase insurance products for their employees), employees (who select among available product designs and benefits), and individual consumers (who obtain health care services and who may also shop for insurance directly through the individual market). Depending on the context, “consumers” are also sometimes referred to as “members” (e.g., when describing membership in different insurance products) or as “patients” (e.g., when discussing treatment or care received).

II. Health Plans²

- A. Health plans continue to pay providers widely different amounts to care for patients of comparable health.
- B. Variation in provider total medical expenses (“TME”) exists across Massachusetts and within separate geographic areas.
- C. Growth in prices of medical services, not utilization, is still the primary cost driver for each of the major commercial health plans in Massachusetts.
- D. The design of health plan products affects risk selection (which types of consumers tend to purchase which types of products), total medical spending, and care management.

III. Providers

- A. Providers are taking on increased performance risk under extremely complex contracts that lack consistency in incenting providers to coordinate care, manage costs, and successfully take on risk.
- B. Providers are taking on increased insurance risk without consistent mitigation by health plans. That is, contracts between health plans and providers vary widely with respect to protecting against extraordinary claims and adjusting for the health status of the provider’s patient population.
- C. Providers are aligning in ways that are not explained by care coordination or risk contracting requirements, though those reasons are often cited. Provider consolidation and alignments have significant market implications that should be measured and monitored, particularly where consolidation may reduce access to lower-cost options for consumers and undermine efforts to promote value-based decisions by purchasers.

These market trends can sometimes be in tension, or work at cross-purposes. For example, many health plans have taken steps to promote global risk contracts as a cost saving mechanism. But since these contracts generally apply only to HMO and POS members, purchasers’ shift to PPO products is in tension with the promotion of risk contracts. In another example, trends in risk contracting and provider alignments often encourage providers to keep care “in system.” These trends can be in tension with the growth in tiered and high cost-sharing products that incent consumers to choose providers based on quality and efficiency, which may or may not correspond with keeping care “in system.”

This Report (Part IV) suggests ways that regulators – e.g., the Health Policy Commission (“HPC”), the Center for Health Information and Analysis (“CHIA”) (formerly the Division of

² In this Report, “health plans” are sometimes referred to as “payers,” e.g., when discussing government payer programs, or in other contexts where “payer” is more commonly used. We received data from the four largest commercial health plans in Massachusetts: Blue Cross Blue Shield (“BCBS”), Fallon Community Health Plan (“FCHP”), Harvard Pilgrim Health Care (“HPHC”), and Tufts Health Plan (“THP”). Throughout this Report, we refer to these health plans as “major” commercial health plans in Massachusetts.

Health Care Finance and Policy (“DHCFP”)), and the Division of Insurance (“DOI”) – may help the market address some of these tensions. We recommend:

- HPC and CHIA, in developing the provider registration program and reporting requirement, should require sufficiently detailed information about operations and finances across all books of business to support other key regulatory functions (e.g., certification of accountable care organizations, certification of risk bearing provider organizations, evaluation of the impact of provider operations on the state health care cost growth benchmark). For example, HPC and CHIA should require providers to submit information concerning whether the provider’s physicians are employed or affiliated, how payments are structured from the provider to its physicians, and information concerning key provisions in physician participation and/or employment agreements.
- In assessing the cost and market impact of proposed provider alignments, HPC should consider proposed changes in contract prices, any expected changes in referral patterns, market share, and volume to higher cost facilities, and the impact of all of these factors on total costs to consumers and purchasers across all lines of business. This includes analysis of any potential increase in hospital or physician payment rates due to a proposed provider alignment (e.g., if a lower paid physician group aligns with a higher paid physician group). To make such an analysis, HPC should require providers to explain any anticipated impact on costs and provide analysis to support how and when the proposed alignment would reduce health care costs.
- CHIA should require quarterly reporting by private and public payers to track the effects of different health plan product designs and payment arrangements including the reporting of TME, utilization, cost, and quality by product design and payment arrangement.
- DOI should develop minimum standards to protect risk-bearing providers from excessive insurance risk (e.g., develop a consistent approach to adjusting for changes in health status and exclude extraordinary claims from risk budgets).
- CHIA and DOI should require regular reporting from public and private payers of information sufficient to monitor trends in premiums, health status, product design and payment methodology in the merged market, large groups and self-insured groups, and across those groups to track cost and market changes over time. This includes developing more consistent product definitions so that information is reported uniformly.

Because of the finite scope of our examination, this Report does not and could not report on all of the efforts being made to improve our health care system. Our goal is not to assess who is right or wrong, but to measure and report on market initiatives that may inform policy discussions and government oversight of total health care spending. The AGO greatly appreciates the courtesy and cooperation of the market participants who provided information for

this examination.³ We look forward to our continued collective efforts to ensure that affordable, high quality health care is available to all Massachusetts residents.

³ The AGO issued civil investigative demands pursuant to G.L. c. 118G, § 6½(b) to four major Massachusetts health plans and eleven provider organizations. We gathered detailed cost, quality, financial, and operational information, including risk contracts and settlements; health care cost, utilization, and total medical expenses data; information on plan membership, product design, and benefit design; analysis of provider financial, operational, and business performance; physician contracts; and documents related to provider consolidations and affiliations. In addition, we conducted nearly three dozen interviews and meetings with providers, health plans, health care experts, consumer advocates, employers, and other key stakeholders. To assist in its review, the AGO engaged consultants with extensive experience in the Massachusetts health care market, including an actuarial consulting firm and experts in the areas of payer-provider contracting and health care quality measurement and evaluation.

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INTRODUCTION

This Report is organized into four parts. Parts I, II, and III respectively consider recent market developments relevant to each of the three principal health care market actors: purchasers (employers and consumers), health plans, and providers. Part IV discusses implications of those findings for government efforts to improve the health care system, with a focus on identifying information necessary to measure and monitor an efficient health care market.

This Introduction provides context for this year's examination. It describes how this Report builds on the AGO's previous examinations and outlines the role of purchasers, payers, and providers in our health care market.

Health Care Market Dysfunction and Rising Health Care Costs

Growth in health care spending has exceeded economic growth in every recent decade. Since 1970, health care spending per capita has grown at an average annual rate of 8.2% nationwide, or 2.4 percentage points faster than nominal gross domestic product.⁴ In Massachusetts, from 2003 to 2011, premiums for individual and family coverage grew by 67% and 72% respectively, rising to an average individual premium of \$5,823 and family premium of \$16,953.⁵ These premium increases significantly outpaced income growth in Massachusetts, resulting in average premiums as a percent of median household income increasing from 12.6% in 2003 to 18% in 2011.⁶ The persistence of this trend suggests systemic differences between health care and other economic sectors where the rate of economic growth is typically more in line with growth rates for the overall economy.

In our 2010 and 2011 Reports, we identified wide variations in prices that are not explained by differences in quality, complexity of services, or other factors the health care market should reward. In significant measure, this market dysfunction resulted from historic negotiating and contracting practices that went unchallenged, in part because the system lacked the transparent, reliable information needed to identify, measure, and correct the dysfunction. As described in our prior Reports, without other fundamental changes, a shift to global payments may actually exacerbate the price escalation associated with market dysfunction by establishing widely different per member per month rates based on historic pricing disparities.

Shortly after release of the 2010 Report, the Massachusetts legislature enacted Chapter 288 of the Acts of 2010, which, among other important provisions, required standardized public reporting of TME, relative prices, quality performance, and hospital costs. As a result, CHIA published a baseline report on provider price variation in November 2012 and a supplemental report in February 2013, finding that:

⁴ KAISER FAMILY FOUND., HEALTH CARE COSTS, A PRIMER: KEY INFORMATION ON HEALTH CARE COSTS & THEIR IMPACT, at 5 (May 2012) [hereinafter KAISER HEALTH CARE COSTS], available at <http://www.kff.org/insurance/upload/7670-03.pdf>.

⁵ CATHY SCHOEN ET AL., THE COMMONWEALTH FUND, STATE TRENDS IN PREMIUMS & DEDUCTIBLES, 2003-2011: ERODING PROTECTION & RISING COSTS UNDERSCORE NEED FOR ACTION, at 20 (Dec. 2012), available at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Dec/State-Trends-in-Premiums-and-Deductibles.aspx>.

⁶ *Id.* at 24.

- (1) Every health plan pays providers significantly varying prices for hospital and physician services,⁷ and pays prices that vary less for other health care services;
- (2) The degree of price variation differs by health plan, with generally less variation for larger health plans;
- (3) Providers with larger commercial market share are associated with higher prices; and
- (4) Higher priced providers, which CHIA defined as providers with relative prices in the top 25% of a health plan's network, account for approximately four out of every five dollars that health plans pay.⁸

In blending the prices paid by the ten largest health plans in 2011, CHIA reported that eight acute care hospitals were consistently above the 75th percentile for hospital prices: Berkshire Medical Center, Children's Hospital, Dana-Farber Cancer Institute, four hospitals in the Partners system (Brigham and Women's Hospital, Martha's Vineyard Hospital, Massachusetts General Hospital, Nantucket Cottage Hospital), and UMass Memorial Medical Center.⁹ These findings are consistent with the findings in our 2010 and 2011 Reports, showing that price disparities for hospitals and physician groups persist.¹⁰ Because CHIA is statutorily required to collect and report relative price information, this Report does not detail the continuing wide variation in hospital and physician prices. CHIA's recent reports highlight the continuing need to address the effects of market leverage identified in our 2010 and 2011 Reports.

Last year, building on Chapter 288 and earlier reforms, the Massachusetts legislature enacted Chapter 224 of the 2012 Acts, which established significant new systems for measuring and evaluating market performance, including registration of provider organizations, cost and

⁷ Payments for hospital and physician services account for about 70% of total commercial health care spending in Massachusetts. See DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFFICE OF HEALTH & HUMAN SERVS., MASS. HEALTH CARE COST TRENDS, PREMIUMS & EXPENDITURES, at 18 (May 2012) [hereinafter DHCFCP COST TRENDS MAY 2012], available at <http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2012/premiums-and-expenditures.pdf>; DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFFICE OF HEALTH & HUMAN SERVS., MASS. HEALTH CARE COST TRENDS, TRENDS IN HEALTH EXPENDITURES, at 13 (June 2011), available at <http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2011/health-expenditures-report.pdf>.

⁸ CTR. FOR HEALTH INFO. & ANALYSIS, HEALTH CARE PROVIDER PRICE VARIATION IN THE MASSACHUSETTS COMMERCIAL MARKET, at 2-3 (Feb. 2013) [hereinafter CHIA PROVIDER PRICE VARIATION FEB. 2013], available at <http://www.mass.gov/chia/docs/r/pubs/13/relative-price-variation-report-2013-02-28.pdf>; CTR. FOR HEALTH INFO. & ANALYSIS, HEALTH CARE PROVIDER PRICE VARIATION IN THE MASSACHUSETTS COMMERCIAL MARKET, at 1-2 (Nov. 2012) [hereinafter CHIA PROVIDER PRICE VARIATION NOV. 2012], available at <http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2012/price-variation-report-11-2012.pdf>.

⁹ CHIA PROVIDER PRICE VARIATION FEB. 2013, *supra* note 8, at 8.

¹⁰ OFFICE OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B): REPORT FOR ANNUAL PUBLIC HEARING, at 15-16 (JUNE 22, 2011) [hereinafter AGO 2011 REPORT], available at <http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf>; OFFICE OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B): REPORT FOR ANNUAL PUBLIC HEARING, at 10-16 (MAR. 16, 2010) [hereinafter AGO 2010 REPORT], available at <http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf>.

market impact reviews, and certification of risk-bearing and accountable care organizations.¹¹ Chapter 224 created these and other systems to increase public scrutiny of price variation and market performance, but it did not establish a framework for reining in wide price variations. Instead, Chapter 224 created a “special commission to review variation in prices among providers” in 2013.¹²

Through Chapter 58 of the Acts of 2006, Massachusetts expanded coverage to 98% of its population through the shared responsibility of providers, health plans, individuals, employers, and the government. Since that time, the public and private sectors have made important strides in developing systems for improved market transparency and accountability, which provide a foundation for controlling health care cost growth. In implementing these systems, Massachusetts still faces significant challenges in addressing historic market dysfunction, aligning payments with value, and controlling overall health care spending. To achieve these goals, all health care market participants must be actively engaged in promoting value-based health care. In this Report, we examine how the decisions of the following market participants directly impact health care spending:

- **Purchasers**

Employers and individual consumers both play an important role in selecting different insurance products, benefit designs, and health care providers. Our findings this year indicate that purchasers are increasingly engaged in health care decisions, as many are shifting to products that give them increased control and options for health care spending.

- **Health Plans**

Health plans serve as an intermediary between purchasers (the “demand” side of the health care market) and providers (the “supply” side), by spreading risk, negotiating payments, and managing benefits to cover illness and accidents. Health plans are engaged in designing and implementing payment arrangements that differ in the incentives and choices they offer to providers, and in designing and implementing insurance products that differ in the incentives and choices they offer to purchasers.

- **Providers**

Providers span a spectrum, from individual physicians to community health centers to multibillion dollar systems that combine academic medical centers and community hospitals with thousands of affiliated physicians. Providers negotiate to participate in health plan networks, are increasingly entering risk contracts for their delivery of care, and are increasingly joining together to form larger organizations.

This Report analyzes a number of market developments with respect to each of these market participants. We highlight where market trends may be in tension, or where we lack

¹¹ MASS. GEN. LAWS ch. 6D, § 11 (2012) (registration of provider organizations); MASS. GEN. LAWS ch. 6D, § 13 (2012) (cost and market impact reviews); MASS. GEN. LAWS ch. 176T (2012) (certification of risk bearing provider organizations); MASS. GEN. LAWS ch. 6D, § 15 (2012) (certification of accountable care organizations).

¹² 2012 Mass. Acts 224, § 279.

clear, consistent performance measures to track the impact of these trends on health care costs and quality. We also suggest ways for the government to mitigate these tensions, improve transparency, and encourage the development of best practices. We hope that this Report provides useful information for the Commonwealth's continuing efforts to promote access to quality health care, while controlling costs.

I. PURCHASERS/CONSUMERS¹³

Purchasers/consumers represent the “demand” side of the health care market. Their decisions, including which health insurance products to enroll in, when and where to get care, and how much, help shape the health care products and services that health plans and providers supply, and hence, total medical spending. Purchaser/consumer decisions are shaped by the information, incentives, and choices available to them, as well as their own preferences, needs, resources, and capabilities. As in other economic sectors, purchasers in health care vary widely in these preferences and characteristics; they differ in their health status, affluence, and socio-cultural background, all of which affect how, where, and when they access health care.¹⁴

Our findings indicate that purchasers are responding to different insurance product offerings and are seeking options to control health care spending. Below, we examine the growth in membership in tiered and limited network products, PPO products, and high-deductible products, and how these trends affect market initiatives designed to improve quality and control costs. Importantly, increasing enrollment in PPO products has resulted in a corresponding shift in membership out of risk contracts, which has implications for the implementation of global payment arrangements.

Some of these membership trends have been influenced by ongoing efforts to promote an efficient health care market by giving purchasers more incentives and options for value. For example, Chapter 288 of the 2010 Acts required health plans to offer at least one tiered or limited network product priced 12% less than un-tiered or broad network products of comparable benefits.¹⁵ This statutory requirement is one factor underlying the recent growth in tiered and limited network products. In general, however, there has been scant analysis of the reasons underlying shifts in purchaser enrollment, such as the cost and quality associated with different

¹³ The charts in Part I are based on membership data produced to the AGO by the four largest commercial health plans in Massachusetts. In general, the health plans focused on members living in Massachusetts. BCBS produced data on all members living in Massachusetts and insured through a Massachusetts account. HPHC and THP produced data on all members living in Massachusetts. FCHP produced data on all members insured through a Massachusetts account (including members living outside of Massachusetts, who represent about 5% of FCHP's total membership).

¹⁴ See, e.g., KAISER HEALTH CARE COSTS, *supra* note 4, at 8 (showing that in 2009, five percent of the population was responsible for about half of total health care spending, while the 50% of the population with the lowest expenses accounted for 2.9% of total spending); AGO 2011 REPORT, *supra* note 10, at 27-31 (showing that commercial health plan members in more affluent neighborhoods have higher total medical spending); Sarah Mundi et al., *The Influence of Race/Ethnicity and Socioeconomic Status on End-of-Life Care in the ICU*, 139(5) CHEST 1025, 1031 (May 2011), available at <http://journal.publications.chestnet.org/data/Journals/CHEST/22096/103011.pdf> (controlling for socioeconomic status, finding “racial and ethnic differences in end-of-life care in the ICU” that may be due to treatment preferences, values, and/or disparities).

¹⁵ MASS. GEN. LAWS ch. 176J, § 11 (2010).

types of insurance products. In the final section of Part I, we identify metrics that would enable market participants to better track, understand, and ultimately shape the purchaser decisions that are central to our collective efforts to lower costs and improve quality.

A. Membership in Tiered and Limited Network Products Has Grown¹⁶

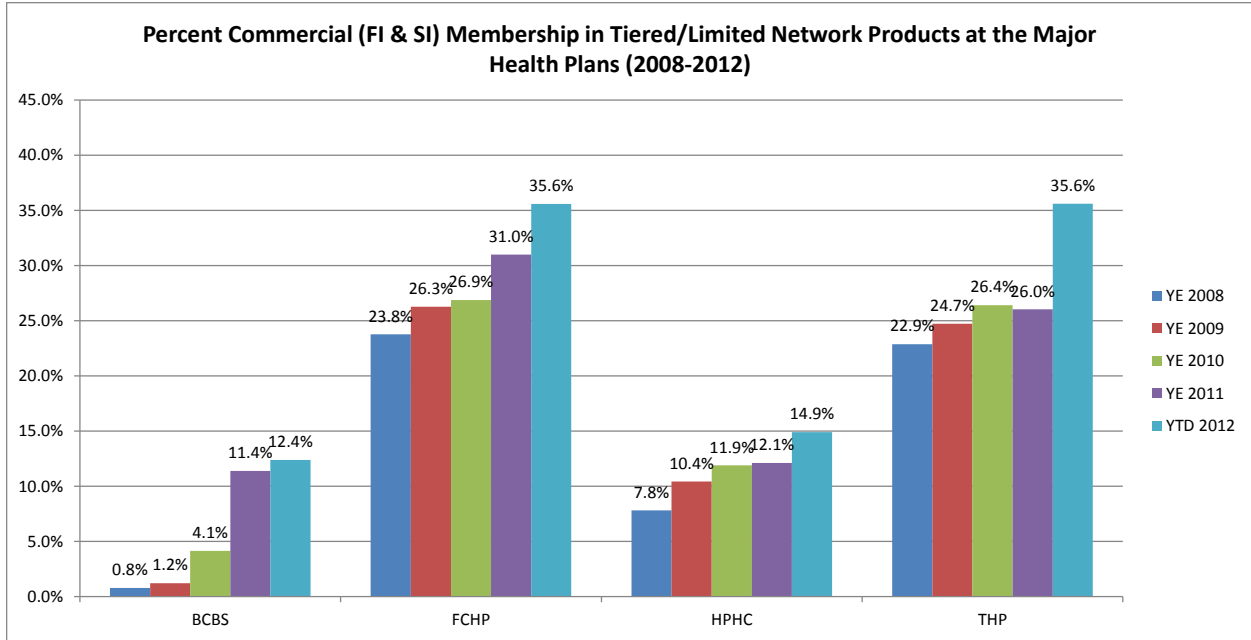
Tiered and limited network products are a leading example of using product design to encourage consumers to obtain care from more efficient providers, which results in immediate cost savings. Prior to the wider introduction of tiered and limited network products fostered by Chapter 288, consumers had little to no incentive to switch to more efficient providers because they were not rewarded with the cost savings associated with that switch. Instead, those savings would be spread across the premiums of all members of a health plan, including those who did not choose more efficient providers. While there are important costs that insurance is designed to pool, such as the cost of chronic or unexpected health events, spreading the cost of unwarranted price variations results in two key dysfunctions: (1) it de-sensitizes consumers from value-based choices and (2) it diminishes providers' incentives to compete on value.

Tiered and limited network products improve on past efforts to encourage prudent purchasing through product design in several ways. Historically, product design has focused predominantly on increases in "flat" copayments and deductibles that are not related to the value provided by the provider. The principle behind increases in flat copayments or deductibles is to sensitize the consumer to the fact that health care services have a cost and discourage over-utilization. But flat copayments and deductibles do not differentiate between efficient versus inefficient providers, and apply to necessary as well as unnecessary services. As a result, they may discourage needed care, as well as disproportionately impact the chronically ill. Additionally, once expended, deductibles do not effectively sensitize consumers to avoid unnecessary care, or help shift needed care to more efficient providers.

Tiered and limited network products seek to reduce costs by shifting care to more efficient providers. Tiered network products typically allow consumers broad choice in where they receive care, and differentiate (or "tier") the consumer's copayment depending on the cost and quality of the provider chosen by the consumer. Tiered products can lower premiums for consumers at the point of enrollment, and can result in lower out-of-pocket copayments if the consumer chooses a lower-cost, high-quality provider at the point of service. Limited network products offer consumers a select, or "limited," set of providers from whom they can receive a full range of health care services. These providers should be more efficient, with high quality and lower costs, resulting in lowered premiums for consumers at the point of enrollment.

As shown below, purchasers have increasingly moved to these products in recent years, suggesting a continued opportunity for health plans to market these product designs and pass on resulting savings to consumers. The below chart shows how the proportion of membership in such products has grown at Blue Cross Blue Shield ("BCBS"), Fallon Community Health Plan ("FCHP"), Harvard Pilgrim Health Care ("HPHC"), and Tufts Health Plan ("THP").

¹⁶ For purposes of this Report, in reporting on tiered network membership, we focus on products that include tiering for inpatient or outpatient services.



NOTES

- (1) For BCBS and FCHP, 2012 information is as of April 2012; for HPHC, it is as of July 2012; for THP, October 2012.
- (2) BCBS data reflects enrollment in Blue Options and Hospital Choice Cost Sharing (“HCCS”) (tiered networks), to the extent a program was in place in a given year (e.g., BCBS introduced HCCS in 2011). Based on how data was produced, some membership in custom tiered accounts is not reflected in the above chart.
- (3) FCHP data reflects enrollment in Advantage Plans (custom tiered accounts), Direct Care and Steward Community Care (limited networks), and Tiered Choice, to the extent a program was in place in a given year (e.g., FCHP introduced Steward Community Care and Tiered Choice in 2012).
- (4) HPHC data reflects enrollment in ChoiceNet (tiered network), Focus Network (limited network), Group Insurance Commission (“GIC”) tiered networks, and Tiered Network NH, to the extent a program was in place in a given year (e.g., HPHC introduced ChoiceNet and Focus Network in 2011). Based on how data was produced, a small percentage of membership in custom tiered accounts is not reflected in the above chart.
- (5) THP data reflects enrollment in Designated Provider Option products (custom tiered accounts usually offered by hospital employers); Navigator and Your Choice (tiered networks); Select and Steward Community Choice (limited networks); and Spirit (a GIC tiered and limited network). Based on how data was produced, a small percentage of membership in custom tiered accounts is not reflected in the above chart (less than 1% of THP’s total membership in 2011).

Growth in tiered and limited network membership has differed at each of these health plans by product type and market segment (merged market versus large group market). As shown in the following table, growth in tiered network products has been much greater than growth in limited network products. Membership in tiered network products at these health plans more than doubled from 2008 to 2012, while membership in limited network products grew by 45%. In 2012, 89% of the total membership in tiered and limited network products at these four health plans was in tiered products. Only FCHP, which operates primarily in central Massachusetts, had more significant membership in limited network products, with 40,169 members in such products in 2012. Combined, the other three health plans had fewer than 13,000 members in such products in 2012.

Growth in Tiered v. Limited Network Membership

| | YE 2008 | | YTD 2012 | |
|--------------|----------------|---------------|----------------|---------------|
| | Tiered | Limited | Tiered | Limited |
| BCBS | 12,987 | 0 | 168,656 | 0 |
| FCHP | 0 | 34,402 | 13,142 | 40,169 |
| HPHC | 47,490 | 0 | 88,938 | 3,852 |
| THP | 108,693 | 1,848 | 154,177 | 8,666 |
| Total | 169,170 | 36,250 | 424,913 | 52,687 |

NOTES

- (1) For BCBS and FCHP, 2012 information is as of April 2012; for HPHC, as of July 2012; for THP, October 2012.
- (2) The 8,666 limited network members noted for THP in 2012 include 6,176 members in the Spirit product, which features a limited network as well as tiered cost-sharing.

These plans also experienced different levels of growth in tiered and limited network products by market segment: the merged market (individuals and small groups of 50 or fewer employees) and the large group market (groups of more than 50 employees). The following table shows 2012 enrollment in tiered and limited network products by market segment. BCBS and FCHP had a higher percentage participation in these products in the merged market than HPHC and THP. At the same time, BCBS had lower penetration in the large group market than FCHP, HPHC, and THP. In addition to showing the proportion of members enrolled in these products by market segment, we note (in gray) the number of members that the percentage figure represents. A lower penetration in the large group market can still translate into a larger number of members, since the large group market consists of many more members than the merged market.

2012 Membership in Tiered and Limited Network Products by Market Segment

| | % Commercial Membership in Tiered/Limited Network Products | | | | | |
|--------------|--|--------|----------------|---------|----------------|---------|
| | Individual/Small Group | | Large Group | | Total | |
| BCBS | 33.9% | 79,202 | 7.9% | 89,454 | 12.4% | 168,656 |
| FCHP | 30.3% | 15,136 | 38.2% | 38,175 | 35.6% | 53,311 |
| HPHC | 1.7% | 2,801 | 19.7% | 89,989 | 14.9% | 92,790 |
| THP | 3.4% | 3,219 | 44.0% | 159,624 | 35.6% | 162,843 |
| Total | 100,358 | | 377,242 | | 477,600 | |

NOTES

- (1) For BCBS, 2012 information is as of April 2012; for FCHP, it is as of April 2012; for HPHC, as of July 2012; for THP, October 2012.

The steady growth in tiered/limited network products in recent years reflects positive purchaser engagement, and a growing interest in these products. Further analysis is needed to understand the drivers of differences in membership growth at each health plan by product type and market segment – particularly to determine if there are factors that may restrict the availability or viability of tiered or limited network products in certain geographic areas or for certain market segments.

B. Membership in PPO Products Has Grown

In HMO and POS products, unlike PPO and indemnity products, members select a PCP who functions as a care coordinator. The PCP assists the member in obtaining medical services and restricts referrals for services that are not medically necessary. PPO and indemnity products do not require members to select a PCP or obtain referrals. The distinction between HMO/POS and PPO/indemnity products has important implications for global risk contracts and care coordination. Global payments are premised on increasing the financial incentives, through upside savings and/or downside risk, for a member's selected PCP group to take responsibility for the total cost and quality of the member's care, including care the member receives from other providers. Given this premise, commercial health plans in Massachusetts currently apply global risk contracts only to members who are enrolled in products that require selection of a PCP who functions as a "gatekeeper" in coordinating referrals to other providers (HMO/POS products).¹⁷

As shown below, the proportion of members enrolled in PPO products at three of the four largest commercial health plans has increased over the past four years. The popularity of PPO plans poses a challenge to improving care coordination through designated PCP managers and global payment arrangements. There are still steps that market participants can take, however, to improve care coordination for PPO members. For instance, using claims data, health plans can identify providers who might assist in coordinating a PPO member's care, even if the provider does not serve as a gatekeeper for referrals. Health plans can provide additional member information to these providers – claims-level information – to assist these providers in understanding and managing the PPO member's care.

Each of the three major health plans has developed "PPO attribution" models to attribute PPO members to providers based on factors other than explicit PCP selection. In general, these models analyze PPO claims data to determine whether a given PPO member has recently received "primary care" services – e.g., an annual physical, a Pap smear, or the like. The health plan then attributes the member to the provider that delivered the primary care service.¹⁸ Health plans provided information indicating that this method allows them to assign 79% or more of PPO members to a provider group.¹⁹

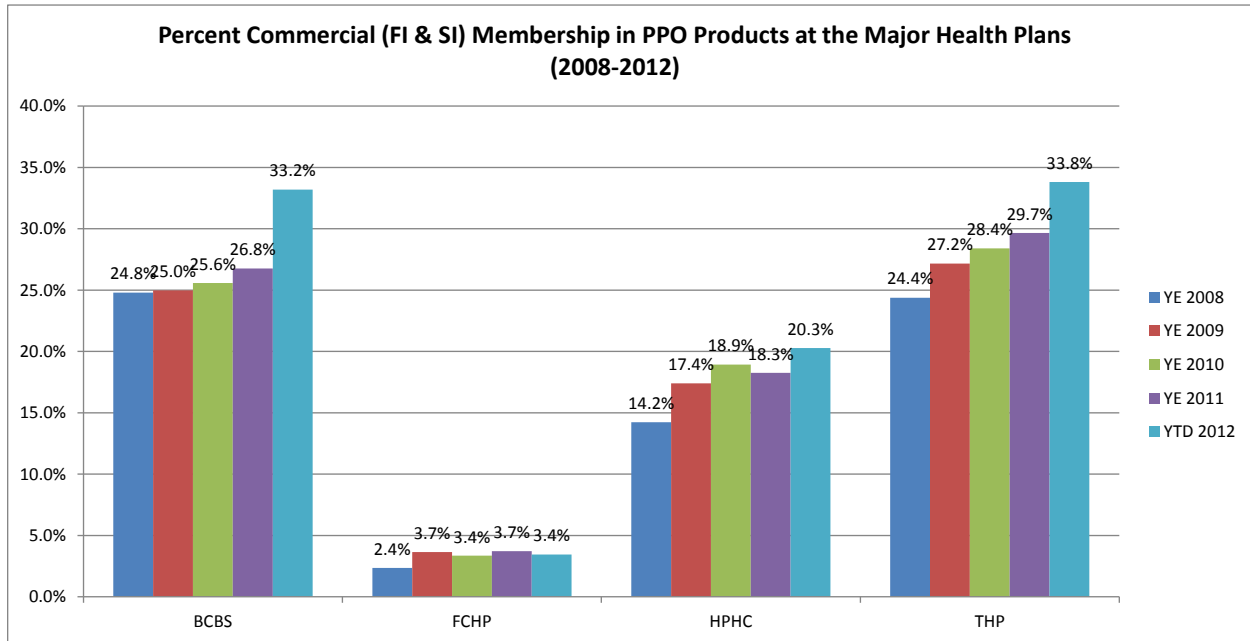
These providers do not necessarily have "direction" over attributed members' care, however, because PPO products do not require the member to consult with the provider, or

¹⁷ This distinction between products that require designation of a gatekeeper PCP, and those that do not, is centrally relevant to the topics of product design and payment arrangements examined in this Report. Thus, for purposes of this Report, we generally analyze HMO and POS member data together, and PPO and indemnity member data together. As BCBS is the only major Massachusetts health plan that offers commercial indemnity products, references to PPO data for BCBS include indemnity data, a modest component of BCBS business in Massachusetts (for example, in 2010, revenue for indemnity members accounted for 3.7% of the commercial revenue that Massachusetts hospitals received from BCBS).

¹⁸ Challenges to PPO attribution include instances where a member did not recently receive any primary care services, or received primary care services from more than one provider.

¹⁹ The results of these PPO attribution models are consistent with reports indicating that about 90% of adult Massachusetts residents identify as having a "personal health provider." DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFFICE OF HEALTH & HUMAN SERVS., HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS, at 18 (Nov. 2010), available at <http://www.mass.gov/chia/docs/r/pubs/10/key-indicators-november-2010.pdf>.

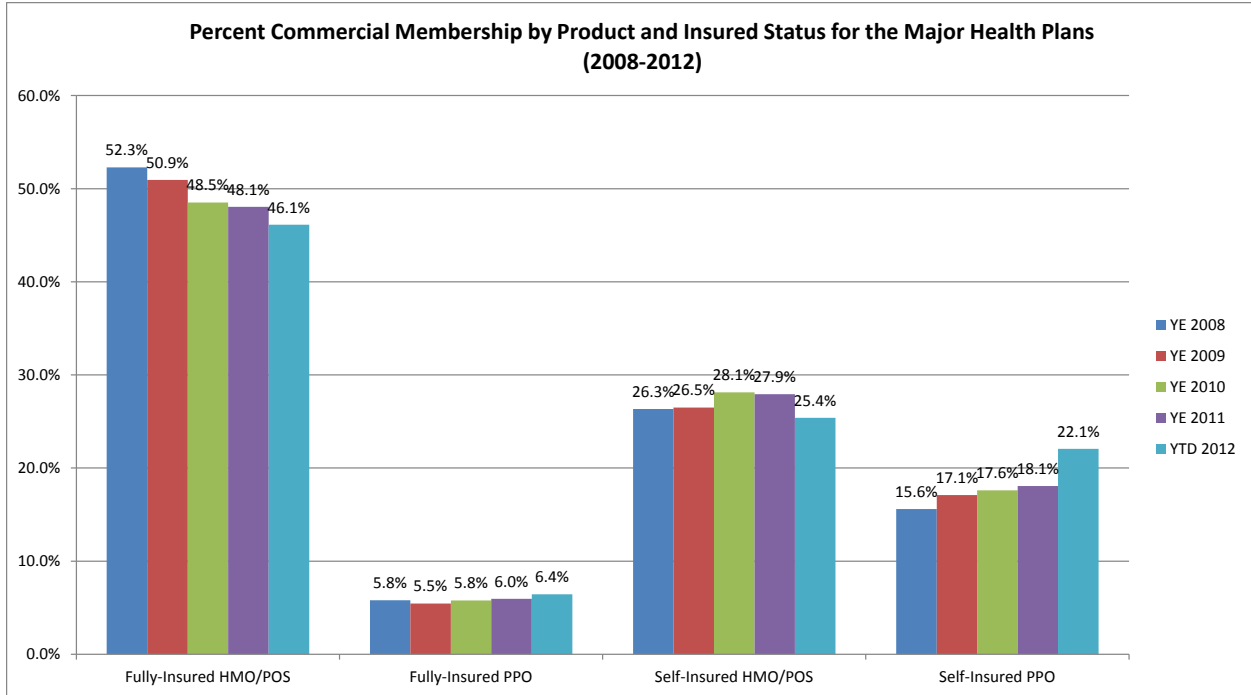
obtain referrals for care from other providers. For these and other reasons, none of the commercial health plans in Massachusetts currently include PPO members in risk contracts; that is to say, health plans do not hold provider groups responsible for the total cost and quality of the care for members whose products do not situate the provider in the role of a coordinator and “gatekeeper” of care referrals. Because of the implications of PPO products for care coordination and global payment arrangements, it is important to track the proportion of the commercial market enrolled in PPO products.



NOTES

(1) For BCBS and FCHP, 2012 information is as of April 2012; for HPHC, it is as of July 2012; for THP, October 2012.

In particular, as shown in the next chart, enrollment in self-insured PPO products is growing. In a self-insured product, the employer group offers health benefits directly to its employees and is responsible for the cost of those benefits. Accordingly, health plans do not “insure” self-insured products; rather, they serve as a “third-party administrator” that provides claims processing, provider contracting, and other administrative services to the employer group. The employer retains the risk for the cost of its health benefits. By contrast, in a fully-insured plan, the employer contracts with the health plan to assume the risk for the cost of members’ health expenses. Because self-insured plans are considered an employee benefit governed by the federal Employee Retirement Income Security Act of 1974, and not “health insurance,” state health insurance laws do not always apply to self-insured plans the same way they do to fully-insured plans. For example, in Massachusetts, state laws mandating certain benefits for health insurance plans typically do not apply to self-insured plans.



NOTES

(1) For BCBS and FCHP, 2012 information is as of April 2012; for HPHC, it is as of July 2012; for THP, October 2012.

C. Membership in High-Deductible Products Has Grown

In recent years, there has been a well-documented trend in health care benefit “buy-down,” in which employers and individuals have increasingly shifted to products with higher member cost-sharing – principally, higher deductibles – in exchange for lower premiums. A deductible is a flat annual amount a member must pay out-of-pocket for covered services before the health plan begins covering claims in a given year.²⁰ While deductible amounts differ across insurance products and health plans, in Massachusetts, a product with an individual deductible of \$1,000 or more is often identified as a high-deductible product.²¹

DHCFP has reported on this trend in Massachusetts’s merged individual/small group market. From 2008 to 2010, the proportion of the individual market enrolled in high-deductible products increased from about 45% to 55%.²² Over the same period, small group plan enrollment in high-deductible products increased by one-quarter, with 27% of the small group market enrolled in a high-deductible product in 2010.²³ Trends in Massachusetts mirror national trends: nationwide, enrollment in high-deductible plans has increased 35% since 2006, with 34%

²⁰ Deductibles can be applied to a variety of product designs – HMO, PPO, tiered network, and limited network products. Deductibles do not necessarily apply equally to all types of claims; for example, under the federal Patient Protection and Affordable Care Act, deductibles may not apply to “preventive” services. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 166 (2010).

²¹ The federal government defines a high-deductible health plan that qualifies individuals for a Health Savings Account as a plan with a minimum individual deductible of \$1,200. Rev. Prod. 2011-32, 2011-22 I.R.B. 835, available at <http://www.treasury.gov/resource-center/faqs/Taxes/Pages/HSA-2012-indexed-amounts.aspx>.

²² DHCFP COST TRENDS MAY 2012, *supra* note 7, at 10-11.

²³ *Id.*

of all employees enrolled in a plan with a deductible of \$1,000 or more and 14% of employees in a plan with a deductible of \$2,000 or more in 2012.²⁴ DHCFCP reported that this continued growth in high-deductible products significantly shifts cost-sharing risk to consumers and may hinder access to medical services.²⁵

D. Purchaser Decisions Affect Health Plans and Providers Implementing Risk Contracts

Purchaser trends in shifting to certain products can impact other market initiatives designed to lower costs and improve quality. In this section, we discuss potential tensions between purchaser trends and the activities of other market participants, highlighting the importance of monitoring these trends and their impact on efforts to improve quality and control costs.

1. Enrollment in PPO Products Results in Membership Shifting Out of Risk Contracts

As discussed above, health plans in Massachusetts do not apply risk contracts to members enrolled in PPO products. Growth in PPO products thus results in membership shifting out of risk contracts. Providers and health plans in Massachusetts are investing in significant changes to their systems and culture to implement risk contracts while purchasers are increasingly shifting to products that do not support risk contracting. For example, as shown in the following table, membership cared for through risk contracts at BCBS (which has promoted risk contracting through its Alternative Quality Contract (“AQC”))²⁶ decreased from 2010 to 2012 (by 18,943 members), after increasing in previous years. This net decrease in risk membership occurred even as other factors operated to increase risk membership at BCBS. For example, BCBS entered into AQC contracts with six additional provider groups that went into effect in January 2011 or January 2012, including with the largest provider system in Massachusetts, bringing additional PCPs and thousands of members under risk. Notwithstanding these new risk contracts, risk membership decreased overall, suggesting the impact of a combination of factors, including (1) members shifting to PPO products and (2) a general loss of HMO/POS lives at BCBS.²⁷

Change in Risk Membership at BCBS from 2010 to 2012

| Number of New Providers at Risk in 2011 and 2012 | Members Initially Associated with New Risk Contracts | Net Change in Risk Membership from 2010 to 2012 |
|---|---|--|
| 6 | About 400,000 | -18,943 |

²⁴ MATTHEW RAY ET AL., KAISER FAMILY FOUND., THE PREVALENCE AND COST OF DEDUCTIBLES IN EMPLOYER SPONSORED INSURANCE: A VIEW FROM THE 2012 EMPLOYER HEALTH BENEFIT SURVEY (Nov. 2012), available at <http://www.kff.org/insurance/snapshot/chcm110212oth.cfm>.

²⁵ DHCFCP COST TRENDS MAY 2012, *supra* note 7, at 1.

²⁶ BCBS introduced the AQC global payment model in Massachusetts in 2009.

²⁷ These changes in risk membership have differed by market segment: a higher proportion of the merged market is in risk contracts at BCBS compared to the large group market, and the large group market has experienced greater decreases in risk membership than the merged market.

The growing proportion of the market enrolled in PPO products raises important questions as we consider efforts, like the promotion of risk payments, intended to improve care coordination and lower costs. For example, is the investment in risk contracts going to yield desired results if purchasers continue to shift towards PPO products? What are the implications of different market segments being enrolled in risk contracts in different proportions? Health care policy discussions are focused on improving care coordination, yet purchasers appear to be moving away from products that require a coordinating PCP.

2. Tracking, Analyzing, and Shaping Purchaser Decisions

Our findings indicate that purchasers are making value-sensitive decisions that can have a beneficial impact on TME. To support these value-based decisions, purchasers need options for value, and access to data relevant to their decision-making. Purchasers should have access to information on the financial and quality performance of different product and benefit designs, as well as data on other drivers of premium differences, to enable them to evaluate premium differentials and make more informed purchasing decisions. To support meaningful analysis, health plans, DOI, and CHIA should develop more consistent product definitions across health plans. With hundreds of product variations in the market (e.g., tiered products that vary significantly in the types of services that are tiered and in the range of cost-sharing differentials), meaningful reporting will require more consistent definitions of product categories.

Tracking product enrollment trends will improve our understanding of how purchaser activities relate to other market initiatives designed to lower costs and improve quality. For example, in addition to the impact of PPO growth on risk membership, product enrollment trends have other important implications for risk contracting. As discussed further in Part II.D below, the mix of products that a member population is enrolled in (e.g., high cost-sharing or low cost-sharing, tiered or non-tiered) influences the TME of that population. As risk providers seek to manage the TME of their risk population, they need information on the mix of products in which their risk members are enrolled, to evaluate whether changes in TME are driven more by shifts in product enrollment, or by providers' own care management efforts. Information on product enrollment is also important because certain product designs may create incentives for consumers that differ from the incentives of their providers pursuant to risk arrangements or other contractual relationships. As discussed in Part III.C below, consumer incentives under tiered and other product designs to seek care from more efficient providers may come into tension with provider incentives based on clinical affiliations or other contractual relations to keep care in the provider's own system, even where there are lower-cost options outside the system.

To support prudent purchasing, market participants should also examine the factors underlying purchaser enrollment trends. To date, there has been very little evidentiary review of these factors. In discussions, market participants have offered a number of potential explanations for the growth in PPO and self-insured products. Regarding growth in self-insured accounts, health plans have cited interest in "the added flexibility that comes with this funding mechanism," including "exemption from state mandated benefits" and other regulatory requirements, "enhanced cash flow, as self-insured groups pay claims only after being billed by

the health plan,” and “increased cost savings, as employers pay for actual claims incurred and not for administrative expenses levied by most health insurers.”²⁸

Regarding growth in PPO products, health plans have cited increased employer interest in products that cover services outside of Massachusetts and “greater satisfaction among employees who are not limited to a closed network (e.g., HMO) and can choose to see other providers of their own choice.”²⁹ A preliminary review of data received raises the possibility that purchasers may be responding to differentials in premiums driven by differences in underlying TME. We received data for 2009 to 2011 showing that in many cases, there were not material differences in the TME associated with HMO/POS products compared to PPO/indemnity products. However, for the largest health plan, the health status adjusted TME of its HMO products was consistently more than \$100 per member per month (“PMPM”) higher than the TME associated with its PPO products.³⁰ Questions concerning TME differences among insurance products, and how that TME factors into pricing of those products, merit further examination as we seek to track product performance, understand purchaser enrollment trends, and promote prudent purchasing.

Just as purchaser decisions impact the activities of other market participants, so too do the decisions of health plans and providers. In Part II, we examine trends in health plan activities, including the payment arrangements they negotiate with providers, and the insurance products they design and offer purchasers.

II. HEALTH PLANS

Health plans play an important role in efforts to improve health care quality and control costs. Health plans design provider reimbursement arrangements that vary by price, payment method, and quality incentives, among other factors. To the extent these reimbursement arrangements tie payment to quality, efficiency, and other value-based factors, they can play an important role in improving quality and controlling costs. In our 2010 and 2011 Reports, we highlighted the role of payments that are not tied to value in driving health care spending growth. We also examined whether different payment methods have resulted in lower medical spending in Massachusetts to date. This year, we continue to examine the central role of reimbursement

²⁸ DHCFCP Hearing on Health Care Cost Trends (2012) (written testimony of HPHC, THP, Response to Exh. C, Q. 3), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

²⁹ DHCFCP Hearing on Health Care Cost Trends (2012) (written testimony of BCBS, HPHC, Response to Exh. C, Q. 3), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

³⁰ This raises important questions for further examination, including: what underlies this significant TME difference between HMO and PPO products? Do PPO members use fewer services – and if so, what factors would explain such lower utilization? Alternatively, is this TME differential driven by higher payment rates from this health plan to providers for HMO versus PPO business? If so, what are the implications of significantly differing HMO and PPO payment rates? Part of the reason for lower health status adjusted PPO TME may be that this health plan’s student members are enrolled almost exclusively in PPO products, and health status adjustment tools can do a poor job reflecting the true health status of very healthy members (like students). That said, presuming the entire student population at this health plan had an average TME of only \$1 PMPM in 2011, there would still be more than a \$100 PMPM difference between health status adjusted HMO and PPO TME. This indicates that the presence of the student population in PPO products does not adequately explain the differential between HMO and PPO TME that we observed. More analysis is required to assess the factors accounting for lower PPO TME at this health plan.

arrangements – including their design, complexity, and whether they pay based on value – in influencing health care cost growth and variation in levels of medical spending for patients around the Commonwealth (Parts II.A-C).

In addition to designing provider reimbursement arrangements, health plans play an important role in designing and offering different insurance products to attract purchasers (subject to government rules on topics like risk pooling, guaranteed issue, and minimum creditable coverage). These products differ in the information, incentives, and choices they offer purchasers and consumers. Our findings this year show that different product and benefit designs influence consumer decisions to use health care services, and thus impact levels of medical spending (Part II.D).

Health plans have invested significant premium dollars in designing and marketing different insurance products and implementing various payment methods. They possess key claims information and other health care performance data (e.g., cost, quality, utilization) that would enable detailed analysis of the role of different product designs and payment arrangements in improving quality and controlling costs. Yet, despite the potential impact of product designs and payment methods on total medical spending, health plans do not consistently analyze their performance. We propose that health plans more rigorously test and report on the efficacy of different product designs and payment arrangements, including their relative efficacy.

A. Health Plans Continue to Pay Providers Widely Different Amounts to Care for Patients of Comparable Health

In our 2010 and 2011 Reports, we found that health plans pay providers widely different prices that are not adequately explained by differences in the quality or complexity of care delivered, or other value-based factors. This year’s examination underscores this continuing market dysfunction, and finds that where recent progress has been made in linking payments to value, these approaches feature inconsistent payment standards that fail to mitigate historic disparities. In the future, pricing disparities will only increase if providers are all held to the same level of price increases based on state cost growth goals or other benchmarks.³¹

Price variation exists in both fee-for-service (“FFS”) and global payment arrangements. In a FFS arrangement, a health plan pays a provider for each service rendered, based on an agreed upon price for each service. Under a global payment arrangement, the health plan and provider organization negotiate a “global budget” for the care of members in the provider’s risk contract (HMO and POS members who have selected a PCP at the provider organization). The global budget is a targeted maximum amount the health plan will pay for the cost of all of the care these members receive in a given year (including the cost of care the members receive from other providers). Throughout the year, the health plan pays the provider on a FFS basis for the services it directly provides to its risk members. At the end of the year, the health plan totals all of the FFS payments it made to the risk provider and other providers for the care of these members to determine the total annual cost of care for these members. If the total cost of care is less than the negotiated global budget, the provider may “earn” a surplus payment from the

³¹ See MASS. GEN. LAWS ch. 6D, § 9(b-e) (2012) (establishing a statewide health care cost growth benchmark).

health plan. If the total cost of care exceeds the budget, the provider may owe a deficit payment to the health plan.³²

Recent legislation in Massachusetts has increased transparency for both FFS and global payment arrangements. Chapter 288 of the 2010 Acts requires health plans to report relative prices and TME.³³ Chapter 224 of the 2012 Acts requires health plans to report on global budgets and other alternative payment arrangements.³⁴ In particular, health plans that utilize alternative payment methodologies must report to CHIA negotiated budget amounts that assume a neutral health status score using an industry accepted health status adjustment tool. Such reporting will enable CHIA to track reimbursement under global payment arrangements on a “comparable” basis, as we do below.

Wide variations in FFS payments are well-documented in our 2010 and 2011 Reports, as well as in CHIA’s recent Price Variation Reports.³⁵ In this section, we focus our analysis on provider reimbursement under risk arrangements, which to date reflect and perpetuate the disparities in underlying FFS payments. We examine (1) variation in provider risk budgets, (2) variation in quality and infrastructure payments available under risk contracts (non-claims based payments), (3) variation in total reimbursement under risk contracts, and (4) how variation in HMO payment rates intersects with variation in PPO payment rates.

1. Health Plans and Providers Negotiate Budgets of Different Sizes to Care for Patients of Comparable Health

We examined global risk contracts, annual settlement reports, standardized health status scores that reflect differences in the demographics and sickness of each provider’s risk population, and the value of medical services excluded from risk budgets. This information enabled us to compare the effective size of risk budgets negotiated between health plans and provider organizations, adjusted for differences in the health status of the patient population covered by, and the medical services included in, each budget.³⁶ Comparing risk budgets is important because budgets reflect differences in the dollars available to providers for the care of patients of comparable health, even though they may not equal the dollars ultimately paid to providers.

A valid comparison of the performance of provider organizations requires accounting for differences in the populations served by those provider organizations. Some providers may care for patients who are, on average, sicker than the patients cared for by another provider. Without an adjustment for health status, such a provider may falsely appear to be less efficient. Health

³² For more information on global risk arrangements, see Part III.A below at 47.

³³ MASS. GEN. LAWS ch. 118G, § 6 (2010).

³⁴ MASS. GEN. LAWS ch. 12C, § 10(d) (2012).

³⁵ CHIA PROVIDER PRICE VARIATION FEB. 2013 and CHIA PROVIDER PRICE VARIATION NOV. 2012, *supra* note 8.

³⁶ To compare the effective size of risk budgets, it was necessary to make certain adjustments so that budgets for comparable populations and medical services are shown. Using information received from each health plan, the AGO adjusted budgets to reflect (1) equivalent population health status (or demographics where health status was unavailable) and (2) equivalent medical services, including the value of any services excluded from risk budgets. These adjusted budgets are not necessarily equivalent to provider TME due to factors such as the impact of risk contract provisions like risk share and surplus/liability caps.

status measurement tools use demographic information, such as age and gender, and data on past diagnoses to assess the relative health of a population that is served by a given provider group. These tools produce health status scores indicating the average sickness of the provider group's patients.

One commonly used health status measure is DxCG.³⁷ The lower a provider's DxCG score, the healthier that provider's patients are on average. For each of the three major health plans, we examined DxCG scores for providers in their network from 2008 to 2011, to measure variation in health status across provider groups, as well as trends over time.³⁸ For each health plan in 2011, we found the DxCG score of the provider system with the highest score (indicating the least healthy population) was 1.7 to 2.3 times that of the provider system with the lowest score. In other words, for one major health plan, one provider system's HMO/POS patients were, on average, more than twice as "sick" or "morbid" as the provider system with the healthiest HMO/POS population. In examining the DxCG scores of local practice groups (the physician practices that constitute a provider system), we observed even greater variation. For example, for each of the three major health plans in 2011, the DxCG score of the local practice group with the highest score was 2.2 to 2.5 times that of the group with the lowest score.³⁹

Variations in health status scores may be shaped by geography, local demographics, or any number of other factors. As the market continues to encourage the development of provider systems focused on population care management, it is important to monitor trends in health status and adjust for differences in health status in comparing provider performance. Adjusting risk budgets to account for health status differences is designed to minimize undesired incentives for providers to manage target budgets by seeking a healthier population, or avoiding less healthy patients. However, as discussed more fully in Part III.B, health status measurement tools are not fully accurate, nor are they applied consistently across risk contracts. Monitoring changes in health status across providers over time will help us better understand the interplay of health status and population care management, as well as identify any undesired incentives for providers to manage budgets by avoiding higher-risk, vulnerable populations.

The following charts show differences in the health status adjusted budgets of risk providers at the three largest commercial health plans.⁴⁰

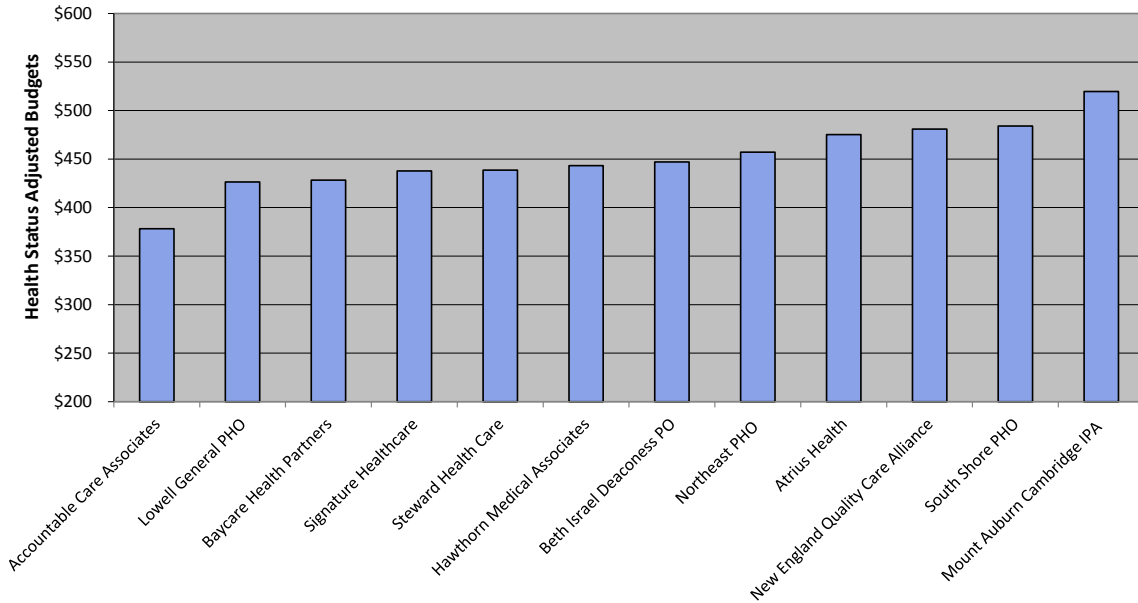
³⁷ For 2012 risk arrangements, each of the three major commercial health plans used DxCG scores to adjust budgets.

³⁸ Health plans calculated these DxCG scores based on HMO and POS members who selected a PCP in the given provider system. Based on information indicating that DxCG may not measure pediatric health status as accurately as adult health status, we excluded from our analysis provider groups that care primarily or exclusively for pediatric populations.

³⁹ In addition, for two out of the three major health plans, average health status scores increased approximately 3% annually from 2008 to 2011 (meaning the health plan's population became more morbid over time). For the third major health plan, we were unable to compare health status trends due to updates over time in how the health plan calculated health status scores.

⁴⁰ Because of differences in how health plans calculate health status scores, we caution against comparing the PMPM value of risk budgets across health plans.

Variation in BCBS's Provider Group Health Status Adjusted Budgets (2011)

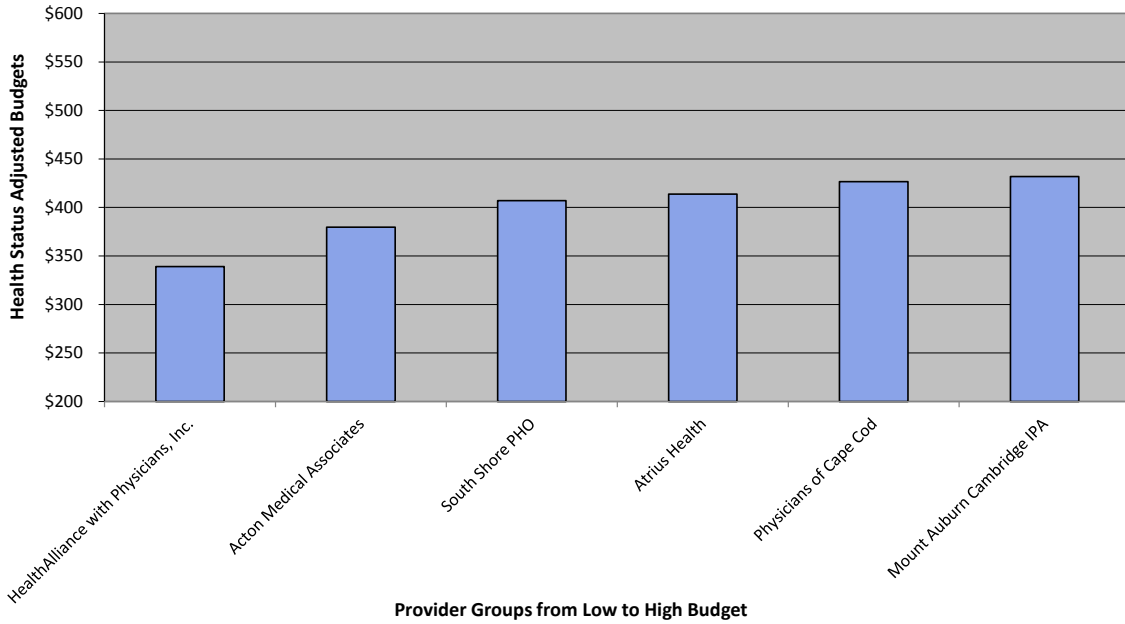


Provider Groups from Low to High Budget

NOTES

- (1) Budgets are for the care of fully-insured and self-insured HMO/POS members who selected PCPs at the above provider groups.
- (2) Budgets include estimates for any services that are excluded, or “carved out,” from budgets, such that each budget reflects all medical services. Budgets are adjusted for the health status of the population covered and for a consistent mix of pharmacy benefits.
- (3) 2011 risk arrangements (non-AQC) with Fallon Clinic and Health Alliance Physicians Inc. are not included because we did not have sufficient data to adjust budgets comparably with the above cohort.
- (4) Southcoast Physicians Network entered the AQC in 2009, but is not shown separately because it joined New England Quality Care Alliance’s AQC in 2011.

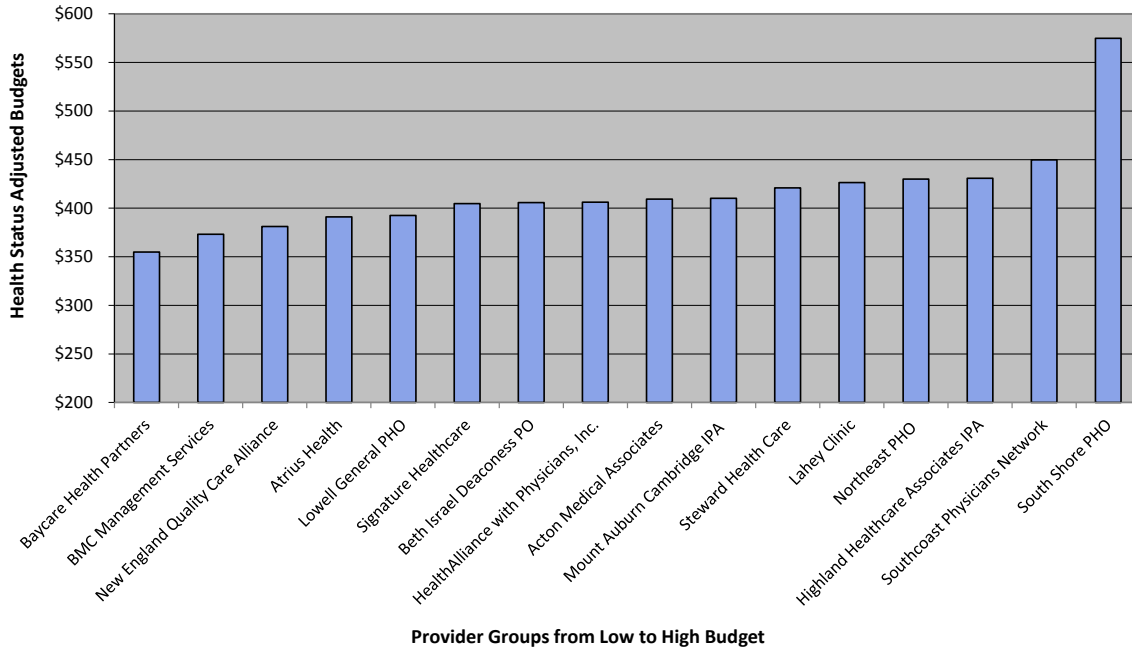
Variation in HPHC's Provider Group Health Status Adjusted Budgets (2010)



NOTES

- (1) Budgets are for the care of fully-insured HMO/POS members who selected PCPs at the above provider groups.
- (2) Budgets include the value of any services carved out of budgets, such that each budget reflects all medical services, and are adjusted for the demographics of the population covered.

Variation in THP's Provider Group Health Status Adjusted Budgets (2011)



NOTES

- (1) Budgets are for the care of fully-insured HMO/POS members who selected PCPs at the above provider groups.
- (2) Budgets include the value of any services carved out of budgets, such that each budget reflects all medical services, and are adjusted for the health status of the population covered.
- (3) As noted on p.20, n.36 above, adjusted budgets are not necessarily equivalent to provider TME due to factors such as the impact of risk contract provisions like risk share. The total value of most unadjusted budgets and services carved out of budgets is within 5% of actual TME. However, for South Shore PHO for example, due to the impact of risk share provisions in its risk contract, the value of its unadjusted budget and carved-out services is about 25% higher than its actual TME.

As illustrated above, health plans and providers negotiate budgets of significantly different sizes to care for patients of comparable health. If Provider A's risk budget is effectively \$100 PMPM more than Provider B's, assuming each provider has 20,000 member months at risk, Provider A would effectively have \$2 million more per year to manage the care of an equivalent number of patients of comparable health. Since many risk budgets are based on providers' historic pricing and spending levels, they entrench historic disparities that are not explained by differences in quality or value.

2. Health Plans Pay Providers Different Amounts for Non-Claims Based Payments

To monitor growth in total health care spending and analyze whether health plans are paying providers based on value, it is important to track and report on all sources of payments from health plans to providers. These include payments for quality performance, monies to fund care infrastructure, and any other non-claims based health care dollars that health plans pay providers. These non-claims based payments are part of total medical spending and should be

included when analyzing health care costs and provider reimbursement.⁴¹ Indeed, Chapter 288 of the 2010 Acts requires that health plans include non-claims based payments when they report TME and relative prices.⁴² In addition, as a condition of accreditation, health plans are required to disclose to DOI the amount and purpose of each supplemental payment made to providers.⁴³

Quality Payments. Health plans generally do not pay providers for quality performance beyond pay for performance programs that offer providers limited dollars for achieving certain quality benchmarks. As noted in our 2011 Report, pay for performance programs have historically represented few dollars compared to overall reimbursement.⁴⁴ BCBS's AQC is a notable exception; it incorporates a pay for performance program that ties significant PMPM dollars to the achievement of quality benchmarks for a provider's risk population. Tying significant dollars to quality performance is a positive step towards tying payments to value. However, in implementing this program, BCBS has not enforced consistent quality payment standards across participating providers.

In evaluating how consistently BCBS pays its AQC providers for quality performance, we examined (a) quality measures tracked, (b) methodology for scoring quality performance, and (c) payment rates for each level of quality performance. We found that in general, BCBS tracks the same quality measures for each provider and scores their performance using consistent methodologies. However, BCBS pays providers different amounts for the same quality score. While quality incentives do not necessarily have to be uniform, there does not appear to be a reasoned explanation for the lack of consistency in linking quality payment with quality performance. Such inconsistency may instead reflect factors not tied to value that impact health plan and provider system negotiations.

For AQC contracts effective prior to August 2010 (loosely called AQC version 1.0, as compared to AQC 2.0 contracts effective August 2010 or later), quality payments are based on a percentage of underlying risk budgets (meaning that higher-budgeted/more expensive providers receive higher payments for achieving a given quality score). For AQC 2.0 contracts, quality payments are based on specific PMPM amounts for the quality score earned. There is still significant variation in these specific PMPM amounts from contract to contract, but by de-linking quality payments from budgets, BCBS took steps to reduce the variation in quality incentives from AQC 1.0 to AQC 2.0. Thus, variation in quality payments for the same quality score decreased for AQC 2.0 providers.

Other Supplemental Payments. In addition to payments for quality performance, most health plans make other non-claims based payments to providers for a variety of reasons. These include payments to fund the development of care management infrastructure (e.g., to hire case managers or pay for health information technology). Similar to quality payments, payments for

⁴¹ *But c.f.* Zirui Song et al., *The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality*, 31(8) HEALTH AFFAIRS 1885, 1887 and 1891 (2012) [hereinafter HEALTH AFFAIRS AQC] (concluding that AQC contracts resulted in lowered medical spending based only on "claims-level fee-for-service payments" and not including quality payments, surplus or deficit payments, or any other supplemental payments to providers).

⁴² MASS. GEN. LAWS ch. 118G, § 1, 6 (2010).

⁴³ MASS. GEN. LAWS ch. 176O, § 9A(c) (2010).

⁴⁴ AGO 2011 REPORT, *supra* note 10, at 18 n.17, 25 n.31.

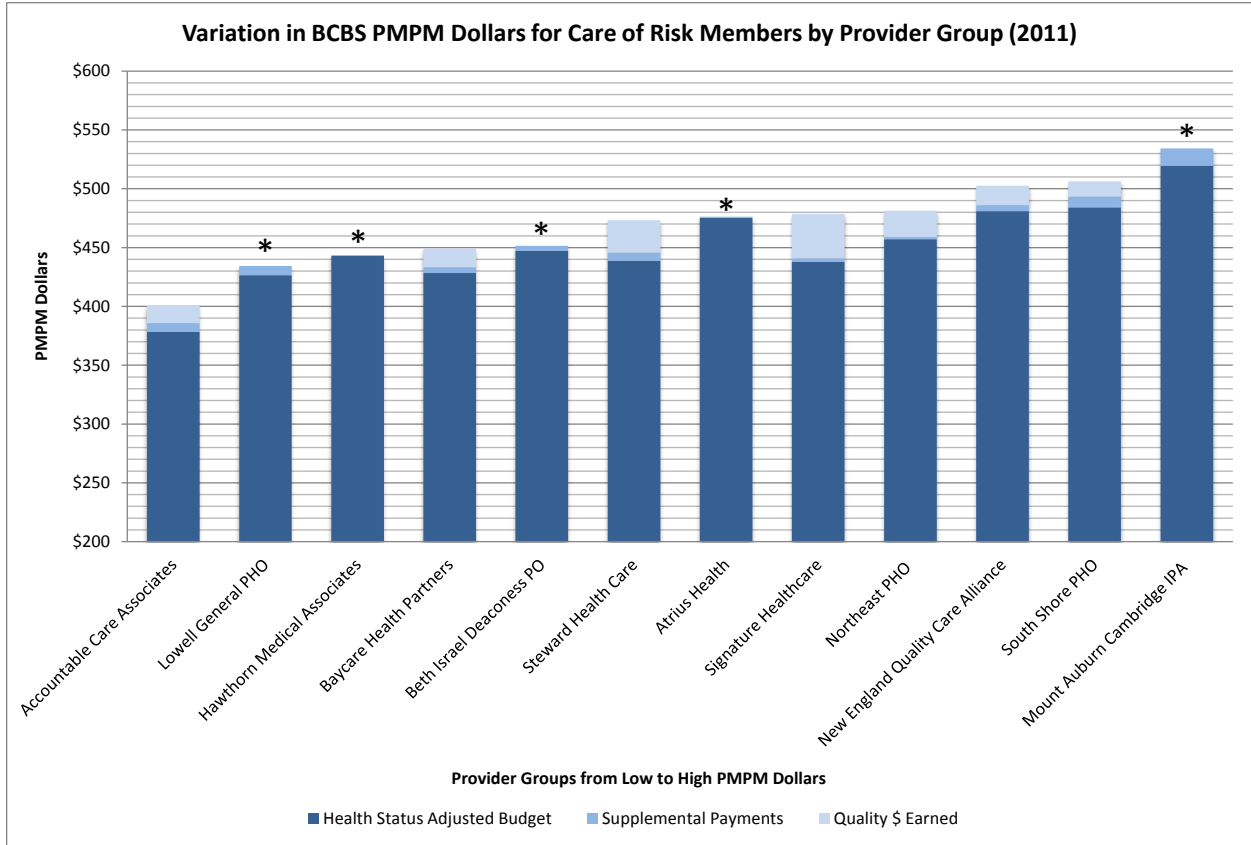
care infrastructure and other supplemental payments vary widely from provider to provider. For example, in 2011, one major health plan paid one provider \$8 PMPM in supplemental payments for each member in the provider's risk contract, while it did not make any supplemental payments to another risk provider. If each provider had 20,000 member months at risk, that \$8 PMPM difference would translate into an additional annual payment of \$160,000.

Non-claims based payments can be effective tools for incenting improvements in provider performance. However, as discussed more fully in Part III.A below, given that these payments are among the dozens of provisions that are individually negotiated between health plans and providers of varying sophistication and clout, the resulting financial incentives are not necessarily consistent, predictable, or fair across contracts.

3. Including All Major Sources of Payment Under Risk Contracts, Reimbursement Varies Widely

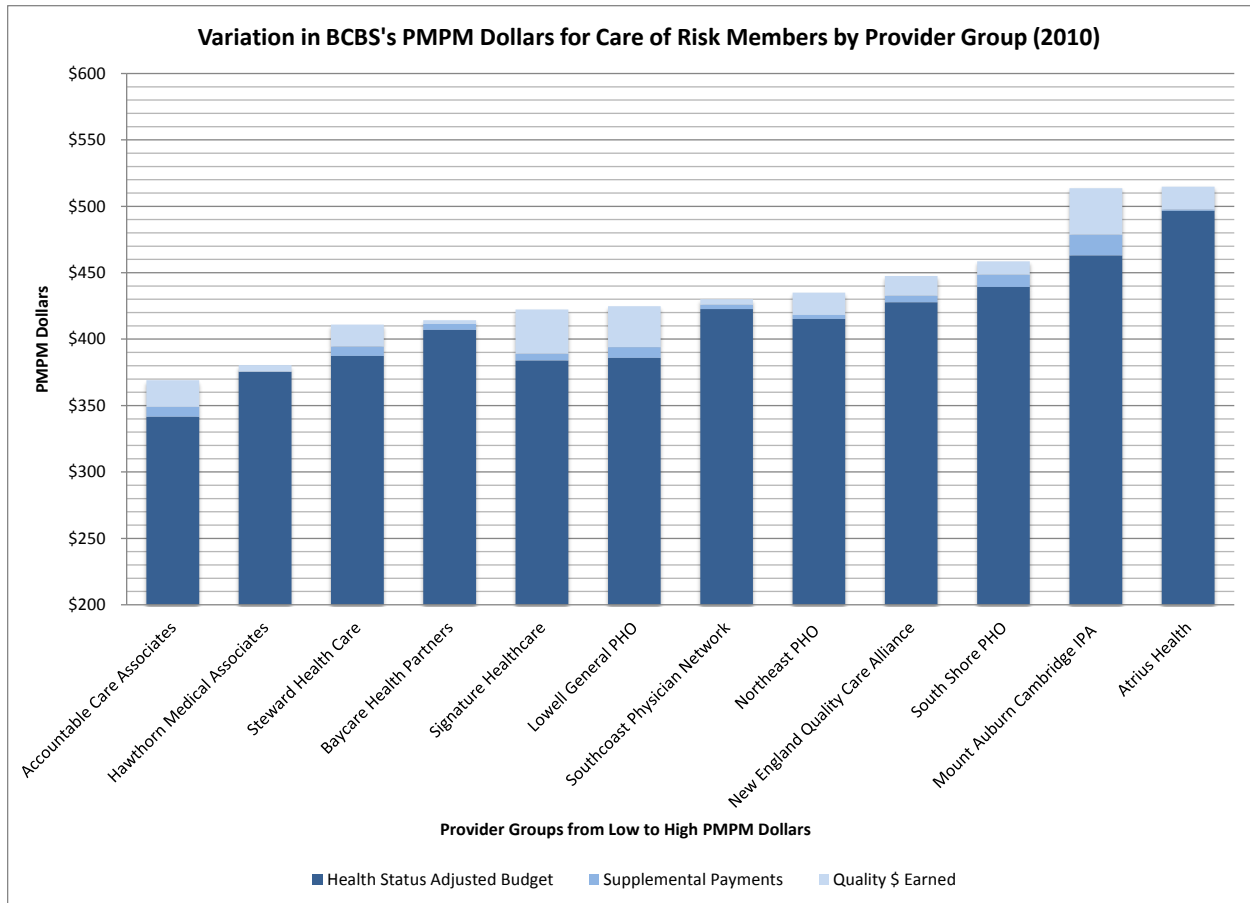
As documented above, health plans and providers not only negotiate budgets of widely different amounts to care for patients of comparable health, but they also negotiate different quality incentives and supplemental payments to manage the care of these patients. The charts that follow aggregate these major sources of payment for BCBS 2010 and 2011 risk providers.⁴⁵ The 2011 chart is incomplete where asterisked because BCBS 2011 risk contract settlements for those provider groups were not yet available.

⁴⁵ We did not receive sufficient information to develop charts for the other major health plans. To its credit, BCBS appears to track its quality and other supplemental payments more consistently than other health plans that provided information for this examination. Going forward, as CHIA reports on all sources of payments to providers, it will be important to do so consistently for all health plans.



NOTES

- (1) We were not able to include information on quality dollars earned for asterisked (*) providers because these providers' final settlements for 2011 were not available at the time of preparation of this Report.
- (2) Budgets are for the care of fully-insured and self-insured HMO/POS members who selected PCPs at the above provider groups.
- (3) Budgets include estimates for any services carved out of budgets, such that each budget reflects all medical services. Budgets are adjusted for the health status of the population covered and for a consistent mix of pharmacy benefits.



NOTES

- (1) Budgets are for the care of fully-insured and self-insured HMO/POS members who selected PCPs at the above provider groups.
- (2) Budgets include estimates for any services carved out of budgets, such that each budget reflects all medical services. Budgets are adjusted for the health status of the population covered and for a consistent mix of pharmacy benefits.

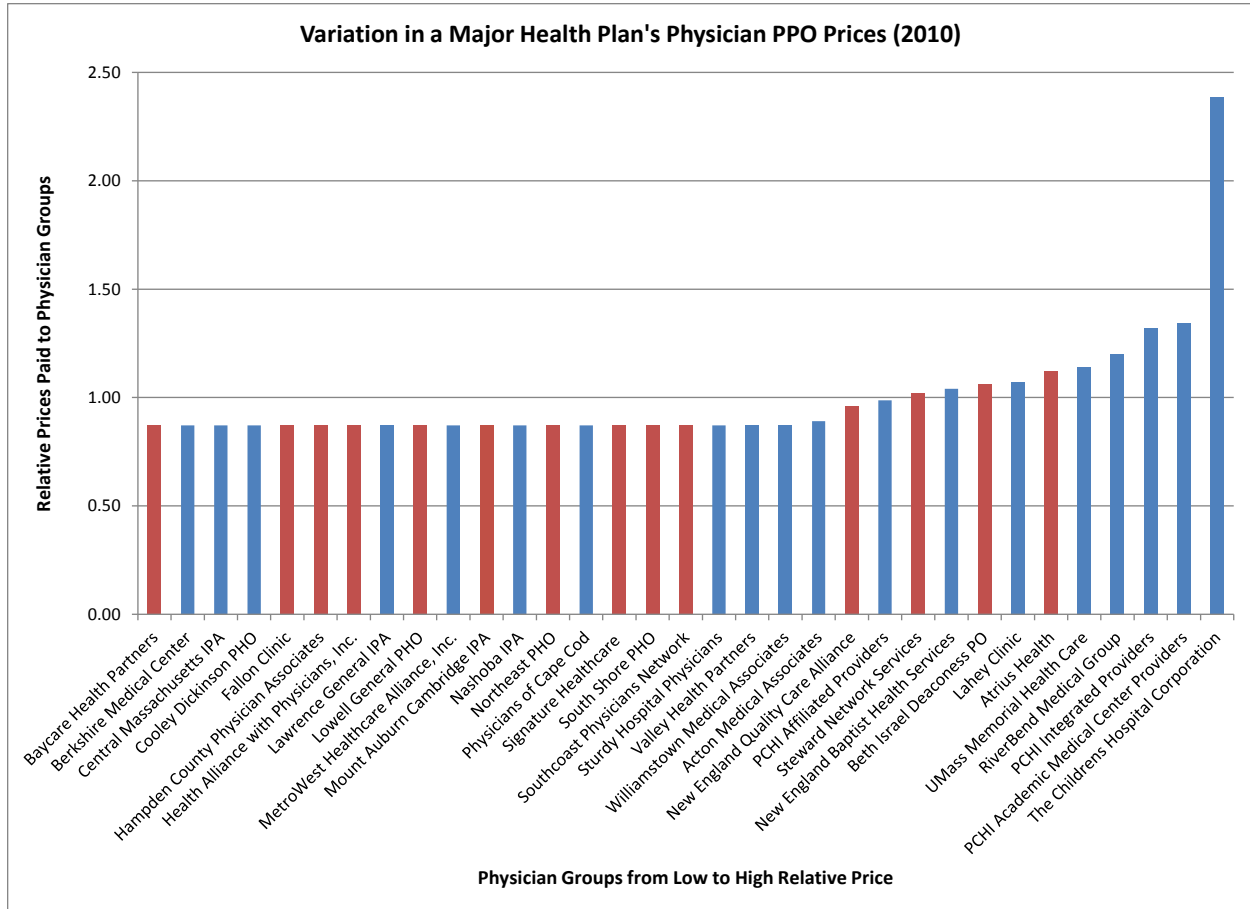
4. Like Variation in HMO Risk Budgets, Health Plans and Providers Negotiate Widely Different Rates for the Care of PPO Patients

Similar to the unexplained variation in risk budgets for HMO populations, health plans negotiate widely different payment rates for PPO patients. Given the sizeable and growing PPO population documented in Part I.B, these rate disparities can significantly affect the revenue a provider organization can earn.⁴⁶ This section describes the variation in PPO and HMO rates that health plans pay hospitals and physicians and recent market developments in tying PPO rates to value.

Variation in PPO and HMO Rates. Data from 2010 to 2011 shows that, like overall variation in prices, PPO prices vary considerably. Data from the three major health plans shows

⁴⁶ For example, in 2009, PPO business accounted for more than 40% of the commercial revenue that Massachusetts hospitals received from BCBS and THP. In 2010, for BCBS, this figure increased 2.5 percentage points, to 48.6% of the commercial revenue that hospitals received from BCBS.

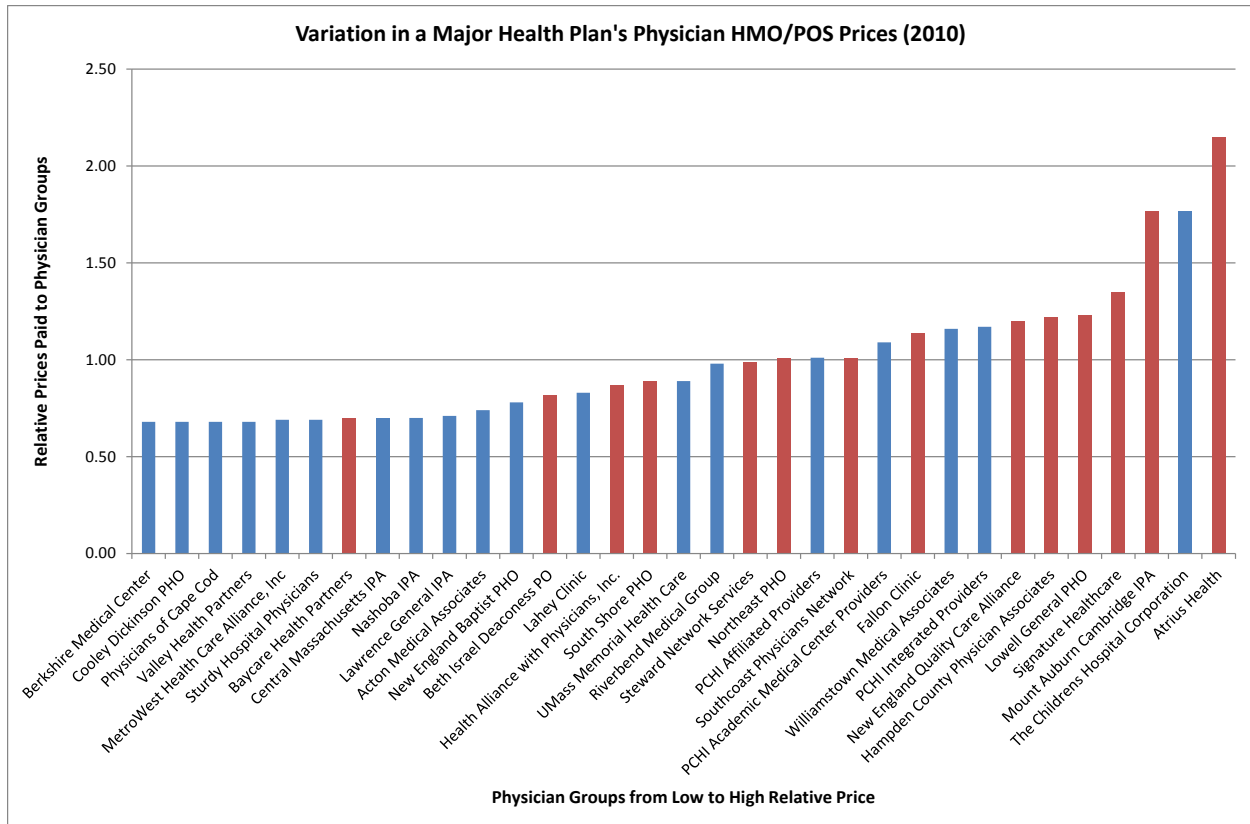
that in 2011, hospitals with the highest PPO rates in each health plan’s network were paid between 2.5 and 3.5 times more than hospitals with the lowest PPO rates. Similarly, variation exists in physician PPO rates. Below is a chart showing variation in one major health plan’s relative PPO prices for physician groups in 2010, with groups that were in risk contracts for their HMO business shown in red.



NOTES

- (1) This chart reflects the prices paid to the physician group for the care of PPO patients.
- (2) Physician groups that were in risk contracts for their HMO business in 2010 are shown in red, while all other physician groups are shown in blue.
- (3) Prices are expressed as relative to the average of all physician group PPO rates for the health plan. A relative price of 1.34 indicates the physician group was paid more than 1.5 times the rate that the lowest paid physician groups were paid in 2010 (which had relative prices of .87).
- (4) Physician groups are ordered from low to high prices. Where groups have the same relative price (e.g., two-thirds of the groups in the above chart, from Baycare Health Partners to Williamstown Medical Associates, had the same relative price of .87 in 2010), they are listed alphabetically from left to right.

A health plan and provider may negotiate HMO rates – either as a FFS price or pursuant to a global budget arrangement – that are different than a provider’s PPO rates. The below chart shows variation in the same health plan’s relative HMO rates to physician groups, with groups in risk contracts shown in red.



NOTES

- (1) This chart reflects the prices paid to the physician group for HMO/POS patients who selected a PCP at the group. Prices paid for the care of HMO/POS patients who are referred to the group, but whose PCP is not at the group, are not reflected in the above chart.
- (2) Physician groups that were in risk contracts for their HMO business in 2010 are shown in red, while all other physician groups are shown in blue.
- (3) Prices are expressed as relative to the average of all physician group HMO/POS rates for the health plan. A relative price of 2.15 indicates the physician group was paid more than 3 times the rate that the lowest paid physician groups were paid in 2010 (which had relative prices of .68).
- (4) Physician groups are ordered from low to high prices. Where groups have the same relative price (e.g., four groups in the above chart, from Berkshire Medical Center to Valley Health Partners, had the same relative price of .68 in 2010), they are listed alphabetically from left to right.

By comparing the relative HMO and PPO rates that this health plan negotiated with physician groups, it is clear that there can be a significant differential *between* the group's HMO rates and its PPO rates, creating another level of complexity and variation in payment rates.⁴⁷ As shown above, compared to other groups across the state, some groups were able to negotiate higher rates for both HMO and PPO business (e.g., Atrius Health), some were able to negotiate higher rates for HMO business or for PPO business (e.g., Mount Auburn Cambridge IPA, Lahey Clinic), and some have lower rates for both books of business.

Regarding hospital rates, for two of the three major health plans in 2011, a given hospital's PPO rate could be more than 60% higher or lower than its HMO rate. For the other major health plan, a given hospital's PPO rate could range from about 15% higher to 20% lower

⁴⁷ Differences *between* a provider's HMO and PPO rates also exist for the other two major health plans.

than its HMO rate. This means that hospitals must manage around variation in rates across multiple streams of revenue. A provider's revenue projections will almost certainly change year to year depending on whether local employers switch from HMO to PPO products, or vice versa, thereby affecting the proportion of HMO versus PPO patients that obtain care from the provider. As shown above, certain providers have been able to negotiate higher rates for both HMO and PPO business, and are thus better insulated from potential changes to their bottom line resulting from shifts in product enrollment. For other providers, variation between HMO and PPO rates represents another level of complexity and potential source of dysfunction in managing their business and competing on value. These providers must manage the impact of differentials between their PPO and HMO rates (to be able to project and maintain revenue).

Developments in Linking PPO Rates to Value. As demonstrated in our 2010 and 2011 Reports, the factors underlying price variation, including variation in PPO prices, have not been linked to value. In this examination, we reviewed evidence of some potentially promising developments in seeking to tie PPO rates to factors that may reflect value. While these developments appear to be a step in the right direction, more work needs to be done. Careful analysis reveals that even the process of linking rates to performance continues to reflect significant inequities that are contradictory to the very goal of establishing payment standards that reflect value.

In reviewing how health plans negotiate PPO rates with providers, we examined certain developments in establishing "earning standards" for PPO rates. Just as BCBS has tied significantly more dollars to quality performance in its HMO risk contracts, it has likewise begun to link PPO payments for some of its providers to certain standards of efficiency and quality performance under the AQC. Linking payment rates to "performance" is a positive step in incentivizing providers to improve quality and lower costs. However, BCBS has linked PPO rates to AQC performance in a way that reduces the potential benefit to the market. First, some but not all providers have a contractual link between AQC performance and PPO rates. For providers whose PPO rates are not linked to performance, their market clout, rather than measurable performance, continues to drive PPO payment levels. Moreover, the PPO rates of these providers – who are not "held" to any performance standard – typically exceed the highest achievable PPO rates that could be earned by those providers whose rates *are* linked to performance. For example, comparing the BCBS contracts that have implications for four physician organizations ("PO") affiliated with academic medical centers in Boston shows that for 2013, the PPO rates for Beth Israel Deaconess PO and Boston Medical Center physicians are tied to efficiency and quality performance under the group's AQC, while the PPO rates for Brigham and Women's PO and Massachusetts General PO physicians are not tied to efficiency or quality performance under Partners HealthCare System and Partners Community HealthCare's AQC. Moreover, even if Beth Israel Deaconess PO and Boston Medical Center physicians could earn the maximum PPO rate available to them through perfect quality scores and high efficiency performance, their rates would still be at least 25% to 30% lower than the PPO rates guaranteed to physicians at Brigham and Women's PO and Massachusetts General PO.

B. Variation in Provider TME Exists Across Massachusetts and Within Separate Geographic Areas

In addition to relative prices and health status adjusted risk budgets, TME is another important metric of the costs and resource use associated with different providers in Massachusetts. TME measures the total cost of care for a patient over a period of time, such as a month or a year. It is expressed as a PMPM dollar figure that reflects the average monthly medical expenses paid by the health plan and the member⁴⁸ for all of the health care services the member receives in a year (e.g., physician visits, hospital stays, drugs, laboratory tests, and any other services). TME thus reflects both the volume of services received by each member (utilization), as well as the amount paid for each service (price).

For analytic purposes, the TME of HMO and POS members can be attributed to the provider group where the member selected his/her PCP. Because PCPs can play a central role in informing the type, location, and quantity of services a member receives in a given year, attributing HMO/POS TME to provider groups provides a measure of the level of resource use (efficiency) of a provider group in managing the care of its patients.⁴⁹ As discussed in Part II.A, in accordance with standard industry practices, health plans adjust their TME data with health status scores to improve the validity of comparisons. Failing to do so could make a provider caring for a sicker population appear, inaccurately, to be less efficient. Note that each health plan calculated health status scores for its network according to its own methodology, such that the reader should not necessarily compare health status adjusted TME across health plans.

In analyzing the level of medical spending associated with different providers, we note that providers operate in different geographies around the state. Some providers, like Lowell General PHO, operate in one locality (the Merrimack Valley), while others, with hundreds or thousands of affiliated physicians, operate in multiple geographies throughout the state, each with their own competitors, dominant health plans, and patient characteristics. For provider systems operating in multiple geographies and comprising multiple local practice groups, CHIA gathers TME data both for the provider system, and for each local practice group. For example, for a large provider system with physician practice sites in the suburbs west of Boston (Metro-West), on the South Shore, and in downtown Boston, CHIA tracks the TME associated with each of these local practice groups, as well as the “blended” TME for the entire provider system. A local practice group in one area of the state can have a very different health status adjusted TME than another local practice group, even though both belong to the same provider system.

Below, we compare the medical spending of practice groups that operate in the same geography. We compare spending within a geographic area for two reasons. First, providers in the same geographic area are located near the same secondary and tertiary centers to which they can refer their patients for care, and they can be expected to encounter similar business pressures in terms of physician recruitment, real estate expenses, and the like. Analyzing the TME of

⁴⁸ For the health plan, this includes claims-based and non-claims based payments to providers; for the member, this includes the cost-sharing amounts that members pay providers, including copayments, deductibles, and coinsurance.

⁴⁹ Health plans do not usually attribute the TME of PPO members to providers in analyzing provider TME, as providers may not have the same level of direction over members in products that do not require the member to consult with and obtain referrals from the provider.

providers in the same locality sheds light on whether, despite these similarities, these providers are associated with significantly differing health status adjusted TME. Second, all three major health plans negotiate risk budgets based on a provider's historic TME. To the extent two providers in the same locality have differing TME, we can expect their risk budgets to differ as well. Variations in TME, or in underlying risk budgets, may result in cost escalation if patients gravitate to the higher-paid providers.⁵⁰

We examined the 2011 TME of local practice groups across the state. We excluded from our analysis any TME figure that was calculated on fewer than 10,000 member months. For purposes of this analysis, we grouped local practice groups in the same area together and compared their respective TME. We saw the same pattern repeated from region to region: there is significant variation in health status adjusted TME within a region, as well as across the state as a whole. For illustrative purposes, we present data from one major health plan showing variation in TME for several geographic areas in eastern Massachusetts (Bristol County, Merrimack Valley, Metro-North, Metro-West, North Shore, and South Shore⁵¹).

Our intent is not to provide an exhaustive catalogue of geographic areas in the Commonwealth, nor to engage in a market analysis for antitrust purposes.⁵² Instead, based on data annually reported to CHIA, we believe the following provides useful insight into how providers in different geographies are performing. We present a snapshot of the different levels of medical spending associated with different practice groups and a sense of the potential savings if patients were to select more efficient providers. Under payment reform, as global budgets are based on a provider's historic TME, the variation shown below also indicates that different levels of resources may be available for the care of patients in the same geography.

The following map shows variation in health status adjusted provider TME for several different geographies. Each provider is represented by a colored bar, and the height of the bar reflects the provider's 2011 TME. Comparing the regions shown in this map indicates:

- There are high TME and low TME providers in each geographic area. The range in TME from the lowest-spending to highest-spending provider in a given region varies from \$30 PMPM to more than \$100 PMPM;

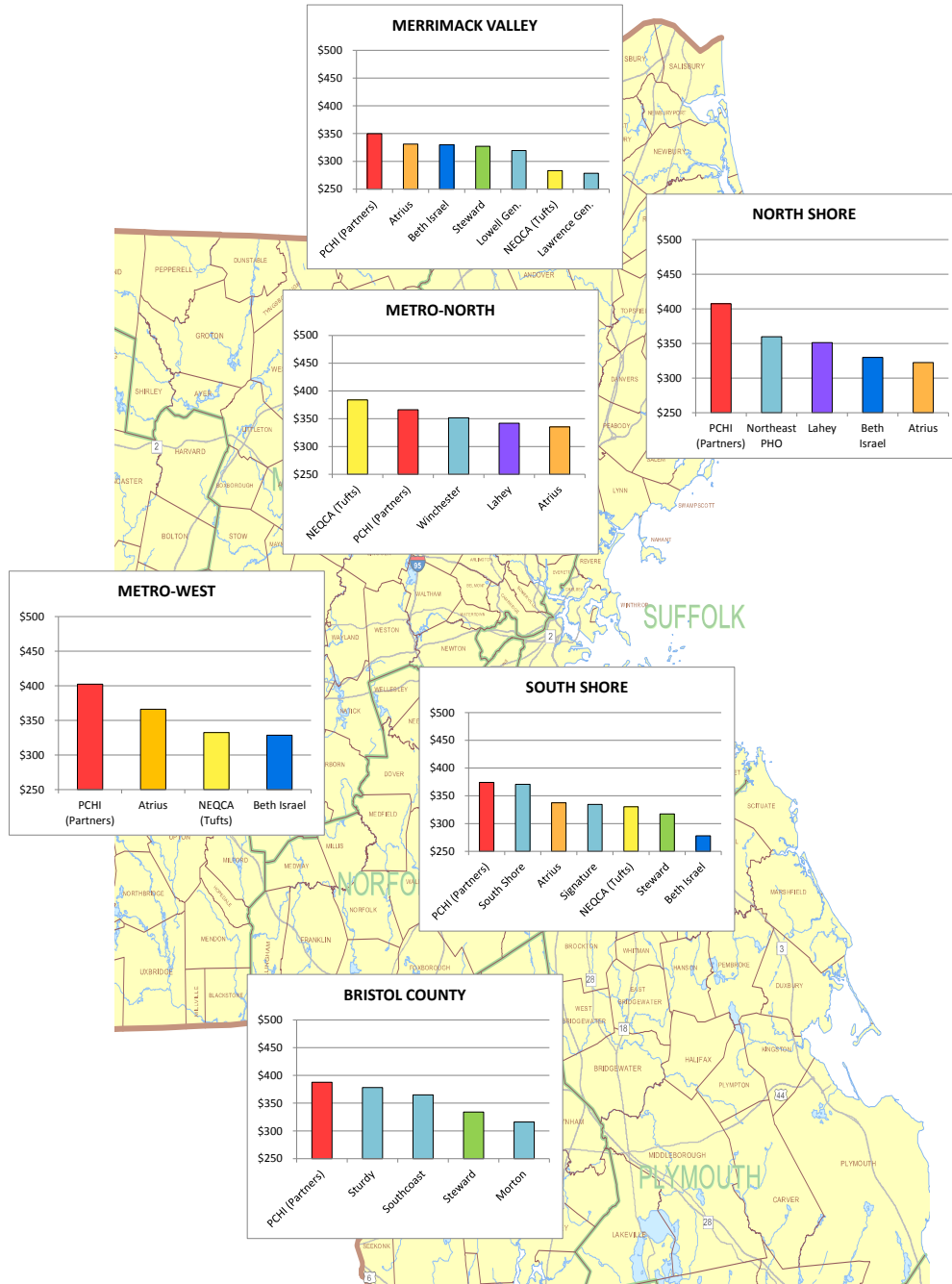
⁵⁰ Note a higher budget does not necessarily mean more is spent on direct patient care. For example, the result of a higher budget may be that the provider receives a higher surplus payment from the health plan. Nor does a higher budget mean better quality care. As well documented in the AGO's 2010 and 2011 Reports, higher payments have not reflected higher quality care.

⁵¹ Examples of towns we included in each region: Attleboro, Dartmouth, Fall River, New Bedford, Taunton (Bristol County); Chelmsford, Lawrence, Lowell, Methuen (Merrimack Valley); Burlington, Medford, Melrose, Wakefield, Wilmington, Winchester, Woburn (Metro-North); Dedham, Framingham, Marlborough, Natick, Needham, Newton, Northborough, Southborough, Wellesley, Westborough (Metro-West); Amesbury, Beverly, Danvers, Gloucester, Hamilton, Ipswich, Lynn, Lynnfield, Merrimac, Peabody, Salem, Wenham (North Shore); Abington, Braintree, Bridgewater, Brockton, East Bridgewater, Easton, Halifax, Hingham, Holbrook, Hyde Park, Kingston, Middleborough, Milton, Norwell, Norwood, Quincy, Plymouth Weymouth, Whitman (South Shore). We grouped these towns into regions for data reporting purposes only.

⁵² None of the analyses in this Report constitutes a market analysis for antitrust purposes.

- For provider systems operating in multiple geographies, there is significant TME variation across the local practice groups constituting one system, with variation usually exceeding \$40 PMPM in each system across the regions shown;
- TME appears to be comparatively high or low for different geographic regions. For example, for this health plan, the average TME of providers in Metro-West appears to be higher than the average TME of providers in the Merrimack Valley.

Variation in A Major Health Plan’s Provider Group TME by Region (2011)



Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D, § 8

The following tables show, for each of the three major health plans, variation in the local TME of individual provider systems that operate in multiple geographies.⁵³ From health plan to health plan, there is also variation in how costly a given local practice group is relative to other practice groups in the area. For example, at BCBS, Atrius’s Boston practice groups have higher TME than the other Boston practice groups shown. By contrast, at HPHC, Atrius’s same Boston practice groups have TME that is on par or lower than the TME of other Boston providers shown.⁵⁴

Provider System TME by Region (2011)

| BCBS | Atrius Health | Beth Israel Deac. PO | Lahey Clinic | NEQCA | PCHI (Partners) | Steward |
|------------------------|----------------------|-----------------------------|---------------------|--------------|------------------------|----------------|
| Boston | \$503 | * | * | \$466 | \$499 | \$458 |
| Bristol County | * | * | * | \$490 | \$427 | \$505 |
| Cambridge/Arlington | \$503 | * | * | * | \$444 | * |
| Cape Cod | * | * | * | * | * | \$442 |
| Merrimack Valley | \$503 | * | * | \$420 | \$432 | \$420 |
| Metro-North | \$503 | * | \$423 | \$473 | * | * |
| Metro-West | \$540 | * | * | \$447 | \$464 | * |
| North Shore | \$503 | * | * | * | \$445 | * |
| Route Two | \$503 | * | * | * | \$489 | * |
| South Shore | \$487 | * | * | \$458 | \$463 | \$444 |
| Other | * | \$424 | * | \$422 | \$435 | \$451 |
| System-Wide TME | \$508 | \$424 | \$423 | \$459 | \$464 | \$455 |

| HPHC | Atrius Health | Beth Israel Deac. PO | Lahey Clinic | NEQCA | PCHI (Partners) | Steward |
|------------------------|----------------------|-----------------------------|---------------------|--------------|------------------------|----------------|
| Boston | \$401 | * | * | \$400 | \$461 | \$401 |
| Bristol County | * | * | * | * | \$413 | \$412 |
| Cambridge/Arlington | \$427 | * | * | * | \$416 | * |
| Cape Cod | * | * | * | * | * | \$484 |
| Merrimack Valley | \$461 | * | * | * | \$445 | \$406 |
| Metro-North | \$430 | * | \$442 | \$412 | \$441 | * |
| Metro-West | \$413 | * | * | * | \$449 | * |
| North Shore | \$406 | * | * | * | \$454 | * |
| Route Two | \$511 | * | * | * | \$458 | * |
| South Shore | \$422 | * | * | * | \$446 | \$380 |
| Other | * | \$422 | * | \$391 | * | \$358 |
| System-Wide TME | \$419 | \$422 | \$442 | \$399 | \$449 | \$423 |
| THP | Atrius | Beth Israel | Lahey | NEQCA | PCHI | Steward |

⁵³ Examples of towns included in each of the additional regions shown in these tables: Boston, Dorchester, Watertown, West Roxbury (Boston); Arlington, Belmont, Cambridge, Everett, Somerville (Cambridge/Arlington); Brewster, Falmouth, Hyannis, Mashpee, West Yarmouth (Cape Cod); Acton, Ayer, Concord, Harvard, Westford (Route Two).

⁵⁴ Across health plans, we compare whether a given practice group tends to be higher cost, lower cost, or on par with other area providers. However, because of differences in how health plans calculate health status scores, we caution against comparing specific PMPM values across health plans.

| | Health | Deac. PO | Clinic | (Partners) | | |
|------------------------|---------------|-----------------|---------------|-------------------|--------------|--------------|
| Boston | \$313 | \$355 | * | \$350 | \$417 | \$332 |
| Bristol County | * | * | * | * | \$388 | \$334 |
| Cambridge/Arlington | \$362 | * | * | * | \$337 | * |
| Cape Cod | * | \$388 | * | \$383 | * | \$391 |
| Merrimack Valley | \$331 | \$330 | * | \$283 | \$350 | \$327 |
| Metro-North | \$335 | * | \$342 | \$384 | \$366 | * |
| Metro-West | \$366 | \$329 | * | \$332 | \$402 | * |
| North Shore | \$322 | \$330 | \$351 | * | \$407 | * |
| Route Two | \$368 | * | * | * | \$407 | \$257 |
| South Shore | \$337 | \$278 | * | \$330 | \$374 | \$317 |
| Other | * | * | \$336 | * | * | \$312 |
| System-Wide TME | \$343 | \$346 | \$344 | \$337 | \$395 | \$339 |

NOTES

(1) An asterisk (*) denotes data that is not available because of how the health plan tracks and reported data to the AGO, or because the provider system does not have local practice groups located in the region.

Statewide variation in health status adjusted provider TME has been well documented in our 2010 and 2011 Reports, as well as more recent CHIA reports. This first examination of differences in provider TME by region highlights (i) significant unexplained variation in provider TME within separate geographic areas and (ii) significant unexplained variation in the local TME of individual provider systems that operate in multiple geographies. These preliminary findings raise important questions that merit further analysis, including: the implications of significant variation in provider TME within each region for efforts to control costs and develop fair and reasonable risk budgets; whether differences in levels of medical spending for patients of comparable health are equitable or prudent; the implications of regional variations in TME for purchaser options in different regions; and the factors underlying significant differences in local practice group efficiency within the same provider system. Monitoring regional differences in TME across health plans and for provider systems that operate in multiple geographies may shed light on potential cross-subsidizations or resource distribution inequities that are in tension with efforts to align health care costs with value.

C. Growth in Prices Is Still the Primary Cost Driver for Each Major Health Plan

Data from the three largest commercial health plans in Massachusetts shows that growth in prices for medical care continued to drive overall increases in medical spending from 2009 to 2011.⁵⁵ This finding is consistent with DHCFP’s finding that, from 2008 to 2009, price growth

⁵⁵ Health plans track the growth of allowed medical claims and other payments to providers to determine the amount of spending growth due to increases in unit price, as compared to changes in utilization, provider mix, service mix, demographics, benefit design, or other factors.

was the principal driver of health care spending increases in Massachusetts.⁵⁶ It is also consistent with national trends.⁵⁷

In general, for each of the three major health plans, total medical spending continued to increase from 2009 to 2011, but at a lower rate each year. Although prices similarly increased at a lower rate each year from 2009 to 2011, they remained the primary driver of increases in medical spending. For example, at BCBS, total medical spending increased each year from 2009 to 2011. More than 50% of that increased spending resulted from price growth each year.

In contrast to continued price increases, utilization of medical services decreased for at least two of the three major health plans from 2009 to 2011. For example, at THP, utilization decreased by 1% from 2009 to 2010, and again by 2.2% from 2010 to 2011.

We anticipate that CHIA will continue to monitor and report on trends in health care spending in Massachusetts. It is important that the Commonwealth continue to analyze and report on all aspects of provider payments, including how providers are being paid, how much they are being paid, and whether those payments are tied to value.

D. Health Plan Product Designs Affect Risk Selection, Total Medical Spending, and Care Management

This section examines the cost and quality performance of different health plan product designs that purchasers/consumers are increasingly selecting.⁵⁸ We examined products for which we have performance data of varying levels of maturity. For example, since the growth in tiered and limited network products is quite recent (many of the currently available tiered/limited network products were only introduced in the last one to three years), data on the performance of such products still needs to mature. For other product trends, like the well-documented growth in high cost-sharing products, we have more mature performance data.

Our preliminary findings indicate that product and benefit design influence consumer choices in several important ways, each of which impacts TME and merits further analysis. These initial findings demonstrate the importance of rigorous and standardized analysis of product performance over time, so we can better understand how product design may be used as an effective tool for improving quality and controlling costs. We organize our findings on the impact of product and benefit design as follows: (1) differences in the health status of members enrolled in different products; (2) the TME and utilization performance of different products; and (3) the intersection of product design and population care management under risk contracts.

1. Product Design Affects Risk Selection: Healthier Consumers Appear to Be Attracted to Certain Products

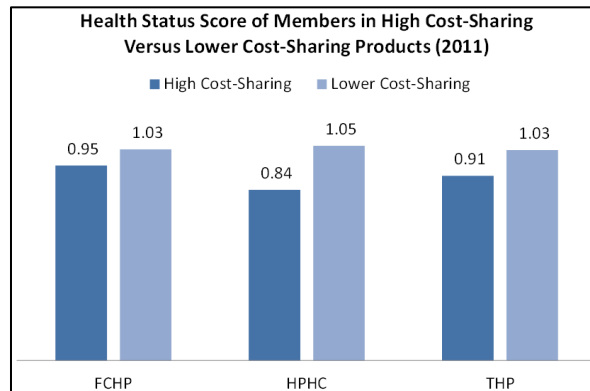
⁵⁶ CHIA PROVIDER PRICE VARIATION NOV. 2012, *supra* note 8, at 5 (from 2008 to 2009, unit price growth accounted for more than 85% of the 7.3% increase in health care spending for inpatient services; for physician and other professional services, unit price growth accounted for nearly 90% of the 5.5% increase in spending).

⁵⁷ See, e.g., HEALTH CARE COST INSTITUTE, 2011 HEALTH CARE COST & UTILIZATION REPORT (Sept 2012), available at http://www.healthcostinstitute.org/files/HCCI_HCCUR2011.pdf.

⁵⁸ See Part I for a detailed discussion of trends in member enrollment in different products.

A threshold question in analyzing the cost and quality performance of different insurance products, and their implications for population care management, is determining whether certain products tend to attract healthier members. This question is important for at least two reasons. First, in analyzing the TME performance of different products, it is important to know whether a product is associated with lower medical spending simply because it attracts healthier members, or whether it has lower TME *even after taking into account health status*. It is possible to design a product that has below-average TME simply because it attracts those members in a risk pool who are of above-average health, and thus already consume fewer health care resources. It would be a different matter to design an insurance product that incents underlying changes in consumer behavior – for example, an increase in preventive services or an increase in care at more efficient providers – that result in lower TME even after taking into account health status. Second, for purposes of population care management, it is important to understand whether different product designs are associated with members of different health status. This has implications for how risk is pooled, distributed, and paid for across our health care market.

We reviewed the health status (also called “risk profile”) of members enrolled in two types of products that have grown in recent years: high cost-sharing and tiered/limited network products. The next chart shows that at FCHP, HPHC, and THP, members enrolled in high cost-sharing products had a health status score in 2011 that was on average eight to 21 points lower than members enrolled in the health plan’s other products (showing that members in the high cost-sharing products were on average younger and/or healthier). BCBS studied similar cohorts and found that in 2010, members in high cost-sharing products (defined by BCBS as products with at least a \$500 individual deductible) had an average health status score about 12 points lower than those in “first dollar coverage” products (products with minimal cost-sharing).



NOTES

- (1) High Cost-Sharing defined as any product in which an individual deductible or copayment of \$1,000 or more may apply to any in-network benefit at any tier level.
- (2) Lower Cost-Sharing defined as any product that is not a High Cost-Sharing product.
- (3) FCHP data reflects fully-insured and self-insured HMO members. HPHC and THP data reflects fully-insured and self-insured HMO and PPO members.

Regarding tiered and limited network products, we received information from BCBS regarding the health status of members in its Options Tiered Network, available since late 2008. In comparing members enrolled in Options versus members who were not over a 30-month period, BCBS found no material differences in health status between the two populations. We also reviewed information on limited network products from the health plan with the most experience offering such products. In 2011, members enrolled in FCHP’s Direct Care limited

network, first introduced in 2002, had an average health status score that was seven points lower than the average score of members enrolled in FCHP's broader network products.

Our initial findings indicate consistent health status differences for some product designs (e.g., for all four major health plans, high cost-sharing products appear to attract healthier members). For other product/benefit designs, such as BCBS's Options Tiered Network, we have initial information indicating no material differences in health status. Market participants should consistently track and report on the risk profile of different product designs, both to promote products that result in sustainable cost savings, and to monitor the distribution of and payment for risk within our health care market.

2. Product Design Affects TME: Certain Products Appear to Be Associated with Lower Medical Spending on a Health Status Adjusted Basis

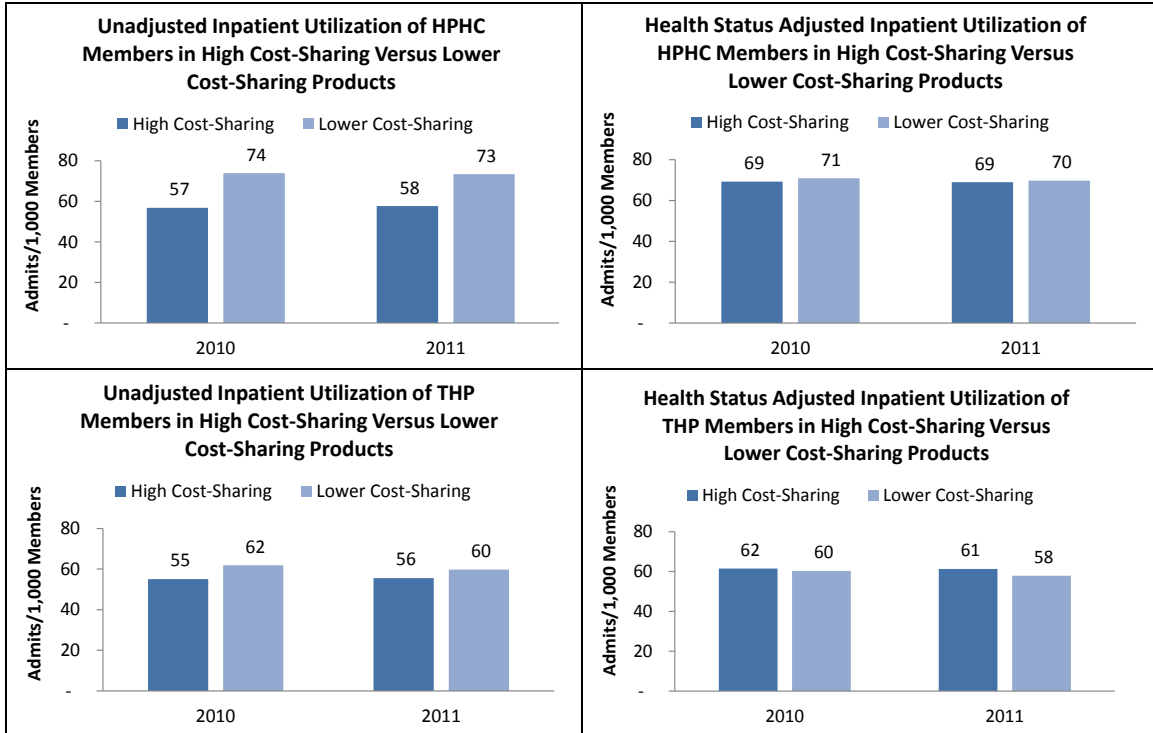
In this section, we continue to examine high cost-sharing and tiered/limited network products, focusing on their cost and quality performance.

a. High Cost-Sharing Products

In 2011, BCBS conducted research on its "consumer driven health products" ("CDHP"), which it defined as products with a \$500, \$1,000, or \$2,000 deductible. Consistent with other reported data, this research indicated that membership in CDHP at BCBS had climbed significantly in recent years. The study compared members enrolled in CDHP with those enrolled in plans with minimal cost-sharing (i.e., "first dollar coverage" or "FDC") to assess whether CDHP provide cost savings. The study examined the utilization rates and TME associated with both populations, which consisted of fully-insured and self-insured members who were continuously eligible from 2008 to 2010.

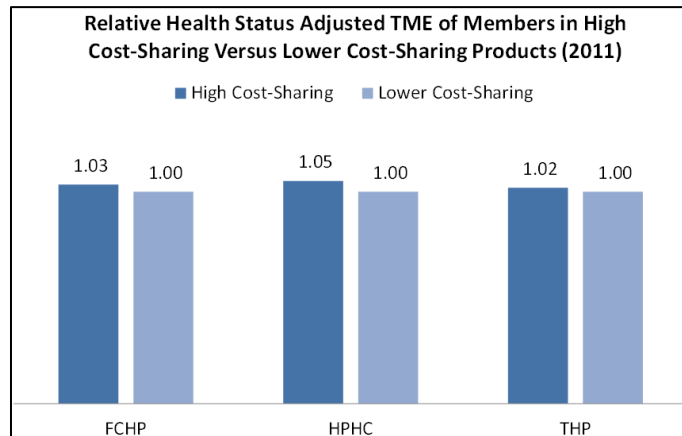
The study found that in the first year (2009), the health status adjusted TME of CDHP members was about 2% lower than the health status adjusted TME of FDC members, and in the second year (2010), it was about 0.9% lower. The study also indicated that overall utilization by CDHP members decreased by 1% to 5% over the two-year period (reflecting a decrease in use of hospital and other services, but including an increase in use of preventive services and generic prescriptions). The study indicated that, consistent with national studies, CDHP appear to provide cost savings due to behavior changes, including lower utilization of non-preventive services, greater use of preventive services, and greater usage of generic prescriptions.

The next set of charts examines 2010 and 2011 data from HPHC and THP on inpatient utilization for members in high cost-sharing products versus lower cost-sharing products. For HPHC, the chart on the left shows that, prior to health status adjustment, inpatient utilization for high cost-sharing products appears to be lower than for lower cost-sharing products. However, once adjusted for the fact that members in high cost-sharing products are healthier, utilization rates, shown in the chart on the right, appear very similar in both cohorts. The preliminary data for THP is consistent with the HPHC data.



In contrast to BCBS’s initial study, this data indicates that on a health status adjusted basis, high cost-sharing products at HPHC and THP have not been associated with reduced utilization. Note that the HPHC and THP member populations shown above were not necessarily the same over the two-year period (i.e., the members tracked in 2010 are not necessarily the same as those tracked in 2011). For these and other reasons, the above charts should be considered preliminary findings that raise important questions for future review by health plans and other market participants.

The following chart presents the difference in health status adjusted TME for members in high cost-sharing products versus lower cost-sharing products at three major health plans in 2011. For this snapshot in 2011, the chart shows that health status adjusted TME at these health plans (shown on a relative basis) was in fact higher for high cost-sharing products than for lower cost-sharing products. Thus, while unadjusted TME for high cost-sharing products may be lower, once adjusted for health status – similar to the inpatient utilization rates shown above – anticipated cost savings do not appear to bear out. This remains a subject ripe for further analysis.



b. Tiered Network Products

In 2012, BCBS conducted an initial study on whether its Options Tiered Network has resulted in cost savings. The Options Tiered Network was launched in late 2008 and groups hospitals and physicians into three tiers. Each tier is associated with a different level of member cost-sharing. For example, the tier that BCBS calls “Enhanced” has the lowest member cost-sharing, to encourage members to use the higher quality/lower cost providers in this tier. Not all services are tiered (e.g., emergency services are never tiered). Within non-emergent services, inpatient admissions, outpatient surgery, high-technology radiology, and primary care provider services are tiered, while laboratory/pathology services and general radiology are not.

The study compared fully-insured and self-insured members enrolled in an Options product with those who were not, focusing on a 30 month period from late 2008 to mid-2011. For both populations, BCBS examined rates of utilization of services, and site of care (whether Options members sought care from providers in the “Enhanced” tier more often than non-Options members). The study examined both tiered and non-tiered services, to assess whether Options members experienced a “halo effect” for non-tiered services (i.e., even for services for which Options does not differentiate cost-sharing, did members nonetheless develop the habit of using providers in the “Enhanced” tier?).

The study’s findings indicate that Options resulted in savings from an overall decrease in utilization and from a shift to use of less costly “Enhanced” providers. After taking into account differences in health status, utilization for Options members appeared to decrease for both tiered and non-tiered services. Non-Options members did not appear to experience the same levels of utilization reduction (and, for certain services, like inpatient admissions and laboratory/pathology, their utilization appeared to increase). BCBS estimated that the lower utilization experienced by Options members compared to non-Options members (which is not explained by health status) resulted in 10.5% to 14% in savings over the 30 month study period.⁵⁹

The study also observed a shift of utilization of services to the Enhanced Tier, with usage of “Enhanced” providers increasing and usage of providers in the other tiers decreasing. Non-Options members did not appear to experience the same increased use of Enhanced providers; they appeared to experience a slight increase in use of Enhanced providers for certain services, but none of these increases was as large as the increases that Options members experienced. In addition, for non-Options members, usage of Enhanced providers for outpatient surgery decreased considerably. The study estimated that the savings from Options members shifting more strongly to Enhanced providers resulted in 0.5% to 1% in premium savings over the study period.

BCBS identified several next steps in evaluating the performance of tiered network products, including:

1. Evaluating results separately for fully-insured versus self-insured members.

⁵⁹ In discussions between BCBS actuaries and the AGO’s own experts, both found the magnitude of decreased utilization for Options members compared to non-Options members to be puzzling. A question for future study is whether the utilization decrease is sustainable, or whether, for example, Options members were still getting accustomed to the nature of the Options product design, which delayed them in using their benefits.

2. Conducting a “multidimensional” analysis that considers the effects of multiple elements of product or benefit design (e.g., the impact of a tiered network that also features a deductible).
3. Developing a longitudinal model to perform similar studies on additional product families over time.

These are timely suggestions for better tracking and understanding the impact of product design on health care costs and quality. The directional findings in this section underscore that product and benefit design can have important effects on utilization, site of care, and thus total medical spending. Market participants, including the state, should develop systems to more consistently and comprehensively measure the performance of different product designs in improving quality and controlling costs.

c. Additional Measures of Performance of Different Product Designs

Before we turn to the intersection of product/benefit design with payment arrangements, we provide a brief overview of some of our findings regarding the quality performance of different product designs, to highlight important areas for further analysis. We received data from two sources, the Commonwealth Health Connector and FCHP, regarding member satisfaction associated with limited network products. Although members enrolled in limited network products could have real or perceived concerns regarding access to care, the limited experience in Massachusetts to date does not appear to bear out those concerns. Enrollees in CommonwealthCare, the state-subsidized health insurance program for low-income residents, appear more satisfied with more limited network plans.⁶⁰ This surprising finding might be explained by differences in other aspects of the health plans, or by other factors. For example, the limited network plans may offer other amenities, guidance, or communications that overcome any negative impression of the fact that the network is narrower than the network available through other health insurance products.

In 2012, the commercial health plan in Massachusetts with the most experience developing limited network products compared the satisfaction of its members in such products with those in broader network products. FCHP found no notable differences in measures of member satisfaction between members in limited network products and those in more traditional products. FCHP’s data also suggests that the quality of care in the limited network products was at least comparable to, if not slightly better than, quality of care in the more traditional products.⁶¹ Taken together, the above findings indicate the importance of continued analysis to monitor how product designs affect health care quality, access, and consumer satisfaction.

⁶⁰ The Connector Authority examined patient satisfaction across five health plans offered by CommonwealthCare, each of which limits access to inpatient services at certain hospitals to varying degrees. The survey data showed that members in more restricted limited network plans were more satisfied with the Commonwealth Care program overall, the choice of health plans available, the range of services covered, and the quality of care available under their plan. On the ratings of choice of doctors and other providers available in the plan, members also rated the more limited plans higher, though that trend was weak.

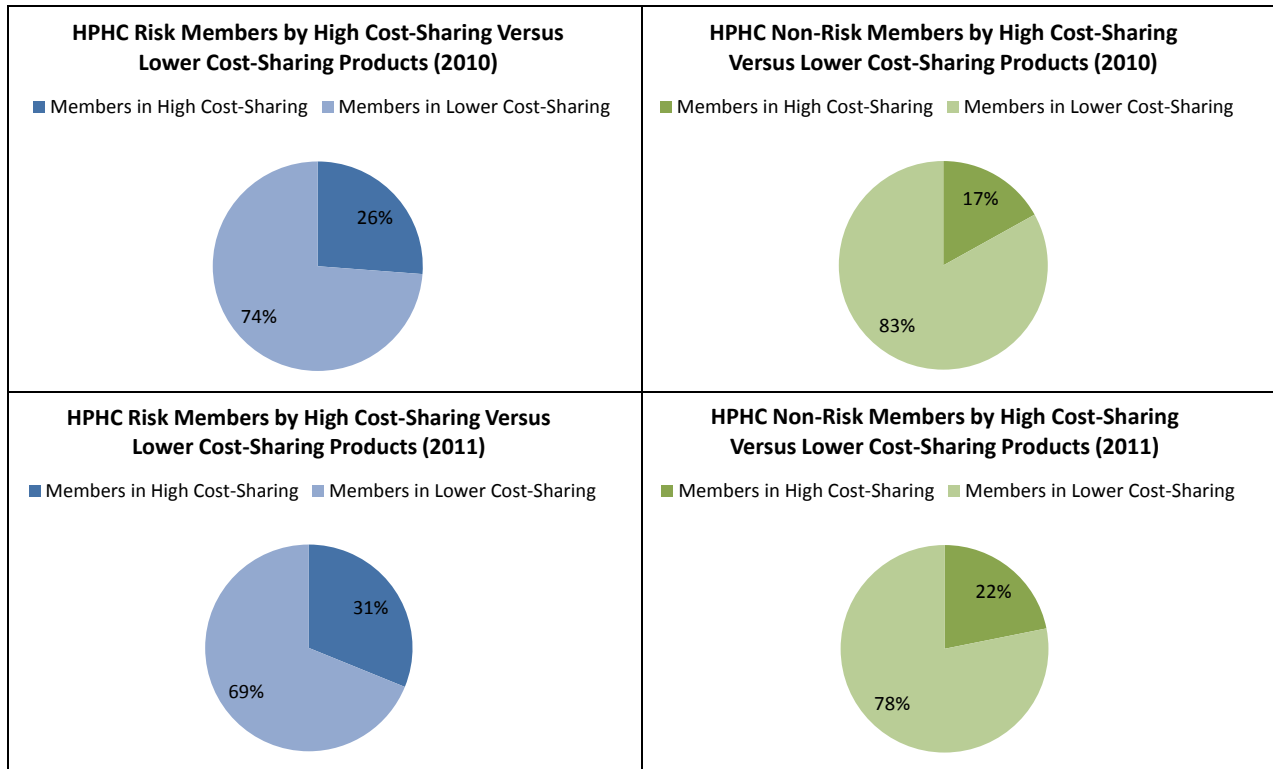
⁶¹ For example, those in the limited network were more likely to receive their recommended flu shot in one of the two years surveyed.

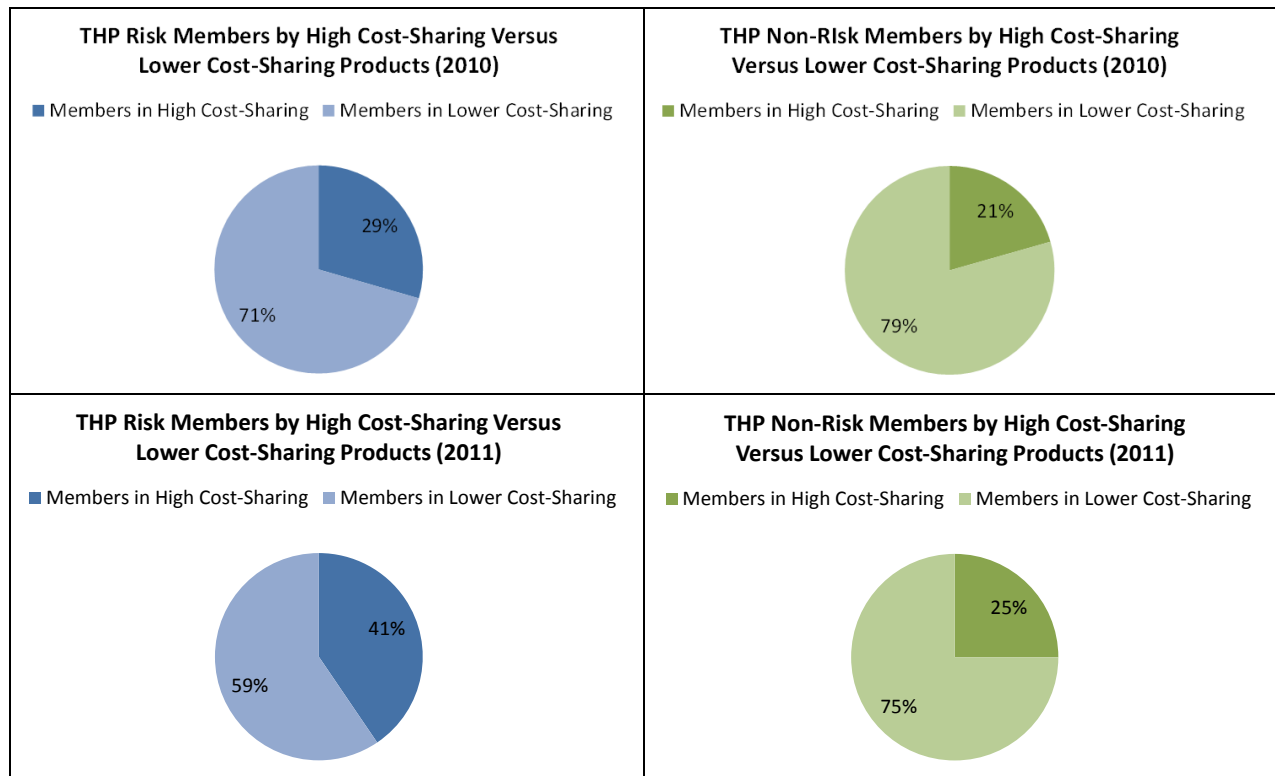
3. Product Design Should Be Considered in Population Care Management

The goal of global risk payments is to encourage providers to manage the total cost and quality of care for a patient population over time. The premises are that global care will be better coordinated, higher quality, and ultimately lower cost, and that risk providers will appropriately consider both costs and quality in making care decisions (e.g., by referring to less expensive specialists and hospitals). As explored in the preceding sections, product and benefit design play a potentially important role in influencing patient behavior in consuming health care services, and can thus materially impact health care costs and quality. Providers – especially those financially at risk for the cost and quality of populations in their care – should have detailed, timely information on the product and benefit mix of those populations. In this section, we present examples of how product and benefit mix raise important questions for population care management.

a. Differences in Product/Benefit Mix of Members Cared for through Risk Contracts

Data we received this year shows that there are differences in the product and benefit mix of members cared for through risk contracts compared to members who are not. For example, below, we present charts for two major health plans showing 2010 and 2011 data. Each chart categorizes the health plan’s members as those who are cared for through risk contracts and those who are not. Within each category (risk and non-risk), the charts show the proportion (mix) of members enrolled in high cost-sharing products versus lower cost-sharing products. The results are the same for both health plans: members in risk contracts are enrolled in greater proportions in high cost-sharing products, compared to members not in risk contracts (i.e., the dark blue slice of the pie charts on the left is consistently larger than the dark green slice of the pie charts on the right). At both plans, this difference persists or grows from 2010 to 2011.



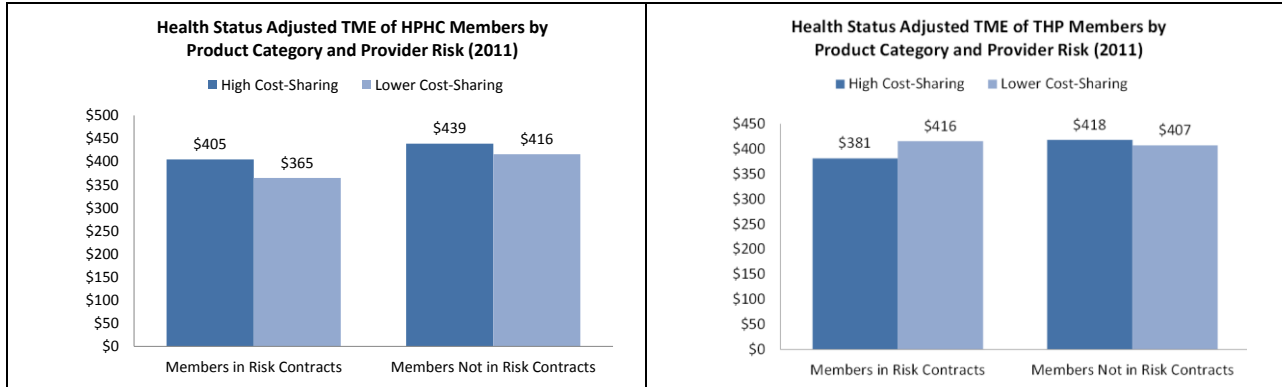


Providers should have access to this type of information on the product and benefit mix of their members over time. Tracking changes in the mix of products and benefit levels in a risk pool over time is important because, as reflected in Part II.D.2 above, differences in the level and type of cost-sharing that members experience can influence how often they seek care, where they seek care, and hence their total medical spending. Shifts in product and benefit mix, like the recent shift to high cost-sharing products, can also affect how consumers utilize certain types of services (e.g., preventive) and how effective providers are in coordinating care. These shifts thus have potentially significant implications for providers, particularly those that manage care under risk contracts.

For a risk provider seeking to increase its members' usage of preventive services over time, it would be important to know if that member pool experienced a significant change in product or benefit mix from one year to the next. This would enable the provider to more accurately assess and calibrate its own performance in improving the quality and controlling the cost of care for that member population. For example, if from one year to the next, a significant proportion of a provider's risk population shifts from tiered/limited network products to un-tiered/broad network products, and correspondingly experiences an increase in TME not explained by health status, it would be important for the provider to be aware of that change in product/benefit mix before concluding that its own care coordination and cost control efforts were failing. It is possible in that scenario that the provider's own efforts to lower costs for its risk population were working at cross-purposes to, or outweighed by, the impact of change in product/benefit design. This is why multidimensional analysis of the relative impact of product design, benefit design, and payment arrangements on TME is critical as we seek sustainably to control costs and improve quality.

b. TME Differences by Product Category and Provider Risk

The final set of charts in this section show, for HPHC and THP, the health status adjusted TME of member populations enrolled in different product designs (high cost-sharing versus lower cost-sharing) – both for populations cared for through risk contracts, and those that are not.



These charts raise questions that merit further analysis. For example, there is no clear pattern of high cost-sharing products resulting in lower TME. A common goal of high-cost sharing products is to influence consumer behavior by making health care costs more transparent to the consumer and to give the consumer a stake in the costs of consuming medical services. However, for HPHC, after risk adjustment, the TME for members in high cost-sharing plans is higher than the TME for members in lower cost-sharing plans. For THP, members in a high cost-sharing product who are also cared for under a risk contract are associated with lower TME. More analysis is required to ascertain whether this lower TME is driven more by risk providers managing care efficiently or by plan design influencing consumer behavior.

Health plans have invested heavily in the design and implementation of new products and payment arrangements, but they have not consistently analyzed how these initiatives influence medical spending trends. To help ensure these investments generate returns, health plans should develop more rigorous tools and analytics to monitor the performance of these initiatives. For example, health plans should regularly report and analyze membership, health status, utilization, and TME data for different product designs and payment arrangements. They should report results comparably for various lines of business over time, to allow for cross-sectional and longitudinal analysis. With more consistent and interoperable reporting, health plans will be able to enhance the statistical credibility of their analyses by aggregating results over larger populations. These types of analyses will provide insight into market trends and their potential impact on state health care cost growth, and they can also indicate whether strategies are working in tandem or at cross-purposes with one another. While these types of analyses require longitudinal review and can be data intensive, they are essential to analyzing and managing cost trends in a holistic manner.

The decisions of health plans in negotiating contracts with providers and designing products for purchasers have important implications for how providers deliver care and how purchasers obtain care. As the intermediary between purchasers and providers, health plans are central to improving system efficiency and to monitoring potential tensions between purchaser and provider incentives. In Part III, we examine trends in provider activities, including the

increased performance and insurance risk they are taking on through global payment arrangements, and their alignments in response to perceived market dynamics.

III. PROVIDERS

Providers represent the “supply” side of the health care market. In providing care, they compete for market share according to consumer demand, business considerations, market rules, and their health care mission, among other factors. Their conduct and choices in delivering care directly impact total medical spending, and are shaped by a number of considerations, including:

- The quality of their own performance in delivering health care (performance risk);
- Their capacity to manage the impact of broader population changes and other “exogenous” factors that affect their delivery of care (insurance risk); and
- Their ability to obtain market share and maximize revenues in a dynamic market environment (business risk).

In this section, we present findings related to each of these considerations, or risks, and highlight implications of provider conduct on the functioning of the health care market and total medical spending. First, we find that providers are increasingly taking on risk for their care delivery performance through global payment contracts that seek to hold them accountable for the total cost and quality of care for the populations they serve. While these global payment contracts seek to increase the level of performance risk to which providers are subject (compared to, for example, historically more modest pay for performance programs), they are being implemented with significant levels of complexity and variation. We need to better understand the significance of this variation and complexity in order to address whether effective contract provisions can be more equitably applied across all contracts in ways that support provider efforts to improve quality and control costs. Second, regarding insurance risk, we find that providers are being exposed to a range of “exogenous” factors that affect their delivery of care. These factors include changes in population demographics over time (e.g., the gradual aging of the Massachusetts population), over which providers have no control, but that materially impact their performance in delivering care. Current global payment arrangements do not consistently mitigate the transfer of insurance risk to providers. Finally, we identify reasons for the Commonwealth to more closely measure the impact of provider mergers and other alignments on efforts to control costs and improve quality. These alignments are shaped by considerations of business risk, not just the requirements of care coordination or risk contracting that many providers cite.

A. Providers Are Taking on Increased Performance Risk Under Complex Contracts

Providers are delivering care pursuant to contracts that vary by price, payment method and quality incentives, among other factors discussed in Part II.A above. We found that the number and complexity of payment arrangements under which providers are managing care is increasing. In particular, the number of providers managing patient care under risk contracts is

increasing. Risk contracts among BCBS, HPHC, THP, and CMS⁶² increased from approximately 19 in 2008 to 52 in 2012.⁶³ This increase coincides with renewed policy interest in global payment mechanisms.

Global payment models have evolved in recent years. The current risk contracting landscape reflects both historic and newer models. For example, currently, BCBS has risk contracts with 17 providers: nine AQC 1.0 providers, 7 AQC 2.0 providers and one non-AQC provider. Additionally, in 2012, CMS introduced two risk contracting models for Medicare FFS beneficiaries: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model.⁶⁴

Each of these global payment arrangements consists of complex terms and payment calculations. Variation in terms and calculations across risk contracts results from dozens of negotiations between individual health plans and providers of varying sophistication and clout. Inconsistent implementation of certain provisions tends to dilute the impact of any “best practices” that the market may identify for successfully incenting provider performance while managing the transfer of insurance risk to providers. These inconsistencies can result in diminished predictability and fairness for health plans and providers alike. Below we describe provisions of risk contracts that may materially impact providers and identify a subset of those provisions that, if more equitably applied, would better support the implementation of best practices in our collective efforts to control costs.

1. Risk Contracts Contain Extremely Complex Provisions

We examined commercial risk contracts effective from 2009 through 2012 from the three largest commercial health plans in Massachusetts, as well as CMS’s Pioneer ACO agreements. We found complexity within and across contracts, including significant inconsistencies in the terms, calculations, and methodologies associated with each risk contract.

The following is a list of provisions contained in risk contracts in Massachusetts that materially affect the value and potential performance of providers.

⁶² This value includes CMS Pioneer ACO and Medicare Shared Savings Plans. Medicare Advantage plans are not included because CMS contracts with health plans to administer those risk arrangements with providers.

⁶³ While overall commercial membership in risk contracts is decreasing for some health plans, the number of commercial risk contracts with providers is increasing significantly.

⁶⁴ Thirteen health systems whose service areas include Massachusetts participate in the MSSP (Physicians of Cape Cod ACO, LLC and Jordan Community ACO, Circle Health Alliance, LLC, Harbor Medical Associates, PC, Accountable Care Clinical Services P.C., Accountable Care Organization of New England, Cambridge Health Alliance, Cape Cod Health Network ACO, LLC, Collaborative Health ACO, Lahey Clinical Performance Accountable Performance Organization, LLC, Pioneer Valley Accountable Care, LLC, Southcoast Accountable Care Organization, LLC, Winchester Community ACO), and five Massachusetts health systems are Pioneer ACOs (Atrius Health, Beth Israel Deaconess Physician Organization, Mount Auburn Cambridge Independent Practice Association, Partners Healthcare System, and Steward Health Care System).

Common Risk Contracting Provisions

| | |
|--------------------------------------|--|
| Target Budget | <p>An initial target budget can be calculated in different ways. It may be negotiated based on the provider’s historic PMPM costs for members in its care, or it may be negotiated as a percent of the health plan’s premium for each of those members.</p> <p>Providers and health plans also negotiate how the target budget will be adjusted each year to incent performance improvement. Sometimes, the following year’s budget is set by establishing a fixed budget trend. Other times, the following year’s budget is pegged to a regional benchmark (i.e., adjusting the budget to reflect overall changes in health care costs across a specific geography).</p> |
| Capitated or FFS Payments | <p>While all risk contracts generally feature a global budget, the way health plans pay providers under that global budget varies. Health plans may pay providers a lump sum at the beginning of each month, based on the provider’s global budget. This is called a capitated payment. Alternatively, the health plan may continue to pay the provider on a claim by claim (FFS) basis. Annually, at time of settlement (or reconciliation), the health plan will compare the total FFS payments the provider received over the course of year to the total amount to which the provider is entitled based on its performance against its global budget. If the FFS payments the provider received over the course of the year exceed the amount to which the provider was entitled based on its performance against its global budget, the provider will owe the health plan a deficit payment. If the provider’s performance against its global budget entitles it to more money than it was paid over the course of the year on a FFS basis, the provider will receive a surplus payment from the health plan.</p> |
| Risk Share | <p>In Full Risk or Partial Risk arrangements, providers will share in any budget surplus or deficit with the health plan. Under Full Risk models, providers collect (or pay) 100% of any budget surplus or deficit. Under Partial Risk models, providers are responsible for a portion of any budget surplus or deficit, which varies by contract and may change based on provider quality performance.</p> <p>In Upside Only arrangements, providers may share in any budget surplus, but are not at risk for any portion of a budget deficit.</p> <p>Under any Full Risk, Partial Risk, or Upside Only arrangement, provider share of any surplus or deficit may be subject to a maximum PMPM amount (or “liability/surplus cap”).</p> |
| Services Included in the Risk Budget | <p>Providers may be at risk for only a subset of medical services. For services that are “carved out” of the budget, costs of those services are excluded from the calculation of the target budget, as well as the subsequent annual settlement of the cost of services received by risk members against the budget. Examples of services that we found carved out of risk budgets include behavioral health services, out of area services, and high cost drugs.</p> |
| Risk Population | <p>The member population for which a provider is at risk may vary across contracts. Typically, providers are at risk for members who have selected a PCP within that provider’s organization (i.e., members in HMO/POS products). Providers may be at risk only for fully-insured HMO/POS members, or they may be at risk for all of their HMO/POS members, both fully-insured and self-insured.</p> |

| | |
|-----------------------|--|
| Risk Adjustments | <p>Risk adjustments are adjustments made to the budget to mitigate the transfer of insurance risk to providers and account for factors outside a provider’s control (e.g., aging or increasing morbidity of a provider’s risk population). Those adjustments include, but are not limited to the following:</p> <p>A health status adjustment may be made to budgets to reflect changes in the level of sickness of a provider’s risk members from year to year. For example, if a provider’s population becomes significantly healthier (or less healthy) in the second year of a risk contract due to large healthy groups joining (or leaving) the provider’s risk membership, the provider may be unfairly rewarded (or penalized) for factors beyond its control without a health status adjustment.</p> <p>A mandated benefit adjustment may be made to reflect new benefits mandated by law that health plans must cover. For example, if the Commonwealth mandates that health plans must cover a group of services (e.g., hearing aids for children), a provider’s budget may be adjusted upward to reflect that increase in spending due to increased plan coverage.</p> <p>A unit price adjustment may be made to account for increases in the costs associated with the care of a provider’s risk members that are due to the health plan agreeing to increase the prices it pays to other providers (over which the risk provider has no control). For example, if Provider A’s risk members receive a portion of their care at Provider B, and the health plan raises Provider B’s prices, Provider A’s budget may be adjusted upward so that Provider A will not be penalized for Provider B’s increased rates.</p> |
| Risk Mitigation | <p>Payers may contractually mitigate a provider’s potential exposure to risk in several ways. First, payers may limit the transfer of risk to the provider by setting limits on risk exposure in the aggregate or by truncating single member claims outside a certain threshold in a year (e.g., risk for costs of caring for any individual capped at \$100,000). Second, payers may transfer risk to providers but then require providers to obtain individual stop loss insurance either from the payer or from a third party. Third, payers may require a certain level of financial reserves, a line of credit, or may impose a withhold from provider payments as a hedge against a potential budget deficit.</p> |
| Quality Incentives | <p>Provider risk arrangements, like other forms of provider contracts, may include monetary incentives for quality achievement. These quality incentives are based on a selection of quality measures, which usually varies from health plan to health plan, which providers must meet to earn payments for performance on those metrics.</p> |
| Supplemental Payments | <p>Provider risk arrangements, like other forms of provider contracts, may also include supplemental guaranteed payments. These supplemental payments may include, but are not limited to, medical management fees (MMF), infrastructure payments, and/or administrative fees.</p> |

Variation in each of these contract provisions may materially affect the potential compensation and the levels of risk exposure for providers. Certain Massachusetts providers have a long history of risk contracting, while others are new to the practice. The fair and consistent application of these provisions across providers may significantly impact whether individual provider groups are successful in managing risk.

Even within a single provider group, variation in implementing risk contracts may unnecessarily complicate the provider’s risk management practices. For example, one provider may simultaneously manage patient care under three risk contracts, two of which are partial risk

arrangements and one of which is an upside-only arrangement. Within these three contracts, this provider is at risk for two different sets of services, and its budgets are adjusted in three different ways. A second provider may manage patient care under two risk contracts. Under one risk contract, the provider shares in 70% of any surplus or 40% of any deficit limited to \$29 PMPM, after the budget is adjusted for any changes in mandated benefits, unit prices, and health status. Under the second risk contract, the provider shares in 42.5% of any budget surplus or deficit, limited to a \$15 PMPM liability/surplus cap after the budget is adjusted for health status (but not for changes in mandated benefits or unit prices). The provider's financial performance could prove very different under these two contracts.

At a minimum, variation in risk contracts complicates a provider's efforts to manage risk and achieve financial stability. Greater consistency in risk contracts and incentives would ease providers' administrative burden and promote predictability and effective planning. It may also improve fairness across contracts. Health plans and providers may each have views as to "best practices" for sharing risk and incentivizing efficient performance. Assuming these views have been developed, at best, they are then subject to multiple rounds of negotiations that have resulted in inconsistent and uncertain implementation of risk contracts. For providers and health plans with less clout, views on best practices can become particularly diluted, or entirely unrealized. The Commonwealth's market-based cost containment efforts, as well as the efforts of health plans, providers, and purchasers, would benefit from greater consistency and fairness in the implementation of risk contracts.

2. More Equitable Application of Certain Provisions of Risk Contracts Would Better Support Provider Efforts to Lower Costs and Improve Quality

Based on our examination, we found considerable variation in the implementation of certain risk contract provisions, and it is unclear how some of these provisions affect provider performance. Increased transparency of contractual provisions and their effects on provider performance would inform market participants' efforts to develop best practices, lower costs, and improve quality. For example, as HPC and DOI respectively conduct market impact reviews and monitor the transfer of insurance risk to providers, both would benefit from increased transparency around risk contract provisions and their effects. In addition, under Chapter 224 of the 2012 Acts, health plans must report to CHIA certain information concerning their alternative payment contracts.⁶⁵ This information includes negotiated budgets, measures of provider performance, the value of services carved out of budgets, individual stop loss budget allowances, and quality payments, among other items, that will increase transparency and understanding of these important provisions.⁶⁶

In our review of existing risk contracts, we identified at least three key provisions that could be more equitably applied across provider risk contracts: (1) implementation of quality incentives, (2) risk adjustments to budgets, and (3) approaches to risk mitigation. Risk adjustments and risk mitigation approaches are discussed more fully with reference to insurance risk in Part III.B below.

⁶⁵ See Part II.A, *supra* at 19.

⁶⁶ MASS. GEN. LAWS ch. 12C, § 10(d) (2012).

With respect to quality incentives, tying payment to value-based factors like quality performance is an important tool for improving market function and incenting providers to improve quality and reduce costs.⁶⁷ However, we found that each of the major health plans approaches quality incentives inconsistently across their provider contracts. Although health plans may reasonably approach quality incentives and measures in different ways, and even focus on certain measures for select providers but not others (who already perform well on those measures), payment for quality performance should be more consistent. For example, quality incentives are not available for all THP risk providers. For those providers who have negotiated quality payments, THP measures and pays for quality performance in inconsistent ways. On the other hand, as described in Part II.A.2 above, BCBS has a more consistent approach to measuring quality performance across contracts. Each of its AQC risk providers is incentivized for quality performance. In general, BCBS measures and calculates quality performance consistently across those AQC contracts. However, AQC quality payment rates and total payouts for equivalent quality achievement vary significantly by provider. Thus, a consistent formula for gauging quality nonetheless results in widely disparate results for providers, again attributable to multiple negotiations and the leverage of the negotiating parties.

B. Providers Are Taking on Increased Insurance Risk Without Consistent Mitigation by Health Plans

As discussed in our 2011 Report, global payment contracts that seek to increase providers' performance risk also generally increase the level of insurance risk to which providers are exposed.⁶⁸ This year, we continued our review of the transfer of insurance risk to providers and focused on three contractual provisions introduced above: risk share, risk adjustments, and risk mitigation approaches. We found that payers and providers address these types of provisions differently from contract to contract, exposing some providers to greater insurance risk. Reviewing differences in target budgets and negotiated trends may appear to be straightforward comparisons, like comparing FFS price variations, but the financial implications of target budgets depend heavily on interrelated factors of risk share (what happens to surpluses or deficits on the target budget), and risk adjustment and mitigation (what happens when exogenous factors present when the target budget was established change). The greater the risk share a provider takes on, the greater the need to counterbalance with health status adjustment and other forms of insurance risk mitigation to protect the provider from financial hardship caused by factors beyond its control (while keeping the provider at financial risk for factors under its control).

⁶⁷ Each health care provider facility, medical group, or provider group in the Commonwealth is required to report on a standard set of health care quality measures to be developed by the Commonwealth pursuant to Chapter 288 of the 2010 Acts and, later Chapter 224 of the 2012 Acts. MASS. GEN. LAWS ch. 12C, § 14 (2012). A Statewide Quality Advisory Committee was formed to develop and recommend quality measures for the Standard Quality Measure Set. In addition, Chapter 288 and Chapter 224 require payers to tier providers based on standard quality measure set (and by cost performance as measured by health status adjusted TME and relative prices). MASS. GEN. LAWS ch. 176J, § 11 (2012).

⁶⁸ See AGO 2011 REPORT, *supra* note 10, at 22-23; see also KELLY DEVERS & ROBERT BERENSON, CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES, 12 n.34 (Oct. 2009) (describing as a key challenge to provider risk contracting making providers accountable for performance risk without subjecting them to insurance risk).

Below, we survey the range of health plan and provider efforts to limit the level of insurance risk transferred to providers, which may also help minimize financial incentives for providers to avoid or limit the provision of care to higher cost individuals. We present two categories of approaches: (1) methods to adjust target budgets for exogenous factors not related to the provider’s historic trend; and (2) methods to mitigate or restrict providers’ exposure to extraordinary individual and/or aggregate claims experience. Based on our examination of commercial risk contracts as well as Medicare Pioneer ACO agreements, we found that current risk contracts neither consistently nor adequately limit the transfer of insurance risk to providers. We suggest how market participants, including the Commonwealth, can better monitor and limit the transfer of insurance risk to providers through DOI’s certification of risk bearing provider organizations.⁶⁹ Further, we recommend that health plans make available to providers information that would better enable providers to manage risks and coordinate care under all product lines.

1. Approaches to Adjust Target Budgets for Exogenous Factors Not Related to the Provider’s Historic Trend

One way to limit provider loss due to insurance risk is to adjust the provider’s risk budget to account for factors that impact the total cost of care for the provider’s risk population, but that are generally beyond the provider’s control. We identified several types of risk budget adjustments in payer-provider contracts, each of which is defined in the “Common Risk Contracting Provisions” in Part III.A.1:

- Health status adjustments
- Mandated benefits adjustments
- Unit price adjustments

Whether a given adjustment is included in a contract, and how the adjustment is calculated, is negotiable and varies across contracts. Focusing on the above three categories of risk budget adjustments, the table below shows which adjustments were present in the 2012 risk contracts for the three largest commercial health plans and for CMS’s Pioneer ACO agreement.

| ADJUSTMENTS PRESENT IN 2012 RISK CONTRACTS | | | | |
|---|-------------|-------------|------------|--------------------|
| | BCBS | HPHC | THP | CMS (P-ACO) |
| Health Status | Yes | Sometimes | Sometimes | No |
| Mandated Benefits | Sometimes | No | No | Yes |
| Unit Price | Sometimes | No | No | n/a |

Our examination focused in particular on health status adjustment. For 2012 risk arrangements, the three largest commercial health plans used DxCG to adjust budgets.⁷⁰ Measures of health status, including DxCG, are imperfect and thus do not fully reflect relative and absolute changes in the morbidity of the patient population cared for by risk providers over

⁶⁹ MASS. GEN. LAWS ch. 176T (2012).

⁷⁰ HPHC is transitioning from adjusting for demographics using its own proprietary Age/Sex factor to adjusting for health status with instead using DxCG. As described in its transcribed interview, HPHC intends to transition all of its risk providers whose budgets are adjusted with Age/Sex to being health status adjusted using DxCG.

time.⁷¹ This means that although health plans and providers adjust budgets based on changes to DxCG scores, those adjustments cannot fully reflect all of the changing health needs of the underlying population.

Even with these limitations on health status adjustment methods, there is general agreement that such methods are necessary to measure and track the health status of populations being served by provider groups. Notwithstanding this general agreement, not every provider's risk budget is adjusted for health status even for risk contracts with significant partial and full risk arrangements. Our examination indicates that some providers are reluctant to include a health status adjustment because (1) they have low confidence in health status adjustment methodologies, or (2) they believe such adjustments are unnecessary based on their historic experience with risk arrangements. The failure to include a health status adjustment provision exposes such providers to insurance risk factors that are part of the health plan's function and responsibility. As reviewed in our 2011 Report, many risk providers in Massachusetts have historically been higher paid and have cared for patient populations that are healthier than average.⁷² That historic experience of generous budgets and healthy populations is not a sound basis on which to proceed without consistent health status adjustment as risk contracts are implemented more widely.

Most health plans and CMS recognize the importance of health status adjustments but use different methodologies. CMS uses two different forms of adjustments. For the Medicare Shared Savings Program, CMS adjusts budgets for changes in health status based on the CMS-HCC (hierarchical condition category) model used in Medicare Advantage plans. For Pioneer ACO budgets, CMS adjusts yearly budgets based on the historical claims data of risk members, adjusted year to year, instead of using a health status adjustment tool.⁷³

In the commercial market, BCBS's approach to adjusting AQC 2.0 risk budgets provides a good example of health status adjustment. BCBS adjusts AQC 2.0 risk budgets based on changes in the health status of a provider's risk population, relative to the network. This approach appears to be reasoned, considering that AQC 2.0 budgets are adjusted yearly to reflect network trend. In other words, if a risk provider's budget is tied to changes in network trend, it appears reasonable to only adjust that provider's budget for changes in health status as compared to network changes in health status. BCBS's approach to adjusting AQC 1.0 budgets for health status does not appear to be as reasoned.

The use of inconsistent or insufficient health status adjustment methodologies can lead to significantly different upward or downward adjustments to risk budgets for equivalent changes in population health status. For example, in 2011, one major health plan used four different approaches to adjusting risk budgets, summarized in the following table:

⁷¹ See AGO 2011 REPORT, *supra* note 10, at 45; see also SOC'Y OF ACTUARIES, A COMPARATIVE ANALYSIS OF CLAIMS-BASED TOOLS FOR HEALTH RISK ASSESSMENT (2007), available at <http://www.soa.org/Files/Research/Projects/risk-assessmentc.pdf>.

⁷² See AGO 2011 REPORT, *supra* note 10, at 23 n.24, 45.

⁷³ See CTRS. FOR MEDICARE & MEDICAID INNOVATION, PIONEER ACO APPLICATION, available at <http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Application-Form.pdf>.

| Variation in a Major Health Plan’s Health Status Adjustment of 2011 Risk Budgets | | |
|--|--|--|
| | Description of Health Status Adjustment | Limitations |
| Method 1 | Provider Current Year DxCG Score - Provider Prior Year DxCG Score | 1-2% minimum/maximum upward budget adjustment 1% minimum downward budget adjustment, unlimited maximum downward budget adjustment |
| Method 2 | Provider Current Year DxCG Score - Provider Prior Year DxCG Score | 4% maximum upward budget adjustment |
| Method 3 | Provider Current Year DxCG Score / Provider Prior Year DxCG Score | n/a |
| Method 4 | Provider Current Year DxCG Score / Provider Prior Year DxCG Score | Unlimited downward adjustment relative to network |

The difference between a 2% maximum upward adjustment (Method 1) and a 4% maximum upward adjustment (Method 2) could mean significant dollars to a provider. Consider the following hypothetical: if Provider A has a budget of \$300 PMPM, and the health status of Provider A’s risk pool increases (i.e., gets worse) due to a large, healthy employer group leaving Provider A’s risk contract, Provider A’s budget could be adjusted a maximum of \$12 PMPM (or \$240,000 for 20,000 member months) under Method 1, and \$6 PMPM (or \$120,000 for 20,000 member months) under Method 2.

Differences in health status adjustments may result in significant differences in dollars added or subtracted from risk budgets for equivalent health status changes. Such differences are in tension with efforts to lower costs and improve quality since they are more reflective of negotiating clout than the best available measures for actual changes in the health status of providers’ risk populations. Health status adjustment methodologies should be evaluated by market participants and the government to determine best practices in mitigating the risk of exogenous changes in population health status being transferred to providers. Budgets should be adjusted through consistent methodologies to avoid excessive transfer of insurance risk.

2. Approaches to Mitigate Providers’ Exposure to Extraordinary Individual and/or Aggregate Claims Experience

In addition to risk budget adjustments, we reviewed other approaches to protecting providers against financial loss due to insurance risk. In general, the major commercial health plans and CMS evaluate a provider’s ability to bear financial risk in different ways, with varying considerations and requirements.⁷⁴ Major approaches to mitigating provider financial loss include: (1) claims truncation; (2) individual stop loss insurance policies; and (3) aggregate stop loss insurance policies.

Claims Truncation. One health plan excludes high-cost, or “outlier,” claims from some of its risk arrangements. Excluding outlier claims from budget calculations, also known as “claims truncation,” is an effective tool to protect providers from the risk of unusually high-cost

⁷⁴ See, e.g., DHCFP Hearing on Health Care Cost Trends (2012) (written testimony of BCBS, HPHC, and THP, Response to Exh. C, Q. 7), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

individuals in a given year. For example, if Provider A has negotiated a claims truncation threshold of \$150,000, then any yearly costs above \$150,000 for a single member will not be included in the total yearly costs of member care that are measured against Provider A's risk budget at time of settlement. The claims truncation threshold may vary based on the size of a provider's risk pool, resulting in lower thresholds for providers with fewer risk members. Beyond a certain threshold in a given year, the cost of caring for a very high cost patient relates more to the patient's intensive health care needs than to any provider's failure in care delivery performance. The use of claims truncation helps reduce a provider's exposure to unusual costs associated with a patient's intensive health care needs that are beyond the provider's control.

Individual Stop Loss Insurance. Instead of truncating claims, some health plans require providers to purchase individual stop loss insurance policies. Individual stop loss insurance policies insure providers against the yearly costs above an identified amount for any single patient.⁷⁵ Although similar to claims truncation, this approach increases administrative costs and effectively transfers insurance costs to providers over time. For example, if a provider files a claim under an individual stop loss policy for an expensive patient, the provider's premium the following year will increase due to that claim. In contrast, under the claims truncation approach, there is no increased premium or other penalty for patients whose cost of care exceeds the threshold.

Aggregate Stop Loss Insurance. Neither claims truncation nor individual stop loss insurance addresses the risk that aggregate stop loss insurance is designed to address. In fact, few providers purchase aggregate stop loss insurance policies.⁷⁶ Aggregate stop loss insurance is designed to smooth the impact of a large number of sub-catastrophic cases, where a large number of yearly member costs are high, but do not exceed any claims truncation threshold or individual stop loss attachment point. This means, for example, that most risk providers are not currently protected against the high costs of responding to a serious flu pandemic, in which case they would be at financial risk for an unusually large number of unanticipated sub-catastrophic cases. A provider's ability to manage and reduce aggregate expenses is critical to a provider's risk contracting success.

3. Approaches to Mitigating Provider Insurance Risk Should Be Monitored and Best Practices Should Be Developed

Although payers may examine to a certain degree a provider's ability to bear risk when negotiating a risk contract with that provider,⁷⁷ no payer thoroughly examines the scope of risk a provider bears across all of its risk contracts. Chapter 224 of the 2012 Acts tasks DOI with the important responsibility of examining and certifying a provider's ability to bear downside risk

⁷⁵ There may be other, business reasons for obtaining individual stop loss insurance. For example, if individual health care providers within a larger provider system are accountable for some portion of any deficit or surplus, the provider system may purchase an individual stop loss insurance policy to spread the risk more evenly across individual providers.

⁷⁶ See AGO 2011 REPORT, *supra* note 10, at 46.

⁷⁷ See, e.g., DHCFP Hearing on Health Care Cost Trends (2012) (written testimony of BCBS, BMC HealthNet, CeltiCare, FCHP, HPHC, Neighborhood Health, Network Health, THP, and United, Response to Exh. C, Q. 7), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

across all payers.⁷⁸ The statute requires provider organizations entering or renewing alternative payment contracts with a downside risk component to apply for a risk certificate with DOI (or a waiver if the provider organization demonstrates it does not bear *significant* downside risk). Under Chapter 224, the risk bearing provider organization's annual filing must include:

1. A list of all payers with which the provider organization has entered into alternative payment contracts with downside risk;
2. Financial statements showing assets, liabilities, reserves, and three-year operations projections;
3. A financial plan, including copies of insurance and other agreements and a statement of the applicant's plan to protect itself from potential losses from downside risk;
4. A utilization plan describing the methods by which the risk-bearing provider organization will monitor inpatient and outpatient utilization; and
5. An actuarial certification that alternate payment contracts are not expected to threaten the financial solvency of the risk-bearing provider organization.

On November 20, 2012, DOI issued Bulletin 2012-08 concerning implementation of risk certification.⁷⁹ According to Bulletin 2012-08, DOI will issue regulations implementing the certificate and waiver process after a Transition Period, from November 4, 2012 through December 31, 2013. During the Transition Period, providers must apply for and receive a Transition Period Waiver in order to enter into and/or continue to participate in contracts that subject providers to downside risk. The application requirements for a Transition Period Waiver are considerably narrower than the statutory requirements for applying for risk certification. For example, although Transition Period Waiver rules require a provider to submit a list of all payers with which the provider organization has entered (or will enter) an alternative payment contract with downside risk, no financial statements, revenue projections, or statement of potential losses are required beyond a statement of 2011 net patient service revenue. In addition, Bulletin 2012-08 does not require submission of any information during the Transition Period concerning how the provider plans to protect itself from potential losses (e.g., insurance agreements, reserves). During the Transition Period, DOI should consider requiring providers to submit the percentage of their revenue at risk for 2012 and a statement of ways in which the applicant is protecting itself from potential losses.

DOI should consider developing certain solvency and risk standards for providers to be certified, which may include, but are not limited to: (1) claims truncation thresholds to control the amount of insurance risk shifted from a health plan to a provider, (2) prudent approaches to adjusting risk budgets for changes in health status beyond the control of the provider, and (3) appropriate levels of aggregate stop loss insurance to protect the financial viability of a provider taking on risk.

⁷⁸ MASS. GEN. LAWS ch. 176T (2012).

⁷⁹ DIV. OF INS., TRANSITIONAL RULES FOR CARRIERS AND PROVIDER ORGANIZATION RELATIVE TO THE CERTIFICATION OF RISK-BEARING PROVIDER ORGANIZATION, BULLETIN 2012-08 (Nov. 2012), available at <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/2012-doi-bulletins/bulletin-2012-08.html>.

4. Additional Health Care Performance Data Would Support Providers in Their Efforts to Coordinate Patient Care Under All Lines of Business

As discussed in our 2011 Report, effective care coordination is key for providers to improve health care delivery. Appropriate data is necessary for providers to effectively coordinate care for patients across all lines of business (HMO and PPO). Health plans should make health care data more readily available to providers to inform their efforts to coordinate patient care regardless of payment arrangements. DOI and CHIA should work with health plans and providers to develop standards to ensure that providers receive adequate and reliable information to coordinate care and manage patient populations. Below are examples of key data that health plans hold and should more readily share with providers.

1. Claims data to support provider care of all patients. Claims data is critical to assist providers in managing the cost and quality of care for their patients. Currently, health plans give provider groups claims data associated HMO members who have selected a PCP with that provider. PPO claims data would be similarly critical to helping providers manage the care of their PPO patients. If health plans share broad claims data with providers, these providers can better identify care improvement opportunities that apply across all patients, irrespective of whether they are in a risk agreement.
2. Information on projected membership growth and shifts in various products and benefit designs throughout the contract period. As discussed in Part II.D above, shifts in product and benefit designs can materially impact consumer choices and medical spending. Providers should have this data to better plan for and manage the care of their patient populations.
3. Data to enable providers to analyze the impact of contract terms before executing contracts and during the course of contracts. This includes full transparency on how health plans project a provider's financial performance in the contract over time, assumptions regarding regional medical trends and pricing, and how the contract will impact budgeted premium pricing trends. When entering into HMO and PPO contracts with payment rates that could vary significantly, it is important for providers to know the impact of contractual terms to analyze projected financial performance under these contracts.

C. The Impact of Provider Alignments on Efforts to Lower Costs and Improve Quality Should Be Measured and Monitored⁸⁰

Below, we provide a brief overview of provider alignments occurring in the Commonwealth. We also offer examples of why it is important to measure and monitor the implications of provider alignments for efforts to lower costs and improve quality.

1. Alignment Activity in Massachusetts

Providers in Massachusetts are exploring different ways of affiliating and consolidating.⁸¹ These alignments include clinical affiliations, mergers and acquisitions, and various forms of physician network development, including direct hospital employment of physicians.

Clinical Affiliations. Short of mergers, clinical affiliations, or “clinical bridges,” are contractual arrangements, typically between an academic or specialty care hospital and a community hospital, for the provision of certain services, such as emergency pediatric, cardiac, or cancer care services. Through these clinical collaborations, academic physicians and residents may provide coverage and technical support for certain services at the partner site. Market participants have explained that these arrangements may help a community hospital attract and retain patients through co-branding, and by allowing patients to receive specialty services locally. Clinical bridges have proliferated in many areas of Massachusetts, and may or may not precede more permanent corporate integration. They can have a significant impact on referral patterns⁸² and the cost of care, as explored further in Part III.C.2 below.

Mergers and Acquisitions. In Massachusetts and other states, hospitals, physicians, and providers of post-acute and ancillary services are exploring different forms of clinical, financial, and strategic alliances at the corporate level, involving mergers and acquisitions. In addition to hospital mergers, this includes activity among physicians, including smaller physician groups joining larger hospital-based physician groups, and movement of physicians from one group to another.

We have also observed vertical integration of health plans and providers. Partners acquired Neighborhood Health Plan in 2012.⁸³ Last August, New England Quality Care Alliance, Tufts Medical Center, and Vanguard Health Systems announced their joint development of a cooperative insurance plan authorized under the federal Affordable Care Act.⁸⁴ Steward’s development of limited network products with both FCHP and THP is a further

⁸⁰ The following discussion is for policy purposes and is not an analysis under antitrust law.

⁸¹ For information on hospital alignments in Massachusetts over the past several decades, see *Massachusetts Hospitals: Closures, Mergers, Acquisitions and Affiliations*, Mass. Hosp. Ass’n, available at <http://www.mhalink.org/Content/NavigationMenu/AboutMHA/HospitalDirectory/HospitalClosuresMergersAcquisitionsandAffiliations/default.htm>.

⁸² Trends in where patients are referred for care their PCP does not provide (e.g., specialist or hospital care).

⁸³ In the Matter of the Proposed Acquisition of Control of Neighborhood Health Plan, Inc., by Partners HealthCare System, Inc., Docket No. F2012-01 (Div. of Ins. Sept. 14, 2012) (mem. of decision & order), available at <http://www.mass.gov/ocabr/docs/doi/legal-hearings/f2012-01.pdf>.

⁸⁴ Press Release, Minuteman Health, CMS awards \$88.5M loan to Massachusetts for new health insurance model: Minuteman Health (Aug. 31, 2012), available at <http://minutemanhealth.org/Announcement-Minuteman-Health.html>.

example of the development of new relationships between health plans and providers in Massachusetts.⁸⁵

Physician Network Development. As discussed in Part I.B above, physicians play a central role in a well-coordinated provider system. In particular, PCPs help coordinate patient care across a continuum of settings, providing referrals for specialist, hospital, and post-acute care. Through their role in influencing where patients receive care, physicians can impact the volume trends (and thus the financial performance) of provider organizations. In risk contracts, PCPs are also financially relevant, since the size of risk budgets are based on the number of members cared for by a system's PCPs. Providers assert that adding PCPs and their associated members expands system volume, which can help spread the cost of investment in care infrastructure and, to a degree, may improve opportunities to earn a surplus.⁸⁶

Provider organizations recruit physicians through affiliation and direct employment. In certain types of affiliations, the provider organization negotiates rates and contracts with health plans on behalf of the physician (though the physician typically continues to bill the health plans directly in a private practice). The affiliation between the physician and provider organization is usually memorialized in an "Affiliation Agreement," "Group Participation Agreement," and/or "Physician Participation Agreement" ("PPAs"), which outlines conditions of participation and termination. PPAs may also include specific language regarding patient referrals. While referral expectations vary across contracts, we reviewed PPAs indicating that physicians should refer members to other affiliated or employed providers within the provider organization. PPAs may also outline certain organization-directed (as opposed to health plan-directed) referral protocols, such as requiring "prior authorization" for referrals outside of the system, or retrospective review of referral patterns.

Provider organizations also recruit physicians through direct employment, which is a growing trend nationally.⁸⁷ Provider organizations assert several advantages to direct employment, such as potentially greater control over patient referrals and, thereby, the potential

⁸⁵ See FCHP, HMO Merged Market Rate Filings, SERF Tracking Number FCHC-127943901 (Dec. 30, 2011); THP, Small Group Rate Filing for Rates Effective January–March 2012, at Attachment 11 (Sept. 30, 2011) (on file with DOI).

⁸⁶ For example, regarding managing risk for exogenous factors like fluctuations in HMO/POS membership, one major Massachusetts provider testified that its risk contracting membership declined by 44% in one year of a risk contract, and described the challenges of earning back the investment in infrastructure necessary to manage risk under its contract. DHCFCP Hearing on Health Care Cost Trends (2012) (written testimony of Beth Israel Deaconess PO, Response to Exh. B, Q. 8), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

⁸⁷ See Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May be Needed*, 31(5) HEALTH AFFAIRS 973, 976-977 (2012) ("Respondents confirmed that in most of the twelve markets [studied], hospitals have increased the number of physicians they employ over the past three years. By employing physicians, hospitals can build referral bases to increase their market shares... [H]ospitals negotiating on behalf of their employed physicians are able to obtain higher prices for physician services than can be achieved by independent physicians."); Robert Kocher & Nikhil Sahni, *Hospitals' Race to Employ Physicians – The Logic Behind a Money-Losing Proposition*, 364(19) NEW ENG. J. MED. 1790, 1790 (May 12, 2011) ("More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery system, a trend fueled by the intended creation of accountable care organizations (ACOs) and the prospect of more risk-based payment approaches."), available at <http://www.csi.mt.gov/MedicalHomes/Hospital%20employment%20of%20physicians.pdf>.

for increased referral volume. Individual physicians or practice groups may assert advantages such as a reduction in the administrative load of practice management, capital support, and the security of a salaried model. At the same time, disadvantages of an employment model may include additional fixed costs for the organization, and potentially reduced revenue and independence for the practitioner.

2. The Impact of Provider Alignments Should Be Measured and Monitored

The impact of provider alignments on health care costs and quality should be measured and monitored – particularly alignments that may affect access to care, limit the effectiveness of other approaches to lowering costs, or enhance providers’ market clout.⁸⁸ Below, we explore some factors that should be considered and balanced in evaluating the impact of provider alignments.

First, how will a merger, acquisition, or other provider alignment result in meaningful and measurable improvements in the quality and efficiency of care? As discussed in our 2011 Report, there is no “one size fits all” when it comes to delivering quality, coordinated patient care, and corporate integration does not necessarily result in clinical integration or better delivery system performance.⁸⁹

Second, how will a provider alignment affect the ability of the provider to enter and manage risk contracts? In assessing a provider’s ability to bear risk for a patient population, in addition to considering levels of risk share, budget adjustment, and other risk mitigation factors discussed in Part III.B above, commercial and government payers have set thresholds for the minimum number of lives that should be covered by a risk contract. CMS generally requires a minimum of 15,000 aligned beneficiaries for its Pioneer ACOs, while commercial health plans identified a range of a minimum of 2,000 to 5,000 lives for a risk arrangement that includes health status adjustment.

⁸⁸ Some of these issues have been explored in academic and policy papers from a variety of perspectives. Without endorsing any particular approach, we provide a sample of some of the research in this area: James Robinson, *Hospitals Respond to Medicare Payment Shortfall by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30(7) HEALTH AFFAIRS 1265, 1270 (2011) (“The key policy question is whether hospital consolidation will reduce costs through better management of capacity, technology, and staffing or, rather, increase costs by facilitating the price increases that permit continued inattention to these cost drivers”); ROBERT WOOD JOHNSON FOUND., THE SYNTHESIS PROJECT, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (June 2012) (surveying research across U.S. markets that demonstrates hospital mergers generally result in higher prices and that physician-hospital consolidation has not led either to improved quality or reduced costs), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; William B. Vogt, *Hospital Market Consolidation: Trends and Consequences*, National Institute for Health Care Management (Nov. 2009), available at http://nihcm.org/pdf/EV-Vogt_FINAL.pdf; Glen A. Melnick et al., *The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices*, 30(9) HEALTH AFFAIRS 1728 (2011) (studying effects of health plan and hospital market concentration on prices)

⁸⁹ See AGO 2011 REPORT, *supra* note 10, at 37-44.

Minimum Number of Lives for Participation in Risk Arrangements⁹⁰

| | |
|---------------------------------------|-------------|
| CMS Pioneer ACO | 15,000 |
| CMS Medicare Shared Savings Program | 5,000 |
| Massachusetts Commercial Health Plans | 2,000-5,000 |

In certain circumstances, comparatively small providers have managed risk contracts even below payer-specific minimums. For example, Acton Medical Associates’ roughly 6,100 risk lives in mid-2012 included about 2,300 for THP, 2,800 for HPHC, and only 1,000 for FCHP.⁹¹ CMS approved Mount Auburn Cambridge IPA to participate as a Pioneer ACO with fewer than 11,000 risk lives. For larger providers well above the payer-specific minimums, the need for further alignments to manage risk becomes increasingly tenuous.⁹²

While a provider alignment may improve an organization’s ability to bear risk or promote more efficient, coordinated care, those potential benefits should be balanced against the concerns of increasing market leverage and reducing consumer options. The need to balance these considerations is increased because providers with higher payment rates have already amassed far greater resources to recruit physicians and invest in other provider alignments, and as a result are better positioned to secure referrals to their organizations.⁹³ Highly-resourced providers can offer immediate and long-term financial advantages to physicians: the opportunity to receive higher payment rates under existing contracts immediately upon joining the provider organization;⁹⁴ greater infrastructure and other supplemental payments; better financial terms in buy-outs of practices;⁹⁵ capital support; and income guarantees that shield physicians from the

⁹⁰ See CTR. FOR MEDICARE & MEDICAID SERVS., PIONEER ACO REQUEST FOR APPLICATIONS, available at <http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf>; Medicare Shared Savings Program, 42 C.F.R. § 425.110 (2011); DHCFFP Hearing on Health Care Cost Trends (2011) (health plan written testimony, e.g., written testimony of THP, Response to Exh. B, Q. 8; written testimony of HPHC, Response to Exh. B, Q. 7), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2011-health-care-cost-trends/witness-testimony/written-testimony-from-witnesses.html>.

⁹¹ DHCFFP Hearing on Health Care Cost Trends (2012) (written testimony of Acton Medical Associates, Response to Exh. C, Q. 2), available at <http://www.mass.gov/chia/researcher/health-care-delivery/health-care-cost-trends/2012-health-care-cost-trends/health-care-cost-trends-witness-testimony.html>.

⁹² See A. Frakt et al., *Beyond Capitation: How New Payment Experiments Seek to Find the ‘Sweet Spot’ in Amount of Risk Providers and Payers Bear*, 31(9) HEALTH AFFAIRS 1951, 1953 (2012) (based on the history of provider consolidation in response to 1990s capitation that left some with diseconomies of scale, suggesting there is a “sweet spot” that balances the need to be big enough to bear risk with concerns about the increased market leverage that comes with consolidation).

⁹³ A recent physician workforce study found that 94% of community hospitals, citing fewer applicants and the inability to offer competitive salaries, have significant difficulty filling vacancies. MASS. MED. SOC’Y, 2012 PHYSICIAN WORKFORCE STUDY, 26-27 (2012), available at <http://www.massmed.org/News-and-Publications/Research-and-Studies/2012-MMS-Physician-Workforce-Study/#.UXAahrU4tPM>.

⁹⁴ One health plan estimated that migrations of roughly 1,200 physicians between Massachusetts physician groups over the past two years resulted in an overall 10% increase in physician payments. For provider organizations subject to growth caps in their payer contracts (provisions that “cap” the number of new physicians who can join and benefit from the contract’s rates), such rate increases may be phased in over a period of time. In addition, highly-paid providers can circumvent growth caps by using their resources to match contract payment rates for newly-added physicians. See AGO 2010 REPORT, *supra* note 10, at 42-43.

⁹⁵ Buyout costs can include practice acquisition costs and costs associated with early exit clauses (e.g., contractual penalties for the physician group to exit early from its current organization).

downside risk of any global contracts the organization has executed.⁹⁶ Greater resources can also mean the option to selectively and successfully recruit the highest revenue physician groups, which can be those in affluent geographies with higher commercial payer mix.⁹⁷ This trend in increasing referrals and volume to the higher-priced providers in Massachusetts, well-documented in our 2010 Report,⁹⁸ is in tension with efforts to meet our state health care cost growth benchmark. HPC's provider registration process can increase transparency around these affiliations and relationships that influence care referral patterns in Massachusetts.⁹⁹

Provider alignments may also mute the impact of product design in encouraging care at more efficient providers. Contractual expectations among hospitals, physicians, and other providers may result in a physician consistently referring patients "in-system," even when lower-cost care options are available. This may at times place referral expectations in tension with consumer cost-sharing incentives and/or patient preferences, and consumers may not be aware of these referral expectations. While keeping patients within a single provider organization may improve care coordination, a directive to keep care in-system may also mean treatment decisions that are not always informed primarily by quality and efficiency considerations. Purchasers should be aware that in addition to network limitations of their insurance products, the expectations of their physician's employment or affiliation arrangement may affect care delivery.

Chapter 224 provides important opportunities for regulators to address the intersection of increased affiliations and cost control, and to balance competing tensions. In particular, HPC's review of provider material changes allows for a comprehensive evaluation of proposed provider alignments, including their impact on short and long-term health care spending, consumer choice, and quality.¹⁰⁰ HPC's cost and market impact review requires a multi-factor analysis of a proposed transaction, including such factors as the provider organization's size and market share by service and service areas, comparative prices and health status adjusted TME, impact on competing options for delivery and impact on existing service providers within markets, how the provider is attracting patient volume and recruiting professionals and facilities, and the role of the provider serving at-risk, underserved or government payer populations.¹⁰¹ We encourage HPC to carefully consider the interplay of these factors and the impact of potentially increased market leverage on cost savings initiatives in order to assess whether the proposed alignments will, on balance, result in a more efficient and effective health care system and preserve lower

⁹⁶ Provider organizations are bearing risk in different ways, under multiple models and varied terms, as discussed in Part III.A above. Whether and how provider organizations in these different risk contracting models are aligning incentives *within* their organization also varies depending on the resources of the organization. As discussed in our 2011 Report, some physicians may be shielded from the risk borne by the overall organization (through employment or otherwise), or may benefit from special terms of recruitment deals that shield new physicians from any decrease in income, regardless of performance, potentially undermining the ability of risk contracts to incent improvements in physician performance.

⁹⁷ For business risk reasons, a health system seeking to recruit physicians may evaluate the desirability of a practice based on factors ranging from the population served to the mix of payers represented (e.g., populations with a higher than average proportion of commercial versus public payers).

⁹⁸ AGO 2010 REPORT, *supra* note 10, at 38-40.

⁹⁹ MASS. GEN. LAWS ch. 6D, § 11(b) (2012) (requiring provider organizations to file with HPC "organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations" and "the number of professionals affiliated with or employed by the organization").

¹⁰⁰ MASS. GEN. LAWS ch. 6D, § 13(a) (2012).

¹⁰¹ MASS. GEN. LAWS ch. 6D, § 13(d) (2012).

cost options for consumers, including Medicaid and other vulnerable populations. Such proposed transactions should be carefully scrutinized to assess whether increases in price garnered from greater market leverage of larger providers exceed the potential increased efficiency that may result from planned care coordination in the consolidated enterprise.¹⁰² If aligning providers contend that the new affiliation will eventually save money, then HPC should request that the aligning providers submit an analysis underlying their contention during HPC's cost and market impact reviews. HPC should continue to track post-alignment performance. Regulators will have to carefully monitor the level of provider corporate integration that promotes care coordination in order to ensure that consolidations do not result in increased costs, volume concentration at high-clout providers, or reduced options for consumers to receive care from more efficient providers.

IV. GOVERNMENT

In this final section, we examine the ongoing role of government as market regulator in the context of purchaser, health plan, and provider efforts to lower costs, promote efficiency, and improve health care delivery in Massachusetts. We conclude with a set of recommendations to state agencies which were created or given greater market oversight responsibility as part of Chapter 224 of the 2012 Acts: the Health Policy Commission, the Center for Health Information and Analysis, and the Division of Insurance.

In looking at the role of government as market regulator, we are mindful that the government also functions as a health care purchaser, payer, and provider, and that its actions in those capacities have significant implications for the private market, just as the actions of the private market have significant implications for the government. In important respects, the increased market transparency, measurement, and oversight that the legislature gave regulators applies to the government itself as purchaser, health plan and provider. The government should support and participate in efforts to improve the health care delivery system by engaging in market initiatives as a purchaser, health plan and provider, and by addressing tensions and other concerns that unreasonably limit opportunities to improve delivery system efficiency and effectiveness as regulator.

Regulators should consider market rules and consumer protections in light of the changing context of purchaser, health plan, and provider activity. For example, rules that prohibit discriminatory, unfair, or predatory conduct by health plans are vital in ensuring that health plans treat consumers fairly while remaining financially viable. With increasing market consolidation and expanding provider responsibility under alternative payment arrangements, regulators similarly will need to ensure that providers do not engage in discriminatory, unfair, or predatory conduct that might improperly limit care options for vulnerable populations or place undue risk on providers themselves.

By setting fair market conduct and transparency rules, regulators can promote purchasers' value-based decisions and encourage health plans' and providers' creative efforts to increase care

¹⁰² Studies of the impact of risk contracts on medical spending to date show that savings have largely been the result of redirecting site of care to lower cost providers, not in materially reducing utilization or the amount of services used. *See, e.g., HEALTH AFFAIRS AQC, supra* note 41, at 1889.

delivery efficiency. There is no single best model for health care payment or delivery, and no easy answer to control health care costs. Regulators must recognize and balance the varied interests and market-driven strategies of diverse purchasers, health plans, and providers.

We recommend:

A. Health Policy Commission

- In developing the provider registration program pursuant to G.L. c. 6D, § 11 and reporting requirements pursuant to G.L. c. 12C, § 9, HPC and CHIA should require sufficiently detailed information about operations and finances across all books of business to support other key regulatory functions (e.g., certification of accountable care organizations and of risk bearing provider organizations, evaluation of the impact of provider operations on the state health care cost growth benchmark). For example, HPC and CHIA should require providers to submit information concerning whether the provider's physicians are employed or affiliated, how payments are structured from the provider organization to its physicians (e.g., distribution of surpluses from risk settlements, quality payments, infrastructure fees and any other payments), and information concerning key provisions in physician participation and/or employment agreements (e.g., referral requirements).
- In assessing the cost and market impact of proposed provider alignments pursuant to c. 6D, § 8, HPC should consider proposed changes in contract prices, any expected changes in referral patterns, market share, and volume to higher cost facilities, and the impact of all of these factors on total costs to consumers and purchasers across all lines of business. This includes analysis of any potential increase in hospital or physician payment rates due to a proposed provider alignment (e.g., if a lower paid physician group aligns with a higher paid physician group). To make such an analysis, HPC should require providers to submit documents explaining any anticipated impact on costs and provide analysis to support how and when the proposed alignment would reduce health care costs.
- HPC through provider registration pursuant to c. 6D, § 11, and DOI through risk-bearing provider organization certifications pursuant to G.L. c. 176T, should require disclosure of sufficiently detailed information about provider contracting and management to establish, or help market participants establish, best practices that minimize excessive provider risk of insolvency.
- HPC through and cost and market impact reviews pursuant to c. 6D, § 8 should require disclosure of sufficiently detailed information about provider management of care delivery to establish, or help market participants establish, best practices that prevent exposing consumers to discrimination based on health condition.
- In certifying ACOs pursuant to c. 6D, § 15, HPC should consider requiring disclosure of how commercial and public payer referral patterns change over time and if they are consistent with market share changes.

B. Center for Health Information and Analysis

- In developing and maintaining the payer and provider database pursuant to G.L. c. 12C, § 12, CHIA should gather, report and analyze data in a format and level of specificity that enables market participants and the government to analyze the data across market segments and lines of business. For example, CHIA should:
 - Require claims to be reported for all “private health care payers” and all “public health care payers” as those terms are defined by c. 12C, § 1;
 - Support continuous efforts to improve the health system’s efficiency and effectiveness by allowing purchasers, health plans, and providers direct access to de-identified claims data and TME information from all public and private payers.
- In requiring uniform reporting by private and public payers pursuant to c. 12C, § 10, CHIA should:
 - Require quarterly data reporting to track the effects of different health plan product designs and payment arrangements including TME, utilization, cost and quality.
 - Require reporting of non-claims based payments by category (surplus payments from risk settlements, quality payments, infrastructure, and other types of payments), provider, product line (including HMO, PPO, fully-insured, self-insured), and market segment. CHIA should use this information to analyze and report on (1) the proportion of non-claims based payments in each category (surplus payments from risk settlements, quality payments, infrastructure, and other types of payments); (2) how supplemental payments are being allocated across products (including HMO, PPO, fully-insured, self-insured); (3) the amount of non-claims based payments by provider.
 - Require reporting of health status adjustment using a standard, industry accepted health status adjustment tool (considering a publicly available tool) to promote consistencies in health status adjustment reporting and potentially enable analyses of reporting metrics (TME, risk budgets) across health plans.
 - Require payers to report TME with improved granularity in local practice group, product line and market segment to enable CHIA (or other agencies) to conduct regional analyses of TME as we do in Part III.B.
 - Consider defining a PPO attribution model to attribute PPO members to providers based on factors other than explicit PCP selection. CHIA should then require these payers to report TME for PPO patients by provider, using this PPO attribution model.
- CHIA and the DPH should use their existing authority under G.L. c. 12C, § 14 and G.L. c. 111, § 25P to issue a Standard Quality Measure Set (“SQMS”) and implement a process for health care providers to report their performance under the SQMS to enable other agencies to use a consistent set of quality measures in their work, including but not limited to DOI’s methodology for tiering products pursuant to G.L. c. 176D, § 11, G.L. c. 176J, § 11, and c. 176O §§ 2 and 17.

- CHIA should require sufficient reporting of (i) the number of affiliated and employed health care providers by registered provider organizations pursuant to G.L. c. 12C, § 9 and (ii) payments to providers by health plans pursuant to G.L. c. 12C, § 10 so that it may analyze and report on the impact of additions in or contractions of affiliated and employed health care providers (e.g., due to physician recruitment or provider alignment efforts) on health plan payments to providers.
- CHIA, DOI and the Commission to Review Variation in Prices Among Providers should consider the impact of patient affluence on differences in provider medical spending, including the impact of any such differences on vulnerable populations and potential adjustments for socioeconomic risk factors when (a) analyzing variation in health status adjusted TME; (b) analyzing variation in negotiated monthly or yearly budget for alternative payment contracts; (c) analyzing relative prices paid by insurers to providers; and (d) making recommendations to reduce provider price variation based on analysis of acceptable and unacceptable factors contributing to such variation.

C. Division of Insurance

- In certifying risk-bearing provider organizations pursuant to G.L. c. 176T, DOI should require those organizations to submit robust information pertaining to the amount of downside risk they are bearing and the ways in which, across risk contracts, they are managing their risk exposure.
- In developing regulations pursuant to c. 176T, DOI should develop minimum standards to protect risk-bearing providers from excessive insurance risk (e.g., claims truncation thresholds per percentage of revenue at risk) and related standards to limit or otherwise mitigate the transfer of insurance risk by health plans, including self-insured plans.
- DOI and CHIA should use their authority to require health plans to report information sufficient to monitor trends in premiums, health status, product design and payment methodology in the merged market, large groups and self-insured groups, and across those groups to track cost and market changes over time. This includes developing more consistent product definitions (e.g., tiered products, global payment arrangements) so that information is reported uniformly.
- DOI and CHIA should use their authority to examine purchaser enrollment trends to further understand the reasons underlying the success of different market initiatives, such as tiered and limited network products.

The Office of the Attorney General looks forward to collaborating with the Health Policy Commission, the Center for Health Information and Analysis, and the Division of Insurance as they move forward to meet the significant responsibilities they have been delegated by the Legislature. Purchasers, health plans, providers and the government collectively share the opportunity to promote a value-based health care market that controls future health care cost growth while maintaining quality and access. We will continue to strive to illuminate facts about the Massachusetts health care market that should be considered as those efforts proceed.

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