Presentation to the Health Policy Commission: CHIA’s Annual Report
Agenda

- Overview
- Total Health Care Expenditures
- Public Insurance Programs
- Commercial Insurance
- Questions
Overview

- CHIA’s role in establishing the metrics to evaluate the performance of the Massachusetts health care system
- Annual Report publication materials
  - 100+ page report
  - Extensive databooks
  - Technical documentation
- Acknowledgments
  - Data submitters for their role in facilitating this report through supplemental filings
  - CHIA’s staff & actuaries for their work producing the report
Total Health Care Expenditures (THCE)

- $61.1B: Total Health Care Expenditures
- $8,907: THCE per capita
- 1.6%: Growth rate per capita
The initial estimate of THCE per capita growth is 1.6% for 2017, the second consecutive year it fell below the health care cost growth benchmark.
Total Health Care Expenditures
Insurance Categories, 2017

$61.1B Total Health Care Expenditures

- Commercial $22.8B (+3.1% (2016-2017))
- MassHealth $17.2B (-0.2%)
- Medicare $17.0B (+1.9%)
- NCPHI $2.5B (+5.3%)
- Other Public $1.65B (+10.2%)

For more information, see page 12 of CHIA's Annual Report
HPC Presentation | September 12, 2018
Total Health Care Expenditures
Service Categories, 2016-2017

Health care spending decelerated across all service categories, with the highest growth in pharmacy and outpatient spending.

For more information, see page 18 of CHIA’s Annual Report
HPC Presentation | September 12, 2018
Alternative Payment Methods
Insurance Categories, 2015-2017

IN 2017, THE LARGEST INCREASE IN APM ADOPTION RATES WAS IN THE MASSHEALTH PCC PLAN.

For more information, see page 50 of CHIA’s Annual Report

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Public Insurance Programs
MassHealth

$17.2B
MassHealth Expenditures, 2017

-0.2%
Expenditure Trend, 2016-2017

-2.4%
Member Months, 2016-2017
### Public Insurance Programs

**MassHealth MCO Service Categories, 2016-2017**

<table>
<thead>
<tr>
<th>Service</th>
<th>2016 TME</th>
<th>2017 TME</th>
<th>Percent Change 2016 Preliminary TME</th>
<th>Percent Change 2018 Final TME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>$99</td>
<td>$99</td>
<td>0.4%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>$98</td>
<td>$99</td>
<td>0.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Physician</td>
<td>$65</td>
<td>$65</td>
<td>0.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$97</td>
<td>$110</td>
<td>12.2%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Other Prof.</td>
<td>$19</td>
<td>$21</td>
<td>4.8%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Other</td>
<td>$25</td>
<td>$25</td>
<td>0.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Non-Claims</td>
<td>$42</td>
<td>$48</td>
<td>2.3%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

*PHARMACY SPENDING PMPM CONTINUED TO GROW FASTER THAN OTHER SERVICES, BECOMING THE LARGEST CATEGORY IN 2017.*

For more information, see page 46 of CHIA’s *Annual Report*.

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<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures, 2017</td>
<td>$17.0B</td>
</tr>
<tr>
<td>Expenditure Trend, 2016-2017</td>
<td>1.9%</td>
</tr>
<tr>
<td>Beneficiaries, 2016-2017</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

For more information, see page 15 of CHIA’s Annual Report

HPC Presentation | September 12, 2018
Public Insurance Programs
Medicare Program Spending, 2016-2017

MEDICARE EXPENDITURES GREW AT SIMILAR RATES FOR BENEFICIARIES COVERED UNDER TRADITIONAL AND MEDICARE ADVANTAGE.

For more information, see page 15 of CHIA’s Annual Report
Commercial Insurance

$22.8B

Commercial Expenditures, 2017

3.1%

Expenditure Trend, 2016-2017

0.4%

Member Months, 2016-2017
Commercial Insurance Service Categories, 2016-2017

COMMERCIAL SPENDING PMPM SLOWED ACROSS THE FOUR MAJOR SERVICE CATEGORIES IN 2017.

For more information, see page 45 of CHIA’s Annual Report
IN 2017, MORE THAN ONE IN FOUR (28.2%) MASSACHUSETTS CONTRACT MEMBERS WERE ENROLLED IN AN HDHP. THESE PLANS WERE MORE COMMON AMONG SMALLER EMPLOYER GROUP PURCHASERS.
Commercial Insurance
Cost-Sharing by Market Sector, 2015-2017

Member Cost-Sharing continued to be higher, and grew faster, among smaller employer groups.

For more information, see page 80 of CHIA’s Annual Report
Fully-insured premiums increased by 4.9% from 2016 to 2017. Small group members experienced the largest percentage increase (+6.9%).

For more information, see page 72 of CHIA's Annual Report
MEMBER COST-SHARING AND FULLY-INSURED PREMIUMS GREW FASTER THAN WAGES AND INFLATION IN 2017.

Note: Total Medical Expenses reflects commercial full-claim only.
State Perspective on Health Care Cost Trends

Dr. David Auerbach
Director of Research and Cost Trends, Massachusetts Health Policy Commission
In 2017, total healthcare spending growth in Massachusetts was well below the national rate, continuing a multi-year trend.

Annual growth in per-capita healthcare spending, MA and the U.S., 2000 – 2017

Notes: US data include MA. US and MA figures for 2017 are preliminary.

Commercial spending growth in Massachusetts has been below the national rate since 2013, generating billions in avoided spending.

Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017

Notes: US data includes Massachusetts. US and MA figures for 2017 are preliminary.

Since 2013, total hospital spending growth (inpatient and outpatient) in Massachusetts has been far below national growth rates.

2013 – 2017 cumulative growth in commercial spending by service category, MA and U.S.

If Massachusetts commercial spending grew at the national rate from 2013-2017, residents would have spent $1.7B more in 2017 alone ($367 per person).

Notes: US data include Massachusetts. Pharmacy spending is net of rebates.
### Average annual growth in spending by component for top 3 payers, 2015 – 2017

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Unit price</td>
<td>1.7%</td>
<td>2.6%</td>
<td>3.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Utilization</td>
<td>0.8%</td>
<td>1.1%</td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>Provider and/or service mix</td>
<td>0.6%</td>
<td>-1.1%</td>
<td>1.1%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.9%</td>
<td>3.0%</td>
<td></td>
<td>4.6%</td>
</tr>
</tbody>
</table>

**Notes:** Average of medical expenditure trend by year 2015-2017. BCBSMA = Blue Cross Blue Shield of Massachusetts; THP = Tufts Health Plan; HPHC = Harvard Pilgrim Health Care.

Source: HPC analysis of Pre-Filed Testimony Pursuant to the 2018 Annual Cost Trends Hearing
Massachusetts inpatient hospital admission rates show little change since 2014 and continue to exceed the U.S. average.

Inpatient hospital admission rate per 1,000 residents, MA and the U.S., 2001-2017

Notes: US data include Massachusetts.
Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2016), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2017).
Across all inpatient discharges, the rate of discharge to institutional post-acute care continued to decline in 2017

Note: Out-of-state residents are excluded. Rates adjusted for age, sex, and changes in DRG mix. Several hospitals were excluded (UMass, Clinton, Cape Cod, Falmouth, Marlborough) due to coding irregularities in the database.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2010-2017).
Massachusetts readmission rates did not show any improvement in 2016

Thirty-day readmission rates, MA and the U.S., 2011-2016

Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare 2011-2016); Center for Health Information and Analysis (MA All-payer 2011-2016).
2017 was the first year with a small increase in community hospitals’ share of community-appropriate discharges since 2012

MA share of community appropriate discharges by hospital type, 2012-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Share</th>
<th>AMC &amp; Teaching Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>59.1%</td>
<td>40.9%</td>
</tr>
<tr>
<td>2013</td>
<td>59.0%</td>
<td>41.0%</td>
</tr>
<tr>
<td>2014</td>
<td>57.8%</td>
<td>42.2%</td>
</tr>
<tr>
<td>2015</td>
<td>57.7%</td>
<td>42.3%</td>
</tr>
<tr>
<td>2016</td>
<td>57.6%</td>
<td>42.4%</td>
</tr>
<tr>
<td>2017</td>
<td>57.9%</td>
<td>42.1%</td>
</tr>
</tbody>
</table>

Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases’ diagnosis-related groups (DRGs). The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs.
Sources: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database (2012-2017).
Overall APM adoption was relatively unchanged in 2017, but by 2018 MassHealth’s ACO program should drive statewide APM coverage toward 50%.

Notes: Original Medicare data for 2017 is a preliminary estimate.
Source: Centers for Medicare and Medicaid Services (Original Medicare 2015-2017); HPC analysis of Center for Health Information and Analysis Annual Report APM Databooks (Commercial 2015-2017); additional data supplied by MassHealth (MassHealth 2018).
* Managed care eligible includes MCO and PCC Plans, including new ACO options in 2018.
In 2017, Blue Cross Blue Shield of Massachusetts continued to lead the commercial market in APM adoption for PPO members.

While Massachusetts has among the highest premiums in employer markets, particularly for small employers, Connector premiums continue to rank among the lowest in state exchanges in 2018.

Annual premiums for single coverage in the employer market and average annual unsubsidized benchmark premium for a 40-year-old in the ACA Exchanges, MA and the U.S., 2013-2018

Notes: US data include Massachusetts. Employer premiums are based on the average premium according to a large sample of employers within each state. Small employers are those with less than 50 employees; large employers are those with 50 or more employees. Exchange data represent the weighted average annual premium for the second-lowest silver (Benchmark) plan based on county level data in each state. These plans have an actuarial value of 70%, compared to 85%-90% for a typical employer plan, and are thus not directly comparable to the employer plans.

Massachusetts continues to have lower deductibles than the US, although the average deductible exceeds the IRS definition for high deductible plans

The increase in high deductible plans in Massachusetts may have lowered overall commercial spending growth in 2017 by roughly 0.2 percentage points*

Notes: US data include Massachusetts. Employer deductibles are based on the average deductible according to a large sample of employers within each state. Employer plans that do not have a deductible aren’t included in the average deductible calculation. Sources: US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017); Internal Revenue Service (for definition of high deductible plans 2013-2017).

Nearly a third of total income for lower-income, commercially insured residents is consumed by health care costs, leading to higher rates of outstanding medical debt.

- **Employer premium contribution**
- **Employee premium contribution**
- **Out-of-pocket health spending**
- **Taxes going to health care**

**Health Connector 139%-299% FPL**
- Employer premium contribution: 13%
- Employee premium contribution: 32%
- Out-of-pocket health spending: 23%
- Taxes going to health care: 17%

**Commercial 139%-299% FPL**
- Employer premium contribution: 17%
- Employee premium contribution: 29%
- Out-of-pocket health spending: 24%
- Taxes going to health care: 16%

**Commercial 300%-400% FPL**
- Employer premium contribution: 29%
- Employee premium contribution: 24%
- Out-of-pocket health spending: 23%
- Taxes going to health care: 17%

**Commercial 400% + FPL**
- Employer premium contribution: 32%
- Employee premium contribution: 23%
- Out-of-pocket health spending: 17%
- Taxes going to health care: 16%

Note: Figures rounded to nearest whole number. Total income represents total family income and includes employer payments, if any, toward health insurance premiums. One-person families and families with children and two adults are included in the analysis. Data are combined using survey weights which represent the population of Massachusetts. Insurance status is self-reported in the survey. "Commercial" represents insurance received through work or a union; "Health Connector" represents all private, non-group plans available through the Health Connector. Sources: Massachusetts Health Interview Survey (CHIA), data from 2017 on 1,633 respondents from family- and single-headed households with employer-sponsored and private health insurance, representing roughly 2.9 million state residents. Other data sources include the US Agency for Healthcare Research and Quality US and state government tax and budget data.