



**MASSACHUSETTS**  
HEALTH POLICY COMMISSION

HEARING ON THE POTENTIAL MODIFICATION OF THE  
**HEALTH CARE COST  
GROWTH BENCHMARK**



**March 13, 2019**

# HEARING PARTICIPANTS AND PRESENTING STAFF

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Board of Commissioners, Health Policy Commission

David Seltz, Executive Director, Health Policy Commission

David Auerbach, Director of Research and Cost Trends,  
Health Policy Commission

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Ray Campbell, Executive Director, Center for Health  
Information and Analysis

Zi Zhang, Senior Director of Research, Center for Health  
Information and Analysis

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Representative Jennifer Benson, Chair, Joint Committee on  
Health Care Financing

Senator Cindy Friedman, Chair, Joint Committee on Health  
Care Financing

Honorable Members, Joint Committee on Health Care  
Financing

# PRESENTATION OVERVIEW

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- I. What is the health care cost growth benchmark and how is it set?
- II. How has Massachusetts performed against the health care cost growth benchmark?
- III. How does Massachusetts compare to the U.S.?
- IV. What is driving health care spending growth in Massachusetts?
- V. What are the future projections for health care spending growth in the U.S.?
- VI. Why should Massachusetts continue to focus on health care costs and affordability?
- VII. What can market participants and policymakers do to advance the goal of a more efficient, high-quality health care system in Massachusetts?

## **SECTION I.**

**What is the health care cost growth benchmark and how is it set?**

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

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## Chapter 224 of the Acts of 2012

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



## GOAL

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



## VISION

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

# Two independent state agencies work together to monitor the state's health care performance and make data-driven policy recommendations



## Massachusetts Health Policy Commission (HPC)

- **Policy hub**
- Independent state agency governed by an 11-member board with diverse experience in health care
- Duties include:
  - Sets statewide health care cost growth benchmark
  - Enforces performance against the benchmark
  - Certifies accountable care organizations and patient-centered medical homes
  - Registers provider organizations
  - Conducts cost and market impact reviews
  - Holds annual cost trend hearings
  - Produces annual cost trends report
  - Supports innovative care delivery investments

## Center for Health Information and Analysis (CHIA)

- **Data hub**
- Independent state agency overseen by a Council chaired by the Secretary of Health and Human Services
- Duties include:
  - Collects and reports a wide variety of provider and health plan data
  - Examines trends in the commercial health care market, including changes in premiums and benefit levels, market concentration, and spending and retention
  - Manages the All-Payer Claims Database
  - Maintains consumer-facing cost transparency website, CompareCare

## The Health Care Cost Growth Benchmark

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- The benchmark is a target for controlling the growth of total health care expenditures across all payers based on the state's long-term economic growth rate as measured by potential gross state product (*see next slide for more information*).
- If the target is not met, the HPC can require individual health care providers or health plans to implement **Performance Improvement Plans** and submit to strict monitoring.

### TOTAL HEALTH CARE EXPENDITURES

- **Definition:** Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources
- **Includes:**
  - All categories of medical expenses and all non-claims related payments to providers
  - All patient cost-sharing amounts, such as deductibles and copayments
  - Net cost of private health insurance

# What is Potential Gross State Product?

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## Potential Gross State Product (PGSP)

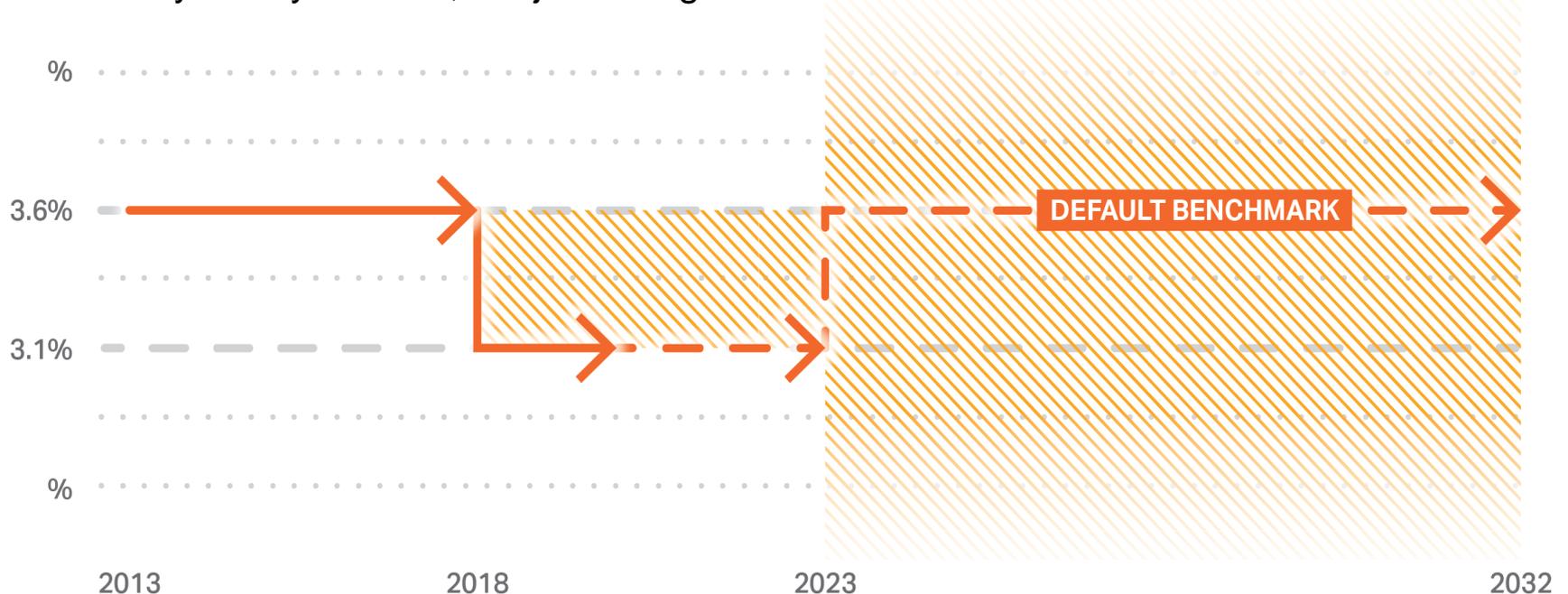
Long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle

### Process

- Every year, the Secretary of Administration and Finance and the House and Senate Ways and Means Committees meet to develop an estimate for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is included in a joint resolution by January 15th of each year
- The Commonwealth's estimate of PGSP is developed with input from outside economists
- The PGSP estimate is used by the HPC to establish the Commonwealth's health care cost growth benchmark

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

- **Years 1-5:** Benchmark established by law at PGSP (3.6%).
- **Years 6-10:** Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.
- **Years 10-20:** Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



 HPC Authority to Modify Benchmark

 Default Benchmark

## Benchmark Modification Process – Key Steps

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### HPC PROCESS TO MODIFY

- The HPC's Board must hold a **public hearing** prior to making any modification of the benchmark.
- Hearing must consider **data** and **stakeholder testimony** on whether modification of the benchmark is warranted.
- Members of the Joint Committee on Health Care Financing may participate in the hearing.
- If the HPC's Board votes to maintain the benchmark at the default rate of 3.1%, the **annual process is complete**.
- If the HPC's Board votes to modify the benchmark to some number between 3.1% and 3.6%, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for further legislative review**.

### LEGISLATIVE REVIEW

- Following notice from the HPC of an intent to modify, the Joint Committee must hold a public hearing within 30 days.
- The Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing.
- The General Court must act within 45 days of public hearing or the HPC Board's modification of the benchmark takes effect.

# Benchmark Modification Process – 2019 Timeline

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**December 31, 2018**

3.6% PGSP established in consensus revenue process

 **March 13, 2019**

**Public hearing of HPC's Board and Joint Committee on potential modification of benchmark**

**April 3, 2019**

Board votes whether to modify benchmark; if Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

**April 15, 2019**

Statutory deadline for Board to set benchmark

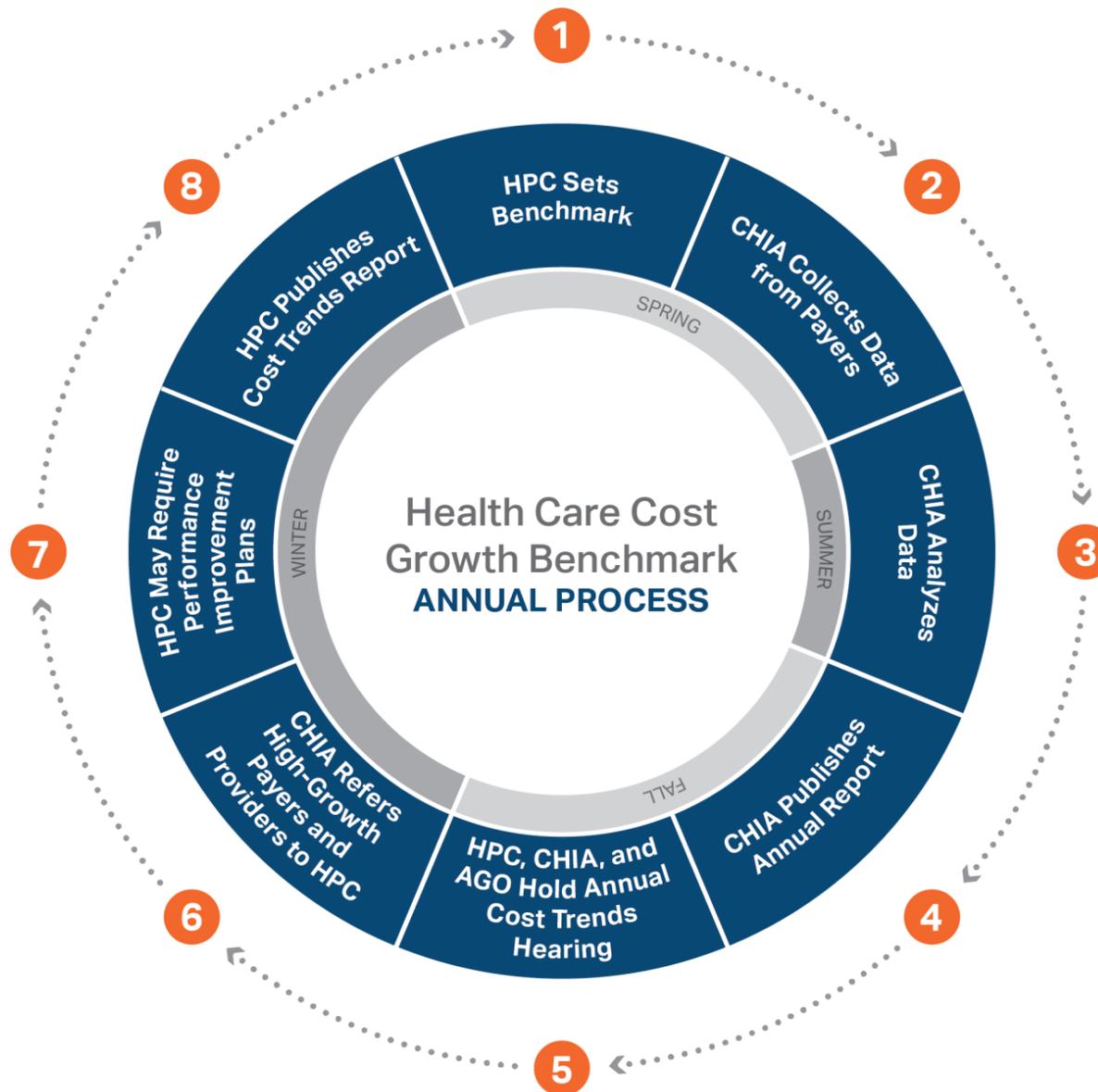
**April 2019**

Joint Committee holds a hearing within 30 days of notice

**May 2019**

Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; the Legislature has 45 days from hearing to enact legislation which may establish benchmark; if no legislation, then the Board's vote to modify takes effect

# Annual Timeline for HPC and CHIA to Establish the Health Care Cost Growth Benchmark and Evaluate the State's Performance

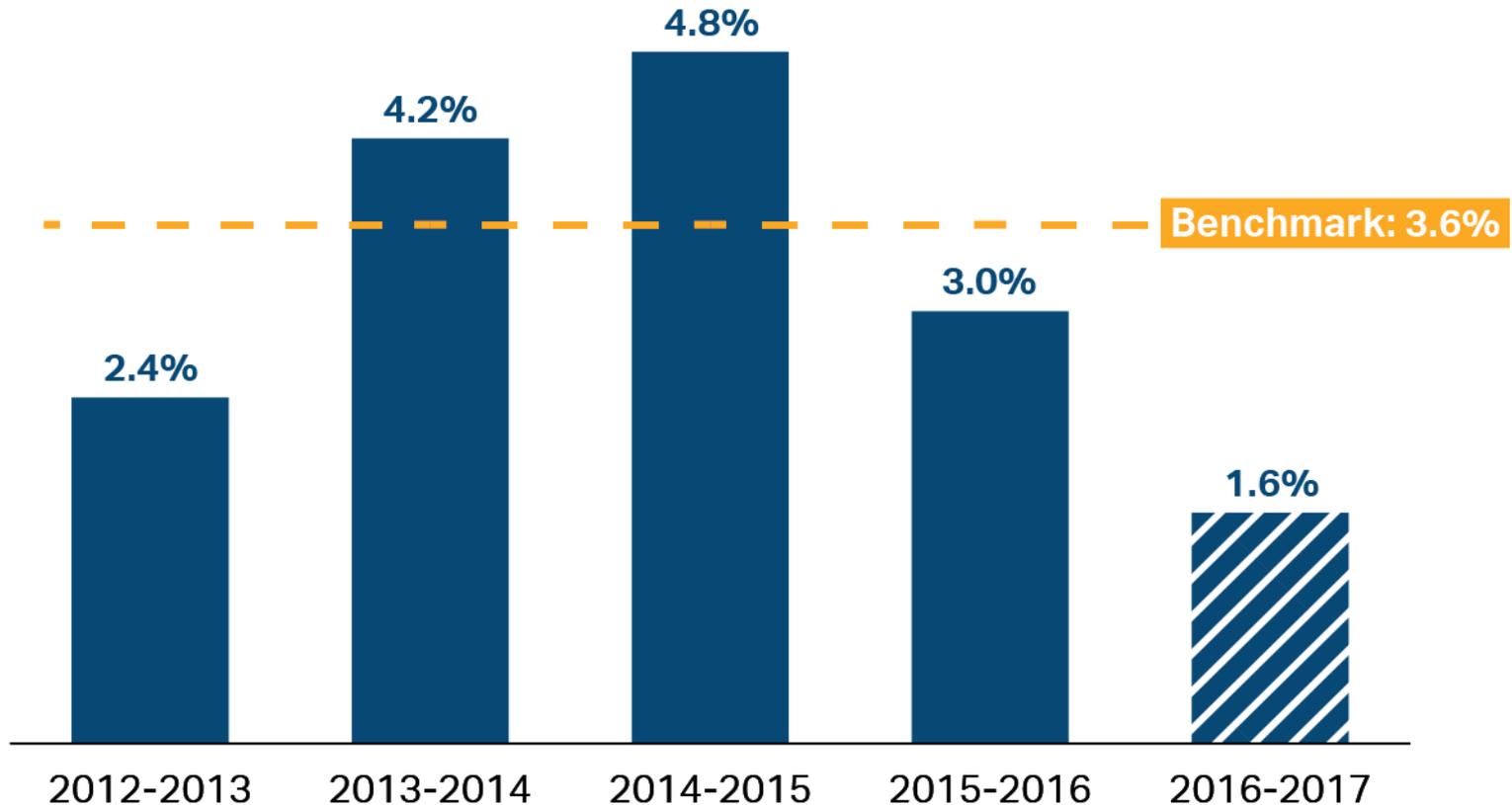


## **SECTION II.**

**How has Massachusetts  
performed against the health  
care cost growth benchmark?**

# Growth in THCE per capita was 1.6% from 2016 to 2017, below the health care cost growth benchmark of 3.6%

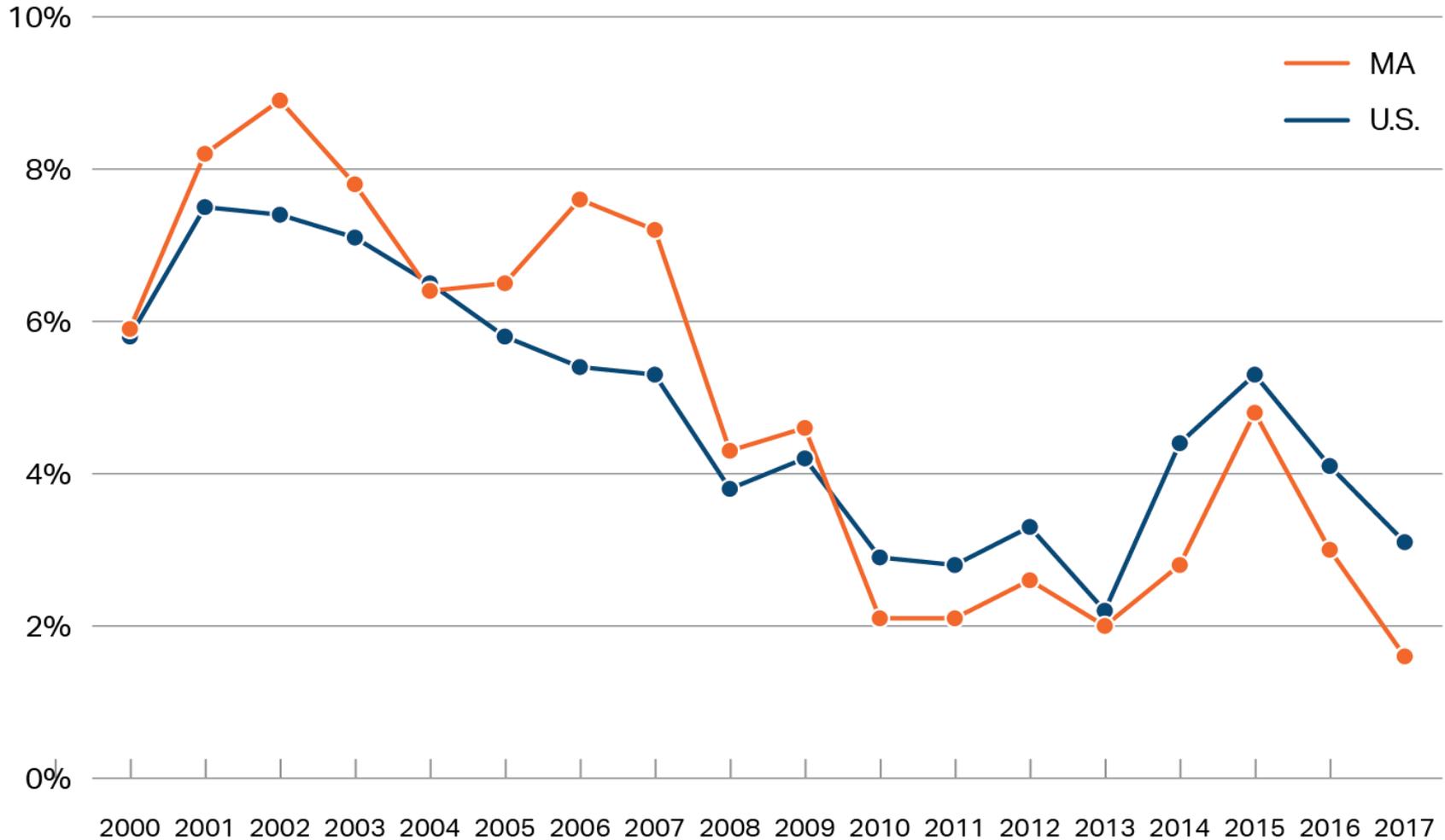
Annual growth in total health care expenditures per capita in Massachusetts



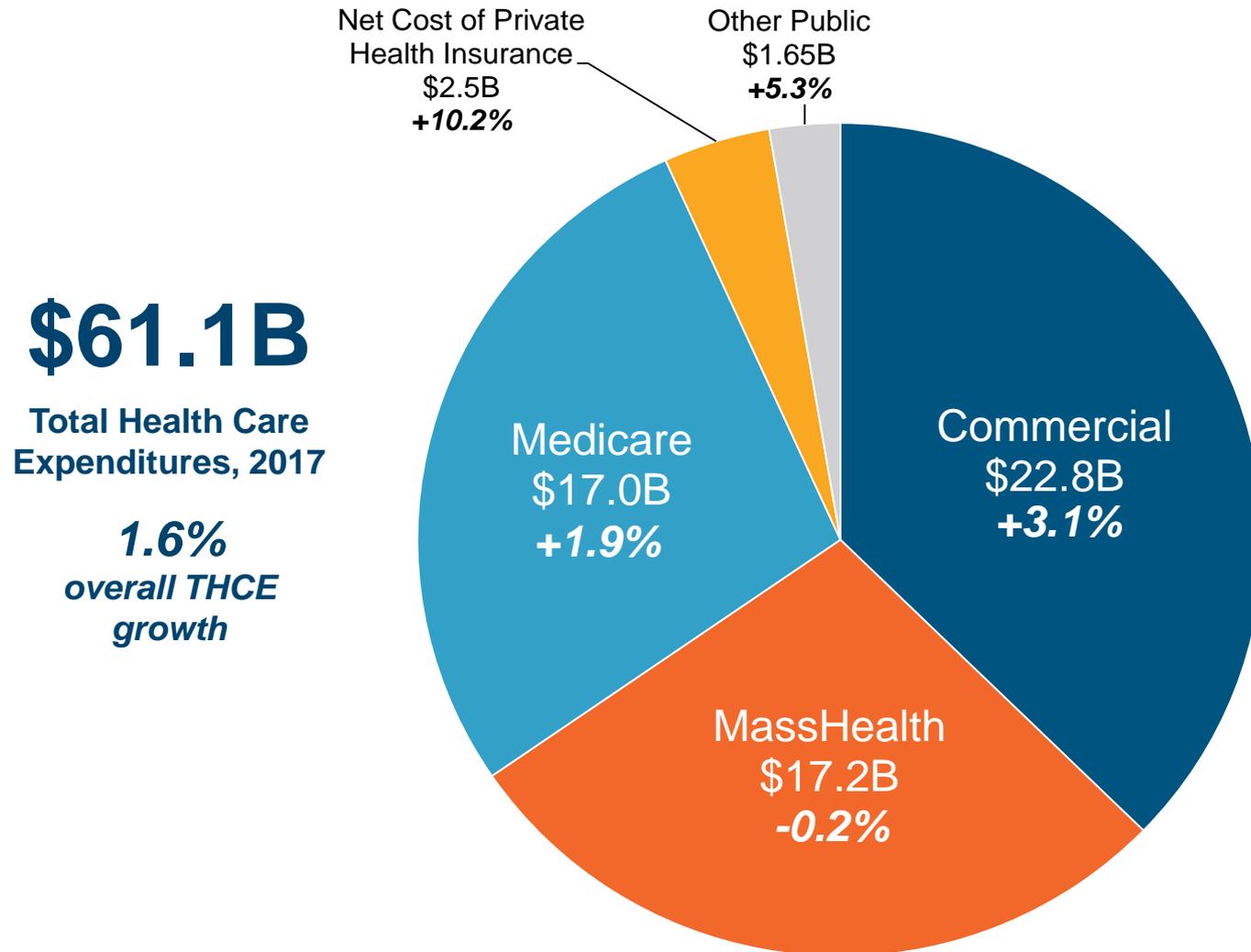
Annual growth averaged 3.2% between 2012 and 2017

# In 2017, total health care spending growth in Massachusetts was again below the national rate

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

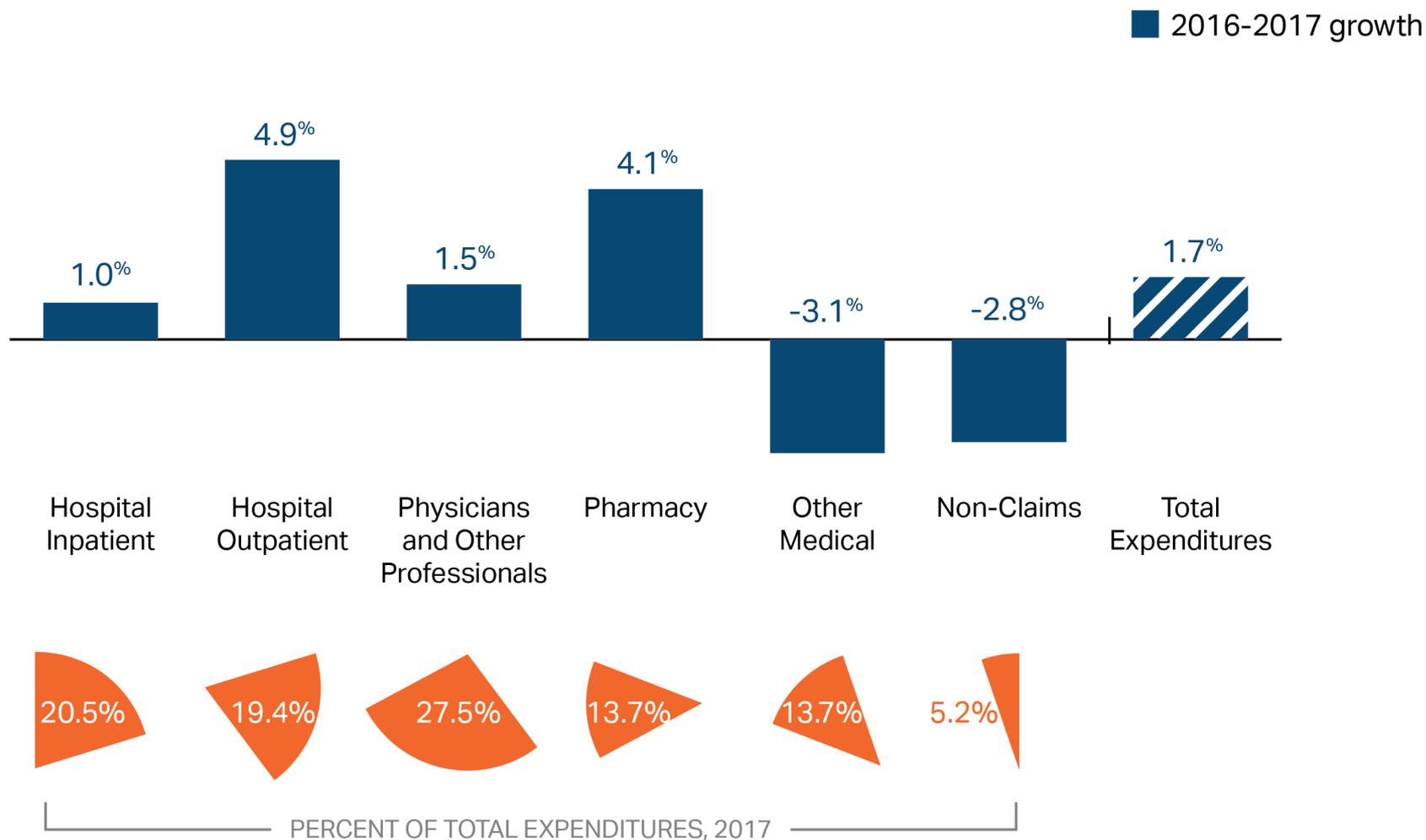


# THCE exceeded \$61 billion in 2017, with varying growth rates by market segment; commercial spending increased faster than the overall trend



# Hospital outpatient and pharmacy spending were the fastest-growing categories in 2017, continuing a multi-year trend of high growth

Rates of spending growth in Massachusetts in 2017 by category, all payers

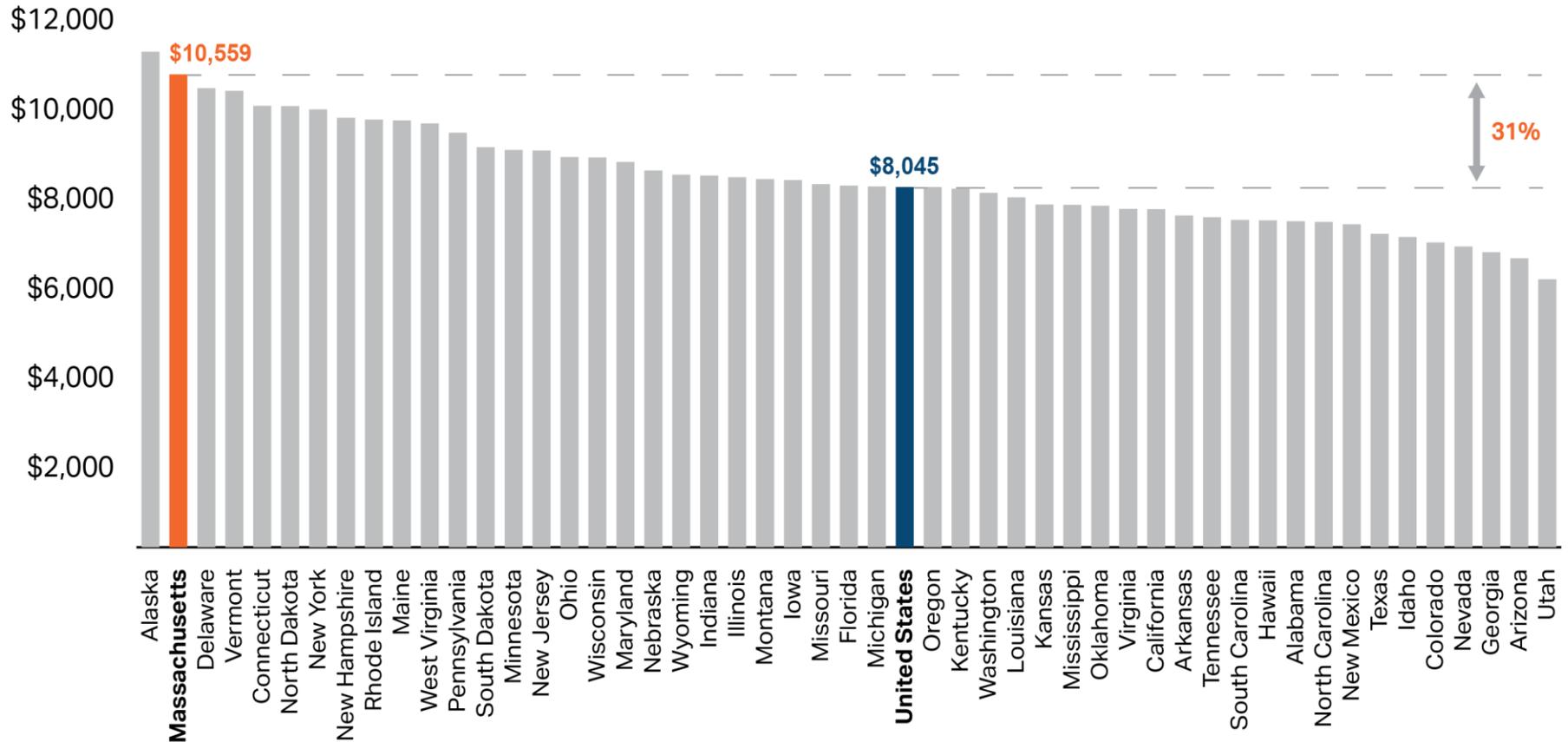


## **SECTION III.**

**How does Massachusetts  
compare to the U.S.?**

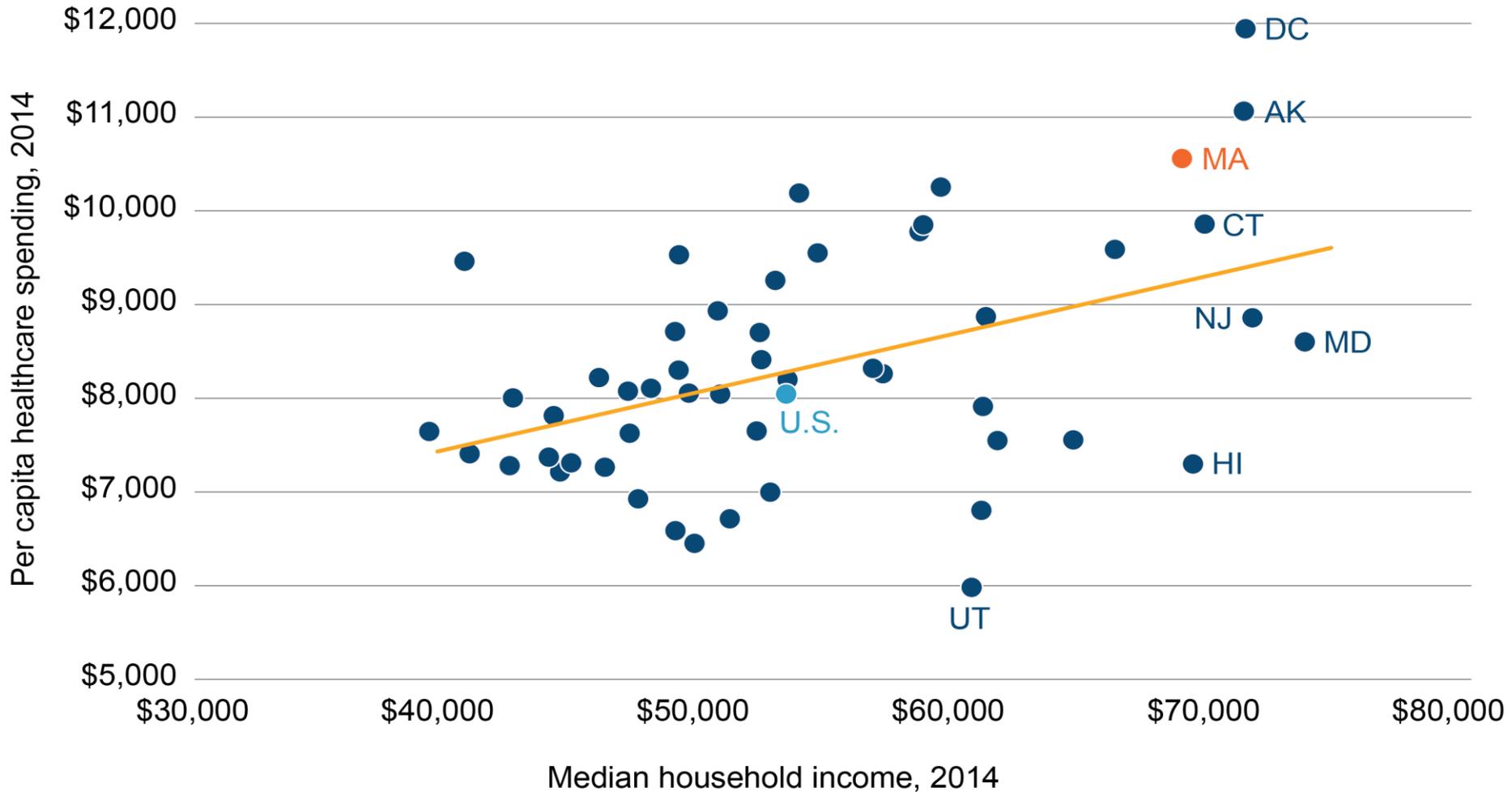
# Massachusetts has the second-highest per capita spending on health care of any state in the U.S., 31% higher than the national average

Personal health care spending, per capita, by state, 2014



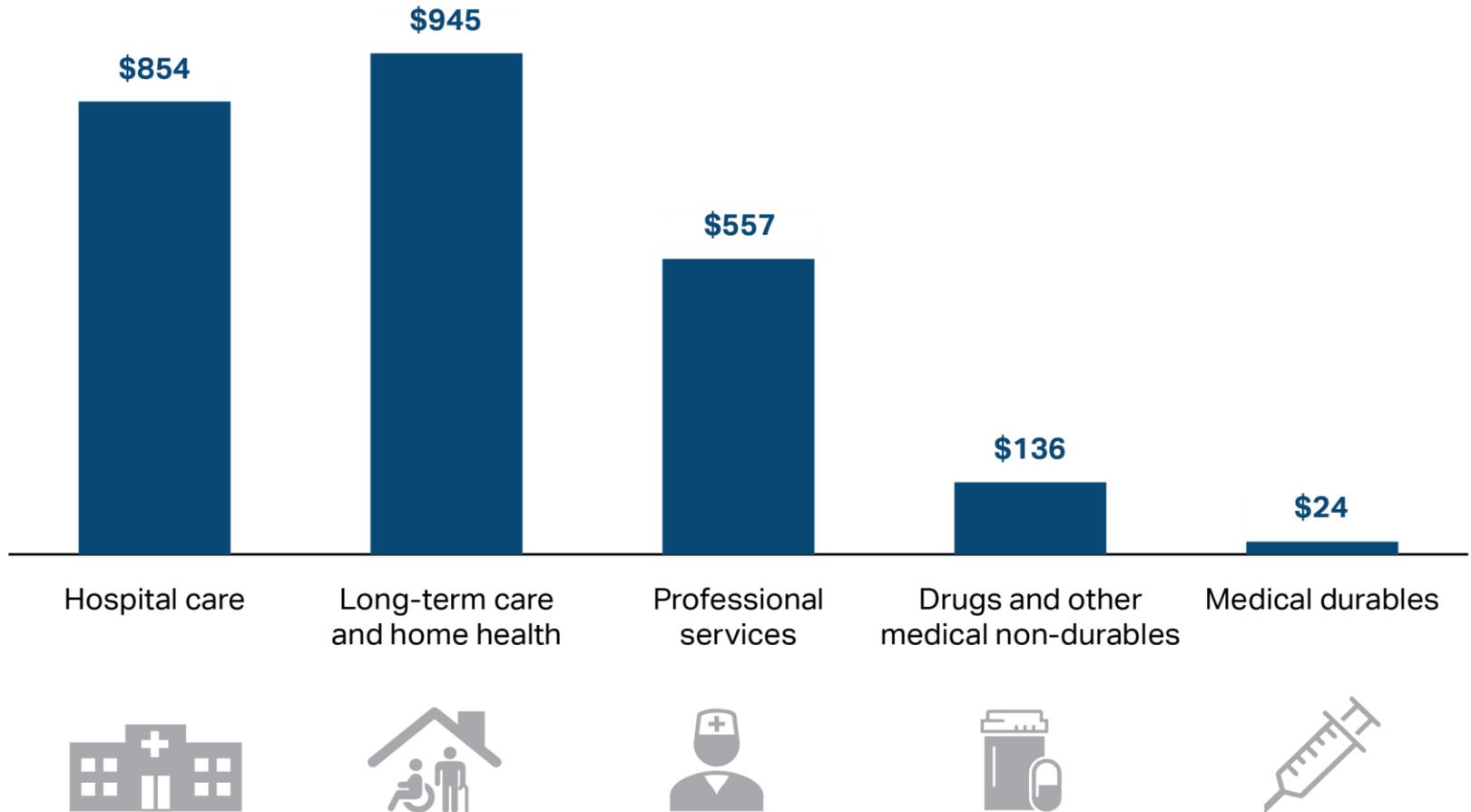
# However, health care spending in Massachusetts remains high, even accounting for higher levels of income

Health care spending per capita and median household income, by state, 2014



# Hospital care and long-term care are the biggest contributors to higher spending levels in Massachusetts compared to the U.S.

Annual spending per person in Massachusetts in excess of the U.S. average



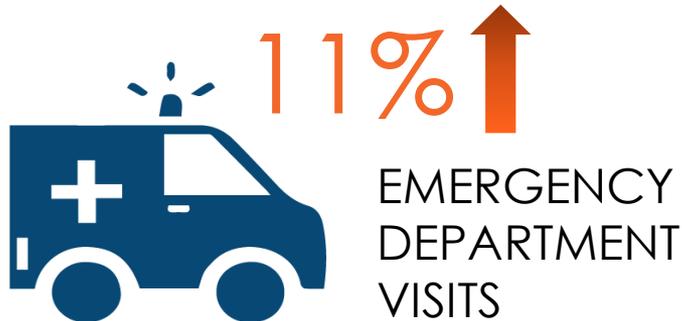
# Massachusetts uses high-cost settings of care to a much greater degree than the U.S., including hospital outpatient utilization that is 45% above the national average

Rates of hospital and institutional post-acute care use in Massachusetts relative to the U.S. average, 2016

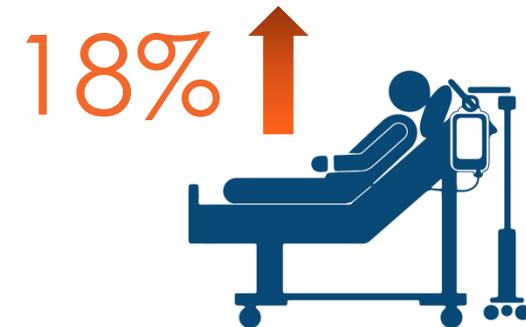
INPATIENT DISCHARGES



HOSPITAL  
OUTPATIENT VISITS

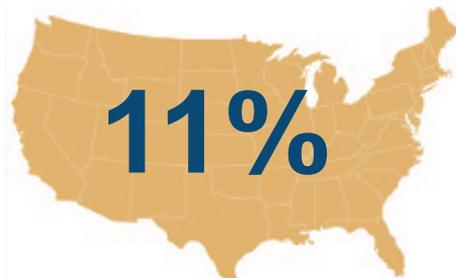
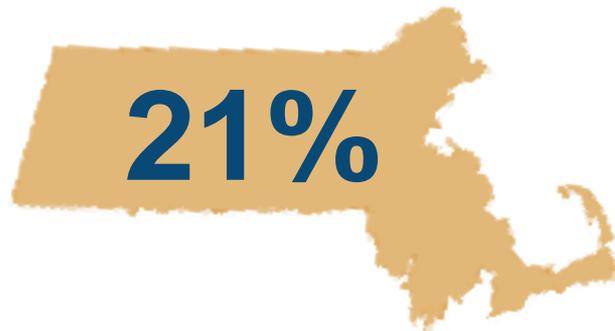


POST ACUTE CARE  
DISCHARGES

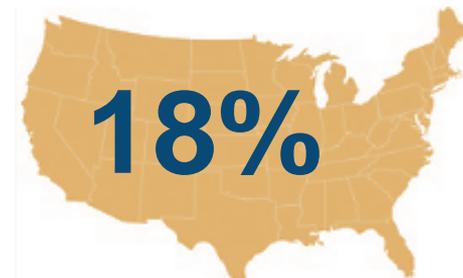
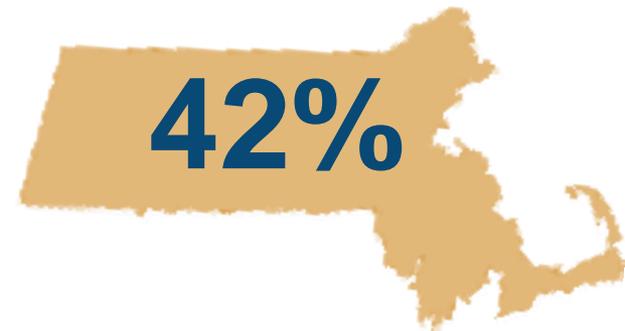


## Additionally, Massachusetts uses expensive hospital settings for both routine office visits and inpatient care at twice the national rate

Share of routine office visits at a hospital outpatient setting

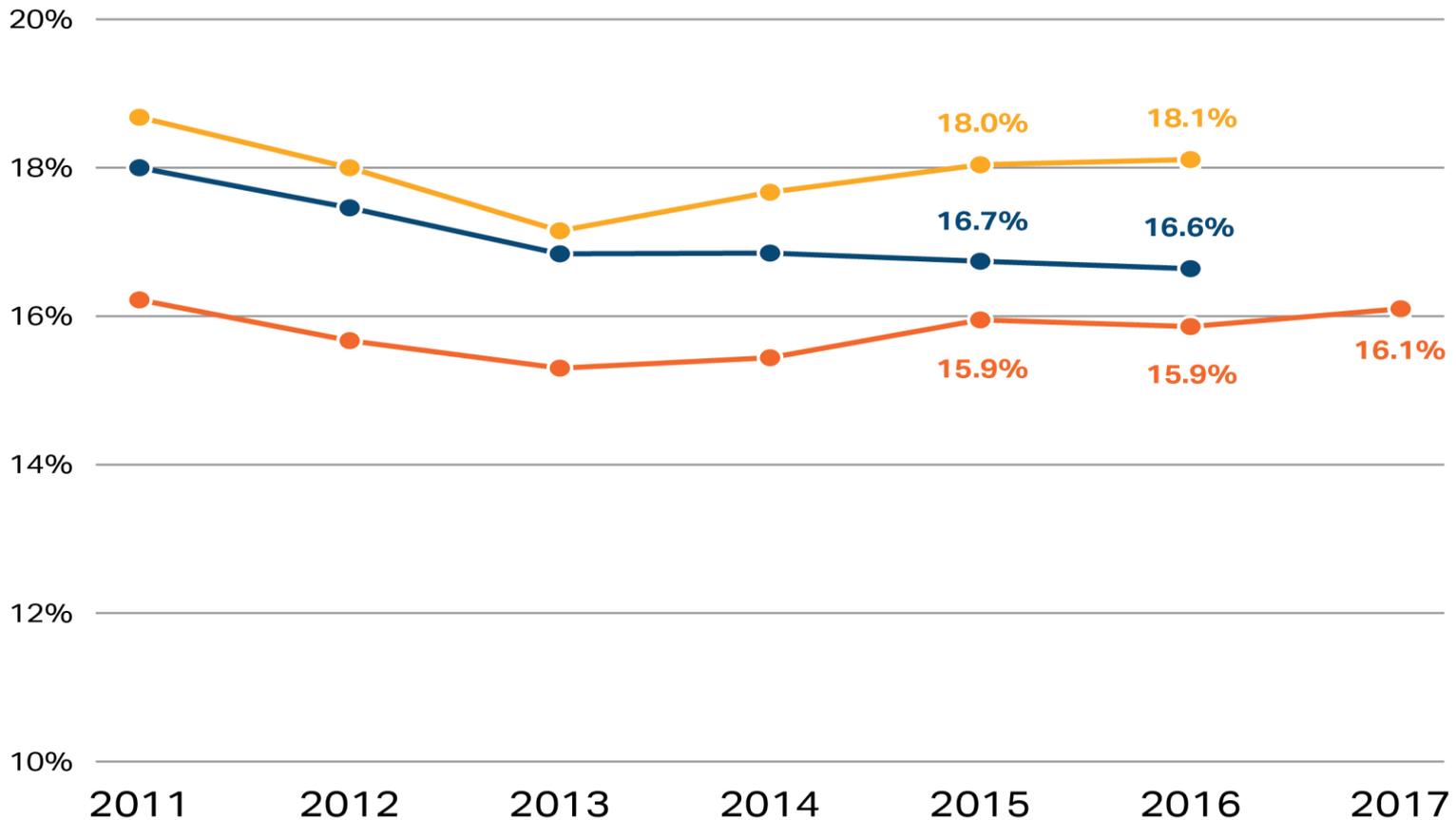


Share of inpatient discharges at a teaching hospital



# Massachusetts hospital readmission rates continue to increase, even as the rest of the U.S. makes progress; MA is the 2<sup>nd</sup> worst performing state

Thirty-day hospital readmission rates, Massachusetts and the U.S., 2011-2017



MA Medicare

U.S. Medicare

MA All-payer

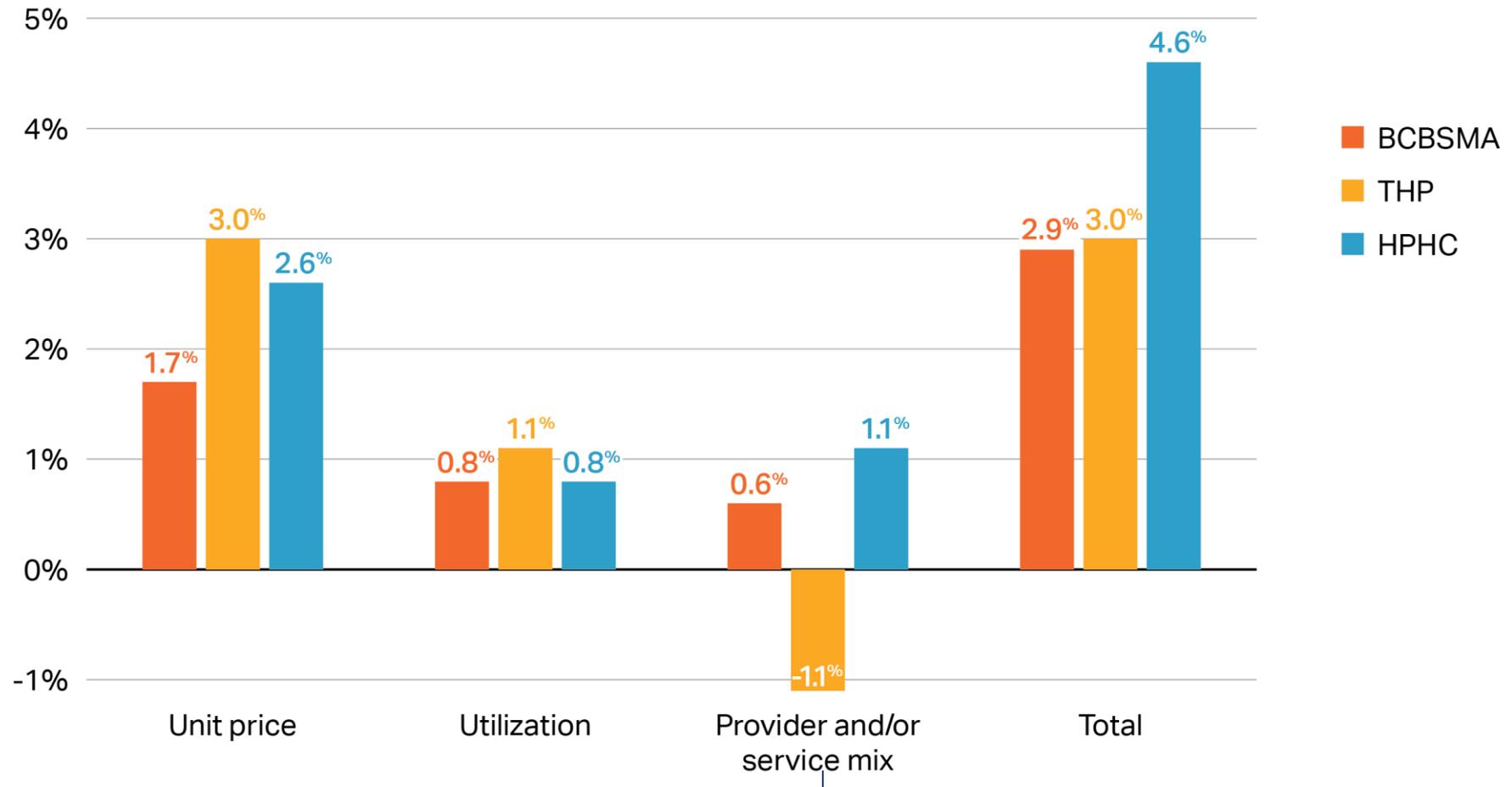
Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare 2011-2016); Center for Health Information and Analysis (MA All-payer 2011-2017).

## **SECTION IV.**

**What is driving health care  
spending growth in  
Massachusetts?**

# Massachusetts health care spending growth from 2015 to 2017 was mostly driven by price increases

Contribution to total spending growth as reported by the three largest Massachusetts payers, 2015-2017 average

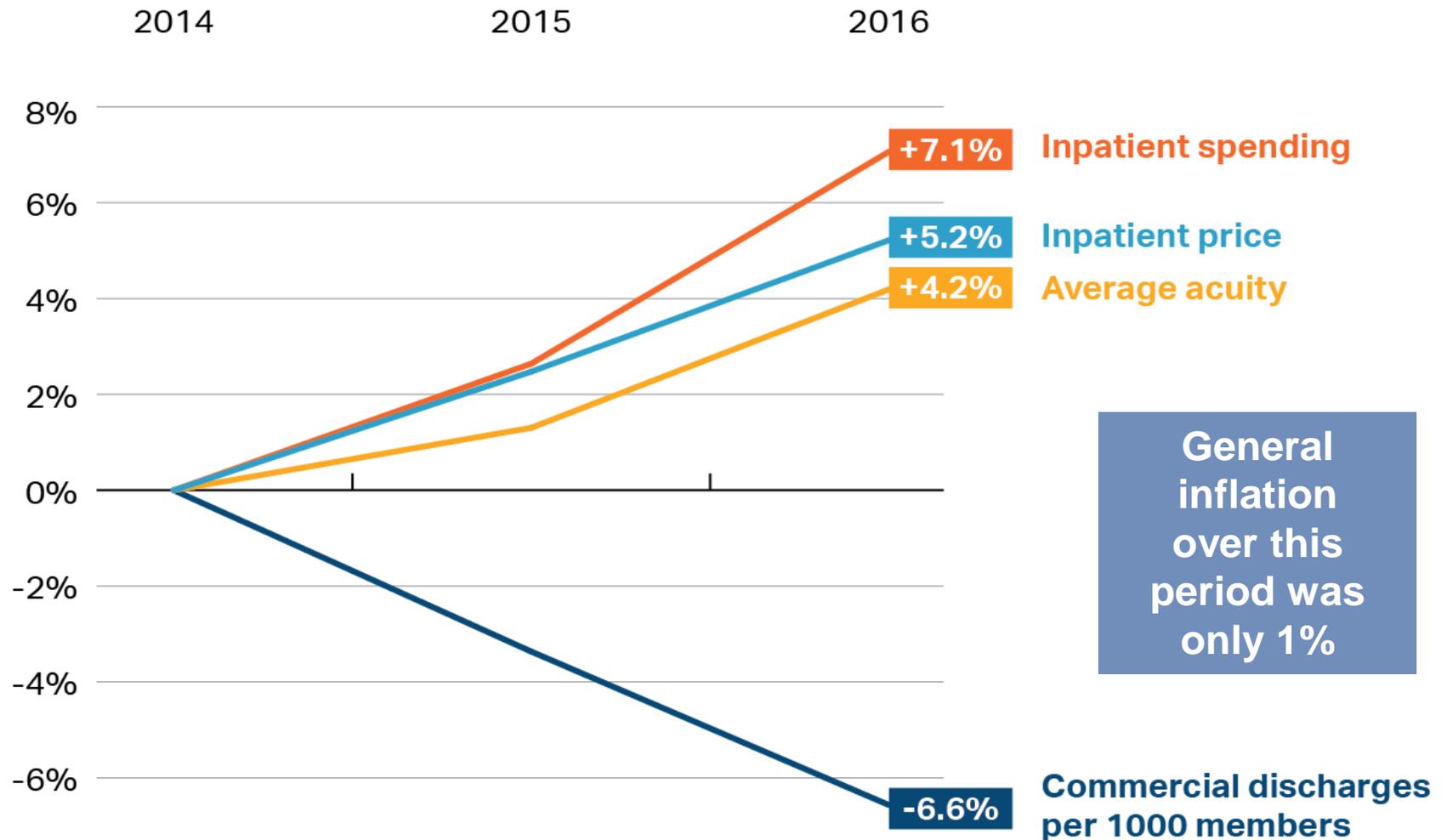


Notes: "Provider mix" means the different providers used by health plan subscribers and "service mix" refers to the range, type and intensity of health care services used. Health care spending can increase or decrease based on subscribers using higher or lower cost providers as well as more or less expensive services.

Sources: Pre-filed testimony pursuant to HPC 2018 Cost Trends Hearing

# Although commercial inpatient utilization has declined, inpatient spending has continued to increase, driven by increasing prices and acuity

Change in average commercial inpatient prices, utilization, acuity and spending, 2014-2016

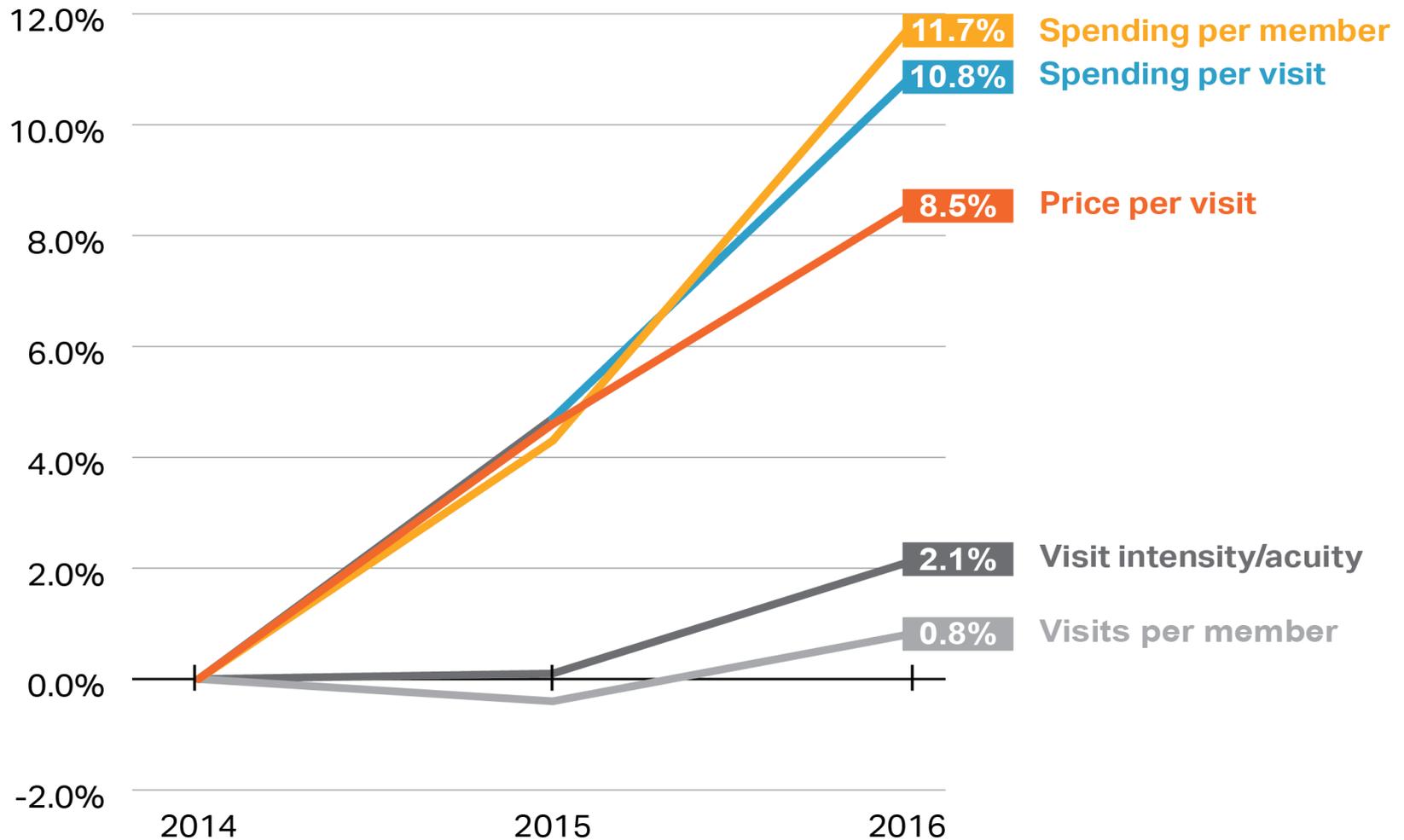


Notes: Price analysis includes facility portion only, adjusted for changes in acuity and provider mix over time, and excludes claims with invalid payment codes, outlier claims at each hospital, and some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial TME trend represents facility payments to the three largest commercial payers in MA, acuity trend was calculated for all commercial discharges using Medicare DRG case weights, and discharge trend is per 1000 commercial members for all commercial payers.

Sources: HPC analysis of All-Payer Claims Database, 2016; CHIA hospital discharge data sets for 2014-2016; CHIA Total Medical Expense files.

# Commercial emergency department (ED) spending also increased due to significant price increases, despite very little utilization growth

Change in average commercial emergency department prices, utilization, acuity and spending, 2014-2016



Notes: Analysis based on commercial discharges in the Massachusetts All-Payer Claims Database for the three largest commercial payers only.  
Source: Massachusetts All-Payer Claims Database, 2014-6.

# Rapidly rising drug prices are contributing to higher spending and affordability challenges for Massachusetts residents

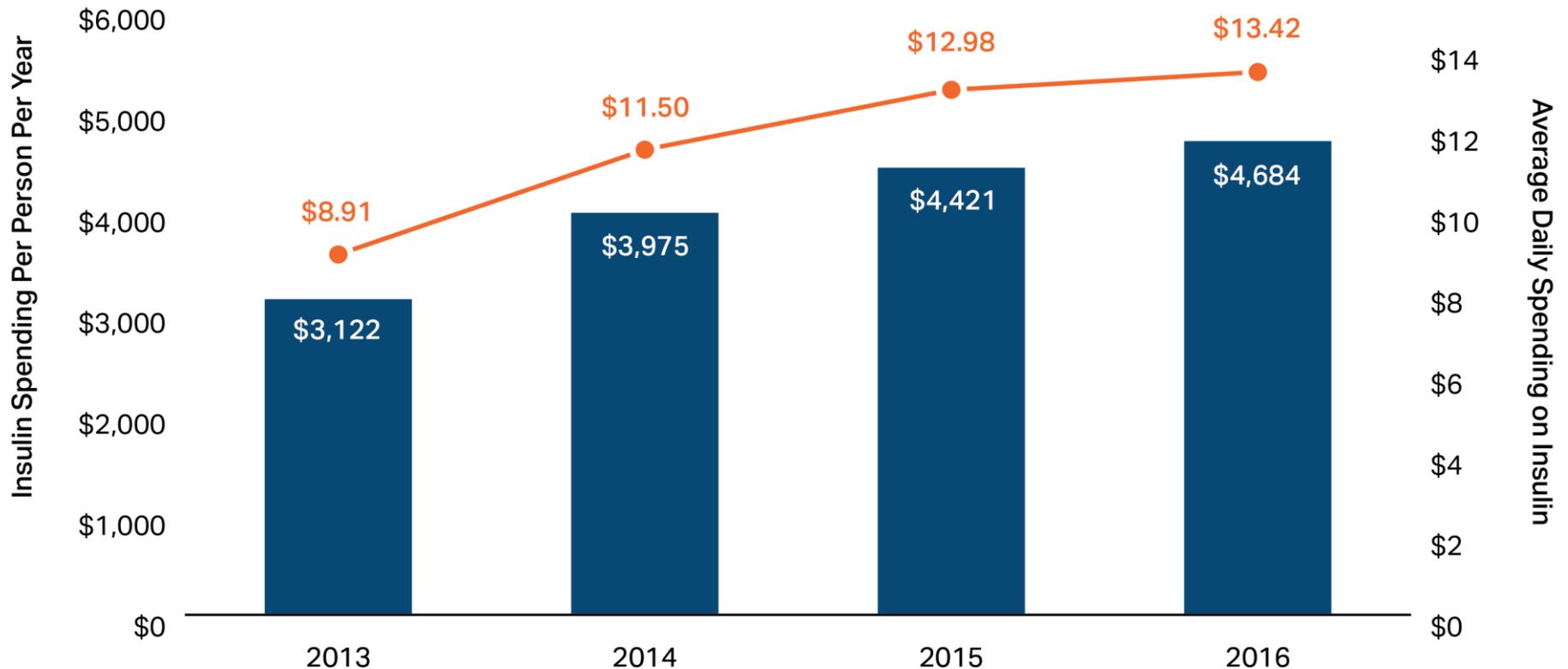
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## SPOTLIGHT ISSUE

- Spending on prescription drugs has been among the fastest growing categories of health care in recent years. This trend contributes to patient affordability challenges, particularly for those patients with ongoing pharmaceutical treatment needs.
- To further understand this dynamic, the HPC analyzed the All-Payer Claims Database (APCD) to understand **spending and price trends of insulin** for a sample of commercially insured patients. Patients with diabetes typically require frequent doses of insulin to regulate glucose levels.
- Due to data limitations, the HPC's analysis is restricted to 2013-2016. However, recent data from the Centers for Medicare and Medicaid Services (CMS) indicates that the **price of common insulin products continued to increase** in 2017, 2018, and 2019.

# For Massachusetts residents with diabetes, annual spending on insulin products increased by 50% from 2013 to 2016

Annual and average daily spending on insulin products per person per year, 2013-2016

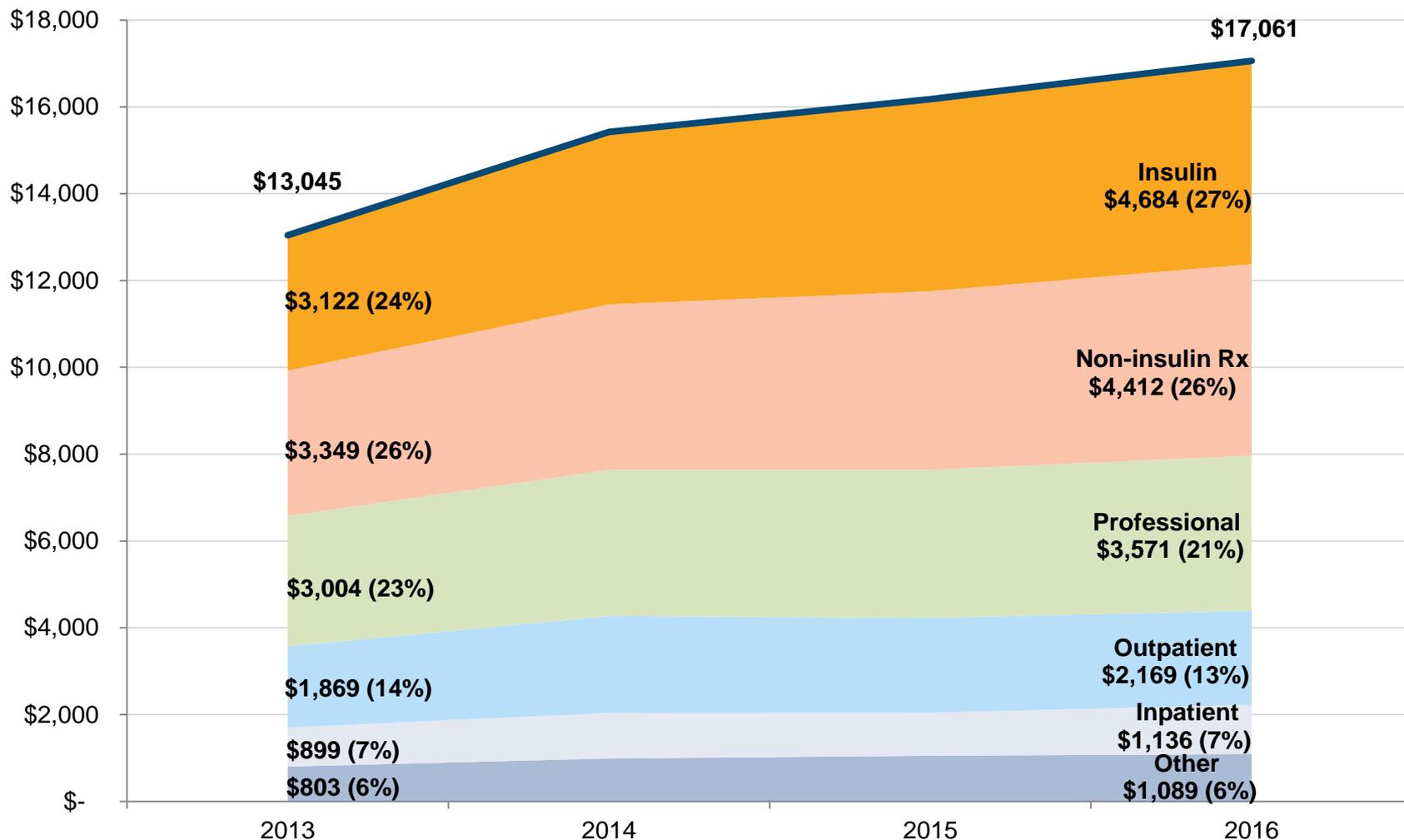


Notes: The average daily use of any insulin products was 59 units per person on average in each study year. Average daily spending on insulin is calculated by multiplying the average unit price and the average daily volume of insulin. Actual insulin use may vary by person. The study population was limited to individuals with full-year medical and prescription drug coverage, **who were identified as having diabetes by the Johns Hopkins ACG system**, who have insulin pharmacy claims, and an ACG risk score less than 5. This methodology resulted in over 9,000 individuals in our sample each year.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2013-2016

# Insulin spending was the largest contributor to their health care spending growth, accounting for 27% of total spending in 2016

Category of spending and contribution to total health care spending per person per year, 2013-2016



Notes: 'Other' category includes spending on home health assistance, durable medical equipment, hospice care, and care received in a skilled nursing facility. Spending categories defined by the Health Care Cost Institute (HCCI).

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2013-2016; [HCCI January 2019 brief](#).

# By 2016, average annual out-of-pocket spending for insulin was \$340; 18% of individuals paid more than \$500 and 6% paid more than \$750

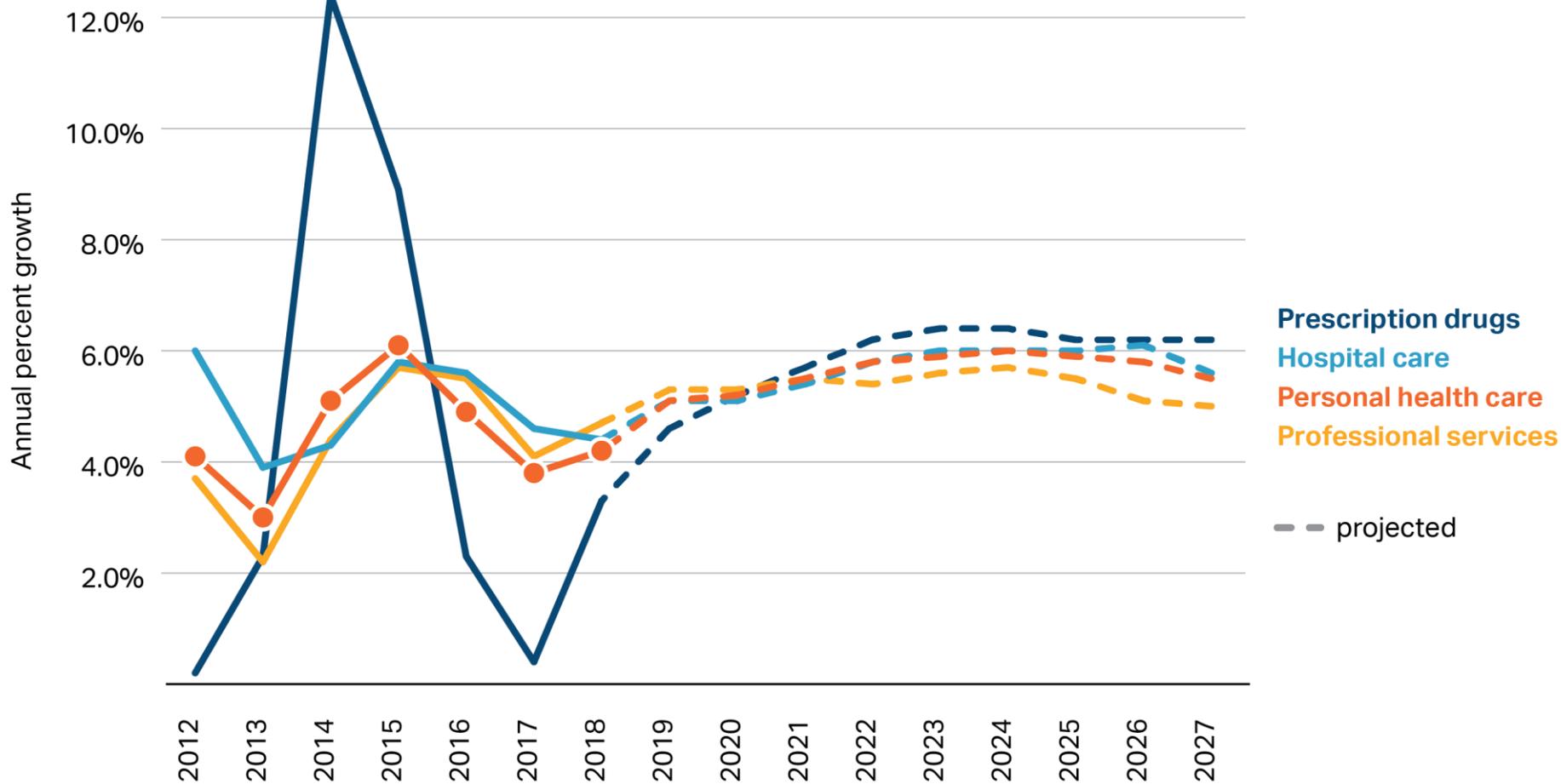
Annual out-of-pocket spending for insulin products, 2013-2016



## **SECTION V.**

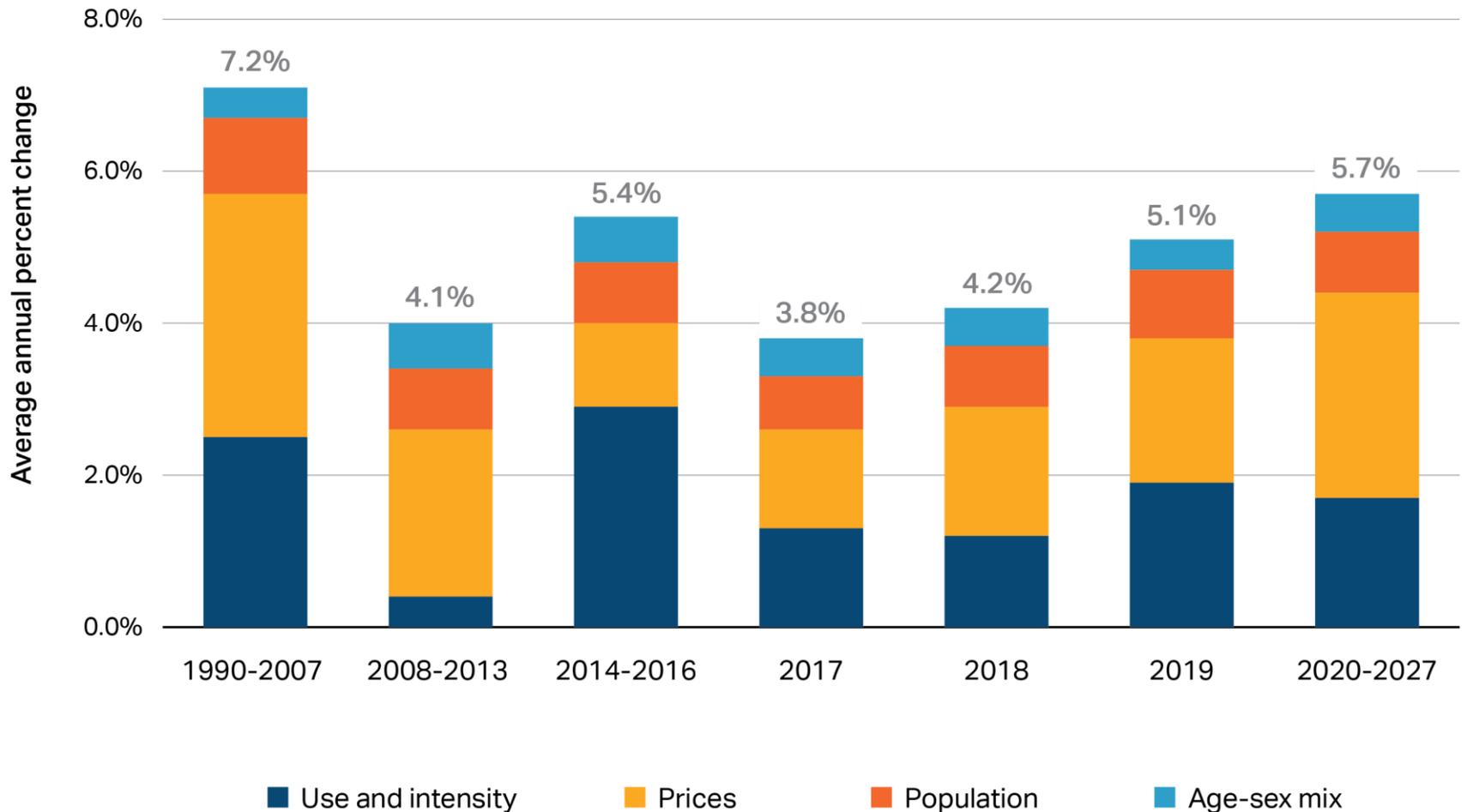
**What are the future projections  
for health care spending  
growth in the U.S.?**

# National health care spending growth is projected to increase more than 5 percent annually from 2018-2027, driven by prices, specialty prescription drugs, and population aging



# Price is projected to be a continued driver of future spending growth

Factors accounting for growth in personal health care expenditures, selected calendar years from 1990-2027

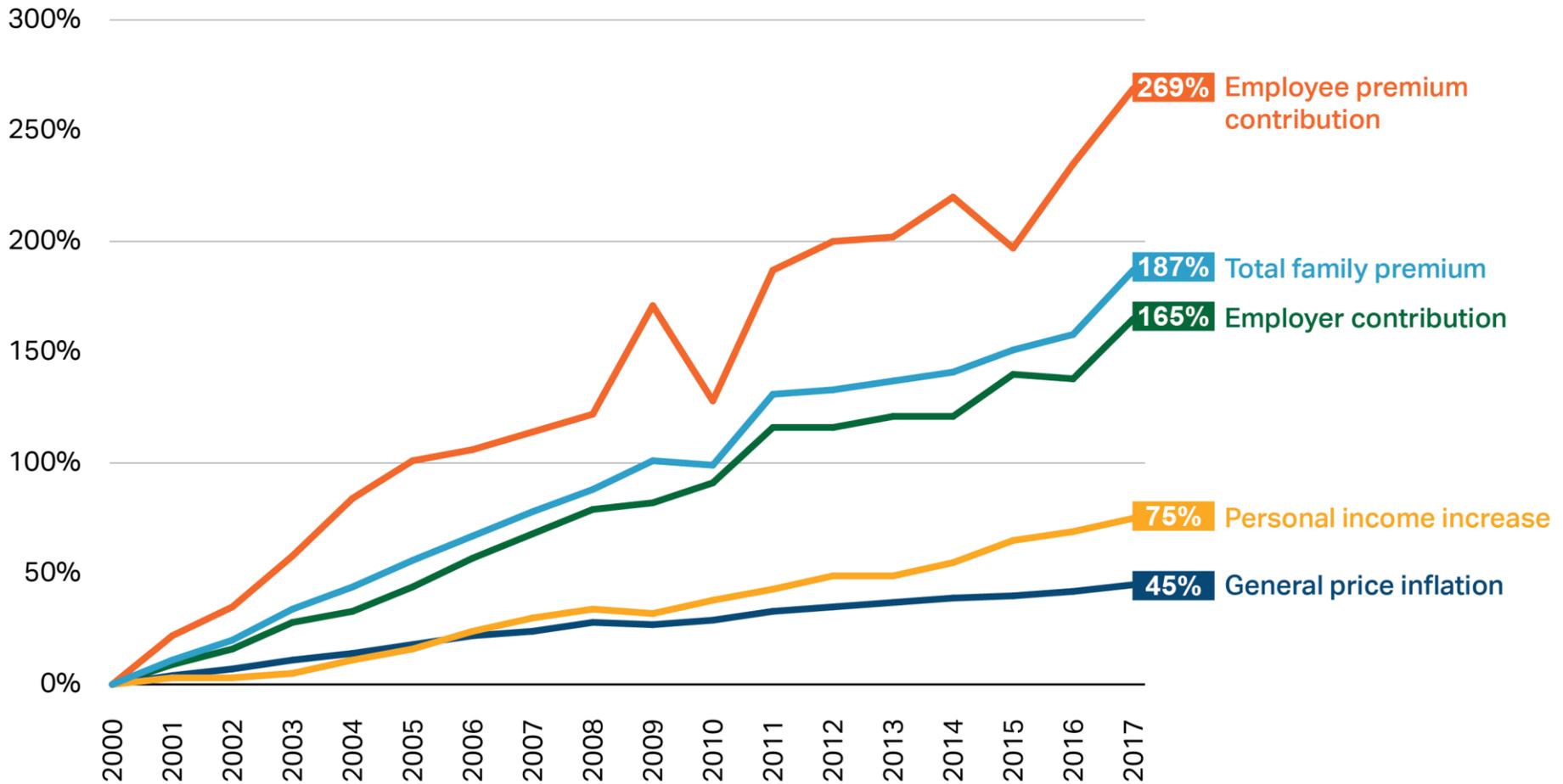


## **SECTION VI.**

**Why should Massachusetts  
continue to focus on health  
care costs and affordability?**

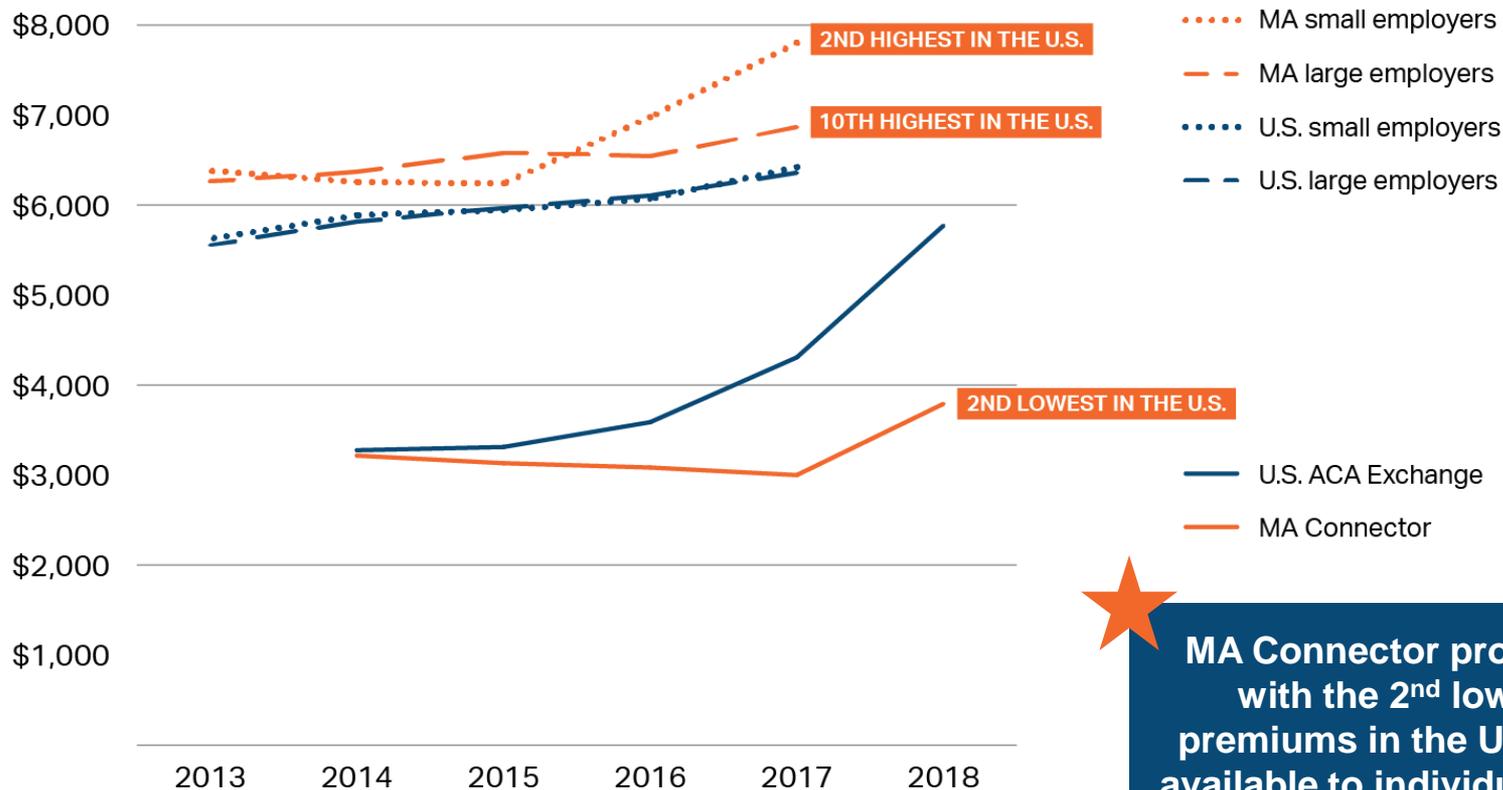
# Cumulative premium growth has far outpaced income growth and inflation from 2000 to 2017 in Massachusetts

Cumulative percentage increase in each quantity between 2000 and 2017



# Insurance premiums for large Massachusetts employers are the 10<sup>th</sup> highest in the U.S., while premiums for small employers are now the 2<sup>nd</sup> highest

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



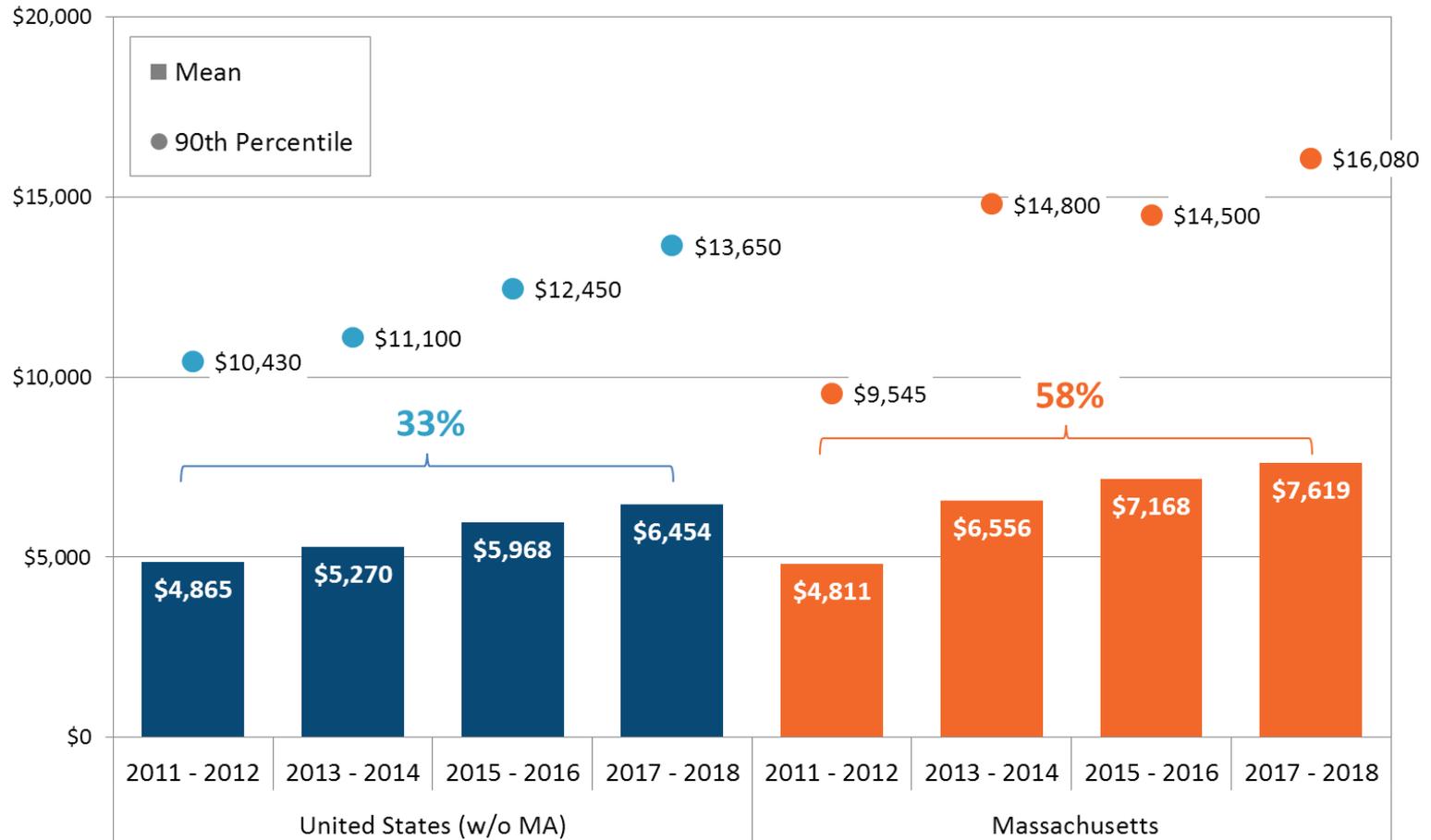
**MA Connector products, with the 2<sup>nd</sup> lowest premiums in the U.S., are available to individuals and small employers**

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 without adjustment.

Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov (marketplace premiums 2014-2018); US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017)

# The amount that middle-class Massachusetts employees spend annually on their health care (cost-sharing and employee premium contribution) has grown markedly and now exceeds the rest of the U.S.

Annual out-of-pocket health care spending and employee premium contributions for individuals with employer-based insurance between 139% and 500% of the federal poverty level



**Notes:** Includes all out-of-pocket spending on health insurance premiums, copays, deductibles, prescriptions, over-the-counter medicine, and any uncovered services that the respondent paid for directly. Most figures represent family coverage.

**Source:** Current Population Survey Annual Social and Economic Supplement (ASEC), U.S. Bureau, 2011-2018

# Affordability Challenges in Massachusetts Based on CHIA's Health Insurance Survey

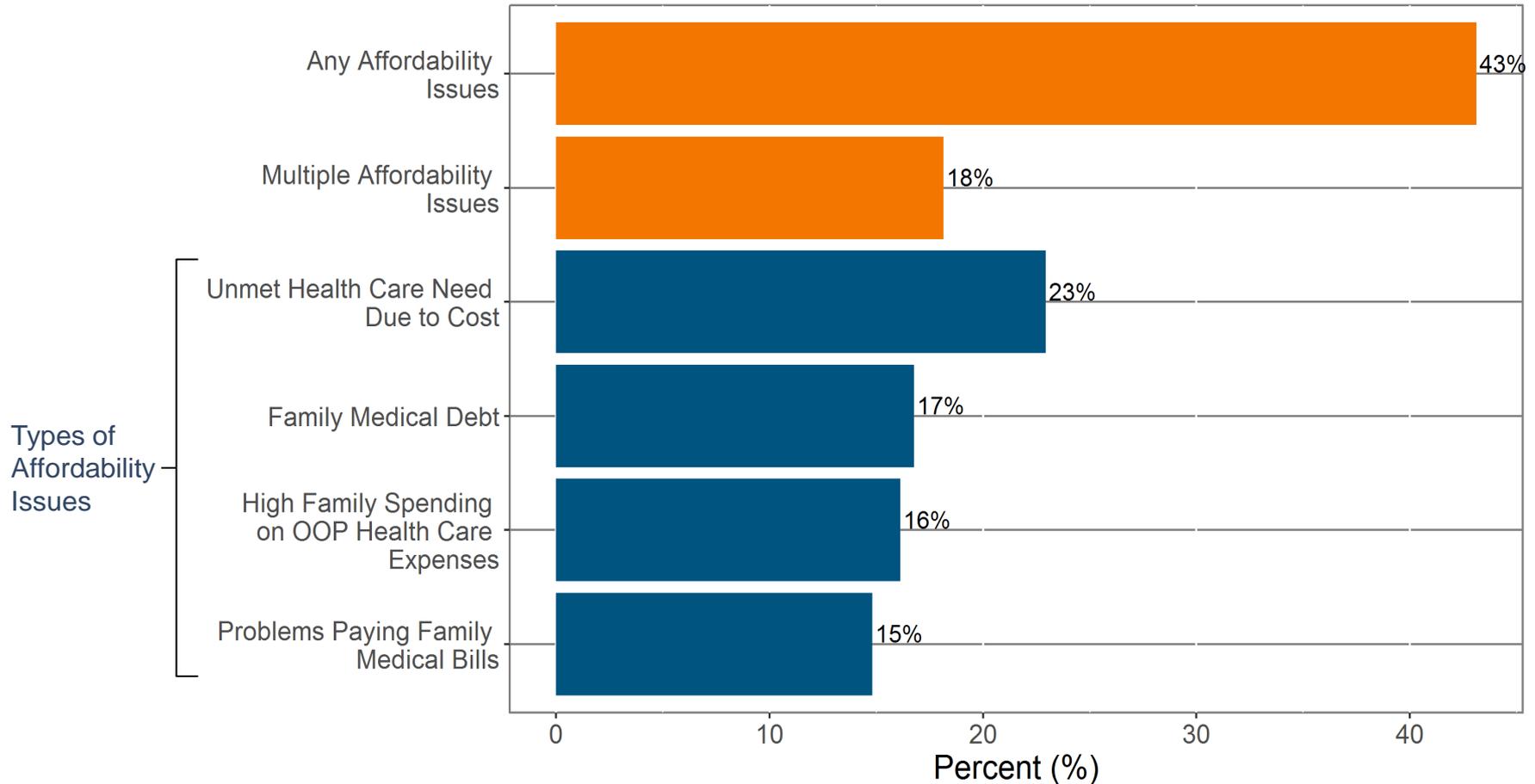
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## SPOTLIGHT ISSUE

- While Massachusetts continues to lead the nation in insurance coverage, findings from CHIA's *Massachusetts Health Insurance Survey* suggest that affordability challenges remain.
- A further analysis (soon to be released) looked at affordability issues faced in the prior 12 months by residents with insurance all year. These affordability issues included:
  - Problems paying family medical bills
  - Family medical debt
  - Unmet health care need due to cost
  - High family spending on out-of-pocket (OOP) health care expenses
    - 5% or more for families with incomes less than 200% of the federal poverty level (FPL)
    - 10% or more for families with incomes 200% FPL or higher

# In 2017, 43% of insured residents reported having an affordability issue in the past 12 months and 18% of insured residents reported having multiple affordability issues

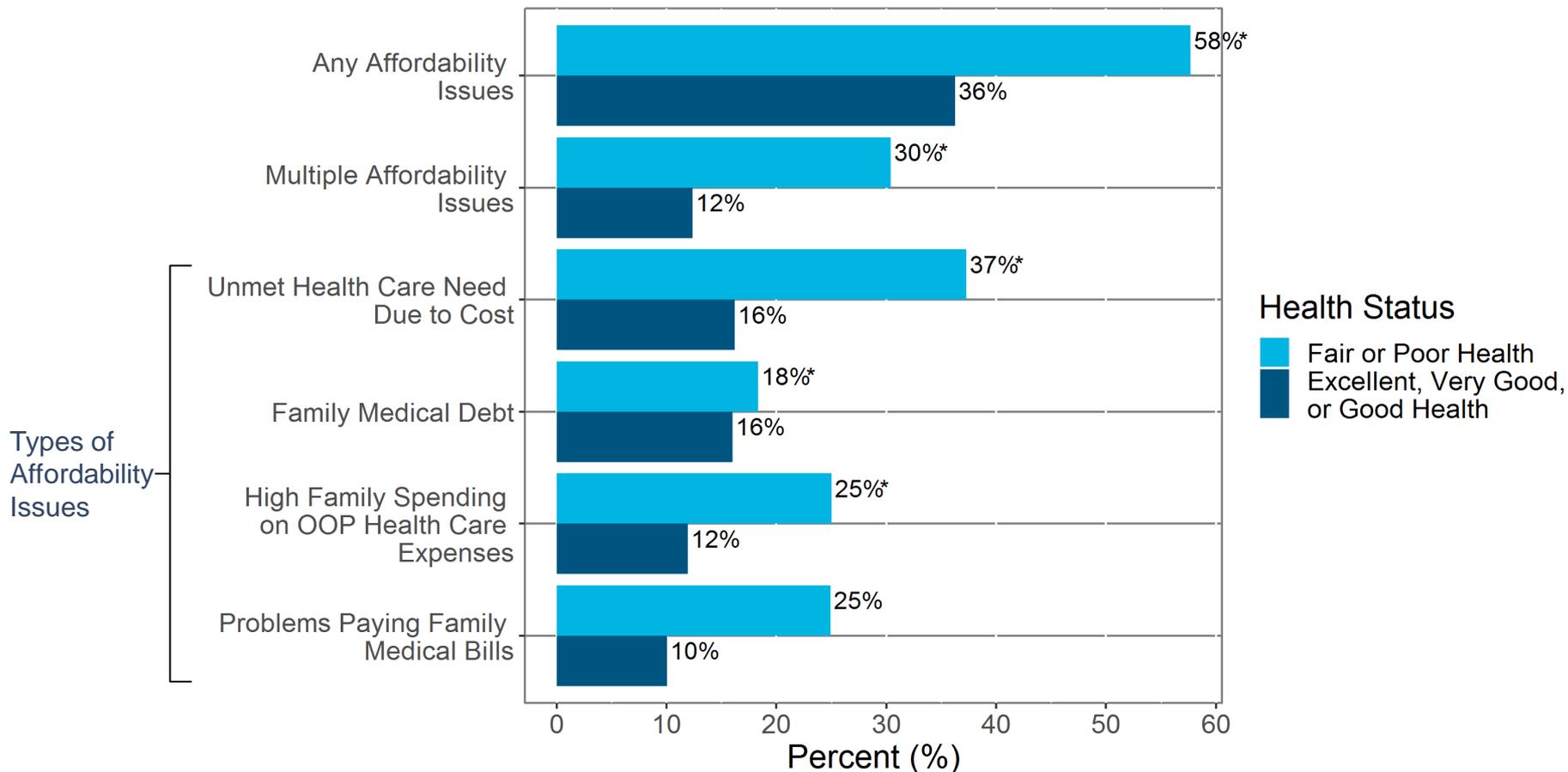
Overall Health Care Affordability, CHIA Health Insurance Survey, 2017



\*Difference from value for "Excellent, Very Good, or Good Health" is statistically significant at the 5% level.

# Insured residents in fair or poor health, who have more need for health care services, have high rates of affordability issues

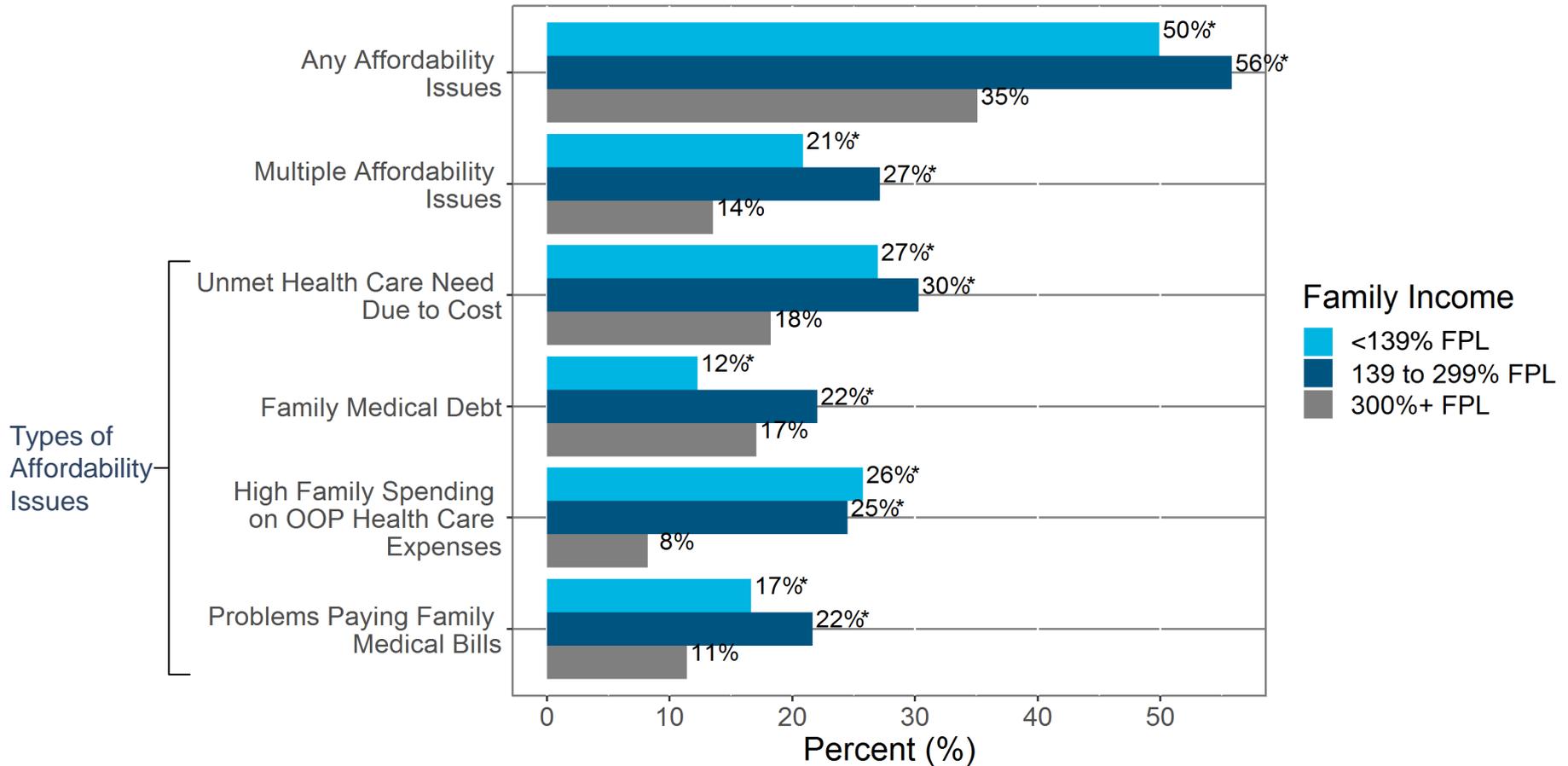
Health Care Affordability by Health Status, CHIA Health Insurance Survey, 2017



\*Difference from value for "Excellent, Very Good, or Good Health" is statistically significant at the 5% level.

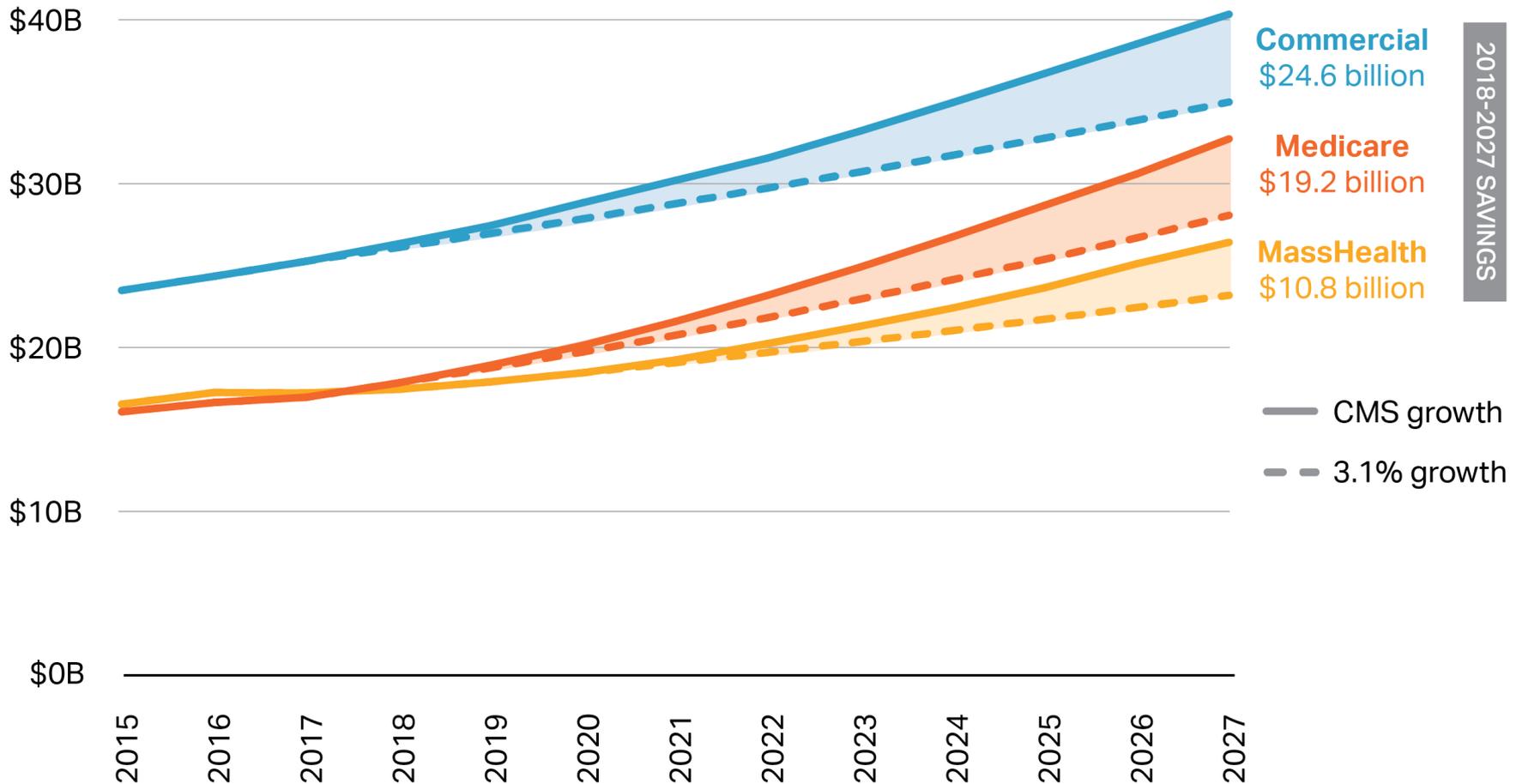
# Insured residents with low to moderate family income are more likely to struggle with affordability

Health Care Affordability by Family Income, CHIA Health Insurance Survey, 2017



\*Difference from value for “300%+ FPL” is statistically significant at the 5% level.

# Massachusetts would save \$55 billion between 2018-2027 if per capita spending grows 3.1% annually rather than at CMS' projected growth rates



## The HPC estimates that savings of this magnitude would provide significant relief to Massachusetts residents and the state budget

If Massachusetts health care spending grew at 3.1% across all payer categories rather than the national projected rates, in 2027:

Total spending on health care would be **14% lower**, a difference of **\$12.6 billion** (from \$99.5B to \$86.9B)

**13% lower**  
family premiums  
(\$27,300 vs.  
\$31,500)

**\$6,600 more**  
in take-home pay  
per worker  
*\*2018-2027*

**\$1.24 billion**  
in additional state  
income tax revenue  
*\*2018-2027*

Notes: Some calculations based on "Benefits of Lower Healthcare Cost Growth for Massachusetts Employees and Employers," Jon Gruber and Ian Perry, Blue Cross Blue Shield Foundation of Massachusetts, 2012.

Sources: See previous slide and U.S. Agency for Healthcare Research and Quality.

## **SECTION VII.**

**What should market participants and policymakers do to advance the goal of a more efficient, high-quality health care system in Massachusetts?**

## Policy Recommendations in the HPC's Annual Cost Trends Report

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The 2018 Annual Cost Trends includes a set of eleven policy recommendations necessary to continue progress in achieving the Commonwealth's goal of better health, better care, and lower costs.

### HPC Recommendations by Topics

1 Administrative Complexity

2 Pharmaceutical Spending

3 Out-of-Network Billing

4 Provider Price Variation

5 Facility Fee Reform

6 Demand-Side Incentives

7 Unnecessary Utilization

8 Social Determinants of Health

9 Health Care Workforce

10 Innovations in Integrated Care

11 Alternative Payment Methods

# In 2018, the HPC modeled the savings impact of seven strategies to reduce spending in Massachusetts, totaling nearly \$5 billion in five years

## SUMMARY OF OPPORTUNITIES FOR SAVINGS

TARGET	SCENARIO	FIVE YEAR SAVINGS
I. Post-Acute Care (PAC)	Reduce all-payer discharges to institutional PAC to 15% without increasing home health use.	\$1.37b
II. Hospital Readmissions	Reduce readmissions by 20% from the 2015 level by 2022.	\$1.04b
III. Alternative Payment Methods (APMs)	Increase use of APMs in HMOs to 68% by 2022 (93% in large providers, and 36% for other providers), and to 40% by 2022 for PPO plans.	\$494.6m
IV. Community Appropriate Inpatient Care	Gradually shift 25% of commercial and Medicare community appropriate care from teaching hospitals to community hospitals.	\$211.4m
V. Avoidable Emergency Department (ED) Use	Redirect 20% of primary care treatable visits to a primary care setting; redirect 33% of non-emergent ED visits to a lower-cost setting; and eliminate another 33% of non-emergent ED visits.	\$351.7m
VI. Prescription Drugs	Limit growth of prescription drug prices to 1.55%.	\$230.5m
VII. Hospital Outpatient Care	Reimburse select outpatient procedures at a site-neutral rate, starting in 2018.	\$1.06b
<b>TOTAL</b>		<b>\$4.76 billion (~2.1% THCE)</b>
<i>Commercial Savings</i>		<i>\$2.55b</i>

# **PUBLIC TESTIMONY**

# Upcoming 2019 Meetings and Contact Information



## Board Meetings

Wednesday, April 3 (3:00 PM)  
Wednesday, May 1 (1:00 PM)  
Wednesday, July 24  
Wednesday, September 11  
Monday, December 16



## Committee Meetings

Wednesday, June 5  
Wednesday, October 2  
Wednesday, November 20



## Contact Us

Mass.Gov/HPC  
 @Mass\_HPC  
[HPC-Info@state.ma.us](mailto:HPC-Info@state.ma.us)



## Special Events

**2019 Cost Trends Hearing**  
Day 1 – Tuesday, October 22  
Day 2 – Wednesday, October 23