MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

March 8, 2016

Hon. Jeffrey Sánchez, House Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02113

Hon. James T. Welch, Senate Chair
Joint Committee on Health Care Financing
State House, Room 309
Boston, MA 02113

re: House Bill 3931 – Initiative petition: The Massachusetts Fair Health Care Pricing Act

Dear Chairman Sánchez and Chairman Welch:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 health plans that provide health care coverage to more than 2.7 million Massachusetts residents, I am writing with regard to House Bill 3931, the Massachusetts Fair Health Care Pricing Act initiative petition.

Our member health plans provide coverage to a broad range of individuals, including those on Medicaid, low-income seniors enrolled in Senior Care Options plans, individuals in employer-sponsored plans, and consumers purchasing coverage on their own. They also continually set the standard for the rest of the country for clinical quality and member satisfaction, consistently ranked among the nation's best by the National Committee for Quality Assurance's (NCQA) and offering innovative programs that improve quality, coordinate care, and integrate medical care, behavioral health and substance abuse services, and pharmacy benefits to meet the specific needs of their members.

Keeping health care affordable is ***the*** number one challenge facing all of us in the health care system and the rising cost of health care is a significant challenge for Massachusetts employers and consumers. The expansion of coverage as a result of our state's health reform efforts and the Affordable Care Act requires holding all entities – health plans, hospitals, physicians, and pharmaceutical and device manufactures – accountable for containing health care costs. Multiple state reports have reached many of the same conclusions about the factors driving health care costs. Specifically, the price of services that doctors and hospitals charge is the main reason for increasing health care costs and significant gaps exist between the highest and lowest paid providers with no correlation to quality. As premiums reflect the cost of care, containing the cost of medical services and closing the gap between lower-paid providers and higher-cost providers are essential to ensure a more competitive and functioning marketplace.

Two years ago, we engaged Freedman HealthCare to analyze the major state reports on health care costs. In its analysis, Freedman HealthCare reviewed the 16 state reports that had been published from 2008-2013 and identified the following 10 major health care cost trends and cost drivers:

1. Provider prices, not utilization of health care services, is the biggest cost driver in the Massachusetts market.
2. There is a significant gap between the highest and lowest paid providers.
3. Health care is most often delivered in higher priced settings.
4. High prices do not directly correlate with high quality of care – in other words, the highest paid providers do not necessarily provide the highest quality of care.
5. Providers with the highest public payer case mix have the lowest commercial reimbursement.
6. Academic medical centers are associated with higher health care costs.

7. In response to increasing provider prices, the commercial market is seeing higher health care premiums and increased consumer cost sharing.
8. Market share impacts health care costs by influencing provider reimbursement rates, total medical expenses, and patient volume.
9. There is growing policy concern that provider consolidation may lead to higher prices, rather than savings from integration of care or improved efficiency.
10. Despite its increasing promotion, the widespread adoption of global payments faces significant challenges, and there is limited evidence to suggest that global payments produce cost savings.

Recently, MAHP, along with Associated Industries of Massachusetts, the National Federation of Independent Business, and the Retailers Association of Massachusetts, asked Freedman HealthCare to re-examine the 2014 findings in light of nine additional reports published by state agencies from 2014-2015. In conducting its analysis, Freedman HealthCare assessed the progress of its prior findings, noting that the 10 trends discussed in the 2014 review remain unchanged, and identified the following four new findings:

1. Performance against the cost benchmark has been mixed since it was first measured in 2013.
2. Pharmaceutical costs have been increasing and are expected to increase in the future.
3. The state is increasingly focused on behavioral health – specifically on the high costs associated with behavioral health conditions, the challenges of clinical and administrative integration of care, and the need for better data.
4. Due to persistent and increasing disparities in provider prices over the past several years, the state is recommending policy action be taken to reduce excessive price variation.

As the Attorney General's September 2015 *Examination of Health Care Cost Trends and Cost Drivers* report noted, many of the fundamentals of the market dysfunction first documented by the office in 2010 remain unchanged and persist, including wide variation in provider prices that are not based on quality, acuity, or complexity and that higher priced providers continue to draw greater patient volume from lower-priced institutions. The Center for Health Information and Analysis' February 2016 provider price variation chart book (*Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market*) found that commercial payments continued to be concentrated among the highest-priced acute hospitals in 2014 and that for physician groups the share of payments to higher-than-average priced providers grew from 81.5% in 2012 to 85.2% in 2013. The growing disparity leaves fewer resources for lower-paid providers to invest in new services, while the pressure to raise rates to support these providers makes it more difficult for health plans to meet the Commonwealth's health care cost benchmark as the level of payments to higher-cost providers continues to grow.

Making health care more affordable should focus on the findings of the Freedman HealthCare analysis and implementing measures to address unwarranted price variation and the growth in prices charged by providers. While well-intentioned, we do not believe that the initiative petition is an appropriate mechanism to address price variation. However, given the projected growth in health care spending and issues identified in multiple state reports on price variation and provider prices, action is necessary to address market dysfunction.

Principles for Addressing Price Variation

Despite our opposition to addressing price variation through the initiative petition process, we believe that the Committee should consider measures to address unwarranted variation, including additional tools to assist health plans in negotiating contracts to provide meaningful relief for employers and consumers. The following principles seek to balance the dual goals of cost containment and addressing unwarranted differences in prices among providers and may assist the Committee in reviewing potential approaches.

1. Provider prices may vary for justifiable reasons, including quality of care, acuity, regional differences and patient mix, but should not vary due to size, geographic isolation or market clout.

2. Reducing the variation in provider prices should result in meaningful relief for consumers and employers by lowering health care costs.
3. Reducing provider price variation should be done responsibly. Commercial and government subsidized markets should be treated separately to account for the uniqueness of each population. Broad exclusions of providers should not be permitted.
4. Strategies to reduce provider price variation should focus on rebalancing current health care spending and not imposing new fees or assessments.
5. Strategies to reduce provider price variation should utilize data that reflects the current market and be implemented in a manner that is straightforward to avoid administrative complexity.

Potential approaches:

Nearly 10 years ago, MAHP and its member health plans outlined a comprehensive cost control agenda. During that time, our efforts have included measures intended to address unwarranted price variation. Beyond the initiative petition, there are a number of alternative approaches that we would urge the Committee to consider that would reduce price variation among providers, improve market function and provide cost relief to employers and consumers. Among the potential approaches for the Committee to consider:

- **House Bill 848 – Rate Convergence**
  While the initiative petition seeks to close the gap in prices among providers by reducing rates paid to certain high-cost providers and increasing the rates paid to lower-paid providers, the proposal includes broad exemptions for certain high-priced providers that would limit the potential savings for consumers and employers. An alternative is the approach included in House Bill 848. The proposal would require health plans to reduce the rates they pay to providers above the health plan's 80th percentile and increase rates to providers below the 20th percentile. It includes a more narrow set of exemptions than the initiative petition, which would provide greater savings for consumers and employers, and would be limited in duration, expiring after five years when the dysfunctions in the market have been addressed. While certain technical elements of House Bill 848 would need to be updated to reflect changes in the marketplace since the bill was first introduced in 2011, the proposal would provide meaningful relief in addressing the wide variation in provider rates.

- **Variations in Permissible Provider Increases**
  Another approach to addressing price variation would be to evaluate provider performance under the statewide cost growth benchmark by taking into account differences in provider efficiency. For example, the annual increase for certain high-priced providers could be set at a level below the state's cost growth benchmark, so that their increases could not exceed a rate greater than the cost growth benchmark divided by their relative price. Another example would be for the Center for Health Information and Analysis to take an alternate approach in determining whether a provider's increase exceeded the cost growth benchmark. Currently, providers whose health status adjusted total medical expense growth was above 3.6% are included on the Center's list of providers whose cost growth is excessive. Instead, for certain high-priced providers, the Center could divide the cost growth benchmark by the provider's relative price and if the rate of growth exceeds that level, the provider would be placed on the Center's list of providers whose cost growth is excessive, requiring them to submit a performance improvement plan to the Health Policy Commission on how they will reduce their costs.

- **Cap on Provider Rates**
  A third approach would be to prohibit contracts between a health plan and a provider that exceeded a certain relative price level unless the entities could demonstrate the excess amount was based on value such as quality, acuity or patient mix. If the state determined value was not met, the health plan and provider could be required to reduce the rate either by demonstrating a

glide path to lower the rate or establishing a default rate of the health plan's median relative price if the entities could not agree to a method for lowering the rate.

For these or other proposals, it would be essential that the Health Policy Commission (HPC) serve as the state agency for overseeing, monitoring and implementing measures to address provider price variation. Given its role as the agency responsible for developing policy to reduce health care cost growth, the HPC has the resources and expertise for monitoring the performance of the entire health care system, so that the goals of any price variation proposal are being met, and can analyze the impact proposed changes may have on cost, quality, and access, as well as any further changes that might be necessary.

In addition to these proposals, we would also urge the Committee to provide a favorable report to House Bill 3678. The bill, filed by Attorney General Maura Healey and House Majority Leader Ron Mariano, would increase the legal authority of cost and market impact reports issued by the Health Policy Commission and strengthen the authority of the Attorney General's office if it determines a proposed merger or other transaction would be harmful to the marketplace.

House Bill 3678 is a critical step to maintaining a competitive marketplace. Consolidation does not constitute integration and this legislation would strengthen the process and authority for reviewing mergers and acquisitions by hospitals, physicians and other providers taking place in the delivery system. The bill would provide the Commonwealth with the necessary tools to examine whether changes in the market ultimately benefit consumers and employers through lower costs and, when necessary, prevent those transactions that will make health care more expensive.

The provider consolidation taking place today will reshape the health care system and could make health care more expensive for employers and consumers. Some have suggested that the wave of mergers, acquisitions and clinical affiliations among hospitals, physicians and other providers is necessary and will result in better integration and improved quality for patients. However, there is a growing body of research among national policy experts that greater consolidation does not, in fact, lead to better care and lower prices, but rather merely leads to enhanced bargaining power with no notable improvement in quality of care for patients. House Bill 3678 would help to ensure that state policymakers have the tools they need when reviewing proposed mergers, acquisitions and clinical affiliations by hospitals, physician organizations and other providers to ensure that provider consolidations ultimately benefit employers and consumers through lower costs and better care.

We appreciate the opportunity to offer our comments on House Bill 3931 and we look forward to working with the Committee on measures to address provider price variation.

Sincerely,

Lora Pellegrini
President & CEO