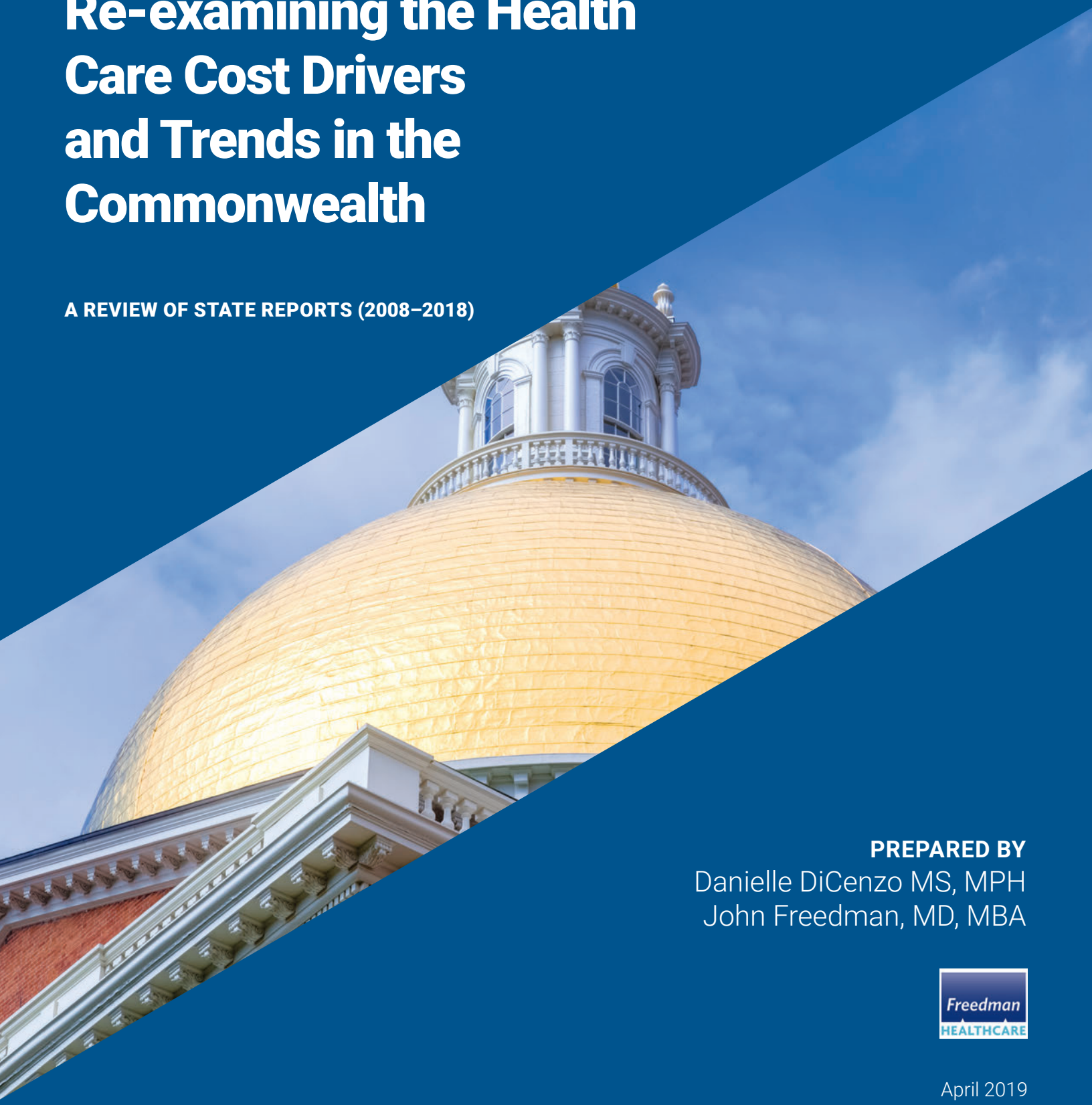
# Re-examining the Health Care Cost Drivers and Trends in the Commonwealth

**A REVIEW OF STATE REPORTS (2008–2018)**

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April 2019

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# Executive Summary

Massachusetts is recognized as a national leader in access to health coverage and high-quality care. Despite these successes, Massachusetts consistently has one of the most expensive health care systems in the nation. To contain these high health care costs and increase transparency in the health care market, the Commonwealth has implemented legislative reforms for over a decade. State agencies such as the Attorney General's Office (AGO), the Center for Health Information and Analysis (CHIA), and the Health Policy Commission (HPC) regularly evaluate the progress of these state efforts and publish reports on key trends observed in the Massachusetts health care market. These reports provide valuable information that sheds light on persistent issues as well as on emerging themes related to health care costs, quality, and utilization.

In 2014, the Associated Industries of Massachusetts, Massachusetts Association of Health Plans (MAHP), the National Federation of Independent Business, and the Retailers Association of Massachusetts engaged Freedman HealthCare (FHC) to review state reports published between2008 and 2013. FHC identified common themes in reports and identified 10 key findings. In 2015, FHC analyzed nine new reports that were published between 2014 and 2015 to add four new findings to the previous 10.

This year's paper took a retrospective look at nine new state reports since 2015 as well as the previously examined reports published in 2015 and earlier. Reviewers then consolidated common themes into 14 findings, separating primary cost drivers and other health care market trends, shown in Table 1. This paper aims to provide a comprehensive view of the Massachusetts health care market to help policymakers and other stakeholders better understand health care cost drivers and trends.

## Table 1. Key Findings

### Primary Cost Drivers of Massachusetts Health Care Expenditures

| | |
|---|---|
| 1. | Provider price, not utilization of health care services, remains the biggest health care cost driver in Massachusetts. |
| 2. | Provider price variation remains an issue. There is a large and persistent gap in reimbursement between the highest and lowest paid providers. |
| 3. | Academic Medical Centers (AMCs) are associated with higher health care costs. Routine care is regularly delivered at AMCs, driving up spending and taking volume away from community hospitals. |
| 4. | Pharmaceutical costs, particularly specialty and doctor-administered drugs like cancer chemotherapy, are a major cost driver in Massachusetts and nationally. |
| 5. | Hospital outpatient services represent a growing share of total health care expenditures. |
| 6. | The effects of provider consolidation, such as market leverage, lead to higher prices and large disparities in provider prices. |

### Other Notable Trends in the Massachusetts Health Care System

| | |
|---|---|
| 1. | Massachusetts has made considerable progress in meeting the health care cost growth benchmark. The Commonwealth beat the benchmark for the most recent two years and has improved compared to national trends. Despite this, Massachusetts still has among the highest health care costs in the nation. |
| 2. | The highest paid providers do not necessarily provide the highest quality of care. |
| 3. | Providers with the highest public payer case mix have the lowest commercial reimbursement. |
| 4. | In response to increasing provider prices, consumer cost sharing is rising in the commercial market, impacting mostly low-and middle-income residents. |
| 5. | Alternative Payment Models (APMs) are growing in MassHealth and Medicare. After an initial rapid rise, APMs have leveled off in the commercial market. |
| 6. | Surprise billing and facility fees for outpatient care are problematic and leave many consumers with out-of-pocket medical bills despite having comprehensive coverage. |
| 7. | There are opportunities to reduce unnecessary utilization. |
| 8. | Administrative costs can burden the system and impede transparency. |

# Introduction

Massachusetts has been recognized as a national leader in access to coverage and quality of care. Today, Massachusetts boasts the lowest uninsured rate in the nation, with 2.5% of residents uninsured compared to the US average of 8.6%.[1] Over the past two years, Massachusetts has had the lowest average premiums of any individual marketplace in the country.[2] Despite these achievements in access, the state's spending remains among the highest in the country.

To help rein in health care spending, the Commonwealth implemented several legislative reforms, including Chapter 224 of the Acts of 2012 and other statewide efforts, to contain costs and increase transparency in the health care market.

Chapter 224 established a first-in-the-nation, annual statewide benchmark for health care cost growth, set at 3.6% growth for 2013 through 2017 and then lowered to 3.1% growth for 2018. To support and evaluate cost-containment efforts, state agencies such as the Attorney General's Office (AGO), the Center for Health Information and Analysis (CHIA), and the Health Policy Commission (HPC) regularly monitor and report health care cost and utilization trends. For example, the HPC has performed Cost and Market Impact Reviews (CMIRs) on proposed provider consolidations and acquisitions to determine their impacts on the state's health care market. In addition, CHIA leverages its statewide data collection efforts to publish annual analyses of provider price variation, total health care expenditures, and other market trends to help identify opportunities to bend the cost trend on health care spending.

Since the commencement of these reforms, growth in health care spending in Massachusetts has begun to moderate. The Health Policy Commission's 2018 Annual Health Care Cost Trends report noted, for 2017, Massachusetts' Total Health Care Expenditures (THCE) grew at 1.6% per capita, lower than the 3.6% health care cost growth benchmark set by the HPC.[3] While we should be proud of this achievement, Massachusetts' health care costs remain among the highest in the country. Historically, high health care spending has been attributed to high prices charged by providers and hospitals rather than the amount of care individuals receive. For close to 12 years, Massachusetts state agencies have collected detailed health plan and provider claims data and other information and issued state reports identifying the key cost drivers in the Massachusetts marketplace.

In 2014, the Massachusetts Association of Health Plans (MAHP) released Understanding the Health Care Cost Drivers and Trends in the Commonwealth: A Review of State Reports (2008–2013), a summary of state reports issued during the period that identified common findings observed in the Massachusetts health care market. The analysis, which was performed by Freedman HealthCare (FHC), drew from 16 cost and quality reports published by various state agencies, identifying 10 key findings that were recurring themes in the reporting, as shown in Table 2.

In February 2016, MAHP, along with Associated Industries of Massachusetts, the National Federation of Independent Business, and the Retailers Association of Massachusetts, asked FHC to re-examine the 2014 findings in light of nine additional reports published by state agencies from 2014 to 2015. In conducting its analysis, FHC assessed the progress of its prior findings, noting that the 10 trends discussed in the 2014 review remain unchanged, and identified four new findings, as shown in Table 2.

## Table 2. Key Findings Identified in the 2014 Review and Added in the 2016 Review of State Reports

### Findings Identified in 2014

| | |
|---|---|
| 1. | Provider price, 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 (AMCs) are associated with higher health care costs. |
| 7. | In response to increasing provider prices, the commercial market is seeing increased consumer cost sharing. |
| 8. | Market share impacts health care costs by influencing price, utilization, and available resources. |
| 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. |

### Findings Added in 2016

| | |
|---|---|
| 11. | Performance against the cost growth benchmark is mixed. |
| 12. | Pharmaceutical costs have been increasing and are expected to continue to increase in the future. |
| 13. | The state is increasingly focused on the high costs associated with behavioral health conditions, the challenges of clinical and administrative integration of care, and the need for better data. |
| 15. | 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. |

In 2019, MAHP, along with the business community, once again asked FHC to review the latest state reports (nine in total) and provide a 10-year compilation of state reports that identifies key and persistent cost drivers and trends in the Massachusetts marketplace.

# Methodology

Reviewers identified nine reports examining health care cost and quality that were published between September 2016 and February 2019 by three leading state agencies in Massachusetts: the Center for Health Information and Analysis (CHIA), the Health Policy Commission (HPC), and the Attorney General's Office (AGO). Reviewers analyzed the results and recommendations of each report to distill common findings. While this paper focuses primarily on the recent reports, reviewers took a comprehensive approach that also considered the 25 state reports published since 2008 that were discussed in previous versions of this paper. A common finding is defined as one that was mentioned in at least two reports. It is important to note that this is not an exhaustive list of findings but rather an attempt to gather the most salient ones that appear in multiple reports. It should be noted that most of these reports focus on the commercial market, particularly of the top three insurers, although some also analyzed MassHealth and Medicare.

# Summary of Reviewed Reports

Table 3 presents the nine new reports analyzed for this paper.

## Table 3. Reports Analyzed

| | | Agency | | |
|---|---|---|---|---|
| **Report Title** | **Date Published** | AGO | CHIA | HPC |
| Annual Health Care Cost Trends Report | 10/12/2017 | | | ✓ |
| | 3/28/2018 | | | ✓ |
| | 2/20/2019 | | | ✓ |
| Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, §17 | 10/7/2016 | ✓ | | |
| | 10/13/2016 | ✓ | | |
| | 10/11/2018 | ✓ | | |
| Performance of the Massachusetts Health Care System, Annual Report | 9/1/2016 | | ✓ | |
| | 9/1/2017 | | ✓ | |
| | 9/1/2018 | | ✓ | |

The nine new reports explore a variety of topics related to the Massachusetts health care market, including cost drivers and trends, provider price variation, total medical expenses, and emerging topics of interest such as health care equity, community-appropriate care, and out-of-network care.

From each agency, reviewers examined the signature annual report from 2008 onward.

- CHIA has reported on the Performance of the Massachusetts Health Care System Report annually since 2014. This report includes the calculation for total health care expenditures, enrollment and coverage trends, quality of care, premiums, and member cost-sharing, as well as payer use of funds.[4]
- The HPC has produced an Annual Cost Trends Report since 2013, which profiles Massachusetts health care spending and delivery, tracks progress year over year, and makes recommendations to curb spending and increase quality.[5]
- The AGO reviews and analyzes health care costs and trends to promote the Commonwealth's health care cost-containment goals.[6] Reviewers analyzed their most recent three reports, each focusing on a different facet of cost growth. There were two reports released in 2016, one examining pharmaceutical cost growth and the other examining the inequities of cost growth of premiums and out-of-pocket expenses across market segments and socioeconomic status. The 2018 report examines administrative complexities and the associated cost burden.

# Key Findings

This year's analysis re-examined the 14 findings identified in the 2015 review of state reports and updated them with the key findings derived from the new state reports published since 2016. Reviewers determined 14 findings, many of which provide more recent data that are consistent with previous findings, while others reflect how the health care market has changed since the last review. They have been divided into two categories: primary drivers of health care costs and notable trends in the Massachusetts health care system.

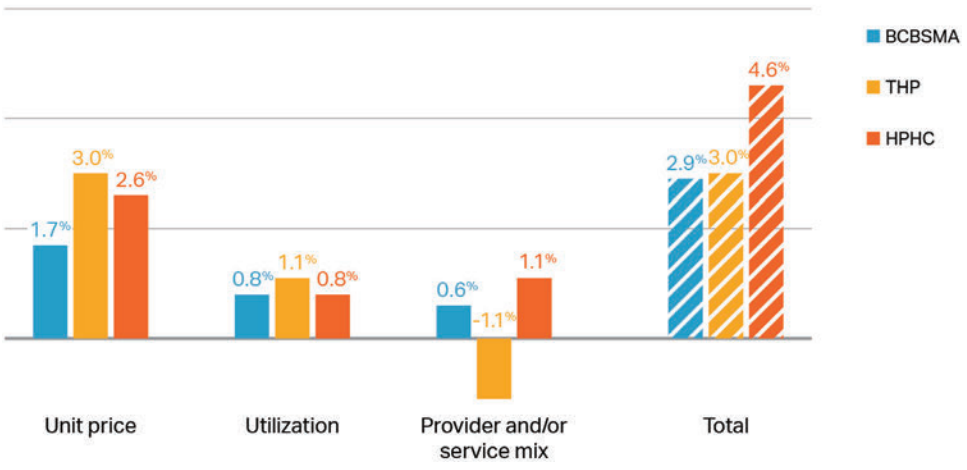
# Primary Cost Drivers of Massachusetts Health Care Expenditures

**FINDING 1**

## Provider price, not utilization of health care services, remains the biggest health care cost driver in Massachusetts.

The previous two reviews have noted that provider prices have been consistently increasing Massachusetts' health care spending. Price, rather than utilization, has been identified as the primary driver of spending since 2001, and CHIA estimates that approximately 50% of spending growth in Massachusetts is typically explained by growth in unit prices.[7,8] Recently, this proportion has been even larger. Figure I shows provider price's contribution to annual spending growth in recent years compared to utilization and provider mix.[9] Price accounted for 59%, 100%, and 57% of cost growth for the three largest health plans from 2015 to 2017.

### Figure I. Average Annual Growth in Spending by Component for Top 3 Payers, 2015–2017



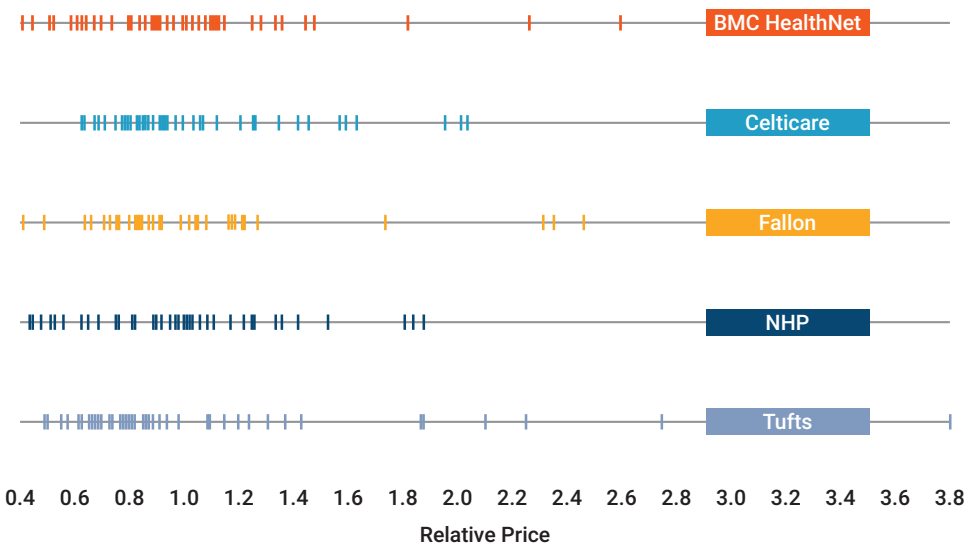

SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS HEARING, OCTOBER 2018. SLIDE 26.

FINDING 2

## Provider price variation remains an issue. There is a large and persistent gap in reimbursement between the highest and lowest paid providers.

Provider price variation has been a recurring theme since 2010 and remains a central concern in the Massachusetts health system. Reports by AGO, CHIA, and the HPC have all "consistently documented that the extent of variation and the distribution of hospital prices have been generally consistent since 2010, and that variation in physician prices has increased somewhat since 2009."[8] There is a wide gap in prices paid to providers across the Commonwealth. The HPC reported that the highest-paid hospital received anywhere from 3 to 8 times the payments of the lowest-paid hospitals.[10] Variation exists in both the commercial and public market. Commercial insurers pay the highest-paid hospital 2.7 times more per discharge than the lowest-paid hospital, whereas Medicare pays the highest-paid hospital 1.5 times more per discharge than the lowest-paid hospital. Figure II shows the relative price paid for hospital inpatient services in the MassHealth MCO market; for example, Tufts pays the highest-paid hospital 280% of Tufts' average price. There is greater provider price variation within small-payer networks. The statewide reports examined in this paper may underestimate the full extent of variation because they typically include only the largest payers in the state.

### Figure II. Health Policy Commission 2016 Cost Trends Report




SOURCE: HPC ANALYSIS OF CENTER FOR HEALTH INFORMATION RELATIVE PRICE DATA, 2014.

Total health care spending per patient also varies substantially by provider system. The spread between provider systems is widening, after narrowing from 2012 to 2015. After accounting for patient health risk, spending per patient at the costliest system was 30% higher than at the least costly, as of 2016.[7]

The AGO has reported that price variation in the Massachusetts market is correlated to market leverage. Leverage is comprised of factors such as size, geographic location, and "brand name".[11] The Special Commission on Provider Price Variation, a group of experts convened pursuant to Chapter 115 of the Acts of 2016, defined warranted and unwarranted factors that contribute to provider price variation. Unwarranted factors include (1) market power, (2) brand, (3) geographic isolation, (4) government payment shortfalls, and (5) research. The HPC has urged the Commonwealth to reduce unwarranted provider price variation. Since first documented by the AGO in its 2010 report, Massachusetts has made little progress regarding provider price variation. The HPC recommended that direct policy action is likely the most effective way to address this issue, and it has urged the Commonwealth to reduce unwarranted variation in provider prices by advancing data-driven interventions and direct policy action in multiple reports.[3,7,9,10,12]

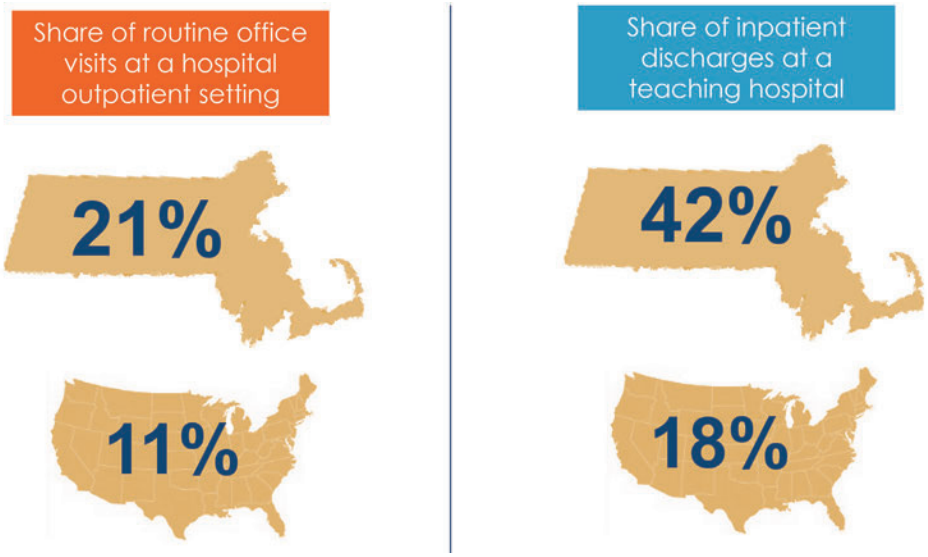
**FINDING 3**

## Academic Medical Centers (AMCs) are associated with higher health care costs. Routine care is regularly delivered at AMCs, driving up spending and taking volume away from community hospitals.

The 2014 and 2016 reviews shared evidence from several state reports that AMCs are associated with higher prices, higher payments, and higher patient volume than hospitals designated as Disproportionate Share Hospitals (DSHs) or community hospitals. New reports indicate that this trend has continued in recent years. AMCs have been associated with higher health care costs compared to teaching and community hospitals. Statewide outpatient spending was on average 66% higher at AMC-anchored organizations than at physician-led organizations.[3] For example, one high-priced AMC-anchored organization spent twice as much on outpatient care as a more efficient physician-anchored one.[7] A cohort study performed by the HPC found that spending at AMC-anchored organizations was over 70% higher than at physician-led organizations for outpatient services such as labs, tests, and minor surgeries.[3]

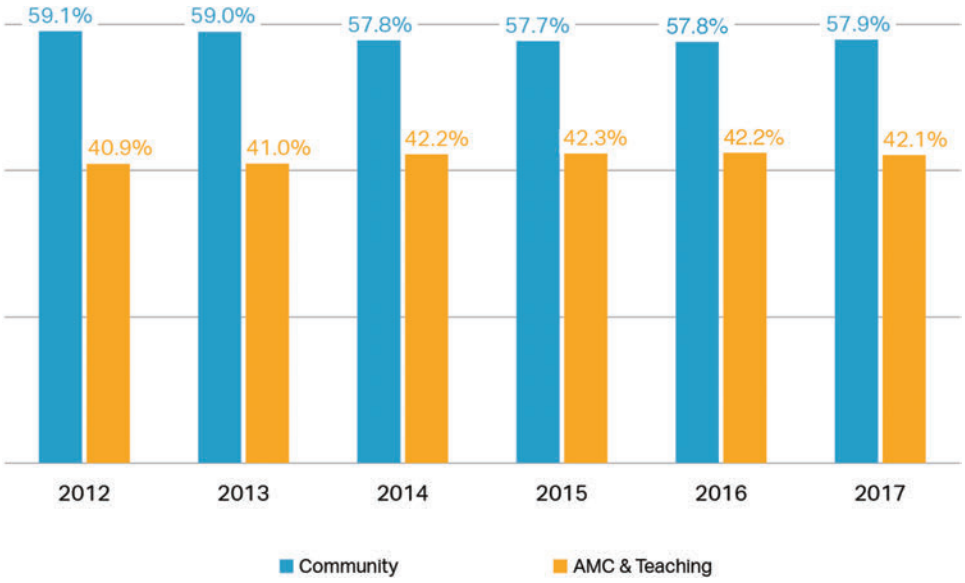
AMCs and teaching hospitals continue to provide a large proportion of community-appropriate care, which contributes to higher health care spending. Massachusetts utilizes more expensive teaching hospitals for both routine and inpatient care, as shown in Figure III. Lower-cost community hospitals can safely provide inpatient care for low-acuity conditions. The share of community-appropriate inpatient care treated at community hospitals has slightly worsened in Massachusetts, from 59.1% in 2012 to 57.9% in 2017, as shown in Figure IV. Massachusetts should work toward shifting more care to the most appropriate and high-value setting.

## Figure III. Medicare Payment Advisory Commission Comparison of Massachusetts Utilization of Hospital Outpatient Settings and Teaching Hospitals to National Average




SOURCE: HEALTH POLICY COMMISSION, 2019 COST GROWTH BENCHMARK PRESENTATION SLIDE 23.

## Figure IV. Share of Community-Appropriate Discharges by Hospital Type, 2012–2017




SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS REPORT CHARTPACK.

FINDING 4

## Pharmaceutical costs, particularly specialty and doctor-administered drugs like cancer chemotherapy, are a major cost driver in Massachusetts and nationally.

Pharmaceutical spending has consistently been among the fastest-growing categories of spending. Payments to pharmacies grew 5.0% from 2016 to 2017, rising $464 million from $9.3 billion to $9.7 billion.[14] Although the rate of spending growth has moderated from that of prior years, pharmaceutical spending has still surpassed the HPC benchmark every year. Pharmacy spending accounted for 36.5% of total health care expenditure growth in 2017, meaning that over a third of the growth in spending went to pharmaceuticals.

Specialty drugs are the largest driver of pharmaceutical spending, even after applying all discounts and rebates received by plans. Oncology drugs represent the highest drug expenditure by therapeutic class, totaling $700 million in 2014.[3] This aligns with national trends, which report oncology drug spending increasing 15.9% from 2013 to 2017.[3] Most oncology drugs are covered under a patient's medical benefit and are reimbursed for both the price of the drug itself and its administration by a provider. Therefore, the price is negotiated with payers and subject to wide provider price variation. An analysis by the HPC found that for 14 of 15 injectable chemotherapy drugs examined in 2016, the price per unit at the highest-priced hospital was more than double that of the lowest-priced hospital.[3] This is of concern because spending on drugs covered under medical benefits grew 9.5% in 2016, and the HPC expects even faster growth in the future due to the large number of chemotherapy and other drugs in the pipeline for approval.[3]

The AGO, CHIA, and the HPC have all recognized the complexity of measuring pharmacy expenditure due to the presence of prescription drug rebates negotiated by Pharmacy Benefit Managers (PBMs), as well as discounts and other price concessions. There is opportunity for enhanced transparency throughout the entire pharmaceutical distribution chain to better understand how drug prices are developed.[15a] The HPC has recommended authorizing reforms in the MassHealth pharmacy program, increasing price transparency and accountability, and adding pharmaceutical and medical device manufacturers as Cost Trends Hearing witnesses.[3]

FINDING 5

## Hospital outpatient services represent a growing share of total health care expenditures.

Hospital outpatient spending has exceeded the benchmark in recent years and is one of the top drivers of total health care expenditure growth. Spending on hospital outpatient care increased by 5.5% (2015–2016) and 4.8% (2016–2017). In 2017, outpatient expenditure accounted for 38.4% of total health care expenditure growth, outpacing even pharmacy.

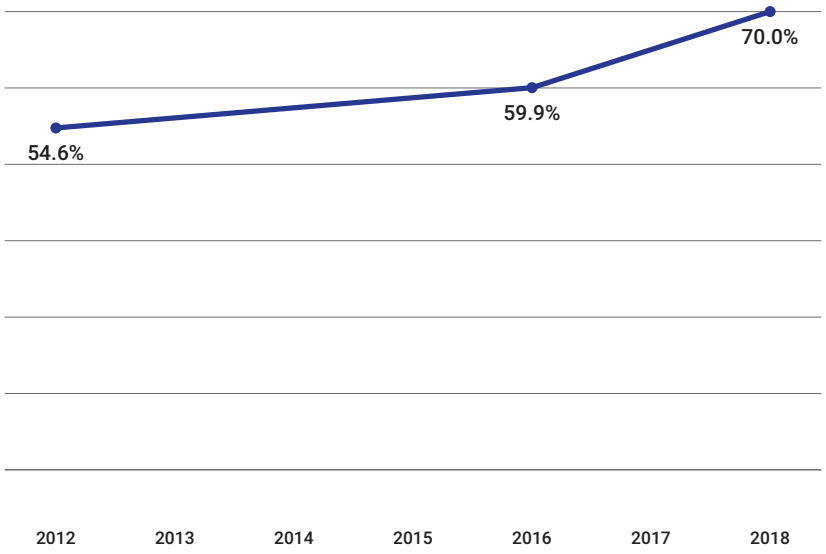
Facility fees contribute to outpatient spending. Hospital outpatient departments can charge facility fees in addition to the professional fees charged by physicians or other practitioners.[3] When a hospital's satellite location, such as a physician office or urgent care center, charges facility fees, it can increase prices, widen provider price disparities, and give an economic advantage to the hospital-owned site over lower-cost independent sites. The HPC recommends acting to limit newly licensed and existing sites that can bill as hospital outpatient departments and implementing site-neutral payments for select services. Further, the HPC recommends that outpatient sites that charge facility fees should be required to clearly disclose this to patients before care is delivered.[3]

**FINDING 6**

## The effects of provider consolidation, such as market leverage, lead to higher prices and large disparities in provider prices.

State reports reviewed for this analysis, as well as those discussed in the 2016 and 2014 papers, documented the harmful effects of provider consolidation and the potential impacts that market changes such as mergers and acquisitions may have on costs, access, and quality. The effects of provider consolidation, such as market dominance that leads to higher prices and large disparities in provider prices, are discussed elsewhere. Despite expressed concern over consolidation, it continues. Following the recent Beth Israel–Lahey merger, the top five health systems will account for 70% of all commercial inpatient stays in the state. This continues the trend of increasing market consolidation, as shown in Figure V.

### Figure V. Inpatient Market Share of the Top 5 Health Systems, 2012–2018




SOURCE: DATA OBTAINED FROM HEALTH POLICY COMMISSION.

There is a growing policy concern that provider consolidation leads to higher prices rather than achieving quality improvement or improved efficiency. The HPC notes that although some argue consolidation may lead to efficiencies, evidence has shown that consolidation is not associated with increased quality and is associated with higher prices.[12]

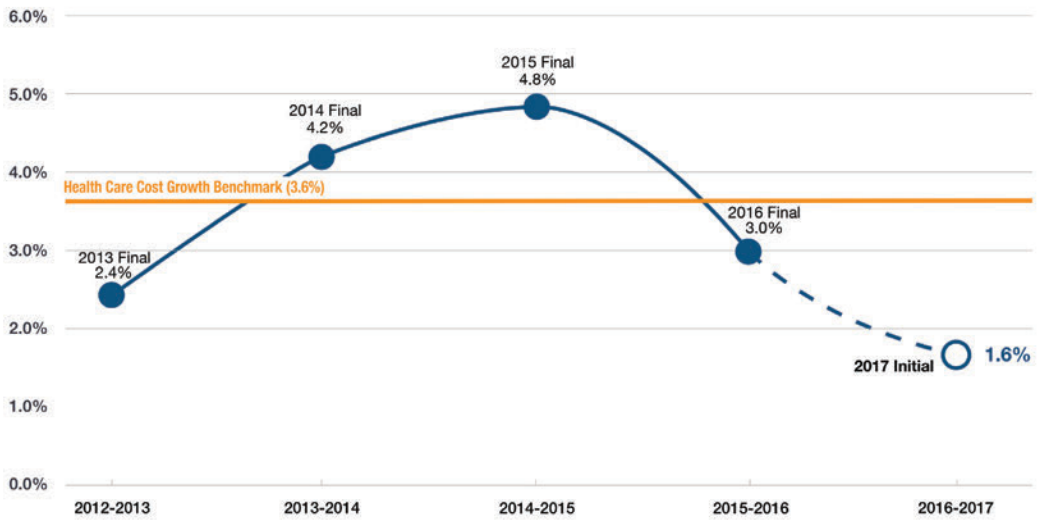
# Other Notable Trends in the Massachusetts Health Care System

**TREND 1**

## Massachusetts has made considerable progress in meeting the health care cost growth benchmark. The Commonwealth beat the benchmark for the two most recent years and has improved compared to national trends. Despite this, Massachusetts still has the second highest health care costs in the nation.

The HPC, as part of Chapter 224 of the Acts of 2012, established a health care cost growth benchmark to serve as a statewide target for the rate of growth of total health care expenditures.[5] Over the past two years the Commonwealth has met the benchmark of 3.6% growth, following two years of exceeding the benchmark. See Figure VI.

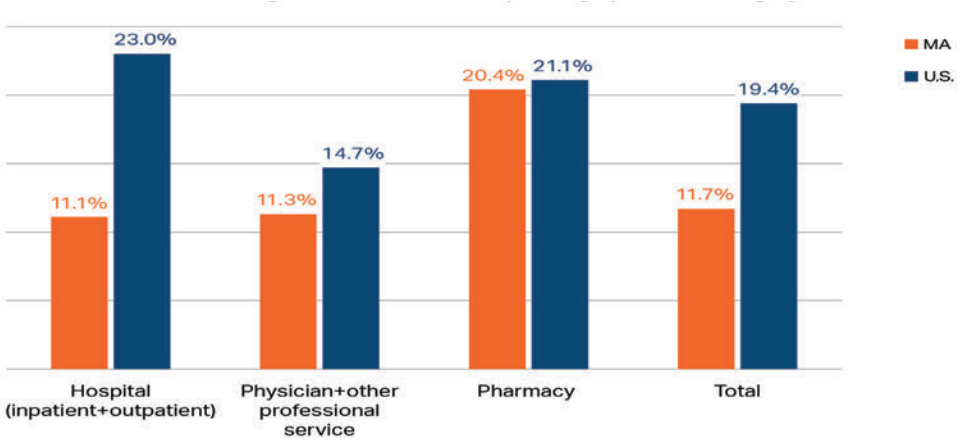
### Figure VI. Total Health Care Expenditures Growth Rates, 2012–2017




SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS HEARING. OCTOBER 2018. SLIDE 7.

Further, Massachusetts' total health care spending growth has been below the national growth rate since 2013.[9] Figure VII shows that Massachusetts has been below national growth rates in hospital care, physician and other professional services, and pharmacy spending.

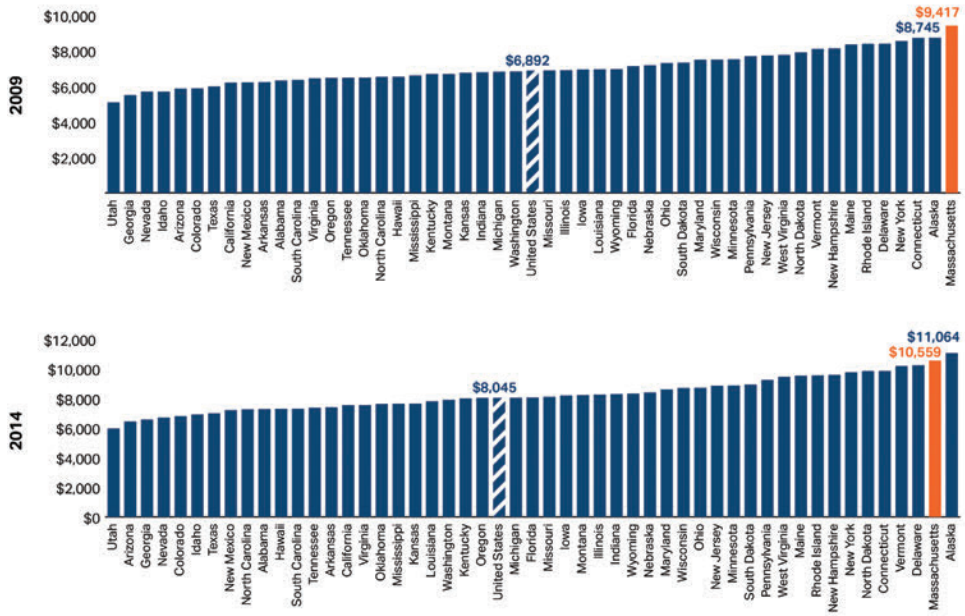
## Figure VII. 2013–2017 Cumulative Growth in Commercial Spending by Service Category, MA and US




SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS HEARING. OCTOBER 2018. SLIDE 24.

Despite recent success in limiting growth of health care spending, Massachusetts' total per capita health care spending is still among the highest in the nation. See Figure VIII.

## Figure VIII. Total Per-Capita Health Care Spending by State, 2009 and 2014




SOURCE 1: HEALTH POLICY COMMISSION. 2017 ANNUAL HEALTH CARE COST TRENDS REPORT.
SOURCE 2: CENTERS FOR MEDICARE AND MEDICAID SERVICES STATE HEALTH EXPEDITURE ACCOUNTS, 2009 AND 2014.

The high spending is also reflected in premium prices. Massachusetts has the second-highest premiums in the nation for small employers and the tenth-highest premiums in the nation for large employers. For more on this, see Trend #4 to the right.[9]

TREND 2

## The highest-paid providers do not necessarily provide the highest quality of care.

Higher prices paid to hospitals or physician groups do not appear to reflect quality of care.[12] A 2016 HPC analysis found that on average, quality of care at all Massachusetts acute hospitals, including several nationally recognized institutions, is similar despite wide provider price variation. Previous analyses done by both CHIA and the AGO have yielded similar results: higher-priced providers were not associated with better quality of care than lower-priced providers.[11,15b] Instead, as discussed above in Finding #6, Massachusetts prices are correlated with the market leverage of the provider organization.

TREND 3

## Providers with the highest public payer case mix have the lowest commercial reimbursement.

State reports have noted that providers with higher public payer mixes receive relatively lower commercial rates.[12] Providers that are federally designated as Disproportionate Share Hospitals (DSHs) receive high volumes of publicly insured patients and simultaneously receive lower reimbursement rates from commercial insurers. DSHs receive a low (14%) share of all hospital inpatient commercial payments. Teaching hospitals receive another 14% compared to the 19% that goes to community hospitals, while the largest share, 40% of commercial inpatient payments, goes to AMCs.[16]

TREND 4

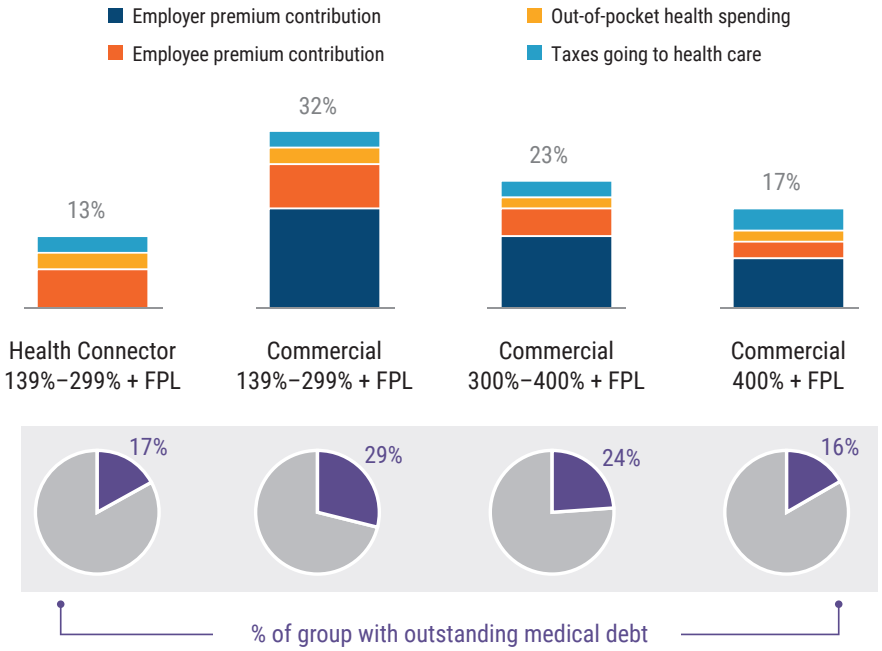
## In response to increasing provider prices, consumer cost sharing is rising in the commercial market, impacting mostly low and middle-income residents.

Commercially insured residents are paying more in out-of-pocket spending. Between 2016 and 2017, out-of-pocket spending increased at a faster rate, 5.7%, than inflation, average wages, and premiums. This amounts to a $52 per member, per month increase. In 2017, 21% of residents spent over $3,000 out of pocket. Additionally, premiums are continuing to rise. As of 2017, Massachusetts has the second-highest premiums in the nation, increasing 4.9% to $483 per month for large employer groups last year, with premiums for small employer groups increasing even more at 6.9%.[17]

High-deductible health plans (HDHPs) are expanding rapidly. In 2017, 28.2% of private commercially insured members were enrolled in an HDHP, a jump of 8 percentage points from 2015 and a 39% increase in two years. This increase was disproportionately shared by small and mid-size employer-sponsored insurance, with 50% of those members enrolled in an HDHP.

There are also inequities in health care costs for Massachusetts residents. An AGO report found that after adjusting for health status, in the commercial market, more is spent on the health care of residents of higher-income communities compared to lower-income communities.[15b] Lower-income residents spend a greater share of their paycheck on health insurance and have a larger proportion of members with medical debt, as shown in Figure IX.

## Figure IX. Portion of Total Income Devoted to Health Care Spending for Massachusetts Residents by Type of Coverage in 2017




SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS REPORT.

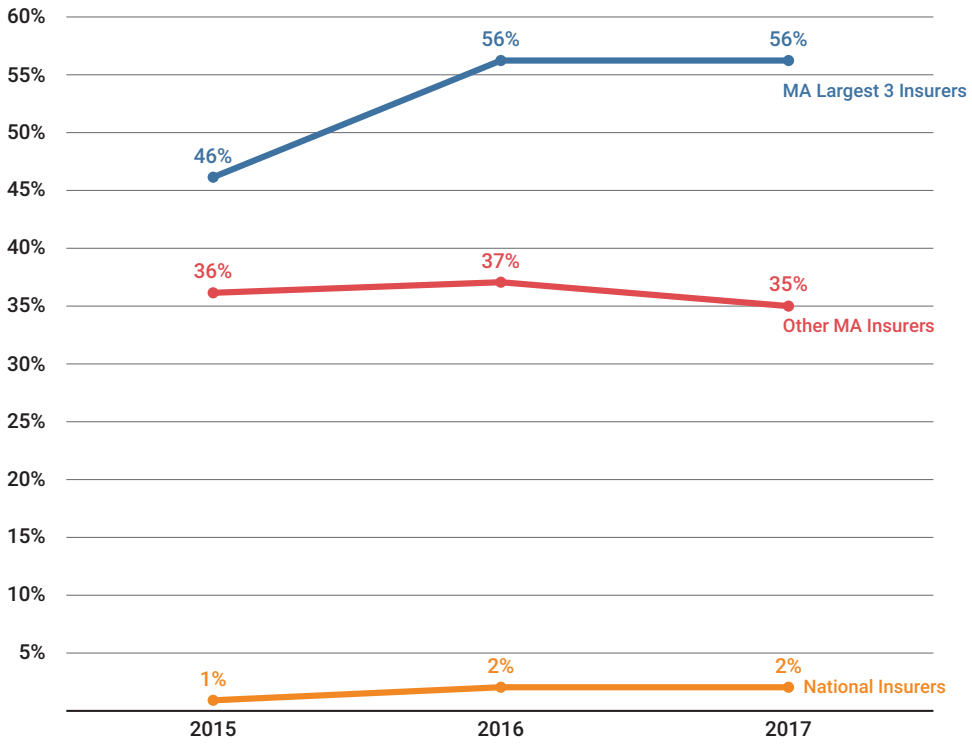
Earlier reports have recommended exploring tiered networks as part of an effort to engage patients in making high-value choices. As highlighted in several reports, consumer-directed efforts to reduce health care costs and consumer cost sharing include enrollment in limited network plans, tiered network plans, and other value-based insurance products, as well as efforts to increase consumer awareness and education. However, take-up in these products has been relatively low.[3,7,10,15b]

TREND 5

## Alternative Payment Models (APMs) are growing in MassHealth and Medicare. After an initial rapid rise, APMs have leveled off in commercial insurance.

There has been slowing uptake in Alternative Payment Models (APMs), such as global payment contracts, in the Massachusetts commercial market. In 2017, the rate of APM adoption declined by 1% to 41% overall. APM contracts rose among the three largest Massachusetts insurers, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Plan, and Tufts Health Plan, from 46% in 2015 to 56% in 2017 (see Figure X). There has been wider adoption of members in Health Maintenance Organizations (HMOs) as opposed to Preferred Provider Organizations (PPOs) at 73% versus 28%, respectively, in 2017.

### Figure X. Proportion of Member Months Under APMs by Massachusetts and National Insurers, 2015-2017




SOURCE: DATA OBTAINED FROM HEALTH POLICY COMMISSION 2018 ANNUAL HEALTH CARE COST TRENDS REPORT CHARTPACK.

Progress has been made in the adoption of APMs outside of the commercial market. It is estimated that nearly 75% of MassHealth's managed care members were enrolled in APMs through MassHealth's Accountable Care Organizations (ACO) program in 2018. In Medicare plans, adoption of APMs increased from 40% in 2016 to 49% in 2017.[3]

The HPC found some evidence to suggest that higher adoption of APMs by primary care provider (PCP) groups is associated with lower total medical expenditure. PCP groups with lower rates of APM adoption in 2013 had more than double the spending growth of PCP groups, with higher rates of APM adoption.[10] The HPC has noted that many providers have had trouble balancing APM and fee-for-service patients because of conflicting contract incentives. They have suggested that a critical mass of APM patients is necessary to reach financial success, which has not yet been seen in the Massachusetts market. To increase adoption and effectiveness of APMs, the HPC recommends aligning quality measurement in APMs, adopting HPC ACO certification standards, incorporating bundled payments, and reducing disparities in budget levels to reduce spending. To realize the potential benefits of APMs, the HPC recommends implementing more meaningful risk. Two-sided risk contracts allow for maximizing incentives available to providers through the additional accountability.[3]

**TREND 6**

## Surprise billing and facility fees for outpatient care are problematic and leave many consumers with out-of-pocket medical bills despite having comprehensive coverage.

Out-of-network billing occurs when a patient receives a bill for services from providers who do not have a negotiated rate with the patient's insurer. Some patients seek out-of-network providers for certain scheduled services knowing that their insurer will cover less of the expense or even none of it. However, in emergency situations or situations that involve multiple providers at an in-network facility, patients often do not know they have been seen by an out-of-network provider until they receive a bill. Research has shown that this is especially the case with emergency physicians.[18]

The HPC found that among the top three payers in the commercial market, there were over 30,000 individuals with out-of-network bills for over 70,000 medical claims in 2014 alone. The HPC also found that commercial insurers often pay much higher rates to out-of-network providers compared to in-network providers for the same service.[19] This means that out-of-network billing is adding to Massachusetts' total medical expenditure. For example, insurers paid $143 for a moderate-severity Emergency Department visit with an in-network provider and $248 for the same service with an out-of-network provider.

State reports have called for governmental action. On the consumer side, the HPC recommends establishing protections from surprise billing scenarios and balance billing, including requiring advance patient notification of a potential out-of-network provider.[3] On the provider/insurer side, the HPC recommends establishing a reasonable and fair reimbursement through a statutory or regulatory process.[3]

**TREND 7**

## There are opportunities to reduce unnecessary utilization.

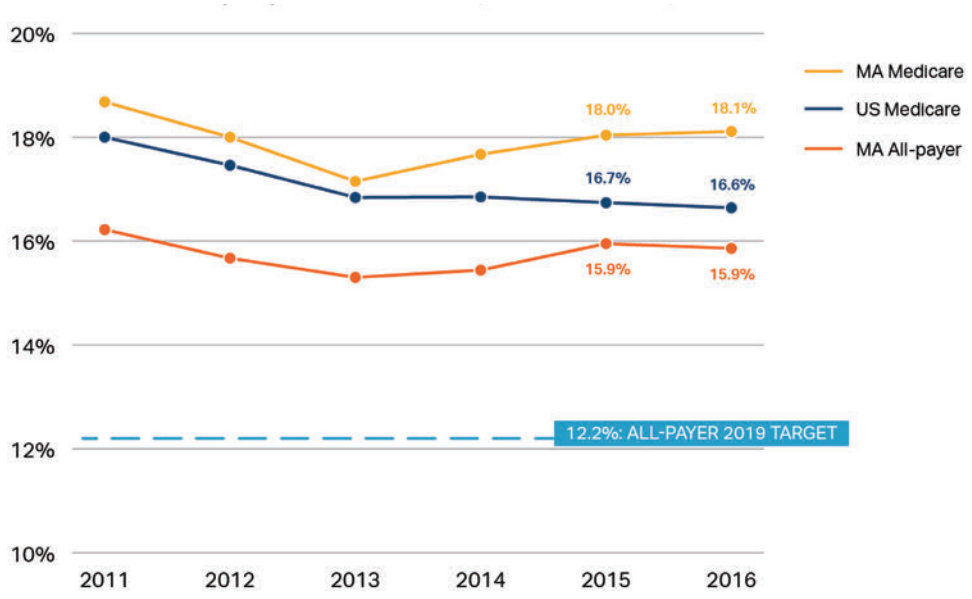
A key component of promoting an efficient health care system is reducing unnecessary utilization. This includes low-value care, post-acute care, readmission rates, and avoidable emergency department (ED) visits.

Reducing low-value care has been identified as a way to address the burden of wasteful health care costs and create a more efficient health care system. Low-value care has been defined as "medical procedures that have been shown to provide little benefit and, in some cases, have the potential to cause harm to a particular population of patients."[20] These tests and procedures have been recognized as being non-evidence-based and typically unnecessary by the Choosing Wisely Initiative, comprised of clinicians and researchers from over 70 medical specialties.[20] An HPC analysis found that a fifth of commercial patients over a two-year period received at least one of the 19 low-value-care procedures and services measured. Spending on this care totaled $80 million, including $12 million paid out of pocket. This is likely an underestimate, because the analysis did not include spending on additional follow-up tests and procedures or indirect costs such as work time lost.

Post-acute care in an institutional setting, such as a skilled nursing facility, an inpatient rehabilitation facility, or a long-term care hospital, is far more expensive than home health care. Discharges to post-acute institutional settings accounted for $1.7 billion of health care spending across the state in 2016. Massachusetts discharges more patients to post-acute institutional settings compared with the US overall.[10] After adjusting for patient acuity, the HPC found that discharges remained relatively constant between 2010 and 2015. However, in recent years we have seen a 2% decline from 2015 to 2017 in post-acute care discharges and an increase in home health discharges, reflecting a shift away from institutional post-acute care. This is in part driven by a change in discharge patterns for musculoskeletal conditions, which have decreased post-acute hospitalization by 6.5% from 2014 to 2017.[21]

Hospital readmissions occur when a patient is admitted to the hospital within 30 days after being discharged from an initial hospitalization, excluding planned hospitalizations. Readmission is often an indicator of poor care coordination across treatment settings and suboptimal discharge planning. As part of the Affordable Care Act, Medicare began providing an incentive to hospitals to reduce their 30-day readmission rates with the Hospital Readmission Reduction Program (HRRP), which has focused hospitals' attention nationwide on developing strategies to avoid readmission. Nationally, readmission rates have been falling consistently since 2011 from about 18% to 16%. In Massachusetts, readmission rates fell with US trends until 2013 but have since increased, widening the gap with the rest of the US, as shown in Figure XI.

## Figure XI. Thirty-Day Readmission Rates, MA and the US, 2011–2016




SOURCE: HEALTH POLICY COMMISSION, 2018 ANNUAL HEALTH CARE COST TRENDS REPORT CHARTPACK.

Non-urgent or preventable care is too often rendered in the emergency department. The HPC reported that 42% of all ED visits in the Commonwealth in 2015 were potentially avoidable. In 2017, one-third of Massachusetts residents reported that their last ED visit was not for an emergency.[9] Avoidable ED visits are broken into two categories: visits that could be addressed by a primary care provider and visits that do not require any medical care. Solutions presented by the HPC include connecting patients with retail clinics and urgent care centers, expanding provider office hours and availability of nurse hotlines and telehealth, and granting nurse practitioners full practice authority.[22]

TREND 8

## Administrative costs can burden the system and impede transparency.

Administrative complexity adds costs to the system and impedes transparency. A report from the AGO found that commercial fee-for-service payments are determined using varying complex methods across payers, providers, and insurance products with little consistency.[17] Hospital outpatient payment is particularly complex, requiring additional resources for negotiation and administration in the absence of standardization within and across payers.[17] The AGO recommends further investigation of the administrative costs associated with current reimbursement methods, reducing complexity and exploring increased standardization, and establishing real-time, service-level price transparency for employers, consumers, policymakers, and providers.[17]

# Conclusion

New state reports published between 2016 and 2018 echo the findings of previous reports, reflecting that market conditions in Massachusetts health care have remained largely unchanged. Massachusetts' first-in-the-nation cost-growth benchmark has been successful in stemming the growth of health care spending in the Commonwealth. However, because of historically high rates of payments to providers, Massachusetts remains among the highest cost states for health care in the country.

Massachusetts data shows that provider prices, not utilization, continue to be the leading driver of health care costs. Wide variation in prices received by providers persists and contributes to higher costs that are unrelated to quality. Opportunities exist to help lower costs by addressing hospital outpatient prices, pharmaceutical spending, care in high-cost settings, and by reducing the significant variation in provider prices.

The reports published by Massachusetts state agencies continue to serve as an important resource in understanding cost drivers and trends within the health care system. Each report offers policy recommendations to curb health care spending without sacrificing access or quality and should help inform policymakers' discussions and decisions of ongoing and future efforts to improve the Massachusetts health care system.

| | | Previous Reports | | | | | | | New Reports | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Finding** | Agency | 2008 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| 1. Provider price, not utilization rates, remains the biggest health care cost driver in Massachusetts | AGO | | ✓ | | | ✓ | | | | | |
| | CHIA | | | ✓ | ✓ | | | | | | |
| | HPC | | | | | ✓ | ✓ | ✓ | | | ✓ |
| | DOI | ✓ | | | | | | | | | |
| 2. Provider price variation remains an issue. There is a significant and persistent gap in reimbursement between the highest and lowest paid providers. | AGO | | ✓ | ✓ | | ✓ | | ✓ | | | |
| | CHIA | | ✓ | ✓ | ✓ | ✓ | | ✓ | | | |
| | HPC | | | | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| | Special Commission PPV | | | | | | | | | ✓ | |
| 3. Academic medical centers (AMCs) are associated with higher health care costs. Routine care is regularly delivered at AMCs, driving up spending and taking volume away from community hospitals. | AGO | | | | | | | | | | |
| | CHIA | | ✓ | | ✓ | ✓ | | ✓ | | | |
| | HPC | | | | | | ✓ | ✓ | | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 4. Pharmaceutical costs, particularly specialty and doctor-administered drugs like cancer chemotherapy, are a major cost driver in Massachusetts and nationally. | AGO | Prior reports not reviewed for this finding | | | | | | ✓ | ✓ | | |
| | CHIA | | | | | | | ✓ | | ✓ | ✓ |
| | HPC | | | | | | | ✓ | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 5. Hospital outpatient services represent a growing share of total health care costs. | AGO | Prior reports not reviewed for this finding | | | | | | | ✓ | | |
| | CHIA | | | | | | | | | ✓ | ✓ |
| | HPC | | | | | | | | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 6. The effects of provider consolidation, such as market leverage, lead to higher prices and large disparities in provider prices. | AGO | | ✓ | | | ✓ | | ✓ | | | |
| | CHIA | | ✓ | | ✓ | ✓ | | ✓ | | | |
| | HPC | | | | | ✓ | ✓ | ✓ | ✓ | | ✓ |
| | DOI | | | | | | | | | | |
| | Special Commission PPV | | | | | | | | | ✓ | |

| | | Previous Reports | | | | | | | New Reports | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Finding** | Agency | 2008 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| 1. Massachusetts has made considerable progress in meeting the health care cost growth benchmark. It beat the benchmark for the most recent two years and has improved compared to national trends. Despite this, Massachusetts still has among the highest health care costs in the nation. | AGO | Prior reports not reviewed for this finding | | | | | | ✓ | ✓ | | |
| | CHIA | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | HPC | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 2. In response to increasing provider prices, consumer cost sharing is rising in the commercial market, impacting mostly low- and middle-income residents. | AGO | | ✓ | | | ✓ | | ✓ | ✓ | | |
| | CHIA | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | HPC | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 3. Provider prices correlate with market leverage, not quality of care. | AGO | | ✓ | ✓ | | ✓ | | ✓ | | | |
| | CHIA | | | ✓ | ✓ | ✓ | | ✓ | | | |
| | HPC | | | | | ✓ | ✓ | ✓ | | ✓ | |
| | DOI | | | | | | | | | | |
| 4. Providers with the highest public payer case mix have the lowest commercial reimbursement. | AGO | | ✓ | | | | | | | | |
| | CHIA | | | ✓ | ✓ | ✓ | | ✓ | | | |
| | HPC | | | | | | | ✓ | | | ✓ |
| | DOI | | | | | | | | | | |
| 5. Alternative Payment Models (APM) are growing in MassHealth and Medicare. For commercial insurance, after an initial rapid rise, APMs have leveled off. | AGO | | ✓ | ✓ | | ✓ | | ✓ | | | |
| | CHIA | | | ✓ | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| | HPC | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 6. Surprise billing and facility fees for outpatient care are problematic and leave many consumers with out-of-pocket bills, despite having comprehensive coverage | AGO | Previous reports not reviewed for this finding | | | | | | | | | |
| | CHIA | | | | | | | | | | |
| | HPC | | | | | | | | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| | Special Commission on PPV | | | | | | | | | ✓ | |
| 7. Massachusetts has opportunities to reduce unnecessary utilization. | AGO | Previous reports not reviewed for this finding | | | | | | | | | |
| | CHIA | | | | | | | | | | |
| | HPC | | | | | | | | ✓ | ✓ | ✓ |
| | DOI | | | | | | | | | | |
| 8. Administrative costs can burden the system and impede transparency. | AGO | Prior reports not reviewed for this finding | | | | | | | | | ✓ |
| | CHIA | | | | | | | | | | |
| | HPC | | | | | | | | | | ✓ |
| | DOI | | | | | | | | | | |

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# Re-examining the Health Care Cost Drivers and Trends in the Commonwealth

A REVIEW OF STATE REPORTS (2008–2018)