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Ensuring Stability in Health Care Access and Costs: The Need for Robust Reporting and Oversight Across the Entire Health Care System

As health care spending continues to rise at both the state and federal levels, employers and consumers find themselves grappling with mounting expenses at pharmacy counters, provider offices, and hospitals. They also face higher contributions to health insurance through increased premiums, deductibles, and co-payments. Since health insurance premiums reflect price increases by hospitals, providers, and pharmaceutical manufacturers, this impact is not surprising. In Massachusetts, even as annual health care spending spiked to $71.7 billion in 2022,[1] hospitals expressed concerns over financial strain and demanded large premium increases from insurers while pharmaceutical companies sounded alarms over the impact of the federal Inflation Reduction Act on their revenues. This raises a pressing question: where is this vast amount of health care dollars going and who oversees its trajectory?

This OnPoint provides insight into the regulatory and financial oversight requirements on three key sectors of the health care ecosystem – hospitals and health systems, pharmaceutical companies, and health plans. It outlines the existing statutory and regulatory framework, or its conspicuous absence, that serves as a guardrail dictating spending and profits for each sector. As policymakers consider ways to temper cost growth, a comprehensive understanding of the oversight and reporting requirements in place for each sector today, paired with a full picture of the financial performance of each sector, is vital for developing strategies to tackle the underlying drivers of health care costs. Indeed, the Steward Health Care crisis underscores the imperative to understand the urgent need for robust financial reporting and accountability to ensure a stable health care system.

State Oversight: An Imbalanced Approach

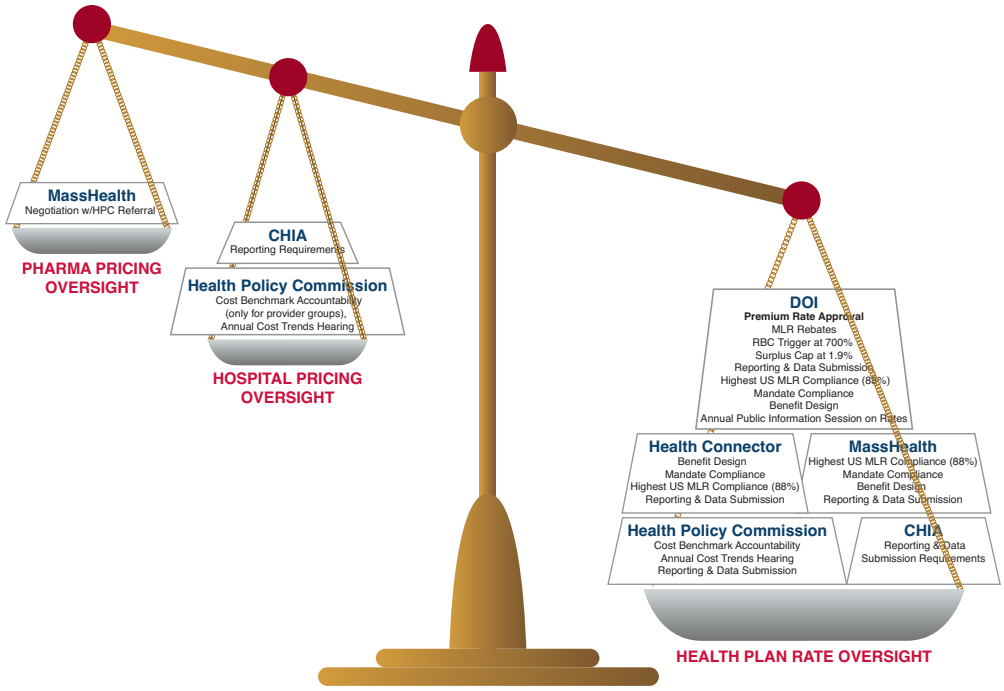

Figure 1: MAHP Chart on state oversight requirements for health plans, hospitals, and pharmaceutical manufacturers

With the creation of the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC) in Chapter 224 of the Acts of 2012, Massachusetts established an oversight framework for health plans and provider groups requiring accountability to an annually set health care cost growth benchmark and submission of detailed financial data to CHIA and the HPC. Under this regulatory structure, CHIA has developed reporting requirements for certain providers, including acute hospitals, non-acute hospitals, and both private and public payers. These requirements encompass a number of metrics such as costs, financial performance, utilization, and total medical expenses.[2] At the same time, the HPC has developed reporting requirements for providers and payers to furnish financial information and potentially provide testimony during its annual Cost Trends Hearing, and to ensure accountability to the benchmark through the performance improvement plan (PIP) process, which subjects entities with over benchmark spending to an improvement plan. Other targeted reporting requirements are placed on commercial payers and provider organizations to streamline dispute resolution processes, ensuring efficient resolution of conflicts and upholding consumer protection standards by the Office of Patient Protection, operated by the HPC.[3] It is noteworthy that this framework excludes pharmaceutical manufacturers and hospitals, which in 2022 accounted for over 50% of total health care expenditures in the Commonwealth.[4]

While the framework put in place under Chapter 224 provides a baseline for oversight and transparency, additional statutory and regulatory requirements offer more robust regulation. The following sections detail additional oversight measures for three crucial sectors within our health care system: health plans, hospitals and health systems, and pharmaceutical manufacturers.

Health Plan Oversight

Health plans are subject to a series of stringent state and federal requirements regarding their financial performance, including a cap on contributions to surplus, federal and state medical loss ratio (MLR) requirements, and robust rate review through the Division of Insurance (DOI). In other words, state and federal requirements regulate how much of the premium dollar should go to medical care, how much is allowable for administrative spending, and how much surplus (or profit) a health plan can make in a given year.

Oversight of Prices Charged

Transparency in Coverage. The federal transparency in coverage rule requires health plans to provide pricing information empowering consumers with the cost of a covered item or service before receiving care as of July 1, 2022. This pricing information can be used by third parties, such as researchers and app developers, to help consumers better understand the costs associated with their health care. Additional requirements went into effect starting on January 1, 2023, providing further access to pricing information for 500 identified items and services and enhancing consumers' ability to shop for the health care that best meets their needs. The final stage went into effect on January 1, 2024, requiring plans to make price comparison information available with regards to all covered items and services.[5]

Premium Rate Review. Massachusetts state law has a comprehensive and transparent premium rate review process that mandates that licensed health plans file proposed rates with the DOI for all insured products offered and for each product available to individuals and small groups in the merged market. Health insurance premiums are developed prospectively, reflecting the anticipated cost and utilization of services for the upcoming year. Filings are developed by actuaries based on comprehensive quantitative member claims data from a recent historical experience period to ensure that rates are calculated using allowed rating factors and are neither inadequate nor excessive based on the projected experience for a future time. Rates are considered actuarially sound and approved by the DOI if projected premiums are adequate to provide for all anticipated costs, including health benefits, administrative expenses, taxes, and assessments, and required reserves. All base rates are subject to the Commissioner's disapproval if the rates are deemed to be excessive, inadequate, or unfairly discriminatory.[6]

In addition, annually the DOI holds a public information session where interested parties may provide comments on health plans' proposed rate changes. Under the process outlined in 211 CMR 66, health plans must annually present summaries of their premium rate filings and respond to the DOI's questions as part of the public information process. The DOI's review of rate filings will always adhere to the requirements outlined in 211 CMR 66.08.[7]

Oversight of Profits

Medical Loss Ratio Calculation and Rebates to Consumers. State and federal laws governing health plans' MLR require fully insured health plans to spend a certain percentage of premiums on medical care and limit the portion of premium dollars that can be spent on administration, marketing, and profit. The Affordable Care Act requires health plans in the individual and small group markets to spend at least 80% of premiums on claims and quality improvement; the MLR threshold for large group plans is 85% of premiums. Massachusetts imposes even more stringent rules, requiring health plans in the individual and small group markets to spend 88 cents of every premium dollar on health care services. If a health plan does not meet these thresholds, it is required to issue premium rebates to members. Rebates ensure that no health plan can make excessive surplus or profits or spend too much on administration. In the three-year period 2020-2022, health plans issued a total of $166 million in premium rebate checks to individuals and employers in Massachusetts.

1.9% Cap on Contribution to Surplus. Massachusetts state law also requires that if a health plan's contribution to surplus exceeds 1.9% of premiums or if the aggregate MLR for plans is less than 88%, premium rates filed by the health plan may be disapproved as excessive by the DOI.[8] Surplus is typically directed into health plan reserves, which is money set aside to pay for unanticipated claims costs to ensure that hospitals and providers are paid.

Oversight of Financial Solvency

Regulatory Actions to Ensure Financial Viability. State regulations outline the measures in place to ensure the financial stability, compliance, and accountability of health plans in Massachusetts. The DOI can take regulatory actions against a health plan under certain conditions. If the Commissioner finds that the health plan is in an unsound financial condition, engaging in fraudulent practices, inadequately reserving for unearned premiums, or failing to comply with legal requirements, among other issues, the Commissioner may pursue various actions including administrative supervision, rehabilitation, liquidation of the health plan, or revocation or suspension of its license. Before taking any action, the Commissioner must notify the health plan and provide an opportunity for a hearing. However, in certain urgent situations such as emergencies or fraudulent conduct, the Commissioner may order immediate suspension of its license without a hearing.[9]

Comprehensive Financial Reporting. Health plans are subject to extensive reporting requirements to the DOI that cover various aspects of financial disclosure and examination. Plans are required to promptly report any significant losses or claims that may impact on their financial stability. They must submit quarterly financial filings and file unaudited annual reports verified by top executives by March 1 of each year. Additionally, plans undergo annual audits by independent certified public accountants and must submit audited financial reports to the Commissioner by June 1. Examinations conducted by the Commissioner assess the health plan's financial condition and operations, with reports generated afterward. Furthermore, plans must inform the Commissioner of any material changes to their operations. The engagement of an independent certified public accountant is mandatory for audits, and additional reports may be requested by the Commissioner if deemed necessary.[10]

Risk-Based Capital Reporting and Oversight. Separate and distinct from both MLR and surplus requirements, state and federal regulators utilize an additional tool known as the risk-based capital (RBC) formula to assist them in the financial analysis of health plans. While surplus represents the difference between assets and liabilities, the RBC formula is used to establish a minimum amount of capital appropriate for a health plan to support its overall business operations in consideration of its size and risk profile. RBC is intended to be a minimum regulatory capital standard, requiring health plans with higher amounts of risk to hold higher amounts of capital, protecting the plan against insolvency, ensuring sufficient capital to pay unanticipated claims, and allowing the plan to develop new products, invest in new technology, and comply with new regulatory requirements.

On the national level, a majority of health plans have RBC over 1,000%, with close to 40% of health plans reporting an RBC between 1,000% and 10,000%.[11] Massachusetts state law requires that if health plans' RBC ratio exceeds 700%, they are required to submit to a hearing before the DOI.[12] The median RBC level in Massachusetts for MAHP member plans has hovered between 440% and 550% for the past five years, and health plans are required to comply with stringent RBC reporting requirements under 211 CMR 20.00. [13] See Figure 2.[14]

Figure 2: MAHP analysis of RBC ratio for five years for MAHP member plans.

Health Plans	2018	2019	2020	2021	2022
Risk-Based Capital Ratio (Median)	446%	459%	537%	516%	515%

Source: DOI's health plans annual financial statements.

By adhering to rigorous reporting requirements and undergoing regular audits, health plans demonstrate their dedication to financial integrity and ethical conduct. This not only safeguards the interests of their members by providing assurance regarding the organization's financial health but also contributes to the overall stability and reliability of the health care industry. Through these actions, health plans reinforce their role as trusted stewards of individuals' health and well-being, fostering a sense of confidence and reliability in the services they provide.

Hospital Oversight

In contrast to the strict oversight requirements imposed on health plans, hospitals operate within a regulatory framework that lacks comparable controls over profit margins and surplus. Unlike health plans, hospitals are not subject to caps on profit margins or mandates regarding expenditure allocation. Moreover, there are no provisions for rebates to consumers based on hospital profitability. Instead, oversight of hospital finances primarily revolves around reporting obligations outlined in Chapter 224 to the CHIA and HPC. As a result, hospitals have greater flexibility in managing their financial affairs.

Oversight of Prices Charged

Hospital Price Transparency Rule. A series of hospital price transparency requirements have been implemented through federal rulemaking[15] requiring hospitals to disclose information about their standard charges for health care services, enabling patients to access pricing information before receiving treatment by:

- Posting Chargemaster Rates: Hospitals are required to make their chargemaster, or list of standard charges for health care services, publicly available on their website. This includes the prices for medical procedures, tests, and other services provided by the hospital.
- Displaying Shoppable Services: Hospitals must also disclose the prices for shoppable services, which are non-emergency health care services that patients can schedule in advance. These services often include procedures like imaging tests, laboratory tests, and outpatient surgeries.
- Providing Price Estimators: Hospitals are encouraged to offer online price estimation tools or other resources that allow patients to obtain personalized estimates of their out-of-pocket costs based on their insurance coverage and specific health care needs.[16]

In addition, M.G.L. Ch. 111 § 228 requires that providers give notice to consumers receiving services on whether the care provider is in the patient's health insurance network in addition to an estimate of the payment amount for which a patient would be responsible for any elective procedure, test, or service.[17] However, unlike premiums, there is no mechanism to reject these charges or prices.

Oversight of Profits

There are no statutory or regulatory requirements governing oversight of hospital or health system profits.

Oversight of Financial Solvency

Hospital Reporting Requirements. The reporting requirements for acute and non-acute hospitals and related organizations involve the submission of various financial and operational data to CHIA. Both acute and non-acute hospitals are mandated to file annual hospital cost reports. Moreover, they are required to submit a copy of its audited financial statements. Parent organizations are similarly obligated to provide consolidated audited financial statements, accompanied by any additional information as per CHIA regulations. Additionally, acute hospitals, affiliated physician organizations, and their parent organizations are required to submit standardized financial filings quarterly and annually. Furthermore, acute hospitals must provide compensation data for their top 10 compensated employees on an annual basis.[18]

Pharmaceutical Company Oversight

The complete lack of oversight for pharmaceutical manufacturers is a significant concern within the health care landscape in Massachusetts. Unlike health plans and hospitals, pharmaceutical manufacturers operate with minimal regulatory scrutiny and oversight. They are not subject to any reporting requirements to entities such as the CHIA or the HPC, which means there is no comprehensive data available to assess their financial performance or pricing practices at both state and federal levels. This lack of transparency is particularly concerning given the high drug prices are a significant contributor to health insurance premium increases and high out-of-pocket costs for consumers and pharmaceutical spending was the fastest growing service category accounting for nearly 20% of Massachusetts total health care spending in 2022 alone. Without visibility into their finances, it is challenging to understand how drug prices are set and whether they are reasonable and justified. Additionally, pharmaceutical manufacturers are not subject to the health care cost growth benchmark, further exacerbating the lack of accountability in controlling health care expenditures related to medications. The absence of regulatory controls in this sector underscores a critical gap in oversight, leaving consumers and policymakers with limited tools to address escalating drug costs and ensure affordability and accessibility of essential medications.

Oversight of Prices Charged

Inflation Reduction Act. Beginning in January 2023, the Inflation Reduction Act (IRA) requires drug companies to pay a rebate to Medicare for increasing their prices faster than inflation. In addition to that, beginning April 1, 2023, for certain Medicare Part B drugs and biologics with prices that have increased faster than the inflation rate, the beneficiary coinsurance will be 20% of the inflation-adjusted payment amount, resulting in lower out-of-pocket costs for beneficiaries. As a result, the Biden administration has subjected 27 drugs to Medicare inflation rebates and the coinsurance adjustment rates.[19] The IRA further allows Medicare to negotiate better prescription drug prices under the Medicare Drug Negotiation Program. As a part of this process, Centers for Medicare & Medicaid Services will also publish negotiated maximum fair prices for the first 10 Medicare Part D drugs selected for the Medicare Drug Negotiation Program by September 1, 2024, and these prices will be in effect starting January 1, 2026.

MassHealth Direct Negotiation Process and the HPC Drug Pricing Review. Massachusetts state law allows the Executive Office of Health and Human Services and MassHealth to negotiate directly with pharmaceutical drug manufacturers for additional rebates. If negotiations fail, the HPC is empowered to investigate the pricing of the drug. Upon referral from MassHealth, the HPC can gather information on high-cost drugs' pricing, including through a standardized reporting form developed in collaboration with manufacturers. Using this data, the HPC may propose a value for the drug and determine whether the manufacturer's pricing is excessive. Additionally, the HPC, in consultation with MassHealth, may suggest a supplemental rebate for the drug.[20]

Oversight of Profits

There are no statutory or regulatory requirements governing the oversight of pharmaceutical companies' profits.

Oversight of Financial Solvency

There are no statutory or regulatory requirements governing the oversight of pharmaceutical companies' financial solvency.

Recommendations

As our state navigates a shifting landscape and policymakers contemplate legislative and policy approaches to tackle the dual challenges of escalating health needs and health care costs, MAHP recommends the following enhancements to oversight of health plans, hospitals and health systems, and pharmaceutical companies:

- **Establish a Regulatory Framework for Monitoring Hospital and Health System Solvency:** State law and regulations currently provide a robust reporting, monitoring, and intervention framework to ensure the financial solvency of health plans in Massachusetts, but these same protections are lacking for hospitals and health systems. The state should establish a similar framework, requiring hospitals and health systems to not only report on financial metrics, but maintain minimum ratios of assets to liabilities to ensure sufficient capital to continue operations.

For those hospitals and health systems unable to meet minimum requirements, the state should establish a corrective action plan process with levels of state oversight and intervention tied to the severity and root cause of the financial challenges. This could include, similar to the DOI's oversight of health plans, options such as administrative supervision, rehabilitation, receivership, or revocation of licensure. While hospitals and health systems are subject to financial reporting requirements today through CHIA, oversight and enforcement should be under the purview of the HPC.

- **Enhance Existing Hospital and Health System Financial Data Collection and Reporting:** Payments made in lieu of taxes annually, expressed both in dollars per hospital and as a percentage of each hospital's revenue, should be collected to provide greater transparency into the financial operations of health care entities. By furnishing such information, stakeholders, including policymakers, regulators, and the public, would gain a nuanced understanding of the financial contributions' hospitals extend to their communities, as alternatives to conventional tax obligations. Additionally, understanding these payments in relation to each hospital's revenue provides context for evaluating their financial sustainability and the impact on their operational budgets.

- **Strengthen Accountability within the Cost Growth Benchmark:** The HPC's PIP process allows them to hold individual entities accountable by creating an incentive to limit spending growth. However, the current scope of referable entities under the PIP process is restricted to health plans and primary care provider groups. This omission excludes crucial players such as pharmaceutical manufacturers or hospitals, thereby limiting the process's effectiveness in holding all entities accountable. We strongly urge the HPC to recognize the necessity of comprehensive system-wide accountability, especially in the face of persistent rises in pharmaceutical and hospital spending. It is imperative for the entire system to be held responsible for adhering to the cost growth benchmark.

- **Require Accountability and Reporting for Pharmaceutical Companies:** In Massachusetts, unlike health plans and hospitals, pharmaceutical manufacturers operate with minimal regulatory scrutiny and oversight. They are not subject to any reporting requirements to entities such as the CHIA or the HPC as established through Chapter 224 of the Acts of 2012. MAHP recommends pharmaceutical accountability by implementing robust regulatory oversight. This step would facilitate the compilation of comprehensive data necessary for assessing pharmaceutical companies' financial performance and pricing practices.

- **Require Pharmaceutical Companies to Participate in the Cost Trends Hearing:** As part of the commonwealth's annual health care cost trends hearings, pharmaceutical and biotech companies should be required to submit data to the HPC and Attorney General and be called as witnesses to testify under oath. Requiring drug manufacturers to be part of the annual hearings would be an important step toward understanding the impact pharmaceutical pricing has on the statewide cost benchmark, whether the costs associated with these therapies offer value in comparison to other therapies and treatments, and whether they are improving patient care.

- **Require Transparency in Prescription Drug Pricing:** The HPC, in collaboration with CHIA, should identify a list of prescription drugs for which the state spends significant health care dollars and for which prices have increased significantly over certain time periods, or drugs that are new to the market that have significantly impacted the cost growth benchmark. The HPC should require those manufacturers to provide an explanation for the increase, including disclosures of research, development, marketing, and manufacturing costs as well as the profits attributable to those drugs. Likewise, pharmaceutical companies that propose to raise their prices by 10% or more before the introduction of a new drug whose price may threaten the cost benchmark should be required to provide notice to the HPC 60 days before the new prices are to take effect, explaining the rationale for the increase so that consumers, employers, providers, health plans, and the state have notice before the increase takes effect.

- **Expand the HPC's Drug Pricing Review Authority:** The state has seen evidence of price increases for brand name, generic, and specialty drugs nationally and locally, which contribute to spending by health plans and employers. Policymakers should have a regulatory oversight and check on excessive price increases on prescription drugs by evaluating cost-effectiveness of high-cost prescription drugs. MAHP supports the drug pricing review process established in 2020 that allows the HPC to assist in managing pharmaceutical spending by conducting reviews of high-cost drugs referred to it by MassHealth. The commission assesses them to determine whether the pricing is unreasonable or excessive in relation to the value. MAHP strongly supports the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts.

Footnotes

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