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**ANNUAL REPORT ON THE  
PERFORMANCE OF THE MASSACHUSETTS  
HEALTH CARE SYSTEM**

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**SEPTEMBER 2014**



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for health  
information  
and analysis



# Annual Report on the Performance of the Massachusetts Health Care System: September 2014

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# Executive Summary

In 2013, the Massachusetts health care system performed favorably on a number of indicators. Notably, the overall per capita growth in Total Health Care Expenditures (THCE) was below the Commonwealth's 2013 health care cost growth benchmark established in Chapter 224 of the Acts of 2012, and commercial premium levels and member cost-sharing did not increase from 2012, while benefit levels remained steady. Recent statewide reforms may have influenced these positive results; however, slower spending growth in the Commonwealth was consistent with spending growth rates nationwide.

These health system performance trends are better than in recent years, but several areas of concern remain. Although per capita growth in THCE was lower than the benchmark, it rose faster than inflation, and Massachusetts health care costs are still among the

country's highest. Furthermore, the generally favorable overall trends obscure significant variation in individual experience; for example, premiums and member cost-sharing vary substantially between different groups. Finally, the adoption of alternative payment methods, which has been promoted as an important strategy to reduce health care costs, stalled in 2013 among payers and providers.

This report considers performance in the first full year following the enactment of the 2012 cost containment law. CHIA will continue to monitor and report on health care system performance indicators in order to evaluate whether or not the Commonwealth's favorable performance in 2013 reflects a new trend of long-term, sustainable cost containment.

## Key Findings from this Annual Report:

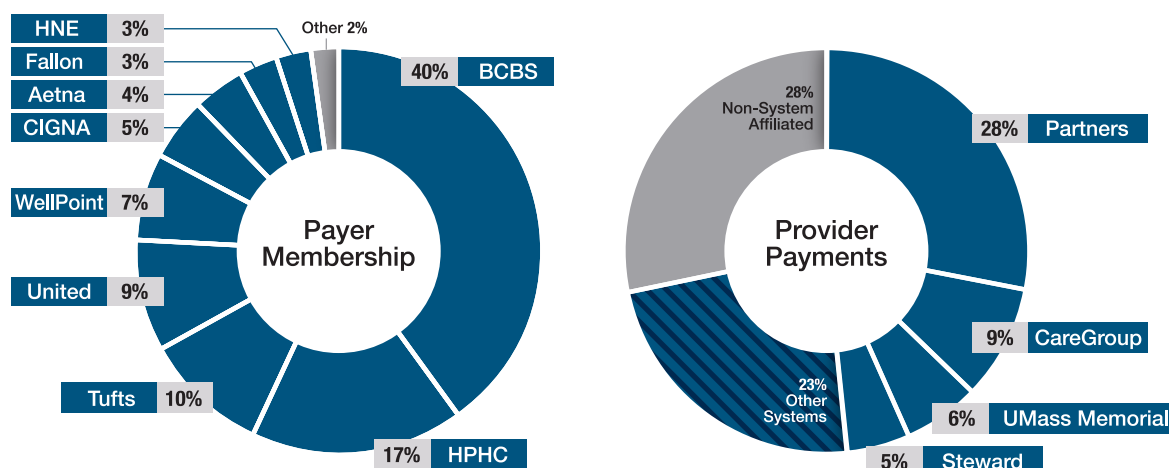
- From 2012 to 2013 THCE grew by +2.3%, below the +3.6% health care cost growth benchmark.
- THCE totaled \$50.5 billion in 2013, \$7,550 per resident.
- Public spending comprised 60% of THCE.
- Both the biggest insurer, Blue Cross Blue Shield of MA, and the biggest physician group, Partners Community HealthCare Inc. (PCHI), reported spending increases that were among the largest.
- In contrast to the previous trend of premium increases paired with declining benefit value, premiums and benefit levels remained virtually unchanged, and member cost-sharing did not increase from 2012 to 2013.
- Commercial member enrollment with primary care providers paid under alternative payment methodologies decreased slightly to 34.3% in 2013.
- There was slow but steady growth in enrollment in self-insured plans from 2012 to 2013, contributing to a decrease in HMO enrollment.

## The Massachusetts payer and provider markets are highly concentrated.

### 1 Market Share by Payer Membership (2013) and Provider Payments (2011)

BCBS covered four out of every 10 commercial members in Massachusetts. The top six payers covered nearly 90% of commercial membership.

Partners received 28% of all dollars spent on acute hospital and physician services, more than three times greater than the next biggest system. Nearly three-quarters of payments went to various integrated provider systems (compared to stand-alone hospitals or other physician groups).



Notes: Harvard Pilgrim Health Care (HPHC) includes Health Plans Inc. membership. Some provider consolidation activity has occurred since this data was collected.

Source: CHIA (payer-reported data)

## Background

In 2012, the Massachusetts Legislature passed Chapter 224 of the Acts of 2012 (Chapter 224), An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. Chapter 224 created the Center for Health Information and Analysis (CHIA) to monitor the Massachusetts health care system and to provide information to support improvements in quality, affordability, access, and outcomes. In this Annual Report and in other reports in the Health System Performance series, CHIA provides statistics and analysis to support these goals.

The Massachusetts health care market is characterized by significant concentration of both payers and providers. In 2013, the three largest payers accounted for approximately two-thirds of members enrolled in commercial coverage;

Blue Cross Blue Shield of Massachusetts of MA (BCBS) alone enrolled 40% of members. Together, the four largest provider systems accounted for nearly 50% of the total market. In 2011, Partners HealthCare (Partners) alone received 28% of total hospital and physician payments in Massachusetts.

### See Figure 1

The Massachusetts health care system is also notable for its concentration of Massachusetts-based, non-profit entities in both the provider and payer markets. Massachusetts providers that are members of national chains are in the distinct minority, as are for-profit provider organizations.<sup>1</sup>

For-profit hospitals have, however, been gaining market share in the Commonwealth.<sup>2</sup> Similarly, while the three largest payers are Massachusetts-based and non-profit entities, in recent years, commercial

member enrollment in Massachusetts has increased slightly among national, for-profit payers.

Approximately 58% of Massachusetts members enrolled in commercial coverage are enrolled in self-insured coverage (where a payer provides administrative services but the employer holds the insurance risk for the coverage), slightly below the national average.<sup>3</sup> Massachusetts has a relatively high proportion of commercial coverage enrollees who choose HMO products (54%)<sup>4</sup> rather than PPO products. However, PPO enrollment has grown, along with increasing enrollment in self-insured plans.<sup>5</sup>

Finally, Massachusetts is characterized by a high rate of insurance coverage – approximately 97% of residents – relative to other states, and covers a greater share of its residents through Medicaid than other states.<sup>6</sup>

<sup>1</sup> Health Policy Commission (2014). 2013 Cost Trends Report. Available from: <http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf> (Accessed August 13, 2014).

<sup>2</sup> Weisman, Robert. "For-profit hospitals put to the test in Mass." The Boston Globe [Boston]. 12 July 2013. Available from: <http://www.bostonglobe.com/business/2013/07/11/tenet-healthcare-plans-acquire-vanguard-health-could-reverberate-massachusetts/6Wyn5911vMTM4rgpTdHjcl/story.html> (Accessed August 13, 2014).

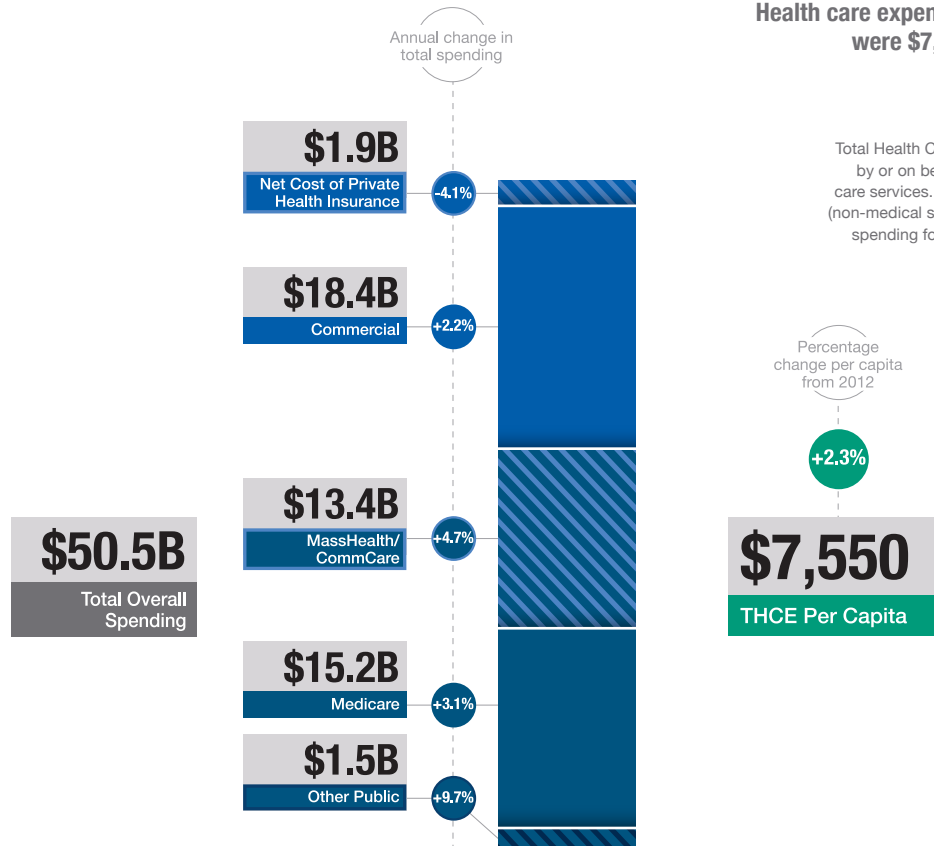
<sup>3</sup> Based on Annual Premiums Data Request to CHIA - see Supplement 10. According to the Kaiser Family Foundation's 2013 Employer Health Benefits Survey, in 2013, 61% of covered workers were in a self-funded plan: <http://kff.org/report-section/ehbs-2013-section-10/> (Accessed August 13, 2014).

<sup>4</sup> Based on payer-reported total medical expense data to CHIA in May 2014. According to the Kaiser Family Foundation, in 2012, Massachusetts had a 33.8% HMO penetration rate, the third highest

**Health care expenditures per Massachusetts resident were \$7,550 – an annual increase of +2.3%.**

## Components of Total Health Care Expenditures 2013 2

Total Health Care Expenditures represents the total amount paid by or on behalf of Massachusetts residents for insured health care services. It includes the net cost of private health insurance (non-medical spending by commercial health plans), and medical spending for commercially and publicly-insured MA residents.

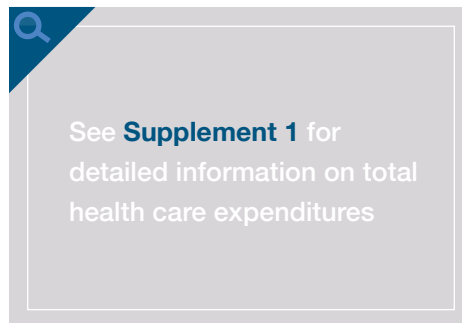


Source: CHIA (payer-reported data) and other public sources. See Technical Appendix.

## Total Health Care Expenditures

### See Figure 2

Each year, the Health Policy Commission sets a target for the annual growth of Total Health Care Expenditures (THCE) in the Commonwealth. For 2012-2013, this growth “benchmark” was +3.6%. Based on information submitted by payers in Massachusetts, CHIA estimates that



actual THCE increased to \$7,550 per resident – including children – in 2013.<sup>7</sup> This represents a +2.3% increase from the previous year – well below the benchmark,

but exceeding overall inflation of +1.5%.<sup>8</sup> THCE totaled \$50.5 billion in 2013, an increase of \$1.5 billion over 2012.

The THCE measure was created by the Legislature to reflect the total amount paid by or on behalf of Massachusetts residents for insured health care services. With limited exceptions, it includes all payer expenditures on medical and administrative services, member cost-sharing (deductibles, co-payments, and co-insurance), and federal and state spending on health care services.

## THCE includes spending for commercial coverage, the net cost of private health insurance, Medicaid, and Medicare for Massachusetts residents.

state rate (excluding Puerto Rico). Data includes all licensed HMOs which may include Medicaid and/or Medicare only HMOs. Available from: <http://kff.org/other/state-indicator/hmo-penetration-rate/> (Accessed August 13, 2014). For this report, Massachusetts’ commercial HMO population data is reported by payers to CHIA and does not include these public program enrollees.

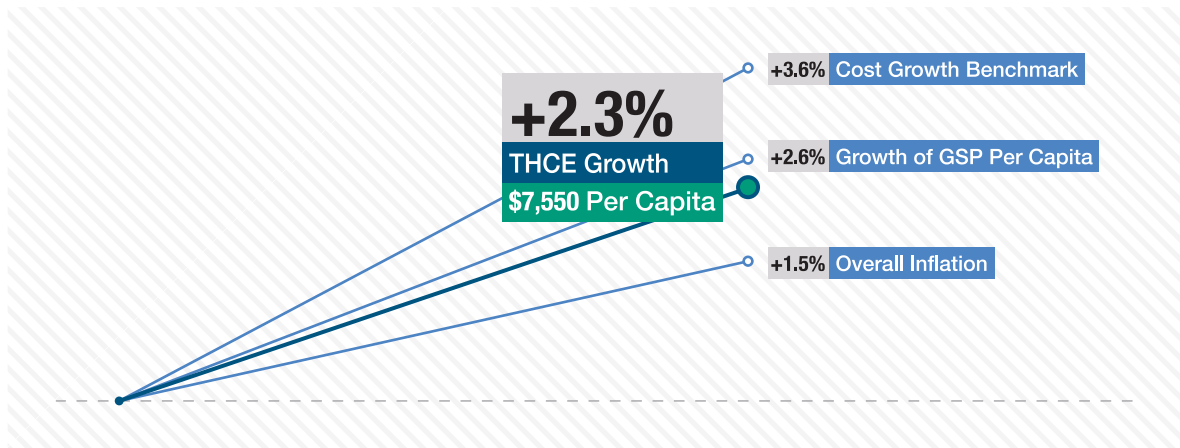
<sup>5</sup> See Supplement 10 for more information on commercial insurance products, including HMO enrollment by plan.

<sup>6</sup> Center for Health Information and Analysis, Massachusetts Health Care Coverage: 2012 Estimate (2013). Available at: <http://www.mass.gov/chia/docs/r/pubs/13/2012-mass-insurance-coverage.pdf> (Accessed August 13, 2014). Final health insurance coverage rate results for 2012 will be reported in 2014 based on CHIA’s Massachusetts Health Insurance Survey (MHIS). For state-by-state comparison of Medicaid coverage rates for the non-elderly, see: Kaiser Family Foundation, Medicaid Coverage Rates for the Nonelderly by Age. Available at: <http://kff.org/medicaid/state-indicator/rate-by-age-3/> (Accessed August 13, 2014).

**Total Health Care Expenditures per capita grew by +2.3%, below the health care cost growth benchmark.**

### 3 Total Health Care Expenditure Growth in Context

Per capita health care expenditures grew faster than inflation from 2012-2013 but growth in THCE was slower than overall per capita economic growth and the health care cost growth benchmark set by the Legislature and the Health Policy Commission.



Source: CHIA and other public sources. Inflation data from Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Gross State Product data from U.S. Bureau of Economic Analysis: Widespread But Slower Growth in 2013: Advance 2013 and Revised 1997 – 2012 Statistics by State.

THCE does not include a variety of other health care expenditures that are more often paid directly by consumers, including over-the-counter expenditures, spending for services not covered by a health insurance plan, and vision and dental care. These other expenditures are important components of consumer spending on health care, but are not considered in this report.

The major components of THCE are commercial coverage, the Net Cost of

Private Health Insurance (NCPHI)<sup>9</sup>, Medicaid, and Medicare. Total spending in the commercial market – accounting for changes in price, utilization, and membership – increased by +2.2% from 2012 to 2013. Total Medicare spending increased by +3.1% and spending by state programs (MassHealth and Commonwealth Care) increased by +4.7%. Detailed discussions of each of these components are presented later in this report and supplements.

While 2012-2013 THCE growth was below the benchmark, it is notable that the state economy also grew slowly over this period. Moreover, health care expenditure growth has been slowing nationwide. It is difficult to distinguish the effect of Massachusetts-specific policy on THCE because the observed trend is broadly consistent with nationwide trends.<sup>10</sup>

■ See Figure 3

## Total health care expenditures increased by +2.3% from 2012 to 2013 - well below the benchmark, but exceeding overall inflation of +1.5%.

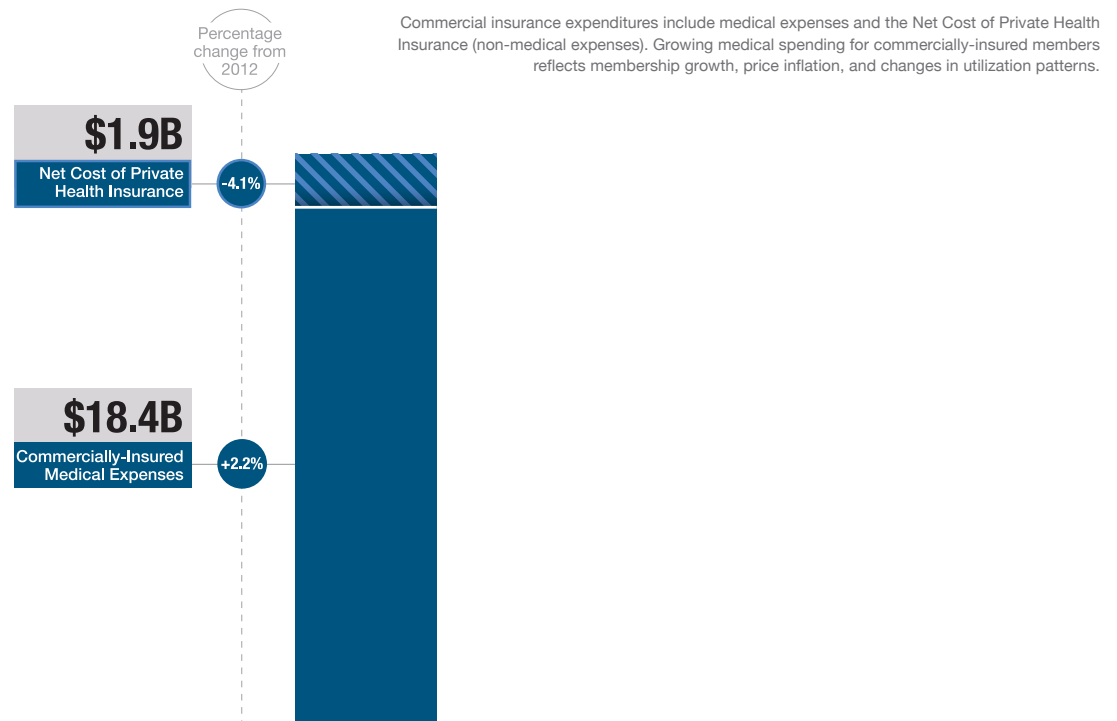
<sup>7</sup> CHIA will revise 2013 THCE in 2015 based on final reported data. See Technical Appendix for more information.

<sup>8</sup> The THCE per capita growth rate is similar to the projected 3% per capita growth rate of National Health Expenditures between 2012 and 2013. See Cuckler et al. (2013). National health expenditure projections, 2012-22: Slow growth until coverage expands and economy

improves. Health Affairs, 32(10), 1820-1831. Note that the National Health Expenditures metric is more comprehensive and contains certain spending categories that are not included in the THCE model such as dental services, government public health activities, and research. See the methodology paper on National Health Expenditure Accounts. Available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf> (Accessed August 13, 2014).

**Commercially insured medical spending grew +2.2% while non-medical expenses fell.**

#### Commercial Insurance Expenditures 2012 - 2013 **4**



Source: CHIA (payer-reported data) and actuarial estimate of non-data filers

## Commercial Insurance Expenditures

Four out of every ten THCE dollars are associated with commercial insurance spending. The bulk of these expenditures are for medical care: \$18.4 billion in 2013. Just under \$2 billion – about one out of every ten THCE dollars – are related to the commercial payers' administration of insurance.

### See Figure 4

#### Commercial Premiums

Commercial expenditures on medical and administrative services are funded by premiums and member cost-sharing. The average 2013 fully-insured Massachusetts commercial health plan premium was \$430 per member per month (PMPM), or approximately \$5,154 per member per year.<sup>11</sup> Both premiums and benefit levels<sup>12</sup> were essentially unchanged from 2012 to 2013 in

the overall market, as well as for the state's two largest payers, BCBS and Harvard Pilgrim Health Care (HPHC).

This is in contrast to previous years, in which statewide premiums increased while benefit levels declined. As late as 2011 to 2012, average premiums were increasing by 2.1% year-over-year; this increase was

Average Massachusetts premiums did not increase from 2012 to 2013, and benefit levels remained steady, while overall inflation was 1.5%.

See **Supplement 2** for detailed information on premium and benefit level trends, including payer-specific data

<sup>9</sup> NCPHI captures the costs to Massachusetts residents associated with the administration of commercial health insurance. This includes the costs associated with commercial administration of public programs such as Medicaid Managed Care Organizations. For more information on the NCPHI calculation, see CHIA's Massachusetts Total Health Care Expenditure Methodology (2013) at <http://www.mass.gov/chia/docs/r/pubs/13/thce-methodology.pdf> (Accessed August 13, 2014).

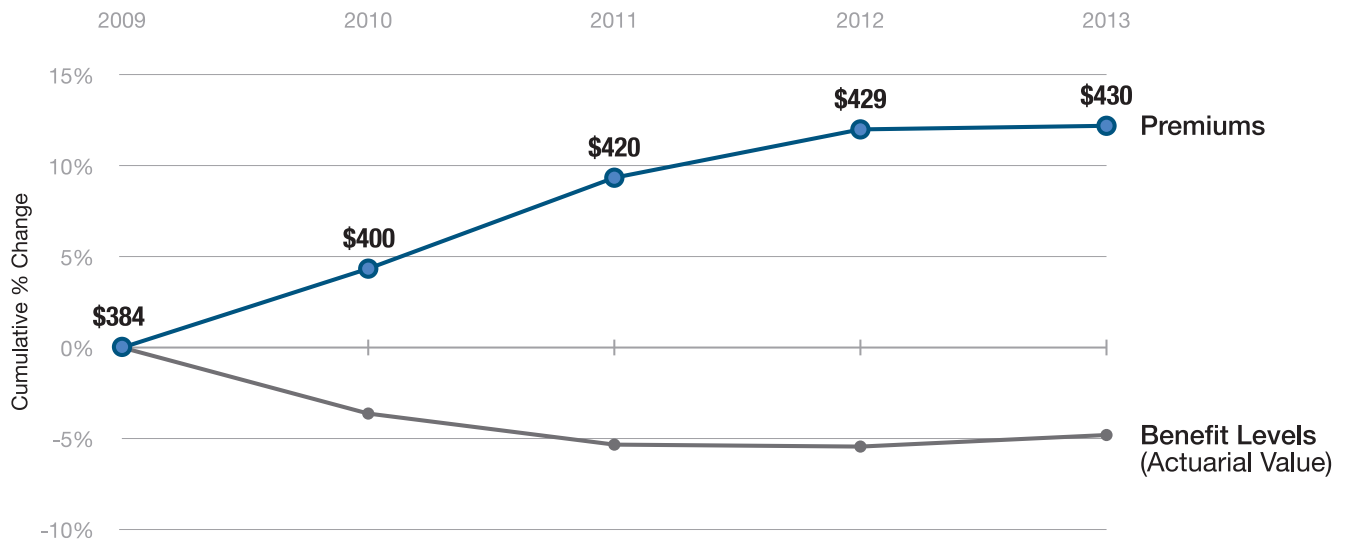
<sup>10</sup> Anne B. Martin, Micah Hartman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team (2014). National Health Spending in 2012: Rate of Health spending Growth Remained Low For the Fourth Consecutive Year. *Health Affairs*, 33(1), 67 – 77.

<sup>11</sup> Commercial premium levels were determined based on fully-insured contract members. For more information on contract membership, see Supplement 10.

## Premiums and benefit levels held steady in 2013.

### 5 Average Premium and Benefit Level Trends 2009 – 2013

From 2012 to 2013, average premium and benefit levels remained virtually unchanged, stalling the previous trend of premium increases paired with declining benefit values. Since 2009, premiums have increased about 12% (inflation over the period was less than 9%).



Notes: Benefit levels measured by average actuarial values (not shown). 2009-10 data does not include CIGNA and WellPoint; this does not materially impact overall market trends.

Source: CHIA (payer-reported data)

See CHIA's 2014 Employer Survey for more information about employer-sponsored insurance in the Commonwealth. Results are expected in late 2014.

impacted by changing group and member factors. Adjusting for these differences, however, premiums have remained virtually unchanged since 2011, while inflation rose by 3.6%.<sup>13</sup>

#### See Figure 5

Payer-to-payer comparisons of premium levels are complicated by differences in plan design and membership health status, among other factors. For instance, while Tufts Health Plan (Tufts) reported the highest average premiums (\$455 PMPM), its benefit levels were also high relative to most other payers. Health New England (HNE), conversely, had the lowest average premium of the larger payers (\$385 PMPM)<sup>14</sup>, while also offering the lowest average benefit

levels. While notable, this information alone is not sufficient to evaluate whether this variation is efficient or appropriate. This variation may be representative of the broad spectrum of plan offerings in the commercial market: some members may prefer the lower up-front costs and the higher cost-sharing of the average HNE plan while others might prefer the reverse, represented by the average Tufts plan.

#### See Figure 6

Premium increases across market sectors were slight from 2012 to 2013.<sup>15</sup> However, both the Individual segment of the Merged Market and the Mid-Size Group market sectors reported notable premium increases from 2011 to 2012 (+3.9% and +4.1% respectively).

<sup>12</sup> Benefit levels are measured by actuarial value, a measure of the proportion of expenditures covered by insurance versus patient cost-sharing. See Supplement 2 and the Technical Appendix for more detail.

<sup>13</sup> Adjusting for factors such as group size, geography, and the age or gender of membership yields a metric called "adjusted premiums," which increased only 0.4% between 2011 and 2013. See Supplement 2 for more information.

<sup>14</sup> Those "larger" payers include the commercial payers in Massachusetts that report more than 50,000 fully-insured contract members. For more information on contract membership, see Supplement 10.

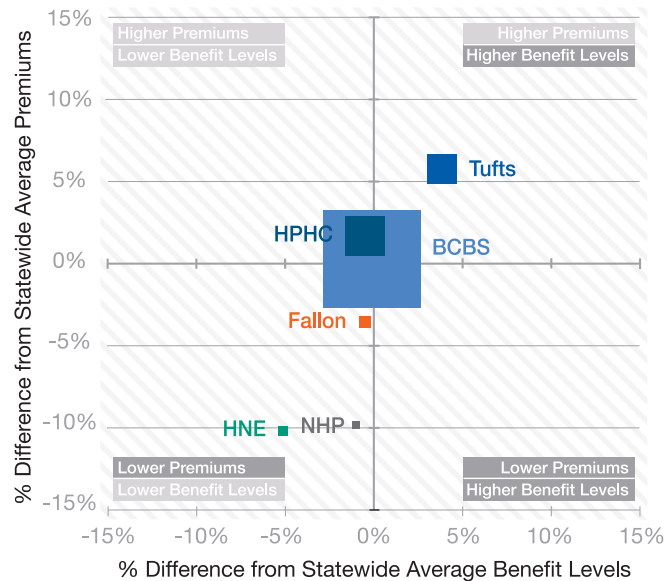
<sup>15</sup> Employers were segregated into the following employee-size categories for analysis: Individuals, Small Group (1-50 enrollees), Mid-Size Group (51-100 employees), Large Group (101-499 employees), and Jumbo Group (500+ employees). In the Small Group, only those

The larger plans had higher premiums in 2013, but their benefit levels were also higher.

## Fully-Insured Market Premiums and Benefit Levels Relative to Statewide Average 2013

6

Throughout the Massachusetts market, higher premiums tended to be associated with higher benefit levels. Variation in plan design offers choice to consumers between plans with higher premiums and higher benefit levels versus others with lower premiums and lower benefit levels.



Notes: Benefit levels measured by average actuarial values. WellPoint and CIGNA excluded from the figure due to low fully-insured populations. Square size reflects fully-insured enrollment.

Source: CHIA (payer-reported data)

Members who purchase individual insurance (that is, separate from their employers) have consistently faced higher premiums and above average year-over-year premium increases.<sup>16</sup> In 2013, the average premium for individual insurance in the Merged Market was \$461 PMPM, the highest premium among all market sectors. The 2013 average premiums PMPM were lowest in the Small Group segment of the Merged Market

(1-50 enrollees) and the Jumbo Group (500+ employees), at \$421 and \$423 respectively. For the Small Group sector, this may be due to lower benefit levels, while in the Jumbo Group it may be due in part to stronger employer negotiating leverage.<sup>17</sup>

### Member Costs for Commercial Insurance

Member costs include contributions to premiums and cost-sharing for medical care (deductibles, co-payments, and co-insurance). There are other out-of-pocket expenses (such as over-the-counter expenditures, spending for services not covered by a health plan, and some vision and dental care) which are not included in this report.

See **Supplement 3** for more information on member cost-sharing

On average, in 2013, Massachusetts members paid an estimated 26% of total premiums, while employers paid the remaining three-quarters.<sup>18 19</sup>

Cost-sharing for medical care was unchanged between 2012 and 2013. On average, members paid \$48 PMPM in cost-sharing. Within this figure, though, there is a broad distribution of expenditures between members: members of Jumbo Group companies were responsible for less medical cost-sharing, \$39 PMPM,

## Member cost-sharing did not increase from 2012 to 2013.

employers that met the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04 were included. Individuals and the Small Group form the "Merged Market" in Massachusetts, in which small group insurance laws apply to all small business and individual plans issued by an insurance carrier.

<sup>16</sup> The Individual segment of the Merged Market had average premiums of \$436, \$453, and \$460 PMPM,

for the years 2011, 2012, and 2013 respectively, the highest of all market sectors. Individual premiums increased by 3.9% from 2011 to 2012 and 1.8% from 2012 to 2013.

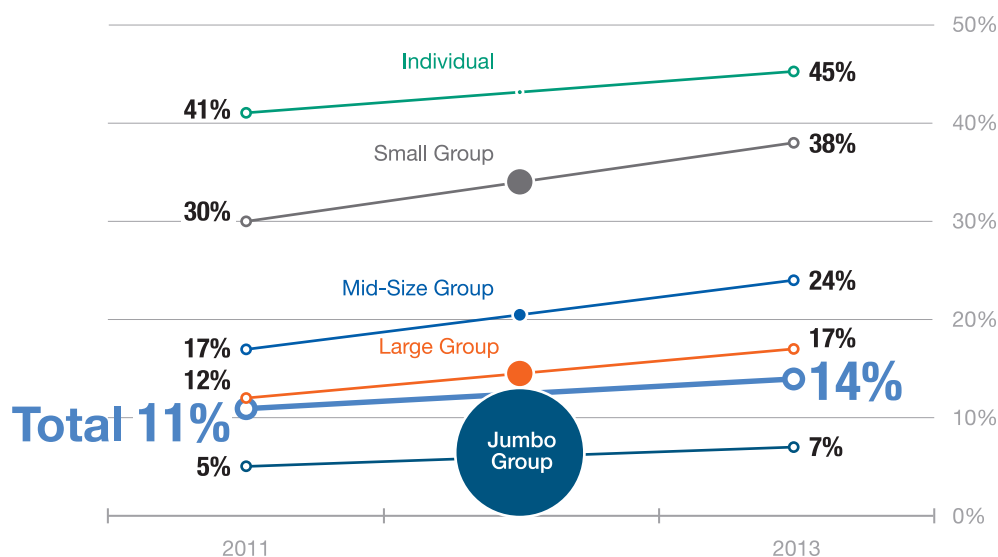
<sup>17</sup> For more information on premiums by payer and market sector, see Supplement 2.

<sup>18</sup> Proportion of consumer premium contribution in Massachusetts is reported from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) for single and family plans.

## Enrollment in High-Deductible Health Plans continued to increase in 2013.

### 7 High Deductible Health Plans by Market Sector 2011 – 2013

Total enrollment in High-Deductible Health Plans increased from 11% in 2011 to 14% in 2013. Nearly half of Individual plan enrollees were in HDHPs, but far more HDHP members were associated with the Large and Jumbo Groups (dot size reflects enrollment).



Notes: HDHPs were defined within this report as plans meeting IRS deductible levels. HDHP IRS standard deductible levels were \$1,200 in 2011-12 and \$1,250 in 2013. Figure shows membership of market sectors as of 2013.

Source: CHIA (payer-reported data)

compared with \$70 PMPM in the Individual segment of the Merged Market.

Moreover, in all groups, a small proportion of members typically pay significantly more than these average amounts due to plan design and high utilization, while the majority of members, with lower utilization, pay less and in some cases may pay nothing.<sup>20</sup>

The high rate of medical cost-sharing in the Individual segment may be due, in part, to higher enrollment in High Deductible Health Plans (HDHPs).<sup>21</sup> While HDHPs remain a small minority of the overall market, 45% of individual plan members were enrolled in HDHPs. Overall HDHP membership increased between 2011 and 2013, from 11% to 14% of all reported fully- and self-insured members.<sup>22</sup>

HDHP enrollment growth has been greatest in the Jumbo Group market sector, increasing from 5% to 7% of insured members; followed by the Mid-Size Group, increasing from 17% to 24% of insured members.

#### See Figure 7

Together, premiums and cost-sharing fund two kinds of expenditures: medical care expenses, and non-medical expenditures such as plan administration. These expenses are covered in more detail in the following sections.

### Commercial Medical Care Expenses

CHIA monitors medical care spending using a metric called Total Medical Expenses

(TME). From 2012 to 2013, commercial, per-member TME rose just +1.7%, slightly faster than overall inflation, to \$430 PMPM. This represents a slower commercial TME growth rate than in previous years.<sup>23</sup>

The slower growth in medical expenses observed in Massachusetts is consistent with the national trend in health care spending compared to prior years.<sup>24</sup> This may suggest that slower Massachusetts TME growth

See **Supplement 4** for more information on statewide medical care expenses and medical care expenses by payer

MEPS-IC is an annual national survey managed by the Agency for Healthcare Research and Quality that collects data on the number and types of private health insurance plans offered by private and public sector employers. Source: <http://meps.ahrq.gov> (MEPS) (Accessed August 13, 2014).

<sup>19</sup> Employee contribution to premium is one part of an overall compensation arrangement. Health care expenditures ultimately crowd out other spending; high employer contributions may simply

obscure the effect that health care costs have on wages and other spending. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/08/30/youre-spending-way-more-on-your-health-benefits-than-you-think/> (Accessed August 13, 2014).

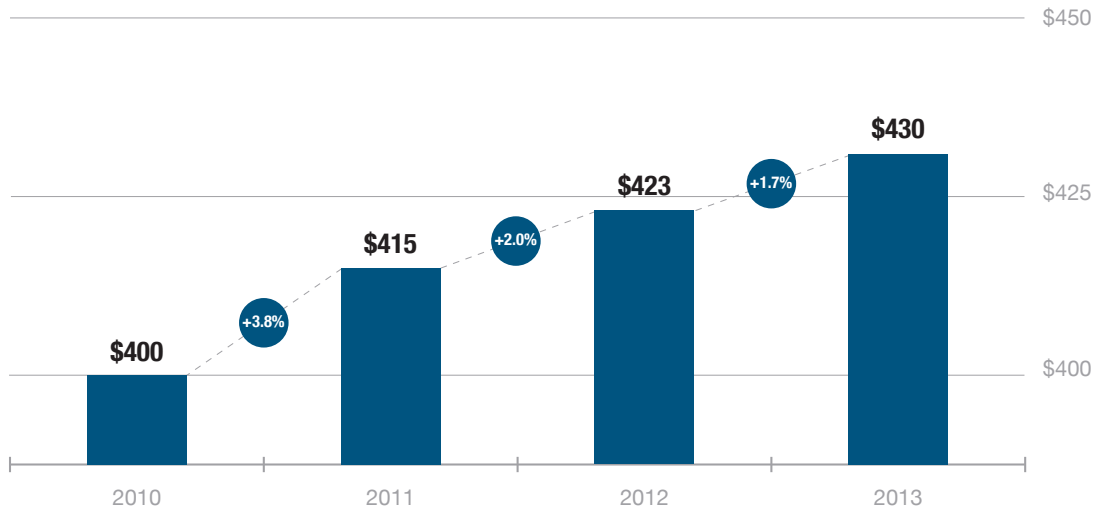
<sup>20</sup> See the Massachusetts' Health Policy Commission's and CHIA's joint publication, Massachusetts Commercial Medical Care Spending: Findings from the All Payer Claims Database at <http://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf> (Accessed August 13, 2014).

## Growth in commercial medical spending has slowed in recent years.

8

### Statewide Total Medical Expenses PMPM 2010 – 2013

Total Medical Expenses are the full amount paid to providers for covered health care services delivered to a payer's member population (payer and member cost-sharing payments combined). Statewide TME grew to \$430 PMPM in 2013, a 1.7% increase



Source: CHIA (payer-reported data)

may not be solely the result of approaches adopted in Massachusetts.

#### See Figure 8

### Total Medical Expenses by Service Category

About three-quarters of commercial medical expenditures are payments to doctors and hospitals. This proportion has remained fairly consistent for the last four years (2010-2013). Over that period, hospital inpatient expenditures have grown more slowly (+1.2% annually) than outpatient expenditures (+2.0% annually)<sup>25</sup>, consistent with the long-term trend of care shifting out of the inpatient setting, as care management, technology, and payment incentives increasingly support outpatient settings.<sup>26</sup>

Pharmacy expenditure growth (+0.5% annually) has been well below general inflation in recent years, also consistent with national trends.<sup>27</sup>

#### See Figure 9

Overall, there has been relatively little change in the allocation of dollars to medical service categories in recent years despite changes in regulation, insurance product design, and payer-provider contracting strategy. This could indicate that the current balance in spending between inpatient, outpatient, and pharmacy is basically efficient, or that recent policy and practice changes have not been sufficient to dramatically shift the setting in which care is typically delivered.

### Total Medical Expenses by Commercial Payer

There was significant payer variation in per member TME changes from 2012 to 2013. This variation in TME may reflect underlying variation in payment rates and contracting, utilization management

About three-fourths of commercial medical expenditures are payments to doctors and hospitals.

<sup>21</sup> HDHPs were defined within this report as those plans meeting IRS standard deductible levels: plans with deductibles of \$1,200 in 2011 and 2012, and \$1,250 in 2013.

<sup>22</sup> In some cases, employers may have implemented financing mechanisms such as health reimbursement accounts or funded health savings accounts to support employee spending that would otherwise be out-of-pocket. For a closer look at consumer-driven health plans, see <http://www.mass.gov/anf/docs/hpc/health-policy-commission-section-263-report-vfinal.pdf> (Accessed August 13, 2014).

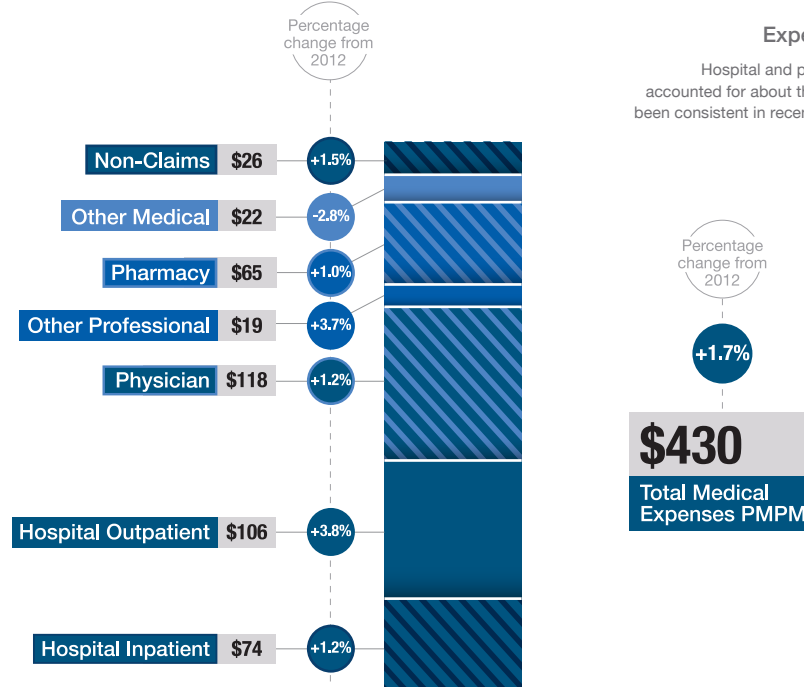
<sup>23</sup> Statewide TME increased by 3.8% from 2010 to 2011, and 2.0% from 2011 to 2012. For historical TME data, see Center for Health Information and Analysis. TME Data Supplement (2013). Available from: <http://www.mass.gov/chia/docs/r/pubs/13/2012-tme-data-supplement.pdf> (Accessed August 13, 2014).

<sup>24</sup> Anne B. Martin, Micah Hartman, Lekha Whittle, Aaron Catlin and the National Health Expenditure

## Hospital and Physician payments accounted for most medical spending.

### Commercial Total Medical Expenses by Service Category 2013 9

Hospital and physician payments (including non-claims payments) accounted for about three-quarters of all medical expenses. This ratio has been consistent in recent years, although there is a gradual, consistent shift from inpatient to outpatient settings.



Notes: Other Professional includes payments generated from claims to health care providers for services provided by a licensed practitioner other than a physician. Other Medical includes payments generated from claims to health care providers for medical services not otherwise included in other categories, including skilled nursing and home health services.

Source: CHIA (payer-reported data)

strategies, benefit design, and the health status of the membership, among other factors. Of these potential factors influencing TME, CHIA has only payer-reported membership health status information available as a variable to hold constant.

#### ■ See Figure 10

The Health Status Adjusted Total Medical Expense (HSA TME) metric accounts for variations in health status of a payer's full-claim members.<sup>28</sup> This metric allows for a more refined comparison of TME trends between payers.<sup>29</sup> Most payers reported that their covered populations had higher risk scores in 2013 than in 2012, indicating member populations with greater health care needs. Only one plan – BCBS, the largest

The only commercial payer to exceed the 3.6% benchmark for health status adjusted total medical expenses was the state's largest: Blue Cross Blue Shield at +3.65%.

Massachusetts commercial payer – reported an increase in HSA TME that was slightly above the Health Policy Commission's benchmark for overall health care spending growth (+3.65% compared to +3.6%).<sup>30</sup>

#### Total Medical Expenses by Managing Physician Group

Four of the largest managing physician groups were associated with HSA TME above the +3.6% benchmark in any of the three major commercial payers' networks. Among these,<sup>31</sup> PCHI was the only physician group that was both higher than the network average and had an increasing HSA TME across all three major Massachusetts payers between 2012 and 2013. BIDCO and NEQCA had consistent increases in HSA TME across all three payers, but did not

Accounts Team (2014). National Health Spending in 2012: Rate of Health Spending Growth Remained Low For the Fourth Consecutive Year. (2014). Health Affairs, Vol. 33(1), 67 – 77. Available from: <http://content.healthaffairs.org/content/33/1/67.abstract> (Accessed August 13, 2014).

<sup>25</sup> Outpatient expenditures include expenditures for hospital outpatient, physician services, and other professional services combined.

<sup>26</sup> See CHIA's Massachusetts Hospital Profiles– Data through Fiscal Year 2012 (2014) at <http://www.mass.gov/chia/docs/r/hospital-profiles/2012/massachusetts-hospital-profiles-report-fy12.pdf> (Accessed August 13, 2014).

<sup>27</sup> IMS Institute for Healthcare Informatics (2013). Declining Medicine Use and Costs: For Better or Worse? Available from: <http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnextoid=5b21ee0a8e631410VgnVCM10000076192ca2RCRD> (Accessed August 13, 2014).

## There was significant variation in payer medical expense trends from 2012 to 2013.

### 10 Health Status Adjusted Total Medical Expenses by Payer 2012 – 2013

The Health Status Adjusted Total Medical Expense (HSA TME) metric accounts for variations in health status of a payer's full-claim members. This metric allows for a more refined comparison of TME trends between payers than looking at unadjusted TME alone. Differences in HSA TME levels (dollar amounts) reflect variation in provider prices, utilization patterns (e.g. provider network), and covered services.

Payer	2013 Health-Status Adjusted TME	% Change in Health-Status Adjusted TME
Aetna	\$413	0.17%
BCBS	\$298	3.65%
Celticare	\$143	0.24%
Cigna	\$231	-1.42%
Fallon	\$332	2.44%
HPHC	\$309	0.92%
HNE	\$246	0.31%
NHP	\$315	-7.90%
Tufts	\$304	2.38%
United	\$313	-19.81%

Notes: HSA TME is not comparable across payers due to differences in risk adjustment tools. BMC and Network Health did not offer commercial health plans in 2012

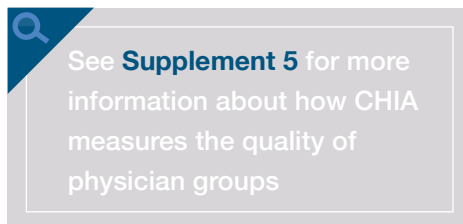
Source: CHIA (payer-reported data)

have HSA TME that was above the network average for all payers. These three groups are associated with academic medical centers. The other group to exceed the benchmark, Steward Network Services, reported the largest increase in HSA TME in Tufts' network (+5.8%), but remained near the network average.

In contrast, Mount Auburn Cambridge IPA (MACIPA), a group affiliated with Mount Auburn Hospital and Cambridge Health Alliance, saw the largest decrease in HSA TME from 2012 to 2013, -9.2% for BCBS members. However, MACIPA's HSA TME level remained above the BCBS network average, and its trend for other payers' members was mixed.

### See Figure 11 Quality of Managing Physician Groups

CHIA also evaluates the quality of physician groups using measures selected from the Massachusetts Standard Quality Measure Set (SQMS). Massachusetts managing physician groups have generally positive scores on patient experience measures and most clinical quality measures reported.<sup>32</sup> The quality differences between managing physician groups, based on these scores, appear to be small.



Massachusetts managing physician groups had the highest patient-experience scores on the measure of patient-provider communication and the lowest scores on organizational access, a measure of whether patients can get a primary care appointment when wanted or needed. The clinical quality scores were highest on measures of how well the groups managed their patients' chronic diseases, including comprehensive diabetes care and cholesterol management for patients with cardiovascular conditions. Performance was the lowest on chlamydia screening and antidepressant medication management.

### Commercial Administrative Costs

Statewide, \$1.9 billion was spent on the "net cost of private health insurance" (NCPHI) in 2013, which represents premium dollars

<sup>28</sup> "Full-claim members" are those members where the payer directly covers – and reports to CHIA – all components of TME, including self-insured plans. See Technical Appendix for more information.

<sup>29</sup> The tools used for adjusting TME for health status of a payer's covered member population vary among payers so that adjustments are not uniform or directly comparable across payers. Please note that TME data is not adjusted for differences in covered benefits within payers and

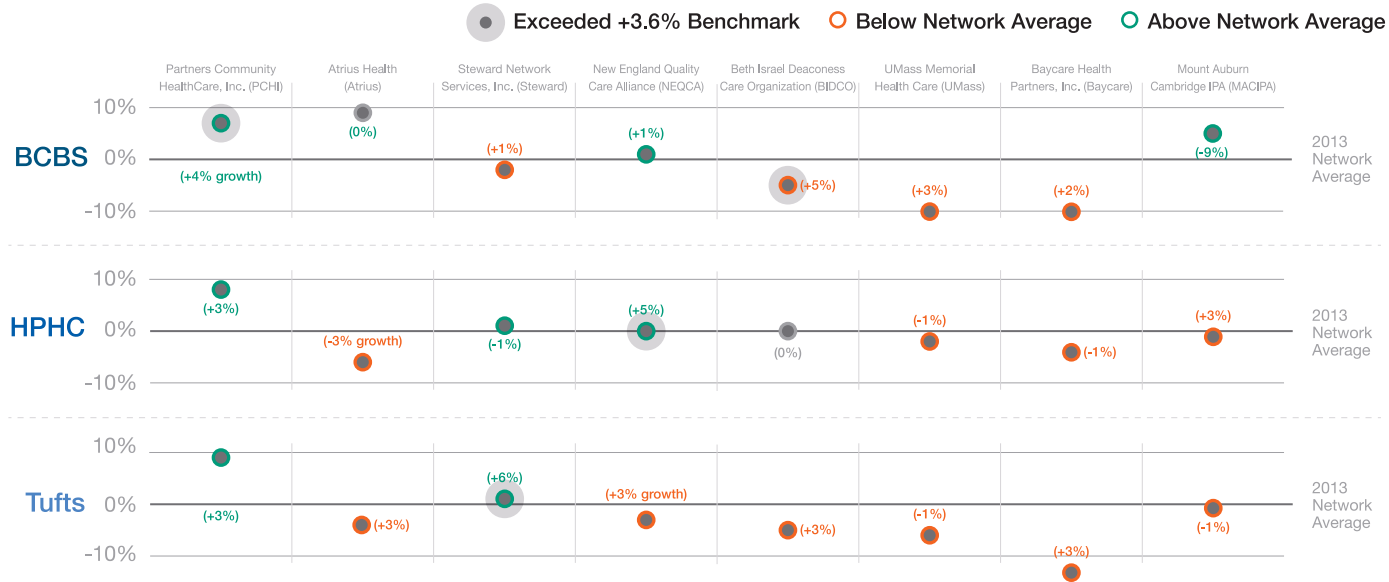
between payers. Thus, the unadjusted TME reflects the actual spending for each payer's member population without adjusting for differences in benefits and member health status.

<sup>30</sup> BCBS's unadjusted TME only grew +2.1%, but at the same time, its members' health status improved by +1.5%, resulting in a higher growth in HSA TME.

Physician Group medical expense trends varied statewide and across payer networks.

11 Managing Physician Group Health Status  
Adjusted Total Medical Expenses 2013

The health status of physician groups' patient panels is a significant driver of changes in expenditures. However, each payer measures member health status slightly differently, so comparisons are only possible within each payer. Dots with an additional ring indicate the four groups with HSA TME growth above +3.6%.



Notes: Includes the largest physician groups in the major payers' networks. TME reflects only patients attributed to a physician group (primarily HMO membership).

Source: CHIA (payer-reported data)

that were spent on administering health care plans.<sup>33</sup> There was a 4.1% reduction in NCPHI spending from 2012 to 2013.

The vast majority of premium revenue is used to fund medical care on behalf of enrolled members. About ten cents of the average commercial health insurance dollar is spent on various administrative expenditures.<sup>34</sup> Premium revenues that are not spent on medical care are used by payers to cover expenses in the broad categories of general administration, broker commissions, premium taxes and fees, and rebates, with the remainder representing surplus (profit) during a given year. In 2013, general administrative expenses comprised two-thirds and broker commissions nearly one-quarter of all non-medical claims

See **Supplement 6** for more information about non-medical expenses at commercial health plans

payer spending. Overall, payers retained 3% of non-medical spending as surplus on their fully-insured business, although some payers, such as NHP, reported larger surpluses (23.4% of their retention dollars).<sup>35</sup>

Payers that spend less than a specified portion of collected premiums on medical

expenses (and other qualifying expenses), as measured by their Medical Loss Ratio (MLR)<sup>36</sup>, are required to provide rebates to certain enrollees<sup>37</sup>. The average 2013 MLR for Massachusetts-based payers was 0.90, ranging from NHP's 0.85 to BCBS' 0.92.<sup>38</sup>

See Figure 12

The average 2013 Medical Loss Ratio (MLR) for Massachusetts payers was 0.90.

<sup>31</sup> These physician groups had the largest membership across the three major commercial payers: BCBS, HPHC, and Tufts.

<sup>32</sup> Data is provided by Massachusetts Health Quality Partners (MHQP) and reflects the experience of adult members in the state's five largest commercial carriers.

<sup>33</sup> NCPHI also includes the cost of administering certain Medicaid and Medicare managed care plans by commercial payers.

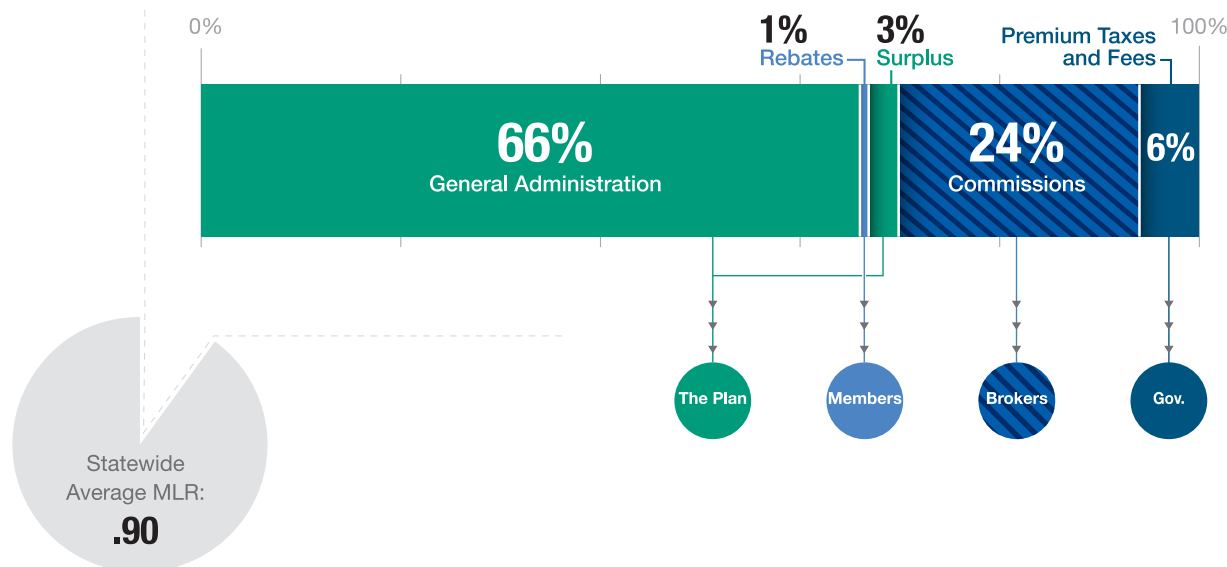
<sup>34</sup> Average payer-reported retention in 2013 was \$46.22 PMPM, or approximately 10.8% of premiums

<sup>35</sup> BCBS, Fallon and WellPoint all reported losses in 2013 on their fully-insured business; MLR and retention decomposition data from payer submitted federal CCIIO data, as analyzed by Oliver

About ten cents of every premium dollar went to non-medical spending, but surpluses were only a fraction of the remainder.

## 12 Components of Massachusetts Payer Retention 2013

Premium revenues that are not spent on medical care are used by payers to cover expenses in the broad categories of general administration, broker commissions, premium taxes and fees, and consumer rebates, with the remainder representing surplus (profit) during a given year.



Source: Oliver Wyman analysis of submitted federal CCIO data for eight payers.

## Public Health Care Program Expenditures

In 2013, spending for public coverage accounted for nearly 60% of THCE. Medicare and state programs (MassHealth and Commonwealth Care) were the largest public program components of THCE.

See Figure 13

### State Programs: MassHealth and Commonwealth Care

The largest health insurance programs administered by the state are MassHealth and Commonwealth Care. Together, spending for these programs make up about a quarter of THCE in Massachusetts.<sup>39</sup> Nearly a quarter of Massachusetts residents received benefits from one of these public programs, compared to 18% nationally.<sup>40</sup>

### Total Medical Expenses by Public Program

MassHealth is comprised of a variety of programs that differ significantly based on eligibility and administration and are better examined individually. Total Medical Expenses (TME) for MassHealth programs varied significantly by patient population. The majority of MassHealth members (approximately 67%) were enrolled in either

See **Supplement 7** for more information on MassHealth and Commonwealth Care expenses

In 2013, spending for public coverage accounted for nearly 60% of THCE.

Wyman. MLRs may not fully reconcile those reported by payers to Massachusetts Division of Insurance for rebate purposes.

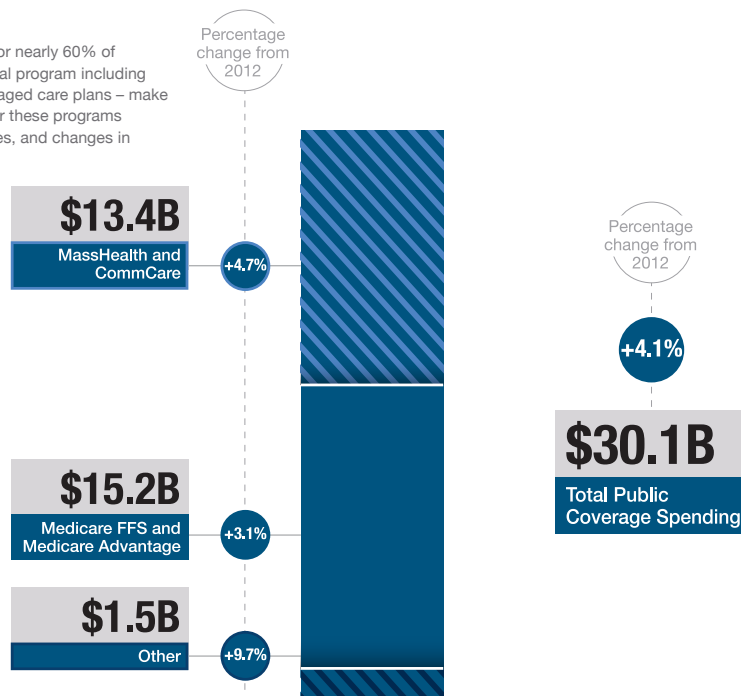
<sup>36</sup> Massachusetts' 2012 and 2013 Medical Loss Ratios (MLR) were 0.90 for Small Group (under 51 benefit eligible employees) and 0.85 for Large Group (51+ total employees); Massachusetts' Small Group MLR was higher than the 0.80 federal standard, while the Large Group MLR

was consistent. Massachusetts' 2011 MLR for Small Group was 0.88; it will be 0.89 for 2014. Massachusetts Division of Insurance has this definition set as the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments. Other adjustments may also be made.

## Medicare is the biggest public program, but MassHealth and Commonwealth Care together are nearly as large.

### 13 Public Health Care Program Expenditures 2013

In 2013, spending for public coverage accounted for nearly 60% of Total Health Care Expenditures. Medicare – a federal program including traditional Medicare and Medicare Advantage managed care plans – make up about half of that. Growing medical spending for these programs reflects membership growth, payment rate increases, and changes in utilization patterns.



Notes: Other public health care program expenditures include Health Safety Net payments, Medical Security Program expenses and Veteran Affairs expenditures. By statute, Total Health Care Expenditures does not include non-medical expenses for public programs.

Source: CHIA and other public sources. See Technical Appendix.

See **Supplement 8** for more information on medical expenses for Massachusetts Medicare beneficiaries

the Primary Care Clinician (PCC) plan, which is administered by MassHealth, or in one of the MassHealth MCO plans that are administered by commercial payers.<sup>41</sup>

MassHealth PCC plan TME grew by 1.4% between 2012 and 2013. TME for the MassHealth MCO plans PMPM grew by 3.9%. Direct TME comparisons between these programs are not possible due to program differences, including differences in the member populations.<sup>42 43</sup> MassHealth

increases should be considered in the context of MassHealth's long-term growth in annual per-member spending of only +1.1% between 2005 and 2012.<sup>44</sup>

#### See Figure 14

MassHealth members in other programs serving special populations were significantly more expensive than those in the PCC Plan and the MCOs, due in part to variation in health status and related utilization patterns.<sup>45</sup> However, per-member expenses for these more expensive populations changed only slightly between 2012 and 2013.

The Commonwealth Care program – which covers only a small fraction of members

compared to MassHealth – enrolls all members in MCO coverage. These MCO plans reported a PMPM spending change of 3.0% between 2012 and 2013.

#### Medicare

Medicare is a group of programs covering different services for Massachusetts elderly and disabled populations. These programs are funded and administered by the federal government. Combined, the Medicare programs spent \$15.2 billion on care for

See **Supplement 9** for further discussion of other public health care programs

<sup>37</sup> The average rebate-eligible member received a rebate of \$4.48 per member per month in 2013, down from \$8.32 in 2012.

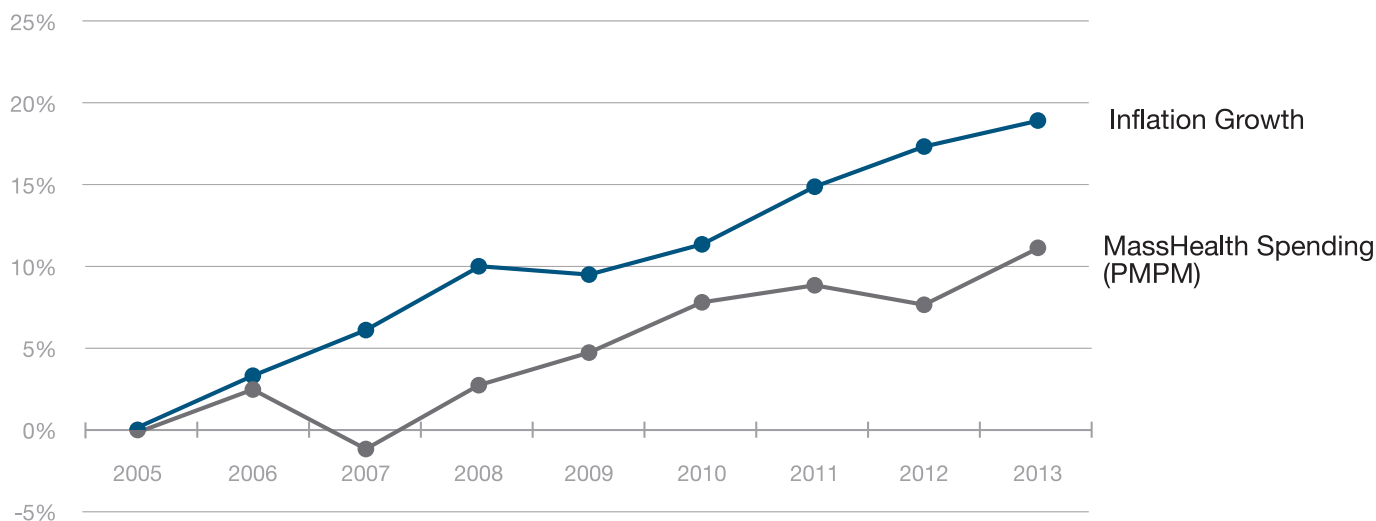
<sup>38</sup> Unlike NCPHI, reported retention includes Massachusetts contract-lives (instead of residents) and rebates. Retention is calculated as premiums minus incurred claims. NCPHI is a calculation that includes some elements of retention, while excluding others.

<sup>39</sup> Spending for the Group Insurance Commission (GIC), because it is an employer, is captured in commercial expenditures. The GIC which purchases health insurance coverage for state employees, spends nearly \$2 billion annually on commercial health insurance (including fully- and self-insured products). GIC expenditures are included in the commercial plan expenditures discussed above, and are not included here. Available at <http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/annual-reports/annual-report-fy-2013-financial-and-trend.html> (Accessed August 13, 2014).

## MassHealth program expenditures have not grown as fast as general consumer prices.

### 14 MassHealth Spending PMPM and Inflation Growth Rate 2005 – 2013

MassHealth spending has increased significantly in recent years, but most of that increase has been due to increased membership. Over this period, per member spending has grown more slowly than overall inflation, despite the uptick in per member spending in 2013.



Source: Blue Cross Blue Shield Foundation / Massachusetts Medicaid Policy Institute; Inflation data from Bureau of Labor Statistics: Consumer Price Index (CPI) Data

Massachusetts beneficiaries, making up 30% of THCE and half of all public program expenditures included in THCE. Total Medicare spending in Massachusetts grew +3.1% from 2012 to 2013, driven primarily by increases in enrollment.

Medicare Parts A and B (inpatient and outpatient services) had a +0.4% increase in spending and a +2.5% increase in enrollment. Medicare Advantage (Part C) plans reported a +10.8% increase in spending and a +4.3% increase in enrollment. Part D (Pharmacy) plans had a +10.3% growth in both expenditures and enrollment during this time period.

For Parts A and B services, per-beneficiary spending dropped -2.1% from 2012 to 2013. Part D spending per beneficiary was

flat (+0.1%), reflecting national trends in pharmacy spending.<sup>46</sup>

Medical spending trends per beneficiary per month for Medicare Advantage plans, which are administered by commercial payers, varied widely. Overall, these plans reported an increase in per member per month spending of +6.3% from 2012 to 2013.<sup>47</sup>

### Other Public Health Care Programs

Other public health care programs account for just 3% of THCE, and accordingly have little impact on statewide trends. The Veterans Health Administration (VA) is the largest of these, accounting for \$1.1 billion in 2013, a 20% total increase from 2012. This growth was consistent with national VA spending trends.<sup>48</sup>

Two smaller state government programs, the Medical Security Program (MSP) and the Health Safety Net (HSN), contributed approximately \$0.4 billion to THCE.

### Administrative Costs of Public Health Care Programs

CHIA did not study the administrative costs of publicly-administered health care programs. By statute, these costs are not included in THCE. However, public health care programs often spend far less than commercial plans on administration as a share of total expenditures.<sup>49</sup> In state fiscal year 2013, MassHealth spent less than 3% of total expenditures on administration.<sup>50</sup>

<sup>40</sup> For state-by-state comparison of Medicaid coverage rates for the non-elderly, see <http://kff.org/medicaid/state-indicator/rate-by-age-3/> (Accessed August 13, 2014).

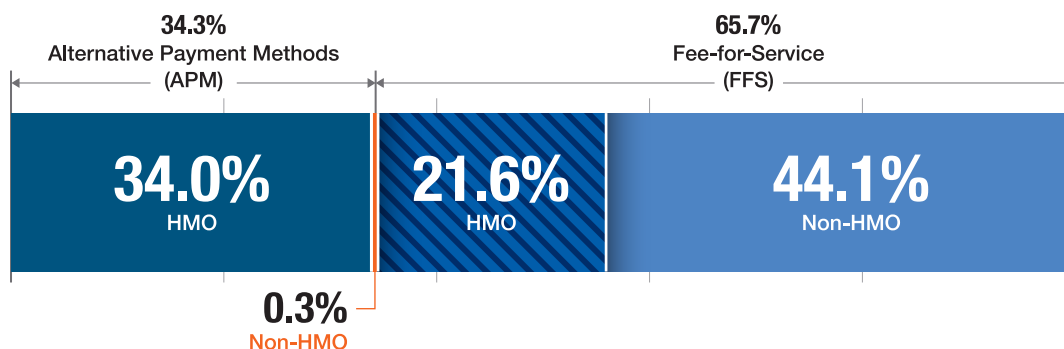
<sup>41</sup> Massachusetts Medicaid Policy Institute (April 2014). MassHealth: The Basics- Facts, Trends and National Content [PowerPoint slides]. Retrieved from <http://bluecrossmafoundation.org/publication/updated-masshealth-basics-facts-trends-and-national-context> (Accessed August 27, 2014).

<sup>42</sup> For example, compared with the MCO program, PCC plan members have higher health acuity than MCO plans. For a detailed consideration of the differences between the PCC and MCO plans, see the 2013 Final Report of the Massachusetts Medicaid Delivery Model Advisory Committee, available at <http://www.mass.gov/anf/medicaid-delivery-model-commission.html> (Accessed August 27, 2014).

## The proportion of members whose care was paid under APMs declined slightly in 2013.

### 15 Commercial Payer Use of APMs 2013

Adoption rates of global payment contracts in Massachusetts have been above national adoption rates. However, proportionally fewer members were enrolled with primary care providers paid under such APMs in 2013. Although APMs are associated almost exclusively with HMO products, opportunities to expand APM adoption remain in both the HMO and PPO categories.



Source: CHIA (payer-reported data); Catalyst for Payment Reform National Scorecard on Payment Reform, 2013.

## Alternative Payment Methodologies

One approach to controlling health care costs that has significant support in Massachusetts

See **Supplement 10** for more information on Massachusetts health insurance coverage

is the adoption of Alternative Payment Methodologies (APMs), particularly global payment contracting. Prior work has indicated that global payment contracts are the only APM widely used in the state.<sup>51</sup>

Adoption rates of global payment contracts—contracts in which medical providers assume a portion of the risk of the cost of caring for a patient population—in Massachusetts have been above national adoption rates.<sup>52</sup> However, proportionally fewer commercial members were enrolled with primary care

providers paid under all APMs in 2013 (34%) than in 2012 (35%).

Additionally, APMs are mainly used today for patient care within HMO-type insurance plans.<sup>53</sup> However, the proportion of commercial members (MA residents only) enrolled in HMO-type products decreased by 10.8 percentage points between 2010 and 2013. This trend was concurrent with a slow but continuing shift toward enrollment in self-insured coverage, in which HMO plan designs are used much less regularly than

## Proportionately fewer members were enrolled with primary care providers paid under alternative payment methodologies in 2013 than in 2012.

<sup>43</sup> Calculation of PCC Plan expenditures includes certain additional services that are not included in the calculation of MCO expenditures; services provided through MBHP are calculated separately.

<sup>44</sup> Massachusetts Medicaid Policy Institute (April 2014). MassHealth: The Basics—Facts, Trends and National Context [PowerPoint slides]. Retrieved from <http://bluecrossmafoundation.org/publication/updated-masshealth-basics-facts-trends-and-national-context> (Accessed August 27, 2014).

<sup>45</sup> These programs include members with disabilities, members over age 65, and those with special health care needs.

<sup>46</sup> Schumock, G. T., Li, E. C., Suda, K. J., Matusiak, L. M., Hunkler, R. J., Vermeulen, L. C., & Hoffman, J. M. (2014). National trends in prescription drug expenditures and projections for 2014. *American Journal of Health-System Pharmacy*, 71(6), 482–499.

See **Supplement 11** for detailed information describing adoption of alternative payment methodologies

in fully-insured coverage.<sup>54</sup> Expanding the use of APMs will be easier if this trend is reversed or if payers and providers begin contracting using such APMs for PPO-enrolled business.

See **Figure 15**

There are potential barriers to greater adoption of these new approaches. As of 2012, APMs were far more popular for Massachusetts-based payers than for national payers covering Massachusetts residents. If APMs are not consistent with the national payers' multi-state strategies, the payers may be unlikely to adopt them as aggressively in Massachusetts absent additional incentives or regulation. Because Massachusetts-based payers account for a significant majority (82%) of the market, the use of APMs by state-based plans may be sufficient to materially influence care delivery by Massachusetts providers, even if the national plans are slower to adopt APMs.

Enrollment in self-insured plans increased in 2013, contributing to a decrease in HMO enrollment.

## Conclusion

In 2013, the Massachusetts health care system performed favorably on a number of indicators. Overall per capita growth in Total Health Care Expenditures was below the benchmark, commercial insurance premiums were essentially unchanged from 2012, and benefit levels and member cost-sharing held steady. Beneath these broad trends, few health plans or provider groups experienced growth above the benchmark. However, the exceptions – the state's largest health plan and largest provider group, among others – require continued monitoring.

The policies implemented under Chapter 224 and previous laws may be partially

responsible for these favorable trends; however, the slower growth in health care expenditures is also occurring throughout the U.S. It is unclear to what extent Massachusetts' favorable trends can be attributed to specific state-level efforts versus changes in the national health care financing and delivery systems.

Adoption of alternative payment methods stalled in 2013, despite the emphasis on this approach in Chapter 224. To date, there is virtually no adoption of alternative payment methods by payers in the growing PPO population.

Massachusetts still bears among the highest health care costs in the nation, and health

care expenditures – despite beating the benchmark – still grew faster than inflation. Over time, the impact of state-specific policy will be measured by the extent to which statewide health care expenditure growth is below national trends, especially if and when the broader economy surges. CHIA will continue to monitor changes in performance to determine if these favorable trends will result in sustainable improvements to health system performance.

This report is the first in the 2014 series of Health System Performance reports. Later this year, CHIA will be publishing more information and analysis on providers' relative prices, quality metrics, and Massachusetts hospitals.

<sup>47</sup> Overall Medicare Advantage TME is unadjusted for health status, as adjustment tools vary among reporting payers. See Data Appendix for Medicare Advantage TME information.

<sup>48</sup> Data is available from the National Center for Veterans Analysis and Statistics, available at <http://www.va.gov/vetdata/Expenditures.asp> (Accessed August 27, 2014). The VA reported +25% in spending per beneficiary over this period.

<sup>49</sup> Congressional Budget Office, "Designing a Premium Support System for Medicare," November 2006, 12. Available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7697/12-08-medicare.pdf> (Accessed August 27, 2014).

<sup>50</sup> MassHealth Administration + HHS IT = \$0.185 billion out of \$12.4 billion = 1.47%, rounding up generously to account for other expenditures related to MH administration. Available at [http://bluecrossmafoundation.org/sites/default/files/download/publication/FY-2014\\_GAA\\_Budget-Brief\\_FINAL.pdf](http://bluecrossmafoundation.org/sites/default/files/download/publication/FY-2014_GAA_Budget-Brief_FINAL.pdf) (Accessed August 27, 2014).

<sup>51</sup> See CHIA's Alternative Payment Methods in the Massachusetts Commercial Market: Baseline Report (2012 Data) (2013), available at <http://www.mass.gov/chia/docs/r/pubs/13/alternative-payment-methods-report-2012-data.pdf> (Accessed August 27, 2014).

<sup>52</sup> Catalyst for Payment Reform (2013). National Scorecard on Payment Reform. Available from: <http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard> (Accessed August 27, 2014)

<sup>53</sup> In 2013, only one plan – Tufts – applied an Alternative Payment Methodology for Group Insurance Commission members enrolled in the Tufts' PPO products. See Technical Appendix for more information.

<sup>54</sup> Self-insured coverage also permits greater flexibility in plan design, as these plans are not subject to Massachusetts health insurance regulations. See Supplement 10 for more information.

# Glossary of Terms

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**Actuarial Value (AV):** A measure of a plan's generosity. The estimated percentage of the total allowed costs paid by the plan, as opposed to the percentage paid by the participant. Actuarial values may be estimated by several different methods.

**Alternative Payment Methods (APMs)** are payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service (FFS) basis.

**Claims, Allowed:** The total cost of medical claims after the provider or network discount.

**Claims, Incurred:** The total cost of medical claims, after the provider/network discount and after member cost sharing.

**Consumer Assessment of Healthcare Providers and Systems – Patient Centered Medical Home (CAHPS-PCMH):** A survey that assesses patients' experiences with health care providers and staff in doctor's offices. The expanded PCMH survey also includes items that address coordination of care and other features of PCMHs.

**Cost-Sharing:** The amount of an allowed claim for which the member is responsible; includes copayments, deductibles, and coinsurance payments.

**Fully-Insured:** A fully-insured employer contracts with a payer to cover a portion of pre-specified medical costs for its employees and dependents.

**Health Care Cost Growth Benchmark (Benchmark)** is the projected annual percentage change in THCE in the Commonwealth, as established by the Health Policy Commission (HPC). The health care cost growth benchmark is tied to growth in the state's economy, the potential gross state product (PGSP). Chapter 224 has set the PGSP for 2013 at 3.6 percent. Subsequently, HPC established the health care cost growth benchmark for 2013 at 3.6 percent.

**Healthcare Effectiveness Data and Information Set (HEDIS)** a measurement tool to assess to provider performance on important dimensions of clinical care.

**Health Maintenance Organizations (HMOs):** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. These plans generally require members to coordinate care through a primary care physician, but may also provide open access to in-network providers.

**High-Deductible Health Plans (HDHPs):** Health plans with deductibles exceeding \$1,200 for 2012 and 2011 and \$1,250 for 2013.

**Managing Physician Group TME** measures the total health care spending of members whose plans require the selection of a primary care physician associated with a physician group, adjusted for health status.

**Market Sector:** Average employer size segregated into the following categories: Individual products (post-merger), Small Group (1-50 enrollees), Mid-Size Group (51-100 employees), Large Group (101-499 employees), and Jumbo Group (500+ employees). In the Small Group market segment, only those small employers that met the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04 were included.

**Medical Loss Ratio (MLR):** Massachusetts Division of Insurance has set the MLR definition as the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments. Massachusetts' 2012 and 2013 Medical Loss Ratios (MLR) were 0.90 for Small Group (under 51 benefit eligible employees) and 0.85 for Large Group (51+ total employees); Massachusetts' Small Group MLR was higher than the 0.80 federal standard, while the Large Group MLR was consistent. Massachusetts' 2011 MLR for Small Group was 0.88; it will be 0.89 for 2014. Other adjustments may also be made.

**Payer Retention:** The difference between the total premiums collected by payers and the total spent by payers on incurred medical claims.

**Preferred Provider Organizations (PPOs):** Plans that identify a network of "preferred providers", but that allow members to obtain coverage outside of the network, though to typically higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.

**Premiums, Adjusted:** Premium rates adjusting for membership differences in age, gender, area, group size, and benefits across payers. See Technical Appendix for more detail.

**Premiums, Earned:** The total gross premiums earned prior to any Medical Loss Ratio rebate payments, including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance).

**Premiums, Earned, Net of Rebates:** The total gross premiums earned after removing Medical Loss Ratio rebates incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance).

**Self-Insured:** A self-insured employer takes on the financial responsibility and risk for its employees' and employee-dependents' medical claims, paying claims administration fees to payers or Third Party Administrators (TPAs).

**Third Party Administrators (TPAs):** Companies that contract with self-insured employers to administer their claims, or to grant them access to their networks and negotiated provider fees.

**Total Health Care Expenditures (THCE)** is a measure of total spending for health care in the Commonwealth. Chapter 224 of the Acts of 2012 defines THCE as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses (TME) reported by CHIA; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by CHIA.

**Total Medical Expenses (TME)** is defined as the total medical spending for a member population based on allowed claims for all categories of medical expenses and all non-claims related payments to providers. TME is expressed on a per member per month (PMPM) basis.



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