



# Massachusetts Health Care Cost Trends 2010 Final Report

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Commonwealth of Massachusetts

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## Executive Summary

When Massachusetts passed its landmark health reform law (Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*), it established a model for the nation in creating a path to achieve near universal health insurance coverage of its residents. Chapter 58 was designed to expand coverage, and that effort has proven to be a success, with over 97 percent of the state's residents now insured. However, the reform law of 2006 was not intended to tackle health care costs specifically, and their continued escalation is causing significant challenges in Massachusetts. The state's individuals, families, and employers, as well as state and local government, are all struggling under the weight of high and rapidly rising costs of health care, which is creating barriers to accessing care, cutting into wage growth, stifling job creation, and preempting spending in other sectors of the economy.

Chapter 305 of the Acts of 2008 - *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care* – mandated a series of initiatives to begin to address the growth in health care costs and created a framework for the Division of Health Care Finance and Policy (“Division”) to analyze health care spending in Massachusetts and examine the factors contributing to its increase.

This final report presents a summary of the key findings in the preliminary reports released by the Division and the Office of the Attorney General (“OAG”), respectively, a summary of findings and information generated through written and oral testimony presented during public hearings held in March, and recommendations for mitigating the annual growth in health care costs.

### The Urgent Need to Address Rising Health Care Costs in Massachusetts

Health care contributes significantly to the Massachusetts economy—directly through employment in places where care is delivered and indirectly through industries, such as biotechnology and pharmaceuticals, that have been drawn to Massachusetts to be near some of the most influential medical centers and research facilities in the world. However, per capita spending on health care in Massachusetts is 15 percent higher than the rest of the nation, even when accounting for the state's wages and spending on medical research and education.<sup>1</sup> While the economic activity associated with the health care sector and the near-universality of health insurance coverage in the state are important features of Massachusetts' economy, the continued increases in health care spending – if uncontrolled – will hinder its economic performance and limit investments in other sectors of the economy. If the rate of growth in health care spending in Massachusetts were kept to the level of growth in the national per capita GDP (3.9 percent) - instead of growing at its current projected rate of 6.0 percent annually - total cumulative savings from 2011 to 2020 – or spending available for other sectors of our economy - would exceed \$90 billion.<sup>2</sup>

Moreover, increases in the cost of health insurance negatively impact economic activity as businesses are unable to afford to hire new workers since the cost of health benefits consume

more of employers' bottom lines. Additionally, with health insurance premiums rising faster than the overall economy, over time Massachusetts' employers – who historically have been much more generous than their national peers in their rate of offer of health insurance coverage to employees - may be forced to drop coverage for their employees or substantially reduce benefits.

To mitigate their increased spending on health insurance benefits, employers have been shifting costs of care to employees through increased levels of co-payments, coinsurance and deductibles as well as increases in the portion of individual and family premiums for which employees are now responsible.<sup>3</sup> These increases in out-of-pocket health care costs to employees consume increasingly substantial portions of individual and family budgets, impairing their ability to save for other needs, such as retirement, housing, and their children's college educations. Additionally, families have less money available to spend on consumer goods which could stimulate economic activity in other sectors of the Massachusetts economy.

Rising health care costs are a national problem, not unique to Massachusetts or directly caused by Chapter 58's expansion of access to coverage. In the past two decades, the percent of family income dedicated to health insurance has more than doubled from 7 percent of the nation's median family income in 1987 to 17 percent in 2006. Without action, economists estimate that the proportion of family income devoted to health insurance could rise to more than a third of median family income by 2016.<sup>4</sup> Clearly such an increase is unsustainable and underscores the need for immediate action to change this trajectory.

Given this economic imperative, the Division recognizes that concrete and thoughtful interventions are necessary to exert some control over annual health care cost increases in Massachusetts. But while the need for action is immediate, the tools presently available to state government are limited and can not fundamentally change the underlying dynamics leading to high cost increases. As such, the Division recommends a few "blunt" strategies to serve as necessary, yet temporary measures to control health care costs from continuing to increase at unsustainable levels. At the same time, the Division recommends immediate action from all stakeholders to develop an integrated health care delivery model that more systemically mitigates health care cost growth and improves health care quality. Such a transition must address both the amount of health care we use (driven by demand for and supply of services), and the price we pay for such care. Developing an integrated delivery system will require leadership and sustained commitment from all Massachusetts stakeholders – legislators, the Administration, physicians, hospitals, consumers, employers, and insurers – to achieve the kind of breakthrough in mitigating health care costs that the Commonwealth achieved in providing near universal access to health care coverage. This report establishes a framework for that effort.

## **Opportunities to Address Rising Health Care Costs**

The findings from the Division's preliminary reports, the investigation by the Office of the Attorney General, and the testimony at the public hearings identified many opportunities to improve the efficiency of health care delivery in Massachusetts. In particular, there was broad consensus on the following key opportunities:

- Health care costs are growing at an unsustainable rate. Cost containment efforts should focus primarily on mitigating the growth in medical expenses, which account for the majority of the growth in health insurance premiums in recent years.
- Price increases are the key driver behind the growth in medical costs. Price increases, due to both higher negotiated rates and care moving to higher cost settings, account for the majority of the growth in health care costs.
- There is wide variation in the prices that are paid by health insurers, reflecting an imbalance in the health care marketplace that merits intervention.
- The predominance of a fee-for-service payment methodology rewards volume rather than value. Payment methodologies must be realigned to promote an integrated delivery system that rewards quality, cost-effective, patient-centered care provided in the most appropriate settings.
- The lack of integration in the health care delivery system is costly. The high rates of hospital readmissions and relatively high incidence of avoidable or preventable emergency department use suggest that the health care delivery system could be better integrated to more effectively serve patients in appropriate, lower cost settings.
- The health care system lacks a system-wide health IT infrastructure. Leveraging and implementing system-wide information technologies (such as electronic medical records) would allow the delivery system to be better integrated and facilitate more effective patient care coordination.
- Certain provisions in provider contracts impede competition and innovation. With providers consolidating and expanding their geographic presence, the Commonwealth must carefully address non-competitive contractual arrangements between providers and insurers, which may lead to higher prices as determined by the Office of the Attorney General.
- Health resource planning needs strengthening. Health service capacity should be analyzed and planned for in order to meet the geographic needs of the population and better leverage existing services to meet current and future needs.
- Insurers should develop and promote insurance product options that direct care to efficient, lower cost providers. There are opportunities to modify insurance regulations to enhance the role of insurers to offer more cost-effective products, such as select and tiered network products, and to promote management of patient care more effectively.
- There is limited information available to guide consumers and purchasers of health care to make better health care purchasing decisions. There is opportunity to help inform choices made by consumers and purchasers of health care and to increase provider and payer accountability by making information on price and quality readily available and presented in easily understandable formats.

## Policy Recommendations

This report outlines both short-term and long-term recommendations. First, immediate actions are presented to address the urgent problem of rising health care costs, including:

- Pursue and leverage federal reform opportunities to fund innovation in cost control in Massachusetts;
- Implement immediate oversight of health insurance premiums and provider rates;
- Develop market-oriented health insurance products and government tools that will address premium volatility and lower premiums for consumers and employers; and
- Initiate legislative review of provider contract provisions that may now limit competition.

Second, the report presents a longer-term framework for developing an integrated and sustainable health care system which incorporates five key components:

- Oversight and direction provided by an independent public entity;
- Payment reform involving all payers;
- Support for health care delivery system redesign and system-wide adoption of health information technology;
- Transparency of cost and quality information; and
- Investment in evidence-based public health and wellness initiatives.

Although these strategies will take a number of years to implement, steps need to be taken immediately to move toward these goals. These fundamental changes to the delivery and financing of health care are critical to the Commonwealth's long-term success in mitigating health care cost increases while also improving quality.

## Short-Term Interventions: Controlling Health Care Cost Growth

### 1. Leverage the Policy and Funding Opportunities in the Federal Health Reform Law

On March 23, 2010, President Obama signed into law comprehensive health reform, the *Patient Protection and Affordable Care Act*. While many aspects of the new law focus on the expansion of access to health insurance (e.g., an individual mandate, subsidies for purchase of health insurance, employer responsibilities, health insurance reforms, and other policy tools already implemented in Massachusetts), there are several opportunities for states to participate in pilots and grant programs that allow for increased innovation and provide financial supports and resources for improving care delivery, public health and wellness aims, workforce development, health information technology, and payment reform. Massachusetts should leverage federal funds to support innovation consistent with the state's health care policy goals. Some of the most promising of these federal opportunities are:

- Premium relief for small business: Beginning in 2010, the law allows for federal tax credits to offset 35 percent of health insurance costs for small businesses.
- Oversight of premium rates: The law requires that there be systematic review of increases in health insurance premiums and reporting of medical loss ratios.

- Funding for innovative payment approaches to improve health care delivery: The law establishes the Center for Medicare and Medicaid Innovation to administer a variety of innovative pilot and demonstration projects aimed at integrating the health care delivery system. Opportunities exist for projects affecting all payers as well as those focused on Medicare and Medicaid and include topic areas such as payment bundling, global payments, pediatric accountable care organizations, and patient-centered medical homes.
- Opportunities for projects that focus on managing care for those residents at highest risk: Funds may also be available for projects that demonstrate innovative approaches to improve care and reduce costs for individuals with multiple chronic conditions as well as projects on community-based prevention and wellness programs.

It is strongly recommended that the Commonwealth avail itself of all such appropriate opportunities for federal funding and waivers made available through this historic law.

## 2. Implement Immediate Oversight of Health Insurance Premiums and Provider Rates

In the immediate term, the Legislature should pass legislation that strengthens administrative, regulatory, and legislative authority to oversee, and -- where necessary -- intervene in both insurer premiums and provider rates. It is essential that government plays an active role to ensure the health care marketplace functions appropriately and moves expeditiously to address rising costs when it does not. We must focus on both providers and insurers in order to address the current inequities in the Massachusetts health care marketplace. It is recommended that these short-term tools remain in place until the broader system reforms discussed below are achieved.

Oversight of health insurance premiums and provider rates are admittedly blunt tools with which to influence health care cost growth. However, the economic imperative is critical enough to warrant their use as temporary means of providing relief to the businesses and families of the Commonwealth while adjustments are made to develop a fully integrated health delivery system. As short-term interventions, and when coupled with other market-oriented adjustments, insurance premium and provider rate oversight can immediately help to address cost growth and current market inequities, such as price variation, described in the Division's preliminary reports and testimony of witnesses at the public hearings. Government oversight and market-based strategies are not mutually exclusive. As expert witness Paul Ginsberg of the Center for Studying Health System Change suggested in his testimony, regulatory oversight can work in concert with market-oriented approaches to achieve the Commonwealth's objectives to mitigate cost growth.

### *Insurer Premium Oversight*

In February 2010, the Division of Insurance (DOI) issued emergency regulations requiring insurers participating in the merged market to submit premium rates to the DOI for its review at least 30 days before their proposed effective date. The DOI leveraged existing statutory authority which allows it to disapprove premium rate increases that are determined to be excessive or unreasonable relative to the benefits provided.

The Governor's jobs bill – "*An Act Providing for Job Creation by Small Businesses*" – would expand the DOI's authority by creating a benchmark that if exceeded would lead to automatic hearings on the rates that a company may charge in the small group market. The Legislature

should authorize development of a similar regulatory tool to apply to all products in the marketplace—not just the small group market.

In addition, the Legislature should explore methods and policy tools that can be used to influence the self-insured segment of the health insurance market (50% of the private health insurance market), which is currently unregulated by the Commonwealth per ERISA.<sup>5</sup>

The Legislature should also consider legislation that would modify rating standards around age bands and wellness rating factors, and allow for shock buffers to immediately help protect businesses from staggering increases in health insurance premiums. Legislation should also be enacted to create an open enrollment period for individuals.

### *Provider Rate Oversight*

The Governor’s jobs bill also proposes oversight of rates paid by health insurance companies to providers. As indicated by the Division’s analysis and findings, underlying rates of increase in provider payments have been the key driver in rising premiums in recent years. Therefore, the provider rate review process is a necessary short-term tool to lower the rate of provider price increases and simultaneously, increase the effectiveness of insurer premium reviews by the Division of Insurance.

It is important to note that a “flat freeze” in rates will not address existing price variation or payment inequities between providers. The Legislature should enact a rate review process that considers both the proposed increases in provider rates and payment levels relative to a statewide median with a specific focus on lowering the rate of price increases for high cost providers.

In the short-term, review of provider levels of payment, fee schedules, and components of total medical expense should seek to address the wide variation in prices and reward low cost providers, as well as immediately address overall cost growth. Such an approach should ensure the viability of efficient, low-cost providers in the marketplace, prioritize their role in an integrated health care delivery system, and establish them as key “building blocks” in a transition toward payment reform.

The provider rate review process should also be designed to consider the public payer mix of the provider, the relative level of proposed rates compared to similarly situated providers, the historical provider rate increases, the extent to which the facility provides complex or unusual medical procedures, and the financial standing of the provider.

While oversight of health insurance premiums and provider rates are not ideal long-term strategies, they are necessary short-term interventions to mitigate the unsustainable levels of health care cost growth that has occurred in recent years. When a defined transition to a fully integrated payment and health care delivery system has been achieved, these interventions should no longer be necessary.

Mitigating the rate of growth in prices is a shared responsibility of both providers and payers. In the absence of legislation, insurers should use existing negotiating tools to influence provider rates and rate increases. It is imperative that insurers and providers work together to lower the rate of growth in provider rates immediately.

### **3. Create and Effectively Market Health Insurance Products with Select Networks of High Performing Providers**

The variation in prices paid to providers demonstrates an immediate opportunity for health insurers to develop and promote insurance products which direct care to efficient, lower cost providers, similar to recent efforts by the Group Insurance Commission. These products may include provisions that allow for differing levels of cost sharing based on tiers of providers within the network.

As is included in the Governor's jobs bill, the Massachusetts Association of Health Plan's Affordable Health Plan, and a recent proposal by the Associated Industries of Massachusetts, legislation should be enacted which permits the Division of Insurance to require that every insurer that participates in the merged market create and offer to all participating employers and individuals a product which includes a select network of high-quality, low-cost providers. As part of this initiative, the Division of Insurance should facilitate insurer development and promotion of such select network products. The Division of Insurance will hold hearings in early May on issues related to select networks and network adequacy. Consideration should be given to the fact that some geographic areas of the state may have insufficient provider capacity to develop select networks and therefore this option may only be available in certain regions of the state.

While there is a similar ability to regulate the insurance products offered through fully-insured large employers, the state has no ability to regulate self-insured employers. The Division of Insurance should work with the business community to encourage employers to be more prudent purchasers of health care for their employees.

In addition, employers should be incentivized to design and use employee engagement strategies that will help employees be proactive about their health and well-being. Such strategies are also necessary to promote awareness among employees about health care costs and service utilization.

### **4. Provider Contract Provisions**

According to analysis and information gathered by the Office of the Attorney General and the Division of Insurance, some contracts between insurers and providers include provisions that may limit fair and open competition, perpetuate market disparities, and inhibit product innovation. The Legislature should review the following provisions and consider addressing the parameters around provider-insurer contracts that might influence their inclusion:

- Anticompetitive provisions

The OAG and DOI found that some contracts between insurers and providers include clauses that inhibit competition by tying rates of payment in one contract to those included in a contract with another party. In some cases, these clauses may reduce the development of select networks, tiered networks, or other products, and may actually lead to automatic increases in rates of payment based on what an insurer or provider is able to negotiate in contracts.

- "Tie-in deals" in contract negotiations

The OAG and DOI found that some providers will only enter into contracts with health insurers if the insurer also agrees to contract for all the services available from the provider or to include all affiliated providers within the contract. These “all-or-nothing” contracts limit the ability of the insurer to develop provider networks that most cost-effectively serve its members.

## **Long-Term Solutions: Creating an Integrated Health Care Delivery System**

Achieving a sustainable growth rate in health care costs requires a careful and holistic change in the way in which the Massachusetts delivery system is organized, how providers are paid, and what measures we use to both hold our delivery system accountable and reward quality. The following recommendations fall into five broad categories – all of which must be addressed – in order to develop a high-performance, integrated delivery system that achieves better health outcomes and lowers costs for Massachusetts residents:

1. Creation of an oversight entity to design and implement the transition to an integrated delivery system, including establishing performance targets and monitoring progress;
2. Payment reform – which is a necessary component but not in and of itself sufficient to achieve overall integration and lower costs;
3. Delivery system redesign to ensure more efficient organization, communication, and coordination of care among providers and to support the provision of integrated, patient-centered care in the most appropriate setting;
4. Transparency of cost and quality information for consumers and employers; and
5. Investment in public health and wellness initiatives.

Critical to the success of these reforms will be the involvement of all payers – including Medicare. Therefore, in addition to state legislation, federal waivers and other necessary authorizations are essential to support some of these strategies.

Together these longer-term recommendations will help the Massachusetts health care marketplace operate more effectively by using public oversight and accountability to spur integration, innovation, and competition. Rather than viewing policy solutions as strictly government-based regulatory methods or market-based approaches, these recommendations recognize that systemic change requires both government oversight and industry leadership to incentivize and create the necessary conditions for effective market competition, as well as consumer and employer engagement.

### **1. Oversight Entity**

As the Commonwealth tackles mitigating health care costs and restructuring its delivery system to increase efficiency and integration of care, it needs to designate an entity to guide its decision-making and implementation strategy. At present, multiple state agencies share responsibility for various components of provider monitoring, health insurance premium oversight, and quality and performance measurement. Currently there is no entity which sets overall targets for health

spending or its rate of growth for the Commonwealth. For the system to move forward in a unified direction, an independent public entity that coordinates and leverages existing public and private resources should be assembled to set overall spending targets, monitor progress toward these targets, and make other related decisions. The oversight entity would be responsible for overseeing implementation of all of the following recommendations – with a particular focus on the payment and delivery system reforms. In time, the responsibilities of this entity should evolve from implementation to monitoring.

The oversight entity could also be responsible for ensuring that a mechanism exists for dissemination of public information about the various reforms. Employers and consumers will need to be aware of how new regulations may affect their health care choices and be encouraged to make cost effective decisions. Research shows that public awareness campaigns were successful in educating the public about the individual mandate created under Chapter 58 of the Acts of 2006. A Division of Health Care Finance and Policy survey report<sup>6</sup> found that in 2008, 8 out of 10 households were aware of the individual mandate.

Such an entity could be governed by a Board of Directors composed of government officials and subject matter experts in specific fields. Staff support for the Board could be provided by the relevant state government agencies, including the Division of Health Care Finance and Policy, the Department of Public Health, the Department of Mental Health, the Executive Office of Elder Affairs, and the Division of Insurance, among others.

## **2. Payment Reform**

In order to transition the health care delivery system in Massachusetts towards greater efficiency and integration, the Division recommends that comprehensive payment reform be enacted. This proposal builds upon the unanimous recommendations of the Special Commission on the Health Care Payment System, the framework outlined by the Health Care Quality and Cost Council in its *Roadmap to Cost Containment*, and the testimony of most witnesses at the Division's public hearings on health care cost trends. Payment reform efforts must aim to move the entire Massachusetts health care system to one in which the interests of providers, payers, and consumers are aligned to support high quality, cost-effective care delivered at the right time and in the most appropriate setting.

An integrated payment methodology will help address many of the factors contributing to increasing health care costs as found in the Division's preliminary reports and the investigation by the Office of the Attorney General. Removing the inflationary incentives inherent in the current predominantly fee-for-service system as well as rewarding integrated care delivery will help mitigate cost growth over time and reduce expenditures on unnecessary care.

In order to address the wide variation in prices and to ensure that current market inequities are not perpetuated in a new payment system, the oversight entity should be given authority to set limits on the maximum degree of price variation permissible and narrow such variation over time. In addition, such an oversight entity should prioritize primary care and low-cost, high quality providers who can successfully manage a wide spectrum of services in its system redesign.

Active monitoring by the oversight entity and public reporting on quality of care and outcomes will also be critical to this transition. The oversight entity should establish a core, common set of measures for rewarding improved processes and outcomes to be used by all payers. Moreover, the oversight entity will need to establish safeguards against underutilization of services and protection against inappropriate denials of services or treatment.

To encourage widespread adoption of integrated payment methods throughout the Massachusetts health care system and in recognition of the growing enrollment in self-insured plans, the oversight entity should provide incentives for participation to self-insured employers. In addition, the Executive Office of Health and Human Services should seek a federal waiver to permit Medicare to participate in the state's integrated payment system. Since Medicare represents a significant portion of provider revenues, its payment policy plays a central role in determining incentives and delivery practices in the Commonwealth.

### **3. Health Care Delivery System Redesign**

Providers must be incented to move towards greater integration and coordination. Such efforts must support effective communication across the continuum of patient care needs and across different providers.

#### *Creation of Integrated Care Organizations*

The creation of Integrated Care Organizations (ICOs) would ensure that providers work collaboratively to meet patient care needs. ICOs should be composed of licensed and accredited health care providers including at least one acute care hospital and one primary care physician practice that includes a behavioral health component. ICOs would be responsible for delivering integrated health services including all services required under Minimum Creditable Coverage standards. The oversight entity should monitor the formation of ICOs including size, scope, excess consolidation, and possible barriers to entry, all of which could impact market power; this will be critical to ensuring appropriate competition among ICOs.

ICOs should prioritize and incentivize primary care as central to meeting patients' care needs and reflecting the principles of a patient-centered medical home model. Of critical importance to the feasibility and sustainability of the ICO model is that flexibility be given to entities forming ICOs to be either fully integrated organizations, multi-specialty providers, or "virtual organizations" that can manage a meaningful spectrum of services. In addition, different levels of integration with financing and risk should be explored, such as those outlined by Stuart Altman and colleagues from Brandeis University's Heller School which allow for shared savings models as well as fully globally capitated models.<sup>7</sup>

ICOs should allow for some of the savings generated by efficiencies to be kept by the entities themselves to invest in their own systems of coordination (e.g., health information technology). There should also be opportunities for consumers and employers that utilize efficient ICOs to share in some of the savings. It is also recommended that ICOs be permitted and encouraged to participate in reinsurance arrangements to help mitigate the impact associated with unforeseen risk.

### *Provide Technical Assistance to Providers Forming ICOs*

Some providers are better prepared, from a capital resource perspective, for the transition towards integrated ICOs. The Commonwealth should seek out public-private partnerships to provide technical assistance in the form of grants and expertise to providers that are not as well equipped to form ICOs. Extending legal, corporate, and financial supports would allow an incubation period for essential, but less capitalized, community providers to form ICOs, which will allow them, over time, to compete.

### *Promote the System-wide Adoption of Health Information Technology*

The use of health information technology (HIT) would enhance coordination across providers, provide patients with electronic access to their own health information, and make information more readily available for supporting strategies to improve population health. As suggested by the Health Care Quality and Cost Council's *Roadmap to Cost Containment*, thoughtfully designed health technology tools can be used to reduce unnecessary and duplicative testing, reduce the administrative burden on providers, and improve clinical quality. Chapter 305 of the Acts of 2008 charged the Massachusetts eHealth Institute and the HIT Council with ensuring that all providers have and utilize electronic health records and interoperable networks by January 1, 2015. The eHealth Institute's HIT Plan<sup>8</sup> outlines 6 strategies to meet its goals. They include 1) establish multi-stakeholder governance; 2) establish a privacy framework to guide the development of a secure HIT environment; 3) implement interoperable health records in all clinical settings and assure they are used to optimize care; 4) develop and implement a statewide health information infrastructure to support care coordination, patient engagement, and population health; 5) create a local workforce to support HIT related initiatives; and 6) monitor success.

Provisions in the recently passed national health reform law offer new opportunities for streamlining health information technology's role in the Commonwealth's health care delivery system. In addition, the American Reconciliation and Recovery Act (ARRA) of 2009, has led to substantial federal funding efforts to support the adoption of interoperable electronic health records and to develop the capacity for system-wide health information exchange.

The Division recommends that current efforts to promote and expand the use of HIT continue to be supported by the Commonwealth and that both providers and payers continue to work together to create uniform standards for usage and interoperability of health information technology across providers. These standards and goals should apply not just to hospitals and physician groups, but also to home health and long-term care providers.

### *Promoting the Expansion of Successful Chronic Care Models*

It is widely recognized that a small portion of the population accounts for a disproportionate share of health care expenditures. These costs are largely driven by treatment of chronic disease and other long-term illnesses. By 2015, an estimated 150 million Americans will have at least one chronic condition. Among nonelderly adults, the number who report having one or more of seven major chronic conditions has increased from 28% in 1997 to 31% (or 58 million) in 2006.<sup>9</sup> A number of pilots and small programs serving chronic care and other high need populations have been implemented in various places throughout the state. For example, the Senior Care Options program which integrates funding and services for seniors who are dually eligible for MassHealth and Medicare has shown promising results. The Commonwealth should work with

the Federal Coordinated Health Care Office, a new office within the Centers for Medicare and Medicaid Services created under the federal health reform law to focus on improving care coordination for persons dually eligible for Medicare and Medicaid, to expand Senior Care Options and develop programs for dually eligible individuals under 65 years of age. In addition, current barriers to such expansion – such as reserve threshold levels which can be very difficult for small organizations to meet - should be examined for possible modification.

#### *Strengthen Determination of Need and Health Resource Planning*

As included in the Health Care Quality and Cost Council's *Roadmap to Cost Containment*, the state should enhance its capacity to analyze patient needs by region to insure that Determination of Need and other health care planning are informed by current trends, demographic characteristics, patterns of utilization, and other relevant factors. Legislation would be needed to expand the Massachusetts Department of Public Health's authority to examine demographic trends and changes in medical technologies and to use state-of-the art methodologies in reviewing Determination of Need applications. Additional funding would be required to ensure adequate staffing and other resources at the Department of Public Health to support this critical health resource planning function.

#### *Monitoring and Oversight of Advertising Spending by Providers*

The Legislature should consider implementing a process to review spending on advertising by health care providers as part of the Massachusetts Department of Public Health's licensing process. For budgets over a given threshold, DPH could require that a percentage of such monies to be spent on advertising be dedicated to a fund for the purposes of financing public health and wellness campaigns across the Commonwealth.

### **4. Transparency of Cost and Quality Information**

Central to achieving a more effective and integrated delivery system is robust data on health care cost and quality as well as easily accessible and understandable health care information for consumers, employers, insurers, and researchers. Efforts are already well underway to support this goal. The Health Care Quality and Cost Council has been collecting insurance carrier claims data on the privately, fully insured for nearly three years and it currently posts data on 19 inpatient conditions and 18 diagnostic tests on its consumer website, *My Health Care Options*. The Division recently proposed regulations to collect and make available data on all private claims (including self-insured – who represent half of the privately insured - as well as fully insured claims). The Division is also working with the Office of Medicaid and the Commonwealth Health Insurance Connector Authority to incorporate MassHealth and Commonwealth Care data, respectively, and has submitted an application to the Centers for Medicare/Medicaid Services to obtain Medicare data as well. The result will be one of the only all payer, all provider claims databases in the country and will facilitate unprecedented transparency, through access to and analysis of medical and clinical expenditures in Massachusetts.

This expanded database will inform the ongoing development of new performance measures to be reported publicly by the Division. These measures would enable consumers to make choices based on knowledge of the differences in quality and price of the providers through whom they seek care, as well as hold providers accountable for high quality, cost-effective performance.

The Division also intends to make analytic datasets available to researchers and health care organizations in order to support their efforts in understanding variations in health care quality and costs. While many large purchasers and providers already have data to analyze such issues in-house, the Division seeks to “democratize” such knowledge by giving access to a broader audience. Open and transparent price and quality information will be critical to the formation of a competitive marketplace and to transition towards an integrated delivery system.

Finally, analysis of this data will be critical to the oversight entity’s role in monitoring the impact of reforms on quality, access, and costs.

## **5. Public Health and Wellness**

The Division recommends that the Commonwealth explore options for public-private partnerships to invest in evidence-based public health interventions that promote wellness and reduce the incidence and prevalence of chronic conditions. While savings are not likely to be realized in the short-term, the transition towards a wellness (not illness) model is a necessary and responsible investment to improve the health and productivity of the Massachusetts population. This is a critical challenge that cannot be ignored and requires immediate attention.

### *Investing in Population-based Prevention of Chronic Disease and Other Illness*

A recently published analysis of Medicare spending found that two-thirds of the rise in national health care spending from 1987 to 2006 is a result of the growing prevalence of treating chronic disease.<sup>10</sup> The Boston Foundation reported in 2007 on the Greater Boston area’s “unique and powerful reasons to respond to the rising tide of preventable chronic disease,” citing its aging workforce which will become susceptible to the onset of serious chronic disease. The Foundation warned against rising levels of obesity, diabetes, and other preventable chronic diseases that “present not just a health challenge, but also a challenge to the region’s economic competitiveness, as rising levels of chronic disease reduce productivity, drive up health care costs and squeeze out the ability to invest in other key priorities like education and public safety.”<sup>11,12</sup> Similarly, the Massachusetts Department of Public Health has examined the trends regarding overweight and obesity and their relationship to increased chronic disease prevalence and recommended that comprehensive and sustained policies and programs be implemented across a wide variety of sectors including schools, municipalities, clinical sites, employers, and others, with a focus on changing the social and economic determinants of health.

### *Investing in Wellness Programs*

The economic urgency surrounding the actual health of Massachusetts’ residents is significant. Efforts to promote wellness are underway by the Executive Office of Health and Human Services, through its broad-based *Mass in Motion* initiative, which has implemented regulatory changes such as calorie labeling in restaurants and body mass index (BMI) testing in schools, expanded workplace wellness programs, and successfully engaged foundations in public-private partnerships to jointly support local city and town wellness endeavors. One such municipal program exists in Fitchburg, where Mayor Lisa Wong established health living as a community priority, local lawmakers focused on improving the region’s quality of life, and a strong network of collaborators is now mobilized to address obesity. Two new farmers’ markets opened last year and residents are now able to exercise using the markers stenciled on downtown sidewalks for a one-mile walking loop from City Hall.<sup>13</sup> This impressive work allowed the city to successfully

gain a prestigious Robert Wood Johnson Foundation grant called *Healthy Kids Healthy Communities*.

This level of innovation around wellness is also evident in the private sector, with local employers such as EMC Corporation, reflecting the growing consensus that the Commonwealth needs all stakeholders – government, private employers, health care and social service providers, and the public – to approach the improvement of our workforce’s health with intensity, creativity, and resources. Employers and health plans should be encouraged to include an employee engagement strategy in their benefit plans that would promote individual employee and family wellness. Such plans might include personal health assessments so that wellness initiatives can be targeted to the circumstances of each employer’s workforce. Incentives should be developed to ensure that employers of all sizes are encouraged to develop work-based wellness programs and are able to realize savings in health insurance premiums for undertaking these important steps.

#### *Promote Smoking Cessation Benefits*

The Massachusetts Department of Public Health estimates that \$4.3 billion is spent annually on excess direct health care costs due to smoking.<sup>14</sup> Recent evidence of the immediate impact smoking cessation benefits had on the MassHealth population’s utilization of high cost services suggests that these services should be made available to the broader, privately insured population. An evaluation by the Department of Public Health found that within one year, users of the smoking cessation benefit had dramatic reductions in hospitalizations for heart attacks, declines in emergency and clinic visits for asthma, and a significant decrease in acute birth complications.<sup>15</sup>

The Division recommends that the Department of Public Health be given resources to work with business leaders and other purchasers to ensure employers and insurers are made aware of the positive impact which this benefit can have in the short-term and encouraged to promote its use.

## **Conclusion**

As was the case with designing public policy for the Commonwealth to achieve near universal coverage through Chapter 58, policies aimed at improving the efficiency of the health care system and mitigating the growth of health care costs must involve all key stakeholders through “shared responsibility.” Developing the overall market conditions for providers and health insurers to compete on the basis of cost and quality—not utilization and volume—will require action by employers, consumers, and government, as well as a careful transition to a health care delivery system that is integrated and aligns financial incentives with better health care outcomes.

Massachusetts is well-equipped to take on this next challenge in health care reform because of its industry leadership, forward-looking public policy, and a history of innovation in both clinical medicine and care delivery. It is time for the state to take immediate action and set the course forward to developing a health care delivery system that is more economically sustainable, integrated, and patient-centered.

## I. Introduction

When Massachusetts passed its landmark health reform law (Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*), it established a model for the nation in creating a path to achieve near universal health insurance coverage of its residents. Chapter 58 was designed to expand coverage, and that effort has proven to be a success, with over 97 percent of the state's residents now insured. However, the reform law of 2006 was not intended to tackle health care costs specifically, and their continued escalation is causing significant challenges in Massachusetts. The state's individuals, families, and employers, as well as state and local government, are all struggling under the weight of high and rapidly rising costs of health care, which is creating barriers to accessing care, cutting into wage growth, stifling job creation, and preempting spending in other sectors of the economy.

### A. About this Report

Chapter 305 of the Acts of 2008 - *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care* – mandated a series of initiatives to begin to address the growth in health care costs. Particularly, it created a framework by which to understand health care spending in Massachusetts and examine the factors contributing to its growth. The law gave new authority and responsibility to the Division of Health Care Finance and Policy (“the Division”) to annually collect and analyze comprehensive data on health care costs in Massachusetts and to hold public hearings to discuss the findings of its analysis and inform the development of recommendations to improve the efficiency of the health care system in Massachusetts. In addition, the Office of the Attorney General (“OAG”) was directed to conduct analysis to evaluate factors that contribute to cost growth within the Commonwealth's health care system and participate in the Division's public hearings process.

Based on data submitted by Massachusetts health insurers, as well as published studies on health care spending, the Division released a series of reports on February 12, 2010 focusing on three key areas which contribute to health care spending: the structure of the Massachusetts health care delivery system, trends in health insurance premiums by market segment, and trends in health care utilization and medical claims. In addition, pursuant to new authority granted under Chapter 305, the Office of the Attorney General conducted an in-depth examination of health care cost trends and cost drivers. On January 29, 2010, the Office of the Attorney General published a preliminary report of its findings. These reports served as a basis for discussion at the public hearings convened by the Division on March 16, 18, and 19, 2010.

This final report presents a summary of the key findings in the preliminary reports released by the Division and the Office of the Attorney General, respectively, a summary of findings and information generated through written and oral testimony presented during public hearings held in March, and recommendations for mitigating the growth in health care costs based on specific findings included in the preliminary reports and revealed during the hearings.

## B. Overview of the Massachusetts Health Care System

Designing a strategy for the Commonwealth to effectively address the rising cost of health care requires a clear understanding of the state's health care system and the role it plays in the state's economy and health of its residents. Health care contributes significantly to the Massachusetts economy—directly through employment in places where care is delivered and indirectly through industries, such as biotechnology and pharmaceuticals, that have been drawn to Massachusetts to be near some of the most influential medical centers and research facilities in the world.

Health care accounts for over 13 percent of the state's \$365 billion Gross State Product (GSP) and is the largest employer in the state of Massachusetts, employing 15 percent of the total workforce. In addition, the health care sector provides a steady and stable source of well-paying jobs to Massachusetts residents. Between 2001 and 2006, health care salaries grew on average 33 percent, compared to 16 percent for employees in other Massachusetts industries.<sup>16</sup>

Academic medicine also contributes significantly to the Massachusetts economy. Due to the large presence of research and academic medical centers, Massachusetts receives far more National Institutes for Health (NIH) research funding per capita than any other state in the country and a study by the Association of American Medical Colleges estimated that the economic activity generated by academic medicine in Massachusetts was about 2.8 times a 28-state average.<sup>17</sup>

Beyond the key role health care plays in the state's economy, coverage for and access to health care in Massachusetts compare favorably to other states. Massachusetts is ranked first among all states in terms of access to health care and seventh overall on the 2009 Commonwealth Fund *State Scorecard*.<sup>18</sup> Massachusetts hospitals are often cited as among the best in the nation in terms of the quality of health care services provided, scoring higher than national average on treatment of major conditions.<sup>19</sup> Furthermore, Massachusetts health insurers are consistently rated among the top ten best insurers in each category nationwide.<sup>20</sup>

Despite these many positive features of the health care delivery system in Massachusetts, per capita spending on health care in the state is 15 percent higher than the rest of the nation, even when accounting for the wages and spending on medical research and education in Massachusetts.<sup>21</sup> Nearly half of this difference is due to greater spending on hospital services – including both inpatient and outpatient care – and 25 percent of this difference is due to greater spending on nursing home care. In addition, adjusted per capita spending on home health care is more than 70 percent greater in Massachusetts than the national average.

While trends in the rate of growth in overall health care spending in Massachusetts have historically followed those of the nation, in more recent years it appears that Massachusetts may be experiencing higher increases as evidenced by the higher rate of growth in employer-sponsored premiums since 2002. Employer-based coverage for family premiums in Massachusetts grew 47 percent from 2002 to 2008 whereas during the same period the comparable growth rate for the nation was only 38 percent.<sup>22</sup> However, those figures are not adjusted for the reduction in benefits over time, so the trends may be reflecting that

Massachusetts employers are maintaining more comprehensive coverage than their national counterparts.

In addition, while Massachusetts ranks high among states overall on the 2009 Commonwealth Fund *State Scorecard*, it ranks 33rd among all states on measures related to avoidable hospital use and cost. Poor performance on these measures indicates opportunities for greater efficiency, consumer engagement regarding use of timely care in the appropriate setting, and improved coordination of care.

Potentially preventable hospital admissions and unnecessary use of emergency departments are key areas where the cost impact of uncoordinated systems of care is on stark display. Recent Division research highlights the trends in these two areas of health spending. A study of preventable hospitalizations indicated that 13 percent of inpatient admissions in Massachusetts were potentially preventable and that they accounted for an estimated \$639 million in hospital costs in 2008 alone.<sup>23</sup> Another study of non-emergency use of the state's emergency departments found that nearly one-half of outpatient emergency department visits by Massachusetts residents were considered potentially preventable or avoidable, amounting to more than \$514 million of spending in 2008.<sup>24</sup> Avoidable emergency department visits increased by 13 percent from 2004 to 2008.

Behind these figures are unfortunate instances in which Massachusetts residents could have been spared a recurrence of an illness, inappropriately complex treatment in a busy emergency department, or the discomfort and anxiety of an overnight hospital stay had their health care been better coordinated. As the state presses forward to build a higher quality and more efficient health care system, it must focus on the potential benefits to patients in the form of better integrated care.

### **C. The Urgent Need to Address Rising Health Care Costs in Massachusetts**

While the economic activity associated with the health care sector and the near-universality of health insurance coverage in the state are important features of Massachusetts' economy and civic life, continued increases in health care spending – if uncontrolled – will hurt our economy's performance, blunt our chances for an economic recovery, and limit investments in other sectors of the economy. With no action to mitigate the trends in health care cost growth in the state, the significant gains achieved in access to coverage could erode. Chapter 58 of the Acts of 2006 appropriately included as part of the requirement that all adults in Massachusetts obtain health insurance coverage the caveat that this "individual mandate" only apply to those for whom "affordable" coverage is available. As the cost of health insurance premiums rises faster than wages, either the affordability standards will need to be made more stringent or more adults will be exempted from the individual mandate, reducing the impact of this critical provision of Massachusetts' health reform law. Furthermore, greater numbers of employers may start substantially reducing benefits or may drop coverage, leading to more residents enrolling in public coverage programs further straining the state's budget.

In addition, increases in the cost of health insurance negatively impact economic activity as businesses are unable to afford to hire new workers since the cost of health benefits consume more of employers' bottom lines. Massachusetts' employers have consistently been strong contributors toward health insurance coverage for their employee populations. More than three-quarters (76 percent) of Massachusetts employers with three or more employees offered health insurance coverage to their employees in 2009 compared to only 60 percent of the same size employers nationwide. Additionally, while employers nationally have been dropping coverage, Massachusetts employers have increased their rates of offer of employee health insurance since the passage of health reform.<sup>25</sup> With health insurance premiums rising faster than the overall economy, even Massachusetts' employers may over time be forced to drop coverage for their employees.

To mitigate their increased spending on health insurance benefits, employers have been shifting costs of care to employees through increased levels of co-payments, coinsurance and deductibles as well as increases in the portion of individual and family premiums for which employees are now responsible.<sup>26</sup> These increases in out-of-pocket health care costs to employees consume increasingly substantial portions of individual and family budgets, impairing their ability to save for other needs, such as retirement, housing, and their children's college educations. Additionally, families have less money available to spend on consumer goods which could stimulate economic activity in other sectors of the Massachusetts economy.

Rising health care costs are a national problem, not one unique to Massachusetts or caused by Chapter 58's expansion of access to coverage. In the past two decades, the percent of family income dedicated to health insurance has more than doubled from 7 percent of the nation's median family income in 1987 to 17 percent in 2006. Without action, economists like Len Nichols of the Center for Health Research and Ethics at George Mason University estimate that the proportion of family income devoted to health insurance could rise to 34 to 45 percent of median family income by 2016.<sup>27</sup> Clearly such an increase is unsustainable and underscores the need for immediate action to change this trajectory. If the rate of growth in health care spending in Massachusetts were kept to the level of the national per capita GDP (3.9 percent) – instead of growing at its current projected rate of 6.0 percent annually - total cumulative savings from 2011 to 2020 – or spending available for other sectors of our economy - would exceed \$90 billion.<sup>28</sup>

In its report on the economic case for national health reform, the White House's Council of Economic Advisors<sup>29</sup> found that slowing the growth in health care costs would have substantial benefits. In particular, the Council found that containing the growth in health care costs would "raise standards of living by improving efficiency thereby freeing up resources that can be used to produce other desired goods and services." Because of the significant and rising business costs devoted to health insurance, the Council also found that mitigating the growth in health care costs would also "raise employment in the short and medium runs."<sup>30</sup>

Based on these facts, the Division recognizes that concrete and thoughtful interventions are necessary to exert some control over annual health care cost increases in Massachusetts. But while the need for action is immediate, the tools presently available to state government are limited and can not fundamentally change the underlying dynamics leading to high cost increases. As such, the Division recommends a few "blunt" strategies to serve as necessary, yet

temporary measures to control health care costs from continuing to increase at unsustainable levels. At the same time, the Division recommends immediate action from all stakeholders to develop an integrated health care delivery model that more systemically mitigates health care cost growth and improves health care quality. Such a transition must address both the amount of health care we use (driven by demand for and supply of services), and the price we pay for such care. Developing an integrated delivery system will require leadership and sustained commitment from all Massachusetts stakeholders – legislators, the Administration, physicians, hospitals, consumers, employers, and insurers – to achieve the kind of breakthrough in mitigating health care costs that the Commonwealth achieved in providing near universal access to health care coverage. This report establishes a framework for that effort.

## II. Key Findings from Preliminary Reports

The Division and the Office of the Attorney General conducted comprehensive analysis of health care cost trends data to help identify factors which may be contributing to the unsustainable growth in health care costs in Massachusetts. The full reports are included in Appendices A and B of this report, with a summary of findings from each presented below.

### A. Summary of Findings from Preliminary Reports Issued by the Division of Health Care Finance and Policy

The Division analyzed comprehensive data provided by Massachusetts health insurers and produced analyses summarizing trends in private insurance premiums, medical claims spending, and payment methodologies used to pay providers.

#### 1. Massachusetts Private Insurance Premium Trends

Average private fully-insured premiums per member increased 12.2 percent from 2006 to 2008. Premiums grew more slowly in 2008 (5.0 percent) than they did in 2007 (6.9 percent) across all market segments.<sup>31</sup> The Division found that employers and individuals purchased less comprehensive coverage over the time period studied, indicating that the overall increase in premiums would have been larger had benefits and cost sharing levels remained constant, also indicating that costs are being shifted to consumers.

The growth in the cost of premiums during this period was caused almost entirely by growth in medical expenses, as opposed to growth in insurer administrative and other non-medical costs. On average, in Massachusetts more than 88 percent of premiums are spent on medical expenses. This compares favorably to national figures, which indicate that on average less than 84 percent is spent on medical services, with the remaining 16 percent devoted to health insurer administrative and other non-medical spending. However, as total premiums are higher in Massachusetts, the administrative cost per member may not be substantially different, or may even be higher.

The Division also analyzed premium data by market segment – including trends for the small (those with 50 or fewer covered employees), mid-sized (with 51 to 499 covered employees), and large group markets (with 500 or more covered employees). Premiums charged to small employers grew faster on average than premiums charged to mid-size and large employers, when adjusted for differences in benefits, demographics and location among the three market segments. From 2007 to 2008, adjusted<sup>32</sup> small group premiums grew 5.8 percent, while mid-size group premiums grew 4.8 percent, and large group premiums grew 5.4 percent. Adjusted premium levels also were higher for small employers. In 2008, adjusted small group premiums were 5.8 percent higher than adjusted large group premiums and 4.9 percent higher than adjusted mid-size group premiums. For the most part, higher medical expenses – and not higher administrative and other non-medical expenses - in the small group market drove these differences.

Despite regulatory restraints on the variation in premiums that can be charged to individual employers within the small group market, there remains significant volatility and variation in premium rates charged to small businesses, particularly for those employers with fewer than 10 employees. The Division modeled different premium growth scenarios which show that even small changes in the ages or size of given employer group can have a dramatic impact on premium trends from year to year.

While the report did not explicitly analyze the impact of the merger of the small and non-group markets as a result of Chapter 58, data presented show that on average, premiums in the individual merged market in 2008 were 33 percent lower than premiums in the residual non-group market. This difference is likely due to a combination of the new rating rules and risk pooling available for individuals in the newly merged market, as well as the reduction in benefits purchased by individuals through the merged market compared with the residual non-group market. The addition of more affordable options for individuals purchasing coverage directly rather than through an employer, as well as the individual mandate, resulted in a more than doubling of the number of persons who purchased individual coverage over the time period studied.

## **2. Health Spending Trends for Privately Insured<sup>33</sup> in Massachusetts**

Between 2006 and 2008, private spending per member for health care in Massachusetts grew by 15.5 percent, or 7.5 percent annually. Spending per person includes money spent on covered services for people with private insurance, including both the amounts paid by health plans as well as by the enrollees through cost sharing. Most of this growth in spending (more than 75 percent) occurred in outpatient hospital facilities and physician and professional services. Imaging services (such as MRIs, CT scans and X-rays), outpatient procedures and cancer therapies contributed substantially towards the growth in spending in hospital outpatient facilities. Pharmacy spending grew much slower than average spending growth – due to increased use of generic pharmaceuticals over brand name drugs.

Increased prices were found to be the most important factor driving rising health care spending – representing roughly 90 percent of the growth in spending for inpatient hospital care and 80 percent of growth in spending for physician and professional services. Both higher prices and greater utilization of services drove increased spending for hospital outpatient facility services.

Care is being provided in increasingly expensive settings over time. Outpatient facility-based care in Massachusetts is now almost entirely hospital-based and much of the growth in outpatient hospital expenditures was for care provided in teaching hospitals located in the metro Boston area.<sup>34</sup> In addition, inpatient admissions are shifting toward higher-cost providers with the percent of total private inpatient admissions occurring at teaching hospitals increasing by nearly 5 percent over the three year time period.

There is wide variation in prices paid by private insurers for the same service by different providers across the state. The variation in prices for commonly provided services was greatest for facility charges, which varied by as much as 18 to 1 for some high-volume outpatient facility services. Variation was as large as 3 to 1 for some high-volume professional services.

Growth in health spending varied by insurance market segment, with expenditures per member growing faster for those enrolled in self-insured and large group plans (with 500 or more employees) when compared with those enrolled in mid-sized (with 51 to 499 employees) and small group plans (with 50 or fewer employees). This difference was largely due to small and mid-sized employers shifting more costs to employees in the form of higher cost-sharing over the time period studied.

### **3. Methods Used by Health Insurers to Pay Providers in Massachusetts**

Through a survey of insurers, the Division found that fee-for-service payment methods, which offer few incentives to reduce the volume of unnecessary services, are the dominant method of payment in all types of plans. Fee-for-service payment encourages more utilization of services, rather than encouraging good outcomes or high quality, and therefore contributes to health care cost growth. Preferred provider organizations, which represent the majority of private members, reported no capitation payments (payments made per member rather than per service) and health maintenance organizations used capitation to pay only a small proportion of primary care providers and specialists - 16 percent and 5 percent, respectively. Capitation payments were more commonly used to reimburse primary care providers participating in insurer Medicare and Medicaid managed care products.

## **B. Summary of Findings from the Office of the Attorney General**

The analysis performed by the Office of the Attorney General focused on health care prices and payments made to providers by health insurers as well as a review of contracts between providers and insurers. The Office of the Attorney General has summarized its seven major findings as follows:

- Prices paid by health insurers to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.
- Price variations are not correlated to (1) quality of care, (2) the sickness of the population served or complexity of the services provided, (3) the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.
- Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.
- Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for risk-sharing providers than for providers paid on a fee-for-service basis.
- Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.
- Higher priced hospitals are gaining market share at the expense of lower priced hospitals, which are losing volume.
- The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

### III. Summary of Public Hearings on Health Care Cost Trends

Pursuant to the provisions of M.G.L. c.118G, §6 1/2 the Division of Health Care Finance and Policy held public hearings on Tuesday, March 16; Thursday, March 18; and Friday, March 19, 2010 at the Joseph P. Healey Library University Club, 11th floor, University of Massachusetts Boston. (See Appendix C for materials related to the hearings). The hearings were presided over by the Commissioner for the Division along with a panel of state partners including the Assistant Attorney General, the Commissioner for the Division of Insurance, and the Commissioner for the Department of Public Health. Prior to the hearings, the Division and the Office of the Attorney General requested written responses to key questions to help inform the discussion at the hearings.

The goal of these hearings was to elicit feedback and foster public discussion under oath as required by Chapter 305 from key stakeholders in the Massachusetts health care delivery system including providers, insurers, employers, and consumers.<sup>35</sup> Beyond simply focusing on the problem, however, these hearings intended to unearth actionable solutions from health care experts and stakeholders that could help mitigate health care cost growth in the Commonwealth.

Below is a summary of the key themes and ideas generated through the public hearing process. Included is a sample of specific comments made through written or oral testimony. The quotes included below are not intended to negate any written or oral testimony provided by others not quoted here, but rather are provided for illustrative purposes only. The entirety of all written and oral testimony collected by the Division is included in Appendix C.

#### A. Urgent Need for Immediate Action

National and local health care policy experts testifying at the hearings acknowledged the remarkable work Massachusetts has done to date to ensure access to health insurance coverage. They stressed that the Commonwealth must now turn to reforming the delivery and payment systems to mitigate cost growth in order to sustain those gains in access. In his testimony, Len Nichols of the Center for Health Policy Research and Ethics at George Mason University noted that “all eyes are on Massachusetts.” Opening remarks made by key officials including the Governor, Senate President, and other legislative leaders highlighted the importance of taking action to address cost growth. In addition, the urgent need to address rising health care costs was also corroborated by testimony from stakeholders across the system including providers, insurers, employers, and consumers:

- Many of those testifying, including Senate President Therese Murray and Nancy Turnbull of Harvard School of Public Health remarked that Massachusetts’ health insurance costs are increasing 3-4 times faster than wages, resulting in a significant diversion of resources away from other sectors of the economy and dampening job growth.
- Small employer, Eric Michelson of Michelson’s Shoes reported that his company is currently charged \$23,000 per year for family coverage, which represented an increase of

25 percent over rates charged in 2008. He testified that this increase alone costs his company more than the cost of an additional employee.

- In his statement, Governor Deval Patrick noted that small businesses are paying 74 percent more in monthly premium costs than one decade ago and that immediate short-term solutions are needed to relieve the burden on small employers.
- In their written testimony, representatives of the Town of Saugus noted that prior to joining the Group Insurance Commission health care costs as a self-insured entity were escalating—increasing from \$5.2 million to \$8.9 million from 2004 to 2007.
- Cindy Parks Thomas of the Schneider Institute for Health Policy at Brandeis University’s Heller School and Nancy Kane, of the Harvard School of Public Health and also a member of the federal Medicare Payment Advisory Commission, noted in their testimony that the Commonwealth must balance the trade-off between the health care industry as a leading employer and the negative impact of escalating costs on job growth in the rest of the economy.
- Virtually all participants—providers of health care, purchasers of health care, insurers and experts – agreed that payment reform is a critical part of the long-term solution, albeit not the only component and that primary care provides the foundation for any successful payment and integration model.
- Most agreed that given the urgency of the problem, interim cost containment measures are necessary to begin immediately addressing cost growth as well as inequities in payment rates across providers. It was recognized that any short-term solutions should align with and build towards the long-term vision.

## B. Payment Systems

There was near universal agreement among health care providers, insurers, consumers, employers, experts and other stakeholders testifying throughout the hearings that the Commonwealth must move away from the dominant fee-for-service payment model. In his testimony, Paul Levy of Beth Israel Deaconess Medical Center noted that the current payment system is broken and James Roosevelt, Jr. of Tufts Health Plan, Barbara Spivak of Mount Auburn IPA, and Gene Lindsey of Atrius Health noted that capitated payment arrangements can and have led to better quality of care for patients. National expert Stephen Shoenbaum of The Commonwealth Fund’s Commission on High Performance Health Systems testified that other countries that do better than the U.S. on cost and quality measures have two things in common—some form of global payment combined with standards and goal setting within those arrangements. Dr. Shoenbaum also stressed the need to move towards greater integration and accountability along three dimensions or axes in order to achieve greater performance in health care: 1) the level of integration and organization of care delivery, 2) the level of bundling of services into payments, and 3) the proportion of total payments that are provided based on performance in the form of process milestones and outcomes achieved. He testified that all three are necessary for achieving higher performance.

Other themes discussed regarding a new payment model included the following:

- In their testimony, Robert Restuccia of Community Catalyst, Inc. and Andrew Dreyfus of Blue Cross Blue Shield of Massachusetts (BCBSMA) noted that a new global payment model should include all payers (private and public), which would benefit providers who face disproportionate shares of public payer patient populations.
- Paul Ginsberg of the Center for Studying Health System Change and Dianne Anderson of Lawrence General Hospital, among others, testified on the urgent need to address today's price inequities and stressed that new payment models should not "build in" current price disparities.
- Health care providers and payers agreed that new payment models should be designed to provide incentives to improve care through better coordination and reward quality and outcomes rather than utilization. Thomas Glynn of Partners Healthcare noted that fee-for-service models provide limited incentive to increase efficiency of care and endorsed the expanded use of pay for performance payment models.
- Testimony of experts Stephen Schoenbaum of The Commonwealth Fund, Stuart Altman of the Heller School at Brandeis University, and Alan Weil of the National Academy for State Health Policy noted that any new payment model adopted should set aggregate expenditure goals or targets.
- Under global payment arrangements, financial risk may be delegated from insurers to providers and that risk must be managed within that provider community. Barbara Spivak of the Mount Auburn Cambridge IPA cautioned in her testimony that care be taken to ensure that providers are equipped to manage that financial risk with adequate information and analytics for tracking spending and quality.
- Jack Dutzar of Fallon Clinic and other providers and payers testified that global payment arrangements should enhance payments for primary care.

### **C. Provider Price Differentials**

Written testimony provided by BCBSMA, Tufts Health Plan, United, Harvard Pilgrim Health Care and Fallon Community Health Plan in response to questions from the Office of the Attorney General includes data that indicates wide price variation across providers. Oral and written testimony on price differentials included the following:

- Many providers, including those from Lawrence General Hospital, Beth Israel Deaconess Medical Center, and Tufts Medical Center, among others, acknowledged that such wide variation in prices for the same services delivered by equally qualified providers is not justified.
- Written and oral testimony from several providers including Lawrence General Hospital as well as analysis by the Office of the Attorney General point to price differentials that are driven by market power rather than complexity or quality of care.

- Written and oral testimony of several providers including Dale Lodge of Winchester Hospital, Ralph de la Torre of Caritas Christi Health Care and the Ambulatory Surgery and Laser Center of Cape Cod and payers such as Fallon Community Health Plan and Neighborhood Health Plan reported that higher priced provider organizations and systems are gaining market share by offering higher payments and salaries to physician groups. They indicated that this is done at the expense of lower cost providers losing physicians and is contributing to rising health care costs.
- Providers and payers alike acknowledged that quality currently plays a small role in contract negotiations.
- Testimony by Lawrence General Hospital as well as analysis by the Office of the Attorney General identified that disproportionate share hospitals (DSH) which serve a greater proportion of publicly insured patients tend to be among the lowest paid by private insurers.
- The Office of the Attorney General found that of the top ten highest paid hospitals, only two are teaching hospitals.

#### **D. Transparency of Price and Quality**

Oral and written testimony from consumers, employers, and health care system experts stressed the benefits of full transparency of both price and quality as a means to help inform choices made by consumers and purchasers of health care and to increase provider and payer accountability. National expert Paul Ginsburg of the Center for Studying Health Systems Change cautioned that price transparency should be combined with consumer incentives to ensure it does not have an inflationary impact on the market. Testimony regarding transparency of price and quality measures included the following:

- Barbra Rabson of Massachusetts Health Quality Partners and Donald Goldmann of the Institute for Healthcare Improvement testified that price transparency should be used in conjunction with quality transparency to promote better quality.
- Experts and stakeholders, including several health care providers and employers such as Delia Vetter of EMC Corporation, noted that reporting of price and quality measures should be standardized and reported regularly to ensure accurate comparisons and real time information.
- A few of those testifying, including James Roosevelt, Jr. of Tufts Health Plan and Andrew Dreyfus of BCBSMA cautioned that care should be taken so that reporting on prices does not create a “race to the top,” and suggested that the government may need to play a role to prevent that unintended outcome.
- Several of the experts testifying as well as health care providers such as Paul Levy of Beth Israel Deaconess Medical Center and Thomas Glynn of Partners Healthcare and payers including Andrew Dreyfus of BCBSMA agreed that provider contracts should specifically include standardized quality measures.
- Some witnesses noted that information on total medical expenses per member – which accounts for patient casemix and the full complement of services received -- should be made publicly available and used by providers so they can review their own performance,

particularly related to services received by their patients outside of their care. Some providers such as Jack Dutzar of Fallon Clinic testified that many providers do not necessarily know where they stand on total medical expenses and would value any standardized information given back to them to help them better manage their patients' care and resulting costs.

- Witnesses pointed out that most transparency tools are currently designed for medical professionals, not the average consumer. Consumer friendly tools must be developed. Paul Ginsburg of the Center for Studying Health System Change testified that unless consumers are given financial incentives to become more price sensitive in their purchasing of health there is a danger that consumers may choose higher priced providers assuming that higher price means better quality. Many consumer advocates pointed out that transparency and cost sharing are not the most effective or appropriate ways to moderate cost growth.
- The Office of the Attorney General found that written testimony in response to their request for information on direct and indirect costs demonstrates a current lack of transparent information about provider costs. Responses varied, with some providers indicating they do not maintain such cost information and others relying on 403 cost reports submitted to DHCFP, which may point to a need for both increased transparency and standardized measures.

## E. Coordination of Care

It was suggested throughout the written and oral testimony that payment reform will have a positive impact on the health care delivery system if it aligns financial incentives with patient health outcomes. Witnesses testified that a better integrated system will reduce waste and improve the quality of care patients receive. Health information technology and strong primary care were recognized as critical foundations for supporting such improved systems of care. Stuart Altman, from the Brandeis' Heller School for Social Policy, testified that a new system may need to be "phased-in" with different levels of integration from fully integrated, to partial integration, to allowing providers to opt to remain within traditional fee-for-service payment models. However, he recommended that all levels of integration be held accountable to operate within an aggregate budget target. Other observations included:

- Expert witness Stephen Schoenbaum of The Commonwealth Fund noted that Massachusetts ranks 33rd in the nation on avoidable hospital use on the Commonwealth Fund *State Scorecard*. This is the result of a relatively higher hospital readmission rate.
- Several provider groups and experts testified that Accountable Care Organizations (ACOs) should include behavioral health, which can impact medical needs and outcomes.
- Better coordination and communication during transitions in care presents an opportunity for improved efficiency. Testimony from Deborah Chollet of Mathematic Policy Research, Inc. indicated that the timely provision of a primary care visit following a hospital discharge has been shown to reduce the likelihood of a clinically-related readmission.
- Gary Gottlieb of Partners Health Care observed that there are great opportunities for efficiency if care is better coordinated for the 10 percent of patients who represent 70 percent of spending. He also recommended that successful pilots be brought to scale to

leverage the impact these programs can have on improving patient care and reducing costs.

- In his testimony, expert Stephen Schoenbaum strongly supported payment reform but also cautioned that the market implications of greater integration with ACOs may result in larger organizations with greater leverage to drive up prices.
- Barbara Spivak of Mount Auburn Cambridge, IPA testified that based on her experience, it is important that clinical risk management within the ACO or medical home be done by on-site clinicians and managers in order to be effective.
- Health care providers such as Jack Dutzar of Fallon Clinic testified that because primary care providers are the key to a better coordinated care system, investments in primary care should be made. It was suggested that primary care physician payment should be increased.
- Written testimony from several community health centers noted that community health centers can play an important role in coordinating care and ensuring that their patients seek care in appropriate settings. For example, Lynn Community Health Center called attention to several successful pilot projects designed to reduce unnecessary emergency department utilization by connecting patients to primary care options.
- Experts and stakeholders agreed that investments should be made in health information technology to ease administrative burden, improve communication, and enhance quality of care. It was also suggested that an integrated e-health system would promote a better understanding of patient care for primary care providers.

## F. Health Plan Benefit Design

Much of the written testimony and conversation at the hearings strongly suggested that insurance products with “limited” or “select” provider networks be designed and offered to all consumers. In response to the research showing that care is moving into higher cost settings and to higher cost facility-based providers (even for commonly provided services that could be delivered in lower-cost, community-based settings), several different payers, such as Fallon Community Health Plan, Neighborhood Health Plan, and Harvard Pilgrim Health Care, pointed in their written testimony to the potential for savings through health insurance products priced at lower rates because they would, by design, send patients to lower cost providers for care. The limited network product strategy was endorsed by many hearing witnesses including Dale Lodge of Winchester Hospital, Michael Widmer of the Massachusetts Taxpayers Foundation and Delia Vetter of EMC Corporation. These products would permit patients to use higher cost settings for tertiary care if not available in their network, as needed, but for an additional price to the consumer. There was significant support for this strategy as a short-term solution for mitigating health care cost growth, and as a strategy to create more affordable coverage options for employers and consumers. Two options for directing patients to lower cost settings were explored: the creation of select delivery networks which patients could choose as they selected a health insurance option; and the creation of products that included open networks, but with varying levels of consumer cost sharing, such as copayments and coinsurance, based on the relative efficiency of providers.

Key themes from testimony on this subject included the following:

- Select or limited networks can result in lower premiums. This will require a cultural shift among Massachusetts' consumers and employers, who have grown accustomed to open networks. Paul Levy of Beth Israel Deaconess Medical Center, Andrew Dreyfus of BCBSMA, and Barbara Spivak of Mount Auburn IPA also noted that limited networks have not historically worked because employers have not been able to counter the myth that reputation equals quality and because quality data is not widely available. As such, employer and consumer education are integral to the success of this approach.
- Some Division of Insurance regulations related to provider network adequacy may need to be revisited in order to permit such products, especially in less population-dense areas of the state, as pointed out by James Roosevelt, Jr., of Tufts Health Plan and Deborah Enos of Neighborhood Health Plan.
- Ensuring that patients are able to utilize the appropriate care for complex health problems is of paramount importance in benefit design. The goal should be to redirect service use for basic, non-tertiary care to lower cost, high quality settings while ensuring coordination across the full continuum of care, as noted by Richard Lopez of Atrius Health.
- Many consumer advocacy groups expressed concerns about adequacy of coverage with limited network plans, particularly in parts of the state that have dominant provider systems.
- Small business owner Eric Michelson of Michelson's Shoes testified that he is reluctant to move his employees to a limited network product because many of his employees, especially his older employees, have developed strong ties to specific providers that may not be covered in limited networks.

## G. Role of the Public Sector

Witness comments on the role of government in addressing the health care cost crisis ranged considerably – from Nancy Kane of the Harvard School of Public Health and Julie Pinkham from Massachusetts Nurses Association advocating for strong government oversight of prices for health care services to the request by Mark Gaunya of the Massachusetts Association of Health Underwriters that Minimum Creditable Coverage regulatory requirements be reduced. However, on the whole, the majority of witnesses expressed agreement that deregulation of the Massachusetts health care marketplace and the reduction of governmental oversight have had several significant unintended consequences, some of which have led to an upward spiral of health care costs. Testimony offered included the following:

- Many witnesses and experts such as Len Nichols of the Center for Health Policy Research and Ethics at George Mason University and Steve Schoenbaum of The Commonwealth Fund agreed that Massachusetts state government has a special responsibility and opportunity to take a leadership role in bending the cost curve, given the state's individual mandate requirement and expansion of access to health insurance, as directed by Chapter 58.
- Witnesses such as Amy Whitcomb Slemmer of Health Care for All noted that the Commonwealth can play a stronger role in disseminating public health information and

educating consumers about health care choices. Many felt the state should implement state-wide campaigns focused on wellness and health and educating consumers about choosing cost effective care settings.

- Many witnesses including Paul Levy of Beth Israel Deaconess Medical Center recommended that the public sector play a role in facilitating transparency of provider price and quality information.
- While some witnesses recommended or approved of rate regulation as a means of controlling health care costs, others recommended governmental “oversight” which would have the capacity to deny excessive increases in prices. Others recommended that the public sector play a stronger role in controlling the disparities in payment rates paid to different providers through constraints on the overall growth rates or levels paid to providers. Ralph de la Torre of Caritas Christ Health Systems offered the idea that government collect a “luxury tax” from those providers with higher payments who receive higher payments and revenues collected through that mechanism made available for investments in the development of health information technology and other needed infrastructure in the health care system.
- Multiple witnesses pointed to the problems caused by the lapse in power of the Determination of Need process (DoN) and health resource planning, which were policy tools designed to control capital expansion and technology acquisition so that such expansions of capacity in the state’s health care system would be tied to community need, rather than business imperatives. Paul Levy of Beth Israel Deaconess Medical Center noted that hospitals – especially research facilities – naturally seek to possess complex specialty capacities to support their research missions, but may do so without regard for the extent of community need.

## H. Cost Shifting

The theme of cost shifting between public and private payers arose frequently in written testimony and at the hearings. Declining payments from both Medicaid (MassHealth) and Medicare were pointed to by many payers, like United Healthcare<sup>36</sup> and providers, such as Quincy Medical Center,<sup>37</sup> as a significant factor in cost shifting to the private insurance market. Hospitals are cross-subsidizing and using the extra revenue from private payers to cover shortfalls caused by declining payments from public payers. In addition, some providers mentioned the need to cross-subsidize services with lower payment rates relative to costs (e.g., behavioral health) from services that command higher payments (e.g., interventional cardiology and imaging) as a means to ensure these services – which provide a critical service to our society – are maintained.

- A few witnesses, including Deborah Chollet of Mathematica Policy Research, Inc. and Nancy Kane of the Harvard School of Public Health, suggested that cost shifting from public to private payers may be a reflection of market failure and a lack of competition. When there is an imbalance of market power between providers and insurers, providers may demand higher rates to cover their higher costs rather than identify efficiencies to reduce costs where feasible. They pointed to evidence from a recently published article in *Health Affairs* which stated that “hospitals with strong market power and higher private-payer and other revenues appear to have less pressure to constrain their costs. Thus, these

hospitals have higher costs per unit of service, which can lead to losses on Medicare patients. Hospitals under more financial pressure—with less market share and less ability to charge higher private rates—often constrain costs and can generate profits on Medicare patients.”<sup>38</sup>

- Disproportionate share hospitals (DSH) who rely on government payment for a majority of their patients argued that the declining payment levels from MassHealth are unsustainable, and will result in lower cost community hospitals going out of business. Ellen Zane of Tufts Medical Center and Dianne Anderson of Lawrence General Hospital stated this outcome would have a tragic effect on the communities they serve, and would also perpetuate the upward spiral of health care spending in the state, as lower cost providers would disappear over time.
- Nancy Kane of the Harvard School of Public Health suggested that lower rates of payment from Medicaid, in particular, could be interpreted as part of the non-profit mission of tax exempt hospitals to deliver care.
- The Office of the Attorney General reports that written testimony from health care providers in response to its pre-hearing written questions indicated that providers with higher prices had higher commercial margins and larger government payer losses. These variations in reported margins indicate the providers likely have significantly different cost structures, which may affect their commercial prices and margins.

## I. Consumer Education

Throughout nearly every panel at the cost hearings, the theme of consumer engagement arose. Despite the diversity of recommended solutions to the health care cost problem, there was virtual consensus among witnesses that a key component of any solution will need to be enhanced consumer engagement. Some witnesses, such as Frank Romano of Essex Health Care argued that consumers need to bear greater financial responsibility for the health care utilization and the health-influencing lifestyle choices they make. However, the area of strongest agreement related to the need for increased awareness about health care costs and the cost implications of consumers’ health care decisions, as well as the need to make price and quality information available and accessible to all employers and consumers.

- Nearly all consumer advocates expressed the need to use caution in determining how to best use price sensitivity as a tool for changing consumer behavior.
- Many witnesses suggested that there needs to be a public campaign to educate the public on health care costs which could encourage the public to be smart (and cost-sensitive) utilizers of health care services.
- There was widespread consensus that consumers need to have incentives to use low cost, high quality providers, whereas today, the consumer is largely shielded from the cost impact of those decisions.
- Deborah Banda of AARP pointed out that most of the transparency tools that do exist now are designed for medical professionals, not the average consumer.
- Consumers should be financially incentivized to make better decisions about health care at the point of selecting an insurance plan and a provider network, not at the point of

service, when anxiety and urgency are more likely to be at play and may color decision making, according to Nancy Turnbull of the Harvard School of Public Health.

- Written and oral testimony focused on the need for consumers to have standardized, accurate information to enable them to make informed choices about low cost, quality care. Today, this type of information is limited and consumers may instead rely on media, advertisements on television, etc.
- The Office of the Attorney General reports that written testimony submitted by providers in response to its pre-hearing written questions showed that some highly paid providers have spent significantly more resources on advertising compared to their lower compensated peers.<sup>39</sup>

## IV. Policy Recommendations

### A. Opportunities to Address Rising Health Care Costs

The findings from the Division's preliminary reports, the investigation by the Office of the Attorney General, and the testimony at the public hearings identified many opportunities to improve the efficiency of health care delivery in Massachusetts. In particular, there was broad consensus on the following key opportunities for developing policy solutions:

- Health care costs are growing at an unsustainable rate. Cost containment efforts should focus primarily on mitigating the growth in medical expenses, which account for the majority of the growth in health insurance premiums in recent years.
- Price increases are the key driver behind the growth in medical costs. Price increases, due to both higher negotiated rates and care moving to higher cost settings, account for the majority of the growth in health care costs.
- There is wide variation in the prices that are paid by health insurers, reflecting an imbalance in the health care marketplace that merits intervention.
- The predominance of a fee-for-service payment methodology rewards volume rather than value. Payment methodologies must be realigned to promote an integrated delivery system that rewards quality, cost-effective, patient-centered care provided in the most appropriate settings.
- The lack of integration in the health care delivery system is costly. The high rates of hospital readmissions and relatively high incidence of avoidable or preventable emergency department use suggest that the health care delivery system could be better integrated to more effectively serve patients in appropriate, lower cost settings.
- The health care system lacks a system-wide health IT infrastructure. Leveraging and implementing system-wide information technologies (such as electronic medical records) would allow the delivery system to be better integrated and facilitate more effective patient care coordination.
- Certain provisions in provider contracts impede competition and innovation. With providers consolidating and expanding their geographic presence, the Commonwealth must carefully address non-competitive contractual arrangements between providers and insurers, which may lead to higher prices as determined by the Office of the Attorney General.
- Health resource planning needs strengthening. Health service capacity should be analyzed and planned for in order to meet the geographic needs of the population and better leverage existing services to meet current and future needs.

- Insurers should develop and promote insurance product options that direct care to efficient, lower cost providers. There are opportunities to modify insurance regulations to enhance the role of insurers to offer more cost-effective products, such as select and tiered network products, and to promote management of patient care more effectively.
- There is limited information available to guide consumers and purchasers of health care to make better health care purchasing decisions. There is opportunity to help inform choices made by consumers and purchasers of health care and to increase provider and payer accountability by making information on price and quality readily available and presented in easily understandable formats.

## B. Overview of Recommendations

This report outlines both short-term and long-term recommendations. First, immediate actions are presented to address the urgent problem of rising health care costs, including:

- Pursue and leverage federal reform opportunities to fund innovation in cost control in Massachusetts;
- Implement immediate oversight of health insurance premiums and provider rates;
- Develop market-oriented health insurance products and government tools that will address premium volatility and lower premiums for consumers and employers; and
- Initiate legislative review of provider contract provisions that may now limit competition.

Second, the report presents a longer-term framework for developing an integrated and sustainable health care system which incorporates five key components:

- Oversight and direction provided by an independent public entity;
- Payment reform involving all payers;
- Support for health care delivery system redesign and system-wide adoption of health information technology;
- Transparency of cost and quality information; and
- Investment in evidence-based public health and wellness initiatives.

Although these strategies will take a number of years to implement, steps need to be taken immediately to move toward these goals. These fundamental changes to the delivery and financing of health care are critical to the Commonwealth's long-term success in mitigating health care cost increases while also improving quality.

## C. Short-Term Interventions: Controlling Health Care Cost Growth

### 1. Leverage the Policy and Funding Opportunities in the Federal Health Reform Law

On March 23, 2010, President Obama signed into law comprehensive health reform, the *Patient Protection and Affordable Care Act*. While many aspects of the new law focus on the expansion of access to health insurance (e.g., an individual mandate, subsidies for purchase of health insurance, employer responsibilities, health insurance reforms, and other policy tools already

implemented in Massachusetts), there are several opportunities for states to participate in pilots and grant programs that allow for increased innovation and provide financial supports and resources for improving care delivery, public health and wellness aims, workforce development, health information technology, and payment reform. Massachusetts should leverage federal funds to support innovation consistent with the state's health care policy goals. Some of the most promising of these federal opportunities are:

- Premium relief for small business: Beginning in 2010, the law allows for federal tax credits to offset 35 percent of health insurance costs for small businesses.
- Oversight of premium rates: The law requires that there be systematic review of increases in health insurance premiums and reporting of medical loss ratios.
- Funding for innovative payment approaches to improve health care delivery: The law establishes the Center for Medicare and Medicaid Innovation to administer a variety of innovative pilot and demonstration projects aimed at integrating the health care delivery system. Opportunities exist for projects affecting all payers as well as those focused on Medicare and Medicaid and include topic areas such as payment bundling, global payments, pediatric accountable care organizations, and patient-centered medical homes.
- Opportunities for projects that focus on managing care for those residents at highest risk: Funds may also be available for projects that demonstrate innovative approaches to improve care and reduce costs for individuals with multiple chronic conditions as well as projects on community-based prevention and wellness programs.

It is strongly recommended that the Commonwealth avail itself of all such appropriate opportunities for federal funding and waivers made available through this historic law.

## **2. Implement Immediate Oversight of Health Insurance Premiums and Provider Rates**

In the immediate term, the Legislature should pass legislation that strengthens administrative, regulatory, and legislative authority to oversee, and -- where necessary -- intervene in both insurer premiums and provider rates. It is essential that government plays an active role to ensure the health care marketplace functions appropriately and moves expeditiously to address rising costs when it does not. We must focus on both providers and insurers in order to address the current inequities in the Massachusetts health care marketplace. It is recommended that these short-term tools remain in place until the broader system reforms discussed below are achieved.

Oversight of health insurance premiums and provider rates are admittedly blunt tools with which to influence health care cost growth. However, the economic imperative is critical enough to warrant their use as temporary means of providing relief to the businesses and families of the Commonwealth while adjustments are made to develop a fully integrated health delivery system. As short-term interventions, and when coupled with other market-oriented adjustments, insurance premium and provider rate oversight can immediately help to address cost growth and current market inequities, such as price variation, described in the Division's preliminary reports and testimony of witnesses at the public hearings. Government oversight and market-based strategies are not mutually exclusive. As expert witness Paul Ginsberg of the Center for Studying Health System Change suggested in his testimony, regulatory oversight can work in concert with market-oriented approaches to achieve the Commonwealth's objectives to mitigate cost growth.

### *Insurer Premium Oversight*

In February 2010, the Division of Insurance (DOI) issued emergency regulations requiring insurers participating in the merged market to submit premium rates to the DOI for its review at least 30 days before their proposed effective date. The DOI leveraged existing statutory authority which allows it to disapprove premium rate increases that are determined to be excessive or unreasonable relative to the benefits provided.

The Governor's jobs bill – “*An Act Providing for Job Creation by Small Businesses*” – would expand the DOI's authority by creating a benchmark that if exceeded would lead to automatic hearings on the rates that a company may charge in the small group market. The Legislature should authorize development of a similar regulatory tool to apply to all products in the marketplace—not just the small group market.

In addition, the Legislature should explore methods and policy tools that can be used to influence the self-insured segment of the health insurance market (50% of the private health insurance market), which is currently unregulated by the Commonwealth per ERISA.<sup>40</sup>

The Legislature should also consider legislation that would modify rating standards around age bands and wellness rating factors, and allow for shock buffers to immediately help protect business from staggering increases in health insurance premiums. Legislation should also be enacted to create an open enrollment period for individuals.

### *Provider Rate Oversight*

The Governor's jobs bill also proposes oversight of rates paid by health insurance companies to providers. As indicated by the Division's analysis and findings, underlying rates of increase in provider payments have been the key driver in rising premiums in recent years. Therefore, the provider rate review process is a necessary short-term tool to lower the rate of provider price increases and simultaneously, increase effectiveness of insurer premium reviews by the Division of Insurance.

It is important to note that a “flat freeze” in rates will not address existing price variation or payment inequities between providers. The Legislature should enact a rate review process considers both the proposed increases in provider rates and payment levels relative to a statewide median with a specific focus on lowering the rate of price increases for high cost providers.

In the short-term, review of provider levels of payment, fee schedules, and components of total medical expense should seek to address the wide variation in prices and reward low cost providers, as well as immediately address overall cost growth. Such an approach should ensure the viability of efficient, low-cost providers in the marketplace, prioritize their role in an integrated health care delivery system, and establish them as key “building blocks” in a transition toward payment reform.

The provider rate review process should also be designed to consider the public payer mix of the provider, the relative level of proposed rates compared to similarly situated providers, the historical provider rate increases, the extent to which the facility provides complex or unusual medical procedures, and the financial standing of the provider.

While oversight of health insurance premiums and provider rates are not ideal long-term strategies, they are necessary short-term interventions to mitigate the unsustainable levels of health care cost growth that has occurred nationally and locally in recent years. When a defined transition to a fully integrated payment and health care delivery system has been achieved, these interventions should no longer be necessary.

Mitigating the rate of growth in prices is a shared responsibility of both providers and payers. In the absence of legislation, insurers should use existing negotiating tools to influence provider rates and rate increases. It is imperative that insurers and providers work together to lower the rate of growth in provider rates immediately.

### **3. Create and Effectively Market Health Insurance Products with Select Networks of High Performing Providers**

The variation in prices paid to providers demonstrates an immediate opportunity for health insurers to develop and promote insurance products which direct care to efficient, lower cost providers, similar to recent efforts by the Group Insurance Commission. These products may include provisions that allow for differing levels of cost sharing based on tiers of providers within the network.

As is included in the Governor's jobs bill, the Massachusetts Association of Health Plan's Affordable Health Plan, and a recent proposal by the Associated Industries of Massachusetts, legislation should be enacted which permits the Division of Insurance to require that every insurer that participates in the merged market create and offer to all participating employers and individuals a product which includes a select network of high-quality, low-cost providers. As part of this initiative, the Division of Insurance should facilitate insurer development and promotion of such select network products. The Division of Insurance will hold hearings in early May on issues related to select networks and network adequacy. Consideration should be given to the fact that some geographic areas of the state may have insufficient provider capacity to develop select networks and therefore this option may only be available in certain regions of the state.

Insurers have reported that they have been unsuccessful in their efforts to market select network products to employers and individuals because of the intense marketing by certain providers (identified as those typically receiving higher prices). Employers should be encouraged to provide employees with a choice of products that make transparent the difference in premium prices reflected in the available delivery system networks. Clear and concise information on the quality of care and outcomes of providers participating in the different delivery networks should also be made available to employers and employees.

The Commonwealth (potentially through its oversight entity) should consider establishing ways to ensure that a range of hospitals, including disproportionate share hospitals, are ensured opportunities to join such limited network products based on their willingness to conform to standards set by the limited network.

While there is a similar ability to regulate the insurance products offered through fully-insured large employers, the state has no ability to regulate self-insured employers. The Division of

Insurance should work with the business community to encourage employers to be more prudent purchasers of health care for their employees.

In addition, employers should be incentivized to design and use employee engagement strategies that will help employees be proactive about their health and well-being. Such strategies are also necessary to promote awareness among employees about health care costs and service utilization.

#### **4. Provider Contract Provisions**

According to analysis and information gathered by the Office of the Attorney General and the Division of Insurance, some contracts between insurers and providers include provisions that may limit fair and open competition, perpetuate market disparities, and inhibit product innovation. The Legislature should review the following provisions and consider addressing the parameters around provider-insurer contracts that might influence their inclusion:

- Anticompetitive provisions

The OAG and DOI found that some contracts between insurers and providers include clauses that inhibit competition by tying rates of payment in one contract to those included in a contract with another party. In some cases, these clauses may reduce the development of select networks, tiered networks, or other products, and may actually lead to automatic increases in rates of payment based on what an insurer or provider is able to negotiate in contracts.

- “Tie-in deals” in contract negotiations

The OAG and DOI found that some providers will only enter into contracts with health insurers if the insurer also agrees to contract for all the services available from the provider or to include all affiliated providers within the contract. These “all-or-nothing” contracts limit the ability of the insurer to develop provider networks to most cost-effectively serve its members.

### **D. Long-Term Solutions: Creating an Integrated Health Care Delivery System**

Achieving a sustainable growth rate in health care costs requires a careful and holistic change in the way in which the Massachusetts delivery system is organized, how providers are paid, and what measures we use to both hold our delivery system accountable and reward quality. The following recommendations fall into five broad categories – all of which must be addressed – in order to develop a high-performance, integrated delivery system that achieves better health outcomes and lowers costs for Massachusetts residents:

1. Creation of an oversight entity to design and implement the transition to an integrated delivery system, including establishing performance targets and monitoring progress;
2. Payment reform – which is a necessary component but not in and of itself sufficient to achieve overall integration and lower costs;

3. Delivery system redesign to ensure more efficient organization, communication, and coordination of care among providers and to support the provision of integrated, patient-centered care in the most appropriate setting;
4. Transparency of cost and quality information for consumers and employers; and
5. Investment in public health and wellness initiatives.

Critical to the success of these reforms will be the involvement of all payers – including Medicare. Therefore, in addition to state legislation, federal waivers and other necessary authorizations are essential to support some of these strategies.

Together these longer-term recommendations will help the Massachusetts health care marketplace operate more effectively by using public oversight and accountability to spur integration, innovation, and competition. Rather than viewing policy solutions as strictly government-based regulatory methods or market-based approaches, these recommendations recognize that systemic change requires both government oversight and industry leadership to incentivize and create the necessary conditions for effective market competition, as well as consumer and employer engagement.

### **1. Oversight Entity**

As the Commonwealth tackles mitigating health care cost growth and restructuring its delivery system to increase efficiency and integration of care, it needs to designate an entity to guide its decision-making and implementation strategy. At present, multiple state agencies share responsibility for various components of provider monitoring, health insurance premium oversight, and quality and performance measurement. Currently there is no entity which sets overall targets for health spending or its rate of growth for the Commonwealth. For the system to move forward in a unified direction, an independent public entity that coordinates and leverages existing public and private resources should be assembled to set overall spending targets, monitor progress toward these targets, and make other related decisions. The oversight entity would be responsible for overseeing implementation of all of the following recommendations – with a particular focus on the payment and delivery system reforms. In time, the responsibilities of this entity should evolve from implementation to monitoring.

The oversight entity could also be responsible for ensuring that a mechanism exists for dissemination of public information about the various reforms. Employers and consumers will need to be aware of how new regulations may affect their health care choices and be encouraged to make cost effective decisions. Research shows that public awareness campaigns were successful in educating residents about the individual mandate created under Chapter 58 of the Acts of 2006. A Division of Health Care Finance and Policy survey report<sup>41</sup> found that in 2008, 8 out of 10 households were aware of the individual mandate.

Such an entity could be governed by a Board of Directors composed of government officials and subject matter experts in specific fields. Staff support for the Board could be provided by the relevant state government agencies, including the Division of Health Care Finance and Policy, the Department of Public Health, the Department of Mental Health, the Executive Office of Elder Affairs, and the Division of Insurance, among others.

## 2. Payment Reform

In order to transition the health care delivery system in Massachusetts towards greater efficiency and integration, the Division recommends that comprehensive payment reform be enacted. This proposal builds upon the unanimous recommendations of the Special Commission on the Health Care Payment System, the framework outlined by the Health Care Quality and Cost Council in its *Roadmap to Cost Containment*, and the testimony of most witnesses at the Division's public hearings on health care cost trends. Payment reform efforts must aim to move the entire Massachusetts health care system to one in which the interests of providers, payers, and consumers are aligned to support high quality, cost-effective care delivered at the right time and in the most appropriate setting.

An integrated payment methodology will help address many of the factors contributing to increasing health care costs as found in the Division's preliminary reports and the investigation by the Office of the Attorney General. Removing the inflationary incentives inherent in the current predominantly fee-for-service system as well as rewarding integrated care delivery will help mitigate cost growth over time and reduce expenditures on unnecessary care. For example, to the extent that health care costs are rising due to care being provided in more expensive locations, an integrated payment model will create incentives for providers to move care to more cost-effective settings. Also, to the extent that more costly services are being provided when less costly services of similar clinical value could be substituted, providers will have an incentive to order the more cost-effective service, especially when payment incentives are aligned to reward such outcomes.

A study by RAND<sup>42</sup> found that bundled payments models provide one of the most promising options for reducing spending with the potential to reduce health care costs up to 5.9%. It is noted in the study that to achieve that level of savings, new policies would need to be formulated and implemented effectively. According to the RAND study, the best evidence to date regarding cost savings that could be realized through integrated and bundled payment systems is from Medicare demonstration projects, which provide limited but promising results (10 percent reduction in a project bundling payment for coronary artery bypass graft surgery).

In order to address the wide variation in prices and to ensure that current market inequities are not perpetuated in a new payment system, the oversight entity should be given authority to set limits on the maximum degree of price variation permissible and narrow such variation over time. In addition, such an oversight entity should prioritize primary care and low-cost, high quality providers who can successfully manage a wide spectrum of services in its system redesign.

Active monitoring by the oversight entity and public reporting on quality of care and outcomes will also be critical to this transition. The oversight entity should establish a core, common set of measures for rewarding improved processes and outcomes to be used by all payers. Moreover, the oversight entity will need to establish safeguards against underutilization of services and protection against inappropriate denials of services or treatment.

To encourage widespread adoption of integrated payment methods throughout the Massachusetts health care system and in recognition of the growing enrollment in self-insured plans, the

oversight entity should provide incentives for participation to self-insured employers. In addition, the Executive Office of Health and Human Services should seek a federal waiver to permit Medicare to participate in the state's integrated payment system. Since Medicare represents a significant portion of provider revenues, its payment policy plays a central role in determining incentives and delivery practices in the Commonwealth.

Additional key features of payment reform should include:

- The oversight entity should establish benchmarks for the transition of all integrated health services to be delivered by Integrated Care Organizations (ICOs) and reimbursed by all payers under a global payment methodology.
- The oversight entity should establish standard risk adjusters to be utilized by all payers which recognize past resource requirements with comparable patients, clinical health status and probability of illness, socioeconomic case mix, and geographic location.
- There should be explicit payment methodologies to recognize teaching, support for standby services, and disproportionate share status.
- There should be allowances made for waiving requirements related to global payments in support of innovative or pilot programs which have demonstrated material savings or improvements in the delivery and quality of care.
- ICOs should be permitted and encouraged to participate in reinsurance arrangements to help mitigate the impact associated with unforeseen risk.

### **3. Health Care Delivery System Redesign**

Providers must be incented to move towards greater integration and coordination. Such efforts must support effective communication across the continuum of patient care needs and across different providers.

#### *Creation of Integrated Care Organizations*

The creation of Integrated Care Organizations (ICOs) would ensure that providers work collaboratively to meet patient care needs. ICOs should be composed of licensed and accredited health care providers including at least one acute care hospital and one primary care physician practice that includes a behavioral health component. ICOs would be responsible for delivering integrated health services including all services required under Minimum Creditable Coverage standards. ICOs need not be large, multi-hospital systems, and the Commonwealth's market would be best served by ICOs of varying sizes. Many small physician groups are and will be able to coordinate a wide spectrum of care for patients and manage risk appropriately. To this end, the oversight entity should monitor the formation of ICOs including size, scope, excess consolidation, and possible barriers to entry, all of which could impact market power; this will be critical to ensuring appropriate competition among ICOs.

ICOs should prioritize and incentivize primary care as central to meeting patients' care needs and reflecting the principles of a patient-centered medical home model. Of critical importance to the feasibility and sustainability of the ICO model is that flexibility be given to entities forming ICOs to be either fully integrated organizations, multi-specialty providers, or "virtual organizations" that can manage a meaningful spectrum of services. In addition, different levels

of integration with financing and risk should be explored, such as those outlined by Stuart Altman and colleagues from Brandeis University's Heller School which allow for shared savings models as well as fully globally capitated models.<sup>43</sup>

ICOs should allow for some of the savings generated by efficiencies to be kept by the entities themselves to invest in their own systems of coordination (e.g., health information technology). There should also be opportunities for consumers and employers that utilize efficient ICOs to share in some of the savings. It is also recommended that ICOs be permitted and encouraged to participate in reinsurance arrangements to help mitigate the impact associated with unforeseen risk.

#### *Provide Technical Assistance to Providers Forming ICOs*

Some providers are better prepared, from a capital resource perspective, for the transition towards integrated ICOs. The Commonwealth should seek out public-private partnerships to provide technical assistance in the form of grants and expertise to providers that are not as well equipped to form ICOs. Extending legal, corporate, and financial supports would allow an incubation period for essential, but less capitalized, community providers to form ICOs, which will allow them, over time, to compete.

#### *Promote the System-wide Adoption of Health Information Technology*

The use of health information technology (HIT) would enhance coordination across providers, provide patients with electronic access to their own health information, and make information more readily available for supporting strategies to improve population health. As suggested by the Health Care Quality and Cost Council's *Roadmap to Cost Containment*, thoughtfully designed health technology tools can be used to reduce unnecessary and duplicative testing, reduce the administrative burden on providers, and improve clinical quality. Chapter 305 of the Acts of 2008 charged the Massachusetts eHealth Institute and the HIT Council with ensuring that all providers have and utilize electronic health records and interoperable networks by January 1, 2015. The eHealth Institute's HIT Plan<sup>44</sup> outlines 6 strategies to meet its goals. They include 1) establish multi-stakeholder governance; 2) establish a privacy framework to guide the development of a secure HIT environment; 3) implement interoperable health records in all clinical settings and assure they are used to optimize care; 4) develop and implement a statewide health information infrastructure to support care coordination, patient engagement, and population health; 5) create a local workforce to support HIT related initiatives; and 6) monitor success.

Provisions in the recently passed national health reform law offer new opportunities for streamlining health information technology's role in the Commonwealth's health care delivery system. Section 1104 of the recent Patient Protection and Affordable Care Act tweaks HIPAA's administrative simplification provisions by requiring the Secretary of Health and Human Services to develop standards such as those that would allow for point-of-care eligibility determinations, minimize the need for paper attachments to claims submissions, and describe all data elements (including reason and remark codes) in clear terms. In addition, the American Reconciliation and Recovery Act (ARRA) of 2009, has led to substantial federal funding efforts to support the adoption of interoperable electronic health records (EHRs) and to develop the capacity for system-wide health information exchange.

The Division recommends that current efforts to promote and expand the use of HIT continue to be supported by the Commonwealth and that both providers and payers continue to work together to create uniform standards for usage and interoperability of health information technology across providers. These standards and goals should apply not just to hospitals and physician groups, but also to home health and long-term care providers.

#### *Promoting the Expansion of Successful Chronic Care Models*

It is widely recognized that a small portion of the population accounts for a disproportionate share of health care expenditures. These costs are largely driven by treatment of chronic disease and other long-term illnesses. By 2015, an estimated 150 million Americans will have at least one chronic condition. Among nonelderly adults, the number who report having one or more of seven major chronic conditions has increased from 28% in 1997 to 31% (or 58 million) in 2006.<sup>45</sup> A number of pilots and small programs serving chronic care and other high need populations have been implemented in various places throughout the state. For example, the Senior Care Options program which integrates funding and services for seniors who are dually eligible for MassHealth and Medicare has shown promising results. The Commonwealth should work with the Federal Coordinated Health Care Office, a new office within the Centers for Medicare and Medicaid Services created under the federal health reform law to focus on improving care coordination for persons dually eligible for Medicare and Medicaid, to expand Senior Care Options and develop programs for dually eligible individuals under 65 years of age. In addition, current barriers to such expansion – such as reserve threshold levels which can be very difficult for small organizations to meet - should be examined for possible modification.

#### *Strengthen Determination of Need and Health Resource Planning*

The construction of unnecessary facilities and the proliferation of the use of new, expensive technology can drive up the cost of health insurance premiums and may not contribute to better health outcomes. In addition, the construction of new and attractive facilities by academic medical centers in close proximity to community hospitals may jeopardize the long-term financial health of those needed community-based providers. In addition, while new technological advances in medical equipment may be desired, their efficacy in improving quality may not always be supported by clinical literature. Overuse of new technology can come with certain risks, such as additional exposure to radiation. While legislative action and new Massachusetts Department of Public Health regulations in the last two years have increased the oversight of new construction and new technology, there are still continuing challenges.

Accordingly, as included in the Health Care Quality and Cost Council's *Roadmap to Cost Containment*, the state should enhance its capacity to analyze patient needs by region to insure that Determination of Need and other health care planning are informed by current trends, demographic characteristics, patterns of utilization, and other relevant factors. Legislation would be needed to expand the Department of Public Health's authority to examine demographic trends and changes in medical technologies and to use state-of-the art methodologies in reviewing Determination of Need applications. Additional funding would be required to ensure adequate staffing and other resources at the Department of Public Health to support this critical health resource planning function.

### *Monitoring and Oversight of Advertising Spending by Providers*

The Legislature should consider implementing a process to review spending on advertising by health care providers as part of the Massachusetts Department of Public Health's licensing process. For budgets over a given threshold, DPH could require that a percentage of such monies to be spent on advertising be dedicated to a fund for the purposes of financing public health and wellness campaigns across the Commonwealth.

## **4. Transparency of Cost and Quality Information**

Central to achieving a more effective and integrated delivery system is robust data on health care cost and quality as well as easily accessible and understandable health care information for consumers, employers, insurers, and researchers. Efforts are already well underway to support this goal. The Health Care Quality and Cost Council has been collecting insurance carrier claims data on the privately, fully insured for nearly three years and it currently posts data on 19 inpatient conditions and 18 diagnostic tests on its consumer website, *My Health Care Options*. The Division recently proposed regulations to collect and make available data on all private claims (including self-insured – who represent half of the privately insured - as well as fully insured claims). The Division is also working with the Office of Medicaid and the Commonwealth Health Insurance Connector Authority to incorporate MassHealth and Commonwealth Care data, respectively, and has submitted an application to the Centers for Medicare/Medicaid Services to obtain Medicare data as well. The result will be one of the only all payer, all provider claims databases in the country and will facilitate unprecedented transparency, through access to and analysis of medical and clinical expenditures in Massachusetts.

This expanded database will inform the ongoing development of new performance measures to be reported publicly by the Division. These measures would enable consumers to make choices based on knowledge of the differences in quality and price of the providers through whom they seek care, as well as hold providers accountable for high quality, cost-effective performance.

Similarly, the database could be used to develop uniform, core performance measures and provider reporting tools to align all providers and payers towards a common set of goals. Such a strategy would reduce the administrative complexity currently faced by many providers who have to respond to multiple sets of performance measures with slightly different definitions. The Division, at the direction of the Health Care Quality and Cost Council, has convened an Expert Panel on Performance Measurement to lead efforts in this area.

The Division also intends to make analytic datasets available to researchers and health care organizations in order to support their efforts in understanding variations in health care quality and costs. While many large purchasers and providers already have data to analyze such issues in-house, the Division seeks to “democratize” such knowledge by giving access to a broader audience.

Open and transparent price and quality information will be critical to the formation of a competitive marketplace and to transition towards an integrated delivery system. This data will need to be used thoughtfully and carefully by the oversight entity and others in order to ensure that the transparency of data does not lead to a “race to the top” wherein all providers begin to seek the rates of the highest paid providers in the marketplace.

## 5. Public Health and Wellness

The Division recommends that the Commonwealth explore options for public-private partnerships to invest in evidence-based public health interventions that promote wellness and reduce the incidence and prevalence of chronic conditions. While savings are not likely to be realized in the short-term, the transition towards a wellness (not illness) model is a necessary and responsible investment to improve the health and productivity of the Massachusetts population. This is a critical challenge that cannot be ignored and requires immediate attention.

### *Investing in Population-based Prevention of Chronic Disease and Other Illness*

A recently published analysis of Medicare spending found that two-thirds of the rise in national health care spending from 1987 to 2006 is a result of the growing prevalence of treating chronic disease.<sup>46</sup> The Boston Foundation reported in 2007 on the Greater Boston area's "unique and powerful reasons to respond to the rising tide of preventable chronic disease," citing its aging workforce which will become susceptible to the onset of serious chronic disease. The Foundation warned against rising levels of obesity, diabetes, and other preventable chronic diseases that "present not just a health challenge, but also a challenge to the region's economic competitiveness, as rising levels of chronic disease reduce productivity, drive up health care costs and squeeze out the ability to invest in other key priorities like education and public safety."<sup>47,48</sup> Similarly, the Massachusetts Department of Public Health has examined the trends regarding overweight and obesity and their relationship to increased chronic disease prevalence and recommended that comprehensive and sustained policies and programs be implemented across a wide variety of sectors including schools, municipalities, clinical sites, employers, and others, with a focus on changing the social and economic determinants of health.

### *Investing in Wellness Programs*

The economic urgency surrounding the actual health of Massachusetts' residents is significant. Efforts to promote wellness are underway by the Executive Office of Health and Human Services, through its broad-based *Mass in Motion* initiative, which has implemented regulatory changes such as calorie labeling in restaurants and body mass index (BMI) testing in schools, expanded workplace wellness programs, and successfully engaged foundations in public-private partnerships to jointly support local city and town wellness endeavors. One such municipal program exists in Fitchburg, where Mayor Lisa Wong established health living as a community priority, local lawmakers focused on improving the region's quality of life, and a strong network of collaborators is now mobilized to address obesity. Two new farmers' markets opened last year and residents are now able to exercise using the markers stenciled on downtown sidewalks for a one-mile walking loop from City Hall.<sup>49</sup> This impressive work allowed the city to successfully gain a prestigious Robert Wood Johnson Foundation grant called *Healthy Kids Healthy Communities*.

This level of innovation around wellness is also evident in the private sector, with local employers such as EMC Corporation, reflecting the growing consensus that the Commonwealth needs all stakeholders – government, private employers, health care and social service providers, and the public – to approach the improvement of our workforce's health with intensity, creativity, and resources. Employers and health plans should be encouraged to include an employee engagement strategy in their benefit plans that would promote individual employee and family wellness. Such plans might include personal health assessments so that wellness

initiatives can be targeted to the circumstances of each employer's workforce. Incentives should be developed to ensure that employers of all sizes are encouraged to develop work-based wellness programs and are able to realize savings in health insurance premiums for undertaking these important steps.

#### *Promote Smoking Cessation Benefits*

The Massachusetts Department of Public Health estimates that \$4.3 billion is spent annually on excess direct health care costs due to smoking.<sup>50</sup> Recent evidence of the immediate impact smoking cessation benefits had on the MassHealth population's utilization of high cost services suggests that these services should be made available to the broader, privately insured population. An evaluation by the Department of Public Health found that within one year, users of the smoking cessation benefit had dramatic reductions in hospitalizations for heart attacks, declines in emergency and clinic visits for asthma, and a significant decrease in acute birth complications.<sup>51</sup>

The Division recommends that the Department of Public Health be given resources to work with business leaders and other purchasers to ensure employers and insurers are made aware of the positive impact which this benefit can have in the short-term and encouraged to promote its use.

## V. Conclusion

As was the case with designing public policy for the Commonwealth to achieve near universal coverage through Chapter 58, policies aimed at improving the efficiency of the health care system and mitigating the growth of health care costs must involve all key stakeholders through “shared responsibility.” Developing the overall market conditions for providers and health insurers to compete on the basis of cost and quality—not utilization and volume—will require a careful transition to a health care delivery system that is integrated and aligns financial incentives with better health care outcomes, as well as action by employers, consumers, and government. Each must play a role in making the system more efficient.

- Providers must continue to identify and root out waste and other inefficiencies in their operations. Providers must invest in the creation of new care delivery models which ensure coordination of care across the continuum of patient care needs in all settings and support delivery of timely care in the most appropriate settings.
- Insurers must design payment models, insurance products, and provider networks which align financial incentives to support improved outcomes and quality of care and allow for the offering of products with affordable premiums and incentivized copayments.
- Employers must play an active role in supporting the wellness of their employees and support innovative insurance product designs and provider networks which promote use of cost-effective, high quality providers by their employees.
- Consumers must be active in promoting their own health and well-being and become aware of the differences in quality and price of the providers through whom they seek care.
- Finally, government must develop parameters, benchmarks, and balanced oversight to guide the transition to a more efficient, integrated health delivery system, monitor progress towards this new system, and intervene as needed. Critical to the success of this transition will be government’s role in serving as a clearinghouse for comprehensive quality and cost information to ensure consumers, employers, insurers, and state entities have the data necessary to make prudent health care purchasing decisions.

The specific recommendations presented in this report include some policy changes that can have an impact in the short-term (i.e. within the next 2-3 years) assuming legislative actions are taken where needed. Given the urgency of the issue, it is recommended that these strategies be pursued without delay to provide relief to families and businesses. However, achieving a sustainable decrease in health care cost growth requires more dramatic improvements in the overall way in which the Massachusetts delivery system is organized, how providers are paid, and what measures we use to hold our delivery system accountable. The state must take action now to put in place the necessary legislative authorizations to move toward the ultimate goal of a more coordinated, efficient, and patient-centered health care delivery system.

Such a transition will be challenging for all key stakeholders, as it requires a fundamentally new model for providing care (both in terms of delivery and payment) and demands creativity from all involved in the delivery of care to and promotion of health among the Commonwealth's residents. The path may be difficult, especially as Massachusetts will be first among states to comprehensively tackle health care cost growth, but the responsibility will be shared among many. Indeed, Massachusetts is well-equipped to take on this next challenge in health care reform because of its industry leadership, forward-looking public policy, and a history of innovation in both clinical medicine and care delivery. It is time for the state to take immediate action and set the course forward.

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