

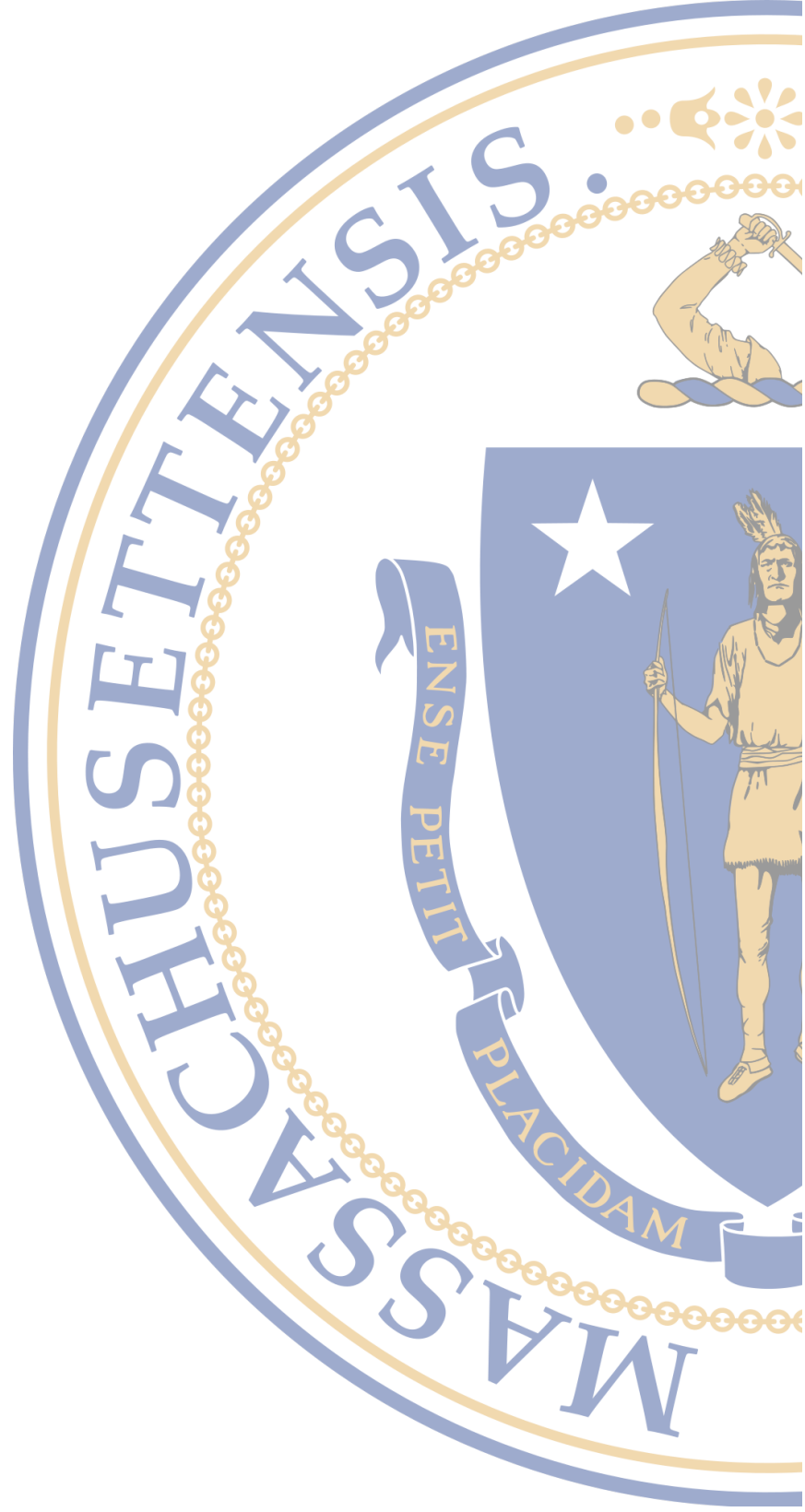
The seal of the Commonwealth of Massachusetts is partially visible on the left side of the page. It features a blue shield with a Native American figure holding a bow and arrow. Above the shield is a crest with a bent arm holding a sword. A ribbon scrolls around the shield with the motto "SVB LIBERTATE QUIETEM". The words "SIGILLUM REIPUBLICAE" are written in a circular path around the shield.

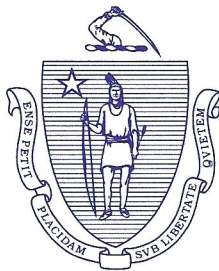
Special Commission on PROVIDER PRICE VARIATION REPORT

March 15, 2017

Representative Jeffrey Sánchez, Co-Chair
House Chair of the Joint Committee
on Health Care Financing

Senator James T. Welch, Co-Chair
Senate Chair of the Joint Committee
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March 15, 2017

I write to acknowledge the hard work, leadership, and collaboration that members of the Special Commission on Provider Price Variation displayed throughout its operation.

As a Chairman of the Commission, I had the pleasure of helping to guide this important conversation about provider price variation in Massachusetts, but it was our Commission members who gave that conversation life and led it to bear fruit. I extend my gratitude to the subcommittee chairs, Deborah Devaux, Connie Englert, and Kate Walsh, for their commitment. The breadth of the Commission report and the strength of its recommendations speak to the full Commission's efforts more than I could hope to do here.

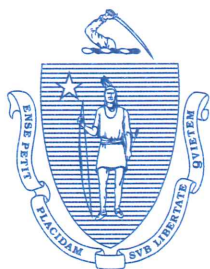
I would also like to thank my legislative director and counsel, Michael Cannella, for his work throughout the process.

Our work on provider price variation does not end with this report and its recommendations. The recommendations offer a guiding light on our journey to improve the financing and delivery of healthcare in Massachusetts. I look forward to continuing that journey.

Sincerely,

A handwritten signature in blue ink that reads "James T. Welch".

James T. Welch
Hampden District



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March 15, 2017

The Special Commission on Provider Price Variation spent the last six months tackling complex issues in healthcare, including the payer-provider contracting relationship, the impact of healthcare market forces, how transparency can be implemented meaningfully, and a potential role for the state in reviewing provider rates. The conversation was engaging and informative, but at times challenging.

Given the complexity of the issues at hand and the short time frame, we created a process to allow all members to engage in a respectful dialogue and tackle the breadth of this issue. I did not want to revisit old reports and analyses and rehash old debates. Instead, I wanted to foster objective, focused discussions and hopefully find some points of agreement. Although the Commission's mandate was specific in some areas, it was also quite broad. Therefore, the Commission's work was informed by systemic concerns, such as continued increases in healthcare costs and how to support community providers.

Considering the size of the Commission, as well as the time frame, we created three subcommittees to allow Commission members to continue conversations between meetings and draft initial recommendations in their respective topic areas to bring back to the full Commission. In addition, to facilitate thoughtful and in-depth conversations, the Commission invited nationally-recognized industry experts to each meeting, where they presented on their areas of expertise. Once the Commission drafted its recommendations, we assembled a final panel of experts to challenge and expand our thinking. To engage members of the public and stakeholders not represented on the Commission, we held a public listening session. These issues impact all residents of the Commonwealth so we wanted to provide an opportunity for people to address the Commission.

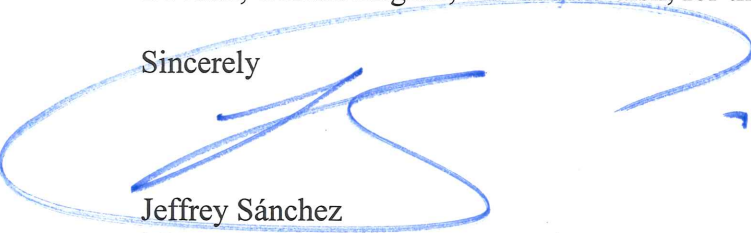
From the beginning, in my role as Chair of the Commission, my goal was for all stakeholders to come together, discuss action-oriented ideas that address the challenges in our healthcare market, and see if Commission members could reach consensus. It was not easy work, but over the course of nine meetings, all of which were open to the public, and almost a dozen subcommittee meetings, a few common themes emerged. Commission members agreed that higher payments

are justified for high-quality providers and providers that care for sicker or high-cost patients. The Commission also agreed that patients receiving emergency services or those cared for without their knowledge by an out-of-network provider should not be subject to a surprise bill. Members emphasized the fact that small businesses face unique hurdles when they purchase health insurance and may need additional resources. There was also recognition that it is essential to design innovative insurance products that appeal to consumers and employers. There was broad agreement that patients need more accessible, actionable, and understandable information, both when they choose their plans and when they access care. Finally, Commission members agreed that all stakeholders must work to ensure the sustainability of providers across the Commonwealth. The Commission also recognized that any proposed actions should not increase total healthcare spending in the Commonwealth or increase the financial burden on patients and employers.

Our discussions and these recommendations are merely the beginning of a conversation. There is a lot of uncertainty at the federal level as we wait and see how Congress and the Trump Administration is going to act regarding the future of healthcare. Massachusetts is a leader in healthcare innovation and policy reform and I look forward to continuing the conversation.

Finally, I'd like to thank my staff for all their work on this effort, specifically, Sarah Sabshon (Chief of Staff), Timothy O'Neill (Committee Director), Erin Liang (Committee Counsel) and Sharone Assa (Research Analyst). I'd also like to thank the subcommittee chairs, Deborah Devaux, Connie Englert, and Kate Walsh, for their hard work throughout this process.

Sincerely



Jeffrey Sánchez

Massachusetts State Representative
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TABLE OF CONTENTS

Figures Table of Contents	i
Index of Acronyms & Abbreviations	iii
Executive Summary	1
Introduction	13
 Chapter 1: Provider Price Variation in Massachusetts & Nationally	 16
Section I: Price Variation Metrics & Reporting in Massachusetts	16
Section II: Massachusetts Trends in Price Variation	19
Section III: Direct and Indirect Effects of Price Variation in Massachusetts	22
Section IV: Price Variation in Other States and Nationally	24
Section V: Effect of Price Variation on Massachusetts Residents	26
 Chapter 2: Rate Adjustment & Factors Influencing Price Variation	 30
Section I: Commercial Contracting & Rate Setting	30
Section II: Medicare & Medicaid	31
Section III: Factor Discussion	37
Section IV: Global Budgets	56
 Chapter 3: Healthcare Contracting & Market Forces	 60
Section I: Legislative & Legal Efforts to Bolster Competition in the Massachusetts Healthcare Market & Nationally	61
Section II: Component Contracting	63
Section III: Out-of-Network Billing in Support of Promoting Limited/Tiered Network Products	67
Section IV: Material Change Notice & Cost and Market Impact Reviews	70
Section V: Acquisitions & Mergers of Physician Organizations	72
 Chapter 4: Demand-Side Incentives in Healthcare	 75
Section I: Demand-Side Incentives in Healthcare	75
Section II: Structure of Healthcare Markets	76
Section III: Health Plan Designs That Reward High-Value Providers	79
Section IV: Shopping for Healthcare Services	85

Chapter 5: Price Transparency	88
Section I: Price Transparency in Healthcare	89
Section II: Massachusetts Price Transparency Laws	91
Section III: Price Transparency Initiatives	93
Chapter 6: State Monitoring of the Healthcare Market	96
Section I: Monitoring the Healthcare Market in Massachusetts	96
Section II: All-Payer Rate Setting in Maryland and Vermont	98
Section III: Efforts to Curb Spending Growth in Rhode Island	101
Section IV: Additional State Monitoring in Massachusetts	104
Recommendations	108
Glossary	119
Appendices	123
Appendix A: NIH Funding by State, 2016	
Appendix B: Relative Price & Payer Mix of All Acute Care Hospitals in Massachusetts	
Appendix C: Special Commission Slides	
Appendix D: Presentations to the Special Commission	
Appendix E: Testimony from the Special Commission’s Listening Session	
Acknowledgements	124

FIGURES TABLE OF CONTENTS

Chapter 1: Provider Price Variation in Massachusetts & Nationally

Figure 1.1: Distribution of Acute Hospital Blended Relative Price by Payer, 2014	17
Figure 1.2: Proportion of Growth in Total Medical Expenditures at Blue Cross Blue Shield, 2010-2015	18
Figure 1.3: Acute Hospital Blended Relative Price by Cohort, 2014	21
Figure 1.4: Unit Price Drives Spending Increases, 2014-2015	22
Figure 1.5: Share of Community Appropriate Discharges by Hospital Type, 2011-2015	23
Figure 1.6: Academic Medical Center Commercial Price Comparisons, 2014	26
Figure 1.7: Growth in Insurance Premium Spending Per Enrollee, 2005-2015	26
Figure 1.8: Average Annual Family Premium & Employer Contribution by Wage Quartile, 2015	27
Figure 1.9: Massachusetts Residents by Income, 2015	28
Figure 1.10: Distribution of Risk-Adjusted Medical Spending by Average Annual Income for One Major Massachusetts Payer's Members, 2014	29

Chapter 2: Rate Adjustment & Factors Influencing Price Variation

Figure 2.1: Medicare Inpatient Prospective Payment System	33
Figure 2.2: Medicare Outpatient Prospective Payment System	34
Figure 2.3: Medicare Ambulatory Surgical Center Payments	34
Figure 2.4: MassHealth Enrollment by Payer Type, 2016	36
Figure 2.5: Graduate Medical Education Payments in the United States	42
Figure 2.6: Massachusetts Medicare Funding for Graduate Medical Education, 2000-2012	43
Figure 2.7: MassHealth Supplemental Payments, FY2016	47
Figure 2.8: United States Medical and Health R&D Expenditures, 2015	53
Figure 2.9: NIH Funding for Hospitals Compared to Universities, 2015	54
Figure 2.10: NIH Funding by Hospital System in Massachusetts, 2016	55

Chapter 3: Healthcare Contracting & Market Forces	
Figure 3.1: Notice of Material Changes, 2013-2016	62
Figure 3.2: Retail Clinics and Urgent Care Centers in Massachusetts, 2008-2016	71
Chapter 4: Demand-Side Incentives in Healthcare	
Figure 4.1: Demand-Side Incentive Applications in Healthcare	76
Figure 4.2: Premiums by Group Size Relative to 2012 Small-Group Premiums, 2012-2015	77
Figure 4.3: Employer Size and Plan Options, 2014	78
Figure 4.4: Commercial Enrollment in Limited and Tiered Network Plans, 2013-2015	80
Figure 4.5: Shoppable Services in Healthcare	86
Chapter 6: State Monitoring of the Healthcare Market	
Figure 6.1: Vermont All-Payer ACO Model Agreement Timeline	101
Figure 6.2: Primary Care Spending in Rhode Island, 2008-2015	103

LIST OF ACRONYMS & ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
AGO	Office of the Attorney General
AIM	Associated Industries of Massachusetts
AMC	Academic Medical Center
APAD	Adjudicated Payment Amount per Discharge
APC	Ambulatory Payment Classification
APEC	Adjudicated Payment per Episode of Care
APM	Alternative Payment Method
AQC	Alternative Quality Contract
ASC	Ambulatory Surgical Center
BCBS	Blue Cross Blue Shield of Massachusetts
BMC	Boston Medical Center
CHIA	Center for Health Information and Analysis
CMIR	Cost and Market Impact Review
CMMI	Centers for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
Connector	Commonwealth Health Insurance Connector Authority
DHHS	U.S. Department of Health & Human Services
DME	Direct Medical Education
DMH	Department of Mental Health
DOI	Division of Insurance
DPH	Department of Public Health
DRG	Diagnosis-Related Group
DSH	Disproportionate Share Hospital
ED	Emergency Department
EOHHS	Executive Office of Health & Human Services
FFS	Fee-For-Service
FTC	Federal Trade Commission
GIC	Group Insurance Commission
GMCB	Green Mountain Care Board
GME	Graduate Medical Education
GPC	Group Purchasing Cooperative
HDHP	High Deductible Health Plan
HMO	Health Maintenance Organization
HPC	Massachusetts Health Policy Commission
HPHC	Harvard Pilgrim Health Care
IME	Indirect Medical Education

IPPS	Inpatient Prospective Payment System
LNP	Limited-Network Plan
LTNP	Limited- and Tiered-Network Plan
MACRA	Medicare Access and CHIP Reauthorization Act
MAHP	Massachusetts Association of Health Plans
MCN	Notice of Material Change
MCO	Managed Care Organization
MedPAC	Medicare Payment Advisory Commission
MHA	Massachusetts Health & Hospital Association
MIPS	Merit-Based Incentive Payment System
NIH	National Institutes of Health
OHIC	Rhode Island Office of the Health Insurance Commissioner
OPPS	Outpatient Prospective Payment System
PACE	Program for All-Inclusive Care for the Elderly
PAPE	Payment Amount Per Episode
PCC	Primary Care Clinician Plan
PCP	Primary Care Provider
PIP	Performance Improvement Plan
PMPM	Per-Member-Per-Month
PPO	Preferred Provider Organization
RP	Relative Price
RPO	Registration of Provider Organizations
SCH	Sole Community Hospital
SCO	Senior Care Options
THP	Tufts Health Plan
TME	Total Medical Expense
TNP	Tiered-Network Plan

EXECUTIVE SUMMARY

In May 2016, the Massachusetts Legislature passed Chapter 115 of the Acts of 2016 to address health system viability and provider price variation, or differences in prices paid to providers for the same set of services. The Act establishes the Special Commission on Provider Price Variation, a twenty three-member group consisting of legislators, insurers, providers, employers, and other stakeholders. The Act directs the Commission to identify acceptable and unacceptable factors contributing to price variation, examine price variation in other states, and review certain payer-provider contracting practices.

Commission members addressed these and related topics over the course of nine meetings. Members also participated in one of three subcommittees – market forces, state monitoring, and transparency – to examine in greater detail various proposals raised at full Commission meetings. Subcommittees drafted recommendations, which the Commission considered at subsequent meetings. This report is the result of this comprehensive process. It builds off the work of state agencies, considers the extent of price variation in Massachusetts and nationally, and explores reasons for and steps to address price variation. The Commission did not examine whether overall price levels are too high or too low, as this was not part of its statutory charge.

Per the Commission's charge, the report concludes with recommendations to reduce unwarranted provider price variation. These recommendations seek to balance appropriate payments to providers and ensure stability in the market, while keeping in mind the impact on premiums and total healthcare costs in the Commonwealth. It is important to note that not all Commission members agree with each recommendation. The full report details member conversations including places of disagreement.

RECOMMENDATIONS

MARKET FORCES

Warranted & Unwarranted Factors for Price Variation

The Special Commission on Provider Price Variation recommends the following factors be considered warranted or unwarranted reasons for provider price variation in Massachusetts. This list is intended to apply to both acute-care hospitals and other provider types (e.g., physicians), although the methods for measuring the factors would likely vary between hospitals, physicians, and other provider types. Also, it should be noted that this list does not consider the methodology or weight that such factors could or should be given in determining pricing.

This recommendation should be considered a policy document that serves as a guide for transparency and deliberation during price negotiations between providers and payers. The feasibility and effectiveness of this recommendation, with respect to

preventing unwarranted factors from influencing rates, could be evaluated and monitored through a transparent, objective, and accountable process with ongoing oversight by the appropriate state agency, such as the Health Policy Commission (HPC) or the Division of Insurance (DOI).

Addressing provider price variation must keep in mind the dual goals of making healthcare more affordable for employers and consumers and addressing unwarranted differences in prices paid to providers. The influence of factors is complex and varied. In the current payment environment, every hospital is paid at a different level for the same services by different payers, and some types of services are reimbursed at rates higher than others.

WARRANTED FACTORS:

Warranted factors should be clearly defined and measureable and not used as proxies for unwarranted factors:

Patient acuity

Prices should reflect whether providers generally care for sicker or more complex patients (e.g., provide tertiary or quaternary care). For inpatient care, the case-mix index may be the most appropriate measure of patient acuity, but further research may be needed to identify the most accurate case-mix adjuster for ambulatory outpatient hospital services. Patient acuity measures should be further reviewed and evaluated with reference to socio-economic factors and in conjunction with evolving scientific and medical developments.

High-cost outliers

Although most payers offer some type of cost-based reimbursement for high-cost outliers, it may also be appropriate for pricing levels to be higher for providers who care for high-cost outliers. For example, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS-DRG payments. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The provider is paid 80% of costs above the fixed-loss threshold. Since outlier cases are unpredictable and outlier payments may not cover the full cost of care, it may be appropriate for pricing levels to be higher for providers who care for a substantial number of high-cost outliers, provided that there is transparency on providers' cost structures. It is important to ensure that this factor is not already incorporated into another factor, such as patient acuity, to avoid the potential for multiple counting of the same elements.

Quality

Providers offering higher quality of care, particularly as measured by clinical outcomes and including measures that capture patient experience/satisfaction, such as willingness to recommend, may receive higher prices to reward this higher value. There may be additional payments or reductions in payments based on performance on a set of quality measures, which should also take into consideration contracts that already provide financial incentives or penalties based on quality. There is agreement

that outcome and patient experience measures should be improved and expanded over time.

FACTORS REQUIRING ADDITIONAL ANALYSIS:

Analysis either by the Health Policy Commission and/or the Center for Health Information to Determine their Impact on Overall Healthcare Costs and Validity as Warranted Measures

Area wages

To the extent providers have different labor costs, driven by labor costs in the region from which they draw employees, prices should reflect those differences. Medicare adjusts its payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital, compared to the national average hospital wage level. The Medicare wage index is revised each year and is based on wage data reported in hospital cost reports, which are publicly available. To avoid circularity, the Medicare wage index uses the average hospital wage levels for all hospitals in a given geographic area or labor market using Core-Based Statistical Areas (CBSAs), as defined by the Office of Management and Budget. There should be greater transparency surrounding providers' cost structures, including the cost of labor, to understand how wages vary among providers, particularly providers in the same geographic region. This information should be available as part of the contract negotiation between payers and providers to justify the influence of this factor in pricing determinations.

Low/no-margin services

Higher prices may also be warranted for providers that provide a higher proportion of services that yield little or no margin but that are demonstrably needed by the community. Margin data for hospitals, however, is not uniform, may be unreliable, and is impacted by allocation decisions at the provider level. Better insight into underlying provider costs is needed to determine whether a service is truly low- or no-margin. A uniform, definitive approach into underlying provider costs is necessary and needs more research by the HPC and the Center for Health Information and Analysis (CHIA) before being considered as a factor.

Teaching

Teaching payments reflect the higher costs providers incur in maintaining a medical education program, beyond the costs accounted for through acuity and outlier adjustments. With any decrease in federal funding provided to Massachusetts by the federal government, shortfalls in federal funding should not be automatically borne by the commercial market. There should be recognition that this is a societal good with benefit for the Commonwealth, and that there needs to be a sustainable appropriate funding mechanism aside from commercial and government payers. CHIA and the HPC should examine the extent of graduate medical education funding in other states as well as whether and to what extent there is an appropriate role for a commercial health plan and/or state government to fund these activities. Further, greater transparency is needed to understand the costs associated with teaching in relation to underlying costs, including lower labor costs associated with residents providing care. Similar to other factors, if teaching is to be considered a

justifiable factor, other factors, such as acuity and outliers, would need to be taken into account, so that there is no duplication in payment factors.

Stand-by capacity

Some hospitals maintain 24/7 stand-by capacity for unique, specialized services that meet recognized community need. Acuity adjustments and outlier payments reimburse providers when a service is utilized by a patient. Standby capacity, on the other hand, is the cost of ensuring that a service is available when needed, regardless of whether it is utilized sufficiently to cover fixed costs. It may be appropriate for prices to reflect the costs of maintaining stand-by capacity for unique and specialized services. It is important, however, to document those services for which costs are not covered and to examine the extent to which the costs of maintaining this capacity are not already reimbursed through higher payments associated with higher patient acuity and/or high-cost outliers. It is also important to note that demand for stand-by care in rural areas may be more variable and therefore justified as a cost of serving the community.

Socioeconomic status of patient population

The resources needed to meet the needs of low-income populations are different than for other commercial sub-populations. Work to date has identified that healthcare costs vary for higher-income populations compared to lower-income populations. Research shows that lower socioeconomic status is associated with higher costs. Additional investigation is needed to determine whether costs relating to socioeconomic status are accounted for in commercial reimbursement rates. If changes are warranted, then work is needed to identify appropriate payment adjustments.

UNWARRANTED FACTORS:

Market power or bargaining clout, brand, and geographic isolation do not warrant price variation and do not provide societal benefits. Potential government payment shortfalls and research do not warrant price variation in commercial rates but do have a societal impact that needs to be recognized.

Factors with no societal impact

Market Power

In this context, market power refers primarily to the negotiating leverage conferred by size or relative market position, compared to payers and other provider organizations. Patient experience/willingness to recommend and provider referral preferences, which are factors that warrant variation, may contribute to a provider's size and brand. Size and brand alone, however, should not be considered a differentiating factor for price variation.

Brand

State reports have found that brand does not correlate to with high performance on a wide variety of quality measures. Although patient satisfaction and provider referral

relationships may contribute to a provider's brand, brand alone should not be considered a differentiating factor for price variation.

Geographic Isolation

Health plan's networks must reflect local geography and demographics to ensure that members have sufficient access to necessary care. However, geographic isolation alone is not a valid factor for price variation. Further, DOI monitors and reviews health plan networks to determine whether members have reasonable and timely access to a broad range of providers and services. In some cases, however, geographically-isolated providers may merit higher prices, if they are the sole provider of low-margin services in their area. This factor, however, should be examined in the context of whether this is already covered by higher payments for wages, standby costs, and other factors referenced above.

Factors with societal impact

Government payment shortfalls

There is a persistent dynamic among governments, providers, and commercial payers (including employers) concerning what constitutes sustainable, appropriate government funding by Medicare, Medicaid, and the Group Insurance Commission. Providers are concerned about possible future reductions in government funding, and have used commercial payments to some degree to balance any difference between payment and the cost of providing care. Payers and employers on the Commission, however, noted that it is not viable to expect commercial payers to automatically make up the difference in any potential government shortfalls. There should be recognition that serving those insured by public payers is a societal need that requires a sustainable government funding mechanism.

Research

Currently, research costs are covered by public funding (e.g. National Institutes of Health), philanthropy, and other private sources. There are differing opinions among Commission members about whether research costs should be included in commercial payment rates. To the extent that maintaining academic research programs may result in costs not covered, and given the economic importance of medical research to the Commonwealth and to patient care, if the current funding model changes, some on the Commission feel a that sustainable and appropriate broad-based funding mechanism is essential. Other Commission members do not believe that commercial health plans and employers should be expected to fund these efforts.

Address “Surprise Billing” and Out-of-Network Issues to Protect Consumers and Support Network Participation

As a key part of an overall strategy to address provider price variation through market mechanisms, the Special Commission on Provider Price Variation applauds the increased use of limited- and tiered-product designs. These products, designed appropriately, can be an important tool to enable patients and consumers to have the benefit of lower-cost coverage options, promote high-value providers, and help address price variation.

Certain issues concerning these types of plans, however, merit a strong recommendation for legislative action. These issues occur when patients receive care out-of-network and then receive what is sometimes called a surprise bill. There are two situations in which this occurs. First, the patient is cared for by a non-participating provider in an emergency. Second, the patient is cared for without his or her knowledge by a non-participating provider at an in-network facility. For example, a patient is scheduled for surgery with a participating surgeon but receives services from a non-participating anesthesiologist, pathologist, or radiologist. In this situation, the patient did not know or make a decision to see the non-participating provider. Out-of-network billing must be addressed so that patients are protected and payers are able to develop innovative plans.

The following issues must be addressed and resolved together as a package, since the absence of any one solution will lead to inappropriate results.

1. Consumer awareness of “surprise billing” scenarios,
2. Patient protections to prevent balance-billing, and
3. A maximum reasonable provider reimbursements for out-of-network services.

1) CONSUMER AWARENESS

Health plans educate patients on the benefits of in-network care and the risks of receiving care out-of-network. Toll-free member service lines, Explanation of Benefits guidance, and cost estimation tools are all used to demonstrate that no network is all-inclusive. Planned out-of-network care or inadvertent leakage can lead to additional costs for the consumer and the healthcare system.

Massachusetts should adopt additional member protections – similar to measures adopted by California, Connecticut, and New York – that define specific surprise bill and non-surprise bill scenarios, including a reminder that patients can be billed when they knowingly choose to receive services from a provider that is not participating in their health plan. Providers should inform patients when the patient is going to be cared for by a non-participating provider. Likewise, health plans should assist their members in determining which physicians and hospitals are in- or out-of-network.

2) PROTECTING PATIENTS FROM BALANCE BILLING

Effective balance-billing prohibitions are necessary to protect patients. Massachusetts should enact into law prohibitions on patients being billed by providers for the portion of their care not covered by their insurance plan. This patient protection should only apply when a patient receives emergency services (emergency room and any associated admission or care) or a non-participating provider provides care in a participating hospital or facility. If a member decides to seek care out-of-network, no protection should be implemented, since patients should appropriately bear the risk of a planned decision.

One possible model for adoption in Massachusetts is the National Association of Insurance Commissioners (NAIC) model act. It has comprehensive requirements on

network adequacy and would give DOI sufficient authority to determine whether a network is adequate, by providing quantitative standards.

3) ESTABLISHING AN OUT-OF-NETWORK PAYMENT RATE

There was consensus among Commission members that establishing a default rate of payment for services rendered out-of-network is a critical part of any recommendation. This protection is particularly important for incenting the creation of robust networks necessary for novel insurance product designs that can help address provider price variation.

In setting a maximum reasonable price for out-of-network services, the state should adhere to the following key principles. First, the overall impact should result in cost savings to consumers and employers and have minimal additional administrative expense to both providers and payers. Second, there should be a reasonable, transparent, and simple approach to applying a rate, not a cumbersome metric that is non-transparent or easily administered. Finally, any rate should ensure that current in-network participation levels by providers are improved upon. The set rate must not inadvertently be at such a high level as to entice providers to leave a network, or at such a low level as to make a health plan indifferent as to whether the provider is in- or out-of-network.

Commission members examined the following two scenarios in detail:

1. The patient receives emergency care from a provider participating in a health plan's broad network but that provider has either opted out of or not been selected for participation in a tiered- or limited network product; or
2. The patient receives care in a contracted facility from a physician that is not contracted with the health plan (e.g. Emergency, Radiology, Anesthesia, and Pathology [ERAP]).

Scenario 1: A provider's payment for emergency out-of-network services, as described above, should be set at its currently-contracted rate with that health plan or at a level slightly above that rate (e.g., 10%). The rate should be set by statute to ensure both easy administrative processing and regulatory certainty in the marketplace. The HPC, or other appropriate state entity, should convene a workgroup of interested parties for the specific and time-sensitive purpose of drafting recommendations on this rate, to be filed with the legislature. A statutorily set rate should incent robust network development, as well as significantly lower the cost of care.

Scenario 2: Where a provider does not have a contract with the health plan, the default rate should be at a level significantly below charges but not below Medicare. The appropriate entity should convene a workgroup of interested parties for the specific and time-sensitive purpose of advising the HPC so that it can draft recommendations on this rate, to be filed with the legislature. Like the prior scenario, this rate should be codified in statute in such a manner as to incent robust network development, as well as significantly lower the cost of care.

Tiering Transparency and Participation

The Special Commission on Provider Price Variation endorses the need for improved transparency regarding the provider tiering by health plans. Health plans and providers should collaborate to facilitate further offerings of tiered- and limited-network products as an important option for consumers and employers.

TIERING DISPLAY

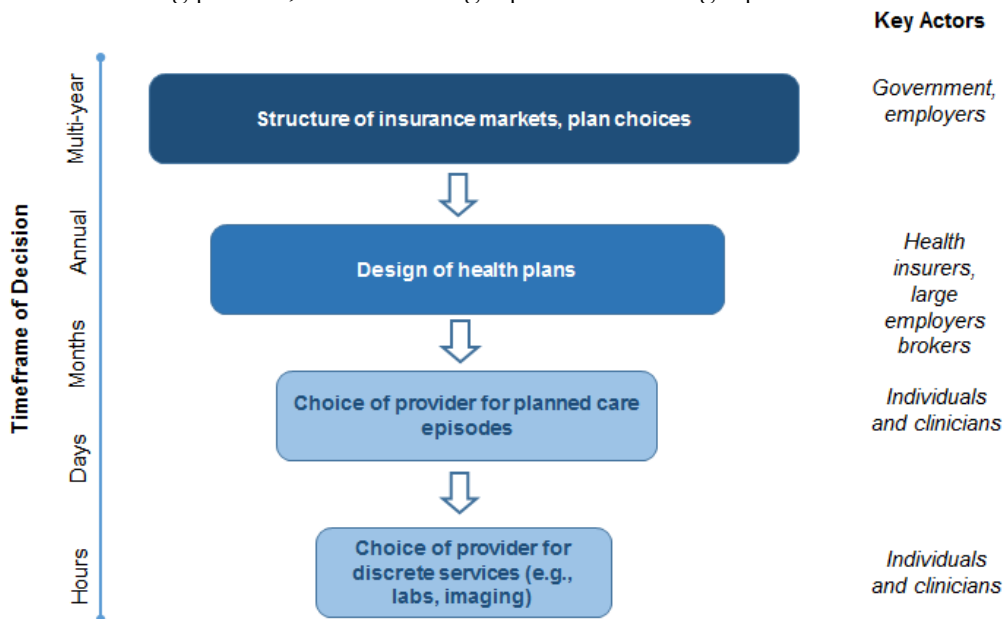
Health plans should develop a uniform method for displaying a hospital's assigned benefit tier so that information on how the hospital performed on cost and quality benchmarks is presented in a consumer-friendly format for patients and providers.

TIERING TRANSPARENCY

Upon request by a hospital, health plans should provide the methodology used for a hospital's tier placement, including the criteria, measures, and data sources, as well as hospital-specific information used in determining the hospital's quality score, how the hospital's quality performance compares to other hospitals, and the data used in calculating the hospital's cost-efficiency.

TRANSPARENCY

These recommendations are designed to improve transparency at each point in the decision-making process, from selecting a plan to choosing a provider.



¹ This chart is based off a visual created by the Health Policy Commission presented by David Auerbach at a meeting of the Special Commission on December 13, 2017.

These recommendations were guided by the following principles:

1. The definition of transparency is broader than price comparisons at the point-of-service, because efforts to implement transparency solely at this point in the decision-making process have been met with limited success.
2. The opportunity and challenge of improving transparency should affect each sector of the industry and occur at each decision-point along the continuum, recognizing differences within sectors (e.g. small- and large-group insurance market; large and small employers; specialty hospitals/surgical centers and academic medical centers).
3. Efforts to improve transparency should not add to the administrative and financial burden on small businesses in the Commonwealth.
4. Transparency for transparency's sake is not the goal. Tools must be developed that educate and inform insurers, employers, providers, and patients about the fiscal and clinical implications of product design, network access, out-of-pocket expenses, and other considerations.
5. Wherever possible, these recommendations seek to further explore, support, and enhance existing legislative and regulatory mechanisms to improve transparency.
6. Elements of successful transparency efforts in other states (e.g., New Hampshire website) should be adopted.
7. Effective transparency tools must include quality as well as cost information. The quality data should be as granular as possible where it exists and should reflect developments in quality measurements. Standard quality metrics should be developed to provide consistency and support improved quality.
8. Transparency tools need to adapt continually to be relevant.

Transparency Website

As mandated by Chapter 224 of the Acts of 2012, CHIA will establish a consumer website. The development of this website will be informed by a thorough stakeholder process and the principles articulated above and take into account the following recommendations.

- CHIA will release a beta site by July 1, 2017, with a focus on supporting consumers and small business owners.
- CHIA will create an educational platform to provide information along the decision point continuum, including publishing a multi-payer weighted average price for a market basket of “shoppable” services. This will likely require payers to provide pricing information.
 - Full transparency includes specific information about access to behavioral and substance abuse services, drug formularies, and other costs, which can be opaque to employers and employees when selecting plans.
- There shall be a strong partnership between CHIA, the Commonwealth Connector Authority (Health Connector), the HPC, and the Group Insurance Commission to leverage work already complete or underway and to ensure consistent methodology and analytics.

- When consumers seek information on out-of-pocket costs, the website will direct consumers to their insurer's website, wherever possible.
 - Interactive decision-tree tools should be developed to inform consumers and employers about the ramifications of their plan choice; for example, how choosing a tiered network impacts the patient's choice of hospital.

Support for Small Employers

Small businesses should be additionally supported through the following actions:

1. When considering the user requirements for its website, CHIA should place specific emphasis on interactive decision tools and educational materials to support consumers and small business owners who may not have access to data or expertise.
2. DOI should prioritize implementation of the Ch. 224 mandate to create standardized, understandable, and timely explanation of benefits forms that includes information about lower-cost alternatives.
3. The Commonwealth should pursue opportunities to improve the purchasing power of smaller businesses and consider Professional Employer Organizations (PEOs), as allowed.
4. Insurers and small employers should work together to develop tools for employers to understand trends within their insured population, while protecting the privacy of individuals.

STATE MONITORING

These recommendations were guided by the following principles:

1. Unwarranted provider price variation is a problem in Massachusetts.
2. There are providers that are being greatly underpaid due to unwarranted factors, just as there are providers being overpaid based on unwarranted factors. Underpayment and overpayment are both signs of market failure and are equally problematic.
3. Ensuring access to efficient and affordable healthcare in the community requires that providers are fairly paid according to warranted factors.
4. Short term differential (preferential) investments may be required.
5. Policies to address unwarranted variation in prices should not increase total healthcare spending in the Commonwealth.
6. The Commission recognizes the importance of innovation that drives patients to high-quality, low-cost providers.

Compression of Provider Rates

The Special Commission recommends a direct, multi-component proposal with a date-certain implementation and a mechanism for periodic review to address unwarranted price variation. The proposal aims to promote price compression in Massachusetts for providers in both single- and multi-year contracts. The

components authorize a state entity to disapprove payer-provider contracts and/or allow for differential growth rates for hospitals whose prices are subject to the influence of unwarranted factors, and ensure that hospitals subject to the most significant levels of underpayment get immediate relief. This proposal aims to hold both payers and providers accountable for ensuring the compression of provider rates. The Commission recommends that Part 1 & Part 2 be implemented together to address disparities in payment.

PART 1: REGULATE GROWTH IN RATES

The Special Commission recommends, in order to control overall healthcare costs, to compress overall provider prices, and enable the establishment of a minimum or floor as described in Part 2, that the state implement one or both of the following. The Commission recognizes that these two actions taken together would make the most meaningful impact on provider price variation.

- An enhanced role for the appropriate state entity, such as DOI or the HPC, to review and approve insurance contracts using unwarranted and warranted factors in provider payments, such as those found in Recommendation #1. Payer-provider contracts may be reviewed, and keeping in mind the administrative burden on all stakeholders, the appropriate entity will more closely examine those contracts where providers receive relatively high or low rates (outlier contracts), as defined by the legislature. Contracts with rates based on unwarranted factors will be subject to disapproval. The state entity should utilize these factors to close the gap between high-cost outliers and more efficient, lower-reimbursed, high-value providers, and ensure that plan designs are promoting high-value providers and helping to control the growth in statewide healthcare costs.
- Overall, growth in provider rates in Massachusetts would be consistent with the statewide benchmark on total spending growth. The rate of growth in prices for individual providers or groups of providers would be designed such that providers with low commercial prices would be able to increase their rates more rapidly than providers with high prices due to unwarranted factors.

The implementing state entity shall take measures to protect consumers and address any potential for disruptions in care. The appropriate state entity shall ensure that any savings above those needed to implement Part 1 and Part 2 is returned to employers and consumers through premium relief, while also re-allocating some savings to high-value/efficient providers in an effort to achieve the goal of compressing price variation while also lowering overall TME.

PART 2: RATE MINIMUM OR FLOOR FOR COMMUNITY HOSPITALS

In order to correct for apparent underpayment, the Commission recommends a minimum rate or floor for hospitals in Massachusetts. This floor should take into account the limits set in Part 1, ensuring premiums do not increase for consumers and employers, and warranted and unwarranted factors for price variation. The formula should be determined by the legislature in conjunction with appropriate state entities.

Monitoring Patterns of Utilization

The HPC shall track patient movement across various providers in the state and assess the impact of that movement on statewide cost and quality (e.g. leakage or patient migration between community hospitals and academic medical centers). This information will help evaluate the impact of tiering, better inform the HPC's review of mergers and acquisitions in the Commonwealth, and potentially assist in driving appropriate care to community hospitals.

Meaningful Consumer Incentives

The HPC, DOI, and other appropriate state entities should take measures to encourage the use of more meaningful consumer incentives to promote high-value choices including, but not limited to, contribution policy, increasing price differentials among tiers, increasing the premiums between limited- and tiered-network plans and broader commercial plans, tiering plans based on primary care provider, and other efforts to enhance consumer choice through innovative product design. Current insurance constraints on limited- and tiered-network plans should be revisited and possibly relaxed, to encourage uptake and adoption.

Total Medical Expense (TME)

The Commonwealth shall continue to refine its methodology to measure TME in order to better capture the healthcare market.

INTRODUCTION

The *Massachusetts Fair Health Care Pricing Act*, an initiative filed in 2016 but not included on the ballot, would have set a floor and ceiling on commercial payments to certain healthcare providers.¹ In May 2016, the Massachusetts Legislature passed *An Act Relative to Equitable Health Care Pricing* to further explore the issues of healthcare pricing and rising healthcare costs.² In addition to creating a \$45 million fund to be distributed to lower-priced hospitals over five years,³ the Act establishes a Special Commission on Provider Price Variation.⁴ The Commission, a twenty three-member group consisting of legislators, insurers, providers, employers, and other stakeholders, must identify acceptable and unacceptable factors contributing to price variation, examine price variation in other states, and review certain payer-provider contracting practices.⁵ The Act requires the Commission to release a final report, including steps to address unwarranted price disparities, by March 15, 2017.

The Commission focused its work according to the following mission statement:

The purpose of this Commission is to substantially advance the dialogue on provider price variation in Massachusetts and to make recommendations to address unwarranted price variation, where appropriate. Commission members have been chosen because of their unique perspectives, backgrounds, and expertise. Over the course of several meetings, the Commission shall examine a range of factors that affect provider payment rates and shall discuss both unwarranted and warranted variation. In addition, the Commission shall investigate transparency initiatives, explore possibilities to foster greater competition in the market, and discuss ideas related to state monitoring that could alleviate unwarranted price variation. The Commission shall report on the results of its discussions.

The Special Commission held nine public meetings between September 2016 and March 2017. Each meeting focused on a specific topic, informed by the Special Commission's statutory charge.⁶ After establishing a work plan in the first meeting,

¹ The language of the ballot initiative was also filed as legislation in 2015 by Senator Benjamin B. Downing. See S.574, 2015-2016 Sess. (Mass. 2015), "An Act relative to Equitable Health Care Pricing."

² H.4348, 2015-2016 Sess. (Mass. 2016).

³ 2016 Mass. Acts 115, § 4 (2016).

⁴ The Massachusetts Legislature previously authorized a commission on provider price reform under Chapter 288 of the Acts of 2010. See 2010 Mass. Acts 288, §67. The Commission published its report on November 9, 2011. Another commission was created under Chapter 224 of the Acts of 2012 but was never convened. See 2012 Mass. Acts 224, § 279.

⁵ 2016 Mass. Acts 115, § 9.

⁶ Id.

members spent the second and third meetings discussing acceptable and unacceptable factors for commercial rate variation. Members examined these factors in the context of Medicaid and Medicare, to understand how programs with uniform payment schemes take into account the characteristics of different providers. Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management at Harvard University, gave an overview of Medicare's reimbursement methodology. Matthew Klitus, the Chief Financial and Strategy Officer at MassHealth, spoke to members about MassHealth's payment system.

In the following four meetings, the Special Commission engaged in action-oriented discussions about payer-provider contracting and market forces, plan design and consumer incentives, price transparency, and state monitoring. At the fourth meeting, Professor Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, spoke about payer-provider contract negotiations, provider competition, and the impact of market forces on price variation. At the fifth meeting, the Special Commission discussed plan design and other levers to incentivize consumers to make high-value choices. David Auerbach, the Director for Research and Cost Trends at the Massachusetts Health Policy Commission, described how these demand-side incentives may indirectly reduce price variation.

At the sixth meeting, Katherine Baicker, the C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health, presented on price transparency and price variation, including how patients respond to price transparency initiatives. In the seventh meeting, Special Commission members heard from Kathleen Hittner, the Health Insurance Commissioner for the state of Rhode Island. Commissioner Hittner discussed regulations in Rhode Island that aim to reduce price variation, address rising healthcare costs, and foster delivery system innovation. Professor Majette, Robert Berenson, Institute Fellow at the Urban Institute, and Paul Ginsburg, the Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution, attended the eighth meeting to engage with members regarding the final recommendations. In the ninth meeting, members reviewed a draft report and made final comments.

To facilitate the work of the Special Commission, the Chairs, Representative Jeffrey Sánchez and Senator James Welch⁷, created three subcommittees: Market Forces, State Monitoring, and Transparency. The subcommittees enabled Commission members to both continue the dialogue between meetings and advance conversations about provider price variation at subsequent Commission meetings. Led by subcommittee chairs, each subcommittee met a minimum of three times. In these public meetings, subcommittee members delved into their respective topics and drafted preliminary recommendations.

Chairman Sánchez and Chairman Welch recognized that the work of the Special Commission on Provider Price Variation affects all citizens in the Commonwealth,

⁷ Representative Jeffrey Sánchez and Senator James Welch are the House and Senate chairs of the Joint Committee on Health Care Financing.

including Massachusetts residents concerned with rising healthcare costs. Therefore, in addition to the Commission and subcommittee meetings, the Chairs held a public listening session. This session allowed members of the public and stakeholders not represented on the Commission to share their perspectives. The session was well attended and many that testified submitted written testimony (See Appendix E).

This comprehensive report on provider price variation in Massachusetts is the product of these efforts. The report builds upon analyses of price variation by the Office of the Attorney General, the Health Policy Commission, and the Center for Health Information and Analysis. It takes into account feedback from all stakeholders, including Commission members and those testifying at the public hearing.

Chapter 1 provides a background on price variation in Massachusetts and nationally. Chapter 2 examines a variety of warranted and unwarranted reasons for price variation, in the context of Medicare, MassHealth, and state rate-setting systems. Chapter 3 examines payer-provider contracting practices and healthcare market forces. Chapter 4 defines and explores demand-side incentives, including where and when demand-side incentives can be used to encourage consumers and employers to make high-value choices. Chapter 5 discusses the role of price transparency. Chapter 6 analyzes the potential for state monitoring and intervention to address provider price variation.

This report is published at a challenging time for Massachusetts, given the uncertainty over the future of Medicaid and the Affordable Care Act. Even in this ambiguous federal policy environment, the Chairmen and all members of the Special Commission on Provider Price Variation are pleased to present these recommendations, and are optimistic that this report will further state efforts to address healthcare costs, quality, and access.

CHAPTER 1 – PROVIDER PRICE VARIATION IN MASSACHUSETTS AND NATIONALLY

INTRODUCTION

Massachusetts is a health policy innovator and a national leader in ensuring access to affordable care. As part of this commitment, three state entities collect and report on a wealth of data from payers and providers, including healthcare claims, costs, relative prices, medical expenses, and other relevant data.¹ This information, which forms the basis of this report, enables the Commonwealth to analyze trends in the healthcare sector, including provider price variation.

Section I of this chapter provides background on price variation metrics and reporting in Massachusetts. Section II analyzes trends in price variation from 2008 to the present. Section II also identifies hospital characteristics that correlate with high prices. Section III examines the direct and indirect effects of price variation in Massachusetts. Finally, Section IV compares price variation in Massachusetts with price variation in other states in the region and across the United States, including variation in prices paid for specific services.

SECTION I: PRICE VARIATION METRICS AND REPORTING IN MASSACHUSETTS

The Center for Health Information and Analysis (CHIA) collects information² from payers to generate two metrics on healthcare sector performance: provider relative price (RP) and total medical expense (TME).³ Relative price is an aggregate measure of all prices paid to a provider,⁴ in relation to the average price paid to all providers in that payer's network. Hospital inpatient and outpatient relative prices may be calculated separately or as one "blended" relative price, the overall price level for that hospital. By definition, a payer's average RP is 1.0. This means that a provider with an inpatient RP of 1.2, for example, is paid on average 120% of that payer's average price for inpatient services. Because an RP of 1.0 represents a different dollar amount for each payer, relative price values are not comparable across payers.⁵ Relative price considers the full range of prices, so in some circumstances it is also helpful to consider variation between .8 and 1.2 RP. For some payers, the majority of hospitals are within this range; for other payers, there is a wider spread (See Figure 1.1).

¹ MASS. GEN. LAW ch. 12C, § 16 (2016).

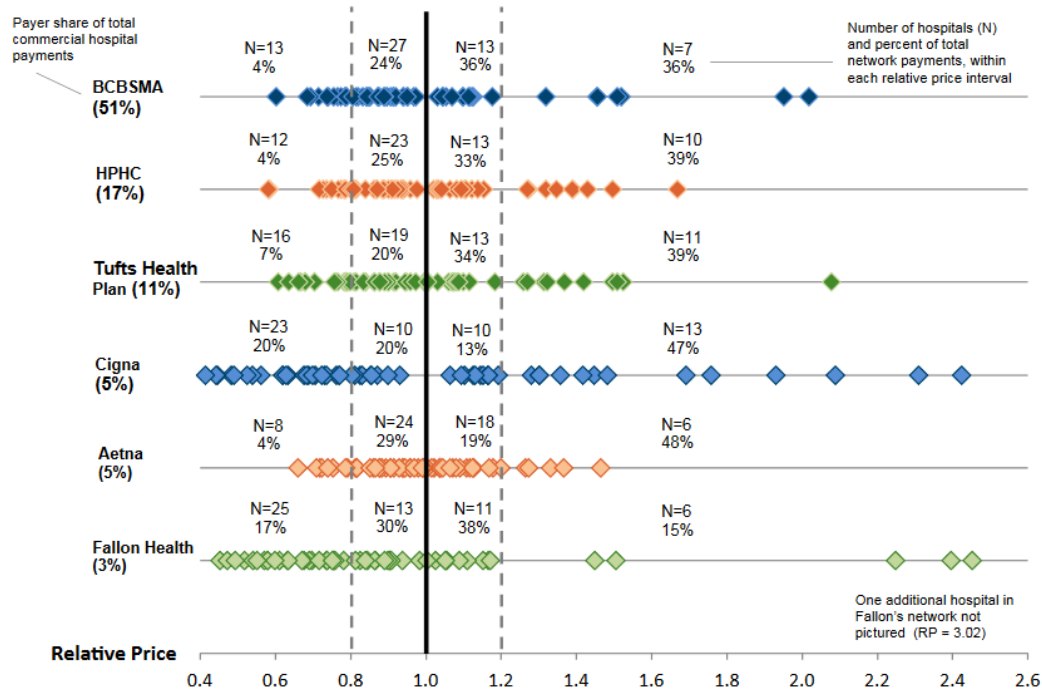
² This information includes provider claims, member cost-sharing payments to providers, and all non-claims related payments to providers, such as those made under alternative payment methodologies.

³ These measures are the basis for price variation analyses and are referred to throughout this report.

⁴ Providers are compared by category: hospitals, physicians, other groups.

⁵ Center for Health Information and Analysis, *Methodology Paper: Relative Price* (Boston, MA, September 2016).

Figure 1.1: Distribution of Acute Hospital Blended Relative Price by Payer, 2014⁶

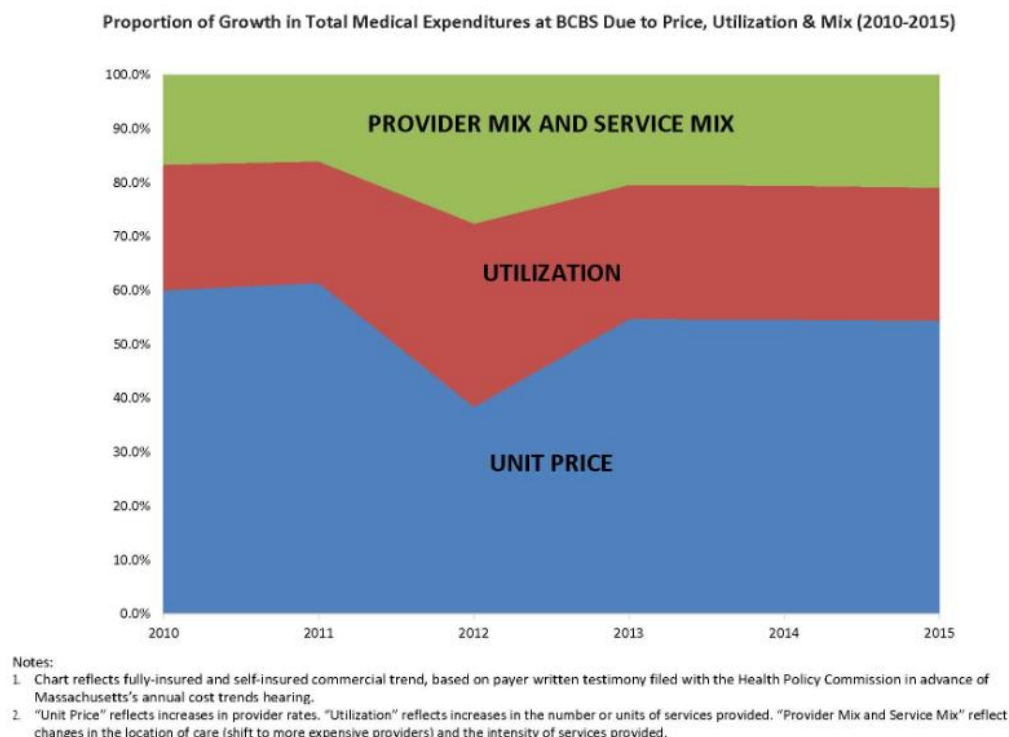


CHIA recently finalized its methodology for calculating a statewide RP value for acute care hospitals.⁷ This allows for a comparison of RP across payers. Collecting information on prices is important because approximately 50% of spending growth in Massachusetts is typically explained by growth in unit prices (See Figure 1.2).

⁶ Center for Health Information and Analysis, *Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market* (Boston, MA, February 2015), slide 6. The graph includes the top six commercial payers ranked by share of total payments.

⁷ MASS. GEN. LAW ch. 29, § 27TTT (2016); Center for Health Information and Analysis, *Methodology for the Calculation of Statewide Relative Prices* (Boston, MA, January 2017).

Figure 1.2: Proportion of Growth in Total Medical Expenditures at Blue Cross Blue Shield, 2010-2015⁸



While RP tracks prices, TME tracks prices and utilization: the total amount paid to providers, both by patients and insurers, for all services. This measure is reported on a per-member-per-month (PMPM) basis. For providers, TME is currently only calculated for primary care provider (PCP) groups.⁹ It represents all spending for all healthcare providers that a patient uses, which is then attributed back to that patient's PCP group.¹⁰ CHIA standardizes and adjusts RP and TME to account for differences among providers in the quantity and types of services provided, the types of insurance products offered by the payer to the provider, patient case mix/health status, and any other unique factors that apply to a given provider's payment history.¹¹

In addition to CHIA, two other state entities monitor healthcare market trends, including provider price variation. The Office of the Attorney General (AGO) uses

⁸ Updated graphic provided to Health Care Financing staff by the Office of the Attorney General, November 7, 2016.

⁹ There is no TME figure for other types of providers, like hospitals or specialist physicians. In other words, a patient's spending on hospital care is included in the TME for that patient's PCP group, regardless of whether the hospital is affiliated with the PCP group.

¹⁰ Center for Health Information and Analysis, *Annual Report on the Massachusetts Health Care System, Supplement 5: Managing Physician Group Total Medical Expenses and Quality* (Boston, MA, September 2014).

¹¹ Id.; Center for Health Information and Analysis, *Methodology Paper*, supra note 5.

its authority to interview relevant stakeholders and subpoena information from payers and providers, including contract documents and cost data. The AGO relies on this information, along with CHIA data, to publish reports examining cost trends and drivers.¹² The Health Policy Commission (HPC) is an independent agency that monitors the Commonwealth's healthcare payment and delivery systems.¹³ The HPC holds annual public hearings and requires testimony under oath on cost and price trends, including factors that contribute to cost growth.¹⁴ The HPC uses this testimony, CHIA data, and data from other sources to annually report on healthcare cost trends and the drivers of healthcare spending.¹⁵ The data in this report are taken from these and other applicable sources.

SECTION II: MASSACHUSETTS TRENDS IN PRICE VARIATION

Beginning with the AGO's 2010 examination on cost trends and drivers, successive reports by the AGO, the HPC, and CHIA conclude that price variation exists in Massachusetts. The 2010 report examines commercial health plan payments to health care providers.¹⁶ The AGO collected data from five major Massachusetts payers and 15 providers, including academic medical centers (AMCs), teaching hospitals, community hospitals, disproportionate share hospitals (DSH), physician groups, and one ancillary service provider.¹⁷ The report documents that in 2008, the differences in relative payments to hospitals¹⁸ within the networks of the three largest Massachusetts insurers, Blue Cross Blue Shield (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP), were approximately 0.75 – 1.4, 0.4 – 1.6, and 0.6 – 2.0, respectively. This means that the differences in payments made by those insurers to the lowest-paid versus the highest-paid hospitals were 90%, 300%, and 240%, respectively.¹⁹ The report also finds wide variation in physician prices: 224% for BCBS and approximately 130% for both HPHC and THP.²⁰ The report concludes that there is significant variation in payments made to hospitals and

¹² MASS. GEN. LAW ch. 12, § 11N (2016).

¹³ MASS. GEN. LAW ch. 6D, § 5 (2016).

¹⁴ § 8.

¹⁵ Id. In its 2015 Cost Trends Report, the HPC also did an original multivariate analysis of the factors correlated with higher relative prices and issued a standalone report on provider price variation. See Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2016).

¹⁶ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing* (Boston, MA, March 16, 2010), 6 [hereinafter Office of the Attorney General, *Examination 2010*].

¹⁷ Id. at 6. CHIA defines academic medical centers as principal teaching hospitals with case mix intensity greater than 5% above statewide average, extensive research programs, and extensive resources for tertiary and quaternary care. Teaching hospitals are non-AMC hospitals that report at least 25 full-time equivalent medical school residents per 100 inpatient beds. Community hospitals are non-teaching hospitals with a public-payer mix of less than 63%. DSH hospitals are teaching or community hospitals with a public-payer mix of 63% or more. Health Policy Commission, *Provider Price Variation*, supra note 15, at 4.

¹⁸ Prior to the passage of Chapter 224, there was no standardized methodology for relative price. The AGO's 2010 report calculates "payment relativity"; this metric that is comparable to relative price. Office of the Attorney General, *Examination 2010*, supra note 16, at General Appendix, 1.

¹⁹ Id. at 10-12.

²⁰ Id. at 12-15.

physician groups that are providing the same services within the same geographic area. The report finds further that hospital and physician variation was relatively stable between 2004 and 2008.²¹

Recent reports by the AGO, the HPC, and CHIA²² reinforce these original findings. The reports have consistently documented that “the extent of variation and the distribution of hospital prices have been generally consistent since 2010, and that variation in physician prices has increased somewhat since 2009.”²³ For example, between 2010 and 2014, BCBS consistently paid the highest-priced hospitals 2.5 to 3.4 times more than the lowest-priced hospitals for the same set of services. The same pattern was true for HPHC and THP.²⁴ This stable trend in hospital price variation has also persisted for prices paid to physician groups between 2009 and 2013. HPHC paid its highest-priced groups 2.26 to 3.32 more than the lowest-priced groups, with similar trends for BCBS and THP.²⁵ Mirroring the trend in relative price, there is also persistent variation in physician organization budgets. For example, for one large commercial carrier in 2013, health-status adjusted PMPM payments ranged from approximately \$370 to \$515. Incentive payments varied as well.²⁶

These reports identify additional key characteristics of provider price variation in Massachusetts. First, there is little change in each provider’s relative price year over year.²⁷ This means that the same providers consistently receive higher payments. Second, there is significant variation in both fee-for-service rates and global budgets.²⁸ Third, hospital prices vary significantly within hospital cohorts (See Figure 1.3).²⁹ Finally, there tends to be higher price variation within the networks of smaller payers; therefore, the reports may underestimate the full extent of variation.³⁰

²¹ Id. at 15-16.

²² See Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, September 18, 2015) [hereinafter Office of the Attorney General, *Examination 2015*]; Health Policy Commission, *Provider Price Variation*, supra note 15; Center for Health Information and Analysis, *Health Care Provider Price Variation*, supra note 6.

²³ Health Policy Commission, *Provider Price Variation*, supra note 15, at 2.

²⁴ Id. at 6-7.

²⁵ Id. at 8.

²⁶ AGO, *Examination 2015*, supra note 22, at 18. This percentage is derived from data listed in the report.

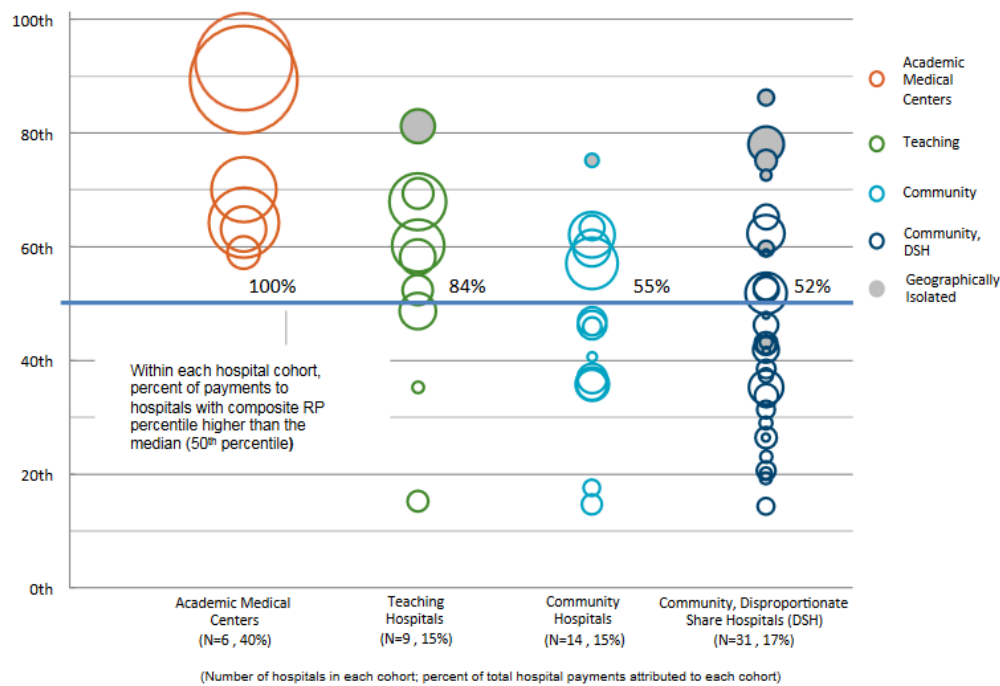
²⁷ Id. at 19; Health Policy Commission, *Provider Price Variation*, supra note 15, at 6-8.

²⁸ Health Policy Commission, *Provider Price Variation*, supra note 15, at 5. Data indicate that fee-for-service rate differentials have been baked in to global budgets. Id.

²⁹ Id. at 4.

³⁰ Id.

Figure 1.3: Acute Hospital Blended Relative Price by Cohort, 2014³¹



The AGO, CHIA, and the HPC have also examined provider characteristics that correlate with higher prices. The AGO’s 2010 report was the first to outline which factors do *not* correlate with or adequately explain high hospital prices. These factors include high input costs, patient acuity, and quality performance, as determined by process of care, outcomes, efficiency, and patient experience metrics.³² Instead, this and successive reports conclude that high prices correlate with market power or market leverage, defined broadly by the AGO as “the ability [of a provider] to influence the other side during negotiation.”³³ Provider leverage impacts the market significantly when an insurer cannot credibly threaten to exclude a provider from its network.³⁴ When the insurer cannot “walk away from the table,” the provider has greater leverage to demand higher prices. This is why higher prices are also correlated with the size of the hospital system, the level of hospital competition, whether or not the hospital provides certain specialized services, and the identity of

³¹ Center for Health Information and Analysis, *Relative Price*, supra note 6. Composite RP percentile for each hospital is equal to the simple average of all payers’ blended RP percentiles for that hospital. “Blended” denotes that inpatient and outpatient RP results are combined. Circles are sized according to hospitals’ shares of total hospital commercial payments. Grey color denotes geographically isolated hospitals, where the provider is the sole acute hospital within a 20-mile radius. Six hospitals were omitted because they deliver care to specific patient populations, based either on age or type of medical condition. These specialty hospitals are not considered comparable with other cohorts. Hospitals shown accounted for 87% of total hospital payments in 2014. For the RP for all acute hospitals in Massachusetts, see Appendix B.

³² AGO, *Examination 2010*, supra note 16, at 16-28.

³³ Id. at 28.

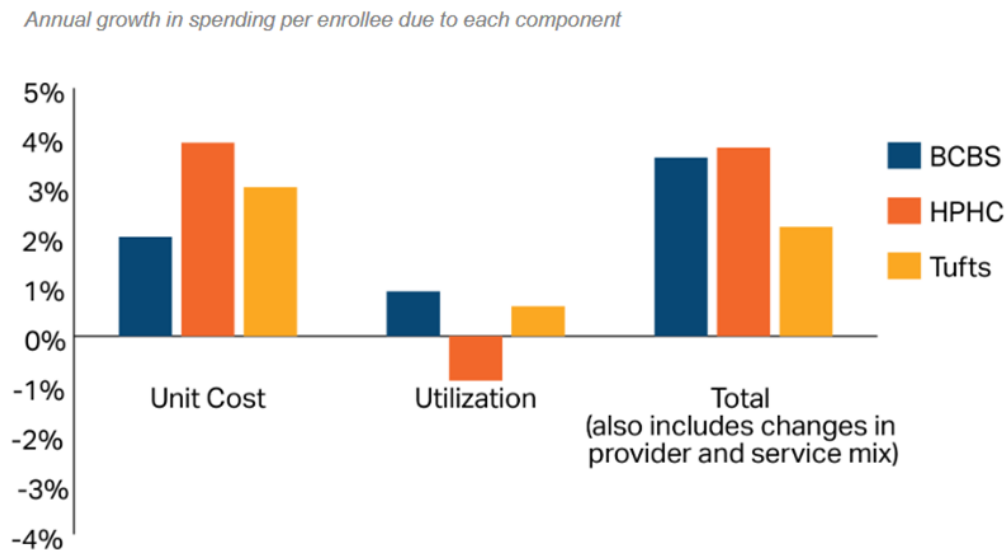
³⁴ Health Policy Commission, *Provider Price Variation*, supra note 15, at 1.

the affiliated hospital system (reflecting brand as well as other characteristics).³⁵ Hospitals that treat a greater percentage of Medicare and Medicaid patients (and, as a result, have a smaller proportion of commercial patients) also tend to receive relatively lower commercial rates.³⁶ Chapter 3, *Contracting and Market Forces*, further explores the relationship between lack of competition and higher relative prices.

SECTION III: DIRECT AND INDIRECT EFFECTS OF PRICE VARIATION IN MASSACHUSETTS

Healthcare spending is a function of price (how much reimbursement a provider receives for a given service) and utilization (how many units of that service are provided). The AGO and the HPC have determined that increases in prices, not utilization, primarily drive growth in total healthcare spending.³⁷ For this reason, the direct result of provider price variation is an increase in total healthcare costs (See Figure 1.4; see also Figure 1.2).³⁸

Figure 1.4: Unit Price Drives Spending Increases, 2014-2015³⁹



An indirect but related effect of price variation is its impact on hospital service mix. According to an HPC survey, many patients believe that brand and higher cost

³⁵ Id. at 11-14. As used here, “brand” refers to affiliation with certain health systems and/or good reputation independent of high performance on quality metrics.

³⁶ Id. at 11.

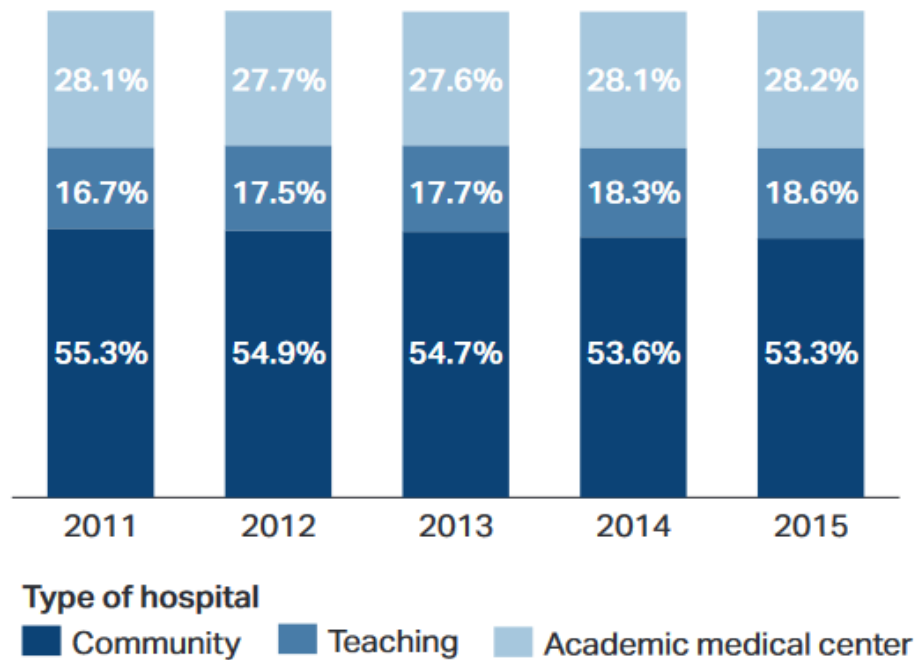
³⁷ AGO, *Examination 2010*, supra note 16, at 35-38; Zach Cooper, et. al., *The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured* (Health Care Cost Institute, May 2015), 2-3.

³⁸ Health Policy Commission, *Provider Price Variation*, supra note 15, at 9. This assumes that any decrease in growth rates for non-dominant providers does not fully offset the increase in total cost growth caused by high payments to dominant providers.

³⁹ Health Policy Commission, *Annual Health Care Cost Trends Hearing* (Boston, MA, October 17, 2016), slide 15, available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/cth16-presentation.pdf>.

indicate quality.⁴⁰ Therefore, patients may gravitate toward seeking care at higher-priced institutions, leading to higher total costs.⁴¹ Figure 1.5 illustrates this trend: year over year, Massachusetts AMCs continue to provide nearly 30% of community-appropriate care (See Figure 1.5).⁴²

Figure 1.5: Share of Community Appropriate Discharges by Hospital Type, 2011-2015⁴³



Note: Discharges which could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs).

Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

Furthermore, this shift in volume enables higher-paid hospital systems to invest in capital improvements. New services and improvements improve quality in some circumstances; in others they tack on “bells and whistles,” further shifting patient

⁴⁰ Health Policy Commission, *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Boston, MA, 2016), 40.

⁴¹ Further discussions of patient behavior can be found in Chapters 4, *Demand-Side Incentives*, and Chapter 5, *Transparency*.

⁴² Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 49. Community-appropriate care is care that can be safely and effectively delivered in a community hospital, as opposed to a teaching hospital or AMC. All AMCs have relative prices that exceed the network median across all payers. See Figure 1.3.

⁴³ Id.

volume without improving patient care.⁴⁴ Even absent price increases, shifts in volume to higher-priced institutions increase spending.

In addition to increasing total costs, shifts in volume may threaten the financial stability of non-dominant hospitals. The HPC's report on community hospitals notes that any further shifts in commercial patient volume may lead to community hospital closures. When a lower-priced community hospital closes, the patients that sought care at that hospital might be forced to visit a higher-priced hospital. This increases total spending.⁴⁵ It is important to acknowledge, however, that increases in commercial prices alone may not shore up certain hospitals, particularly those that treat a relatively small proportion of commercially-insured patients. Reducing price variation, however, would to some extent improve the financial position of these hospitals.⁴⁶ In addition, it should be noted that for many residents in the Commonwealth, including those living in Boston, Worcester and Springfield, an AMC or teaching hospital is their community hospital. For these residents, care delivered at these hospitals might be considered appropriate.

SECTION IV: PRICE VARIATION IN OTHER STATES AND NATIONALLY

Provider price variation is not unique to Massachusetts.⁴⁷ New York, Rhode Island, Vermont, and New Hampshire have all published reports on the causes and extent of provider price variation within their borders.⁴⁸ All reports conclude or assume that high prices are correlated with a provider's position within the healthcare market, which the reports define in terms of size, competitive position, and/or brand. Although these studies were designed differently and use slightly different methodologies, the results are informative.⁴⁹ The New York report concludes that depending on region, in 2014 the highest-priced hospitals were paid blended prices 150% to 270% more than the lowest-priced hospitals.⁵⁰ The Rhode Island report determines that in 2010 its highest-paid hospital received rates that were 210% more for inpatient care and 73% more for outpatient care.⁵¹ The Vermont report finds that in 2012 its highest-paid hospital was paid 180% more for inpatient care.⁵² Finally, the New Hampshire report finds that in 2009 its highest-paid hospital was paid 217%

⁴⁴ AGO, *Examination 2015*, supra note 22, at 21-22.

⁴⁵ Health Policy Commission, *Community Hospitals*, supra note 40, at 32-33.

⁴⁶ Id. at 4, 7.

⁴⁷ "National Chartbook of Health Care Prices – 2015," Health Care Cost Institute, last accessed February 27, 2017, www.healthcostinstitute.org/report/national-chartbook-health-care-prices-2015.

⁴⁸ New York State Health Foundation, *Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement* (December 2016); Xerox, *Variation in Payment for Hospital Care in Rhode Island: Prepared for the Rhode Island Office of the Health Insurance Commissioner and the Rhode Island Executive Office of Health and Human Services* (December 2012); Wakely Consulting Group, *Price Variation Analysis: Prepared for the Green Mountain Care Board* (August 2014); Katharine London, et. al., *Analysis of Price Variation In New Hampshire Hospitals: Prepared for the New Hampshire Insurance Division* (April 2012).

⁴⁹ All results are adjusted for case mix/complexity of service provided.

⁵⁰ New York State Health Foundation, *Hospital Prices*, supra note 48, at 41.

⁵¹ Xerox, *Rhode Island*, supra note 48, at 14-16.

⁵² Wakely Consulting Group, *Price Variation*, supra note 48, at 21.

more than the lowest-paid hospital for inpatient discharges and 213% for outpatient episodes.⁵³ In comparison, in Massachusetts the highest priced hospitals are paid 250% to 340% as much as the lower-priced hospitals.⁵⁴

Provider price variation exists not just within states but across and within hospital referral regions (HRRs).⁵⁵ The Health Care Pricing Project recently published the most comprehensive study to date on price variation. The report uses data collected by the Health Care Cost Institute, comprising four years of insurance claims data for three major insurers that collectively insure 27.6% of individuals with employer-sponsored insurance.⁵⁶

The report examines price variation across 306 HRRs for seven common, uncomplicated procedures delivered in the hospital setting. After adjusting for extraneous variables like case mix, the study finds that inpatient prices in the highest-spending HRR, averaged over three years, are more than 400% higher than those in least expensive HRR.⁵⁷ The price ratio⁵⁸ of the most-expensive to the least-expensive hospitals ranges from 6.13 (percutaneous transluminal coronary angioplasty) to 11.99 (MRI). This study examined HRRs in Massachusetts but only reported on the 25 most populated HRRs. The raw data on wage-adjusted hospital inpatient prices from 2008-2011, however, finds that HRRs in Massachusetts are in the lowest-priced quintile (\$6,548-10,474).⁵⁹ This means after adjusting for income, average prices in Massachusetts HRRs are less than in many other areas of the country. On the other hand, the HPC has found that maternity episode spending in Massachusetts for low-risk pregnancies varies from approximately \$9,722 to \$18,475 (190%).⁶⁰ It is also important to note that Boston's AMCs are near the bottom in terms of rates, when compared to similar institutions across the country (See Figure 1.6).

⁵³ Katharine London, *Analysis of Price Variation*, supra note 48, at 4 (percentage calculated from reported data).

⁵⁴ Health Policy Commission, *Provider Price Variation*, supra note 15, at 6.

⁵⁵ Hospital Referral Regions are regional healthcare markets for tertiary medical services. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery. "The Dartmouth Atlas of Health Care," Dartmouth Atlas Project, accessed February 1, 2017, <http://www.dartmouthatlas.org/tools/faq/researchmethods.aspx>.

⁵⁶ Zach Cooper, et. al., *The Price Ain't Right?*, supra note 37.

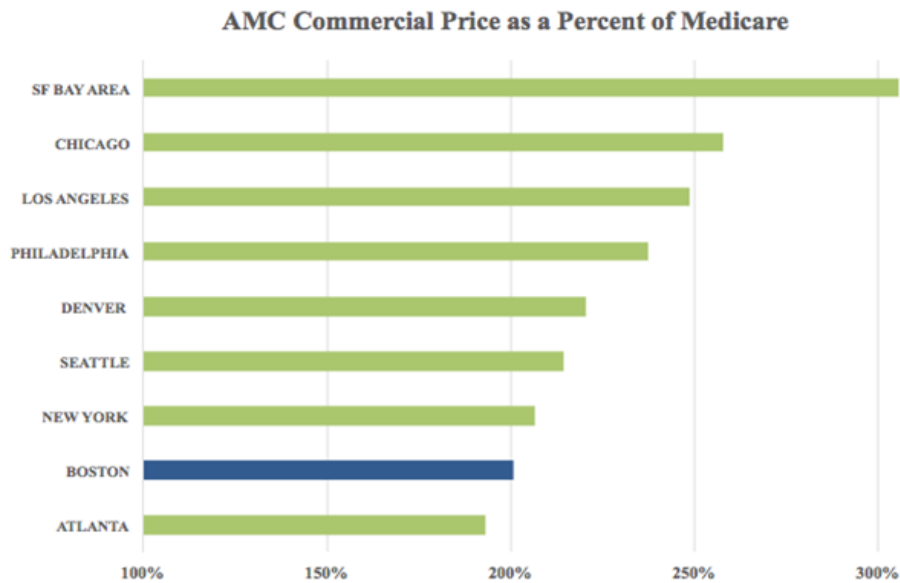
⁵⁷ Id. at 19.

⁵⁸ Id. at 10-12. Price ratio measures how many times more expensive the highest-cost service is, compared to the lowest-cost service.

⁵⁹ Id. at 52.

⁶⁰ Health Policy Commission, *Provider Price Variation*, supra note 15, at 5.

Figure 1.6: Academic Medical Center Commercial Price Comparisons, 2014⁶¹



SECTION V: EFFECT OF PRICE VARIATION ON MASSACHUSETTS RESIDENTS

Even though there is significant price variation in Massachusetts, since 2012 growth in commercial premium spending has been consistently below the national trend⁶² (see Figure 1.7), and income-adjusted premiums in certain markets are lower than average.⁶³

Figure 1.7: Growth in Insurance Premium Spending Per Enrollee, 2005-2015⁶⁴



⁶¹ Chancellor Consulting Group, Inc., *Analysis of Truven Claims Data (2014) and Medicare 100% (2014)*.

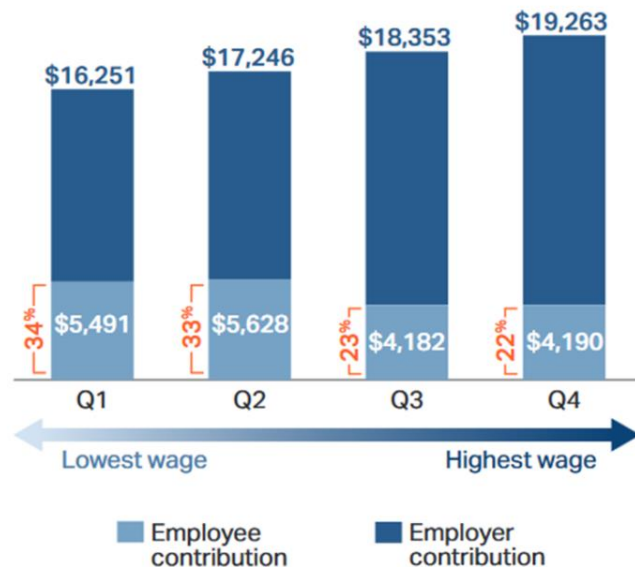
⁶² Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 14.

⁶³ Sara R. Collins, et. al., *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* (Commonwealth Fund, October 2016).

⁶⁴ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 14.

The cost of healthcare, however, is still burdensome for some residents (See Figure 1.8). Although Massachusetts has a higher than average median income, it ranks seventh highest among states in degree of income inequality.⁶⁵ In Massachusetts, 39% of residents are low- to middle-income (See Figure 1.9).

Figure 1.8: Average Annual Family Premium & Employer Contributions by Wage Quartile, 2015⁶⁶



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2015

“Despite the suggestion that Massachusetts’ health care costs are affordable, continued increases in the cost of health care are a serious threat to small businesses, so it’s important to provide a complete picture on health care spending on the Commonwealth.” – Jon Hurst, President of the Massachusetts Retailers Association, testimony to the Special Commission

In addition, although out-of-pocket spending is relatively similar across income brackets, low-wage employees spend a greater share of their paycheck on health insurance premiums.⁶⁷ Massachusetts employee healthcare costs also continue to grow.⁶⁸ Despite several years of low premium growth, the Massachusetts Division of

⁶⁵ United States Census Bureau, *American Community Survey Briefs: Household Income 2015*, by Kirby G. Posey (Washington, D.C., September 2016).

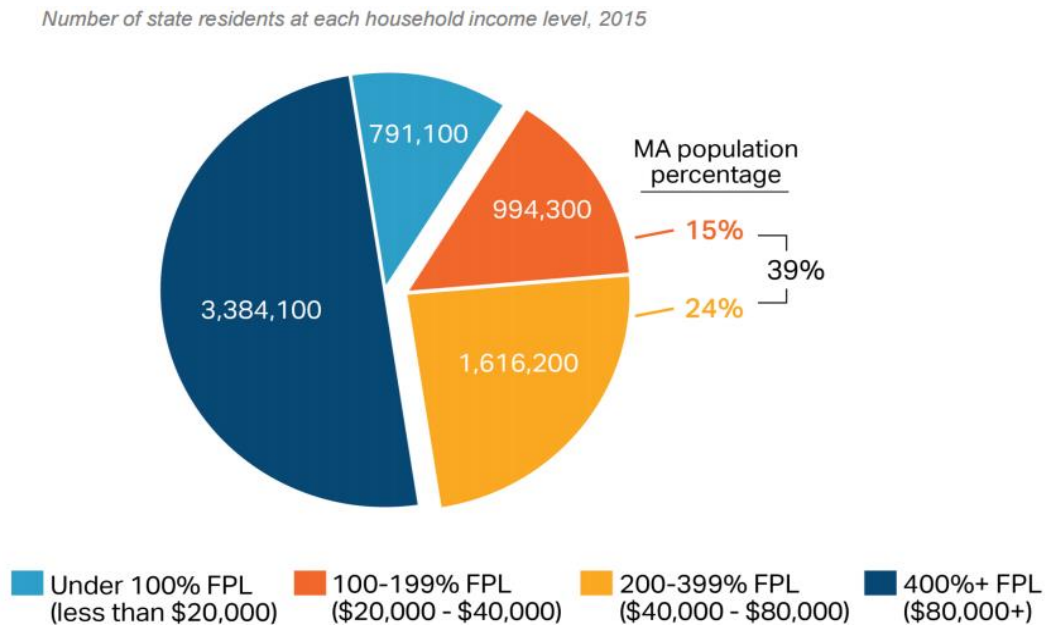
⁶⁶ Id. at 19.

⁶⁷ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 19.

⁶⁸ Collins, *Slowdown in Employer Insurance*, supra note 63.

Insurance has reported base rate increases in the small group and individual markets between 5.4% and 8.3% from the end of 2015 through the first quarter of 2017.⁶⁹ Anecdotally, this burden may fall disproportionately on those that live in geographically-isolated or rural areas.

Figure 1.9: Massachusetts Residents by Income, 2015⁷⁰



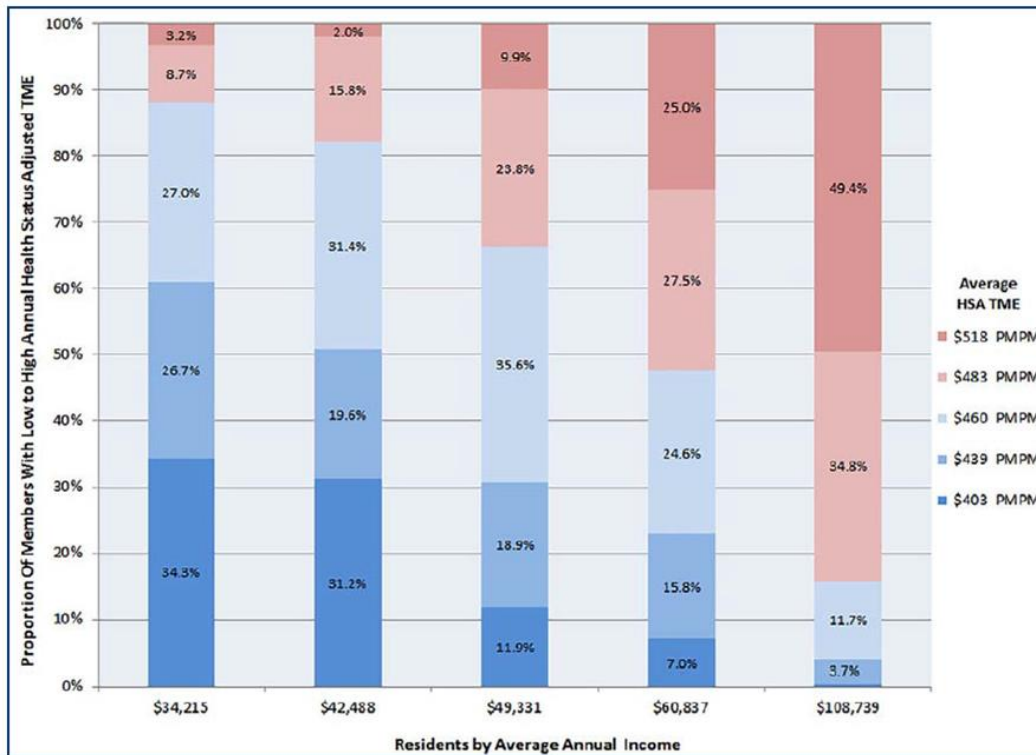
Furthermore, although premium growth has slowed, Massachusetts premiums are still the fifth-highest in the country.⁷¹ Finally, an analysis by the AGO concludes that, on average, there is higher commercial medical spending on higher-income residents. (See Figure 1.10).

⁶⁹ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 41.

⁷⁰ Health Policy Commission, *Select Findings: 2016 Cost Trends Report* (Boston, MA, January 11, 2017), slide 11.

⁷¹ Health Policy Commission, *Massachusetts Health Care Spending*, supra note 39, at slide 6.

Figure 1.10: Distribution of Risk-Adjusted Medical Spending by Average Annual Income for One Major Massachusetts Payer's Members, 2014⁷²



⁷² Graphic provided to Health Care Financing staff by the Office of the Attorney General, November 7, 2016. Chart reflects per-member-per-month (PMPM) 2014 health status-adjusted TME for one major payer's commercial members (HMO, POS, PPO, and indemnity), reported by Massachusetts zip code. Income data is from the IRS Statistics on Income Division. It reflects 2013 adjusted gross income for one major payer's 2014 commercial membership, reported by Massachusetts zip code.

CHAPTER 2 – RATE ADJUSTMENT & FACTORS INFLUENCING PRICE VARIATION

INTRODUCTION

As part of its statutory charge, the Special Commission on Provider Price Variation must examine whether the following factors are acceptable reasons for price variation:¹

- Location
- Quality
- Costs
- Medical education
- Services provided by disproportionate share hospitals and other providers serving underserved or unique populations
- Use and continued advancement of medical technology and pharmacology
- Research
- Stand-by service capacity
- Emergency service capacity
- Market share of individual providers and affiliated providers
- Provider size
- Advertising
- Care coordination between/among medical and allied health professionals

Section I of this chapter provides background on commercial contracting and rate-setting systems, including Medicare, Medicaid, and systems in Maryland and Vermont. Section II more closely examines Medicare and Medicaid, as these public programs served as the starting point for the Special Commission’s discussion about acceptable and unacceptable factors for price variation. Section III details each factor in the Special Commission’s charge, including discussion highlights. Section IV discusses global budgets and all-payer rate setting in Maryland and Vermont.

SECTION I: COMMERCIAL CONTRACTING & RATE SETTING SYSTEMS

In the commercial market, insurers and providers negotiate how much providers are paid for medical goods and services. Like any negotiation, provider payments reflect the parties’ respective bargaining positions. For example, if an insurer covers a large percentage of the patient population, it is able to steer a large amount of business to the “in-network” providers with which it contracts. Providers may agree to accept relatively lower rates from the insurer in order to access this patient volume and capture this source of revenue. On the other hand, if a provider has a good

¹ 2016 Mass. Acts 115, §9.

reputation or strong brand name, offers specialty services, or is the largest or only provider in the area, it may have the leverage to demand higher prices. This is because insurers compete among themselves to offer the most attractive plans to consumers and employers. If insurers cannot guarantee access to a variety of providers, they are at a competitive disadvantage.² It is important to note, of course, that greater health plan leverage does not benefit consumers or decrease total spending, unless adequate regulation and/or competition among health plans causes insurers to pass through savings to purchasers.

In contrast, Medicare, Medicaid, and the states of Maryland and Vermont regulate the rates that providers receive. Under these rate-setting systems, the federal or state government establishes how much providers are paid for medical goods and services. For Medicaid and Medicare, the government sets and periodically updates a detailed list of provider payments.³ Maryland sets a global budget for hospitals, under which hospitals are paid a fixed annual amount for inpatient and outpatient services. This is an all-payer system, meaning that Medicare, Medicaid, and commercial payments are set in the same manner.⁴ In 2017, Vermont began implementing a voluntary all-payer system, under which accountable care organizations (ACOs) comprised of different types of providers are paid under a global budget.⁵ These systems are prospective, meaning that rates are set in advance and reflect the costs that the typical efficient provider is expected to incur.

Regardless of how a provider is reimbursed, all of these payment systems allow for variation in reimbursement rates. There are many reasons why some providers receive higher payments than others. For example, average wages are higher in many big cities, so payments must reflect those higher operational costs. The Special Commission on Provider Price Variation was convened to discuss these acceptable reasons for price variation.

SECTION II: MEDICARE & MEDICAID

MEDICARE

Medicare is a federal health insurance program for people ages 65 and over and people under 65 with permanent disabilities and certain diseases. It covers

² Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2015); Anna Sommers, Chapin White, and Paul Ginsburg, *Addressing Hospital Pricing Leverage Through Regulation: State Rate Setting* (National Institute for Healthcare Reform: May 2012).

³ MedPAC, *Hospital Acute Inpatient Services Payment System* (Washington, D.C., October 2016); MedPAC, *Outpatient Hospital Services Payment System* (Washington, D.C., October 2015); MASS. GEN. LAWS Ch. 118E, §§13C, 13D (2016).

⁴ National Conference of State Legislatures, *Equalizing Health Provider Rates: All-Payer Rate Setting* (Denver, CO: June 2010).

⁵ Shannon Muchmore, "Vermont's All-Payer ACO Will Begin in January," *Modern Healthcare*, October 26, 2016, <http://www.modernhealthcare.com/article/20161026/NEWS/161029930>; Centers for Medicare and Medicaid Services, Letter to Hal Cohen (Washington, DC, October 24, 2016), available at <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>.

approximately 55 million people⁶ in the United States and pays for a wide variety of medical services, including inpatient and outpatient procedures, physician visits, and nursing care. It is funded primarily through payroll taxes, general revenue, and beneficiary premiums.⁷

Medicare pays facilities for most episodes of care through two payment systems, one for inpatient services and one for outpatient. Under the Inpatient Prospective Payment System (IPPS), once the hospital discharges a patient, it reports to Medicare the patient's diagnoses, procedures, and other information. Medicare uses this information to assign the case to one of 757⁸ diagnosis-related groups (DRGs). Each DRG reflects the patient's principal diagnosis, procedure(s) provided, complications or comorbidities, and certain other characteristics. The DRG has a corresponding payment weight, which reflects the average level of resources needed to treat a typical Medicare patient in that DRG, relative to the average level of resources needed to treat all Medicare patients. More complex and costly conditions are assigned higher weights. For example, in Fiscal Year 2017 the DRG weight for one type of concussion treatment is 1.48, while the DRG weight for a certain type of heart transplant is 27.10.⁹ In this way, hospitals can expect to receive higher payments for episodes of care that, on average, are relatively more costly to provide.¹⁰

After the case is assigned a DRG, the weighted DRG is multiplied by standardized base payment rates.¹¹ Base payment rates are designed to cover the operating and capital costs that an efficient healthcare facility can be expected to incur. These rates are adjusted to account for geographic factors. The resulting adjusted base payment rate reflects both the cost of care provided and location-adjusted internal costs. The actual payment the hospital receives takes into account additional factors (See Figure 2.1), such as the hospital's performance on quality measures and payments for

⁶ "Total Number of Medicare Beneficiaries," Kaiser Family Foundation, last modified March 2016, <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D>.

⁷ "Issue Brief: An Overview of Medicare," Kaiser Family Foundation, last modified April 2016, <http://kff.org/medicare/issue-brief/an-overview-of-medicare>.

⁸ The number of DRGs can change each year. The 2017 IPPS Final Rule specifies 575 DRGs. See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Table-5.zip>; "FY 2017 IPPS Final Rule Homepage," Centers for Medicare and Medicaid Services, last modified August 15, 2016, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html>.

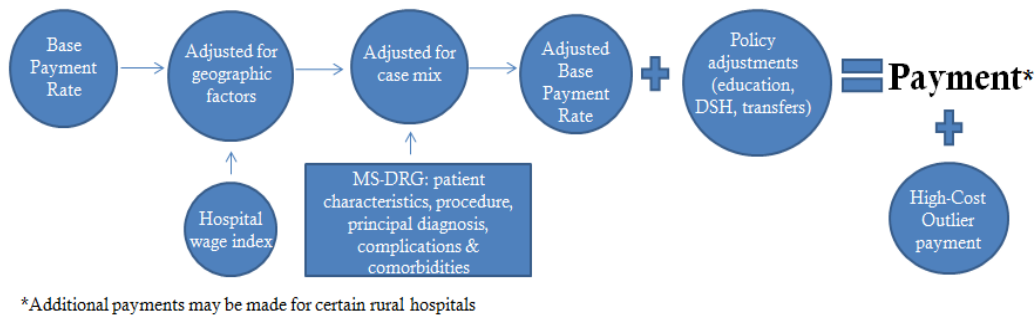
⁹ "FY 2017 Final Rule and Correction Notice Tables," Centers for Medicare & Medicaid Services, accessed December 15, 2016. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html> (Click on Table 5).

¹⁰ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Acute Care Hospital Inpatient Prospective Payment System* (Washington, D.C., February 2016).

¹¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10.

graduate medical education.¹² Approximately 15% of acute care hospitals are exempted from the IPPS. These hospitals are mostly specialized or small and rural.¹³

Figure 2.1: Medicare Inpatient Prospective Payment System



Commission member Stuart Altman, appointed by Senate President Rosenberg, was consulted by Congress when it was creating the DRG system. Dr. Altman provided the Commission with his perspective on the IPPS. He said that Congress grappled with how to establish a uniform base or unadjusted payment rate, since the actual cost of providing the same service varies from hospital to hospital. Dr. Altman added that another consideration is that hospitals that are paid more tend to be less efficient. In other words, the more an institution is paid, the higher its costs will be, because additional money will be spent in inefficient ways. To solve this problem, Congress and the Administration decided that each DRG should reflect the average cost to all hospitals of providing that service. Congress then determined how much to adjust each rate to reflect legitimate cost differences like teaching and wages. Political concerns also played a role in arriving at that final number.

The Outpatient Prospective Payment System (OPPS) is similar to the IPPS (See Figure 2.2), in that Medicare pays hospitals a fixed amount for providing the service. Each case is assigned to an ambulatory payment classification (APC), which is analogous to a DRG. In a similar manner, the APC is then adjusted to reflect provider characteristics. As the figures below illustrate, the APC is also the basis for payments to ambulatory surgical centers (ASCs), although the methodology for determining ASC payments is different (See Figure 2.3).¹⁴

¹² MedPAC, *Inpatient*, supra note 3.

¹³ Stuart Altman (statement to the Special Commission on Provider Price Variation, October 11, 2016).

¹⁴ MedPAC, *Outpatient*, supra note 3; Medicare Learning Network, *Hospital Outpatient Prospective Payment System* (Washington, D.C., January 2016).

Figure 2.2: Medicare Outpatient Prospective Payment System

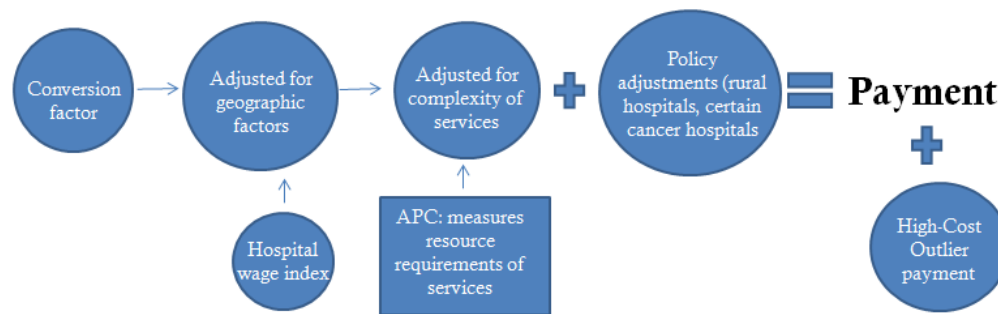
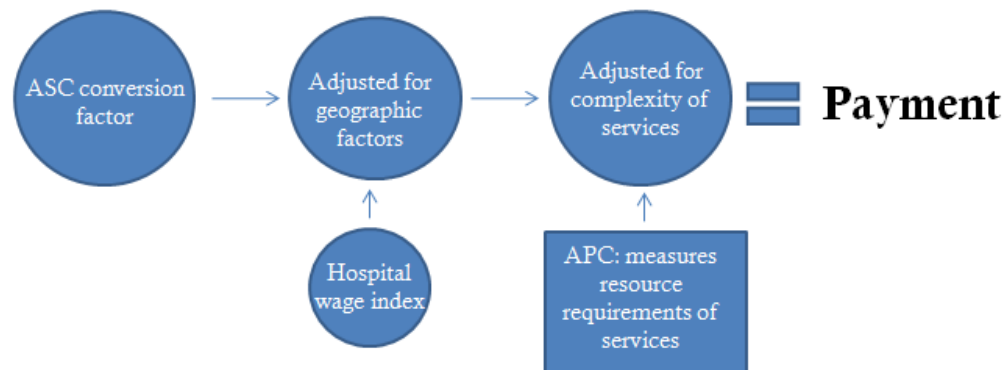


Figure 2.3: Medicare Ambulatory Surgical Center Payments



The Department of Health and Human Services annually updates DRG and APC groupings, payment rates, and the types and amounts of rate adjustments. Among other factors, updates reflect changes in technology, practice patterns, and inflation. DRGs and APCs do not include the costs of physician and other professional services and certain goods and services, which are reimbursed according to a fee schedule.¹⁵

MEDICAID (MASSHEALTH)

MassHealth, a joint federal- and state-funded program, is the public payer for medical care for the state's low- and middle-income residents.¹⁶ Covering one in four Massachusetts residents, or 1.8 million patients, MassHealth is the second-largest

¹⁵ Medicare Learning Network, *Inpatient*, supra note 10; Medicare Learning Network, *Outpatient*, supra note 14; Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25 (2006): 57-69.

¹⁶ For more information on MassHealth eligibility, see MassHealth & Massachusetts Health Connector, *Member Booklet 2016 for Health and Dental Coverage and Help Paying Costs* (Boston, MA, October 2016).

healthcare payer in Massachusetts. MassHealth spending accounts for approximately 37% of the state's budget each year.¹⁷ The federal government, however, reimburses Massachusetts for more than half of this amount.¹⁸ The MassHealth population is made up of 32% non-disabled children, 14% adults with disabilities, 43% non-disabled adults, and 8% adults over the age of 65.¹⁹

MassHealth itself is comprised of several different programs, which vary in methods of payment and patient populations served (See Figure 2.4). MassHealth pays for care in two ways – fee-for-service (FFS) and capitation. FFS payments reimburse providers for each individual service provided. Capitation payments, often used in the context of managed care, reimburse providers a flat amount, usually per month for each individual enrolled. In addition, some services are covered by MassHealth but are not included in the capitation rate. These “wrap” services are paid through FFS.

MassHealth FFS is a traditional insurance program, under which providers are paid for each billable service rendered. Members enrolled in MassHealth FFS are generally people under the age of 65 who are not enrolled in another MassHealth program, individuals with other primary insurance coverage, and patients who live in an institutional setting, such as a nursing home. Approximately 31% of MassHealth patients are enrolled in the FFS program.²⁰ Similar to the FFS program, the Primary Care Clinician Plan (PCC) reimburses providers for medical services on a FFS basis. Primary care providers (PCPs) are directly paid an additional fee, however, to coordinate the patient's medical care. Behavioral health services under the PCC plan are not paid through FFS and are instead covered by a separate behavioral health plan under a capitated payment arrangement. Dental and long-term care benefits are included and paid through FFS. As of January 2016, approximately 21% of MassHealth patients are enrolled in the PCC plan.²¹

MassHealth has several managed care programs, including the Managed Care Organizations (MCOs), Senior Care Options (SCO), Program for All-Inclusive Care for the Elderly (PACE), One Care, and CarePlus. Participating providers in these programs are paid a capitated fee to manage patient benefits and provide services. SCO and PACE focus on coordinating care for MassHealth's older members. One Care coordinates long-term services and supports, physical healthcare services, and behavioral health services for members who are dually-eligible for MassHealth and Medicare. SCO, One Care, and PACE serve approximately 3% of MassHealth consumers.²² CarePlus was created as part of the Medicaid expansion under the

¹⁷ This percentage represents gross state spending, prior to any federal reimbursement.

¹⁸ “MassHealth: The Basics,” Blue Cross Blue Shield Foundation of Massachusetts, last updated June 2016, http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf.

¹⁹ Id.

²⁰ Id.

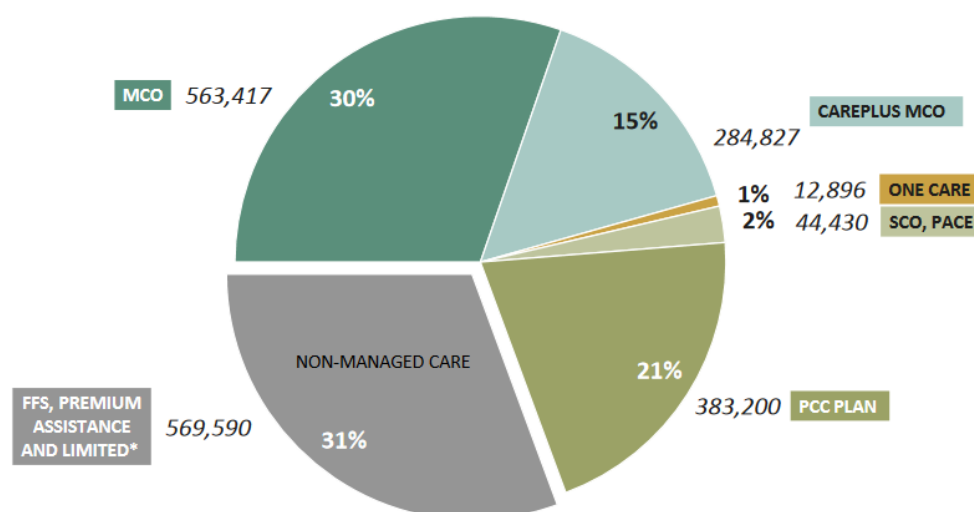
²¹ Id.

²² Id.

Affordable Care Act. The program is for residents ages 21 to 64 that are not eligible for MassHealth Standard²³ and have an income below 133% of the federal poverty level.

Figure 2.4: MassHealth Enrollment by Payer Type, 2016²⁴

MASSHEALTH ENROLLMENT BY PAYER TYPE, JANUARY 2016



*MassHealth Limited provides coverage for emergency medical services for 136,000 undocumented non-citizens.
SOURCE: MassHealth, January 2016 Snapshot Report.

Similar to Medicare, MassHealth FFS pays for episodes of care. MassHealth establishes a state-wide base rate and then adjusts the rate for patient acuity, area wage index, and outlier payments, with a possible penalty for excessive readmissions. For inpatient services, MassHealth reimburses providers an Adjudicated Payment Amount per Discharge (APAD).²⁵ This payment covers the member's entire acute inpatient stay, from admission to discharge. There are some exceptions to the APAD payment system; for example, psychiatric and rehabilitation services are paid separately.

Through December 2016, MassHealth paid a Payment Amount Per Episode (PAPE) for hospital outpatient services.²⁶ The PAPE covered all acute outpatient hospital services delivered to a member on a single calendar day. Certain services,

²³ MassHealth & Massachusetts Health Connector, *Member Booklet*, supra note 16. MassHealth Standard covers many different population groups, including pregnant women, adults living with children younger than age 19, and adults with disabilities. Income eligibility varies for each group. Id.

²⁴ "MassHealth: The Basics," supra note 18.

²⁵ MassHealth, *Notice of Proposed Agency Action: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services*, effective October 1, 2015, (Boston, MA, 2015).

²⁶ Id.

like laboratory services, were not included. In December 2016, MassHealth moved from the PAPE to the Adjudicated Payment per Episode of Care system (APEC). The APEC is similar to the PAPE in that it pays one rate per encounter; however, the methodology is prospective instead of retrospective and better accounts for the actual cost and complexity of services provided. Similar to Medicare's episode-based payment systems, APADs and APECs do not cover physician and other professional fees.

MassHealth sets rates by regulation for twenty-seven different categories of ambulatory services provided in various provider settings. For example, the Medicine Regulation includes rates for all services performed by physicians, including professional fees. Other regulations cover payments for diagnostics, laboratory tests, and medical services.²⁷ A regulation can contain thousands of codes with corresponding payment rates. MassHealth reviews its regulations and promulgates new rates in three year cycles. The Center for Health Information and Analysis (CHIA) provides MassHealth with essential data, including data published in the annual hospital cost reports, and performs necessary analytic work. A single rate is set for a given service, which is the same for all non-hospital based providers participating in MassHealth.²⁸ Rates for inpatient and outpatient hospital services are set by contract each year via the Acute Hospital Request for Applications process.

SECTION III: FACTOR DISCUSSION

Medicare and/or MassHealth payment systems adjust for several of the factors that are part of the Commission's charge. By discussing the factors in the context of public programs, members were able to get a sense of how uniform payment systems account for differences among providers. The Commission began by discussing factors for which Medicare and MassHealth adjust reimbursement rates. At a second meeting, the Commission discussed factors that are not adjusted for by these systems. At several points during these discussions, hospital representatives noted the effect on commercial prices of relatively lower MassHealth payments. Some hospitals are able to shift unreimbursed costs to commercial payers; many others do not have that leverage.

LOCATION

According to provider representatives on the Commission, salaries and wages account for almost 70% of total hospital expenses. Since labor costs vary based on location, both Medicare and MassHealth adjust payments for expected labor costs. Medicare's IPPS adjusts rates using the hospital area wage index, which compares the average hourly wage for hospital staff in a given area to the national average. Hospitals operating in higher-cost areas receive a 69.6% adjustment to the operating base payment rate. Hospitals in lower-cost areas receive a 62% adjustment.²⁹

²⁷ Matthew Klitus, "MassHealth" (presentation to the Special Commission on Provider Price Variation, Boston, MA, November 1, 2016).

²⁸ *Id.*

²⁹ Medicare Learning Network, *Inpatient*, *supra* note 10.

Medicare's OPPS uses the same area wage index. In Massachusetts, the difference in payment due to geographic variation or differences in wage area is 30%.³⁰ Beginning in October 2016, differences in payments based on geographic variation increased due to an adjustment to the rural floor.³¹ MassHealth uses the same Centers for Medicare & Medicaid Services (CMS) wage area indices as Medicare but a slightly different methodology.³² Medicare and MassHealth also adjust physician fees to account for geographic variations in the cost of practicing medicine. Medicare physician reimbursement rates are 9% higher in metro Boston than in other parts of Massachusetts.³³ MassHealth uses a methodology based on Medicare's payment system.

Commission members expressed reservations about using location and/or wages as an acceptable reason for provider price variation. Health plans and hospital representatives commented on the unintended consequences of Medicare's "rural floor" payment rule, under which Medicare must reimburse a state's urban hospitals for employee wages at least as much as it reimburses its rural hospitals.³⁴ Massachusetts' only rural hospital is Nantucket Cottage Hospital, a nineteen-bed hospital with relatively high wages, due to its remote location and the high cost of living in that area. Although it may make sense to consider commercial costs by region, one member expressed concern about using Medicare's methodology as a baseline metric. Another member was concerned about the effect of adjusting rates for location in the context of tiered-network plans. These plans steer members to high-value providers, but when a geographically-isolated hospitals is placed in a higher tier, this can drive patients out of their community.

³⁰ "Details for Title: FY 2017 Final Rule and Correction Notice Table," Centers for Medicare & Medicaid Services, last accessed March 8, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending> (click on "Tables 2 and 3"). This calculation does not include the rural floor budget neutrality adjustment; see next paragraph for a discussion of the rural floor. If the rural floor adjustment is included, the range of difference in payment is approximately 12%. Only certain areas are subject to the rural floor. Cambridge-Newton-Framingham, MA, Pittsfield, MA, Providence-Warwick, RI-MA, Springfield, MA and Worcester, MA-CT are subject to the rural floor. Rural Massachusetts, as defined by CMS, Barnstable Town, MA and Boston, MA are not.

³¹ "FY 2017 Final Rule and Correction Notice Tables," Centers for Medicare & Medicaid Services, accessed January 25, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>. See the following paragraph for a discussion of the rural floor.

³² Material provided by MassHealth to the Joint Committee on Health Care Financing staff, August 2, 2016 and January 12, 2017. For example, a fifteen minute evaluation and management visit in 2016 reimburses physicians \$79 in metro Boston and \$75 in the rest of the Commonwealth. Health Policy Commission, *Provider Price Variation*, supra note 30.

³³ Health Policy Commission, *Provider Price Variation*, supra note 30.

³⁴ Balanced Budget Act of 1997, § 4410. See also Liz Kowalsky, "How a Tiny Hospital Has Imperiled Mass. Medicare Funds," *Boston Globe*, May 2, 2016, <https://www.bostonglobe.com/lifestyle/health-wellness/2016/05/01/partners-healthcare-errors-costs-all-mass-hospitals/17ZloAaDKzTFst9kmbBuwM/story.html>.

As part of its price variation working group, the Massachusetts Health & Hospital Association (MHA) discussed using a hospital's provision of low- and no-margin services³⁵ as a better justification for higher rates. MHA members agreed that geographic isolation in of itself does not warrant higher rates. During the Commission's discussion, it was suggested that any system using location as a basis for rates must consider employee migration patterns, as many healthcare professionals in Massachusetts commute to higher-wage settings.

QUALITY

Medicare and MassHealth adjust payments, both positively and negatively, to incentivize high performance on quality measures. Medicare's IPPS makes three quality adjustments. The Hospital Value-Based Purchasing Program rewards performance on measures like patient experience, clinical care outcomes, and cost reduction. To fund the program, Medicare reduces hospital base payments, meaning that lower-performing hospitals experience a net loss. Two other penalty programs, the Hospital Acquired Condition and Hospital Readmissions Reduction Programs, reduce base rates for hospitals with a high incidence of hospital-acquired conditions³⁶ or excessive readmissions for certain medical conditions. Overall, roughly 2% of base payments are redistributed based on performance and quality measures. Under both the IPPS and the OPDS, providers must also report certain quality metrics to receive full payments.³⁷

MassHealth provides incentives for high-quality performance and penalties for readmissions. Under MassHealth's Pay for Performance Program, inpatient hospitals can earn payments in addition to their base rates, depending on their performance on pre-selected quality measures. The slate of measures evolves from year to year. Hospitals are scored on selected measures, and those scores are compared with those of other hospitals that provide similar services. Poor performance results in no additional payment. In recent years, the total payment to all hospitals has ranged from \$25 to \$40 million a year.³⁸ In addition, to encourage hospitals to limit readmissions, MassHealth penalizes providers for preventable readmissions. The penalty is a reduction of up to 4% in the hospital's per-discharge base payment rate for the upcoming year.³⁹ MassHealth also denies payments for serious reportable

³⁵ The Massachusetts Health & Hospital Association's Price Variation Workgroup Report includes examples of low- and no-margin services: inpatient psychiatry, obstetrics and newborn nursery services, dialysis, pulmonary function. Massachusetts Health & Hospital Association, *Report of the Massachusetts Health & Hospital Association Price Variation Workgroup* (Boston, MA: September 2016).

³⁶ A Hospital Acquired Condition is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. "Quality Definitions and Methodology," American Hospital Directory, last modified May 14, 2015, https://www.ahd.com/definitions/hqi_acq_cond_measures.html.

³⁷ Medicare Learning Network, *Inpatient*, supra note 10; Medicare Learning Network, *Outpatient*, supra note 14; Joseph Newhouse, "Medicare" (presentation to the Special Commission on Provider Price Variation, October 11, 2016).

³⁸ Material proved by MassHealth to the Joint Committee on Health Care Financing staff, August 2, 2016.

³⁹ Id.

events, like care ordered by a person impersonating a physician or a wrong-side surgery. These events are rare and must also be reported to the Massachusetts Department of Public Health (DPH).⁴⁰

In addition to facility payments, Medicare adjusts physician rates to reflect quality. Physicians must report certain quality measures in order to receive full Medicare payments. Further, through 2018, Medicare will phase in a value-based payment modifier, which adjusts physician payments upwards or downwards based on the quality of care provided in relation to its cost. Beginning in 2019, Medicare will begin implementing provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation fundamentally changes the way physician fees are set and annually updated.

Under MACRA, physicians choose one of two payment tracks, both of which reward or penalize physicians based on quality. The Merit-Based Incentive Payment System (MIPS) will grade physicians on quality of care, resource use, clinical practice improvement activities, and meaningful use of electronic health records. Based on those scores, Medicare will adjust physician rates upwards or downwards by an increasing percentage, from 4% in 2019 to 9% after 2022. Under the Alternative Payment Model (APM) track, physicians will join a practice, such as an ACO, that is paid to deliver coordinated care and assume financial risk for a group of patients. Under this track, the practice must meet a set of quality measures, comparable to measures under MIPS, to receive full payment.⁴¹

Most Commission members agreed that although the quality of a provider's performance justifies price variation, there are challenges to measuring and reporting quality. Roberta Herman, representing the Group Insurance Commission, informed the Commission that she spent a large portion of her early career on quality measurement. She commented on the risk of deciding on behalf of patients which measures are important, since different patients value different measures. She also questioned whether quality metrics can provide a degree of differentiation sufficient to justify price variation. Karen Tseng, representing the Office of the Attorney General, reminded Commission members that surveys suggest that quality is a reason why residents of the Commonwealth would be willing pay more for healthcare services. She agreed that it can be difficult to measure quality, but if quality is not a basis for deciding where to direct healthcare dollars, then "what is the alternative?"

⁴⁰ Id.

⁴¹ "MACRA: Delivery System Reform, Medicare Payment Reform," Centers for Medicare & Medicaid Services, accessed December 30, 2016, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>; "The Medicare Access & CHIP Reauthorization Act of 2015: The Path to Value," Centers for Medicare & Medicaid Services, accessed January 2, 2017, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>; "Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program Final Rule: AMA Summary," American Medical Association, last Modified October 19, 2016, <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/macra/macra-qpp-summary.pdf>.

Quality and case mix could be tools to better align payments. David Torchiana, representing Partners Healthcare, clarified that quality measures may encompass reputation. This is a justified factor that includes measures such as willingness to recommend, which appears on the CMS quality survey.

Hospital representatives on the Commission stated that quality measures must be standardized, in order to make “apples to apples” comparisons among providers. They pointed out that for some quality measures, there is little differentiation among providers. Therefore, the Commission must consider which measures have the most impact, as the Commonwealth encourages providers to invest in population health and value-based care and providers across the state embrace “paying for value” initiatives. Several members noted that lower-paid organizations are at a disadvantage, however, because they do not have sufficient funding to invest in new programs.

HIGH-COST OUTLIERS

Where actual treatment costs greatly exceed the reimbursement rate, both Medicare and MassHealth make additional high-cost outlier payments. For Medicare patients, cases are identified by comparing the estimated cost of providing that service to a DRG-specific “fixed loss” threshold. Under both the IPPS and the OPPIs, if actual costs exceed a fixed amount, the hospital is paid some percentage of the amount above that threshold. For most inpatient procedures, for example, Medicare pays 80% of the amount above the threshold. The threshold is updated annually. High-cost outlier payments account for 5% of base payments and are financed by reducing base rates, so that payments do not increase total Medicare spending.⁴²

MassHealth also makes high-cost outlier payments. On the inpatient side, these payments apply to admissions exceeding \$25,000. Hospitals are reimbursed for 80% of actual costs above this threshold.⁴³ Outlier payments are built into the APAD and APEC rates and typically represent 5-10% of the total value of payments. MassHealth recently began reimbursing outpatient cases for high-cost outliers. Outpatient service costs of \$2,000 or more are eligible. Just as on the inpatient side, MassHealth pays 80% of the difference between the reimbursement rate and the actual cost of care.⁴⁴ MassHealth reviews the outlier threshold each year and updates it where appropriate. Because these payments do not cover the full cost of care, hospitals are still incentivized to increase efficiency.

Dr. Altman provided members with some background on outlier payments. These payments were established at the same time as the DRG system. Congress wanted to pay hospitals a greater amount for serving sicker patients, so that hospitals would not have a financial incentive to avoid high-cost patients. Congress arbitrarily came up with a threshold of 5-6% above the average rate. Dr. Altman said this percentage,

⁴² MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Outpatient*, supra note 14; Newhouse, “Medicare,” supra note 37.

⁴³ Klitus, “MassHealth,” supra note 27.

⁴⁴ *Id.*

however, is not actually related to costs. Were the Commission to consider a methodology, he advised it not to rely on Medicare's system.

Commission members, including hospitals and health plan representatives, agreed that payments for high-cost patients are appropriate and important. Dr. Torchiana highlighted the high number of transfer patients that Massachusetts General Hospital and Brigham and Women's Hospital receive. Dr. Torchiana noted that the cost of caring for those patients is 80% higher than the average case, and those patients represent 40% of hospital mortality.

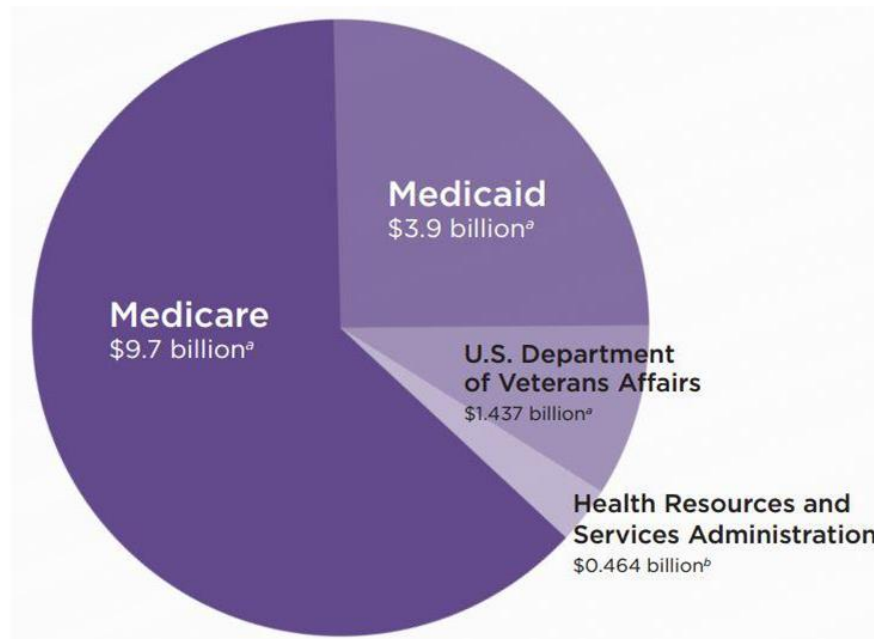
GRADUATE MEDICAL EDUCATION

Graduate Medical Education (GME) trains future physicians in clinical- and hospital-based settings. Medical school graduates and resident physicians participate in training programs for three to seven years, depending on medical specialty, and are supervised directly by faculty members. Although 2% of United States residents live in Massachusetts, Massachusetts teaching hospitals train 5% of all medical residents.⁴⁵ Funding for GME comes from multiple sources (See Figure 2.5). The largest source is Medicare, which contributes almost \$10 billion annually.⁴⁶

⁴⁵ Amy Nordrum, "The High Cost of Healthcare: America's \$15B Program To Pay Hospitals For Medical Resident Training Is Deeply Flawed," *International Business Times*, August 13, 2015, <http://www.ibtimes.com/high-cost-healthcare-americas-15b-program-pay-hospitals-medical-resident-training-2040623>.

⁴⁶ Jay Greene, "Hospitals Say They Subsidize Graduate Medical Education, but Cost-Benefit Unknown," *Crain's Detroit Business*, July 19, 2015, <http://www.modernhealthcare.com/article/20150719/NEWS/307199999>.

Figure 2.5: Graduate Medical Education Payments in United States⁴⁷



a. Data from 2012

b. Data from 2011 and 2013

Medicare funding is distributed through two mechanisms, direct and indirect payments. Direct medical education (DME) payments cover the costs required to run a training program, such as resident stipends, faculty salaries, and hospital administrative costs. These payments are made separately from the IPPS.⁴⁸ Indirect medical education (IME) payments cover the higher patient care costs associated with training new residents, such as costs due to longer inpatient stays and more frequent testing. These payments are adjusted for in the base rate.⁴⁹ Both payments are formula-driven, meaning they do not reflect the actual financial impact of operating residency programs.⁵⁰ The number of residents a hospital can claim for its Medicare reimbursement is capped, but almost all Massachusetts hospitals meet or are above their cap (See Figure 2.6).⁵¹

⁴⁷ Jill Eden, Donald Berwick and Gail Wilensky, *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, D.C.: National Academies Press, 2014).

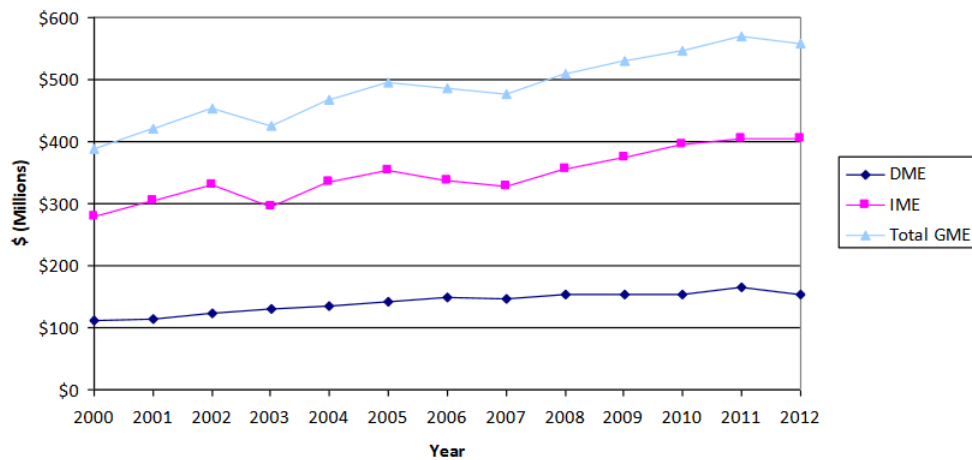
⁴⁸ "Medicare Direct Graduate Medical Education (DGME) Payments," Association of American Medical Colleges, accessed December 30, 2016, https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html.

⁴⁹ "Medicare Indirect Medical Education (IME) Payments," Association of American Medical Colleges, accessed December 30, 2016, https://www.aamc.org/advocacy/gme/71150/gme_gme0002.html.

⁵⁰ Barbara Wynn, Robert Smalley, and Kristina M. Cordasco, *Does it Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs* (RAND Corporation, 2013).

⁵¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Executive Office of Health & Human Services, *Report of the Special Commission on Graduate Medical Education* (Boston, MA, 2013).

Figure: 2.6: Medicare Funding for Graduate Medical Education in Massachusetts, 2000-2012⁵²



In addition to Medicare, other federal programs, private industry, and physician organizations fund graduate medical education.⁵³ While most states also use Medicaid funding to support GME, Massachusetts does not.⁵⁴ The Massachusetts Department of Mental Health (DMH), however, does provide \$5 million annually to psychology residents through its Residency Training Grants. Instead of tying the funding to an exact number of residents, the money pays a portion of the residency program's costs. In return, DMH provides input on the curriculum and residents participate in DMH training opportunities.⁵⁵

Although training residents is an important aspect of the healthcare system, it is unclear how hospitals distribute Medicare payments or how much it actually costs a hospital to train a resident. For years, teaching hospitals across the country have maintained that they lose money training residents, and have pressed for higher reimbursements rates. On the other hand, senior residents have the same duties as licensed physicians, but are paid less than a fifth of that physician's salary.⁵⁶ The Medicare Payment Advisory Commission once estimated that teaching hospitals do incur an extra 2.7% in expenses for each patient they treat, compared to non-teaching hospitals. GME payments, however, are partially based on a formula that covers 5.5% of each Medicare bill.⁵⁷ There seems to be interest among healthcare stakeholders in taking a closer look at GME funding. There have been proposals to decrease funding, increase transparency around how GME dollars are spent, and

⁵² Executive Office of Health & Human Services, *Graduate Medical Education*, supra note 51.

⁵³ Id.; Department of Mental Health, email message to Joint Committee on Health Care Financing staff, December 28, 2016.

⁵⁴ Tim Henderson, *Medicaid Graduate Medical Education Payments: A 50-State Survey* (Washington, D.C.: Association of American Medical Colleges, 2013).

⁵⁵ Executive Office of Health & Human Services, *Graduate Medical Education*, supra note 51.

⁵⁶ Nordrum, "High Cost of Healthcare," supra note 45.

⁵⁷ Id.; Lane Koenig, et al., "Estimating the Mission-Related Costs of Teaching Hospitals," *Health Affairs* 22 (2003): 112-122.

reward hospitals for training more PCPs.⁵⁸ The Medicare Payment Advisory Commission has suggested a new performance-based GME program.⁵⁹

Commission members agreed on the importance of teaching activity and acknowledged the challenges around determining the correct payment level. At the same time, most members agreed that teaching status on its own is not a justifiable reason for price variation. John Fernandez, representing the Conference of Boston Teaching Hospitals, however, did emphasize that GME payments do not fully cover teaching costs. Dr. Altman pointed out that Medicare has made cuts to the teaching adjustments over the years; however, some analysts believe that the adjustments are still too large. He noted also that commercial payers indirectly pay for teaching, because hospitals may make up for GME payment shortfalls by charging higher rates.

DISPROPORTIONATE SHARE HOSPITALS & SERVICES PROVIDED TO UNIQUE AND/OR UNDERSERVED POPULATIONS (DSH)

Although eligibility criteria differ, both Medicare and MassHealth provide additional payments to hospitals that serve a higher percentage of patients insured through public programs. Under the IPPS, hospitals that serve a high percentage of Medicare and Medicaid patients are eligible for disproportionate share hospital (DSH) payments. The original rationale for DSH payments was to compensate hospitals for the higher operating costs associated with treating a larger share of low-income Medicare patients. The reasoning was that these patients tend to be more costly, so DRG payments, which are based on the cost of an average patient, are inadequate. Over time, there became a second and broader justification for DSH payments: preserving access to care for all low-income patients by supporting the hospitals that they tend to use.⁶⁰

Medicare formulas for determining DSH payments are complex and take into account the hospital's percentage of low-income patients, location, size, and level of charity care provided. Large urban hospitals, as defined by Medicare,⁶¹ are also eligible for DSH payments if they have 100 or more beds and receive 30% of total inpatient revenue from state and local governments for uncompensated or charity care. Medicare's IPPS also makes special payments to certain rural hospitals that, because of location and patient mix, tend to be less financially stable. For example, hospitals located at least 35 miles from another hospital and hospitals that meet

⁵⁸ Nordrum, "High Cost of Healthcare," supra note 45.

⁵⁹ MedPAC, *Report to the Congress: Aligning Incentives in Medicare* (Washington, D.C., June 2010).

⁶⁰ "Medicare Disproportionate Share (DSH) Payments," Association of American Medical Colleges, accessed December 18, 2016, <https://www.aamc.org/advocacy/medicare/155102/dsh.html>; Sarah Mutinsky, "Medicaid and Medicare DSH: Current Rules and Future Challenges," *American Essential Hospitals*, June 26, 2015, https://essentialhospitals.org/wp-content/uploads/2015/07/Mutinsky_MedicaidMedicareDSH_062415_vF.pdf.

⁶¹ Medicare calls these hospitals "Pickle Hospitals." See Section 1886(d)(5)(F)(i)(II) of the Social Security Act.

other location requirements are eligible for sole community hospital (SCH) payments.⁶²

Medicare's OPPS makes budget-neutral adjustments for two categories of hospitals. Most services provided at SCHs are eligible for a 7.1% payment increase. In addition, cancer and children's hospitals have permanent "hold harmless" statuses, meaning that if the OPPS methodology changes and payments to these hospitals are lower than what they would have received under the previous policy, the hospitals receive additional payments to make up the difference. Cancer hospitals, which are more likely to care for high-cost patients, also receive adjustments so that their ratio of payments to costs is comparable to other hospitals.⁶³

The Executive Office of Health and Human Services (EOHHS), which comprises MassHealth and other agencies, compensates hospitals that provide a disproportionate amount of care to underserved populations, through several supplemental payment programs (See Figure 2.7). This population is medically complex and often requires a greater amount of hospital resources. Medicaid payments are often lower than Medicare and commercial payments, so supplemental payments support these hospitals' ability to serve MassHealth members and uninsured populations and transition to risk-based delivery systems.⁶⁴ In fiscal year 2016, MassHealth supplemental payments totaled \$900 million.⁶⁵ Several members of the Commission noted that even with supplemental payments, certain hospitals are not fully compensated for the cost of providing care to MassHealth members and the uninsured.

⁶² MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Newhouse, "Medicare," supra note 37. In Massachusetts, Cape Cod Hospital is the only designated SCH. See "FY 2017 Final Rule and Correction Notice Data Files," Centers for Medicare & Medicaid Services, accessed January 25, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>.

⁶³ Medicare Learning Network, *Outpatient*, supra note 14; MedPAC, *Outpatient*, supra note 3.

⁶⁴ Massachusetts Executive Office of Health and Human Services, *MassHealth Medicaid Section 1115 Demonstration* (Boston, MA, 2016).

⁶⁵ Klitus, "MassHealth," supra note 27.

Figure 2.7: MassHealth Supplemental Payments, FY2016⁶⁶

Program	Recipients	Qualifications	FY16 Value (\$M)
Delivery System Transf. Initiative (DSTI)	7 Hospitals	Hospitals with Medicaid volume >1 SD <u>above</u> statewide mean + commercial volume >1SD <u>below</u> statewide mean (Boston Medical Center, Cambridge Health Alliance, Holyoke Hospital, Lawrence General Hospital, Mercy Medical Center, Signature Brockton Hospital, Carney Hospital)	200.0
Public Service Hospital	2 Hospitals	Authorized in 1115 Waiver specifically for CHA and BMC	140.0
Public Hospital Transf. Initiative (PHTII)	1 Hospital	Authorized in 1115 Waiver specifically for CHA	220.0
MassHealth Essential	5 Hospitals	Non-profit teaching hospitals affiliated with state-owned medical school or public acute hospital with Medicaid patient days ≥ 7% (Cambridge Health Alliance, UMass Memorial Hospital, Clinton Hospital, Health Alliance Hospital, Marlborough Hospital)	213.0
High Medicaid Discharge Hospitals	12 Hospitals	Hospitals with > 2.7% of statewide Medicaid discharges (Baystate Hospital, Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham And Women's Hospital, Cambridge Health Alliance, Lawrence General Hospital, Lowell General Hospital, Massachusetts General Hospital, Mercey Hospital, Southcoast Hospital, Tufts Medical Center, UMass Memorial Hospital)	115.0
High Public payor	35 Hospitals	Hospitals whose Medicaid + Medicaid volume >= 63% (Boston Medical Center, Steward Carney Hospital, Inc. Holyoke Hospital, Cambridge Health Alliance, Mercy Hospital, Lawrence General Hospital, Southcoast Health Systems, Signature Healthcare Brockton Hospital, Athol Memorial Hospital, North Shore Medical Center, Berkshire Medical Center, Wing Memorial Hospital, Clinton Hospital, Steward Saint Anne's Hospital, Baystate Franklin Medical Center, Falmouth Hospital, Steward Holy Family Hospital (combined), Baystate Medical Center, Morton Hospital Cape Cod Hospital, Steward Good Samaritan Medical Center, HealthAlliance Hospitals, Inc., Noble Hospital, Fairview Hospital, Harrington Memorial Hospital, Martha's Vineyard Hospital, Saint Vincent Hospital, Steward St. Elizabeth's Medical Center, Sturdy Memorial Hospital, Heywood Hospital, Lowell General Hospital, UMMC, Steward Norwood Hospital, Marlborough Hospital, Nashoba Valley Medical Center, Beth Israel Deaconess Hospital - Plymouth)	24.0
High Complexity pediatric	4 Hospitals	Pediatric Hospitals that treat high complexity children (Boston Childrens Hospital, Tufts Floating Hospital, Shriners Hospital for Children, Shriners Burn Hospital)	15.0
Total			927.0

Under Massachusetts' new 1115 Medicaid Waiver, approved in November of 2016, many of these supplemental payments will be restructured. Some will be linked to MassHealth ACO participation and will include performance-based accountability

⁶⁶ Id. High public payer and pediatric payments were appropriated in FY2017 GAA Budget and were eliminated in December 2016 under the Governor's 9C authority. DSTI and PHTII are risk-based transformation incentive payments, not payments for Medicaid services. Funding totals for DSTI, Public Service Hospitals, PHTII, and MassHealth Essential include intergovernmental transfer funds from providers that serve as the means to get federal matching dollars. See Massachusetts Executive Office of Health and Human Services, *MassHealth*, supra note 64.

requirements, under which a portion of the payments are at risk and linked to performance measures.⁶⁷

Commission members were divided as to whether hospitals that serve a larger number of low-income patients should receive higher commercial rates; in other words, whether commercial payers should subsidize perceived shortfalls in Medicaid reimbursements. The health plans and employer representatives pointed to the already high cost of insurance for consumers and employers. They asked the Commission to focus on commercial disparities among providers, not public-payer shortfalls. Several members noted that providers with higher public-payer mixes receive relatively lower commercial rates.⁶⁸

“We must level the playing field in our hospital payment system and ensure our community and safety net hospitals have the resources we need to provide the quality care our patients deserve. Our private insurance rates shouldn’t suffer just because the majority of our patients are MassHealth beneficiaries.” – Sheilah Belin, Medical Assistant at Boston Medical Center, member of 1199 Service Employees International Union, testimony to the Special Commission

Other members felt that there is a community-wide obligation to pay for the care for low-income residents. When the MHA workgroup discussed DSH payments, there was a sense that commercial rates should recognize provider DSH status, because funding care for those populations is a societal responsibility.

Another hospital representative agreed that there should be a shared responsibility to care for low-income people, but the Commission should instead recommend that “innovator providers,”⁶⁹ such as retail and unaffiliated urgent care clinics competing with community hospitals, accept MassHealth patients.

Several Commission members stated that aside from current adjustments and supplemental payments, payment systems should take into account the social determinants of health or the socioeconomic factors that influence health. Kate Walsh, representing Boston Medical Center, commented that although supplemental

⁶⁷ Centers for Medicare & Medicaid Services, *MassHealth Medicaid Section 1115 Demonstration*, 11-W-00030/1, (November 4, 2016).

⁶⁸ Health Policy Commission, *2015 Cost Trends Report*, supra note 2.

⁶⁹ These providers do not have to accept Medicaid and are not subject to Department of Public Health Determination of Need Process and the Health Policy Commission Cost and Market Impact Reviews. See 105 Mass. Code Regs 100 (2017); MASS. GEN. LAWS ch. 6D § 13 (2016). They are also not included in ACO certification requirements. See Health Policy Commission, *Final Accountable Care Certification Standards For Certification Year 1* (Boston, MA, April, 2016); Executive Office of Health and Human Services, *Section 1115 Demonstration Project Amendment and Extension Request* (Boston, MA, July 22, 2016). Ambulatory surgical centers began accepting MassHealth in January 2015. See 130 CMR 423.000 (2015).

payments help address the cost of caring for complex patients, they do not address health disparities.⁷⁰

NEW TECHNOLOGIES, DEVICES, AND PHARMACEUTICALS

There can be a time lag between when a costly therapy becomes available and when a DRG is updated to reflect that cost. For this reason, Medicare provides temporary add-on payments to hospitals for up to three years, for both inpatient and outpatient care, to offset the costs of new technologies, drugs, biologics, and devices that result in better patient outcomes. CMS evaluates applications by manufacturers, technology firms, and others and considers newness, cost, and the potential for substantial clinical improvement over existing technology. The payment amount is based on the cost to the hospital of using the new technology. Between the beginning of this program in 2001 and 2015, CMS approved 19 of 53 applications for new inpatient therapies.⁷¹

Health plans and hospital representatives agreed that providing new technology does not in of itself justify significant differences in reimbursement rates. Dr. Torchiana commented that speaking as a physician who practiced in a technologically-dense field, he believes that not all new technology represents a clinical advance. Therefore, it is important to maintain a cap on the number of new technologies that qualify for this payment, since incremental advances are often modest or nonexistent. He acknowledged that some new discoveries, such as Sovaldi,⁷² are stunning advancements in medicine, but these advances come with a monumental price tag. Figuring out how to pay for these technologies is a difficult problem. Ms. Walsh added that the struggle to pay for new technologies is something that all healthcare providers face, and is therefore not justifiable reason for price variation.

STAND-BY SERVICES

Stand-by services are services that a hospital unit provides on a 24-hour basis. These units must be staffed at all times. In addition, the care provided tends to be episodic and high-intensity, requiring specially-trained staff, specialized equipment, and dedicated space. For these reasons, stand-by units tend to have relatively higher overhead costs. Stand-by units include trauma centers, burn centers, and psychiatric units.

Trauma and Burn Centers

Level I trauma centers provide comprehensive care for patients with severe or life-threatening physical injuries. There are nine Level I trauma centers in Massachusetts,

⁷⁰ Several Commission members and providers in other public forums have stated that MassHealth payments do not reimburse the full cost of the episode of care.

⁷¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Newhouse, “Medicare,” supra note 37; John Hernandez, et al., “US Hospital Payment Adjustments for Innovative Technology Lag Behind Those In Germany, France, And Japan,” *Health Affairs* 34 (2015): 266.

⁷² Sovaldi treats chronic Hepatitis C. It is considered a breakthrough drug, but in the United States is among the most expensive.

seven in the greater Boston area, one in Worcester, and one in Springfield.⁷³ These centers must be certified by DPH and verified by the American College of Surgeons.⁷⁴ Burn units are specialized units that treat patients with severe burns. There are five burn units in Massachusetts, four in Boston, and one in Worcester.⁷⁵

A number of factors determine whether trauma and burn centers are profitable. Unprofitable trauma centers treat a higher percentage of Medicaid patients and are generally located in low-income urban areas. In contrast, trauma centers may be profitable if they are located in wealthy or suburban areas, treat a greater percentage of commercially-insured patients, and/or receive relatively higher payments from commercial insurers.⁷⁶ There is little research on the profitability of burn centers; most analyses take for granted that burn centers are unprofitable because of high fixed costs that are not fully reimbursed.

The majority of Commission members agreed that although the provision of these services is important and the costs to provide them are not shared equally, stand-by capacity is not a justifiable reason for price variation. Many thought it was outside the scope of the discussion. Hospital representatives informed Commission members that several hospital service lines, including burn centers, lose money. These lines are cross-subsidized by more profitable service lines, an inherent part of how hospitals ensure overall financial stability. In contract negotiations, parties do not discuss stand-by services. The provider's rates depend on its relative leverage; burn and trauma costs are built into base rates and are part of the cost of doing business. Hospitals make the strategic decision to offer these services, based on community need or as a business decision. One hospital representative said that unless an entity can demonstrate that it is particularly expensive to maintain a stand-by service, the Commission should not focus on this topic.

Psychiatric Units and Twenty Four-Hour Behavioral Health Services

Members agreed, and independent research confirms,⁷⁷ that unique issues surround the provision of behavioral health services in the Commonwealth. As of October

⁷³ Baystate Medical Center, UMass Memorial Medical Center, Beth Israel Deaconess Medical Center, Boston Medical Center, Boston Children's Hospital (pediatric), Massachusetts General Hospital, Tufts Floating Hospital for Children (pediatric), Tufts Medical Center.

⁷⁴ 105 CMR 130 (2016).

⁷⁵ Brigham & Women's Hospital, Shriner's Hospital, Massachusetts General Hospital, Boston Medical Center, and UMass Memorial Medical Center.

⁷⁶ "Trauma Drama: Patients for Profits?," *Emergency Medicine News* 36 (March 2014) 22-23; Yu-Chu Shen, Renee Y. Hsia and Kristen Kuzma, "Understanding the Risk Factors for Trauma Center Closures," *Medical Care* 47 (2009) 968-978; Samir M Fakhry, et al., "Trauma Center Finances and Length of Stay: Identifying a Profitability Inflection Point," *Journal of the American College of Surgeons* 210 (2010) 817-821; Emily Friedman, "The Roller-Coaster Supply of Burn and Trauma Care," *Hospital & Health Networks Magazine*, April 7, 2015, <http://www.hhnmag.com/articles/3589-the-roller-coaster-supply-of-burn-and-trauma-care>.

⁷⁷ "Behavioral Health Compendium," Health Policy Commission, accessed January 3, 2017, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/key-findings-bh-compendium.pdf>; Margaret Hoy and Michael Bailit, *Barriers to Behavioral and Physical Health Integration in Massachusetts* (Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts, June 2015); Center for Health Information and Analysis, *Behavioral* (footnote continued)

2016, Massachusetts had 2,662 DMH licensed inpatient beds at 55 hospitals and five Intensive Residential Treatment Programs.⁷⁸ Psychiatric units tend to treat a higher percentage of Medicaid patients, for whom providers are reimbursed relatively less. This means that organizations serving many behavioral health patients may struggle financially. This leads to “ED boarding,” in which these patients remain in the emergency department (ED) even after they are ready for discharge. ED boarding may be due in part to insufficient locations to transfer psychiatric patients. In addition to affecting quality of care, ED boarding can be costly. In Massachusetts, community hospitals serve a higher proportion of behavioral health patients than academic medical centers (AMCs) and teaching hospitals, so they experience more ED boarding.⁷⁹ On the other hand, new payment methods, such as global budgets, have incentivized some Massachusetts providers to expand behavioral health services, since providing more psychiatric care may prevent future hospitalizations and save money in the long run.⁸⁰

Several members asserted that reimbursement by payers for psychiatric services is low. Others argued that profitability per case can vary substantially, depending on the payer. Ms. Walsh stated that payments for geriatric psychiatric care are relatively strong compared to Medicaid and even some commercial payments. Marylou Sudders, Secretary of the Executive Office of Health and Human Services, agreed, stating that there has been growth in certain psychiatric service lines, such as geriatric services, because Medicare is the payer and it pays well. Average profits may also differ for services provided in free-standing psychiatric units. For this reason, it was suggested that any conversation about psychiatric reimbursement should not lump all beds together. Steven Walsh, representing the Massachusetts Council of Community Hospitals, explained that the issue of behavioral health underpayment goes back to a number of causes; for example, Medicare’s usual and customary charges, developed in the 1960s, the traditional separation of behavioral and physical healthcare, and economic disparities. He asked the Commission to focus on price variation in the commercial market and not on underpayments by public payers.⁸¹

Lynn Nicholas, representing the Massachusetts Health & Hospital Association, noted that during a discussion with her members regarding low- or no-margin

Health & Readmissions in Massachusetts Acute Care Hospitals (Boston, MA, August 2016); Center for Health Information and Analysis, *Access to Substance Use Disorder Treatment in Massachusetts* (Boston, MA, April 2015); Center for Health Information and Analysis, *Task Force on Behavioral Health Data Policies and Long Term Stays* (Boston, MA, June 2015).

⁷⁸ Department of Mental Health, email to Joint Committee on Health Care Financing staff, October 24, 2016.

⁷⁹ Health Policy Commission, *2015 Cost Trends Report*, supra note 2.

⁸⁰ Massachusetts Health & Hospital Association, *Price Variation Workgroup*, supra note 35; Robert Preidt, “Psychiatric Patients Face Longer Waits in ER,” *HealthDay*, September 13, 2016, <http://health.usnews.com/health-care/articles/2016-09-13/psychiatric-patients-face-longer-waits-in-er>; Liz Kowalczyk, “Steward Healthcare Expanding Psychiatric Facilities,” *Boston Globe*, August 7, 2014, <https://www.bostonglobe.com/metro/2014/08/06/hospitals-expanding-psychiatric-units/FCKNHUP5thhG93ncAUaYeM/story.html>.

⁸¹ 2016 Mass. Acts 115, §9.

services, hospitals placed psychiatric services at the top of the list.⁸² They agreed that behavioral healthcare is not provided equally in all communities. Hospitals that do offer complex and costly services should get increased payments, possibly at the expense of other hospitals. Not all beds and services are alike, and payments should reflect the cost of providing certain types of complex care. For example, forensic capabilities and services for dual-diagnosis and/or violent patients are more costly to offer than substance use disorder services for commercially-insured patients.

ADVERTISING

Before 1980, the American Medical Association considered advertising for services unethical. Today, the Federal Trade Commission regulates advertisements for healthcare services, which are treated no differently than advertisements for other services.⁸³ Since the ban was reversed in 1980,⁸⁴ healthcare entities have steadily increased the amount and type of advertising that they produce. National spending on advertising in the healthcare industry increased almost 20% from 2011 to 2014.⁸⁵ Advertising costs, however, still make up less than 1% of a typical hospital's budget.⁸⁶

Hospitals advertise on billboards, in magazines, and online. In addition, social media and digital marketing strategies have made it easier for hospitals to reach their target audience.⁸⁷ Patient advocates and even some healthcare practitioners, however, view advertising as wasteful since it is designed to increase market share, not direct patients towards needed services.⁸⁸ In fact, advertising may encourage patients to seek inappropriate care. These stakeholders argue that advertisements provide little usable information to patients and instead focus on emotional appeal.⁸⁹ Advertising for healthcare services relates to the issue of price transparency and brand name. In many markets, consumers have the incentive and tools to shop for bargains. In the healthcare market, however, insurance coverage shields patients from the direct costs of their care. In addition, costs are often not disclosed until after the service has been provided. Even if patients want to obtain information on cost or quality prior to the service, it may be very difficult to do so. At the same time,

⁸² Massachusetts Health & Hospital Association, *Price Variation Workgroup*, supra note 35.

⁸³ Yael Schenker, Robert Arnold and Alex John London, "The Ethics of Advertising for Healthcare Services," *The American Journal of Bioethics* 14 (2014): 34-43.

⁸⁴ Am. Med. Ass'n v. Fed. Trade Comm'n, 638 F.2d 443 (1980).

⁸⁵ Elizabeth Rosenthal, "Ask Your Doctor if This Ad is Right for You," *New York Times*, February 27, 2016, http://www.nytimes.com/2016/02/28/sunday-review/ask-your-doctor-if-this-ad-is-right-for-you.html?_r=0.

⁸⁶ Amanda Erikson, "The Average Marketing Budget for a US Hospital," *AZCentral*, accessed November 18, 2016, <http://yourbusiness.azcentral.com/average-marketing-budget-hospital-17444.html>.

⁸⁷ Jan Greene, "Healthcare Marketers Reshape Ad Strategies," *Modern Healthcare*, October 30, 2015, <http://www.modernhealthcare.com/article/20151030/MAGAZINE/310309995>.

⁸⁸ "Editorial: Hospitals Spend Millions Luring Patients Away from Each Other," *Des Moines Register*, December 19, 2016, <http://www.desmoinesregister.com/story/opinion/editorials/2016/12/18/editorial-hospitals-spend-millions-luring-patients-away-each-other/95517504>.

⁸⁹ Schenker, "Ethics of Advertising," supra note 83, at 38-39.

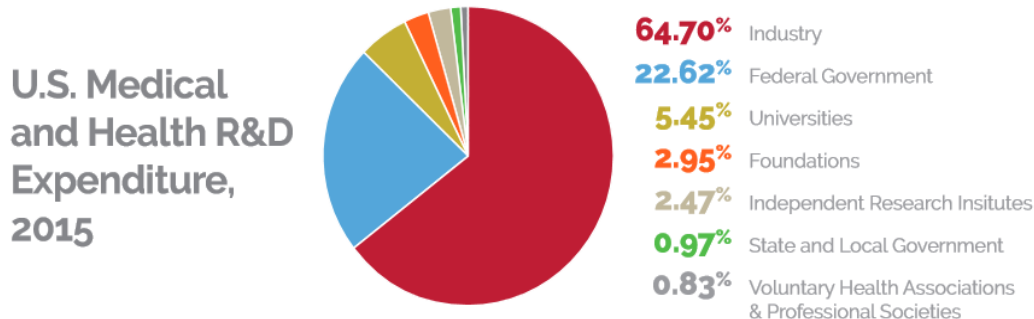
patients are becoming more active decision-makers regarding where they receive care. In the absence of other signals, brand name and advertising may be influential.

Commission members agreed that advertising is part of the cost of doing business, not a justifiable reason for provider price variation. They distinguished advertising from constructive efforts to provide unbiased cost and quality information to consumers. Mr. Walsh noted, for example, that there is a role for publicly-subsidized advertising to promote the use of community hospitals, almost all of which do not have a sizeable advertising budget. Over time, this could lower total healthcare spending in the state.⁹⁰ Several Commission members commented on the power of brand name and the fact that many patients make their decisions based on brand. Mr. Walsh stated that advertising may be necessary to fight the power of brand and move patient volume to high-value, low-cost providers.

RESEARCH

In 2015, the nation spent \$158.7 billion on medical and health research and development (See Figure 2.8).⁹¹ The main sources of funding are the government and industry stakeholders. The majority of government funding comes from the National Institutes of Health (NIH), which is part of the U.S Department of Health and Human Services. The NIH is the primary government agency responsible for medical research, investing approximately \$32 billion each year.⁹²

Figure 2.8: United States Medical and Health R&D Expenditure, 2015⁹³



Massachusetts has one of the highest concentrations of life science researchers in the United States.⁹⁴ Because of its large number of AMCs and strong biotechnology

⁹⁰ Massachusetts Fiscal Year 2017 budget appropriated money for a community hospital marketing campaign. 2016 Mass. Acts 133, § 179.

⁹¹ Research America, *US Investments in Medical and Health Research and Development* (Arlington, VA: 2016), available at https://www.researchamerica.org/sites/default/files/2016US_Invest_R%26D_report.pdf.

⁹² "Budget," National Institutes of Health, last modified April 4, 2016, <https://www.nih.gov/about-nih/what-we-do/budget>.

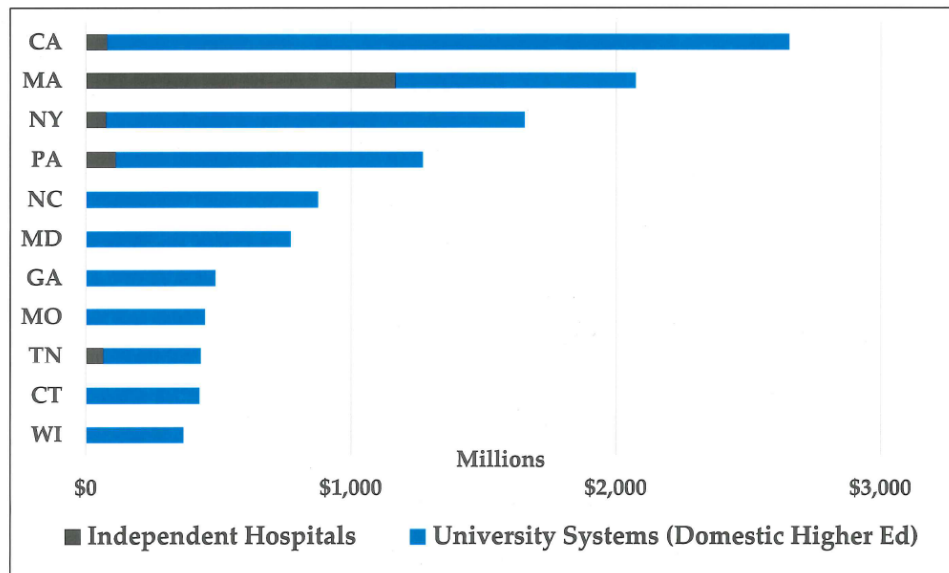
⁹³ Research America, *US Investments*, supra note 91.

⁹⁴ Beethika Khan and Jaqueline C. Falkenheim, *Regional Concentration of Scientists and Engineers in the United States* (Arlington, VA: National Science Foundation, 2013).

presence, Massachusetts receives more NIH funding per capita than almost any other state.⁹⁵ In 2016, Massachusetts received approximately \$2.5 billion.⁹⁶ Unlike in many other states, Massachusetts hospitals and not universities attract the majority of NIH dollars, because of how certain Massachusetts hospitals are structured (See Figure 2.9).

Figure 2.9: NIH Funding for Hospitals Compared to Universities, 2015⁹⁷

**NIH Funding Received by Hospitals vs. Universities –
State Comparison**



Commission members agreed that research is both a societal good and integral to the Commonwealth’s economy. Members disagreed, however, as to whether spending on research is a justifiable reason for commercial price variation. Dr. Torchiana stated that Partners Healthcare receives the most NIH funding in Massachusetts. In addition, every dollar Partners receives is matched by a foundation, philanthropic source, or industry partner. Therefore, Partners’ total research budget is \$1.4 billion dollars (twice the amount indicated in Figure 2.10). Nonetheless, industry and government funding do not fully cover direct and indirect research costs. Research in the clinical setting requires investment in staff, technology, and physical space. Research institutions must comply with rigorous methodological research standards, as well as governing laws and regulations. In addition, the process of applying for

⁹⁵ “Connect With Partners, Price Variation and Research: 3 Facts to Consider,” Partners Healthcare, October 31, 2016, <http://www.connectwithpartners.org/2016/10/31/price-variation-and-research-3-facts-to-consider>.

⁹⁶ “NIH Awards by Location and Organization,” National Institutes of Health, accessed December 19, 2016, <https://report.nih.gov/award/index.cfm>. For a breakdown of 2016 NIH funding by state, see Appendix A.

⁹⁷ Material provided by Partners Healthcare System to the Joint Committee on Health Care Financing staff, November 1 2016.

grants is very expensive. Funding from patents and clinical revenue offset these costs. Medical research also significantly contributes to the Massachusetts economy.

Figure 2.10: NIH Funding by Hospital System in Massachusetts, 2016

<u>Hospital</u>	<u>NIH Funding</u>
Partners (System)	\$690M
Boston Children's Hospital	\$140M
Beth Israel Deaconess	\$123M
Dana-Farber	\$128M
Boston Medical Center	\$27M
Massachusetts Eye & Ear	\$20M
Tufts Medical Center	\$19M

Dr. Altman noted that aside from patient care, AMCs spend the most money on research. This is an issue at both the state and federal levels. He said that commercial payers already indirectly subsidize research because hospitals funnel hundreds of millions of dollars of commercial payments into research. In addition, Medicare indirectly pays for research, because rates to teaching hospitals are higher than necessary. Dr. Altman noted further that in a market-based system, research should not be funded through patient care dollars but at the community, state, and/or federal levels.

Community hospital representatives noted that research capacity and spending do not drive provider price variation. The majority of hospitals across the state do not conduct research, yet price variation persists among those organizations. The issue is reimbursement variation, which can be addressed while still maintaining the billions of dollars that Massachusetts receives in research funding each year. Other hospital representatives encouraged the Commission to be cautious when discussing research funding. Ms. Nicholas highlighted the fact that at one point, most medical research and innovation came out of Europe. As European countries switched to single-payer systems, however, they by and large stopped paying for research through healthcare dollars. Ms. Nicholas stated that this led to the demise of superior research in those countries. Ms. Nicholas suggested that perhaps AMCs should get paid more on a relative basis than community hospitals that do not conduct research. There should not, however, be a big dollar differential. In her working group, MHA members decided that research is not a reason for significant price variation.

CARE COORDINATION BETWEEN/AMONG MEDICAL AND ALLIED HEALTH PROFESSIONALS

Many patients in the Commonwealth have healthcare needs that require more than traditional medical or pharmaceutical services. Care coordination is a concerted effort by a group of healthcare professionals and others to facilitate and manage the

appropriate delivery of services to a patient.⁹⁸ Care coordination encompasses a variety of practices, such as assigning a care coordinator to answer patients' questions and handle logistics, sending an advanced practice nurse to check in on a high-risk patient at home, and managing a patient's transition from one type of provider to another. Both providers and payers implement care coordination initiatives, which may include many types of healthcare professionals, including allied health professionals.⁹⁹

Care coordination services can benefit patients but may necessitate additional staff and information technology, which can lead to increased costs. There are many different mechanisms to pay for care coordination services, including monthly payments for staff and infrastructure, upfront payments for initial costs, designated funding, agreements with payers to employ case managers, and quality bonuses. The shift towards APMs and accountable care models has given providers greater flexibility to use resources for care management, since global budgets can be used to pay for nonclinical services.¹⁰⁰ It is important to note that the goal of care coordination is to enhance the patient's experience and improve outcomes, not necessarily produce savings.¹⁰¹ There have been many pilot programs within Medicare and state Medicaid programs; evaluations of those pilots show minimal, if any, consistent savings to date.¹⁰²

Commission members stated that care coordination is not a justifiable reason for price variation. Several members noted that as providers in the Commonwealth are increasingly reimbursed through APMs, with a focus on total medical expenditure, they will make the right investments to coordinate patient care.

SECTION IV: GLOBAL BUDGETS

As explained in Section I, a global budget is a payment mechanism under which a single payment covers all healthcare costs for a patient over a given period of time. Under the most advanced type of global budget arrangement, if a provider meets certain quality measures and stays within its budget, it earns a net profit. If a provider exceeds the budget, there is a net loss. As the Massachusetts healthcare market moves towards increased adoption of APMs, discussions of warranted and unwarranted factors for price variation become less important. Global budgets

⁹⁸ "What is Care Coordination," Agency for Healthcare Research and Quality, last reviewed June 2014, <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html>.

⁹⁹ Allied health professionals (for example, occupational therapists, speech pathologists, and social workers) do not directly work in medicine or pharmacy, but support these functions through diagnostics, therapy, rehabilitation, and other services.

¹⁰⁰ Melanie Evans, "Demand Grows for Care Coordinators," *Modern Healthcare*, March 28, 2015, <http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289980>.

¹⁰¹ J. Michael McWilliams, "Cost Containment and the Tale of Care Coordination," *New England Journal of Medicine* 375 (2016): 2218-2220.

¹⁰² Deborah Peikes, Arnold Chen, and Jennifer Schore, "Effects of Care Coordination on Hospitalizations, Quality of Care, and Healthcare Expenditures among Medicare Beneficiaries: 15 Randomized Trials," *Journal of the American Medical Association* 301 (2009): 603-618.

incentivize providers to reduce unnecessary care and focus on disease prevention and population health, since profits increase when utilization decreases. Global budgets also provide a source of fixed revenue, which allows providers to make investments and plan for future improvements.

Medicare has several global budget pilots, including the Next Generation ACO Model. Participants in the Next Generation Model receive an all-inclusive per-beneficiary-per-month payment for each member attributed to the ACO. This program is built upon Medicare's Shared Savings Program and Pioneer ACO Models, but it allows providers to take on higher levels of financial risk and offers greater opportunities to coordinate care.¹⁰³ There are 18 Next Generation ACO Models in the United States and two in Massachusetts: the Pioneer Valley ACO in Springfield and the Steward Integrated Care Network in Boston.¹⁰⁴ To date, the results of demonstration projects across the country have been mixed.¹⁰⁵ There is no conclusive evidence that ACOs save money, and it has been challenging to incentivize providers to take on risk. CMS, however, has stated that patients receive better care through ACOs and that it will continue to change and refine the program.

In the commercial market, Blue Cross Blue Shield created the Alternative Quality Contract (AQC) in 2008 to reduce healthcare costs and improve quality. The AQC gives participating providers an annual budget to meet the healthcare needs of their patients. It also requires providers to achieve certain quality targets. Providers share in any savings generated and must absorb any costs exceeding the budget.¹⁰⁶ A *New England Journal of Medicine* article concludes that in the four years following implementation, AQC enrollees had lower medical spending growth and improved quality, compared to similar populations in other states.¹⁰⁷

Maryland is the only state in which commercial insurers and providers do not negotiate payment rates. Instead, since 1971 Maryland has operated an all-payer hospital rate-setting system, under which an independent state agency determines and annually updates hospital payments. The linchpin of this system is a federal waiver, under which providers receive equal rates from Medicare, Medicaid, and commercial insurers. Prior to 2014, hospitals were paid a set amount per inpatient case and per outpatient visit. This is similar to how Medicare pays providers. In addition, during most of the waiver time period, Maryland had volume controls in

¹⁰³ "Next Generation ACO Model," Centers for Medicare & Medicaid Services, accessed December 19, 2016, <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>.

¹⁰⁴ Id.

¹⁰⁵ Jordan Rau and Jenny Gold, "Medicare Yet to Save Money Through Heralded Medical Payment Model," *Kaiser Health News*, September 14, 2015, <http://khn.org/news/medicare-yet-to-save-money-through-heralded-medical-payment-model>; "Experts Debate: Have ACO Models Been Successful?," *Advisory Board Company*, August 19, 2016, <https://www.advisory.com/daily-briefing/2016/08/19/have-aco-models-been-successful>.

¹⁰⁶ Josh Seidman, et al., "Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract," *Avalere Health LLC*, March 2015, <https://www.bluecrossma.com/visitor/pdf/avalere-lessons-from-aqc.pdf>.

¹⁰⁷ Zirui Song, et al. "Changes in Healthcare Spending and Quality 4 Years into Global Payment," *New England Journal of Medicine* 371 (2014): 1704-1714.

place, under which a hospital with excessive admissions received proportionately lower rates. This reduced hospitals' incentive to increase the amount of services provided.¹⁰⁸

In 2014, Maryland re-negotiated its federal Medicare waiver. Instead of payments per visit or per episode, hospitals are now paid through a global budget. Maryland annually updates each hospital's budget to reflect the characteristics of the hospital and its service area. Among other factors, updates reflect changes in the cost of wages, service area demographics, and the hospital's market share. Annual adjustments are also made for performance on quality metrics. The objective is to create a budget that incentivizes quality improvement and reflects the expected costs of operating that hospital efficiently.¹⁰⁹ This is a five-year demonstration, under which Maryland must meet savings, spending, and quality targets. By 2019, Maryland will transition to a global budget model for all providers, not just hospitals. Preliminary analyses indicate that Maryland is meeting most of its Medicare requirements and is on track to fulfilling the terms of the waiver.¹¹⁰

In October 2016, Vermont obtained permission from CMS to set up an All-Payer ACO Model that reimburses providers through a global budget. Similar to the payment system in Maryland, a group of providers will receive a fixed amount of money to care for a group of patients. Global budgets will be similar across all payers and rates will be adjusted to account for differences among providers. As in Maryland, participating providers will have to meet spending and quality targets.

Vermont's system is first of its kind in several respects. First, money will be funneled through an ACO. The state will offer providers the opportunity to participate in existing Medicare ACOs, and it will provide start-up investments to spur the development of ACOs operated by Medicaid, commercial payers, and self-insured plans. Second, provider and payer participation is voluntary. Vermont will incentivize participation; for example, by offering providers predictable payments, facilitating care coordination, and providing data analytics. In addition, participating providers will automatically be in compliance with MACRA. Vermont's goal is to cover 70% of insured residents and 90% of Medicare beneficiaries under an ACO model by 2022. At the time of this report's publication, implementation is in its early stages, so it is

¹⁰⁸ Robert Murray, et al., *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* (Washington, D.C.: Urban Institute, November 2015); Centers for Medicare & Medicaid Services, "Maryland All-Payer Model to Delivery Better Care and Lower Costs," accessed December 9, 2016, <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model>.

¹⁰⁹ Robert Murray, *Hospital Rate Setting*, supra note 108; Maryland Health Services Cost Review Commission, *Agreement Between the Health Services Cost Review Commission and Anne Arundel Medical Center, Inc. Regarding Global Budget Revenue and Non-Global Budget Revenue* (MD, 2015).

¹¹⁰ Ankit Patel, et al., "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model," *New England Journal of Medicine* 373 (2015) 1899-1901; "Monitoring of Maryland's New All-Payer Model: Biannual Report," Health Services Cost Review Commission, April 2016, <http://www.hsrc.maryland.gov/documents/legal-legislative/reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2016.pdf>.

too soon to determine the ACO Model's effect on spending, quality, and health outcomes.¹¹¹

During a brief Commission discussion about global payment models, Ms. Nicholas acknowledged that community hospitals have fewer resources and weaker infrastructure, and therefore struggle with global budgets. Mr. Walsh, however, noted that community hospitals are still excited about the promise of global payments. Many hospitals have been providing wrap-around services to the community for a long time, but under a FFS structure they are not being paid to do so. Several members cautioned that since global budgets are based on existing FFS rates, rate disparities are “locked in.” Moving forward, it will be important to re-base community hospital rates to adequately reimburse hospitals for the services that they provide.

¹¹¹ Green Mountain Care Board, *Draft Vermont All-Payer Accountable Care Organization Model Agreement*, (VT, 2016), available at http://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/DRAFT_APM_Agreement_UNDER_LEGAL_REVIEW.pdf; “Vermont All-Payer ACO Model,” Centers for Medicare & Medicaid Services, last accessed January 3, 2016, <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model>; Virgil Dickson, “Vermont Gets Preliminary OK to Move Towards All-Payer System,” *Modern Healthcare*, September 28, 2016, <http://www.modernhealthcare.com/article/20160928/NEWS/160929874>; Mattie Quinn, “Vermont Takes a Health Risk That Many States Abandoned,” *Governing*, December 6, 2016, <http://www.governing.com/topics/health-human-services/gov-vermont-all-payer-health-care-maryland.html>; Vera Gruessner, “VT All-Payer Model Aligns Costs for Public, Private Insurers,” *Health Payer Intelligence*, October 11, 2016, <http://healthpayerintelligence.com/news/vt-all-payer-model-aligns-costs-for-public-private-insurers>.

CHAPTER 3 – HEALTHCARE CONTRACTING AND MARKET FORCES

INTRODUCTION

As part of its mandate, the Special Commission must review certain healthcare contracting practices. First, the Commission must examine contracts that require payers to pay the same or similar prices to all provider locations for a multi-location healthcare provider, where geographic differences in the provider's site do not support charging the same or similar prices. During its discussion of rate adjustment, the Commission discussed factors that correlate with higher prices for facilities within a health system, regardless of location. These factors include affiliation with certain healthcare systems and provider size. Second, the Commission must examine the feasibility of requiring insurers to contract separately with all provider locations within a healthcare system, as opposed to contracting with the healthcare organization as a unit.¹ This practice is known as separate or component contracting.²

The Commission expanded its directive and considered additional market forces solutions to address provider price variation. Market forces solutions aim to correct distortions and inefficiencies in the marketplace by increasing competition, so that differences in prices reflect so-called warranted reasons for price variation. It is important to foster competition among healthcare providers and insurers in light of increasing consolidation in healthcare markets, both in Massachusetts and nationally.³

Section I of this chapter summarizes previous efforts in Massachusetts to increase competition in the healthcare market, including proposals to require component contracting. Section II explores the theory and history of component contracting and the Commission's feedback on this solution. Sections III, IV, and V detail additional contracting and market forces solutions discussed by the Commission.

Many Commissioners have noted that market forces solutions, although necessary, are part of a menu of options to reduce price variation. Further chapters explore additional solutions, including consumer-targeted initiatives and state regulation.

¹ Act Relative to Equitable Health Care Pricing, 2016 Mass. Acts 115.

² Gwendolyn Majette, "Healthcare Contracting & Market Forces" (presentation to the Special Commission on Provider Price Variation, Boston, MA, November 29, 2016).

³ Bara Vaida and Alexander Wess, *Health Care Consolidation* (Washington, D.C.: Alliance for Health Reform, 2015); Robert Weisman, "Hospital Mergers May Drive Up Costs," *Boston Globe*, October 3, 2013, <https://www.bostonglobe.com/business/2013/10/02/health-care-leaders-warn-that-hospital-consolidation-could-drive-costs/ZAg3Wy0tomHOPK3UNiHw0J/story.html>.

SECTION I: LEGISLATIVE & LEGAL EFFORTS TO BOLSTER COMPETITION IN THE MASSACHUSETTS HEALTHCARE MARKET & NATIONALLY

CHAPTER 288 AND CHAPTER 224

In 2006, Massachusetts passed its landmark health reform law, which extended coverage to all residents.⁴ Chapter 58 achieved near-universal healthcare coverage, increased access to care, and improved health outcomes.⁵ In the ten years since Chapter 58, the Massachusetts Legislature has continued to prioritize healthcare reform and innovation. These important gains in access, however, have contributed to the trend of rapidly increasing healthcare costs. The Legislature responded to this problem in 2010 with the passage of Chapter 288 and again in 2012 with the passage of Chapter 224.

Chapter 288, an *Act to Promote Cost Containment, Transparency, and Efficiency in Health Insurance for Individuals and Small Businesses*,⁶ prohibits a number of practices that the Office of the Attorney General (AGO) and others had identified as anti-competitive. To bolster the development of limited- and tiered-network products (LTNPs), the law prohibits guaranteed participation clauses, under which an insurer is required to include a provider in an LTNP. The law also prohibits clauses that require all facilities within a healthcare system to be placed in the same tier within a tiered-network plan. For limited-network products, the law prohibits all-or-nothing clauses, under which an insurer is required to include in its network all provider members of a healthcare system.⁷ The law also prohibits most favored nation clauses, under which a dominant insurer/provider demands the lowest/highest price and precludes the other party from offering similar or better terms to its competitors.⁸ Additionally, Chapter 288 granted providers the right to opt-out of the new LTNP 60 days before the new plan is submitted to the Commissioner of the Division of Insurance for approval. Finally, Chapter 288 requires providers to make price and quality information available to the state and the public.⁹ These provisions are designed to “level the playing field” among providers with varying degrees of market leverage.

Chapter 224, *An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*,¹⁰ did not directly address insurer/provider contracting but did create oversight mechanisms to track and review proposed provider ownership and affiliation agreements. First, in order to contract with payers, providers are required to register with the Health Policy Commission (HPC). Providers must submit details about their ownership, governance, operational structure, affiliates, employed and affiliated professionals,

⁴ Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 58.

⁵ Kelly Love and Robert Seifert, *10 Years of Impact: A Literature Review of Chapter 58 of the Acts of 2006* (Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts, 2016).

⁶ 2010 Mass. Acts 288.

⁷ MASS. GEN. LAWS ch.176O, § 9A (2016).

⁸ MASS. GEN. LAWS ch.176D, §§ 3, 3A (2016).

⁹ MASS. GEN. LAWS ch.176O, §§ 7, 9A (2016).

¹⁰ 2012 Mass. Acts 224.

licensed facilities, and other pertinent information.¹¹ The purpose of the Registration of Provider Organizations process is to give the HPC necessary information to monitor provider transactions in the market. Chapter 224 also creates the Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) processes. Under the MCN process, providers must notify the HPC when they wish to make certain acquisitions, mergers, and affiliations (See Figure 3.1). If the HPC reviews the filed information and determines that the proposed material change may reduce competition or increase total spending, it can conduct a more detailed CMIR and refer the matter to the AGO for further investigation.¹²

Figure 3.1: Notices of Material Change, 2013-2016¹³

April 2013 to Present		
Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	18	24%
Physician group merger, acquisition, or network affiliation	18	24%
Acute hospital merger, acquisition, or network affiliation	15	20%
Formation of a contracting entity	13	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	6	8%
Change in ownership or merger of corporately affiliated entities	5	7%
Affiliation between a provider and a carrier	1	1%

Other states, the federal government, and private parties have addressed provider consolidation and anti-competitive contracting practices. In 2016, the California Legislature introduced a bill that prohibits several provisions, including all-or-nothing and price secrecy clauses. In addition, the bill would limit out-of-network rates for emergency services.¹⁴ The Department of Justice and the Federal Trade Commission (FTC),¹⁵ the two agencies that monitor competition in the healthcare marketplace, have addressed the market clout that may result from the movement

¹¹ MASS. GEN. LAWS ch. 6D, § 11 (2016).

¹² § 13. The regulations state that HPC must refer the report under certain circumstances, and may refer any report “as appropriate.” 958 Mass. Code Regs 7.14 (2015).

¹³ Information provided by the Health Policy Commission to the Joint Committee on Health Care Financing staff.

¹⁴ S.B. 932, 2016 Leg., Reg. Sess. (Cal. 2016).

¹⁵ The Federal Trade Commission is a federal agency that oversees healthcare provider mergers and acquisitions.

toward Accountable Care Organizations (ACOs).¹⁶ The agencies released a policy statement encouraging providers to form ACOs but identifying conduct by dominant ACOs that may be anti-competitive. For example, contracts should not contain guaranteed and most favored nation clauses and should not require providers to work exclusively within an ACO.¹⁷ Recent lawsuits by private parties have also alleged anti-competitive practices by providers. In California, for example, a union and a group of self-insured employers jointly sued the largest provider in northern California. The complaint alleges that certain clauses are anti-competitive. One clause states that the health plan must encourage its members to receive all of their care from that provider system.¹⁸ As healthcare costs continue to rise, we can expect further actions by governments and private parties to address anti-competitive practices.

SECTION II: COMPONENT CONTRACTING

As discussed in Chapter 1, a provider's market leverage refers to whether an insurer can credibly exclude that provider from its network. This is why mergers and acquisitions correlate with higher prices.¹⁹ After a consolidation, providers that had formerly competed against one another are able to bargain as a unit. If these providers collectively serve a large portion of the market, it becomes difficult for an insurer to exclude these providers from its network. If the insurer is unable to refuse to negotiate with the provider unit, the provider's bargaining power is enhanced and the provider can command higher prices.²⁰

¹⁶ For background on federal healthcare antitrust enforcement, see Department of Justice, *The Role of Antitrust Enforcement in Health Care Markets*, by Bill Baer (Washington, D.C., November 13, 2015), available at <https://www.justice.gov/opa/file/794051/download>; "Health Care," United States Department of Justice, last modified Sept. 29, 2016, <https://www.justice.gov/atr/health-care>; "Health Care Competition," Federal Trade Commission, accessed Jan. 11, 2017, <https://www.ftc.gov/news-events/media-resources/mergers-competition/health-care-competition>.

¹⁷ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011).

¹⁸ Complaint, *UFCW v. Sutter Health*, No. 14-538451 (Apr. 7, 2014). For another example of a recent lawsuit alleging anti-competitive practices, see Complaint, *United States v. Carolinas Healthcare Sys.*, 3:16-cv-00311 (June 9, 2016). The complaint alleges that a dominant provider required anti-competitive steering provisions in contracts with payers. On a side note, it is important to recognize, that lawsuits can be imperfect vehicles for increasing competition: they may be costly and burdensome, and their results are unpredictable.

¹⁹ Asher Schechter, "The True Price of Reduced Competition: Hospital Monopolies Drastically Drive Up Prices," *Pro-Market*, March 14, 2016, <https://promarket.org/the-true-price-of-reduced-competition-in-health-care-hospital-monopolies-drastically-drive-up-prices>; David Cutler and Fiona Morton, "Hospitals, Market Share, and Consolidation," *Journal of the American Medical Association* 301 (2013): 1964-1970.

²⁰ Office of the Attorney General, *Examination of Healthcare Cost Trends and Cost Drivers, Report for Annual Public Hearing* (Boston, MA, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>; Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2015), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>; Eric Roberts, Michael Chernew and J. Michael Williams, "Market Share Matters: Evidence Of Insurers and Provider Bargaining Over Prices," *Health Affairs* 36 (2017): 141-148, available at <http://content.healthaffairs.org/content/36/1/141.full.pdf+html>.

The theory behind component contracting is that one can simulate the competition among providers that existed before they consolidated by requiring each provider within a system to negotiate with insurers separately and independently. Implementing component contracting requires policies and procedures to ensure each provider does in fact negotiate as a separate entity. For example, each provider location needs its own negotiating team, which would be prohibited from sharing confidential information with other teams. In theory, the insurer would be able to negotiate lower rates, because providers would compete on price to maximize their chances of getting the insurer's business. In a way, component contracting is an extension of the prohibition on all-or-nothing contracting. Whereas all-or-nothing prohibitions allow an insurer to select which provider locations to include in its network, component contracting also enables the insurer to negotiate directly with each location.²¹

Massachusetts has a history of exploring component contracting as a solution to high provider prices. Several bills introduced during recent legislative sessions, including the House version of Chapter 224,²² would have required certain or all providers within a healthcare system to negotiate separately.²³ The 2011 Special Commission on Provider Price Reform also suggested prohibiting system-based contracting.²⁴ The idea gained wider attention in 2014, however, when prohibitions on all-or-nothing contracting were included in a proposed consent judgment between the Commonwealth of Massachusetts and Partners Healthcare.²⁵ Under this agreement, the Commonwealth would have allowed Partners, an already dominant healthcare system, to acquire South Shore Hospital and two hospitals within Hallmark Health Systems under certain conditions. The agreement, which did not include a component contracting remedy, would have settled claims related to the acquisition that the Commonwealth might otherwise have challenged on antitrust grounds.

The consent judgment was rejected by the Superior Court, in part because of testimony questioning the feasibility and efficacy of component contracting.²⁶

²¹ Majette, "Contracting & Market Forces," supra note 2; Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review* 105 (2015): 172-203; Leemore Dafny et al., Letters from Economists to Judge Sanders, (Boston, MA, 2014); Tasneem Chitty, *Expert Testimony, Review of Partners Healthcare System's Proposed Acquisitions of Hallmark Health Corporation* (Boston, MA, Health Policy Commission, September 3, 2014).

²² H.B. 4155 § 66, 2011-2012 Leg., Reg. Sess. (Mass. 2012).

²³ Id.; H1916, 2015-2016 Leg., Reg. Sess. (Mass. 2015); H0602, 2011-2012 Leg., Reg. Sess. (Mass. 2011); H1471, 2011-2012 Leg., Reg. Sess. (Mass. 2011).

²⁴ Executive Office of Administration and Finance and the Division of Health Care Finance and Policy, *Recommendations of the Special Commission on Provider Price Reform* (Boston, MA, 2011), available at <http://www.chiamass.gov/assets/docs/g/special-comm-ppr-report.pdf>.

²⁵ Final Judgement by Consent, Commonwealth v. Partners HealthCare System, SUCV2014-02033-BLS (June 24, 2014).

²⁶ Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent, Commonwealth v. Partners HealthCare System, SUCV2014-02033-BLS2 (Jan. 29, 2015); Dafny, Letters from Economists, supra note 21; Health Policy Commission, *Review of Partners Healthcare System's Proposed Acquisitions of Hallmark Health Corporation* (Boston, MA, 2014). The proposed consent judgment prohibited all-or-nothing contracting, not component contracting. Much of the
(footnote continued)

Moreover, additional analyses, models, and a high-profile real-world example²⁷ support the conclusion that component contracting would not restore competition or lower prices. First, component contracting rests on the assumption that rival providers do not want to lose business to one another. This holds true for actual competitors but is unlikely where providers are part of the same system. For example, suppose that Hospitals A and B operate in the same area and are part of the same organization. Even if the hospitals are forced to negotiate separately, revenues generated by each hospital flow to the same parent organization. In this case, it does not really matter which hospital a patient visits. Neither Hospital A nor Hospital B has an incentive to lower its prices, since the insurer's only threat is to take its business to the other hospital in the same system. A paper modeling the effects of component contracting supports this reasoning.²⁸ It determines that component contracting results in the same or slightly higher prices than those negotiated by the single entity.²⁹

There may be additional drawbacks to component contracting. It increases administrative costs, because providers must maintain firewalls between teams, and because both providers and insurers must execute a greater number of contracts.³⁰ Component contracting requires state monitoring and regulation to ensure compliance. Finally, component contracting addresses the lack of competition among providers that, but for the merger or acquisition, would have been competitors. If all facilities within that health system were independent, however, it does not necessarily follow that they would compete for the same business. Health systems are typically comprised of diverse groups of providers that provide specific services to specific regions; only some of these markets overlap. It would be inefficient to require these facilities to contract separately. In this case, component contracting would also not lower prices, since each facility would retain its unique monopoly over a particular market.

There is only one real-world example of component contracting, and it did not lower prices. In the early 2000s, the FTC began to review previously-approved hospital mergers, to examine their effects on prices. In 2004, the FTC filed a complaint against Evanston Northwestern Healthcare alleging that the health system's acquisition of rival Highland Park Hospital enabled it to raise its prices.³¹ In 2007, the FTC ruled that the merger was anti-competitive.³² At that point, however, the

testimony to Judge Sanders analyzed the related issue of component contracting, including the requirement for separate negotiating teams.

²⁷ See below for an analysis of the efficacy of the FTC's *Evanston Northwest Healthcare Corporation* decision, which ordered component contracting.

²⁸ Gowrisankaran, "Prices Are Negotiated," supra note 21.

²⁹ Majette, "Contracting & Market Forces," supra note 2; Gowrisankaran, "Prices Are Negotiated," supra note 21; Dafny, Letter from Economists, supra note 21; Chipty, *Expert Testimony*, supra note 21.

³⁰ Commission members (statements to the Special Commission on Provider Price Variation, Boston, MA, Nov. 29, 2016).

³¹ *Evanston Northwest Healthcare Corp.*, Docket No. 9315 (Fed'l Trade Comm'n Feb. 10, 2004) (complaint).

³² *In re Evanston Northwest Healthcare Corp.*, Docket No. 9315 (Fed'l Trade Comm'n Aug. 6, 2007) (opinion).

hospitals had been integrated for several years and had created joint service lines and training programs. The standard antitrust remedy to a merger or acquisition is to block the consolidation. Where a consolidation has already taken place, antitrust agencies typically favor a structural remedy – breaking apart or divesting the entities.³³ In this case, however, the FTC was concerned that breaking apart the hospitals would negatively affect patient care. Instead, it imposed a component contracting remedy. The health system was allowed to remain as is, but the hospitals were required to contract separately for ten years.

The effects of the remedy have not lived up to expectations. Notably, no insurer has chosen to contract separately, despite the theoretical pro-competitive benefits of doing so. Perhaps independent negotiations would have been administratively difficult, or perhaps insurers realized that the hospitals did not have a true incentive to bargain down their prices. In any case, component contracting did not lower prices, and the FTC has since distanced itself from this remedy.³⁴

Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, briefed Commission members on component contracting and the Evanston case. The majority of members agreed that component contracting would not reduce provider price variation and could have negative unintended consequences. According to Lynn Nicholas, representing the Massachusetts Health & Hospital Association (MHA), the MHA workgroup decided that component contracting would inhibit the formation of ACOs, since it is not feasible for facilities within an integrated system to contract separately. Other provider representatives agreed that health systems often rearrange service lines among facilities. For example, a system might centralize cardiac care in one hospital. Component contracting does not work in this situation.

Payer representatives agreed that component contracting would probably not lower prices and could cause drastic and unintended consequences. For example, a provider system could evade the separate contracting requirement by restructuring its components. In addition, component contracting would create administrative complexity, which could be destabilizing to both payers and providers. Several Commission members, however, thought that there might be value in examining all-or-nothing clauses in insurer/provider contracts. Lora Pellegrini, representing the Massachusetts Association of Health Plans, pointed out that some ACOs are not truly clinically integrated. In that case, all-or-nothing contracting could be prohibited. Karen Tseng, representing the AGO, stated that prohibiting all-or-nothing clauses is simpler in principle than requiring component contracting, especially since these clauses are already prohibited in LTNP contracts. She agreed that coordination and clinical integration are important but do not necessarily justify all-or-nothing contracting.

³³ Ryan D. DeMotte and Andrea M. Ferrari, *Lessons from Evanston: FTC Orders Novel Remedy in Hospital Merger Case* (Delaware: K&L Gates, 2007).

³⁴ Gowrisankaran, “Prices Are Negotiated,” *supra* note 21; Dafny, Letter from Economists, *supra* note 21; Chipty, *Expert Testimony*, *supra* note 21; DeMotte, *Lessons from Evanston*, *supra* note 33.

One assumption underlying separate contracting is that when a lower-priced provider joins a higher-priced system, its rates increase. Ms. Nicholas stated this did not happen when some hospitals joined the higher-priced Beth Israel Deaconess system. The newly-acquired providers received referrals and access to specialists but not rate increases. She stated that conversations about market leverage generally assume that health systems negotiate as a unit and that rates increase as a result. Ms. Nicholas wondered if this was actually true. Payer representatives answered that health systems do not necessarily contract as a unit. There is no immediate and direct correlation between joining a provider system and automatically receiving higher rates, although rates may increase over time. According to one payer, however, system-wide contracting is the norm.

SECTION III: OUT-OF-NETWORK BILLING IN SUPPORT OF PROMOTING LIMITED/TIERED NETWORK PRODUCTS

Although the Commission was not enthusiastic about component contracting, there was interest in other policies to reduce price variation and increase provider competition. Many members felt that out-of-network billing practices warrant closer scrutiny. Out-of-network bills are charges that arise when a patient receives services from a provider outside of the patient's insurance network. These bills raise public policy concerns when the patient did not have prior knowledge that those services would be performed by an out-of-network provider.

This can occur in two situations. First, the patient may have been taken to an out-of-network emergency facility. In this case, the patient was unable to request, and it would have been medically inadvisable to transport the patient to, an in-network hospital. Second, healthcare professionals do not necessarily belong to the same networks as the facilities in which they work. This means that a patient may unknowingly receive care from an out-of-network doctor at an in-network facility. The resulting charge to the patient is known as a surprise bill.³⁵ In both cases, the out-of-network provider may, at his or her discretion, bill full charges, since there is no contractual relationship between the patient's insurer and the provider.

Massachusetts has several out-of-network billing protections. Health maintenance organizations and preferred provider organizations must pay out-of-network emergency facilities a "reasonable amount," which is less than full charges.³⁶ In addition, two health insurance laws protect consumers from surprise bills. First, when an insured patient visits an in-network facility, the patient is not responsible for out-of-network charges for services performed by an out-of-network provider, unless the patient had a "reasonable opportunity" to choose to have the service performed by an in-network provider.³⁷ Theoretically, this means that a patient is not

³⁵ Health Policy Commission, *Policy Brief on Out-of-Network Billing* (Boston, MA, 2015), <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-out-of-network.pdf>.

³⁶ MASS. GEN. LAWS ch. 176G, § 5(f) (2016); MASS. GEN. LAWS ch. 176I, § 3 (2016).

³⁷ MASS. GEN. LAWS ch. 176O, § 6 (2016).

responsible for a surprise bill unless he or she affirmatively consented to receive care from an out-of-network provider. Second, health plans must establish a phone number and website that allow consumers to request their estimated or maximum out-of-pocket costs for a proposed admission, procedure, or service. The patient cannot be required to pay more than the disclosed amounts for the covered healthcare benefits that were provided, absent unforeseen circumstances.³⁸

In addition, several Massachusetts laws address price transparency and consumer notice of out-of-network billing practices. In addition to binding out-of-pocket cost estimates for medical services, Evidence of Coverage documents must explain what out-of-network charges are and the circumstances in which a consumer may receive an out-of-network bill.³⁹ Prior to any admission, procedure, or service and upon request, providers must disclose allowed charges or the estimated maximum allowed charge. In addition, upon request the provider must provide the patient with sufficient information to obtain out-of-pocket cost estimates from the patient's health plan.⁴⁰ Finally, several laws allow consumers to obtain quality, price, and out-of-pocket cost information from providers, insurers, and a state website.⁴¹

“We agree that patients should be taken out of the middle and held harmless when there is a “surprise lack of coverage” resulting in balancing billing. There should be more transparency around the insurers’ network of providers so patients can make informed choices when they have the ability to predict medical needs.” – Massachusetts College of Emergency Physician, testimony to the Special Commission

Although these laws, on paper, provide consumers with information and protect them from unexpected bills, there are still several ways in which a consumer might end up paying an out-of-network bill. First, although insurers must pay out-of-network emergency facilities a “reasonable amount,” the law does not explicitly

prohibit these facilities from balance-billing the patient. Balance billing is the practice of sending a bill to the patient for the difference between the amount reimbursed by the insurer and the out-of-network charge.

Second, there is no streamlined or standardized way for a consumer to take advantage of existing protections. This means that a consumer may unknowingly pay an out-of-network bill for which the consumer is not responsible.⁴² In fact, the surprise billing protection does not explicitly prevent providers from sending

³⁸ § 23; *see also* MASS. GEN. LAWS ch. 32A, § 27 (2016).

³⁹ Ch. 176O, § 6.

⁴⁰ MASS. GEN. LAWS ch. 111, § 228 (2016).

⁴¹ For example, Chapter 224 requires providers to report quality measures to CHIA. CHIA must make quality information available to consumers on its website. Health insurance consumer protections require payers to make available provider quality information upon member enrollment or request. MASS. GEN. LAWS ch. 12C, § 20 (2016); Ch. 176O, § 7; Ch. 176O, § 9A.

⁴² Health Policy Commission, *Out-of-Network Billing*, *supra* note 35.

surprise bills. Rather, it is part of a health insurance consumer-protection law that specifies the content of Evidence of Coverage documents.⁴³ In addition, studies indicate that current protections may not provide adequate notice and price transparency. For example, a Health Care For All analysis determined that three insurers' websites were not consumer-friendly, and the Pioneer Institute concluded that many hospitals were unable to comply in a timely fashion with cost-disclosure requirements.⁴⁴

Finally, current laws do not establish a mechanism for resolving payment disputes between payers and providers. Although out-of-network billing is generally considered a consumer protection issue, there are implications for provider price variation. Insurers may decide to shield their members from out-of-network bills by paying some or all of the complete charge. This is known as holding the patient harmless. Certain providers, however, receive roughly the same amount of business whether they are in- or out-of-network. These providers include high-volume emergency facilities and in-demand hospital-based specialists. These providers may leverage this dynamic to receive higher rates, or in some cases, may decide not to contract at all.⁴⁵ In addition, insurers are only able to offer premium discounts on LTNPs because the providers participating in those products are lower-cost. It is difficult to develop, market, and realize savings from LTNPs if a smaller network results in a greater number of higher-cost out-of-network bills that are paid by the insurer or the patient.

Comprehensive out-of-network billing laws require a three-pronged approach. First, there must be a fair default rate for out-of-network services. Second, there must be consumer education, notice to patients, and provider price transparency, so that consumers only receive out-of-network bills when they affirmatively choose to visit an out-of-network provider. Third, where the health plan pays the provider the appropriate default rate, that provider must be prohibited from balance-billing the patient.

Commission members agreed that regulating out-of-network billing practices could protect patients, address increasing healthcare costs, and encourage innovative health plan designs such as refinements to LTNPs. Stuart Altman, appointed by Senate President Rosenberg, commented that this issue cuts across several areas of Commission discussion, including making markets work, transparency, and the role of government. There was some disagreement, however, regarding the breadth of the regulations. Several members cautioned against applying these protections too broadly: if a provider could leave the negotiation and still receive a high rate, this would negate the ability of insurers to create leverage. Ms. Nicholas suggested that

⁴³ Ch. 176O, § 6.

⁴⁴ Barbara Anthony and Scott Haller, *Mass Hospitals Weak on Price Transparency* (Boston, MA: Pioneer Institute, 2016); Health Care for All, *Consumer Cost Transparency Report Card* (Boston, MA, 2015). Note: The Pioneer studies collected information by cold-calling hospitals. The prices provided were hospital charges and not the negotiated reimbursement between the provider and the contracting plans. See Chapter 5 for more information on transparency.

⁴⁵ Health Policy Commission, *Out-of-Network Billing*, supra note 35.

the Commission focus on emergency facilities and ERAP (emergency, radiology, anesthesiology, pathology) hospital-based physicians. It is important to note that Ms. Pellegrini disagreed with the Commission's final recommendation, which could allow for a default rate of slightly above the provider's contracted rate (See Recommendations).

SECTION IV: MATERIAL CHANGE NOTICES & COST AND MARKET IMPACT REVIEWS

As previously noted, when a provider above a certain revenue threshold wishes to make a material change to its governance or operations, it must submit a MCN to the HPC. The HPC reviews data regarding the parties' performance and the parties' plans and stated goals for the material change to determine how and when the material change could impact health care spending and market functioning, including whether it could result in efficiencies and care delivery improvements. The HPC may then conduct a CMIR – a comprehensive analysis of the parties' business and relative market position as well as the impact of the transaction on health care costs, quality and access – for particular material changes anticipated to have a significant impact on healthcare costs or market functioning. Throughout the CMIR process, the HPC solicits data and documents from the parties and other market participants, including relevant payers. The HPC releases a preliminary report, gives the parties an opportunity to respond to the report, and then releases a final CMIR report.

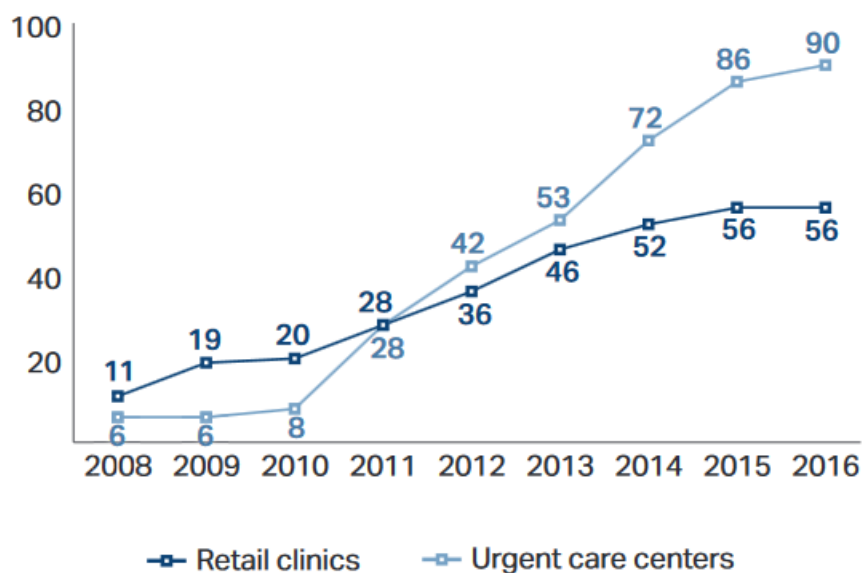
The HPC must refer the final report to the AGO where the provider has a dominant market share and significantly higher prices and total medical spending than other providers. The HPC may refer any other report at its discretion. The AGO may choose to investigate the provider for engaging in unfair methods of competition or anti-competitive behavior, and may file an action in court to temporarily or permanently halt the material change.⁴⁶ Therefore, the MCN/CMIR process operates as a pre-transaction review that gives the public and relevant parties an opportunity to assess the impacts of proposed transactions, encourage positive outcomes, and avert or minimize negative impacts on the market before they occur.

Several Commission members stated that the MCN/CMIR process is accomplishing its goals and that the HPC has been successful in its role. Speaking as Chairman of HPC's Board, Dr. Altman reminded Commission members that the HPC is not interested in conducting CMIRs for most material changes. The HPC focuses on changes that are likely to have a major impact on prices and competition. It issues a report to help stakeholder groups understand the possible effects of the material change, not to express an opinion for or against the change. The HPC's role is simply to make information available to the AGO, the Department of Public Health, and other agencies. Several members agreed that shining a light on these transactions is important.

⁴⁶ MASS. GEN. LAWS ch. 6D, § 13; 958 Mass. Code Regs 7 (2015); MASS. GEN. LAWS ch. 12, § 11N; MASS. GEN. LAWS ch. 93A, § 4.

Other members felt that the MCN/CMIR process could be modified or strengthened. Ms. Pellegrini suggested giving the HPC authority to reject proposed material changes if certain conditions could not be proven. Howard Grant, representing Lahey Health, suggested that the HPC scrutinize more closely the effect of physician employment transitions from lower- to higher-cost organizations, because the cumulative impact of these changes could raise healthcare costs significantly. Steve Walsh, representing the Massachusetts Council of Community Hospitals, suggested that the HPC could take on a strategic role. It could use the statewide health plan to direct resources to high-value community hospitals, maintaining access to services for patients and allowing them to receive care close to home. This would benefit the long-term health of community hospitals. Several Commission members also felt that certain “innovative” providers, such as limited-service clinics and urgent care centers, are expanding their market imprint and should help fund the HPC and CHIA (See Figure 3.2).

Figure 3.2: Retail Clinics and Urgent Care Centers in Massachusetts, 2008-2016⁴⁷



Sources: HPC analysis of data provided by CVS MinuteClinic (retail clinics) and HPC analysis of data from HIPPA Space.com (urgent care centers), 2016

SECTION V: ACQUISITIONS & MERGERS OF PHYSICIAN ORGANIZATIONS

The Evanston case challenged the merger of competitors. This so-called horizontal integration limits the number of providers offering the same service in a given area. This type of consolidation may increase a health system’s bargaining power, which

⁴⁷ Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 31.

may lead to higher prices. Another concern raised by the AGO and other stakeholders is vertical integration, which occurs when hospitals/hospital systems and physicians/physician organizations enter into contractual, ownership, or employment relationships. These entities are not competitors, but they do provide complementary services. Vertical integration may increase a hospital or healthcare system's market clout in several ways. The hospital may be able to lock up a pool of referring physicians, either because an integrated clinical care arrangement naturally facilitates this patient flow or because physicians agree to refer patients to that hospital. Vertical integration also enables all-or-nothing contracting between the hospital/physician group and the health plan. Finally, vertical integration can bolster a health system's brand name, making it harder for an insurer to exclude that health system from its network.⁴⁸ In recent years, there has been an increase in vertical integration in Massachusetts, and some stakeholders are concerned that the state does not adequately monitor or regulate these arrangements.⁴⁹

Commission members discussed two reasons why vertical integration may lead to higher prices. First, a hospital or health system might make the strategic decision to employ an in-demand physician. In order to lure the physician away from competitors, the hospital would have to offer higher rates than the physician would otherwise receive. Rates are not the only thing, however, that may make joining a hospital system appealing to physicians. Hospitals can make health information technology investments, reduce revenue uncertainty, and provide access to cutting edge technology. Although this practice often increases payments to physicians, it does not increase total spending or the rates paid by insurers and consumers. Rather, employing physicians is an internal business decision that hospitals make for a number of reasons. For example, the organization may seek to better integrate care or standardize best practices.

Members agreed that the Commission should not focus on hospital payments to physicians, which reflect strategic choices made by the hospital. Ms. Nicholas noted, however, that there could be a more standardized approach to reporting information about physician cost and payments to the state. This would enhance our understanding about the effect of physician payments, referral patterns, and prices, contributing to a more complete picture of hospital financial performance. The HPC or CHIA could also make this information transparent to stakeholders and consumers. Kate Walsh, representing Boston Medical Center (BMC), emphasized that although transparency is important, health systems must have the autonomy to

⁴⁸ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, 2013), available at <http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>; Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending," *Health Affairs* 33 (2014): 759-763, available at <http://content.healthaffairs.org/content/33/5/756.full.pdf+html>; Robert Kocher and Nikhil Sahni, "Hospitals' Race to Employ Physicians – The Logic Behind a Money-Losing Proposition," *New England Journal of Medicine* 364 (2011): 1790-1793, available at <http://www.nejm.org/doi/full/10.1056/NEJMp1101959#t=article>.

⁴⁹ Office of the Attorney General, *Cost Trends*, supra note 48. The FTC addresses the impact of vertical integration in its guidance on the formation of ACOs. See 76 Fed. Reg. 67026.

make internal business decisions. As an example, she discussed BMC's labor floor costs. BMC pays \$1 million more than similar organizations each year to cover the labor floor. Staff include midwives, obstetricians, obstetrical trainees, maternal-fetal medical specialists, family medicine residents, and attending physicians. BMC staffs the labor floor this way because it views training family physicians as an obligation to the community.

There is another way, however, in which vertical integration may lead to higher prices. As discussed above, a hospital or health system may acquire or employ physicians as a way to increase its bargaining leverage with insurers. Several members stated that the Commission should examine this cause of price variation, since greater health system bargaining power ultimately leads to higher hospital and physician rates. Furthermore, a hospital that wishes to compete with a dominant provider for physicians must match the higher rates that the dominant provider offers. If that hospital has less market leverage, and thus receives relatively lower rates from insurers, it could be forced to take money out of its coffers. This puts the lower-priced hospital at an even greater competitive disadvantage.

Provider representatives, however, stated that a hospital does not automatically increase its bargaining power with insurers when it employs or acquires physicians. Several members noted that many types of hospitals are acquiring and employing physicians, because physicians are eager to enter into these arrangements. There are many reasons for this shift, including reduced administrative burdens, access to state of the art technology, and increased operational efficiencies. One member noted that this trend is the reality of today's healthcare market and does not just benefit dominant health systems.

Commission members briefly discussed another area of concern, facility fees. If a hospital acquires a physician practice or outpatient clinic, it may be able to charge a facility fee – a separate bill for the facility, on top of the bill for physician services. Dr. Altman explained that facility fees were established in the early 1980's, when the DRG payment system was created. Hospitals argued that they provided services to more complex patients, and that they needed to charge facility fees to make up the cost difference. According to Dr. Altman, there is some truth to this argument. Medicare did not anticipate, however, that the healthcare outpatient delivery system would change drastically. Today institutions linked to hospitals provide a greater volume of basic care, meaning that facility fees apply to a greater number of cases. These patients are not necessarily more complex or costly than those treated in independent practices. Facility fees, which generate billions of dollars in annual revenue, affect commercial rates as well because hospitals that bill Medicare this way must do so for all commercial insurers.⁵⁰ Despite its effect on healthcare costs,

⁵⁰ Sandra G. Boodman, "'Facility fees' are Surprise Cost for Many Patients," *Kaiser Health News*, October 6, 2009, <http://khn.org/news/fees>; Kelly Gooch, "6 Things to Know About Facility Fees," *Becker's Hospital Review*, March 22, 2016, <http://www.beckershospitalreview.com/finance/6-things-to-know-about-facility-fees.html>.

however, most Commissioners decided that issue was too off-topic, given the Commission's charge.

Most Commission members felt that exploring the nuances of hospital affiliations with physician organizations and other forms of vertical integration should not be a Commission priority. Members expressed strong support, however, for increased transparency and reporting of prices that result from these transactions.

CHAPTER 4 – DEMAND-SIDE INCENTIVES IN HEALTHCARE

INTRODUCTION

Demand-side incentives are strategies or mechanisms to encourage consumers, employers, and employees to make high-value choices. For consumers, this can reduce out-of-pocket costs and lower premiums. Demand-side incentives can also reduce overall system spending, which is beneficial for all stakeholders. In addition, these incentives can reduce unwarranted price variation. If enough consumers visit high-quality, low-cost providers, this can incentivize higher-priced providers to reduce their prices to capture greater patient volume.

The Special Commission discussed how to leverage demand-side incentives to reduce price variation. Section I outlines the circumstances in which demand-side incentives can be used. It also summarizes pre-requisites for and the limitations of demand-side incentives. Section II considers the role of health insurance market structures. Section III examines how plan design can promote high-value choices. Section IV discusses how shopping tools can incentivize the use of lower-cost providers and services.

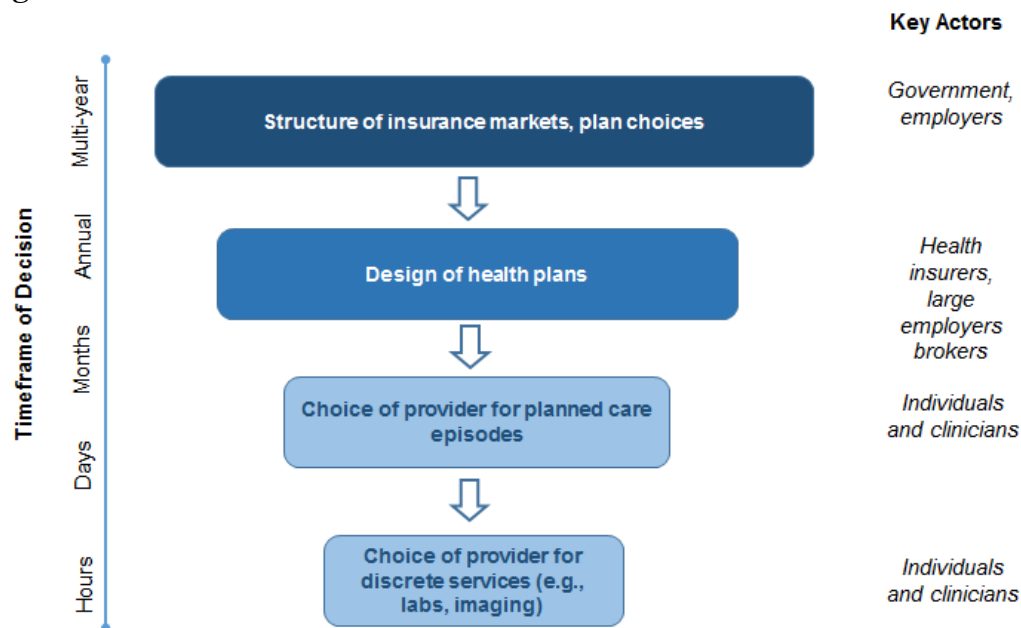
SECTION I: DEMAND-SIDE INCENTIVES IN HEALTHCARE

David Auerbach, Director of Research and Cost Trends at the Massachusetts Health Policy Commission (HPC), presented to the Commission on demand-side incentives. Dr. Auerbach explained that demand-side incentives have the potential to increase the use of efficient health plan designs, shift volume to higher-value providers, and reduce spending and prices through competition.¹ There are several points along the healthcare continuum in which demand-side incentives operate (See Figure 4.1). The highest level is through plan selection and the structure of insurance markets. Here large employers and government actors can take steps to offer and incentivize the uptake of high-value plans. For example, the Group Insurance Commission (GIC) offered all members a three-month “premium holiday” if they enrolled in a limited-network plan.² At the next level, health insurers can design and market high-value plans, which affect choices made by providers and consumers. Finally, patients and clinicians can identify and choose high-value providers for planned episodes of care and discrete services.

¹ David Auerbach, “Demand-Side Incentives to Address Provider Price Variation” (presentation to the Special Commission on Provider Price Variation, Boston, MA, Dec. 13, 2016).

² Auerbach, “Demand-Side Incentives,” *supra* note 1.

Figure 4.1: Demand-Side Incentives in Healthcare



As this chapter discusses, at each of these levels there are barriers and disincentives to choosing high-value providers. For this reason, the Special Commission agreed that demand-side incentives alone will not solve the problem of unwarranted provider price variation. Nonetheless, in a variety of circumstances demand-side incentives can lower costs and shift patient volume to high-value providers.³ Commission members agreed that influencing consumer demand is a key component of making markets work.

SECTION II: STRUCTURE OF HEALTHCARE MARKETS

At the highest level, government agencies and employers can promote high-value choices when they select which plan designs and benefits to make available to consumers. This can influence uptake of products that are cost-effective and reward choice of high-value providers. For example, health insurance exchanges can foster competition among payers seeking to offer the most attractive plans to consumers and small businesses. Exchanges can facilitate competition in a number of ways, with the goal of steering shoppers to plans that reward high-value providers.⁴

The Massachusetts state exchange is the Commonwealth Health Insurance Connector Authority (Connector). For consumers eligible for state subsidies, the Connector pays a fixed amount, regardless of plan choice. Consumers that choose higher-cost plans pay larger premiums, which may shift preferences to lower-cost

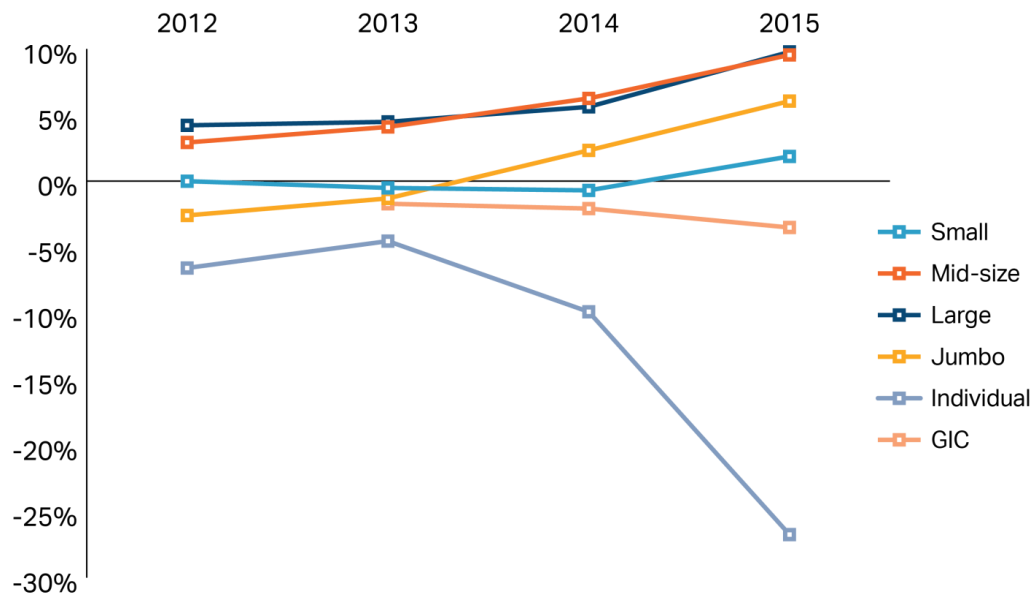
³ Id.

⁴ As a prerequisite, there must be a sufficient number of participating insurers. Studies show that when competition among carriers decreases, insurance premiums increase. Leemore Dafny, *Evaluating the Impact of Health Insurance Consolidation: Learning From Experience* (New York, NY: Commonwealth Fund, 2015).

products. The Connector is also an active purchaser. It limits the number of plans to five per region, requiring carriers to compete on price. Active purchasing incentivizes carriers to offer low-premium products, including limited- and tiered-network plans (LTNPs).⁵ Finally, the Connector facilitates lower-priced offerings by standardizing coverage documents, which allows consumers to easily compare plans.

Large employers, such as the GIC, are in the best position to reproduce these conditions and facilitate the adoption of high-value plans, because they purchase insurance for a large number of consumers.⁶ The pro-competitive features of the Connector and the GIC contribute to lower premiums in those markets, compared to other segments of the commercial insurance market (See Figure 4.2).

Figure 4.2: Premiums by Group Size Relative to 2012 Small-Group Premiums, 2012-2015⁷



Smaller employers are not as capable of replicating these competitive conditions. 69% of small Massachusetts businesses (50 or fewer employees)⁸ and 40% of mid-size businesses (50-99 employees) offer only one choice of plan (See Figure 4.3).⁹ In response to an HPC survey, small- and mid-sized businesses stated they do not have enough employees and/or they find it too complicated to offer multiple plans.¹⁰ These businesses are more likely to offer a broad-network plan to accommodate the

⁵ Auerbach, “Demand-Side Incentives,” *supra* note 1.

⁶ The Group Insurance Commission provides health insurance options for all state employees as well as a number of municipalities that have chosen to participate.

⁷ *Id.* Note that the individual coverage line represents both subsidized and unsubsidized coverage.

⁸ Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 69.

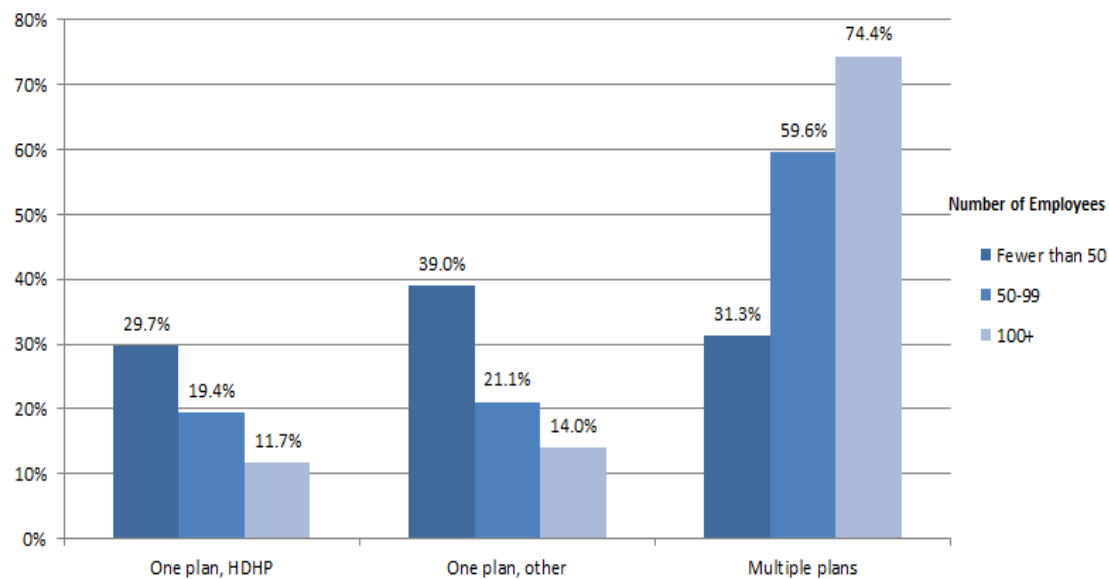
⁹ *Id.*

¹⁰ *Id.*

health needs of all employees.¹¹ Furthermore, many eligible businesses do not take advantage of the Connector to purchase insurance for their employees. A recent report by the Associated Industries of Massachusetts (AIM) found that less than 1% of businesses use the Connector. 90% of employers have either “not considered using the Massachusetts Connector” or are “not really sure what the Massachusetts Connector is.”¹²

Even when employers offer more than one plan, few offer products like LTNP that reward high-value providers. Approximately 8% of the non-GIC commercial market¹³ is in a tiered-network plan, and commercial enrollment in limited-network plans is approximately 3%.¹⁴ These factors collectively point to the need for a significant amount of education and outreach to smaller employers by the state, brokers, and other actors.

Figure 4.3: Employer Size and Plan Options, 2014¹⁵



Several times members discussed how small business health insurance purchasing cooperatives (co-ops) could reproduce the pro-competitive features of the large-group and self-insured markets. Under this model, small businesses (those with up to

¹¹ For example, a business owner needing to provide LGBTQ-related services many only have one choice of plan, as many LGBTQ health services are only provided by out-of-state or non-network providers.

¹² Associated Industries of Massachusetts, *Trends and Practices Among Massachusetts Employers: 2016 Report* (Boston, MA: 2016).

¹³ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, June 30, 2015).

¹⁴ Center for Health Information and Analysis, *Massachusetts Tiered Network Membership* (Boston, MA 2016).

¹⁵ Health Policy Commission, *2016 Cost Trends Report*, supra note 7, at 69.

50 and in some cases 100 employees) join together to form a larger purchasing pool. This allows co-ops to negotiate with insurers for lower premium rates and broader benefit packages. A number of states established co-ops in the mid-1990s. By 2009, 28 states operated some version of a co-op.¹⁶ Massachusetts administers the Group Purchasing Cooperative (GPC) program, under which groups of eligible small businesses can seek approval from the Division of Insurance (DOI) to form purchasing associations.¹⁷ Up to six GPCs can operate at a time;¹⁸ since 2010, the DOI has certified five.¹⁹ The Transparency Subcommittee recommended that the Commonwealth explore opportunities to improve the purchasing power of smaller businesses (See Recommendations).

SECTION III: HEALTH PLAN DESIGNS THAT REWARD HIGH-VALUE PROVIDERS

LTNPs have the potential to steer consumers to high-value providers in different ways. In contrast to Preferred Provider Organizations (PPOs), limited-network plans (LNPs) include a narrow set of high-value providers. In most circumstances, consumers must pay out-of-network rates when they visit providers outside this network. Tiered-network plans (TNPs), on the other hand, may be as broad as PPOs. They steer consumers to lower-cost/higher-quality providers by placing providers in different cost-sharing “tiers.” Higher-cost/lower-quality providers are placed in less favorable tiers, according to the carrier’s tiering methodology. In most circumstances consumers pay greater co-pays or coinsurance amounts to visit these providers. Some plans, such as the plan offered by Polar Beverages, also require higher deductibles for services provided at unfavorably-tiered hospitals. (See Feature: Polar Beverages Tiered Health Plans). Most products have two or three tiers. Both LNPs and TNPs are designed to have lower premiums.²⁰ Together these plans make up approximately 20% of the commercial market (See Figure 4.4).

¹⁶ “Health Insurance Purchasing Cooperatives: State and Federal Roles,” National Conference of State Legislatures, accessed February 6, 2017, <http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx>.

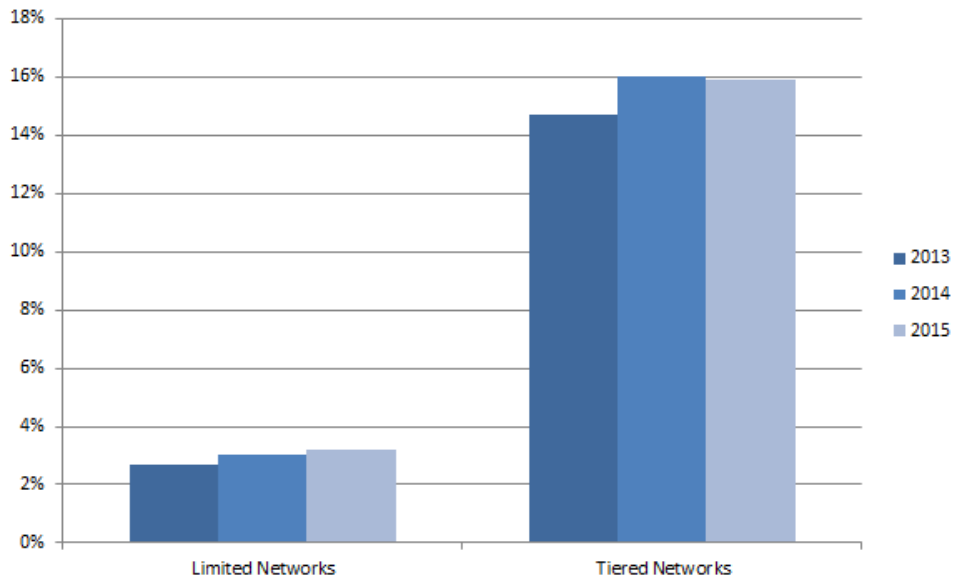
¹⁷ MASS. GEN. LAWS ch. 176J, §12 (2016).

¹⁸ Id. at (b). Note: The Affordable Care Act places limitations on acceptable rating factors, prohibiting state-specific rating factors. The state’s Group Purchasing Cooperative rating factor will be phased out entirely on January 1, 2018. See Kevin Connihan, Letter to Louis Gutierrez (Washington, D.C., June 16, 2015).

¹⁹ These GPCs are the Associated Subcontractors of Massachusetts, Massachusetts Association of Chamber of Commerce Executives, Massachusetts Society of Certified Public Accountants, Retailers Association of Massachusetts, and Spring Healthcare Cooperative. Massachusetts Division of Insurance, *Certified Group Purchasing Cooperatives* (Boston, MA, April 30, 2015), available at <http://www.mass.gov/ocabr/docs/doi/2012-group-purchasing-coop.pdf>.

²⁰ Massachusetts carriers that serve more than 5,000 members must offer an LTNP with a base premium at least 14% lower than the base premium for the carrier’s most actuarially-similar non-LTNP plan. MASS. GEN. LAWS ch. 176J, §11.

Figure 4.4: Commercial Enrollment in Limited and Tiered Network Plans, 2013-2015²¹



It is unclear how many additional consumers would select an LTNP if their employer offered one. Dr. Auerbach and Commission members, however, noted a number of barriers to the uptake of LTNPs. Consumers prefer and are used to a wide choice of providers. Karen Tseng, representing the Office of the Attorney General (AGO), explained that tiered plans without enough brand-name providers begin to look like LNP, which constrains their popularity. In addition, networks must be robust, so that patients have access to comprehensive and accessible coverage. Steven Walsh, representing the Massachusetts Council of Community Hospitals, noted that people who live in geographically-isolated areas or whose plans exclude higher-priced providers may have to seek out-of-network care or travel longer distances to access care. Consumers may also be concerned that switching to an LTNP could disrupt their care. Furthermore, Dr. Auerbach pointed out that consumers may view LTNPs as an insurance company scheme to make more money. This is especially true where consumers equate provider cost and quality.²² Finally, consumers may be wary of plans that require them to second-guess their physician’s decisions; for example, as to where the patient seeks specialist care. For these reasons, Commission members agreed that making LTNPs work requires additional consumer education. These plans can be difficult to explain to members, and patients need to understand their choices both at the point of enrollment and the point of service.

²¹ Auerbach, “Demand-Side Incentives,” *supra* note 1.

²² Health Policy Commission, *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Boston, MA, March 2016), 40.

In some cases, LTNPs may not even have lower premiums. In that case, the consumer has little incentive to purchase the product. The AIM report found that on average, surveyed employees contribute the same or a greater premium amount to a TNP as they do to a PPO plan.²³ Payer representatives have explained a number of reasons why LTNP premiums are not always significantly lower; for example, limitations to risk adjustment methodologies. Premium subsidies, although an important way to make plans affordable, also blunt the effect of premium differentials.

Polar Beverages Tiered Health Plan

Five years ago, Polar Beverages, a self-insured employer based in Massachusetts, switched its Massachusetts employees to a tiered health plan. The plan has three tiers – Enhanced, Standard, and Basic. The Enhanced tier contains the highest-quality, lowest-cost providers. Employees that visit these providers have little or no cost-sharing. Employees are still free to visit any covered provider, but they must pay higher deductibles and higher cost-sharing amounts to visit non-Enhanced providers.

Steve Carey, the Vice President of Human Resources for Polar Beverages, represents large employers on the Special Commission on Provider Price Variation. He explained that for Polar, the most important and challenging aspect of moving to a tiered-network plan was employee education. Polar undertook an extensive education process, including mandatory annual meetings with all employees. It created a patient portal, on which employees can look up pricing and quality information. Polar also established a healthcare concierge service to help employees with questions about hospitals and specialists, costs of services, and other matters. When the concierge service began, it was provided through an outreach program run by St. Vincent's Hospital. Later, Polar brought a dedicated concierge professional in-house. Mr. Carey and two of his colleagues also keep themselves available to answer employee questions.

More than 90% of Polar employees receive services from providers in the Enhanced tier. The majority of employees are satisfied with the plan, and premiums have increased at a lower rate since Polar began offering this plan. Mr. Carey explained that without extensive education, however, the plan would not have been as successful in keeping down premium costs.

Despite these limitations, the right set of incentives can increase LTNP uptake, produce savings, and potentially reduce price variation. For example, as noted above, in 2012 the GIC offered its members no premiums for three months if they switched to an LNP. 10% of its membership switched plans, resulting in 36% lower spending per person compared to the broad-network plan. LNPs produced savings because of decreased use of high-cost providers and hospital and specialist care, with no reduction in quality or member health. Both healthier and sicker members reduced spending. In addition, although a greater number of healthier members joined an LNP, the differential was not large enough to separate the risk pools. Spending on primary care did increase, but the spending was more than offset by the decrease in specialist visits. Overall, GIC spending fell by 4.2%. Although some consumers were

²³ Associated Industries of Massachusetts, *Trends and Practices*, supra note 11, at 16.

confused or dissatisfied with their plans,²⁴ the majority of people who switched plans remained in LNPs in subsequent years.²⁵

As Figure 4.4 indicates, consumers tend to prefer TNPs, because they are less restrictive than LNPs. TNPs have been shown to change patient preferences and indirectly reduce price variation. A study in the *American Journal of Managed Care* found that when selecting a new provider, certain populations tend to choose favorably-tiered providers. This changed the marketplace – physicians in the worst tier experienced a 10-15% decrease in market share.²⁶ Another study examined a Blue Cross Blue Shield Massachusetts hospital TNP that has large cost-sharing differentials among tiers. For example, the co-pay at preferred hospitals is \$150, compared to \$1,000 at non-preferred hospitals. Based on claims data, the authors concluded that if all members switched to a TNP, scheduled admissions to non-preferred hospitals would drop 7.6%, and admissions to middle and preferred hospital would increase by .9% and 6.6%, respectively.²⁷ In addition, there is anecdotal evidence that some providers reduce their prices so that they can be placed in a preferred tier.²⁸

Although TNPs encourage the use of high-value providers, in certain circumstances they do not change patient choices. Several Commission members noted that cost-sharing differences among tiers become less relevant once the consumer reaches his or her deductible. Cost-sharing differences become irrelevant once the consumer reaches the out-of-pocket maximum. Ms. Tseng explained that 75% of medical spending is by people who exceed the out-of-pocket maximum on an annual basis. Out-of-pocket maximums should not be removed – they are important consumer protections. They must be paired, however, with additional incentives.²⁹

Furthermore, Dr. Auerbach explained that consumers often prioritize perceived provider value over cost. Consumers may choose a brand-name provider, even if unfavorably tiered, if they equate cost with quality. Similarly, in a stressful situation, patients may become indifferent to out-of-pocket costs and choose a provider without regard to tier. As noted above, consumers may also associate cost and quality. Provider representatives noted that this is a major reason why they are frustrated by perceived lack of transparency in tiered products. The primary factors that determine tier placement are cost and quality so when high-quality providers are

²⁴ In the Commission meeting, Ms. Pellegrini noted that the GIC needed to create a separate re-enrollment period for a small number of members who were unhappy with their LNP.

²⁵ Jonathan Gruber and Robin McKnight, “Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees” (Cambridge, MA: National Bureau of Economic Research, September 2014); Auerbach, “Demand-Side Incentives,” *supra* note 1.

²⁶ Anna Sinaiko, “Variations in Response to Tiered Physician Networks,” *American Journal of Managed Care* 22 (2016): 420-425.

²⁷ Matthew B. Frank, et. al., “The Impact of a Tiered Network on Hospital Choice,” *Health Services Research* 5 (Oct. 2015):1628-48.

²⁸ Dolores Mitchell, testimony to the Health Policy Commission, 2015; statement by Lora Pellegrini to Special Commission members.

²⁹ For example consumers could receive a cash rebate for choosing a high-value provider. See Section IV.

placed in an unfavorable tier, consumers may view them as low-quality. Improved transparency would help consumers understand what they are purchasing when they choose a physician or hospital.

The Commission discussed ways to increase uptake of TNPs by changing the provider “opt-out” provision, increasing the cost differentials among tiers, and improving transparency in health plans’ tiering methodology. Lora Pellegrini, representing the Massachusetts Association of Health Plans, emphasized that the opt-out provision, which allows providers that otherwise contract with a payer to opt-out of participating in a TNP,³⁰ is a significant barrier to creating robust TNPs. She said that providers should be required to participate in TNPs if they participate in broader-network plans. Deborah Devaux, representing Blue Cross Blue Shield of Massachusetts, added that at the very least, providers that opt out of TNPs should be required to participate when delivering emergency services. Lynn Nicholas, representing the Massachusetts Health & Hospital Association (MHA), disagreed. She stated that the MHA believes that the opt-out provision should remain in place, and that providers should not be required to participate in a given tiered product. She added, however, that the MHA work group discussed how greater differentials among tiers could really affect patient decision-making. David Torchiana, representing Partners Healthcare, added that TNP innovations require a consistent tiering methodology among carriers.

Some members noted that it is difficult to create TNPs in regions with few hospitals or consolidated health systems. For example, Steven Carey, representing Polar Beverages, said that Baystate Medical Center acquired several favorably-tiered hospitals and then raised those hospitals’ rates. This pushed the hospitals out of the most-favorable tiers. As a result, his employees have fewer lower-cost options. In addition, employees that had been receiving care at the smaller hospitals found themselves facing higher out-of-pocket costs. Mr. Walsh added that tiering cannot move the market if price variation causes lower-cost providers go out of business. Mark Goldstein, representing Anna Jaques Hospital, pointed out that some community hospitals are so under-reimbursed that they lose money with each patient. In this case, additional patient volume hurts, not helps. He expressed concern that tiering does not directly impact price disparities for these hospitals.

The Market Forces Subcommittee presented two recommendations to the Commission on health plan tiering and methodology. First, health plans should develop a uniform method for displaying a hospital’s assigned benefit tier. Information on how the hospital performed on cost and quality benchmarks should be presented in a consumer-friendly format for both providers and patients. Second, upon request, health plans should provide the methodology used for a hospital’s tier placement, including criteria, measures, and data sources. Health plans should also provide the hospital-specific information used to determine the hospital’s quality score, how the hospital’s performance compares to other hospitals, and the data used in calculating the hospital’s cost-efficiency (See Recommendations).

³⁰ MASS. GEN. LAWS ch. 176O, § 9A (2016).

Ms. Devaux noted an additional and major barrier to LTNP uptake: out-of-network providers can bill full charges, even when the patient has no choice of provider. As explained in Chapter 3, patients in emergency situations do not choose which emergency room to visit. Patients may also receive care from a non-contracted provider in a contracted facility. Ms. Devaux explained that after factoring in just the costs of out-of-network emergency care, LTNPs do not realize a significant portion of their potential cost savings. She recommended setting a rate for out-of-network services when they are provided to patients that do not have a choice of provider.

New Tiering Policy at the Group Insurance Commission

The Group Insurance Commission (GIC) is enhancing its tiering program for two large products (Tufts Navigator and Harvard Pilgrim Independence). Tiering will be based on provider group value instead of individual performance and is being extended to include primary care physicians, in addition to specialists and hospitals. Since primary care physicians are usually the source of downstream referrals to specialists and hospitals, the GIC expects this approach to be more effective in steering members to higher value practitioners across the care spectrum. Members will pay lower copays for providers and facilities in lower tiers. For example, patients may select a primary care provider and pay \$10, \$20, or \$40 for Tier 1, 2, or 3 respectively. A patient can be referred to a specialist in the same tier or a different tier. Co-pays for specialists are \$30, \$60, and \$90.

The Commission also discussed an innovative health plan design proposed by the AGO. Under this plan, the consumer would choose a primary care provider (PCP) at the point of enrollment. The consumer's premium would reflect the efficiency of the health system with which the PCP is aligned. The assumption is that through referrals and recommendations, the PCP, where appropriate, would keep the patient's care within that higher-quality, lower-cost facility.³¹ Ms. Tseng explained that this product could shift patient volume to high-value systems and keep appropriate care in the community. These products are also fairer to consumers, because patient premiums directly reflect the efficiency of the providers they choose. In addition, these products are in harmony with payment reforms that require provider systems to take on risk and coordinate care within the system.

Ms. Tseng stressed that this idea is at the concept level and would be part of a menu of options to lower costs. There are important questions that still need to be answered, such as how to avoid adverse risk selection and how to price premiums in relation to broader-network plan. In addition, there must be effective actuarial modeling to anticipate spending based on PCP choice. Payer representatives stated that this type of plan might be worthwhile, but success would hinge on provider participation. One payer cautioned that given the uncertainty around the future of the Affordable Care Act, developing these products will probably not be a priority in the near future. Howard Grant, representing Lahey Health, stated that he was

³¹ For more information, see Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, Oct. 13, 2016).

impressed with this idea, because it encourages both physicians and consumers to make value-based decisions. Currently there are few financial implications for physicians that join or contract with high-cost networks. Ms. Nicholas stated that she discussed this idea with the MHA work group. Although the group had some concerns about the details of implementation, it was interested in exploring a pilot program. Finally, several Commission members noted that the success of this product depends on employer buy-in.

SECTION IV: SHOPPING FOR HEALTHCARE SERVICES

In recent years there has been a movement both nationally and in Massachusetts to make price and quality information available to consumers so they can shop for services. As healthcare costs continue to rise, patients are being asked to pay a greater share of costs and be more active decision-makers. Increased access to price and quality information can help patients choose high-value, low-cost providers, leading to lower out-of-pocket costs. Shopping based on value can also reduce price variation by encouraging providers to compete on price and quality.³²

“Consumers must be able to translate cost and quality transparency data into healthcare decisions. This means explicitly showing consumers their options, and supplying decision aids to teach how to navigate through data, and how to use cost and quality information to reach an informed decision about treatment.” – Health Care For All, testimony to the Special Commission

Although consumer shopping can lower costs and reduce price variation for certain services, it has limitations. Only certain healthcare services or procedures are “shoppable.” A healthcare service is shoppable if it can be planned in advance and is

offered by more than one provider. In addition, sufficient information on quality and price must be available.³³ The information must be combined with easy-to-use shopping tools, and there must be immediate and significant savings.³⁴ Furthermore, as the market moves towards models like ACOs and as healthcare systems take on more risk, shopping could negatively impact care coordination. In addition, quality measures may confuse patients. Patients may be confronted with too many, too few,

³² Health Care Cost Institute, *Spending on Shoppable Services in Health Care*, (Washington, D.C., Mar. 2016).

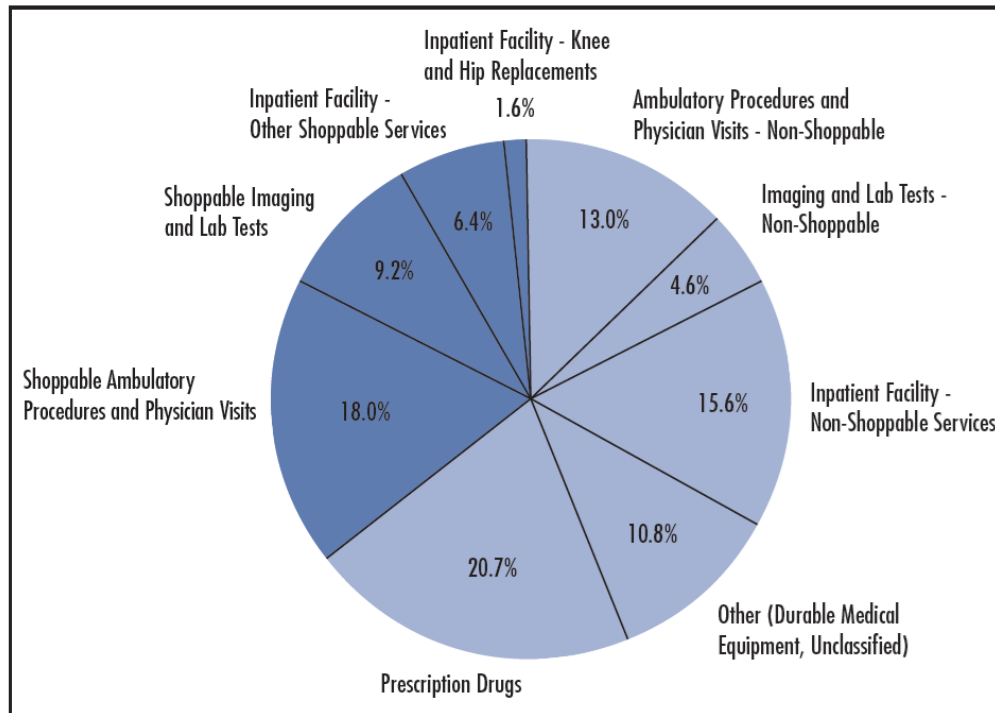
³³ Id.; Auerbach, “Demand-Side Incentives,” supra note 1.

³⁴ Jon Gabel et al., *Price Transparency Tool Attracts Users But Does Not Lead to Use of Lower-Priced Services* (NJ: Robert Wood Johnson Foundation, September 2016); Judith Hibbard, et. al., “An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care,” *Health Affairs*, 31 (2012) 560-568; Auerbach, “Demand-Side Incentives,” supra note 1.

or the wrong measures.³⁵ Finally, spending on shoppable services only accounts for a third of total spending, so there are limits to its potential to reduce total costs.³⁶

Figure 4.5 Shoppable Services in Healthcare³⁷

Figure 1
Shoppable Services Account for One-Third of Total Spending



Note: Shoppable services were identified in claims data based on the diagnosis-related group for inpatient facility stays or the Healthcare Common Procedure Coding System and Current Procedural Terminology codes for outpatient facility and professional services.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents

The Commission discussed cash-back programs, an example of a demand-side incentive used to promote consumer shopping. These programs provide cash rebates to consumers when they make high-value choices. Consumers use a website to search for services and view price information, quality scores, and even reviews from other patients. If the patient chooses a low-cost provider, the patient gets a refund check in the mail. Insurers typically use a vendor for these services, such as Vitals or Castlight.³⁸ There is some evidence that these programs promote competition in the

³⁵ David Newman and Amanda Frost, "Reimagining the Consumer Role in Improving Value," *Health Affairs Blog*, June 10, 2016, <http://healthaffairs.org/blog/2016/06/10/reimagining-the-consumer-role-in-improving-value>.

³⁶ Chapin White and Megan Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle* (Washington, D.C.: National Institute for Health Care Reform, 2014).

³⁷ Id.

³⁸ See, e.g., <https://www.vitalssmartshopper.com> and www.castlighthealth.com. See also Priyanka Dayal McCluskey, "Employers Reward Workers who Shop Around for Health Care," *Boston Globe*, (footnote continued)

market and result in savings.³⁹ Roberta Herman, representing the GIC, praised the concept of cash-back rebates. She informed Commission members that each GIC plan has some variation of a shopping program for a finite number of services. She noted, however, that its impact on costs is modest and it requires proactive outreach to encourage use.

Commission members agreed that consumers should be encouraged to shop for value and that shopping tools can reduce healthcare spending and encourage consumers to seek high-value care. Ms. Nicholas, however, noted, that although shopping tools produce short-term benefits, the MHA working group was concerned about longer-term implications. For example, cash-back rebates can encourage patients to seek care outside their network, which negatively impacts care coordination. Hospitals might also lose revenue from profitable service lines that cross-subsidize low- and no-margin services. This could hurt certain hospitals in the long run, especially those that are smaller and do not have brand power. This is mostly a concern, however, for ambulatory care services; shopping on the inpatient side could drive patients to lower-cost hospitals. John Fernandez, representing the Conference of Boston Teaching Hospitals, cautioned that these tools could be a “cherry picking mechanism,” driving healthy, insured, non-complex cases to surgery centers.

Commission members talked briefly about reference pricing, under which the insurer pays a fixed amount for a procedure (the reference price) and the patient pays all costs above that amount. In 2011, CalPERS⁴⁰ implemented a reference pricing program. The program sets a maximum contribution for knee and hip replacement surgeries, cataract removal surgeries, colonoscopies, and several other elective procedures. The program resulted in a shift in patient volume to designated facilities, as well as decreases in hospital prices.⁴¹ Stuart Altman, appointed by Senate President Rosenberg, commented that when California implemented CalPERS, prices for procedures at several institutions were above the reference price. The hospitals lowered their prices so attract patients. Just like cash-back programs, however, reference pricing only works for a limited number of services.

November 28, 2016, <https://www.bostonglobe.com/business/2016/11/27/employers-rewarding-workers-who-shop-around-for-health-care/JKkmu5BI7q6fNEgbZzyZmN/story.html>.

³⁹ Auerbach, “Demand-Side Incentives,” *supra* note 1; Ha Tu and Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire’s Price Transparency Experiment*, (Robert Wood Johnson Foundation and California Healthcare Foundation, April 2014); Paul Bennett, “Vitals Aims to be the Priceline of American Healthcare,” *Forbes*, July 23, 2015, <http://www.forbes.com/sites/teconomy/2015/07/09/vitals-aims-to-be-the-priceline-of-american-healthcare/#51fea2127674>.

⁴⁰ The California Public Employees’ Retirement System is the largest employer and healthcare purchaser in the state.

⁴¹ White, *Reference Pricing*, *supra* note 36; James Robinson and Timothy Brown, “Increases in Consumer Cost Sharing Redirect Patient Volume and Reduce Hospital Prices for Orthopedic Surgery,” *Health Affairs* 32 (2013): 1392-1397.

CHAPTER 5 – PRICE TRANSPARENCY

INTRODUCTION

Chapter 4 discusses demand-side incentives, or ways to encourage patients to make high-value choices. These mechanisms rely on the availability of meaningful information, such as the cost difference between visiting one provider over another, to guide decision-making. Which information is available and how it is shared with the target audience are key questions facing those that seek to use price transparency to reduce provider price variation. Solutions to these questions involve multiple actors – providers, payers, employers, patient advocates, and the state – at various points in time and across the continuum of care.¹ Each of these stakeholders plays a role in making critical information available and understandable so that patients and employers can make high-value choices.²

At the Commission meeting, all members agreed that transparency is essential to lowering consumer out-of-pocket costs and decreasing the total cost of care. Research at the national level, however, concludes that patients may not have optimal access to the right information.³ Although the Massachusetts Legislature has passed several laws to increase transparency, many Commission members stated that employers and consumers need additional information and better transparency tools.

This chapter explores the potential of transparency initiatives to improve the healthcare system's efficiency. Commission members also analyzed transparency tools and strategies they felt could best address provider price variation. Section I discusses the role of price transparency in healthcare, including challenges around the use of available information. Section II summarizes Massachusetts price transparency legislation. Section III encapsulates members' feedback on price transparency initiatives, including a website currently in development by the Center for Health Information and Analysis (CHIA).

¹ Anna D. Sinatko and Meredith B. Rosenthal, "Increased Price Transparency in Health Care – Challenges and Potential Effects," *New England Journal of Medicine* 364 (2011): 891-894.

² Maura Calsyn, *Shining Light on Health Care Prices* (Washington, D.C.: Center for American Progress, 2014).

³ Bruce Jaspen, "Health Care Prices Remain a Secret in Most States," *Forbes*, July 8, 2015, <http://www.forbes.com/sites/brucejaspen/2015/07/08/health-care-price-information-still-elusive-in-most-states/#6f936fb1616a>; "Medical Price Transparency Law Rolls Out: Physician Must Help Patients Estimate Costs," Massachusetts Medical Society, January 3, 2014, <http://blog.massmed.org/index.php/2014/01/mass-medical-price-transparency-law-rolls-out-physicians-must-be-able-to-estimate-costs-for-patients>.

SECTION I: PRICE TRANSPARENCY IN HEALTHCARE

Unlike most consumer-driven industries, healthcare is an anomaly, in that prices are generally not disclosed before the consumer purchases the product.⁴ Without readily-available, useful, and understandable ways to shop for services, consumers lack the tools to choose high-value care, and are trapped in a system that encourages cost-blind treatment.⁵ Employers too need mechanisms to help them understand and shop for health insurance, since they are in the best position to select high-value plans and give employees the information they need to choose among those plans.

Price transparency is particularly important given the trend towards employer-sponsored high-deductible health plans (HDHPs).⁶ Employees with HDHPs have lower premiums but must pay higher annual deductibles before the insurer covers a portion of the costs.⁷ Employers view these plans as a tool to contain costs while still

“As costs continue to rise, it is increasingly difficult for many consumers to not only afford the health care services they need, but to navigate and understand why price varies so widely among hospitals and providers. These high costs are reflected in increased premiums, and in higher deductibles and other cost sharing.” – Health Care For All, testimony to the Special Commission

offering competitive healthcare coverage. In 2014, 45% of Massachusetts employers offered HDHPs, a 12% increase over three years and more than double the national percentage.⁸ The highest uptake in HDHPs in Massachusetts is in the small-group market, in which 47% of members have a HDHP.⁹ This trend is caused in part by year-over-year increases in small-group market premiums.¹⁰

⁴ Amanda Frost and David Newman, *Spending on Shoppable Services in Health Care* (Washington, D.C.: Health Care Cost Institute, March 2016).

⁵ Megan Collado and Andrea Ducas, “Patients, Physicians, And Price Transparency: If You Build It, Will They Come?” *Health Affairs Blog*, August 31, 2016, <http://healthaffairs.org/blog/2016/08/31/patients-physicians-and-price-transparency-if-you-build-it-will-they-come>.

⁶ *Health Policy Brief: High-Deductible Health Plans* (Health Affairs, February 4, 2016), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf.

⁷ In calendar year 2016 the minimum deductible was \$1,300 for an individual and \$2,600 for a family. “IRS Provides Guidance on Calendar Year 2016 High Deductible Health Plans, Out-of-Pocket Maximum Deductible Levels, and Health Savings Account Contribution Limitations,” Blue Cross Blue Shield Office of National Health Reform, August 3, 2015, <http://www.bcbsm.com/health-care-reform/reform-alerts/irs-provides-guidance-2016-deductibles-out-of-pocket-max-hsa.html>.

⁸ Center for Health Information and Analysis, *Massachusetts Employer Survey: 2014 Summary of Results* (Boston, MA, October 2014).

⁹ Center for Health Information and Analysis, *Performance of the Massachusetts Health Care System: Annual Report* (Boston, MA, September 2016).

¹⁰ Between 2012 and 2014, small-group market premium increases were modest. See Commonwealth Connector Authority, *Request for a State Innovation Waiver Under Section 1332 of the Affordable Care Act* (Boston, MA, February 2, 2016), 11. Small-group market premiums, however, increased by an average of 6.1% in 2015 and 6.7% in the first half of 2016. See Office of the Attorney General, *Examination of* (footnote continued)

According to a Health Policy Commission (HPC) survey, many employees, particularly those working for small businesses, are only offered a HDHP.¹¹ Since individuals enrolled in HDHPs pay more out-of-pocket, the onus rests on them to control their healthcare costs. This can be especially challenging for fixed- and lower-income patients, as they must pay their deductible first before the plan covers a portion of out-of-pocket costs. This can discourage people from seeking needed medical treatment.¹²

Proponents of HDHPs, however, argue that these plans encourage consumers to use higher-value care. To make efficient choices, though, consumers need access to information about both cost and quality. In the absence of actionable information, HDHPs may simply increase out-of-pocket costs.¹³ Katherine Baicker, the C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health, presented to the Commission on price transparency in the context of price variation. Dr. Baicker noted that out-of-pocket prices are sometimes more salient to patients than their medical symptoms. This may lead patients to avoid seeking care, which may increase costs in the future and lead to poorer health outcomes.

Despite their importance, however, there are limitations to the capacity for price transparency tools to change consumer behavior and reduce price variation. Several studies determine that even where these tools are available, there is low consumer utilization.¹⁴ For example, New Hampshire launched a state-run transparency website in 2007; in the following three years, only 1% of the state's residents used the site.¹⁵ Patients may also be unaware of the resource; there is room here for employers, payers, and others to encourage uptake. In addition, for some services patients only pay a small portion of the actual cost of care, leaving little incentive to choose a low-cost provider. Further, patients often associate quality and cost, and assume that higher-priced providers are of higher quality.¹⁶ If the incentive leads to the "wrong" choice, the incentive is ineffective or even counter effective. Several Commission members identified this as a major disadvantage of price transparency initiatives.

Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing (Boston, MA, October 13, 2016), 1.

¹¹ An HPC survey determined that 29.7% of employees in businesses with fewer than 50 employees are offered only a HDHP. The percentages are 19.4% for businesses with 50-99 employees and 11.7% for businesses with more than 100 employees, respectively. Health Policy Commission, *Select Findings: 2016 Cost Trends Report* (Boston, MA, January 11, 2017), slide 48.

¹² Sarah Kliff, "This Study is Forcing Economists to Re-Think High Deductible Health Plans," *Vox*, October 14, 2015, <http://www.vox.com/2015/10/14/9528441/high-deductible-insurance-kolstad>.

¹³ Ifrad Islam, "Trouble Ahead for High Deductible Health Plans?," *Health Affairs Blog*, October 7, 2015, <http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans>.

¹⁴ Kevin G. Vlopp, "Price Transparency: Not a Panacea for High Health Care Costs," *Journal of the American Medical Association* 315 (2016): 1842-1843; Ateev Mehtotra, Tyler Brannen, and Anna Sinaiko, "Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?," *Inquiry: Journal of Health Care Organization, Provision and Financing* 1 (2014) 1-3.

¹⁵ Mehtotra, "Use Patterns," supra note 14.

¹⁶ Sinaiko, "Increased Price Transparency," supra note 1, at 892.

Finally, consumers are generally unaccustomed to having access to cost and quality information, and transparency websites are not always easy to navigate. Dr. Baicker pointed out several ways to maximize the user's experience. For example, consumers should be able to compare prices side-by-side in a way that conveys that the options are of the same quality. In addition, there must be a reasonable number of providers; too many choices may simply confuse the consumer.¹⁷

SECTION II: MASSACHUSETTS PRICE TRANSPARENCY LAWS

Massachusetts and 37 other states have passed some form of price transparency legislation.¹⁸ The breadth and effectiveness of this legislation varies widely. As explained in Chapter 3, a variety of Massachusetts laws require payers and providers to make price information available to consumers. Payers must establish a toll-free number and website that gives consumers real-time out-of-pocket cost estimates, including facility fees.¹⁹ Payers must also disclose in- and out-of-network cost-sharing policies and utilization review criteria.²⁰ Similar requirements apply to providers. Within two business days, a provider must disclose the allowed amount or charge of a service, including any facility fees. Upon request, the provider must provide the patient with sufficient information to obtain out-of-pocket cost estimates from the patient's health plan. If the provider cannot predict the treatment or diagnostic code, the provider must disclose the estimated maximum allowed amount or charge.²¹

Aside from these requirements, payers, at their discretion, may help patients obtain cost estimates based on procedure codes. In this case, the payer, with the patient's permission, obtains the procedure code from the provider.²² To make this process easier for patients, providers, and payers, Mass Collaborative²³ developed a form that assists patients in getting specific information from providers to bring to their payer for a reliable estimate.²⁴ Massachusetts health plans, including Blue Cross Blue

¹⁷ Katherine Baicker, "Patient Choice, Price Transparency, and High-Value Care" (presentation to the Special Commission on Provider Price Variation, Boston, MA, January 10, 2017).

¹⁸ Francois de Brantes and Suzanne Delblanco, *Report Card on State Price Transparency Laws* (Newtown, CT: Catalyst for Payment Reform, July 2016).

¹⁹ Absent unforeseen circumstances, the consumer is not required to pay more than this disclosed amount. See MASS. GEN. LAWS ch. 176O, § 23 (2016); MASS. GEN. LAWS ch. 32A, § 27 (2016).

²⁰ Ch. 176O, § 6.

²¹ MASS. GEN. LAWS ch. 111, § 228 (2016).

²² "Bulletin 2013-10, Carrier Compliance with Transparency With Respect to the Estimated or Maximum Allowed Charge for a Service and Insureds' Out-of-Pocket Health Care Costs," Massachusetts Consumer Affairs and Business Regulation, December 13, 2016, <http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-10.html>.

²³ Mass Collaborative is a "voluntary, open organization of more than 35 payers, providers, and trade associations dedicated to reducing complex and cumbersome healthcare administrative processes in Massachusetts." "Who We Are," Mass Collaborative, accessed March 3, 2017, <http://www.masscollaborative.org>.

²⁴ Mass Collaborative, *Massachusetts Medical Price Transparency Law and Cost Estimate Worksheet* (Boston, MA, January 2015), available at <http://www.masscollaborative.org/downloads/Cost-Estimate-Worksheet.pdf>.

Shield, have also invested in state-of-the-art cost estimation tools, to help patients identify both the price of the service as well as their out-of-pocket cost.²⁵

Despite these laws, two recent studies conclude that it may still be challenging for Massachusetts consumers to obtain price information. In 2015, Health Care For All reviewed three major Massachusetts insurers' price transparency websites, and created a "report card" to determine how helpful, accessible, and comprehensive each website was. It found numerous flaws. For example, some insurers did not offer information about the costs of inpatient procedures and others reported the total cost of a service but did not specify the patient's out-of-pocket costs.²⁶ To receive an "A," the insurer's website had to meet all criteria, including allowing the user to compare costs of multiple providers on one screen, clearly differentiating between total and out-of-pocket costs, and earning a high overall usability score. Across all measures, no plan received a mark higher than "B-." The report did note, however, that each insurer told Health Care For All that it planned to improve its website in the following months.²⁷

"Price transparency in healthcare requires nothing short of cultural change in the way consumers/patients and employers, aided by payers, providers and the state, consider healthcare options." – Pioneer Institute, testimony submitted to the Special Commission

A 2016 study by the Pioneer Institute highlights gaps in consumer access to provider information. Although surveyed providers eventually provided the price information requested, few providers had systems in place to provide timely and fully accurate information when first contacted.²⁸ Overall, most

hospitals were unable to answer questions about costs within two business days, as required.²⁹ The survey also found that 60% of Massachusetts residents were unaware of price transparency requirements, and the minority that were aware described accessing the information as a frustrating and complex process.³⁰

These studies offer evidence that initial efforts to promote the availability and use of healthcare price information have not had the desired effect. This suggests that there

²⁵ Blue Cross Blue Shield, for example, launched new online "Find a Doctor" and "Estimate Costs" tools in December 2015. See Blue Cross Blue Shield of Massachusetts, *Profile Testimony, Health Policy Commission 2016 Cost Trends Hearing* (Boston, MA: September 2, 2016).

²⁶ Felice J. Freyer, "Insurers Asked to Improve Health Cost Websites," *Boston Globe*, July 14, 2015, <https://www.bostonglobe.com/metro/2015/07/13/group-gives-health-insurers-low-grades-for-price-information-tools/nXjVsj4m0qXVNPz8ISS1CO/story.html>.

²⁷ Health Care for All, *Consumer Cost Transparency Report Card* (Boston, MA: 2015), 1-2, 6.

²⁸ Barbara Anthony and Scott Haller, *Mass Hospitals Weak on Price Transparency* (Boston, MA: Pioneer Institute, 2016).

²⁹ Id. at 2.

³⁰ Id. at 1.

is a significant need for additional price transparency initiatives in Massachusetts, especially in the internet realm, the most utilized consumer platform.

SECTION III: PRICE TRANSPARENCY INITIATIVES

Price transparency tools can direct consumers to high-value providers, fostering competition and decreasing the market clout of certain providers. Consumer decisions, however, are affected by their perception of the party providing the information. Insurance companies tend to have the most information, since they pay or process member claims and they have access to cost and utilization data and patterns. The issue is that consumers may not trust insurers to steer them towards high-quality care.³¹ Dr. Baicker explained that the most trusted sources of information are physicians and social connections. Therefore, it is important that physicians have some interest in containing the total cost of care (for example, by participating in a global budget arrangement), so that they are incentivized to recommend high-value providers. Dr. Baicker also noted that even information that comes from a trusted source needs to be presented in a digestible way to the target audience.³²

The Commission discussed whether existing transparency laws should be amended or strengthened, to address the fact that consumers may still find it difficult to get price estimates. Commission members agreed that current price transparency laws are important. Nonetheless, Karen Tseng, representing the Office of the Attorney General, clarified that the laws do not explicitly designate an enforcement agency.³³ Majority Leader Ronald Mariano, appointed by House Speaker DeLeo, and Steven Walsh, representing the Massachusetts Council of Community Hospitals, served in the Legislature when the transparency laws were passed. They explained that the Legislature intentionally chose not to delegate these responsibilities to an agency. This was part of a compromise between legislators and payers/providers, who agreed in good faith to comply. Mr. Walsh and other members stated that compliance has improved and that the Commission should focus on whether additional laws should be passed.

³¹ Baicker, “Patient Choice,” *supra* note 17.

³² Id. See also Katherine Baicker, et al. “Behavioral Hazard in Health Insurance,” *Quarterly Journal of Economics* (2015): 1623- 1667, available at <http://people.hbs.edu/jschwartzstein/BehavioralHazard.pdf>.

³³ Some state entities, however, provide guidance and monitor parties using existing processes. In December 2013, for example, the Division of Insurance released a bulletin outlining requirements for payers regarding estimated or maximum allowed charges. See “Bulletin 2013-10,” *supra* note 22. In addition, as part of its annual Cost Trends Hearings, the Health Policy Commission collects testimony on efforts by payers to increase consumer access to health care information. See MASS. GEN. LAWS ch. 6DA, § 8 (2012). As part of their 2016 Cost Trends Hearings pre-filed testimony, payers were asked to submit data regarding the number of individuals that ask for an estimated or maximum allowed amount or charge for a proposed admission or procedure. See Health Policy Commission, “Testimony,” accessed February 27, 2017, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/testimony.html>.

HEALTH CONNECTOR SMALL BUSINESS FEATURE

Through a unique partnership, Massachusetts will work with the District of Columbia's group market exchange¹ to implement an employee choice model for small businesses in the Commonwealth. Many small business employees are only offered one plan choice. Therefore, small business owners have the greatest need for a platform that enables them to offer a range of products to their employees. The Massachusetts Health Connector currently hosts a small business platform, but only a relatively small number of employers have taken advantage of it. As of 2016, approximately 6,000 small business employees and their dependents enrolled in a Health Connector product. The low uptake could be due to lack of awareness of the option. Employers may also find it more convenient to use a single vendor for both health insurance and other benefits, such as long-term and disability insurance. In addition, the website currently lacks several features that allow for greater employer choice and flexibility.

In contrast to the current website, through which the employer selects one plan or one carrier for all employees, employee choice will give employees access to multiple plans. Employers may have the option of choosing a carrier and allowing their employees to select their preferred plan from among the carrier's plans at different actuarial value levels, or the employer can select a given actuarial value for a plan, and allow employees to choose among carriers. Employers are then able to set a fixed-contribution for a reference plan the employer selects. Based on the employee choice model the employer selects, employees can choose to purchase a plan that is more expensive or less expensive than the reference plan to meet their needs. Depending on the plan the employee selects, employees can save up to 30% of an average small group plan for comparable benefits.

The Health Connector anticipates that new employee choice options may prove attractive to smaller employers, such as those with fewer than five employees. A wider selection of plans means that employees can pick the plan that best fits their needs. Employee choice also gives employers greater financial predictability and promotes competition among payers in the small-group market. The Health Connector recognizes that carrier availability and the ability to work within the new platform are key, and anticipates a pilot program for October 2017 coverage and full launch for January 2018 coverage.

David Torchiana, representing Partners Healthcare, emphasized the importance of ensuring that information is understandable to patients. Information should be publicly available, but medical literacy is a barrier to presenting complex information. This is one reason why many consumers do not use price transparency websites, even where available. He said that as electronic health records become more universal and patient portals become more popular, patient-reported outcomes will be easier to gather and report. That information is very valuable to patients. Dr. Torchiana stated that gathering and presenting data at the appropriate medical literacy level is an area in which the state could focus its efforts. Leader Mariano agreed that the state has a role to play in this area. Richard Frank, a healthcare economist appointed by Governor Baker, underscored that any effort needs to factor in how consumers process information.

Commission members also discussed a state-run transparency website currently under development by the CHIA. The website will enable patients to compare prices for common shoppable services, using data from the Massachusetts All-Payer Claims Database.³⁴ Roberta Herman, representing the Group Insurance Commission, and Lynn Nicholas, representing the Massachusetts Health & Hospital Association, stated that CHIA should consider focusing on high-volume, shoppable conditions. Ray Campbell, Executive Director of CHIA, attended the meeting. He explained that CHIA is studying other websites and working to overcome design challenges to create a flexible, accessible site.

³⁴ The All-Payer Claims Database is a compilation of medical, pharmacy, and dental claims submitted by commercial insurers and public programs. Center for Health Information and Analysis, *Overview of the Massachusetts All-Payer Claims Database* (Boston, MA, March 2014). Third-party administrators may elect to but are not required to submit claims. Gina Stephan, “Are All-Payer Claims Databases now ‘Some Payer Claims Databases’ after Gobeille v. Liberty Mutual?” *Wolters Kluwer*, May 15, 2016, <https://www.wolterskluwerfs.com/article/are-all-payer-claims-databases-now-some-payer-claims-databases-after-gobeille-v-liberty-mutual.aspx>.

CHAPTER 6 – STATE MONITORING OF THE HEALTHCARE MARKET

INTRODUCTION

After discussing the impact on provider price variation of market forces, demand-side incentives, and increased transparency, the Special Commission turned its attention to the potential role for the state in monitoring the healthcare market. State monitoring policies involve a variety of stakeholders and encompass a range of activities, from approval of payer/provider contracts to tracking costs throughout the healthcare system. In its more targeted forms, state monitoring includes provider rate-setting and caps on growth in rates. Over the course of its meeting on this topic, Commission members discussed possible roles for the state in addressing provider price variation.

Section I of this chapter summarizes Massachusetts laws that monitor the healthcare marketplace. Section II examines two states, Maryland and Vermont, that have established all-payer controls on provider rates. Section III discusses the state of Rhode Island, which monitors provider rates, payment methodologies, and quality as part of its annual insurance rate review. This section includes information presented by Dr. Kathleen Hittner, Health Insurance Commissioner for the state of Rhode Island, along with Commission feedback and questions. Section IV outlines state monitoring solutions discussed by the Commission.

SECTION I: MONITORING THE HEALTHCARE MARKET IN MASSACHUSETTS

Chapter 224¹ establishes the Health Policy Commission (HPC), an agency charged with the broad task of “monitor[ing] the reform of the health care delivery and payment system.”² This includes setting healthcare cost growth goals, enhancing the transparency of provider organizations, monitoring and reviewing the impact of changes in the healthcare marketplace, monitoring the development of alternative payment methodologies and new care delivery models, and fostering innovations in delivery and payment.³

In accordance with statute, the HPC sets an annual cost growth benchmark. The benchmark is the maximum growth rate for total per-capita medical spending in the Commonwealth across all sectors. Through December 2017, the benchmark is equal to growth in potential gross state product (3.6%). After 2017 the benchmark is pegged to potential gross state product minus 0.5% (3.1%), but may be modified by

¹ Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, 2012 Mass. Acts 224.

² MASS. GEN. LAW ch. 6D, § 5 (2016).

³ Id.

the HPC to fall between 3.6% and 3.1%.⁴ The HPC also conducts annual public hearings to investigate the causes of growth in total healthcare expenditures in relation to the benchmark. These hearings explore systemic trends like utilization patterns, price transparency efforts, and innovations in benefit design. The focus, however, is on “factors that contribute to cost growth,” including provider price variation. The Office of the Attorney General (AGO) may intervene in the hearings, and providers and payers are required to provide testimony under oath to the HPC, the Center for Health Information and Analysis (CHIA), and the AGO. Testimony may include information about price variation within and across payer networks, along with variation in global budgets and total medical expenses.⁵ In addition to informing the HPC’s future work on this topic, the hearings are a way to shine light on the healthcare system and make the performance of the healthcare sector more transparent.

In addition to annual hearings, the HPC also tracks cost growth for payers and providers. CHIA annually provides the HPC with a list of all providers and payers whose cost growth, based on health status-adjusted total medical expense (TME),⁶ is excessive and who threaten the ability of the state to meet the healthcare cost growth benchmark.⁷ The HPC reviews factors such as the entity’s prices, market share, financial condition, and any current strategies to reduce spending growth. In 2016, the HPC may require certain entities to file and implement a performance improvement plan (PIP) where it identifies “significant concerns” about that entity’s costs and determines that a PIP could result in meaningful, cost-saving reforms.⁸ The PIP is a plan created by the healthcare entity and approved by the HPC. It identifies the causes of and implements specific strategies to reduce cost growth. The entity carries out the PIP over the course of eighteen months, after which the HPC evaluates its success. The HPC may require additional actions to lower costs, and can fine an entity up to \$500,000 for failure to file, implement, or report on its PIP. The HPC has the further option to conduct a Cost and Market Impact Review (CMIR)⁹ of provider organizations identified by CHIA in years where total health care expenditures exceeded the healthcare cost growth benchmark.¹⁰

Another function of the HPC is to enhance the transparency of provider organizations. Through the Registration of Provider Organizations (RPO) program, the HPC and CHIA collect data on provider organizations in the Commonwealth. In order to contract with payers, providers¹¹ need to register with the HPC, and must

⁴ § 9(d).

⁵ § 8.

⁶ Providers on this list are only primary care provider groups. Health status-adjusted TME does not exist for other types of providers, such as specialists and hospitals.

⁷ MASS. GEN. LAW ch. 12C, § 18 (2016).

⁸ MASS. GEN. LAW ch. 6D, § 10 (2016); Health Policy Commission, *Bulletin 2016-01: Interim Guidance for Payers, Providers, and Provider Organizations Relative to Performance Improvement Plans and Cost and Market Impact Reviews* (Boston, MA, March 13, 2016).

⁹ See Chapter 3 for a discussion of Cost and Market Impact Reviews.

¹⁰ § 10; Health Policy Commission, *Bulletin 2016-01*, supra note 8.

¹¹ Small and lower-revenue providers do not need to register. See § 1.

submit details to the RPO program about their ownership, governance, operational structure, affiliates, employed and affiliated professionals, licensed facilities, and other pertinent information.¹² This publicly-available data is vital to understanding the current structure of and trends in the healthcare marketplace. It is helpful to policymakers and researchers as well as market participants. Finally, the HPC is required to certify accountable care organizations (ACOs) and patient-centered medical homes.¹³

In addition to the HPC, CHIA and the AGO monitor cost trends. As explained in Chapter 1, CHIA collects and publishes healthcare data, including provider relative prices and market share.¹⁴ The AGO has the authority to compel information from payers and providers, including contract documents and cost data, and interview relevant stakeholders. It uses this information and CHIA data to publish an annual report examining cost trends and drivers.¹⁵

SECTION II: ALL-PAYER RATE SETTING IN MARYLAND AND VERMONT

As discussed in Chapter 2, Maryland has operated an all-payer hospital rate-setting system since 1971. Unlike rate-setting systems in other states, this model has survived in some form until the present.¹⁶ This is primarily due to a Maryland-specific Medicare waiver, enacted into federal law, which allows Maryland's rate-review commission to set Medicare reimbursement rates.¹⁷ The original waiver required that growth in Medicare payments per case remain less than the national average. Hospitals were paid itemized rates for a given service; Maryland also established maximum payments per case and volume controls on total services provided. These limits incentivized hospitals to reduce costs, avoidable readmissions, and unnecessary care, since in most cases providing additional or more intense services would not increase reimbursement.¹⁸

In 2008, Maryland's costs per admission were below the national average and there was a narrow and stable distribution of hospital earnings. As the health system evolved, however, the rate-setting methodology inadvertently contributed to rapid increases in Medicare charges per case. Maryland worried that it would not continue

¹² § 11.

¹³ §§ 14, 15.

¹⁴ MASS. GEN. LAW ch. 12C, § 16 (2016).

¹⁵ MASS. GEN. LAW ch. 12C, § 11N (2016).

¹⁶ Between the late 1960s and 1997, at least twenty-seven states had some rate-review or rate-setting system. Massachusetts had a rate-setting system in some form from 1974 until 1991. Robert Murray, et. al., *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* (Washington, D.C., Urban Institute, November 2015).

¹⁷ Id. at 43-44.

¹⁸ Id. at 45-46; "Maryland All-Payer Model to Delivery Better Care and Lower Costs," Centers for Medicare & Medicaid Services, accessed December 9, 2016, <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model>. See also Rahul Rajkumar, et. al., "Maryland's All-Payer Approach to Delivery-System Reform," *New England Journal of Medicine* 370 (2014) 493-495.

to meet the terms of its Medicare waiver. In 2014, Maryland received approval from the Centers for Medicare & Medicaid Innovation (CMMI) to build off existing global payment pilots and establish a system of global budgets for all hospitals.¹⁹ Under this system, revenue earned throughout the year cannot exceed a set amount. Other provisions in the waiver limit growth in revenue and spending per capita.²⁰ As Chapter 2 discusses, Maryland's performance to date has been mixed but reports indicate some positive results: growth has stayed below the limit and Maryland has almost fully implemented global budgeting for hospitals, without hurting hospital margins. Maryland anticipates extending rate-setting to the entire spectrum of care by 2019.²¹

Vermont has also collaborated with the federal government to facilitate system transformation and address provider price variation. In 2011, Vermont established the Green Mountain Care Board (GMCB), an independent agency tasked with overseeing the creation, implementation, and efficacy of healthcare payment and delivery reforms.²² Consistent with this role, the GMCB has extensive approval authority over provider and insurer rates, hospital and ACO budgets, and Vermont's certificate of need process.²³ The GMCB also manages Vermont's all-payer claims database.²⁴

The GMCB started Vermont on the path to healthcare reform in 2013. Vermont created a multi-payer ACO model, under which providers that stayed under budget were able to keep a portion of the savings.²⁵ These shared-savings programs were

¹⁹ 42 U.S.C. § 1315a (2016). The Affordable Care Act created CMMI "to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care." "About the CMS Innovation Center," Centers for Medicare & Medicaid Services, accessed February 28, 2017, <https://innovation.cms.gov/About>.

²⁰ Murray, *Hospital Rate Setting Revisited*, supra note 16, at 52-55; Centers for Medicare & Medicaid Services, "Maryland's All-Payer," supra note 18; See also Maryland Health Services Cost Review Commission, *Agreement Between the Health Services Cost Review Commission and Anne Arundel Medical Center, Inc. Regarding Global Budget Revenue and Non-Global Budget Revenue* (2015).

²¹ Ankit Patel, et al., "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model," *New England Journal of Medicine* 373 (2015) 1899-1901; "Monitoring of Maryland's New All-Payer Model: Biannual Report," Health Services Cost Review Commission, April 2016, <http://www.hsrc.maryland.gov/documents/legal-legislative/reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2016.pdf>; Rajkumar, "Maryland's All-Payer Approach," supra note 18; Advisory Board Company, *Maryland's All-Payer Global Budget Cap Model and its Implications for Providers* (Washington, D.C.: May 23, 2016).

²² VT. STAT. ANN. tit. 18 § 9375(b) (2016). Parallel authority was also given to the Secretary of Administration to support the efforts of the GMCB. 3 V.S.A § 2222a(c)(9) (2016).

²³ VT. STAT. ANN. tit. 18 § 9375(b) (2016). The GMCB even has the authority to approve provider workforce plans and health information technology implementation strategies of health sector participants. *Id.*

²⁴ VT. STAT. ANN. tit. 18 § 9410 (2016).

²⁵ Agency of Administration, *Vermont Health Care Innovation Project Quarterly* (Montpelier, VT, February 23, 2016), 2, available at <http://legislature.vermont.gov/assets/Legislative-Reports/VHCIP-Report-to-the-Legislature-February-2016.pdf>. The State Innovation Model grant program provides federal funds to "advance multi-payer health care payment and delivery system reform models . . . to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory." "State Innovation Models Initiative: General Information," Centers for Medicare & Medicaid Services, accessed February 28, 2017, <https://www.cms.gov/innovationcenter/innovationmodels/stateinnovationmodels>.
(footnote continued)

based on Medicare's upside risk only ACOs, and the results were mixed. The Medicaid ACO saved \$15.7 million; commercial and Medicare ACOs did not achieve savings but did improve upon certain quality metrics.²⁶ Based on these outcomes, in 2015 the Vermont Legislature authorized the GMCB and Vermont's Secretary of Administration to explore with CMMI the feasibility of an all-payer model. The goal of this model was to transition payments for all providers from fee-for-service (FFS) to alternative payment methodologies (APMs).²⁷ After a year-long stakeholder engagement process, the state entities brought their proposal back to the Legislature, which granted them the formal authority to apply for an 1115 Waiver from the Centers for Medicare & Medicaid Services.²⁸ Vermont received permission in late 2016 to establish the all-payer model.²⁹

There are several notable features of Vermont's all-payer model. Payers must adhere to a 3.5% aggregate per-capita cost growth cap target for the five year period of the active demonstration. In addition, the GMCB will annually recommend Medicaid reimbursement increases, to bring payments more in line with Medicare FFS rates. The model also incorporates investments in population health, with corresponding performance targets. Finally, the agreement extends the GMCB's regulatory authority to Medicare ACOs, allowing the GMBC to direct investments in infrastructure and care delivery models.³⁰ The agreement provides that the all-payer model will operate over a period of six years, with the first year serving as a preparatory period (See

Medicaid Services, accessed February 28, 2017, <https://innovation.cms.gov/initiatives/state-innovations>.

²⁶ Vermont Health Care Innovation Project, *Vermont's Year 2 Medicaid and Commercial ACO Shared Savings Program Results* (Montpelier, VT, October 2016), available at http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/VHCIP%20Webinar%202015%20SSP%20Results_10-28-16%20FINAL.pdf.

²⁷ 2015 Vt. Acts and Resolves No. 54, Sec. 1.

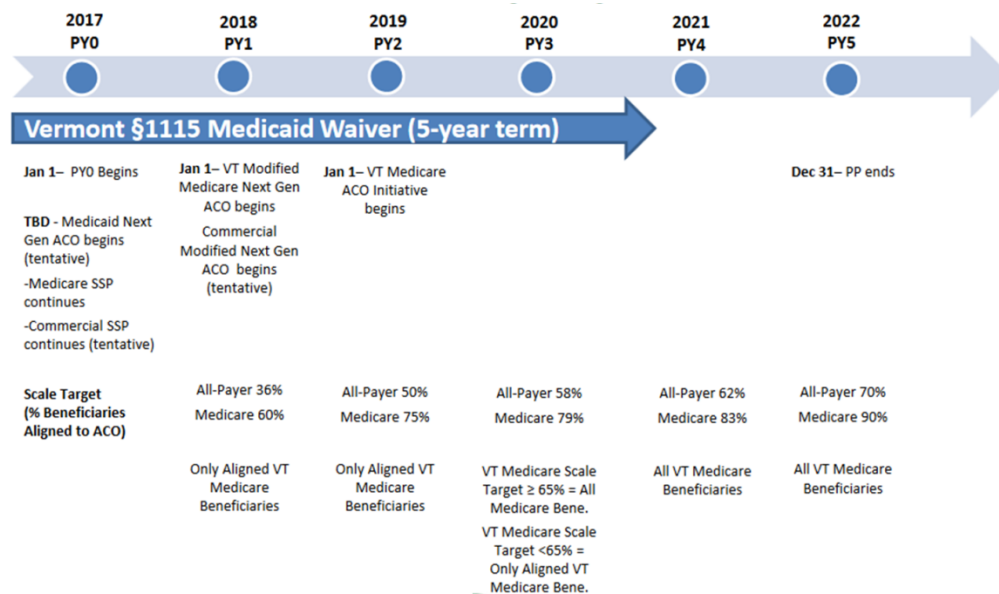
²⁸ 1115 Waivers allow states to use Medicaid funds in ways not otherwise permitted by law. This provides states with a way to test innovative delivery and payment reform systems. Social Security Section § 1115, 42 U.S.C. 1315 (2014). The arrangement needs to create a value-based, all-payer payment model that “provides direct payments from Medicare to providers or ACOs without state involvement; maximizes alignment between payers; strengthens investments in primary care; incorporates social determinants of health; integrates mental health, substance abuse treatment and community-based providers into the overall health care system; prioritizes local and regional health care provider collaborations; allows providers to choose whether to participate in an ACO; evaluates access to care, quality of care, patient outcomes and social determinants of health; protects patient rights and includes processes and protocols for shared decision-making while taking into account an individual's needs, preferences, values and priorities; and ensures a robust grievance and appeals process through their [Office of the Health Care Advocate].” Green Mountain Care Board, *In re: Vermont All-Payer Accountable Care Organization Model Agreement* (Vermont, October 31, 2016), 4, available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-FINAL-Justification.pdf>.

²⁹ Vikki Wachino, Letter to Hal Cohen, Secretary, Vermont Agency of Human Services, October 24, 2016, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>. See also Centers for Medicare & Medicaid Services, *Vermont All-Payer Accountable Care Organization Model Agreement* (October 27, 2016), available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf>.

³⁰ Green Mountain Care Board, *In re: Vermont*, supra note 28, at 10. See also Centers for Medicare & Medicaid Services, *Vermont All-Payer*, supra note 29.

Figure 6.1).³¹ This lead-up time may prove necessary for Vermont to meet the year-over-year Medicare and all-payer member ACO attribution goals.³² Additional operational and structural details have yet to be developed.

Figure 6.1: Vermont All-Payer ACO Model Agreement Timeline³³



SECTION III: EFFORTS TO CURB SPENDING GROWTH IN RHODE ISLAND

Rhode Island is the only state in the country with a dedicated Office of the Health Insurance Commissioner (OHIC). The Rhode Island Legislature created OHIC in 2004 and gave it broad authority to improve the quality, accessibility, and affordability of healthcare in Rhode Island.³⁴ OHIC's duties go beyond those of other state divisions of insurance. OHIC not only ensures health insurer solvency and consumer protections but also requires insurers to improve the quality and efficiency of care delivery.³⁵ One of the unique functions of OHIC is its ability to regulate growth in provider rates through its annual review of insurer premium rate filings.

³¹ Green Mountain Care Board, *In re: Vermont*, supra note 28, at 8.

³² Centers for Medicare & Medicaid Services, *Vermont All-Payer*, supra note 29, at 9. The goal is that by 2022, 70% of all insured residents and 90% of Medicare beneficiaries will be attributed to an ACO. Id.

³³ Green Mountain Care Board, *All-Payer Accountable Care Organization Model Update*, by Pat Jones and Melissa Miles (Montpelier, VT, January 12, 2017), slide 11, available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/Implementing%20the%20All-Payer%20Model%202017-01-12FINAL.pdf>.

³⁴ R.I. Gen. Laws §42-14.5-2 (2014).

³⁵ "About OHIC," Office of the Health Insurance Commissioner for the State of Rhode Island, accessed February 8, 2017, <http://www.ohic.ri.gov/ohic-about.php>.

When reviewing insurer rates, OHIC focuses on three goals: cost growth containment, payment reform, and care transformation. OHIC assesses whether the insurer has met affordability standards, including whether the insurer has adhered to rate growth ceilings in its contracts with providers.³⁶ Commercial hospital inpatient and outpatient rates cannot grow by more than the federal consumer price index-urban³⁷ (CPI-Urban) plus 1%.³⁸ OHIC requires that half the rate increase be earned through quality performance. ACOs have been given a bit more flexibility, since they are newer and less-established entities. Their rate limits are CPI-Urban plus 3% in 2016, but will be gradually reduced to 1.5% by 2019.³⁹ Even though OHIC only oversees the fully-insured market, growth limits influence costs in the self-insured market.⁴⁰

Rate growth limits have been in place for five years. In her presentation to the Commission, Dr. Kathleen Hittner, the Health Insurance Commissioner for the state of Rhode Island, stated that the limits have been very effective. She acknowledged that when Rhode Island first established growth caps, some insurers argued that it would be more difficult to negotiate with hospitals. Hospitals too were skeptical, worrying that the limits would affect operating margins. OHIC, however, does have a waiver option and is open to reconsidering growth limits that might inhibit innovation. Dr. Hittner said that she encourages insurers and providers to speak to her about this process. She informed Commission members that OHIC also has the ability to attach stipulations to its approval of rate increases. These stipulations typically involve provider price transparency.⁴¹ David Torchiana, representing Partners Healthcare, asked about Rhode Island's statewide medical cost and premium trends. Dr. Hittner responded that premium rates have been reasonable compared to other states. It is not unusual for there to be 0% premium increases on Rhode Island's state health exchange. Rhode Island has seen increases in total medical expense between 3% and 3.5% over the past several years.⁴²

OHIC review also fosters payment reform and care transformation. Currently, approximately 30% of healthcare payments in Rhode Island are through APMs. The goal is to achieve 50% APM uptake by the end of 2018. OHIC has an Alternative Payment Methodology Committee that defines which APMs qualify and sets the

³⁶ R.I. Code R. §32-1-2:1 (2015). These affordability standards were written into regulation in 2010.

³⁷ OHIC uses the National Consumer Price Index for All Urban Consumers: All Items Less Food and Energy.

³⁸ Regulations adopted in February 2015 required the 1% additive factor to decrease by 0.25% each year until 2019. Rhode Island hospitals sought relief from this provision in 2016. OHIC's revised regulations, effective January 2017, hold the growth cap for hospital inpatient and outpatient services at +1%. Information provided by OHIC to Joint Committee on Health Care Financing staff, February 21, 2017.

³⁹ Kathleen Hittner, "Provider Price Variation & the Cost of Healthcare in Rhode Island" (Presentation to the Special Commission on Provider Price Variation, January 31, 2017).

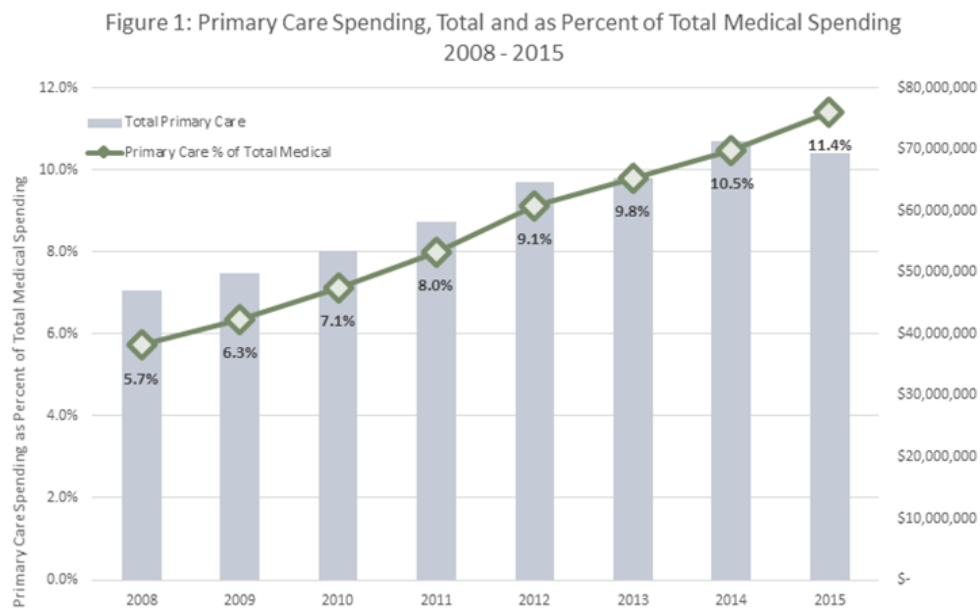
⁴⁰ Id. Payers and providers sometimes execute a single contract for all plans; thus, OHIC's review process may indirectly limit the rates paid by self-insured plans.

⁴¹ Hittner, "Provider Price Variation," supra note 39.

⁴² Hittner, "Provider Price Variation," supra note 39. Note: This is an average across the small-group, large-group and individual markets.

annual targets.⁴³ In addition, OHIC's Care Transformation Collaborative is working to improve the efficiency and quality of care through innovations in primary care. At present, 50% of primary care practices have transitioned to patient-centered medical homes.⁴⁴ The goal is to increase that number to 80% in the near future. Dr. Hittner acknowledged that achieving this target will be challenging. Most of these practices are smaller and do not have electronic medical records, making measurements for shared savings and risk management difficult.⁴⁵ Rhode Island's health insurance affordability standards also mandate that commercial insurers increase payments to primary care providers by 1% each year, without increasing total spending. In 2010, spending on primary care was 7.1% of total medical spending. By 2015, it had increased to 11.4% (See Figure 6.2).

Figure 6.2: Primary Care Spending in Rhode Island, 2008-2015⁴⁶



Lynn Nicholas, representing the Massachusetts Health & Hospital Association, asked Dr. Hittner about the financial health of Rhode Island's insurers and providers. Dr. Hittner acknowledged that her response might not be popular but suggested that some hospitals are not necessary and certain facilities may need to close. She referenced a study from several years ago showing that Rhode Island has two hundred excess hospital beds. This number may be even higher today, given that care is increasingly provided in outpatient settings. She clarified that specialties like behavioral health may not have excess beds, so one strategy is to repurpose beds.

⁴³ Hittner, "Provider Price Variation," supra note 39.

⁴⁴ Patient-centered medical homes are delivery systems through which a patient's primary care provider coordinates specialist visits and oversees continuity of care. Office of Legislative Research, *Rhode Island's Health Insurance Affordability Standards*, by Alex Reger (Hartford, CT, August 22, 2016), available at <https://www.cga.ct.gov/2016/rpt/2016-R-0146.htm>.

⁴⁵ Hittner, "Provider Price Variation," supra note 39.

⁴⁶ Hittner, "Provider Price Variation," supra note 39, at slide 15.

Cory King, a member of Dr. Hittner’s staff, explained that the financial strain certain hospitals experience may also be due to lower public-payer rates. Dr. Hittner added that she does not believe that employers and consumers should be forced to pay the difference when public-payer rates decrease. OHIC’s rate growth limits prevent this cost-shift.

Roberta Herman, representing the Group Insurance Commission, asked what the product suite is like in Rhode Island’s market. Dr. Hittner responded that there are quite a variety of plans in Rhode Island and OHIC reviews each plan to ensure network adequacy. She noted, however, that high deductibles in certain plans are placing a strain on employers. OHIC is working on this issue, but this is also a national problem.

SECTION IV: ADDITIONAL STATE MONITORING IN MASSACHUSETTS

Commission members discussed options for additional monitoring in Massachusetts, including rate compression, which involves reducing the variation in rates between the lowest- and highest-paid hospitals, which can include setting a minimum rate or floor for lower-paid hospitals. Members also discussed encouraging the use of more meaningful consumer incentives for high-value choices, including the promotion of tiered-network plans (TNPs). Finally, members considered state monitoring of utilization patterns among different types of hospitals (See Recommendations).

“We should all admit the reality that our very expensive healthcare system in Massachusetts has a number of root causes, many of them not only Massachusetts in origin as there are many systemic challenges in healthcare delivery and financing across the US.” – Paul Hattis, Professor at Tufts University School of Medicine and member of Greater Boston Interfaith Organization’s Strategy Team, testimony to the Special Commission

The Commission discussed a two-part rate compression proposal. The proposal establishes a rate minimum or floor to provide immediate relief to the lowest-paid hospitals and recommends implementing one or both of the following mechanisms. First, a state entity should be authorized to reject payer/provider contracts if it determined

that payments were based on unwarranted factors for price variation. In addition, or in the alternative, the state entity should establish and ensure compliance with differential limits on growth in reimbursement rates. Rates paid to lower-paid providers should be allowed to increase more rapidly than rates paid to higher-paid providers. Taken together, this proposal increases payments to providers at the bottom and either directly or over time reduces rates paid to providers at the top. This would compress price variation while also lowering TME (See Recommendations).

Steven Walsh, representing the Massachusetts Council of Community Hospitals, explained that State Monitoring Subcommittee members did not discuss at length

which agency would be best suited to regulate growth in provider rates. It chose the Division of Insurance (DOI) because the agency currently approves payer contracts. In addition, the Subcommittee did not agree on whether the entity should review payer/provider contracts for unwarranted factors, to monitor growth in rates, or both. Karen Tseng, representing the AGO, explained that two pricing factors contribute to increases in TME in the Commonwealth. First, TME increases when rates increase, both in FFS and risk contracts. Second, even if rate growth is frozen, TME increases when the market share of higher-priced providers grows and patient volume shifts to more expensive providers. She said that at a concept level, this proposal addresses both of these problems. Richard Frank, a healthcare economist appointed by Governor Baker, added that the proposal's intent is not to shock the system, but to create a "glide path" towards price compression or narrower price differences. He stated that limiting rate growth, in particular, accomplishes this goal. Dr. Torchiana did not support the Commission's recommendation regarding compression. He stated that taking funding from higher-priced institutions will harm hospitals in Massachusetts who are already competing with their international peers. He emphasized that the unemployment rate is very low, premium growth is low, and placing a cap on hospital prices is not an answer to the healthcare challenges in the Commonwealth.

“Hospitals like Lawrence General Hospital are part of the solution for cost savings to the Commonwealth and every person who seeks healthcare in Massachusetts. Every time someone chooses my hospital they save the system. We are part of the solution for unsustainable health care costs – but only if we are sustainable!” –
Dianne Anderson, CEO of Lawrence General Hospital, testimony to the Special Commission

Commission members supported increasing rates for the lowest-paid providers, but also agreed that it is important to keep total costs down. Several members expressed concern about the funding source for the immediate lift. Mr. Walsh explained that there are several options to fund the rate increase, including using funds appropriated by

Chapter 115 of the Acts of 2016, which created the Special Commission. Chapter 115 establishes the Community Hospital Reinvestment Trust Fund and designates \$45 million to be distributed to hospitals with relative price levels under 1.2.⁴⁷ Funding could also come from the process itself. For example, if a state entity rejected a contract based on unwarranted factors, the payer and provider would have to negotiate lower rates. The resulting contract would yield savings that could be used to fund those providers at the bottom. Mr. Walsh emphasized that it would take a very small amount of money to increase payments to these providers to some minimum threshold.

Several members suggested a more detailed approach to setting the minimum rate floor. Dr. Torchiana asserted that as the nuances of rate-setting pile up, it becomes

⁴⁷MASS. GEN. LAWS. ch. 12C, § 23.

clear that regulating a little bit is not necessarily realistic. Each hospital has a different commercial payer mix. Therefore, the impact of a lift would be different for each institution. Dr. Torchiana suggested that the threshold take this into account, to ensure that providers receive approximately the same financial benefit. Ms. Nicholas suggested using an additional filter, such as warranted and unwarranted factors for variation, to determine how the money is distributed. Lora Pellegrini, representing the Massachusetts Association of Health Plans, stated that payments to community hospitals should take into account the fact that not all community hospitals are losing money. Robert Berenson, Institute Fellow at the Urban Institute, served as an expert panelist at the Commission meeting. He suggested that the members look at West Virginia's approach to setting a rate floor, which bases the floor on hospital input costs.

Commission members also discussed which state entity could implement the rate compression proposal. All members acknowledged that new legislation would be necessary to grant the implementing entity the statutory power to regulate. Dr. Frank suggested using DOI's existing power to approve rates, since the new responsibility could be layered on to the existing rate-review process. Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, serving as an expert panelist at the Commission meeting, agreed. She noted that the proposal would give payers greater power at the negotiating table: they would have the leverage to refuse certain provider demands, by pointing to the fact that the contract might not be approved.

Ms. Pellegrini, however, added that DOI only regulates the payers, so additional measures are necessary to hold providers accountable. She made it clear that this language was necessary in order for her to support the recommendation. She emphasized that her smaller plans feel that there is a great risk that dominant providers would simply refuse to do business with them. Since plans that do not include certain providers are unappealing to consumers, fewer consumers would choose these products. This would threaten the plans' market position and financial stability and disrupt patient care. Ms. Pellegrini suggested granting authority to the HPC. Ms. Nicholas responded that her members would be extremely opposed to granting the HPC this authority, since there is no hospital experience represented on the HPC Board. She added that expanding DOI's role makes sense because it would give DOI greater capacity to comprehensively regulate health insurance. Finally, Ms. Nicholas stated that no business entity should be forced to deal or contract with another entity. House Majority Leader Ronald Mariano, appointed by House Speaker DeLeo, initially expressed his support for granting the authority to the HPC but ultimately suggested that the legislature determine the appropriate entity.

To address Ms. Pellegrini's concerns, Professor Majette suggested that the Commission consider building off the HPC's Performance Improvement Plan (PIP) process. PIPs could be used to hold providers and not just payers accountable to rate compression requirements. Professor Majette emphasized that the PIP process is already in place and could be adapted to this application. Secretary Marylou Sudders, representing the Executive Office of Health and Human Services, noted that PIPs

have an important role, but DOI needs to maintain its statutory authority over plans. She suggested placing regulatory authority with DOI and using the HPC's PIP process as a "bully pulpit." Mr. Walsh noted that neither entity is perfectly suited to the role, since DOI regulates payers and the HPC primarily monitors providers. Commission members ultimately agreed to leave the decision to the Legislature in the event that legislation is filed. Members agreed also that any enabling legislation should include robust provisions to protect consumers from disruptions in care. Speaking to the overall work of the Commission, Professor Majette added that any legislation should minimize additional regulatory burdens on payers or plans as complex federal and state regulatory systems are already in place.

In addition to rate compression, Commission members briefly discussed a proposal to incentivize consumers to make high-value choices. Ms. Pellegrini raised a concern with TNP "opt-out" provisions. As discussed in Chapter 3, Chapter 288 of the Acts of 2010 prohibits payer/provider contracts that contain certain anti-competitive clauses; for example, that a limited-network product include all providers in a health system.⁴⁸ Chapter 288, however, also grants participating providers 60 days to opt out of a new TNP.⁴⁹ Ms. Pellegrini stated that if a payer attempts to increase the price differentials among tiers, DOI could treat this as a new product, which triggers the 60-day provider opt-out window. This is a barrier to creating innovative TNPs, since TNPs that do not include a variety of providers may be unpopular with employers and consumers.

Ms. Pellegrini suggested that if there is no new contract for that product, then the opt-out provision should not apply. Ms. Tseng stated that this recommendation is intended to study these sorts of unintended consequences of cost-control laws. Rick Lord, representing the Associated Industries of Massachusetts, commented that meaningful consumer incentives are key to increasing competition and lowering costs. He noted that TNPs are not the solution but are an important part of it. He said that DOI needs tools to make TNPs more attractive, so that consumers and employers who have not embraced TNPs to date can make high-value choices. The Commission recommended that current insurance constraints on LTNP should be revisited and possibly relaxed, to encourage adoption and consumer uptake.

Finally, Commission members agreed with a State Monitoring Subcommittee recommendation to track patient movement among providers, to assess the impact on statewide cost and quality (e.g., patient leakage or migration from community hospitals to academic medical centers). Paul Ginsburg, the Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution, served as an expert panelist at the Commission meeting. He noted that Massachusetts is somewhat atypical compared to other states, because Massachusetts academic medical centers play a larger role in the delivery of non-tertiary care.

⁴⁸ Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Business, 2010 Mass. Acts 288.

⁴⁹ MASS. GEN. LAWS ch. 176O, § 9A (2016).

SPECIAL COMMISSION ON PROVIDER PRICE VARIATION

RECOMMENDATIONS

MARKET FORCES RECOMMENDATIONS

Warranted & Unwarranted Factors for Price Variation

The Special Commission on Provider Price Variation recommends the following factors be considered warranted or unwarranted reasons for provider price variation in Massachusetts. This list is intended to apply to both acute-care hospitals and other provider types (e.g., physicians), although the methods for measuring the factors would likely vary between hospitals, physicians, and other provider types. Also, it should be noted that this list does not consider the methodology or weight that such factors could or should be given in determining pricing.

This recommendation should be considered a policy document that serves as a guide for transparency and deliberation during price negotiations between providers and payers. The feasibility and effectiveness of this recommendation, with respect to preventing unwarranted factors from influencing rates, could be evaluated and monitored through a transparent, objective, and accountable process with ongoing oversight by the appropriate state agency, such as the Health Policy Commission (HPC) or the Division of Insurance (DOI).

Addressing provider price variation must keep in mind the dual goals of making healthcare more affordable for employers and consumers and addressing unwarranted differences in prices paid to providers. The influence of factors is complex and varied. In the current payment environment, every hospital is paid at a different level for the same services by different payers, and some types of services are reimbursed at rates higher than others.

WARRANTED FACTORS:

Warranted factors should be clearly defined and measureable and not used as proxies for unwarranted factors:

Patient acuity

Prices should reflect whether providers generally care for sicker or more complex patients (e.g., provide tertiary or quaternary care). For inpatient care, the case-mix index may be the most appropriate measure of patient acuity, but further research may be needed to identify the most accurate case-mix adjuster for ambulatory outpatient hospital services. Patient acuity measures should be further reviewed and evaluated with reference to socio-economic factors and in conjunction with evolving scientific and medical developments.

High-cost outliers

Although most payers offer some type of cost-based reimbursement for high-cost outliers, it may also be appropriate for pricing levels to be higher for providers who care for high-cost outliers. For example, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS-DRG payments. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The provider is paid 80% of costs above the fixed-loss threshold. Since outlier cases are unpredictable and outlier payments may not cover the full cost of care, it may be appropriate for pricing levels to be higher for providers who care for a substantial number of high-cost outliers, provided that there is transparency on providers' cost structures. It is important to ensure that this factor is not already incorporated into another factor, such as patient acuity, to avoid the potential for multiple counting of the same elements.

Quality

Providers offering higher quality of care, particularly as measured by clinical outcomes and including measures that capture patient experience/satisfaction, such as willingness to recommend, may receive higher prices to reward this higher value. There may be additional payments or reductions in payments based on performance on a set of quality measures, which should also take into consideration contracts that already provide financial incentives or penalties based on quality. There is agreement that outcome and patient experience measures should be improved and expanded over time.

FACTORS REQUIRING ADDITIONAL ANALYSIS:

Analysis either by the Health Policy Commission and/or the Center for Health Information to Determine their Impact on Overall Healthcare Costs and Validity as Warranted Measures

Area wages

To the extent providers have different labor costs, driven by labor costs in the region from which they draw employees, prices should reflect those differences. Medicare adjusts its payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital, compared to the national average hospital wage level. The Medicare wage index is revised each year and is based on wage data reported in hospital cost reports, which are publicly available. To avoid circularity, the Medicare wage index uses the average hospital wage levels for all hospitals in a given geographic area or labor market using Core-Based Statistical Areas (CBSA's), as defined by the Office of Management and Budget. There should be greater transparency surrounding providers' cost structures, including the cost of labor, to understand how wages vary among providers, particularly providers in the same geographic region. This information should be available as part of the contract negotiation between payers and providers. to justify the influence of this factor in pricing determinations.

Low/no-margin services

Higher prices may also be warranted for providers that provide a higher proportion of services that yield little or no margin but that are demonstrably needed by the community. Margin data for hospitals, however, is not uniform, may be unreliable,

and is impacted by allocation decisions at the provider level. Better insight into underlying provider costs is needed to determine whether a service is truly low- or no-margin. A uniform, definitive approach into underlying provider costs is necessary and needs more research by the HPC and the Center for Health Information and Analysis (CHIA) before being considered as a factor.

Teaching

Teaching payments reflect the higher costs providers incur in maintaining a medical education program, beyond the costs accounted for through acuity and outlier adjustments. With any decrease in federal funding provided to Massachusetts by the federal government, shortfalls in federal funding should not be automatically borne by the commercial market. There should be recognition that this is a societal good with benefit for the Commonwealth, and that there needs to be a sustainable appropriate funding mechanism aside from commercial and government payers. CHIA and the HPC should examine the extent of GME funding in other states as well as whether and to what extent there is an appropriate role for a commercial health plan and/or state government to fund these activities. Further, greater transparency is needed to understand the costs associated with teaching in relation to underlying costs, including lower labor costs associated with residents providing care. Similar to other factors, if teaching is to be considered a justifiable factor, other factors, such as acuity and outliers, would need to be taken into account, so that there is no duplication in payment factors.

Stand-by capacity

Some hospitals maintain 24/7 stand-by capacity for unique, specialized services that meet recognized community need. Acuity adjustments and outlier payments reimburse providers when a service is utilized by a patient. Standby capacity, on the other hand, is the cost of ensuring that a service is available when needed, regardless of whether it is utilized sufficiently to cover fixed costs. It may be appropriate for prices to reflect the costs of maintaining stand-by capacity for unique and specialized services. It is important, however, to document those services for which costs are not covered and to examine the extent to which the costs of maintaining this capacity are not already reimbursed through higher payments associated with higher patient acuity and/or high-cost outliers. It is also important to note that demand for stand-by care in rural areas may be more variable and therefore justified as a cost of serving the community.

Socioeconomic status of patient population

The resources needed to meet the needs of low-income populations are different than for other commercial sub-populations. Work to date has identified that healthcare costs vary for higher-income populations compared to lower-income populations. Research shows that lower socioeconomic status is associated with higher costs. Additional investigation is needed to determine whether costs relating to socioeconomic status are accounted for in commercial reimbursement rates. If changes are warranted, then work is needed to identify appropriate payment adjustments.

UNWARRANTED FACTORS:

Market power or bargaining clout, brand, and geographic isolation do not warrant price variation and do not provide societal benefits. Potential government payment shortfalls and research do not warrant price variation in commercial rates but do have a societal impact that needs to be recognized.

Factors with no societal impact

Market Power

In this context, market power refers primarily to the negotiating leverage conferred by size or relative market position, compared to payers and other provider organizations. Patient experience/willingness to recommend and provider referral preferences, which are factors that warrant variation, may contribute to a provider's size and brand. Size and brand alone, however, should not be considered a differentiating factor for price variation.

Brand

State reports have found that brand does not correlate to with high performance on a wide variety of quality measures. Although patient satisfaction and provider referral relationships may contribute to a provider's brand, brand alone should not be considered a differentiating factor for price variation.

Geographic Isolation

Health plan's networks must reflect local geography and demographics to ensure that members have sufficient access to necessary care. However, geographic isolation alone is not a valid factor for price variation. Further, DOI monitors and reviews health plan networks to determine whether members have reasonable and timely access to a broad range of providers and services. In some cases, however, geographically-isolated providers may merit higher prices, if they are the sole provider of low-margin services in their area. This factor, however, should be examined in the context of whether this is already covered by higher payments for wages, standby costs, and other factors referenced above.

Factors with societal impact

Government payment shortfalls

There is a persistent dynamic among governments, providers, and commercial payers (including employers) concerning what constitutes sustainable, appropriate government funding by Medicare, Medicaid, and the Group Insurance Commission. Providers are concerned about possible future reductions in government funding, and have used commercial payments to some degree to balance any difference between payment and the cost of providing care. Payers and employers on the Commission, however, noted that it is not viable to expect commercial payers to automatically make up the difference in any potential government shortfalls. There should be recognition that serving those insured by public payers is a societal need that requires a sustainable government funding mechanism.

Research

Currently, research costs are covered by public funding (e.g. National Institutes of Health), philanthropy, and other private sources. There are differing opinions among Commission members about whether research costs should be included in commercial payment rates. To the extent that maintaining academic research programs may result in costs not covered, and given the economic importance of medical research to the Commonwealth and to patient care, if the current funding model changes, some on the Commission feel a that sustainable and appropriate broad-based funding mechanism is essential. Other Commission members do not believe that commercial health plans and employers should be expected to fund these efforts.

Address “Surprise Billing” and Out-of-Network Issues to Protect Consumers and Support Network Participation

As a key part of an overall strategy to address provider price variation through market mechanisms, the Special Commission on Provider Price Variation applauds the increased use of limited- and tiered-product designs. These products, designed appropriately, can be an important tool to enable patients and consumers to have the benefit of lower-cost coverage options, promote high-value providers, and help address price variation.

Certain issues concerning these types of plans, however, merit a strong recommendation for legislative action. These issues occur when patients receive care out-of-network and then receive what is sometimes called a surprise bill. There are two situations in which this occurs. First, the patient is cared for by a non-participating provider in an emergency. Second, the patient is cared for without his or her knowledge by a non-participating provider at an in-network facility. For example, a patient is scheduled for surgery with a participating surgeon but receives services from a non-participating anesthesiologist, pathologist, or radiologist. In this situation, the patient did not know or make a decision to see the non-participating provider. Out-of-network billing must be addressed so that patients are protected and payers are able to develop innovative plans.

The following issues must be addressed and resolved together as a package, since the absence of any one solution will lead to inappropriate results.

1. Consumer awareness of “surprise billing” scenarios,
2. Patient protections to prevent balance-billing, and
3. A maximum reasonable provider reimbursements for out-of-network services.

1) CONSUMER AWARENESS

Health plans educate patients on the benefits of in-network care and the risks of receiving care out-of-network. Toll-free member service lines, Explanation of Benefits guidance, and cost estimation tools are all used to demonstrate that no network is all-inclusive. Planned out-of-network care or inadvertent leakage can lead to additional costs for the consumer and the healthcare system.

Massachusetts should adopt additional member protections – similar to measures adopted by California, Connecticut, and New York – that define specific surprise bill and non-surprise bill scenarios, including a reminder that patients can be billed when they knowingly choose to receive services from a provider that is not participating in their health plan. Providers should inform patients when the patient is going to be cared for by a non-participating provider. Likewise, health plans should assist their members in determining which physicians and hospitals are in- or out-of-network.

2) PROTECTING PATIENTS FROM BALANCE BILLING

Effective balance-billing prohibitions are necessary to protect patients. Massachusetts should enact into law prohibitions on patients being billed by providers for the portion of their care not covered by their insurance plan. This patient protection should only apply when a patient receives emergency services (emergency room and any associated admission or care) or a non-participating provider provides care in a participating hospital or facility. If a member decides to seek care out-of-network, no protection should be implemented, since patients should appropriately bear the risk of a planned decision.

One possible model for adoption in Massachusetts is the National Association of Insurance Commissioners (NAIC) model act. It has comprehensive requirements on network adequacy and would give DOI sufficient authority to determine whether a network is adequate, by providing quantitative standards.

3) ESTABLISHING AN OUT-OF-NETWORK PAYMENT RATE

There was consensus among Commission members that establishing a default rate of payment for services rendered out-of-network is a critical part of any recommendation. This protection is particularly important for incenting the creation of robust networks necessary for novel insurance product designs that can help address provider price variation.

In setting a maximum reasonable price for out-of-network services, the state should adhere to the following key principles. First, the overall impact should result in cost savings to consumers and employers and have minimal additional administrative expense to both providers and payers. Second, there should be a reasonable, transparent, and simple approach to applying a rate, not a cumbersome metric that is non-transparent or easily administered. Finally, any rate should ensure that current in-network participation levels by providers are improved upon. The set rate must not inadvertently be at such a high level as to entice providers to leave a network, or at such a low level as to make a health plan indifferent as to whether the provider is in- or out-of-network.

Commission members examined the following two scenarios in detail:

1. The patient receives emergency care from a provider participating in a health plan's broad network but that provider has either opted out of or not been selected for participation in a tiered- or limited network product; or

2. The patient receives care in a contracted facility from a physician that is not contracted with the health plan (e.g. Emergency, Radiology, Anesthesia, and Pathology [ERAP]).

Scenario 1: A provider's payment for emergency out-of-network services, as described above, should be set at its currently-contracted rate with that health plan or at a level slightly above that rate (e.g., 10%). The rate should be set by statute to ensure both easy administrative processing and regulatory certainty in the marketplace. The HPC, or other appropriate state entity, should convene a workgroup of interested parties for the specific and time-sensitive purpose of drafting recommendations on this rate, to be filed with the legislature. A statutorily set rate should incent robust network development, as well as significantly lower the cost of care.

Scenario 2: Where a provider does not have a contract with the health plan, the default rate should be at a level significantly below charges but not below Medicare. The appropriate entity should convene a workgroup of interested parties for the specific and time-sensitive purpose of advising the HPC so that it can draft recommendations on this rate, to be filed with the legislature. Like the prior scenario, this rate should be codified in statute in such a manner as to incent robust network development, as well as significantly lower the cost of care.

Tiering Transparency and Participation

The Special Commission on Provider Price Variation endorses the need for improved transparency regarding the provider tiering by health plans. Health plans and providers should collaborate to facilitate further offerings of tiered- and limited-network products as an important option for consumers and employers.

TIERING DISPLAY

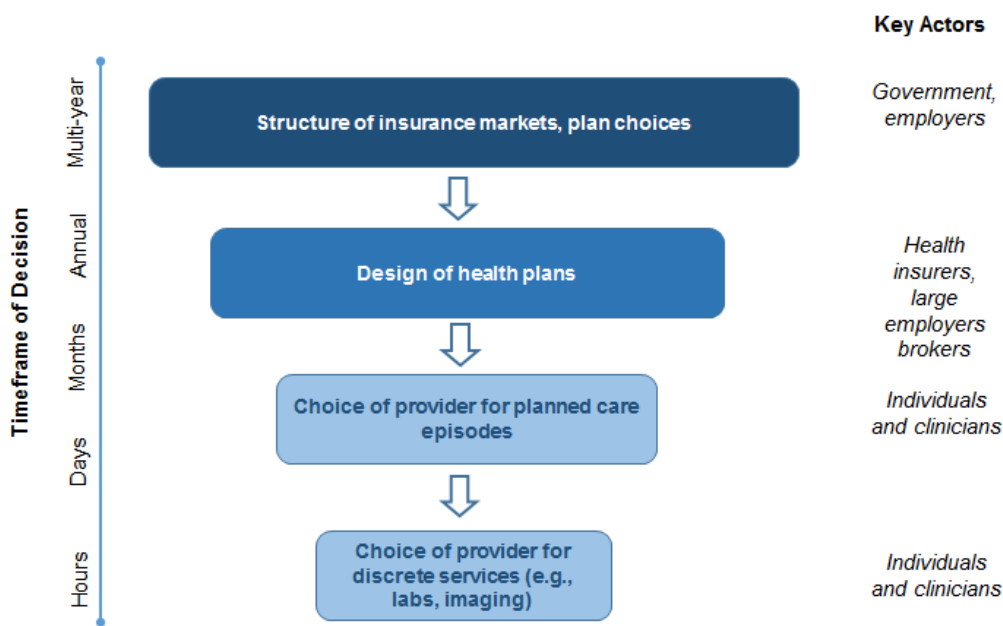
Health plans should develop a uniform method for displaying a hospital's assigned benefit tier so that information on how the hospital performed on cost and quality benchmarks is presented in a consumer-friendly format for patients and providers.

TIERING TRANSPARENCY

Upon request by a hospital, health plans should provide the methodology used for a hospital's tier placement, including the criteria, measures, and data sources, as well as hospital-specific information used in determining the hospital's quality score, how the hospital's quality performance compares to other hospitals, and the data used in calculating the hospital's cost-efficiency.

TRANSPARENCY RECOMMENDATIONS

These recommendations are designed to improve transparency at each point in the decision-making process, from selecting a plan to choosing a provider.



1

These recommendations were guided by the following principles:

1. The definition of transparency is broader than price comparisons at the point-of-service, because efforts to implement transparency solely at this point in the decision-making process have been met with limited success.
2. The opportunity and challenge of improving transparency should affect each sector of the industry and occur at each decision-point along the continuum, recognizing differences within sectors (e.g. small- and large-group insurance market; large and small employers; specialty hospitals/surgical centers and academic medical centers).
3. Efforts to improve transparency should not add to the administrative and financial burden on small businesses in the Commonwealth.
4. Transparency for transparency's sake is not the goal. Tools must be developed that educate and inform insurers, employers, providers, and patients about the fiscal and clinical implications of product design, network access, out-of-pocket expenses, and other considerations.
5. Wherever possible, these recommendations seek to further explore, support, and enhance existing legislative and regulatory mechanisms to improve transparency.
6. Elements of successful transparency efforts in other states (e.g., New Hampshire website) should be adopted.
7. Effective transparency tools must include quality as well as cost information. The quality data should be as granular as possible where it exists and should reflect developments in quality measurements. Standard quality metrics should be developed to provide consistency and support improved quality.
8. Transparency tools need to adapt continually to be relevant.

¹ This chart is based off a visual created by the Health Policy Commission presented by David Auerbach at a meeting of the Special Commission on December 13, 2017.

Transparency Website

As mandated by Chapter 224 of the Acts of 2012, CHIA will establish a consumer website. The development of this website will be informed by a thorough stakeholder process and the principles articulated above and take into account the following recommendations.

- CHIA will release a beta site by July 1, 2017, with a focus on supporting consumers and small business owners.
- CHIA will create an educational platform to provide information along the decision point continuum, including publishing a multi-payer weighted average price for a market basket of “shoppable” services. This will likely require payers to provide pricing information.
 - Full transparency includes specific information about access to behavioral and substance abuse services, drug formularies, and other costs, which can be opaque to employers and employees when selecting plans.
- There shall be a strong partnership between CHIA, the Commonwealth Connector Authority (Health Connector), the HPC, and the Group Insurance Commission to leverage work already complete or underway and to ensure consistent methodology and analytics.
- When consumers seek information on out-of-pocket costs, the website will direct consumers to their insurer’s website, wherever possible.
 - Interactive decision-tree tools should be developed to inform consumers and employers about the ramifications of their plan choice; for example, how choosing a tiered network impacts the patient’s choice of hospital.

Support for Small Employers

Small businesses should be additionally supported through the following actions:

1. When considering the user requirements for its website, CHIA should place specific emphasis on interactive decision tools and educational materials to support consumers and small business owners who may not have access to data or expertise.
2. DOI should prioritize implementation of the Ch. 224 mandate to create standardized, understandable, and timely explanation of benefits forms that includes information about lower-cost alternatives.
3. The Commonwealth should pursue opportunities to improve the purchasing power of smaller businesses and consider Professional Employer Organizations (PEOs), as allowed.
4. Insurers and small employers should work together to develop tools for employers to understand trends within their insured population, while protecting the privacy of individuals.

STATE MONITORING RECOMMENDATIONS

These recommendations were guided by the following principles:

1. Unwarranted provider price variation is a problem in Massachusetts.
2. There are providers that are being greatly underpaid due to unwarranted factors, just as there are providers being overpaid based on unwarranted factors. Underpayment and overpayment are both signs of market failure and are equally problematic.
3. Ensuring access to efficient and affordable healthcare in the community requires that providers are fairly paid according to warranted factors.
4. Short term differential (preferential) investments may be required.
5. Policies to address unwarranted variation in prices should not increase total healthcare spending in the Commonwealth.
6. The Commission recognizes the importance of innovation that drives patients to high-quality, low-cost providers.

Compression of Provider Rates

The Special Commission recommends a direct, multi-component proposal with a date-certain implementation and a mechanism for periodic review to address unwarranted price variation. The proposal aims to promote price compression in Massachusetts for providers in both single- and multi-year contracts. The components authorize a state entity to disapprove payer-provider contracts and/or allow for differential growth rates for hospitals whose prices are subject to the influence of unwarranted factors, and ensure that hospitals subject to the most significant levels of underpayment get immediate relief. This proposal aims to hold both payers and providers accountable for ensuring the compression of provider rates. The Commission recommends that Part 1 & Part 2 be implemented together to address disparities in payment.

PART 1: REGULATE GROWTH IN RATES

The Special Commission recommends, in order to control overall healthcare costs, to compress overall provider prices, and enable the establishment of a minimum or floor as described in Part 2, that the state implement one or both of the following. The Commission recognizes that these two actions taken together would make the most meaningful impact on provider price variation.

- An enhanced role for the appropriate state entity, such as DOI or the HPC, to review and approve insurance contracts using unwarranted and warranted factors in provider payments, such as those found in Recommendation #1. Payer-provider contracts may be reviewed, and keeping in mind the administrative burden on all stakeholders, the appropriate entity will more closely examine those contracts where providers receive relatively high or low rates (outlier contracts), as defined by the legislature. Contracts with rates based on unwarranted factors will be subject to disapproval. The state entity should utilize these factors to close the gap between high-cost outliers and more efficient, lower-reimbursed, high-value providers, and ensure that plan designs are

promoting high-value providers and helping to control the growth in statewide healthcare costs.

- Overall, growth in provider rates in Massachusetts would be consistent with the statewide benchmark on total spending growth. The rate of growth in prices for individual providers or groups of providers would be designed such that providers with low commercial prices would be able to increase their rates more rapidly than providers with high prices due to unwarranted factors.

The implementing state entity shall take measures to protect consumers and address any potential for disruptions in care. The appropriate state entity shall ensure that any savings above those needed to implement Part 1 and Part 2 is returned to employers and consumers through premium relief, while also re-allocating some savings to high-value/efficient providers in an effort to achieve the goal of compressing price variation while also lowering overall TME.

PART 2: RATE MINIMUM OR FLOOR FOR COMMUNITY HOSPITALS

In order to correct for apparent underpayment, the Commission recommends a minimum rate or floor for hospitals in Massachusetts. This floor should take into account the limits set in Part 1, ensuring premiums do not increase for consumers and employers, and warranted and unwarranted factors for price variation. The formula should be determined by the legislature in conjunction with appropriate state entities.

Monitoring Patterns of Utilization

The HPC shall track patient movement across various providers in the state and assess the impact of that movement on statewide cost and quality (e.g. leakage or patient migration between community hospitals and academic medical centers). This information will help evaluate the impact of tiering, better inform the HPC's review of mergers and acquisitions in the Commonwealth, and potentially assist in driving appropriate care to community hospitals.

Meaningful Consumer Incentives

The HPC, DOI, and other appropriate state entities should take measures to encourage the use of more meaningful consumer incentives to promote high-value choices including, but not limited to, contribution policy, increasing price differentials among tiers, increasing the premiums between limited- and tiered-network plans and broader commercial plans, tiering plans based on primary care provider, and other efforts to enhance consumer choice through innovative product design. Current insurance constraints on limited- and tiered-network plans should be revisited and possibly relaxed, to encourage uptake and adoption.

Total Medical Expense (TME)

The Commonwealth shall continue to refine its methodology to measure TME in order to better capture the healthcare market.

GLOSSARY

Academic Medical Center (AMC): For the purpose of this report, unless otherwise noted, an AMC is a major adult hospital that 1) has extensive research and teaching programs; 2) is a principal teaching hospital for a medical school; 3) allocates extensive resources for tertiary and quaternary care; and 4) is a full-service hospital with a Case Mix Index intensity that is more than 5% above the state average.

Accountable Care Organization (ACO): A network of health professionals that share responsibility for providing coordinated care to a group of patients.

Acuity: A measurement that characterizes the health status or relative sickness of a patient population.

All-payer rate-setting: A system under which payment rates that are the same for all patients who receive the same service or treatment from the same provider. “All payers” include private health insurance plans, Medicaid, and Medicare (under an approved waiver from the federal government).

Case Mix Index (CMI): The average of the DRG relative case weights for all of a hospital’s volume.

Centers for Medicare & Medicaid Services (CMS): The federal agency responsible for administering the Medicare and Medicaid programs.

Charge: The dollar amount the hospital bills for a service. This is generally more than the amount paid to the hospital by insurers.

Cost and Market Impact Review (CMIR): A comprehensive analysis of the parties’ business and relative market position, as well as the impact of the proposed material change on health care costs, quality and access, for particular proposed material changes anticipated to have a significant impact on healthcare costs or market functioning.

Cost growth benchmark: The maximum annual growth rate for total per-capita medical spending in the Commonwealth across all sectors.

Diagnosis Related Group (DRG): A method used by Medicare to reimburse for hospital inpatient cases by classifying different types of admissions into one of approximately 575 codes (DRGs).

Deductible: The amount a member pays for covered healthcare services before the insurance plan starts to pay all or some charges.

Disproportionate Share Hospital (DSH): A community hospital that is disproportionately reliant upon public revenues by virtue of having a public-payer

mix of 63% or greater. Public payers include Medicare, MassHealth, and other government payers, including Connector Care and the Health Safety Net.

Fee schedule: An insurer's list of prices for each good or service provided. Most insurers have a "base" or "standard" fee schedule. Insurers and providers negotiate "multipliers" or "enhancements" to the base fee schedule; for example, a provider with a 1.2 multiplier for radiology services would be paid 120% of the standard fee schedule rate for covered radiology services.

Global budget: A fixed amount of funding for a fixed period of time (typically one year) paid to a provider to care for a specified population, as opposed to fixed payments for individual services or cases.

Health Maintenance Organization (HMO): A HMO is a plan that has a closed network of providers, outside of which coverage is not provided, except in emergencies. These plans generally require members to coordinate care through a primary care physician.

High-Deductible Health Plan (HDHP): A plan with a higher deductible than a traditional insurance plan. In calendar year 2016, the minimum deductible was set at \$1,300 for an individual and \$2,600 for a family.

Horizontal integration: The combining of market participants that offer goods and services in the same segment of the market (e.g., tertiary hospital care).

Limited-Network Plan (LNP): A plan that includes a narrow set of providers, compared to the carrier's general network.

Managed care: A healthcare delivery system organized to manage cost, utilization, and quality. Managed care provides for the delivery of health benefits and additional services through contracted arrangements with managed care organizations (MCOs) that accept a set payment for those services.

Material Change: A proposed transaction involving a provider or provider organization, such as a merger with or an acquisition of or by a hospital or hospital system, as defined by 958 CMR 7.02.

Material Change Notice (MCN): Notification to the Health Policy Commission by a provider or provider organization prior to making a material change to its operations or governance structure.

Medical Loss Ratio (MLR): The sum of a payer's incurred medical expenses, expenses for improving healthcare quality, and expenses for deductible fraud, abuse detection, and recovery services, divided by the difference of premiums minus taxes and assessments. The term is used to indicate the proportion of premium dollars spent on clinical services and quality improvement.

Network: The universe of providers, including acute hospitals and subacute facilities, physicians, and ancillary providers, with which an insurer contracts to provide medical services to its members.

Out-of-network bill: Charges that arise when a patient receives services from a provider outside of the patient's insurance network.

Payer: An insurer or health plan that provides some form of healthcare coverage to patients.

Payment method: The structure that an insurer uses to reimburse healthcare providers. A variety of payment methodologies exists, such as fee-for-service, per-diem, and capitation.

Performance Improvement Plan (PIP): A plan created by a healthcare entity and approved by the Health Policy Commission that identifies the causes of and implements specific strategies to reduce cost growth.

Preferred Provider Organization (PPO): A health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Members pay less if they use providers that belong to the plan's network.

Price: The contractually-negotiated amount (reimbursement rate) that an insurer agrees to pay a particular hospital, physician, or other healthcare provider for a given healthcare service.

Primary Care Provider (PCP): A health professional qualified to provide general medical care for common healthcare problems, who supervises, coordinates, prescribes, or otherwise provides or proposes healthcare services, initiates referrals for specialist care, and maintains continuity of care within the scope of his/her practice.

Provider: A physician, other health professional, or hospital that provides medical services to patients.

Provider system or provider network: A group of physicians, health professionals, and/or hospitals that jointly contract with health insurers.

Relative price: A calculated, aggregate measure that compares a provider's prices within a payer's network for a standard mix of insurance products (e.g., HMO, PPO and Indemnity) to the average of all providers' prices in that network. The relative price method standardizes the calculation of provider prices, while accounting for differences in the quantity and types of services delivered by providers and for differences in the types of insurance products offered by payers.

Risk-sharing contract: A contract between a health insurer and a provider that puts the provider at risk for some or all of the costs associated with the provision of medical care to a particular population. There are various types of risk-based

contracts, such as capitated or global contracts and withhold arrangements, under which the return of withheld amounts depends on keeping total medical expense below a certain level.

Teaching hospital: A hospital that reports at least 25 full-time equivalent medical school residents per 100 inpatient beds in accordance with Medicare Payment Advisory Commission standards and which does not meet the criteria to be classified as an academic medical center.

Tiered-Network Plan (TNP): A plan that steers consumers to certain providers by placing providers in different cost-sharing “tiers.” In most circumstances members have higher out-of-pocket costs if they visit a provider that is unfavorably tiered.

Total Medical Expenses (TME): The total cost of care for the patient population that is associated with a group of primary care providers, usually expressed as a dollar amount per patient (or member) per month. TME includes all of the medical expenses incurred by those member patients, regardless of where care is incurred (i.e., it includes physician visits as well as all hospital, laboratory, imaging, pharmacy costs, and other services, wherever those services occur). TME reflects both the price of those services and their frequency of use (i.e., utilization).

Utilization: The amount or number of medical services or units of service used by a given population over a period of time.

Vertical Integration: The combination of market participants that offer complementary goods and services in different segments of the market (e.g., tertiary hospital care and primary care).

APPENDICES

[Appendix A: NIH Funding by State, 2016](#)

[Appendix B: Relative Price & Payer Mix of all Acute Care Hospitals in Massachusetts](#)

[Appendix C: Special Commission Slides](#)

[Appendix D: Presentations to the Special Commission](#)

[Appendix E: Testimony from the Special Commission's Listening Session](#)

ACKNOWLEDGMENTS

Guest Speakers

Joseph Newhouse	John D. MacArthur professor of Health Policy and Management at Harvard University
Matthew Klitus	Chief Financial and Strategy Officer at MassHealth
Gwendolyn Majette	Associate Professor at the Cleveland-Marshall College of Law
David Auerbach	Director for Research and Cost Trends at the Massachusetts Health Policy Commission
Katherine Baicker	C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health
Kathleen Hittner	Health Insurance Commissioner for the state of Rhode Island
Robert Berenson	Institute Fellow at the Urban Institute
Paul Ginsburg	Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution

The Special Commission on Provider Price Variation would like to thank our statutory partners in this work, the Massachusetts Health Policy Commission and the Center for Health Information and Analysis. Executive Directors David Seltz and Ray Campbell, respectively, and their staff assisted the Commission with data requests and drafting support. The Office of the Attorney General, the Commonwealth Health Insurance Connector Authority and specifically Executive Director Louis Gutierrez, MassHealth, and the Group Insurance Commission also assisted in this work. The Special Commission thanks the Massachusetts State House Legislative Information Services for assisting Commission staff offsite and Metro Catering for providing refreshments.

The Special Commission also thanks all the industry experts with whom we connected throughout this process. We'd also like to thank our guest speakers for their presentations to the members and their thoughtful comments. Many of our guest speakers traveled from other states and we appreciate their time.

Finally, we thank the staff of all Special Commission members for providing such timely feedback.