Franklin Pierce School of Law
Institute for Health Policy & Practice
Health Law & Policy

Equitable and Affordable Healthcare: A Shared Responsibility

June 22, 2022

9:00 – 11:30 AM

MASSACHUSETTS
HEALTH POLICY COMMISSION

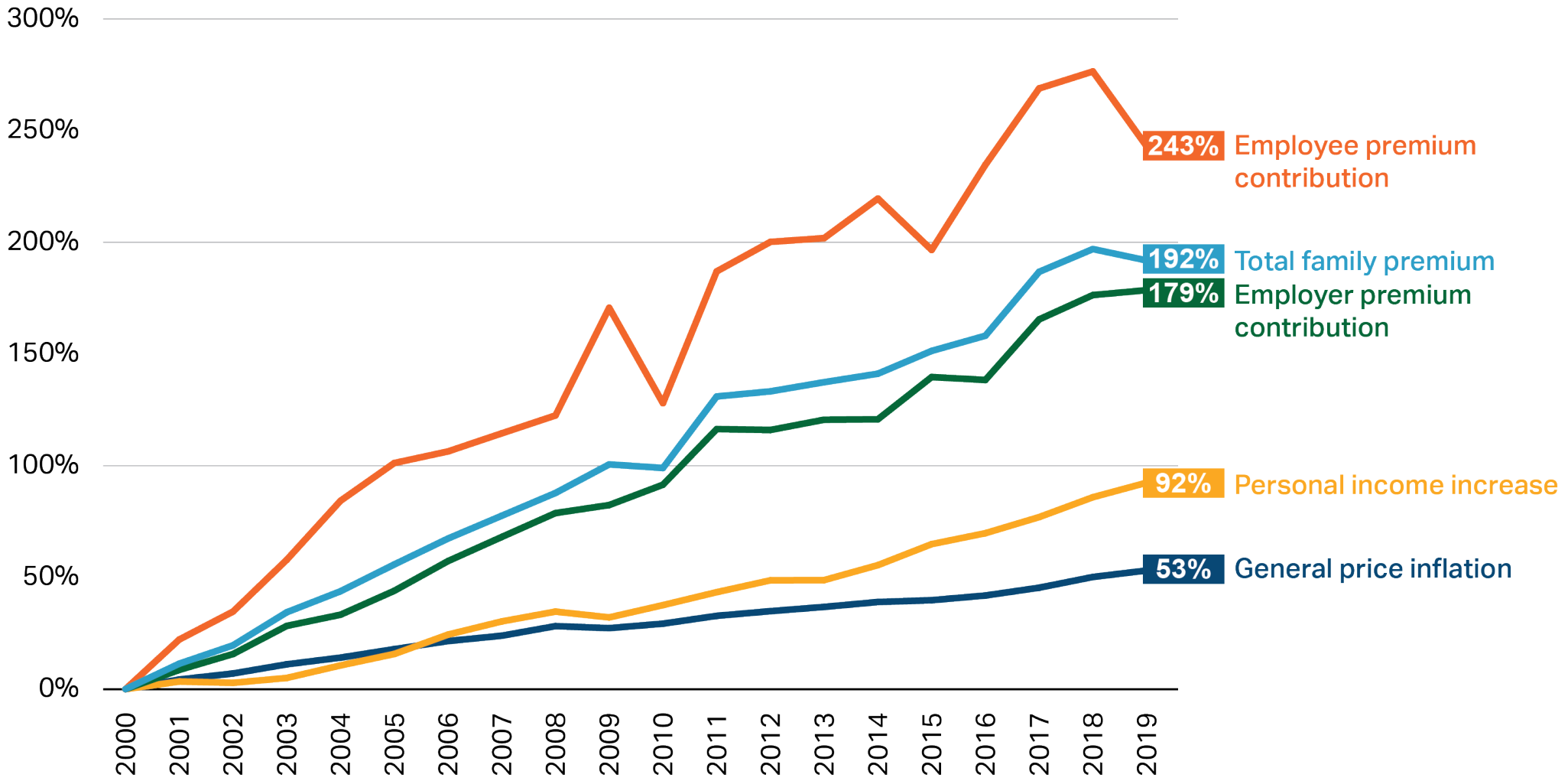
The Role of the Health Policy Commission in Controlling Health Care Spending in MA

Kate Mills, Esq., MPH, Senior Director, Market Oversight & Transparency

How We Got Here: Massachusetts Health Care Reform at a Glance

1990s	**Insurance market reforms** • Guaranteed issue (Insurance policy is offered to any eligible applicant) • Modified community rating and risk pools • Pre-existing condition limitations
2006	**Expansion of insurance coverage (Chapter 58 of the 2006 Acts)** • Individual mandate • Employer responsibility • Medicaid expansion • Insurance exchange
2008	**Health Care Transparency and e-Health (Chapter 305 of the 2008 Acts)** • New state authority to examine cost drivers/conduct cost trend hearings • Support for electronic medical records and information sharing
2010	**Small Business Health Care Relief (Chapter 288 of the 2010 Acts)** • Increased transparency • Development of tiered/limited network products • Reform of unfair contracting practices
2012	**Health Care Cost Containment (Chapter 224 of the 2012 Acts)**

When health spending grows faster than the rest of the economy, families and employers are acutely impacted.



In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

Chapter 224 established two independent state agencies to work together and monitor the state's health care performance and make data-driven policy recommendations.

Massachusetts Health Policy Commission (HPC)		Center for Health Information and Analysis (CHIA)
Policy hub	**PURPOSE**	Data hub
Independent state agency governed by an 11-member board with diverse experience in health care	**OVERSIGHT**	Independent state agency overseen by a Council chaired by the Secretary of Health and Human Services
Sets statewide health care cost growth benchmark Enforces performance against the benchmark Certifies accountable care organizations and patient-centered medical homes Registers provider organizations Conducts cost and market impact reviews Holds annual cost trend hearings Produces annual cost trends report Supports innovative care delivery investments	**DUTIES**	Collects and reports a wide variety of provider and health plan data Examines trends in the commercial health care market, including changes in premiums and benefit levels, market concentration, and spending and retention Manages the All-Payer Claims Database Maintains consumer-facing cost transparency website, CompareCare

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

WATCHDOG

Monitor and intervene when necessary to assure market performance

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

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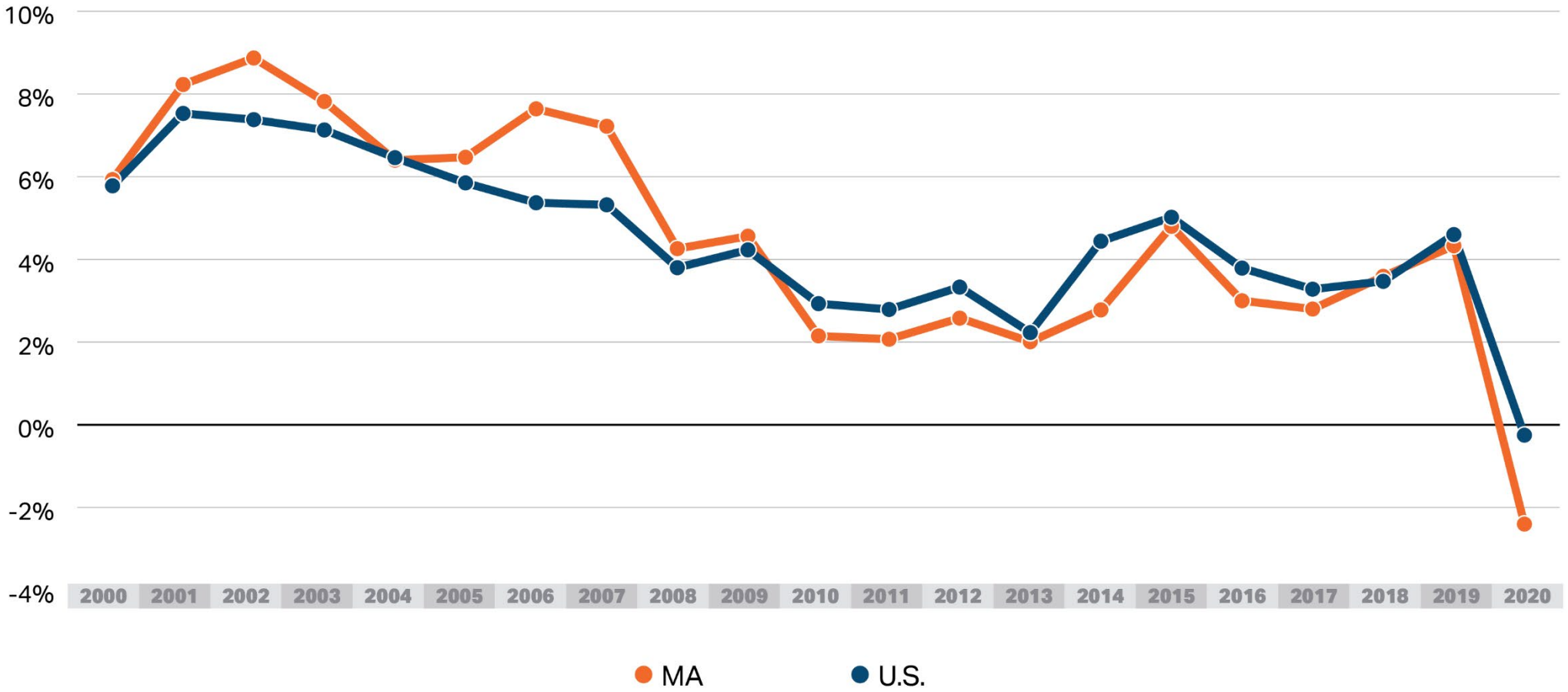
Massachusetts spending growth has been below the US since 2010 but the gap had nearly closed in 2018 and 2019.

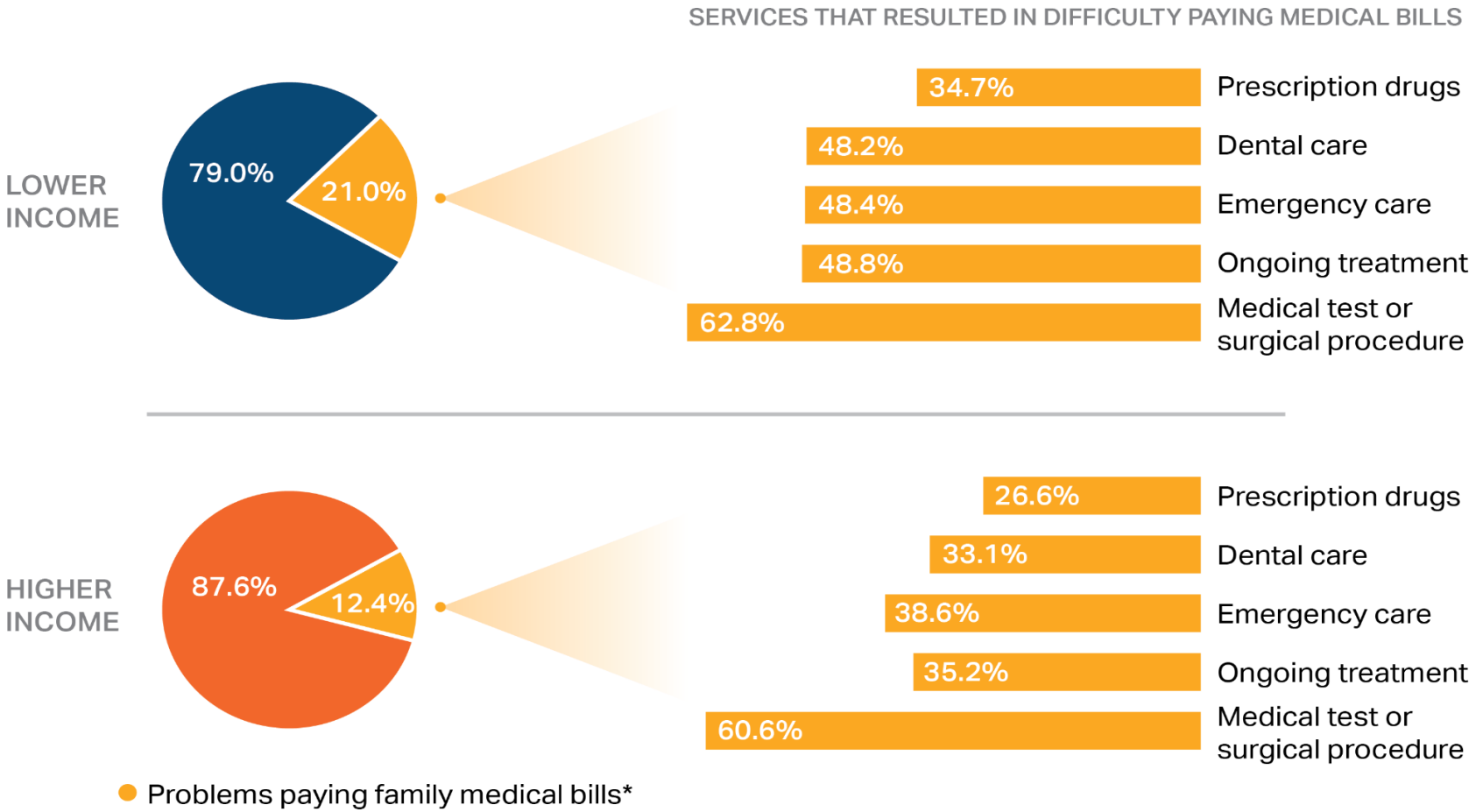
Annual growth in total health care spending per capita in Massachusetts and the U.S., 2000-2020



Notes: U.S. data includes Massachusetts. US data exclude federal COVID-19 relief funding. The decline in per capita spending growth in Massachusetts in 2020 reflects a 2% jump in the state's population as reported in the 2020 Decennial Census relative to that reported by the US Census Bureau for 2019 which was based on the 2010 Decennial Census.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2019 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2020.

Commercially-insured residents with lower incomes were almost twice as likely to struggle with medical bills resulting from common services.

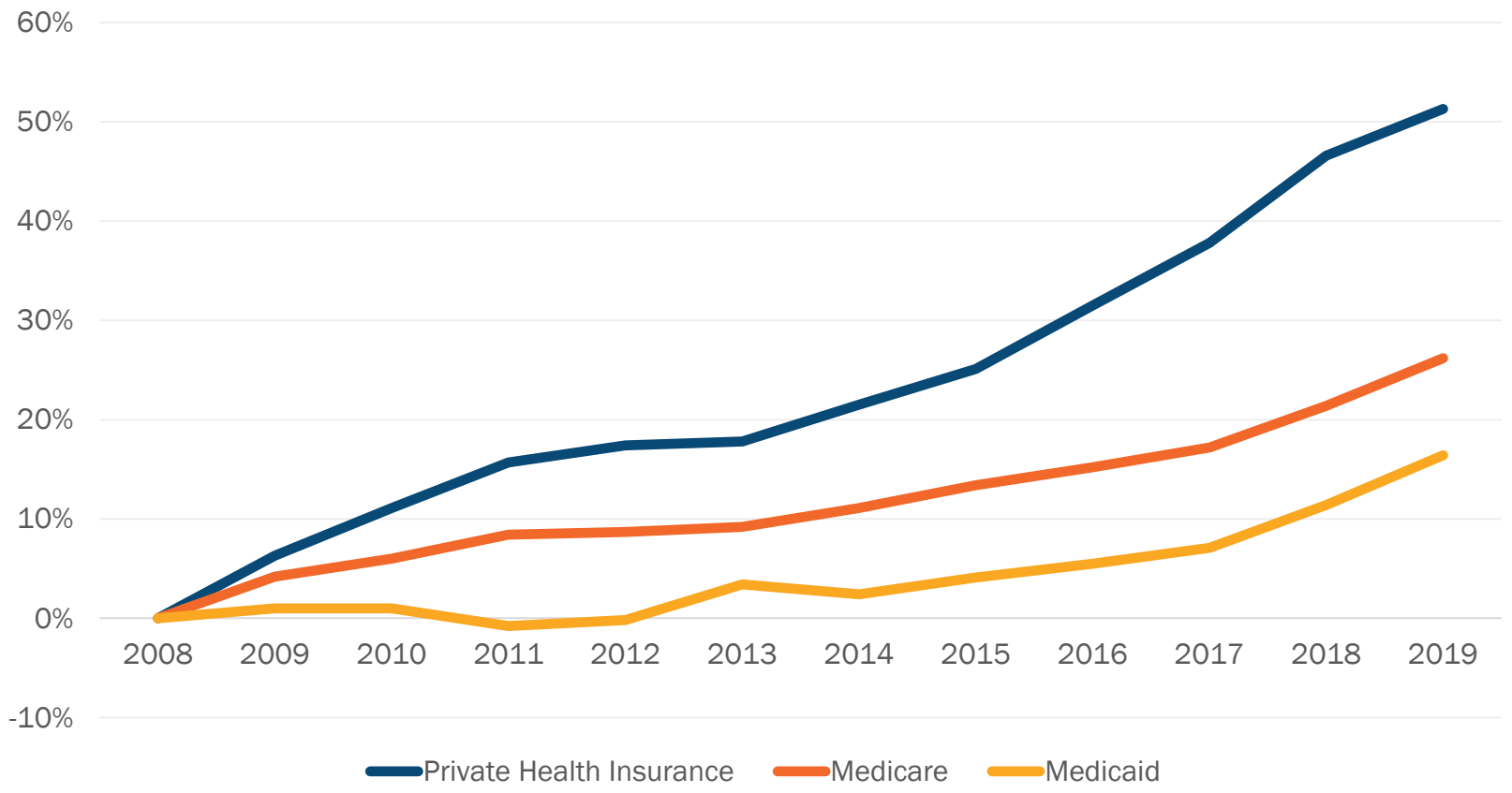
Percent of commercially-insured adults with problems paying family medical bills and services that resulted in difficulty paying medical bills by household income, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019.
Question text: "In the past 12 months, did you have any problems paying or were you unable to pay any medical bills?" "What types of medical services led to those medical bills?"
Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Private health insurance spending has been growing faster than Medicare and Medicaid, largely due to price increases.

Cumulative growth in spending per enrollee by type of coverage since 2008; National Health Expenditures

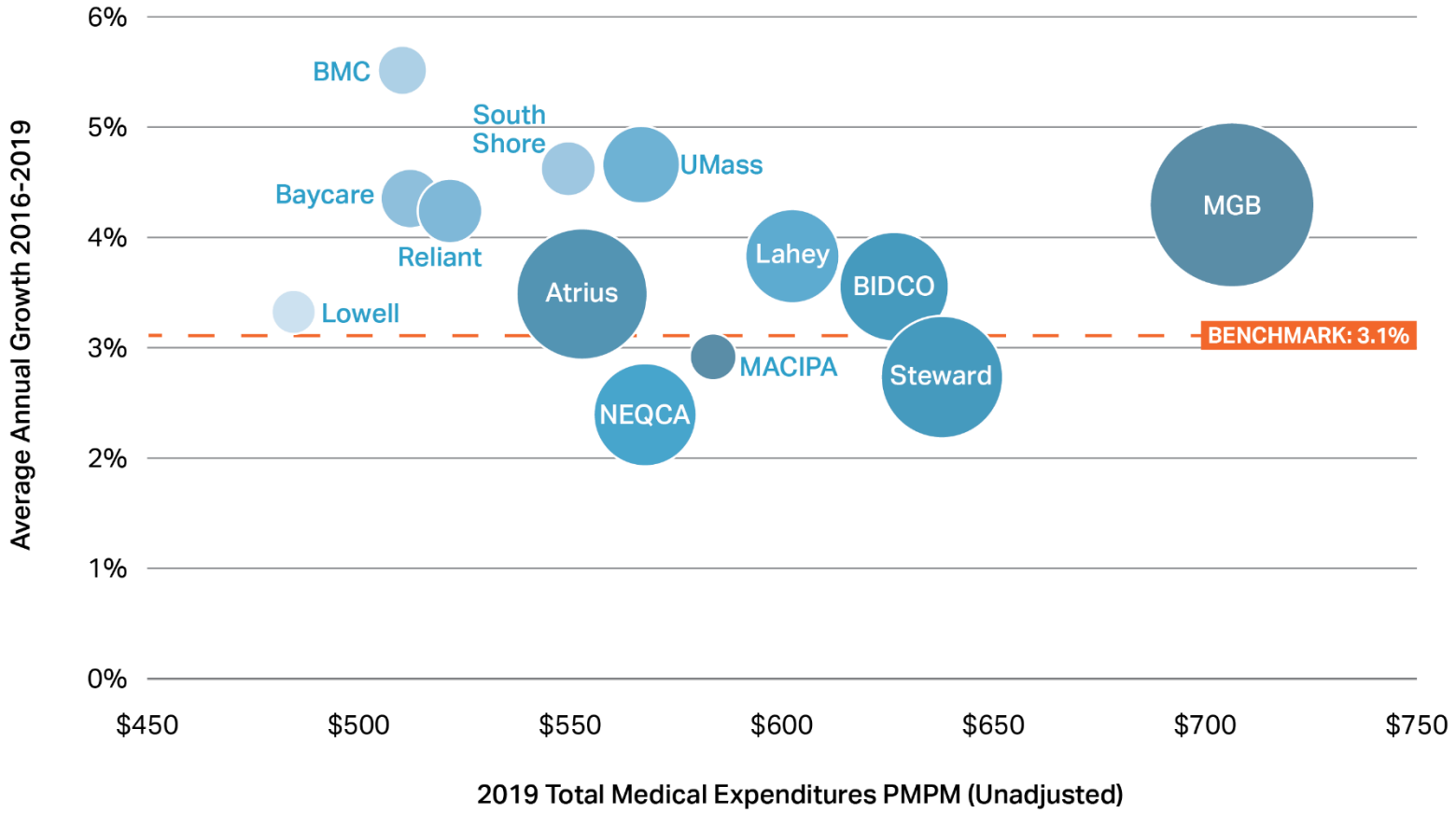


Cooper, Z., Craig, S., Gaynor, M., Harish, N. J., Krumholz, H. M., & Van Reenen, J. (2019). Hospital prices grew substantially faster than physician prices for hospital-based care in 2007–14. Health Affairs, 38(2), 184-189; Peterson-KFF Health System Tracker: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start

- Commercial spending per hospital stay grew 14% from 2015 to 2018 compared to 6% for Medicare.
- Commercial spending growth per hospital stay is mostly driven by **facility spending** growth.
  - Inpatient: facility prices grew 42%; physician prices grew 18% (2007-2014)
  - Outpatient: facility prices grew 25%; physician prices grew 6% (2007-2014)

Commercial spending varies considerably by provider organization; much of the spending difference reflects substantial underlying price variation.

Provider group unadjusted TME per member per month in 2019 and 2016-2019 average annual growth in unadjusted TME



Notes: Bubble size reflect total member months. Only providers with at least 100,000 member months in each year are included. Spending data are for BCBSMA, HPHC and THP only and include PPO plans in addition to HMO and POS. 2019 data is preliminary
Sources: HPC analysis of Center for Health Information and Analysis 2020 and 2019 annual reports; TME databooks.

11

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The Health Care Cost Growth Benchmark

- Sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a cap on spending or provider-specific prices** but is a measurable goal for moderating excessive health care spending growth and **advancing health care affordability**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans** and submit to public monitoring.
- A PIP of an individual provider or health plan is only required following a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, including evaluating cost drivers outside of the entity's control and the entity's market position, among other factors.

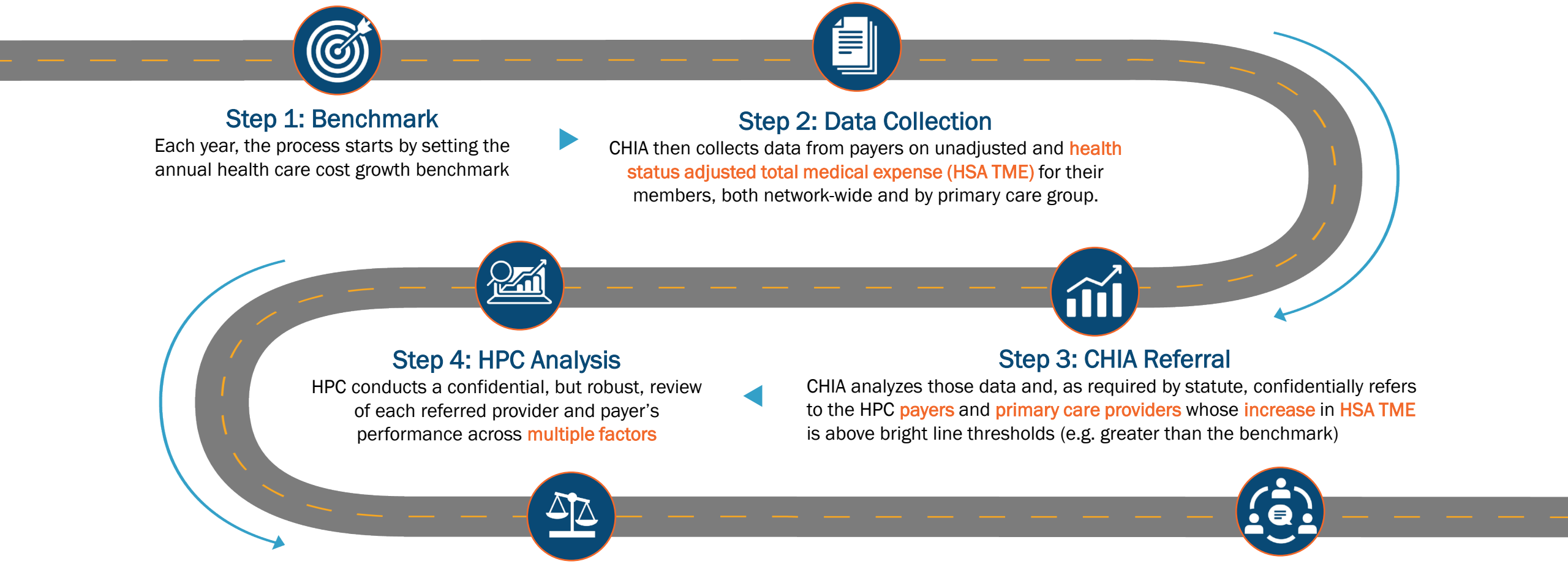
TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

Accountability for the Health Care Cost Growth Benchmark: An Overview



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and health status adjusted total medical expense (HSA TME) for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC payers and primary care providers whose increase in HSA TME is above bright line thresholds (e.g. greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across multiple factors

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the HPC Board votes to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to ongoing monitoring by the HPC during the 18-month implementation. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

Overview of Performance Improvement Plans: Factors Reviewed by the Commission; Mass General Brigham PIP

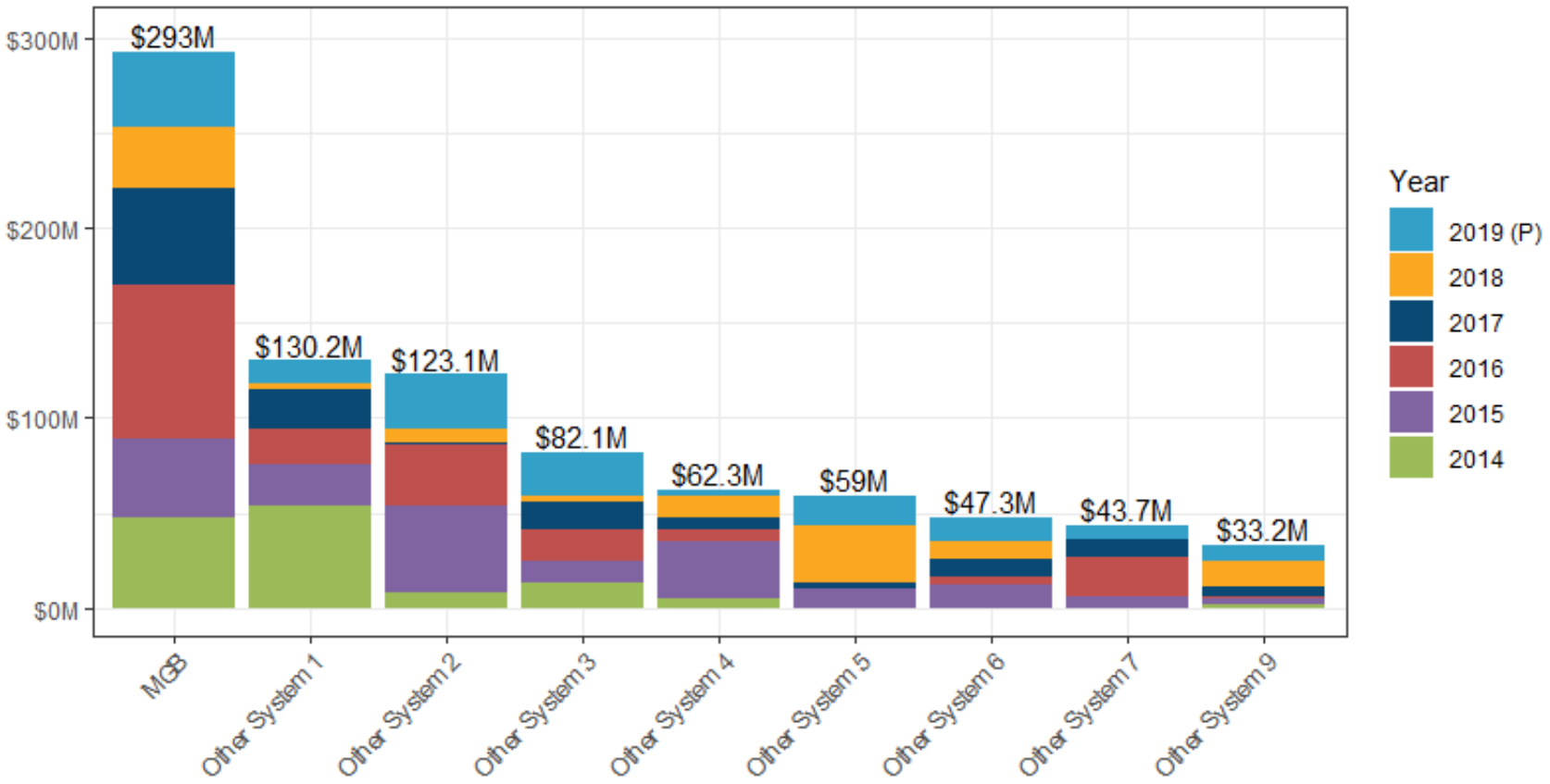
The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies significant concerns about the Entity's costs and determines that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

After reviewing Mass General Brigham's long term spending trends and these regulatory factors, the HPC voted to require a PIP from Mass General Brigham (MGB) on January 25, 2022.

Summary Performance: Mass General Brigham

Cumulative Financial Impact of Above-Benchmark Commercial Spending Growth (2014 – 2019)



Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019. This number represents unadjusted (actual) spending above the benchmark in those contracts with unadjusted spending growth above the benchmark. The figure is presented at the system level and spending for MGB therefore includes the total for PCPO and other affiliated entities for which TME data are available (e.g., CD Practice Associates). The total excludes non-commercial spending and insurance products that either do not require PCP selection (e.g., PPO) or which have carve-outs (i.e., many self-insured plans). Not all of this spending constitutes revenue to the MGB system.

- MGB has had more cumulative commercial spending growth in excess of the benchmark from 2014-2019 than any other provider, totaling $293 million.
- These figures represent unadjusted spending. Because MGB has stated that its primary care patients' health status was not worsening over time, health status adjusted growth understates the spending growth for MGB's primary care patients.

Next Steps: Assessment of a Proposed PIP

STANDARD FOR APPROVAL

- The Board shall approve a proposed PIP if it determines that the PIP:
  - Is reasonably likely to successfully address the underlying causes of the entity's cost growth; and
  - That the entity will be capable of successfully implementing the plan.

REGULATORY FACTORS FOR CONSIDERATION

- Whether the PIP proposes a strategy or activity that has a reasonable economic, business, or medical rationale with a sufficient evidence base;
- The scope and likelihood of potential savings and the potential impact on the Commonwealth's ability to meet the benchmark
- Whether savings and efficiencies are likely to continue after implementation
- The extent to which a proposed PIP carries a risk of negative consequences that would be inconsistent with other policy goals of the Commonwealth; and
- Any other factors the Commission determines to be in the public interest.

HPC's Role in Reviewing Health Care Market Changes

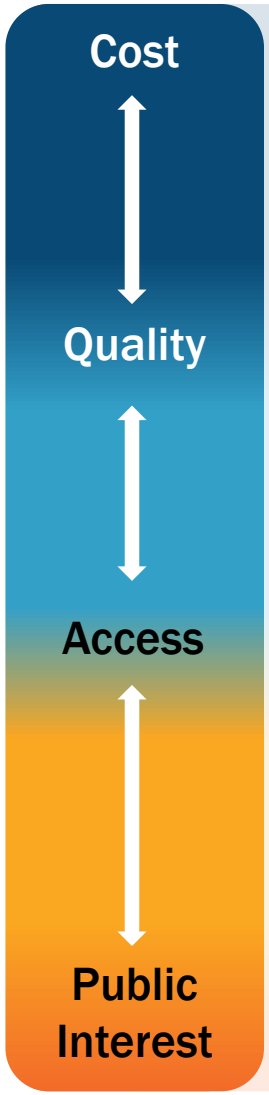
The HPC monitors changes in the health care market and provides objective, data-driven analyses of likely impacts in order to increase public transparency and accountability.

Transactions noticed to date (2013 – Present)

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	34	28%
Physician group merger, acquisition, or network affiliation	29	21%
Clinical affiliation	28	20%
Acute hospital merger, acquisition, or network affiliation	24	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	20	14%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

Statutory Factors for Evaluating Cost and Market Impact

MARKET FUNCTIONING



- Unit prices
- Health status adjusted total medical expenses
- Provider costs and cost trends
- Provider size and market share within primary service areas and dispersed service areas
- Quality of services provided, including patient experience
- Availability and accessibility of services within primary service areas and dispersed service areas
- Impact on competing options for health care delivery, including impact on existing providers
- Methods used to attract patient volume and to recruit or acquire health care professionals or facilities
- Role in serving at-risk, underserved, and government payer populations
- Role in providing low margin or negative margin services
- Consumer concerns, such as complaints that the provider has engaged in any unfair method of competition or any unfair or deceptive act
- Other factors in the public interest

Examples of HPC Market Monitoring Work

Plus public comments on expansions by Boston Children's Hospital and Mass General Brigham under review by the state's Department of Public Health

Benefits of HPC's Reviews of Provider Affiliations

The Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) process, in addition to increasing public awareness of provider affiliations, has produced the following benefits for consumers in Massachusetts:

FUTURE ACCOUNTABILITY Requiring entities to disclose goals for a transaction allows the HPC and others to assess whether those goals have been achieved in the future.

VOLUNTARY COMMITMENTS Some entities have addressed concerns raised by the HPC by making certain public commitments (e.g., increasing access for Medicaid patients, not implementing facility fees at acquired physician clinics).

SUPPORT FOR ENFORCEMENT ACTIONS Findings in HPC market oversight reports have been used by the Massachusetts Attorney General and Department of Public Health to negotiate enforceable commitments to address cost, market, quality, and access concerns.

- CMIR findings may be considered as evidence in Massachusetts antitrust or consumer protection actions, and in Determination of Need reviews.

IMPACTS ON TRANSACTION PLANS In some cases, entities have planned affiliations in part based on the likelihood of a CMIR, and in other cases have decided not to pursue an affiliation after the HPC raised concerns in the MCN or CMIR process.

What's Next? Focusing on Health Equity

Eliminating health inequities is integral to achieving the HPC's mission.

> *The HPC's mission is to advance a more transparent, accountable, and **equitable** health care system through its independent policy leadership and innovative investment programs. The HPC's overall goal is better health and better care – at a lower cost – **for all residents** across the Commonwealth*

RHODE ISLAND COMMERCIAL MARKET AFFORDABILITY POLICY OVERVIEW

JUNE 22, 2022

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

TABLE OF CONTENTS

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

MISSION

- The State of Rhode Island Office of the Health Insurance Commissioner (OHIC) seeks to improve health care access, affordability, and quality. OHIC does so as it: (1) protects the interest of consumers of commercial health insurance, (2) encourages fair treatment of health care providers by commercial health insurers, (3) improves the health care system as a whole, and (4) guards the solvency of commercial health insurers.

FUNCTIONS

- OHIC is a commercial health insurance policy reform and regulatory enforcement agency and the office's functions include:
  - **Health Insurance Rate Review:** OHIC reviews the premiums for comprehensive/major medical plans, Medicare supplement plans, and limited benefit plans sold in the state to ensure they are consistent with the public interest and proper business conduct. Rates may be approved, modified, or rejected.
  - **Health Insurance Form Review:** OHIC reviews coverage documents for comprehensive/major medical plans, Medicare supplement plans, and limited benefit plans sold in the state to ensure they are consistent with the public interest and federal and state requirements. Forms may be approved, modified, or rejected.
  - **Network Plan Certification:** OHIC certifies all network plans in the state to ensure consumer protections are in place such as network adequacy and that provider credentialing and contracting requirements are met.
  - **Benefit Determination and Utilization Review (UR) Agent Certification:** OHIC certifies all benefit determination and UR agents to ensure consumer protections are in place such as timely approval of and payment for covered services and that required denial and appeal processes are followed.

FUNCTIONS

- The office's functions also include:
  - **Consumer and Provider Complaint Resolution:** OHIC investigates and resolves complaints against commercial health insurance companies filed by consumers and providers.
  - **Market Conduct Examinations:** OHIC opens periodic examinations into commercial health insurer market conduct. Examinations may focus on nearly all aspects of commercial health insurer business practices that fall within the jurisdiction of OHIC.
  - **Regulation and Subregulatory Guidance Development:** OHIC issues regulations and subregulatory guidance that implement and interpret OHIC's statutory purpose.

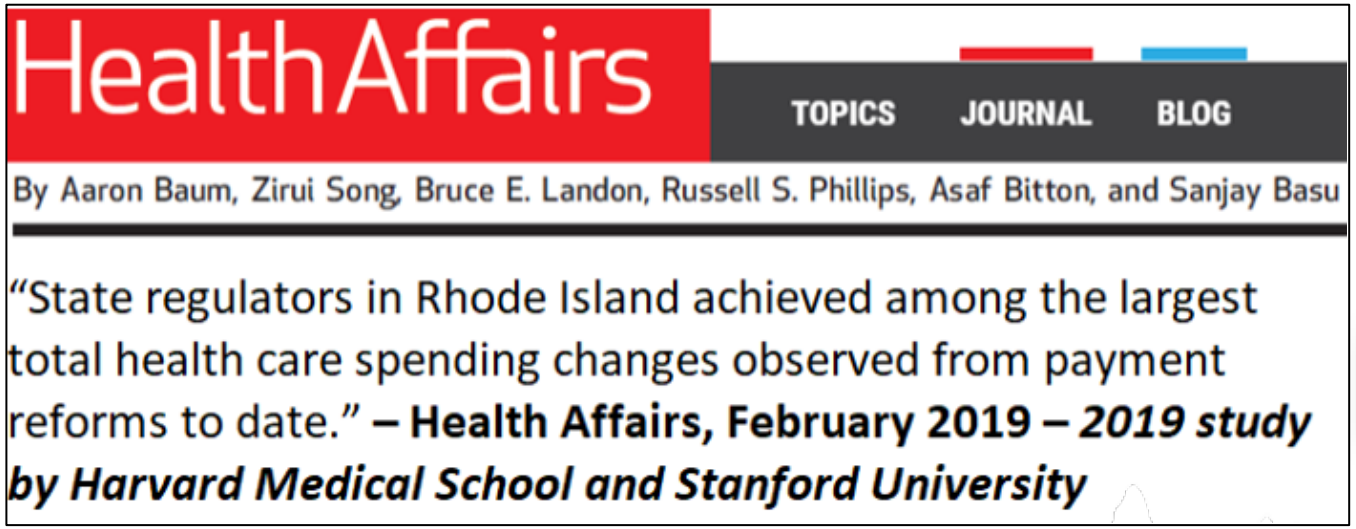
AFFORDABILITY POLICY

- OHIC's policymaking to further affordability rests on four elements:
  1. Health insurance rate review
  2. Affordability Standards
  3. Delivery system reform acceleration
  4. Health care cost transparency and accountability

HEALTH INSURANCE RATE REVIEW

- As noted earlier, one of OHIC's most important functions is to annually review the rates for plans sold by insurers to individuals, small employers, and large employers to ensure they are consistent with:
  1. The public interest
  2. The proper business conduct of the insurer
- Rates may be approved, modified, or rejected.
- Rates are not considered to be consistent with public interest and consistent with the proper conduct of the business of the issuer unless they are also consistent with the legislative purposes OHIC articulated previously.
- OHIC views affordability as an essential part of the public interest and views actuarial soundness as an essential part of proper business conduct.

AFFORDABILITY STANDARDS



DELIVERY SYSTEM REFORM ACCELERATION

HEALTH CARE COST TRANSPARENCY AND ACCOUNTABILITY

GOVERNOR MCKEE'S FY23 BUDGET PROPOSES A HEALTH SPENDING ACCOUNTABILITY PROGRAM

TOP 3 GOALS:

- ✓ UNDERSTAND AND CREATE TRANSPARENCY AROUND WHAT DRIVES COST
- ✓ CREATE ACCOUNTABILITY AMONG INSURERS, PROVIDERS & GOVERNMENT BY TYING COST GROWTH TO ECONOMIC GROWTH
- ✓ LESSEN NEGATIVE IMPACT OF RISING HEALTHCARE COSTS ON RI RESIDENTS, BUSINESSES & GOVERNMENT

THE PATH FORWARD

> **“This advanced VBP compact puts Rhode Island on a clear path toward a payment system that will improve affordability while supporting the reorientation of care delivery to better meet population needs and improve access, equity, patient experience, and quality.” - *Health Insurance Commissioner Patrick M. Tigue***

HEALTH INSURANCE COMMISSIONER

Connecticut's Path to Transformation

OHS
CONNECTICUT
Office *of* Health Strategy

Why the Office of Health Strategy

- Recommendations in 2016 from the State's Healthcare Cabinet recommended more aggressive steps to contain costs in Connecticut and charge an agency with an overarching vision on reform

- One key recommendation was to create OHS to bring together
  - Health care delivery and payment reforms through Innovation
  - Enable transformation through health information technology and the collection of claims data through the state's APCD
  - Use data to drive policy and health systems planning functions
  - Convene stakeholders to get buy-in and transform

OHS CONNECTICUT Office *of* Health Strategy

How OHS Came together (Continued)

- Took the vision of the former Lt. Governor who oversaw health care AND two pieces of legislation to create
  - Part 1 – establish the office and its authority – this happened in the 2017 budget implementer bill and is codified at C.G.S. § 19a-754a
  - Part 2 - make detailed legislative changes necessary to the health systems unit statutory provisions - 2018 session
  - Completed for July 1, 2018
- Bipartisan legislation – both times

OHS CONNECTICUT Office of Health Strategy

Governor Lamont's Executive Order #5 Directs Connecticut's Office of Health Strategy to:

1. Develop annual **healthcare cost growth benchmarks** by December 2020 for CY 2021-2025.
2. Set **targets for increased primary care spending** as a percentage of total healthcare spending to reach 10% by 2025.
3. Develop **quality benchmarks** across all public and private payers beginning in 2022, including clinical quality measures, over/under utilization measures, and patient safety measures.
4. Monitor and report annually on healthcare spending growth across public and private payers.
5. Monitor accountable care organizations and the adoption of alternative payment models.

OHS CONNECTICUT Office *of* Health Strategy

Connecticut's Need for a Cost Growth Benchmark

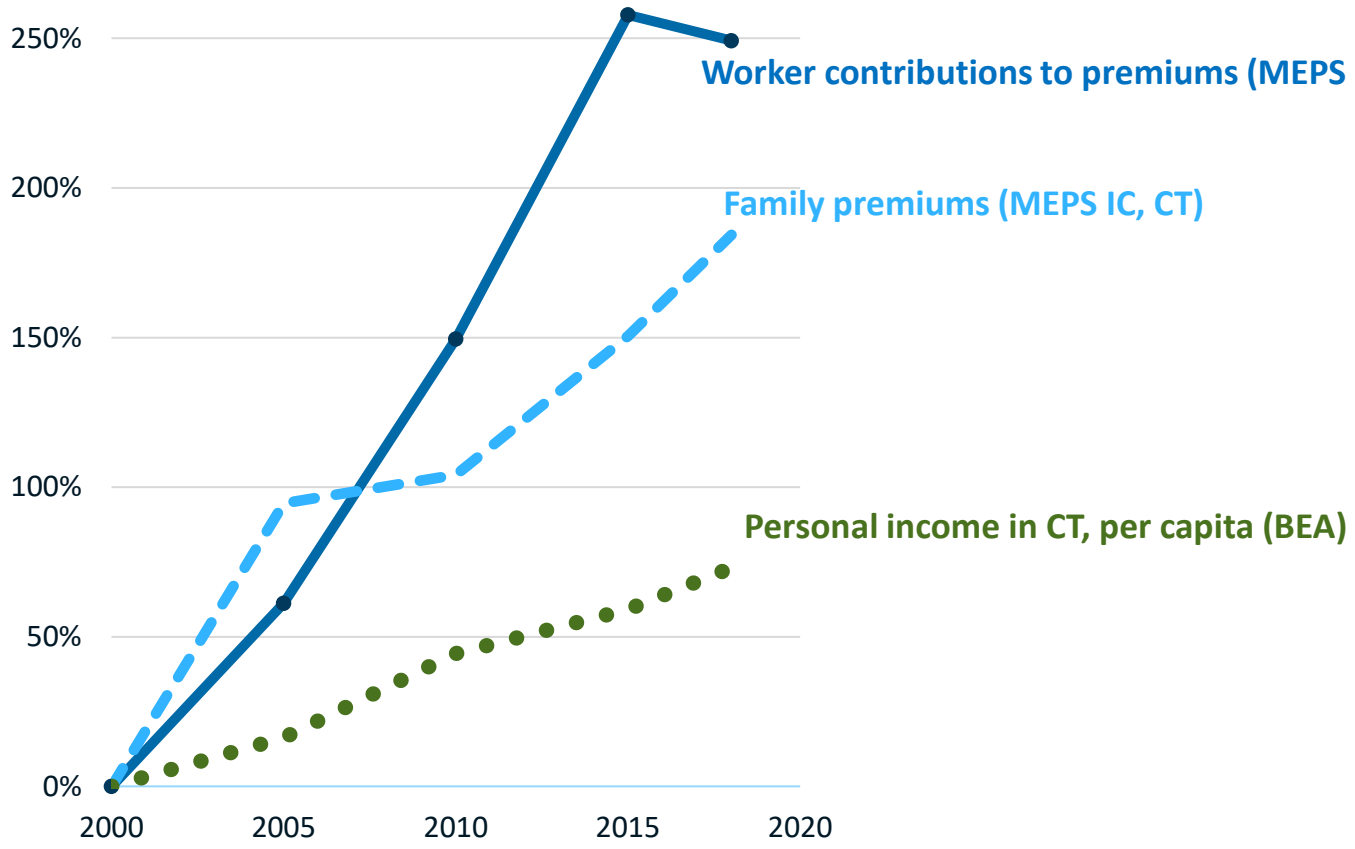
1. For the last two decades healthcare spending has annually grown at a pace *more than double* growth in median household income (4.8% vs. 2.0%).*
2. Connecticut residents can't afford healthcare - not insurance premiums, and not the cost sharing.
3. Governor's strong belief in the need for transparency – back to 2019 session

*Office of Health Strategy. Cost Growth Benchmark Technical Team Meeting #5, June 16, 2020.

OHS CONNECTICUT Office *of* Health Strategy

Healthcare remains unaffordable to many

Since 2000, Connecticut employer-sponsored insurance premiums have grown **two and half times** faster than personal income



Source: Medical Expenditure Survey, Tables D.1 and D.2 for various years

OHS CONNECTICUT Office of Health Strategy

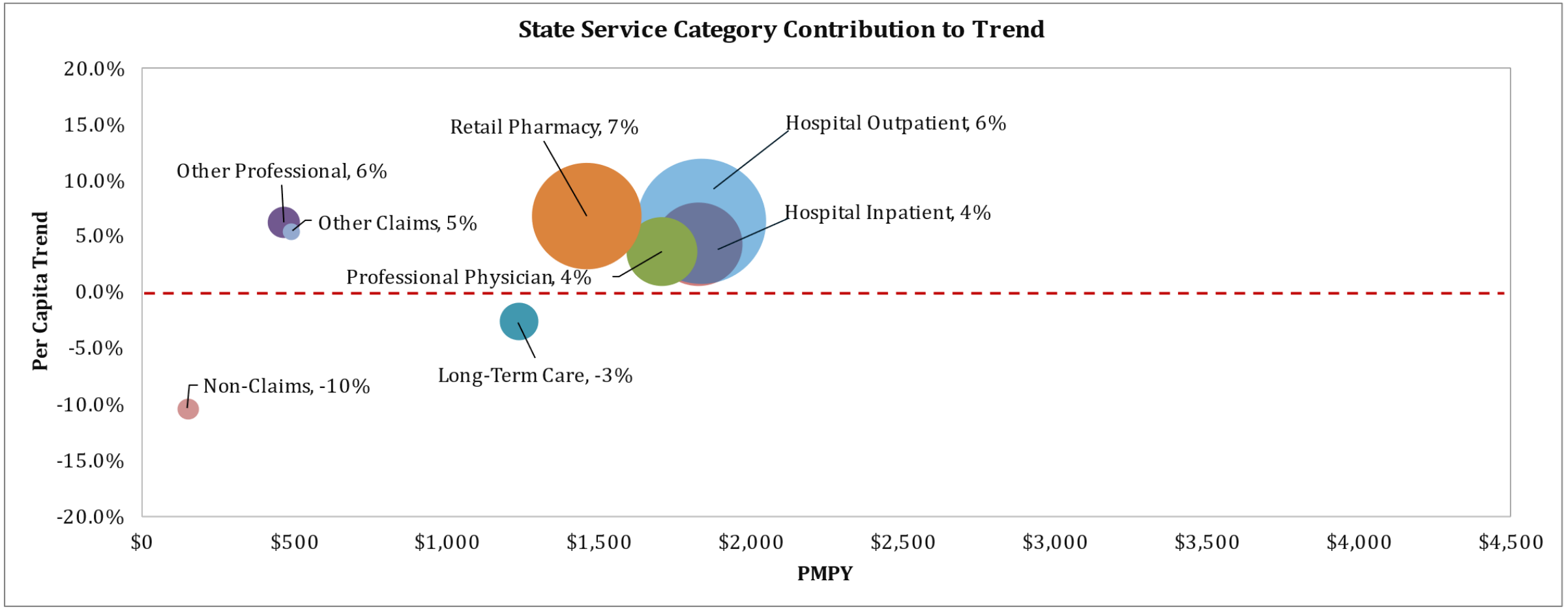
What is a Primary Care Spending Target and Why Set One?

- A primary care target is an expectation for what percentage of healthcare spending should be devoted to primary care.
- The U.S. healthcare system is largely ***specialist-oriented***. Research has shown that ***primary care-oriented*** health systems produce better patient outcomes, lower costs, and improved patient experience of care.
- Connecticut primary care spending is only 5.3% of total spend

Why did Legislation succeed this year?

- No changes in trends to spending
- OHS has been putting out data from the APCD and from the baseline year of benchmark reporting on spending trends in CT – hint, it's not good
- A LOT of engagement of legislators and key stakeholders
- Same leaders in House and Senate in support
- Commitment to do more beyond this – specific policy proposals
- Engagement on upstream work – community benefits bill
- Ability to test impact of policy proposals with the CT Healthcare Affordability Index – recent modeling of healthcare proposals

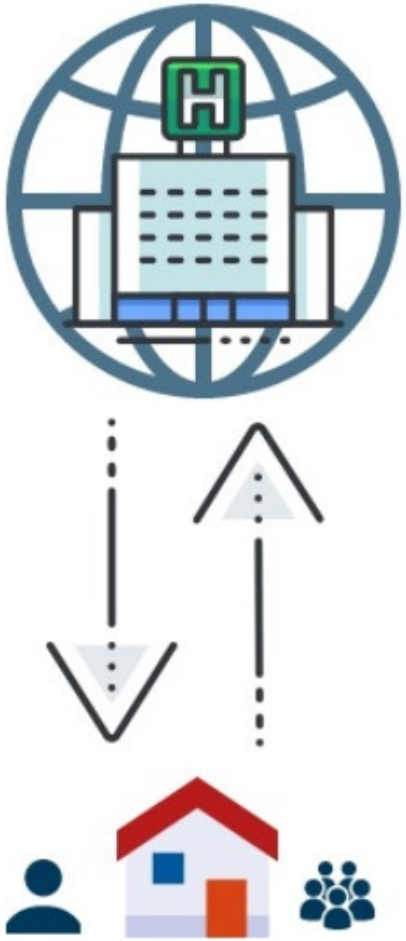
Retail Pharmacy and Hospital Outpatient Drove Connecticut's State Level Spending Growth in 2019



Data are not riskadjusted. They are reported net of pharmacy rebates.
The width of the bubbles represents contribution to trend.

OHS CONNECTICUT Office of Health Strategy

Addressing Healthcare Cost and Quality on the Systemic and Household Level



- **Cost Growth Benchmark**
  - A global, long-term strategy

Monitor Overall Cost Growth

Ensure Quality

Increase Investments in Primary Care

- **Healthcare Affordability Index** [CHAI Interactive Tool]
  - A tool to shape policies that help CT residents by estimating the effect of healthcare reforms/proposals on capacity of CT residents to maintain coverage and meet basic economic needs.

OHS CONNECTICUT Office of Health Strategy