Examination of Health Care Cost Trends and Cost Drivers
Pursuant to G.L. c. 12, § 11N
October 22, 2015

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Previous AGO Reports Identified Challenges in Health Care Transparency and Market Function

• Providers were paid widely different commercial prices that were not explained by differences in quality, complexity of services, or other common measures of consumer value.
• Price increases drove increases in health care spending from 2004 to 2008.
• Higher priced hospitals were gaining market share over lower priced hospitals.
• There was a dearth of standardized, consistently reported metrics of provider cost and quality.
2015 Examination

I. What progress has the Commonwealth made on initiatives to contain health care costs?

II. Has previously identified market dysfunction improved?

III. Recommendations to improve market operation.

Enrollment in Tiered Network Products Has Increased, but Has Not Been Accompanied by a Net Shift in Volume Away from Higher Priced Providers

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Price Variation Unexplained by Quality Persists, Contributing to Providers Having Different Levels of Resources to Carry Out Their Mission

Annual Range in THP Physician Relatives Prices (All Products) 2009 – 2012

Global Payment Arrangements Reflect Historic Payment Differentials and Result in Widely Different Dollars Available to Care for Similar Patient Populations

Variation in Provider Group Health Status Adjusted Resources Available to Care for HMO/POS Risk Patients under Risk Contracts for a Major Commercial Insurer (2013)
Total Medical Spending Is Higher for the Care of Commercial Patients from Higher Income Communities

Higher Priced Providers Continue to Draw Greater Patient Volume

Share of Total Commercial Discharges in Massachusetts by Higher Priced and Lower Priced Hospitals

Note:
1. Discharges exclude discharges for normal newborns and specialty services not fully captured by available discharge data.
2. Higher priced hospitals defined as hospitals with above average prices (relative prices above 1.0) for the largest commercial insurer in 2013.
3. Hospitals without a relative price for 2009 or 2014 were excluded from this analysis.

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If the Distribution of Price Increases Follows Historic Patterns, Price Disparities Will Persist or Worsen

Effect of Increased Pharmacy Trend and Illustrative Provider Contractual Increases on “Allowed” Commercial Unit Price Trend for All Other Providers and Services under State Cost Growth Benchmark

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<tbody>
<tr>
<td></td>
<td>16.7%</td>
<td>$3.2 billion</td>
<td>Utilization 12.5%</td>
<td>$3.6 billion</td>
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<tr>
<td>All Other Expenses</td>
<td>83.3%</td>
<td>$15.8 billion</td>
<td>Unit Price 0.8%</td>
<td>$16.1 billion</td>
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<tr>
<td>Total Medical Expenses</td>
<td>100.0%</td>
<td>$18.9 billion</td>
<td>3.6% Benchmark</td>
<td>$19.6 billion</td>
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Recommendations

• Improve information for businesses, patients, and the physicians that guide patient decisions:
  – Require clear, easily compared information on the cost and quality of different insurance plans and provider systems at the time of health insurance plan and PCP selection.
  – Simplify and strengthen how tiered networks are designed.
  – Promote consumer access to and understanding of health care cost and billing information.

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Recommendations

• Take price disparities into account in implementing reform initiatives:
  – Monitor variation in health status adjusted global budgets.
  – Evaluate provider performance under the statewide cost growth benchmark in ways that take into account existing differences in provider efficiency.

Recommendations

• Monitor and address disparities in the distribution of health care resources:
  – Consider forms of directly regulating the level of variation in provider prices and/or medical spending.
  – Monitor income and health status adjusted medical spending by zip code on an annual basis.
  – Promote the development of population health status metrics that better account for socioeconomic risk factors.