MASSACHUSETTS
HEALTH POLICY COMMISSION

Better Health, Better Care, Lower Costs:

Introduction to the Massachusetts Health Policy Commission

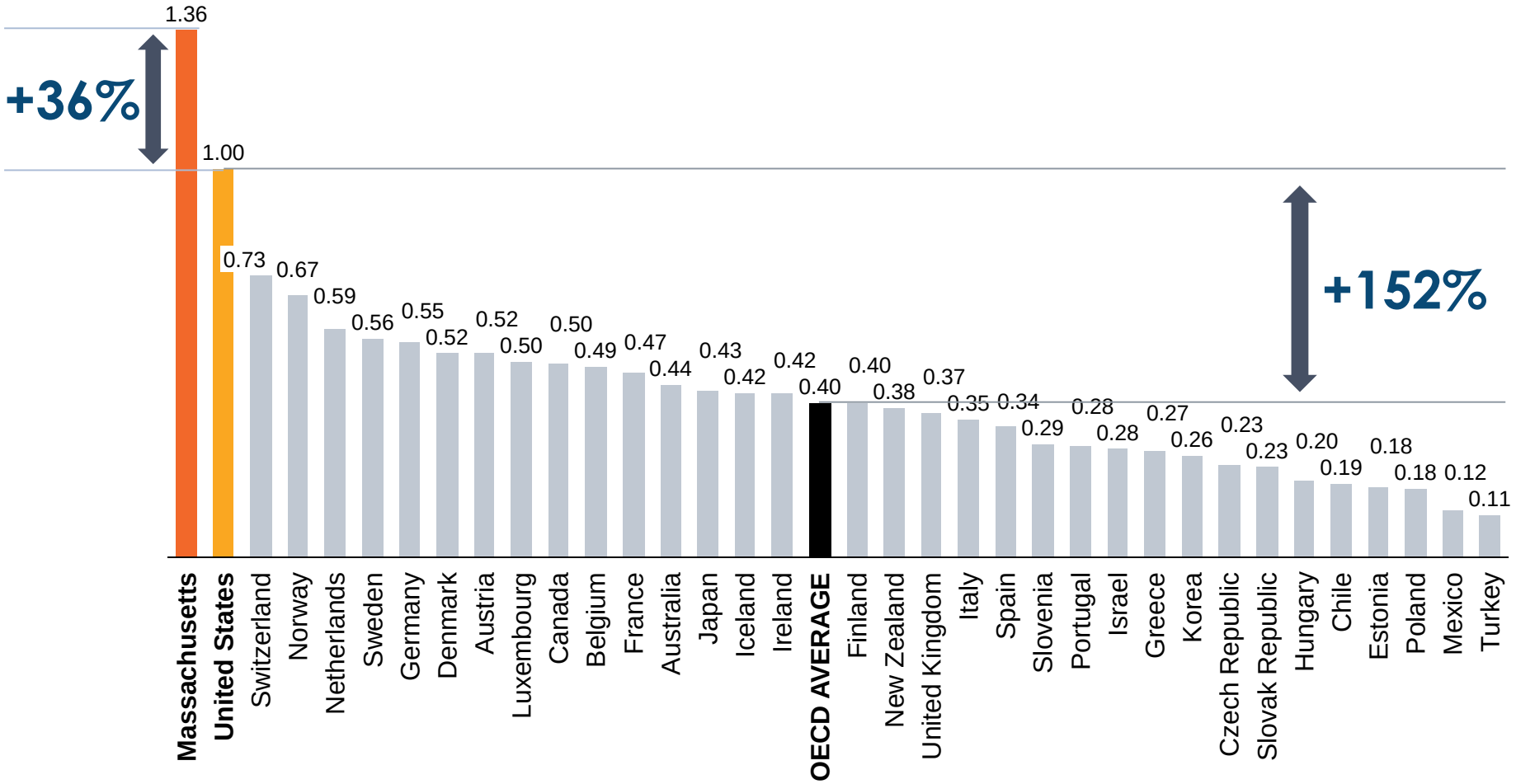
February 25, 2020

Section I.

What is the health care cost growth benchmark and what is the role of the Massachusetts Health Policy Commission?

In 2009, Massachusetts had the highest per person spending on health care of any state; the US spends the most of any OECD country.

Per capita health care expenditures, indexed to U.S. average



Note: OECD country wide averages indexed to US average spending 2013 (or most recent year) expenditure on health, per capita, US$ purchasing power parities (2012 is most recent year available for countries denoted by *). MA per capita spending is from Health Care Expenditures per Capita by State of Residence from 2009 and indexed to US Health Care Expenditures per Capita by State of Residence from 2009.

Source: OECD Health Statistics 2014 - Frequently Requested Data; KFF, "Health Care Expenditures per Capita by State of Residence", 2009

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.

HPC

Health Care Cost Growth Benchmark

- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state's long-term economic growth rate (PGSP):
  - Health care cost growth benchmark for 2013 - 2017 equals **3.6%**
  - Health care cost growth benchmark for 2017 - 2019 equals **3.1%**

- If target is not met, the Health Policy Commission can require health care providers and health plans to implement **Performance Improvement Plans** and submit to strict public monitoring

TOTAL HEALTH CARE EXPENDITURES

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

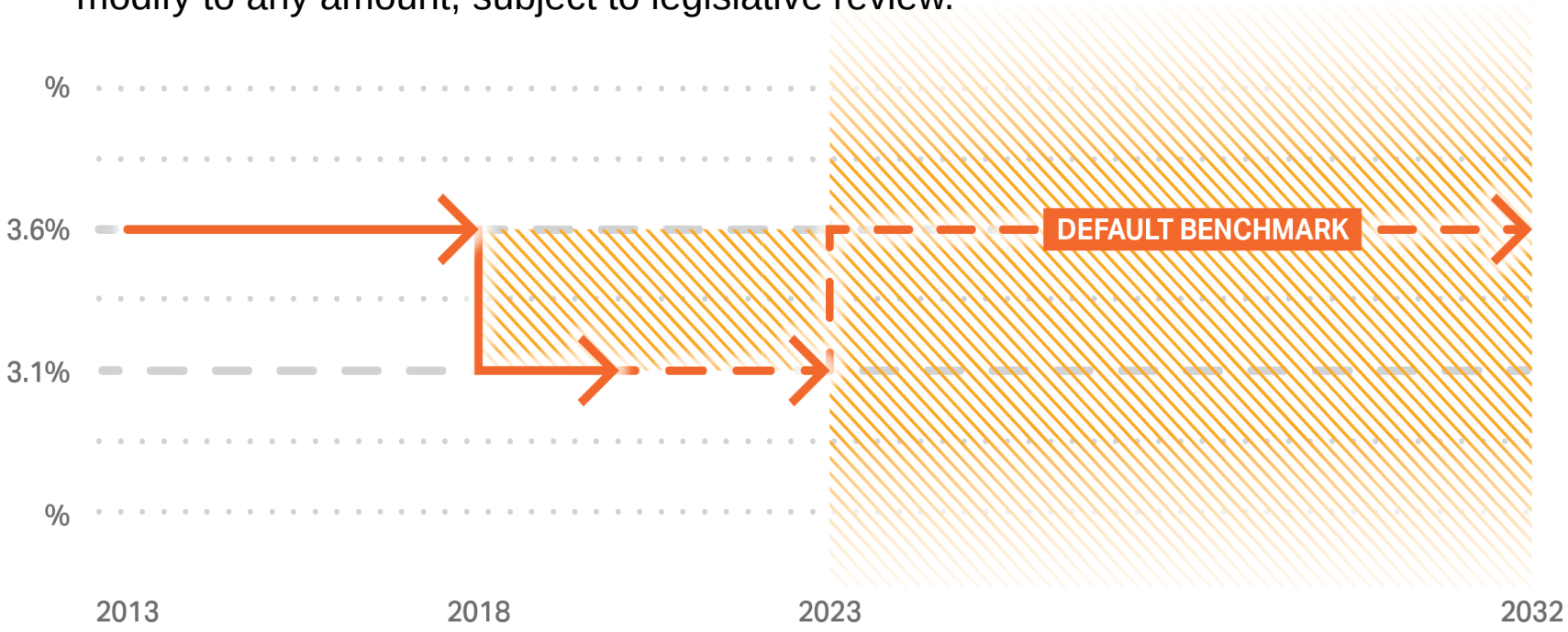
Includes:

- 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

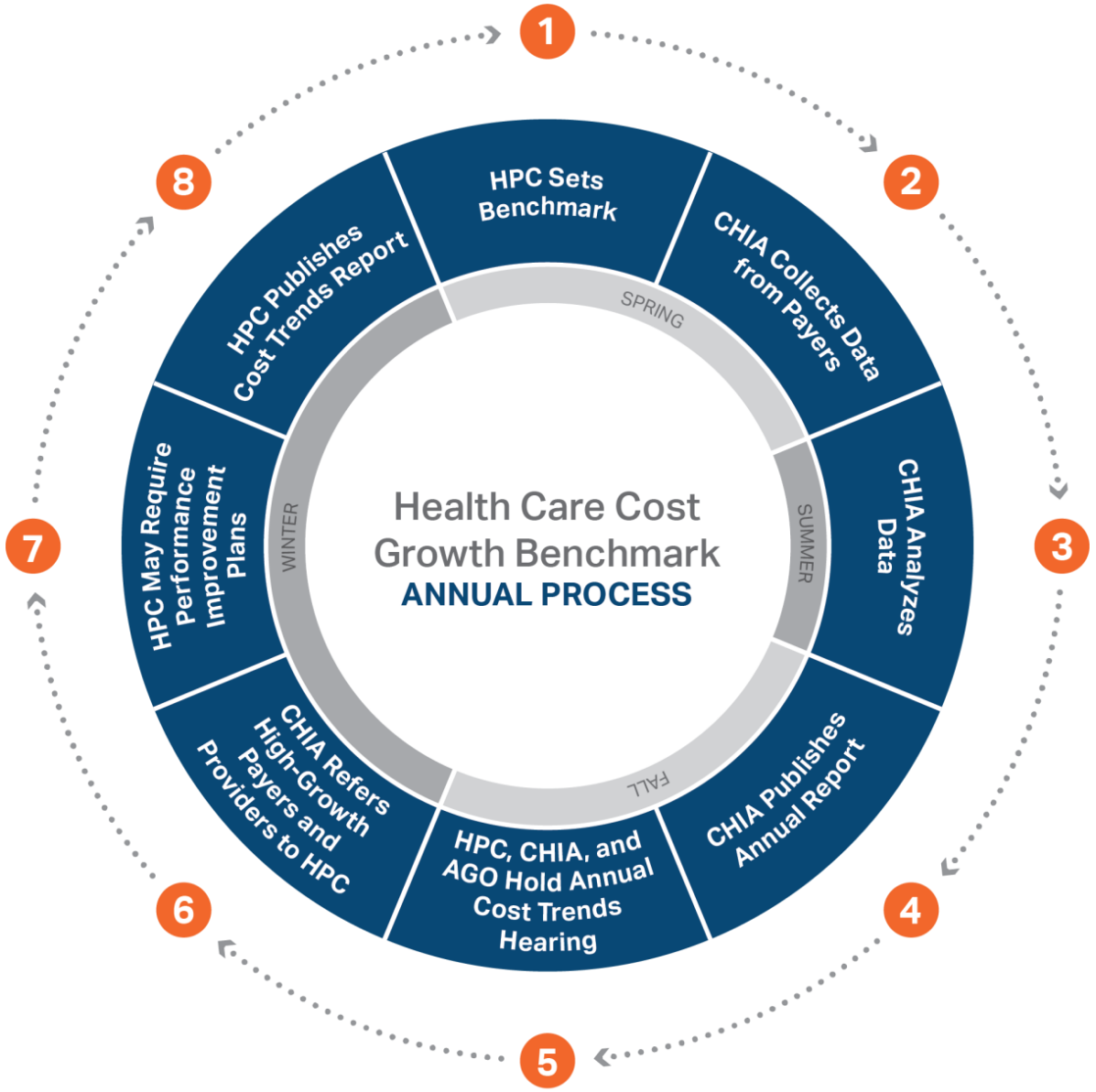
HPC

The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.

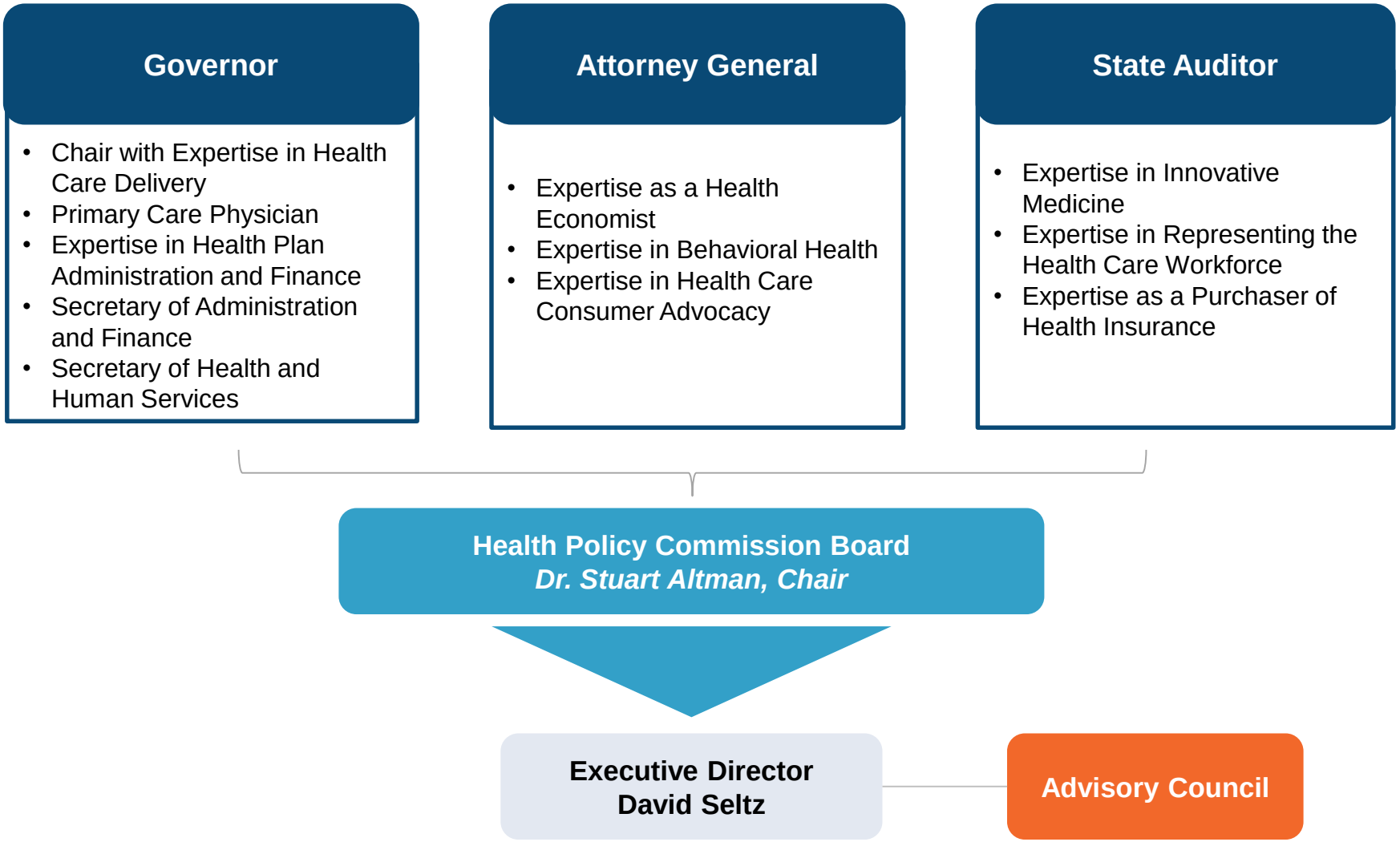
- **Years 1-5:** Benchmark established by law at PGSP (3.6%).
- **Years 6-10:** Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); HPC can modify the benchmark up to 3.6%, subject to legislative review.
- **Years 10-20:** Benchmark established by law at a default rate of PGSP; HPC can modify to any amount, subject to legislative review.



Annual Timeline for HPC and CHIA to Establish the Health Care Cost Growth Benchmark and Evaluate the State's Performance



The HPC: Governance Structure



State efforts to reduce cost growth through the benchmark and the work of the HPC continue to receive broad multi-sector stakeholder support.

Consumer Advocate	"Given the ongoing challenges with **health care affordability** for our state's residents, we believe it's critically important to continue to pursue approaches that signal to the health care community that current efforts to address costs are insufficient. We therefore recommend that the HPC set the 2018 benchmark at equal to the potential gross state product minus 0.5%, or 3.1%."
Business	"As we continue to track **trends in health care cost and utilization**, the cost growth benchmark has become a critical component for understanding year-over-year increases in health care spending."
Business	"We strongly believe that the annual health care cost benchmark can be a major tool in achieving the state's cost goals. The benchmark should be maintained at 3.1% and providers should be encouraged to pursue even more **aggressive and innovative cost reduction measures**."
Provider	"MHA supports the goals we all have to address rising costs and to ensure that **affordable access to health care** in the commonwealth is sustainable. Moving to a 3.1% benchmark is aspirational and potentially achievable."
Provider	"The Medical Society strongly supports the intent of Chapter 224, and the mission of the Health Policy Commission to develop policy to reduce health care cost growth and improve the quality of patient care. The Medical Society strongly supports thoughtful policies to **drive sustainable containment of health care costs** below the benchmark on an ongoing basis- whether at 3.6% or 3.1%. "

The HPC employs four core strategies to advance its mission.

RESEARCH AND REPORT

INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS

CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

MONITOR AND INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE

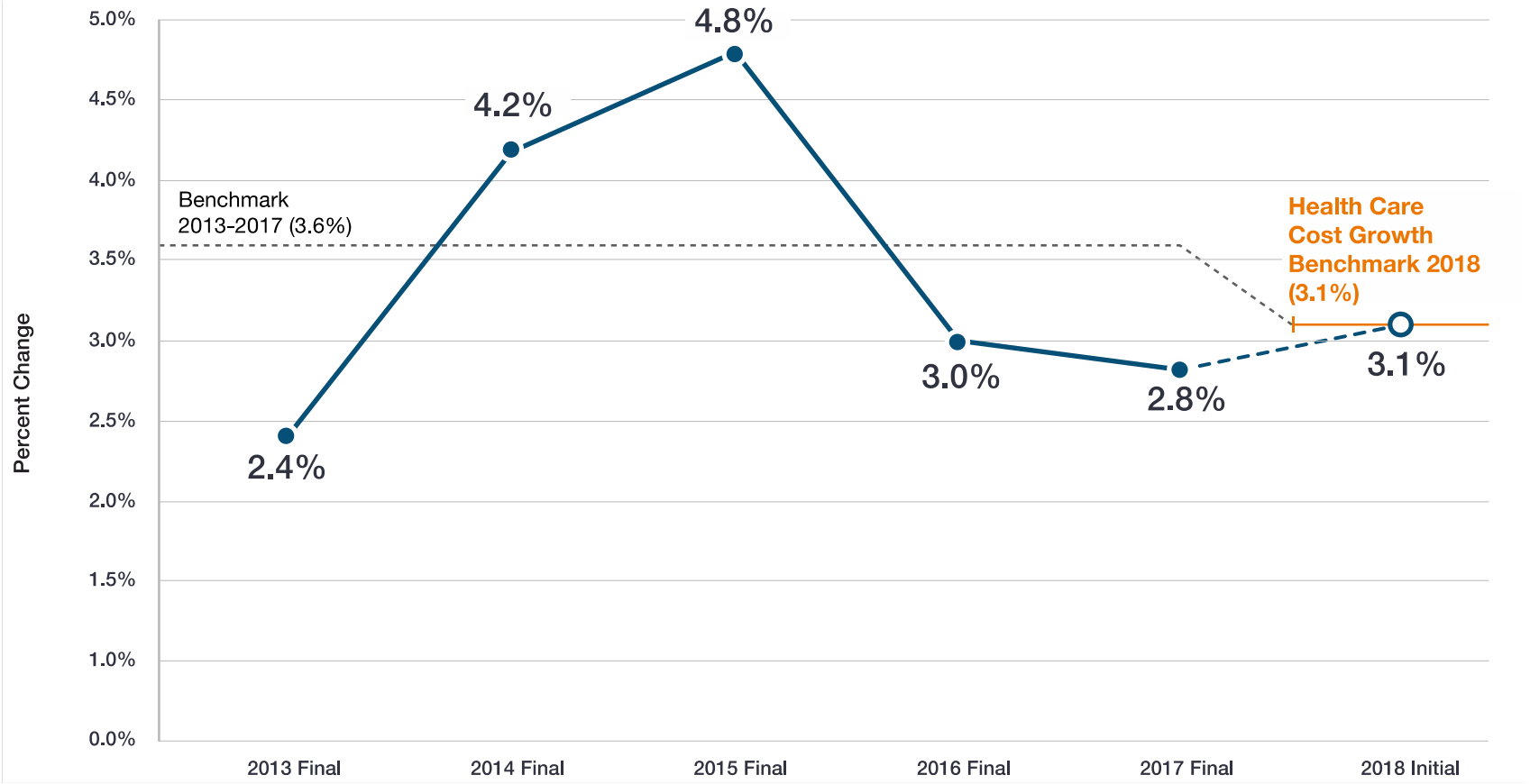
PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

Section II.

How has Massachusetts performed against the health care cost growth benchmark?

From 2012 to 2018, annual health care spending growth averaged 3.4%, below the state benchmark.



The initial estimate of THCE per capita growth for 2018 is 3.1%

This is the third consecutive year it met or fell below the health care cost growth benchmark.

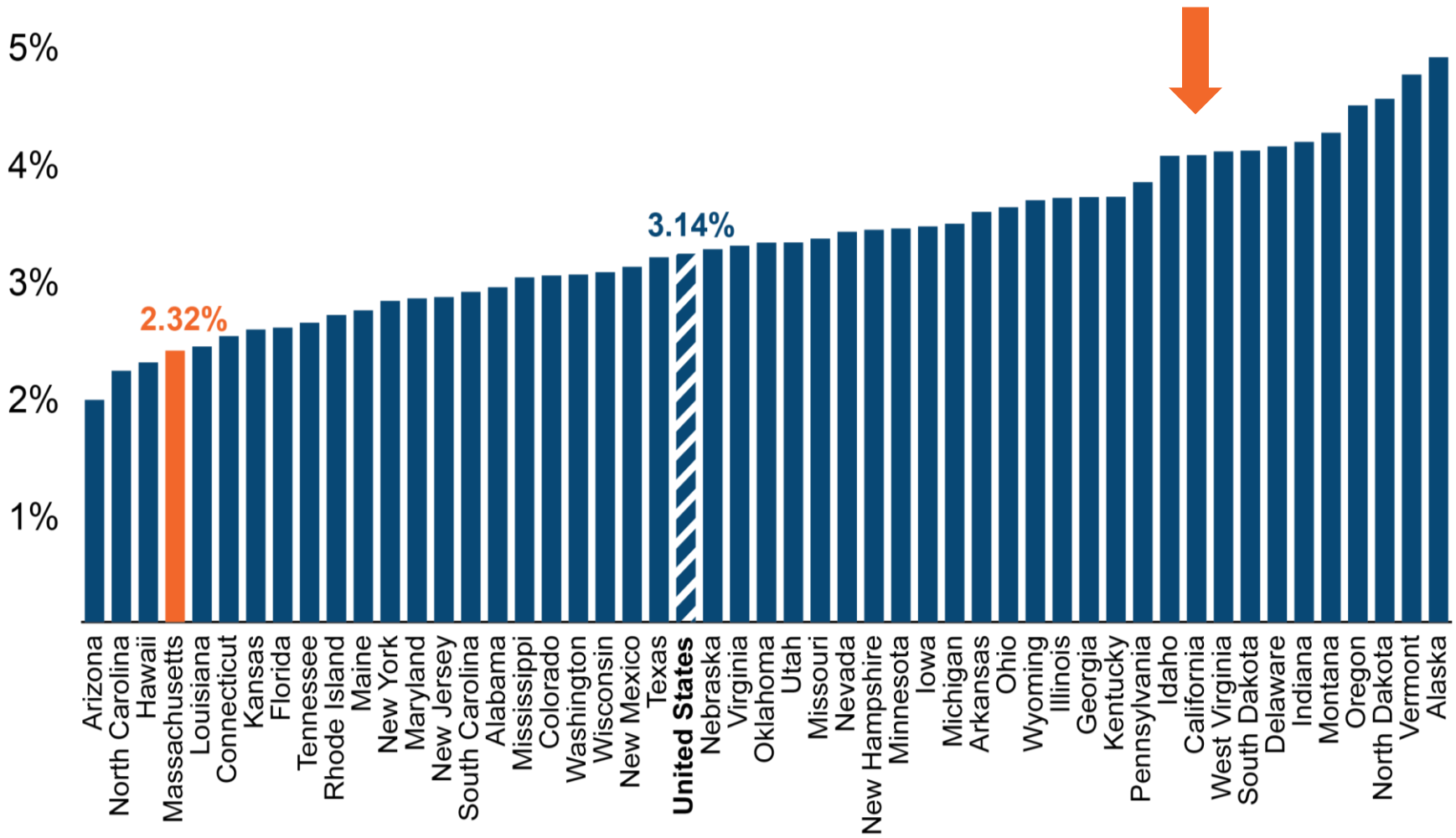
HPC

Section III.

How does Massachusetts compare to the U.S.?

Massachusetts health care spending grew at the 4th lowest rate in the US from 2009-2014; California grew at the 10th fastest rate.

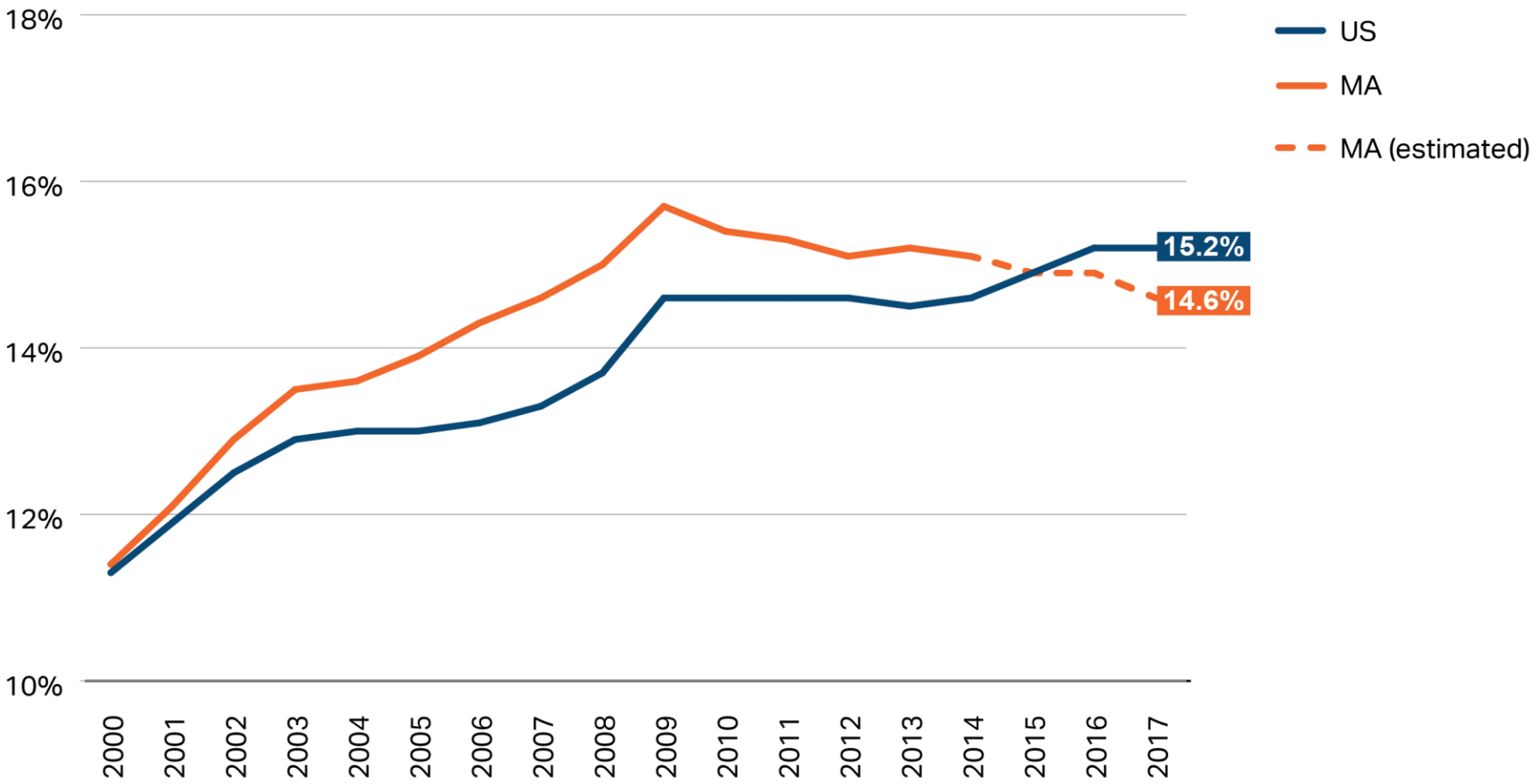
Average annual healthcare spending growth rate, per capita, 2009-2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Driven by lower health care cost growth in recent years, Massachusetts health care spending as a percentage of the state's economy has stabilized and is now below a comparable US figure.

Personal health care expenditures as a percentage of total GDP (or GSP), 2000-2017

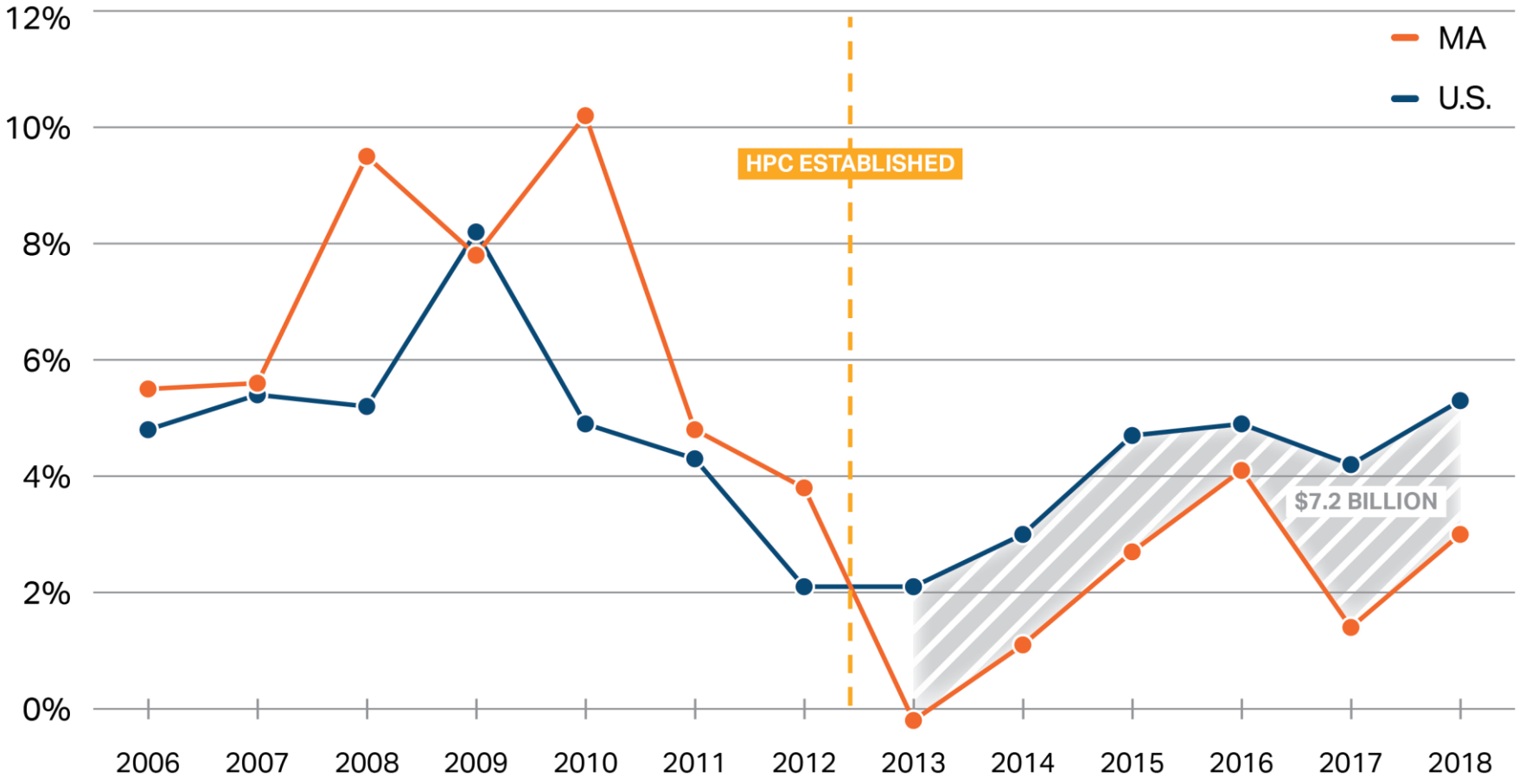


Notes: U.S. data includes Massachusetts. For Massachusetts 2014-2017, annual growth in THCE was applied to Massachusetts' total personal health expenditures according to CMS in 2014.

Sources: Centers for Medicare and Medicaid Services National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2017), and State Healthcare Expenditure Accounts (U.S. 1999-2014 and MA 1999-2014); Center for Health Information and Analysis Annual Report (MA 2014-2017). Bureau of Economic Analysis

Commercial spending growth in Massachusetts has been below the national rate every year since 2013, generating billions in avoided spending.

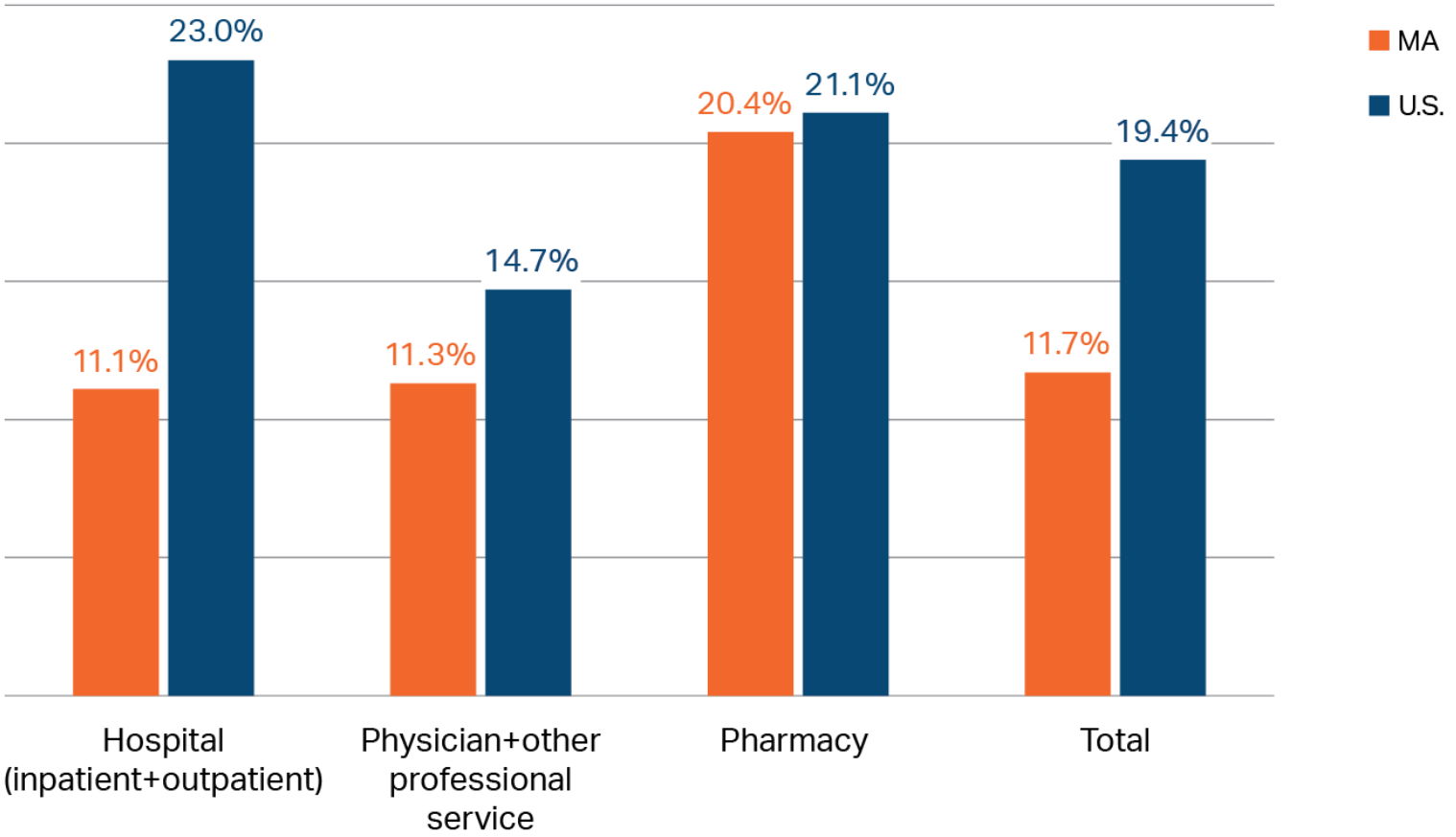
Annual growth in commercial medical spending per enrollee, Massachusetts and the U.S., 2006-2018



Notes: U.S. data includes Massachusetts. U.S. data point for 2018 is partially projected. MA data point for 2018 is preliminary.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018) ; CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

Since 2013, total hospital spending growth (inpatient and outpatient) in Massachusetts has been far below national growth rates.

2013 – 2017 cumulative growth in commercial spending by service category, MA and U.S.



If Massachusetts commercial spending grew at the national rate from 2013-2017, residents would have spent $1.7B more in 2017 alone ($367 per person)

Notes: US data include Massachusetts. Pharmacy spending is net of rebates.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts, Private Health Insurance Expenditures and Enrollment Data (U.S. 2013-2017); Center for Health Information and Analysis Annual Reports (MA 2013-2017).

Section IV.

How does the HPC evaluate changes to the health care market?

Overview of Cost and Market Impact Reviews (CMIRs)

1. Market structure and new provider changes, including consolidations and alignments, have been shown to impact health care system performance and total medical spending

2. Chapter 224 directs the HPC to track “material change[s] to [the] operations or governance structure” of provider organizations and to engage in a more comprehensive review of transactions anticipated to have a significant impact on health care costs or market functioning

3. CMIRs promote transparency and accountability in engaging in market changes, and encourage market participants to minimize negative impacts and enhance positive outcomes of any given material change

Overview of Cost and Market Impact Reviews (CMIRs)

The HPC tracks proposed "material changes" to the structure or operations of provider organizations and conducts "cost and market impact reviews" (CMIRs) of transactions anticipated to have a significant impact on health care costs or market functioning.

WHAT IT IS

- Comprehensive, multi-factor review of the provider(s) and their proposed transaction
- Following a preliminary report and opportunity for the providers to respond, the HPC issues a final report
- CMIRs promote transparency and accountability, encouraging market participants to address negative impacts and enhance positive outcomes of transactions
- Proposed changes cannot be completed until 30 days after the HPC issues its final report, which may be referred to the state Attorney General for further investigation

WHAT IT IS NOT

- Differs from Determination of Need reviews by Department of Public Health
- Distinct from antitrust or other law enforcement review by state or federal agencies

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	22	23%
Physician group merger, acquisition or network affiliation	20	21%
Acute hospital merger, acquisition or network affiliation	19	20%
Formation of a contracting entity	17	18%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	11	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

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 CMIR 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.

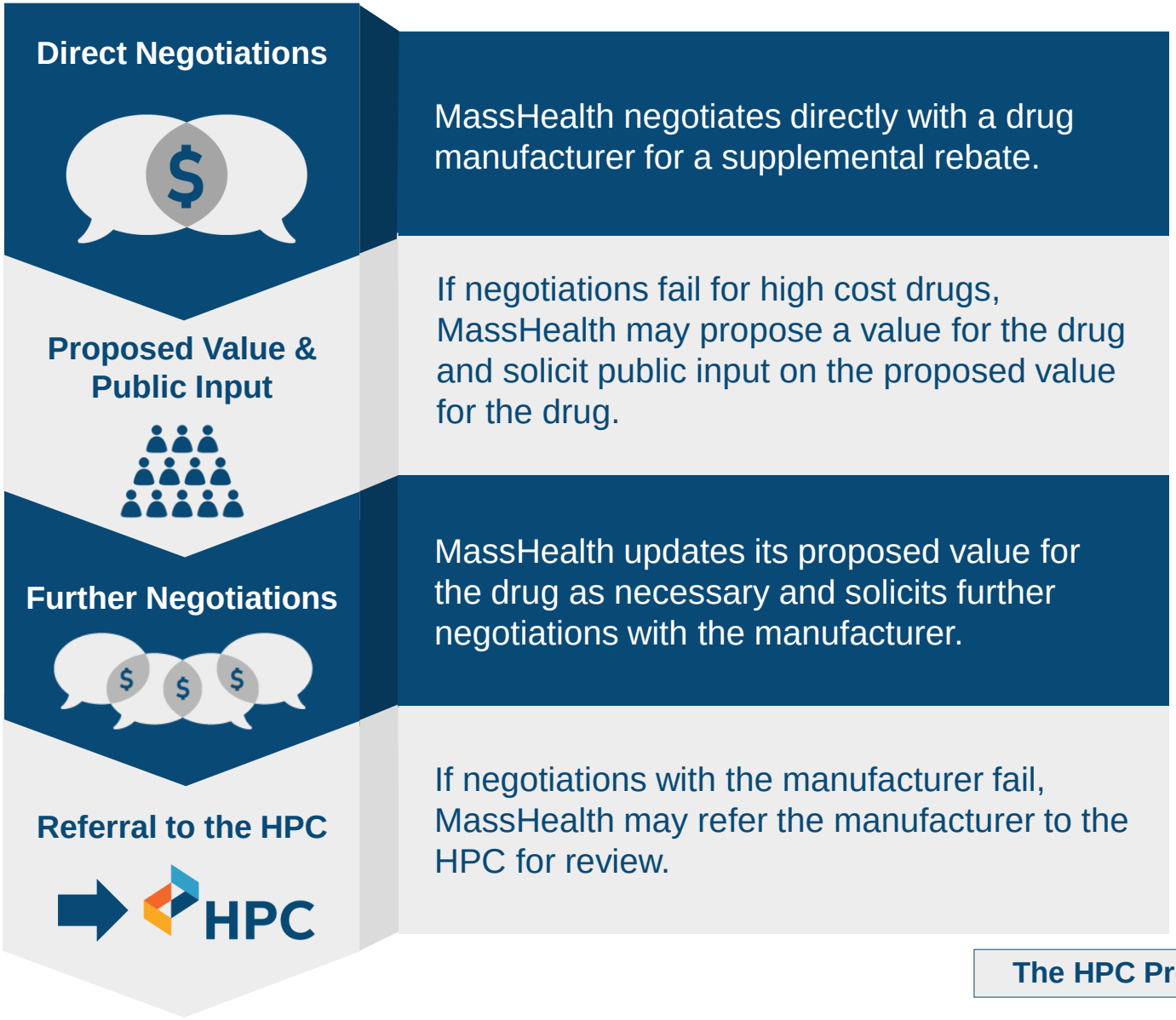
Impacts on Transaction Plans: In some cases, entities have planned affiliations in part based on the likelihood of a CMIR, and in other cases have decided not to pursue an affiliation after the HPC raised concerns in the MCN or CMIR process.

HPC

Section V.

How does the HPC review the value and pricing of drugs?

The Medicaid (MassHealth) Process



The HPC Process

The HPC Process

Notice & Requests for Information

HPC notifies the manufacturer that it has been referred by MassHealth for review and requests information, including completion of the Standard Reporting Form.

Review

HPC reviews information submitted by the manufacturer.

Determination

HPC may:

- Identify a proposed value for the drug;
- In consultation with MassHealth, propose a supplemental rebate for the drug;
- Determine that the manufacturer's pricing of the drug is unreasonable or excessive in relation to HPC's proposed value for the drug; or
- Close its review of the drug.

HPC determines that a manufacturer's pricing is *potentially unreasonable or excessive,* notifies the manufacturer of the need for additional review, and requests additional information, including the manufacturer's justification of its pricing of the drug.

HPC reviews information submitted by the manufacturer and solicits information from stakeholders.

Within 60 days of receiving completed information from the manufacturer, HPC issues a determination on whether the manufacturer's pricing of the drug is unreasonable or excessive in relation to HPC's proposed value for the drug.

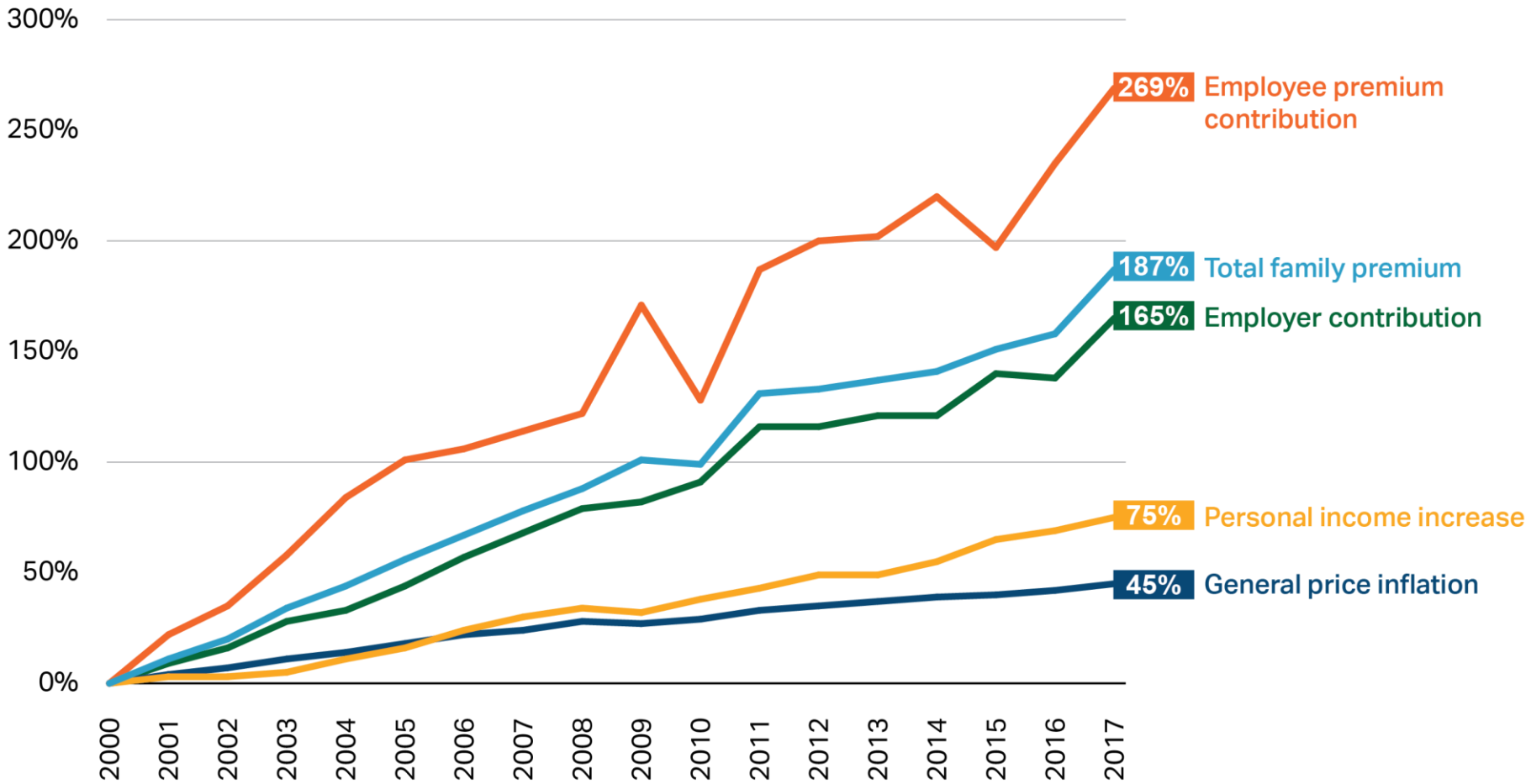
HPC

Section VI.

Why should states focus on health care costs and affordability?

Cumulative premium growth has far outpaced income growth and inflation from 2000 to 2017 in Massachusetts.

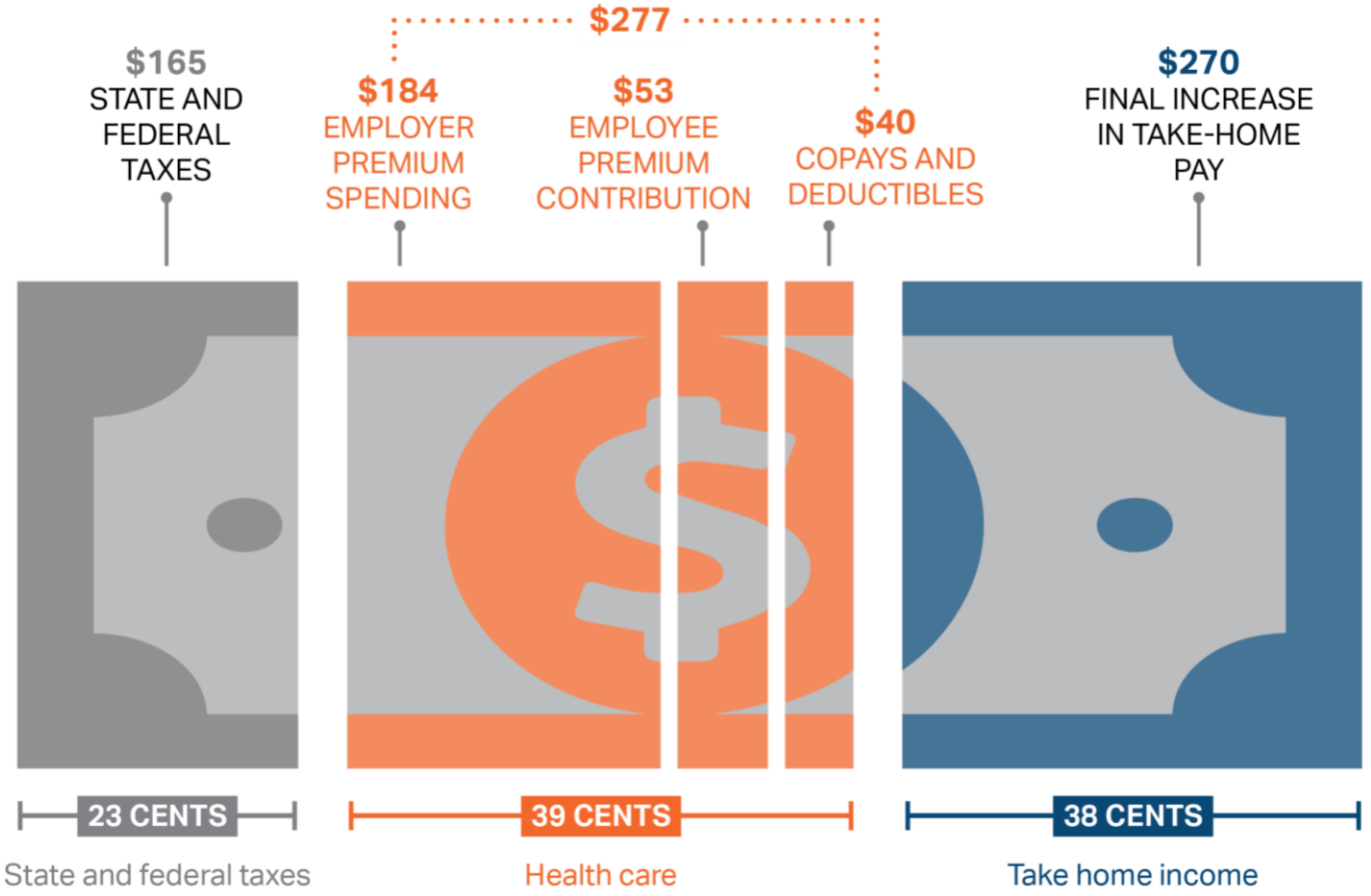
Cumulative percentage increase in each quantity between 2000 and 2017



Sources: Center for Health Information and Analysis Annual Reports (MA 2014-2017), US Agency for Healthcare Research and Quality; Medical Expenditure Panel Survey (Insurance component); US Bureau of Economic Analysis, US Bureau of Labor Statistics

Why focus on health care costs? Nearly 40 cents of every additional dollar earned by Massachusetts families between 2016 and 2018 went to health care, more than take home income.

Allocation of the increase in monthly compensation between 2016 and 2018 for a median Massachusetts family with health insurance through an employer



Notes: Data represent Massachusetts families who obtain private health insurance through an employer. Massachusetts median family income grew from $95,207 to $101,548 over the period while mean family employer-sponsored insurance premiums grew from $18,955 to $21,801. Compensation is defined as employer premium contributions plus income as recorded in the ACS and is considered earnings. All premium payments are assumed non-taxable. Tax figures include income, payroll, and state income tax.

Sources: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component (premiums) American Community Survey (ACS) 1-year files (income), and Center for Health Information and Analysis 2019 Annual Report (cost-sharing).

HPC

Section VII.

What should market participants and policymakers do to advance the goal of a more efficient, high-quality health care system?

The HPC makes annual policy recommendations to the Legislature and Governor on opportunities to achieve health care savings.

The 2019 Annual Cost Trends Report includes a set of fifteen policy recommendations necessary to continue progress in achieving the Commonwealth's goal of better health, better care, and lower costs.

HPC Recommendations by Topics

1. Primary and Behavioral Health Care
2. Ambulatory Care
3. Coding Intensity
4. Pharmaceutical Spending
5. Benchmark Accountability
6. Employer Engagement
7. Administrative Complexity
8. Facility Fees
9. Out of Network Billing
10. Alternative Payment Methods
11. Health Disparities
12. Innovative Investments
13. Low Value Care
14. Provider Price Variation
15. Affordability

What's Next for the HPC?

Contact Information

For more information about the Massachusetts Health Policy Commission

Visit us
http://www.mass.gov/hpc

Follow us
@Mass_HPC

Email Us
HPC-INFO@mass.gov