MASSACHUSETTS
HEALTH POLICY COMMISSION

Opportunities to Reduce Health Care Costs in Massachusetts:

Trends and Outlook from the Massachusetts Health Policy Commission

neebc
ANNUAL SUMMIT
& TRADE SHOW

May 16, 2023

Agenda

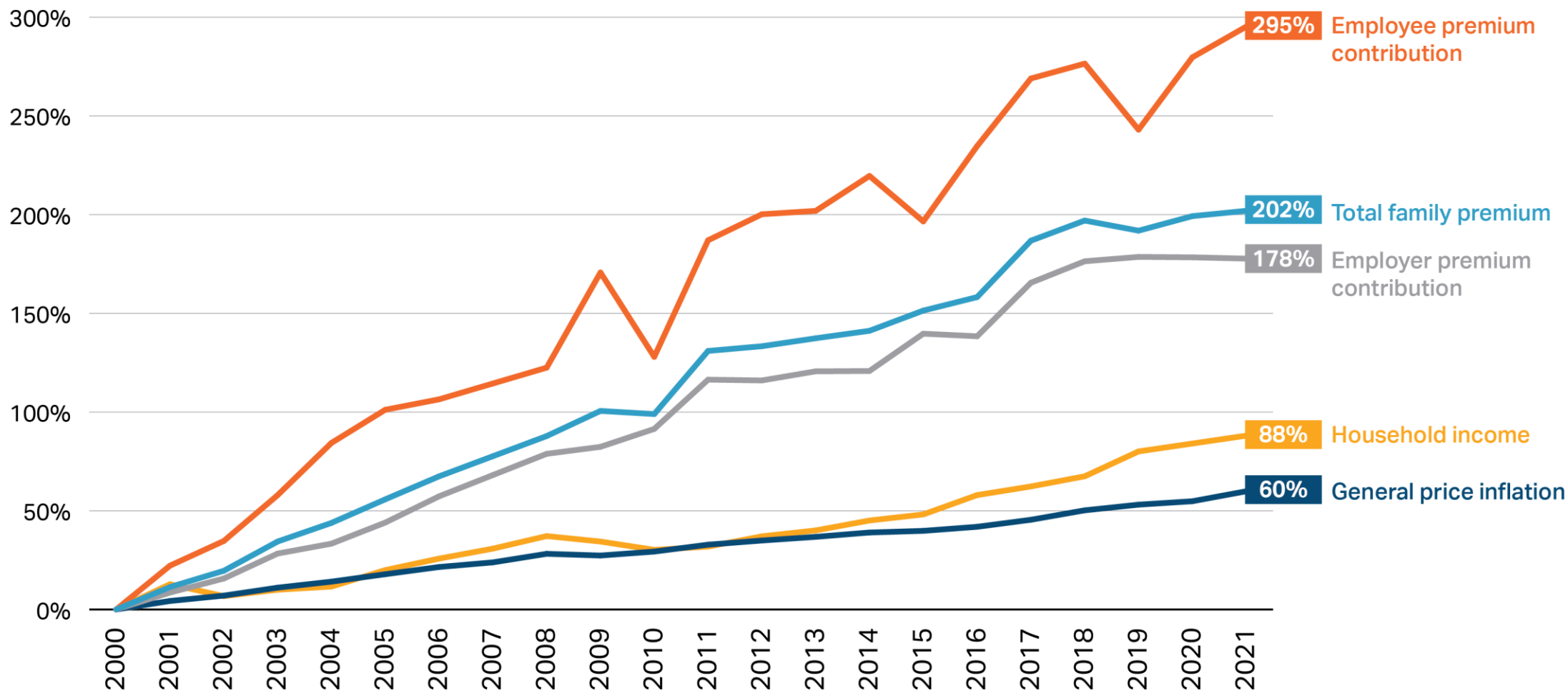
Role of the HPC

Current Trends

What's Next? HPC Policy Recommendations

Discussion

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



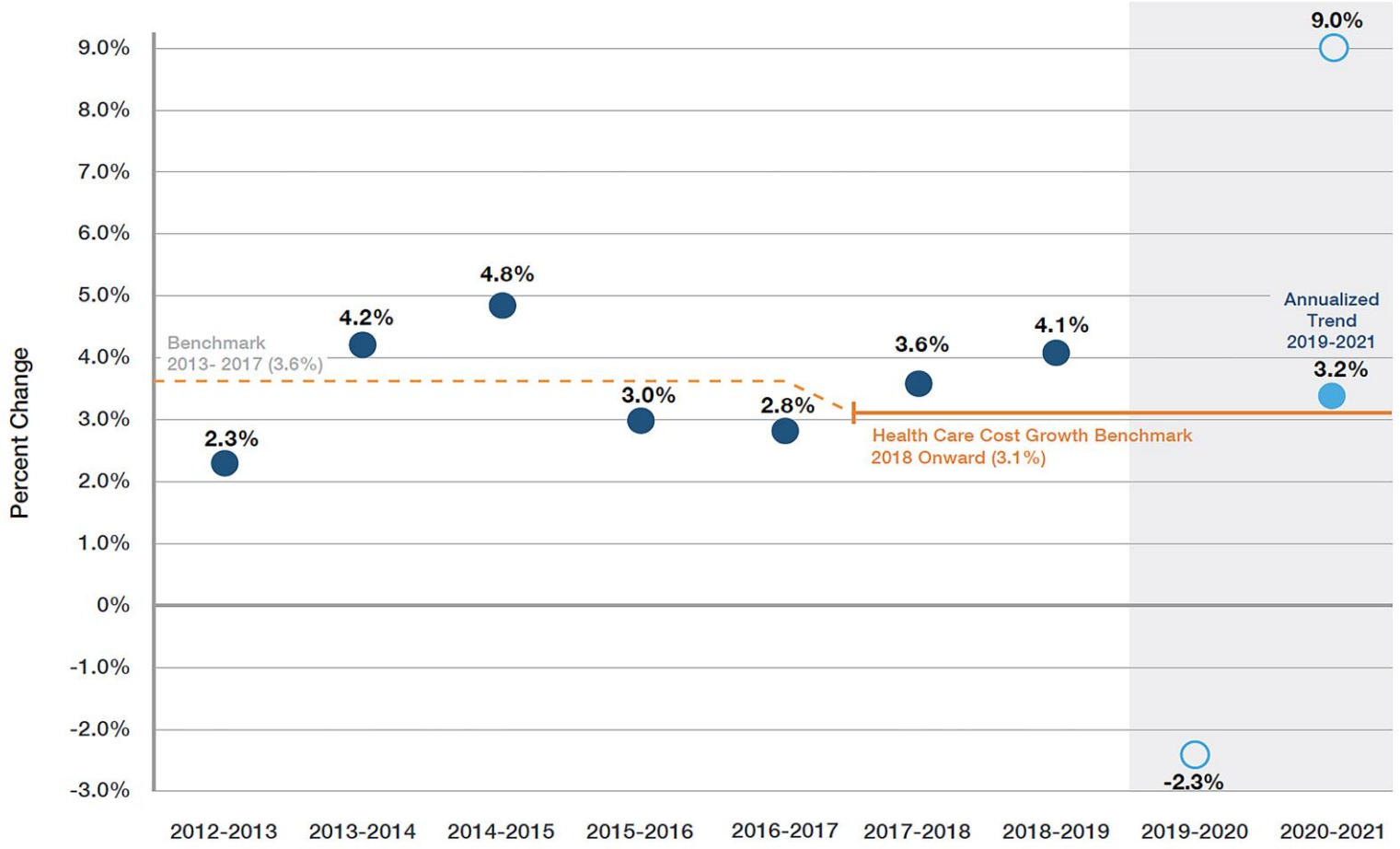
The Health Care Cost Growth Benchmark

- Setting a statewide benchmark is effective as a collective call to action to address the **unsustainable growth of health care costs,** which threaten the financial well-being of our residents, the competitiveness of the state's economy, and efforts to reduce health care disparities.
- The benchmark is a **prospective target** for measuring and moderating the **growth** of total health care expenditures across all payers (public and private) tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a hard cap on spending or provider price increases,** but rather a measurable goal for moderating excessive health care spending growth and **advancing health care affordability and equity**.
- 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 (PIP)** and submit to public monitoring.

The benchmark is not a bright line limit applied indiscriminately to all payers, providers, spending categories, or insurance sectors.

From 2012 to 2021, the average annual growth rate for health care spending in Massachusetts was 3.5%, below the initial goal of 3.6%.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2021

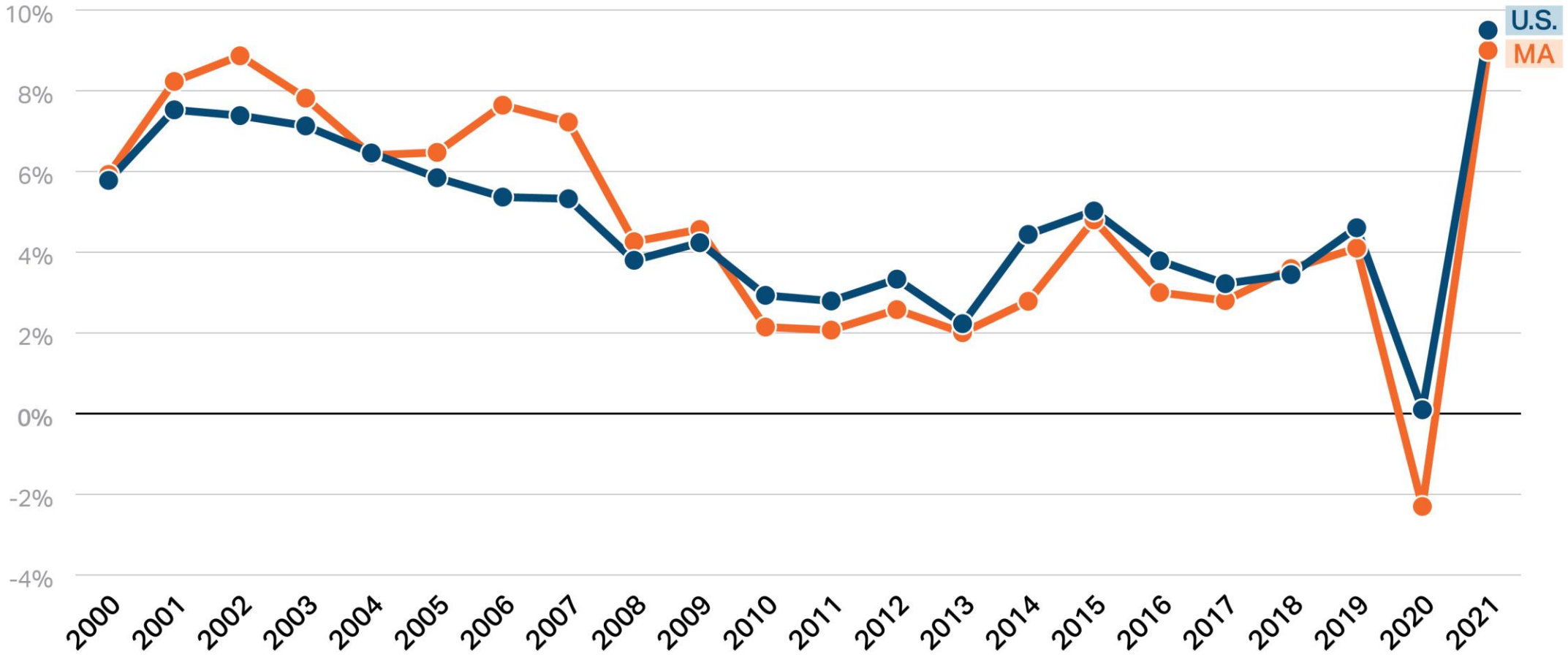


The average annual growth rate for the first two years of the COVID-19 pandemic was 3.2%.

Source: Massachusetts Center for Health Information and Analysis, Annual Reports on the Performance of the Massachusetts Health Care System 2013-2023.

Massachusetts' overall rate of spending growth was below the comparable U.S. rate for 11 of the past 12 years.

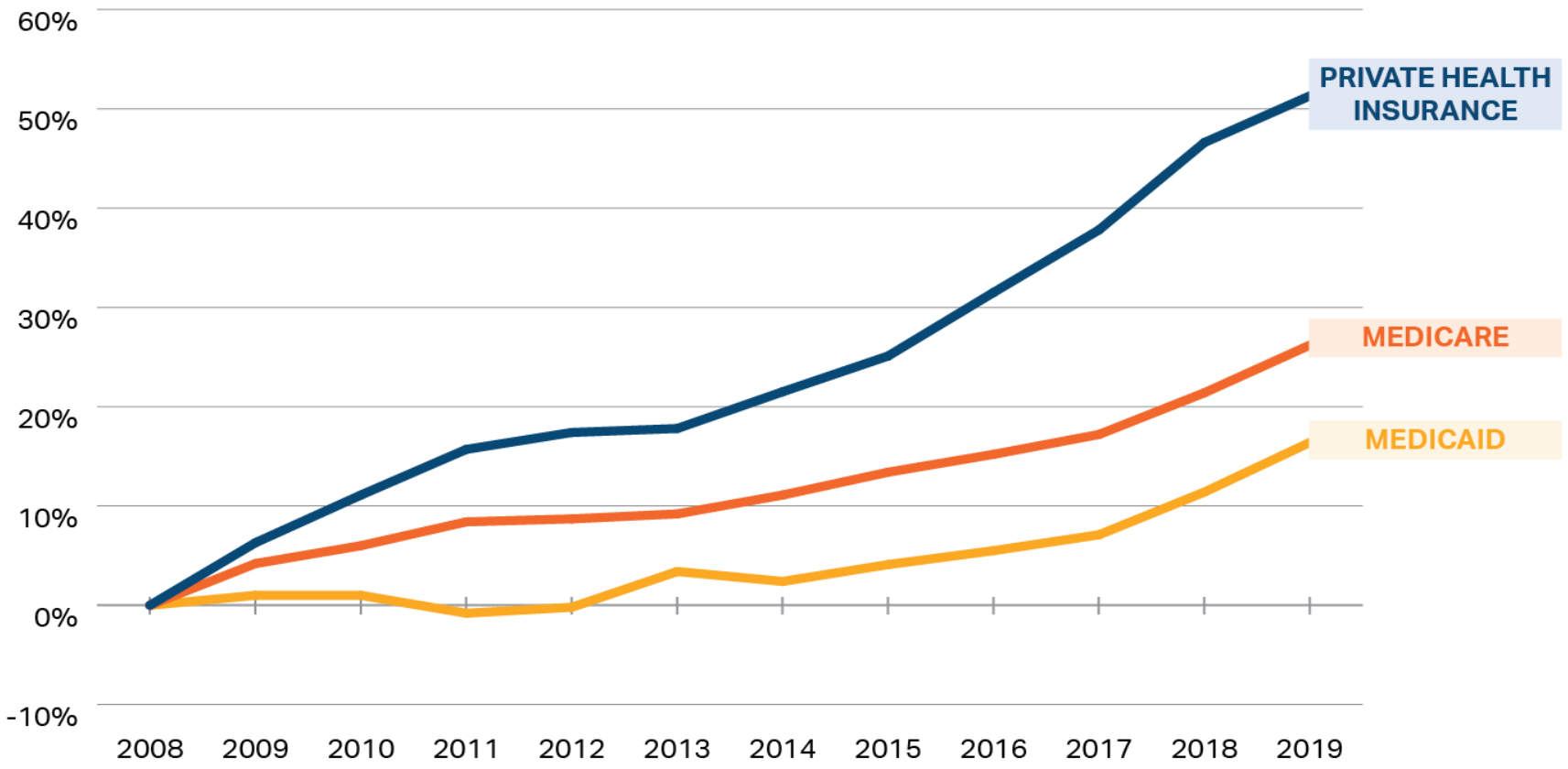
Annual growth in per capita health care spending from the previous year to the year shown, Massachusetts and the U.S., 2006-2021



Notes: U.S. data includes Massachusetts. Massachusetts and US data exclude federal COVID-19 relief funding.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2021 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, growth in Total Health Care Expenditures per capita, 2014-2021.

Commercial health insurance spending is growing faster than Medicare and Medicaid across the U.S., largely due to provider and prescription drug price increases.

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



Commercial price increases were highest in hospitals from 2015 to 2019:

- Hospital inpatient: 30.8%
- Hospital outpatient: 22.5%
- Prescription drugs: 13.6%
- Professional services: 13.0%

Sources: Peterson-KFF Health System Tracker: https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-start; https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf

Prescription drugs and hospital services were leading drivers of commercial spending growth from 2019-2021.

Annual per-member growth rate in spending between 2019-2021:

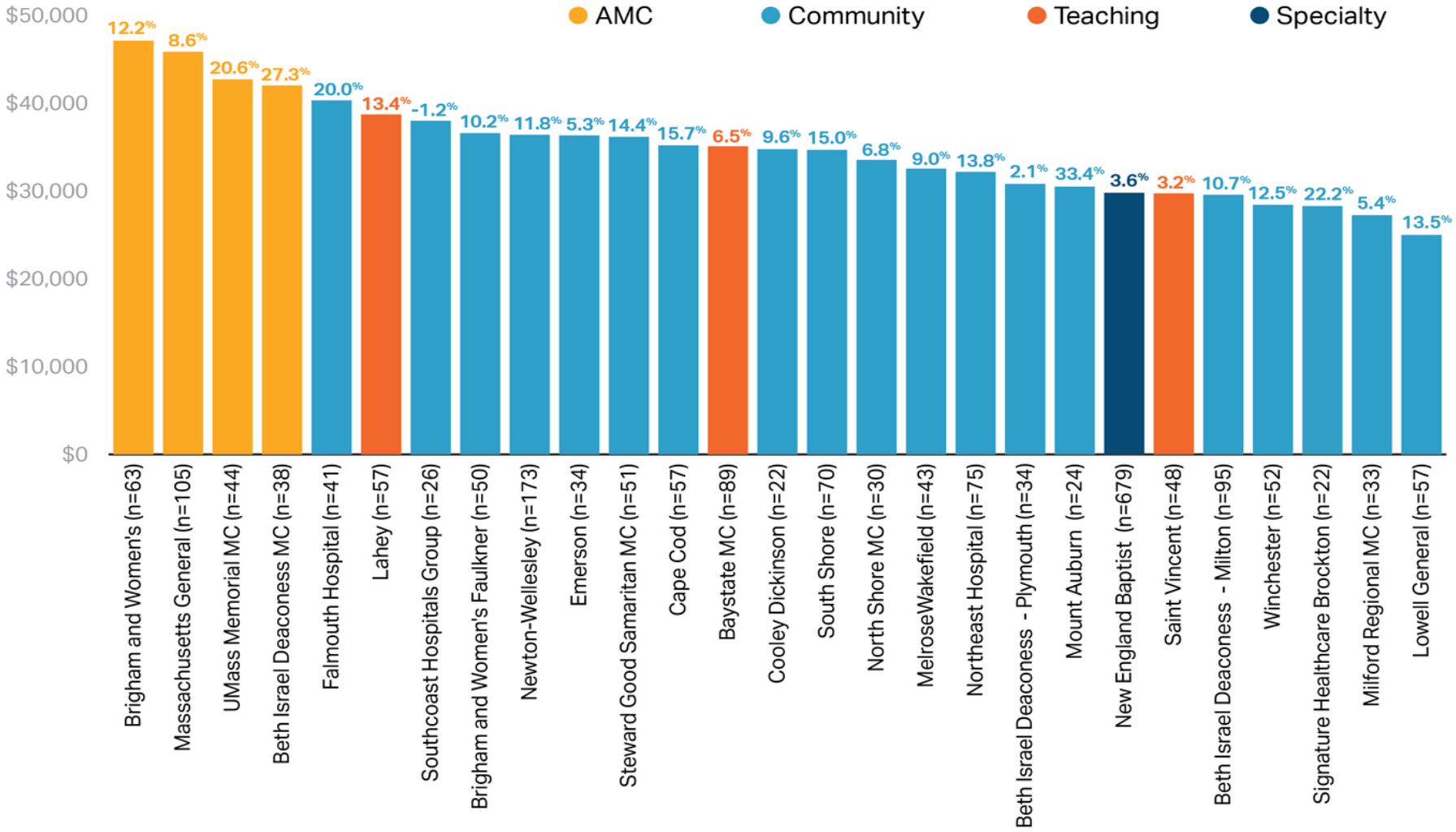
- Retail **prescription drugs** (net of rebates): **7.7%**
- **Hospital outpatient services: 5.4%**
  - *Facility spending: 6.5%*
  - Professional spending: 1.7%
- **Hospital inpatient services: 4.3%**
  - *Facility spending: 4.8%*
  - Professional spending: 1.6%
- **Office, urgent care, retail clinic: 1.2%**

Accounting for 1/3 of commercial spending, these are services such as lab tests, minor surgeries, and MRIs provided on an outpatient basis (no overnight stay) at a facility owned by a hospital

Per-member spending on **retail and clinician-administered prescription drugs combined** now accounts for **25.5%** of commercial spending in 2021 (up from 24.7% in 2019).

Notes: Average rebate percentages are applied to retail prescription drug spending but not clinician-administered drug spending. Clinician-administered drug spending includes the professional spending associated with these encounters. Hospital outpatient spending includes some additional settings that bill on facility claims (UB-04) such as Ambulatory Surgical Centers.
Sources: HPC analysis of the Massachusetts All Payer Claims Database. Retail drug analysis and per-member spending analysis examining retail and clinician-administered drug exclude Anthem.

The average payment for an inpatient major joint replacement in 2019 varied 88.5% from $47,106 at Brigham and Women's Hospital to $24,989 at Lowell General Hospital.



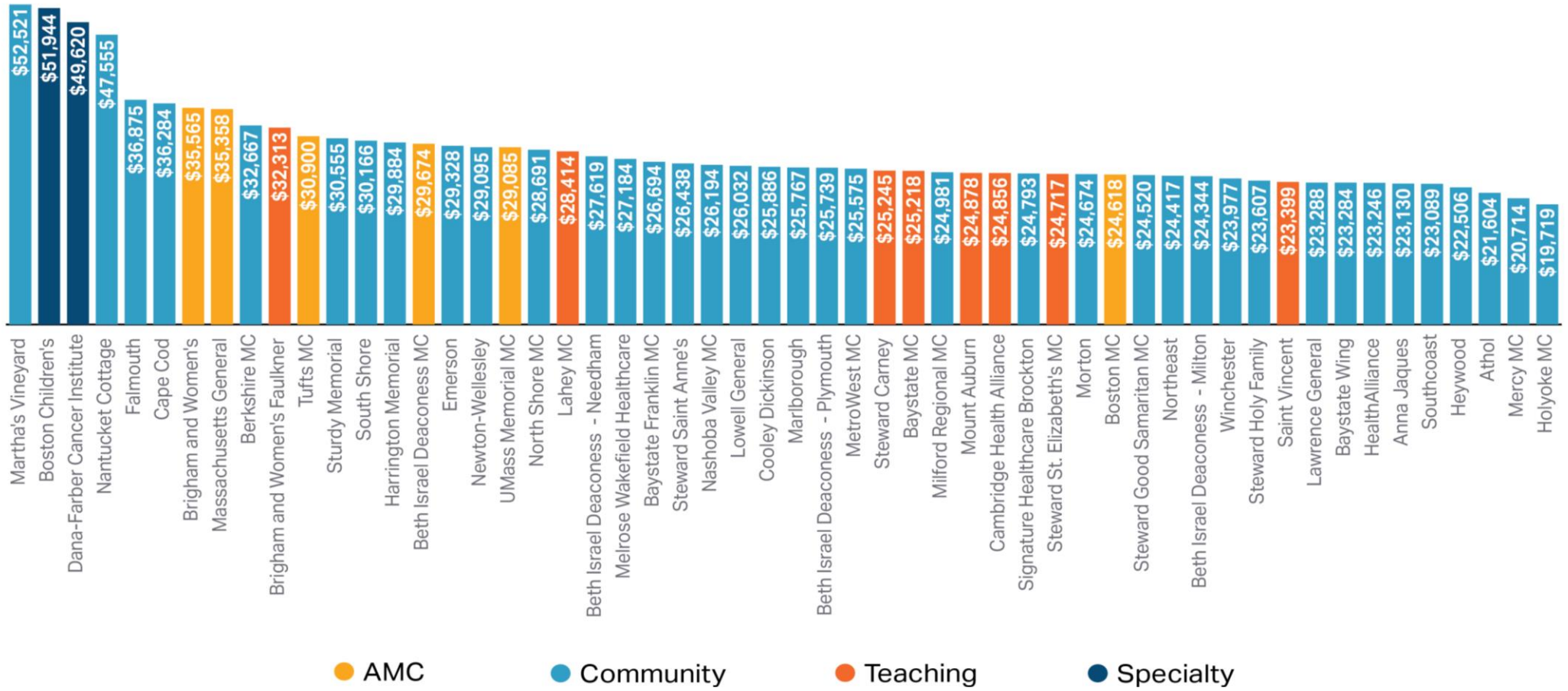
Notes: Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 470 (major joint replacement without major complication or comorbidity) and without COVID-19. Hospital inclusion criteria was at least 20 inpatient stays in both 2018 and 2020. Percent change in average payment by hospital between 2018 and 2020 is listed above each payment bar.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v10 2018-2020

- As with the HPC's last report examining 2016-2018, New England Baptist (a specialty hospital) had by far the largest volume at 679 inpatient stays in the APCD and one of the lower average payments of $29,788.
- Changes in average payments from 2018 to 2020 varied tremendously, from -1% to 33% with over 16 of the 27 hospitals shown having payment increases over 10%.

Commercial hospital outpatient prices vary widely by hospital. The price of a market basket of 50 routine services varied from under $20,000 to more than $50,000 in 2021.

Cost of an identical market basket of HOPD services at each Massachusetts hospital shown in 2021

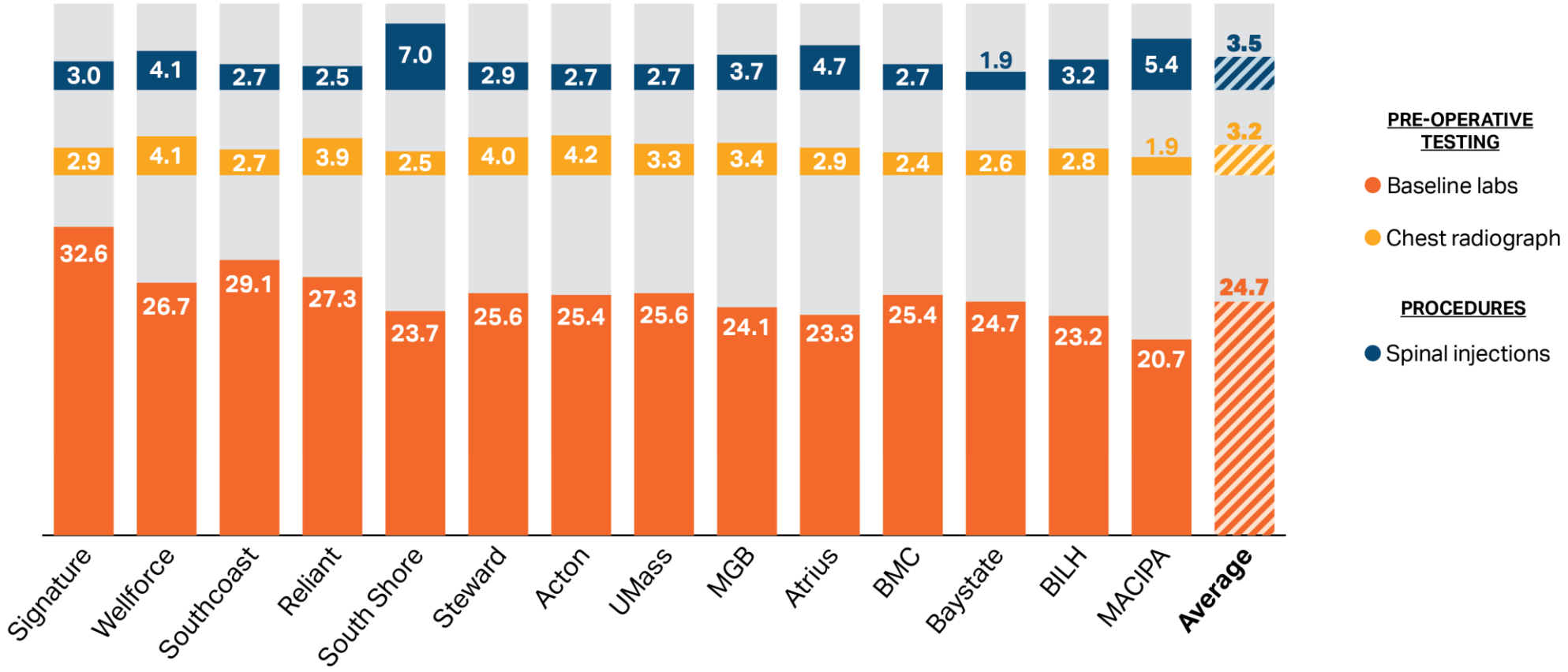


Notes: The graph shows the cost of a fixed quantity of each of the same 50 procedure codes using each hospital's average price for each service in 2021. for each procedure code. Hospitals with fewer than 20 service encounters for any individual procedure code have imputed values based on the average ratio of that hospital's prices to the statewide mean price for their non-missing services. See https://www.mass.gov/doc/4-commercial-price-trends/download (imputation method 2) for more detail and list of procedure codes included in the index and their associated quantities. Some slight adjustments have been made since the publication of this technical appendix that are not yet reflected.

Source: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2019-2021, V 2021. Data for 5 large payers were included in the analysis.

Low-Value Care Opportunity: Between 20% and 33% of eligible patients of the largest provider groups in Massachusetts received unnecessary pre-operative baseline labs.

Low-value pre-operative testing and procedures per 100 eligible commercial patients, 2019: baseline labs, chest radiograph, spinal injections



Notes: Baseline labs = Baseline labs in patients without significant systemic disease undergoing low-risk surgery; Chest radiograph = Chest radiographs occurring less than 30 days before a low or intermediate risk non-cardiothoracic surgical procedure (not associated with inpatient or emergency care). Based on a patient's medical history and inclusion criteria for each low-value measure, a patient could be counted in multiple measures. Results for the low-value stent procedure are not presented by provider organization due to small numbers at some organizations. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Prescription Drug Trends

GROWING SPENDING ON PRESCRIPTION DRUGS

Retail prescription drug spending net of rebates grew from **14.5% to 18.6%** of per-capita commercial health care spending in Massachusetts between 2013 and 2020.[1] Growth in retail prescription drug spending has remained above the benchmark in most years.

SPENDING DRIVEN BY A SMALL NUMBER OF HIGH-COST PRODUCTS

Between 2016 and 2021, the number of specialty prescriptions filled in the U.S. increased 0.5% but gross spending on these medications in retail and non-retail settings increased **42.5%** and accounted for **50%** of total drug spending in 2021.[2]

LAUNCH PRICES CONTINUE TO RISE

The median prescription drug launch price grew from **$2,000 to $180,000** between 2008 and 2021.[3]

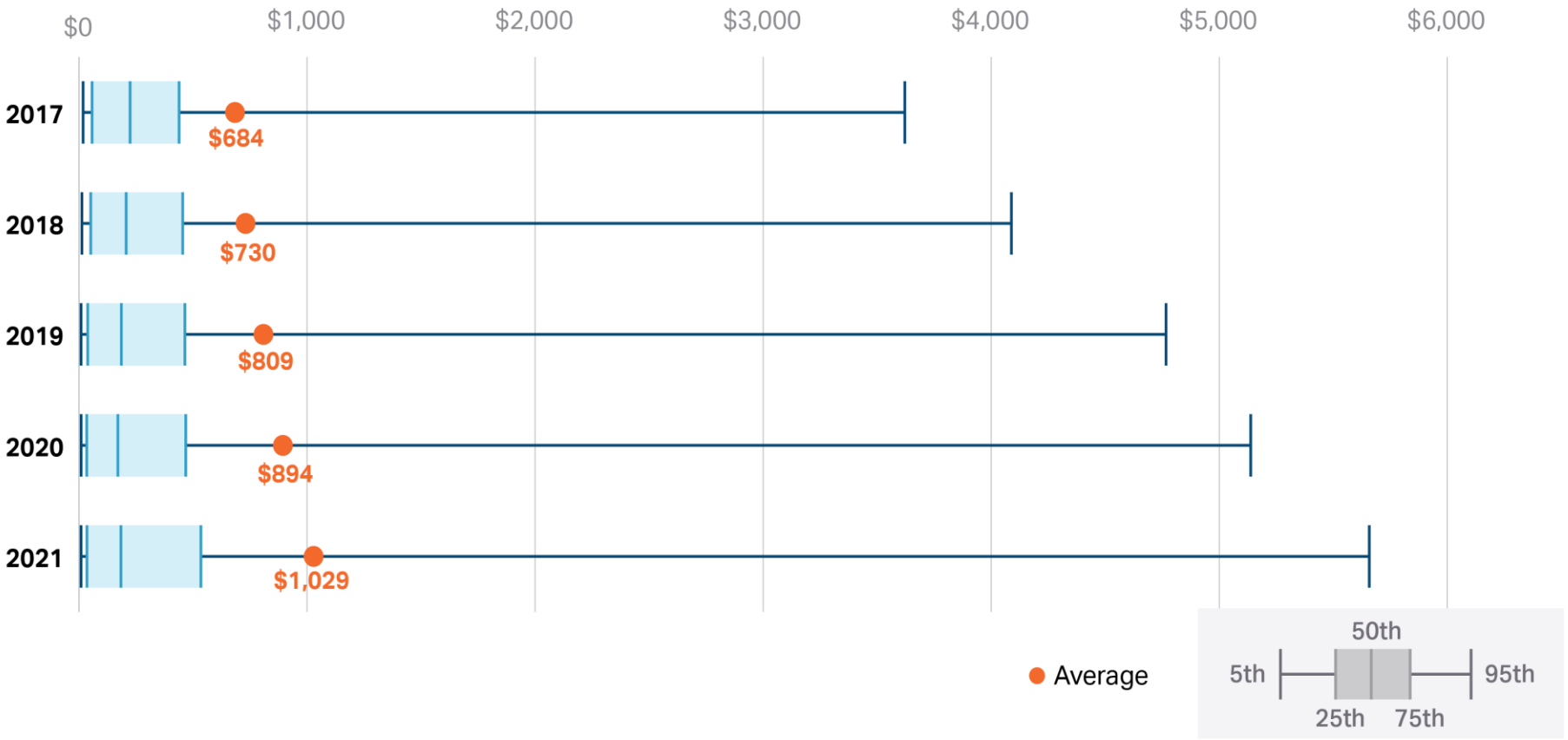
PRICE INCREASES ALSO DRIVE SPENDING GROWTH

CBO found that net prices for branded drugs increased by an average of **6.3% per year** from 2010 to 2017 in the Medicare Part D program, after removing the effects of general inflation.[4]

Sources: 1. HPC analysis of Center for Health Information and Analysis Total Medical Expenditure (TME) Data, which include commercial full claims only.
2. The Assistant Secretary for Planning and Evaluation. Sep 2022. “Trends in Prescription Drug Spending, 2016-2021.”
3. Rome, Benjamin N., Alexander C. Egilman, and Aaron S. Kesselheim. "Trends in Prescription Drug Launch Prices, 2008-2021." JAMA 327.21 (2022): 2145-2147.
4. Congressional Budget Office. Jan 19, 2022. “Prescription Drugs: Spending, Use, and Prices.”

Average commercial spending (gross) per branded prescription increased 15% in 2021 to over $1,000 per prescription, with 6% of prescriptions exceeding $5,000.

Gross spending distribution per branded prescription, 2017-2021

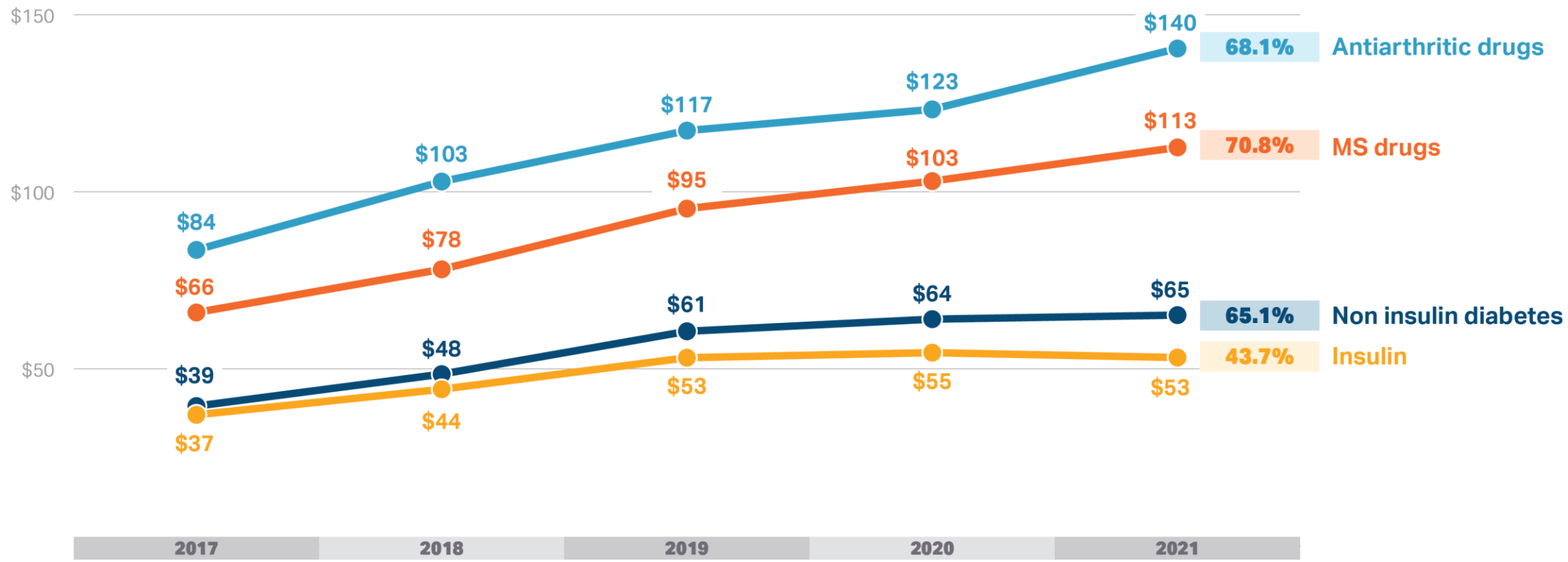


- The price of generic drugs has remained stable, with an average spending of $30 per prescription in 2017 and $31 in 2021.

Notes: Claims with implausible spending and cost-sharing values were excluded. COVID-19 vaccines were excluded from analysis in 2021.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims database, 2017-2021. Data for 4 large payers were included in the analysis.

Average out of pocket spending for a 30-day supply of prescription drugs for several common chronic conditions grew more than 60% from 2017 to 2021.

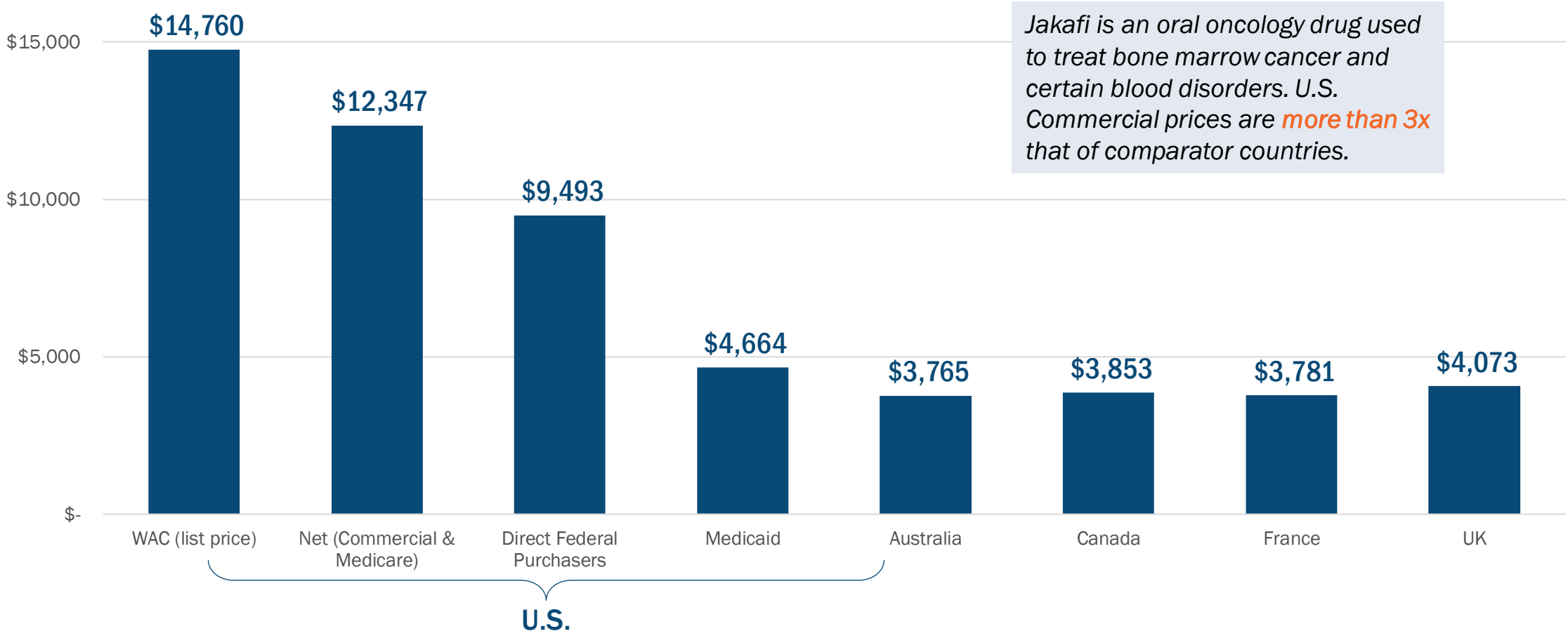
Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2017-2021



Notes: Drugs were identified based on lists or clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, American Diabetes Association, and National MS society. Clinician-administered drugs, which are typically covered under a plan's medical benefits, are excluded.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims database, 2017-2021. Data for 4 large payers were included in the analysis.

Drug Pricing Opportunity: A recent HPC examination of high cost drugs found that U.S. commercial prices are at least 3x more expensive than prices in four comparator countries.

Price for a month supply of Jakafi



Jakafi is an oral oncology drug used to treat bone marrow cancer and certain blood disorders. U.S. Commercial prices are more than 3x that of comparator countries.

Notes: All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.
Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

Primary care spending represented 7.9% of commercial spending in 2019 and 7.3% in 2020.

Market Overview

Commercial spending (full and partial) on primary care and behavioral health totaled $2.8 billion in 2020, a 2.8% decrease from 2019, driven by divergent trends in primary care and behavioral health spending. While behavioral health spending increased 9.2% from 2019 to 2020, primary care spending declined 11.2%. Among commercially-insured members for whom all claims data was available, primary care and behavioral health spending combined represented 14.3% of total health care spending in 2020.[3]

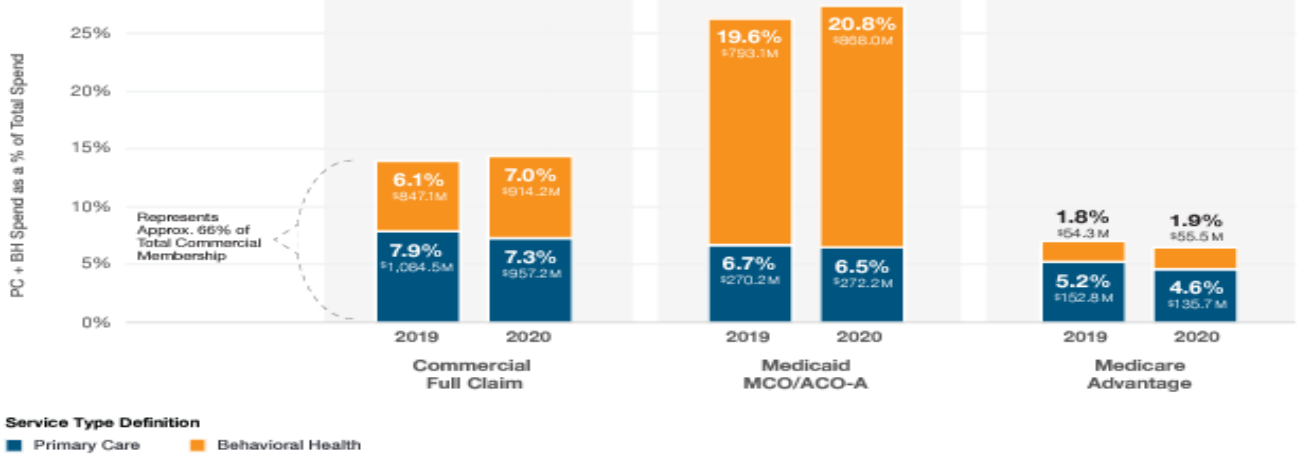
Primary care and behavioral health spending for members in Medicaid MCO/ACO-A plans comprised 27.4% of spending in 2020, totaling $1.1 billion, an increase of 7.2% from 2019. Behavioral health spending, which represented one-fifth of total Medicaid MCO/ACO-A spending, increased 9.4% while primary care spending increased 0.8%.

Medicare Advantage primary care and behavioral health spending totaled $191.2 million in 2020, a 7.7% decrease from 2019. Primary care spending decreased 11.2% while behavioral health spending increased 2.3%. In 2020, primary care and behavioral health spending represented 6.5% of all Medicare Advantage spending.

Primary Care and Behavioral Health Spending by Insurance Category

2019-2020

	COMMERCIAL FULL AND PARTIAL		MEDICAID MCO/ACO-A		MEDICARE ADVANTAGE	
	2019	2020	2019	2020	2019	2020
Member Months	39.2M	38.4M	8.1M	8.2M	2.8M	3.0M
Percent of Members with a BH diagnosis	18.0%	18.5%	26.4%	25.6%	18.1%	18.6%
Total Expenses	$19.8B	$18.7B	$4.1B	$4.2B	$2.9B	$2.9B
Total Primary Care and Behavioral Health Expenses	$2,926.0M	$2,844.9M	$1,063.3M	$1,140.2M	$207.0M	$191.2M



Service Type Definition

Primary Care Behavioral Health

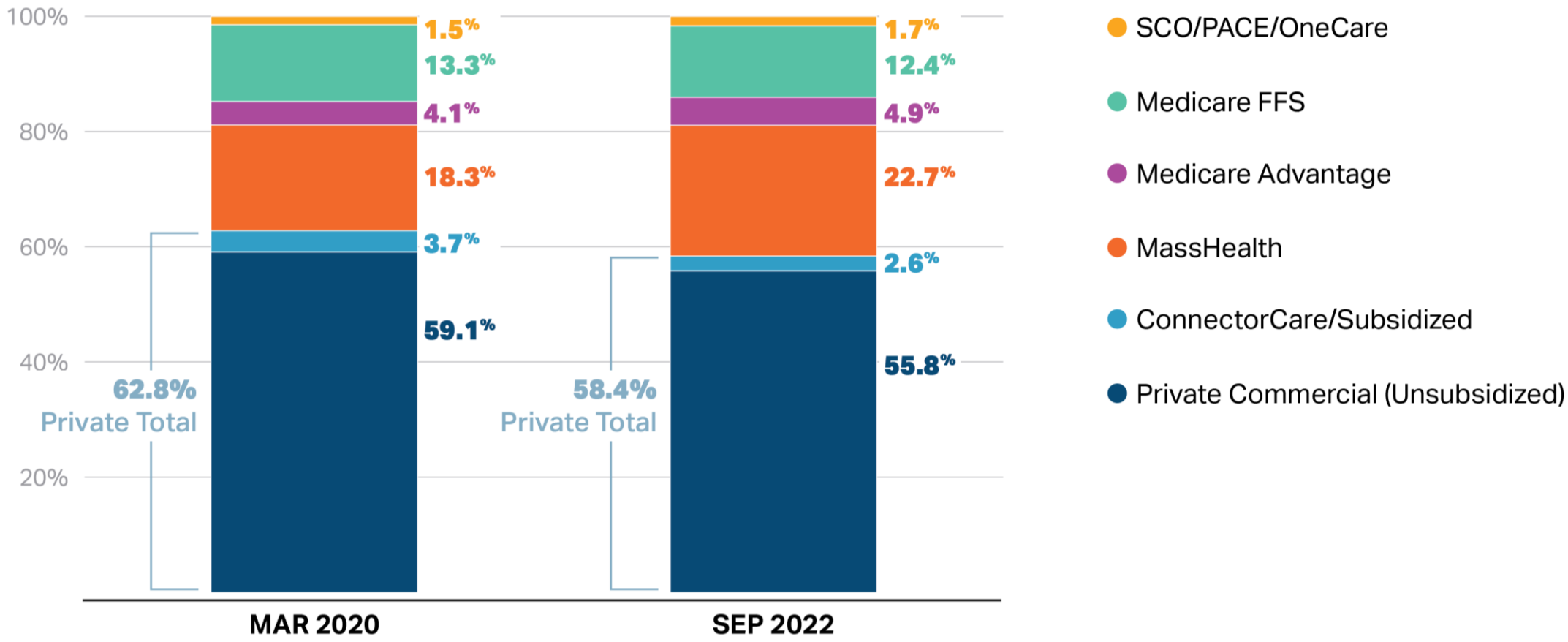
Source: Payer-reported data to CHIA.

Notes: Aetna and Cigna data were excluded due to data quality concerns. Market level totals include commercial partial data, but commercial partial data is excluded from all other analyses. Commercial market totals do not capture total commercial spending due to carved out services. Percent changes are calculated based on non-rounded expenditure amounts. Please see the databook for detailed information.

CHIA Massachusetts Primary Care and Behavioral Health Expenditures: Baseline Report September 2022. https://www.chiamass.gov/assets/docs/r/pubs/2022/PCBH-Report.pdf

The percentage of Massachusetts residents with commercial health insurance coverage declined from 62.8% to 58.4% (a drop of 300,000 residents) since March 2020.

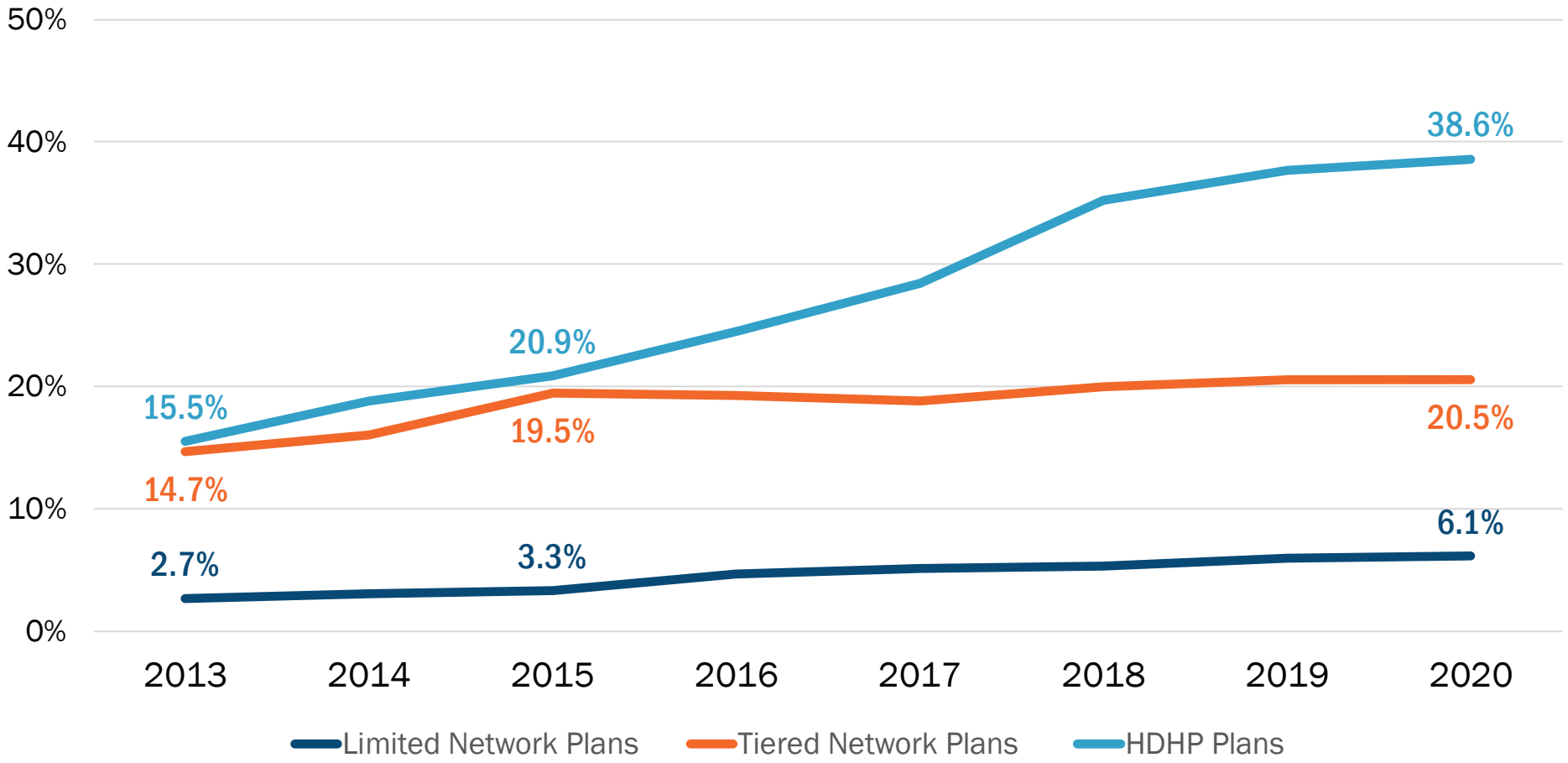
Percentage of Massachusetts residents enrolled in each primary source of coverage



Notes: Slight adjustments were made to account for the fact that the time periods shown were reported in two different data releases. March, 2022 was used as the convergence point. MassHealth includes only members with primary coverage via MassHealth.
Source: Massachusetts Center for Health Information and Analysis: Enrollment trends. https://www.chiamass.gov/enrollment-in-health-insurance/

High-deductible plans have become far more common while tiered and limited networks have remained a small share of all health plans.

Share of all Massachusetts commercial plans with each of the noted benefit design features, 2013-2020



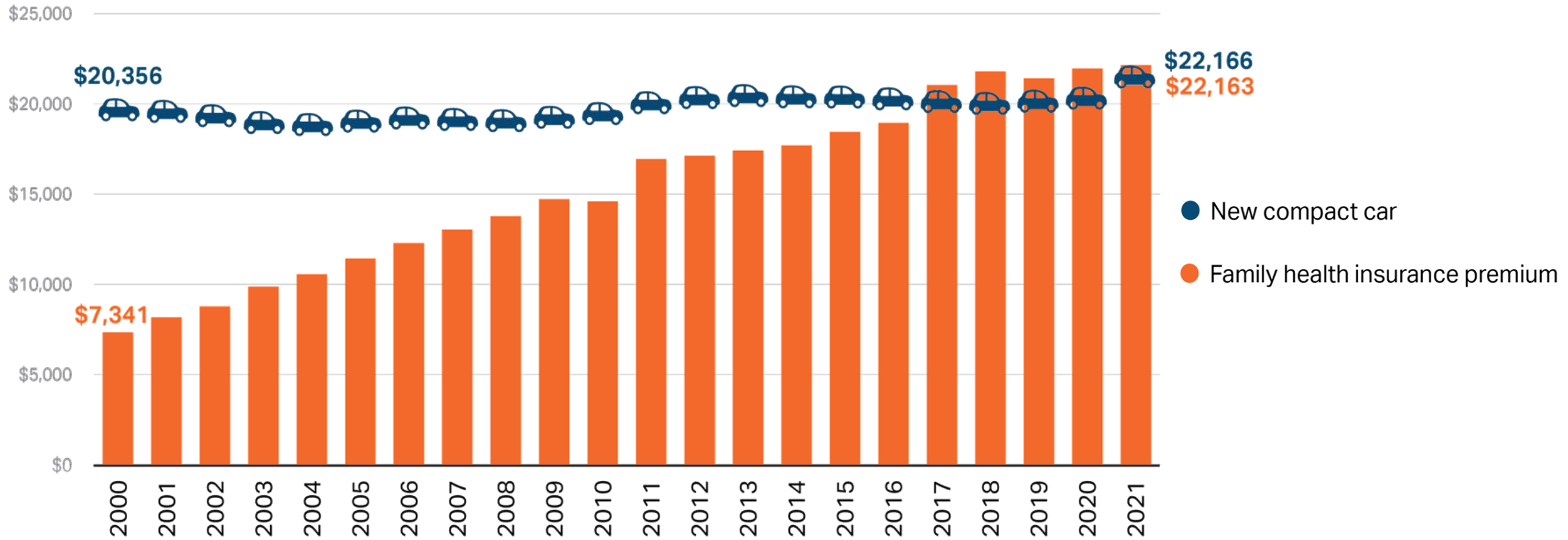
68% of small group plans in 2020 were high-deductible plans.

Notes: High deductible plans are defined federally as a plan having a single/family deductible of $1,250/$2,500 in 2013-2014; $1,300/$2,600 in 2015-7; $1,350/$2,700 in 2018-9 and $1,400/$2,800 for 2020. GIC plans all include tiered networks and do not allow high deductible plans. Excluding the GIC the 2020 percentages would be 41.5%, 14.7% and 5.8% for HDHP, Tiered, and Limited, respectively.

Source: Center for Health Information and Analysis Annual Reports, 2013-2022. Data include the Group Insurance Commission.

Family health insurance premiums in Massachusetts have increased 202% since 2000 while the price of a new compact car increased 9%.

Average Massachusetts family health insurance premium (employer and employee contribution combined) and national cost of a new compact car, 2000-2021



Notes. Data are in nominal dollars of the year shown.
Sources: Family Health Insurance premiums are for Massachusetts from the Agency for Health Care Quality – Medical Expenditure Panel Survey, Insurance Component. Car cost information is based on car-specific inflation from the BLS and the compact car price index from Kelly Blue Book. https://www.prnewswire.com/news-releases/average-new-car-prices-up-nearly-4-percent-year-over-year-for-may-2019-according-to-kelley-blue-book-300860710.html

In a 2021 survey, more than half of Massachusetts adults experienced a health care affordability burden in the past year.

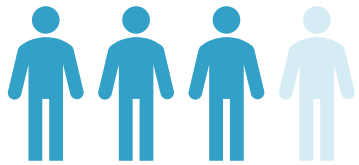
Percent of Massachusetts adults who reported the following outcomes based on survey of 1,158 Massachusetts adults, May 2021

46% of Massachusetts adults delayed or skipped care due to cost, including:

- Skipped needed dental care (27%)
- Delayed going to the doctor or having a procedure done (25%)
- Cut pills in half, skipped doses of medicine, or did not fill a prescription (22%)

Almost 10% of adults reported that due to the cost of medical bills, they:

- Were unable to pay for basic necessities like food, heat, or housing
- Used up all or most of their savings
- Were contacted by a collection agency



3 in 4 Massachusetts residents are worried about affording health care in the future.

Source: Altarum Healthcare Value Hub, Data Brief 97, September 2021," Massachusetts Residents Struggle to Afford High Healthcare Costs; Worry About Affording Care, Leading to Support for Government Actions to Address High Healthcare Costs". Data based on survey of 1,158 Massachusetts adults conducted in May 2021.

What’s next for the HPC?

HPC Agenda for Action - 2023

To kick off 2023, the HPC is pursuing an ambitious action plan to reduce health care cost growth, promote affordability, and advance equity, in addition to ongoing workstreams and responsibilities.

This comprehensive plan will prioritize disseminating data-driven insights and policy recommendations to address the critical challenges facing the health care system today: the workforce crisis, high costs, and persistent health inequities.

- **Bolster the HPC's Cost Containment Activities**
- **Address Health Care Workforce Challenges and Identify Solutions**
- **Advance Health Equity**
- **Enhance Pharmaceutical Pricing Transparency and Accountability**
- **Reduce Unnecessary Administrative Complexity**
- **Upcoming Topics of Actionable Research**

Bolstering Cost Containment Activities: The HPC recommends immediate action to improve state oversight and accountability.

- **Target Above Benchmark Spending Growth.** The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

- **Constrain Excessive Provider and Pharmaceutical Prices.** The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

- **Limit Increases in Health Insurance Premiums and Cost-Sharing.** The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

The 2022 Policy Recommendations reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity.

Contact Us

Follow-up questions?

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