Cracking the Code on Health Care Costs
Lessons Learned from the Massachusetts Model

Senator Richard T. Moore
Senate President Pro Tempore
Massachusetts Senate

NCSL Legislative Summit
Thursday, August 21, 2014
Minneapolis, Minnesota
How we got here…

Health Care Reform Part I | Chapter 58 of the Acts of 2006
How we got here…

**Massachusetts has the lowest rate of uninsurance**

**Percent uninsured, all ages**

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>13.1%</td>
<td>13.9%</td>
<td>14.9%</td>
<td>15.2%</td>
<td>14.7%</td>
<td>14.9%</td>
<td>16.1%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>

**NOTE:** The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

How we got here…

State budget comparison, FY2001 and FY2014

Source: Mass Budget & Policy Center
How we got here…

*Premiums are rising faster than inflation, while benefit levels decline*

**The Massachusetts Model**

<table>
<thead>
<tr>
<th>Year</th>
<th>Premiums</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>$421 (+9.7%)</td>
<td>0.77 (-5.1%)</td>
</tr>
</tbody>
</table>
How we got here…

- **Insurance Reforms**
  - Community Rating, Guaranteed Coverage

- **1990s**

- **2006**
  - **Ch. 58 Passed**
    - Health care reform

- **2008**
  - **Ch. 305 Passed**
    - Health care transparency and e-Health

- **2010**
  - **Ch. 288 Passed**
    - Small business health care relief

- **2012**
  - **Ch. 224 Passed**
    - Health care cost containment
The Massachusetts Model

How we got here…

Health Care Reform Part II | Chapter 224 of the Acts of 2012
Health Care Cost Growth Benchmark

- Sets a target for controlling the growth of total health care expenditures:
  - Annual increase in total health care spending not to exceed economic growth through 2017, growth minus 0.5% for next 5 years, then back to the base growth rate
  - Economic growth rate in 2013, 2014, and 2015 equals 3.6%
- If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring

<table>
<thead>
<tr>
<th>CALENDAR YEARS</th>
<th>COST GROWTH BENCHMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2017</td>
<td>Equal to the Economic Growth Rate</td>
</tr>
<tr>
<td>2018-2022</td>
<td>Equal to the Economic Growth Rate minus 0.5% (may be modified by the HPC)</td>
</tr>
<tr>
<td>2023 and beyond</td>
<td>Equal to the Economic Growth Rate (may be modified by the HPC)</td>
</tr>
</tbody>
</table>
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
  - Net cost of private health insurance

A more holistic measure of health care expenditure growth than just total medical expenditures
Key Strategies for Meeting the Benchmark

1. Transforming the way we deliver care
2. Reforming the way we pay for care
3. Developing a value-based health care market
4. Engaging purchasers through information and incentives

A more transparent, accountable health care system that ensures quality, affordable health care for Massachusetts residents
Key Provisions of Chapter 224

• Sets a benchmark to reduce future health care cost growth to the growth in the state’s overall economy.
• Promotes payment system reform by both public and private payers.
• Promotes delivery system reform to enhance the coordination of care for patients.
• Promotes prevention and wellness, including the expanded adoption of workplace wellness programs through a small business tax credit.
• Invests in the expansion of a statewide, interoperable electronic health record system for all providers.
• Increases scrutiny of health care market power and price variation.
• Supports expansion of the primary care workforce and provides key resources for workforce development and training programs.
• Provides consumers and employers with quality and cost data to inform decision-making.
• Promotes administrative efficiency.
New Implementing State Agencies

**Center for Health Information and Analysis (CHIA)**

- Data and analytics hub
- Independent state agency led by an Executive Director appointed by Governor, Auditor, and the Attorney General
- Duties include:
  - 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, MyHealthCareOptions

**Health Policy Commission (HPC)**

- Policy development hub
- Independent state agency governed by an 11-member board with diverse experience in health care
- Duties include:
  - 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
  - Support investments in community hospitals
Spending rose over last decade, but declined from 2009-2012

Personal health care expenditures* relative to size of economy

Percent of respective economy†

* Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment.
† Measured as gross domestic product (GDP) for the U.S. and gross state product (GSP) for Massachusetts
‡ CMS state-level personal health care expenditure data have only been published through 2009. 2010-2012 MA figures were estimated based on 2009-2012 expenditure data provided by CMS for Medicare, ANF budget information statements and expenditure data from MassHealth, and CHIA TME reports for commercial payers.

Source: Centers for Medicare and Medicaid Services; Bureau of Economic Analysis; Center for Health Information and Analysis; MassHealth; Census Bureau; HPC analysis
Per capita health care spending in Massachusetts is the highest of any state.

<table>
<thead>
<tr>
<th>State</th>
<th>Per capita personal health care expenditures*</th>
<th>State rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>$6,815</td>
<td>1</td>
</tr>
<tr>
<td>MA</td>
<td>$9,278</td>
<td>1</td>
</tr>
<tr>
<td>NY</td>
<td>$8,341</td>
<td>6</td>
</tr>
<tr>
<td>PA</td>
<td>$7,730</td>
<td>10</td>
</tr>
<tr>
<td>OH</td>
<td>$7,076</td>
<td>18</td>
</tr>
<tr>
<td>IL</td>
<td>$6,756</td>
<td>28</td>
</tr>
<tr>
<td>CA</td>
<td>$6,238</td>
<td>42</td>
</tr>
<tr>
<td>TX</td>
<td>$5,924</td>
<td>45</td>
</tr>
</tbody>
</table>

*Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment.

Toted 15.2 percent of the U.S. economy in 2009

Toted 16.8 percent of the Massachusetts economy in 2009
Massachusetts: $14.7 - $26.9B of wasteful spending in 2012

<table>
<thead>
<tr>
<th>Category of wasteful spending</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Overtreatment</strong></td>
<td>The delivery of unnecessary services or treatment in a care setting that is more intensive than needed</td>
</tr>
<tr>
<td>10-12%</td>
<td></td>
</tr>
<tr>
<td><strong>Failures of care delivery</strong></td>
<td>Avoidable spending resulting from care that was not delivered or from care that is delivered poorly (e.g. HAIs, ineffective preventive care)</td>
</tr>
<tr>
<td>3-4%</td>
<td></td>
</tr>
<tr>
<td><strong>Failures of care coordination</strong></td>
<td>Avoidable spending resulting from communication failures and the lack of care integration across settings (e.g. preventable readmissions)</td>
</tr>
<tr>
<td>1-2%</td>
<td></td>
</tr>
<tr>
<td><strong>Pricing failures</strong></td>
<td>Excessive levels of payment for health-care services</td>
</tr>
<tr>
<td>3-7%</td>
<td></td>
</tr>
<tr>
<td><strong>Administrative complexity</strong></td>
<td>Spending not directly associated with clinical care delivery that could be eliminated without affecting the quality of care</td>
</tr>
<tr>
<td>4-14%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21-39%</td>
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</table>
Report on the Performance of the MA Health Care System

On September 2, 2014 the Center for Health Information and Analysis (CHIA) will release its *Annual Report on the Performance of the Massachusetts Health Care System* — which will include a first-ever calculation of the Commonwealth’s Total Health Care Expenditures (THCE) along with several other key indicators.

Amongst these updates:

- **Total Health Care Expenditures**: The annual calculation of THCE will be used to monitor the rate of growth in health care spending and measure the Commonwealth's progress toward meeting its health care cost growth benchmark.

- **Total Medical Expenses (TME)**: TME represents the full amount paid to providers for health care services delivered to a payer’s covered member population (payer and member cost–sharing payments combined).

- **Alternative Payment Methods (APM)**: APM refers to methods of payment that are not solely based on fee-for-service reimbursements. Alternative payment methods include global payments, bundled payments, capitation payments, and other non-fee-for-service based payments.

- **Quality**: CHIA monitors acute hospital and primary care provider group performance on quality measures drawn from the Standard Quality Measure Set, including outcome, patient safety, process and effectiveness, and patient experience measures.
Questions?

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