Slide 1 of presentation:

**Presentation to the Health Policy Commission**2013 Cost Trends Hearings  
October 1, 2013

***Text for slide 1:***  
Good morning, my name is Aron Boros and I'm the Executive Director of CHIA -- the Massachusetts Center for Health Information and Analysis. I've been given the privilege of speaking to you about our annual report on the Massachusetts healthcare market, and by doing so to **kick off two packed days of information, ideas, and questions**. I’d be happy to take questions during the presentation, and we should also have time for a conversation about CHIA’s findings and the larger work of cost containment at the end.

CHIA was established as an independent state agency by last summer’s landmark health care cost containment bill, chapter 224. CHIA’s mission is to **monitor** the Massachusetts healthcare system and to provide **reliable information** and **meaningful analysis** for those seeking to improve healthcare **quality, affordability, access, and outcomes**.

CHIA is not a regulatory agency. Like our name says, we are focused on information and analysis.

To achieve our mission, we have three critical assets:

first, our **unique data assets** including comprehensive expenditure, cost, and other market data from Massachusetts healthcare payers and providers; this includes the all payer claims database, our hospital discharge database, and a variety of other data sets.

Our second critical asset is our **independent perspective**. We are an independent state agency. We take that independence very seriously. It allows us to provide a foundation of reliable information that others – including the administration, the attorney general’s office, and the office of the state auditor – can use to engage in complex policy discussions. Our independence allows us to focus on being reliable and objective in support of the broader public good.

Finally, our third critical asset is our **extraordinary staff**. We are experts in our own data sets, and turning those data into information.

Our **vision** is to apply these assets in pursuit of our mission to be a hub for health care data and analytics in the Commonwealth. We work with a **wide variety of users**, many of whom are here today.

* other state agencies,
* providers like hospitals and physician groups,
* payers in the public and commercial sectors,
* researchers throughout Massachusetts and throughout the country,
* the Patrick administration,
* the legislature,
* The attorney general’s office and the state auditor’s office, and
* individual consumers throughout Massachusetts.

Of particular relevance today, CHIA works very closely with the **health policy commission**. One way of thinking about our respective roles is that CHIA is focused on describing the way the world is, while health policy commission is charged with thinking about how the world should be. Our recent work is testament to this relationship. In August, CHIA published our **Annual Report on the Massachusetts Health Care Market**. That report is part of the foundation upon which today's hearings are built. And CHIA continues to work with the commission on their ongoing project of market oversight and regulation, including the development of their own annual report this winter.

Everyone should have in your materials a one-page overview of our annual report. However there's much more to discover in the full report. You can download a PDF on our website: mass.gov/CHIA. Or e-mail us, and we will send you a printed copy

Today, rather than overwhelm you with the rich detail of that report, I'm instead going to offer **two questions and four numbers.** I hope that these data will be compact enough for the margins of your program, but thought-provoking enough to sustain you through two days of hearings.

Slide 2 of presentation:

**Can I measure it?**

***Text for slide 2:***

First, **"how can I measure this?"** Of course measurement is my job and CHIA’s mission. So I have a particular interest in this question. But I suggest that it's a valuable question for everybody here today, because **what gets measured gets done**. Measurement is perhaps the best way to create accountability. Moreover, **objective measurement** - that is, measurement performed or verified by an objective third-party -- gives us **common ground** to have challenging discussions and to make difficult choices. This common ground is critical. Over the next two days, you will hear many assertions about challenges, efforts and progress from a variety of witnesses. I'll be asking how those assertions can be measured I hope that you will too.

Slide 3 of presentation:

**Compared to what?**

***Text for slide 3:***

My second question is **"what should I compare this to?"** I mentioned earlier that my agency is in the business of turning data into information. The most fundamental way this happens is by providing **comparisons and context**.

Those comparisons might be to national benchmarks or to peer benchmarks within Massachusetts. Sometimes they are self-benchmarks – comparing improvement over time – and sometimes they're just common sense benchmarks. Whatever the measure, I'll be asking questions about how to put data into context to make those numbers more meaningful.

So, two questions that you’ll hear me asking witnesses: “how can I measure that?” and “what should I compare it to?” Hopefully the answers aren’t helpful only to CHIA, but also to all of you.

So with that preview of the questions I'll be asking, I'd like to **kick off the numbers portion of the agenda**.

For each of the four sessions today and tomorrow, I’ve selected a single statistic to add some flavor or context for what you’ll be hearing, and maybe provoke some questions of your own.

The first panel coming up after my remarks is: **Meeting The Benchmark: Achieving Sustainable Health Care Cost Growth In Massachusetts**

As you've already heard, the benchmark is how the Commonwealth will be measuring its success in cost containment. The target growth rate will be compared to the actual measured growth in total health care expenditures. **Next year**, my agency is responsible for calculating and publishing the total health care expenditures in Massachusetts. But we haven't done that yet, so I want to start with a different number.

Slide 4 of presentation:

**Meeting The Benchmark: Achieving Sustainable Health Care Cost Growth In Massachusetts**

**“Three quarters of hospitals and doctors”**

***Text for slide 4:***

**Three-quarters**. That's the fraction of all health care expenditures in the commercial market that are paid to hospitals and doctors. **Everything else** – drugs and devices, lab work, imaging, CHCs, ASCs – make up only one quarter.

Not only that, but between 2010 and 2011, hospital and physician expenditures are growing faster than other expenditures. This means that not only are hospitals and physicians driving expenditure growth, but they are also becoming a larger and larger part of the overall healthcare pot. So, it's worth keeping this fraction in mind while you identify opportunities for cost containment in the next two days and in the next several years.

Slide 5 of presentation

**Transforming The Delivery System: Promoting Accountable, High Quality Care**

**“Thirty Five Percent of commercial insurance enrollees’ care was coordinated by a physician group that was paid using a global budget method. ”**

***Text for slide 5:***

This afternoon, I suggest you hold the number 35% in your head. This afternoon’s panel is titled **Transforming The Delivery System: Promoting Accountable, High Quality Care**

One way or another nearly everyone in Massachusetts is focused on transforming the delivery system. For its part, in chapter 224, the legislature promoted the adoption of alternative payment arrangements, including global budgets, which brings me to 35%. **In Massachusetts, 35% of patients in commercial health plans have primary care providers who are accountable for a global budget.**

Global budgets are alternative payment arrangements that make a provider accountable for all of the costs of health care services received by their patients, even if that care is delivered elsewhere, by other providers. These contracts are generally held by primary care provider organizations for a panel of patients. If the total cost of care for that panel exceeds the global budget these provider organizations generally have some financial accountability for that excess spending. Alternatively if the total cost of care for the panel is less than the budget, the organization might share in some of the savings. Global budgets create incentives for primary care providers to seek efficient ways to deliver high-quality care.

So 35% of patients in commercial health plans have primary care providers who are accountable for a global budget. **Massachusetts is a clear national leader** in the implementation of these kinds of alternative payment methodologies. The work we're doing here is a model for nearly every other state. However, there are **two points** that I’d like to make about that 35%.

The first is that **fee-for-service payments** – which are often described as rewarding volume over value – are still predominant, even here. While we’re a national leader in alternative payment methodologies, nearly two thirds of patients are still navigating a healthcare system with traditional fee-for-service incentives.

Moreover, *primary care* provider groups who are generally accountable to the global budget, not specialists or hospitals. In many cases, even if a primary care provider has the incentives of a global budget, other providers retain individual fee-for-service incentives based on their own compensation or contracting. Which leads me to my **second point**:

**35% may over-estimate the impact of these methodologies on actual care delivery.** This stems from a few reasons. To begin with, it’s unclear **how much a primary care provider can do** to manage the totality of care to a global budget, when most of the dollars go to other kinds of providers (especially hospitals and specialists). In some cases, there are tight relationships between the PCP, the patient, and their other treatment and care. However in others, the PCP may have relatively little influence on the patient’s choices.

The strength of the Primary care provider’s role is probably **highest in HMO plans**, where a PCP referral is often necessary for seeking additional care. In fact, today global budget arrangements are found **only** in these kinds of managed care plans. Both CHIA and the Attorney General found that enrollment in such HMO plans is declining, which again suggests that we should treat the 35% with cautious optimism.

Finally, this 35% figure **doesn’t characterize how *big*** the new incentives are for the managing provider. Some contracts in that 35% may be full capitation, full risk contracts where the physician group really bears full responsibility for the total cost of care. That is, if spending exceeds the budget, the provider is liable for the total cost.

However, in other situations, a provider group may have significant risk corridors which limit its financial exposure, and thus reducing the size of the incentive to focus on value-based care. In fact, earlier this year the Atty. Gen. looked at the **complexity of these contracting arrangements** and found that there is no one standard global budget contract, and that the complexity – and heterogeneity – of these contracts poses a real challenge for both providers, insurers, and policymakers.

So, to summarize: finding that 35% of patients are associated with global budget contracts is an exciting development, and puts Massachusetts in a leadership position with respect to payment reform, but much of the story remains to be told as we evaluate how these contracts actually influence the delivery of care.

Slide 6 of presentation:

**Evaluating Market Structure: Measuring Impact On Cost, Quality, And Access**

**“Forty Five Percent :**

* **BCBS Share of the commercial insurance market.**
* **Share of physician payments to the three biggest physician groups”**

***Text for slide 6:***

Tomorrow morning's panel is titled, **Evaluating Market Structure: Measuring Impact on Cost, Quality, and Access**. For that panel I’ll use one number that does double duty.

Forty-five percent.

45% is a convenient number that gives you a benchmark for concentration in the commercial insurer market as well as an indication of the concentration in the provider market.

On the insurer side, **45% of commercial plan enrollees are Blue Cross** Blue Shield subscribers. Add in Harvard Pilgrim and Tufts, and you capture 80% of commercial plan enrollees.

On the provider side let's talk about concentration in physician payments. **45% of all commercial payments that went to physicians went to one of the top three systems**: Partners, Atrius, and CareGroup. You may not be familiar with CareGroup, which includes two large physician groups: Mount Auburn’s MACIPA physician group and Beth Israel’s BIDPO physician group).

By the way, while this 45% figure is drawn from our analysis of physician groups, we see **similar concentration if you look at hospital** payments.)

So, what do you need to know about these **two sides of the 45% coin**?

On the insurer side, I'll note that despite its size, Blue Cross Blue Shield has some of the **highest premiums** in Massachusetts, and reports some of the **highest total medical expenditures** as well. These figures are unadjusted, so demographics and benefit design may be part of the story, but **we have no evidence** that Blue Cross is able to use its size to drive premiums or expenditures down in a significant way.

On the provider side I'll note that in Blue Cross' network, Partners and Atrius commanded some of the highest prices. But we know that we have to look beyond prices to **evaluate the total efficiency of care on a health status adjusted basis.**

What do I mean by that? Our relative price report shows that we have **wide variation in prices** between different providers in Massachusetts for a standard package of services. This has been widely reported already. However, **price variation might be appropriate or even desirable** if high price providers are delivering high value care as part of a comprehensive treatment approach. This is the idea that patient is seeking the right care at the right place at the right time in a way that the total cost of care is actually reduced. So instead of just looking at prices we also have to look at total medical expenditures for the patients associated with those physician groups. What do we see when we look at total medical expenditures?

Unfortunately, we find that **the three most expensive physician groups in Blue Cross’s network were CareGroups’ MACIPA, Atrius, and PCHI, the partners physician group.** Those three big physician groups end up on the top of the list based on Health Status Adjusted Total Medical Expenditure, not just price.

So market concentration seems to be associated with higher prices AND higher overall expenditures. This is something I’m looking forward to hearing more about tomorrow.

Finally, the fourth panel, tomorrow afternoon, is **Empowering Purchasers: Advancing Transparency, Information, and Incentives**

The part of our Annual Report that’s most relevant to individual purchasers and their incentives is our premiums investigation.

Slide 7 of presentation:

**Empowering Purchasers: Advancing Transparency, Information, And Incentives**

**“Two times (multiplication sign) :**

**Between 2009 and 2011, premiums increased about twice the rate of general inflation, even while cost sharing also grew.**

***Text for slide 7:***

**We found that between 2009 and 2011 premiums grew at twice the rate of overall inflation.** The good news is that as the Gov. noted, more recent premium data seems to be trending down. The bad news is that these higher premiums in 2011 also reflected benefit packages with greater cost sharing – that is, higher deductibles and copayments.

Now, increased cost sharing **pleases my inner economist**; cost sharing gives individual patients a reason to make value-based choices that are driven by considerations of efficiency. Just like a global budget gives a primary care provider an incentive to consider value in treatment and referral decisions. Without meaningful cost sharing patients may lack the right incentives to seek high-value care. So that seems like a good thing.

However, in**creased cost sharing raises warning signs for my inner advocate**. By design, cost sharing affects patients seeking more care to a greater extent. And of course patients seeking more care tend to be sicker patients. So cost-sharing also has the effect of shifting healthcare costs to the sickest patients, an effect we may wish to consider or avoid.

So there are four numbers for four presentations over the next two days. Hopefully those help illuminate the conversation without confusing you or overloading you too many figures.

Before I pass the microphone on, let me talk a little bit about what is next.

Slide 8 of presentation:

**Coming Soon: Total Health Care Expenditures**

* **December 2013: Methodology White Paper**
* **August 2014: CHIA’s Annual Report**

***Text for slide 8:***

**Total health care expenditures.**

The calculation of total health care expenditures represents a novel attempt to capture all medical expenditures in the Commonwealth on an annual basis. The health policy commission will compare annual growth of total health care expenditures to the cost containment benchmark in order to evaluate our success in controlling cost growth over the coming years.

**Nobody has ever tried measuring total expenditures for this purpose before.** Over the next year, CHIA will be using specific data from public and private healthcare payers to put a hard number on the total number of payments to providers for health care services in Massachusetts, as well as the administrative cost of private insurance. Prior to this effort, reports of total expenditures have relied on small samples, survey information, and other estimates. While these reports are valuable, and in fact the commission staff will be using some of them later today, **they do not meet the two-part standard CHIA has set out for itself.**

First, the data we use for Total Health Care Expenditures needs to be **accurate at multiple levels**: to support statewide aggregate reporting and ‘micro’ investigations at the level of regions, payers, and certain providers.

Second, the data needs to be **‘actionable’** in that there is enough **information and context** to inform policy-making throughout the commonwealth. Existing data sources and approaches aren’t up to the task in either respect.

This effort wouldn't even be possible, if it weren't for the sustained leadership of the Gov., the Legislature, and the attorney general’s office in expanding health care price and cost transparency in the Commonwealth over the last 6 years. CHIA will be building on the foundation of relative price, total medical expenditure, the all payer claims database, and the cost trends reports and hearings to deliver a single number by which our success in cost containment will be measured.

I also need to acknowledge the **support and commitment of the Massachusetts carriers**. At CHIA we affectionately refer to the carriers that make up 99% of the commercial market as the “sweet sixteen.” These carriers have been committed to price transparency and the broader efforts of health care reform for many years, and their support has been critical to our continued efforts. Many of you are in the audience today. Thank you. Other states – not to mention our friends in Washington – would be lucky to have our sense of **shared responsibility.**

Measuring total health care expenditures will allow us to have an **objective anchor** for discussions that promise to be challenging. These will be discussions about cost growth, cost containment, and the pressures of healthcare on the Massachusetts economy. And also discussions about what to do about it – whether **through voluntary action** of providers and payers, or through **oversight and regulation** by the Commission and other state agencies.

In the next few months, we will be publishing our preliminary Total Health Care Expenditures methodology, and providing opportunity for public comment. Next August, CHIA is going to publish the **official Total Health Care Expenditures figures for 2012 and 2013** in our Annual Report.

When we do that, you'll be able to see how fast health care expenditures have been growing in the Commonwealth. Perhaps just as importantly, CHIA is calculating this number in a way that will allow us to better understand the drivers of health care costs. This will **empower the Health Policy Commission** and other private and public policymakers to take the steps necessary to contain costs successfully in the years to come.

With that, I will thank the commission for inviting me today, and offer to answer any questions the commissioners might have.

 Center for Health Information and Analysis Website: <http://www.mass.gov/CHIA>