Health Care Spending in Massachusetts: Is It a Crisis or Is It Critical?

Sarah Iselin

May 12, 2011
The mission continues to be relevant today

“To expand access to health care for low-income and vulnerable residents of Massachusetts”
Over the past year, we’ve assessed our work and developed a focused plan for the future

Mission: Expand access to care for low-income and vulnerable residents of MA

Expand access to coverage

Coverage
Maintain and further strengthen coverage gains for low-income and vulnerable populations

Eliminate barriers to care

Affordability
Maintain health reform progress and ensure sustainable access to healthcare for low-income and vulnerable populations by addressing affordability issues

Other initiatives (e.g. current and new programs)
We will pursue a two-pronged approach to our policy work addressing affordability:

1. **Making the case for change**
   - Commission targeted research to deepen understanding of problem, especially impact on low-income and vulnerable populations
   - Communicate data and information about the affordability issue in a digestible way

2. **Advancing/supporting the conversation on solutions**
   - Shine a light on replicable models and innovations, locally and nationally, and broaden conversation to include ideas not currently on the radar
We will also create a new affordability-related grantmaking program area

**Examples of what we might fund**

- Integrated care models in preparation for bundled payments / ACOs
- Case management models to reduce readmission rates
- Technical assistance for developing palliative care models
- Testing of cost-efficient care models in new/different settings

**Based on the experience of other funders, we will likely go broader in our RFP in the first year and then refine grant guidelines as we learn about the most promising approaches**
MASSACHUSETTS NOW HAS THE LOWEST RATE OF UNINSURANCE IN THE COUNTRY

PERCENT UNINSURED, 2000–2010, ALL AGES

NOTE: As of 2008, the state contracted with a new vendor (Urban Institute) to track insurance coverage rates in Massachusetts. The Urban Institute implemented methodological changes to the tracking survey which may affect comparability of the 2008, 2009, and 2010 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.

... but the highest health care spending per person in the world...
and per person health care spending is projected to nearly double by 2020.

Note: The health expenditures are defined by residence location and as personal health expenditures by CMS, which exclude expenditures on administration, public health, and construction. Data for 2005 – 2020 are projected assuming 7.4% growth through 2010 and then 5.7% growth through 2020.

July 7, 2010

The Massachusetts Health Care ‘Train Wreck’

The future of ObamaCare is unfolding here: runaway spending, price controls, even limits on care and medical licensing.
Addressing costs is critical to maintaining gains in coverage.

Public program expansion accounts for most of the newly insured since reform... and public budget pressures have led to coverage cuts.

Total additional insured = 401,000
Change from June 2006 – June 2010

- CommCare 38%
- MassHealth 41%
- Individual 21%

Source: DHCFP. Key Indicators Report 2010; The Boston Globe
When incomes are flat, rising medical costs consume a greater share, leaving less for other needs

Premiums are growing faster than wages and the economy

Single Health Insurance Premiums in MA, 1996-2008

Employer Contributions to Health Insurance
Percent of Individual and Family Premiums

From 2007 to 2009, employers’ percentage contributions to individual and family health insurance premiums declined in Massachusetts, with contributions toward family premiums declining by 7 percentage points. Nationally, employers contributed higher percentages toward individual and family premiums in 2009 (83% and 73%, respectively).

Note: Data reflect medians.
For further information on the 2009 Employer Survey Report, visit www.mass.gov/dhcfp and follow the “Publications and Analyses” link.
Cost remains a significant barrier to care for many Massachusetts residents

Source: Urban Institute, BCBSMA Foundation 2009
The more we spend on health care, the less we have for other things

State Budget FY 2001 vs. FY 2011

+$4.2 B (+37%)

-$4.8 Billion (-19%)

-34%  -26%  -16%

-24%  -13%  -10%

Health Care  Medicaid/HCR  State Ees  Public Health  Mental Health  Education  Infra/Housing  Human Services  Local Aid  Public Safety
Though the quality of Massachusetts health care is among the best in the U.S., even we can improve.

Research on health care in Massachusetts highlights the problems of preventable illness and insufficient emphasis on primary and preventive care.

- Fewer than half of all adults over age 50 receive recommended preventive and screening care.*
- Fewer than half of adult diabetics receive recommended preventive care.*
- Nearly half of emergency department visits are potentially preventable.**
- 8 percent of hospitalizations and 7-10 percent of readmissions could have been avoidable with effective ambulatory care.**

* Cantor et al. 2007
** DHCFP, MA Health System Data Reference 2009
Everyone’s thinking about how to address costs

We should combine screening...

... with annual physical exams.

So we could provide security...

... while holding down health costs.
But nobody really knows how to solve the affordability problem.

“And, in our continuing effort to minimize surgical costs, I'll be hitting you over the head and tearing you open with my bare hands.”

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# Key affordability/cost-related developments in MA

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
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| 2006 | - Chapter 58 passes  
- Begins path to near universal coverage  
- MA Healthcare Quality and Cost Council forms |
| 2007 | - Much of Chapter 58 enacted, e.g.:  
- MassHealth expansion  
- Commonwealth Care  
- Consumer affordability schedule  
- New health plan options for young adults  
- Employer Fair Share |
| 2008 | - Chapter 305 passes  
- Increased transparency about cost drivers  
- Reports on health insurer and hospital "reserves"  
- MassHealth expansion  
- Commonwealth Care  
- Consumer affordability schedule  
- New health plan options for young adults  
- Employer Fair Share |
| 2009 | - Special Commission on Payment Reform  
- Recommends move to global payment  
- QCC Roadmap to Cost Containment released  
- Patient Centered Medical Home Initiative begins |
| 2010 | - DHCFP and AG reports on healthcare cost drivers released  
- Public hearings on healthcare costs held  
- Chapter 288 passes  
- Aims to control premiums for small business, individuals |

2011  
Governor Patrick files payment reform legislation
“How effective do you think each of the following policy strategies would be in improving U.S. health system performance (improving quality and/or reducing costs)?”

- **Fundamental provider payment reform with broader incentives to provide high-quality and efficient care over time**: 85%
  - Very effective: 45%
  - Effective: 40%
- **Bonus payments for high-quality providers and/or efficient providers**: 55%
  - Very effective: 14%
  - Effective: 41%
- **Public reporting of information on provider quality and efficiency**: 53%
  - Very effective: 18%
  - Effective: 35%
- **Incentives for patients to choose high-quality, efficient providers**: 42%
  - Very effective: 15%
  - Effective: 27%
- **Increased competition among health care providers**: 28%
  - Very effective: 10%
  - Effective: 18%
- **Increased government regulation of providers**: 25%
  - Very effective: 9%
  - Effective: 16%
- **More consumer cost-sharing**: 19%
  - Very effective: 5%
  - Effective: 14%

Providers are paid for each service they produce.

- **Incentives for increased volume.** Providers have a financial incentive to increase the number of services they produce.

- **Incentives to deliver more costly services.** Providers have a financial incentive to deliver services with higher financial margins – often more costly services.

- **Little or no incentive for achieving positive results or for care coordination.** Providers have no financial incentive to deliver the most effective care or to coordinate care.

- **Little or no incentive to deliver preventive services and or other services with low financial margins.** Providers have little incentive to provide services with low financial margins—including preventive care and behavioral health care.
Special Commission’s Recommendation

Current Fee-for-Service Payment System

The Problem
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.

Patient-Centered Global Payment System

The Solution
Global payments made to a group of providers for all care. Providers are not rewarded for delivering more care, but for delivering the right care to meet patient’s needs.

Government, payers and providers will share responsibility for providing infrastructure, legal and technical support to providers in making this transition.
DHCFP commissioned RAND to estimate potential savings from a variety of solutions.

Projected savings as a share of spending 2010-2020

<table>
<thead>
<tr>
<th>Solution</th>
<th>Savings 2010-2020</th>
<th>Savings 2020</th>
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<tbody>
<tr>
<td>Utilize bundled payment</td>
<td>-5.9%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Institute hospital all-payer rate setting</td>
<td>-4.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Institute regulation for academic medical centers</td>
<td>-2.7%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Eliminate payment for adverse hospital events</td>
<td>-1.8%</td>
<td>-1.1%</td>
</tr>
<tr>
<td>Increase adoption of HIT</td>
<td>-1.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Institute reference pricing for academic medical centers</td>
<td>-1.3%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Expand scope of practice for NPs and PAs</td>
<td>-1.3%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Promote growth of retail clinics</td>
<td>-0.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Create medical homes</td>
<td>-0.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Decrease resource use at end of life</td>
<td>-0.2%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Encourage value-based insurance design</td>
<td>-0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Increase use of disease management</td>
<td>-0.1%</td>
<td>1.0%</td>
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AG Report: Price increases driving most of the increase in health care costs

Notes:
1) Reflects fully-insured commercial trend.
2) “Unit price” reflects increases in provider rates. “Provider Mix and Service Mix” reflect changes in the location of care (shift to more expensive providers) and the intensity of services provided. “Utilization” reflects increases in the number or units of services provided.
AG Report: Variation in Hospital Prices

Attorney General Report Findings

- Payment differences are *not* correlated to quality, sickness of patients, payer mix, teaching status, or underlying costs.
- Payment differences *are* related to market leverage/negotiating power.
- Higher priced hospitals are gaining market share at the expense of lower priced hospitals.
Massachusetts Hospital Association Ad Campaign

WANTED

...fair payment from government before we all reach the end of our rope.
Governor Patrick using Division of Insurance authority to disapprove premium increases

The Boston Globe

TUESDAY, APRIL 6, 2010

Health insurers sue to raise rates

Say state's veto will cause huge losses

Showdown near on regulatory power

By Robert Weisman

A half-dozen health insurers yesterday filed a lawsuit against the state seeking to reverse last week's decision by the insurance commissioner to block double-digit premium increases — a ruling they say could leave them with hundreds of millions in losses this year.

The proposed rate hikes would have taken effect April 1 for plans covering thousands of small businesses and individuals. Insurers wanted to raise base rates an average of 8 percent to 32 percent, tacked on to that are often additional costs calculated according to factors such as the size and age of the workforce.

Yesterday's legal action sets the stage for a showdown between state regulators and the health insurance industry.

Governor Deval Patrick has made reforming health care costs a centerpiece of his administration and his campaign for reelection — sounding they are stifling the capacity of small businesses to create jobs. At the same time, health insurers argue that government is forcing them to sell policies at a loss that is unsustainable as the costs of medical services climb.

Filing the suit were Blue Cross and Blue Shield of Massachusetts, the state's largest health insurer, and the five commercial members of the Massachusetts Association of Health Plans: Harvard Pilgrim Health Care, Tufts Health Plan, Fallon Community Health Plan, Health New England, and Neighborhood Health Insurers.
Current affordability/cost-related initiatives in MA

While we have some good data & reports about costs, we still lack a broad-based coalition that can drive change.
Affordability is, and will be, the health care issue for the next few years.

Massachusetts has made health care “universally accessible, but not yet universally affordable...Massachusetts led the nation on health care reform and is poised to lead again on cost containment.”

-Governor Deval Patrick

“...I think more immediately the issues of the health care debate and the budget really are going to require our attention”

-House Speaker Robert A. DeLeo

“A careful, phased-in transition of this system-wide reform [removing fee-for-service within 5 years] is achievable. But we need to take the first step this year.”

-Senate President Therese Murray